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To: TMC Board of Trustees and Managers

From: H. Ray Gibbons, FACHE *rdg*

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RE: Summary of 10/8/09 TMC Board/Manager Work Session

The following summarizes the major points of the October 8th TMC Board/Manager Work Session:

The topics discussed were:

- Board Orientation – Refresher
- Annual Program Review
- EHR/EMR Preparation
- RAC's Understanding and Preparation

The work session concluded with the following questions, discussions and consensus for direction:

- Where do we go from here?
 - We go forward as a Team of Board and Management committed to our Mission “to provide a quality, stable, efficient and caring healthcare environment to all those we serve.”
 - We balance TMC high stakes issues, regulatory changes/impacts, development of TMC personal care niche, investment in people and facilities and external stakeholders.
 - We recognize that healthcare operations continue to evolve and the speed of change will continue to escalate.
 - Our responsibility is to continue to grow in the areas of adaptability, openness to what can be and searching for the best frontier models of care for the people we serve.
- How do we move forward?
 - Develop operational plans and strategic directions for:
 - Infrastructure Issues
 - Regulatory Issues
 - Service Area Issues
 - Target Time Line? January 2010

- The following is the consensus direction for ratification / discussion at the October 27, 2009 TMC Board Meeting:
 - Programs and Services – 2010
 - Continue the current level of programs and services
 - Analyze the expansion of the TMC Community Clinic to additional communities
 - Develop specialty physician services with regional providers
 - Continue analysis of frontier models of care and payment sources
 - Infrastructure – 2010
 - Incorporate in the 2010 – 2011 budget cycle
 - Prioritize areas of need by February 2010-
 - ~\$241k exterior & crawl space issues
 - ~\$32k updating and replacement issues – these items will have the highest priority to accomplish
 - Regulatory Issues – 2010
 - Continue education for RAC audits
 - Develop a plan for defensive audits

The following summarizes the major points discussed during the work session. The detail definitions were taken from the following sources:

- *Board orientation- Excerpts from “AAHSA – The Keys to High-Impact Governing”, D.D. Bainbridge “Being a new Board Member” and “The Excellent Board” by AHA.*
- *Annual Review – TMC management prepared annual review presentation*
- *EHR/EMR – excerpts from FAhRM Project PP; HIEM PP and detail from Jack King, Director of NorthCentral Healthcare Alliance.*
- *RAC –federal definitions and discussions*

Board Orientation – Refresher

- TMC Board operates as Committee of the Whole.
- Quorum is 3 of 5 board members which also defines the need for open meeting compliance
 - Informal discussions of 1-2 Board members with CEO are fine with open meeting rules
- Refresher points for each board member:
 - Board role – policy setting and strategic “high stakes issues” vs. operations
 - Board role is partnership with CEO whose responsibility is to effectively manage operations
 - Board is responsible for managing themselves as a governing body
 - Gets to know other board members and builds collegial working relationships that contribute to consensus building
 - Maintains confidentiality of any information given to the board unless in the open meetings of the board

2009 Annual Program Review

- Change in mix of outpatient observation and inpatient days probably a reflection of change in CMS regulatory direction. The impact on the Medicare cost based payments may be the reduction in per diem's effective 10/1/09.
- The complexity of the Medicare cost based payment systems for CAH and RHC directs the intensity of resources used by TMC in these arenas.
- Outpatient volumes are consistent when trended against previous years
- Medical Records and Policies are reviewed at a higher level than required by regulations
- Staffing levels: overall 91 employees 10/08 and 81 employees 10/09
 - Impact probably also part of reduced cost per day and reduction in 10/09 Medicare per diems
 - Additionally management will analyze the following areas for staff planning which could include additions using adding value to patient services as the primary metric:
 - Patient Support Services
 - Community Clinic Services
 - Dietary Services
 - Information Services to include IT and Medical Records
- Infrastructure Issues
 - \$8,239 total for identified items needing replacement due to wear, deterioration or obsolescence.
 - \$16,243 total for issues of compliance *with safety rules and regulations and efficiency.*
 - \$7,067 total for items *necessary to stay in compliance with rules and regulations related to maintaining defined "cleanable surfaces".*

 - \$240,877 Exterior and crawl space issues
 - \$272,426 Total
- Annual Program Review – Take-Away
 - Discussion questions were:
 - Are the services we are providing appropriate?
 - Are our facilities adequate for continuing these services or possibly adding services?
 - What services can we possibly provide?
 - Outpatient Chemotherapy, GI, Ortho, ENT, Dermatology
 - Diabetic foot care, Wellness/Prevention services
 - Assisted Living in Fairfield
 - Continue to establish relationships with specialists and encourage rotations in Choteau for access to care.
 - Continue outreach to Augusta, Fairfield, and possibly Dutton.
 - Promote Adult Day Care Services.
 - Encourage staff involvement in communities activities
 - Consensus was to continue with current services and search for revenue enhancement services. The TMC Community Clinic and existing services should be the primary base for increasing revenues.
- **EHR/EMR Preparation: New terminology**
 - CCHIT, EHR/EMR, HIT, HIE, IMOM, ARRA, Meaningful Use, NMHA OHIT, FAhRM, HEIM,
 - CCHIT- Certification Commission for Healthcare Information Technology
 - EHR/EMR – electronic health record, electronic medical record
 - HIT- Healthcare Information Technology

- *HIE – Health Insurance Exchange – HealthShare Montana*
 - *HealthShare Montana, an organization of healthcare leaders and stakeholders in Montana, proposes to plan, develop and implement a statewide health information exchange (HIE) infrastructure. HIE capabilities will be developed according to requirements that will allow its eventual inclusion as a National Health Information Exchange (NHIE) site representing the State of Montana in the National Health Information Network (NHIN).*
 - *May 9, 2009 - designated by governor as official state health information exchange entity*
 - *Funding via MT legislature and HITECH act...\$1.4M*
 - *5 HSM representatives attending National Governors Association Center for Best Practices*
 - *September 24 – 25, 2009, Washington*
 - *Policies and strategies for implementing provisions of HITECH and Health Information Exchange*
- *IMOM – Image Movement Over Montana – radiology managers with concept of web library for digital images. Concept is to propose IMOM to HealthShare Montana as a pilot project.*
- *ARRA - The American Recovery and Reinvestment Act of 2009 (ARRA)*
 - *Contains provisions to further enable the adoption of healthcare IT by physician practices.*
 - *The se provisions are called the Health Information Technology for Economic and Clinical Health (HITECH) Act*
 - *The goal is to advance technology in the ambulatory environment that includes an individual practice, a group practice organization, or a health system that employs physicians is the key challenge at this juncture.*
 - *Grants and demonstration projects, the potential financial incentive for electronic health record (EHR) adoption is a maximum of \$44,000 per physician that is to be paid based on a 5-year schedule. Eligible physicians will not begin to receive reimbursement until 2011 at the earliest. In order for physicians to be eligible for the maximum payment, implementation must be completed by the beginning of 2011 in order to be able to illustrate "meaningful use" of the EHR by mid-2011 and completed by 2014.*
 - *Final regulations due December 2009- CAH Medicare Share of cost plus 20 points for hospital and RHC. Two year program 2011-2013. Expected limit 100% of cost for software, training and installation.*
 - *Possible \$6 million through HealthShares*
- *Meaningful Use = **Provider Payments***
 - *Payments are tied to what the legislation classifies as "adoption and meaningful use of certified EHR technology." Certification is currently governed by the Certification Commission for Healthcare Information Technology (CCHIT), which sets strict, evolving standards.*
 - *Meaningful use requires the demonstration of satisfactory ePrescribing, interoperability, and reporting capabilities. The legislation further states that the requirements to demonstrate meaningful use can become more stringent over time, but does not offer any specifics. **Therefore, it is important to validate that products are certified and will continue to meet requirements through the reimbursement period***

- **CHICAGO – September 8, 2009** – The Certification Commission(i.e. CCHIT) today announced that it is proceeding with its planned launch of new certification programs on October 7. In addition to an updated comprehensive electronic health record (EHR) certification program, called CCHIT Certified® 2011, the organization will offer a modular certification program called Preliminary ARRA 2011 that is limited to the standards for qualifying EHR technology under the American Recovery and Reinvestment Act (ARRA).
 - “There is a high risk that providers would not achieve meaningful use to qualify for the ARRA incentives in 2011 and 2012 if they wait until late 2010 to implement certified EHR systems and technologies,” said Mark Leavitt, M.D., Ph.D., chair of the Commission.
 - HHS criteria and standards are expected to be published by the end of 2009. Final rules on Meaningful Use are expected later in the Spring of 2010.
- **Brief Summary of NMHA OHIT Grant Project**
 - The Northcentral Montana Healthcare Alliance, through its affiliation with Benefis Health System, has received two parcels of Federal Appropriations funding, that has resulted in a grant from the Office of Health Information Technology (OHIT) to investigate, and implement Electronic Health Record technology in the Critical Access Hospital members of the NMHA.
 - Adoption of Electronic Health Records (EHR) has been on the healthcare radar screen for many years, and NMHA has sought funding from various sources since its inception in 2003. With the arrival of the American Recovery & Reinvestment Act in January 2009, and the implementation of the HITECH ACT, the pressure to adopt EHR technology, especially for rural and frontier healthcare providers, has significantly increased. The ARRA has developed policy that will incentivize adoption of EHR technology to “meaningful use” standards by 2011 for physicians and hospitals. The ARRA has also implemented penalties for lack of adoption that will be applied to physicians and hospitals by 2016.
 - The primary goal of the NMHA OHIT Grant project is to leverage the existing pool of funding, and the acquisition of additional funding, to be able to get the 11 CAH facilities within NMHA to adopt EHR technology to Meaningful Use Standards by 2011-12, but to certainly be able to adopt the technology in advance of the penalties that begin in 2016.
 - At the time of this summary, the standards for “meaningful use” of EHR technology have not been clearly defined, but we are confident that the definition will include four basic tenets: 1. That the system implemented be certified by the Office of the Coordinator of HIT (OCHIT), 2. That the system be used to provide electronic prescribing of physician orders, 3. that the system be able to exchange information with other systems (could be as simple as between RHC and Hospital), and 4. that the system be able to transmit “reportable” information to the Federal Government as part of healthcare reform to improve clinical outcomes and efficiencies.
 - The pilot site for the NMHA OHIT project is Liberty Medical Center in Chester with Marias Medical Center in Shelby and Central Montana Medical Center in Lewistown next in the queue due to their level of preparedness. The remaining sites within NMHA will follow relative to preparedness levels and acquisition of additional funding.

- FAhRM Project
 - Frontier Access to Healthcare in Rural Montana an FCC Project.
 - **Montana Telehealth Alliance**
 - **Maximum support: \$1,957,652**
 - **Statewide telecommunications backbone for health information technology**
 - **Vision of the Project:**
 - **Laying the train tracks**
 - **Transmission of data and video**
 - **End points to hub**
 - **Connecting 6 hubs PHTN (Billings), EMTN (Billings), REACH (Great Falls), HIEM(Kalispell), St Patricks and Community Medical Center(Missoula)**
 - **Hubs to Cloud**
 - **Status of the project**
 - **Original plan – Network Design phase and build out phase**
 - **RFP was posted on the USAC website 5/19/2009**
 - **Allowable contract date 6/19/2009**
 - **Closing date for response for RFP 6/30/2009**
 - **Received 4 responses**
 - **In process of scoring RFP's**
 - **Selection of vendor pending**
 - **Securing match**
- **HIEM – Health Information Exchange of Montana**
 - **HIEM is a not-for-profit corporation formed by seven Northwest Montana healthcare organizations**
 - **Cut Bank**
 - Northern Rockies Medical Center
 - Glacier Community Health Center
 - **Kalispell**
 - Northwest Healthcare
 - **Libby**
 - St. John's Lutheran Hospital
 - Northwest Community Health Center
 - **Ronan**
 - St. Luke Community Healthcare and Clinic
 - **Whitefish**
 - North Valley Hospital
 - **Partnership with University of Montana**
 - **Mission**
 - **Our mission is to securely and reliably exchange Electronic Health Record (EHR) patient information among all health care providers**
 - **Status**
 - *In November 2007, HIEM received support from the Federal Communications Commission to build a secure, dedicated fiber network as part of the FCC Rural Health Care Pilot Program.*

- *The FCC awarded HIEM \$13.6 million to construct this project; first 2 years of 5 years requested.*
- *Requires a 15% cash match (\$2.4M); pursuing multiple sources and scenarios*

➤ **EMR/EHR Preparation:**

- *What does this mean for TMC?*
- *NMHA HIT Readiness Evaluation - 11/30/09*
- *2010 – evaluation with data David Ginsberg analysis*
- *TMCCC – EHR vendor*
- *ARRA funding source 2011 and how to fund TMC CAH HIT components.*
- *IMOM project as it develops – 2010*
- *Continue education/planning as rules and regulations are “in development”*

➤ **Regulatory Audit Contractor Program Formal Definition:**

- Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Section 306, directs the Secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in:
 - 1) identifying underpayments and overpayments;
 - 2) recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).
- Preparation:
 - Do the right thing for the right reason with the best information available.
 - Revenue Integrity = Assess current potential bad habits/broken processes. Conduct a defense audit with a joint focus: declare issues/rebill errors as corrected claims WHILE providing mandatory education to prevent future errors.
 - Internal audits to determine where TMC is at risk.
 - Using PIP to establish process
 - Areas – observation hours billed vs. documented as care; medical necessity to admit; 3 day qualifying inpatient stay for swing stay
- **Impact: RAC documentation could easily be conflict with EHR documentation**