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President's Message

By Britt Thedinger, MD NMA President

The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act) authorized the creation of Patient Safety Organizations (PSOs) to improve the quality and safety of U.S. health care delivery. The Patient Safety Act encourages clinicians and health care organizations to voluntarily report and share quality and patient safety information without fear of legal discovery.

Subsequently in 2005, the Patient Safety Improvement Act was passed by the Nebraska Legislature and signed by Governor Heinemann. This Act directed the five founding Associations (Nebraska Hospital Association, Nebraska Medical Association, Nebraska Academy of Physician Assistants, Nebraska Pharmacists Association, and the Nebraska Nurses Association) to establish a private, nonprofit patient safety organization, independent of state agencies - The Nebraska Coalition for Patient Safety (NCPS). In 2009, NCPS became a federally designated patient safety organization. The goal of both the state and federal legislation is to increase the likelihood that all people who seek health care in Nebraska and

across the U.S. are not harmed by the care that is intended to help them.

Of course, the Act came with no funding. Currently the NCPS is funded by the five founding Associations, 61 hospitals, and sponsors such as COPIC and Blue Cross and Blue Shield of Nebraska. Their annual budget is approximately \$270,000 and the organization has no dedicated researcher(s).



The organization collects data voluntarily supplied from the participating hospitals. The collected information is disseminated quarterly back to the hospitals. As physicians are not members of the Coalition, we never see this information. The hospitals also do not share this data with their physicians. These safety issues include medication errors, falls, sepsis, failure or delayed response, unsafe injections, and retained foreign objects. We need to eliminate these errors which seem to occur over and over.

The NMA went to the NCPS board (comprised of physicians, pharmacists, hospital administrators, and other health care providers) and asked how we could properly fund the Coalition to better collect and disseminate this information. They came back with a request for additional

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President's Message (continued)

staff, including a PhD and Master's trained researcher required to adequately perform their mission. The addition of researchers is intended to support an expansion of services into safety culture assessment and improvement for hospitals and ambulatory care clinics. Also, the researchers will be able to increase the NCPS' ability to apply for grants. With the goal of additional researchers came an updated budget and a need for additional funds of about \$300,000 per year.

To generate these funds, the NMA brought a bill in 2018, LB 1127, which was introduced by Senator Kolterman this last session. LB 1127 called for a \$10/year increase in all health care individuals' licenses to fund the Coalition. This bill was opposed by the Nurse's Association, the Platte Institute, and the Governor. Because it was a short session and time was running out, the bill did not pass.

The NMA believes all physicians and other health care providers should have a financial stake in supporting the NCPS. This would enable all of us to receive quarterly updates and would constantly remind us about the importance of patient safety. Our initial medical license fee is \$300 with a renewal fee of \$121 every other year. These are some of the lowest fees in the country.

This year's bill proposes a \$50 fee every two years be added to a physician's license; \$20 for physician assistants. You can read more about Senator Kolterman's newly proposed bill on page 6.

Finally, we as physicians all agree we need to promote patient safety. In fact the AMA code of medical ethics notes, "Open communication is fundamental to the trust in the patient-physician relationship, and physicians have an obligation to deal honestly with patients in addition to their obligation to promote patient welfare and safety. Concern regarding legal liability should not affect the physician's

honesty with the patient."

The opinion goes on to say we need to disclose, acknowledge, and explain efforts underway to prevent similar occurrences. We need to provide for the continuity of care to patients who have been harmed during the course of care. We should be encouraged to disclose. We need to:

 Support a positive culture of patient safety, including compassion for peers who have been involved in a medical error.

-Enhance patient safety by studying the circumstances surrounding medical error. A legally protected review process is essential for reducing health care errors and preventing patient harm.

-Establish and participate fully in effective, confidential, protected mechanisms for reporting medical errors.

-Participate in developing means for objective review and analysis of medical errors.

-Ensure that investigation of root causes and analysis of error leads to measures to prevent future occurrences and that these measures are conveyed to relevant stakeholders.

Senator Kolterman introduced LB 25 (the former LB 1127) in 2019, but it funds the NCPS by only raising physician licensure fees by \$50. We recently met with the Governor who was more receptive, but still wants to look for other possible funding sources. Your NMA would welcome your thoughts and ideas. The NMA is committed to pursuing patient safety efforts, and we welcome your ideas about how to accomplish this worthy goal.

Britt Thedinger, MD omahabat@cox.net 402.490.5162

Executive Vice President's Message

By Amy Reynoldson
NMA Executive Vice President

"We don't grow when things are easy. We grow when things are challenging." This quote keeps surfacing as 2019 progresses, a new year that provides opportunities of growth for our organization, to serve more physicians, and to work collectively on advocating for NMA members.

This year we welcomed 13 new senators to the Nebraska Legislature, and we saw many changes in the makeup of the legislative committees. This session is shaping up to be an active one that includes bills that will directly affect physicians and their practice as well as their patients. The session began on January 9, 2019, and bill introductions concluded on January 23, 2019. Session will end on June 6, 2019.

The NMA relies heavily on Mueller Robak LLC for our lobbying efforts as well as NMA Vice President of Advocacy and Regulation and in-house legal counsel, Meghan Chaffee, JD. There will be a couple of bills that will focus on patient safety and physician health wellness which directly impacts you and your patients. You are our most important resource, and we need you to communicate important messages to our senators. I encourage you to take opportunities to reach out to your senator and discuss issues that are important to you. We thank those physicians that have been engaged in legislative efforts and invite others to get involved. The NMA Commission on Legislation and Governmental Affairs met on January 31, 2019, to discuss and formulate policy positions on bills that have been introduced that impact physicians. Your expertise is exactly what we need when we are working to protect your profession, practice, and the safety of your patients.

It is important to keep in mind that the relationships

with new senators started before the recent elections. The NMA partnered with a couple of other organizations this past summer and held candidate interviews that were well attended. This provided physicians opportunities to get to know the candidates and learn about what is most important to them. We will continue to forge new relationships with the incoming senators and strengthen existing relationships to help further our efforts for the NMA members.



We are also in full swing of membership renewals and membership recruitment. We thank those of you who have continued to allow the NMA to serve you. The challenge of recruiting new members is demonstrating the value of their membership with our organization. One often does not know what they have access to until they experience a time of need. The NMA has a very comprehensive member benefit package that can be utilized by you, your staff, and your clinic. I encourage you to continue to promote the NMA to your fellow physicians. The NMA distributed new member benefit pamphlets at the start of 2019 which include three new benefits: a physician mortgage program, investment program, and a rental car program.

As we all know, the climate is ever changing in health care. I think that it is safe to say that in 2019 we all need to be prepared to grow a little. Find a way to be involved in the efforts of the NMA, attend events, participate on committees, reach out to your senator to educate them on a specific issue, be part of a fundraiser, recruit new members, and most of all, let us know how we can serve you better. As an organization we are only as effective as our members.

With 2019 well underway, the NMA thanks its members for a very successful 2018. We are excited to see what 2019 has in store for us. $\hfill\Box$

Legislating the Prioritization of Patient Safety

By Senator Mark Kolterman, Legislative District 24

t may seem silly to mandate the prioritization of patient safety in the state, but that's exactly what I proposed in 2018 and is what I am doing this year as well.

For a bit of background on the issue, the federal Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act) authorized the creation of Patient Safety Organizations (PSOs) to improve the quality and safety of U.S. health care delivery. The Patient Safety Act encouraged clinicians and health care organizations to voluntarily report and share quality and patient safety information without fear of legal discovery.

Following the implementation of the Patient Safety
Act, the Nebraska Legislature passed the Patient Safety
Improvement Act in 2005 which protected reported events
from discovery and required the establishment of a private,
nonprofit PSO to receive those events as patient safety
work product. Since Nebraska's Act allocated zero dollars
for funding the PSO, the Nebraska Hospital Association,
Nebraska Medical Association, Nebraska Academy of
Physician Assistants, Nebraska Pharmacists Association,
and the Nebraska Nurses Association took the initiative
to create Nebraska's PSO: The Nebraska Coalition for
Patient Safety (NCPS). The mission of NCPS is to increase
the likelihood that all people who seek health care in
Nebraska are not harmed by the care that is intended
to help them.

The NCPS collects data supplied voluntarily from participating hospitals who pay to be members of NCPS. The collected information is disseminated quarterly back to the hospitals. Health care professionals who directly benefit from this information such as physicians, nurses, physician assistants, pharmacists, and others never see this report as they are not members of the NCPS. Safety issues addressed in the report could include medications errors, falls, sepsis, failure or delayed response, unsafe injections,

and retained foreign objects. These are errors we can, and must learn from.

Prior to the 2018 legislative session, The Nebraska Medical Association (NMA) went to the board of the NCPS and asked how the NCPS can be properly funded in order to better collect and disseminate this information. To generate these funds, the NMA brought a legislative proposal to me which called for a \$10 per year increase in licensure for physicians, physician assistants, pharmacists, occupational therapists, physical therapists, and nurses to fund the Coalition. I introduced LB 1127 because I agreed that a nominal fee of \$10 per year in the name of improving patient safety was well worth the investment.

During the hearing for LB 1127, I laid out the case for the additional funding needed for the NCPS. We heard testimony from patient advocacy organizations, the NCPS board president, physicians, physician assistants, and Nebraska Hospital Association representatives. Despite the oppositions' testimony that \$10 a year is too high an increase of fees, the bill advanced out of committee. Unfortunately, due to the short session and time constraints, we were unable to pass the legislation.

I support patient safety wholeheartedly, as do the members of the NMA, so I introduced a new bill, LB 25, this session to fund the NCPS. This time, the physicians agreed to show their support by increasing their licensure fees by \$25 per year (\$50 biennially), and the physician assistants agreed to the originally proposed \$10 per year (\$20 biennially) amount.

My hope is that this bill receives the full support of the Health and Human Services Committee and the Nebraska Legislature. When we have groups who are willing to step up to the plate and volunteer to contribute more of their hard earned dollars, I don't know how anyone can oppose the effort to further excellent health care and patient safety. Like I said, it may seem silly to mandate the importance of patient safety, but that is precisely what I am doing again this year.

The Physician's Role in Engineering a Culture of Safety

By Katherine J. Jones, PT, PhD
President, Board of Directors
Nebraska Coalition for Patient Safety

Defining a Culture of Safety

Physicians are typically designated leaders in providing patient care, which includes keeping patients safe. Safety culture is one aspect of an organization's culture. Social psychologist Edgar Schein¹ defined organizational culture as the shared assumptions learned by a group as they seek to solve problems originating in the external and internal environments. These assumptions are taught to members of the organization as norms and behaviors that define how to think and feel about those problems.¹ Safety culture is the shared values, norms, and behaviors related to patient safety among members of an organization.² These values, norms, and beliefs indicate the relative importance of patient safety as compared to other organizational goals such as productivity.³

Four beliefs form the foundation of a culture of safety⁴:

- 1. Our processes are designed to prevent failure.
- 2. We are committed to detect and learn from error.
- 3. We have a just culture that disciplines based on risk taking and not outcomes.
- 4. People who work in teams make fewer errors.

Components of a Culture of Safety

Similar to physiological homeostasis, an organization with a strong culture of safety is composed of four interacting systems or components that seek to maintain a constant and optimal internal environment that is highly reliable. Organizational psychologist James Reason⁵ describes these four interacting components as:

1. Reporting culture—the people in direct contact with the risks and hazards in an organization report their errors and near misses formally through a reporting system or informally during briefs, huddles, or debriefs.

- 2. Just culture—an atmosphere of trust exists because people are encouraged and rewarded when they report safety information. In addition, there is a shared accountability among management and front-line staff.⁶ Management is accountable for the systems in which people work and whether their design makes it easy to do the right thing. Front-line staff are accountable for their behaviors, which include human errors, at-risk behaviors, and reckless behaviors. Human errors
- occur at the sub-conscious level and include slips (doing other than as intended), lapses (omissions), and mistakes (incorrect plan).⁷ At-risk behaviors are those in which the extent of risk may be underestimated (e.g. speeding or not participating in a surgical check list). Reckless behaviors are those in which risk is known but disregarded (e.g. texting while driving or not confirming the correct patient using two identifiers).
- 3. Flexible (teamwork culture)—the people in an organization use strategies and tools including structured language (e.g. situation-background-assessment-recommendation) to flatten hierarchies when appropriate so that those who are most knowledgeable about a situation feel psychologically safe to speak up.
- 4. Learning culture—the people in an organization use prospective and retrospective sensemaking tools⁸ such as failure mode and effects analysis, debriefs, root cause analysis, Leadership WalkRounds, and safety huddles to identify the root causes of adverse events. Furthermore, they use change management strategies to implement evidence-based interventions.

Importance of a Culture of Safety

Patient safety culture can be thought of as a cross cutting contextual factor that impacts the effectiveness of all patient safety and quality improvement efforts.² Safety culture is the soil in which you plant your patient safety and quality improvement interventions. Poor quality soil yields a poor harvest. Consequently, evidence indicates that the

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The Physician's Role in Engineering a Culture of Safety (continued)

stronger the safety culture, the lower will be the risk of adverse events⁹ and the higher will be patient satisfaction.¹⁰

Physician's Role in Engineering a Culture of Safety

Physicians are the designated leaders in health care systems. Leaders at each level of an organization—whether within a hospital, unit within a hospital, or ambulatory setting—engineer the culture of safety among the people they lead by how they:

- · share information,
- · provide feedback,
- · hold people accountable, and
- role model behaviors.¹

As leaders, physicians should be aware of the culture of safety within the organizations and units they lead. The Agency for Healthcare Research and Quality has developed a family of surveys that assess safety culture in hospitals, medical offices, nursing homes, ambulatory surgery centers, and retail pharmacies. These surveys identify strengths and areas in need of improvement in the safety culture of the organization within which they were conducted.

Finally, as leaders, physicians should have the ability to execute the behaviors and practices associated with the four key components of a culture of safety:

- 1. Role model and support formal reporting of events by using your organization's event reporting system. Role model informal reporting by leading briefs, huddles, and debriefs.
- Improve system design to make it easier for fallible human beings to avoid human errors, at-risk, and reckless behaviors. Know how to manage human errors, at-risk, and reckless behaviors using just culture principles and strategies.

- 3. Be just as competent in your team skills as you are in your clinical skills.
- 4. Participate in sensemaking of patient safety events during root cause analyses, safety huddles, time-outs, and debriefs.

For more information about safety culture surveys in all settings, team training, just culture training, or sensemaking of patient safety events, contact the Nebraska Coalition for Patient Safety, Nebraska's only federally-listed Patient Safety Organization https://www.nepatientsafety.org/contact.

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Patient Safety in Outpatient Clinics: It's Not Just for Hospitals

By Dan Rosenquist, MD

Ithough the movement in patient safety began in the early 1990s, it was the landmark publication of *To* Err is Human by the Institute of Medicine in 1998 where it received the attention of the general public and gave purpose and mission to the project. While it was difficult for most clinicians, including myself, to accept that between 44,000 and 98,000 patients died as a result of their medical care, it is now recognized that the number was grossly underestimated due to limitations and design of the study. Since publication, most hospitals have formed patient safety committees, that involve physicians as active and contributing members, with the goal of improving outcomes and decreasing the overall cost of care. Through the campaign of Just Culture and other movements, we are able to learn from our errors and share our processes that benefit the health of our communities.

While hospitals have been actively working to improve patient safety, outpatient clinics, where a large percent of care is received, have not shown the same focus. Previous studies demonstrate that only two to three percent of outpatients suffered a patient safety event compared to 10 percent of hospital patients; however, outpatient visits outnumber facility-based encounters by a factor of seven to eight, creating cause for alarm for office-based practices. And while more severe injuries may be associated with inpatient events, the same events can occur in outpatient facilities. Most hospitals have procedures in place to identify and study safety events, but this is not standard practice for outpatient clinics.

Much of the patient safety information gathered in hospitals, including the lessons learned and recommendations made, can also be applied to outpatient clinics and facilities. Organizations such as the Agency for Healthcare Research and Quality (AHRQ), ECRI Institute, National Quality Forum, and the American College of Physicians have issued recommendations for improved patient safety in office-based practices.

One of the concerns that comes to the forefront is medication management and safety. While medication reconciliation is often taken for granted by the general public, active practitioners recognize the difficulty of this task. Medication lists at the time of discharge are often inaccurate due to additions, discontinuations, or medications being held during admission with the intention of restarting after dismissal. Failure to identify and document adverse reactions, along with delayed completion and transmission of the discharge summary, can lead to frustration for clinicians, patients, and family. The Prescription Drug Monitoring Program (PDMP) does include all medications prescribed to the patient (an industry-leading attribute of the Nebraska PDMP), but limitations and errors still exist, and patients continue to suffer the consequences. All physicians should have the Nebraska PDMP bookmarked on our computers and should also consider the use of approved proxies to gather this information when appropriate.

Antibiotic stewardship and opioid use, additional facets of medication management and safety, represent another area where improvement can be made. The unnecessary use of an antibiotic or narcotic may, by itself, create a patient safety event.

Additional lessons learned in hospital settings that can be applied to outpatient clinics include the use of two patient identifiers, verbal readbacks, time-outs prior to procedures, and hand hygiene policies.

A common area of frustration for clinicians is the electronic health record (EHR). In its present form, the functional limitations of the various programs, as well as the lack of connectivity and interoperability, presents obstacles for desired safety initiatives. When working with EHRs, it is important to check for information that has been shared between providers and review the record for use during care. Taking time to review the record could prevent the need to explain an adverse outcome that may have been

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Physician, Heal Thyself – and Thy Patient in the Process



By Steven Wengel, MD

Allow me to introduce myself. I am an Omaha native and graduate of UNL and UNMC. I am a geriatric psychiatrist and have worked at UNMC for all of my 27-year career. I've been intrigued by the beneficial effects of interventions like exercise, mindfulness, and meditation on reducing stress for many years.

I have been practicing a 10 minute per day meditation technique called the "Relaxation Response" developed by Herbert Benson, MD, at Harvard off and on for many years as a way of managing my own stress. I now have been given an opportunity to use this longstanding interest in stress and stress management in my new role at UNMC. As of February 2018, I have been serving as UNMC's first assistant vice chancellor for campus wellness. In this role, I've been charged with developing and overseeing UNMC's wellness activities for our students, residents, and faculty physicians, as well as other members of our campus in other disciplines. As part of my job, I keep track of new research on topics like physician burnout and depression. As you will probably agree, you can hardly pick up a medical journal or newsletter without seeing an article on burnout.

By now, I suspect every physician reading this is very aware of the epidemic of burnout amount in our ranks. You probably already know that research by the Mayo Clinic reports that 54% of U.S. physicians report at least one symptom of burnout, and you may well know that there are an estimated 300-400 physician suicides each year, or roughly one per day. Burnout is a work-related syndrome characterized by symptoms of emotional exhaustion, low sense of personal accomplishment, and depersonalization (i.e., treating others in a dehumanizing way such as referring to patients by their diagnosis instead of their name). One point to clarify is that burnout itself is not considered a mental illness — it's a work-related phenomenon. It's also not a sign of personal weakness or personal failing. Burnout, though, has been linked to a

number of serious complications to physicians themselves, including depression, substance abuse, reduction in work hours/early retirement, relationship problems, and sometimes tragically, suicide.

What you may not be as aware of, however, is burnout's effects on our patients. Intuitively it makes complete sense that a physician (or nurse, for that matter) who is experiencing burnout would not be as attentive to their patients' needs as one not suffering from burnout. The science on this would corroborate that sense.

A study published in 2010 looked at the relationship between burnout symptoms and medical errors in U.S. surgeons. For every one-point increase on a depersonalization scale there was an associated 11% increase in likelihood of the surgeon reporting a medical error. More recently, a meta-analysis published in JAMA Internal Medicine in September reviewed 47 published studies, which included surveys of 47,000 US physicians. The results were sobering, if not surprising. Physician burnout was associated with a two-fold risk of patient safety incidents, poorer quality of care due to low professionalism, and reduced patient satisfaction. Burnout has also been associated with unnecessary test ordering, lower patient compliance with treatment, longer recovery time after discharge, and even increased patient mortality.

Nurses, of course, are not immune from work-related stress and burnout either. About one-fourth of nurses working in emergency departments experience burnout, about the same proportion of ICU nurses testing positive for post-traumatic stress disorder. Other studies of oncology nurses put their burnout rates at 30-35%. Nursing burnout has been associated with increased turnover, higher risk of sharps injuries, lower patient satisfaction, and higher rates of hospital-acquired infections.

Clearly, stress and burnout in health care professionals is a major problem, and appears to be growing over time. The big question, obviously, is what can be done? That is complicated, but I personally like the three-fold strategy employed by Stanford University, where they focus on 1)

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What Nebraska is Doing to Reduce HAIs and Antimicrobial Resistance

By Maureen Tierney, MD, MSc.

Head of the Healthcare Associated Infections/Antimicrobial Resistance Program, Epidemiology and Informatics Unit, Nebraska DHHS

bout 10 years ago the CDC began funding offices within each state dedicated to reducing the incidence of health care associated infections (HAIs). The effort and the funding expanded dramatically after the infection control breakdowns that were considered responsible for the transmission of Ebola to two nurses in Dallas in 2014. The Nebraska DHHS HAI/AR (Healthcare Associated Infections and Antimicrobial Resistance Program) has grown from a half time physician (me) in 2013 to a program of the 10-12 full or part time professionals based either at the state DHHS office or via subawards with Nebraska Medicine or CHI. Our overall goals are to decrease HAIs, antimicrobial resistance, and CDI in Nebraska by creating, supporting, or partnering with the following efforts.

Nebraska's HAI Program works with public health partners to reduce HAIs and AR by:

- Monitoring the numbers of HAIs to help facilities reduce these types of infections
- Performing surveillance on antimicrobial susceptibility date to detect resistant organisms or outbreaks earlier
- Supporting programs (with CDC funding and partnering with) that encourage the correct use of antibiotics to decrease antimicrobial resistance and side effects
- Assessing and supporting infection control practices at health care facilities by supporting and partnering with the ICAP Program
- Providing public education
- Providing education to health care professionals
- Implementing a Safe Injection Program
- Participating in CDC's Making Dialysis Safer Campaign

The HAI/AR program activities can be viewed in full by visiting the website which has sections both for the public and healthcare providers.

http://dhhs.ne.gov/publichealth/HAI/pages/Home.aspx

There are specific resources and education programs for health care professionals in several areas including:

HAI Reporting and NHSN Validation-

- Validates NHSN reporting from facilities
- Provides mentorship to infection preventionists about NHSN reporting
- Collaborates to create solutions to reduce higher rates of HAIs
- Holds quarterly calls with infection preventionists around the state

In Outbreak Detection and Management-

- Manages antibiotic data registry to detect novel resistant organisms and identify clusters
- Collaborates with the Nebraska Public Health Laboratory
- Advises local health departments on identifying and managing HAI outbreaks
- Advises health care facilities on how to report CREs and what to do about colonization testing around a case patient: CRE Investigation Response Guidelines
- More specific guidance on CRE management can be found on the website.
- Advises health care facilities and local health departments on investigating surgical site infection (SSI) outbreaks using the following tools: Nebraska SSI Outbreak Response Guidelines 2018 and SSI Outbreak Investigation Line List Template

Antibiotic Stewardship

Nebraska DHHS supports antibiotic stewardship to decrease antimicrobial resistance by encouraging the correct use of antibiotics. There are three major stewardship efforts ongoing in the state independent of specific institutions. Nebraska Medicine and CHI facilities have developed their own excellent stewardship programs.

Nebraska Antimicrobial Stewardship and Assessment Program (ASAP) is a program based at Nebraska Medicine and supported by Nebraska DHHS through our CDC

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Patient Safety & The PDMP



By Senator Sara Howard, Legislative District 9 Chair of Health & Human Services Committee

very day, more than 115 people in the U.S. die after overdosing on opioids. Nebraska, and many other states, are working to address opioid misuse, abuse, and overdose. We now know the great consequences of excessive

opioid prescribing and its direct impact on patient safety. During my time in the Nebraska Legislature, one of my many priorities is to lead the charge to address this opioid epidemic.

So that is precisely what I have done. In 2016, I brought legislation to improve Nebraska's prescription drug monitoring program (PDMP), operated by the Nebraska Health Information Initiative (NeHII). NeHII is the secure, online, web-based Health Information Exchange (HIE) for the state. The Nebraska Department of Health and Human Services, along with NeHII, have been awarded federal grants that have allowed the PDMP information to be accessed at no cost to the state, prescribers, and dispensers. Under LB 471, I outlined two phases. First, on January 1, 2017, all controlled substances dispensed in our state were required to be reported to the PDMP. The second phase began on January 1, 2018 and requires all prescriptions to be entered into the system.

For prescribers to have access to all prescriptions and controlled substances dispensed is a tremendous win for patient safety. The prescriber is now looking at a complete image of the patient, his/her prescription history, and timeframes. By providing this necessary information, it allows physicians to get a complete picture of the history and current need. By accessing the PDMP when

considering prescribing an opioid, prescribers are able to determine if this patient is at risk for addiction, is doctor-shopping, or is in genuine need of an appropriate amount of opioids to address acute pain.

The most recent legislative priority to address patient safety was an opioid package I introduced and prioritized, which was passed by the Legislature last year: LB 931. This opioid package was a series of bills introduced by myself, Sen. Lindstrom, and Sen. Kuehn. This bill prohibits medical practitioners from prescribing opioids for more than a seven-day supply for patients under the age of 18, unless the practitioner documents the medical condition that necessitates a greater quantity, is associated with a cancer diagnosis, or is necessary for palliative care.

It also requires practitioners to have necessary conversations with patients about the risks of addiction and overdose when receiving the first and third opioid prescription. We may take for granted that many physicians are having these critical conversations prior to this legislation. However, this legislation ensures that no patient slips through the cracks and is unaware of the serious effects of these drugs. Due to the changing nature of medicine, LB 931 sunsets on January 1, 2029, for the Legislature to reevaluate if these statutes align with current practice.

Moving forward, I will continue to champion the cause for patient safety by ensuring the PDMP is properly funded and prioritize protecting patients from addiction and overdose from potential over-prescribing. Nebraska's PDMP is an integral part of the physician-patient relationship and can play a vital role in protecting patients from risks of addiction and overdose when utilized.

CDC/NCHS, National Vital Statistics System, Mortality. CDC Wonder, Atlanta, GA: US Department of Health and Human Services, CDC; 2017. https://wonder.cdc.gov.

Writing a Better Future by Empowering Patients to Be Equal Partners in Health Care

By Evelyn McKnight

ealth care is generally safe and provides quality care to thousands of Nebraskans in a variety of settings. We are fortunate that medical advancements can help us enjoy longer, healthier, and more fulfilling lives. However, we must admit that medical error happens, causing unnecessary pain, suffering, and malpractice litigation.

In 2000, I was diagnosed with breast cancer. It took all the energy I had to come to our local clinic for treatment. I had no idea that syringes were being reused and saline bags were being used improperly. To my dismay, I was one of the 99 people in Fremont, Nebraska, who was infected with hepatitis C in 2001 while undergoing treatment for cancer. For a description of the outbreak from a patient, medical and legal perspective, see the book that I co-authored with Travis Bennington: A Never Event: Exposing the Largest Outbreak of Hepatitis C in American Healthcare History.

With the hope that no American would have to go through what my 98 fellow Nebraskan and I did, I have devoted myself to patient safety education and outreach. I am particularly proud of our work on the Safe Injection Practices Coalition (SIPC), which is led by the CDC and the CDC Foundation. Through this work, we designed the ongoing "One and Only Campaign" to empower patients and re-educate health care providers regarding safe injection practices.

Empowering patients to ask questions fosters a patient/ physician partnership, improves patient care, and reduces medical error and cost. There are many materials on injection safety for patients and providers on the One and Only website. On the page What to ask Healthcare Providers, patients are urged to ask health care providers this question before an injection: "Will there be a new needle, new syringe, and new vial for this injection?"

There are other worthwhile resources on the web that you can recommend to your patients that encourage good communication and adherence. The National Patient Safety

Foundation has developed three core questions that summarize the content of the patient visit. The Ask Me 3 questions are:

What is my main problem?

What do I need to do?

Why is it important for me to do this?

The Agency for Healthcare Quality and Improvement has a robust website with guidance for patients on communication with physicians. The "Questions to ask your Doctor" page provides questions to ask before the patient visit, during the visit and after the visit. The discussion that follows from these questions builds trust and leads to better results, quality, safety, and satisfaction.

I wish I had had these tools to communicate with my physician when I was diagnosed with breast cancer 18 years ago. I believe that many fewer patients would have been infected with a deadly disease if I had asked the doctor or the nurse "Will there be a new needle, new syringe, and new saline bag for this infusion?"

We can't change the past, but we can write a better future. I urge you to empower your patients to be equal partners in improving health care by providing resources that provide useful questions.



Patient Safety in Outpatient Clinics: It's Not Just for Hospitals (continued)

avoided in the first place.

Just Culture is another method to improve patient safety in outpatient clinics. Most hospital administrators, nurses, and staff understand the meaning of Just Culture, including the process and benefits of the program, but outpatient clinicians and staff are not as familiar with these concepts. Learning and understanding Just Culture empowers health care providers at all levels to report patient safety issues, study them, determine the best course of action for improvement, and to implement new procedures. Improving patient safety in all health care settings helps our patients receive the best care possible.

These are just a few of the patient safety concerns identified through study and research, and most of these are relatively inexpensive to implement in the outpatient clinic, especially when one recognizes the time it takes to manage each of the adverse outcomes. These also

only represent the tip of the iceberg when we look at the opportunities that exist. But these can also set the tone for future changes.

Physicians cannot do this alone. It takes the work of all practitioners and staff, as well as our patients and families, and other community resources to improve patient safety. As physicians, we can be leaders and advocates for improved health care for all Nebraskans.

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The Joint Commission. National Patient Safety Goals: Ambulatory Health Care Accreditation Program.

American College of Physicians. Patient Safety in the Office-Based Practice Setting. Philadelphia: ACP; 2017 Position Paper

Physician, Heal Thyself – and Thy Patient in the Process (continued)

improving individual resilience; 2) creating a culture of wellness; and 3) improving efficiency of practice. I also like what Christine Sinsky, MD, an internist and AMA's vice president of professional satisfaction, has to say. She is a strong advocate for 20% of any interventions to be targeted at individual physicians (e.g., by resilience-enhancing activities such as mindfulness, meditation, etc.). This, of course, leaves 80% of the work to be done at the

systems level, as most of the drivers of burnout stem from things outside of the individual, such as administrative burdens associated with modern medical care rather than the intrinsic challenges of the work. This is clearly a "work in progress" but I am encouraged by some new initiatives coming down the pike from the AMA and other national physician advocacy groups. Stay tuned.

Necrology

Russell E. Beran, MD Omaha, NE 12/11/2018

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MD Omaha, NE 11/1/2018 Robert B. Synhorst, MD

Lincoln, NE 10/22/2018

August E. Van Wie, MD Grand Island, NE 12/1/2018

What Nebraska is Doing to Reduce HAIs and Antimicrobial Resistance (continued)

grant. ASAP provides guidance to facilities to help develop antibiotic stewardship programs. ASAP develops tools to assist in development of stewardship programs through its website, presentations, and its YouTube channel.

MDStewardship is a group of Omaha-based infectious disease doctors who provide telestewardship to remote institutions. These services may be available to some rural critical access hospitals on a scholarship basis from DHHS or hospitals may consult with them privately. Great Plains Quality Innovation Network (GPQIN) promotes antimicrobial stewardship through two programs, one in outpatient settings and one in long-term care facilities.

Other efforts include a Safe Injection Program. Nebraska DHHS is funded by CDC to recruit and train injection safety champions at every location in Nebraska where injections and IV infusions are administered. We have developed a safe injection course in conjunction with the CDC which provides free CME. The Infection Control Assessment and

Promotion Program (ICAP) provides voluntary confidential assessments and guidance to improve infection control quality at different types of healthcare facilities around the state. The program is supported by a grant from the CDC and is based at Nebraska Medicine. The Making Dialysis Safer Campaign (CDC)is a partnership of organizations and individuals working to prevent dialysis bloodstream infections that Nebraska was invited to be a part of.

Additional HAI Program Partners

Nebraska's HAI Program coordinates and HAI Advisory
Council that meets quarterly with stakeholders. The
program also collaborates with the following organizations:
Nebraska Hospital Association, Greater Omaha APIC,
Nebraska Healthcare Association, and the Nebraska
Infection Control Network, among others. The Healthcare
Associated Infections Program routinely shares its work with
others across the nation.

New Members

Columbus

Andrew Baldwin, MD Amanda Wilson, DO

Council Bluffs, IA

Rohini Garq, MBBS

Fremont

Patty Terp, MD

Gothenburg

Garret Shaw, MD

Grand Island

Marcus Kirkpatrick, MD

Kearney

Kyle Myers, MD Scott Wewel, MD

Lincoln

Scott Akin, MD

Heidi Barker, DO Bryan Beals, MD

Carlos Calisto Perez, MD

Michael Clare, MD

Behzad Elahi, MD

Trevor Gregath, MD

Quinton Kelly, MD

Andrew Moellering, MD

Julie Overcash, MD

Ali Piper, MD

Humaira Qasimyar, MD

Alexander Ryan, DO

Kelsey Shaver, MD

Wes Whitten, MD

Matthew Wittry, DO

Norfolk

Ray Heller, MD

North Platte

John Eitzen, MD

Offutt AFB

William Pryor, MD

Omaha

Conner Beyersdorf

Dwight Bollinger, MD

Tom Carroll

Eric Daubach

Melissa Davison

Taylor Doescher

Jeffrey Ebel, MD

Harrison Greene

Megan Hunke

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Paige Phillips

Allyson Pietrok

Anna Ripp

Drew Thompson

April Vonderfecht

Paul Witt

Papillion

Sajan Mahajan, MD

Scottsbluff

Brittany Folks, MD

Jason LaTowsky, MD

Luke Sittner, DO

South Sioux City

Melissa Austreim-Krell, MD

Tecumseh

Nicole Turner, MD

Ask a Lawyer

Record Retention¹

recently joined a pediatric practice that has been active in my community for 40 years. The practice has been busy, and it looks like nothing has been thrown away. As the "new doc on the block," the job of dealing with

the practice's old records (both patient and business records) is now "all mine." Where

should I start?

Congratulations on beginning your practice! My sympathies on this new "records management" job. Your question, "Where to

start?" raises another: "Paper or plastic?" meaning, "Are we talking about paper records or electronic records?" Assuming the bulk of the practice's old, inactive records are paper, here is where I would start and how I would approach getting the paper-side of your records management job started.

1. Is the practice storing the records off-site? If so, start there first, especially if the practice is paying to store the records or if the storage location may be a potential liability "time-bomb."

Dealing with off-site, paid storage and possibly eliminating or shrinking an office expense is obviously a good thing. Addressing potential liability "time-bombs" including storing old records in commercial storage lockers not operated by a professional records management company, locked garden sheds at a physician's home, old farm sheds on hunting land, and the like may save the practice's reputation and its physicians' professional licenses. It may also help avoid an expensive, practice-killing HIPAA breach.

2. Next, determine the types of records involved. Patient records? Business records? Or both? For patient records:

Since yours is a pediatric practice, we recommend the following retention periods: For persons under the age of 21 when the professional service was provided, the later of the date of service ("DOS") plus 10 years or the date the patient would turn age 25. Neb.Rev.Stat. §§ 25-213 and 25-222. Note that the age of majority in Nebraska (age 19) does not apply in deciding how long to retain a patient record. For practices that serve both adults and children,

we recommend DOS plus 10 years for persons age 21 or older when the professional service was provided and following the record retention period for patients under the age of 21 as stated above.

3. Next, review what business records the practice has like old payer contracts, office machine leases, office leases, partnership or corporation documents, and the like.

The focus here is whether the records are still active or whether they have been replaced by another business record. All information related to contracts or agreements that the practice currently has in effect should be stored in the practice's office. Documents such as old contracts or letters and other writings (email) which are part of or related to a contract, such as amendments or addenda, or which are important clarifications of a contract or agreement, should be retained for as long as the contract is in effect plus at least 6 additional years after it expires or is terminated. Neb. Rev. Stat. § 25-205 (statute of limitations — written contracts).

For example, you have a payer contract that expired and was replaced by another agreement over 10 years ago. That old payer contract can be discarded.

Another example, you find an employment agreement for a physician who was hired 10 years ago and is still at the practice. That agreement should be retained with the other personnel records related to the physician until the physician leaves the practice plus at least six years after. If the employment agreement is replaced with a new employment agreement signed by the physician, retain the superseded employment agreement for at least six years and then discard.

Example #3: Your practice had its corporate documents (articles of incorporation, bylaws, and Buy-Sell) "overhauled" last year by the practice's attorney. You find the set of corporate documents that were replaced last year. What should you do? We recommend that you wait for at least six years to pass before you dispose of the prior set of corporate documents.

Ideally, a physician office should have a policy about what records are created or maintained by the practice,

(continued on Page 18)

Physician Review Sites

Exercise caution and restraint in dealing with negative online comments

By COPIC's Patient Safety and Risk Management Department

With the prominence of social media and websites that offer customer reviews, there are endless opportunities for sharing one's opinions. However, the legitimacy of these opinions and making decisions based on them can be a charged discussion, especially when it comes to medical care. For physicians, negative reviews can be frustrating because of concerns about how these may impact patient satisfaction scores or may not reflect the actual care provided. There is reason to be concerned. A recent Mayo Clinic Proceedings study¹ showed that non-physician variables—such as interactions with desk staff, appointment access, waiting time, and billing—can appear to reflect unfairly on negative physician reviews.

According to a 2014 JAMA article¹, nearly 20% of surveyed patients said that physicians' ratings on websites are very important, and 40% said the websites are somewhat important, when looking for a primary care physician. Of those who used the web to search for physicians, 35% say they picked a doctor based on good ratings, while 27% reported avoiding those with bad ratings. While you can't control what is posted, you can control how you react and take steps to deal with this issue.

A January 2016 *Medscape* article² titled, "Trashed on the Internet: What to do Now" offered this advice regarding physician review sites:

- Recognize that negative reviews can happen to any physician.
- Most review sites allow you to submit a complaint if you believe a comment is fraudulent; they may be able to track down the IP address of the reviewer and, if the post is illegitimate, remove it.
- Reviews that sound irrational to you are likely to sound irrational to others.

- Many reviews focus on a Better Medicine Better Lives provider's indifference,
 bedside manner, or customer service rather than his or her medical skills. Consider these types of comments as opportunities to improve your practice.

Other actions to consider when monitoring your online reputation:

- On a regular basis, do a search on your name and/or the name of your practice to see what comes up.
- Set up Google Alerts (www.google.com/alerts) for your practice name and the names of your physicians.
- If you are listed on a physician review site, review your profile to make sure the information is up-to-date and accurate.
- Some review sites provide resources to help encourage your patients to post reviews. For example, Healthgrades offers postcards to give to patients that include a personalized link they can use to complete a survey about you.

Some Popular Online Physician Review Sites:

www.healthgrades.com www.vitals.com www.ratemd.com www.yelp.com www.angieslist.com

- 1. JAMA. 2014;311(7):734-735. doi:10.1001/jama.2013.283194
- 2. http://www.medscape.com/viewarticle/851005

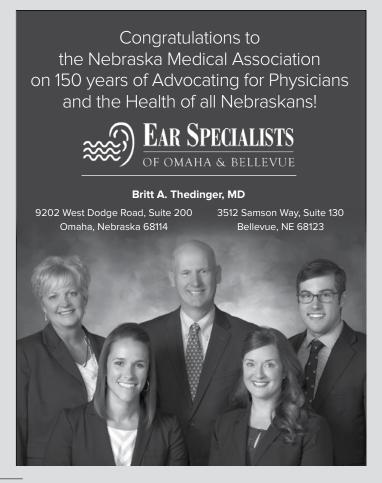
Ask a Lawyer (continued)

where they are stored, how they are secured and protected from destruction or tampering, and how they can be accessed and retrieved when needed. Your records management policy should describe how records will be destroyed and how you will document the destruction of those records. To maintain confidentiality and to comply with applicable privacy laws, shredding of paper records is strongly recommended.

Next time, we will address some additional records retention questions and records management generally.

 Portions of this article were originally published in March 2014; Updated and revised, December 2018. Ask a Lawyer is a regular feature of Nebraska
Medicine. If you have a legal question of general interest,
please write the Nebraska Medical Association. Answers
to your questions will be provided by the Nebraska
Medical Association's legal counsel, Cline, Williams, Wright,
Johnson & Oldfather, L.L.P., 1900 U.S. Bank, 233 South 13th
Street, Lincoln, Nebraska 68508-2095. The answers in this
issue were provided by Jill Jensen of the Cline Williams
Law Firm. Questions relating to specific, detailed and
factual situations should continue to be referred to your
own counsel.

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Should I Worry About Inflation?

BRAD REMPE, CFP®, AIF®, Lead Advisor

When the prices of goods and services increase over time, consumers can buy fewer of them with every dollar they have saved. This erosion of the real purchasing power of wealth is called inflation. Inflation is an important element of investing. In many cases, the reason for saving today is to support future spending. Therefore, keeping pace with inflation is a crucial goal for many investors.

To help understand inflation's impact on purchasing power, consider the following illustration of the effects of inflation over time. In 1916, nine cents would buy a quart of milk. Fifty years later, nine cents would buy only a small glass of milk. And more than 100 years later, nine cents would buy only about seven tablespoons of milk. How can investors potentially prevent this loss of purchasing power from inflation over time?

INVESTING FOR THE LONG TERM AND OTHER "TIPS"

As the value of a dollar declines over time, investing can help grow wealth and preserve purchasing power. Investors should know that, over the long-haul, stocks historically have outpaced inflation, but there also have been stretches where this has not been the case. For example, during the 17-year period from 1966–1982, the return of the S&P 500 Index was 6.8% before inflation, but after adjusting for inflation, it was 0%. Additionally, if we look at the period from 2000–2009, the so-called "lost decade," the return of the S&P 500 Index dropped from –0.9% before inflation to –3.4% after inflation.

Despite some periods where stocks have failed to outpace inflation, one dollar invested in the

S&P 500 Index in 1926, after accounting for inflation, would have grown to more than \$500 of purchasing power at the end of 2017, and would have significantly outpaced inflation over the long run. However, the story for US Treasury bills (T-bills), is quite different. In many periods, T-bills were unable to keep pace with inflation, and an investor would have experienced an erosion of purchasing power. After adjusting for inflation, one dollar invested in T-bills in 1926 would have grown only to \$1.51 at the end of 2017.

While stocks are more volatile than T-bills, they also have been more likely to outpace inflation over long periods. The lesson here is that volatility is not the only type of risk that should concern investors. Ultimately, many investors may need to have some of their portfolio in growth investments that outpace inflation to maintain their standard of living and grow their wealth.

CONCLUSION

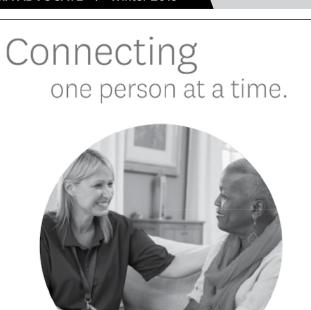
Inflation is an important consideration for many long-term investors. By combining the right mix of growth and risk management assets, investors may be able to blunt the effects of inflation and grow their wealth over time. Remember, however, that inflation is only one consideration among many that investors must contend with when building a portfolio for the future.

The right mix of assets for any investor will depend upon that investor's unique goals and needs. At Foster Group we help our clients weigh the impact of inflation and other important considerations when preparing and investing for their future.

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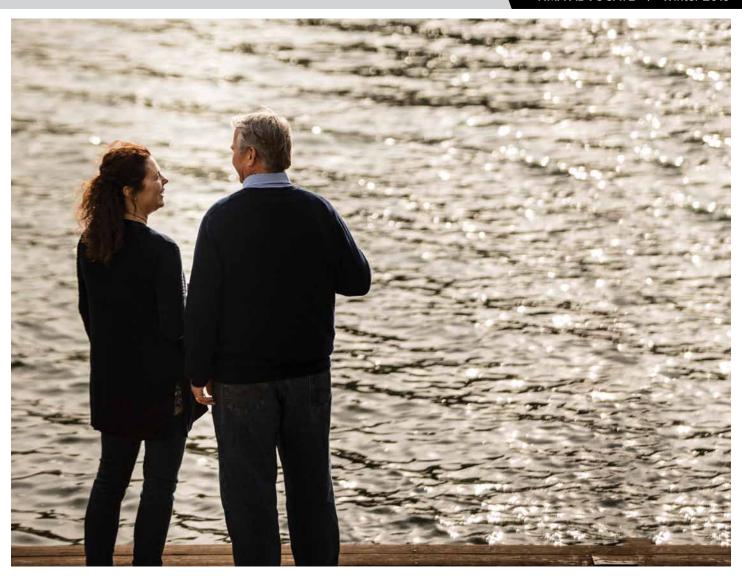
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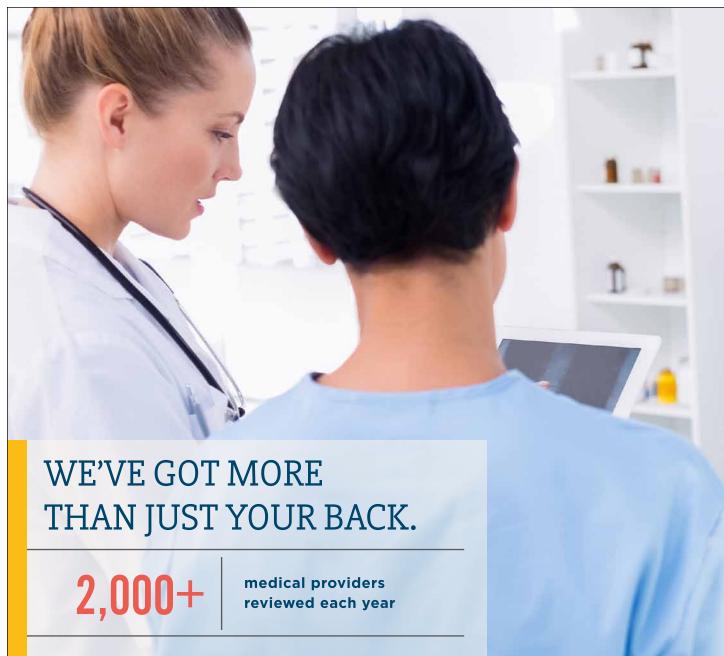
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