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Healthier Nebraska

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NHA

in this issue

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Great Plains Health

Changing the landscape of healthcare

When a five-story building in North Platte is constructed, residents can't help but notice. In fact, it changes the entire landscape of the community. That's what happened when Great Plains Health added GPWest, a new 116-bed patient tower, to its hospital campus.

GPWest adds more than 217,000 square feet to its regional medical center, nearly doubling the center's size and providing patients, visitors and health professionals in western and central Nebraska the space necessary to improve quality, outcomes and the overall patient experience.

"In the past few years, we've created a focus and even a sense of urgency on going from good to great as an organization," said Mel McNea, Great Plains Health CEO. "As we grow our services, staff and facilities, it's reassuring to see the alignment of our medical staff, our community and our employees, each vested in bringing advanced healthcare as close to home as possible for our patients and families."

And grow they have. In the past seven years, Great Plains Health has added eight new service lines and programs, including a heart & vascular center featuring board-certified interventional cardiologists and an electrophysiologist, a spine center, critical care pulmonology services, a hospitalist program, infectious disease, endocrinology, a wound healing center and a medical helicopter transport program. In addition, the hospital has doubled the size of its orthopedic surgeon offerings. "At nearly 30 medical specialties in all, inpatient volumes have increased dramatically, so a building that accommodated such growth in a more modern, healing environment was the next logical step," said McNea.

The $100 million transformational project was funded through the issuance of revenue bonds, hospital savings and the generous support of Great Plains Health Care Foundation donors, physicians and employees and the North Platte community.

All private rooms, with improved technology and comfort

All 116 beds in the new patient tower are acuity adaptable private rooms, each with its own bath.

Decentralized nursing stations support increased direct patient care at the bedside, and the latest Philips monitoring system allows providers to remotely monitor patients. The installation of the GetWell Network puts Great Plains Health on the map as the first hospital in the state to install this

electronic interactive communication tool that allows patients to engage in their daily schedules, care plans, goals, pain assessment and care team. It also offers more than 4,000 videos and games and provides patients and families a tool to leave messages for their physicians and each other and even order meals. "Studies have shown that when patients are engaged in their healthcare, they have better outcomes," said Tadd Greenfield, chief clinical officer.

Patients and their families will appreciate expanded waiting areas and family nutrition centers, and private consultation rooms on each floor will enhance physician interactions.

Visitors will enjoy thoughtful touches including complimentary valet parking, a coffee bar, a larger gift shop, a new chapel, business center and a new cafeteria with more seating and dining choices.

An art-of-healing environment designed to calm the soul

The front door of the hospital is flanked by 35,000 square feet of garden space: a healing garden on the west offering a tranquil and private outdoor space for patients and families and a gathering garden for employees and the public to enjoy on the east. The beauty of the outdoors was brought inside with the art-of-healing design featured in the nearly 550 pieces of art selected around a concept called the Constructive Healing Cycle. This cycle follows the elements of nature to create a calm, supportive environment. The collection is featured as an art tour that patients and visitors can enjoy during their stay at Great Plains Health.

Putting patients first means putting safety first

Storm safety. The stairwells in the new patient tower at Great Plains Health do not contain drywall and electrical wiring that can be torn loose by a tornado and block evacuation routes.

"We took our design cue from the lessons learned by hospitals on the front lines in the Joplin, Missouri, tornado," said Tom Didier, Great Plains Health

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engineering director. Oxygen lines have been installed behind paintings in the hallways so that oxygen-dependent patients being evacuated to the safety of interior hallways will not require cumbersome tanks that can interfere with safe passage.

Infection control. Separate elevators keep vulnerable patients or those with communicable illness from crossing paths with visitors. Laminar airflow hoods in operating rooms and the C-section room help keep fields of operation sterile. Nurse servers allow caregivers to receive pharmaceuticals, supplies and fresh linens on the patient side of rooms. Supply stocking and collection of used linens will occur on the corridor side of the cabinet, reducing in-room traffic, noise and infection risk to the patient. Proven sources of infection, such as shower curtains and curtains around beds, have been eliminated. "We don't just meet the minimum standard; we really worked hard to be on the cutting edge of safety," said Didier.

Personal safety. Rooms designed to accommodate dialysis reduce risk to renal patients by eliminating the need to transport them. Bariatric lifts allow larger patients to be more safely moved from bed to chair or restroom. Lighting provides clear pathways to restrooms to reduce the risk of falls. Security camera systems monitor the interior and exterior of the facility, including the parking lot. And a special fire alarm system identifies the exact location of each of the 1,800 smoke detectors in the building, to reduce response time in the event of a fire.

"Great Plains Health is a first-class facility based on best practice research and design," said Dave Pederson, Great Plains Health board chairman. "There are not a lot of communities our size that can put together a project like this. I'm really excited for the people in this area to experience what we have here." HN

Healthy Beverages in the Healthcare Workplace: Going Beyond Chronic Care

By Tami Frank, Program Coordinator, Partnership for a Healthy Lincoln (HealthyLincoln.org)

Hospitals have a role in prevention as well as chronic care. Two initiatives piloted in Lincoln hospitals have been shown to be successful in raising awareness and affecting real change. Interestingly, both have to do with healthy beverages. The first focuses on reducing sugar-sweetened beverage consumption and the second on promoting the ultimate healthy beverage for infants – breastmilk.

Why Focus on Beverages

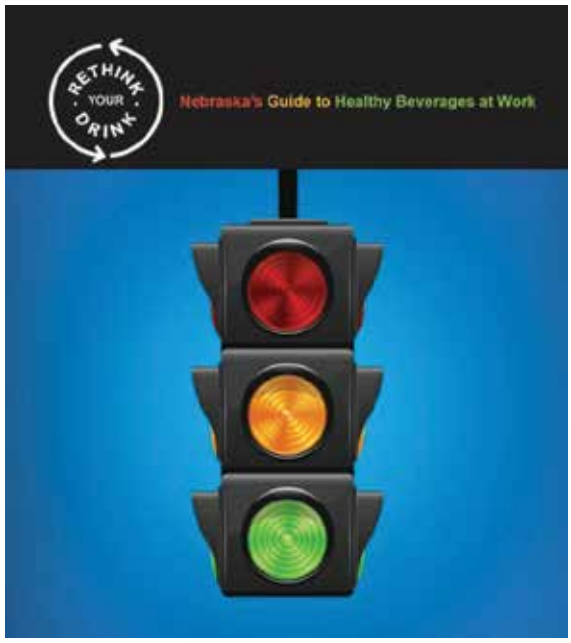
Interested in a $27,000 cost savings?...hold that thought for later. Pop, energy drinks, sports drinks, sweetened tea, sweetened coffee drinks, juice drinks and even too much fruit juice are the #1 source of added sugar in the American diet. Lots of factors play a role in obesity. However, in attempts to improve the health of patients, families and staff, it a difficult to ignore that nearly 50% of all added sugars come from sugar-sweetened beverages. Let's do a bit of math: One 20 ounce pop has 240 calories. One 20 ounce pop a day equals 87,600 calories in a year or about 25 lbs. And you can buy these beverages everywhere - as part of a standard meal option at restaurants, in vending machines at work, school and maybe church, even in the check-out line at the copy shop.

What are Healthy Beverages

With so many beverage options available and companies attempting to market their product in the healthiest light to fit the current trend, it's hard to know what drinks are actually "healthy". Luckily, Nebraska's "Rethink Your Drink" campaign kit provides an easy-to-understand stoplight approach to help people identify healthy beverage options and make informed decisions.

Driving Change in the Workplace

Education on its own does not affect behavioral change. It's also important to make the healthy choice, the easy choice. Recently, Partnership for a Healthy Lincoln, in collaboration with the 3 worksite wellness councils across the state and the Nebraska Department of Health and Human Services released **Nebraska's Guide to Healthy Beverages** at Work. Following the Rethink Your Drink stoplight approach, the guide offers evidenced based steps to developing a healthy beverage policy in your workplace utilizing a staged approach to change at a pace designated by your organization. The brief guide is full of tools and resources to help organizations improve the culture of wellness in their organization. Download a copy of the guide at **www.healthylincoln.org**.



Breastmilk - the Ultimate Healthy Beverage

We can't talk about healthy beverages without acknowledging breastmilk as the original healthy beverage for infants. The 2012 PRAMS data from the Centers for Disease Control and Prevention (CDC) indicates nearly 90% of moms in Nebraska initiate breastfeeding. However, under half continue to breastfeed past 4 months. The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding until 6 months and continued breastfeeding for the first year. In a study published by AAP, the most common factors mothers cited for discontinuing to breastfeed were:

- Lack of encouragement or education from their doctor
- Lack of confidence in their ability to breastfeed
- Challenges when returning to work/school

Policies, systems and environmental change are needed to support breastfeeding moms in our culture as well. Hospitals can evaluate their policies and practices on uninterrupted skin to skin time for the first hour of baby's life, not supplement with formula unless medically indicated, and provide adequate lactation support services giving new moms the tools they need to succeed. Find out how both Lincoln hospitals worked together to support breastfeeding moms in Lancaster County at:
http://www.healthylincoln.org/initiatives/breastfeeding.html.

And the $27,000? One of Lincoln's hospitals signed on to the "Rethink Your Drink" campaign and discontinued providing free sugar sweetened beverages to their staff, patients and their families on each floor…$27,000 is the amount they saved in the first year while "walking the talk" to create a healthy environment for all they serve.

About the Author: Tami Frank is program coordinator for Partnership for a Healthy Lincoln (HealthyLincoln.org), a non-profit organization dedicated to improving community health by decreasing obesity and increasing fitness. Ms. Frank also serves as project director for the Lincoln Community Breastfeeding Initiative.

Butler County Health Care Center trustee steps down after 45 years on board of directors

Reprinted with permission of The Banner-Press, David City, NE

Compared to its humble beginnings, Butler County Health Care Center in David City now is poised to take on the future of rural health care, with all of its challenges.

It's been a long journey to get to this launch pad, and these days, John Klosterman is among the very few who can say they've been on board from the start.

Now the longtime local businessman, cattle feeder and former U.S. Navy lieutenant is 79. One of the first County Board-appointed trustees, he is stepping down from the Board of Trustees after 45 years. The June 30 board meeting will be his last. He said his age and his health are telling him it's time.

The upgrade of the hospital over the past 15 years is only part of the facility's well documented history.

The county-owned hospital was born with a 1971 bond issue for $1.3 million. It was valued at more than $26 million just a couple years ago. Thanks to upgrades that started in 2002, it has changed its focus to outpatient care, established a wellness center and doubled its surgery capabilities.

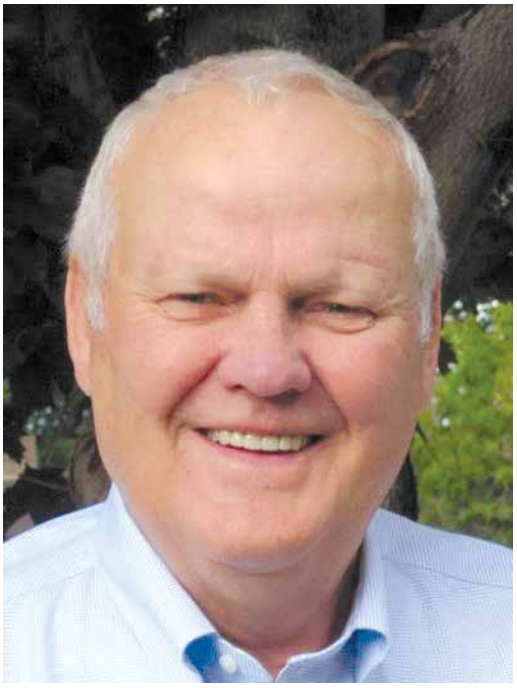
And since its beginning, it has not needed tax dollars for operations. The board of trustees aimed for self-sufficiency.

"I don't know of any community service obligation that I've taken on in my life that brought me more personal rewards than watching this place grow," Klosterman said.

Even in this challenging era of rural health care, the Butler County medical scene is a shining star, as many observers will tell you.

Klosterman, however, remembers the late 1960s and early 1970s when the David City Hospital was outdated, and the decision whether to build a county hospital was far from a sure thing.

Equipped with a community-booster attitude taught by his father, Klosterman was 36 years old when banker and city hospital trustee Paul Kosch asked him to join the campaign.



John Klosterman

"What became immediately clear to me was how important it was for a small town to keep good medical services, because without that, who is going to move here or retire here or whatever?" he said.

The County Board of Supervisors appointed volunteers to oversee operations of the hospital. Kosch and Klosterman were joined by Wilfred Kozisek, Bruno; Betty Eller, Bellwood; and Jim Foster, Ulysses.

"Kosch had some experience in the David City hospital," he said. "Everyone else was an absolute novice."

Klosterman served as the chairman of the board for 37 years. He worked closely with Dr. Larry Rudolph, considered a pioneer in rural medicine, who died in 2013. He said he became like a brother to Dr. Gerald Luckey, whom Rudolph recruited.

Before Luckey arrived in 1974, Rudolph was swamped, working around the clock. Two other doctors had left town.

"I used to sit down at the clinic and do paperwork for Larry," Klosterman said. He also spent many hours with Rudolph visiting Omaha and Lincoln, working to recruit more doctors to David City.

The combination of Rudolph, Luckey and Dr. Vic Thoendel arriving in town marked a key period for local medical services.

"When things finally started to turn around here, they turned around big time," Klosterman said.

Remembering the difficult times, the Board of Trustees leaned heavily on the doctors' expertise to help make sure the hospital stayed on solid ground.

"We had to constantly be looking at the services we provided," Klosterman said. "What services can we economically provide? What (services) are people leaving town for?"

Klosterman said his service on the board has been a labor of love. He visits the hospital at least once a week and he spends an average of a day a month of time spent on board duties. He pores over healthcare journals and attends conferences.

"I often tell people this place has been like a fourth child for me," Klosterman said.

The community service was an extension of his family, he said, especially his father Henry Klosterman.

"He was very community oriented. He gave a lot of his time to David City and to the University (of Nebraska), which I've tried to keep up too," Klosterman said. "It was a natural for me to do that kind of stuff."

Klosterman said board members commonly say that the job takes about three years to grasp. Butler County has been lucky to have dedicated trustees. Continuing education is a requirement for board service, he said.

"If you think you might want to be on the hospital board because it is an honor, you need to get that out of your head real quick," he said. "It takes commitment, time and a great deal of work."

He said the county had the good fortune to hire good administrators, naming the late Jo Ellen Vrbka, Roger Reamer, now at Seward Memorial Hospital, and current administrator Don Naiberk, who worked with the board to steer the hospital through the major expansion that started in 2002.

"We couldn't have had a better administrator than we have with Don

Jason Lavicky (board member), Bev Struebing (Board Member) Jerry Roh (Board Chair) Jim Egr (Board Secretary), Don Naiberk (CEO) John Klosterman, not picture is Diane Moravec (Board Vice Chair)

Naiberk," Klosterman said. "It was very gratifying to me when he said he was going to build a house here, because that meant he was going to stay."

The administration and the board have built good relationships with local doctors, and Klosterman said the community is well served by keeping the hospital and doctors independent of each other.

Klosterman said the future is bright for the local medical services. As the veteran doctors approach retirement, two new doctors, Robert Daro and Alisha O'Malley, are poised to begin their practices here.

Another of Klosterman's projects, the Future Generations Health Care Foundation, which supports the hospital's needs through local giving, is nearing completion of a campaign to raise $450,000 to help recruit new doctors. The fund will help doctors defray the high cost of education and make the community more competitive.

The public is catching on to the value of the hospital's spacious wellness center, which surrounds the physical therapy area. Its futuristic glass wall offers a view of the city park. The center boldly asserts that local healthcare hinges on prevention and wellness. The hospital was ahead of the curve already, with its first wellness center built in 1987.

"Let's just keep (patients) out of the system if we can. Let's keep them healthy and well," Klosterman said. "That's the cheapest form of medicine."

Klosterman lives only a few blocks away from the hospital, so he said it's very likely that he'll still be dropping by to say hello to the staff.

"I feel great about this place, we have good people on the board, and good people on the staff," he said. "One of the things that has made it so much fun for me is the staff here. They are just great people. They are very dedicated."

Klosterman's wife Beth, also an active community leader, said that she never suggested her husband had served long enough.

"I have always been very proud of the things he's done with the hospital," she said. "He's always got another project. (He had to) get through the renovation and I think the timing worked out just about right," she said.

What others said

David City attorney Jim Egr, who has served on the board for 35 years, said Klosterman set the tone from the start of the county owned hospital.

"He has always been the advocate of staying on the cutting edge for the hospital," Egr said.

While a longtime chairman might easily come to dominate a board, Egr said Klosterman always wanted trustees to present their ideas.

"He would have ideas and take leadership roles." Egr said. "John never dominated the hospital board. Everybody has opinions and shares those opinions, There were disagreements. We tried to reach consensus and compromise."

Egr said one unique part of the board's approach was building its reserves for upgrading facilities.

A check from the hospital's revenue is written to a fund in the amount determined to be the value of depreciation of the hospital facility and equipment. When the most recent expansion called for a $12

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million revenue bond, the hospital already had $4 million on hand.

"Some places just write off their depreciation, we actually physically do it with a check," Egr said.

BCHCC Administrator Don Naiberk said the David City hospital is known far and wide, thanks to Klosterman.

"John has played such an enormous role in the success of our hospital. He is well known throughout the state for his service on the board as well as his advocacy for health care in our state," Naiberk said.

Klosterman's circle grew in the past decade when he became involved in the Western Regional Trustee Symposium, an annual conference offered to healthcare trustees to promote healthcare governance excellence. Its attendees represent hospitals in eleven states: Nebraska, Nevada, Arizona, North Dakota, South Dakota, Idaho, Utah, Wyoming, Colorado, New Mexico and Montana.

"John was the Nebraska trustee chair of this organization about five years ago when the event was held in Omaha," Naiberk said. "He attended several of these, and he is well known by many."

At last year's meeting in Henderson, Nev., Klosterman was recognized as the trustee with the longest tenure of service on a hospital board of those states present.

"People all over the country have heard of our hospital, and most of them have heard about it because of John," Naiberk said.

Although Klosterman says that Dr. Luckey deserves much of the credit for helping to guide the hospital through its evolution, Luckey turns the praise around.

"John has been a driving force in making the Butler County Health Care Center a model for health care delivery in Nebraska," Luckey said. "He was heavily involved in planning and overseeing the building of the new hospital in 1972-73. His vision for the future is demonstrated in his major participation in the recent remodeling of the hospital and expansion of the Wellness Center as we focus more on wellness and prevention of disease."

Luckey said Klosterman believes in research.

"He has devoted much time to attending healthcare seminars and researching hospital related literature," Luckey said. "His interaction with our hospital administration has been time-consuming for him but very helpful in guiding them. He has continually maintained a close relationship with the physicians in David City."

Klosterman's legacy?

"He has helped provide a healthcare system in David City that is attractive to physicians, nurses, and allied health care providers, so that we can provide the best quality of care to the David City community that is possible," Luckey said.

Dr. Mark Carlson said the medical community will miss Klosterman's presence.

"John has done a great job over the many years he has served on the board of the hospital. We would like to thank him for all his work and dedication to our hospital and the healthcare of Butler County," Carlson said. HN

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

Creating a scope of practice

The process for creating a scope of practice is a deliberate and thorough exercise, as it should be, because enhancing the quality of care and ensuring the patient's safety are the most important priorities. A scope of practice for any provider group requires statutory authority; however, long before legislation is drafted and debated, an applicant group must go through a credentialing review process that includes three stages of evaluation to examine whether such initiative is in the public's best interest. The results are intended to be advisory to the Legislature as it assesses the need for state regulation of health professionals.

Nebraska law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Department of Health and Human Services, Division of Public Health. The director of this division will then appoint a technical review committee to review the application and make recommendations regarding whether or not the application should be approved. Those recommendations are made in accordance with statutory criteria that focus on public health, safety and welfare.

The recommendations of the technical review committee take the form of written reports that are submitted to the State Board of Health and the director of the division along with any other materials requested by those review bodies. The Board of Health and the director formulate their own independent reports on credentialing proposals. All three reports are submitted to the Legislature to assist state senators in their review of proposed legislation.

Two years ago, a state survey of a Nebraska hospital brought to the forefront a Nebraska law prohibiting physicians from delegating tasks to unlicensed health care practitioners, specifically surgical first assistants. Soon after, the State issued a cease and desist order informing all health care facilities that it was illegal for a physician to delegate in this manner.

Immediately, hospital personnel began researching the role of surgical first assistants in Nebraska and quickly found that surgical assisting, like many allied health occupations, is not regulated in Nebraska and began the preliminary research for developing licensure of surgical first assistants. A white paper was drafted and submitted to the Nebraska Hospital Association (NHA) Board of Directors for review. The NHA Board voted to sponsor the effort to create a scope of practice and licensure for surgical first assistants. Shortly after, a stakeholder group was convened to further develop the application. The collaboration resulted in an application submitted in February, officially beginning the credentialing review process.

The primary goal of this proposal is patient safety through increased regulation of surgical first assistants. Licensure will ensure that individuals in the field of surgical assisting meet a standard of education and training that the state determines is appropriate. Surgical first assistants possess training specific to the intricacies involved in the surgical first assisting position and licensure will allow them to function as trained under the law.

Licensure will also increase access to services across the state. Surgeons will have greater access to the assistance necessary for providing services to patients in need. A licensed surgical first assistant can increase the availability of appropriate surgical staff. This will promote cost-effective employment of qualified individuals to assist surgeons, enabling them to provide a higher quality of care while lessening the risk of surgical procedures. Additionally, licensure of surgical first assistants will boost workforce development as more individuals seek out the training necessary to fulfill licensure requirements.

The surgical first assistant is a trained individual who is able to actively assist the surgeon in completing the operation safely and expeditiously by helping to provide exposure, maintain hemostasis, and serve other technical functions. The surgical first assistant works under the personal supervision of a physician as an allied health care provider, providing quality health care service.

The proposed scope of practice for a surgical first assistant includes, but is not limited to, the following:

1. Assisting the surgical team in the intraoperative care of a surgical patient,
2. Positioning the patient,
3. Preparing and draping the patient for the operative procedure,
4. Providing visualization of the operative site,
5. Assist with hemostasis,
6. Assist with closure of body planes,
    a. Utilizing running or interrupted subcutaneous sutures with absorbable or nonabsorbable material,
    b. Utilizing subcuticular closure technique with or without adhesive skin closure strips,
    c. Closing skin with method indicated by surgeon (suture, stapes, etc.),
    d. Postoperative subcutaneous injection of local anesthetic agent as directed by the surgeon,
7. Applying appropriate wound dressings,
8. Providing assistance in securing drainage systems to tissue,
9. Preparing specimens, such as grafts, and
10. Performing tasks during a surgical procedure delegatable under the personal supervision of a licensed physician appropriate to the level of competence of the surgical first assistant.

To ensure that training for surgical first assistants can occur in Nebraska, the proposal requires that trainees are allowed, under state law, to perform tasks integral to the accredited program in which the trainee is enrolled while unlicensed. This proposal requests statutory language, similar to that which applies to physician assistants, be developed and included in the legislative proposal to facilitate training of surgical first assistants in the state. This will also pave the way for development of accredited programs in educational institutions across the state. The proposed language is as follows: Notwithstanding any other provision of law, a trainee may perform medical services when he or she renders such services within the scope of an approved program.

The second part of this proposal requests creation of a mandatory registry with a competency assessment requirement for surgical technologists. The purpose of the registry is to assist the State in ensuring that individuals functioning in the surgical technology occupation meet the competency requirements necessary to provide quality care in the state.

Completion of an accredited surgical technology program is not a requirement of the registry but a component of the information collected. The registry shall include the highest level of education of the registrant. Applicants will be required to provide a copy of their transcript in support of an indication that a surgical technology program has been completed. The proposal also requests that the documentation includes an opportunity for the applicant to acknowledge possession of certification in surgical technology from a private certifying board.

The proposed model for the mandatory registry qualifications requires that the applicant must:

1. Be at least 19 years of age;
2. Be of good moral character; and
3. Be a citizen of the United States, or an alien lawfully admitted into the United States;
4. Submit to the Department:
   a. A completed application including:
      1. Applicant name, address, birth date, last four digits of the applicant's Social Security Number;
      2. Identification of any felony or misdemeanor conviction along with date of occurrence and county in which the conviction occurred;
      3. Whether or not the applicant has completed an accredited program in surgical technology;
      4. Whether or not the applicant has obtained private certification in surgical technology; and
      5. Certification of competency assessment completed by a licensed health care professional.
   b. All records, documents or information requested by the Department;
   c. The required non-refundable fee as determined.

Surgical technologists are allied health professionals who are an integral part of the team of medical practitioners providing surgical care. They work under the direction of hospital and clinic policies to ensure that the operating room environment is safe, equipment functions properly and the operative procedure is conducted under conditions that maximize patient safety. As part of the registry application, a determination will be made by a licensed health care professional and placed in writing that the surgical technologist is competent to perform the appropriate functions.

These items would be defined in statute as the range of functions and procedures for surgical technologists. The proposal also requests statutory language will include wording that clarifies that surgical first assistants are also able to perform those same functions.

Substantial work has been done by many collaborative partners in developing this initiative, yet the credentialing review process is only the first part of creating a scope of practice and licensed status for surgical first assistants. The second part requires securing statutory authority. Legislation must be drafted, introduced and debated; a process requiring a majority of 49 senators to advance this through three stages of debate and the governor to sign it into law. That chapter will begin when the Legislature convenes in January 2016.

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

By Elisabeth Hurst, director of advocacy

Big issues expected during short session

Musty hearing rooms, peeling paint and the familiar faces of legislative staff and special interest representatives are quickly coming into focus as summer turned into fall. So much excitement builds quickly, anticipation for the possibilities of the next legislative session. Which senators will tackle the token issues this year? What new, innovative ideas will come to bear?

Term limits have created more uncertainty than previous years. Generally, the preceding legislative session and placement along the campaign cycle is a good indicator of what issues will rise to the top of the legislative agenda. For instance, the session immediately following an election year tallies more bills introduced on the classic platform issues such as tax reform, education financing and workforce development. The elected representatives generally learn within their first year, however, that these issues are issues for a reason.

Cutting taxes means you have to replace lost revenues, either through reduced spending or additional assessments. Both of these options mean taking away from a different program or burdening a different group, which usually is not popular with the beneficiaries of the eliminated program or the newly assessed population. Increased educational spending equates to a tax increase, which is not popular in this neck of the woods. Workforce development generally requires offering subsidies to the parties putting forth educational and recruitment efforts, again, requiring more dollars.

Once the new crop of officeholders finds their footing, policy proposals reflecting personal and professional interests hit the docket. Representatives often develop legislation, personal commitments, for which they advocate throughout their tenure and remain fixtures on the agenda year after year until legislation is either passed or the policymakers are voted out of office.

The short, 45-day session of the 104th Nebraska Legislature begins in January, just a few short months away, and will likely mirror the second session in 2014. Bills of interest introduced will address taxes, access to behavioral and mental health, repeal of the helmet law, transformation of the Medicaid program, roads improvement, workforce development, health care professional scopes of practice, prescription drug monitoring and pharmacy regulation, law enforcement body cameras, government agency oversight and many more areas of law. Interim studies are a great indicator of session proposals; hearings for these are now underway.

The 49 state senators, 19 of who are still in their first year of office, are now more aware that cutting taxes is not as simple as it sounds. A portion of the 400-650 bills expected to be introduced next will attempt to address taxes, specifically property tax, through shifts or cuts in spending. A primary focus of this fall's interim study hearings are focused on educational spending, which relies almost exclusively on property tax. Nebraska's annual state budget allots over $1.6 billion annually for education. Even with such a high dollar figure, Nebraska still ranks 49 in the nation for percentage of state government funding for education (based on the most recent figures available). This statistic makes it difficult to argue that Nebraska is doing enough to fund education while pursuing cuts.

The state Legislature has evaluated Nebraska's funding mechanism for education, the Nebraska Tax Equity and Educational Opportunities Support Act (TEEOSA), in the past and most recently during this year's joint Education and Revenue Committee assessment of the current formula. The current formula, including equalization funding, seems the most aggressive since TEEOSA's creation in 1990. If the committees identify a new model that helps reduce reliance on local funding, namely property taxes, rest assured it will include a new revenue source to accommodate the shift.

Funding sources for supplementing roads will also come up, though perhaps more subtly now that the gas tax has been established for implementation in January.

Helmet repeal efforts are also expected to return, but with a surge in motorcycle related deaths this summer, it will be a tough sell.

Funding for dormant programs, shortchanged during the last decade, will arise. The chair of the Appropriations Committee is in his last year and agencies, both private and public, will bring funding requests to the table in the hopes that the committee will support the requests based on knowledge of lean years past.

What you will not see is the annual death penalty law repeal as it was successful this past session. The fate of the new legislation will be addressed in the general election long after the short session has ended.

Several state senators have voiced interest in state health care reform, introducing fledgling policies on potential solutions for the uninsured. None of the policies' details have been released thus far and their viability is questionable at this time. Innovation is key, however, as the elementary approach to Medicaid expansion has been thwarted for three consecutive years.

One potential proposal introduces the model of direct primary care. The approach is less of a gap-filler than a new physician model of care delivery. Another potential proposal seeks to resurrect this year's more progressive Medicaid expansion model and fund it through a facility tax. The reasoning is that if opponents of past proposals resist expansion due to the eventual burden on the state coffers, assigning an alternative funding source, namely hospitals, will turn those opponents into supporters.

Will either of these ideas move through the legislative process? Anything can happen. Rest assured that any proposals involving reform of Nebraska health care will be heavily scrutinized and not without compromise. If there is anything that remains constant from year to year in the realm of policymaking, it is the knowledge that good policy takes investments of time and effort. The Nebraska Hospital Association will be on hand to offer both.

If you have any questions about interim studies, their respective hearings or the upcoming legislative session, feel free to contact Elisabeth Hurst, director of advocacy, at ehurst@NebraskaHospitals.org. HN

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By Kevin Conway,
vice president, health information

Sustaining rural health services

According to the North Carolina Rural Health Research Program, from 2010 through 2014, 47 rural hospitals ceased providing inpatient services in 23 states across the country. Among the 47 closed hospitals, 26 hospitals no longer provide any health care services ("abandoned") and 21 continue to provide a mix of health services, but no inpatient care ("converted"). These closures have affected approximately 800,000 people in the markets with abandoned hospitals and 700,000 people in the markets with converted hospitals. In Nebraska, Tilden Community Hospital was one of those closed hospitals.

One of the key findings from the North Carolina report was, "in the year of closure, abandoned rural hospitals had lower profitability and liquidity than converted rural hospitals. A negative cash flow margin may have limited conversion as an option for abandoned rural hospitals." Stressed rural hospitals have been a focus of both state hospital associations and the American Hospital Association (AHA).

The AHA has formed the 30-member Ensuring Access in Vulnerable Communities Task Force. The AHA Vulnerable Communities Task Force consists of two subcommittees, a rural subcommittee and an urban subcommittee. Members of each subcommittee include association and hospital leaders. As you can guess by the two subcommittees, the task force will work to confirm the characteristics of vulnerable rural communities and of vulnerable urban communities. The task force will identify strategies and federal policies to help ensure access to care in these areas.

In addition, state hospital associations with rural area convened to identify common themes and discern elements for sustaining rural health services. Part of the discussion was around models/ideas states are investigating for sustaining future rural health services. From the discussion, the following guiding principles were developed:

- Community and consumer centric (community support).
- Model flexibility and community choice. This includes scalable solutions for emerging payments and delivery models.
- Clinical integration – social and health services.
- Collaboration (both locally and regionally).
- Health Authority Integration (alignment).
- Identification and access to core/ essential Services.
- Address workforce shortages and best use of available resources.
- Promote efficiency and value.
- Reimbursed fairly with focus on addressing population health.
- Utilizing technology to drive outcome improvement.
- New payment models must be viable at state and federal level.

Emerging model discussion focused on "new model" to augment Critical Access Hospital (CAH) status. Reimbursement should be cost based or negotiated global budget with subsidy, with costs including administrative and regulatory mandated expenses. Value-based incentive inclusion and local financial participation should be part of negotiation. Services outside of core would be fee schedule billing and not part of subsidize. Core services are either provided directly or by agreement within or outside local rural system:

- Transitional Care (this is bedded patient but without inpatient status)
- EMS (ambulance, transportation and community paramedics)
- Primary Care
- Diagnostic Services
- Rehabilitative Services
- Behavioral Health
- Pharmacy
- Oral Health
- Prevention/Wellness

Sen. Grassley, Chuck (R-IA) introduced the Rural Emergency Acute Care Hospital Act, or REACH Act , on June 23. It was cosponsored by Sen. Cory Gardner (R-CO), Sen. Joni Ernst (R-IA) and Sen. Thad Cochran (R-MS). The REACH Act. S.1648, would allow a rural emergency hospital conversion from any facility that was either a CAH or a rural hospital with at most 50 beds, or such hospital that ceased operations five years before the Act. A rural emergency hospital:

- must provide 24-hour emergency medical care and observation care not exceeding an annual per patient average of 24 hours or more than 1 midnight;
- does not provide any acute care inpatient beds and has protocols in place for the timely transfer of patients who require acute care inpatient services or other inpatient services,
- may provide "extended care services";
- has elected to be designated as a rural emergency hospital;

- has received approval to operate as one from the state;
- is certified by the Department of Health and Human Services (HHS); and has
- verified as a level IV trauma center, or employs Advanced Trauma Live Support trained staff and has transfer agreement with level I or level II trauma center.

Rep. Sam Graves (R-MO) introduced H.R.3225, Save Rural Hospitals Act, on July 27. It was cosponsored by Dave Loebsack (D-IA). The Save Rural Hospitals Act includes a number of regulatory and financial improvements the Nebraska Hospital Association has been advocating on.

The act eliminates Medicare sequestration, establishment of meaningful use support payments for rural facilities struggling to maintain MU compliance, permanent extension of the rural ambulance and super-rural ambulance payment. Also regulatory changes for elimination of the CAH 96-hour condition of payment, rebase of supervision requirements for outpatient therapy services at CAHs and rural prospective payment system facilities and modification to the two-midnight rule and RAC audit and appeals process.

The act also creates the Community Outpatient Hospital (COH) to provide a new model for rural hospitals. It will ensure access to emergency care and allow hospitals the choice to offer outpatient care that meets the population health needs of their rural communities. Includes grants for quality improvement, population health and emergency services. Payment for qualified outpatient services is equal to 105 percent of the reasonable costs of providing services. Costs associated with having a backup physician available via a telecommunications system shall be considered reasonable costs.

To become a COH, the facility must be a CAH, or is a hospital with not more than 50 beds that located in a rural area; or closed within the past 5 years, and:

- provides emergency medical care and observation care available on a 24-hour basis;
- does not provide care over 2 or more consecutive midnights;
- does not provide any acute care inpatient beds and has protocols in place for the timely transfer of patients who require other inpatient services;
- level IV or higher trauma center, or has available for consultation on a 24-hour basis a health care professional who successfully completed the Advanced Trauma Life Support Course within the preceding 4 years; and
- has in effect a transfer agreement with a level I or level II trauma center designated under section 1231(1) of the Public Health Service Act.

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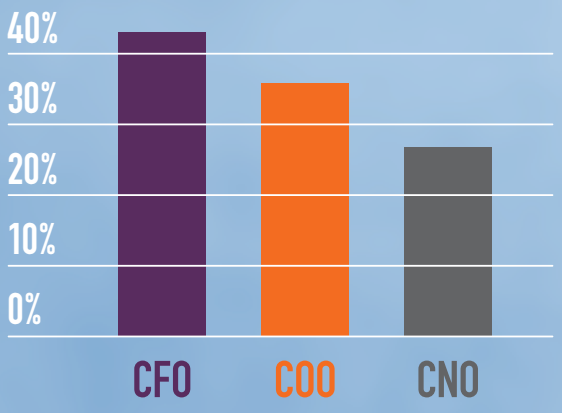

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By David Burd, FHFMA
vice president, finance

It's never too late to get involved

Attempting to make a legislative or regulatory change at the federal level is not an easy task. A lot of effort is involved by many stakeholders and results are often achieved over the course of years rather than months. However, getting involved and being persistent can make a difference. The good news is that it is never too late to get involved.

Two major rural health care concerns the Nebraska Hospital Association (NHA) and our member hospitals have been attempting to get addressed by Congress include the physician supervision requirements for outpatient therapeutic services and the 96-hour rule for critical access hospitals (CAHs). Both of these issues have a significant negative impact on rural hospitals in Nebraska (and across the country) and the patients they serve. The NHA has been working with the Nebraska congressional delegation, the American Hospital Association (AHA) and other stakeholders for several years to obtain some resolution to these misguided requirements.

Congressman Adrian Smith has introduced legislation that targets both the physician supervision and 96-hour rule concerns. The bills that have been introduced in both the House of Representatives and the Senate on these two issues include the following:

- H.R. 169 / S. 258 (Critical Access Hospital Relief Act of 2015)
  - House bill was introduced by Rep. Smith to remove the condition of payment requirement that a physician certify that a patient can reasonably be expected to be discharged or transferred within 96 hours
  - House bill is cosponsored by Congressman Jeff Fortenberry and the Senate bill is cosponsored by Sen. Deb Fischer

- H.R. 170 (Rural Health Care Provider Relief Act of 2015)
  - Introduced by Rep. Smith and would extend the moratorium on enforcement of the physician supervision requirements through 2015

- S. 257 (Protecting Access to Rural Therapy Services Act)
  - Introduced to permanently address the physician supervision requirement concerns by adopting a default standard of "general supervision" for outpatient therapeutic services
  - Cosponsored by Sen. Fischer

The strong support of the Nebraska congressional delegation, especially on these two issues, is much appreciated. Nebraska's delegation has helped lead the way. Efforts by hospital leaders in Nebraska and across the country to educate policymakers on the significance of these issues have paid off. A lot of progress has been made toward resolving these issues. The bills discussed above have several cosponsors and bipartisan support. However, while much has been achieved, the job is not finished.

At the time of this writing, football season has just started. In football terms, we are in the fourth quarter, and it is time to carry the ball across the goal line. It is time for Congress to pass the bills addressing the concerns regarding both the physician supervision and 96-hour rule requirements. It is time for Congress to address these misguided requirements once and for all. The health care industry is facing many challenges as it transitions from a volume-based system to a value-based system. Addressing the concerns regarding the physician supervision and 96-hour requirements will remove roadblocks and unnecessary burdens and therefore allow hospitals to maximize their focus on important initiatives that increase the quality of care and reduce its cost.

Several NHA member hospitals have been actively involved in advocacy efforts to communicate the importance of resolving these issues. Your efforts are appreciated!

There is still time to get involved. Now is the time to contact your Senators and House Representative and urge them to work with their colleagues in Congress to finish the job. While we have come a long ways and much has been accomplished, it is time for resolution. Now is the time for the final push across the goal line!

David Burd, vice president, finance, can be reached at dburd@NebraskaHospitals.org.

By Monica Seeland, RHIA
vice president, quality initiatives

Benchmark report measures Nebraska health care quality performance

The Agency for Healthcare Research & Quality publishes a yearly "state snapshot" of all 50 states, providing information on how health care in Nebraska compares to national benchmarks. The National Healthcare Quality Report quality measures are compared to achievable benchmarks, which are derived from the top-performing states.

Better performance by a state can mean higher or lower values of a measure, depending on the desired outcome. For example, low values are desirable for measures such as infant mortality, whereas high values are desirable for measures such as preventative screening.

In the latest report, Nebraska "achieved benchmark or better" in 83 measures, was "close to benchmark" in 81 measures and was "far from benchmark" in 35 measures.

The categories of achievement have been standardized across the measure definitions so that:

- **Far away from benchmark** - a state's value for a measure has not achieved 50 percent of the benchmark.
- **Close to benchmark** - a state's value for a measure is worse than a benchmark but has achieved between 50 and 90 percent of the benchmark.
- **Achieved benchmark or better** - a state's value for a measure is at least 90 percent of the benchmark value if not fully, 100 percent achieved. This category also includes the case in which the measure's value is equal to or better than the benchmark.

Nebraska achieved benchmark in areas such as "adult patients who did not receive good communication about discharge instructions" (a low score is better); "hospital patients with pneumonia who received the initial antibiotic consistent with current recommendations (a higher score is better); and "home health care patients whose ability to walk or move around improved" (a higher score is better).

Areas in which Nebraska was "far away from benchmark" included "home health care patients who had an emergency department visit that did not require hospitalization" (a low score is better), "potentially avoidable hospitalizations for acute conditions per 100,000 visits, adults 18 & older" (a low score is better); and "adults who had a doctor's office or clinic visit in the last 12 months who sometimes or never got advice to quit smoking from provider, commercial plan"(a low score is better).

This report is one example of the information that is available to consumers about health care delivery in Nebraska. If you have questions about this or any other health care information, feel free to discuss them with your health care provider. To view the entire report, go to http://nhqrnet.ahrq.gov/inhqrdr/state/select.

Monica Seeland, vice president, quality initiatives, can be reached at mseeland@NebraskaHospitals.org. HN

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