

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 54, May 2009

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Electronic Health Records: Who Owns and Controls Them?

By David Howe

A fully implemented, interoperable patient electronic health record can be invaluable to patient and provider alike.

A click of a computer mouse can place immediately before any of a patient's providers an up-to-date patient medical history—ailments, allergies, treatments, medications, lab tests results, X-rays, etc. And, once captured on electronic record, there's no laborious information-copying or need for print-outs that can be misplaced or lost in the process of sharing the records among a patient's providers.

But who owns these records? Who has control over how they are used or shared? And, with whom can they be shared?

The hospital owns the records, whether they are paper records or electronic ones, said Michelle Kuhlmann. She is the Thayer County Health Services (TCHS) health information director and HIPAA (Health Insurance Portability and Accountability Act) compliance officer at the TCHS hospital in Hebron.

Those records are stored on hard drives where data is secure and written to redundant disks. The data is also backed up on tape media periodically. "Additionally, replication software provides us with a real-time copy of hospital record changes off-site," Kuhlmann said. In the event of a catastrophe, she added, "All we'd have to do is dial into that backup, and we'd be on real time."

The hospital and its partners (rural clinics, two pharmacies, a nursing home, an assisted living

facility, and network hospital St. Elizabeth Regional Medical Center in Lincoln) have been implementing a comprehensive health information technology system over the past several years. They've had help from a \$1.6 million Critical Access Hospital HIT grant that TCHS won about 1½ years ago. The system, of course, includes electronic patient medical records.

Those records may originate in one of two ways, Kuhlmann said: as MediNotes in an office setting at any of the TCHS rural clinics or as HMS records in a hospital setting through a patient stay at the hospital in Hebron. ("MediNotes" and "HMS" are vendor names for the electronic record software)

The two types of electronic records are electronically compatible, and providers at the clinics and hospital can see patient information in either format, Kuhlmann said.

A physician at the hospital can pull up both records, she said. "Our physicians really like to look at the clinic record (MediNotes), because the majority of the patient's health information is in that record." Also, health information from MediNotes can be scanned into the hospital's HMS patient records, she said.

Both MediNotes and HMS records are considered a physical asset of the hospital, because the hospital is required to maintain and store them, Kuhlmann said. The hospital must keep these records for 10 years after a patient leaves the system, either because the patient transferred to another healthcare system or because of death. In

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the case of a minor who leaves the TCHS system, the records must be maintained until age 22.

Health records that patients bring with them when entering the TCHS system from another part of the country or another health provider are scanned into the TCHS electronic health record for that patient. That record becomes a permanent record owned by TCHS, Kuhlmann said.

While TCHS owns the patient health records, patients have authority over who can or can't see their health records. A hospital patient might, for example, ask that a specific provider not be given access to his or her medical records.

By the same token, a patient can direct that his or her records be shared with whomever that patient chooses, even an unaccredited provider, for example. "Technically, by law, we can't really deny them," Kuhlmann said. That's true of both MediNotes and HMS electronic records and of paper records.

TCHS, subject to certain patient requests, manages access to patients' electronic health records.

The hospital can limit access to portions of the record that are appropriate for various hospital personnel to see. For example, access to electronic health records by hospital business office personnel is limited to what they need for business office purposes, Kuhlmann said.

"If you need it (information to do your job), you will have access to it," she said. For example, a problem arose in conjunction with emergency room patients who had visited a TCHS clinic but had never been to the hospital. That meant no electronic medical record existed at the hospital when such patients entered the ER. To facilitate ER care, registered nurses in the ER were granted access to MediNotes that were created for those patients during their visit to a TCHS clinic.

"Lots of times, we will discuss these kinds of issues on what they (providers and other personnel) need and what they don't need," Kuhlman said. This is a process that she is involved in, along with other hospital personnel responsible for electronic health record oversight. Such policies are subject to ongoing review. □

MARK YOUR CALENDARS

2009 National Rural Health Association Annual Conference

May 5-9, 2009 - Miami, Florida

Nebraska Rural Health Advisory Commission Meeting

June 19, 2009 - 1:30 p.m. - Lincoln, NE

NRHA Rural Pharmacy Conference

September 9-11, 2009 - Kansas City, MO
www.RuralHealthWeb.org

Nebraska Certified Rural Health Clinics Coding & Billing Workshop

September 17, 2009 (all-day)
Holiday Inn & Convention Center; Kearney, NE

2009 Nebraska Rural Health Conference

September 17-18, 2009
Holiday Inn Convention Center - Kearney, NE
<http://www.nebraskaruralhealth.org/>

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

Public Health Association of Nebraska (PHAN) Conference

October 8-9, 2009; Ramada Inn, Kearney, NE
"Invest in Public Health -It's Good Business"
<http://www.publichealthne.org/conferences.htm>

NRHA: Minority and Multicultural Health Conference

December 9-11, 2009 - Memphis, TN
www.RuralHealthWeb.org

Grand Island Independent story on veterans' mental health services

"Mental health services offered to veterans" by Tracy Overstreet ran in the Grand Island Independent on Monday, April 13, 2009. Read it online at:

<http://www.theindependent.com/articles/2009/04/13/news/local/doc49e29817a19ee695770432.txt>

Nebraskans weigh in on electronic medical records

By Tarik Abdel-Monem, Mitch Herian and Nancy Shank
University of Nebraska Public Policy Center, March 2009.

Electronic medical records (EMRs) continue to be in the national spotlight. In 2004, President Bush first called for all Americans to have a personal EMR as part of a nationwide domestic agenda.

President Obama restated the push for electronic medical information in a speech in January of 2009: "To improve the quality of our health care while lowering its cost," he said, "we will make the immediate investments necessary to ensure that, within five years, all of America's medical records are computerized."

Sharing health information electronically is believed to have a number of wide-ranging benefits, the most obvious being that a quick access to electronic health information via computer will lead to better healthcare and better health outcomes.

Many physicians and policymakers support greater use of EMRs. However, wide-scale adoption of EMRs has not yet occurred for a number of reasons, including the current policy and regulatory environment, costs associated with moving to computerized records systems, and lack of uniform standards for sharing information electronically. Public acceptance and support for the use of EMRs is another fundamental issue that will need to be addressed.

In November of 2008, the University of Nebraska Public Policy Center (PPC) convened a public input project funded by a Community Technology Fund eHealth

grant provided by the Nebraska Information Technology Commission. The overall purpose of the project was to determine what Nebraska residents currently think and know about EMRs, what their privacy and security concerns are, and what role they think the state should take in regard to electronic health information exchange.

Working with members of the state's eHealth Committee and Health Information, Security and Privacy Committee, the PPC gathered information from state residents by first administering a survey to 168 people in a random sample of residents about EMRs and related issues and then convening a discussion about EMRs among 34 of those survey respondents.

The study found that Nebraskans are generally comfortable with the use of EMRs and understand their benefits. Eighty-one percent of survey respondents believed the use of EMRs can reduce medical errors, and 71 percent believed they can reduce healthcare costs.

When asked if they would prefer to see similarly qualified physicians who either used an electronic records system or did not use one, 43 percent of respondents indicated that they would rather see the physician using an electronic record system and only 5 percent would prefer to see the doctor without one. However, 52 percent of respondents were unsure, indicating that many Nebraskans may not know enough about the pros and cons of electronic versus paper medical records systems.

Secondly, although Nebraskans are generally comfortable with the security of electronic medical records, some concerns

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Hebron's CAH-HIT model

Please go to the website www.thayercountyhealthservices.com to review the progress that the Thayer County Health System has taken to address HIT in their community and area. Stories, information and activities are listed to help each of us to think about the advent of the digital world in our health care system.

still do exist. Sixty-three percent of survey respondents believed that electronic records were more secure than paper ones, whereas 9 percent believed paper records were more secure.

When asked about their greatest security concern, 68 percent of respondents believed that computer hacking or system outages were the greatest potential problem with EMRs. Twenty-four percent were concerned that an employer, insurance company, or provider would use their personal health information inappropriately.

Thirdly, Nebraskans would like greater education about EMRs. Seventy-two percent of survey respondents said it was very important for state government to take a role in providing more information about EMRs to consumers.

Results from the deliberative discussion provided support for the notion that more education about EMRs might increase public support for their use. For example, when first surveyed about EMRs, 45 percent and 58 percent of respondents, respectively, believed that the use of EMRs increases patient privacy and lowers health care costs. Following the deliberative discussion—in which participants had an opportunity to learn more about EMRs during a question and answer session with a

panel of experts—those figures increased to 81 percent and 97 percent respectively.

Finally, many Nebraskans are already using technology in gathering information about health and health care. Eighty-five percent of survey respondents reported that they use the Internet to search for information about health issues, and 45 percent have used a health insurance company's Web site. Only 23 percent of respondents, however, reported having used e-mail to communicate with their healthcare providers, though 70 percent believed that patients should be able to e-mail their doctors as part of their healthcare.

The project demonstrated that Nebraskans are generally comfortable with the use of EMRs but that further information and education would be helpful to consumers as the call for their use continues. Additional public input activities with larger sample sizes should be convened to further gauge Nebraskans' knowledge and attitudes toward EMRs.

A full copy of the University of Nebraska Public Policy Center's report about the project with all survey data is available at <http://ppc.nebraska.edu>. For further questions, please contact Tarik Abdel-Monem, research specialist, at (402) 472-3147 or tabdelmonem@nebraska.edu. □

Minnesota begins first community paramedic course in U.S.

In an effort to expand the scope of rural paramedics, the Community Healthcare and Emergency Cooperative (CHEC) teamed up to create the first "community paramedic course." The CHEC is comprised of EMS and rural health leaders from Minnesota, Nebraska, Australia, and Canada. The collaborative was formed with the goal of developing a new community health provider model for rural and underserved communities.

The program has designed modules in primary care, public health, disease management, prevention and wellness, mental health, and dental care. Community paramedics that take these courses can broaden their knowledge in other areas of healthcare while filling a healthcare gap in the community. According to Anne Willaert, MS, who helped to develop the curriculum, the

CHEC "interviewed EMTs and paramedics from rural communities...Many said they were the 'go-to' person in the community...and want to do more than quick emergency treatment."

Ten paramedics, with varying backgrounds and occupations, have enrolled in the programs' pilot project at Hennepin Technical College. The collaborative will use the pilot to evaluate the effectiveness of the program. The programs' website states that the curriculum can be adapted to meet the needs of other communities and can thrive "through the combined efforts of those that have a stake in maintaining the health and well-being of its residents."

More information can be found on the CHECs Community Paramedic Web site, www.communityparamedic.org □

Integrated care: a model that works

By David Howe

One in every four children who visit a primary care facility has a behavioral disorder, says Dr. Joseph Evans, psychologist and director of the Department of Psychology in the Munroe-Meyer Institute (MMI) at the University of Nebraska Medical Center.

That underscores the importance of integrating behavioral and primary healthcare — particularly in rural areas where availability of behavioral healthcare services significantly lags behind that of urban settings.

In few places throughout the U.S. is the concept of integrated care being advanced as steadfastly as in Nebraska, where the emphasis is on locating behavioral and primary healthcare under the same roof in rural areas. Evans said integrated care pays off in the following ways:

- Eases the heavy demands on pediatricians and family practice physicians, especially in rural areas where the population-to-provider ratio is high and psychological services are not readily available.
- Facilitates consults and referrals between primary care providers and behavioral healthcare providers, which can lead to better-coordinated care — improved use of medications, for example. And that collaborative care may reduce overuse of primary care.
- Offers convenience to those patients and their families who are referred to behavioral healthcare providers. Patients and families don't have to travel to one place for primary care and elsewhere — long distances, in some cases — for behavioral healthcare. Patients are also more likely to adhere to scheduled follow-up care when they can find both primary care and behavioral health services at the same location.
- Allows confidentiality by having primary and behavioral healthcare in the same building. That can be a factor in a community where, for some, a stigma is attached to seeking mental healthcare.

Major drivers behind integrated care, particularly in rural Nebraska, are the MMI and the Nebraska Internship Consortium in Professional Psychology (NICPP).

NICPP is the largest such internship consortium in the country, Evans said. Through this consortium, which is co-directed by psychologists Dr. Susan Swearer at the University of Nebraska-Lincoln and Dr. Keith Allen at MMI, the focus is on creation of internships for graduate students and post-doctoral fellows in child psychology at behavioral health and primary care facilities in the state, especially in pediatric clinics.

Of the 29 interns in the consortium program this year, 10 are in the MMI child psychology program, an award-winning program that has earned Dr. Evans the 2008 American Psychology Foundation Cummings

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Who is MMI?

MMI is the state's designated agency for research and education in developmental disabilities. Along with MMI, the consortium partners include: University of Nebraska-Lincoln Counseling and Psychological Services, Omaha Public Schools, Beatrice State Development Center, Catholic Social Services, Center for Health and Counseling-Creighton University, Boys Town, and Quality Living.

The program's specialty clinics provide behavioral healthcare services to children, adolescents, and their families in a cooperative effort by community pediatricians/family practice physicians and the MMI Psychology Department at the UNMC. Clinics have been established in a number of rural areas, such as Chadron, Crawford, Gordon, Rushville, Alliance, Crete, Columbus, Hastings, Kearney, Grand Island, and Fremont.

The 10 doctoral interns and six post-doctoral fellows at MMI have been recruited to Nebraska from the following institutions: University of Nebraska-Lincoln, Oklahoma State University, Syracuse University, Illinois State University, Louisiana State University, University of Southern Mississippi, Mississippi State University, Western Michigan University and University of Tennessee. Also, the NICPP integrated care internship program offers practicum experiences for counseling students at the master's degree level from Chadron State College, University of Nebraska at Kearney, University of Nebraska at Omaha, and Doane College.

The consortium's goal "is to provide an integrated, individually tailored and coordinated series of learning experiences that will serve the aspiring professional psychologist with opportunities to:

- practice and expand on previously held knowledge and learned skills.**
- develop new skills and knowledge.**
- experience personal and professional growth and development, thus contributing to the emergence of a competent, scientist/practitioner professional psychologist."**

PSYCHE prize of \$50,000 awarded for his and MMI's efforts toward integration of behavioral and primary healthcare. The Nebraska Rural Health Association has also honored Dr. Evans and MMI for accomplishments in integrated care.

MMI has established about 15 integrated care clinics around the state since 1997, most in rural areas. The program includes 10 doctoral interns and six post-doctoral fellows. The institute is approaching its goal of adding two new clinics a year with an average between 1.5 and 1.7 new clinics annually.

Through the program, doctoral interns acquire 2,000 hours of practice, which are part of the requirements to become a licensed psychologist. An outline of the program's characteristics can be found at www.unl.edu/nicpp/intro/characteristics.shtml.

Ideally, the interns have a rural background or some type of rural roots, Evans said. Secondly, the program is interested in interns with ties to Nebraska "in some shape or form." The idea is to encourage these students to practice in rural Nebraska, once they've completed their internships. And, half of those who go through the NICPP internship program do just that.

"Our goal is to train students to handle 85 percent of the behavioral problems that come into a pediatric practice," Evans said. Those behavioral issues include school attendance or academic problems, attention-deficit hyperactivity disorder, bed-wetting, juvenile delinquency, and sleep disorders, Evans said.

Doctoral candidate Rebecca (Becky) Gathje, a Hastings, Nebr., native and one of the current 29 interns, gives the internship program high marks. She has gradually taken on increased professional responsibility under the supervision of Dr. Nancy Foster, who heads the Kearney Behavioral Clinic, and under other licensed psychologists at the Kearney, Hastings, and Grand Island Behavioral Health Clinics. "The majority of what I've learned about working in an integrated primary care setting has been through the training I've received under the internship program," said Gathje, who will graduate from Syracuse University this spring with a Ph.D. in school psychology.

The daughter of a pediatrician in a Nebraska practice, Gathje traces her interest in integrated

care back to her high school days when she had an opportunity to observe an outreach clinic that was just being established.

She said primary care physicians have told her that having psychologists working with them in their practices is a time- and money-saver. She has noticed that a lot of people become comfortable with going to their primary care doctor's office for medical services. And for those with behavioral healthcare needs, that same-office comfort is important to them when they need specialized psychological services.

A rural integrated care internship dove-tailed with Anita Lovell's background, education, and career plans. She grew up on a farm near Pender with six siblings and enjoys working with children. She entered the MMI child psychology program with a master of arts in counseling from Doane College and interned at the Nebraska City Behavioral Health Clinic under the supervision of Amanda Volkmer, M.S., a licensed mental health practitioner at the clinic.

Interning at an integrated health care facility "has been a huge experience for me," Lovell said. "I've taken an extraordinary amount of knowledge from my experience at the clinic." One of the many benefits from her internship, she noted, was the opportunity to gain experience in teaching parents techniques for managing their children's behavior.

Through her internship, she said, she has discovered the value of having primary care and mental healthcare in the same facility. For one thing, it provides confidentiality. And for families who live in a rural area and need to access behavioral healthcare, it means not having to drive long distances for that care in a large city. "Physicians are right there," she added. "That's a bonus, a two-in-one visit." It facilitates behavioral management and medication management right there in the same clinic.

Lovell has completed her internship and is now employed by Behavioral Health Solutions, a company established by Volkmer, her internship supervisor. That company offers mental health services in the same Nebraska City clinic where Lovell completed her internship. So, yet again, the internship program's goal of encouraging behavioral healthcare providers to practice in an integrated care setting in a rural area is achieved.

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Patient Safety

By Kim Galt - Creighton Health Services

Is patient safety on your mind? If not, it likely will be after you read the Institute of Medicine's report, *To Err is Human*.

According to the report, errors are the fifth-leading cause of death in the United States, totaling up to 98,000 deaths annually. The magnitude of this problem is arresting. If patient safety is buzzing around your head, there's good news: Patient Safety Organizations (PSOs) are being formed to address and offer solutions to these errors.

Creighton Health Services Research and Patient Safety Program (CHRP) at Creighton University recently announced its formal PSO listing. It is one of the first 50 institutions certified as a national PSO by the Agency for Healthcare Quality and Research.

So, what is a PSO? A PSO is a public or private organization that collects, aggregates, and analyzes information related to quality and safety of the care provided in any health care setting. Voluntarily created under the Patient Safety and Quality Improvement Act of 2005, these organizations establish a framework for healthcare providers to report errors, "near misses," or other adverse patient safety events that cause harm to patients.

A key component of a PSO is the privacy protections it offers for reporting errors. Reporting remains confidential and cannot be used in liability cases. Practitioners are more likely to report errors when the process results in practice change and improvement rather than being linked to punitive action. CHRP PSO will apply uniform and consistent de-identification protocols to all patient safety event data it receives.

The CHRP PSO is interested in improving the safety of health care experiences for our citizens by using reporting to help teach health care providers and patients about how to improve safe delivery of care. The learning needs of rural and isolated practitioners in all fields of health care are of high priority and interest to us as well as the various health care entities and organizations they provide services from. We share the need to learn how to improve the ways we can deliver safe care.

We have chosen to highlight areas of work. One area of focused CHRP PSO interest is medication error reporting and practice improvement in safety. The Institute of Medicine's report, *Preventing Medication Errors*, identified pharmacists and pharmacy services as a key area where medication error reduction and prevention is needed.

Errors that cause harm include physicians writing prescriptions that could interact dangerously with other drugs a patient is taking, nurses putting the wrong medication – or wrong dose – in an intravenous drip, and pharmacists calculating the dose incorrectly as the result of a misplaced decimal. Quality improvement is the one incentive health care practitioners have to report to PSOs. It is the shared goal of all PSOs to improve the safety and quality of health care delivery.

The CHRP has been addressing the topic of improving patient safety in pharmacy practice with its "Pharmacists for Patient Safety" project. The project implemented an accelerated model for safety problem identification and solution sharing among pharmacists within their local communities. It strives to create a communication community among rural and urban pharmacists in various Nebraskan pharmacies

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

MMI cont'd from p. 6

MMI director Evans said the child psychology program and internship program give students training on how to work in an integrated system with other providers. "Most psychologists don't get that kind of experience during graduate school." □

Ready to Put Workforce Data to Work

By David Howe

Health workforce numbers collected in Nebraska over the past 10 years show what was generally expected: Too few healthcare professionals of all types are available to serve much of the state's rural population.

That data became a starting point in addressing those shortages. In a 2-year study initiated in 2007 by Dr. Harold Maurer, Chancellor of the University of Nebraska Medical Center (UNMC), the staff at UNMC's Nebraska Center for Rural Health Research of the College of Public Health has used that decade of data to analyze the depth and nature of those shortages.

Preethy Nayar, M.D., Ph.D., assistant professor of Health Services Research Administration at UNMC, lays out the study's three goals: 1) measure the supply of healthcare professionals in Nebraska, 2) assess need for current healthcare professionals, and 3) project future needs for those professionals.

"This is the first attempt at a comprehensive report across all health professions across the state," said Dr. Nayar, who directed the 2-year study, headed by Dr. Keith J. Mueller, Interim Dean of the College of Public Health. The study is based on what she describes as "a decade of reliable data."

Now it's time to put that data and the findings

to work in developing strategies on how best to address health professional staffing challenges in Nebraska. That's being done with input from healthcare stakeholders. Seventy to 80 stakeholders will be meeting this June 17 on the UNMC campus in Omaha, says Dr. Nayar. It's the second of two such stakeholder meetings, the first having been held in February 2008.

Those stakeholders include representatives of professional health and education associations, including the following: Nebraska Hospital Association; Nebraska Rural Health Association; Nebraska Medical Association; Nebraska Department of Health and Human Services, including the Department's Office of Rural Health; and the Nebraska State Education Association.

Dr. Nayar and Dr. Mueller described the workforce study's findings in an article that appeared in the February 2009 issue of this newsletter.

Provider-to-population ratios were determined across all healthcare professions. Those ratios were determined for the state as a whole and county-by-county. Nebraska faces a challenge in training and retaining adequate numbers of healthcare professionals in rural areas, just as many other states do, according to Dr. Nayar.

The UNMC study, funded by the University

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Safety *cont'd from p. 7*

simplify the process of reporting a problem and receiving a network-wide disseminated solution.

The State of Patient Safety in Nebraska Pharmacy is a report recently produced by the CHRP. The report was created to disseminate information about patient safety issues Nebraska pharmacists and their patients face across various practice settings and locations. A survey was sent to all Nebraska pharmacists, and 24 percent responded with information concerning personal and electronic health records, safety improvements, and problems with practice-specific technologies, culture, workload, training, and new pharmaceutical product safety problems. Nearly half the respondents reported a story conveyed by a patient addressing safety concerns.

The State of Patient Safety in Nebraska Pharmacy's findings suggest pharmacists want to

engage in communication about safety concerns and participate in an information sharing and learning network that improves patient safety in their practices. The findings also suggest the need to develop a rapid dissemination system to relay potential solutions for local practice incorporation. These findings, and the establishment of the CHRP PSO, will offer possible solutions to the problems isolated rural practitioners encounter. Through the organization, solutions will be developed and disseminated to address and minimize the errors and near misses encountered.

If you would like to work with our PSO, we would like to hear from you. For information contact: Linda Scheirton, Ph.D., CHRP PSO Coordinator; or Mavis Hall, B.S. at 402-280-5172 or via email at mavishall@creighton.edu. □

NOTE: "The 'Pharmacists for Patient Safety' research was funded through the Dyke Anderson Patient Safety Grant and the Nebraska Department of Health and Human Services. Partial funding was contributed through the Nebraska Office of Rural Health."

Southeast Nebraska Health Information System will provide seamless care

In June 2008, the Southeast Nebraska Behavioral Health Information Network, Inc., announced the award of a \$540,000 Health Resources Services Administration Rural Health Network Development grant to assist in development of a health information exchange among behavioral health providers, primary care physicians, rural hospitals and the emergency behavioral health system in Southeast Nebraska.

In the past year, the network has received \$2 million in funding from federal and state agencies for health information exchange development.

In case of crisis

Electronic information exchange can make a big difference in treatment of behavioral health problems.

The episodic needs of persons in psychological distress present challenges to rural professionals. At times, while waiting for medication adjustments or changes to care, patients with mental illness find themselves in a severely deteriorating state. If not quickly or adequately treated, their condition can lead to disability, unemployment, substance abuse, homelessness, inappropriate incarceration or suicide.

The situation may lead to an emergency protective custody action where the patient is transported to Lincoln for inpatient behavioral health assessment and treatment. Without information, professionals are often in the dark regarding patients' previous or current behavioral health treatment. They may be starting over in treating an

individual who, in reality, has an extensive record of service provision.

Electronic information exchange will allow immediate viewing of prescribed medications, treatment plans, and contact information for family members. In a crisis, this can save days of time and thousands of dollars of expense.

Rural health development resources

The HRSA Rural Health Grantee Technical Assistance Program provides support to grantees for rural health network development and planning.

"Fortunately, this has allowed the network to gain the technical advice of Keith Williams," said Ken Foster, president of the southeast Nebraska network and vice president for regional development and strategic planning for BryanLGH Health System.

"One of his recommendations is coupling of health information exchange development with telehealth services, particularly in specialties such as psychiatry."

Williams is the CEO of the Community Health Network, a statewide non-profit group in Tennessee whose members include 17 community health center organizations operating 100 clinics, and the Tennessee Primary Care Association.

He has led an expansion of the network's information technology services for community health centers and affiliates as well as implemented a 55-site, statewide telehealth network. Williams is vice president of the board of directors of the National Cooperative of Health Networks. □

Rural Can't Wait

Making Change Work for Rural Nebraska

Annual Nebraska Rural Health Conference

Thursday and Friday September 17 and 18

Holiday Inn Convention Center - Kearney, Nebraska

Keynote speakers

Mark Scott • **Alan Morgan**, President of the National Rural Health Association.

For additional information, or to be a sponsor or exhibitor at the 2009 conference, contact Melissa Beaudette at mbeaudette@mwhc-inc.com or (402) 421-7995.

Go to the NeRHA Web site (www.nebraskaruralhealth.org) for registration, exhibit, and sponsorship information.

2009 Annual Nebraska Rural Health Conference

by John Roberts

Rural Can't Wait – Making Change Work for Rural Nebraska is the theme for this year's Nebraska Rural Health Conference scheduled for Thursday and Friday September 17 and 18, at the Holiday Inn Convention Center in Kearney.

The annual conference provides a forum to address rural health concerns and to develop and promote effective solutions at the local, state and national levels. This year the conference will cover key issues ranging from national trends impacting rural health, such as workforce shortages, healthcare reform, health information technology, the medical home model, behavioral health reform and EMS to discovering the changing health delivery models currently in Nebraska.

One of this year's keynote speakers is Mark Scott. Mark will share his story about leading a small, rural Oregon hospital's successful attempt to profoundly change the way patients, their families, staff and employees experience healthcare. It is the account of an extraordinary effort that led to a remarkable transformation of an entire organization.

Their courage to be first has captured the

attention of all the healthcare industry. Mark Scott and Leland Kaiser have just released *Courage to Be First*. This is the first book for each of them, but definitely not their first collaboration.

Another keynote speaker will be Alan Morgan, President of the National Rural Health Association. Alan will give us the latest from Washington D.C. on health care reform. President Obama and Congress will be developing a plan over the summer to provide affordable, accessible health care for all Americans that builds on the existing health care system and uses existing providers, doctors and plans to implement the plan. What will this really mean for rural health? Alan will help us to sort it all out.

Sponsors and exhibitors are a critical part of bringing the conference to care providers at a reasonable cost, and we appreciate them. Please consider sponsoring or being an exhibitor at the 2009 conference. For additional information, contact Melissa Beaudette at mbeaudette@mwhc-inc.com or 402-421-7995.

Go to the NeRHA Web site (www.nebraskaruralhealth.org) for registration, exhibit, and sponsorship information. Watch for more news in future editions of ACCESS and on the NeRHA web site. □

Nebraska Rural Health Association Awards Nomination

Each year, the Nebraska Rural Health Association honors people who have contributed to rural health care through leadership at its annual conference. These awards recognize individuals and organizations who take on leadership roles in healthcare and their communities. Each year, the Nebraska Rural Health Association solicits nominations for four awards and your input is very valuable to us.

The **Integrated Rural Healthcare Award** is open to any provider giving primary care, mental health, and substance abuse collaborative care in rural areas of our state (outside of Douglas, Lancaster and Sarpy counties). The distinction of this award is the collaborative model, the methodology, the types of providers, the issues they are having problems with and the successes they have seen. The provider can be an individual, a team, a system or partnership. Integration can be with two or all three of the components (primary care, mental health, and substance abuse). Nominations are accepted from patients, fellow providers, or employees of the provider.

The **Outstanding Rural Health Practitioner**

Award recognizes an individual that is a direct service provider who provides direct patient care such as physicians, nurses, physician assistants, nurse practitioners and others. This individual must exhibit outstanding leadership in bringing and/or improving health services in rural Nebraska. Factors taken into consideration include providing outstanding care; collaboration and multi-disciplinary teamwork; involvement in the community; involvement in education; and lasting contribution to the rural health care system.

The **Rural Health Achievement Excellence Award** recognizes an individual in the health care industry or leadership and noteworthy initiative in promoting the development of community oriented rural health care delivery. Factors for selection should include: distinctive efforts to promote and/or improve rural healthcare and provide lasting contributions to health care. This award recognizes noteworthy initiatives in the development of community-oriented rural health care delivery.

The **Rural Health Distinctive Consumer Advocate Award**: It is important to recognize that

Continued on page 11

Workforce Data *cont'd from p. 11*

of Nebraska Foundation Larson Medical Fund, shows a favorable number of providers per capita in Nebraska's urban areas but not in most rural communities. "We do have an issue of maldistribution for many of the (types of) providers," Dr. Nayar said.

Eighty-four of the state's 93 counties are non-metro counties. Those counties have 42% of the state's population. Yet, that 42% is served by only 28% of the physicians in Nebraska, 20% of the psychiatrists, 32% of the nurse practitioners, 35% of the dentists, and 37% of the pharmacists, said Dr. Nayar, citing 2008 data.

Workforce study data show that 79 counties have no psychiatrist, 18 are without a physician, 20 without a dentist, 37 without a mental health professional, 22 without a pharmacist, 37 without a nurse practitioner, 24 without a physician assistant, and 10 without a registered nurse.

However, she said, "I would add a caveat. Some of those are 'Frontier Counties.'" Those are counties with seven or fewer people per square mile. Some of those counties may be too sparsely populated to feasibly support a healthcare professional in the county, she said.

Beyond the matter of too few providers for the population being served is the aging of practicing professionals. Many of them are approaching retirement age in rural communities, which underscores the importance of projecting future needs for health professionals, Dr. Nayar said.

The 10 years of staffing data collection was

carried out by two sources. The Health Professions Tracking System (HPTS) in the College of Public Health at UNMC collected the data on physicians, dentists, pharmacists, nurse practitioners and physicians. Data on other health professional staffing was collected through the Nebraska Department of Health and Human Services licensure and regulation system, and based on addresses of the licensees. One limitation to that method of data collection, Dr. Nayar said, is that just because a provider is licensed in Nebraska doesn't necessarily mean that licensee is practicing in Nebraska.

The workforce study ends this August. Its findings and strategies developed with the assistance of stakeholders in meetings such as the one this June will be made available to the Nebraska Legislature.

Data collection and findings from the study are being shared with the state's Office of Rural Health that offers Nebraska medical students loan repayment incentives for practicing in the state after graduation and administers the National Health Service Corps scholars program through which medical scholarships are granted.

Strategies developed from the study findings might, for example, look at developing rural health incentives and place more emphasis on promoting rural health opportunities in medical school training programs, according to Dr. Nayar.

"The central message," she said, "is that we have a lot of success in growing our own, but we do have challenges in retaining them. We do export a lot of professionals, but that's part of our mission." □

Awards *cont'd from p. 10*

rural health care delivery systems will survive only with the involvement of rural consumers. This award honors an individual consumer, who is not an employee in the health care or health insurance industry, for active participation within his or her community and/or region regarding rural health service delivery issues. For example, the award winner may have testified to the state or national legislature on rural consumers' health care needs or made lasting contributions to rural health care in their community, region, or state. The nominee should be current on rural consumer health care issues and must have shown leadership in community and education regarding health care changes, needs, or improvements.

Awards will be presented at the annual Nebraska Rural Health Conference in September. □

Notice to our Readers

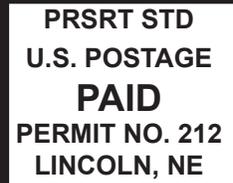
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ACCESSory Thoughts

Dennis Berens, Director
Nebraska Office of Rural Health

Health Care Reform in 2009

Webster: REFORM: *to put an end to an evil by enforcing or introducing a better method or course of action.*

Wikipedia: REFORM: *a beneficial change, or sometimes a reversion to a pure original state.*

"Reform" is serious stuff whether we consider a dictionary definition of the word or if we just look at what is happening in our society: close to 50 million uninsured, a bankruptcy every 30 seconds caused in some way by health care debt, and neighbors who have just lost their jobs and insurance.

How would you like to see this changed?

The context of our current health care reform discussions looks and feels different from the 1992 version of health care reform. One issue that remains is that of terminology. We need to make sure that we understand the terms that are being used and ask for definitions when needed.

So what would I ask for in 2009? What would be the beneficial change that I would want for rural areas?

I propose eight ideas that I think would help rural areas and people. I framed all of them in the context of health care access:

1. Access means more than insurance. Do we want prevention, integration, and care closer to our homes?
2. Access means a new way to think about how we provide basic health care services. Should we utilize an income-based model over an employer-based model as the basis for health care reform discussion?
3. Access must now include the health care workforce. Whom do we recruit, how do we train the recruits, and what incentives must we offer to get them to serve in remote areas?

4. Access now means that we look at the role, scope and practice models of our present health care workforce. What else could each of them do? How do we allow for creation of new health care and prevention models?
5. Access now includes a renewed focus on quality. Personal health records can help us to push this issue from the bottom up. The citizen, the marketplace and the payers are all asking for better quality.
6. Access means looking for the best use of the many tools we now have at our disposal. Broadband, health information technology, electronic health records and even more Internet tools are available to serve our health care continuum of needs. How do we change the health care provider culture to better use these resources?
7. Access means reframing terms such as "consumer choice" to "consumer empowerment." Empowerment and choice most often happens in a larger societal context. What types of choices do we want, and what choices, collectively, can we have? Empowerment enables choices to be taken by each of us.
8. Access should now include linking of all safety net provider systems. Other public and private health care systems also need to be linked in new ways. Rural and underserved populations should be able to find the health services they need within their local areas, in person and/or through support from telecommunication models.

I put these eight on the table to help us begin to identify what reform models are most important to each of us. Begin the conversations in your community and send your recommendations to those you see as players in this year's reform efforts.

And bring your ideas to the Annual Rural Health Conference on Sept. 17-18 in Kearney, Nebraska. We will have a session or two on this important issue. Together we can bring reform. We can create a better model. □