HEALTHTECH S3
strategy solutions support

July

HTS3 Working for YOU!

Health care organizations must be able to respond to the power of consumerism in today's changing environment. What exactly does that mean? There is evidence that as a result of diminishing reimbursements to providers, there is a need for physicians to see more patients in a day therefore causing patients to feel that there is less time to speak with their doctor. The reality for both providers and patients causes considerable frustration for each.

The Internet provides an avenue that offers a heightened awareness about health care issues and subsequently, patients are becoming more aware of how to use their consumer power to change the health care landscape.

Health care organizations must increasingly design services and experiences to the varying needs and desires of different populations and generations. A recent survey found that millennials place importance on high-tech experiences such as telemedicine and wearable health-monitoring devices while Generation X, baby boomers, and those born between 1925 and 1945 all value face-to-face contact with health care providers. Each group does have different preferences; the younger consumers prefer access to specialists, Gen X favors same-day primary care appointments, boomers desire home visits, and older consumers require more intensive services according to the survey findings..

HTS3 consultants can help you in developing strategies that improve experiences and efficiencies in workflow that improve overall satisfaction. Today's healthcare organizations must be effective in managing people of all generations, finances, clinical outcomes, as well as provider, employee and consumer satisfaction. For expert assistance, contact any of the following experts:

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Regulatory Report

Proposed bill seeks to implement changes for MU program. Rep. Michael Burgess, R-Texas, has introduced legislation that would allow more providers to

remain in the Medicare hospital meaningful use program. The bill would end increasingly strict measures for providers that want to stay in the program and is expected to make it easier to achieve meaningful use in the future. Source: Health Data Management 7/3.

In the Medicare Inpatient Prospective Payment System (IPPS) rule, CMS issued a proposal to redistribute Medicare DSH payments using the narrow definition of "uncompensated care" which was reported on the unaudited Worksheet S-10. The policy would result in a $3B shift in Medicare DSH funding nationwide. Medicaid DSH cuts begin in October 2017 and continue through 2025.

Federal funding for the Children's Health Insurance Program (CHIP) will expire on October 1. There are Congressional committees working to try to extend the program.

Bipartisan legislation has been introduced called the Rural Hospital Access Act of 2017, H.R. 1955/S.872 which would make permanent both the Medicare Dependent Hospital program and the Medicare low-Volume hospital payment adjustment. Currently, each of these programs is due to expire on September 30.

There have been rumblings that legislation may be introduced regarding increased oversight of the 340B program, yet nothing concrete has occurred.

The Joint Commission has partnered with the American Society for Healthcare Engineering (ASHE) and launched a new resource for accredited organizations called the new Physical Environment Portal. The purpose of this portal is to provide guidance and education and to help organizations reduce non-compliance with the Environment of Care/Life Safety standards.

TJC has revised and added to the Medication Management (MM) standards. Some of the MM revisions include:

- *Implementing a policy to provide emergency backup for essential medication dispensing equipment identified by the organization*
- *Implementing a policy to provide emergency backup for essential refrigeration for medications identified by the critical access hospital*
- *Managing hazardous medications in behavioral health care settings that engage in the medication management processes*
- *Adding "wasting" of medications to the required written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication*
- *Implementing a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews when automatic dispensing cabinets (ADCs) are used*
- *Recording the date and time of any medication administered in the patient's clinical record (not sure why this is a revision since this should be a standard practice already)*
  Source: TJC Daily Update. June 28, 2017

There are additional Environment of Care and Records of Care revisions being proposed as well.

"The additional revisions to the LS and EC chapters include new, revised, and relocated elements of performance (EPs) that address topics such as the following:"

- *Testing of emergency lighting systems*
- *Inspection and testing of piped medical gas and vacuum systems*
- *Updating pertinent NFPA code numbering in references*
- *Adding more specificity to existing Eps*
  Source: TJC Daily Update. June 28, 2017

The revised standards will go into effect on January 1, 2018.

The Joint Commission announces the implementation of new and revised pain assessment and management standards, effective January 1, 2018, for its accredited hospitals. The enhanced pain assessment and management standards include the following new requirements:

- *Identifying a leader or leadership team that is responsible for pain management and safe opioid prescribing*
- *Involving patients in developing their treatment plans and setting realistic expectations and measurable goals*
- *Promoting safe opioid use by identifying high-risk patients*
- *Monitoring high-risk patients*
- *Facilitating clinician access to prescription drug monitoring program databases*
- *Conducting performance improvement activities focusing on pain assessment and management to increase safety and quality for patients*
  Source: jointcommission.org

The Centers for Disease Control and Prevention (CDC) released their Health, United States, 2016, on the health of the nation. Some of the reported highlights are:

- *Between 1975 and 2015, life expectancy increased for the total population and for males and females. However, between 2014 and 2015,* ***life expectancy declined by 0.1 years for the total population, 0.2 for males, and 0.1 for females.***

- *The* ***infant mortality rate decreased 63 percent****, from 16.07 to 5.90 deaths per 1,000 live births between 1975 and 2015.*

- *Between 1975 and 2015,* ***the age-adjusted heart disease death rate decreased 61 percent from 431.2 to 168.5 deaths per 100,000 population****. The* ***age-adjusted cancer death rate decreased 21 percent from 200.1 to 158.5 deaths per 100,000 population.*** *Heart disease and cancer remain the top two causes of death in the United States.*

- *Between 1974 and 2015, the* ***age-adjusted prevalence of current cigarette smoking declined from 36.9 percent to 15.6 percent among persons aged 25 and over.***

- *The* ***age-adjusted percentage of adults aged 20 and over with obesity increased steadily from 22.9 percent in 1988–1994 to 37.8 percent in 2013–2014.***

- ***Prescription drug use increased for all age groups*** *between 1988-94 and 2013-14. Among adults 65 and over, use of five or more prescription drugs in the past 30 days increased from 13.8 percent to 42.2 percent during the same period.*

- *The percentage of persons with an overnight hospital stay was lower in 2015 than in 1975 for males and females under age 75, and was not significantly different in 2015 than in 1975 for males and females aged 75 and over.*

- *Between 1975 and 2014, the number of community hospital beds per 1,000 resident population fell by almost one-half from 4.6 to 2.5. The* ***average length-of-stay*** *per hospital stay* ***fell by almost one-third from 7.7 to 5.5 days,*** *and occupancy rates declined almost 16 percent from 75.0 percent to 62.8 percent.*

- *Between 1975 and 2015, the share of personal health care expenditures paid for:*
    - *Hospital care decreased from 45.3 percent to 38.1 percent;*
    - *Physician and clinical services remained the same at about one quarter (22.4 percent–23.4 percent);*
    - *Nursing care facilities and continuing care retirement communities decreased from 7.1 percent to 5.8 percent;*
    - *Home health care increased from 0.5 percent to 3.3 percent;*
    - *Dental services decreased from 7.1 percent to 4.3 percent;*
    - *Prescription drugs increased from 7.1 percent to 11.9 percent;*
    - *Other types of care increased from 10.6 percent to 13.2 percent.*

- *Between 1978 and September 2016 (preliminary data), the percentage of children under age 18 who were uninsured decreased from 12.0 percent to 5.0 percent; the percentage with Medicaid coverage increased from 11.3 percent to 39.2 percent; and the percentage with private coverage decreased from 75.1 percent to 53.5 percent.*

- *The* ***rural (nonmetropolitan) share of the population declined*** *between 1970 and 2015; the suburban share of the population increased. . (Source: cdc.gov)*

Register now for an AHRQ webinar on July 17 from 2:30 to 4p.m. ET about technologies developed to improve care planning and communication with aging adults. Presenters will discuss technologies designed to integrate information about seniors' homes with their medical records. Discussions will also highlight technologies that provide health information, resources and tools to connect aging adults with families, providers and peers to aid in healthy aging. Earn 1.5 hours of continuing medical education / continuing education credits for participating.

Register now for an AHRQ webinar on Aug. 2 from noon to 1 p.m. on "Creating a Learning Health Care System: The Role of Practice Facilitators in Primary Care." The event, part of the agency's EvidenceNOW initiative, will explore how practice facilitators can help primary care practices become learning health care systems, which are organizations that systematically collect, analyze and use evidence to improve care. EvidenceNOW practice facilitators will share insights on how to foster a culture of learning and quality improvement in small- and medium-sized primary care practices. Source: AHRQ.gov

Cyber threats and cybersecurity

If you are confident about the security of your servers and content with personal protection on your home desktop and cell phone, you may want to do some reading about cybersecurity. Recently, I attended the Healthcare Association of New York State's Annual Membership Conference where William F. Pelgrin, Esq., Co-Founder and Partner, CyberWA, Global Strategic Advisor and Chair, Global Cyber Alliance spoke about his personal experience with identity theft and his motivation to spend the remainder of his career helping people avoid such a travesty. Over time, he has broadened his expansive knowledge and expertise and has helped many industry sectors including health care.

"There are two types of people: Those that have had a cyber event and know about it, and those who have had a cyber event and don't know about it." Cyber threats are a growing yet already significant risk, according to Mr. Pelgrin, and healthcare is in the crosshairs of cyber attacks constantly. Cyber attacks have become an epidemic. Pelgrin's advice is that healthcare organizations need to take action now to protect their patient data, prevent attacks, and plan their responses and recovery steps should an attack ever occur.

He stated that cybercrime can result in "stolen money, damaged data, theft of intellectual property, embezzlement, fraud, reputational harm, lost productivity, and more. Cybercrime has become profitable, and patient records are quite valuable on the black market.

Mr. Pelgrin told the audience that just as providers must be concerned about patient care, they must also be concerned about protecting access to patient information. According to Pelgrin, preventing cybercrime is a critical part of providing safe healthcare.

Hacking attacks mainly result from human error. Some of the human errors that may not have been thought about include bad passwords, falling for social engineering scams, lack of planning, education and exercises, limited spending on cybersecurity, employee errors, and bring your own device (BYOD) policies all contribute to breaches of security and inappropriate access to electronic health records. With such user errors—particularly bad passwords—we make it easy for hackers, according to Pelgrin, and we remain tremendously susceptible to falling for targeted phishing efforts in which we click on dangerous links or provide secure information to malicious actors via phone or email.

So how can health care organizations and providers protect themselves? Pelgrin's simple answer was, "Be smarter." Do not store all patient records on a single system. Encrypt sensitive data. Mr. Pelgrin reported that 166,000 laptops are lost at top airports each year. What measures do you have in place to assure that such an event does not occur? He also advised that finding a thumb drive where the origin is unknown should never be plugged into a laptop or desktop.

Mr. Pelgrin encouraged the audience to develop an action plan that includes: developing a comprehensive list of all of the critical and secure data you have, so you know what you need to protect moving forward; configure your security systems so they are used consistently to their fullest extent; limit and manage administrator privileges; patch regularly, updating all apps, software and operating systems on-time and finally, monitor the applications, processes and activities for malicious behavior, and act quickly when you spot something unusual.

> *The only truly secure system is one that is powered off, cast in a block of concrete and sealed in a lead-lined room with armed guards.*
>
> — Gene Spafford

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.*
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