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 58, May 2010

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An Overlooked VA Care Benefit?

by David Howe

Some military veterans who need assistance with the cost of care-giving may qualify for a benefit called "Veteran's Aid and Attendance Benefit."

It helps with the cost of such on-caring care needs as assisted living, in-home care, and nursing home care for veterans and their spouses, who have limited financial resources.

Although this Veterans Administration benefit has been available for a number of years, it's not widely known, according to an ACCESS newsletter reader, who called attention to the benefit.

The benefit is available to both veterans who receive service-connected disability compensation and those who have non-service-connected disabilities, according to Aaron Nielsen, Public Affairs Officer in the U.S. Regional Veterans Affairs office in Lincoln.

The Aid and Attendance benefit is also available to veterans' spouses who need ongoing care. "The veteran must be service-connected for a disability at the 30% rate or higher," Nielsen said.

For veterans with a non-service-connected disability that requires on-going care, Aid and Attendance Benefit eligibility is subject to income and net worth limitations.

That's not the case, however, for veterans receiving service-connected disability compensation. They can qualify for the Aid and Attendance benefit, regardless of net worth or income, including whatever level of disability (Special Monthly Compensation) they receive, according to Nielsen. The Aid and Attendance Benefit is in addition to the monthly disability compensation, he said. "It's just an additional amount of money." There is no income threshold, or net worth limit.

For non-service-connected disabilities, Aid and Attendance Benefit covers the amount by which a veteran's total household income falls short of the Maximum Aid and Attendance Benefit, which is based on such factors as marital status and number of dependents (see several examples in the table on page two).

For example, a married veteran who needs on-going care, has no dependents, and has total household income of $15,000, would be eligible for the difference between the $15,000 annual household income and the maximum benefit of $19,736, or a benefit of $4,736 annually to cover care costs.

Household income that counts toward the eligibility includes any pensions and Social Security minus un-reimbursed "common medical expenses." Those common medical expenses could be anything from hearing aids and batteries to wheelchairs and medical exams—even acupuncture. Household income used in calculating eligibility is reduced by those medical costs, according to Nielsen.

Net worth is another financial factor in determining eligibility for Aid and Attendance in conjunction with a non-service-connected

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VA Care *cont'd from p. 1*

disability. Net worth can't exceed $80,000. The VA does an "Asset Determination" to establish net worth, Nielsen said. "This program is not designed to save the veteran's nest egg," he added. It's designed to help veterans and their spouses with the cost of in-home care, assisted living facilities, and nursing homes in circumstances where financial resources are limited.

Assets that count toward the $80,000 limit are "basically something that could be quickly turned into income," he said. That would include such assets as farmland, commercial real estate, stocks, and bonds.

A couple of items that don't count toward the $80,000 net worth limit are a residence and an automobile.

Veterans on Medicare or Medicaid cannot draw either of those benefits in addition to Aid and Attendance, according to Nielsen. "Basically, they are not entitled to both." However, he said, those receiving Medicare or Medicaid can receive an additional $90 per month as Aid and Attendance.

Other qualifying factors for the Aid and Attendance Benefit, whether for service-connected or non-service-connected disability:

- Received a discharge other than dishonorable from the military service.
- Served at least 90 days or more of active military duty, including at least one day during the war-time period. (Those who entered active duty on or after October 16, 1981, may have to meet a longer minimum period of active duty). War-time periods for World War II are December 7, 1941, through December 31, 1946. For the Korean Conflict, it's June 27, 1950, through January 31, 1955. For the Vietnam War, it's August 5, 1964, through May 7, 1975, and for veterans who served "in country", it's before August 5, 1964, and February 28, 1961, through May 7, 1975. For the Gulf War, it's August 2, 1990, through a date to be set by law or Presidential Proclamation.

About 1,350 veterans in Nebraska are currently receiving non-service-connected pensions. The VA doesn't break out how many of those veterans are receiving Aid and Attendance, Nielsen said. However, he added, "If I were to guess, I would say a majority."

VA County Service Officers can answer questions about this benefit and other VA benefits, Nielsen said. "Every county has a VA County Service Officer. They know all of the benefits." In a few cases, a couple of counties in Nebraska may share a Service Officer, he added. County Service Officers are usually located in the county courthouse.

VETERAN'S STATUS	2010 MAXIMUM BENEFIT*
Veteran with no spouse or dependent children	$19,736
Married veteran who requires aid, with one dependent	$23,396
Surviving spouse of veteran	$12,681
Veteran is healthy but the spouse requires care	$15,493

**Add $2,020/year for each additional child to any category.*

Application forms for the Aid and Attendance Benefit "can get a little lengthy," Nielsen noted. But, County Service Officers can help with applications. Once the initial application is completed, annual paperwork is simpler, according to Nielsen.

Service officers are "invaluable" in helping veterans. They are able to tell veterans about other benefits that they may be entitled to, he added.

"We try to reach every veteran out there and encourage them to file (for benefits)," Nielsen said. There is no cost. "Lots of vets feel they don't deserve it. But it's something they're entitled to." ☐

2010 Nebraska Rural Health Conference
September 16-17, 2010
Kearney Holiday Inn
Kearney, Nebraska

Sessions planned include:

- Skill Training for Challenging Times
- Health Care Reform and its Impact for America and Rural Nebraska
- Health Information Technology: The Latest Information
- Nebraska Legislative Update
- Workforce Challenges and Opportunities
- High-Tech Extension Center Support for Rural Providers
- Behavioral Health Issues and Actions
- Rural Health award presentations

...and many other topics of interest!

For more information, contact Melissa Beaudette at mbeaudette@mwhc-inc.com

California connection a first for Health Information Exchange

by David Howe

Thayer County Hospital CEO Joyce Beck's February visit to a California medical center for a wellness check amounted to a bit of trail-blazing in health information technology.

Her medical center visit in California was to complete a wellness check, which she began in Hebron, Nebr. It involved use of open source software developed under the federal Office of the National Coordinator (ONC) for Health Information Technology.

Beck's electronic health record (EHR) at the hospital in Hebron, Nebr., was exchanged with the Alliance Medical Center in Healdsburg, Calif. Her trial run involved software standards, protocols, etc. developed under the auspices of the Nationwide Health Information Network (NHIN). Her health record exchange was a national first, she said. "I was the first patient to use this software to exchange patient information between two Health Information Exchanges (HIEs)." But, back to that in a moment.

First, some explanation. The focus in health information exchange has been mainly on exchanges linked together within states. Tying those health information exchanges together across the U.S. has lagged. NHIN's focus, on the other hand, is devoted to protocols, legal agreements, specifications, and services designed for secure exchange of health information over the internet among health information exchange networks across the U.S., not just locally.

Under NHIN standards set forth by the ONC in the U.S. Department of Health and Human Services, an open-source gateway software called CONNECT has been developed. It supports interconnectivity among health information exchanges being set up around the country. Software code written under those

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Save the Date!
2010 Nebraska Rural Health Conference
September 16-17, 2010 - Kearney, NE
Info: www.RuralHealthWeb.org

CONNECT *cont'd from p. 3*

standards can be interfaced with this gateway software at less cost than code written under other standards, according to Beck. That's why it's important for Thayer County Health Services to participate in NHIN and use vendors with software that interfaces with the gateway software under NHIN standards, Beck said.

It's the first Nebraska hospital to sign up with NHIN, according to Beck. She acknowledged that not many hospitals are on NHIN at this time. "But, in my opinion, it's the future," she added.

Providers taking the NHIN route include the Veterans Administration and the Department of Defense, she said. Serving the local community's military veterans is one of the hospital's important missions, Beck said. "That's another reason we chose NHIN."

Among other NHIN Cooperative participants, according to a Health and Human Services Health Information Technology website are: Centers for Disease Control and Prevention, National Cancer Institute, Social Security Administration, several universities, and other health information entities.

Software company Mirth Corporation, whose software has been built on the foundation of the aforementioned open-source CONNECT software under NHIN standards, describes in a news release the cross-country exchange of Beck's health information:

"By using Mirth's Meaningful Use Exchange (Mirth MUx)—built on the foundation of the open source CONNECT software developed by the Federal Health Architecture program under the Office of the National Coordinator—California-based Redwood MedNet and Nebraska-based Thayer County Health Services securely bridged their respective Health Information exchanges. They safely and successfully exchanged live patient records, the first such demonstration to take place between health information exchanges in the U.S., using the CONNECT software.

"The cross-country health data demonstration began on January, 29, when a patient (Beck) went to an office visit at Thayer County Health Services. That office visit was documented by an encounter note listing current medications and a new laboratory test. Then, in the first week of February, the patient took a sightseeing vacation to visit the Redwood rainforest on the North coast of California. The patient scheduled an office visit on February 5, at Alliance Medical Center, a Federally Qualified Health Center in Healdsburg, Calif.

"During the patient visit, Redwood MedNet enabled the clinic staff at Alliance to download the patient medication history and lab test from the office visit the prior week at Thayer County Health Services by using the Mirth MUX CONNECT gateway. During the office visit in Healdsburg, the Alliance physician noted the patient's prior lab test and medication history from Nebraska. On the basis of this data, the physician decided that a different laboratory test was needed.

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MARK YOUR CALENDARS

NRHA Rural Medical Educators Conference
May 18, 2010 - Savannah, GA

2010 National Rural Health Association Annual Conference
May 18-21, 2010 - Savannah, GA

NRHA Medication Use in Rural America Conference
June 16 - 18, 2010 - Kansas City, MO

Nebraska Rural Health Advisory Commission Meeting
June 18, 2010 - Lincoln, NE

NRHA Quality and Clinical Conference
July 21 - 23, 2010 - Portland, Maine

2010 Annual Nebraska Rural Health Conference
September 16-17, 2010 - Kearney, NE
www.RuralHealthWeb.org

NRHA Rural Health Clinic Conference
Sept. 28 - 29, 2010 - Kansas City, MO

NRHA Critical Access Hospital Conference
Sept. 29 - Oct. 1, 2010 - Kansas City, MO

NRHA Rural Multiracial and Multicultural Health Conference
Dec. 1 - 3, 2010 - Tucson, AZ

CONNECT *cont'd from p. 4*

"After the office visit, the patient walked next door to the laboratory at Healdsburg District Hospital for the new lab test. Within 45 minutes, the electronic lab test result had been pushed from the hospital lab to Alliance Medical Center via Redwood Med Net, and the test result was also instantly available via the Mirth MUx CONNECT gateway to the patient's primary care provider in Nebraska."

Describing her experience with the trial run, Beck said, the physician in California pulled up her Hebron electronic health record on his laptop. "It's like it (record in Nebraska and in California) is in the same place," she said. "I can't describe what a wonderful experience that was. It was like a glimpse into the future. This is the way we could deliver healthcare and we could do it nationwide."

Back in Hebron, Beck's physician Dr. Bryan Hubl, a staff physician at Thayer County Health Services hospital, had immediate access to her electronic health record with the newly added California lab test results.

He views interoperable electronic health records as a way to exchange health information quickly over long distances. You can go right to the information you want in the medical records, he said, which is a time-saver.

He noted, however, that in view of multiple software providers, progress toward meeting government standards for interoperable electronic health records nationwide has a ways to go. "I still think we're very early on. We are just getting started."

The technology for health information exchange among providers nationwide "can come rapidly," Beck said. Developing legal agreements among providers for that exchange will come more slowly, she added.

An important next step envisioned by Beck is development of a comprehensive agreement to govern the exchange of health data through NHIN. Such an agreement is being developed by a work group within NHIN. It's called DURSA, or Data Use and Reciprocal Support Agreement.

The NHIN website describes DURSA thus: ". . .a vehicle for creating trust relationships among the NHIN health information exchanges participating in the NHIN. It memorializes the expectations for NHIN health information exchanges in a 'network of networks' with respect to the behavior and activities of other NHIN health information exchanges."

Such an agreement would be a "multi-party agreement" negating the need for "point-to-point" agreements with each NHIN health information exchange. Point-to-point agreements would be "difficult, costly, and inefficient as the number of NHIN health information exchanges increases," the website stated.

Meanwhile, Thayer County Health Services is among several rural hospitals which have applied for a Beacon Grant. This federal grant would help fund other providers in Nebraska who could follow suit under NHIN. Those providers include hub hospitals such as St. Elizabeth Medical Center and Bryan LGH in Lincoln, critical access hospitals in Auburn and Crete, physician clinics and long-term care facilities. ☐

2010 Lifespan Health Services Conference

"Setting a Course for a Lifetime of Good Health"

May 11 & 12, 2010

Holiday Inn Convention Center - Kearney, Nebraska

Topics Include: Healthy Weight, Genetics, Social/Emotional and Mental Health, Prevention through screening, health maintenance, NESIIS, Reproductive Health, Research Lifecourse Topics and many more

Sponsored by:
Nebraska Department of Health and Human Services - Division of Public Health - Lifespan Health Services and Development Systems, Inc.

By John Roberts

Nebraska Rural Health Association is promoting The Florence Challenge for all of Nebraska's Rural Health Care Providers

When Florence Nightingale walked into the Scutari Barrack Hospital on November 4 of 1854 it was what one eyewitness called "a vast field of suffering and misery." More than a thousand soldiers were sick and dying, most of them still in the uniforms they'd been wearing on the battlefield days or weeks before. Infection was rampant and rats ran wild. There was no ventilation or fresh water, the food was inedible, and there were virtually no drugs or medical supplies. Amputations were performed without anesthesia in full view of other patients, and most amputees quickly succumbed to gangrene. The orderlies were often drunk, and refused to empty chamber pots or go near the sickest patients. There was no money for even the most basic essentials. Several dozen patients died every day.

And we think we have a health care crisis!

If Nightingale were to visit your hospital today, she would be astonished by the technology you have available to you. She would think it nothing short of miraculous that you can: pump fresh air into a patient's room without having to open a window and pray for a breeze; look inside a patient and see what's wrong without having to cut the patient open; cut a patient open to repair a damaged organ, sew the patient back up, and send him or her back home later the same day; and that there is a simple pill that could have saved all those thousands of British soldiers who died of infection while fighting for their queen.

She would also be dismayed that we actually require a movement for patient-centered care (what other kind is there?, she would wonder). She would be nonplussed to see caregivers sitting in the break room gossiping about patients or coworkers. For all of the hundreds of books and articles that have been written about workplace empowerment, she would wonder why there is so much learned helplessness in modern hospitals (she herself once said that the secret of her success was that she never gave or took an excuse).

Were she to return today, Florence Nightingale would challenge us to foster a spirit of ownership in our personal approach to work and a culture of ownership in our hospital organizations. She would challenge us to eradicate toxic emotional negativity and foster a stronger sense of commitment, engagement and pride. She would challenge us to bring down the silo walls and promote a spirit of fellowship and belonging.

Nightingale died one hundred years ago, and so while her spirit still lives in every hospital, she herself will not be showing up at your front door to issue that challenge to you and your people. So I've done the next best thing. I

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Veterans hotline and online chat

With Help Comes Hope

Are you in crisis? Please call 1-800-273-TALK

Are you feeling desperate, alone or hopeless? Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), a free, 24-hour hotline available to anyone in suicidal crisis or emotional distress. Your call will be routed to the nearest crisis center to you.

- Call for yourself or someone you care about
- Free and confidential
- A network of more than 140 crisis centers nationwide
- Available 24/7

Present Challenges . . . Future Hopes for telehealth

By Donna Hammack

Helping people learn more about telehealth and inspiring them to develop new uses for it are the reasons behind a conference, "Present Challenges . . . Future Hopes," that will be held in Omaha on July 22 and 23.

Sponsored by the Nebraska Statewide Telehealth Network, the 1 1/2 day conference will take place at the Embassy Suites in the Old Market (day one) and at the University of Nebraska Medical Center (day two).

The conference will feature national experts, including David Blumenthal, National Coordinator for Information Technology, discussing the resources for and the uses of electronic health records, etc. for the delivery of quality services.

Telehealth is defined as the delivery of health-related services and information via telecommunications technologies. Telehealth is an expansion of telemedicine, but unlike telemedicine, which focuses mostly on the curative aspects, telehealth also encompasses preventive and informational and curative. Originally meant to describe administrative or educational functions related to telemedicine, today telehealth encompasses a myriad of technology solutions.

The July conference is dedicated to creating awareness and increasing knowledge of telehealth and information technology while inspiring attendees to develop new applications appropriate to their unique situations. Physicians and other health care professionals will learn how to use technology to diagnose and manage health care for patients.

Featured speakers from across the country represent various aspects of telehealth. Steve VanHoosen, chair of the education committee of the NSTN says, "The conference will provide something for everyone, whether a novice or an experienced practitioner in telehealth."

Following is a listing of individuals who have committed to sharing their expertise:

July 22, 2010

- Joe Tracy, VP of telehealth services, Lehigh Valley Health Network, Allentown, Pa., will speak on "Changing the System." He is currently chair of the Center for Telehealth and E-Health Law in Washington, D.C.; he chairs the HIMSS Legislation and Regulation Review Task Force; and is former vice chair of the Telemedicine Association's Policy Review Committee.
- **An understanding of fundamental and changing issues related to telehealth** will be presented by members of the Great Plains Telehealth Resource Center: Marilyn Dahlmer, RN. who will discuss reimbursement, credentialing, standards of care, patient education and informed consent, clinical documentation, patient preparation and presentation; and Mary DeVany who will discuss expanding program awareness, building internal support, tracking important data, and addressing sustainability.
- **Successful Telehealth Applications in Teleburn and TeleICU** will be demonstrated by Joe Tracy. Ann Bynum, Ph.D., from the University of Arkansas will explain a **successful home monitoring** project that manages asthma in a rural pediatric population.

July 23, 2010

- Bob Bartee, vice chancellor for external affairs at the University of Nebraska Medical Center, will welcome **David Blumenthal M.D. M.P.P., National Coordinator for Health Information Technology,** who will share a national vision to advance healthcare technology.
- Joyce Beck, administrator of Thayer County Hospital in Hebron, Nebraska, will talk about how a critical access hospital became **a model paperless CAH producing quality outcomes.**
- **The Angels Program (Maternal-fetal**

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program) will be presented by Dr. Ann Bynum. Utilizing interactive compressed video, conferences enable physicians to confer with specialists about real-time cases. A call center and clinical consultations are available, providing subspecialty support directly to hometowns.

- The **political landscape on the federal level** will be explored with Greg Billings from the Telehealth Leadership Initiative, Washington, D.C
- Dennis Berens from the Nebraska Office of Rural Health and president of the National Rural Health Association will address **challenges and opportunities for the future.**
- All aspects of **Tele-Emergency** from training to subspecialty support (telestroke, teletrauma, etc.) will be covered by Dr. Robert Galli from the University of Mississippi Medical Center. The program has seen more than 120,000 patients with trained nurse practitioners at rural hospitals linked to the medical center's Level 1 trauma center.
- The **seven steps of developing a home telehealth program** will be presented by Sam Burgiss, Ph.D., who has done extensive work in this area at the University of Tennessee. He has developed a manual for the National Rural Health Association.

Participants may take advantage of additional learning opportunities with a tour of UNMC facilities, including the new simulation center. Time for networking with colleagues has been built into the conference schedule, talking place in the quaint Old Market setting. Participants are encouraged to bring their families and enjoy the ambiance.

Conference registration is $80 for two days and $50 for one day. Conference rate at the Embassy Suites $109 (honored for the days of the conference as well as for three days before and after). For more information, contact Donna Hammack at 402-219-7052 or dhammack@stez.org. ☐

"PRESENT CHALLENGES...Future Hopes"

A Telehealth & Information Technology Conference

Thursday, July 22 – 12:00 p.m.
Embassy Suites, Omaha NE

Friday, July 23 – 8:00 a.m.
UNMC Omaha, NE

- **Learn about telehealth applications from experienced providers:**
  - **High-risk Obstetrics**
  - **Teleburn**
  - **TeleICU**
  - **Tele-Emergency**
- **Get great rates for registration/hotel**
- **Network and learn from colleagues**
- **Receive the latest updates on–reimbursement, credentialing and more**
- **Learn how to create a paperless environment in a CAH**

This event is sponsored by the Nebraska Statewide Telehealth Network.
For questions please contact dhammack@stez.org.

Rural Health Clinic "bits and pieces"

by Janet Lytton

Nebraska Medicaid is going to the Prospective Payment System. With this payment methodology, there are no year-end settlements to or from clinics. All RHCs are still required to submit a copy of their annual cost report to the Department of Health and Human Services.

In order for this state to set clinic rates, the IRHCs are being asked to submit copies of their prior cost reports. For a clinic that has been an IRHC on or before 1999, the clinic needs to send Nebraska Medicaid a copy of their "settled" Fiscal Year 1999 and 2000 cost reports and for a new clinic after 2000, the clinic needs to send to Nebraska Medicaid their first Fiscal Year's "settled" cost report. When Medicaid receives these cost reports they will set your rate.

For the older clinics (certified before 1999) the rate will be an average of the 1999 and 2000 average cost and that rate will be updated on an annual basis for every year thereafter by the Medicare Economic Index (MEI). Clinics Certified after 2000 will have a rate set at the first year's cost and then updated on an annual basis for every year thereafter by the Medicare Economic Index. Once the rates are set, the rates will increase per the Medicare Economic Index for each year thereafter. CMS computes the MEI on an annual basis and is most generally posted during the last quarter of the year.

RHCs are required to submit claims to NE Medicaid by line item entry. This will require that there be only one 521 revenue code on the claim and there must be an E & M CPT code associated with that revenue code. If the patient only had a procedure performed, this procedure code must be cross-referenced (changed) to an E & M code. This code should have the charge of the procedure reflected in the charge field locator. Please note, it is not against coding guidelines to submit claims in this manner if it is the request of the payer. All other CPT codes and associated revenue codes are to be listed on the claim, i.e. 250 (drugs).

Many of the IRHCs in the state have been assigned Cahaba as the payer of their Medicare RHC claims. Cahaba took over the workload of Riverbend Government Benefits Administration, as the IRHC Medicare payer. However, if there is a clinic that is going through or contemplating certification as an RHC, these clinics will have Wisconsin Physician Services (WPS) as their Medicare RHC claims payer. WPS is the Medicare Administrative Contractor (MAC) for CMS Region V. This includes any clinics that are adding sites to their present clinic operation.

For any RHCs with the FYE of 12/31/09, the cost reports are due by the end of May, 2010. Since there have been so many problems for clinics trying to use the new IACS system to obtain the Provider Statistical Reimbursement Summary, Cahaba has sent out the reports for this past fiscal year. It will be the clinic's responsibility to obtain this report in the future. It is suggested that each clinic continue to get on the IACS system and have all passwords and access capability throughout the year so it won't be such a burden next year.

The NARHC Spring Institute in San Antonio was a huge success with lots of good information and the largest attendance to date. The next conference will be in October 2010 in Reno, Nevada. You can get all the information at www.narhc.org. To date, none of the proposed RHC regulations have been adopted. These were not part of the new Healthcare Reform Bill. In the new healthcare reform bill, FQHCs have been given the "go ahead" to contract with RHCs to serve the "uninsured" and the RHC can negotiate a rate for serving these patients. As a result, the FQHC will be allowed to include these patients in their practice. This is seen as a "win, win" situation as this will utilize all clinics and not have an area construct a new FQHC facility.

For more information, contact Janet at RHCconsultJL@hotmail.com. ☐

The economic impact of Critical Access Hospitals in Nebraska

By David Palm

What is the economic impact of a Critical Access Hospital? Michelle Lampman from the Nebraska Center for Rural Health Research estimated the impact of the 65 Critical Access Hospitals on the state's economy.[1] To determine that impact of Nebraska CAHs in 2006, the IMPLAN software model was used to predict changes in overall economic activity as a result of change in the Critical Access Hospitals (CAH). The IMPLAN software model analyzes county level data using an economic input-output model. Certain information required for reporting CAH impact could not be obtained from the 2006 IMPLAN database alone. For supplemental data, the Center used the information from *American Hospital Association Annual Survey Database: Fiscal Year 2007 & 2008* to calculate estimates used to analyze CAH data (see table below).

Job creation

- One job created in a Critical Access Hospital in Nebraska would lead to the creation of another 0.85 job in other sectors of the state's economy.
- The 7,931 jobs in Critical Access Hospitals in Nebraska created (through a 1.85 multiplier)[2] an additional 6,741 jobs in Nebraska.
- The overall job creation due to Critical Access Hospitals in Nebraska (directly and indirectly) in Nebraska is estimated at 14,672 jobs.

Income Earned

- One dollar of income earned in a Critical Access Hospital in Nebraska would lead to another $0.73 of income earned in other sectors of the state's economy.
- The $296.89 million of income earned in Critical Access Hospitals in Nebraska has created (through a 1.73 multiplier) another $216.73 million of income in the state.
- The overall income earned due to Critical Access Hospitals in Nebraska (directly and indirectly) in Nebraska is estimated at $513.62 million.

Economic Output

- One dollar spent in Critical Access Hospitals in Nebraska would lead to another $0.85 spent in other sectors of the state's economy.
- The $823.90 million spent in Critical Access Hospitals in Nebraska has created (through a 1.85 multiplier) another $700.31 million of spending in the state.
- The overall economic output (direct and indirect) into Critical Access Hospitals in Nebraska is an estimated $1.52 billion.

Conclusion

In conclusion, Critical Access Hospitals have a significant economic impact on their communities. Although the economic impact is substantial in terms of jobs created and income earned, these hospitals also benefit the community in other less direct ways by providing charity care, community health education, and outreach services (e.g., nutrition and fitness programs), and medical education (e.g., scholarships for future health professionals). In comparison with urban and regional hospitals, the economic impact of Critical Access Hospitals is relatively small. However, these hospitals are usually one of the largest employers in the community, so the proportional economic impact on the community is likely to be greater.

For more county and statewide economic impact studies, go to http://www.unmc.edu/rural/NeRHW. Most Nebraska counties have now been analyzed. ☐

[1] Michelle Lampman, "Economic Impact of Critical Access Hospitals in Nebraska," unpublished data, the Nebraska Center for Rural Health Research, the University of Nebraska Medical Center, February 2009.

[2] Multipliers represent the measure of total change throughout an economy from one unit change for a given sector. Multipliers are derived from the direct and indirect spending, plus induced effects (e.g. household spending based on the income earned from the direct and indirect effects) obtained from the IMPLAN database Total Requirements Table. Specifically, the Type SAM Multipliers, which are Type II Multipliers that have been adjusted based on spending patterns amongst different income groups were used.

The Economic Contribution of All Hospitals on the State's Economy (2006)

	Current Amounts	Multiplier	Additional Amounts Created	Total Impact on State Economy
Jobs	41,000	1.95	79,950	120,950
Expenditures	$4.2 Billion	2.1	$8.8 Billion	$13 Billion

Patient Safety Demonstration Project – opportunity to participate

By Jennifer Faber, Pharm.D. and Kevin Fuji, Pharm.D. (Creighton University)

The Creighton Center for Health Services Research and Patient Safety (CHRP) is currently conducting the Pharmacists for Patient Safety Project, led by Dr. Jennifer Faber, Dr. Kevin Fuji, and Dr. Kim Galt. This project is continuing work initiated by the Dyke Anderson Patient Safety Grant, in which a statewide survey of Nebraska pharmacists was conducted to assess and better understand the patient safety issues faced in practice. Pharmacists described a range of patient safety problems, covering everything from time and workload issues, to the increased use of health information technology. Pharmacists want to share their patient safety experiences with others through a rapid feedback safety reporting system to help each other improve safety and quality for their patients.

A Patient Safety Event Reporting website was created to provide pharmacists a HIPAA-compliant mechanism to share patient safety problems they are experiencing in their practice. The CHRP Expert Safety Panel, composed of interdisciplinary patient safety experts, will review patient safety event reports and develop best-practice recommendations for addressing the patient safety event. These recommendations will be disseminated out through an e-mail list-serve of all participating pharmacists. It is believed this is beneficial to rural pharmacists, who are often geographically isolated and may not have a good outlet for sharing their safety problems with others.

Initial testing of the Patient Safety Event Reporting website has begun with two pilot sites. Anyone interested in participating in the project is encouraged to contact Dr. Jennifer Faber (JenniferFaber@creighton.edu) or Dr. Kevin Fuji (kfuji@creighton.edu).

This research project is co-sponsored by the Community Pharmacy Foundation and the Nebraska State Office of Rural Health, and has been approved by the Creighton University Institutional Review Board (#08-14972). ☐

Funds To Achieve Long-Term Economic Growth in Rural Areas

In April, Agriculture Under Secretary for Rural Development Dallas Tonsager announced that USDA is accepting applications for business and community development grants to help rural communities.

The funding is being provided through USDA Rural Development's Rural Business Opportunity Grant (RBOG) program, which provides grants for technical assistance and planning activities to improve economic conditions in rural cities or towns of 50,000 people or fewer.

Funding under the RBOG program can be used to pay for economic planning, technical assistance, and training for rural communities, entrepreneurs or economic development officials. Under this round of funding, priority consideration will be given to applications that best demonstrate strong regional or multi-jurisdictional collaboration, referred to as 'great regions', leadership capacity, and those that represent varying demographics (including underserved and under-represented communities). The amount of funding available is $2.48 million.

Applications are due June 28, 2010. More information on how to apply for a USDA Rural Business Opportunity Grant is available at http://www.rurdev.usda.gov/rbs/coops/rbog.htm

To be eligible for funding, an applicant must be a public body, non-profit corporation, Indian Tribe or cooperative with members that are primarily rural residents. Applicants must also have significant expertise in the activities proposed and the financial strength to ensure the objectives of the proposed grant can be accomplished.

For more information, contact Jay Fletcher at (202) 690-0498☐

To be notified when a new issue of ACCESS is available, please go to http://www.dhhs.ne.gov/newsletters/access/ and click on 'Subscribe to Access Newsletter.' (You will also be offered other health-related newsletters from the Department.) After subscribing, you will receive an e-mail notice from the Department letting you know that your subscription has been successfully created.

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

FLORENCE *cont'd from p. 6*

made her a character in the book The Florence Prescription: From Accountability to Ownership, which is the foundation for The Florence Challenge.

By taking The Florence Challenge, we are asking participants to do three things. First is read the book, since the 8 essential characteristics of a culture of ownership that it describes also happen to be essential qualities for a meaningful and rewarding work experience: commitment, engagement, passion, initiative, stewardship, belonging, fellowship, and pride. The unabridged eBook edition of The Florence Prescription is available as a free download at The Florence Challenge website; members of the Nebraska Rural Health Association can also purchase books for just five dollars each.

Second is to take The Self-Empowerment Pledge, which includes seven life-transforming promises, one for each day of the week, on responsibility, accountability, determination, contribution, resilience, perspective, and faith. The resource section of The Florence Challenge website includes links to a slide show on The Pledge as well as a mini-poster for printing.

Third is to join what Carol Jean Hawtrey (a character in The Florence Prescription) called "the positivity conspiracy" by refusing to participate in toxic emotional negativity, and by replacing the words "not my job" with "how can I help?" (If you would like to see an advance copy of my article on "A Positive Approach to Negative People" that will appear in H&HN Weekly in June, email me at joe@joetye.com and I'll send it right out.

The Florence Challenge website also includes a growing array of resources to help you as a leader foster a stronger culture of ownership in your organization. This includes special reports on "The Invisible Architecture of Your Organization" and "Moving from a Culture of Accountability to a Culture of Ownership," a PowerPoint presentation with study questions for The Florence Prescription, and a leader's guide for implementing The Florence Challenge.

You can sign up your hospital to participate in The Florence Challenge by going to: http://theflorencechallenge.com/

For more information on our September 16-17, 2010 conference, please e-mail mbeaudette@mwhc-inc.com.

Joe Tye, the challenge coach, will be the Keynote Speaker at the 2010 Nebraska Rural Health Conference, September 16-17, 2010 in Kearney, Nebraska.□

2009 Family Medicine Survey

by Monica Sanford (SORH intern)

Loan repayment tops the list of concerns for family medicine physicians in Nebraska, according to a survey by the Office of Rural Health last summer.

Other items on the list are financial matters like income disparity, issues related to rural practice, recruiting new family medicine physicians, and practice related issues. The 10-question survey was distributed to Nebraska's 755 family medicine physicians in August 2009. The responses provide important insight for policy writers and educational training centers into the state of family medicine practice in Nebraska.

This is the office's first survey and in-depth analysis of the family medicine physician workforce in Nebraska since 1995. (A complete summary report is available on the Office of Rural Health website, http://www.dhhs.ne.gov/orh/.)

The response rate was excellent, with 391 surveys returned, or 52 percent of the family medicine physicians surveyed. In addition, the Office of Rural Health analyzed demographic data on all 755 physicians, which was provided by the University of Nebraska Medical Center (UNMC) Health Professionals Tracking Service (HPTS).

The demographic analysis reveals a workforce that is now three-quarters male. The percentage of female physicians has risen about 15 percent since 1995. Physicians are mostly between the ages of 36 and 60. Fifty-

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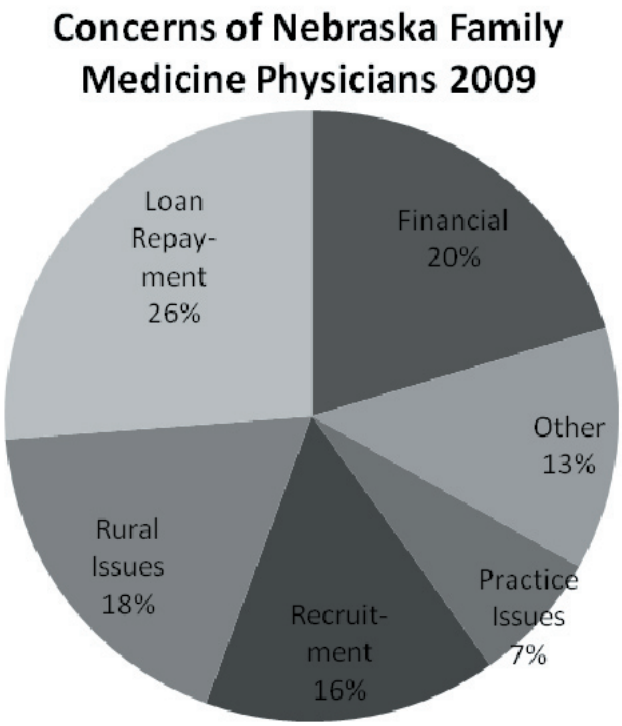
five percent are 50 years of age or younger, with an average age of 48.6 years. With the exception of a high number of Asian physicians, the percentage of minority physicians is lower than the percentage of minorities in the general population. Only 6.5 percent speak any language other than English. Three percent speak Spanish.

According to the (UNMC) Health Professionals Tracking Service, in rural areas and small towns, family medicine physicians make up more than 80 percent of the physician workforce. Only a 10th of Nebraska rural and small-town physicians are specialists. This makes family medicine critical to rural Nebraska's health care system. About half of all family medicine practices within the state are currently recruiting another physician, physician's assistant, or nurse practitioner. Of those practices that are recruiting, 47 percent are located in rural areas with fewer than 2,500 people.

Seventy percent of survey respondents said they intend to remain in their current practice location for seven or more years. Of those who intend to leave their practice, 63 percent plan to retire. Fifteen percent intend to leave the state, and nearly half of that group currently practices in a rural area with a population below 2,500 people.

Few specialists practice in rural areas and small towns in anesthesiology, general surgery, and obstetrics. Thirty-one (31) percent of the responding rural family medicine physicians have discontinued offering obstetrics care, and another 5 percent plan to discontinue it.

The Family Medicine Survey results indicated that providing obstetric practice in rural areas is difficult for family medicine physicians because of the lack of staff support. Many no longer have the capability to perform C-sections under anesthesia and local hospitals are either too far away or the hospital is only able to provide only basic obstetric care. Practicing obstetrics can be detrimental to a physician's lifestyle, especially in rural areas, where they essentially find themselves on



call 24/7 with very little help. Physicians often cease providing obstetric care when they near retirement age, sometimes passing it off to younger partners. Others discontinue in order to spend more time with their own families. Family medicine physicians in urban areas on the other hand often find that there are more than enough OB/GYN specialists to go around and their services are unnecessary. Physicians in both areas cited a decline in the demand for such services, sometimes to the point where they didn't feel they could keep the necessary skills in practice.

The survey also found that financial concerns among family medicine physicians are being exacerbated by the rising level of incurred student debt. Physicians who completed their residencies since 2000 have an average student debt of $125,640 (in 2009 dollars). Respondents working in rural health clinics usually had around a $20,000 additional debt than other family medicine physicians.

Twenty-nine percent of physicians responding to the survey said they received some kind of state or federal assistance to repay medical school loans. Generally, physicians who received loan repayment found

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it to be an important factor in their decision to practice in rural areas, according to our survey responses.

Issues specific to rural practice made up 18 percent of all comments in survey responses. In this category, 41 percent cited hardships directly related to rural practice. Most rural lifestyle hardships centered around lower pay, longer working hours, being on call and lack of call sharing, finding replacements when physicians want to retire, and issues concerning the local hospitals and emergency departments. Twenty-six percent were concerned with gaps in rural healthcare, 9 percent pointed out trade-offs physicians make in choosing a rural lifestyle, and another 6 percent pointed to hardships for physicians' families that arise because they live in rural areas. The remainder of comments had to do with physicians' concerns about the lack of psychiatrists, pharmacists, specialist physicians, and family medicine physicians who offer obstetric care in rural areas.

The comments section also revealed that many physicians feel that the long hours and low pay make rural practice less appealing than urban practice. Others pointed out that there are drawbacks particular to physicians with families, such as the inability of physician's spouses (especially if both are physicians) to find jobs in the same area, or the lack of opportunities offered by local schools for their children. Six (6) percent of physicians didn't feel that loan repayment was enough of an incentive to practice in rural areas given the lifestyle tradeoffs.

The most frequent comment by family medicine physicians in our survey was, why would new graduates go into family medicine when they can make more as specialists doing procedures with higher reimbursement rates.

Survey results seem to indicate that rural lifestyle and low pay are the issues of greatest concern to family medicine physicians practicing in Nebraska today. The impact of state and federal programs may be limited, but the Office believes loan repayment may continue to be of help. Previous studies have suggested the most effective means of ensuring enough family medicine physicians in rural areas is to recruit candidates from those areas starting as early as high school. The Nebraska Office of Rural Health is available to work with communities to both recruit youth into medical school and then recruit medical school graduates back into rural practice.

For more information about this study, contact Thomas Rauner at (402) 471-2337 or thomas.rauner@nebraska.gov. For information about the Nebraska Rural Health Systems and Professional Incentive Act programs, contact Marlene Janssen at (402) 471-2337, or marlene.janssen@nebraska.gov. ☐

Commentary: Workforce 2020

By Roger Wells, Rural Health Advisory Commission

About 10 years ago, my colleague became interested in building a house. It has been his dream for a long time; once he was married and in a stable job, it was time for the dream to become a reality.

Before he began planning the house itself, he made the more important choices regarding the lifestyle and the location and the view he wanted each morning when he got up. Land drainage, water, electrical access, the distance from his work and access to major roadways were his initial concerns.

As time marched forward, he found a beautiful location, removed from but accessible to his work. It had a great view and a sense of peace one might expect in a rural community. It was the location, more than any footing, which was the foundation for the house. And the planning continues, down to the knobs on the drawers.

Like my friend's well-planned house, the Nebraska Health Care Workforce 2020 is now in the planning stage. The Rural Health Advisory Commission will guide various stakeholders to build the plan that is focused on

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rural communities and their needs. What we do now is shaping the future for the professionals of the building we call Workforce 2020.

Our landscape is influenced by storm clouds and the rain, lightning and thunder of legislative changes. But rain brings fresh new grass and flowers whose seeds were planted years ago by current health care workers. The rain also brings new sprouts of ideas to be considered, adapted and fostered.

A recent study by the University of Nebraska Center for Rural Health Research included many recommendations for the future of the professional healthcare workforce. Some of the items included planning ahead with a state health workforce center. This is an absolute need now. The plan for a workforce cannot be started without a view of the needs of the public in rural Nebraska. This includes EMS in remote areas, mental health access, and the traditional needs for access to dentistry, pharmacy and medical care.

Workforce 2020 will gather and analyze data about both the needs of the communities and the needs of healthcare professionals who value a lifestyle not overburdened by long hours and little backup support. Use of new technology and partnerships to help retain workers and improve patient access are at the forefront of the planning process.

These "buildings" of the future must be started now. Planning only on the basis of today's situation is like simply papering over cracks in a house's wall. We need to start planning for the future, developing partnerships, and looking for the ideal model. To accomplish this, team building starts now. Public representatives and professional organizations need to come together to work with the Rural Health Association to start the building process.

According to the recent study by the Center for Rural Health Research, about one third of the medical work force are in the "pre-retirement" age group of 55 years or older and are beginning to leave the workforce. More than 50 percent of medical graduates are now female, while 65 percent of today's rural providers are male. Already, healthcare professionals want to reduce their time at work from the historical standard of 60 to 80 hours a week to a more family friendly schedule.

Communities are having problems recruiting and maintaining EMS volunteers are because of the total time required and directives for education and certification. Nursing homes have more demands and regulations and limited staff resources. Dentists are starting remote dentistry telemedicine as a new service, a new "sprout" for the dental profession.

Our opportunity for the development of a Workforce 2020 is now. We must begin with a dream and then collect data to be developed into an interdisciplinary team-based approach aimed at goals, priorities, and needs assessment. We'll start at the Nebraska Rural Health Association meeting in Kearney. See you in September. ◻

2010 Nebraska Rural Health Conference
September 16-17, 2010
Kearney Holiday Inn
Kearney, Nebraska

Sessions planned include:

- Skill Training for Challenging Times
- Health Care Reform and its Impact for America and Rural Nebraska
- Health Information Technology: The Latest Information
- Nebraska Legislative Update
- Workforce Challenges and Opportunities
- High-Tech Extension Center Support for Rural Providers
- Behavioral Health Issues and Actions
- Rural Health award presentations

...and many other topics of interest!

For more information, contact Melissa Beaudette at mbeaudette@mwhc-inc.com

CIMRO of Nebraska awarded Health Information Technology Regional Extension Center Cooperative Agreement

by Jennifer Rathman

CIMRO of Nebraska has created Wide River Technology Extension Center (Wide River TEC) as Nebraska's Regional Extension Center for Health Information Technology (HIT). Regional Extension Centers were established as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act. $6.6 million was awarded to CIMRO of Nebraska, the Medicare Quality Improvement Organization for the state of Nebraska, as a four-year cooperative agreement grant from The Office of the National Coordinator for Health Information Technology (ONCHIT) to establish Wide River TEC to assist Nebraska healthcare providers with implementing and using Electronic Health Records (EHRs).

In April, Wide River TEC announced the appointment of two leadership staff. Dr. Bob Rauner has been selected as the Principal Clinical Coordinator and Todd Searls, most recently with National Jewish Health (NJH) in Denver, Colorado, has been named the Director.

Dr. Rauner, originally from Sidney, Nebraska, obtained a medical degree from the University of Nebraska Medical Center and completed a residency in family medicine at the Lincoln Family Medicine Program. His prior clinical practice includes five years as a rural family physician in Sidney and the last seven years as a faculty physician at the Lincoln Family Medicine Program. He recently completed a term as the president of the Nebraska Academy of Family Physicians. He will be finishing his master's degree in public health at the Johns Hopkins Bloomberg School of Public Health in May. Dr. Rauner stated, "I look forward to beginning this important work. Wide River TEC has tremendous potential to improve the healthcare for Nebraskans, working in collaboration with our numerous partners and supporters."

Searls joins Wide River TEC after having spent the past several years as a Clinical Systems Supervisor at National Jewish Health. In this capacity, he served as the technical lead and coordinator for NJH's Electronic Medical Record (EMR) implementation, heading a team of analysts who maintained the EMR build and hardware, while at the same time facilitating the adoption of the EMR for both the Divisions of Adult and Pediatric Medicine, totaling almost 200 physicians across 20+ specialties. Since 2001, Searls has implemented and advanced a host of healthcare IT initiatives through senior leadership positions in both independent provider-owned practices, as well as large multi-facility healthcare systems. "I am honored and pleased to accept the position of Director at Wide River TEC. With so many new federal regulations facing Nebraska physicians, my first priority will be to assist these providers in navigating the technical and regulatory challenges ahead, so they may continue to focus on what matters most – their patients," stated Searls.

Wide River TEC will offer technical assistance, guidance and information on best practices to support and accelerate healthcare providers' efforts to become meaningful users of EHRs, as well as the ability to exchange health information with other providers and agencies. Wide River TEC services will be available to all healthcare providers in the state, including those who already have an EHR in place.

Priority will be given to Nebraska practitioners providing primary care in individual and small-group practices; Critical Access Hospitals providing primary care; rural health clinics; Federally Qualified Health Centers; and other settings that serve uninsured, underinsured and medically-underserved populations. Individual provider education and training will be conducted through onsite visits and individualized technical assistance. A team approach will be utilized, with highly-trained nursing informatics and technical specialists providing technical assistance.

If you are a Nebraska practitioner interested in learning more about Wide River TEC's services, visit the Wide River TEC Web site to download the commitment form at www.widerivertec.org. For more information, contact Greg Schieke, Senior Vice President at gschieke@widerivertec.org ◻

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ACCESSory Thoughts

Dennis Berens, Director
Nebraska Office of Rural Health

Workforce is not a four-letter word -- yet.

When I started at the Office of Rural Health in 1990, health workforce issues were what everyone was talking about and wanting help to address. In particular, it was the lack of rural doctors and nurses.

Now it's clear that we're facing many of the same problems again, and things will likely only get worse.

So what happened in the last 20 years?

For one thing, we worked hard in the training centers to find new ways to recruit future professionals. Our office and others stakeholders worked to increase state and federal incentives to entice needed professionals into our rural areas. Local communities reviewed their own incentives and recruitment strategies, and we began to explain to our children that there would be a lot of jobs in the health and health care sector. What did we miss?

I think we missed the need for a long-range plan, at least 20 to 30 years in length, by which all stakeholders could agree to a strategy for sustainability. I also don't think we saw the huge impact that communication and technology would have on our citizenry and our health professionals. We also forgot that the census is only a 10-year window, and we didn't see that life expectancy and expectations were changing -- rapidly. Add the fact that we may lose 40 percent of our professional workforce within the next 10 years due to retirements. We begin to see what must now be addressed.

This issue of ACCESS includes several workforce related stories. We hope these will be helpful as you begin to think about the next steps that will need to be taken to provide an adequate healthcare workforce in rural Nebraska. So what is next?

The Nebraska Rural Health Advisory Commission and the Nebraska Rural Health Association are working together to try to answer that question and figure out what to do next. They are reaching out to other stakeholders to identify the issues, the resources and most importantly the vision that will be needed to keep us all focused on the future. This is a tall order for two small entities, but it is the mission that they agreed was necessary.

Your role will be to agree to help when asked and to volunteer our ideas, our vision and our expertise to assist. We need to work closely with our rural communities to ensure that they have a voice at this and any table that is working on helping them to find quality health professionals. That should include ensuring that our K-12 schools are preparing students for the health care sector and encouraging our kids to consider serving their fellow man right here at home.

The four-letter word that I would like to celebrate in a year or two is "done."

Let's talk about this some more at the Rural Health Conference in Kearney on Sept. 16-17. ☐