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President’s Report ~ Jerry Jurena

AHA Advocacy Agenda 2016: AHA’s 4th area is “Enhance Quality and Patient Safety”.

• Quality Measurements. AHA is working to prioritize and simplify quality reporting.
• Accreditation Standards and Medicare Conditions of Participation. AHA is working to modify standards so they support integrated and coordinated care.
• Health Disparities. AHA continues to support efforts to reduce health care disparities.
• Patient Safety. AHA advocates for the development of knowledge and adoption of practices to make care safer.
• Adjusting Outcome Measures to Account for Socioeconomic Factors. AHA is urging Congress to the Establishing Beneficiary Equity in the Hospital Readmission Program Act.
• Quality Measurement for new Payment System. AHA will continue to work with CMS and others to identify meaningful and valid measures for use in payment programs.

Burleigh County Opioid Discussion: On Tuesday Senator Heitkamp lead a discussion on the epidemic of Opioid use in North Dakota. Utilization is on the rise inundating hospitals. The programs to affectively treat people with addiction problems is short of the demand; therefore, by the time a problem is recognized, it is a crisis. Law enforcement and hospitals are seeing the problem first hand with not enough trained staff or facilities to address the problem. Solutions are expensive and need trained people.

Quality – CMS: Last Friday CMS sent out an RFP to move to the next step in Quality. HEN 2.0 will become HIIN in October. On Tuesday and Wednesday of this week I listened to calls on the process. Commitment to continue with collection of quality data will be required from hospitals. Quality Health Associates (QHA), Barb Grout and her team, will be working with NDHA as we move forward. Again the time frame will be short. CMS is requiring a quick turnaround of information. As CMS continues to move toward pay for performance I believe this is important to make a commitment to. As I get information NDHA or QHA will be sending it out.

Jim Long retirement: Jim Long’s retirement party was on June 2nd. Matt Shahan started on April 4th and at that time Jim stepped into a full-time consultant role which goes until June 3rd. Thereafter he will be in supplemental, as needed, role until the end of the calendar year. I wish Jim all the best in his retirement.

Dr. Wakefield – future of rural health care: On Friday Dr. Mary Wakefield will be in Mayville presenting on the future of health care in rural areas. I will pass on information next week.

US House of Representatives V. Burwell:
Potential Impact & Implications

On May 12, Judge Rosemary Collyer of the Federal District Court for the District of Columbia issued an injunction that, if implemented, would prevent the federal government from reimbursing health insurers for cost-sharing reductions. Judge Collyer stayed her injunction pending appeal; therefore, the federal government will continue to reimburse insurers for these costs and consumers should not experience any immediate disruption in coverage or changes in cost sharing assistance. The AHA issued a Legal Advisory on May 19 that provides greater detail on the legal arguments and issues.

The attached Member Advisory summarizes what the initial ruling may mean for hospitals and health systems, including those selling plans on the public exchanges, in the short term and the potential implications of a final adverse ruling.
Physician Recruitment ~ Kevin Malee

The Site Visit Schedule

When putting together the Itinerary for the site visit, make sure the schedule is packed. The visit is competitive and several things need to be presented to the candidate to make the best impression of our opportunity and community.

All events (meeting, tours, introductions, meals, social events etc.) need to come together seamlessly and the Ambassador can help keep all on schedule. Physicians are used to busy schedules, so error on the side of too much activity, rather than too little activity. I have experienced gaps in site visits that have actually unraveled the event, so keep things busy and moving throughout the visit.

Do not forget the spouse, a key decision maker. Recruit the spouse much the same way we recruit the physician. Find out needs and expectations from the spouse (have a conversation by phone before they arrive for the site visit) and address all in the site visit. Finally, if kids are part of the site visit (ages 12-18) recruit them as well. Kids of this age can be very influential in the decision making process.

If I can assist you in your physician recruitment efforts, please contact me. I can be reached at northdakotarec@comcast.net or 701-320-2109.

Hospital EHR Use, Data Exchange Continue to Climb

An estimated 84% of non-federal acute care hospitals had at least a basic electronic health record in 2015, up from 76% in 2014 and 28% in 2011, according to a report released by the Department of Health and Human Services’ Office of the National Coordinator for Health Information Technology. Eight in 10 small, rural and critical access hospitals had at least a basic EHR, up from seven in 10 in 2014 and two in 10 in 2011. Psychiatric and children’s hospitals continued to lag other hospitals at 15% and 55%, respectively. Psychiatric hospitals are ineligible for the Medicare and Medicaid EHR Incentive Programs, while children’s hospitals are only eligible for the Medicaid program. With respect to interoperability, 26% of hospitals could electronically find patient health information and send, receive and use patient summary of care records from sources outside their health system in 2015, up from 23% in 2014. Interoperability increased in all areas except the ability to integrate data without manual entry. Among other barriers to electronic health information exchange, nearly half of hospitals continue to report greater challenges exchanging data across different vendor platforms and one-third report difficulty matching or identifying patients. The findings are from the Information Technology Supplement to the AHA Annual Survey.

Register Now for Webinar on Using Health Information Technology to Improve Primary Care

Registration is open for a June 22 webinar that will highlight how primary care practices can use health information technology (IT) to improve quality and patient outcomes, especially related to heart health. The event is part of AHRQ’s EvidenceNOW program, a grant initiative dedicated to helping thousands of small- and medium-sized primary care practices use current evidence to improve cardiovascular care for millions of Americans nationwide. Despite its potential to improve care, health IT is currently underused in primary care practices. Webinar presenters will highlight incentives and effective tools that support the use of health IT in quality improvement, as well as challenges that may arise in implementation. In addition, an EvidenceNOW grantee will discuss how health IT can support adoption of the “ABCS” of heart health – aspirin use by high-risk individuals, blood pressure control, cholesterol management and smoking cessation.

Mark your calendars for NDHA’s 82nd Annual Convention and Trade Show
October 4-6, 2016 @ the Hilton Garden Inn in Fargo!
2016 NDHA Convention Sponsors

Thank you to the following companies who have committed to sponsoring NDHA’s 2016 Annual Convention!

- **HSI Solutions** - Diamond Level
- **MMIC Group** - Bronze Level
- **HCIS/Coverys** - Gold Level
- **EAPC Architects** - Bronze Level
- **Avera eHealth** - Silver Level
- **Blue Cross Blue Shield ND** - Bronze Level
- **McGough Construction** - Bronze Level
- **NorthStar Technology** - Bronze Level
- **Quality Health Associates of ND** - Breakfast
- **Myers Thompson, P.A.** - Bronze Level

NDHA Education Update

If you would like to be added to an email distribution list to receive updates on specific education events, please email Pam at pcook@ndha.org. Follow this link to register for educational events: [http://www.ndha.org/education/education-events/](http://www.ndha.org/education/education-events/)

- June 7  Enhancing Patient Safety Outcomes
- June 13  Hierarchical Condition Categories (HCCs)
- June 15  Top 5 Strategies for Revenue Health During EHR Transitions
- June 16  CAHs: Developing a Compliance Plan  (Nursing CEU’s provided)
- June 16  Integrating EMS for Care Coordination & Disaster Response
- June 28  No Master Plan, No Mission, No Margin

NDNPA 8th Annual Pharmacology Conference

The NDNPA is gearing up for their 8th Annual Pharmacology Conference to be held in Fargo on September 29-30. Included in this week’s attachments you will find a conference agenda as well an invitation to display at the conference. You can also use the following link to register online for the exhibits: [http://ndnpa.org/conference/exhibitors/](http://ndnpa.org/conference/exhibitors/)

For additional information, please contact Tina Lundeen at 701-231-7747 or email tina.lundeen@ndsu.edu.


After years of The Joint Commission advocating for this change, the Centers for Medicare & Medicaid Services (CMS) will begin surveying to the 2012 version of the National Fire Protection Association’s Life Safety Code® as of July 5, 2016. The Joint Commission will follow suit as of that effective date.

The May 4, 2016, final rule† announcing CMS’s decision requires hospitals to follow the NFPA 101® 2012 edition of the Life Safety Code as well as the NFPA 99® 2012 edition of the Health Care Facilities Code. While the rule adopts most of the proposals that CMS made in 2014, CMS removed a proposed requirement for hospitals to install smoke-purging systems in operating rooms. George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission, says the proposal was “unnecessary” and “prohibitively expensive.”

Follow this link to access the federal register. [https://www.federalregister.gov/articles/2016/05/04/2016-10043/medicare-and-medicaid-programs-fire-safety-requirements-for-certain-health-care-facilities](https://www.federalregister.gov/articles/2016/05/04/2016-10043/medicare-and-medicaid-programs-fire-safety-requirements-for-certain-health-care-facilities)
Medicare’s “Big Data” Tools Fight & Prevent Fraud to Yield Over $1.5 Billing in Savings in 2015

By Dr. Shantanu Agrawal, Raymond Wedgeworth and Kelly D. Bowman

A version of this commentary was published in May 24 editions of Modern Healthcare. New anecdotal content has been added. Please see the following link to view the original content – http://www.modernhealthcare.com/article/20160524/NEWS/160529960/commentary-medicares-big-data-tools-to-fight-and-prevent-fraud-yield

Over the past five years, the CMS has successfully implemented a Fraud Prevention System using “big data” and predictive analytics approaches to fight fraud, waste and abuse in the Medicare fee-for-service program.

Taking “big data” mainstream has given the CMS the ability to better connect with public and private predictive analytics experts and data scientists, as well as collaborate more closely with law enforcement. The Fraud Prevention System’s “big data” effort has had a profound impact on fraudulent providers and illegitimate payments by allowing us to quickly identify issues and take action.

For example, the FPS identified a home health agency in Florida that billed for services that were never rendered. Due to the FPS, CMS placed the home health agency on prepayment review and payment suspension, referred the agency to law enforcement, and ultimately revoked the agency’s Medicare enrollment. In Texas, FPS identified an ambulance company submitting claims for non-covered services and services that were not rendered. Medicare revoked the ambulance company’s enrollment. Likewise, FPS identified that an Arizona medical clinic had questionable billing practices, such as billing excessive units of services per beneficiary per visit. Upon review of medical records, it was discovered that physicians had been delivering repeated and unnecessary neuropathy treatments to beneficiaries. The medical clinic was revoked in 2015 from Medicare enrollment.

Through cases like these, the CMS is seeing impressive results nationwide. This predictive analytics technology contributed to more than $1 billion in savings in 2014 and 2015.

The Fraud Prevention System, or FPS, is innovative in that we have moved beyond the reactive “pay and chase” approach toward a more effective, proactive strategy that aims to prevent these illegitimate payments in the first place. Since its June 2011 inception, the FPS has identified significant savings by running sophisticated analytics on 4.5 million Medicare claims on a daily basis, prior to payment. Year after year, the FPS has continued to improve its ability to identify or prevent fraud. Since the beginning of the program, over $1.5 billion in inappropriate payments has been identified by the system through new leads or contributions to existing investigations. Also, in 2015, the CMS marked its first-ever national return-on-investment of $11.60 for every dollar the federal government spends on this program integrity system.

As we moved toward preventing inappropriate payments, we also successfully developed ways to measure costs avoided due to removing certain providers from the Medicare program and tracking return on investment. These methodologies to calculate cost avoidance have achieved certification by HHS’ Office of Inspector General, the first such certification in the history of federal healthcare programs.

The CMS is now working to develop next-generation predictive analytics with a new system design that even further improves the usability and efficiency of the FPS. Using it and other advanced tools, we are committed to addressing fraud, waste and abuse in the Medicare program to better protect beneficiaries and taxpayers.