The Meaningful Care Organization – Patient-Centered Strategies for the Intersection of MU and ACOs

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MU and ACOs
(Meaningful Use and Accountable Care Organizations)
**Meaningful Use (MU)**

American Recovery and Reinvestment Act of 2009

HITECH Act

Meaningful Use

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$36 billion will be spent on the implementation of Electronic Health Records (EHRs)\(^1\)

- $5.7 billion paid through May\(^2\)
  - 48 percent of all eligible hospitals have received an incentive payment

- Medicare EHR incentive payments end in 2016
  (Medicaid payments end in 2021)

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Accountable Care Organizations (ACOs)

Patient Protection and Affordable Care Act of 2010

Medicare Shared Savings Program

Accountable Care Organizations

Accountable Care Organizations (ACOs)

- Voluntary groups of physicians, hospitals and other healthcare providers:
  - Responsible for care of a clearly defined Medicare population
  - Designed to foster patient-centered, coordinated care
  - If it succeeds in providing high-quality care while reducing cost, it shares in savings achieved for Medicare

Accountable Care Organizations (ACOs)

- 32 Pioneer ACOs\(^1\)
- 27 Medicare Shared Savings ACOs\(^1\)
  - 5 employing the Advanced Payment Model
- 221 total ACOs identified through the end of May\(^2\)
  - 118 are hospital-sponsored ACOs


Currently part of an ACO? Plan to implement or join an ACO?

- Yes - 11%
- No - 89%
- Yes - 61%
- No - 39%

Source: January 2012 survey of hospitals, physician organizations and health systems reported in: Tocknell MD. The Unsettled State of the ACO. HealthLeaders Media Intelligence Report. April 2012.
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Accountable Care Organizations (ACOs)

- $510 million in estimated Medicare savings in the first three years (2012-2014)\(^1\)
  - $560 million to $1.13 billion in bonuses paid to those ACOs over that period\(^2\)
- Top Driver for the organization creating an ACO – To engage physicians (56 percent of the respondents that are or plan to be part of an ACO)\(^3\)

\(^1\)Section III.F. of the Preamble to the ACO Regulations. Federal Register Vol. 76(67):19640.
\(^2\)Section III.C.3. of the Preamble to the ACO Regulations. Federal Register Vol. 76(67):19639.
\(^3\)Tocknell MD. The Unsettled State of the ACO. *HealthLeaders Media Intelligence Report*. April 2012.

Intersection of MU and ACOs

**MU Goals\(^1\)**
- Improve caregiver decisions
- Better outcomes

**ACO Goals\(^2\)**
- Better care for individuals
- Better health for populations
- Slower growth in costs through improvements in care

**Patient-Centered Strategies**

Meaningful Use Objectives

- **Stage 1 Objectives for Hospitals**
  - 14 Core Objectives, 10 Menu Objectives (attain 5)
  - First eligible payment year: 2011

- **Stage 2 Objectives for Hospitals (proposed)**
  - 16 Core Objectives, 5 Menu Objectives (attain 3)
  - First eligible payment year: 2014
  - Effectively incorporate all Stage 1 objectives, along with additional objectives and higher measurement thresholds
### Stage 2 Meaningful Use Objectives

<table>
<thead>
<tr>
<th>Core Objectives</th>
<th>Patient Input</th>
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<th>Patient Input</th>
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<tbody>
<tr>
<td>Demographics</td>
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<td>Syndromic Surveillance</td>
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<td>View, Download and</td>
<td>Output</td>
<td>Menu Objectives</td>
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<tr>
<td>Transmit to Third Party</td>
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<td>Imaging Results</td>
<td></td>
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<td>Privacy and Security</td>
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<td>Advance Directives</td>
<td>Input</td>
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<tr>
<td>Smoking Status</td>
<td>Input</td>
<td>ePrescribing</td>
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<tr>
<td>Lab Results into EHR</td>
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<td>Electronic Medication</td>
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<tr>
<td>Patient-Specific Education</td>
<td>Output</td>
<td>Administration Record</td>
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<tr>
<td>Medication Reconciliation</td>
<td>Input</td>
<td>Family Health History</td>
<td>Input</td>
</tr>
</tbody>
</table>

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**Why Focus on Patient-Centered Strategies that are “Output Oriented”?**
Patient Satisfaction

- Starting in October, 1 percent of Medicare payments will be withheld for payment to hospitals with above average patient satisfaction scores.
  - $850 million in incentive payments

Rau J. *Kaiser Health News*; April 28, 2011,

Patient Satisfaction

- Survey metric: Nurses “always” communicated well
  - Top 3 states
    + Louisiana – 81%
    + South Dakota – 81%
    + Maine – 80%
  - Bottom 3 states
    + Washington DC – 68%
    + Nevada – 69%
    + California – 70%

Source: Hospital Compare  hhs.gov
Patient Satisfaction

- **Survey metric:** *Doctors “always” communicated well*
  - **Top 3 states**
    - Alabama – 86%
    - Louisiana – 86%
    - Mississippi – 85%
  - **Bottom 3 states**
    - Nevada – 73%
    - Washington DC – 76%
    - New York – 76%

Source: Hospital Compare  hhs.gov

Patient Satisfaction

- **Survey metric:** *Given information for recovery*
  - **Top 3 states**
    - New Hampshire – 87%
    - Vermont – 87%
    - Utah – 87%
  - **Bottom 3 states**
    - Washington DC – 77%
    - New Jersey – 78%
    - Mississippi – 78%

Source: Hospital Compare  hhs.gov
"Output Oriented" Meaningful Use Objectives

Patient-Specific Education

Patients who are provided patient-specific education resources

Number of unique patients admitted to the hospital’s inpatient or emergency departments during the reporting period

> 10%
**View, Download and Transmit to Third Party**

- 2 Measures for this Meaningful Use objective
- Both must be satisfied in order to meet the objective

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**Patients whose information is available online within 36 hours of discharge**

Number of unique patients **discharged** from the hospital’s inpatient or emergency department during the reporting period

> 50%

**Patients who view, download or transmit to a third party the information provided online**

Number of unique patients **discharged** from the hospital’s inpatient or emergency department during the reporting period

> 10%
The informed consent discussion conducted by the surgeon should include:

1. The nature of the illness and the natural consequences of no treatment.
2. The nature of the proposed operation, including the estimated risks of mortality and morbidity.
3. The more common known complications, which should be described and discussed. The patient should understand the risks as well as the benefits of the proposed operation. The discussion should include a description of what to expect during the hospitalization and post hospital convalescence.
4. Alternative forms of treatment, including nonoperative techniques.

Argument for Informed Consent

- Only 39% of 3,269 closed claims against anesthesiologists were judged to have adequate informed consent\(^1\)
- Inadequate informed consent was pursued as a secondary cause in more than 90% of ophthalmologic malpractice cases\(^2\)
- Lack of informed consent is one of the top 10 reasons for hospital malpractice claims\(^3\)

\(^3\)Glabman M. *Trustee* 2004;57(2):12-16.

Argument for Informed Consent

- Needs to be electronic
- Can’t be a “Medical Miranda Warning”
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Argument for Informed Consent

- Need the consent for the Pre-Procedure Verification and/or the Time-Out
- Verification of the consent is one of the most effective practices for avoiding wrong-patient/wrong-procedure/wrong-site surgery


WHO Surgical Safety Checklist

Surgical Safety Checklist

Before induction of anaesthesia (with at least one anesthetist)

- Has the patient confirmed his/her identity, site, procedure, and consent?
- Is the site marked?
- Is the site visible?
- Is the anesthesiologist machine and medication checklist complete?
- Is the patient re-ready for anaesthesia?
- Does the patient have: known allergy?
- Difficult airway aspiration risk?
- Yes, and equipment assistance available
- Risks to patient, blood loss, swelling of body
- Yes, and associate respiratory access and fluids planned

Before skin incision (with nurse, anaesthetist and surgeon)

- Confirm that team members have been identified by name and title
- Confirm the patient’s name, procedure, and where this incision will be made
- Anesthetic premedication has been given within the last 15 minutes
- Yes
- Not applicable

Anticipated Critical Events

To Surgeon: What are the critical or non-critical steps? How long will the case take? What is the anticipated blood loss?

To Anaesthetist: Are there any patient-specific concerns?

To Operating Team: Has surgery (including indicator results) been confirmed? Are there equipment issues or any concerns?

To Essential Operating Personnel: Are they essential and operating personnel?
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Argument for Informed Consent

For Confirmation and Cross-Check
Procedure listed on the consent form: Finger - Trigger Finger Release (Trigger Finger Release)
Anatomical location/surgical site listed on the consent form: Left hand - ring finger.

Pre-Procedure Instructions

- Reduce the risk of potentially life-threatening perioperative complications.


Courtesy of the Baltimore VA Medical Center
Pre-Procedure Instructions

- Lower the incidence of preventable surgery cancellations.


Best Practices for Viewing, Downloading and Transmitting Patient Information
Discharge Instructions

- Providing patients with incomplete information at discharge can result in patient harm.


Hospital Readmissions Reduction Program

- HRRP was created under the PPACA
- Effective October 1, 2012
- Establishes penalties for excessive readmissions with maximum payment reductions of:
  - 1 percent in 2013
  - 2 percent in 2014
  - 3 percent in 2015 and beyond

Source: Section 3025 of the Patient Protection and Affordable Care Act added section 1886(q) to the Social Security Act. 42 CFR part 412 (§412.150 through §412.154).
Discharge Instructions

- Reduced the 14-day readmission rate three-fold by employing procedure-specific discharge instructions (4.1 per 1,000 outpatient procedures to 1.5 per 1,000).


- Most valuable if they are sent well prior to the 36-hour threshold
  - Provided prior to admission
  - Paper as well as electronic
Developing Initiatives in Your Own “Meaningful Care Organization”

Resources


<table>
<thead>
<tr>
<th>“Meaningful Care” Checklist</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the initiative patient-centered?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Does it reduce risk?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Does it enhance safety?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Does it leverage the patient?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Can you utilize HIT (EHR or other systems)?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Does it support Stage 1 or Stage 2 Meaningful Objectives?</td>
<td>✔</td>
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Questions?

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