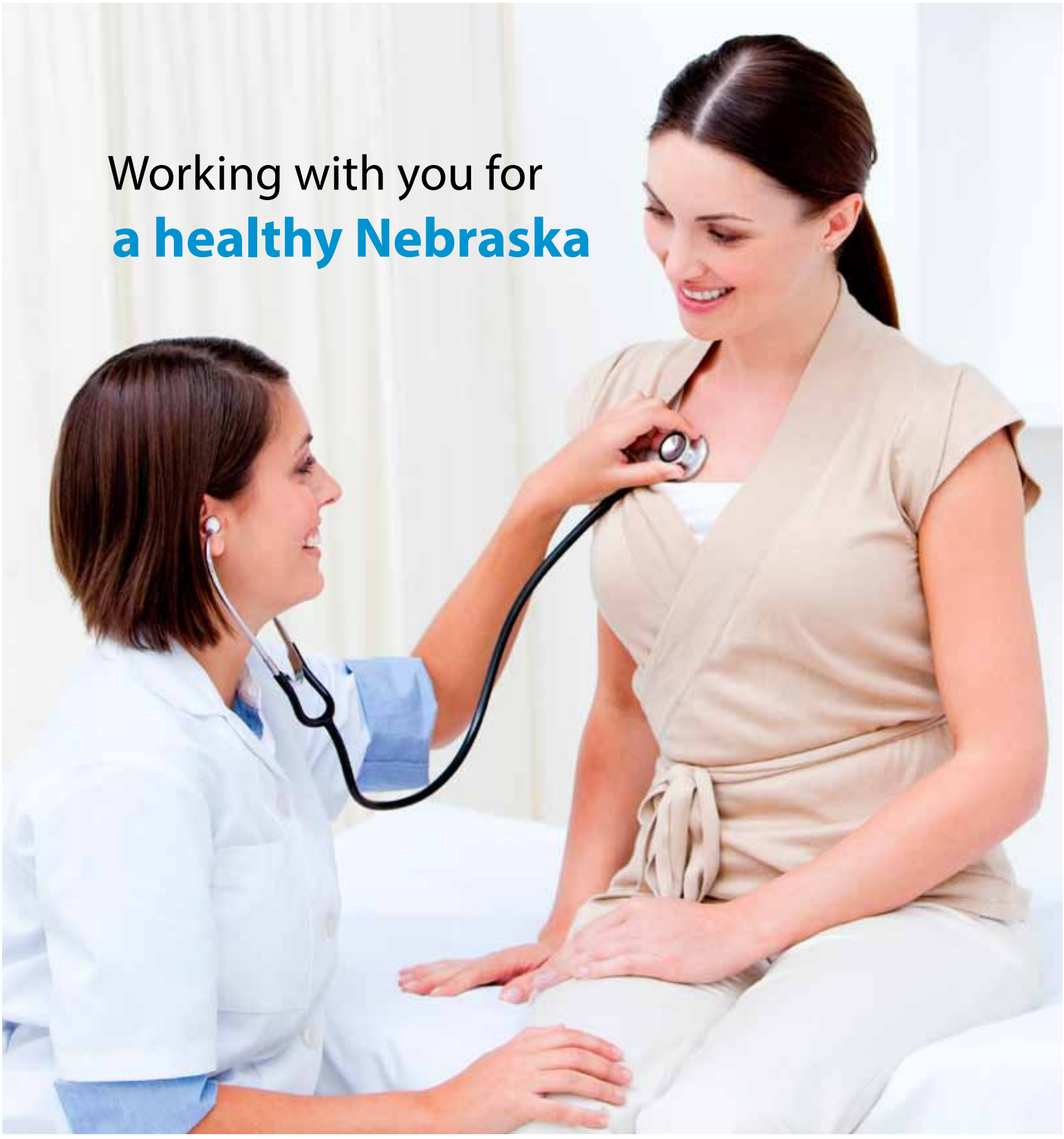
WINTER 2013 • VOLUME 16 NUMBER 4

Healthier Nebraska

CHILDREN'S HOSPITAL & MEDICAL CENTER
OMAHA, NE

NHA Nebraska Hospital Association
The influential voice of Nebraska's hospitals

Laura J. Redoutey, FACHE
President



NEBRASKA

nebraskablue.com

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

Healthier Nebraska
WINTER 2013

» A magazine for and about
Nebraska community hospitals and health systems

Healthier Nebraska is published quarterly by the Nebraska Hospital Association, 3255 Salt Creek Circle, Ste. 100, Lincoln, NE 68504, (402) 742-8140, www.nhanet.org.

DISTRIBUTION
Healthier Nebraska is distributed quarterly throughout hospitals in Nebraska. It reaches all hospital department heads including administrators, hospital physicians, managers, trustees, state legislators, the Congressional delegation and other friends of Nebraska hospitals.

NHA

in this issue

pcipublishing.com

Created by **Publishing Concepts, Inc.**
David Brown, President • dbrown@pcipublishing.com
For Advertising info contact
Deborah Merritt • 1-800-561-4686 ext. 109
dmerritt@pcipublishing.com

Edition 67

Children's Hospital & Medical Center reduces pediatric radiation exposure

Vibrant decals act as a distraction technique for children undergoing scans in the Radiology Department at Children's Hospital & Medical Center, further promoting a child-friendly environment and safer imaging.

Twisted metal. Shattered glass. A 10-year-old is rushed from the scene of a fierce automobile collision to the Emergency Department at Children's Hospital & Medical Center. He says his tummy hurts. His breathing sounds abnormal and he is vomiting. The ER team suspects blunt trauma to the boy's torso and orders a computer tomography (CT) scan. Consumed with worry, his parents can rest easier on one front – their child will not be exposed to any more radiation than is absolutely necessary.

"Whenever radiation is involved in a procedure at Children's, we take every precaution to ensure that the amount of radiation used is the bare minimum necessary to achieve an accurate result," said Sandra Allbery, M.D., a pediatric radiologist at Children's Hospital & Medical Center.

Children's efforts have earned it fresh accolades. The organization recently received the Quest for Excellence Award from the Nebraska Hospital Association for a continuous quality improvement project focused on reducing the radiation dose in CT scans, a diagnostic tool that delivers significantly more radiation than X-rays.

About 68 million CT scans are performed in the U.S. each year, about 10 percent of them in children, according to the American College of Radiology. National Cancer Institute researchers reported last year in "The Lancet" that children and young adults who had multiple CTs have a small increased risk of leukemia and brain tumors in the decade after their first scan.

"We know radiation exposure is a key concern for parents and we've been very proactive in addressing that concern," said Nicole Hardin, Children's radiology manager.

The CT dosing project, she said, supports Children's strategic goal of being the unparalleled leader for pediatric care in the Heartland. The impetus for the initiative was four-fold:

continued on next page

continued from last page

- A trend of young patients often receiving very high radiation doses, often equaling adult dosing parameters, was discovered after reviewing CT images completed at ouside facilities.
- A commitment to support the Image Gently campaign sponsored by the Alliance for Radiation Safety in Pediatric Imaging, an initiative that aims to promote radiation protection in the imaging of children.
- The ongoing evolution of the patient population at Children's.
- A desire to reduce radiation exposure by utilizing non-radiation imaging techniques such as ultrasound and magnetic resonance imaging whenever possible.

An underwater theme welcomes families to Children's radiology department. Customized wraps and sea life decals contribute to a more soothing, child-friendly atmosphere.

"Approximately 40 percent of children seen in our organization have chronic health conditions. These conditions increase the risk of repeated exposures to CT scans," Dr. Allbery said.

"Our project aim was to decrease patient radiation dosage through standardization of the process, while preserving the quality of the images. We also wanted to educate referring physicians about the appropriateness and efficacy of CT as a diagnostic exam for children," she explained.

Hardin adds, "Radiology staff education was essential to the success of this project. All radiology technicians and radiology physicians completed the Image Gently provider training course on reducing CT radiation exposure."

The CT dosing project team, which included a radiology fellow, the radiology patient care manager, radiology technicians and the performance improvement manager, met six times over a five month period. Their work resulted in the implementation of several major processes, including:

- Developing and applying a method to calculate the minimum necessary radiation dose for each patient based on a series of conversion factors for age, size and type of CT exam.
- Requiring a standard review of every CT exam scheduled to determine if CT is the most appropriate way to assess the patient's condition, if there are other concerns such as a significant previous radiation exposure, and if alternatives need to be considered.

Nicole Hardin, Radiology Manager, Children's Hospital & Medical Center

Dr. Sandra Allbery, pediatric radiologist, Children's Hospital & Medical Center

"By developing a process to consistently use these conversion factors, we were able to standardize practice and decrease the mean radiation dose for CT exams by more than one millisievert," Dr. Allbery said.

The results of the project are tangible and substantive, but there is more work to be done.

"We have reduced the radiation dose administered as much as we can while using our current technology," Dr. Allbery said. "Our next steps include moving to new technology to continue to reduce radiation dose."

The Quest for Excellence award is designed to recognize Nebraska hospitals for their outstanding quality improvement activities. It is jointly sponsored by the Nebraska Hospital Association, CIMRO of Nebraska, the Nebraska Association of Healthcare Quality, and the Nebraska Department of Health & Human Services System Office of Public Health.

"It is truly an honor to receive this award," Hardin said. "It supports what everyone here knows in their hearts – that Children's is committed to providing the highest quality in patient care and patient safety." HN

Kearney County Health Services' facility updates improve comfort, care and safety

MINDEN — Kearney County Health Services' (KCHS) new and updated facilities will improve comfort, care and safety for patients, enhance efficiency for medical staff and enable KCHS to better utilize the updated technology.

KCHS held a grand opening in September to showcase the new $10 million construction and remodeling project. The improvement project on the 56 year old facility began two years ago when Kearney County voters approved the bonds to renovate the existing building and construct a new patient room wing.

The 8,600-square-foot expansion added 10 new in-patient private rooms, a new reception and admissions area and a new entrance.

One of the most notable and dramatic changes is the new hospital entrance located at the southwest corner of the hospital. The new covered driveway will help shield patients from inclement weather during pick-up and drop-off.

Inside the new entrance, visitors are greeted at the reception area and will find a spacious waiting room. A nearby private meeting room can be used for hospital admissions and for consultation with medical staff.

"Our new entrance is much more accessible and more welcoming than what we had before," Fred Meis, KCHS administrator, said. "When people came in the old entrance there wasn't a visible reception area and people weren't sure where to go. Now our reception area is the first thing they will see when they walk in the door."

Out of the entire project, Meis indicated he takes the greatest pride in the new acute care rooms.

"Our patients have a much better environment to get better in. People are going to be impressed at how nice these new rooms are."

The new acute wing includes 10 private patient rooms. While the hospital is licensed for 25 beds that capacity has never been reached, Meis said. "The most beds we have had filled ever that I am aware of was nine and we average three or four a day."

Each of the new rooms has several amenities and technologies designed to improve the care and comfort of patients. Each room is fitted with a patient lift system designed to help medical staff get patients in and out of bed, enhancing safety for both patients and staff.

Medical charts are now maintained in a secured database. The new acute wing has computers for medical charting both inside the rooms and in the hallway so nurses have options for recording information.

While bathrooms aren't typically a space one touts, the bathrooms in the new rooms are dramatic improvements over the old rooms according to Meis. "You could barely turn around in our old bathrooms, let alone get a couple nurses in there to assist a patient."

The new spacious restrooms are fully accessible and one of the patient rooms is even equipped with a patient lift that goes from the bed into the restroom.

One of the new patient rooms is designed as an isolation room. The heating, ventilation and air conditioning system for that room is separate from the rest of the hospital and air from the room is circulated through a special HEPA filter.

"If we get a TB (tuberculosis) patient, this room is self-contained and we are ready to treat them.

Before (the remodel) we had to wheel in a large machine to purify the air."

The 7,900-square-foot former acute care wing was renovated and converted into a new, larger two-bay emergency room with waiting area, four outpatient exam rooms with two outpatient physician offices, a pharmacy area, a new nurses' station and a procedure room.

The former ER room was expanded into the new emergency care area. The side-by-side emergency bays provide medical staff quick and easy access to both rooms while providing privacy to patients.

Both emergency bays are equipped with updated technology including a teletrauma system, which allows local doctors to communicate with a trauma center at another hospital for consultation, questions, arrange transport, discuss the patient's statistics and more, without ever leaving the patient's bedside.

A new emergency waiting area provides a comfortable place for families or others who bring patients for emergency care.

"This area gives families a place to gather that does not impede our trauma team. It also provides a space where medical staff can consult with families," Meis said.

A procedure room was also constructed for diagnostics such as

scopes and can also be used as an overflow emergency care area.

Meis said that the new hospital layout maximizes efficiency. "There were so many things about the old layout that created more work for our staff. We were just use to it."

Moving patients and medical staff from one area of care to another area is part of the designed improvements. Before the improvement project, there was no interior connection between the clinic and the hospital.

"Our staff had to take patients the long way through the hospital waiting area if they needed an x-ray or lab work."

The renovation included a hallway connecting the clinic to the hospital. Medical staff along with patients can easily move between the two care areas now. The laboratory, which provides services for both the clinic and the hospital, was also renewed.

The location of the new nurses' station was another feature that improved efficiency, according to Meis. "We strategically placed that station between the two halls and the new pharmacy is right there at the nurses' station. Before, our nurses had to run down the hall to pick up medicine for patients in the hospital."

Part of the old acute wing was also renovated to create the new outpatient area.

Two new offices in the outpatient area for visiting physicians provide space for the doctors to work in. The offices can utilize the telemedicine systems that allow physicians in different locations to consult over a teleconferencing system.

Another busy part of outpatient services at KCHS is cardiology. Three cardiologists hold clinics at Kearney County Hospital, often conducting follow-up visits with their patients. The new cardiac rehabilitation room was part of the hospital addition. It sits adjacent to the outpatient area providing easy access for visiting physicians to conduct stress tests and observe patient progress. This area is double the size of the old cardiac rehabilitation area and includes some new equipment in a sunny room with plenty of windows.

While not as glamorous as the spacious patient rooms, the new paging system for nurses has been well-received by patients and staff. The system allows nurses to respond to patient pages quicker and also to communicate directly with the patient through the paging system itself. Through the new system, administration can collect and track data on the timeliness of patient care and better address problems that may arise. Perhaps no one will be as happy for the completion of the project as the staff at the hospital.

"The entire staff was fantastic. Doing the project in phases helped, but the staff still had to work around the transition," Meis commented. "Everybody is excited to see the end. Everyone is really positive about the changes, our doctors will be happy." HN

By Bruce Rieker, J.D.
vice president, advocacy

State speeches will provide insight into 2014 priorites for health care

At the beginning of each year, the president gives the country a State of the Union address. Likewise, Nebraska's governor delivers a state of the state address. In light of those two important speeches, it may be worthwhile to examine how the State of the Union and the State of the State addresses affect the state of health care.

There are more than 1.8 million people living in Nebraska; slightly more than one-half of one percent of our country's population of 318 million. The United States has 5,724 hospitals of which 1,328 are classified as critical access hospitals (CAHs) — hospitals limited to 25 beds or less and deemed necessary to ensure access to care. Nebraska has 90 community hospitals, of which 65 are CAHs, and collectively those institutions employ 42,000 people and provide care to more than 11,000 patients each day.

Hospitals contribute significantly to the goal of improving the overall health of Nebraskans, all-the-while focusing on aiding the less fortunate as part of their mission and purpose. Nearly all of Nebraska's hospitals are nonprofit. In exchange for the benefits of nonprofit status, hospitals are required to fulfill a unique role in their communities. That role has three parts:

1. to reinvest the assets of the organization in a way that expands and improves access to health care for the community;
2. to invest their resources to educate and train health care professionals; and,
3. to provide care to the poor regardless of their ability to pay. In 2011, Nebraska's nonprofit hospitals spent more than $1.1 billion – 22.4 percent of their net revenues – in support of those three efforts.

Charity care results from a hospital's policy to offer health care services free of charge or on a discounted fee schedule to individuals who meet predetermined financial criteria. As the number of uninsured and underinsured grows, so does the need for charity care. Because of the high costs of health care and insurance, hospitals are bearing a significant portion of the financial burden imposed by this population — $106 million in 2011 — and that amount continues to grow each year. Recognizing this increasing need, Nebraska hospitals have established financial aid policies to assist patients who cannot afford hospital care. In addition, hospitals routinely provide assistance to patients applying for government program benefits.

Health care services provided to low-income and special needs populations through government programs such as Medicare and Medicaid produce hospital revenue shortfalls – $514 million in 2011 – because the payments received are less than the cost of providing care. In many instances, Medicare and Medicaid payments are based on outdated information that does not accurately reflect the changing nature of health services, such as new equipment, new technologies and the rising costs of supplies. Despite the fact that Medicare and Medicaid do not pay hospitals enough to cover the cost incurred by the hospitals caring for patients, hospitals welcome Medicare and Medicaid patients and provide the same quality care they do for all patients.

Hospitals shoulder another burden known as bad debt when patients are unable or unwilling to pay their bills and decline to apply for charity care. In 2011, bad debt incurred by hospitals exceeded $239 million — 45 percent more than the $165 million absorbed in 2008. Hospitals serve as the safety net of the health care system and must provide many services regardless of an individual's ability or willingness to pay. In contrast, other industries can refuse to provide a service or product.

With rising numbers of uninsured, double-digit increases in health insurance premiums and greater use of plans with high deductibles and copayments, bad debt is the fastest growing segment of uncompensated care for hospitals. Due to the uncertainty of many variables associated with the implementation of the Patient Protection and Affordable Care Act (ACA), the majority of Nebraska's hospitals have more than doubled their budgets for bad debt in 2014.

On the subject of budgets, Congress and the president face a financial dilemma of gigantic proportion and one of the biggest fiscal challenges is growth in spending on federal health care programs. Our national debt is $16.7 trillion, or nearly $53,000 per citizen. Congress has failed to pass a budget for the last four years, opting to run the federal government on continuing resolutions, increases in the debt ceiling and other short-term funding methods. Annual revenues are $2.2 trillion while spending is more than $3.8 trillion per year. Our country's debt and budget problems will dominate the rhetoric on Capitol Hill and across the country; however, history gives us little hope that anything will get done in Washington, D.C., during an election year.

Congress and the president need to come together on a spending plan that works for America. However, before they impose more reductions in payments to community hospitals, they should take notice of the cuts made since health care reform was enacted. As part of the payment, the president and Congress cut hospital Medicare reimbursements by

six percent. Since then there have been coding adjustments and sequestration cuts. Together, Nebraska's hospitals have been forced to absorb a reduction in Medicare payments of $1.3 billion — eight percent — over a 10 year period and Congress is currently considering additional cuts of more than $600 million over that same period.

There are many areas that Congress could tackle to address our nation's growing debt and budget issues. None of those changes would be easy but they include: slowing the growth of the federal contributions to the Federal Employee Health Benefits Program (FEHBP), introducing cost sharing responsibilities to TRICARE beneficiaries, basing Social Security cost of living adjustments and other entitlements on the CPI-U index, placing dual eligible Medicare and Medicaid beneficiaries in Medicaid managed care, reforming medical liability, reducing Medicare costs by changing cost-sharing structures for Medicare Parts A and B, raising the age of Medicare eligibility to 67 and reforming pharmaceutical pricing.

In contrast to our federal budget deficit, Nebraska has a balanced budget. For the current biennium, fiscal years 2013-2015, our state's budget is $7.88 billion with $627 million in our cash reserve. During the 2014 legislative session, senators will be faced with several significant issues, including taxes and Medicaid eligibility expansion. The governor and several senators are determined to reform Nebraska's tax structure before their time in office expires and there will be extensive debate in three areas — property taxes, individual and corporate income taxes and sales and use taxes. Likewise, there are many senators determined to strengthen Medicaid and improve the health of Nebraskans by expanding eligibility to individuals earning up to 138 percent of the federal poverty level — $14,856 for an individual and $30,675 for a family of four.

Implementation of health care reform will continue to dominate debate between policy makers. It will also have the constant attention of hospital leaders and other health care providers as they navigate their way through the unknowns of delivery system changes, insurance marketplaces, value-based purchasing programs, bundled payments, accountable care organizations, population health and meaningful use of health information technology and electronic medical records.

Many ACA mandates take effect Jan. 1, 2014. Subsidies and tax credits will be available for individuals eligible to purchase health care coverage through the insurance marketplace. People without qualified health coverage will have to pay penalties. Employers with more than 50 employees must provide qualified coverage or face future fines and penalties. Essential health benefits of all qualified plans must include: emergency services; hospitalization; ambulatory patient services; prescription drugs; maternity and newborn care; mental health, substance abuse and behavioral health treatment; laboratory services; rehabilitative and habilitative services and devices; preventive, wellness and chronic disease management; and pediatric dental and vision care.

Significant changes are in store for hospitals as they continue to see declines in volumes and revenue growth. New business models will be developed to accommodate the transition from a fee-for-service model to a payment structure based on quality and outcomes. Insurance plans may limit hospital and provider choices. Less capital will be available for replacements and new technology. Some hospitals and other providers will form networks to improve outcomes and lower costs. Concerns about access to high quality care and an adequate workforce will continue to abound. Hospitals will wrestle with how to handle the unprofitable, but critical and necessary, needs of their communities.

Hospitals are highly vulnerable to changes in public policy and payment inadequacies. The majority of hospital stays are paid for by government programs such as Medicare and Medicaid and nearly everything hospitals do is regulated by the state and federal government. Every other year the winds of change sweep across our country with elections at the state and federal levels. Elections bring new faces with new agendas and sometimes the balance of power shifts from one party to the other.

The United States Senate is comprised of 53 Democrats, 45 Republicans and two independents; all serving staggered six-year terms. Every two years one-third of the United States Senate is up for reelection unless a senator chooses to retire or resign, as is the case in Nebraska where we will elect a new senator due to the retirement of U.S. Sen. Mike Johanns.

Because of the two-year terms in the United States House of Representatives, all 435 House members are up for re-election unless the incumbent is retiring or there are vacancies. The House of Representatives has 232 Republicans, 200 Democrats and three vacant seats. All three of Nebraska's members of the House — Reps. Jeff Fortenberry, Lee Terry and Adrian Smith — are all running for reelection. Two have opponents; however, we will not know all of the names on the ballot until after the March 3, 2014 filing deadline.

At the state level, Nebraska will see the largest change in political leadership since 2006, when legislative term limits went into effect. In 2014, Nebraska will elect a new governor and at least 17 new members to the legislature because of term limits. Seven more senators are running for re-election and another seat will be up for grabs due to a resignation. With a minimum of 17 new senators, at least 35 percent of the 49 member legislature will be new when it convenes in January 2015.

There is room for hope. Elections can bring the key ingredient of success — leadership. They can also present an opportunity, and a challenge, to educate newly elected representatives on the issues facing hospitals, providers and the health care industry.

Escalating costs of health care, reform and economic challenges may add up to the catalyst that transforms the delivery of care into a system focused on value instead of volume. Insurance marketplaces should bring more consumerism. Better data and transparency will help consumers make more informed decisions. New models of care such as patient centered medical homes focused on population health may be the new norm. More providers may work together with similar goals and incentives.

The journey will be challenging; however, it is one we must take.

Bruce Rieker, vice president, advocacy, can be reached at brieker@nhanet.org. HN

By Jon Borton, MS, vice president, educational services

NHA Leadership Institute 2014 Class XI

The Nebraska Hospital Association (NHA) Foundation Leadership Institute is gearing up for the 2014 Class XI. Officially completing its first decade, the NHA Leadership Institute proudly passed the 200 alumni mark.

In partnership with faculty of Bellevue University, the Institute's mission is to advance the effectiveness of hospitals by providing a quality environment of professional development and support for health care leaders. Coursework focuses on the unique challenges and organizational management techniques facing hospitals. Each year, approximately 30 health care professionals from across Nebraska come together for a 10-month program designed to instruct, inspire and invigorate. Participants establish peer-to-peer connections and lifelong bonds with classmates and faculty.

The NHA Leadership Institute provides up-and-coming leaders within your hospital the necessary skills to become exceptional leaders and puts them on the path to senior management positions. It is important for current CEOs to develop the leadership pipeline to ensure effective succession planning while enhancing employees' contributions to your organizations.

This initiative includes a comprehensive curriculum, combining core leadership competency working sessions and multiple layers of applied practice in health care. Participants in the Leadership Institute will improve their leadership skills and enhance their effectiveness in the health care field, while preserving the care and compassion critical to quality health care delivery.

NHA Leadership Institute success stories

"My experience with the Leadership Institute was one of the most rewarding experiences of my management career. At the time I participated in the Institute, I was still very 'green' in my knowledge of the business and how I needed to improve my leadership skills to take me to the next level in health care. The teachers and presenters gave me the knowledge and confidence to apply for the CEO position at my facility and to be offered that job.

I also used Bellevue University to complete master's degree in health care administration. I encourage every facility to make a commitment to its employees and send them to the Institute, and help insure we have strong leadership in Nebraska moving forward."

Arlan D. Johnson, MHA, 2010 Class VII Leadership Institute graduate
CEO at Howard County Medical Center in St. Paul.

Arlan D. Johnson (left), CEO of Howard County Medical Center and Manuela Wolf, CEO of Harlan County Health System, are both graduates of the 2010 Class VII Leadership Institute class.

"I am thankful that I was given the opportunity to attend the Nebraska Hospital Association Leadership Institute. The program provided a unique and valuable opportunity for me to build on knowledge that I had previously obtained through work experience and formal education by providing a varied curriculum of essential leadership skills.

The networking opportunities were invaluable and from the 360 degree assessment to the coaching session, the program provided me with many of the skills I needed in my growth through the ranks in my organization to my current position as CEO. Course faculty was always helpful and accessible. To this day, I often look toward the knowledge I gained about myself, my co-workers and my organization when facing the various challenges in my day-to-day routine."

Manuela Wolf, RN, BSN, 2010 Class VII Leadership Institute graduate
CEO at Harlan County Health System in Alma.

Questions about the NHA Leadership Institute? Contact Jon Borton, vice president, educational services, at (402) 742-8147 or jborton@nhanet.org.

The more we get together, the happier and healthier we'll be.

At MMIC, we believe patients get the best care when doctors, staff and administrators are humming the same tune. So we put our energy into creating risk solutions that help everyone feel confident and supported. Solutions such as medical liability insurance, physician well-being, health IT support and patient safety consulting. It's our own quiet way of revolutionizing health care.

MMIC

To join the Peace of Mind Movement, give us a call at **1.800.328.5532** or visit **MMICgroup.com.**

By David Burd, FHFMA
vice president, finance

Laws and regulations don't always put the patient first

Health care is a very complex industry that is heavily regulated at both the state and federal levels.

Hospital staff must stay up-to-date on statutes and regulations, which are extensive, complicated and change on a daily basis. Limited resources make this task even more challenging. However, in most cases, laws and regulations seem to have the best interests of the patient in mind and ultimately help ensure that health care services are provided appropriately and safely. Therefore, hospitals dedicate significant resources, both in staff time and funding, to ensure that they are in compliance with all applicable regulations and statutes.

Statutes and regulations should always put patients first. There are times when that doesn't seem to be the case. While written by people that are well-intentioned, some regulations appear to do nothing more than add significant costs to the health care system, without adding any real benefit to the patient. Two examples of requirements that don't seem to be in the best interests of the patient are the 96 hour requirement for critical access hospitals (CAHs) and the physician supervision requirement for outpatient therapeutic services.

The Centers for Medicare and Medicaid Services (CMS) has established conditions of participation and conditions of payment that providers must adhere to in order to participate in the Medicare program and to receive payment for services provided to Medicare patients. In most cases, provisions within the conditions of participation and the conditions of payment are in sync with each other. However, that is not always the case. An example of where they are not in sync involves the length of stay for patients at a CAH.

The conditions of participation allow a CAH to provide acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. However, the conditions of payment require that a physician certify that the patient may reasonably be expected to be discharged or transferred to another hospital — paid under the prospective payment system — within 96 hours after admission to the CAH, which applies to each patient individually instead of on an average basis.

The conditions of payment requirement means that CAHs are not paid for Medicare procedures and treatment that take longer than 96 hours, unless the physician expected the patient to be discharged within 96 hours at the time of admission. There are many procedures that CAHs are qualified to provide where clinical protocol would dictate a stay of longer than 96 hours. If patients are unable to obtain treatment in these situations at their local CAH, they could face long drives to another hospital, ambulance or helicopter fees to be transferred to another hospital or potentially, health risks (including death) due to the delay in treatment. Due to this requirement, Medicare patients face significant inconveniences at the least and potential health complications at the most. Patients are prevented from receiving health care services in their hometown CAH only because of a statute or regulation that requires it, even if it is not in their best interests.

In 2009, CMS mandated a new policy for direct supervision of outpatient therapeutic services. CMS characterized the change as a "restatement and clarification" of existing policy going back to 2001. Direct supervision means that a physician or non-physician practitioner (NPP) must be "immediately available" to furnish assistance and direction throughout the procedure. Hospital outpatient therapeutic services have always been provided by licensed, skilled professionals under the overall direction of a physician. While hospitals recognize the need for direct supervision for certain outpatient services that pose a high risk or are complex, CMS' policy generally applies to services with the lowest amount of risk.

In an environment of continuing shortages of health care professionals, especially in rural areas, the direct supervision requirement will be difficult to implement for hospitals, could ultimately reduce access to care and is clinically unnecessary. The requirement would make hospitals engage more physicians and NPPs for direct supervisory coverage without a clear clinical need and create patient access problems if hospitals are forced to discontinue or limit the hours of certain outpatient services. This is another example of a requirement that ultimately is not in the best interests of patients.

Statutes and regulations play an important role in health care. They are necessary and improve the system overall. They are written by individuals that are well-intentioned but also generally from the east coast and not familiar with the unique challenges that exist in rural states such as Nebraska. It is critical that statutes and regulations take these differences into account. If they do not, they drive up the costs of health care and ultimately hurt the patient. After all, aren't we supposed to be putting the patient first?

David Burd, vice president, finance, may be reached at dburd@nhanet.org. HN

BUILD ON EXPERIENCE.

For healthcare projects, more than for any other type of building project, experience counts. Before you build, talk to the experts in healthcare construction. **TALK TO BD.**

B|D construction

209 East 6th Street ▪ Post Office Box 726 ▪ Kearney, NE 68848 **308.234.1836** ▪ **www.bdconstruction.com**

By Monica Seeland, RHIA
vice president, quality initiatives

Quest for Excellence focuses on quality

The 2013 Quest for Excellence Awards were presented during the 34th Caring Kind Awards Luncheon held Oct. 25 at the Embassy Suites La Vista Conference Center in La Vista. The award winners were Memorial Community Hospital & Health System (MCH&HS) in Blair for the Critical Access Hospital (CAH) division and Children's Hospital & Medical Center in Omaha for the non-CAH division.

Each year Nebraska hospitals compete for the Quest for Excellence Award. The Quest for Excellence Award is a joint initiative of the Nebraska Hospital Association, CIMRO of Nebraska, the Nebraska Department of Health and Human Services and the Nebraska Association for Healthcare Quality, Risk and Safety. The award showcases innovative and reproducible models of patient care to the rest of the health care community. This was the 10th year for the award, designed to recognize and reward hospitals for their quality improvement achievements.

MCH&HS is comprised of a Critical Access Hospital along with three rural health medical clinics, a home health care program and a hospice program. In March of 2013, an elderly patient receiving care on their medical surgical (M/S) unit suffered a fall resulting in a major and permanent injury. At the direction of executive leadership and quality, a response team was organized to carry out a root cause analysis (RCA). This team met and reviewed the timeline for the event and determined immediate causal and risk factors to be mitigated. Further investigation of the fall itself revealed inconsistent practices around patient fall risk assessment and the timeliness of implementing appropriate prevention measures.

Prior to the fall event described above, falls on the M/S Unit were tracked as part of the departmental performance improvement (PI) activity and reported quarterly to the Quality Council. Falls occurring outside of the M/S Unit were monitored, but without a structured PI activity. The concept of completing a post fall huddle had been implemented on the M/S Unit, but the practice was inconsistent. They looked at their current Fall Prevention Policy to determine if changes were needed and whether their practices were consistent with national standards of care.

From left: NHA President Laura J. Redoutey poses with representatives of Memorial Community Hospital & Health System (MCH&HS) in Blair, Janice Fitchhorn, therapy services and sports medicine lead, and Laura Stawniak, chief nurse executive, and with NHA Board President and Avera St. Anthony's Hospital President and CEO Ron Cork. Memorial Community Hospital & Health System received the Quest for Excellence Award, Critical Access Hospital division, on Oct. 25 during the 34th Caring Kind Awards Luncheon in La Vista.

The fall prevention policy was re-tooled to include clearer expectations surrounding utilization of the Morse Fall Risk Model when completing each patient's fall risk assessment. An assessment for risk for injury was also added to the policy. This secondary assessment targets patient conditions, which if there was a fall, the patient would likely sustain injury. The policy was also streamlined in order to assure consistency with manual and electronic documentation of assessments and selected prevention measures.

Once re-tooling was complete and the policy approved, they developed standard operating procedures (SOPs) for both fall risk assessment and for the post fall huddle. These SOPs provide staff with step by step instructions for completing fall risk assessment and implementation of prevention measures, but also assures the right people come together if a fall occurs. Additional tools were pushed out for use during the redesign of their processes. A "Fall and Risk for Injury Interventions" table was created, which is used as a trigger to define appropriate prevention measures for nurses to consider in order to prevent a patient fall.

The "Patient Road Map" was developed to serve as an education tool when teaching patients about their fall risk and what measures the Health Care Team will use to keep patients safe.

To assist with workflow of gathering supplies needed when a patient is deemed a fall risk, they planned, built and implemented a "Fall Risk Kit." This kit contains items that every patient scoring 50 or greater on their fall risk assessment will need implemented as a prevention measure. The kit includes yellow socks, yellow arm-band, yellow star, the "Patient Road Map," a gait belt and a green arm band in case the patient is determined to be a high risk for injury.

Children's Hospital & Medical Center is a 144 bed acute care hospital focusing on the special needs of children. Their project was identified by clinical staff in the radiology department, with input from a parent concerned with the amount of radiation received by their child.

Accurate pediatric radiation dose and risk from a computerized tomography (CT) examination are not easily interpreted. Without adjustments, the radiation risk to the pediatric population is significantly underestimated. A more accurate radiation dose can be obtained by applying conversion factors specific to the patient's size, age and

type of exam. By developing a process to consistently use these conversion factors, they were able to standardize practice and decrease the mean radiation dose for CT exams.

Their project aim was to decrease patient radiation dosage through standardization of the process to determine the radiation dose to be administered, while preserving the quality of the images to allow the radiologists to accurately interpret exams. A secondary aim was to educate referring physicians about the appropriateness and efficacy of CT as a diagnostic exam for children.

From left: NHA President Laura J. Redoutey poses with representatives of Children's Hospital & Medical Center in Omaha, Cheryl Calabro, performance improvement nurse specialist, and Dr. Sandra Allbery, radiologist, and with NHA Board President and Avera St. Anthony's Hospital President and CEO Ron Cork. Children's Hospital & Medical Center received the Quest for Excellence Award, non-Critical Access Hospital division, on Oct. 25 at the 34th Caring Kind Awards Luncheon in La Vista.

Several major process changes were implemented through this project. The first was to develop and apply a prescriptive method to calculate the minimum necessary radiation dose for each patient based on a series of conversion factors for age, size and type of CT exam to be completed. The next process change included a new process where each CT exam scheduled is reviewed by the radiology nurse. During this review, the nurse looks at the patient history, indication for exam and all previous CT exams completed. Once this information is gathered, a radiologist determines if CT is the most appropriate way to assess the patient's condition, or if there are other concerns such as a significant previous radiation exposure.

If the radiologist recommends a different type of exam, the ordering physician is contacted to discuss the alternatives for the patient. Radiology staff education was essential to the success of this project. All radiology technicians and radiology physicians completed training on reducing CT radiation exposure. Since the patient's clinical treatment is guided by the referring physician, communication and education with referring physicians was crucial to the success of this project.

A tri-fold pamphlet was created and distributed to providers, patients and families explaining the risk of radiation, the radiology dose equivalents to environmental radiation exposure and Children's efforts to limit patient radiation exposure. Several educational presentations on the topic of medical radiation exposure were completed, targeting new and referring physicians inside and outside the organization.

Go to http://www.nhanet.org/quality_patient/quest.htm to read more about these projects. The Nebraska Hospital Association congratulates these facilities for their excellent work in quality improvement.

Monica Seeland, vice president, quality initiatives, may be reached at mseeland@nhanet.org. **HN**

NHA volunteers at Food Bank of Lincoln

Nebraska Hospital Association staff volunteered at the Food Bank of Lincoln on Nov. 21 to help the food pantry stock shelves and make preparations for Thanksgiving. Staff who participated are, from left, Lori Brandl, Cindy Vossler, Maria Witkowicz, Vicky Pfeiffer, NHA President Laura Redoutey, Timoree Klingler, Barb Jablonski, Meghan Chaffee and Kim Larson.

The environment of health

By Adrian Sanchez, director of communications

Educating residents on the keys to improving health and longevity and addressing the economic and social barriers to health through community outreach are critical components of improving a community's overall health.

Those were the messages provided by keynote speakers during the Nebraska Hospital Association's (NHA) 86th annual convention held Oct. 23-25 at the Embassy Suites La Vista Conference Center in La Vista. The theme for the NHA 2013 Annual Convention was "Healthy Communities: Hospitals Meeting the Challenge" The theme embraced The World Health Organization's (WHO) definition of a healthy community, which is "one that is continually creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential."

Few communities exemplify the WHO's definition of a health community like the five "Blue Zones" identified through research conducted by the convention's opening keynote speaker Dan Buettner and his team. Blue Zones are places where people reach age 100 at rates up to 10 times greater than in the United States and, with the research, in a sense, reverse engineered those environments of longevity.

Buettner, an internationally recognized researcher, explorer, New York Times bestselling author and National Geographic Fellow, said the keys to longevity are to:

1. Move Naturally — The world's longest-lived people live in environments that constantly nudge them into moving without thinking about it.
2. Purpose — Knowing your sense of purpose is worth up to seven years of extra life expectancy.
3. Down Shift — Even people in the Blue Zones experience stress. What the world's longest-lived people have that we don't are routines to shed that stress. Stress leads to chronic inflammation, associated with every major age-related disease.
4. 80% Rule — Stop eating when the stomach is 80 percent full. The 20 percent gap between not being hungry and feeling full could be the difference between losing weight or gaining it.
5. Plant Slant — Beans, including fava, black, soy and lentils, are the cornerstone of most centenarian diets. A serving size of meat, mostly pork, about the size of a deck of cards is eaten on average only five times per month.
6. Wine at 5 — People in all Blue Zones, except Adventists, drink alcohol moderately and regularly. Moderate drinkers outlive non-drinkers. The trick is to drink 1-2 glasses per day with friends, food or both.
7. Belong — All but five of the 263 centenarians we interviewed belonged to some faith-based community, regardless of denomination. Research shows that attending faith-based services four times per month will add 4-14 years of life expectancy.
8. Loved Ones First — Successful centenarians in the Blue Zones put their families first. This means keeping aging parents and grandparents nearby or in the home, committing to a life partner and investing in their children with time and love.
9. Right Tribe — The world's longest lived people chose, or were born into, social circles that supported healthy behaviors. The social networks of long-lived people have favorably shaped their health behaviors.

While Buettner's presentation focused on the ideal communities for health, Truman Medical Centers' President and CEO John Bluford presented how his hospital was working to re-shape the environments of poor socioeconomic areas in an effort to improve the overall health of those communities.

Bluford, the second keynote speaker at the convention, has led the Kansas City hospital for more than 12 years, and during that time he identified the greatest social determinants of health — safety, security and permanence.

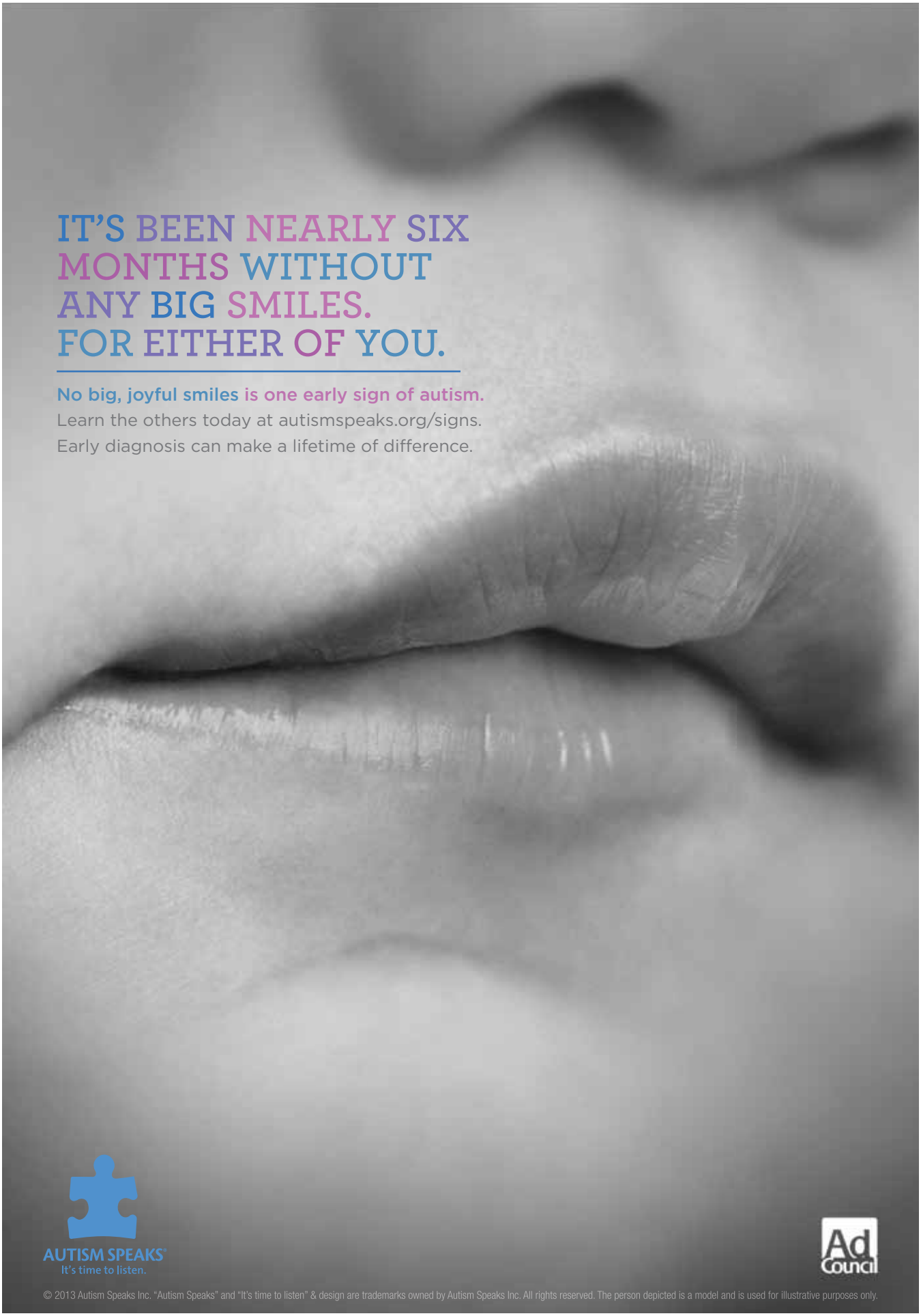
"Stress kills, poverty kills, not being able to pay the bills kills," Bluford said. "We want to stop them from needing to come to the hospital, by making them better. When you increase quality of life, the number of hospital, visitations goes down."

Since one of the biggest financial impacts on the hospital's cost curve is chronic illness, Truman Medical Centers has engaged the community to promote healthy lifestyles in an effort to reduce the numbers of preventable illnesses. A few of the projects the hospital has undertaken include offering a mobile fresh food store to encourage healthy eating, partnering with the Kansas City Chiefs to provide routine vaccinations, health fairs, physicals and healthy education for youth and putting up billboards to replace worn out tobacco and soda ads with uplifting, positive messages that encourage a healthy lifestyle. The hospital also engaged in case management initiatives to help residents monitor and manage their own care in an effort to reduce the number of emergency department visits with successful results.

Bluford acknowledged those efforts required a great network of support from community leaders and the business community and that is why it is important for hospitals to remain active in the community, because "It is difficult for people to say no when it is the right thing to do."

"The more successful we are at this, the less we are utilized," he said.

Adrian Sanchez, director of communications, can be reached at asanchez@nhanet.org.



By Al Klaasmeyer, vice president
NHA subsidiaries

Texting protected health information

Texting has become a way of life for individuals wishing to communicate information to other individuals in a short period of time. While some texting has been beneficial, other forms of texting are ill-advised. Texting unsecured Protected Health Information (PHI) is presumed to be a breach as defined in the HIPAA Omnibus Final Rule as of Sept. 23, 2013.

The definition of unsecured PHI is: "Unsecured Protected Health Information" that is not rendered unusable, unreadable or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance under section 13402 (h) (2) of Public Law 111-5. The unauthorized use of unsecured PHI is considered a breach of security. Severe penalties are assessed on hospitals, clinics, billing agencies and nursing facilities for not providing PHI security that could result in a breach of information.

The loss of PHI takes on many different types of breaches, which include theft of information, unauthorized access or disclosure, loss of information, hacking or informational technology incident, and improper disposal of information. The source of the breaches have occurred with failing to secure PHI on laptops, paper records, desktop computers, portable electronic devices, Electronic Medical Records, network servers and email.

NHA Services, Inc., will be unveiling a solution for the breaches involved with texting and storing of PHI information, partnering with Matrix Mobile Security Solutions to eliminate the potential breaches by use of mobile devices. Matrix Mobile Security Solutions uses their relationships with other security vendors to ensure information and the storage of information is encrypted to provide a barrier to unauthorized persons to thwart the improper use of PHI. In the HIPAA Omnibus Final Rule it is stated, "No breach notification is required for PHI that is encrypted in accordance with the guideline." The technology to encrypt information is available and can provide a sense of assurance the PHI is safe and secure.

The utilization of the technology for encryption is minor in comparison with the potential for fines, cost of the Breach Notification and cost of notification to each and every person whose PHI was improperly obtained. Since 2008, the penalties for Civil Monetary Penalties & Resolution Agreements have exceeded $15.2 million. This figure is expected to increase as investigations from the HHS Office of Civil Rights, State Attorneys General and U.S. Department of Justice continue their efforts to enforce this Final Rule.

Al Klaasmeyer, vice president, NHA subsidiaries, may be reached at aklaasmeyer@nhanet.org.

Nebraska's rural hospitals continue to be shining stars in their communities. Thank you from Beckenhauer Construction for allowing us to partner on your projects.

Jennie M. Melham Memorial Medical Center * Boone County Health Center
Jefferson Community Health Center * Chase County Community Hospital
Kearney County Health Services * Faith Regional Health Services
St. Francis Memorial Hospital * Box Butte General Hospital

BCI BECKENHAUER
CONSTRUCTION, INC.
established 1878
www.beckenhauerconstruction.com

135 years of experience

Nebraska Hospital Association
3255 Salt Creek Circle. Ste. 100
Lincoln, Nebraska 68504

Presorted Standard
U.S. POSTAGE PAID
Little Rock, AR
Permit No. 2437