Winter 2019

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Hoosier Hospitals Make Top 100 Lists!

Several Indiana hospitals are included in two lists from The Chartis Center for Rural Health that feature the top 100 critical access hospitals and rural and community hospitals. The healthcare advisory services and analytics company says the lists are based on the results of the Hospital Strength Index from iVantage Health Analytics, which provides a "comprehensive and objective assessment of rural provider performance."

The Chartis Center says the hospitals that make the lists serve as benchmarks for other rural facilities. "(They) are excelling in managing risk, achieving higher quality, securing better outcomes, increasing patient satisfaction, and operating at a lower cost than their peers."

The Indiana honorees on the lists include:

Top 100 Critical Access Hospitals

- Cameron Memorial Community Hospital - Angola (Steuben County)
- Margaret Mary Health - Batesville (Ripley County)
- Putnam County Hospital - Greencastle

Top 100 Rural & Community Hospitals

- Henry County Memorial Hospital - New Castle
- King's Daughters' Health - Madison (Jefferson County)
- Major Hospital - Shelbyville (Shelby County)
- Marion General Hospital - Marion (Grant County)
- Memorial Hospital - South Bend (St. Joseph County)
- Memorial Hospital and Health Care Center - Jasper (Dubois County)
- Parkview Huntington Hospital - Huntington (Huntington County)
- Parkview Noble Hospital - Kendallville (Noble County)
- Schneck Medical Center - Seymour (Jackson County)

You can connect to the full lists by clicking here.

DCMH Physician Returns from Military Deployment

Decatur County Memorial Hospital originally opened its doors in 1922 as a memorial for World War I veterans. To this day, DCMH recognizes and salutes veterans and active military personnel serving our country. This past year, Dr. Andy Tran, Decatur County Primary Care physician left for military leave. He returned in December after being away for over 100 days.

Dr. Tran has been enrolled in the Army Reserve since September 2015. When asked why he joined, he said, “I have family members in the military, including my dad. My brother is still actively serving. I also wanted to give back to the country that has given me so much opportunities to become the person I am today. Freedom is an important cause, and yet, only 9% of the US population is serving in the military, but only 0.7% is still actively serving to preserve such a cause. That's why soldiers always "thank you for your support", but this country needs it.”

Since Dr. Tran was gone for a few months, he was afraid that he would lose his patient panel and the continuity of care. However, upon his return he found that he had no reason to be concerned. His patients remained true to him and he returned to a full patient load. He added, “I love my patients and take care of them as if they were my own family members.”

Dr. Tran’s favorite part of being in the Army Reserve is, “The feeling of pride in being a part of something bigger than myself, and knowing that my service extends beyond my local community and the state I live in.”

DCMH is happy to have Dr. Tran back in the states and is proud to call him one of their physicians.

He added, “I was very happy to be home, to see my town, my neighborhood, my work and my colleagues. It was a very warm welcome and I missed the familiarity of it all. One good thing about being away for long is that it helped me see that I have a lot of loyal patients, who chose to continue to stay with me and continue to entrust me with their care. I really do appreciate them and DCMH a lot.”

DCMH was sure to give Dr. Tran a big welcome home when he returned to work. He added, “I stay at DCMH and will continue to stay for the people... and I am proud to be a part of a great team. Thanks for a great first day back!”

Thank you Dr. Andy Tran for your great bravery and patriotism you have shown in serving our country!

Minnesota's Small Towns Suffer When Rural Hospitals Stop Delivering Babies

By Megan Knowles
24 January 2109 via *Becker’s Hospital Review*

As a growing number of rural hospitals stop providing planned baby deliveries, Minnesota patients in small towns are struggling to access care, public radio station KNOW reports.

Hospitals often cite legal and insurance costs as reasons for eliminating scheduled baby deliveries, but rural hospitals find it hard to attract physicians to small towns and often must consolidate birthing centers.

It's a trend that has created a lot of problems for rural communities and couples across the U.S. and new risks for pregnant women who must travel hours to deliver their babies.

Grand Marais, Minn., sees this problem firsthand. North Shore Health hospital in Grand Marais stopped delivering babies in 2015.

Although the 16-bed critical access hospital still handles many of the community's healthcare needs, such as prenatal and postnatal care, closing the birthing center led to a dilemma for the area's expecting couples.

The number of hospitals in Minnesota offering birth services dropped by about 18 percent between 2000 and the start of 2015. And rural Minnesota has been hit the hardest: Fifteen of the state's rural hospitals stopped delivering babies during that time — a nearly 38 percent decline.

The decline in services has led to longer drives and bigger worries for would-be parents.

A recent study from Minneapolis-based University of Minnesota study found a significant jump in patient anxiety when the Grand Marais and Ely, Minn., hospitals stopped providing labor and delivery services in the summer of 2015.

The study also described women's worries about the future of their communities when hospitals stop delivering babies.

"I feel like a second-class citizen. ... I feel that the government does not care about rural residents," one person in the study said. "I was outraged, extremely sad, scared (I was pregnant with my second child), and nervous! It is definitely a major loss for the community."

More than half of the nation's rural counties lack obstetrics care, and that number is increasing as rural hospitals manage pressures that are forcing many to stop these services.

"These factors all work together to render some communities deeply vulnerable to poor outcomes around the time of childbirth," said University of Minnesota professor Katy Kozhimannil, PhD, who studies rural healthcare trends.

"And when I say something like poor outcomes around the time of childbirth, I'm not sure that fully conveys the tragedy of losing a mother or losing a baby," Dr. Kozhimannil said. "It's something that can really destroy a life. It can destroy a family, can destroy a community, and it's happening more often in some communities than others."

CMS, DISASTER RECOVERY & BUSINESS CONTINUITY

Lunch & Learn

VANTAGE POINT CONSULTING

Operational requirements and compliance regulations have changed the way the healthcare industry views IT infrastructure. Healthcare organizations need to gain a better grasp on what the CMS regulations state about Disaster Recovery and Business Continuity and how to become compliant.

When: Wednesday, March 6th @ 11am – 1pm
Where: Immedion Data Center, 2425 Technology Blvd, Columbus, IN 47201
Seating is limited. RSVP today to reserve your seat!
RSVP via email or phone: randy.riemersma@immedion.com (317) 345-9227
RSVP online: https://www.eventbrite.com/e/cms-disasterrecovery-and-business-continuity-what-you-needto-know-tickets-54988926359

Join Immedion, Vantage Point Consulting & Rural Health IT for lunch and an informational session on **Wednesday, March 6th**. We will discuss the importance of having a disaster recovery and business continuity strategy, with a focus on compliance for the healthcare community.

- Gain insight on CMS regulations from Cyber Continuity of Operations Branch Director, Rick Ball, of Vantage Point Consulting
- Explore grants and funding options with Earle Rugg, CEO of Rural Health IT
- Learn about Disaster Recovery and Business Continuity planning with Immedion's Bill Creech and Randy Riemersma
- Tour Immedion's Data Center

Meeting Agenda:

1. Welcome Lobby Reception
2. Lunch and Learn
3. Open Discussion and Q&A Session
4. Data Center Tour

Codes Updated for Aprepitant, Rituximab, Other Agents for Hematology and Oncology

by Deborah Marsh
30 January 2019 via *Healio*

The 2019 version of the Healthcare Common Procedure Coding System Level II code set for reporting supplies and services to public and private insurers took effect Jan. 1.

The code set includes updates to several codes for drugs and other agents relevant to hematology and oncology practices.

It is important for clinicians and practice administrators to understand the code changes, as coding is linked to reimbursement from third-party payers.

To support accurate reporting of codes on claims, the nursing and charge entry staff responsible for calculating billing units should review the Healthcare Common Procedure Coding System (HCPCS) code changes.

Health care organizations also should update relevant coding and reimbursement resources, such as charge masters, charge forms and electronic billing systems.

This effort on the front end will save work in the long run because the team will not have to spend time correcting claims returned for using out-of-date codes and descriptors.

Below is a selection of 2019 HCPCS Level II code updates applicable to hematology and oncology.

Aprepitant — New code J0185 (Injection, aprepitant, 1 mg) applies to injectable aprepitant, which is used to prevent acute and delayed chemotherapy-induced nausea and vomiting (CINV). Code J0185 replaces the 2018 code, which was C9463.

The change from a code beginning with C to a code beginning with J is important because Medicare intends C codes for use by Outpatient Prospective Payment System (OPPS) hospitals. Certain other facilities, such as critical access hospitals (CAHs), can use C codes at their discretion. CAH is a designation that CMS gives to eligible rural hospitals to reduce their financial vulnerability and also keep essential services in rural communities, thereby ensuring access to health care in those areas.

In contrast, a wider range of providers — including physician offices — may report other codes, such as A codes and J codes.

Being able to report a code specific to the drug or agent simplifies reporting and reimbursement; however, it is important to emphasize that the existence of a code does not guarantee coverage or payment.

Bortezomib — There is a new code for bortezomib administered by injection. It is J9044 (Injection, bortezomib, not otherwise specified, 0.1 mg).

Relevant diagnoses include multiple myeloma and mantle cell lymphoma.

This new code must be distinguished from J9041 (Injection, bortezomib (Velcade), 0.1 mg).

Emicizumab-kxwh — A new code, J7170 (Injection, emicizumab-kxwh, 0.5 mg), represents emicizumab-kxwh (Hemlibra, Genentech), a monoclonal antibody used to address factor VIII deficiency among patients with hemophilia A.

Fosnetupitant and palonosetron — Code J1454 (Injection, fosnetupitant 235 mg and palonosetron 0.25 mg) represents drugs used to prevent acute and delayed CINV. This new code replaces C9033.

Hexaminolevulinate hydrochloride — New code A9589 (Instillation, hexaminolevulinate hydrochloride, 100 mg) allows the provider to report hexaminolevulinate hydrochloride (Cysview, Photocure), used in conjunction with cystoscopy. The code replaces C9275.

Lutetium Lu 177 dotatate — A9513 (Lutetium Lu 177, dotatate, therapeutic, 1 millicurie) has replaced the old code, C9031. Lutetium Lu 177 dotatate (Lutathera, Advanced Accelerator Applications) is approved to treat gastroenteropancreatic neuroendocrine tumors that are positive for the hormone receptor somatostatin.

Mogamulizumab-kpkc — A new code, C9038 (Injection, mogamulizumab-kpkc, 1 mg), is a C code for use by OPPS hospitals. Mogamulizumab-kpkc (Poteligeo, Kyowa Kirin) is a monoclonal antibody that treats Sezary syndrome and mycosis fungoides.

Rituximab — There are two new codes for rituximab. They are J9311 (Injection, rituximab 10mg and hyaluronidase) and J9312 (Injection, rituximab, 10 mg). The 2018 rituximab code, J9310 (Injection, rituximab, 100 mg), has been deleted.

This change is a good example of why noting the amount stated in the code descriptor is important. One billing unit of the 2018 code J9310 represented 100 mg, but the 2019 codes represent 10 mg per billing unit.

Checking for changes like this in updates helps ensure that claims do not overreport or underreport the amount being billed.

Overreporting units may lead to overpayment, which the provider must return to the payer. Underreporting units may result in reduced initial reimbursement and rework once the problem is discovered. Both overreporting and underreporting may raise questions during a claim audit.

Rolapitant — The new code for injectable rolapitant (Varubi, TerSera Therapeutics) is J2797 (Injection, rolapitant, 0.5 mg). This replaces C9464. Rolapitant is used to prevent delayed-phase CINV.

The codes above are listed in the 2019 update of the HCPCS Level II code set, but health care organizations must watch for quarterly updates — which take effect Jan. 1, April 1, July 1 and Oct. 1 — to ensure they are using the most current version of HCPCS.

Electronic Cigarettes (ENDS-Electronic Nicotine Delivery System)

- Called by many names but it's all the same (e-cigs, vapes, vape pens, hookah pens, mods, juul, etc.).
- E-cigarettes are tobacco products.
- The smoke it emits is not a harmless water vapor! It contains harmful chemicals similar to regular cigarettes.
- E-cigarettes contain nicotine, which is highly addictive, especially to teens.
- The majority of e-cigarette users also smoke traditional cigarettes.
- E-cigarette use has been connected to alcohol and marijuana use.
- The pods for the e-cigarette Juul contain as much nicotine as a pack of cigarettes.
- E-cigarette use negatively affects brain development up to the age of 25.
- Other negative health effects: causes addiction, blurry vision, wounds/burns, airway irritation, cough, increased heart rate, chest pain, increased blood pressure, vomiting, nausea.
- E-cigarette manufactures target youth using marketing. Convenience stores advertise e-cigs targeting youth by placing them where youth will see them (in proximity to candy).
- Social media and celebrity endorsements influence use of e- cigarettes.
- There is free assistance with quitting all forms of tobacco for those 13 yrs. and older: The **Indiana Tobacco Quitline (1-800-QUIT-NOW)**. An evidence-based tobacco cessation program conducted in the privacy of your home 24/7. For more information, contact Tina Elliott at telliott@indianarha.org.

Adams Memorial Hospital Behavioral Health

Adams Memorial Hospital is excited to share more details with the community relative to the transition of our Behavioral Health Department. Although we no longer have an inpatient unit, we continue to offer our services to the community in the form of daily programs located on the 3rd floor of Adams Memorial Hospital.

Our Behavioral Health program continues to offer a daily intensive adult program focusing on multiple mental health and addiction related problems. In addition, we also provide a daily intensive geriatric program called Senior Life Connections for patients 65 and over. Both groups consist of therapy, nursing education, psycho-education, and activities. Adams Outpatient Behavioral Health is currently located at 815 High Street, and continues to see clients for therapy/counseling and medication management. Clients and their therapist work together to determine how often clients receive treatment for optimal outcomes.

Adams Memorial Behavioral Health Outpatient Counseling Team

Adams Memorial Intensive Outpatient Program Team and Assessment Team

Adams Memorial Hospital Behavioral Health has also started an assessment team to help find the correct fit for any mental health problems an individual may have. The assessment team is provided for community convenience 24/7 at the hospital via the Emergency Department, Statcare, or if issues are non-emergent, an individual may make an appointment for an assessment.

Indiana Emergency Medical Services for Children (iEMSC)

Indiana Pediatric Readiness Facility Recognition Program

On behalf of the Indiana Emergency Medical Services for Children (iEMSC) and the Indiana State Department of Health, I am pleased to announce pilot phase of a voluntary 2-tier recognition program for Pediatric Readiness. Pediatric Readiness Facility Recognition Programs are intended to support and recognize emergency departments to ensure they have policies, procedures, and supplies to stabilize a child in a medical emergency. Indiana hospitals may apply to be recognized as a "Pediatric Ready" or "Pediatric Advanced" facility.

To request an application packet please email Program Manager, Margo Knefelkamp at margo.knefelkamp@indianapolisems.org or call 317-630-7742. iEMSC looks forward to working with you through this process. Please contact with any questions.

8th Annual Pediatric Heroes Awards Breakfast

Do you know someone that goes above and beyond for children, or has done something extraordinary for a child? If so, please nominate that pediatric hero by completing this nomination form http://www.indianaemsc.org/documents/2019HealthCareHeroNominationAwardForm_000.pdf

In May 2019 we will celebrate National EMSC Day. Indiana EMSC would like to honor health care providers, public safety workers, and community leaders throughout the state who have had the opportunity to provide excellent care to children. Please take this opportunity to nominate someone within your community who has provided care to children within the area(s) of dispatch of emergency care, pre-hospital care, emergency/hospital care, public safety, community leadership, and pediatric community advocacy work.

Nominations must be received on or before April 7, 2019 and may be emailed to margo.knefelkamp@indianapolisems.org or may be mailed to Indiana EMSC, 3930 Georgetown Rd, Indianapolis, IN 46254

Greene County General Hospital Announces Orthopedics and Sports Medicine Services and Clinic

Greene County General Hospital is thrilled to announce that a new orthopedics and sports medicine service line and clinic, named TeamOrtho, is coming soon. Board-certified orthopedic surgeon, Dr. John Hammerstein, will join the GCGH family in August 2019. He will perform orthopedic surgical services exclusively at Greene County General Hospital as well as practice in the former Ridge Medical Center building located in front of Greene County General Hospital at 1043 North 1000 West Linton, Indiana 47441. The building is undergoing renovations to accommodate the new services.

Dr. John Hammerstein, a 1996 graduate of Indiana University and a later graduate of IU's School of Medicine, played football for Indiana University. A starter for the final three years on the team, Hammerstein was voted team captain his senior year.

Dr. Hammerstein is currently completing an orthopedic sports medicine fellowship at the esteemed Andrew's Research and Education Foundation in Gulf Breeze, Florida. He began the fellowship to broaden his orthopedics practice by gaining experience in sports medicine. While there, he is actively participating in team coverage of Division 1 football with the Auburn Tigers and overseeing local high school athletic teams.

He’s glad to be coming back to Indiana this year, "after growing up in small town America I have wanted to practice in a place like Greene County where patients are also your neighbors. I am looking forward to being involved in the health and well-being of the community."

As a native of Green County, GCGH CEO, Brenda Reetz understands the need for orthopedic services both in the hospital and at the local high schools, “this is going to be a great fit for our community. Having access to local orthopedic services is valuable to our schools, athletes and non-athletes of all ages.”

Adams Health Network New Executive Director

Adams Health Network's Board of Trustees is pleased to announce Scott Smith, MD, as the new Executive Director of Adams Memorial Hospital, while Jo Ellen Eidam will continue to serve as the Chief Executive Officer of Adams Health Network. Dr. Smith's new role as Executive Director of the hospital began January 1, 2019. In addition to his new position, he will continue to serve as Chief Medical Officer of Adams Memorial Hospital as he has since 2016. Dr. Smith was the Medical Director of hospital's Emergency Department for fifteen years, and launched his career at Adams Memorial Hospital in 2000.

With 40 years of healthcare experience, Jo Ellen will continue to provide leadership and vision for the entire Adams Health Network, consisting of Adams Memorial Hospital, Adams Woodcrest, and Adams Heritage.

"We (The Board of Trustees) are very excited to have Dr. Smith stepping into this new role," shares Russ Flueckiger, Governing Board President. "We believe he brings a wealth of knowledge relative to patient focused care and new ideas and energy that will continue to grow and expand our hospital services."

Dr. Smith in a native of Angola, Indiana. He graduated from the University of Houston and earned his medical degree at Baylor College of Medicine. Dr. Smith returned to Northeast Indiana for his residency at the Ft. Wayne Medical Education Program, and is Board Certified in Family Medicine. He is currently enrolled in the Business of Medicine MBA Program at Indiana University’s Kelley School of Business.

Dr. Smith stated that he is looking forward to his expanded leadership role among his over 500 coworkers at the hospital. Smith added, “Healthcare delivery in America has changed significantly in recent years. I’m excited to be a part of the Adams Memorial team that works daily in that changing environment to fulfill our vision of remaining independent and being the trusted healthcare provider for our community.”

Dr. Smith and his wife Dawn live in Decatur. They have four children and a son-in-law. They enjoy doing mission work in Uganda.

More Money Needed for Health Centers, Senators Told

By Joyce Frieden, *News Editor, MedPage Today*
30 January 2019 via *HealthLeaders*

WASHINGTON -- The federal government needs to provide more reliable funding for community health centers and the National Health Service Corps, and more money wouldn’t hurt either, several witnesses said Tuesday at a Senate Health, Education, Labor, & Pensions (HELP) Committee hearing on healthcare providers in underserved communities.

"We were very grateful that in 2018 Congress generously brought the per-resident allocation back up to a more sustainable level," said John B. Waits, MD, CEO of Cahaba Medical Care, a community health center with 10 sites, based in Centreville, Alabama.

"But the last two reauthorizations were each for 2 years and didn't always provide sufficient certainty for teaching health centers to make binding 3-year commitments for the recruits we were authorized to hire and train ... What a difference it will make if Congress gives us stable funding for 5 years. We can budget more efficiently and keep our doors open."

"I'm here to ask your help in funding this incredibly important program," said Andrea Anderson, MD, director of family medicine at Unity Health Care, a CHC here, and part of the center's graduate medical education faculty. "Without action before October, the NHSC will once again face a funding cliff. ... I ask you to continue expanding funding for the NHSC to ensure that all the current applicants are funded. It's imperative to the health of our nation that we do not miss this opportunity." She noted that under current funding, the NHSC can only fund 10% of its scholarship applicants and less than half of its loan applicants.

Anderson's enthusiasm for the NHSC, which recruits physicians to serve in medically underserved areas, came from her own involvement with it. "I signed my NHSC contract in 1997 and came to Unity in 2004 to fulfill my obligation," she explained. "That's a total of nearly 22 years of NHSC ... By making it possible for physicians like me to serve these populations, NHSC helps [with] workforce shortages and social determinants of health."

The corps includes other providers such as physician assistants, nurse practitioners, and dentists, and serves populations in places such as critical access hospitals, mental health centers, prisons, and rural health clinics -- "places where primary care is needed most," she said, adding that because underrepresented minority students are more likely to serve populations similar to their own cultural background, the corp's presence "is impactful and inspirational to the next generation."

Committee members from both sides of the aisle seemed predisposed to hearing the witnesses' message. "Community health clinics are one way [people] can have affordable healthcare close to home," said committee chairman Sen. Lamar Alexander (R-Tenn.), who recently announced he would not seek re-election in 2020. "We must act by the end of September to make sure clinics receive this funding to keep their doors open."

Alexander said he and Sen. Patty Murray (D-Wash.), the committee's ranking member, are planning to introduce legislation to fund community health centers for 5 years at $4 billion a year; it would also fund the NHSC for 5 years.

Murray said several of the most vulnerable clinics in her state are at risk of closing. "We need to do more to provide stability ... I'm glad Sen. Alexander and I are able to do just that ... Funding these programs for the next 5 years will give health centers greater confidence they can hire the people they need."

Sen. Bill Cassidy, MD (R-La.), asked why, if the average resident at a health center earns $57,000 per year, it costs CHCs $150,000 to employ a resident. "How can I defend that [difference]?" he asked.

Much of the added cost can be attributed to fringe benefits and malpractice insurance, said Waits. "And interns see about three patients a day whereas faculty members see 15 to 20," so that is another cost to the facility.

Sen. Lisa Murkowski (R-Alaska) expressed envy for states with lots of community health centers. "We struggle in Alaska to be able to attract those good folks," she said. "We would like to have them up north and we don't have a medical school [to attract people], and that's not going to happen anytime soon." She asked what she could do to solve the problem.

Waits suggested that one way to recruit would be to set up "teaching health centers" where residents could get primary care training, but said stable funding would be needed. "If we were going to set up a teaching health center in Alaska, we would need to know that if we take 2 to 3 years to get set up as a teaching institution and then start recruiting first, second, or third-year students, we've used up 5 years," he said. "It could be done if there was the stability there."

Guaranteed funding for the NHSC loan repayment program also would help, said Dennis Freeman, PhD, CEO of Cherokee Health Systems, a group of community health centers based in Knoxville, Tennessee. "If [centers] could use NHSC as a recruitment tool, I think it would really help."