

# ARRA – What to do with the Facts

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# Appoint a lead ARRA Resource

- Meaningful Use Definition
- Certification Criteria
- Vendors Stimulus Road Maps
- Educate Exec Team on Requirements
- Educate Physicians
- Grants

# Calculate Expected Incentives

## Calculation of Medicare Share for Medicare Health IT Incentive Payments

[Medicare Share = Total Medicare Days / (Total Inpatient Days \* Charity Care Ratio)]

### Total Medicare Days:

Total Medicare Fee-For-Service (FFS) Inpatient Days	57,516
<u>Total Medicare Advantage Days</u>	9,244
Total Medicare Days	66,760

### Total Inpatient Days:

119,136

### Charity Care Ratio:

[Charity Care Ratio = Total Charges Excluding Charity Care / Total Charges]

Total Charges Excluding Charity Care	652,215,043
<u>Total Charges</u>	684,304,597
Charity Care Ratio	0.95

Data in blue text can be changed to reflect more current or accurate information.

Medicare and Total Days include Nursery, Inpatient Psychiatric, and Inpatient Rehabilitation.

Total Charity Care Charges were taken from Worksheet S-10, Line 30 of the Medicare Cost Report.

### Medicare Share for Medicare Health IT Incentive Payments:

58.79%

## Calculation of Maximum Medicare Health IT Incentive Payment Available to Hospital

Base Health IT Incentive Payment Amount: \$2,000,000

### Discharge-Related Amount:

[Discharge-Related Amount = \$200 for each discharge between 1,150 and 23,000]

Total All Payer Hospital Discharges:	29,256
Discharges Eligible for Add-On Amount:	21,851
Per Discharge Add-On Amount:	\$200
Discharge-Related Amount:	\$4,370,200

Subtotal \$6,370,200

[Subtotal = Base Health IT Incentive Payment Amount + Discharge-Related Amount]

Total Discharges include Nursery, Inpatient Psychiatric, and Inpatient Rehabilitation.

### Maximum Medicare Health IT Incentive Payment Available to Hospital (One-Year):

\$3,745,286

[Subtotal \* Medicare Share]



# Meaningful Use Gap Analysis

- Review current Meaningful Use Criteria
  - Hospital
- Understand Deficiencies
- Create and Action Plan for any gaps

Remember Rules still not final



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## Centra Meaningful Use Readiness Assessment

<b>Health Outcomes Policy Priority</b>			Improve quality, safety, efficiency, and reduce health disparities
<b>Care Goals</b>			<ul style="list-style-type: none"> <li>• Provides access to comprehensive patient health data for patient's health care team</li> <li>• Use evidence based order sets and CPOE</li> <li>• Apply clinical decision support at the point of care</li> <li>• Generate lists of patients who need care and use them to reach out to patients (e.g., reminders, care instructions, etc)</li> <li>• Report to patient registries for quality improvement, public reporting, etc</li> </ul>
<b>2011 Objectives - Hospitals</b>		<b>Hospital</b>	<b>Comments</b>
10% of all orders (any type) directly entered by authorizing provider (e.g., MD, DO, RN, PA, NP) through CPOE2			<a href="#">See Quality Measures Tab</a>
Implement drug-drug, drug-allergy, drug-formulary checks			
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 or SNOMED			5-Star but we do not do concurrent coding
Maintain active medication list			
Maintain active medication allergy list			
Record demographics: - Preferred language - insurance type - gender - race - ethnicity			
Record advance directives			
Record vital signs: - Height - Weight - blood pressure - Calculate and display BMI			<a href="#">See Quality Measures Tab</a>



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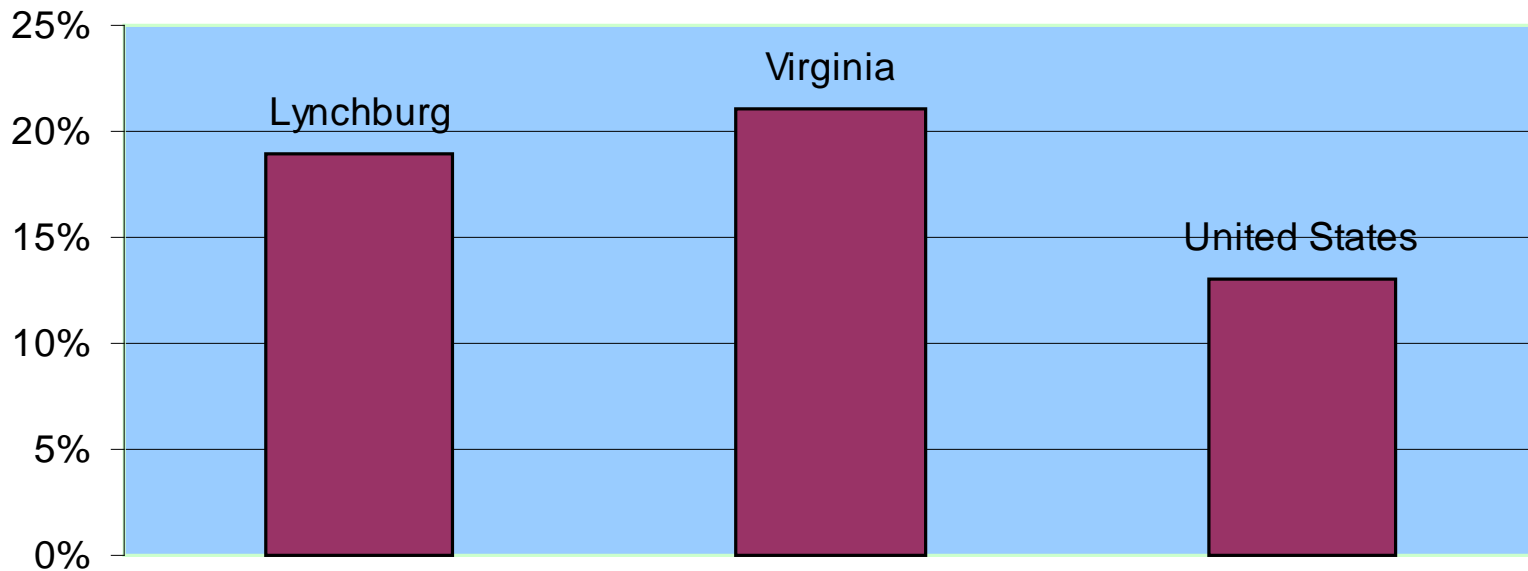
# Quality Measures

Measure ID	2011 Measures	NQF Endorsed Measures	QDS Datatypes (HITEP)	Sites of Care					Relevant Specialties									
				Primary	Secondary	Home	Primary Surgical Center	Health	Care	Cardiology	Endocrinology	Neurology	Obstetrics/Gynecology	Oncology	Orthopedics	Pediatrics	Psychiatry/Psychology	Surgery
23	Report 30-day readmission rate [IP]	<p>Title: All-Cause Readmission Index (risk adjusted)*</p> <p>Title: All-Cause Readmission Index (risk adjusted)*</p> <p>Description: Overall inpatient 30-day hospital readmission rate.</p> <p>Numerator: Measured outcome: 30-day all-cause readmissions for patients discharged from the hospital with a principal diagnosis of HF, as measured from the date of discharge of the index HF admission</p> <p>Denominator: Included population: Index admissions for Medicare fee-for-service beneficiaries age 65 or over admitted to the hospital with a principal ICD-9-CM discharge diagnosis of heart failure and discharged alive</p> <p>Exclusions: Age &lt;65 In-hospital deaths Incomplete data (without FFS Part A, without 12 mo enrollment prior to discharge, without 1 month enrollment post discharge) Transfers out Additional HF admissions within 30 days [IP]</p> <p>Steward: United Health Group</p>	<ul style="list-style-type: none"> <li>- age</li> <li>- hospital admission</li> <li>- hospital discharge</li> <li>- maternity diagnosis</li> <li>- transfer to acute care hospital</li> <li>- death</li> </ul>		X				X	X	X	X	X	X	X	X	X	

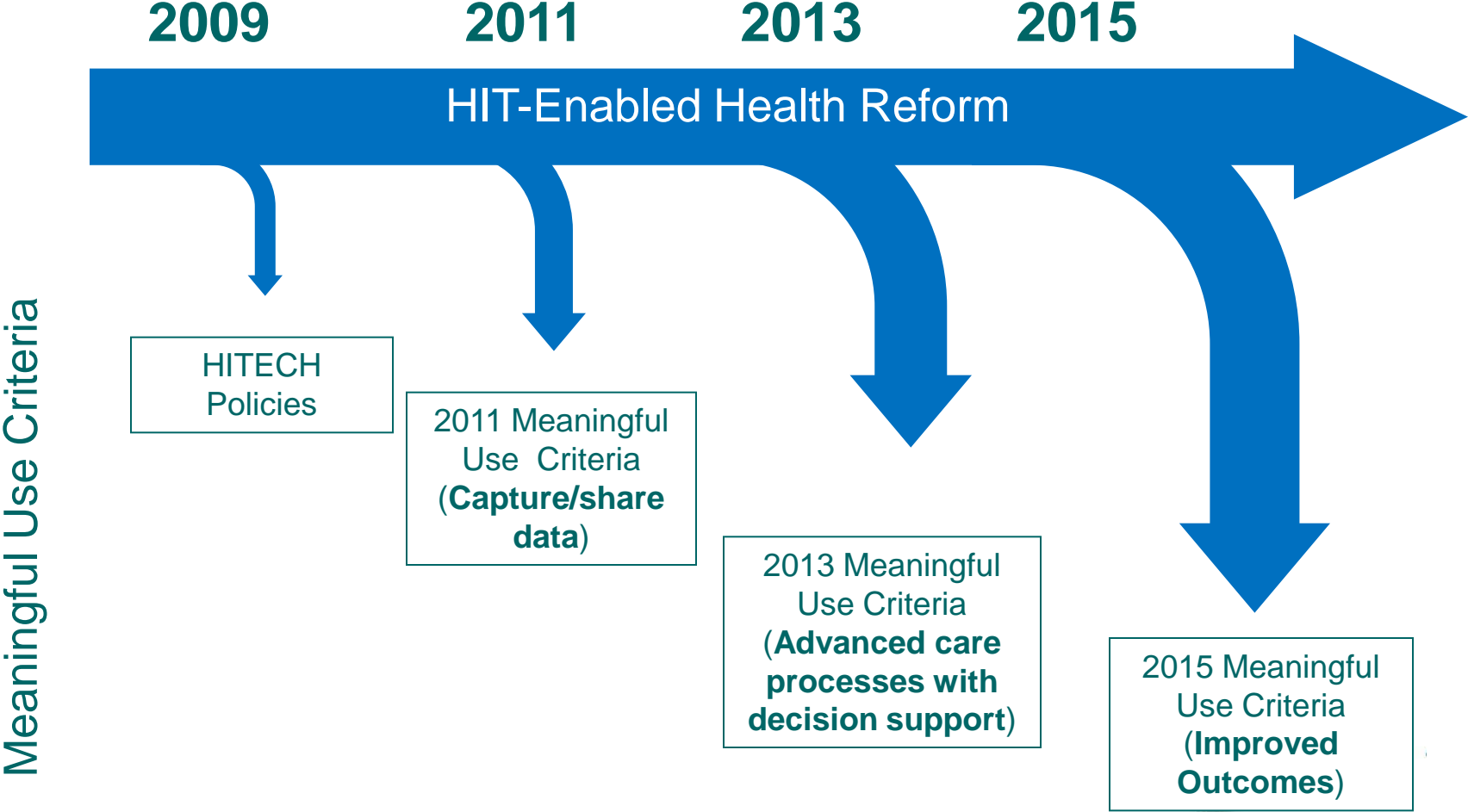


# Current EHR Adoption Rate

**EHR Physician Office Adption Rate**



# It is not enough to simply implement



# Physicians

- Meaningful Use is different than hospitals
- Educate
  - Town Hall Meetings
  - Education Sessions
  - Newsletter
  - Emails

# A Few Differences

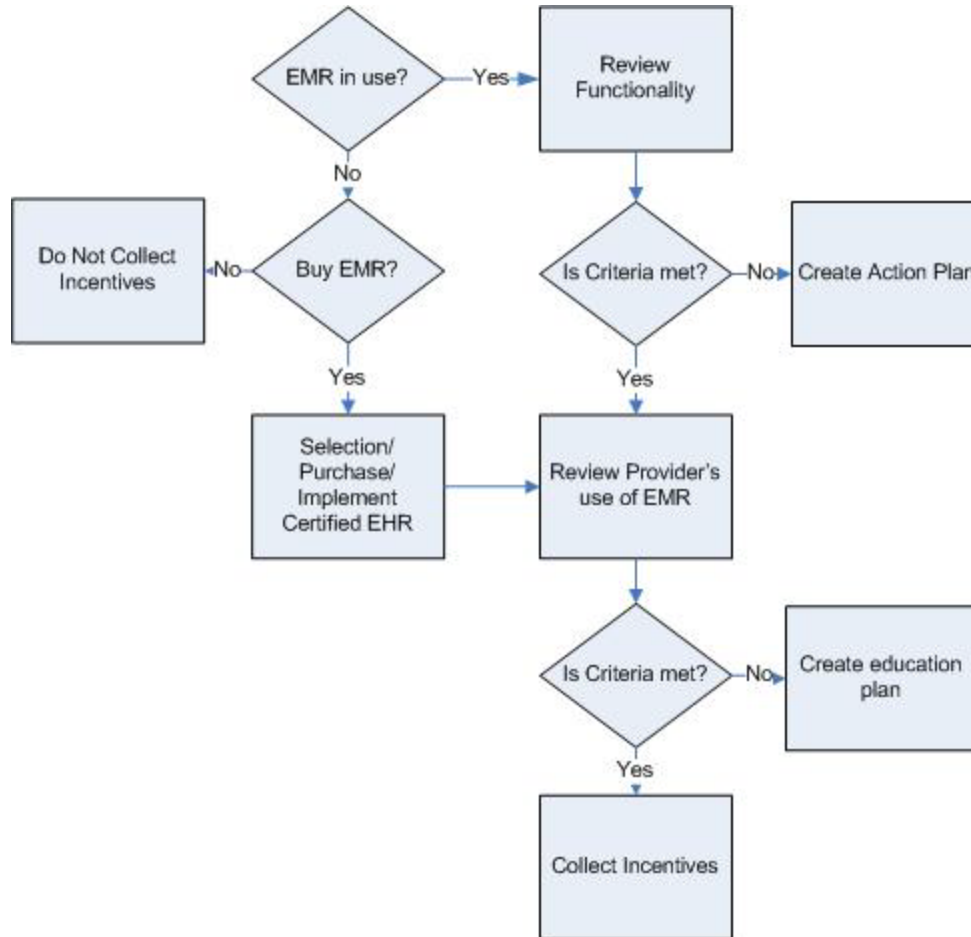
- CPOE required for all orders
- Quality Measures (PQRI +)
- eRx
- Provide patients with an electronic copy of their health information

## Centra Meaningful Use Readiness Assessment

<b>Health Outcomes Policy Priority</b>	Improve quality, safety, efficiency, and reduce health disparities	
<b>Care Goals</b>	<ul style="list-style-type: none"> <li>• Provides access to comprehensive patient health data for patient’s health care team</li> <li>• Use evidence based order sets and CPOE</li> <li>• Apply clinical decision support at the point of care</li> <li>• Generate lists of patients who need care and use them to reach out to patients (e.g., reminders, care instructions, etc)</li> <li>• Report to patient registries for quality improvement, public reporting, etc</li> </ul>	
<b>2011 Objectives - Eligible Providers</b>	<b>Eligible Provider</b>	<b>Comments</b>
Use CPOE for all orders		<b>See Quality Measures Tab</b>
Implement drug-drug, drug-allergy, drug-formulary checks		
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 or SNOMED		<a href="#">5-Star but we do not do concurrent coding</a>
Generate and transmit permissible prescriptions electronically (eRx)		
Maintain active medication list		
Maintain active medication allergy list		



# For each Practice



# Certifications

- October 7, 2009 - The Certification Commission launched its updated and new 2011 certification programs.
  - CCHIT Certified® Comprehensive certification
  - Modular Preliminary ARRA certification program

# CCHIT Certifications

## Certified EHR Comprehensive EHR-C

Rigorous certification of comprehensive EHR systems that significantly exceed minimum Federal standards requirements.

For providers who seek maximal assurance of EHR compliance and capabilities.

## Certified EHR Module EHR-M

Flexible certification of Federal standards compliance for EHR, HIE, eRx, PHR, Registry and other EHR-related technologies.

For providers who prefer to integrate technologies from multiple certified sources.

## Certified EHR Site EHR-S

Simplified, low cost certification of EHR technologies in use at a specific site.

For providers who self-develop or assemble EHRs from noncertified sources.



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# Summary

- Stay informed
- Communicate and Educate
- Keep your eye on the money

# References

- <http://healthit.hhs.gov/portal/server.pt>
- [www.CCHIT.org](http://www.CCHIT.org)
- [www.grants.gov](http://www.grants.gov)