



BROOKVILLE HOSPITAL

THE JOURNEY TO MEANINGFUL USE

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Discussion

- Critical Access Hospital
- Brookville Hospital
- Meaningful use
- Challenges
- Benefits
- Results

Critical Access Hospital

- Legislation enacted as part of BBA of 1997
- Be located in a state that has a Flex Program
- Rural Area location or treated as Rural Area
- 24-hour Emergency Services
- Provide no more than 25 Inpatient Beds
- Distinct Part Units
- Average Annual Length of Stay of 96 hours or less
- 35 miles from nearest hospital, 15 miles if mountainous area or only secondary roads or prior to January 1, 2006 were State certified as a “necessary provider” of health care services to residents of the area.

Critical Access Hospital

- Payment...
 - Inpatient and Outpatient payments for services to Medicare beneficiaries made on the basis of reasonable cost.
 - Not subject to the IPPS or OPPS Prospective Payment Systems

Brookville Hospital Statistics.....

SERVICES.....

- 25 bed inpatient unit
 - Admissions include acute medical and surgical patients
 - Swingbed patients
 - Pediatric patients over the age of 12
 - Telemetry monitoring capabilities
 - 2 higher acuity beds to manage patients needing short term ventilator support or certain IV medications.
 - Average Daily Census of 11
 - Hospitalist Program

Brookville Hospital Statistics.....

- 10 Bed Distinct Part Unit.....Geropsychiatry
 - Average daily census of 8
 - Patients who are 55 years of age or older

- Emergency Department
 - Approximately 10,000 visits per year

- Surgical Services
- Pain Clinic
- Outpatient Services
- Rural Health Clinic

Brookville Hospital Statistics.....

FINANCES.....FY Ending June 30, 2011

Budget Line	Without Meaningful Use	With Meaningful Use	Anticipated MU Dollars
REVENUE	\$25,327,687	\$27,636,687	\$2,309,000
EXPENSE	\$27,527,783	\$27,527,783	
GAIN/LOSS FROM OPERATIONS	(\$2,200,096)	\$108,904	
MA CAH REIMBURSEMENT	\$1,013,425	\$1,013,425	
NET GAIN/LOSS	(\$1,186,671)	\$1,122,329	



MEANINGFUL USE

**THE CARROT AND THE
STICK**

Staging Methodology

- First payment year
 - 90 day consecutive period
- 2013 is latest attainment year to receive full incentive
- Changes/Clarifications
 - Allow for two years to stage 2 if start in 2013
 - Delay in determining level set stage requirements for 2015
 - Subsequent year attainment
 - Medicare – Forfeit payment
 - Medicaid – Skip payment year
- Attestation
 - Submission to CMS for attestation begins January 2011
 - First date to attest April, 2011
 - Expected first payments mid-May 2011

First Payment Year	Payment Year					
	2011	2012	2013	2014	2015	2016
2011	Stage 1 (100%)	Stage 1 (75%)	Stage 2 (50%)	Stage 2 (25%)	TBD	TBD
2012		Stage 1 (100%)	Stage 1 (75%)	Stage 2 (50%)	TBD (25%)	TBD
2013			Stage 1 (100%)	Stage 1 (75%)	TBD (50%)	TBD (25%)
2014				Stage 1 (75%)	TBD (50%)	TBD (25%)
2015+*					TBD (50%)	TBD (25%)

“Please note that nothing in this discussion limits us to proposed changes to meaningful use beyond stage 3 through future rule making.”

What this means for CAHs...

- Eligible for 4 years of enhanced Medicare payments (20% over Medicare share with charity adjustment) with immediate full depreciation of certified EHR costs.
- Penalties for non-users start in 2015 (0.33% reduction in Medicare increases to 1% in 2017)

Understanding the Policy Priorities

Improve quality, safety, efficiency, and reduce health disparities

Engage patients and families

Improve care coordination

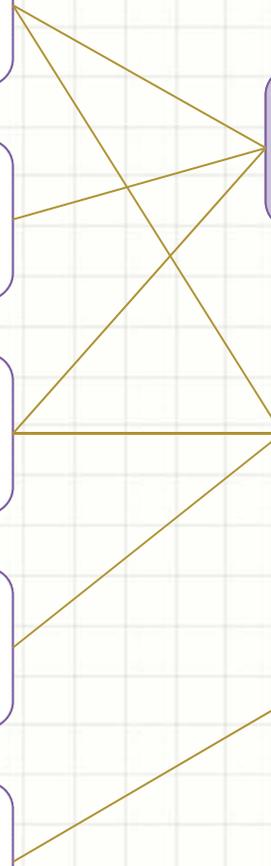
Improve population and public health

Ensure adequate privacy and security protections for personal health information

Improve Quality of Care

Operational Efficiency

Regulatory Compliance





Finance and Patient Safety

Financial Incentive to Enhance
Patient Safety through
implementation of an EHR



Objectives at a Glance

Measures

- Many Threshold's were reduced between preliminary and final rule
- Achievement Information will likely be publically available
- Must select 5 Menu to report on for Stage 1
 - Achieve as many as possible to provide cushion in case there is an issue and to have options to highlight organization when reporting.
 - One must be public reporting
- All menu objectives will be considered core objectives for Stage 2

Objective	Hospital		EP	
	Old	New	Old	New
Core Objectives				
CPOE	10%	↑ 30%	80%	↓ 30%
Problem List	80%	→ 80%	80%	→ 80%
Medication List	80%	→ 80%	80%	→ 80%
Medication Allergy List	80%	→ 80%	80%	→ 80%
Drug-Drug Checking	Enable	→ Enable	Enable	→ Enable
Record Vital Signs	80%	↓ 50%	80%	↓ 50%
Record Smoking Status	80%	↓ 50%	80%	↓ 50%
eRx			75%	↓ 40%
Reporting Quality Measures	44	↓ 15	10+	↓ 6
Clinical Decision Support	5	↓ 1	5	↓ 1
Record Demographics	80%	↓ 50%	80%	↓ 50%
eCopy of Health Information	80%	↓ 50%	80%	↓ 50%
eCopy of Discharge Instructions	80%	↓ 50%	80%	↓ 50%
Clinical Summary at Each Office Visit			80%	↓ 50%
Exchange Key Clinical Information	1 test	→ 1 test	1 test	→ 1 test
Menu Objectives				
Drug-Formulary Checking	Enable	→ Enable	Enable	→ Enable
Lab Test Results	50%	↓ 40%	50%	↓ 40%
Immunization Registry	1 test	↑ test/sub	1 test	↑ test/sub
Reportable Labs	1 test	↑ test/sub		
Syndromic Surveillance	1 test	↑ test/sub	1 test	↑ test/sub
Patient List	1 List	→ 1 List	1 List	→ 1 List
Patient Reminders			50%	↓ 20%
Patient-Specific Education	NA	↑ 10%	NA	↑ 10%
Timely Electronic Access			10%	→ 10%
Advance Directive	NA	↑ 10%		
Medication Reconciliation	80%	↓ 50%	80%	↓ 50%
Summary of Care Record	80%	↓ 50%	80%	↓ 50%

Benefits

1

- Data acquisition and evaluation real time

2

- Hardwire Best Practice
 - Clinical Standards
 - Patient Safety Standards

3

- Decrease Cost
- Efficiency

Challenges

- Finances
- Resources
 - Equipment
 - People
 - Knowledge
- Technology
 - Certified EHR Vendor
- Procedure
- Policies
- Implementation

MU Management/Administration

Financial

- Service Volume Qualification Analysis
- Cash Flow
- Cash Disbursement

Information Technology

- Roadmap Development and Delivery

Operational

- Medicare vs. Medicaid
- MU Measure Reporting
- Attainment Timeline
- Monitor Attainment
- Attestation / Measure Submission
- Education / Awareness
- Executive Updates

Clinical Adoption

- Policy Refinement and Development
- Adoption Accountability

Clinical Quality

- Clinical Quality Measure
- Content Delivery
- Clinical Quality Adoption and Reporting

Recommended Members and Responsibilities

- **Chief Information Officer**

- Ensure IT roadmap will position Hospital and Providers for meaningful use
- Deliver and report on roadmap progress towards meaningful use

- **Chief Financial Officer**

- Determine incentives and penalties for hospitals and providers
- Define cash flow considerations for incentives and penalties
- Determine cash disbursement for incentives
- Establish provider elections for Medicare or Medicaid

- **Chief Quality Officer**

- Drive clinical quality measures content
- Establish clinical quality measures reporting and adoption

- **Chief Compliance Officer**

- Ensure compliance initiatives are incorporated into the roadmap
- Audit compliance to meaningful use

- **Chief Nursing Officer / Chief Nursing Information Officer**

- ◇ Educate staff on impact of meaningful use
- ◇ Ensure nursing workflow is optimized to meet meaningful use and ensure adoption

- **Chief Medical Officer /Chief Medical Information Officer**

- ◇ Educate staff on impact of meaningful use
- ◇ Ensure physician workflow is optimized to meet meaningful use and ensure adoption

- **Meaningful Use Practice Manager**

- ◇ Coordinate and drive the task force
- ◇ Monitor and report on meaningful use attainment
- ◇ Coordinate attestation and submission of measures
- ◇ Drive executive reporting and updates
- ◇ Coordinate meaningful use education
- ◇ Stay current on future recommendations and rule making

Keys to Success

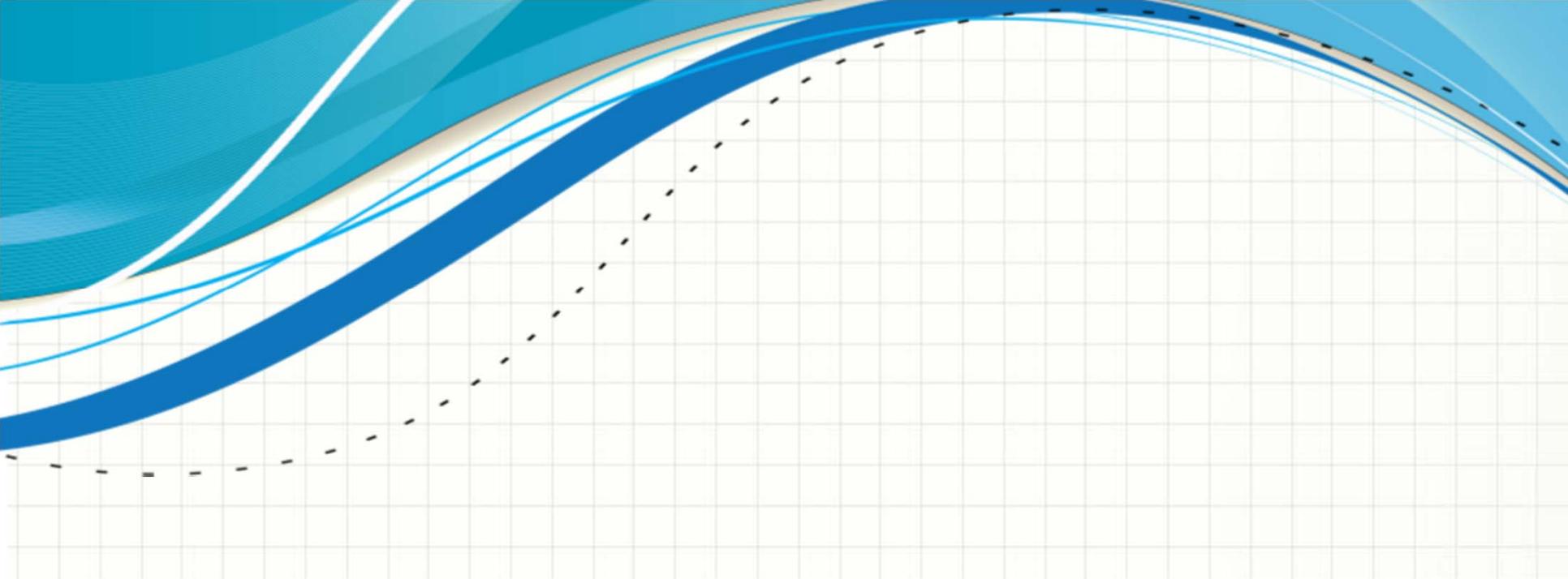
- Act now and strive to be ahead of the requirements
- Stay focused on improving care
- Be conscious about the targets you are striving to achieve and understand the risk
- Keep an eye on progressing policy:
 - State Level
 - Federal HIT Strategic Framework
 - Healthcare Reform
 - Stage 2 and 3 Meaningful Use Recommendations
- Clinical leadership and Organizational readiness is as important as ever

OUR SOLUTION

- Partnership with DRMC (Du Bois Regional Medical Center)
- Remote Hosting
- MA Funding
- Aggressive Timeline
- Big Bang Implementation
- Engagement of Medical Staff
- Project Team

Results

- Stage 1 Meaningful Use attestation on June 22nd 2011
- Applying for MA Meaningful Use
- HIMSS Level 6 Certification
- Project well on its way to Stage 2 and HIMSS Level 7 Validation
- Quality Outcomes



QUESTIONS?