Nebraska Association for Healthcare Quality, Risk, & Safety

http://www.nahqrs.org/

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Wahoo, NE

Fall is in the air and what a beautiful season. The crisp air and bright colors are so refreshing.

I want to start with a "Thank you" to BryanLGH for hosting the first CPHQ (Certified Professional in Healthcare Quality) review course. This opportunity was provided via a grant through the Nebraska Office of Rural Health in conjunction with the Nebraska Association for Healthcare Quality, Risk, & Safety and the Nebraska Critical Access Hospital Networks. I hope several of you were able to take advantage of this free course as it offered valuable information related to quality improvement methods and tools.

The purpose of the CPHQ review course is to help prepare individuals to complete the exam and become certified or just to help increase their knowledge in healthcare quality if they choose not to take the exam. If anyone is interested in taking the course, it will be offered again free of charge in February 2011 to any Nebraska healthcare staff. As members of NAHQRS, I highly encourage everyone to take advantage of this opportunity if you haven't already or have not yet been certified.

At one of our Critical Access Hospital Network meetings, the book "The Florence Prescription: From Accountability to Ownership" by Joe Tye was introduced to the group. I again heard about this book at the Nebraska Rural Health Conference where Joe Tye was the keynote speaker. If you have not read this book, I encourage you to take a look at it. The power of having a culture of ownership within your facility can have a tremendous impact. Some of the quotes from the book include: "proceed until apprehended." "Some of the most influential leaders in an organization don't have a management title. They are leaders because they see what needs to be done, they're willing to take the

initiative, and they're able to influence others to work with them." "We need to be more efficient in systems and operations so that there is more time for the things that really matter, like compassion and listening." This book was great way for me to take a step back from the fast paced world of healthcare and help refocus on issues that really matter and make a difference to our patients.

Thanks to each member for your contribution to NAHQRS. Please continue to let any board member know of any ideas or suggestions you may have to keep our organization moving forward and in a direction of value.

Julie

Member Bio

Erin Starr has been an RN, BSN for 8 1/2 years, of which has been in Fairbury at JCHC for 7 1/2 years. Her first love in nursing was in cardiac care when she worked for a year at Bryan East in progressive care before moving to Fairbury. She worked as charge nurse until she became Director of Patient Safety and Risk Management in October 2007, and then has recently become their Chief Quality Officer. Responsibilities and duties include the Quality Council, attending Board of Director and Medical Staff meetings monthly to given updates on medication errors, variances reported and quality reports. Erin also has recently taken on supervision on several departments; laboratory, radiology, respiratory therapy, disease management and emergency preparedness/employee safety. She has been a NAHQRS member since 2007 and serving on the nominating committee for 2 years.
Her interests include her children, Ben who is 5 and Samantha who is 4.
Erin loves to golf, play volleyball, fish and camp.

To exist is to change, to change is to mature, to mature is to go on creating oneself endlessly.
- Henri Bergson

You must build your life as if it were a work of art.
- Abraham Joshua Heschel

*** Congratulations ***

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Nemaha County Hospital Named 2010 Most Wired

CHICAGO – July 7, 2010 Nemaha County Hospital has been recognized as one of the nation's **MOST WIRED,** according to the results of the 2010 Most Wired Survey released today in the July issue of *Hospitals & Health Networks* magazine. Nemaha County Hospital is the only hospital in Nebraska to make the 2010 Most Wired list.
The 2010 Most Wired survey results are the basis of several awards:

- **Most Wired:** 99 organizations whose responses reflect "Core" development
- **Most Wireless:** 25 organizations focused on wireless applications
- **Most Improved:** The 25 organizations not appearing on the Most Wired list who improved the most from 2009 to 2010 in the survey focus areas
- **Most Wired – Small and Rural:** The 25 small and rural organizations not appearing on the Most Wired list that reflect development in survey focus area

To create this year's list of 99 Most Wired hospitals, Health and Health Networks, in cooperation with McKesson Corporation and CHIME spent 2 years in development, field review and post-survey testing.

Kermit Moore, COO of Nemaha County Hospital states, "In the past, Nemaha County Hospital has competed for awards in the small and rural categories. We earned the Most Improved Award in 2006 and in years 2008 and 2009 we earned the award for Most Wired for Small and Rural Hospitals. In 2010 we earned the Most Wired Award. Our commitment to an electronic medical record provided us the opportunity to benchmark ourselves against every health care organization in the United States, regardless of size. This category includes hospitals of all sizes from a 20 bed facility such as Nemaha County Hospital, to a hospital system with over 4000 beds. This is truly an honor to be recognized among organizations both large and small."

"We have aggressively pursued the use of information technology because we understand that its use can help us to improve the quality and safety of the services we provide to our patients as well as complete other business processes in a more efficient and effective manner", states Marty Fattig, CEO of Nemaha County Hospital. "We have never installed technology with the goal of winning awards or for technology's sake alone."

Stacy Taylor, CFO of Nemaha County Hospital credits a team approach, "All of our staff have diligently worked towards achieving this award. We look forward to continually raising the bar on quality using information technology to better serve our patients and community enhancing our mission of 'Quality Care - Every Time'."

Congratulations Amy Thimm

I'm excited and pleased to announce that we have filled our Rural Health Coordinator position at Saint Elizabeth Health Services. Amy Thimm has accepted the full time position as our Rural Health Coordinator. Amy brings a wealth of unbelievable amount of experience and education to this position.

Amy obtained her Master of Science Degree in Health Services Management for Clarkson College in 2000, Bachelor of Science Degree in Nursing in 1991 from the University of Nebraska Medical Center, Licensed Practical Nurse Degree from Southeast Community College in 1988.

Over Amy's 20 years of healthcare experience she brings extensive experience with physician performance improvement initiatives, hospital quality initiatives, root cause analysis, and a master TeamSTEPPS Trainer. Amy's previous work at Saint Elizabeth's included working directly with the Chief Medical Officer advocating safe practice by all medical staff, performance improvement council, audits, facilitating nursing and physician PEER review activity and reporting and launching the hospital grievance system.

Amy comes to us with previous experience with CAH Link and Health Services as she did support our functions on a part time basis through some job sharing. Amy was instrumental in designing the initial Mock Survey Tool, Root Cause Analysis Process, and External PEER Review.

Amy comes to us from the Nebraska Coalition for Patient Safety as their field coordinator where she has been employed since July of 2009. Amy was responsible for the coordination of quality initiatives for 45 hospital members. Amy was instrumental in serving as the resource for conducting root cause analysis along with database management for all incident reporting for the coalition. Amy also through this role gained valuable experience with various health care boards.

Amy will begin her new position as Rural Health Coordinator with Saint Elizabeth Health Services on Monday October 11. Amy will be involved with all aspects of the work we do in Health Services including Southeast Nebraska Mobile Diagnostic Services Inc. Amy will be joining us in Kansas City for the NRHA Critical Access Hospital meeting on September 30 and October 1st which will be a good time to meet and re-introduce yourself to Amy.

Amy's enthusiasm and passion for rural health care is contagious and she is most definitely looking forward in meeting and working with all of you. Amy will be making appointments to visit with all of you in October.

Please help me in welcoming Amy to her new position.

Tad M. Hunt, MS
Director, Rural Health Strategy
Saint Elizabeth Health Services

Have a new Job? **Get a new phone number?**

Change your email address? **Forgot to tell your best friends?**

If you have changes that we should know about – just click on the link below to forward those changes to the people who really care.

Contact Cathy Broz at dchqi@bwtelcom.net

Improving the Lives of Nebraska Patients by Reducing Pressure Ulcers

Submitted by: Sherri Lovelace, RN – CIMRO of Nebraska Quality Improvement Advisor

As part of the CMS National Patient Safety Initiative (NPSI), CIMRO of Nebraska is coordinating the Pressure Ulcer Prevention Program in the state as part of its 9th Scope of Work contract. The NPSI is a focused effort, as part of the Quality Improvement Organization (QIO) program, designed to protect patients by improving healthcare processes and systems. The goal is for participating nursing homes to demonstrate at least an eight percent relative improvement in pressure ulcer rates by 2011.

The Rural Nebraska Nursing Home Pressure Ulcer Prevention Project held its first monthly teleconference to kick-off the initiative one year ago (September 2009). Nursing homes, representing all areas of the state, partnered to work towards the common goal of pressure ulcer reduction.

To enhance success, CIMRO of Nebraska has utilized the *Advancing Excellence (AE) in America's Nursing Homes Campaign* framework. The framework provides efficient, consistent, evidence-based approaches to address the prevention and minimization of pressure ulcers. The tools and resources available through the campaign are a wonderful way to share best practices and quality improvement methodology for nursing homes. For more information on the AE Campaign, visit http://www.nhqualitycampaign.org/.

In December 2009, participating nursing homes began utilizing the Nursing Home Pressure Ulcer Prevention Plan. The Prevention Plan includes three components:

1. Identify high-risk residents
2. Put prevention plan into place for each individual resident
3. Weekly audits of skin assessments, Braden scales and appropriate pressure ulcer prevention interventions

Pressure ulcers are a healthcare concern affecting the entire community. In January, participating nursing homes joined rural Nebraska hospitals to take part in the Rural Nebraska Pressure Ulcer Prevention Collaborative. The overall goal of the collaborative was to reduce the incidence of pressure ulcers that develop in patients in rural healthcare settings. Collaborative learning sessions served as an opportunity for participating nursing homes and hospitals to network with one another, participate in small discussion groups, and learn from one another and share experiences and best practice improvement efforts. The third and final learning session was held in March 2010. The Outcomes Congress was held in mid-June and served as an opportunity for collaborative members to share and celebrate their successes. This initiative was a stepping stone for patient safety and helped lay the groundwork for communities to work together to ensure a smooth transition from one level of care to another in the area of pressure ulcer prevention.

Participating nursing homes agreed to complete a weekly audit tool to collect data and outcome measures. The data collection tool also identified the total number of residents with pressure ulcers and whether or not they are facility-acquired or community-acquired. All new facility-acquired pressure ulcers called for an immediate Root Cause Analysis (RCA) to assist the home in determining the cause factor(s) and corrective action.

One of the most successful pressure ulcer prevention interventions to date is performing daily skin checks for high-risk residents. Nursing homes identify which residents are at high-risk of developing pressure ulcers using a validated risk assessment tool. Residents falling into the high-risk category have a daily head-to-toe skin check done. If a high-risk resident were to develop a pressure ulcer, staff is then able to identify the potential breakdown at an early stage and implement appropriate treatment and interventions. This early detection reduces the treatment time and related costs to the nursing home and provides residents with less pain and suffering related to pressure ulcer development.

Nursing homes have experienced tremendous success during this initiative. Together the nine participating nursing homes have seen a 64 percent pressure ulcer reduction. By reducing pressure ulcers in Nebraska and sharing our successes with others we are improving the lives of our residents. We look forward to continued success and sharing of best practices as we work to reduce the incidence of pressure ulcers in Nebraska communities.

This material was prepared by CIMRO of Nebraska, the Quality Improvement Organization for the state of Nebraska, under a contract with the Centers for Medicare & Medicaid Services (CMS), a federal agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 9SOW-NE-PS-168/0910

The next CIMRO Quality Forum Vendor Show will be held May 10, 2011 in LaVista.

Please share any ideas for vendors with me or if you would like to volunteer to help with the vendor show for next year contact me at tmazuch@harlancohealth.org.

Thank you for your help!
Tina Mazuch

Nebraska Hospital Association
Monica Seeland, RHIA, Vice President Quality Initiatives

The following is an excerpt from the April 19, 2010 AHA Advisory regarding the healthcare reform law as it relates to quality.

QUALITY, DISPARITIES AND COMPARATIVE EFFECTIVENESS

NATIONAL QUALITY STRATEGY

(Sections 3011-3015, 10302-10305)

Spends $100 million over 10 years

Quality, Disparities and Comparative Effectiveness: The law takes steps toward paying for quality rather than volume of services by implementing "pay-for-reporting" systems across all providers and moving many providers toward value-based purchasing systems in the future. It also applies financial penalties to hospitals with "high" rates of hospital-acquired conditions. The law establishes a national quality improvement strategy, creates a public-private institute to analyze the comparative effectiveness of treatments, and creates a patient safety research center to promote the adoption of best practices. In addition, it contains a number of provisions to improve the delivery of health care services, particularly to low-income, underserved, uninsured minority and rural populations.

The law calls for the HHS Secretary to establish a national quality improvement strategy that includes priorities that have the greatest potential to improve patient outcomes, patient-centeredness and efficiency. These priorities are to apply to all patients, including children and vulnerable populations. In setting the priorities, the Secretary is mandated to take into consideration recommendations submitted by the National Priority Partners that have been convened by the National Quality Forum (NQF). The Secretary also must develop a comprehensive strategic plan to achieve priority improvements and coordinating activities among HHS agencies and with the state Medicaid programs to help achieve these goals.

The national strategy will be updated every three years at most, with the first report due to Congress by January 1, 2011. The selected priorities would become the basis for further work to develop and implement measures to foster improvement and public reporting, including public reporting on hospital quality on *Hospital Compare*. In selecting the measures to use in public reporting and hospital payment under value-based purchasing, the Secretary must choose measures that have been considered by a consensus based organization, such as the NQF, and are recommended by a multi-stakeholder group, such as the Hospital Quality Alliance (HQA).

The legislation also requires the Secretary to:

- ❖ Develop not less than 10 acute/chronic outcome measures (targeting the five most prevalent in each category) by March 23, 2012 (no later than 24 months after enactment)
- ❖ Develop not less than 10 primary/preventive outcome measures (targeting healthy children, chronically ill adults or infirm elderly) by March 23, 2013 (no later than 36 months after enactment)
- ❖ Develop and update (not less than every three years) provider-level outcome measures for hospitals and physicians, as well as other providers that address:
  - (a) risk adjustment
  - (b) accountability
  - (c) sample size
  - (d) the full scope of services that comprise a cycle of care
- ❖ Select efficiency measures
- ❖ Establish and implement an overall strategic framework to carry out the public reporting of performance information

PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS
(Sec. 3008)
Saves $1.4 billion over 10 years
The provision applies a financial penalty to hospitals with high risk-adjusted rates of the hospital-acquired conditions identified by CMS for use in the inpatient PPS hospital acquired conditions policy, or any other condition selected by the Secretary.

Prior to implementation, the Secretary shall submit a report to Congress (January 1, 2012) on the state of the current Hospital-Acquired Conditions Program and possible expansion of the program to other facilities, such as LTCHs, IRFs, SNFs, ASCs and hospital outpatient departments.

Beginning in FY 2015, hospitals in the top quartile of national hospital-acquired condition rates will receive 99 percent of their otherwise applicable Medicare payments for all discharges. The Secretary is required to develop and use a risk-adjustment methodology when calculating the hospital-acquired condition rates.

Prior to FY 2015, the Secretary will calculate and share confidentially with hospitals their hospital-acquired condition rates. The Secretary will report hospital-specific hospital acquired conditions information on the *Hospital Compare* Web site, after allowing hospitals to review the information and to submit corrections.

VALUE-BASED PURCHASING (VBP) FOR SNFs, HHAs, ASCs
(Sec. 3006, 10301)
Budget Neutral
The legislation directs the Secretary to submit to Congress implementation plans for VBP programs for SNFs and HHAs by October 1, 2011, and for ASCs by January 1, 2011. These plans will be created in consultation with stakeholders and will

address the development, measurement and modification of quality and efficiency measures; the reporting, collection and validation of quality data; the structure of proposed value based payment adjustments; criteria for both reductions and incentives and methods for public dissemination. The Secretary will consider experiences with demonstrations that are relevant to VBP in each setting.

QUALITY REPORTING FOR IPFs, IRFs, LTCHs AND HOSPICE

(Sec. 3004, 10322)

Saves $100 million over 10 years

By October 1, 2012, the HHS Secretary must publish quality measures for reporting by IPFs, IRFs, LTCHs and hospices. Providers that fail to report these measures will have their market basket updates reduced by 2.0 percentage points, beginning July 1, 2013 (rate year (RY) 2014), for IPFs, and October 1, 2013 for IRFs, LTCHs and hospices.

MEDICAID QUALITY

Adult Health Medicaid Quality Measures

(Sec. 2701)

Spends $300 million over 10 years

This provision directs the HHS Secretary, in consultation with the states, to develop an initial set of health care quality measures specific to adults who are eligible for Medicaid. By January 1, 2011, the Secretary shall identify, for comment, a recommended core set of adult health quality measures for Medicaid eligible adults and by January 1, 2012, the Secretary shall publish the final set of measures. The section establishes the Medicaid Quality Measurement Program (no later than January 1, 2013), which will expand upon existing quality measures, identify gaps in current quality measurement, and establish priorities for the development and advancement of quality measures and consult with relevant stakeholders. The Secretary, along with states, will report regularly to Congress on the progress made in identifying quality measures and implementing them in each state's Medicaid program.

The initial Report to Congress on adult and children's quality measures is due January 1, 2014, and every three years thereafter. By September 30, 2014 (and annually thereafter), the Secretary shall collect, analyze and make publicly available the information reported by states. By January 1, 2015, the Secretary shall publish changes to the recommended core measure set. States will receive grant funding to support the development and reporting of quality measures. This provision adds a Treasury appropriation of $60 million for each of FYs 2010-2014; funds will remain available until expended.

Medicaid Non-payment for Health Care-acquired Conditions. (Sec. 2702) The law prohibits Federal payments to states for Medicaid services related to health care acquired conditions, effective July 1, 2011. The HHS Secretary, through regulation, will identify conditions consistent with Medicare, but will not be limited to conditions acquired in hospitals, and will take into account the differences between the Medicare and Medicaid programs. The Secretary will consider existing state policies

that limit payment for health care acquired-conditions. State Medicaid programs will be required to adopt policies that will not result in higher payments to hospitals should a patient have a health care-acquired condition during the hospital stay (similar to the Medicare hospital-acquired conditions policy).

MINORITY HEALTH AND REDUCING HEALTH DISPARITIES

(Sec. 4201, 4302, 5307, 10333, 10334, 10403)
Spends $200 million over 10 years for Sec. 4302 (costs of other provisions are subsumed under broader sections or have no change in expenditures)
Minority health and reducing health disparities provisions are incorporated throughout the new law.

Some provisions are indirect and others are direct and specifically targeted. For example, the expansion of coverage, especially to low-income populations, is likely to have a significant effect on reducing health disparities. The coverage provisions also include several provisions to ensure that the information provided by insurance exchanges and the plans offered through them are culturally appropriate to the populations being served. Furthermore, the quality incentive program for health plans under the insurance exchanges will include incentives for the implementation of activities to reduce health and health care disparities, such as the use of language services, community outreach and cultural competency training.

Similarly, there are a variety of broader provisions in the bill that require attention to disparities (among other things) in their execution, such as the development of a national strategy to improve health care quality, the establishment of the national health care workforce commission, improvements to the maternal, infant and early childhood home visiting programs, the establishment of community health teams to support patient-centered medical homes, comparative effectiveness research, and funding priority for school-based health center grantees that serve large populations of medically underserved children.

There are a variety of health professions education and other workforce provisions focused on diversity and improving access to care in underserved areas.
For example:

- Sec. 5307 reauthorizes and expands programs to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs.
- Sec. 5401 raises the funding levels for The Centers of Excellence program, which develops a minority application pool to enhance recruitment, training, and other support for minorities.
- Sec. 5402 reauthorizes and increases funding for diversity in health professions training, including scholarships for disadvantaged students who commit to work in medically underserved areas as primary care providers, and loan repayment assistance and fellowships for faculty positions.

- Sec. 5403 amends the Area Health Education Centers to expand grant authorizations to support interdisciplinary, community-based linkages that target underrepresented minorities and individuals from urban and rural medically underserved communities seeking careers in the health professions.
- Sec. 5404 expands the allowable uses of nursing diversity grants to include completion of associate degrees, bridge or degree completion programs or advanced degrees in nursing.

Other provisions focus directly on minority health and reducing health disparities. Specifically:

- Sec. 10334 elevates the Office of Minority Health (currently within the Office of Public Health and Science within the Public Health Service) to the HHS Secretary's office, to be headed by a new Deputy Assistant Secretary for Minority Health reporting directly to the HHS Secretary. It also establishes a network of new minority health offices in agencies under HHS. These offices will monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives. A similar elevation will move minority health at the NIH from a Center to an Institute.
- Sec. 4302 requires that all federally funded data collection efforts on health care or public health include collection of data on race, ethnicity, primary language, sex, disability and any other indicator of disparity to better understand disparities. The HHS Secretary is required to develop standards for data collection; for race and ethnicity, the Secretary is required to use Office of Management and Budget standards. HHS also is required to collect access and treatment data for people with disabilities. Public reporting of health care quality data by race, ethnicity, primary language, gender and disability is required. Federally funded studies and surveys are required to collect sufficient data to yield statistically reliable results, and HHS is required to share health disparities data, measures and analyses with other relevant agencies.
- Sec. 4201 and Sec. 10403 provide Community Transformation Grants to state and local governments and community organizations for evidence-based community preventive health activities. These grants will be used to help reduce the incidence of chronic disease and develop strategies to reduce racial and ethnic disparities, including social, economic and geographic determinants of health. The law requires that at least 20 percent of the grants go to rural and frontier areas.
- Sec. 10333 provides assistance to minority populations through grant funding to community-based collaborative care networks that provide comprehensive, coordinated and integrated health care services to low-income populations. Entities eligible for grants are consortia of providers with joint governance structures, DSH hospitals and FQHCs. The funds must be used to support efforts to help low-income individuals access appropriate services, enroll in health coverage programs and obtain a regular primary care provider or medical home. Funds also can be used to provide case management and care management, perform health outreach, provide transportation, and expand

capacity through such approaches as telehealth, after-hours services or urgent care, and other direct patient care services.

COMPARATIVE EFFFECTIVENESS RESEARCH AND EVIDENCE-BASED MEDICINE

(Sec. 6301-6302, as amended by Sec. 10602)

Spends $2.5 billion and saves $0.3 billion over 10 years

The law creates an independent Patient-Centered Outcomes Research Institute that is neither an agency nor an establishment of the U.S. Government. The tax-exempt institute will conduct comparative *clinical* effectiveness research to evaluate the clinical effectiveness, risks and benefits of two or more medical treatments, services and items, including health care interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals and integrative health practices. The institute will assist patients, clinicians, purchasers and policymakers in making informed health decisions by advancing the evidence by which diseases and other health conditions can effectively and appropriately be prevented, diagnosed, treated and managed. Specifically, the institute will:

- Identify research priorities and establish a research project agenda
- Carry out the research project agenda, including managing contracts, reviewing and updating evidence, and taking into account potential differences
- Collect data from CMS and other federal, state or private entities
- Appoint expert advisory panels, especially for clinical trials and rare diseases
- Support patient and consumer representatives
- Establish a 15-member methodology committee, which would include the directors of the AHRQ and NIH
- Provide for a peer-review process for primary research
- Release research findings
- Adopt the national priorities, the research project agenda, the methodological standards, and other processes and protocols; and
- Submit annual reports to the Congress, the President and the public

The institute's 19-member board will consist of patients and health care consumers, physicians and providers – including one hospital representative – private payers, pharmaceutical, device and diagnostic manufacturers, members representing state or federal government and others. It also will include the directors of AHRQ and NIH, or their respective designees. Board members will be appointed by the Comptroller General of the United States to hold six-year terms, serving a maximum of two terms.
The board will employ an executive director and other staff.

The Comptroller General has a number of oversight responsibilities with respect to the institute. The institute will review existing research and conduct new research. It will be allowed access to data from federal, state and private entities, including data from clinical databases and registries. It also may enter into contracts with federal agencies, such as AHRQ, and private entities.

Its research will be prioritized based on disease incidence and prevalence, evidence gaps in terms of clinical outcomes, practice variations and health disparities, the potential to improve health and quality of care, and expenditures associated with a health care treatment strategy or condition, among others. The research will be designed to take into account differences among subpopulations and in treatment modalities.

The law also creates an Office of Communication and Knowledge Transfer at AHRQ, in consultation with NIH, to broadly disseminate research findings. All research will be conducted under a set of requirements to ensure transparency, public input, adherence to ethical standards, and disclosure of any conflicts of interest.

The law establishes several limitations around the use of the institute's comparative effectiveness research findings:

- ❖ The institute may not mandate coverage, reimbursement or other policies for any public or private payer, and none of its reports or research findings should be construed as mandates, practice guidelines or policy recommendations.
- ❖ The Secretary is prohibited from making coverage determinations based solely on the institute's research or findings, but can use the evidence for coverage determinations if it includes an iterative and transparent process with public comment and consideration of the effect on subpopulations.
- ❖ The Secretary is prohibited from determining coverage or reimbursement that would lower the value of extending the life of an elderly, disabled or terminally ill individual over that of an individual who is younger and healthier.
- ❖ The institute is prohibited from developing a "dollars per quality-adjusted life year" (or similar measure) to determine what health care services or treatments are cost-effective or recommended. And it would be prohibited from using such a measure as a threshold to determine coverage, reimbursement or incentive programs.

The law creates a Patient-Centered Outcomes Research Trust Fund (PCORTC) to fund the institute and its activities.

The PCORTC is financed in a public/private manner using general funds from the U.S. Treasury, an assessment per Medicare beneficiary, and a fee for insured and self-insured health plans. The fee on health plans would be based on an amount per number of lives covered by the plan and would sunset after FY 2019.

The Federal Coordinating Council created under the *American Recovery and Reinvestment Act of 2009* was terminated as of March 23, 2010.
Program to Establish Shared Decision Making. (Sec. 3506) The purpose of this program is to facilitate collaborative processes between patients, caregivers and clinicians in decision making; to provide information about their treatment options, including the advantages and disadvantages among options; and to facilitate incorporation of patient preferences and values into the medical plan.

If you have any questions or suggestions for future topics, please contact Monica Seeland at 402-742-8152 or mseeland@nhanet.org.

The CAH Conference on Quality will be held November 10 & 11, 2010, at the Ramada Inn in Kearney, Nebraska. This year's expanded format will include the sharing of best practices from several entities. Watch for the brochure in early October.

Click here to view the NHA 2010 Bills of Interest Summary.
For additional legislative updates, visit www.nhanet.org.
If you have questions or would like to share your perspective on a particular bill, please contact Bruce Rieker, Vice President, Advocacy, at (402) 742-8146 or brieker@nhanet.org.

~~~~~~~~ *NEED FOR MENTORS* ~~~~~~~~

Nebraska Hospitals need Mentors for new Quality positions

If you have expertise in the following fields and would like to share your knowledge with others who are in need, please contact Monica Seeland at mseeland@nhanet.org.

Risk Management
Infection Control
Safety & Hazardous Materials
Critical Access Hospital Regs
The Joint Commission Readiness
Policies and procedures
Credentialing
Utilization Review and Management
Professional organizations
HIPAA Privacy
Quality:

- Peer review
- Chart audits
- Performance Improvement Teams
- Performance improvement Models
- Team facilitation
- Reports (graphic display and analysis)
- Data Collection
- Data Aggregation

Other expertise such as Compliance, Statistics, etc. (please specify)

NAHQRS Presents
Davis Balestracci

“Data Sanity” as THE Catalyst to Organizational Transformation

Wednesday October 27, 2010
10:30 AM to 12:00 PM
Allied Session of the
Nebraska Hospital Association Annual Meeting

Davis was the monthly statistical columnist for Quality Digest for four years and has just authored a book summarizing his unique road map to excellence, *Data Sanity: A Quantum Leap to Unprecedented Results*, published by the Medical Group Management Association.

He is a regular speaker at the Institute for Healthcare Improvement forums in the U.S. and Europe.

Posted on our website is a complete bio of Davis, a detailed look at his education topic “Data Sanity”, and what a full day course would look like.

Find complete details at: http://www.nahqrs.org/education.shtml

Active Listening - A Deliberate Choice

Active listening is a deliberate intent to "listen for meaning".
Active listening requires the listener to understand, interpret, and evaluate what they heard. The ability to listen actively can improve personal relationships through reducing conflicts, strengthening cooperation, and fostering understanding.

When interacting, people often are not listening attentively. They may be distracted, thinking about other things, or thinking about what they are going to say next (the latter case is particularly true in conflict situations or disagreements).

Active listening is a structured way of listening and responding to others. It focuses attention on the speaker. Suspending one's own frame of reference and suspending judgment are important to fully attend to the speaker.

It is important to observe the other person's behavior and body language. Having the ability to interpret a person's body language lets the listener develop a more accurate understanding of the speaker's words. Having heard, the listener may then paraphrase the speaker's words. It is important to note that the listener is not necessarily agreeing with the speaker—simply stating what was said.

In emotionally charged communications, the listener may listen for feelings. Thus, rather than merely repeating what the speaker has said, the active listener might describe the underlying emotion ("You seem to feel angry," or "You seem to feel frustrated, is that because...?").

Individuals in conflict often contradict each other. This has the effect of denying the validity of the other person's position. Either party may react defensively or they may lash out or withdraw. On the other hand, if one finds that the other party understands, an atmosphere of cooperation can be created. This increases the possibility of collaborating and resolving the conflict.

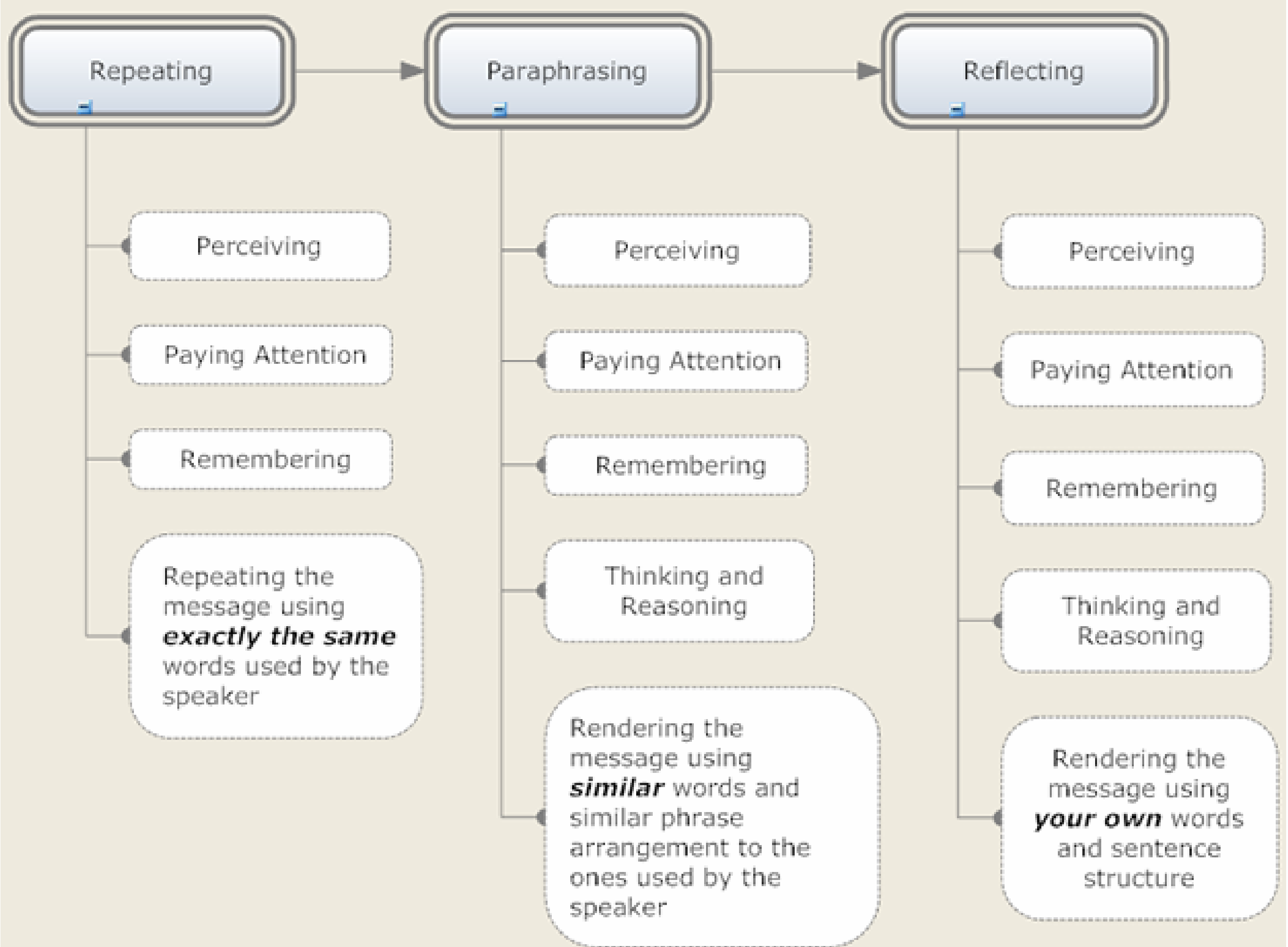
Barriers to Active Listening

All elements of communication, including listening, may be affected by barriers that can impede the flow of conversation. Such barriers include distractions, trigger words, vocabulary, and limited attention span.

Listening barriers may be psychological (e.g. emotions) or physical (e.g. noise and visual distraction). Cultural differences including speakers' accents, vocabulary, and misunderstandings due to cultural assumptions often obstruct the listening process. Frequently, the listener's personal interpretations, attitudes, biases, and prejudices lead to ineffective communication.

Overcoming Listening Barriers

To use the active listening technique to improve interpersonal communication, one puts personal emotions aside during the conversation, asks questions and paraphrases back to the speaker to clarify understanding, and one also tries to overcome all types of environment distractions.
Furthermore, the listener considers the speaker's background, both cultural and personal, to benefit as much as possible from the communication process.
Eye contact and appropriate body languages are also helpful.



The highest level of active listening is when you can render the speaker's message in your own words using your own sentence structure.
Repeating back the speaker's message using your own words and sentence structure demonstrates to the speaker that you truly understand the message and the feelings behind the message.

This conference provides
the help you need
to build and maintain a
solid safety program
for your employees.

October 7, 2010
Scottsbluff, Nebraska

Presented by

nebraska
safetycouncil

With the cooperation of
Western Nebraska Community College

Conference Agenda

Registration & Exhibits Open..8:00-8:45 a.m.

Attitude, Baditude: Creating Positive Attitudes Toward Your Safety Culture *8:45-9:45 a.m.*

Dr. Gary Leitz CSP, Safety Engineer and Trainer, Louisville, Colorado

Do your employees' attitudes towards your safety culture impact how they behave? Can you create positive attitudes and, therefore, increase the likelihood of safe behaviors? Dr. Lietz will bring his 25 years as a Safety Engineer and Trainer to examine the relationship surrounding employee attitudes, behaviors and your safety culture components. We will explore how you can increase the likelihood of employees behaving safely, on their own volition, by creating positive employee attitudes toward your safety culture components.

Exhibitor Break ....9:45-10:00 a.m.

Making "Cents" of Medical Case Management .... *10:00 - 11:00 a.m.*

Jodi Roberts RN, BSN, CLNC, Field Base Case Manager, OHARA, LLC, Omaha, Nebraska

So your employee was injured on the job...now what? High medical costs are not guaranteed...lost-time is not certain...loss of productivity does not need to happen. Understanding effective workers' compensation medical case management could be your key to lower injury costs after a claim. Jodi Roberts brings her knowledge of workers' compensation claims and medical case management to this presentation and will show you how cost savings can be achieved. Her 34 years of experience will help you to identify results-driven case management techniques and recognize potential red flags along the way. You can benchmark your past effectiveness as she reviews case examples of the good, the bad and the ugly.

Exhibitor Break .... 11:00-11:15 a.m.

Employee Involvement and Safety Success .... *11:15 a.m. - 12:15 p.m.*

Dan Saathoff, Regional EHS Manager Auto N. Americas', VPPPA Region VII Vice Chairperson, Eaton Corporation, Kearney, Nebraska

Jill Smith PHR, Sr. Human Resource Representative, BD Diagnositics, Broken Bow, Nebraska

You can read a book or listen to an "expert" but what about getting ideas from someone who has walked in your shoes? Dan Saathoff and Jill Smith will bring their years of experience together for an informative session focusing on the importance of employee involvement in promoting safety in the workplace. They will discuss their triumphs and greatest challenges in reaching their employees. They will cover safety culture and attitudes, safety management principles, incentives and accident prevention. This session will offer countless takeaways. Be prepared to take notes and take ideas home.

Lunch, Networking & Exhibitor Break...12:15-1:15 p.m.

An OSHA Update Like No Other .... *1:15 - 2:15 p.m.*

Doug Fletcher CIH CSP, Compliance Assistance Specialist, OSHA, Omaha, Nebraska

Curious to see how OSHA will affect you and your company in 2010 and beyond? Doug Fletcher gives us an update and he promises, "...there will be more to talk about than time will permit." Here are the topics you want to know about: Changing the Penalty Calculator; Increased Inspections in Nebraska; Focus on OSHA Recordkeeping; Severe Violators Enforcement Program; Protecting America's Workers Act; Recent Osha Standards Changes; Upcoming Changes for Next Year; Big Issues in Nebraska; And more.

Exhibitor Break ....2:15-2:30 p.m.

Workers' Comp. Nightmare – ADA, FMLA and Return-to-Work..................*2:30-3:30 p.m.*

James Hamilton, JD, Baylor Evnen Curtiss Grimit & Witt, LLP, Lincoln, Nebraska

There's little doubt that the ADA, FMLA, and Workers' Compensation connection is one of the most confusing, conflicting and legally dangerous areas of employee relations. Individually, each law is distinct. But when they overlap, the real trouble begins. You need to know what your obligations are and what your actions need to be when FMLA says one thing, ADA says another, and Workers' Comp gets thrown into the mix. In this session, you'll learn what you should do when an employee injury, illness or disability throws you into the middle of this complex trio of laws.

Evaluations & Door Prizes...3:30-3:45 p.m.

Conference Details

Date & Location

October 7, 2010

Western Nebraska Community College
Scottsbluff, Nebraska

Registration*

Until September 15th
Nonmembers: $119.00
(Members: $99.00)

After September 15th
Nonmembers: $139.00
(Members: $119.00)

*Includes Lunch

Win!

Phillips 7" Widescreen
Portable DVD Player

Register two from your company and the third is FREE!

Exhibitors

Top safety and health suppliers will be on hand in the expo area to visit with you about the latest equipment, supplies and services available. Take advantage of extended break periods to make valuable contacts and gather information on the tools and services you need to strengthen your organization's safety program.

Visit our website at www.nesafetycouncil.org for a complete listing of exhibitors at the 2010 Panhandle Conference.

"You always seem to cover the "hot" issues. Well educated speakers." Machelle Marcoe, Kurt Manufacturing, Lyman, Neb.

"Very educational and informative. (Well worth the time.)" James Hite, Kelley Bean Company, Scottsbluff, Neb.

"There is always such a great presentation of topics (and) current issues with a great variety of vendors." SheiLu Arrowsmith, Cirrus House, Inc., Scottsbluff, Neb.

"Relevant topics, interesting speakers, stayed with time-line." Gerald Pennel, Clean Harbors Tech., Kimball, Neb.

2010 Panhandle Conference Registration

Attendees: (Please Print)

1)____________________

2)____________________

3)__________________ *FREE!*

Company: ____________________

Address: ____________________

City:__________ State:____ Zip:______

Phone: (____)________ Fax: (____) ______

E-mail Address: ____________________

☐ Registration Fee Enclosed: Check #______ for $______

☐ Purchase Order Attached. PO # ____________

☐ Charge to: ☐ Mastercard ☐ Visa

Card No: ____________________

Exp. Date:________ 3-digit code back of card:________

Name on Card: ____________________

Cancellation Policy: Advance registration is required for the October 7th Panhandle Safety Conference. Cancellations received three (3) business days prior to the course date will receive a full refund. There will be a 50% charge on late cancellations. Registrants who cancel the day of the program or are "No Shows" will be liable for the full fee.

Mail to: Nebraska Safety Council
3243 Cornhusker Hwy., Suite A10
Lincoln, NE 68504-1592

Phone: 402-483-2511 or 888-704-7233, Ext. 108
Fax: 402-483-2513
Online: www.nesafetycouncil.org

Brochure link http://www.nesafetycouncil.org/images/stories/PDFs/2010_Panhandle_Brochure_Web.pdf

Job Postings

Director Quality Management (RN)
Salary Range: $90,000 - $100,000
Location: Colorado (Denver area)
1078

- The Director of Quality Management will be accountable for QM activities, accreditation surveys, preparing and educating staff and physicians of their survey responsibilities and direct the quality management activities for the medical center.
- She/he will provide counseling and education to facility leadership, clinical personnel, Quality Committee of the Board, and medical staff members related to process improvement and quality management.
- The Director will promote and facilitate optimum performance on core measures, patient safety and other key benchmarks of quality performance. She/he will serve as the facility Patient Safety Officer.
- The Director of Quality Management supervises employees of Quality Management, Infection Prevention and Peer Review. Position Requirements

Licensure/Certification/Registration:

- CPHQ preferred and Colorado Nursing License required.

Education:

- Bachelor's Degree from a nursing program.
- Master's preferred.

Experience:

- Quality management experience required. Supervisory/management experience required. Minimum of 5 years healthcare experience (clinical experience preferred).
- Comfortable and skilled at working with physicians, healthcare providers and other stakeholders in the organization.
- Knowledge of JCAHO, State Health Department regulations and other regulations and laws. Ability to interpret their intent and application. Analytical skills including knowledge of statistics and data analysis methodologies.

SEE MORE POSTINGS AT [WWW.CLONCHASSOCIATES.COM](http://www.clonchassociates.com)

Clonch & Associates
On The Pulse of Hospital Recruitment
Naaman Clonch
President
ph: 813-579-2962
Fax: 813-200-1592
naaman@clonchassociates.com
www.clonchassociates.com
Lutz, FL

I am representing several Healthcare organizations nationwide and have Site Director and Regional Director opportunities available in Quality, Regulatory and Accreditation.

The settings are in three areas: Hospital, Ambulatory and Disease-specific, such as Diabetes or Stroke.

I am actively recruiting for Director-level Nurses who are disciplined, detail-oriented, and who strive for perfection.

My clients are all looking for certain level of management expertise – Nursing Professionals who have managed managers – demonstrated experience – Director-level in Quality/Accreditation. For the regional positions, big points will go to people who have overseen remote workforces (ideal, but not required) – Professionals who have working knowledge of Quality and have been solely responsible for preparation for the accreditation process and has done process improvement.

1. Requirements: BSN with Masters in nursing, healthcare administration or business – MSN preferred. A health care professional with either a clinical or administrative background.
2. At least five years of managerial experience.

Salary range is $90K - $110K, DOE.

If interested, please send resume in Word format to Julie Mantyla at julie@mrspokane.com or call 800-878-2708 x14.

Additional Recruiters

Jane Fischer, Tyler & Company
(610) 558-6100, extension 231
jfischer@tylerandco.com
All inquiries will be handled confidentially.

Katie Schuckman, MBA
Phone: 800 401-6739
talent@besmith.com

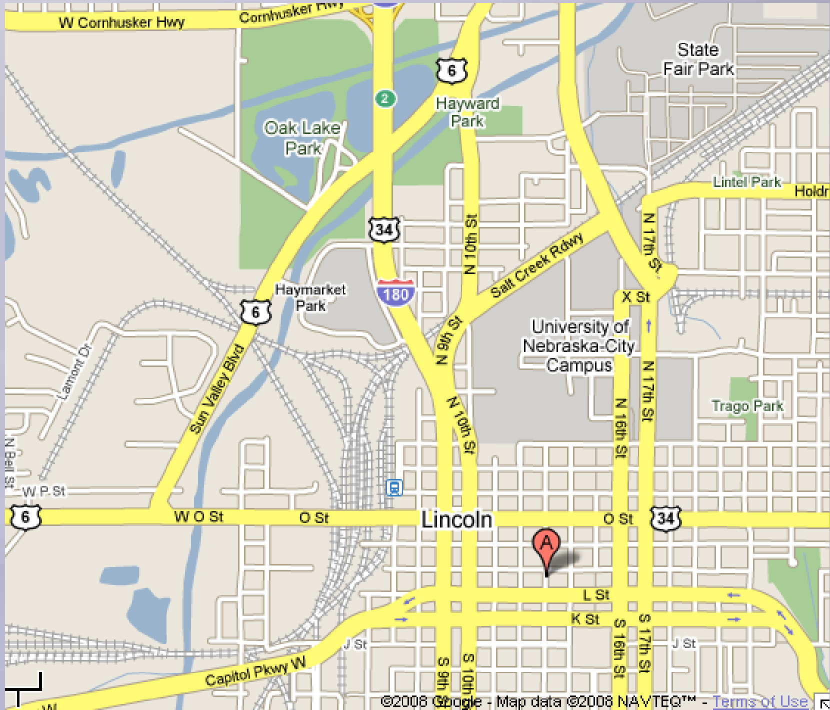
Deborah Nord
dnord@ctlrecruitment.com
Phone: 866 334-1069 ext. 13
Fax: 866 277-3441

Cynthia Balagopalan
The First String, Partners in Healthcare
(949)574-5996 ext 15
cynthia@thefirststring.com

Next Meeting October 27, 2010 (10:30 AM – 3:00 PM)
Cornhusker Marriott Hotel, Lincoln

Cornhusker Hotel
333 S 13th St, Lincoln, NE
(402) 474-7474
Website: http://www.marriott.com/hotels/travel/lnkfs-the-cornhusker-a-marriott-hotel/

Click on the link below to bring up web map:
http://maps.google.com/maps?hl=en&um=1&ie=UTF-8&q=Marriott-Cornhusker&fb=1&cid=0,0,6390896988563727685&near=Lincoln,+NE&oi=manybox&ct=10&cd=1&resnum=1



Future NAHQRS Meetings

December 10, 2010 York
February 4, 2011 Lincoln
April 1, 2011 TBD
June 3, 2011 TBD
August 5, 2011 TBD
October TBD, 2011

Next publish date is November 12, 2010

Comments on this newsletter, or future articles for submission or information, or other tidbits for publication can be sent to Bill Redinger at: wredinger@sfmc-gi.org

Future Newsletter publish dates:

- January 16, 2011
- March 10, 2011
- May 13, 2011
- July 8, 2011
- September 11, 2011