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CAHoots

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Jay County Hospital Welcomes Family First Healthcare

Jay County Hospital held a ribbon cutting and open house in August 2016 to welcome Family First Healthcare, the new healthcare provider practice of Dr. Kristy Mount and Dr. Andrew Stevens to our team. The Family First Healthcare office is located in Jay County Hospital at 500 West Votaw Street, Portland, and provides obstetric, pediatric, and adult medical care for the entire family.

Dr. Mount and her family recently relocated to Portland. Dr. Mount was born in Cincinnati, Ohio, but raised in Brookston, Indiana. She received her Bachelor of Science in Biology from Purdue University. She went on to earn a PhD in microbiology and immunology from Indiana University before attending medical school at Loyola Stritch School of Medicine in Chicago, Illinois. Dr. Mount ultimately decided to become a full-spectrum family medicine doctor because she “loved the idea of being able to treat absolutely anything that walked in the door.” Dr. Mount and her husband have been blessed with two children; and in her spare time, she enjoys spending time with close friends and family, reading, cooking, running, and being active in her church.

Dr. Stevens also recently moved to Portland with his family. Dr. Stevens was born in Pasadena, Texas, but raised in Taylorsville, Utah. He received his Bachelor's degree in Biomedical Engineering from the University of Utah. He decided to go into medicine and was accepted into the University of Utah School of Medicine. While rotating through specialties, he found himself "wanting to practice full-spectrum family medicine (including OB care)." Dr. Stevens is bilingual, speaking Spanish. He and his wife have been blessed with 4 children; and he enjoys spending time with his family, board gaming with friends, and dedicating time in his church and reading.

Drs. Mount and Stevens are excited to join the Jay County Hospital team and care for patients and assist them with their health care needs.

Gibson General Hospital Enters into Affiliation with Deaconess

Gibson General Hospital has entered into a formal management agreement with Deaconess Health System. The goal of this agreement is to enhance services, increase care coordination, and clinical integration between the healthcare providers and the communities they serve. Affiliation allows the hospitals to work together on important initiatives like population health management, staff and physician education, and providing seamless transitions of care from the doctor's office to medical specialists and advanced procedures.

No assets are being purchased; and Gibson General Hospital will remain a local, independent hospital dedicated to providing exceptional care to the people in and around Princeton.

"The Gibson General Hospital Board of Trustees unanimously agreed to enter into a relationship with Deaconess as it adds value and quality to healthcare provided in our community," said Chairman of the Board Robert Gibson.

"We have enjoyed building a relationship with Gibson General and look forward to combining the strengths of our two organizations to enhance the services available in our region," added Linda E. White, President and CEO Deaconess Health System.

In the attached photo – Linda E. White, Shawn McCoy, and Jared Florence from Deaconess and Emmett Schuster, Robert Gibson, and Mike Wood from Gibson General Hospital formalize our affiliation.

Gibson General Hospital Partners with Orthopaedic Associates

Gibson General Hospital is pleased to announce that it has partnered with Orthopaedic Associates to provide orthopaedic services close to home for residents of Gibson County and surrounding communities.

The partnership establishes a new office, Orthopaedic Associates at Gibson General Hospital, which will be located on the second floor of the hospital, and brings two orthopaedic surgeons to the community's medical staff—Dr. Dennis Beck and Dr. Daniel Emerson.

“We’re excited to partner with Orthopaedic Associates to resume services for those in need of orthopaedic care,” said Emmett Schuster, President & CEO of GGH. “Orthopaedic Associates is known for their expertise and high-quality care, and we’re proud to provide convenient access to their experienced surgeons.”

Dr. Beck will see patients at the new office every other Thursday beginning Dec. 8. He is a graduate of the Indiana University School of Medicine and completed his general surgery internship, orthopaedic surgery residency, and orthopaedic trauma fellowship at the University of Louisville School of Medicine.

He joined Orthopaedic Associates in 2003 and is board-certified by the American Board of Orthopaedic Surgery (ABOS), and specializes in general orthopaedics and total joint replacement. He is one of the few surgeons in the area performing anterior hip replacement.

Dr. Emerson will see patients every other Wednesday beginning Dec. 14. He is a graduate of the Indiana University School of Medicine, and completed his orthopaedic surgery residency at Madigan Army Medical Center at Fort Lewis in Tacoma, Washington.

He joined Orthopaedic Associates in 2011 and is board-certified with a subspecialty certificate in orthopaedic sports medicine by the ABOS. His interests include general orthopaedics, trauma, total joint replacement, shoulder and knee surgery, and sports medicine.

Together, GGH and Orthopaedic Associates are also recruiting an orthopaedic surgeon to work full-time in the Gibson General Hospital office.

“We’re excited to be partnering with Gibson General Hospital to bring a higher level of orthopaedic care to the residents of Gibson County and the surrounding area,” said Jerry Blanton, Executive Director of Orthopaedic Associates. “We recognize the need for our services and the importance of seeing patients where they are, and we look forward to expanding on the quality health care services already available at Gibson General Hospital.”

2017 Patient Engagement Requirements for MACRA, Meaningful Use

Sara Heath
22 December 2016
Retrieved from *Patient Engagement HIT (Intelligent Media Network):*
http://patientengagementhit.com/news/2017-patient-engagement-requirements-for-macra-meaningful-use

Eligible hospitals should focus on patient engagement requirements for meaningful use, while clinicians should focus on MACRA provisions.

As 2017 approaches, healthcare professionals should prepare for new sets of reporting requirements, including patient engagement provisions under meaningful use for hospitals and MACRA for eligible clinicians.

With reimbursement rates hinging on successful participation in these programs, hospitals and clinicians alike would benefit from understanding the patient-centered requirements included in both programs.

In addition to meaningful use and MACRA, CMS has recently established an additional set of guidelines and programs to improve patient and family engagement. While these benchmarks may not influence federal incentive payments, they could be key for delivering high-quality, patient-centered healthcare.

With reimbursement rates hinging on successful participation in these programs, hospitals and clinicians alike would benefit from understanding the patient-centered requirements included in both programs.

Below, PatientEngagementHIT.com reviews the 2017 patient engagement requirements hospitals and clinicians should know.

Patient engagement and MIPS

In October, 2016, CMS published the final MACRA implementation rule, which established the Quality Payment Program. Among other things, the nearly 2,400-page rule created a set of patient engagement requirements for eligible clinicians.

These requirements are a part of the Merit-Based Incentive Payment System (MIPS), one of two quality measurement legs of the Quality Payment Program. MIPS includes four quality improvement categories, and most of the patient engagement provisions are under the Advancing Care Information category.

“With these objectives we recognize that the Quality Payment Program provides new opportunities to improve care delivery by supporting and rewarding clinicians as they find new ways to engage patients, families and caregivers and to improve care coordination and population health management,” CMS said in an executive summary of the nearly 2,400-page rule.

Specifically, eligible clinicians will need to offer patients access to their health data and participate in care coordination with other providers. In the first reporting period, set to begin immediately following the New Year, eligible clinicians will be required to meet the following measures:

- Allow one unique patient view, download, and transmit capabilities with their health data
- Allow one unique patient access to their health data via an application programming interface (API)
- Supply patient-specific educational materials to one unique patient
- Extend one unique patient view, download, and transmit capabilities, with that patient then transmitting the data to a third-party provider
- Send or answer at least one secure direct message with one unique patient
- Collect patient-generated health data from one unique patient
- Send or receive a summary of care from a third-party provider for one unique patient

2017 will be a transitional period for eligible clinicians, meaning those clinicians can report these measures for any consecutive 90-day period. Additionally, eligible clinicians may pick their own pace for reporting.

To avoid a negative payment adjustment, clinicians may submit any data to CMS. This will result in a neutral payment adjustment, meaning clinicians will not lose out on payments, but they may not receive any incentive payments either.

For a modest positive payment adjustment, eligible clinicians may submit all requirements for a shortened reporting period.

Providers who submit all measures for the set reporting period will be eligible for a full positive payment adjustment.

Patient engagement and meaningful use

Going into 2017, eligible hospitals and critical access hospitals will still attest to meaningful use. Many of these providers will attest to Stage 2 Meaningful Use as that leg of the program winds down.

In 2017, all participants must attest a full calendar year reporting period, except for those participating in the program for the first time. First-time participants may report any consecutive 90-day period.

Under Stage 2 Meaningful Use, eligible hospitals and critical access hospitals will attest to nine objective measures, one of which being an overarching public health objective that includes four reporting measures.

Specific to patient engagement, EHs and CAHs will need to use certified EHR technology to produce patient-specific education materials for at least one patient. They will also need to offer patients the ability to view, download, and transmit their health data within 36 hours of hospital discharge.

In 2017, eligible hospitals and critical access hospitals have the option to begin reporting to Stage 3 Meaningful Use. Those selecting this option will only need to report for a 90-day period.

According to the Stage 3 Meaningful Use final rule, patient engagement requirements are combined into one overarching rule.

In the Stage 3 Patient Electronic Access Objective, we proposed to incorporate certain measures and objectives from Stage 2 into a single objective focused on providing patients with timely access to information related to their care. We also proposed to no longer require or allow paper-based methods to be included in the measures (80 FR 16753) and to expand the options through which providers may engage with patients under the EHR Incentive Programs. Specifically, we proposed an additional functionality, known as application programming interfaces (APIs), which would allow providers to enable new functionalities to support data access and patient exchange.

Other CMS patient engagement initiatives

While MIPS and meaningful use are the only reimbursement programs requiring patient engagement measures, CMS has recently put some other patient engagement projects into motion.

The agency recently implemented a strategy to improve patient and family engagement as a part of its goal to improve patient-centered healthcare, according to Kate Goodrich, MD, MS, Director of the CMS Center for Clinical Standards and Quality.

“We know that a key strategy to achieving better outcomes is to meaningfully engage patients as partners in decisions about their health care,” she explained in a blog post. “Therefore, one of the six goals outlined in this strategy is: Strengthen person and family engagement as partners in care.”

The Patient and Family Engagement strategy includes four central goals.

First, providers should engage patients and family members in the context of their own health by leveraging relationships with key community players. These community supports can help reinforce healthy living for patients.

Second, providers must identify patient engagement tools that coincide with family values. For example, providers can look into using a patient portal or mHealth wearable to help keep the patient engaged in their care.

Third, providers should foster a “culture of partnership” to make patients feel more comfortable collaborating with providers on their care.

Last, providers should create patient engagement measures to help guide practices in their initiatives.

In addition to the Patient and Family Engagement strategy, CMS has partnered with the Agency for Healthcare Research and Quality to launch two Medicare patient engagement models.

The first model, the Shared Decision Making Model, aims to foster better partnership in patient care and patient satisfaction.

According to a CMS fact sheet, this strategy includes “identifying SDM eligible beneficiaries, distributing the PDA to eligible beneficiaries, furnishing the SDM Service, and SDM tracking and reporting.”

The second model, the Direct Decision Support Model, will empower patients with the information necessary to engage in discussion with their providers about their health.

CMS will appoint Decision Support Organizations to disseminate information to eligible patients and arm them with the education necessary to better communicate with their providers.

“Providing information directly to patients about their health decisions acknowledges that patients make decisions about their medical conditions outside of, as well as inside, their doctor’s office,” said CMS Acting Principal Deputy Administrator Patrick Conway, MD, and AHRQ Director Andy B. Bindman, MD.

These efforts from CMS are a part of the agency’s efforts to promote patient-centered and value-based care. In requiring providers to offer patients access to their health data and incentivizing better engagement practices, the agency aims to improve the patient experience and drive positive care outcomes.

Joint's New Antimicrobial Stewardship Standard Went Into Effect January 1st

Marie Rosenthal
1 January 2017
Retrieved from *Infectious Disease Special Edition*: http://www.idse.net/Resistance--Stewardship/Article/01-17/Joint-s-New-Antimicrobial-Stewardship-Standard-Goes-Into-Effect-Today/38967

The Joint Commission's new Antimicrobial Stewardship Standard goes into effect today. The new Medication Management standard (MM.09.01.01) addresses antimicrobial stewardship for hospitals, critical access hospitals, nursing care centers and other health care providers.

It is well known that misuse and overuse of antibiotics is contributing to a critical stage of antimicrobial resistance, the Joint Commission said. Between 20%–50% of all antibiotics prescribed in acute care hospitals in the United States are either unnecessary or inappropriate, and are among the most commonly prescribed medications in nursing homes, according to the CDC. "Up to 70% of long-term care facilities' residents receive an antibiotic every year," the CDC[1] said.

On June 2, 2015, The Joint Commission participated in the White House Forum on Antibiotic Stewardship. The Joint Commission joined representatives from more than 150 major health care organizations, food companies, retailers, and animal health organizations at the forum to express commitment for implementing changes over the next five years to slow the emergence of antibiotic-resistant bacteria, detect resistant strains, preserve the efficacy of existing antibiotics, and prevent the spread of resistant infections.

Subsequently, The Joint Commission developed the antimicrobial stewardship standard for hospitals, critical access hospitals, nursing care centers, ambulatory care organizations, and office-based surgery practices and conducted a field review in November and December 2015. There was significant support among governmental, association and institutional stakeholders for the antimicrobial stewardship standard for the hospital, critical access hospital and nursing care center accreditation programs, the Joint Commission said.

Click here to watch a video[2] about antimicrobial prescribing in nursing homes and here[3] to read more about the standards.

Do You Have a Unified Emergency Preparedness Program?

Centers for Medicare & Medicaid Services
CMS Rule 3178 *Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*

Effective Date: November 15, 2016
Implementation Date: November 15, 2017

This final rule establishes national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to plan adequately for both natural and man-made disasters, and coordinate with federal, state, tribal, regional, and local emergency preparedness systems. It will also assist providers and suppliers to adequately prepare to meet the needs of patients, residents, clients, and participants during disasters and emergency situations. Despite some variations, the regulations will provide consistent emergency preparedness requirements, enhance patient safety during emergencies for persons served by Medicare- and Medicaid-participating facilities, and establish a more coordinated and defined response to natural and man-made disasters.

[1] https://www.cdc.gov/getsmart/healthcare/learn-from-others/factsheets/nursing-homes.html
[2] https://s3.amazonaws.com/antibioticstewardshipvideo2016/Antibiotic+Stewardship-720HD.mp4
[3] http://www.idse.net/LandingPage/LandingPageLoginRequest?requestedLink=%2FResistance-Stewardship%2Farticle%2F12-16%2FNew-Stewardship-Standard-Designed-to-Protect-Patients%2F38963

Four Major Provisions

Risk Assessment and Emergency Planning: Facilities are required to perform a risk assessment that uses an "all-hazards" approach prior to establishing an emergency plan. The all-hazards risk assessment will be used to identify the essential components to be integrated into the facility emergency plan. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the provider or supplier and considers the particular types of hazards most likely to occur in their areas.

Policies and Procedures: Facilities are required to develop and implement policies and procedures that support the successful execution of the emergency plan and risks identified during the risk assessment process.

Communication Plan: Facilities are required to develop and maintain an emergency preparedness communication plan that complies with both federal and state law. Patient care must be well-coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies and systems to protect patient health and safety in the event of a disaster. During an emergency, it is critical that hospitals, and all providers/suppliers, have a system to contact appropriate staff, patients' treating physicians, and other necessary persons in a timely manner to ensure continuation of patient care functions throughout the facilities and to ensure that these functions are carried out in a safe and effective manner.

Training and Testing: Facilities are required to develop and maintain an emergency preparedness training and testing program. A well-organized, effective training program must include initial training for new and existing staff in emergency preparedness policies and procedures as well as annual refresher trainings. The facility must offer annual emergency preparedness training so that staff can demonstrate knowledge of emergency procedures. The facility must also conduct drills and exercises to test the emergency plan to identify gaps and areas for improvement.

Unified Emergency Preparedness Program

Allowing integrated health systems to have a coordinated emergency preparedness program is in the best interest of the facilities and patients that comprise a health system. Therefore, they have revised the proposed requirements by adding a separate standard to the provisions applicable to each provider and supplier type. This separate standard will allow any separately certified healthcare facility that operates within a healthcare system to elect to be a part of the healthcare system's unified emergency preparedness program. If a healthcare system elects to have a unified emergency preparedness program, this integrated program must demonstrate that each separately certified facility within the system actively participated in the development of the program. In addition, each separately certified facility must be capable of demonstrating that they can effectively implement the emergency preparedness program and demonstrate compliance with its requirements at the facility level.

As always, each facility will be surveyed individually and will need to demonstrate compliance. Therefore, the unified program will also need to be developed and maintained in a manner that takes into account the unique circumstances, patient populations, and services offered for each facility within the system. For example, for a unified plan covering both a hospital and a LTC facility, the emergency plan must account for the residents in the LTC facility as well as those patients within a hospital, while taking into consideration the difference in services that are provided at a LTC facility and a hospital. In addition, the healthcare system will need to take into account the resources each facility within the system has and any state laws that the facility must adhere to.

The unified emergency preparedness program must also include a documented community–based risk assessment and an individual facility-based risk assessment for each separately certified facility within the health system, both utilizing an all-hazards approach. The unified program must also include integrated policies and procedures that meet the emergency preparedness requirements specific to each provider type as set forth in their individual set of regulations. Lastly, the unified program must have a coordinated communication plan and training and testing program. This approach will allow a healthcare system to spread the cost associated with training and offer a financial advantage to each of the facilities within a system. In addition, in some cases this approach will provide flexibility and could potentially result in a more coordinated response during an emergency that will enable a more successful outcome.

Rush Memorial Hospital Accomplishments

Rush Memorial recently installed a new state-of-the art call light system on the MedSurg Unit. This system can track nursing in regards to time spent in room, how fast the light was answered, the date and each time the patient turns on the call light--all of which helps with trending. The system notifies staff in a hierarchy approach to make sure the light is answered within a time frame.

Rush Memorial recently upgraded its Telemetry/Central Monitoring System. This most up-to-date equipment monitors patients when in the ED and MedSurg for any heart arrhythmias. Patient data will interface with our EMR so staff does not have to document the information.

Rush Memorial Hospital Radiology Department received its ACR accreditation.

In 2014, Rush Memorial Hospital and the Rush Memorial Hospital Foundation created the vision of an RMH Shuttle Service. The transportation needs of patients and guests was made a priority. The Rush Memorial Hospital Foundation was given the task of raising monies to accommodate a shuttle, communication system, and wait stations. In December of 2016, the very first ever RMH Shuttle Service was launched. The 8 passenger/2 wheelchair shuttle transports patients and guests to and from parking lots to any of our five hospital campus buildings. Thanks goes to the foundation's gracious individual donors, the RMH Cultivation Club (employee philanthropic organization), and Rush Memorial Hospital for making this vision a reality.

RAISE IT FOR HEALTH

IMPACT OF SMOKING ON HOOSIER HEALTH

The Raise It for Health campaign is focused on raising the tobacco tax by $1.50, restoring tobacco prevention and cessation funding to $35 million, and reducing health care costs for Hoosiers.

A $1.50 increase in the cigarette tax in Indiana will raise over **$300 MILLION** in annual revenue. Raising prices is the single most effective way to reduce smoking.

Over **1 MILLION ADULTS** in Indiana smoke. That's more than 1 in every 5 Hoosiers. An increase in the cigarette tax would help **58,000** of these adults quit smoking.

Indiana ranks **41** among states in overall health. Smoking is a primary factor for the low ranking.

CDC recommends state spending of **$11.24 PER CAPITA** for tobacco prevention and cessation. Indiana currently spends $0.77. More funding means more Hoosiers who quit smoking.

Every year, **4,100** of Indiana's youth become daily smokers. The cigarette tax increase would lead to a 17.5% decrease in youth smoking.

Smoking costs Indiana **$3.17 BILLION** in lost productivity and an estimated **$2.9 BILLION** in health care expenses annually.

A tax that saves lives.

RaiseItForHealthIN.com