June 2017

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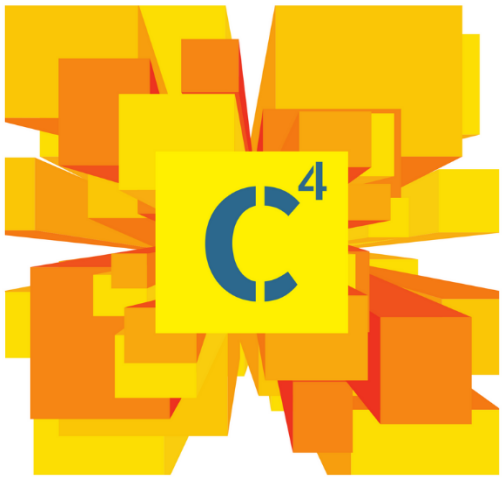

A new feature is being added to our communications in the form of a blog. For those not familiar with this type of information-sharing, a "blog (short for weblog) is a personal online journal that is frequently updated and intended for general public consumption". (Source: Whatis.com) Each week, your talented friends from HTS3 will be writing an interesting blog; some topics being explored may include:

- Solutions for Improving Swing Bed Volume
- Top 3 Healthcare Recruiting Mistakes to Avoid
- The Top 10 Healthcare Jobs in 2017
- Measuring Productivity – The first step to managing staffing costs
- How to write a Critical Access Hospital Annual Report

Join us for informative webinars each month; they're free, they're educational, and they're about current trends in health care and future changes that will affect your organization. Take advantage of these learning opportunities. Your ideas regarding topics that you would like to be presented in a webinar are appreciated, and can be sent to Elizabeth Whitelaw at: elizabeth.whitelaw@gaffeyhealth.com

Regulatory Report

HHS has announced that it will provide over $70 million in grants to address the **opioid crisis** in an effort to prevent and treat opioid use disorders and deaths. The grants include up to $28 million helping states increase access to medication-assisted treatment; $41.7 million to help local governments and tribal organizations train and provide resources to administer emergency treatment; and $1 million to expand access to overdose treatment. HHS also announced up to $3.3 million for a state pilot program to treat pregnant and postpartum women with substance use disorders, and up to $2.6 million to increase recovery support for substance abuse and addiction. (HHS news release, 5/31/17)

Beginning in April 2018, CMS will start mailing Medicare cards with new Medicare Beneficiary Identifiers to people covered by Medicare. This initiative replaces Social Security Number (SSN)-based Health Insurance Claim Number for transactions like billing, eligibility status, and claim status after a transition period. Visit Social Security Number Removal Initiative (SSNRI) Home and Provider webpages for the latest details about the transition at cms.gov

Some recommendations that should be considered when preparing for the transition include:

1. Verify patients' addresses. Patients will not receive a new card if their address is not correct. If the address you have on file is different from the Medicare address you get in electronic eligibility transaction responses, ask patients to correct their address in Medicare's records through Social Security. This may require coordination between your billing and office staff.

2. CMS will have quarterly calls to get more information. Check the website, cms.gov to know when calls are planned.

3. Prepare internally for the conversion to the new MBI Format. Ask your billing and office staff if your system will be ready to accept the 11 digit alpha numeric MBI. If you use vendors to bill Medicare, ask them about their MBI practice management system changes and make sure they are ready for the change. Internally test changes to practice management systems and business processes by April 2018.

The hospital standards are specific to only a Registered Nurse (RN) performing the nursing assessment within 24 hours after admission. It may be possible for an LPN to collect the data and then have an RN review the data and complete the assessment to determine the patient's needs and developing the plan of care.

An LPN may collect data if allowed by the nurse scope of practice act as defined by the state's

Nurse Practice Act, however, the RN must complete the nursing assessment. Based on the Nurse Practice Act, it may be possible for an LPN to perform partial or full assessment in only specific situations, such as personal care and support services.

The Nurse Practice Act varies from one state to the next, therefore, organizations need to work with their nursing leadership and legal counsel to determine the scope of practice as defined by state-specific law and regulation. The Joint Commission does not define the scope of practice for any discipline. (TJC, Daily Update, 06/01/2017)

ADDITIONAL TJC INFORMATION:

Ligature Risks - Assessing and Mitigating Risk For Suicide and Self-Harm

For inpatient psychiatric hospitals, inpatient psychiatric units in general acute care hospitals, and non-behavioral health units **DESIGNATED** for the treatment of psychiatric patients (i.e. special rooms/safe rooms in Emergency Departments or Medical Units):

The requirements found in the Environment of Care (EC) chapter of the accreditation manual at EC.02.06.01 require hospitals to establish and maintain a safe, functional environment. Element of Performance # 1 states "Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided". Therefore, ligature and self-harm risks must be identified and eliminated. While risks are in the process of being eliminated, policies and procedures must be developed and implemented to mitigate the harm posed by such risks. Mitigation plans must include the following: :

1. Ensuring that leadership and staff are aware of the current environmental risks
2. Identifying patients' risk for suicide or self-harm, then implement appropriate interventions based upon risk.
3. Ongoing assessments and reassessments of at-risk behavior as defined by the organization.
4. Ensuring the proper training of staff to properly identify patients' level of risk and implement appropriate interventions
5. Incorporating suicide risk and self-harm reduction strategies into the overall Quality Assessment/Performance Improvement (QAPI) program - see LD.01.03.01 EP 21.
6. If equipment poses a risk but is necessary for the safe treatment of psychiatric patients (i.e. medical beds with side rails on a geriatric unit), the organization must consider these risks in patients' overall suicide/self-harm risk assessments, then implement appropriate interventions to diminish those risks.

In non-behavioral health units (i.e. Emergency Rooms or Medical Inpatient Units) that are NOT DESIGNATED specifically for the treatment of psychiatric patients; however, where

psychiatric patients may temporarily reside, ligature/self-harm environmental risks must also be identified.

All physical risks not required for the treatment of the patient that can be removed, must be removed. Furthermore, an appropriate level of effective surveillance must be implemented if self-harm risks remain in the environment. Organizational policies and procedures must adequately guide staff in the assessment of patients' risk for suicide/self-harm and the implementation of interventions based upon the patients' individual needs. For further information: Sentinel Event Alert # 56; Suicide Risk Booster - available to accredited organizations via their Secure Extranet Site (TJC, Daily Update, May 31, 2017)

Joint Commission has revised the requirements for infection safety goal (June 01, 2017|Publication: eNews Update) TJC has released revised requirements for hospitals related to National Patient Safety Goal 7, reducing the risk of health care-associated infections. The updates, which go into effect Jan. 1, 2018, also include new requirements for nursing care centers. The revised standards include those for multi-drug resistant organisms and central line-associated bloodstream infections.

For your reading pleasure, the following reference discusses some of the survey results that pertain to board responsibilities regarding Quality and Safety. The article, ***Closing the Gap and Raising the Bar: Assessing Board Competency in Quality and Safety*** by McGaffigan, Patricia A. et al. Joint Commission Journal on Quality and Patient Safety, Volume 4, Issue 6, 267 – 274, describes the self-reported results between the board and CEO groups across all areas examined. The results from the survey indicate specific areas of focus for improving governance and leadership at board meetings, along with identifying a number of areas where knowledge and understanding of safety and quality were different between the two groups.

The Centers for Disease Control and Prevention (CDC) reported 77 cases in the past year of the emerging and often multidrug-resistant fungus Candida auris, most in chronically ill patients with long stays at high-acuity skilled nursing facilities. All but eight of the cases were in the New York City area, including 53 in New York and 16 in New Jersey. Illinois reported four cases, and Indiana, Maryland, Massachusetts and Oklahoma each reported one case. CDC alerted health care facilities to the emerging fungus last year. The agency recommends using standard and contact precautions with affected patients, housing them in private rooms, and daily and terminal cleaning of the patient's room with a disinfectant active against C. difficile spores. (CDC Morbidity and Mortality Weekly Report, 5/19/17)

Legionnaire's Disease (LD)

LD can be or become a problem for health care facilities. *Legionella* grows best in buildings with large water systems that are not managed effectively. Investigations of outbreaks by the CDC show that effective water management programs that include specific actions that reduce the risk of *Legionella* from growing and spreading in a building's water systems will help

prevent problems that lead to LD. Health care facility leaders should conduct a risk assessment in their respective organization to determine their vulnerability to LD, and determine what actions need to be taken to prevent LD and any other infections.

Health care facility leaders can

- Build a team focused on keeping their facility's water safe.
- Create and use a water management program to limit *Legionella* and other waterborne germs from growing and spreading. cdc.gov/legionella/WMPtoolkit
- Work with healthcare providers to identify LD cases early and determine if the cases may be associated with a health care facility.
- Report LD cases to local public health authorities quickly and work with them to investigate and prevent additional cases. (Source: cdc.gov)

Grant Opportunity

The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for fiscal year 2017 cooperative agreements to implement the Zero Suicide in Health Systems model, a multi-setting approach designed to raise awareness of suicide, establish referral processes, and improve care and outcomes for adults aged 25 and older who are at risk for suicide. Eligible applicants include public health agencies, tribal organizations, emergency departments, and primary or behavioral health care organizations. SAMHSA expects to award up to 13 grants of up to $700,000 each for up to five years to implement the model. Applications are due July 18. (SAMHSA grant announcement, 5/18/17)

You treat a disease, you win, you lose. You treat a person, I guarantee you, you'll win, no matter what the outcome.

-Patch Adams

***HealthTechS3** is an award-winning healthcare consulting and hospital management firm based in Brentwood, Tennessee with clients across the United States. We are dedicated to the goal of improving performance, achieving compliance, reducing costs and ultimately improving patient care. Leveraging consultants with deep healthcare industry experience, HealthTechS3 provides actionable insights and guidance that supports informed decision making and drives efficiency in operational performance.* www.healthtechs3.com