

ACCESS

Newsletter of the Nebraska Office of Rural Health,
Nebraska Department of Health & Human Services,
Division of Public Health
and the Nebraska Rural Health Association
for all rural health stakeholders

Issue 53, February 2009

NOTICE TO OUR READERS

Dear Reader:

Some changes: The ACCESS newsletter has also been available for almost two years at the following web site: www.dhhs.ne.gov/orh. Back issues are also available on this site.

We have been asked to make all newsletters available in electronic versions. Our next issue will follow these guidelines. As part of our shift to the digital world we are asking you to now subscribe to our electronic newsletter. The information is below.

If you do not have Internet access, we still want you to be able to receive our newsletter. Please send us the back page of the newsletter (a photocopy is fine) with your address label, and a note stating that you don't have Internet access and would like to receive a paper copy. We will do our best to print and mail our next newsletter to you.

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If you prefer, send your e-mail address to Ann.Larimer@nebraska.gov, and we will do this for you. Please e-mail Ann with any questions.

12-lead EKG enables quicker treatment in rural Nebraska area

By David Howe

Medical personnel at the hospital in Hebron have all the information they need to begin appropriate treatment the instant an emergency heart patient arrives by ambulance at the hospital.

That's because the Hebron and Deshler EMT squads serving their south central Nebraska rural communities are equipped with and are authorized to attach 12-lead EKGs linked to a special laptop computer for wireless transmission of the patient's heart rhythm to physicians at the hospital in Hebron while the patient is enroute.

That capability allows the proper personnel, medications and other preparations to be ready and waiting when the patient arrives, explained Thayer County Health Services Hospital CEO Joyce Beck. If necessary, 12-lead data from the rural ambulance service can be transmitted to hospitalists at St. Elizabeth Regional Medical Center in Lincoln, allowing hospital personnel there to provide appropriate treatment immediately upon the patient's arrival. St. Elizabeth Regional Medical Center is the Hebron hospital's network hospital.

This ability to shave precious minutes off the time it takes to initiate treatment of a heart patient after arrival at the hospital comes about through several developments.

The first is a health information technology (HIT) grant under which the hospital at Hebron

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State Hospice Association seeking awards nominations

The state's hospice association, the Nebraska Hospice and Palliative Care Partnership (NHPCP), is seeking nominations for its annual awards program. The awards will be presented at NHP-CP's annual banquet. Held in conjunction with NHPCP's Annual "Living a Good Life...at the End of Life" Conference, the banquet is scheduled for April 8, 2009, at the Embassy Suites in Lincoln.

The Shining Star Award recognizes an individual, group or organization that has done outstanding work in the leadership of end-of-life care in their community or statewide. Nominees should have illustrated outstanding leadership in the promotion of end-of-life services; raised awareness of or educated others on end-of-life issues; developed a new program; or developed or completed outstanding work in an end-of-life coalition.

The Spirit of Hospice Award recognizes individuals that have shown true commitment and outstanding dedication to the hospice philosophy of care. Nominees should have promoted quality hospice care over the last year. They should display openness to the needs of all they have cared for, reverencing the dignity of all areas of diversity.

Outstanding Hospice Volunteer recognition will be given to exemplary hospice volunteers. Outstanding volunteers identified by their hospice programs will be invited to stand and be recognized as their names and hospice programs are announced at the banquet.

Nominations will be accepted through Feb. 20, 2009. Go to nehospice.org to view award details and nomination forms.

NHPCP is a collaborative effort of more than 50 organizations with an interest in good care for terminally and chronically ill Nebraskans. Established as a 501(c)3 community betterment non-profit in 1983, NHPCP includes Nebraska hospices, community end-of-life coalitions, and other health and elder-care organizations. □

MARK YOUR CALENDARS

Rural Health Advisory Commission Meeting
February 20, 2009; 1:30 p.m.
State Office Building, Lincoln, NE
Contact: Marlene Janssen, (402) 471-2337

NE DHHS Public Health Combined Conference - Prevent, Promote, Protect: Working Toward a Healthier Nebraska
April 8-9, 2009 - Cornhusker Marriott - Lincoln, NE
Information routinely updated at www.dhhs.ne.gov/Public_Health/conference

2009 National Rural Health Association Annual Conference
May 5-9, 2009 - Miami, Florida

NRHA Rural Pharmacy Conference
September 9-11, 2009 - Kansas City, MO
www.RuralHealthWeb.org

2009 Nebraska Rural Health Conference
September 17-18, 2009
Holiday Inn Convention Center - Kearney, NE

NRHA: Rural Health Clinic Conference
October 6-7, 2009 - Portland, OR
www.RuralHealthWeb.org

NRHA: Critical Access Hospital Conference
October 7-9, 2009 - Portland, OR
www.RuralHealthWeb.org

NRHA: Minority and Multicultural Health Conference
December 9-11, 2009 - Memphis, TN
www.RuralHealthWeb.org

The 2009 Great Plains TRAC Regional Telehealth Conference Bringing Health Care and Technology Together with Telehealth

July 16-17, 2009 •Park Plaza Bloomington Hotel • Bloomington, MN

This program is specifically designed for individuals directly involved with telehealth activities or planning including: administration, grant writing, information technology, providers, clinical site coordinators, RN's and other clinical personnel.

Conference details and registration form can be found on the Great Plains TRAC website at www.gptrac.org. Contact Great Plains TRAC at contactus@gptrac.org or (888) 239-7092 with any further questions.

<http://www.avera.org/avera/gptrac/edandevents/2009/index.aspx>

EKG *cont'd from p. 1*

and its affiliated partners are implementing a comprehensive HIT system. The grant covered the cost of this latest piece of the system—purchase, training, and integration of 12-lead EKG equipment and “ruggedized” laptop computers (designed to take hard knocks in the field) in the ambulances operated by Hebron and Deshler EMT squads. The grant also covered the cost of equipping the Thayer County ambulance based at Hebron.

This equipment represents a \$25,000 expenditure for each ambulance, according to Wayne Kugel, rescue captain of the Hebron Fire Department Rescue Unit. Hebron and Deshler rescue units would find it difficult to come up with the money for that equipment on their own, he said.

But funding for the equipment and training are only part of the story. Another important step involved a change in licensing by the Nebraska Emergency Medical Services Board. “We had to get special permission from them (the board)” for the EMTs to attach the leads, said Hebron hospital CEO Beck. Prior to the change, only paramedics and

registered nurses were authorized to operate 12-lead EKGs in ambulance transport, according to Dean Cole, EMS program administrator in the Nebraska Department of Health and Human Services. That variance for basic EMTs now applies to all basic EMTs in rural areas of the state, Cole said.

Deshler and Hebron were the first basic EMT ambulance services in the state to utilize the 12-lead EKG system, thanks to efforts by Beck and Dr. Tim Sullivan at the Hebron hospital, Cole said.

Rescue unit captain Kugel at Hebron says training of EMTs on the 12-lead EKG equipment was done by registered nurse Staci Hergott under the guidance of Dr. Sullivan at the Hebron hospital. Training on how to place the leads took about half an hour, followed by another 45 minutes to an hour of hands-on training. The training is for placement of the leads and transmission of EKG data from patient to the receiving hospital. The leads are “really easy to place,” Kugel said.

EMTs are licensed to attach the leads for transmission of

data only. “We do not interpret the EKG,” Kugel said.

In rural areas, where transport times can be long, getting that information to the hospital ahead of the patient’s arrival is especially important, he said. Physicians at the hospital can be prepared with necessary medications and equipment for treatment when every minute counts.

Dan Engle, the Hebron hospital’s director of information technology, said that the defibrillators equipped with 12-lead EKGs and ruggedized laptops for secure wireless communication and training for their use were not available in the U.S. The hospital turned to a European-based company for the equipment and the company’s trainer, who is based in the U.S. That trainer trained the Hebron hospital personnel, who in turn trained the EMTs. The TCHS system’s working in conjunction with rural EMTs using 12-lead EKGs is one of the first in the Midwest, Engle said.

The system includes a PC at the hospital which functions as a server running on software that allows it to receive wireless transmission or e-mail from the ruggedized laptop that transmits data wirelessly from the field, Engle said. The ruggedized laptops are equipped to transmit via cell phone coverage —through Alltel, in this case — to the server at the hospital, making the EKG data available real-time to personnel awaiting the patient’s arrival. The only patient identity in the transmission is age and sex — no patient name. That way, there are no security or privacy issues in the event of, say, data transmitted to a wrong destination or someone intercepting the data in violation of HIPAA law, Engle added.

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In cases where the patient being transferred has a patient electronic health record in the hospital system, that information can be transmitted to the EMTs while en route if necessary.

Kugel said in late December that the Hebron EMTs had used the 12-lead EKG capability seven or eight times since acquiring it in May. It takes about 1½ minutes to place the leads on a patient, he said. Transmitting the data takes roughly another minute.

But what about “dead spots” for cell phone activity that could interrupt the transmission from the field? That could happen, Engle acknowledged. But the software in the special computer onboard the ambulance is designed to automatically re-send the data as soon as the ambulance is out of the dead zone.

Kugel said Hebron’s EMTs have found few dead spots in the Thayer County area that they serve.

He and Engle say that the patient data resulting from the ambulance transmission to the hospital are compatible with E-NARSIS (Electronic Nebraska Ambulance Rescue Service Information System) that the Hebron and Deshler rescue squads adopted several years ago. E-NARSIS generates a run number and record for any patient transported by the EMT squad. That record, which includes the patient’s health information, is available wirelessly to the EMTs in any subsequent transport of that patient.

Engle said an EMT could call in that run number to the hospital at Hebron for a particular patient, which permits E-NARSIS to import that patient’s record from the hospital into the E-NARSIS record for that patient. □

Nebraska Rural Health Plan now available

By David Palm

At its December meeting, the Nebraska FLEX Steering Committee for Critical Access Hospitals approved the Nebraska Rural Health Plan. Although the plan was approved, the public is encouraged to submit comments on the plan until April 1. The plan is available on the Web site of the Nebraska Rural Health Association: <http://www.ne-braskaruralhealth.org>

Limited copies can be obtained by contacting Dave Palm at (402) 471-0146 or david.palm@nebraska.gov. Any comments on the plan should be sent to Dave Palm.

The plan consists of 8 sections. The first section examines the rural and urban differences in achieving the 12 areas (e.g., access to quality health care services, cancer, and heart disease and stroke) that were included in the *Nebraska Rural 2010 Health Goals and Objectives* report.

In general, more progress toward 2010 targets was evident for urban areas, although some improvements were made in rural Nebraska as well. Overall, five objectives were met in the urban counties, while none were met in the rural areas. However, 45 percent of the objectives showed progress in rural areas, compared to only 33 percent in the urban counties. Notable progress in rural areas was made in the following areas: Substance Abuse, Tobacco Use, Heart Disease and Stroke, Injury, and Violence Prevention.

On the negative side, rates for 20 objectives (39 percent) experienced movement away from their 2010 targets in rural Nebraska, while only 29 percent of urban rates did. In rural areas, the categories of Access

to Quality Health Care Services and Cancer had the most indicators where there was movement away from the target.

Health needs in rural areas were also assessed using a more qualitative approach. In August of 2008, staff from the Nebraska Center for Rural Health Research at UNMC and the Nebraska Rural Health Association conducted five focus group interviews across the state. These interviews were designed to collect information from a diverse group of rural health leaders about the major challenges and barriers in providing and obtaining health care services. The participants were also asked to identify some possible strategies that would improve the rural health delivery system.

The focus group interviews identified many challenges and barriers, including:

- The time and distance required to access health care services for many rural residents becomes magnified as gas prices increase.
- Underinsurance is a major problem because many rural residents have purchased high deductible health plans.
- There are severe shortages of many health professionals, including physicians, mental health professionals, nurses, and pharmacists.
- For individuals with mental health problems, medication management is a major concern because of the high costs and the lack of mental health providers to monitor them.
- Many EMTs have full-time jobs, which makes it difficult to provide services during the day.
- It is difficult to recruit dentists to small communities because of the huge expense of buying

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Health Plan *cont'd from p. 4*

new equipment.

- Part D Medicare has had a negative impact on rural pharmacies.
- Electronic health records need to be more affordable and exchangeable.

Several participants also suggested some potential solutions to address the challenges and barriers. These solutions included:

- Options should be explored to pay the federal and state income tax for participants in the state loan repayment program.
- Some organization or agency (e.g., county government) should be responsible for the effectiveness of the EMS system.
- Health care should be viewed as a state economic driver and

an integral part of economic development activities.

- Greater support is needed for Area Health Education Centers (AHECs) to continue rural rotations.
- The telehealth network should be used more effectively for both education and consultation.
- There should be a greater focus on prevention and better coordination with primary care.
- Medical centers should place a greater focus on interdisciplinary training and a team-oriented approach, especially in the area of behavioral health.
- Medical centers should create more rural training sites to expose more practitioners to rural practice. Consideration should be given to expanding the Rural Health Opportunities Program (RHOP).
- Greater support is needed to

pay for the cost of training and travel for EMS volunteers.

There are several other sections of the Plan. Section 2 examines the major factors that impact the rural health care delivery system (e.g., demographic, health information technology, pay-for-performance, and managed care). In Section 3, major changes in the use of Critical Access Hospitals (CAHs) (e.g., trends in utilization, changes in the number and types of services, trends in patients bypassing CAHs) are described. The fourth section analyzes Critical Access Hospital performance by examining financial and quality indicators. Sections 5 and 6 examine the challenges facing the EMS system and the shortage of health professionals. Both sections also contain recommendations. Section 7 describes the attributes

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2009 Nebraska Public Health Conference

Prevent, Promote, Protect:

Working Toward a Healthier Nebraska

save the Date!

**April 8 and 9, 2009
Cornhusker Marriott Hotel
Lincoln, Nebraska**

Reaching Out To...Public and allied health professionals, mental health practitioners, social workers, environmental health specialists, dietitians, nurses, physicians, health educators and advocates, behavioral health practitioners, and others interested in the well-being of Nebraskans.

Sponsored by: Nebraska Department of Health and Human Services, Nebraska Minority Public Health Association, Public Health Association of Nebraska, and The Center for Biopreparedness Education, Creighton University.

Engaging two-day program! Dynamic national speakers!

**Information routinely updated at www.dhhs.ne.gov/Public_Health/conference
Conference schedule and registration will be available on this site by mid-February**

Ronald Cork receives AHA's Shirley Ann Munroe Leadership Award

Ronald Cork, president and CEO of Avera St. Anthony's Hospital in O'Neill, Nebraska, was the 2008 winner of the American Hospital Association's (AHA) Shirley Ann Munroe Leadership Award. The award recognizes the accomplishments of small or rural hospital leaders who have improved health care delivery in their communities through innovative and progressive efforts.

Cork has been president and CEO of Avera St. Anthony's Hospital for 17 years and has 29 years of health care management experience. Avera St. Anthony's Hospital is a 25-bed Critical Access Hospital serving a large rural area in northeastern Nebraska. During his tenure, Cork collaborated with the community to create outreach programs and with hospital staff to develop health care services and expand access for people in the area.

Recognizing the importance of community collaboration in efforts to expand health care services, Cork worked with a committee to obtain a grant providing public transportation for seniors and people with disabilities. Called the Avera Hand-i-van,

the program was so successful that two additional vehicles were added to the service. The hospital also hosts an annual Health Fair, which recently served 1,500 people, focused on screening and preventive health care. Additionally, Avera St. Anthony's sponsors programs for children through the Safe Kids Chapter, which provides free bike inspections, helmets and child passenger safety seat checks.

Additionally, Cork worked to ensure Avera St. Anthony's Hospital was stronger and better able to meet the needs of the community through a major hospital renovation in 2002. Programs expanded at the time included outpatient clinics, a kidney dialysis unit, dietary services, business office and admissions areas, cardiac rehabilitation, oncology and rehabilitation services. The services improve local access to care and reduce transportation time and costs for patients. Cork was recently successful in recruiting to the hospital an orthopedic surgeon and a physician's assistant to provide valuable sports medicine and joint replacement care to the

community. Cork also oversaw the opening of the first eICU (electronic intensive care unit) bed in Nebraska, giving intensive care unit patients constant, around-the-clock care in the rural setting and close to home. Currently, the hospital is reviewing plans for another major renovation to further expand services, including a medical office building and a new emergency department.

In addition to his work at Avera St. Anthony's, Cork is involved in several community organizations. Cork is a charter member and secretary of the Rotary club and serves on the O'Neill Housing Committee; recently, he received the Chamber of Commerce Ambassador Award for his efforts in bringing new business enterprises to O'Neill. Cork received a master's and a bachelor of art's degree in business education at the University of South Dakota in Vermillion.

Shirley Ann Munroe Award. Shirley Ann Munroe was an advocate for small and rural hospitals and was instrumental in the creation of the AHA's Section for Small or Rural Hospitals, a forum working to support small and rural hospitals as they improve their community's health.

The award is sponsored by the AHA's Section for Small or Rural Hospitals and the Health Research and Educational Trust (HRET). It is presented annually to a hospital administrator or chief executive officer who has displayed outstanding leadership in meeting the ongoing challenge of small or rural hospital management. Last year's award recipient was Brian Shockney, president and CEO of Memorial Hospital in Logansport, Ind.

For more information, contact: Elizabeth Lietz at (202) 626-2284 or Matthew Fenwick at (312) 422-2820. □

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of a desirable rural health system and the changes that are needed to build an efficient and effective rural health care system. Finally, Section 8 identifies the changes that are needed in the short-term to begin the transformation to a high performance rural health care system. This transformation includes more effective use of new technology such as telehealth consultation, electronic prescribing of medications, and home monitoring devices. It should also include better integration of primary care services with public health and mental health. Finally, the new rural health care system must continue to transform its culture and identify new measures and processes that will make the system more accountable to both patients and policymakers.

During the next year, the FLEX Steering Committee will continue to refine this new rural model of delivering health care services and the changes that are needed to strengthen and transform the rural health care system. Also, future newsletter articles will describe many of the other sections of the plan, and the progress that has been made in building a high performance rural health care system. □

Behavioral Health Information Exchange: a Continuum of Care

Wende Baker

The Southeast Nebraska Behavioral Health Information Network, Inc. is spearheading the development and implementation of a Health Information Exchange among behavioral health providers in southeast Nebraska.

The recent award of two grants will help create an electronic communication system to share patient information among behavioral health providers, primary care physicians, rural and urban hospitals, and the emergency behavioral health system.

A \$540,000 Rural Health Network Development grant from the Health Resources and Services Administration to Blue Valley Behavioral Health launched the development of the rural portion of the health information exchange.

Recently, the Agency for Healthcare Research and Quality announced the award of a \$1.2 million grant to develop a the health information exchange linking three major providers: the Lincoln/Lancaster Mental Health Crisis Center, BryanLGH Medical Center psychiatric and behavioral health services and Blue Valley Behavioral Health. It is intended that the initial pilot will be expanded to include all of the behavioral health providers in southeast Nebraska.

"The development and implementation of an integrated behavioral health information and data management system will greatly improve care coordination for consumers moving between behavioral health providers in urban and rural areas," said Ken Foster, president of the behavioral health information network and vice president for regional development and strategic planning for BryanLGH

Health System.

Currently, without electronic communication, behavioral health providers are unable to follow the entire treatment path of patients from mental hospitals, protective custody or crisis mental health holds to providers in community settings. As patients transition between primary care providers, mental health providers and inpatient providers, crucial gaps in information may take time to resolve, during which time, patients' problems can become more serious.

"Lack of continuity of treatment puts at risk the safety, quality of treatment and recovery of those most in need of on-going behavioral health care services and demonstrates the case for an electronic continuum of care," said Wende Baker, the network's director. "

The development of the Health Information Exchange for the region will create appropriate and timely access to patient information among the members of the provider care team serving an individual with a mental illness. Although the initial service area includes southeast Nebraska, the possibility exists that the behavioral health system could be used statewide.

Based on national standards, the network is creating the integrated technology and infrastructure to facilitate interoperability. The exchange will:

- Allow for real-time viewing of client information, facility tracking and reporting on clinical indicators, performance indicators, and quality assurance indicators.
- Define standards for data sharing, protection of data, and business practices to create a culture of client safety; develop and assure provider adherence

to the principles and standards for the technical and policy aspects of information sharing.

- Create a standardized system for client placements that can be effectively and efficiently employed to adequately manage and update the waiting and referral lists among facilities, reduce duplication and remove consumers who have entered care in other facilities.
- Improve the emergency protective custody referral process and decrease medication errors.

The network is a consortium that represents a broad cross-section of participants and all aspects of behavioral health care in southeast Nebraska including service providers such as Blue Valley Behavioral Health; BryanLGH Medical Center; Community Mental Health Center of Lancaster County; Heartland Health Alliance; South East Rural Physicians Alliance; Region V Systems; area substance abuse treatment providers; and behavioral health consumers. For more information, contact Wende Baker at **wbaker@region5systems.net** □

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If you have any questions, please e-mail Ann.Larimer@nebraska.gov.

Rural Health Clinic "Bits and Pieces"

**By Janet Lytton,
Director of Reimbursement,
Rural Health Development**

Some key points were raised at the NARHC Annual Conference in St. Louis that may be beneficial for Nebraska's Rural Health Clinic operations.

Bill Finerfrock, executive director NARHC, gave an update on the new regulations that CMS has proposed. Many comments were received about the regulations and are currently under review. Thanks, to all of you who sent comments because this is the only way that the RHC community can get its voice heard. Finerfrock thinks that it will likely be at least four months before we get any indication as to how CMS is going to proceed.

Finerfrock is still lobbying to get the Independent RHC capped rate increased to \$92 per visit. He also verified that the capped rate for 2009 will be \$76.84, a 1.6 percent increase. The redesigning of the shortage areas has been put on hold as there were so many comments submitted on the proposed changes that CMS has said they are going to go back to the drawing board.

It is now close to the end of the year for many of our RHCs, and this means cost reporting. A few things to remember are:

1. Count visits correctly. Count all face-to-face encounters for all payer classes.
2. Keep or produce a log of all your Medicare flu and pneumonia injections. Medicare Advantage are not to be on the Medicare log as they are paid by the Medicare Advantage Company either at time of service or from a log for

that company's beneficiaries (choice is the clinic's).

3. Allocate all expenses directly (or reclassify the expense) to the applicable line item—i.e. do not leave all payroll taxes and fringe benefits on line 45 as this will decrease the clinic's cost per visit; reclassify them to the individual line items.
4. Carve out lab, X-ray, hospital services and any other non-RHC services within your clinic. If you are a clinic that has hours designated for non-RHC services, there MUST be a carve out for that period of time to include all staff, supplies, etc. All clinics will have at least the lab carved out because any lab performed, including the six basic lab tests required, are non-RHC services.
5. Pay attention to your P S & R because the number of visits shown should be the number of visits within your fiscal year.
6. If you are claiming Medicare Bad Debt, remember these accounts cannot be sent to collection and be on your bad debt log. They must be completely written off with no chance for recovery.

Public Health Communications, Inc. (PHC) is partnering with the NARHC to supply any member RHC with a 42-inch LCD television and hookups for clinics to post Public Health Television information and clinic information on a daily basis. The clinic would have the opportunity to have a variety of presentations throughout the day with an area for clinic information and a banner scrolling at the bottom. This will be

free of charge for all members of the NARHC and in addition, the clinic will be given a grant in the amount of \$1,000 per year for the clinic to use in any way it chooses. The company plans to have 3,000 installations within the first three years and 5,700 in the first five years.

PHC has established agreements for the distribution of health education, wellness and social awareness programming via Public Health Television with the following: Centers for Disease Control (CDC), National Center for Health Marketing and Communication (NCHMC), Division of Cultural Communication, Entertainment and Education, U.S. Department of Health and Human Services (HHS), Office of Disease Prevention and Health Promotion, National Institute of Health (NIH), and The Ad Council.

Public Health Television will be installed in the waiting/reception areas of participating Rural Health Clinics, effectively reaching and engaging society's most vulnerable and underserved populations at the point-of-care with targeted and culturally tailored disease management, educational and wellness programming that can improve health outcomes and ultimately reduce healthcare spending.

RHCs will be given more information as it becomes available on the Public Health Television opportunity.

Discussion of the RHC regulations is always a session at the conference. To research the regulations, go to

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Bits and Pieces *cont'd from p. 8*

this site: http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr491_04.html.

The State Operations Manual (SOM) is the surveyors guide to an RHC inspection. You can view what the surveyors are instructed to look for at the following site: http://cms.hhs.gov/manuals/Downloads/som107ap_g_rhc.pdf.

An opportunity for RHCs to contract with an accrediting group may be possible in the near future. CMS has met with a company to explore contracting with RHCs for the survey and certification process.

Because states are having a difficult time keeping up with all the survey processes that are required of them throughout the year for many Medicare facilities, CMS has asked this company if it would develop an accreditation for RHCs. This will allow an RHC to contract with this group for the initial survey – to be completed within a 30 day period following the request – and the subsequent surveys approximately every three years.

Yes, there would be an annual fee involved, and that amount has not been determined. The most positive aspect of this would be that the RHCs and new RHCs would not be subject to “funds available” for the initial survey. At present, clinics in some states have been waiting for an RHC survey for over a year. Fortunately, Nebraska is not one of them. However, the period of time that CMS halted RHC surveys would not have happened if this mechanism would have been in place.

Reach Janet Lytton at RHCconsultJL@hotmail.com. □

Healthcare demand, future staffing on a collision course

By David Howe

Here's a simple formula that sums up a bleak picture for healthcare consumers and employers not only in Nebraska, but the whole nation:

Ageing population + provider retirements = dramatic workforce shortages.

For starters, look at the registered nurse numbers behind that equation. A 2008 Nebraska Workforce Report, commissioned by the Nebraska Hospital Association (NHA), includes a projected 28 percent increase in demand for registered nurses in the state between 2004 and 2014. That's an additional 5,260 RNs. RNs represent the largest category of healthcare providers, according to Olathe, Kansas, based Compdata Surveys Dolan Technologies Corp.

The NHA asked that company to conduct a survey of 85 Nebraska hospitals for vacancies and turnover rates of RNs and 10 other healthcare job descriptions and then compile the Workforce Report. That report includes Nebraska hospital vacancy/turnover rate data, plus projected changes in job demand and predictions of shortages for all 11 job descriptions, based on several sources that Compdata drew on in preparation of its report for the NHA.

The expected 28 percent increase in demand for RNs translates into a projected 20 percent shortage of RNs by 2015, according to the National Center for Health Workforce Analysis. Nebraska has been paddling upstream against an RN nursing shortage of 10 percent to 11 percent since 2000, according to that source. The

shortage is expected to reach 26 percent -- equivalent to 5,300 nurses -- by 2020.

Nationally, the number of RNs in the workforce is projected to fall 36 percent short of demand by 2020, a little more than 1 million RN (full-time equivalent) vacancies. A similar picture is painted for the other 10 health professions surveyed by Compdata, as we'll see in a moment.

Growth in demand for RNs is expected to be especially strong in some healthcare facility types in the state, according to the NHA-sponsored Compdata report, with 39 percent growth occurring in physician offices and home healthcare agencies, 34 percent in outpatient care centers, 20 percent in nursing care facilities, and 22 percent in hospitals. (Those numbers are growth as a percentage of each facility's staffing, not overall demand growth.)

While the numbers for RNs are among the most dramatic among the 11 healthcare job classifications in the Nebraska survey, national projections point to dramatic workforce demand increases for the other 10 as well, said Bruce Rieker NHA vice president of advocacy.

There are roughly 350 healthcare job descriptions, Rieker said. In addition to RNs, the 11 surveyed by Compdata include the following: non-IV certified LPNs, IV-certified LPNs, medical laboratory technicians, medical technologists, occupational therapists, physical therapists, hospital staff pharmacists, radiology technologists, registered respiratory therapists,

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Collision Course *cont'd from p. 9*

and sonographer-ultrasound technologists.

The U.S. Department of Labor projects that job growth between 2004 and 2014 in Nebraska for those 11 categories will range from 12 percent to 33 percent. (See accompanying table on Projections for Healthcare Workers in Nebraska, 2004-2014.)

Equally dramatic national growth in employment demand for those 11 health workforce categories is projected by the U.S. Bureau of Labor statistics, with growth ranging from 12 percent to 27 percent between 2006 and 2016 (see accompanying table on Projections for Healthcare Workers in the U.S., 2006-2016).

“Demand for our (healthcare) services is going to keep going up and up,” Rieker said. The reason: baby boomers, who are moving into that demographic, which requires more healthcare services, running head-on into approaching retirement for many providers, who are themselves baby boomers, Rieker explained. The percent increase in demand for health services is simply outpacing the number of providers being educated to take the baton from retiring providers.

“Nebraska is experiencing a dramatic population shift,” Compdata stated in its survey report. “The population aged 18 to 44 is shrinking, while the population aged 45 and older is significantly growing.”

Compdata’s survey of 85 Nebraska hospitals measured two things for each of the aforementioned 11 health workforce categories: (1) vacancy rate and (2) turnover rate.

Vacancies are an “indication” of employment demand, Rieker said.

The three highest vacancy rates reported by the surveyed hospitals and their percent vacancies in 2008 were: occupational therapists, 14.5 percent; physical therapists, 12.3 percent; and medical laboratory technicians, 11.1 percent.

Survey results for all 11 workforce categories were broken out for each of the five NHA districts into which the state is divided. Vacancy and turnover rates vary widely among the 11 categories and among the five districts. But, in general, rural areas tend to be experiencing the highest vacancy rates, according to the Compdata survey results. In its report, Compdata says: “Vacancy rates tend to be higher for critical access hospitals (CAHs). This is especially prevalent in predominantly rural districts.”

Some examples: Vacancies for staff RNs are 6.1 percent in District 3, which includes the Panhandle, 7.4 percent for District 4 that includes south central Nebraska, and 6.8 percent in District 2 that includes north central and northeast Nebraska. By contrast, the vacancy rate for staff RNs in Districts 1 and 5 that include Omaha, Lincoln, and other metropolitan areas in eastern Nebraska are under 3 percent.

The physical therapist profession came in with the highest overall vacancy rate among CAHs, at 19.8 percent. That position had a 30.4 percent vacancy in District 3, western Nebraska. District 4 was close behind, at 28.6 percent.

So, what’s to be done about the looming demand growth and attendant workforce shortages for these healthcare professions?

Rieker asked rhetorically, “How do we develop capacity

to get more healthcare providers? How do we need to modify or change the way we deliver healthcare to meet those needs?” Healthcare employers are “having to think or rethink how we structure our delivery system to provide the care people need, expect, and demand,” he said.

That might include a focus on medical homes (emphasis on continual, coordinated primary care managed by primary physician, rather than acute care), utilization of more mid-level practitioners, and greater use of technology. “Those are just three of many resources we have to consider to meet this increased demand,” Rieker said.

Other efforts are under way to address the anticipated shortage of RNs, he continued, including University of Nebraska Medical Center (UNMC) additions and expansions of nursing colleges in Omaha, Lincoln, Norfolk, and Scottsbluff. Two-thirds of qualified nursing school applicants are turned away because of limited capacity, Rieker said.

Another step to address the shortage is development of associate degrees for radiology technicians, dental assistants, medical technologists, and nurses.

Other tools, according to Rieker, include:

- Providing more incentives for nurses to fill instructor positions.
- Providing more clinical space in hospitals for healthcare students.
- Offering more public and private partnerships to provide funding for incentives, such as more health education scholarships and student loan forgiveness. Those partnerships can

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Collision Course *cont'd from p. 10*

include the important role that organizations play in health-care career awareness and promotion through such activities as high school career fairs.

Examples of organizations and programs promoting and advancing health profession education in Nebraska include AHECs (Area Health Education Centers), RHEN (Rural Health Education Network), and the RHIP (Rural Health Incentive Program), Rieker said. Economic development groups have an important role to play, too, he added. Healthcare access and quality are important compo-

nents of economic development..

“Adding capacity is difficult when times are good. It is even more challenging when our economy is struggling,” he continued. “Where do financial resources come from?” Medicaid, for example, reimburses an average of 70 percent to 75 percent, according to Rieker. Paying competitive salaries to recruit and retain employees while trying to control the cost of healthcare is a challenge for employers, Rieker added.

Asked about other factors in recruitment and retention, Rieker answered: “More and

more people are looking for work hours that accommodate their schedules.” NHA plans to commission a follow-up survey to identify reasons behind the vacancies and turnover rates that showed up in the 2008 survey by Compdata, Rieker said. “We will look at some of the causes of turnover-- why people aren’t staying in their positions. Is it hours? Is it stressful work conditions? These are questions we need to answer.”

For a copy of the Compdata report, call the NHA at 402-742-8140. □

Projections for Healthcare Workers in Nebraska, 2004-2014

Nebraska	Estimated Employment in 2004	Projected Employment in 2014	Projected Number of New Jobs	Percent Change
Diagnostic Medical Sonographers	370	490	120	+33 percent
Licensed Practical & Vocational Nurses	6,190	6,920	730	+12 percent
Medical & Clinical Laboratory Technicians	900	1,110	210	+24 percent
Medical & Clinical Laboratory Technologists	2,020	2,490	470	+23 percent
Occupational Therapists	790	1,010	220	+27 percent
Pharmacists	1,940	2,520	580	+30 percent
Physical Therapists	1,070	1,360	290	+27 percent
Radiologic Technologists & Technicians	1,910	2,440	530	+28 percent
Registered Nurses	19,140	24,400	5,260	+28 percent
Respiratory Therapists	970	1,230	260	+27 percent

Source: United States Department of Labor, CareerOneStop, America’s Career InfoNet.

Berens named president-elect of National Rural Health Association

National Rural Health Association (NRHA) members have elected Dennis Berens their 2009 president-elect.

Berens has been an active NRHA member since his rural health career began in 1990 when he became director of the Nebraska State Office of Rural Health. He continues in that position today.

“The NRHA is excited about Denny’s new leadership role,” NRHA CEO Alan Morgan says. “He’s a true advocate for improved health care for rural Americans.”

Berens facilitated the formation of the Nebraska Rural Health Association in partnership with the NRHA. He has also participated in each of the NHRA’s annual Rural Health Conferences and Rural Health Policy Institutes for the past 18 years.

In addition to serving on NRHA committees and presenting at educational conferences, Berens is a member of the National Rural Health HIT Coalition and has served on the National EMS/Trauma Advisory Board for Health Resources and Services Administration.

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Health Information Technology Research in Nebraska

The School of Pharmacy and Health Professions of Creighton University is the home of the university-wide Creighton Health Services Research Program (CHRP). CHRP has interdisciplinary health services research expertise that serves community, academic, and government partners by conducting research to improve health services and the care of patients. The mission of CHRP is to improve the quality, safety and efficiency of patient care through the discovery, translation, and dissemination of new knowledge. CHRP has partnered with the Nebraska Office of Rural Health to carry out a stream of projects. **Key projects include:** **1) the Dyke Anderson Patient Safety (or Pharmacists for Patient Safety project).** This project has produced a state-wide 'state of patient safety' description of pharmacists' experiences and the experiences of their patients related to safety in health care. The project has been co-sponsored by the State Board of Pharmacy and the Nebraska State Office of Rural Health. This project continues as a network development project to connect experts in safety with the pharmacists practicing in the state to more rapidly develop an understanding of the problems confronting pharmacists and their patients and share solutions. The problem-solution emphasis has been on the emerging incorporation of health information technologies, patient-pharmacist relationship based care (Therapeutic Drug Management, counseling, use of devices for self-care monitoring, etc.) and socio-economic areas of concern (Medicare part D, access to care). The goal of this project is to produce a sustainable program that will provide a network for pharmacists in this state to continuously learn

from and improve patient safety efforts. **2) the State Analysis of Citizen's Perceptions of the Implications of Personal Health Records (PHRs) and Electronic Health Records (EHRs).** The purpose of this work is to gauge citizens' perceptions of these health information technologies as health information exchange emerges as a model of infrastructure to support health care. This project has identified geographic locations where citizens are using PHR through health professions access to these patients (GIS mapping) and will match citizen and provider perceptions. We are in the process of both surveying and interviewing citizens within these communities and triangulating the information with physician and pharmacist provider perceptions learned through surveying (a mixed methods design). **3) the status of e-prescribing in Nebraska pharmacies.** This project was completed almost two years ago with support from the Nebraska State Office of Rural Health and in partnership with the Nebraska Pharmacists Association. The project described the readiness of community pharmacies to participate in e-prescribing within their communities. **4) the Health Information Security and Privacy project.** This project was supported jointly by the Agency for Healthcare Research and Quality (BRIC Grant Award) and the Nebraska State Office of Rural Health. Three studies were conducted that helped to frame our understanding of the privacy and security issues that need to be overcome to move health information exchange forward in the state. The state's department of health knowledge and planned actions, the professional associations in the state, and the citizens

of the state participated. Three technical reports were produced for use by the state e-Health council and a multi-year action plan for the council has been formed and is in process.

All three of these projects have helped to inform the state of Nebraska e-Health Council as it deliberates its work for the citizens of the state. The opportunities described here have provided educational and social engagement opportunities for students, faculty, community partners, and government partners.

For more information, contact: Kimberly A. Galt, Pharm. D., Associate Dean for Research, Professor of Pharmacy Practice, Director, Creighton University Health Services Research Program (CHRP), Creighton University, 2500 California Plaza - Boyne 143C, Omaha, NE 68178, Phone: (402)280-4259, KGalt@Creighton.edu □

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"Rural health is a mission, not a job," Berens says. "The National Rural Health Association has a special place in America today because it is the large tent where the many mission-driven partners and stakeholders come together to share our challenges and our successes and advocate for changes to fix problem policies and models. We work to link our resources to find ways for rural communities and people to be heard and helped. The opportunities for rural America may never be greater than what they could become now."

The NRHA is a nonprofit organization working to improve the health and well-being of rural Americans and providing leadership on rural health issues through advocacy, communications, education and research. The NRHA membership is made up of 18,000 diverse individuals and organizations, all of whom share the common bond of an interest in rural health. Visit the NRHA online at www.RuralHealthWeb.org □

Nebraska's Veterans Brain Injury Task Force

The Veterans Brain Injury Task Force—which includes representatives from the civilian sector, military sector, and key government agencies—have been meeting to address the increasing needs for brain injury awareness and education as many of our Nebraska veterans return from Afghanistan and Iraq with the wars' signature wound of brain injury.

According to a report produced this spring from the Rand Center for Military Health Policy and Research, approximately 320,000 or 19.5 percent of the U.S. service members returning from Afghanistan and Iraq report experiencing a brain injury during deployment. Since the brain injury screening by the Veterans Administration (VA) began in April 2007, 2,029 Nebraska veterans have been screened for brain injury. Of those screened, 500 Nebraska veterans have screened positive and 316 have agreed to undergo a full brain injury assessment. We anticipate these numbers will continue to grow.

Although the Department of Veterans Affairs (VA) and the Department of Defense (DoD) are working hard to reach out to veterans, statistically, the VA reports only 40 percent of the veterans return to the VA health care system once they are back in their community. There are many reasons why veterans might not return to the VA health care system: some prefer care through private employer-sponsored health plans; some prefer to seek care from their local medical professional because of convenience; and some prefer to seek care from their local medical professional because of their previous knowledge of their health

history.

Because of the low return rate back to the VA for screening, it is very important for community leaders and family members, who are providing support to these veterans, to be aware of the signs and symptoms of brain injury so they can refer the veterans for appropriate treatment. The VA states some common symptoms of brain injury are headaches, dizziness, pain, fatigue, seizures, spasticity, sleep disturbances, vision problems, irritability, liability, depression, personality changes, impaired judgment, slower thinking, physical aggression, substance abuse, decreased concentration and focus. These symptoms can also be commonly seen by a person experiencing PTSD. Because of this, it has been more challenging to identify if a veteran has a brain injury, PTSD, or both.

It is important to identify these issues and seek treatment in a timely manner. Research shows improved outcomes when treatment is implemented early. The Rand report indicated if brain injury goes untreated, just like PTSD and depression, individuals afflicted with these conditions face a greater likelihood of unhealthy behaviors such as excessive smoking, drinking and suicide attempts. These conditions also can impair work and social relationships, disrupt marriages, aggravate the difficulties of parenting and cause problems in children that may extend the consequences of combat trauma across generations.

The Nebraska Veterans Brain Injury Task Force has been working to increase the awareness of brain injury across the state as veterans with brain

injury may not always be able to self identify problems. It is important to reach out to many different audiences as it is felt veterans with brain injury need support not only from the VA and DoD, but also from family members, employers, educators, clergy, the local health care systems, the state, and community leaders to have a successful transition back home.

If you would like more information about brain injury you can go to these websites:

- Center for Disease Control <http://www.cdc.gov/ncipc/tbi>
 - Defense and Veterans Brain Injury Center <http://www.dvbic.org>
 - Brain Injury Association <http://www.biausa.org>
 - Nebraska Brain Injury Network <http://www.braininjury.ne.gov>
- Or you can call:
- Nebraska Brain Injury Hotline for Disability Services 800-742-7594
 - Nebraska/Western Iowa VA Healthcare System- Heather Bojanski at 402-995-4149

If you would like more information about the Veterans Brain Injury Task Force, please email **Peggy Reisher** at preisher@windstream.net. Members of the task force are willing to talk to you or your group to help provide education, awareness and collaboration to better support those veterans who have given so much for our freedom. □

A variety of resources for veterans and their families can be found at:

- <http://www.ptsd.ne.gov>
- <http://www.dhhs.ne.gov/Veterans/>
- <http://www.vets.state.ne.us/>
- <http://www.nebraska.va.gov/> □

Rx for Rural Veterans' Healthcare

By David Howe

The Veterans Affairs, armed with tools in a new federal law, is seeking to improve healthcare access for veterans in rural areas.

Anselm A. Beach, Veterans Health Administration (VHA) representative, demonstrated the need for that effort when he described the scope and activities of the VHA under the new law at the Nebraska Rural Health Association conference in Kearney in September 2008. Several rural healthcare providers at Beach's presentation aired concerns and frustrations about meeting veterans' healthcare needs in rural areas.

Back to those in a moment.

The year-old law, among other things, created the Veterans Healthcare Affairs (VHA) Office of Rural Health (ORH). The ORH is to work with other agencies and institutions in developing policies, education and research to better serve veterans in rural areas, according to Beach, program analyst in the VA's Washington, D.C., office.

Nearly 3 million (38 percent) of the nation's VA enrollees live in areas defined as "Rural" or "Highly Rural," according to data Beach presented at the conference.

In response to concerns expressed by rural providers at his Kearney presentation, Beach said the VA wants to improve healthcare for veterans in rural areas through "outreach and collaboration."

Several Nebraska rural providers raised questions about delivery of VA healthcare services:

- Why can't the VA rely more on VA-approved local rural healthcare providers rather than require veterans in many cases to travel long distances to VA facilities for the same care?
- Couldn't the VA make better use of Nebraska's telehealth

network that is capable of delivering some healthcare services to veterans locally in Nebraska?

- Is there a way to improve communications between rural providers and the VA to reduce confusion and delays in delivering care to veterans in rural areas? It's sometimes difficult to know what VA pays for and what it doesn't, and to know where a veteran needs to go for referrals.
- Couldn't the VA contract with local long-term care facilities for veterans needing such services, rather than sending them to distant VA facilities and compelling them to leave family and friend support behind?

One of those airing concerns at Beach's presentation was Peggy Snell, CFO at the Cherry County Hospital at Valentine.

The new public law seems designed to address concerns like those Snell raised about her own community. Those concerns are echoed by Cherry County Veterans Service Officer Jim Edwards, who wasn't at the conference but responded to questions in a post-conference phone interview. As a county veterans service officer, he works closely with Snell. (Every county has a county VSO, who coordinates with the State Department of Veterans Affairs, advocating for veterans.)

Edwards said many healthcare services for which Cherry County veterans are sent to VA facilities in South Dakota "could be done right here in town." For example, veterans must travel to Winner, S. D., which is 75 miles away, just to have blood drawn, Edwards said. That's a 150-mile round trip for a procedure that could be done locally. Under current regulations, he said, VA doesn't cover cost of care that local providers give veterans

unless it's immediate, emergency care. "A lot of it (care) could be done locally," he added.

He says he's lucky that the county has provided him a budget to transport veterans who, because they are disabled or can't afford the trip, need transportation to VA facilities in Winner, Ft. Meade, Hot Springs, and Sturgis, S. D. for healthcare. He averages 15 to 18 trips and 3,600 miles a month in transporting veterans to VA facilities outside the local community.

The VA, in written responses, said: "Under PL 109-461, the Office of Rural Health will work with other VA Program Offices to support outreach clinics in rural areas, collaborate with different entities to leverage community resources, and expand telehealth programs while ensuring continuity and quality of care.

"VA understands that veterans as well as all citizens residing in rural areas face unique challenges with availability and access to care. Under PL 109-461, VA created the Office of Rural Health to promulgate policies, conduct/coordinate, promote and disseminate research, and to develop best practices and innovations to improve services to veterans who reside in rural areas of the United States."

Addressing the issue of providing more VA healthcare services through local fee-based providers rather than requiring veterans to go outside their community for those services, the VA/VHA responded with the following explanation:

VA/VHA manages one of the largest healthcare systems in the U.S.--157 hospitals or VA Medical Centers (VAMCs) nationwide. VA utilizes the Veterans Integrated Service Networks (VISNs), which manage VAMCs

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within their respective jurisdictional areas. Veterans residing in Nebraska are in the VISN 23 jurisdictional area.

Under the new federal law, the VA's Office of Rural Health "will work with all VISNs to expand programs to enhance access and deploy new models such as sharing agreements, fee basis contracts, and telehealth services with community agencies to leverage existing and community resources while maintaining quality and continuity of care."

In its written responses, the VA said it has "made tremendous strides to enhance access through the development and implementation of Community Based Outpatient Clinics (CBOCs), purchasing care and contracting with local providers through the Fee Basis Program and utilizing technology through its Telehealth Program.

"Under PL 109-461, the Office of Rural Health will work with the VA Program Offices to support outreach clinics in rural areas, collaborate with different entities to leverage community resources and expand telehealth programs. . ."

According to VA, a little more than 37 percent of "rural patients" live within 30 minutes of a VA facility, 83 percent within 60 minutes, and 93 percent within 90 minutes.

In response to questions about getting timely answers and authorizations to requests from the VA after business hours, the VA replied: Rural providers seeking after-business-hours "requests for VA authorization to provide non-VA care at VA expense" should call the Omaha VA Medical Center at (402)995-3249.

The Omaha VA Medical Center is a member of the VA Nebraska Western Iowa Health Care System (VA NWI HCS)

along with clinics in Lincoln, Grand Island, North Platte, Norfolk, and Holdrege, the VA explained. The VA NWI HCS has several patient advocates available to assist veterans and healthcare entities who run into

VA Office of Rural Health Goals

- **Establish a data-driven and collaborative decision-making process to improve the lives of veterans and enhance delivery of care.**
- **Engage in studies and analyses and promulgate best practices (demonstration projects, evaluations, and studies).**
- **Translate research and best practices into policy and facilitate broader execution among established VA program offices and across the continuum of care for all veterans.**

roadblocks while seeking VA Healthcare Services for veterans, according to the VA. If there are eligibility issues, the VA NWI HCS Business Office can be contacted for assistance and clarification at 402-995-3184, according to VA's written responses to questions for this article.

To help resolve some of the rural veterans' healthcare issues, a 13-member Veterans Rural Health Advisory Committee (VRHAC) has been formed. It is to "advise the Secretary of the VA on healthcare issues affecting enrolled veterans residing in rural areas," the VA said in its written response. "The committee will examine issues and strategies towards improving and enhancing VA services for enrolled veterans residing in rural areas."

Advisory committee members, who are appointed by the secretary of the VA, include military veterans, practitioners, and rural health experts in academia and state and federal government.

Ex-officio members include designees of the Department of Health and Human Services and the Department of Agriculture. This advisory committee currently does not include any members from Nebraska, according to the VA.

The advisory committee is one of the Office of Rural Health actions to date. Beach said the ORH also has taken on the following:

- Outreach clinic expansion (to extend access to primary care and mental health services in rural and highly rural areas).
- Mobile health care clinic pilot project to increase access in areas where a fixed point is not feasible. (VA has announced a roll-out early in 2009 of four new mobile health clinics to serve veterans in 24 predominantly rural counties.)
- Expansion of VA's innovative long-term care programs to implement additional home-based primary care and medical foster home programs for rural areas.

Beach acknowledged after his presentation that the VA's efforts under the new federal law are a work in progress. In his presentation, he said the VA "wants to be in touch with the fabric of rural communities" and added that the goal is to "leverage resources and expertise. Clearly, that's where the future lies." □

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CIMRO awarded: 2008 Quality Improvement Organization Champion Award

By Keri McDermott

The national Quality Improvement Organization Champion Award was recently awarded to CIMRO of Nebraska, the Nebraska Medicare Quality Improvement Organization (QIO). This award is given to a QIO with the highest performance based on the Centers for Medicare & Medicaid Services' (CMS) contract requirements. Dr. Barry Straube, Chief Medical Officer & Director, Office of Clinical Standards and Quality, and Mr. Terris King, Deputy Director, Office of Clinical Standards and Quality, presented the award on August 27th at the annual QualityNet Conference in Baltimore, Maryland.

CIMRO of Nebraska received nine "excellent" passes in each of the nine categories in the recent three-year CMS contract, which ended July 2008. An excellent pass indicates expectations were exceeded in each clinical outcome category outlined by CMS. Nebraska's evaluation composite score also exceeded the national average in every task.

Nebraskans are experiencing better healthcare as a result of the quality improvement efforts of CIMRO of Nebraska and healthcare providers in the state. Efforts include sharing of best practices, redesigning care processes to be more effective and efficient, adopting and implementing health information technology and embracing organizational culture change.

"Receiving this award is an outstanding honor and a testament to our commitment to quality improvement," said Greg Schieke, CIMRO of Nebraska's Senior Vice President. "This award speaks volumes about the enduring commitment of CIMRO of Nebraska staff and Nebraska healthcare partners and providers to continually improve healthcare in our state."

CIMRO of Nebraska is an independent QIO under contract with the Centers for Medicare & Medicaid Services to work with Nebraska providers and Medicare beneficiaries to improve the quality of care for Nebraska Medicare beneficiaries. □

2009-2010 NRHA Rural Health Congress elected

The National Rural Health Association (NRHA) is pleased to announce its 2009-2010 Rural Health Congress.

New members are Mark Chustz, Michael Hagen, Thomas Henton, Roger Masse, Rhett Carver Partin, David Pearson, Elizabeth Schnettler, Eric Shell, Kristina Sparks, Susan Starling and W.M. Woods.

"I'm excited about the dynamic team elected by their peers to take the lead in policy changes vital to improving health care for rural Americans," NRHA CEO Alan Morgan says.

The Rural Health Congress is the NRHA's policy-making body. It is made up of elected representatives from each of the association's nine constituency groups, its State Association Council, its State Office Council, its Issue Groups and the association's officers. This grassroots representation reflects the concerns of the NRHA membership. The Rural Health Congress determines the association's positions on public policy through policy briefs and issue papers.

The NRHA is a nonprofit organization working to improve the health and well-being of rural Americans and providing leadership on rural health issues through advocacy, communications, education and research. The NRHA membership is made up of 18,000 diverse individuals and organizations, all of whom share the common bond of an interest in rural health.

Visit the NRHA online at www.RuralHealthWeb.org. All upcoming meetings, conferences, and policy issues are listed. □

Bringing Health Care and Technology Together with Telehealth

July 16-17, 2009
Park Plaza Bloomington Hotel
Bloomington, MN

This program is specifically designed for individuals directly involved with telehealth activities or planning including: administration, grant writing, information technology, providers, clinical site coordinators, RN's and other clinical personnel. Conference details and registration form can be found on the Great Plains TRAC website at www.gptrac.org. Contact Great Plains TRAC at contactus@gptrac.org or (888) 239-7092 with any further questions.

Telehealth Network update:

By Carol Rosenbaum

The first Nebraska State-wide Telehealth Network (NSTN) telehealth conference was a great source of technical assistance. Sixty-three persons from facilities located across the state and also from Wyoming and South Dakota registered for the conference held in North Platte, Nebraska. They included administrators, healthcare staff, technical personnel, and educators.

The conference kickoff was a panel discussion concerning the new Membership and Usage Policy that had just been adopted by the NSTN Governing Board. The panel members included Dale Gibbs from Good Samaritan in Kearney, Dave Glover from DKG in Kearney, and Max Thacker from the University of Nebraska Medical Center (UNMC) in Omaha. Members wanted to know what considered eligible usage of the network according to the Universal Service Administrative Company (USAC) and the Federal Communication Commission (FCC), its parent agency.

The morning continued with sessions on troubleshooting of the telehealth equipment for alleviating hookup issues by Julia Carlson from Regional West Medical Center in Scottsbluff; educational conference management to make conferences run smoother by Carol Rosenbaum from Faith Regional Health Services in Norfolk; information on the NSTN scheduling website by Max Thacker; and how to ensure successful clinical consultations with Marilyn Dahler from Avera Health in Sioux Falls, South Dakota, and Wanda Kjar-Hunt from Good Samaritan in Kearney.

Attendees had their eyes opened during the lunch hour by Nina Antoniotti from the Marshfield Clinic in Marshfield, Wisconsin, who spoke on the Exciting Future of Technology. It was a very out-of-the-box, mind-stimulating presentation as she discussed what she felt would be coming over the next 70 years.

Camelia Rogers from the USAC office in Washington, D.C., gave an informative presentation on the basics of USAC, the agency that provides reduced rates to rural health care providers for telecommunications services necessary for the provision of health care. She discussed eligible services and the application process for eligible service providers. She also discussed the documentation necessary for USAC audits. USAC wants to provide funding, but also wants to prevent waste, fraud, and abuse.

Dan Engle and Michael Pracheil from Thayer County Health Services in Hebron discussed a Federal Flex CAH HIT grant for \$1.6 million (disbursed through the Nebraska Office of Rural Health) that they received to implement electronic health records into their system. The scope of this grant included the Thayer County Hospital (with 7 providers), Hebron Clinic, EMS services (Thayer County and Deshler rescue units), St. Elizabeth's Regional Medical Center (hospitalist and pharmacist), the local retail pharmacy, Blue Valley Lutheran Homes (Nursing Home, Care Home, and Assisted Living), Parkview Haven and Meadowlark Care facilities in Deshler, along

with improved communication with their five outlying remote clinics in Deshler, Davenport, Chester, Milligan, and Bruning.

Dennis Berens, Director of the Nebraska Office of Rural Health, concluded the conference with an excellent presentation on the future of Nebraska telehealth. Berens envisions the NSTN extending beyond hospitals and public health departments to include facilities such as workplace health, prisons and public institutions, and linkage to all licensed health providers used by any citizen.

The format of the conference this year was set up to eliminate breakout sessions by staying together as a group for the day thereby giving all participants the chance to network and to attend all of the excellent presentations. Some comments made by attendees showed they were glad it had been done this way because they were able to gain valuable information from each of the presentations.

The members of the planning committee for this year's conference included: Steve VanHoosen from St. Elizabeth Medical Center in Lincoln, Chair; Martha Ayoub from Good Samaritan in Kearney; Carol Brandl from BryanLGH in Lincoln; Julia Carlson; Emily Gildersleeve from St. Francis Medical Center in Grand Island; Kathy Gosch from Good Samaritan in Kearney; Wanda Kjar-Hunt; Melody Matheson from Regional West Medical Center in Scottsbluff; Laura Meyers from DKG in Kearney; and Carol Rosenbaum. Another conference or training program will be scheduled in 2009. □

Nebraska's Health Workforce: Challenges and Opportunities

Keith J. Mueller, PhD.
Preethy Nayar, MD. PhD

First the good news: Nebraska is ahead of many states in terms of training health professionals.

Now the bad news: We have some problems.

The state faces significant challenges with regard to the geographical distribution of health care providers, the aging of Nebraska's health providers and the difficulties of recruiting and retaining health providers in rural Nebraska.

In September 2007, with funding from the University of Nebraska Foundation Larson Medical Fund, staff of the Nebraska Center for Rural Health Research of the College of Public Health (COPH), University of Nebraska Medical Center (UNMC) undertook a two year project to assess Nebraska's health workforce and to develop strategies to address Nebraska's health workforce needs. As a first step, in February 2008, a statewide stakeholder meeting was held at Mahoney State Park. Representatives of trade and professional associations and educational institutions were invited to this meeting to solicit their input early in the planning process. The research team sought feedback from the stakeholders on the priorities for assessment and analysis, the available data sources and health workforce planning activities currently ongoing in the state.

In the first phase of the project, the project team collected data to assess the current supply of health professionals using available data sources. The data were obtained from the Health Professions Tracking System (HPTS), a unit of the COPH, UNMC and Nebraska's Department of

Health and Human Services licensure and regulation unit. Using licensure data to enumerate health professionals has some limitations because all the health professionals who hold active licenses may not be actively practicing their profession. Also, the licensure data may not give the true location of the health professionals' practice sites. Questions to be answered at this stage were: how many health professionals practice in the state; where do they practice; and how does the current supply of health professionals compare to benchmark ratios used for federal and state shortage area designations and national average ratios of health care providers to population? The significant findings of this phase of the project are that in terms of statewide ratios, for most of the health professions, Nebraska compares favorably to the rest of the nation. For physicians, nurse practitioners, nurse anesthetists, certified nurse midwives, chiropractors and podiatrists, the state's ratio of health providers to population is below the national average. However, for a predominantly rural state such as Nebraska, the significant issue is the rural/urban distribution of health care professionals.

Nine of Nebraska's 93 counties are metropolitan counties. Of the 83 non-metro counties almost half, i.e., 38 are frontier counties (less than 7 persons per square mile). Fifteen of the frontier counties have no health care providers for almost all categories of health professionals. Only three counties in Nebraska: Douglas, Lancaster and Scotts Bluff have health professionals above the national average ratios for all categories

of health professionals. In addition, about a tenth of physicians, pharmacists, psychiatrists, dentists and psychologists are over 60 years of age.

According to the 2007 report of the Association of American Medical Colleges, Nebraska ranks first in the nation in the number of physicians who completed their undergraduate medical education in the state. Seventy to eighty percent of the state's primary care providers (allopathic and osteopathic physicians, nurse practitioners and physician assistants) dentists and pharmacists are graduates of Nebraska medical schools. However, the distribution of professionals continues to be a challenge. Any input from increasing enrollment in medical schools should be combined with special programs to reduce rural/urban maldistribution. Strengthening pipeline programs and state recruitment and retention programs such as loan forgiveness programs, and extending these programs to other health professionals as well, may hold the key to meeting the future health workforce needs of Nebraska.

What is next in this study? In the second phase of the project, the future needs for health professionals will be assessed. In the third phase of the project the research team will develop strategies to address Nebraska's future health workforce needs. A second statewide stakeholder meeting is planned in 2009 to disseminate the findings of the project and solicit input from the stakeholders to develop the final recommendations for Nebraska's health workforce.

Do we have the data we need to monitor needs for health professionals and how

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well those needs are met? The Nebraska Center for Nursing, a unit of the Nebraska Department of Health and Human Services biennially surveys RNs and LPNs at the time of licensure renewal. This has proved to be a good source of data on the nursing workforce and a valuable input into the planning process. The Health Professions Tracking System collects reliable data on several of the health professions: physicians, nurse practitioners; physician assistants; dentists, pharmacists and mental health professionals. However, data on allied health professionals, pharmacy technicians, nursing aides and dental hygienists are not regularly collected.

What are the challenges? Although the aging of the health professionals in the state is not as much of a problem as in some other states, it could be a challenge in addressing Nebraska's future health care needs. Access to care for frontier communities is likely to continue to be a salient issue and will need innovative solutions, given the difficulty in recruiting and retaining health professionals in communities that cannot sustain providers. Another issue that needs to be addressed is the need for better data collection efforts to assess and track all of the state's health professionals on an ongoing basis. The state's Office of Minority Health would certainly be interested in whether the diversity of the health workforce reflects the diversity of Nebraska's population. However, currently, the licensing data does not include information on race/ethnicity and the HPTS data also has incomplete information on race/ethnicity of the health professionals. □

A Conversation with Dr. Marcia Brand

Dr. Brand is the HRSA Associate Director for the Bureau of Health Professions

Q: There has been a sudden rash of media reports about regional workforce shortages in American hospitals, clinics and rural communities. Some are calling it a crisis. Is that going too far?

Dr. Brand: I don't think there's much question that we're looking at a crisis scenario, but it really does depend on where you live. One of the big mistakes that experts have made in trying to estimate the workforce supply over the years is that they've usually averaged it across the nation. They've run the numbers based on overall physician-to-patient ratios, for example, and concluded, 'Well, this looks good; we have plenty of doctors, or dentists or nurses.'

But that really doesn't tell us much if two-thirds of the clinicians in a given health profession are based in big medical centers in Boston, Philadelphia, Chicago, San Francisco, Denver, and Dallas — while the rest of the country goes without. And even where there appear to be adequate numbers of providers, some folks don't have access to them because of poverty, lack of health insurance, etc.

What's the consequence of our inability to describe the health professions workforce?

You're just not getting an accurate picture. We wind up with denial in some places that there's a problem, while people are crying out that they can't find a doctor. So there is a lag in recognition that these might be leading indicators — until it's too late. In the health professions, that's been the historic pattern. This isn't the first time this has happened, although it remains to be seen if this is the worst one we've faced.

The average person reading this might say, a shortage of a million nurses by 2025 — or 100,000 doctors — is kind of hard to miss. How did it reach this stage?

Well, certainly HRSA saw this coming a long time ago. But part of the historic pattern, and it's a legitimate question, is whether state governments aren't better situated to mind their own stores — at least in theory — to fund their own university systems and scholarship programs in the health professions.

Some state legislatures have done a fairly good job of monitoring their workforces. But other states face much bigger challenges...much tighter budgets. Frankly, the best data available in some regions of the country are largely anecdotal — which is a nice way of saying, there isn't much hard evidence we can point to.

So what's the current best guess, if you will?

When you have 49 million Americans without health care, and 20 states reporting significant health care workforce shortages, it's not a subtle academic discussion anymore. And none of them, as we've seen in recent months, are well-positioned to deal with the huge economic and demographic shifts they're now facing.

Most folks in the health care system understand now that we have a serious problem, because it's begun to reach into places that have not traditionally been affected by this before. I'm usually the eternal optimist, but in this case I really do believe we've waited too long.

We need to do something now — right now — to have any hope of turning this around by the time the Baby Boomers hit the system in large numbers.

[Reprinted from the January 2009 *Inside HRSA*]

ACCESSory Thoughts

Dennis Berens, Director
Nebraska Office of Rural Health

Thank you!

Simple words but I send them to all of you as we begin 2009.

Thank you to those of you who provide direct health care services to our citizens.

Thank you to those of you who teach and work with future health care professionals.

Thank you to those of you who work to enhance health policy to improve the quality of life for our citizens.

Thank you to the members of the Nebraska Rural Health Association who voted in the last National Rural Health Association election that enabled me to be the president elect of NRHA for 2009, president in 2010 and past president in 2011.

So where do we go from here in a world that looks very different this January and February than it did one year ago? Let me share a few ideas that are floating around in my head and heart these days.

First, the importance of relationships is being rediscovered across America and Nebraska. Rural residents never really lost this understanding, but in this era of globalization, fast communications, and unsettled economic models, we have come to understand even more that to do good work we need once again to have trust in and with our fellow workers. That means we have to take time to establish a relationship with them. This

should lead to better care, more thoughtful work and a stronger sense of community.

Second, the importance of cooperation and cooperatives is being discussed once again. With a lack of easy funding and credit, we are searching for partners to help us reach our goals. This could take the form of a new cooperative model that actually puts needs of the members at the forefront versus those of the organization.

Third, we are discovering again the importance of community. You have often read in this column my push for a renewed sense of community. We are still going through the culture wars in our nation, and we have seen that sense of community threatened. Rural and urban people of the past had a strong sense of place and community. They created cultures that help them to collectively address adversity and opportunity and, most important, they shared that community culture with their children. It's time to move out of our isolation and into building our new community culture.

I welcome your thoughts about these ideas and any other major focus you want to share. Most of all, I wish for all of you a wonderful new year filled with friends, cooperation and a community that cares for you.

Denny. □



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