Spring 2018

CAHoots Newsletter is funded through the IN FLEX State Office of Rural Health (SORH).

Greene County General Hospital Ahead of the Curve in Stewardship Programs

In July 2016, The Joint Commission, an independent, not-for-profit health care accreditation organization, announced a new Medication Management standard for hospitals, critical access hospitals, and nursing care centers to become effective January 1, 2017. The goal of this standard is to reduce the use of inappropriate antimicrobials in all health care settings due to antimicrobial resistance. The Centers for Disease Control and Prevention (CDC) identified that 20%-50% of all antibiotics prescribed in US acute care hospitals are either unnecessary or inappropriate.

Greene County General Hospital (GCGH) has maintained accreditation by The Joint Commission since 2004. In October of 2016, GCGH initiated their own antimicrobial stewardship program to stay compliant with the imposed standards. The goal of GCGH's antimicrobial stewardship program is to promote the appropriate use of antimicrobials, which includes antibiotics, improve patient outcomes, reduce microbial resistance, and decrease the spread of infections caused by multidrug-resistant organisms.

Dr. Patricia Canfield, Pathologist and GCGH's Physician Director of Laboratory, Respiratory, and Quality Improvement, has been involved with GCGH's antimicrobial stewardship program since its inception. "Due to our diligent administration team led by our Pharmacy Director, we are ahead of more than half of critical access hospitals in implementing this program," Dr. Canfield explains.

GCGH is ahead of the curve in other facets as well. In fact, the antimicrobial stewardship program spurred an opioid stewardship program at GCGH. "We approached the antimicrobial stewardship with a multidisciplinary team" Pharmacy Director, Melissa Toon, RPh, details, "and we had substantial collaboration from the medical staff and support from our administration. With this success, we were able to build the framework for an opioid stewardship program."

GCGH's opioid stewardship program is a pioneer in the region. The opioid epidemic has greatly impacted Indiana by marking a 500% increase in opioid overdoses from 1999 to 2014, according to Indiana University's School of Public Health. In fact, IU reports that opioid overdose fatalities have risen so sharply in Indiana that they overtook the number of motor vehicle deaths in 2008.

Modeling GCGH's opioid stewardship program after the successful antimicrobial stewardship program seemed like a natural fit to a hospital passionate about patient safety. Brenda Reetz, CEO of GCGH immediately supported the program. "Our priority is our patients and patient safety is at the forefront," Reetz explains, "both programs are a work in progress but since we received such a positive response, we are moving forward. With patient safety in mind, we are always looking for ways to improve our programs and expand our collaborations."

GCGH has already launched into action. In 2017, GCGH instituted a new, holistic comfort menu that focuses on giving patients options beyond traditional painkillers. This menu allows patients to choose heating pads, ice

packets, or massage therapy instead of opioids. This proactive approach allows patients to establish a plan before painkillers are needed. GCGH also hosted a DEA sponsored National Prescription Drug Take Back Day on April 28, 2018 in partnership with the Greene County Sheriff's Office. Participants were able to bring their unwanted medications to the hospital for proper disposal. Bryan Woodall, Director of Public Safety, coordinated the event. "It was nice to hear the participants express their appreciation for the opportunity the hospital provided," Woodall described.

National Prescription Drug Take Back Day

Photo was taken at the DEA sponsored National Prescription Drug Take Back Day hosted at Greene County General Hospital in partnership with the Greene County Sherriff's Office on April 28, 2018.

How a Rural, Independent Hospital Can Survive

By John Gregory
http://www.healthexec.com/topics/leadership/how-rural-independent-hospital-can-survive
April 10, 2018

Meadows Regional Medical Center in Vidalia, Georgia, serves a "very rural" area, according to president and CEO Alan Kent, DHA, just the kind of facility that has often been scooped up by larger systems in recent years. Staying independent meant the hospital needed to drive through a series of management-led initiatives on quality, patient growth and staffing levels.

The rural setting can be both "a blessing and a curse," Kent said during his presentation at the American College of Healthcare Executives (ACHE) Congress in Chicago. The 57-bed hospital is considered the go-to facility for oncology and maternity care in the region, participates in an accountable care organization, has a provider-sponsored health plan and often receives the indigent care from five critical access hospitals within a 30-mile radius.

But it also faced challenges from serving a lower share of commercially-insured patients (around 24 to 30 percent, according to Kent), expansions from for-profit chains HCA and Community Health Systems and a $12.9 million Department of Justice settlement all combining to put its independent status in peril.

"It's not the final stake in the ground that says we're going to be independent until we die, but we like being in charge of our own mission," Kent said. "We may have some partnerships down the line. We're talking about a couple of joint ventures but we have to be strong no matter what."

Building up that strength would require a multi-step turnaround initiative. Kent said it was important to break down departmental silos and get managers engaged in the work by having executives set targets for how many changes should be made, but then leaving it to managers as to how to reach those goals.

The first 100-day project focused on reducing waste. Managers decided to start on the small things first, Kent said, which could be simple efficiencies like how patients and staff move around the hospital. It targeted $1.6 million in savings and managers' plans would have resulted in more than $2.9 million by their original estimates. In the end, the hospital validated savings of $1.8 million, beating its initial target.

After the first project, even the skeptical managers began getting more engaged.

"As this moves along, you really see some good impact from peer pressure and you really see some good impact from expectations being raised," Kent said. "People start to get the idea that I can't be a non-player here."

The second phase, focused on reducing barriers for patient volume, was similarly successful. Managers had to start working together to address the time wasted between departments or when dealing with outpatient locations within the system which are used to their own processes. The result, Kent said, was a total of 407 efficiency plans implemented with validated savings of $1.7 million.

The third phase, however, garnered more resistance as the hospital turned its attention to what staffing levels were really necessary. Managers "panicked," Kent said, assuming executives were pushing for layoffs or eliminating vacant positions. They did find areas to make cuts, such as scaling back by one full-time-equivalent MRI tech, but Kent said they found understaffing as often as overstaffing.

The human component made managers initially resistant to any changes, but by providing everyone with data on the ideal staffing in the system, they eventually came around and started making suggestions on where to make operations and processes could be made more efficient. This project did fall short of its goals, however, achieving only $1.1 million of $1.6 million in expected savings.

Kent considered the initiatives as a whole to be successful. For hospitals in similar situations, he recommended sticking to own key principle in designing their own turnaround plans: get everyone to participate.

"People in healthcare need to realize that change is not optional. You have to change to survive," Kent said.

Dr. Ferry Selected as Fellow of ACP

Decatur County Memorial Hospital would like to congratulate pulmonologist Dr. Thomas Ferry for his recent selection to the fellowship in the American College of Physicians (ACP). Fellows of ACP are a distinguished group of doctors dedicated to continuing education in medical practice, teaching, or research. Fellowship is an honorary designation given to recognize ongoing individual service and contributions to the practice of medicine and as such is a mark of distinction. This honorary designation given to recognize ongoing individual service and contributions to the practice of medicine.

To be elected a Fellow, doctors must show that they are always growing and learning thru activities such as teaching, hospital appointments, public service, continuing medical education, publishing scientific articles, and advanced training. Fellows must be recommended by other ACP Fellows who attest to their character, ethics, and excellence in professional medical activities. Ultimately, this designation signifies Dr. Ferry's commitment to excellence in medicine, patient care, and life learning a philosophy we hold true at Decatur County Memorial Hospital.

For more information about the American College of Physicians, visit acponline.org.

Indiana Tobacco Quitline Updates

NRT Promotion
The Indiana Tobacco Quitline is extending ***free NRT*** to any Hoosier who enrolls in the Quitline now until June 30, or while supplies last. Tina Elliott (telliott@indianarha.org) sent out a press release from Indiana State Department of Health about this promotion. This is a HUGE benefit for those who are ready to quit.

New Quit Now Indiana Materials
New materials are now available for order through the Indiana Quitline website. More materials will go live on the webpage as they become available (including e-cigarettes, asthma/secondhand smoke, mental health, opioid/addictions).

Archived Webinar Recordings:
What's the Hype?: JUUL Electronic Cigarette's Popularity with Youth & Young Adults. Recorded: April 26, 2018
From Data to Policy Development: Tobacco Control Tools You Didn't Know You Needed. Recorded: February 14, 2018
Preemption: Why It's a Big Deal in Public Health. Recorded: January 31, 2018

Majority of Hospitals Allow Patient Access to Health Data; Physicians, Consumers Want More Digital Interaction

By Jaime Rosenberg
http://www.ajmc.com/focus-of-the-week/majority-of-hospitals-allow-patient-access-to-health-data-physicians-consumers-want-more-digital-interaction
March 16, 2018

As health information technology (IT) continues and makes its way into the healthcare sphere, hospitals and health systems have worked to leverage these tools to enhance patient engagement with their health data and their providers, with the goal of optimizing care coordination and, ultimately, patient outcomes.

The 2016 American Hospital Association (AHA) Annual Survey Information Technology Supplement has found that the vast majority of hospitals and health systems provide their patients the ability to access their electronic health records (EHRs).

Collecting responses from community hospitals from November 2016 to April 2017, AHA focused on three areas of activity: accessing health data, interacting with health data, and obtaining health services.

In a drastic increase, 93% of hospitals and health systems enable their patients to view information from their EHR online, up from 27% in 2012, according to the report. In 2012, just 16% of hospitals and health systems allowed their patients to download information from their health record; now, 84% do. The survey also found that 83% enable their patients to designate a caregiver to access the information on their behalf.

"Many hospitals and health systems are moving beyond mere access to provide patients with the ability to interact with their health data using health IT," stated the report, with 73% providing patients the ability to electronically transmit summaries of care to a third party, compared with 13% in 2013. The rate of hospitals and health systems enabling patients to electronically request an amendment to update or change their health record has more than doubled, from 32% in 2012 to 79% in 2017.

As the popularity of health IT has expanded, so has its functionalities. Taking advantage of this, many hospitals and health systems have enabled their patients to electronically obtain healthcare services, including secure messaging and appointment scheduling. The report found that 53% allow patients to request refills for prescriptions online, up from 22% in 2012; 68% allow patients to schedule appointments online, up from 37% in 2012; and 87% allow patients to pay their medical bills online, up from 70% in 2012.

"As the healthcare system continues to evolve, patient access to and interaction with their EHRs will continue to grow," stated the report. "Hospital and health systems will continue to invest in the required capabilities and collaboration across the healthcare system."

The report notes that it foresees rural and critical access hospitals, in particular, continuing to expand these functionalities with the increasing prevalence of new care delivery and payment models that are more dependent on access to data and patient engagement.

Mirroring the uptake of health IT in hospitals and health systems, consumers and physicians have indicated their desire for more electronic engagement, according to a recent nationwide poll by Ernst & Young LLP.

More than half of consumers (54%) said that they were comfortable contacting their physician digitally, and a modest amount expressed interest in using technologies like at-home diagnostic testing (36%), using a smartphone or connected device to send information to their physician (33%), and having video consultations (21%). Currently, 63% use or have used technology to track health- or exercise-related data in the past 12 months, with 60% indicating that they would share those data if sharing would assist physicians in treating them.
The survey also revealed a common agreement among physicians that digital technologies and data sharing will effectively contribute to the overall well-being of the population, with 83% believing that increased consumer- and patient-generated data from connected devices would benefit the overall quality of care and enable more personalized plans. Also taking into account burden and cost, 66% of physicians indicated that increased use of digital technology would reduce burden on the healthcare system and its associated costs, and 64% believe that it would reduce burden on doctors and nurses, having a positive effect on physician burnout.

In a recent interview with *The American Journal of Managed Care*®, Jagmeet P. Singh, MD, PhD, FACC, deputy editor of JACC: Clinical Electrophysiology, and Fred Bove, MD, MACC, editor-in-chief of *Cardiology* magazine, discussed how the integration of data from wearable technology into the EHR and the use of telemedicine promotes greater collaboration between the patients and their physician and health system and is helping the shift from episodic to continuous care.

Nurse Practitioner Joins Rush Memorial

Added to our Family Provider and Pediatrics, Leah Freeman, NP

Rush Memorial Hospital Foundation Selects Executive Director

The Rush Memorial Hospital Foundation Board of Directors is pleased to announce the selection of Alle (Wicker) Lilly as the new Rush Memorial Hospital Foundation Executive Director. She will join the team on June 11, 2018.

Opinion: To Reinvent Rural Health Care, Ditch the 'One-Size-Fits-All' Model

Geography shouldn't be an impediment to quality care

By Byron L. Dorgan
https://www.rollcall.com/news/opinion/reinvent-rural-health-care-ditch-one-size-fits-model
April 9, 2018

As policymakers grapple over how to best deliver quality, affordable health care, they cannot ignore the unique challenges faced by the 46 million Americans living in rural areas.

Not only do rural residents rank worse than their urban counterparts on many health metrics such as obesity, tobacco usage and suicides, their communities also face shortages of health care workers and geographic challenges that make it more difficult to address these concerns.

In recent decades, strengthening the financial viability of their health care systems has been a top priority for rural communities and lawmakers. The broader health care system, meanwhile, focused on moving toward a payment system based on value and quality rather than volume.

Policymakers made improvements to how Medicare reimburses for rural services, but ultimately decided that rural communities are not ready to fully participate in new delivery models or programs focused on value. The mentality to "stabilize first and innovate later" has dominated the legislative and regulatory efforts of recent years and continues to affect the rural health policy outlook in Congress and the administration.

Last year, the Bipartisan Policy Center launched a six-month effort with the Helmsley Charitable Trust, speaking with over 100 experts to better understand the implications of existing federal policies and the health care challenges facing rural communities. BPC hosted three roundtable discussions with stakeholders from seven Upper Midwest states (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming) and worked with the Center for Outcomes Research and Education to conduct interviews nationwide with thought leaders in rural health care from across the political spectrum.

Our survey findings were released in BPC's recent report and revealed four areas that require policy attention:

(1) allowing rural communities to define their own needs and services;
(2) creating funding mechanisms that account for rural realities and allow for innovation;
(3) optimizing the full array of health professionals to support a sustainable and diverse workforce;
(4) providing health professionals with the tools and technology for success, such as access to telehealth.

The report's main message is that rural communities have unique strengths and challenges, and should be given the flexibility to figure out how to right-size their local care delivery systems. While Critical Access Hospitals, or CAHs, have been the leading model in rural areas, stakeholders generally agreed that a full-service hospital may not be appropriate for every community. Rural residents must be able to adjust the CAH model to meet their specific needs and ensure they have access to sustainable, quality services.

Current efforts to reform reimbursement using pay-for-performance models are designed for high-volume areas, precluding most rural health care organizations from participating. What rural communities need are funding mechanisms that account for their low patient volumes and reliance on Medicare and Medicaid. Rural-specific quality metrics and some protection against downside risk will be necessary to include these communities in the larger movement toward value-based care.

Geographic and professional isolation, combined with a lack of exposure to rural practice during training and residency programs, make it difficult to recruit and retain health care staff. Connecting providers to a peer network through telemedicine can help prevent burnout but will require updated reimbursement standards and improved broadband infrastructure. Broadening the roles of nontraditional providers such as community health workers and expanding pipeline programs to recruit future providers from local schools can help address staff shortage issues.

Our conversations converged on one fundamental point: Delivering health care in rural communities is distinct from delivering health care in other parts of the country. This tends to go unacknowledged in health policy conversations and puts rural areas at a disadvantage. The piecemeal approach of previous legislative and

regulatory efforts has undermined the rural health care system while largely ignoring significant interdependencies among factors such as CAHs, the rural health workforce and telemedicine.

Comprehensive policies that consider these relationships and identify opportunities for change will lead to more effective results. Ensuring that geography isn't an impediment to quality health care will require a coordinated, bipartisan effort from federal, state and local officials in all 50 states.

Byron L. Dorgan is a former Democratic senator and congressman from North Dakota and a senior fellow at the Bipartisan Policy Center. Caitlin Krutsick is the project manager for the Bipartisan Policy Center's rural health care initiative.

The Bipartisan Policy Center is a D.C.-based think tank that actively promotes bipartisanship. BPC works to address the key challenges facing the nation through policy solutions that are the product of informed deliberations by former elected and appointed officials, business and labor leaders, and academics and advocates from both ends of the political spectrum. BPC is currently focused on health, energy, national security, the economy, financial regulatory reform, housing, immigration, infrastructure, and governance.

"IU Health Jay"

On March 1, Jay County Hospital integrated with IU Health and formed "IU Health Jay". IU Health Jay joined the East Central Region of IU Health. IU Health Jay has been serving Portland and surrounding communities for over 100 years. The facility offers inpatient and outpatient services, along with obstetrics, surgery, behavioral health, emergency services, family medicine and many other specialties.