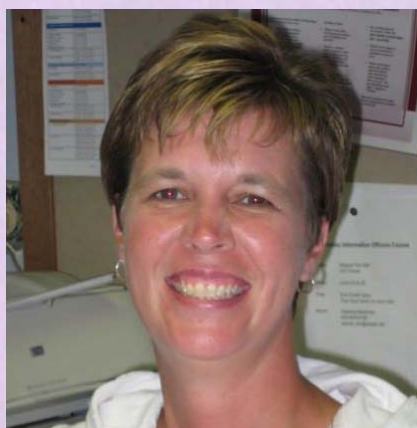


# Nebraska Association for Healthcare Quality, Risk, & Safety

<http://www.nahqrs.org/>

Volume 4 - Issue 1



**Laura Gamble, RN, BSN, EMT B  
President, NAHQRS  
Director of Nursing  
Providence Medical Center  
Wayne, NE**

My name is Laura Gamble and I am your new NAHQRS President for 2011. I will give you a little background about me professionally and personally.

Professionally I work at Providence Medical Center in Wayne, NE. I have worked there for 25 years holding various positions.

Currently I am the Director of Nurses, Co Corporate Compliance Officer, and HIPAA Privacy Officer. I have been helping out in Quality ever since I started as the DON at PMC.

I stay very busy with all these jobs but I learn something new everyday and I see things from all different perspectives.

I love working in a Critical Access Hospital because of the variety of patients and situations you encounter, it is really all I know not having worked anywhere else. I serve on the Rural Quality Improvement Steering Committee through NHA.

Personally I have been married to my husband Randy for 20 years and we have 3 teenage daughters Hannah 16, Kendall 14, and Jamie 11.

This is where I do all of my learning about life and it is all by trial and error, mostly error. I love sports and spend a lot of my time coaching softball and basketball. This lets me spend a lot of time with my kids and get to know the other kids. I am your typical “soccer Mom” even though that is one sport we do not play.

As for being your new President I have “BIG shoes to fill”. Julie Rezac is such a good leader and I learned so much from her while she was our President. I look forward to continue our work together and to work with the others on the Board.

I have met some really great people just in the one year I have served on the Board. The number of talented, professional people that this organization has surpasses many of the organizations I have been associated with in the past. Just think of all of the “Brain Power” in the room when we all get together. I truly believe NAHQRS is a unique organization that has done great things and will continue to do great things in the future, stay tuned!

We have not had our first Board meeting yet to look at what goals we want to set for the New Year but I know there are some great ideas already circulating out there. If anyone has any ideas on what you would like to see as goals please let me or any of the other Board members know. We would love to hear from you. As soon as the goals are set I will let you know.

I hope I can serve you well in 2011. I know we are all busy but if we work together we can accomplish great things. I want to be accessible to each and every one of you so please call me or e-mail me with any ideas or concerns. My e-mail is [lgamble@providencemedical.com](mailto:lgamble@providencemedical.com) or you may call me at (402) 375-3800.

Thank you for letting me serve you as your President.

**Laura**

“What lies behind us and what lies before us are tiny matters compared to what lies within us.”

Ralph Waldo Emerson

# Want to be a new Member or renew your past Membership?

Please follow this link to the new 2011 Application  
<http://www.nahqrs.org/Documents/application.pdf>

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## Quality – Risk Management – Patient Safety

# CMS has approved DNV Healthcare to accredit critical access hospitals

The decision was published in the Nov. 15 Federal Register.  
<http://www.dnvaccreditation.com/pr/dnv/critical-access-accreditation.aspx>

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**Centers for Medicare & Medicaid Services**  
**[CMS–2336–FN]**  
**Medicare and Medicaid Programs;**  
**Approval of Det Norske Veritas Healthcare for Deeming Authority for Critical Access Hospitals**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Final notice.

**SUMMARY:** This final notice announces our decision to approve Det Norske Veritas Healthcare (DNVHC) for recognition as a national accreditation program for critical access hospitals seeking to participate in the Medicare or Medicaid programs.

**DATES:** *Effective Date:* This final notice of approval is effective

December 23, 2010, through December 23, 2014.

### **FOR FURTHER INFORMATION**

#### **CONTACT:**

Lillian Williams, (410) 786–8636.  
Patricia Chmielewski, (410) 786–6899.

### **SUPPLEMENTARY INFORMATION:**

#### **I. Background**

Under the Medicare program, eligible beneficiaries may receive covered services in a critical access hospitals (CAHs) provided certain requirements are met. Sections 1820(c)(2)(B) and 1861(mm) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as a CAH.

The minimum requirements that a CAH must meet to participate in Medicare are set forth in regulation at 42 CFR part 485, subpart F. Conditions for Medicare payment for CAHs are set forth at § 413.70.

Applicable regulations concerning provider agreements are located in 42 CFR part 489, and those pertaining to facility survey and subparts A and B.

For a CAH to enter into a provider agreement with the Medicare program, a CAH must first be certified by a State survey agency as complying with the conditions or requirements set forth in section 1820 of the Act, and 42 CFR part 485 of the regulations. Subsequently, the CAH is subject to ongoing review by a State survey agency to determine whether it continues to meet the Medicare requirements. However, there is an alternative to State compliance surveys. Certification by a nationally recognized accreditation program can substitute for ongoing State review.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation

by an approved national accreditation organization (AO) that all applicable Medicare conditions are met or exceeded, we may “deem” that provider entity as having met the requirements. Accreditation by an AO is voluntary and is not required for Medicare participation. A national AO applying for deeming authority under 42 CFR part 488, subpart A must provide us with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions.

## II. Deeming Application Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for deeming authority is conducted in a timely manner. The statute provides us 210 calendar days after the date of receipt of a complete application, with any documentation necessary to make a determination, to complete our survey activities and application process.

Within 60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accreditation body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** approving or denying the application.

## III. Provisions of the Proposed Notice and Response to Comments

In the July 26, 2010 **Federal Register** (75 FR 43531), we published a proposed notice announcing DNVHC’s request for approval as a deeming organization for CAHs. In the proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.4, we conducted a review of DNVHC’s application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An onsite administrative review of DNVHC’s: (1) Corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its

surveyors; (4) ability to investigate and respond appropriately to complaints against accredited facilities; and (5) survey review and decision making process for accreditation.

- A comparison of DNVHC’s CAH accreditation standards to our current Medicare CAH conditions of participation (CoPs).

- A documentation review of DNVHC’s survey processes to:
  - + Determine the composition of the survey team, surveyor qualifications, and DNVHC’s ability to provide continuing surveyor training.
  - + Compare DNVHC’s processes to those of State survey agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

- + Evaluate DNVHC’s procedures for monitoring providers or suppliers found to be out of compliance with DNVHC’s program requirements. The monitoring procedures are used only when DNVHC identifies noncompliance. If noncompliance is identified through validation reviews, the State survey agency monitors corrections as specified at § 488.7(d).

- + Assess DNVHC’s ability to report deficiencies to the surveyed facilities and respond to the facility’s plan of correction in a timely manner.

- + Establish DNVHC’s ability to provide us with electronic data and reports necessary for effective validation and assessment of DNVHC’s survey process.

- + Determine the adequacy of staff and other resources.

- + Review DNVHC’s ability to provide adequate funding for performing required surveys.

- + Confirm DNVHC’s policies with respect to whether surveys are announced or unannounced.
- + Obtain DNVHC’s agreement to provide us with a copy of the most current accreditation survey together with any other information related to the survey as we may require, including corrective action plans.

In accordance with section 1865(a)(3)(A) of the Act, the July 26, 2010 proposed notice also solicited public comments regarding whether DNVHC’s requirements met or exceeded the Medicare CoPs for CAHs. We received five comments in response to our proposed notice. All of the commenters expressed support for DNVHC’s application for

CAH deeming authority. The commenters stated that DNVHC’s standards are clearly written and closely align with the Medicare CoPs, and that DNVHC’s accreditation program provides CAHs with a viable alternative to other healthcare AOs.

## IV. Provisions of the Final Notice

*A. Differences Between DNVHC’s Standards and Requirements for Accreditation and Medicare’s Conditions and Survey Requirements*  
We compared DNVHC’s CAH accreditation requirements and survey process with the Medicare CoPs and survey process as outlined in the State Operations Manual (SOM). Our review and evaluation of DNVHC’s deeming application, which were conducted as described in section III. of this final notice, yielded the following:

- To meet the requirements at § 485.641(b)(4), DNVHC revised its crosswalk to ensure deficiencies regarding credentialing and quality assurance are correctly cited and crosswalked to the Medicare requirements.

- To ensure consistent and accurate documentation, DNVHC revised its onsite survey protocol to require surveyors use and forward all surveyor worksheets to the corporate office for inclusion in the survey file.

- To meet the survey process requirements at appendix W of the SOM, DNVHC revised its policies to require the medical record sample size be no less than 20 inpatient records.

- To meet the requirements at appendix W of the SOM, DNVHC revised its policies to require the conduct of patient interviews during the survey.

- To meet the requirements at section 5075.9 of the SOM, DNVHC revised its policies to require an onsite survey within 45 calendar days for complaints triaged as operational requiring a special survey.

- To meet the requirements at § 485.608(d), DNVHC revised its standards to address the certification or registration requirements of CAH personnel.

- To meet the requirements at § 485.618(c)(2) and § 485.618(d)(1), DNVHC revised its standards to replace the term physician with “doctor of medicine or osteopathy.”

- To meet the requirements at § 485.618(d)(3)(iii) through

§ 485.618(d)(4), DNVHC revised its onsite surveyor protocol to require surveyors to verify, if applicable, that the CAH has received permission from CMS to use registered nurses with training and experience as qualified professionals in emergency care, on a temporary basis, be included in the list of personnel immediately available to provide emergency care.

- To meet the requirements at § 485.620, DNVHC revised its standards to address the number of beds and length of stay requirements for CAHs.
- To meet the requirements at § 485.623(b), DNVHC revised its standards to include housekeeping and preventive maintenance programs.
- To meet the requirements at § 485.623(c)(3), DNVHC revised its standards to ensure the CAH provides an emergency fuel supply.
- To meet the requirements at § 485.623(d)(7)(iv), DNVHC revised its standards to include the reference to the National Fire Protection Association (NFPA) Tentative Interim Amendments (TIA) 00–01 (101).
- To meet the requirements at § 485.623(d)(7)(i) through § 485.623(d)(7)(iv), DNVHC revised its standards to ensure alcohol-based dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code.
- To meet the requirements at § 485.635(a)(3)(i), DNVHC revised its standards to ensure the CAH's policies include a description of the services provided, either directly or through an agreement or arrangement.
- To meet the requirements at § 485.635(a)(3)(iii), DNVHC revised its standards to ensure the CAH's policies include guidelines for healthcare conditions that may require a patient referral.
- To meet the requirements at § 485.635(a)(4), DNVHC revised its standards to require that a group of professional personnel review the CAH policies on an annual basis.
- To meet the requirements at § 485.635(b)(1), DNVHC revised its standards to ensure direct services of the CAH include the medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.
- To meet the requirements at

§ 485.635(b)(3), DNVHC revised its standards to ensure staff and patients of the CAH are not exposed to radiation hazards.

- To meet the requirements at § 485.635(d)(3), DNVHC revised its standards to ensure drugs and biologicals are administered by and under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted, a physician assistant, in accordance with written and signed orders.
- To meet the requirements at § 485.635(e), DNVHC revised its standards to ensure therapy services provided at the CAH are consistent with the requirements at § 409.17 of our rules.
- To meet the requirements at § 485.638(a)(4)(i), DNVHC revised its standards to ensure the patient's medical record include a brief summary of the episode.
- To meet the requirements at § 485.638(c), DNVHC revised its standards to ensure clinical records are retained longer than six years from the date of the record's last entry, if such is required by State statute, or if the records are needed for a pending proceeding.
- To meet the requirements at § 485.639(b)(3), DNVHC revised its standards to ensure patients receiving surgical services at the CAH are evaluated for proper anesthesia recovery by a qualified practitioner.
- To meet the requirements at § 485.641(b)(1), DNVHC revised its standards to ensure all CAH services that affect patient health and safety are evaluated.
- To meet the requirements at § 485.645(a)(2), DNVHC revised its standards to ensure the CAH provides no more than 25 inpatient beds.
- To meet the requirements at § 485.645(d)(8), DNVHC revised its standards to address the requirement that if the CAH provides or obtains dental services from an outside resource, that service must be in accordance with the requirements at § 483.55 and § 483.75(h).
- To meet the Skilled Nursing Facilities (SNF) requirements applicable to swing beds at § 483.12(a)(1), DNVHC revised its standards to ensure transfer and discharge of a patient includes transfer to a bed outside of the certified facility.

- To meet the SNF swing bed requirements at § 483.20(b)(2), DNVHC revised its standards to ensure the comprehensive assessment is completed within 14 calendar days after admission and not less than every 12 months.
- To meet the requirements at § 483.20(k)(1)(ii), DNVHC revised its standards to ensure that the comprehensive care plan addresses situations where services that would be otherwise required under § 483.25 are not provided due the patient's right to refuse treatment under § 483.10(b)(4).
- To meet the requirements at § 483.20(l)(2), DNVHC revised its standards to ensure the discharge summary includes a final summary of the patient's status and is available for release to authorized persons and agencies, with the consent of the patient or legal representative.
- To meet the requirements at § 412.25(a)(2), DNVHC revised its standards to ensure the CAH's written admission criteria is applied uniformly to both Medicare and non-Medicare patients.
- To meet the requirements at § 412.25(d), DNVHC revised its standards to ensure the CAH has only one psychiatric or rehabilitation unit excluded from the prospective payment systems.
- To meet the requirements at § 412.27(d)(1), DNVHC revised its standards to ensure the CAH provides an adequate number of qualified doctors of medicine and osteopathy for essential psychiatric services.
- To meet the requirements at § 482.11(b)(2), DNVHC revised its standards to require hospitals located in States that do not provide licensure meet the approved standards established by that State.
- To meet the requirements at § 482.12(c)(2) through § 482.12(c)(4)(ii), DNVHC revised its standards to address who can admit patients.
- Regarding our capitalization and capital plan requirements for health maintenance organizations (HMOs) and civil monetary penalties (CMP) that operate hospitals, DNVHC revised its standards to ensure, with respect to such entities, the institutional plan and budget include the following requirements:
  - + The facilities do not provide common services at the same site.

- + The facilities are not available under a contract of reasonable duration.
- + Full and equal medical staff privileges in the facilities are not available.
- + Arrangements with these facilities are not administratively feasible.
- + The purchase of these services is more costly than if the health maintenance organization (HMO) or competitive medical plan (CMP) provided services directly.
  - To meet the requirements at § 485.618, DNVHC revised its standards to clarify that emergency services must be provided directly.
  - To meet the requirements at § 482.13(e)(13), DNVHC revised its standards to address the requirement that States are free to have restraint and seclusion requirements by statute or regulation that are more restrictive than CMS standards.
  - To meet the requirements at § 482.21, DNVHC revised its standards to require that hospitals maintain and demonstrate evidence of its quality assessment and performance improvement program (QAPI) program for review by CMS.
  - To meet the requirements at § 482.21(a)(1), DNVHC revised its standards to ensure QAPI is an ongoing program that shows measurable improvements in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.
  - To meet the requirements at § 482.21(a)(2), DNVHC revised its standards to ensure the hospital's QAPI program includes aspects of performance that assess process of care, hospital service, and operations.
  - To meet the requirements at § 482.21(c)(2), DNVHC revised its standards to address the hospital's responsibility to, among other things, implement preventive actions and mechanisms that include feedback and learning throughout the hospital as part of its performance improvement activities.
  - To meet the requirements at § 482.21(d)(2), DNVHC revised its standards to clarify that a hospital may chose, as one of its quality initiatives, to develop and implement an information technology system to improve patient safety and quality.
  - To meet the requirements at

- § 482.23(c), DNVHC revised its standards to ensure all drugs and biologicals are administered under the orders of a practitioner responsible for the care of the patient as specified at § 482.12(c).
- To meet the requirements at § 482.23(c)(3), DNVHC revised its standards to include the requirement that blood transfusions and intravenous medications must be administered in accordance with State laws and approved medical staff policies and procedures.
  - To meet the requirements at § 482.23(c)(4), DNVHC revised its standards to require blood transfusion reactions be reported immediately to the attending physician.
  - To meet the requirements at § 482.30(a)(2), DNVHC revised its standards to address situations where CMS has determined that the utilization review (UR) procedures established by a State under title XIX of the Act are superior to those listed in 42 CFR part 482, thus requiring hospitals in that State to meet the utilization control requirements at § 456.50 through § 456.245 of this chapter of the regulations.
  - To meet the requirements at § 482.30(c)(4) and § 482.30(e)(2), DNVHC revised its standards to require that the CAH review cases where the patient's length of stay exceeds the mean length of stay for the applicable diagnostic-related group (DRG) and the hospitals charges for covered services exceed the DRG payment rate.
  - To meet the requirements at § 482.30(d)(1)(i) through § 482.30(d)(3), DNVHC revised its standards to ensure determinations regarding admissions or continued stays are made by the practitioner responsible for the patient as specified in § 482.12(c).
  - To meet the requirements at § 482.30(e)(ii), DNVHC revised its standards to require that the utilization review committee conduct a periodic review of each current inpatient receiving hospital services during a continuous period of extended duration for hospitals not paid under the prospective payment system.
  - To meet the requirements at § 482.42(a)(2), DNVHC revised its standards to require the infection

control officer maintain a log of incidents related to infections and communicable diseases.

- To meet the requirements at § 482.43(e), DNVHC revised its standards to require that the CAH periodically reevaluate its discharge planning process.

#### *B. Term of Approval*

Based on the review and observations described in section III. of this final notice, we have determined that DNVHC's requirements for CAHs meet or exceed our requirements. Therefore, we approve DNVHC as a national accreditation organization for CAHs that request participation in the Medicare program, effective December 23, 2010, through December 23, 2014.

#### **V. Collection of Information Requirements**

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

#### **VI. Regulatory Impact Statement**

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget. **Authority:** Section 1865 of the Social Security Act (42 U.S.C. 1395bb). (Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program) (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program). Dated: October 27, 2010.

**Donald M. Berwick,**  
*Administrator, Centers for Medicare & Medicaid Services.*

[FR Doc. 2010–28666 Filed 11–12–10; 8:45 am]

**BILLING CODE 4120–01–P**



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

The 102<sup>nd</sup> Nebraska Legislature convened on January 5, 2011. Senators have ten days, or until January 19, to introduce legislative bills.

As of January 10, 230 legislative bills were introduced - 135 introduced on the first day. To view all of these bills online, go to <http://nebraskalegislature.gov/> and select "Introduced Legislation 2011". On January 18, at 1:30 pm, committee hearings will begin to discuss all of the bills introduced during the first ten days. Committee hearings will again be broadcast via live video streaming; go to <http://www.netnebraska.org/publicmedia/capitol.html> to access the committee hearings.

Some bills of interest to you as health care providers introduced to date include:

- LB 40, introduced by Senator Hadley, to change a sales tax exemption for health clinics
- LB 51, introduced by Senator Krist, to require health clinics to have patient transfer agreements
- LB 68, introduced by Senator Fulton, to allow certified nurse midwives to have clinical privileges
- LB 140, introduced by Senator Lautenbaugh, to change provisions relating to criminal background checks required for health and human services transportation services
- LB 153, introduced by Senator Lathrop, to change reimbursement for medical services under the Nebraska Workers' Compensation Act
- LB 219, introduced by Senator McCoy, to adopt the Health Care Freedom Act

Obviously, a wide variety of bills are introduced each year that affect us as citizens of the State. Go online to find legislative bills to eliminate daylight savings time (LB 101); to prohibit job discrimination based on credit history (LB 113); to change motorcycle helmet provisions and require eye protection (LB 52) or to change provisions relating to mowing weeds in ditches (LB 87). Whether health care related or otherwise, choose to be an active participant in Nebraska's legislative process.

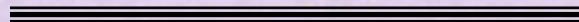


[http://www.nhanet.org/advocacy/advocacy\\_day.htm](http://www.nhanet.org/advocacy/advocacy_day.htm)

[Subscribe to NHA Newslink](#) – Reporting on Nebraska health care news

For additional legislative updates, visit [www.nhanet.org](http://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](mailto:brieker@nhanet.org).



### **Advancing Excellence in America's Nursing Homes Campaign Update**

*Submitted by: Keri McDermott, Communications Director, CIMRO of Nebraska*

The Advancing Excellence (AE) in America's Nursing Homes Campaign just celebrated its fourth birthday, is moving full steam ahead and making considerable progress. Over 6,700 nursing homes are participating in Phase 2 of the Campaign, with 4,725 charter members and almost 1,500 new participants. There are also over 2,700 consumers and over 1,300 nursing home staff registered as Campaign supporters. Although, you can sign up for the Campaign at any time, the transition is shifting from recruitment to performance.



Nebraska efforts are to be commended. Nationally, the Nebraska LANE has shared our recruitment strategies for nursing homes to join the campaign as a best practice for other states. To date, we have approximately 140 Nebraska nursing homes enrolled in phase 2 of the Campaign. Goals are being set and targets met. As a result, care in Nebraska nursing homes is improving.

The Nebraska LANE recently met to determine next steps to assist participating homes. The majority of Nebraska nursing homes have selected pain prevention as their primary Campaign goal. Nebraska AE LANE Partners submitted a grant application to the National Advancing Excellence Field Coordinators. Our grant proposal was accepted. As a result, the Nebraska AE LANE will offer two trainings focusing on pain in the Spring 2011. In addition, a grant goal is to increase our nursing home AE Campaign participation by an additional 5 percent.

The Nebraska LANE is in the process of developing another educational DVD. This DVD will focus on educating caregivers to identify pain. This DVD should be completed and ready in early spring, just in time to accompany the spring trainings.

Pain is serious; it can affect residents' daily activities and quality of life. In addition it can cause depression, sleeplessness or restlessness. How can nursing home staff assist with the prevention or minimizing a residents' pain?

- ✓ Recognize that the resident's pain is subjective; pain is different for different people; what may be mild pain to one may be excruciating to another person.
- ✓ Learn which residents have chronic pain.
- ✓ Ask residents about their pain, or observe residents for pain; notify the charge nurse if a resident says she has pain or if you observe the signs of pain in residents who cannot communicate.
- ✓ A resident with dementia may not be able to verbally tell you he has pain; observe for signs of pain in facial expressions – gritted teeth, frowning, grimacing, etc. or other behavior, such as pacing, aggression or agitation.
- ✓ Ask residents who are unable to sleep if they are in pain.
- ✓ Read the care plans of residents to learn resident-specific interventions for pain.
- ✓ Monitor residents who have pain for nutritional intake and weight loss.
- ✓ Learn how to engage residents with pain in activities to prevent isolation.
- ✓ Recognize that residents may not want to admit they are in pain because they think they are not being a “good patient.” Sometimes they may describe being “uncomfortable” rather than being in “pain.”
- ✓ Follow your nursing home's protocols to identify and manage resident pain.
- ✓ Participate in in-services related to pain management.
- ✓ Talk to the charge nurse if you have questions.
- ✓ Talk to the charge nurse if you have a suggestion that you think might work better for a resident.

The AE Campaign recently developed and released a Pain Management Calculator, which is an easy to use template for nursing homes to better track pain management for its residents. This tool has been well-received and feedback has been positive. If you have not yet reviewed this tool, you can access it at [www.nhqualitycampaign.org/files/PainTrackingForm.xls](http://www.nhqualitycampaign.org/files/PainTrackingForm.xls)

Tools for all of the organizational goals are also available on the Advancing Excellence Web site, [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org). Download the tools from the Resources section of the Web and calculate your measures for staff turnover, consistent assignment, advance care planning and resident and staff satisfaction. Then, log-in to the Web site to enter your data. You can set targets and monitor your progress.

If your nursing home is not a member of the Advancing Excellence Campaign, or you want to learn more, please contact Sherri Hill, CIMRO of Nebraska Quality Improvement Advisor, at 402/476-1399 or via e-mail at [shill2@neqio.sdps.org](mailto:shill2@neqio.sdps.org)

We are excited about the future, upcoming activities and trainings that will be offered by the Nebraska AE LANE. We hope your nursing home is able to participate. We look forward to partnering with you and want to offer thanks for your commitment to this Campaign and quality improvement.



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-202/0111

**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](mailto:tmazuch@harlancohealth.org).**

**Thank you for your help!  
Tina Mazuch**

**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 Donna Jorgensen at [djorgensen@lmchospital.org](mailto:djorgensen@lmchospital.org)**

## Career Opportunities

### **Director of Quality job opportunity in the Chicago area**

I am looking for a Director of Quality, this position is also over CM, UM, Risk, and Infection Control.

Hospital is about 200 beds.

They will consider someone who IS NOT a nurse for this position as well.

Anyone who might be interested could contact me for further info.

Regards,

Erika

Erika Teles

Next Generation Recruiting

[elteles@recruitnextgen.com](mailto:elteles@recruitnextgen.com)

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2011 as the start of a new year may be a time you are looking for a new position.

If you are let me first tell you that our hospitals ALL pay relocation.

The Merraine Group Inc., has been in business for over nine years in New York but works with over 400 hospitals throughout the U.S.

Please look at our web site from time to time: [www.merraine.com](http://www.merraine.com).

We usually have from two to five Quality or Case jobs at a time, but currently we're looking at the following for Directors or Managers of Quality, or Risk, or Case:

Dir. Quality & Risk

#2024AG is a small hospital in Kansas, very well respected, and paying \$80-110K = must provide oversight to peer review activities, infection control, accreditation compliance, quality indicator outcomes, etc.

Must be an RN. CPHQ or CPHRM are strongly desired plus two years management experience in a hospital.

Sr. Dir. Q.A. and P.I.,

#2035JL is a 300 bed hospital in San Francisco, paying \$145-170K = includes oversight of infection control, patient safety, regulatory preparedness, medical staff peer review, case, risk and clinical research.

Must have five years experience in Risk, Quality and Case as well as an RN and a Bachelor's degree.

Dir. Case Mgt.

#2002JL a hospital near San Jose, CA paying \$165-185K = RN needed but a Master's degree will bring one to the higher end of the pay scale - CPUR or CMAC and three years hospital management experience is needed.

Mgr. Case Mgt.

#2035AJL a hospital in San Francisco, CA paying \$115-135K = a 300 bed hospital in San Francisco - candidates must have a BA in health or a BS plus an RN license and three years Case experience. Prior experience with governmental and non governmental payers would be helpful. DRG knowledge is needed.

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**Next Meeting February 4, 2011 (9:30 AM – 3:00 PM)  
Saint Elizabeth Regional Medical Center, Lincoln**

## Saint Elizabeth Regional Medical Center

575 S 70th St, Lincoln, NE

(402) 488-3002

Website: <http://www.saintelizabethonline.com/>

Click on the link  
below to bring up  
web map:

<http://maps.google.com/maps?hl=en&um=1>

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[8&q=saint+elizabeth+lincoln&fb=1&gl=us&hq=saint+elizabeth+lincoln&cid=0,0,11749965786414228024&ei](#)

[=6CAuTdYNge-yBvLDuPQH&sa=X&oi=local\\_result&ct=image&resnum=2&ved=0CCgQnwlwAQ](#)



## Future NAHQRS Meetings

February 4, 2011 Lincoln

June 3, 2011 TBD

October TBD, 2011

April 1, 2011 TBD

August 5, 2011 TBD

December 2, 2011 York

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Next publish date is February 11, 2011

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](mailto:wredinger@sfmc-gi.org)

### Future Newsletter publish dates:

- March 10, 2011
- May 13, 2011
- July 8, 2011
- September 11, 2011
- November 11, 2011