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CAHOOTS

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"The Impact of Medicaid Expansion on Hospital Closures"

By Paige Minemyer
www.fiercehealthcare.com
Jan 9, 2018

Medicaid expansion significantly decreased the number of people without insurance, and in turn may have prevented some cash-strapped hospitals from closing, according to a new study.

Researchers from the University of Colorado School of Public Health compiled financial data on critical access hospitals reported between 2008 and 2016 and found that these facilities in states that expanded Medicaid were six times less likely (or 84% less likely) to close, according to data published in Health Affairs.

Financial margins for these hospitals also improved by 33% in expansion states, according to the study.

Closure rates in both groups of states were similar until diverging circa 2012, the researchers found. This could coincide with a Supreme Court decision that year that made Medicaid expansion optional. There was also a significant number of closures in nonexpansion states in 2013, according to the study, as critical access hospitals expected disproportionate share hospital payments to be phased out.

For-profit hospitals were also more likely to close than non-profit facilities, the study found.

The findings add to the growing body of research that suggests Medicaid expansion was a significant financial boon for hospitals. By significantly decreasing the number of low-income patients without insurance, uncompensated care spending dropped, research showed.

The researchers warned that a rollback of Medicaid expansion could lead to additional rural hospital closures that could cripple access to care for patients in those areas. Increased travel time to another facility could worsen outcomes for people with critical needs, and closures would also likely mean a loss of skilled jobs in regions that need that work.

The impacts are less pronounced in urban areas, the researchers said, as hospitals that close in those regions are typically of poorer quality.

"In rural or smaller communities, hospital closures have a far greater impact because they not only affect the delivery of healthcare services and emergency care, but we also have to consider that these hospitals are the largest employer and often are pillars in those communities," Gregory Tung, Ph.D., an assistant professor in the School of Public Health and one of the study's authors, said in an announcement.

Community Rallies Together to Raise Over $30K for Putnam County Hospital Cancer Center

Saturday, November 18th, over 250 community members put on their best dresses and sharpest suits to raise awareness and funds for the local Cancer Center during the inaugural Putnam County Hospital Benefit Gala. By the end of the night, spirits were high as generous donors rallied to raise over $30,000 that will go directly to the Putnam County Hospital Cancer Center for the purchase of IV pumps to better care for cancer patients.

The gala was an overwhelming success from the release of the news just months before the event. Within two weeks of announcing the event, tickets sold out. Gala and after-party ticket sales generated over $6,500 in revenue that will go directly to the Cancer Center.

Asks were made to community businesses, supporters and vendors asking for contributions, whether it be a financial sponsorship or as a donor to the silent or live auction. The responses from the community were humbling as the hospital began to see the personal impact its Cancer Center has made to so many in the community. More than 50 items/experiences were donated to the auction with more than $11,850 in sponsorships were raised.

The gala opened its doors to the Union Building Ballroom, graciously donated by DePauw University at 6pm. Awaiting those that arrived were students from DePauw University's Phi Kappa Psi fraternity who also donated their evening for the cause, offering complimentary valet parking.

As attendees entered the ballroom, they were greeted with the sounds from DePauw School of Music's string quartet. A complimentary wine tasting and cash bar accompanied the event as gala attendees enjoyed fellowship and bidding on the silent auction items. An elegant dinner was catered by Bon Appetit. Stunning table settings were topped off with centerpieces donated by Eitel's Flowers and crisp white chair compliments of Mary Keck with Putnam County Hospital. A special thank you to DePauw School of Music, Eitel's Flowers and Mary Keck for creating an elegant evening inside of the ballroom.

Putnam County Hospital presented a program at 8pm that educated and enlightened those in attendance of the impact that Putnam County Hospital Cancer Center has in our hometown. Dennis Weatherford, Putnam County Hospital CEO, welcomed and thanked the community for its support and trust in the hospital and cancer services provided close to home. Next, a touching testimonial video, featuring Jim Turpin, was shared with the crowd. The video shared Jim's experience with Putnam County Hospital's Cancer Center as well as how the center's partnership with Franciscan Health helped him received the very best in cancer care as he battled leukemia. Following the video, Jim Turpin personally spoke of his experience and his heart-felt thanks for the care he received. Dr. James Callaghan, Franciscan Health Indianapolis CEO, was next to speak to those in attendance about the partnership with Putnam County Hospital, expressing Franciscan Health's dedication to giving Putnam County patients big city services close to home. Wrapping up the program was Mary Ann Birt. Mary Ann, a breast cancer survivor, spoke of her fight with cancer and how receiving her treatments close to home near family and friends impacted her healing. Putnam County Hospital sends a sincere thank you to Dennis Weatherford, Jim Turpin, Dr. James Callaghan and Mary Ann Birt for sharing their inspiring stories.

Wrapping up the night, silent auction bidding closed and the live auction began. Jeff Rich, a well-known auctioneer in the community, donated his talents for the event. Thousands of dollars were raised as bidders competed for the hot items. A special thank you to Jeff Rich for bringing fun and excitement to the live auction. Silent and live auction items were instrumental in creating a fun atmosphere along with raising $14,815 alone!

Putnam County Hospital thanks the community for a memorable and meaningful evening and is looking forward to planning for 2018.

Putnam County Hospital Cancer Center, partnering with Franciscan Health, offers a peaceful setting for patients who are undergoing cancer treatments close to home. The center provides a comprehensive plan with holistic care that meets the medical, spiritual, and emotional needs of patients. The most up-to-date

treatment is delivered from physicians and medical professionals who know and care about our patients and their families.

Dr. Sameer Ahmed, a physician with Franciscan Physician Network, joined the Cancer Center in 2015. The Cancer Center is also staffed by Registered Nurses who have been oncology trained. Continued education concerning cancer, the most up-to-date treatments, and symptom management is important to us. Registered nurses are oncology-certified through the Oncology Nursing Society (ONS), a national organization. Active membership in the local Illiana Chapter of ONS allows the nursing staff to attend monthly meetings to discuss new and current treatments.

The Cancer Center is accredited by the American College of Surgeons.
For more information about Putnam County Hospital Cancer Center, please call 765.655.2581.

OB Services Are Back at IU Health Paoli Hospital "Best Kept Secret, No Longer a Secret"

Open Letter by Yolanda Yoder, MD
Southern Indiana Community Health Care

On January 27, IU Health announced the reversal of a previous decision to close OB services at IU Health Paoli Hospital. That announcement follows a week of meetings and learning together what the lack of local OB care could mean. From the beginning, IU Health's senior leadership struggled with the decision as they weighed the importance of rural OB services against the financial burden of keeping it going. They were very clear in their desire to "get this right."

One factor was some likely success Southern Indiana Community Health Care (SICHC) has had in recruiting a physician to help ease the C-section call and obstetrics for the population we serve. But a more compelling factor that weighed heavily into the decision was the collaborative priority of Governor Holcomb, State Health Commissioner Dr. Kristina Box and IU Health to focus on lowering the state's infant death rate. Indiana's is higher than other northern states and that's a puzzle many are looking to solve. Prioritizing safe, easy to access prenatal care and delivery sites for Indiana's babies is a small critical piece of that puzzle. As a FQHC Look-alike community health center, SICHC offers that comprehensive pregnancy, birth, infant and family care that can make all the difference.

If nothing else, these last 2 weeks have made us acutely aware of the value of our community's health resources. We are exceeding grateful that IU Health system decided to lead the way by choosing to advocate for equitable health care over cost considerations.

Now it's up to us find ways to work with them for improved outcomes across the spectrum. And let's work together to impact public policy so that other small communities without the strength of IU Health have a chance to be heard too. The next step for all of us is to speak up loudly for national funding to cover the cost of maternity care and other health services in disadvantaged communities. Healthy babies come from healthy pregnancies. It's that simple. Contact your Senators and House of Reps today to add your voice for equitable care. Go to our sichc.org website for links.

And now it's time to thank the OB crew who work hard to make rural OB care what it should be.

We've heard that "best kept secret" comment from many a happy mother when describing their experience delivering at Paoli's childbirth facility. They also say, "if I had known it was like this, I would have had all of my babies here". They go on to describe:

- the attentive care from the nurses with one-on-one focused staffing; like they're part of our family.
- the facility's laboring hot tub, birthing ball and family friendly environment
- flexibility of the OB staff that support and encourage birth plans unique to each couple
- the consistent care offered by the midwife or doctor who they get to know during their prenatal care who then attends their delivery, rather than having an "on call doctor" do the delivery
- the low C-section rate in part due to patient, supportive staff who support natural labor and your body's own timing.

- exceptionally qualified anesthetists who perform high quality epidurals for pain control
- highly trained C-section doctors who stay in Orange County round-the-clock because they believe in the value of critical access to vulnerable populations. A shout out to Dr. Stauffer, our best advocate ever!
- encouraging nurses and lactation consultants who help get breast feeding off to a good start
- the value of having the delivering doctor also manage the baby's care both in the hospital and in the office for years to come. There is comfort in having a doctor who knows the family.

The factors below all help contribute to quality numbers recognized in the IU Health 17 Hospital System.

1) Avoiding elective induction of labor before 39 weeks – shown to positively impact infant outcomes. Recognized by the March of Dimes. Tied for best overall within IU Health.
2) Primary C section rate – Second best overall with a 13 % average over the last 3 years. (IU's goal is to be lower than 29%)
3) Breast feeding rate – Third highest within IU Health
4) Absence of hospital associated infant infections and mother's urinary tract infections related to catheters – Best overall within IU Health

What makes these numbers even more compelling are mother's health risk factors that can lead to complications.

- 30% are smokers (National average is 17%)
- 15% are teenagers (National average is 8%)
- 26% start their prenatal care after the first trimester (NA 16%)
- Early care can identify problems to help avoid complications.
- Amish women with large families are at risk of heavy bleeding at delivery. 91% of them start their prenatal care after first trimester, with 70 % in the last 2 months

SO … many thanks to the IU Health Paoli OB team who provides attentive care in a competent manner that is reflected in quality numbers, despite risk factors. The final outcome says it all … healthy mothers and babies.

And thank you to IU Health System for taking the progressive lead for health equities in Indiana.

"Year in Review: 7 Rural Hospital Closures in 2017"

Written by Ayla Ellison
www.beckershospitalreview.com
January 02, 2018

Eighty-two rural hospitals across the county have closed since 2010, and seven of those facilities shut down last year, according to research from the North Carolina Rural Health Research Program.

The seven rural hospitals that closed in 2017 are listed below in alphabetical order. For the purposes of its analysis, the NCRHRP defined a hospital closure as the cessation in the provision of inpatient services. As of Jan. 2, 2018, all of the facilities listed below had stopped providing inpatient care. However, some of them still offered other services, including outpatient care, emergency care, urgent care or primary care.

1. Campbellton-Graceville (Fla.) Hospital shut down in June, one month after it filed for Chapter 11 bankruptcy.
2. Care Regional Medical Center in Aransas Pass, Texas, closed in August due to extensive damage caused by Hurricane Harvey, according to the *Caller Times*.
3. Copper Basin Medical Center, a critical access hospital in Copperhill, Tenn., closed Oct. 1. After months of financial troubles, Copper Basin Medical Center suspended inpatient services May 9, and officials launched a GoFundMe page to help keep the hospital afloat. The hospital shut down after falling about 94 percent short of its $100,000 goal.
4. Davie Medical Center-Mocksville (N.C.) closed at the end of March, according to *Journal West*. A replacement facility, 50-bed Davie Medical Center, was built in nearby Bermuda Run, N.C.

5. East Texas Medical Center-Trinity closed in August. The hospital closed after Tyler-based East Texas Medical Center decided not to renew its lease of the facility. ETMC said a number of factors contributed to its decision not to renew the lease, including poor utilization and declining reimbursement rates.
6. Pioneer Community Hospital of Patrick in Stuart, Va., closed in phases. The facility closed its emergency department Sept. 13 and began diverting ambulances to other facilities. The hospital continued to provide care to acute care patients until they were stable for discharge or transfer. The hospital offered outpatient care until Sept. 15, when it ceased all services.
7. Timberlands Hospital in Crockett, Texas, closed June 30 after Rockdale, Texas-based Little River Healthcare ended its affiliation agreement with the hospital, according to *KTRE*.

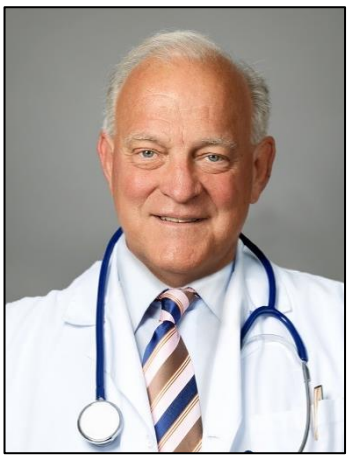
Rush Memorial News …

Rush Memorial Hospital continues to be very busy. Recently added services include:

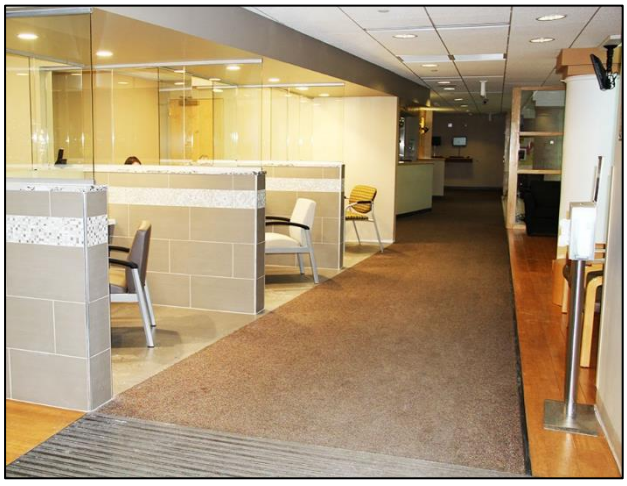
RMH Pulmonology with Dr. Tasbirul Islam

RMH Pain Management with Dr. Edwin Dunteman

New Internist/Family Practice Doctor Dr. Darrell Rinehart



A total remodel of our Imaging and Admission Departments



occurred including relocation of our Out-Patient Lab to admissions area allowing us to be more patient-friendly.

During this time, our Med Surge experienced a first phase redo that included an entire overhaul of 8 rooms (for starters). State of the art beds, call lights, etc., room remodel refreshed this area. Over time, the remaining rooms will be remodeled as well.

Adams Nursing Facility Earns 5-Star Status

Adams Heritage Nursing Facility, a member of Adams Health Network, located in Monroeville, Indiana has once again received 5-Star status from the Centers for Medicare and Medicaid Services (CMS) as of November 29, 2017.

Adams Heritage Nursing Facility Administrator Maria Diaz says the honor comes with "our dedicated staff doing the right thing for the residents."

The 5-Star Quality Rating System is a tool that CMS developed to assist the public in selecting and comparing skilled nursing homes. This system is used throughout the United States.

Created in 2008, this system uses three criteria: Health Care Surveys (both standard and compliant), Quality Measures, and Staffing. The website to review nursing homes ratings can be found by going to www.medicare.gov/nursinghomecompare.

Nursing Home Compare rates nursing facilities with a rating between 1 and 5 stars. Nursing facilities with 5 stars are considered to have much better average quality and nursing facilities with 1 star are considered to have quality much below average.

Diaz added, "Adams Heritage is a 61 bed facility located in southeastern Allen County. Even though we are a small facility, our commitment is huge to give exceptional care to every resident who lives here. Family involvement is always encouraged and we have a devoted staff asking our residents continuously if they have any concerns that needs to be addressed. Our residents are comfortable in voicing their thoughts and my door continues to be open for anyone who needs to speak to me. We keep in mind that this facility is the home for our residents, so our staff strives to achieve a homelike and pleasant environment for all residents."

As a member of Adams Health Network, Adams Heritage has the luxury of utilizing our own Therapy Department for all residents needing rehabilitation in house as well as for outpatients in the community. "Therapy staff is not contracted from an outside source, our therapists are employed by us, and so they are not strangers to our residents. With this in mind, we have the advantage of our therapists seeing and communicating with our residents on a daily basis. Our established relationships give our therapists more insight to help our residents return back to previous or optimal levels of functioning versus an outside contractor being unfamiliar with our residents, or knowing them by paper only", said Diaz. Another benefit of being part of Adams Health Network is that we are fortunate to use other network resources on a routine basis that perhaps a regular nursing home may not have access to.

Adams Heritage is committed to the challenges of the new Federal regulations introduced on 2016 in three phases. These phases will be all in effect by November 28, 2018.

“I am extremely proud of the staff here at our facility. This industry is not easy and we are confronted with many challenges from Federal and State regulations, but we are devoted to make this facility environment the best home for our residents and continue to provide the best quality care”, concluded Diaz.

“Report: Hospitals Not Always Best Fit for Rural Communities”

By Tara Bannow
www.modernhealthcare.com
January 17, 2018

A new report presents an intriguing, yet controversial suggestion: Not all rural communities need critical-access hospitals.

Those hospitals can maintain up to 25 inpatient beds, but researchers with the Bipartisan Policy Center and the Center for Outcomes Research and Education found only three to five of those beds were occupied on average in the seven states they studied, a costly proposition for those facilities.

That presents a complicated question for communities, some of which, researchers argue, would be better served by facilities that mix primary care and emergency services.

"I think it was the realization that the volume being so low in many of these places coupled with the high fixed operating costs makes it, from a long-term perspective, not necessarily financially sustainable," said Dr. Anand Parekh, an author of the report and BPC's chief medical adviser.

For the report, researchers talked to more than 90 thought leaders and stakeholders in seven states last year to learn about the ongoing challenges rural healthcare providers face and the implications of federal policies and areas for improvement.

The states included in the study—Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming—have some of the lowest population densities in the country. Of the nation's nearly 1,340 critical-access hospitals, one-quarter are located in these states, according to the report. All seven states have obesity rates exceeding 31%, and North Dakota and Wyoming have some of the highest smoking rates in the country, at 19.8% and 18.9%, respectively.

Local providers told BPC their patients are older and spread out, and that the lack of access to the care they need can have "devastating consequences," the report says. Shortages in behavioral health and obstetrics providers, nursing homes, ambulance services and non-emergent care were highlighted as rising concerns.

Critical-access hospitals are a touchy subject for stakeholders in the states studied, as they're typically an important economic component of rural communities, but in some cases aren't financially sustainable because of low occupancy. Critical-access hospitals in South Dakota, for example, see an average of five patients per day, the report found.

"Participants in this project struggled to reconcile their opinions that CAHs are no longer the most efficient way of delivering care in rural areas with concerns that closing the hospitals would still create access issues for communities and would have a negative effect on local economies," the report said.

How to reinvent critical-access hospitals to better serve communities is undecided, Parekh said, but it would likely combine primary care with acute services.

A number of different formats have been floated.

"At the end of the day, a transformed entity is better than a closed entity for both the community health and the local economy," he said.

U.S. Sen. Chuck Grassley is championing a proposal before Congress called the Rural Emergency Acute Care Hospital Act, which would create a new Medicare classification to allow rural hospitals to limit themselves to providing emergency and outpatient services. The bill doesn't have a House companion.

"The goal of the REACH Act is also to help rural hospitals stay open while meeting the needs of rural residents for emergency room care and outpatient services," Grassley said in a statement.

The National Rural Health Association, which represents rural hospitals, supports the REACH Act, but prefers its own proposal, the Save Rural Hospitals Act. That would allow for the creation of "community outpatient hospitals," but also includes increased Medicare funding and other provisions.

Nonetheless, Brock Slabach, NRHA's senior vice president, said, "We're willing to work with anybody on working towards a new model."

Another resounding take-home message that emerged: There's no one-size-fits-all policy that will tackle the challenges in every rural community. Solutions will have to be flexible.

Congress and the current presidential administration have largely left rural communities out of value-based payment initiatives, focusing instead on strengthening those systems' financial viability and access to healthcare in those areas, according to the report. Most delivery system reforms under the Affordable Care Act either outright excluded rural healthcare providers or allowed them to participate with little financial risk.

The NRHA has developed a proposal to help critical-access hospitals to dip their toes into value-based purchasing. It would increase hospitals' Medicare reimbursement by 2% if they submit quality data, which they're currently not required to do, and agree to join Medicare managed-care groups. Slabach said the proposal will likely be introduced in Congress next month.

While the ACA didn't address telehealth and other remote-monitoring technologies in rural areas, the new report said it's becoming increasingly important for rural communities. Significant barriers exist, however, including continued discomfort with the technology among providers and staff in the states studied. Local providers said both private and public payers have limits around what types of telemedicine they'll reimburse for, and it's not always the same as an in-person visit.

All states studied have changed laws to allow nurse practitioners to practice independently without direct supervision by a physician. Other states are considering allowing pharmacists to perform medication management for patients, although various provider associations oppose such measures, the report said.

Rural communities are also embracing the use of community health workers, case managers and care coordinators that travel to patients and help arrange their care. In-home care workers who visit several patients a day are also becoming increasingly important in rural areas with aging populations.

The Art of Disguise

E-cigarettes come in a vast array of shapes and sizes. Some electronic nicotine delivery systems (ENDS) resemble their conventional tobacco counterparts: cigarettes, cigars, and even pipes. Some have taken on a shape and form all their own, such as “mods” or tank systems. Others look nothing like traditional tobacco products but could easily be mistaken for colorful ink pens or asthma inhalers.

One of the newer forms of these devices is raising an alarm among educators and parents. Juul is made to resemble a USB device and can be easily concealed. “ . . . The trend to own a vape pen is real, with students bragging on Twitter about using them in class . . . ” says an article published by National Public Radio (NPR).

This trend comes with growing concerns about the potential long-term consequences for youth who use e-cigs. One recent study published by the University of California San Francisco found that youth who use

“alternative tobacco products” such as e-cigarettes are more likely than their peers who do not use e-cigs to be smoking combustible cigarettes one year later.

“We found that teens who experimented with tobacco in any form were at greater risk of future smoking,” assistant professor at UCSF School of Dentistry and senior author Benjamin W. Chaffee, DDS, PhD, is quoted as saying.

Juul cartridges, according to NPR’s article, have a high concentration of nicotine. A single “pod” reportedly has the same amount of nicotine as one pack of cigarettes.

More information about Juul and its impact on youth can be found at www.truthinitiative.org.

For personalized Indiana Tobacco Quitline training for your healthcare providers, please contact Tina Elliott at telliott@indianarha.org.

“CMS Revives Obama-era Critical-Access Hospital Rule”

By Virgil Dickson
www.modernhealthcare.com
January 16, 2018

The CMS plans to release a finalized version of an Obama-era rulemaking that outlines new standards that critical-access hospitals must comply with to continue billing under Medicare.

The federal agency released the proposed version of the rule in June 2016 and it was not finalized before the Trump administration started in January 2017. The CMS plans to release a final version of the rule some time over the next 17 months, according to a Jan. 12 Federal Register notice, which outlined a list of forthcoming rulemakings.

The wide-ranging rule represented the most major change to standards for critical-access hospitals since 1997. It included a requirement that hospitals must have infection prevention and antibiotic stewardship programs for healthcare-related infections and for the proper use of antibiotics. In addition, the CMS proposed that hospitals adopt nondiscrimination policies that expand protections based on gender identity and sexual orientation. The rule also had several provisions meant to hasten patients' access to their healthcare records.

In all, the CMS estimated that implementing the rule would cost the industry $773 million to $1.1 billion.

The rule won wide industry support when it was proposed, although there were some concerns about several of the provisions outlined in public comments.

The Catholic Health Association pushed back against the new anti-discrimination language related to gender identity over concerns that it would conflict with moral or religious objections to providing medical or surgical gender-transition services.

It requested HHS include a religious exemption from the proposed requirements.

Adventist Health System expressed concern about the new anti-infection proposals, as the system questioned whether they would have much impact when healthcare settings outside hospitals aren't required to make similar efforts.

Many antibiotic-resistant organisms come into the hospital from these other settings, according to Adventist. The health system recommended that the CMS clarify the new standard to reflect that there are some circumstances that are beyond the hospitals' control.

Allina Health, a system of 13 hospitals, raised concerns about the rule proposing that patients may access their records via an oral or written request. It wanted the phrase "oral" omitted from the final version of the rule because requests in writing better allow providers time to confirm a patient's identity before documents are released.

Allina also said it was concerned about regulatory burden around a proposal that a request for medical records be completed within 30 days for inpatient stays and within seven days for outpatient visits.

Such an approach would pose an administrative burden; Allina recommended that the CMS adopt one consistent 30-day time frame regardless of the patient's status.

It is unclear whether the CMS will adopt any of the industry's recommendations. The agency hopes to have the final version of the rule out by June 2019.

Decatur County Patient Access Center

Contributed by Jennifer Baltus, RN MSN, Quality Outcomes Coordinator

We survey our patients that visit Tree City Medical Partners and Decatur County Primary Care to determine what action we can take to improve our service performance for our patients. One of the themes in the survey responses was that access to our clinics via phone was not easy or convenient. **So we took action.**

We used a process improvement method that looked at all aspects of the problem.

- It looked at management of the calls by the staff in both clinics, including the differing types of calls that come in – from requests for appointments to requests for refills to requests for information from a medical assistant to requests from other providers – and more!
- It looked at how each different provider wanted their calls and requests handled including variation in appointment times, etc.
- It looked at how each phone operator had their own method of processing the call requests and managing provider appointment scheduling.
- It looked at the staffing matrix to see if we were utilizing enough operators to balance the call volume.
- It looked at the skill set needed to quickly respond to patient needs with the initial call rather than create a need for a call back by the medical assistants that were assisting the providers in the office with the patients that were physically in the office.

Based on the feedback and discovery determined during the review of the current process, it was determined that a central Patient Access Center (PAC) was the best solution to improve our patients' access to care. The improvements required much teamwork. We knew that there would be some bumps along the way, but we were committed to a successful outcome for our patients.

Several steps had to be completed to improve the success of the PAC.

- We had to develop standard work and scripting around the scheduling process that included individual provider preferences and assistance with important data entry that facilitates proper registration, and therefore, appropriate insurance capture and billing.
- We had to train all PAC operators to speak the same standard work to create less variability, which improves accuracy, timing, and speed.
- We had to create a clinical position in the PAC that utilizes a triage nurse to assist with calls that can be answered immediately rather than playing phone tag with patients. This position not only answers the patients in real time, but it removes the burden of returning the calls from the medical assistant that is working alongside the providers in their offices.
- We had to create a centralized space that all PAC operators could share to balance the volume of calls received daily. This did require the sacrifice of some operators who were moved from one facility to join the entire group in one center.
- We had to develop metrics to track the progress of our improvements. Metrics being monitored daily are the volume of calls, the volume of calls that result in a voicemail, and the length of each call conducted.

By collecting this data, Decatur County Memorial Hospital Medical Practices, Tree City Medical Partners and Decatur County Primary Care, are able to strive to achieve their "same-day appointment with a provider" promise to the community.

Mike Robertson, Executive Director Physician Practices, stated, "Despite initial concerns and fears, I knew we were on the right track when after the first day one of the staff members said, "This wasn't as bad as I thought."

With continually modifying the process, all staff are fully engaged while implementing their suggestions. We measure the number of calls/day and the number of voicemails. The data indicates that the average number of calls/day is 550, with a time spent/call approximately 1:50 to 2:10."

Carol Wolff, a former DCPC operator, now a PAC operator, is happy how the overall project turned out. She added, "One advantage to this new system is taking care of the patient better. With all of us together and being alongside a triage nurse, we can better answer the patient's questions and get them the proper care and physician they need."

The medical practices anticipate positive increases in patient experience scores from patient surveys as a reward to putting the patients' first. What is best for the patient is best for us. We are committed to this community and strive for continued progress in all aspects of our care including quality, service, and growth.