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Healthier Nebraska

FILLMORE COUNTY HOSPITAL
GENEVA, NE

Nebraska Hospital Association
The influential voice of Nebraska's hospitals

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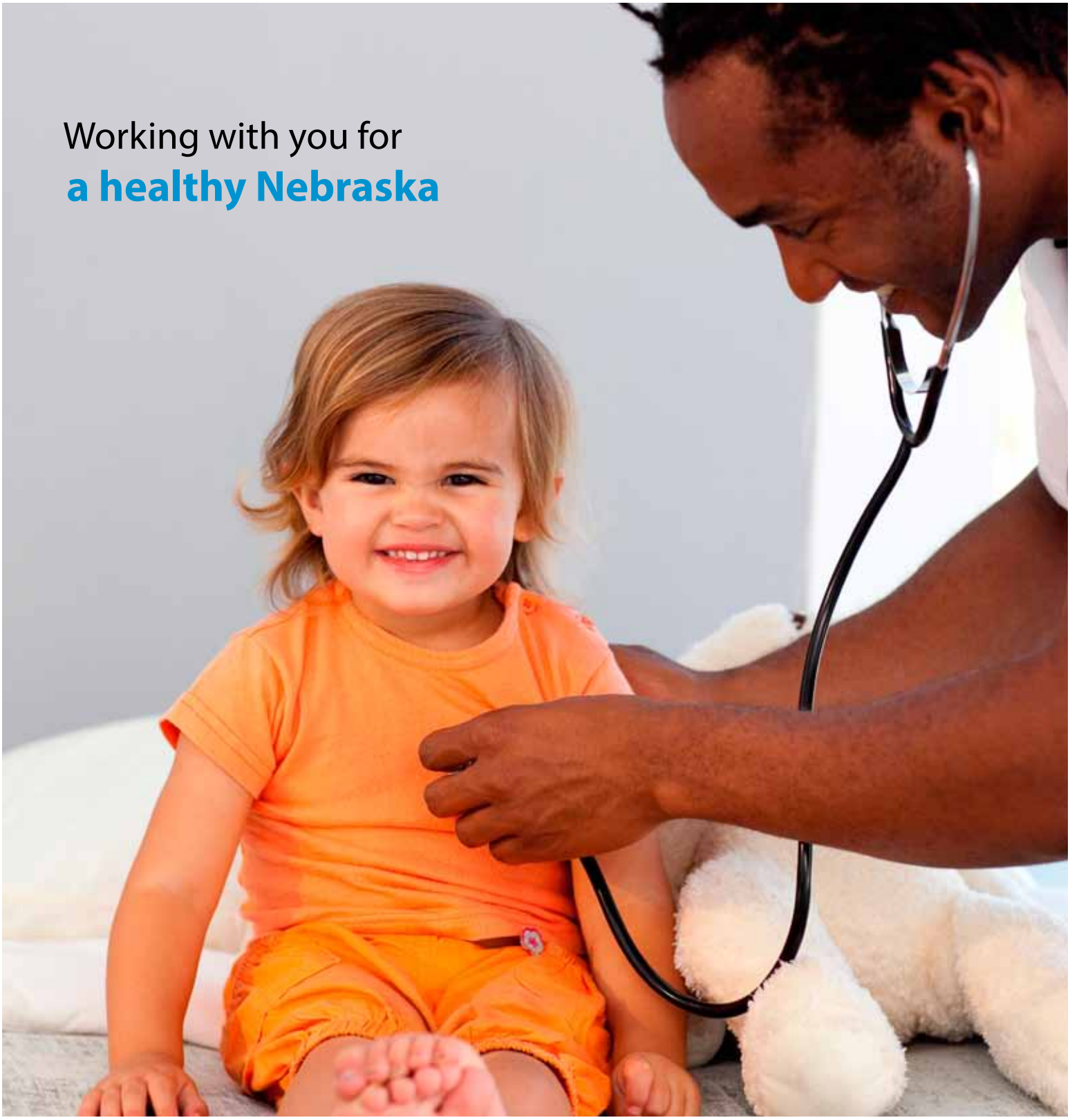

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Edition 64

Fillmore County Hospital — building a culture of ownership

Every day at 6:30 a.m., employees make their way down the halls of Fillmore County Hospital (FCH) to gather at the nurses' station.

It's time to huddle; to welcome the day. To give a shout out to an employee who showed grace under fire yesterday, to celebrate a birthday or anniversary and to trade stories about what's inspiring them this morning.

Paul Utemark, CEO of FCH, takes a minute to let people know that housekeeping has two people sick and they may need help today. The latest winner of the traveling Sparkplug Award is announced – someone who exhibited actions consistent with the hospital's core values program.

They end the huddle with the program's pledge of the day, reciting in unison lines of inspiration and encouragment inpreparation of the opportunities and challenges they will face in the next 24 hours. The messages concentrate on

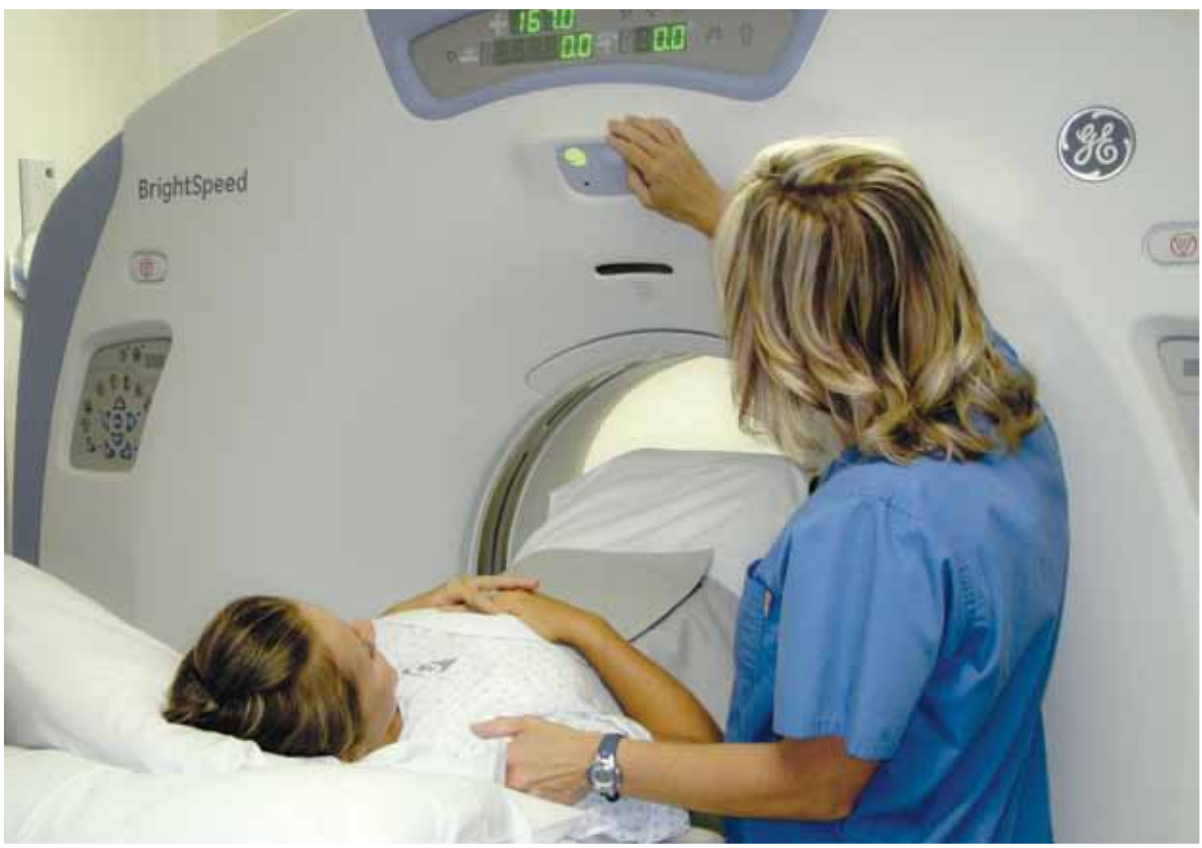
Fillmore County Hospital opened its new $18.5 million, 60,000 square foot state-of-the-art facility to the public on March 1, 2012. One of the many improvements is each patient room now has a wheel chair accessible, spacious bathroom.

authenticity, integrity, awareness, courage, perseverance, faith, purpose, vision, focus, enthusiasm, service or leadership.

Then staff members return to their jobs. The scene repeats at 8:30 a.m. and 4:30 p.m.

Some people may think a five-minute huddle can't have a lasting impact, but at Fillmore County Hospital, it makes the 20-bed, county-owned hospital strong. More than half of all employees have completed the Core Action Values training program during the last two years, marching toward a goal to build a culture of ownership in the hospital, shaped by everyone and every action.

In the simplest terms, it helps people try to be the best they can be and remember their collective service to patients – the people who come to them seeking help, health and peace.



Kim Taylor, a radiology technologist, conducts a CT scan on a patient. The CT scanner is one of the few items carried over from the old facility.

Employees joke that they are working on "their invisible architecture," making it as inviting as their beautiful "outside," a new $18.5 million, 60,000 square foot critical access hospital that opened the doors of its brand new state-of-the-art facility to the public on March 1, 2012.

If winners don't rest on their laurels, then the FCH team is not content to just hang its hat on a nice facility.

And it is a nice building.

Stately brick columns

continued on next page

Paul Utermard, CEO of Fillmore County Hospital, speaks with an obstetrics patient at the new hospital facility.

continued from last page

on the outside, mission design and architecture on the inside, with dark paneled woodwork and fixtures. Every purpose found its ideal space here. FCH is adjoined with Fillmore County Medical Center, PC; a spacious physical therapy area, labor and delivery rooms with homelike touches, specialty clinics, two emergency room bays, a lighted helicopter pad and more.

The facility is quite a step up from the original two-story frame house built by Dr. Royal Woods and Dr. Joseph Bixby, which pre-dated World War I and provided the earliest beginning of the Fillmore County Hospital.

But even on opening day, the FCH message wasn't about the building, but rather about quality, purpose and providing local access to a complete spectrum of exceptional health care.

FCH staff are dedicated to delivering patient and family focused care where compassion, innovation and teaching are vital. The hospital's vision is to be the regional choice for valued health services, and it is recognized for its team's knowledge and compassion in delivering exceptional care, innovative services and trusted outreach and education through all stages of life.

"With all the changes and challenges existing in health care today, our team believes the best way to thrive in this new environment is to build a culture of ownership," CEO Paul Utemark said.

They sum it up in their mission and value statement: "We deliver patient and family focused care where compassion, innovation and teaching are vital."

Whatever degree of care is necessary, FCH staff constantly works to help their patients get back to their day-to-day lives, making a difference in the activities of its patients every day. They work hard to assure the safety and well-being of their patients, and it is their goal to give patients and those who love them the peace of mind that they are in good hands. The quality services provided by FCH are a result of this aspiration — care you need just the way you need it.

"I've worked in many hospitals," senior behavioral health program director Stephanie Knight said. "This one felt different the day I walked in. Everyone welcomed me. The way this hospital looks at things: it's solution focused; it helps you become the best you can be." **HN**

Diane Fort, a radiology technologist, reads the results of a scan in the new energy efficient, state-of-the-art CT scan room.

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Brodstone Memorial Hospital

Superior, NE

With its Victorian homes and quiet neighborhoods, Superior makes for a great place to have a progressive, prosperous hospital. Just minutes from the Kansas border, Brodstone Memorial Hospital provides health care to portions of four counties in Nebraska and three in Kansas. Named for Evelyn Brodstone, Superior's hospital is unique because the majority of its board of directors is required to be female, so the six-member governing board must consist of no more than two male directors.

Brodstone was one of the first hospitals in Nebraska to take "The Florence Prescription" and, just as the characters in the book of the same name, the hospital is not afraid to make changes and keep up with technology. Currently, Brodstone administrators are working with the Lean Project to simplify procedures in order to save time and money.

The Leona M. and Harry B. Helmsley Charitable Trust has been very generous to Brodstone, granting them funds for a 3-D digital mammography unit in 2011 and ePharmacy in 2012. The ePharmacy program allows Brodstone to work with Avera for after-hours pharmacy services.

"We are very fortunate that our full-time pharmacist has always responded for any after-hours calls, but we realized this is not always possible nor should it be," Kori Field, director of nursing, said.

Brodstone is now able to utilize remote pharmacy staff for all their inpatient medication orders after regular business hours. The after-hours pharmacists conduct medication interaction and dosage checks and process orders directly into Brodstone's electronic patient record, as well as serve as a resource for the medical and nursing staff after hours. According to the nursing staff, the remote pharmacists have been a valuable asset to the team and a great addition for patient safety. They appreciate that a professional pharmacist is available to review pharmaceutical orders and they are able to call and consult a pharmacist day or night throughout the week rather than calling staff at home after-hours.

More than 800 mammograms are performed each year at Brodstone. Thanks to the Helmsley Trust, the mammography suite was remodeled and a dressing room was added. The Helmsley Grant also enabled Brodstone to purchase the first digital mammography unit with tomosyntheses, or 3-D, in the state and it remains as one of two in Nebraska. It was important to Brodstone to offer the latest technology, so Brodstone invested the additional $195,000 for the upgrade.

In 2010, construction was completed to add a new clinic and specialty clinic area, enabling physicians to get to the emergency room within moments after being called to treat a patient. Prior to the construction project, physicians would have to cross the parking lot to reach the ER, occasionally in snow and icy conditions. The addition has also contributed to a more cohesive "family" because clinic and hospital staff now work in the same building.

The number of specialists who visit and perform surgical procedures at Brodstone continues to grow. Currently, 22 specialty health care providers conduct visits at least once a month. The most recent specialties added are mental health, neurology, oncology, vascular and infectious disease. Additional cardiology specialists have also been acquired. With the specialty clinic area adjacent to the clinic area, it provides the opportunity for Brodstone's medical staff to consult with the specialists.

The list of surgical procedures

performed at Brodstone continues to grow. The surgical suite completed in 2010 provides room for medical providers and specialists to perform surgery on a daily basis. There are two operating rooms and an endoscopy room with a large outpatient surgery area. Along with a list of other surgeries, Brodstone also does total knee replacements, shoulder and knee arthroscopy and cataracts. Sedation TEEs and MRIs are also available at Brodstone.

Lymphedema therapy has been added to the growing list of services provided. The hospital's physical therapy assistant is also a certified lymphedema therapist. Recently a patient sent a note to Brodstone, "For over 20 years, I have had swelling and constant pain in my legs and arms. This therapy has changed my life. I believed that I would never find relief from the pain, and for that I am very grateful"! Prior to the PTA's lymphedema certification, patients were driving as far away as 90 miles for the service.

Brodstone also encouraged a registered nurse who had been employed for several years at the hospital to become a wound, ostomy and continence (WOC) nurse. A WOC nurse stays up-to-date on current practices for wound care and works with physicians in caring for wounded patients. An ostomy support group has also been established to help those patients that deal with everyday situations.

In January, the Cardiac Rehab Department at Brodstone earned national certification. The certification process is rigorous, sometimes taking as long as a year to complete. The department is one of 11 certified cardiac rehabilitation programs amongst the 65 critical access hospitals in Nebraska. Brodstone's in-house MRI and 16-slice CT are also nationally certified.

Just as other hospitals across the nation, Brodstone has been progressing to Electronic Health Records (EHR). Brodstone installed the inpatient certified upgrade in 2011 and was among the first Nebraska hospitals to successfully attest for Meaningful Use that year. Meeting this goal so early is a testament to the commitment of everyone at Brodstone who worked hard to meet the challenges of integrating EHRs and health information technology into clinical practice. The process is currently in the first stage of the HITECH Act, focusing on getting basic medical information entered into the electronic system.

While other small towns and hospitals struggle with recruiting medical staff, Superior has been very fortunate to continue building theirs. Currently, Brodstone has three family practice physicians, two physician assistants and two nurse practitioners that provide care at two medical clinics, one in Superior and one in Nelson, along with 24 hour a day, seven days a week availability to the hospital.

Brodstone is currently working to refinance their loans, which will result in a significant reduction in interest expense with their last two construction projects. "Who wouldn't want to pay off their debt in 15 years instead of 40?," said John Keelan, CEO of Brodstone Memorial Hospital.

Brodstone Memorial Hospital has been providing care to Nuckolls County residents and the surrounding counties since 1928. Each year they continue to grow, providing additional services when there is a need or opportunity. The Brodstone Memorial Hospital staff consists of nearly 200 employees who deliver quality, affordable health care in a caring, safe and compassionate environment to all persons of such need. HN

Registered mammographers Cindy Hedstrom, diagnostic imaging director, Pam Heitman and Diane Litthell display the new 3-D digital mammography unit.

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

Expanding Medicaid is the healthy, economical choice

Strengthening Medicaid by extending eligibility to individuals earning up to 138 percent of the federal poverty level will greatly improve access for individuals in the early stages of illness, leading to better health outcomes at lower state cost.

Implementation of the Affordable Care Act (ACA) will cost our nation's hospitals $155 billion over 10 years in reduced Medicare reimbursements. Nebraska's share of those reductions is $856 million. When the details of the ACA were hammered out in 2010, the nation's hospital industry was forced to give up that revenue in exchange for gains Congress and President Barack Obama projected from more people with health insurance; coupled with more covered by Medicaid.

In 2012, the United States Supreme Court changed the rules when it decided the federal government could not force states to expand Medicaid eligibility; making expansion in each state optional. After the Court's ruling, some of Nebraska's policy makers said the state should forego Medicaid expansion even though the ACA requires the federal government to pay 100 percent for the first three years, beginning in 2014; 95 percent in 2017; and 90 percent in 2020 and beyond. Some opponents are concerned that the federal government will not live up to its financial obligation. Others fear that even a 10 percent cost share for Nebraska (estimated to be $120-$150 million through 2022) would be a burden on the state budget.

Expanding Medicaid would create the opportunity for more people to see a doctor at the right time and receive more appropriate care in the more appropriate place; care that is much less expensive than treatment in an emergency room where many uninsured seek primary health services. Furthermore, as expansion creates more opportunities for thousands of people to be healthier, it stands to reason that it will lead to a stronger economy because more Nebraskans will be able to work and more children will be ready to learn, easing some of the strain on our state's education system.

Currently, Medicaid eligibility is a means-tested program that provides health care coverage for low-income individuals. States and the federal government share in the costs. Nebraska's current Medicaid share is 45 percent and the federal percentage is 55. The higher federal match that would come with Medicaid expansion only applies to those who are deemed to be "newly eligibles."

Through extended eligibility, health providers will engage individuals earlier in the onset of their illness. Early intervention and treatment result in better health outcomes at lower costs. Expanded eligibility, coupled with patient centered medical homes and similar initiatives help individuals to schedule and keep doctor's appointments; track medications and other medical treatments; get care that is coordinated among all health care providers; and receive health education about smoking, obesity and physical activity.

Aside from providing coverage and care to more people, strengthening the health care provider network, reducing the demand for emergency room services and creating a stronger, healthier work force and children more capable of learning, it is almost unconscionable to think Nebraska might turn its back on the enormous amount of federal assistance that comes with expansion. If Nebraska fails to expand Medicaid, it will leave billions of dollars on the table, billions of tax dollars paid by Nebraskans that will go to other states. Estimates vary about the magnitude of the federal government's share of Medicaid expansion in Nebraska, but according to several reputable studies, the range is calculated to be $2.5-$3.5 billion.

Nebraska hospitals lose hundreds of millions of dollars each year because of bad debt, charity care and under-compensated care for Medicaid and Medicare. Bad debt occurs when services are provided to people who should be able to pay a hospital bill, but do not. Some have no insurance. Others are underinsured, including those with large co-pays and high deductibles. In 2010, Nebraska hospitals absorbed more than $209 million of bad debt.

On top of bad debt, in 2010, Nebraska hospitals provided more than $162 million in charity care — care that goes to uninsured or underinsured patients that cannot afford to pay. As the number of uninsured and underinsured grows, so does the need for charity care and free or discounted health services.

Public programs like Medicare and Medicaid reimburse hospitals at a rate lower than the cost incurred by the hospital to provide care. On average, Nebraska hospitals experience negative margins from Medicare (13 percent) and Medicare (26 percent). For every $100 in expenses a hospital incurs to provide care, it

would receive $87 in reimbursement for a Medicare patient or $74 for a for Medicaid patient. In 2010, Nebraska hospitals incurred nearly $508 million in uncompensated care for providing treatment to Medicare and Medicaid beneficiaries.

Bad debt and charity care, coupled with less than adequate compensation from Medicare and Medicaid, affect the cost of private health insurance. Premiums for private health care policies subsidize all other forms of health care. Some call this the "hidden tax" of public health care plans. The ACA was signed into law under the premise that more people covered by Medicaid and health insurance offered through insurance exchanges should reduce the amount of charity care and bad debt that hospitals experience. At that time, it was also a core component of the ACA that Medicaid expansion was mandatory, not optional as it is today.

A great deal more has been eliminated from hospital payments since the passage of the ACA. As the Legislature considers Medicaid expansion, the Nebraska Hospital Association (NHA) urges the Unicameral to take into consideration the additional federal cuts that have been imposed on hospitals since the ACA was signed into law; together with more cuts currently under consideration by Congress. In addition to the $856 million cut in Medicare reimbursements imposed by the ACA, Nebraska's hospitals will incur Medicare sequestration cuts of $275 million, bad debt payment reductions of $3 million and coding adjustment losses of $114 million through 2022. Collectively, those represent lost revenues exceeding $1.25 billion. In addition, Congress is considering an additional $672 million in reductions. If Medicaid eligibility levels and reimbursements remain the same, Nebraska hospitals will be forced to reduce services to make the necessary budget reductions.

Medicaid expansion will improve the public's health and it makes fiscal sense for Nebraska. That has been the conclusion in other states where some of the most vocal critics of the ACA and Medicaid expansion have reversed their stances to support, justifying the switch because expansion will not only save lives, but also will create jobs and stimulate the economy. Some of the most notable governors that have recently switched their position include:

- Chris Christie, New Jersey
- Rick Scott, Florida
- Jan Brewer, Arizona
- John Kasich, Ohio
- Rick Snyder, Michigan
- Brian Sandoval, Nevada
- Susana Martinez, New Mexico
- Jack Dalrymple, North Dakota

The NHA supports Medicaid expansion. Failure to do so will come at a high price. Health care providers will be forced to continue to absorb more bad debt and charity care. Without expansion, the provider network will become more fragmented. If Nebraska chooses not to extend eligibility, uninsured Nebraskans with serious illnesses will continue to experience long waits for health services and overuse emergency rooms and inpatient medical services because they did not receive appropriate treatment. If the state decides not to expand Medicaid, it will turn its back on billions of dollars of federal assistance, depriving many individuals of the opportunity to improve their health and preventing them from being able to work and learn.

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

HN

By Kevin Conway, vice president, health information

Are you ready for the HIPAA Omnibus Rule?

Last January, the U.S. Department of Health and Human Services (HHS) released its final omnibus rule affecting privacy and security protections for health information established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). "Much has changed in health care since HIPAA was enacted over 15 years ago," HHS Secretary Kathleen Sebelius said. "The new rule will help protect patient privacy and safeguard patients' health information in an ever expanding digital age."

The final rule strengthens privacy and security protections for electronic health information and improves enforcement as provided for by the Health Information Technology for Economic and Clinical Health Act as part of the American Recovery and Reinvestment Act of 2009. The rule also includes the final Breach Notification Rule, which will replace an interim final rule originally published in 2009. The rule also revises the HIPAA Privacy Rule to increase privacy protections for genetic information as required by the Genetic Information Nondiscrimination Act of 2008.

The final rule expands the "business associate" definition to include Health information organizations such as Nebraska Health Information Initiative (NeHII), e-prescribing gateways or other persons that provide data transmission services with respect to protected health information (PHI), organizations offering a personal health record and a subcontractor that "creates, receives, maintains or transmits PHI on behalf of the business associate." HHS also makes it clear that it applies to entities that "maintain" PHI for a covered entity. In the commentary, HHS states that data storage companies that keep PHI on behalf of covered entities in either digital or hard copy form are business associates.

With the expanded definition of business associates, there is also increased liability for business associates and subcontractors. Business associates and their subcontractors are now directly liable for violations of the HIPAA Security Rule and for uses and disclosures of PHI in violation of the HIPAA Privacy Rule. A covered entity is liable for civil monetary penalties based on the act or omission of any of its agents, including its business associates, acting within the scope of the agency. Similarly, a business associate is liable for civil monetary penalties for violations based on the act or omission of any agent of the business associate, including subcontractors, acting within the scope of the agency. Business associates now have additional responsibilities under the new omnibus final rule:

- Document activities and submit compliance reports to HHS when HHS requires such disclosure during and audit to determine whether a covered entity or business associate is complying with HIPAA.
- Disclose PHI as needed by a covered entity to respond to an individual's request for an electronic copy of his or her PHI.
- Notify the covered entity of a breach of unsecured PHI.
- Make reasonable efforts to limit use and disclosure of PHI to the minimum necessary.
- Provide an accounting of disclosures, and
- Enter into business associate agreements (BAA) with subcontractors that comply with the HIPAA Privacy and Security Rules.

BAAs must now require that the business associate comply with the Security Rule requirements and report to covered entities breaches of unsecured PHI. If a business associate subcontracts any its activities involving PHI, the business associate must enter into a BAA with its subcontractor(s). The covered entity is not required to have direct BAAs with business associates subcontractors, which is the responsibility of the business associate.

Subject to certain limitations, the final rule grandfathers existing BAAs until Sept. 22, 2014, to allow covered entities and business associates time to revise the agreements. However, covered entities and business associates are still required to comply with new rules regarding uses and disclosures of PHI beginning on compliance date. This final rule was effective on March 26, 2013, and covered entities and business associates must comply by Sept. 23, 2013.

Kevin Conway, vice president, health information, may be reached at kconway@nhanet.org. HN

No more cuts to hospital reimbursement

By David Burd, FHFMA
vice president, finance

As the federal government attempts to "reform" health care and address the nation's massive deficit, hospitals have repeatedly been the target of significant cuts to reimbursement. These cuts have forced hospitals to make difficult decisions to ensure that they continue to be able to provide critical services to their communities in the years to come. Reimbursement cuts are real and not only impact hospitals, but ultimately impact the patient.

The U.S. national debt is currently more than $16.6 trillion, which amounts to nearly $53,000 per citizen. Most people agree that serious steps need to be taken to reduce the level of debt. However, that is where the agreement generally ends as there are an unlimited number of opinions on how the debt should be reduced. Ultimately, in order to achieve a significant reduction in the national debt, material changes in federal programs and spending will be required. Minor changes or tweaks to current methods will not achieve the desired result.

Several legislative and regulatory changes have recently been enacted that will significantly reduce the reimbursement that Nebraska's hospitals receive for providing care to Medicare patients. Some of these cuts include the following:

- Affordable Care Act (ACA) provisions including market basket reductions, penalties for hospital readmissions and cuts to Disproportionate Share Hospital (DSH) payments;
- Budget Control Act sequestration cut that reduced Medicare reimbursement by two percent;
- Middle Class Tax Relief and Job Creation Act provision that reduced Medicare payments for bad debts to 65 percent; and
- American Taxpayer Relief Act provision that applied a coding adjustment that reduced Medicare payments related to CMS' transition to MS-DRGs.

Several additional reimbursement cuts have also been proposed and are under consideration. The chart below shows the impact of the cuts that have been enacted and those that are under consideration to Nebraska's hospitals.

Impact to Nebraska's Hospitals

Existing Legislative Medicare Cuts

Ten-Year Impact (2013-2022)

ACA Cuts (all provider settings)	($856,283,400)
Sequestration Cuts (all provider settings)	($270,501,800)
Bad Debt Payment Cuts (all provider settings)	($2,838,200)
Coding Adjustment Cuts (inpatient hospital) and Radiosurgery Payment Cut (outpatient hospital)	($65,322,100)

Existing Regulatory Medicare Cuts

Ten-Year Impact (2013-2022)

Coding Adjustment Cuts (inpatient/home health)	($113,871,600)
Total Impact of Existing Cuts	***($1,308,817,100)***

Existing Cuts as a Percent of Total Medicare FFS Revenue * (10-year summary value)	**-8.0%**

Additional Medicare Cuts Under Consideration

Ten-Year Impact (2013-2022)

Outpatient E/M Cuts (outpatient hospital)	($37,869,900)
Indirect Medical Education Cuts (inpatient hospital)	($192,892,800)
Direct Medical Education Cuts (inpatient hospital)	($36,412,600)
Bad Debt Payment Cuts (all provider settings)	($17,000,400)
SCH Program Elimination (inpatient hospital)	($283,851,000)
CAH Payment Cuts (inpatient/outpatient hospital)	($40,261,400)
Total Impact of Cuts Under Consideration	***($608,288,100)***

The American Hospital Association (AHA) has compiled a list titled "deficit reduction alternatives in health care" that includes alternatives that should be considered as part of true reform of the health care delivery system. Too often the term "reform" simply means additional cuts to reimbursement. Some of the alternatives for consideration include:

- Modernizing cost sharing for Medicare and Medicaid;
- Increasing the eligibility age for Medicare;
- Increasing the FICA tax to support Medicare Part A spending;
- Implementing enhanced comparative effectiveness research and programs;
- Improving programs to improve care at the end of life;
- Developing programs to coordinate care for individuals eligible for both Medicare and Medicaid;
- Applying Medicare reforms in the ACA (such as accountable care organizations, medical homes and bundling) to Medicaid;
- Increasing use of generic drugs;
- Modernizing the Medicaid long-term care benefit;
- Medical liability reform;
- Taxing "Cadillac" health plans; and
- Taxing junk foods and sugary drinks.

No one is arguing that all of the items listed above should be implemented. However, reforms that don't just cut payments, but instead reduce spending while also improving quality of care, better coordinating care and enhancing personal responsibility should be considered.

Nebraska hospitals currently have negative margins for both Medicare (13 percent) and Medicaid (17 percent including DSH payments and 27 percent excluding DSH payments). The result is hospitals incur more costs to treat both Medicare and Medicaid patients than they receive in payments from these programs. These margins do not reflect most of the reimbursement cuts that were mentioned above since many of them were just recently implemented or passed by Congress, which means that Medicare and Medicaid margins will only get worse.

Nebraska hospitals recognize that we will all have to do our part in order to make a significant reduction in our national debt. In many ways (as illustrated in the chart above), hospitals have already done that. Nevertheless, we stand ready to work with Congress and other stakeholders to meaningfully reform the health care delivery system. However, with more than $1.3 billion in existing cuts, additional reductions in reimbursement cannot be sustained.

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

By Monica Seeland, RHIA
vice president, quality initiatives

FAMC and GPRMC earn Quest for Excellence Award honors

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

The 2012 winners of the Quest for Excellence award are Fremont Area Medical Center, Fremont, and Great Plains Regional Medical Center, North Platte.

Fremont Area Medical Center was recognized for their work to improve their blood transfusion process. While meeting most national standards for timeliness and quality, they wanted to do better. As is typical with quality improvement initiatives, the solution was multifaceted.

Technology and process changes each played a role. New instrumentation was introduced to their blood bank which automated testing and enhanced quality via standardization and elimination of manual steps. Implementing computerized provider order entry (CPOE) provided for "real time" order communication from the provider to the lab. Institution of electronic alerts as well as a supplemental call from the lab to the patient care area to notify the nurse that the blood was ready, reduced the time it took to begin the transfusion.

Ongoing monitoring demonstrates Fremont Area Medical Center's improved timeliness of care delivery and enhanced efficiency of the blood transfusion process.

Great Plains Regional Medical Center was recognized for the work they undertook to improve medication safety. Due to the high number of medications that are administered to patients, the potential for medication administration errors and actual errors that were identified, improving the process became a priority.

Staff re-education was undertaken to reduce the incidence of overrides of the current electronic dispensing system. This resulted in a significant decrease in the number of medication administration errors identified. Staff determined that administration errors could further be reduced by implementation of CPOE and set an outcome measure of a 50 percent reduction in their error rate from their baseline rate. One year later, they were able to demonstrate a 60 percent reduction in medication administration errors. More importantly, no medication errors resulting in patient harm have occurred since the full implementation of the system in September, 2011.

We congratulate both of the 2012 Quest for Excellence award winners!

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

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MY NHA Nebraska Hospital Association Mid-Year Meeting

May 23-24, 2013
Younes Conference Center
Kearney, NE

May 22, 2013
NHA/HFMA Golf Tournament
Awarii Dunes, Kearney

Thursday, May 23, 2013

Keynote Speaker: **Jack Uldrich**

Jack Uldrich is a renowned global futurist, independent scholar, sought-after business speaker and best-selling author. His books include the best-selling, “The Next Big Thing is Really Small: How Nanotechnology Will Change the Future of Your Business” and the award-winning ”Into the Unknown: Leadership Lessons from Lewis & Clark's Daring Westward Expedition.” His latest book is “Jump the Curve: 50 Essential Strategies to Help Your Company Stay Ahead of Emerging Technologies.”

Mr. Uldrich's other written works have appeared in “The Wall Street Journal,” “The Futurist,” “Future Quarterly Research,” “The Wall Street Reporter,” “Leader to Leader,” “Management Quarterly” and hundreds of other newspapers and publications around the country. He also regularly writes a column on emerging technologies for The Motley Fool and is a frequent guest of the media worldwide having appeared on CNN, MSNBC and National Public Radio on numerous occasions.

In addition to speaking on future trends, emerging technologies, innovation, change management and leadership, Mr. Uldrich is a leading expert on assisting business adaptation. He has served as an advisor to Fortune 1000 companies and is noted for his ability to deliver provocative, new perspectives on competitive advantage, organizational change and transformational leadership.

Highly regarded for his unique ability to present complex information in an entertaining, understandable and digestible manner that stays with his audiences long afterwards, Jack Uldrich has spoken to hundreds of businesses and organizations, including General Electric, General Mills, the Young Presidents Organization (YPO), Pfizer, Invitrogen, St. Jude Medical, AG Schering, Imation, Fairview Hospitals, Touchstone Energy, The Insurance Service Organization, The National Kitchen & Bath Association, The National Paint & Coatings Association and dozens more.

Keynote speaker: **Major General David Rubenstein**

Major General David Rubenstein is the U.S. Army's Deputy Surgeon General. Prior to this assignment he was the Commanding General of Europe Regional Medical Command, Heidelberg, Germany and Command Surgeon for United States Army, Europe and 7th Army. He previously commanded the 30th Medical Brigade and was the U.S. Army Corps Command Surgeon, Heidelberg, Germany. Other commands include Landstuhl Regional Medical Center, Landstuhl, Germany; 21st Combat Support Hospital, Fort Hood, Texas; Task Force Med Eagle, Bosnia and Herzegovina; 18th Surgical Hospital (MASH), Fort Lewis, Wash. and Headquarters Company; 307th Medical Battalion (Airborne) and 82nd Airborne Division, Fort Bragg, N.C. Other assignments have been with the 3rd Medical Battalion, 7th Infantry Regiment, Eisenhower, Madigan, and Beaumont Army Medical Centers, DeWitt Army Community Hospital, the Office of The Surgeon General and the Academy of Health Sciences. He previously served as the Assistant Surgeon General for Force Sustainment, assigned to U.S. Army Medical Command, Fort Sam, Houston, Texas.

He is a graduate of Texas A&M University and the Army War College. He earned a master's degree in health administration from Baylor University and a master's degree in military art and science from the Army's Command and General Staff College. Among his awards and decorations are the Army Distinguished Service Medal, Defense Legion of Merit, Army Meritorious Service Medal, Army Commendation Medal, Army Achievement Medal, Armed Forces Expeditionary Medal, Humanitarian Service Medal, NATO Medal, Overseas Ribbon, Military Outstanding Volunteer Service Medal, Army Superior Unit Award, and German Proficiency Badge (Gold). He has earned the Expert Field Medical Badge, Master and Canadian Parachutist Badges, Ranger Tab, German Marksmanship Badge, Army Staff Identification Badge, The Surgeon General's 'A' professional proficiency designator and German Sports Badge.

MG Rubenstein has received the 2007 Outstanding Federal Healthcare Executive Award from the Association of Military Surgeons of the United States and has been appointed an Honorary Healthcare Administration Graduate Professor at Baylor University. His other honors include being the inaugural recipient of the U.S. Army Medical Service Corps Mentor of the Year Award, induction into the Army Medical Department's Order of Military Medical Merit, induction as an Outstanding Alumnus of the College of Education and Human Development at Texas A&M University and the Medical Service Corps Chief's Award of Excellence. He is listed in four "Who's Who" publications and was included twice in "Modern Healthcare" magazine's list of the 100 most influential people in health care.

His professional credentials include being a board certified health care executive who also served as chairman of the 30,000 member American College of Healthcare Executives. He previously served as a Governor on the College's Board of Governors and on national committees. He also served as the Healthcare Administration Consultant to the Army Surgeon General. His other professional memberships include the Association of the United States Army, Association of Military Surgeons of the United States, American Hospital Association, and Veterans of Foreign Wars of the United States.

MG Rubenstein has authored peer-reviewed professional articles, has two books on military medical history in progress and has served as reviewer in such professional military journals as "Military Review", "Army" and Military Medicine."

Many other educational sessions will be offered at the NHA 2013 Mid-Year Meeting including:

- 6 educational breakout sessions
- Educational sessions for Healthcare Financial Management Association (HFMA) members
- Educational sessions for Nebraska Organization of Nurse Leaders (NONL) members
- Educational sessions for hospital HR Directors
- ACHE face-to-face education panel discussion (1.5 Category I credit hours)
- NHA Leadership Institute Class X - Isaacson session
- Open dialogue sessions for hospital CEOs, HR staff and Clinical Staff (open to NHA members only)

By Al Klaasmeyer, vice president
NHA subsidiaries

Too much, too many different sources

This could be the way to describe the changes that all Nebraska hospitals are experiencing now. Nebraska hospitals, like hospitals in most of the states, are dealing with increased regulation, financial demands and the issues are appearing from many, sources.

The short-list of issues hospitals are currently facing includes sequestration cuts, ICD-10 coding changes and implementation of Community Health Needs Assessments and Electronic Health Records (EHR).

The inability of Congress and President Barack Obama to reach a deal on federal deficit reduction and avoid sequestration is likely to result in further reduction of Medicare payments. Currently, Nebraska hospitals experience a negative 13 percent margin for reimbursement of costs, meaning for every $100 a hospital incurs for treating a Medicare patient, the federal government provides $87 in reimbursement. Hospitals are now anticipating another 2 percent reduction in Medicare provider payments on or after April 1 even though the sequestration order was issued on March 1.

Hospitals will also be required to replace the ICD-9 code sets with ICD-10 code sets on or before Oct. 1, 2014. ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization. This major coding change procedure will require education, training, equipment purchases and testing to forestall a reduction in payments to hospitals and physician clinics.

As part of the Affordable Care Act (ACA), most non-profit hospitals are required to complete a comprehensive community health needs assessment every three years. Hospitals that are required to complete the assessment will face a $50,000 fine for each year that they fail to comply with the law.

Another requirement of the ACA is implementation of EHR in an effort to bring hospitals and health care into the digital age. EHRs for patients are intended to provide more transparency in diagnosing, treating and communicating with individuals responsible for the care of the patient. Hospitals that have either not adopted a certified EHR system or cannot demonstrate “meaningful use” by the 2015 deadline face a 1 percent Medicare reimbursements reduction. The reduction rate increases in subsequent years by 2 percent in 2016, 3 percent in 2017, 4 percent in 2018 and up to 95 percent depending on future adjustments. Meaningful use is a term that those in the hospital world are continuing to hear as a measurement of how hospitals and clinics are progressing on the EHR requirement. Financial incentives are available for providers who have achieved meaningful use and other measurements. It has been argued that the EHR process should not be hurried and should be centered on the success of the process rather than the timeliness of the process. Millions of dollars are being spent on the information technology (IT) systems to meet the regulations.

Hospitals and clinics have traditionally been good stewards of resources to care for patients and address the needs of the community, but the recent demands have placed strains on the process. Quality care for the patient is still the number one priority. There will need to be tough decisions made by many hospitals that while not compromising quality will have effects on how the care is delivered and by whom.

Hospitals are continuing to be asked to do more with less. At some point, this request will result in lapses in access to care due to too much, too many from all sources.

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.

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