

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 61, February 2011

contents

- Doctor of Nursing degree (page 3)
- J-1 Visa program (page 4)
- Nebraska's incentive programs (page 5)
- Rural jobs - rural health (page 6)
- Early childhood mental health (page 7)
- Returning military outreach (page 8)
- Telehealth Network expanding (page 11)

“Souped-up” health information exchange in Nebraska

by David Howe

The Rural Nebraska Healthcare Network's nine hospitals and 32 clinics expect to have more than 600 times the capacity of their existing T1 lines by 2012, to serve their staff and patients.

Those Panhandle hospitals (see accompanying boxed list) and their clinics are being vaulted ahead technologically through a \$17 million-plus Federal Communications Commission (FCC) Rural Health Care Pilot Project approved last fall. The money is financing a fiber optic cable installation that will connect these hospitals and clinics to each other and to other healthcare networks inside and outside of Nebraska.

“It's a remarkable improvement in telecommunications capacity,” said Dr. Todd Sorensen, Rural Nebraska Healthcare Network (RNHN) Project Coordinator and CEO of Regional West Medical Center in Scottsbluff, the hub hospital for the critical access hospitals in the RNHN.

Trenching for the 750-mile fiber optic cable loop linking the RNHN's 41 sites was begun last fall by the construction firm Adesta, LLC. Completion is expected some time the latter part of this year.

Box Butte General Hospital CEO Dan Griess calls the fiber optic system a “dirt road-to-autobahn upgrade” for the RNHN.

To underscore the significance of what it can mean to go from the current 1.5 megabyte/second capacity of a T1 line to fiber optic's 1

gigabyte/second capacity, Sorensen recalled the following actual event: A patient's CT scan was sent via T1 line to a receiving hospital at the same time the patient was placed in an ambulance for transfer to that hospital. The patient arrived before the CT scan transmission was completed. While that might not be the norm, it illustrates how much can be gained by the nearly instantaneous transmission that fiber optic cable offers.

Expanding on that, Griess at the Box Butte General Hospital in Alliance cited as an example a radiological image that takes roughly 25 minutes to move over a T1 line. A file that size would zip through a fiber optic cable “in the blink of an eye,” he added.

He and Sorensen noted that the capacity of fiber optic cable will permit multiple, data-intensive tasks to be carried out simultaneously. These could be interactive audio/video consults between doctors at different facilities, telemedicine conferences, and transmission of radiological images--all being transmitted simultaneously and with lightening speed both among RNHN's 41 facilities and between the RNHN and facilities elsewhere in the state or in other states. That includes hospitals in Denver and Fort Collins to which the network's patients are sometimes referred.

Continued on page 2

Department of Health & Human Services



Nebraska Office of Rural Health • Nebraska Department of Health & Human Services
Division of Public Health • P.O. Box 95026 • Lincoln, NE 68509-5026
(402)471-2337 • <http://www.dhhs.ne.gov/orh/> • Subscribe: <http://www.dhhs.ne.gov/newsletters/access/>

All of this began several years ago when Joni Jespersen, a Hemingford Cooperative Telephone Company employee and Box Butte General Hospital board member was researching communication grants. She discovered the FCC funds for medical communications. She and Hemingford phone company executive Theron Jensen were among early promoters of seeking the funding, according to Griess.

Along with the leap in capacity, the fiber optic cable offers the necessary redundancy and reliability for critical applications such as EMS and telepharmacy. "Using this communication infrastructure, we could emulate a model of patient care used in other parts of the country," Griess said, citing the example of a regional referral hospital in Sioux Falls, South Dakota, which helps to manage intensive care unit patients electronically in a critical access hospital located in Marshall, Minnesota. "The reliability of this fiber optic system would allow us to consider similar patient care models," he added.

Here's some of the background on the funding: \$15 million-plus of the fiber optic cable installation's cost is from the FCC Rural Health Care Pilot Project. The other 15% (\$2 million-plus) is a local matching fund required of the RNHN as a condition of project approval by the FCC's Rural Health Care Division of the Universal Service Administrative Company.

Sorensen explained that an initial effort involving the project was delayed several years ago by FCC restrictions on how the 15% match could be generated. The FCC ruled back then that RNHN's plan to come up with the 15% match by marketing some of its excess fiber optic capacity to a private telecommunications company was not permissible. The FCC later dropped that restriction, allowing the RNHN to generate the 15% matching fund by marketing

excess capacity to Zayo Group, a private telecommunications company. That paved the way for last fall's approval of the RNHN project.

The network has 72 fiber optic cables, of which 24 fibers are for the RNHN's use. Capacity available on the other 48 fibers in the 72-fiber network was marketed to Zayo Group. That company purchased what Sorensen calls an "indefeasible (not capable of being annulled or voided) right to use" of those 48 fibers over the 25-year life of the FCC project.

"Whether we put in 24 fibers or 72, the difference in cost isn't all that much," Sorensen explained. "Once you open up the trench, you should build some excess," he said. "We can add those fibers for relatively minor extra cost."

Most of the fibers will be "dark," available for future expansion, according to Sorensen. The RNHN will start out by using only a small portion of its fiber optic capacity, he added.

RNHN's dark fiber will be available as new technologies come along, some of which may represent exponentially larger data demand, Griess said. "We don't have any clue to what the size of those files (involving new technologies) will be." One example might be "tactile sensations" that make possible virtual hands-on assessment of patients by caregivers at remote sites, according to Griess. Sorensen is confident that no matter how data-intensive those new technologies may turn out to be, they won't exceed the fiber optic system's capacity for many years.

The \$17 million-plus funding covers the cost of bringing the fiber optic capability to the 41 sites in the RNHN, as well as the cost of maintenance and upgrades to the network every 5 years over the 25-year life of the project, according to Sorensen. The funding covers the connection of the fiber optic cable to the hospitals and clinics. Any cost to the hospitals and clinics to that point, he speculated, "would be a small amount."

Continued on page 3

Any equipment and training beyond the connections at the hospitals and clinics will be the responsibility of those hospitals and clinics, according to Sorensen.

“My understanding is that there will be some additional technology” that the hospitals will have to purchase, said Griess at Box Butte General Hospital. “I don’t know if it’s \$5,000 or \$500. I don’t believe it’s going to be a large amount.” □



Rural Nebraska Healthcare Network

Regional West Medical Center, Scottsbluff
Box Butte General Hospital, Alliance
Chadron Community Hospital, Chadron
Garden County Health Services, Oshkosh
Gordon Memorial Hospital, Gordon
Kimball Health Services, Kimball
Memorial Health Center, Sidney
Morrill County Community Hospital, Bridgeport
Perkins County Health Services, Grant
32 clinics affiliated with the above hospitals

UNMC College of Nursing "new" Doctor of Nursing Practice degree

This UNMC degree is designed to prepare nurses in advanced clinical expertise and in methods and strategies to improve patient care quality in today’s complex health care system. The degree also will educate nurses on translating research findings to benefit patients.

The D.N.P. degree can be completed in one to two years by advanced practice registered nurses (APRNs) who already have master’s degrees in nursing, or in three years by those with bachelor’s degrees in nursing.

Beginning in fall 2011, the college will accept 15 APRNs each year in the first two or three years of the program, then accept students with bachelor’s degrees in nursing. In the third year, the degree will be available at the college’s five campuses in Omaha, Lincoln, Kearney, Scottsbluff and Norfolk.

Nurse practitioners, also called APRNs, diagnose, treat, prescribe medication and focus on health promotion. In the coming years, they are poised to help solve the nation’s shortage of primary care physicians. APRNs also encompasses clinical nurse specialists, nurse anesthetists, and nurse-midwives who have master’s or doctorate degrees in nursing with advanced clinical experience.

Virginia Tilden, D.N.Sc., dean of the UNMC College of Nursing, said nationally, the D.N.P. program is fast becoming the degree of choice

for advanced practice nurses. Recent surveys by the college show burgeoning demand for the D.N.P. degree. There are D.N.P. programs available in 35 states and the District of Columbia, and more in the planning stages. Four of the five states bordering Nebraska have programs.

“Over half of all academic medical centers offer this program so we are at a tipping point in the country,” Dr. Tilden said. “I’m delighted the board has supported this proposal so that the college can maintain its prominence nationally among the top-tier schools of nursing in the country.”

Sarah Thompson, Ph.D., UNMC College of Nursing associate dean for academic programs, said the new degree will prepare more nurses to meet the growing health needs of Nebraskans. “This degree is another crucial step towards reducing the shortage of nurses and nurse faculty in the state, especially in rural communities,” Dr. Thompson said. “We believe this additional education will speed the translation of research as well. It’s estimated it takes 15 years after research findings are known to translate that information that will benefit patients.”

The college will be accepting applications soon. For more information contact Dani Eveloff at 1-800-626-8431, or develoff@unmc.edu. □

Nebraska's J-1 Visa Waiver Program

By Michael Gilligan, SORH Intern

What is it, and how has it worked for Nebraska? The J-1 Visa Waiver Program is designed to place physicians in underserved areas in Nebraska. Placements can include both rural and urban settings due to the medical needs identified. The importance of geographical proximity to a physician, whether urban or rural, is an important consideration.

History: Federal to State control

A J-1 visa is granted to foreigners when they attend a medical school in the United States. In the past, after completing their medical training, they were required to return to their original country for a period of two years. Originally, in order for the physician's J-1 Visa to be waived, sponsorship by the federal government was needed in exchange for three years of service to a medically underserved area or population. The United States Department of Agricultural (USDA) handled the underserved rural areas while Housing and Urban Development (HUD) placed foreign physicians within urban areas with criteria such as urban poor, homeless, minorities, immigrants, and high numbers of Medicare and Medicaid patients. This was changed under the Conrad State Waiver Program Act in 1994. This Act permitted individual states to sponsor physicians. In 2001, the USDA and HUD discontinued placing physicians.

Current system: Expanding State Sponsorship

The Conrad State waiver program, originally known as the State 20 program, initially allowed states to place 20 possible foreign physicians and 5 flex slots for each state. The flex positions allowed for placements in areas or populations that did not meet the underserved criteria, but showed a need for a physician. In 2003, the program was expanded to allow for thirty possible physicians per year and 10 flex positions. We now have a State 30 Program. The J-1 visa waiver program in Nebraska is utilized in conjunction with other state and federal incentive programs to attract physicians to our underserved areas. The J-1 Visa program and the state of Nebraska respond to requests from employers such as hospitals or clinics.

The process is: the sponsoring employer makes contact with the foreign physician willing to agree to a three year commitment at their facility. This is followed by submitting the application for a J-1 visa waiver to the Nebraska Department of Health and Human Services (DHHS). Next, the DHHS reviews the J-1 visa waiver application as well as the site wishing to sponsor a physician for a three-year

obligation and acts as the interested government agency for the sponsorship of the application. State sponsorship is evaluated on the applicants need to fill a vacancy for a needed medical provider. Another requirement is for the employer to attempt a hire of a U.S. medical provider. If one is not available, or unwilling to fill the position, the applicant may move forward with the J-1 request. The last step in the process is the DHHS filing its sponsorship of the application to the U.S. Department of State and the Department of Homeland Security's U.S. Citizenship and Immigration Services (USCIS) for approval.

How has Nebraska done?

Beginning in 1994, there have been a total of 155 foreign physicians who have committed to three years of service to Nebraska's disadvantaged communities with the goal of serving those in need. Over those past sixteen years, 110, or seventy-one percent of those physicians have been placed in Non-Metro areas, while 45, or twenty-nine percent of the physicians have served within Metro populations. The breakout by specialty shows that thirty-two percent are primary care specialists, nine percent are mental health specialists, and fifty-nine percent are sub-specialists. Of the overall 155 placements, Nebraska has 79 currently serving within the state, with 32 of those physicians still fulfilling their obligation, and 47 physicians who have stayed in Nebraska beyond their practice obligation. Of those who have remained beyond their obligations, many continue to practice at their original site. The goal is to increase the health access of our rural communities and gaining a new J-1 Visa helps that cause. Although Nebraska does have a need for primary care physicians, the growing number of J-1 visa waiver specialists is welcomed.

Future: What is to become of the State 30 Program?

The Nebraska DHHS will continue to aggressively work at providing physicians for the medical needs of its medically underserved residents. With that goal in mind, the DHHS State 30 program will continue to work at sponsoring J-1 Visa waiver physicians. All applications must be made by the employer and are not sought out by the Nebraska Office of Rural Health (DHHS). Since 2001, Nebraska has increased our average sponsorship from 2.6 to 11.6 J-1 Visa physicians per year. The state hopes to continue successfully sponsoring the much needed physicians in Nebraska.

For more information, contact Thomas. Rauner@Nebraska.Gov. (This research was done by SORH interns Michael Gilligan and Monica Sanford.) □

Nebraska's Rural Health Incentive Program - has it made a difference?

By Marlene Janssen

In December 2010, the Rural Health Advisory Commission (RHAC) released the annual report of the Nebraska Rural Health Systems and Professional Incentive Act. This Act created the RHAC, the loan repayment program for certain health professionals, and redefined the student loan program for medical, physician assistant, dental, and graduate-level mental health students.

Highlights from the annual report include:

Nebraska Student Loan Program

- Buyout rates for student loan recipients have dropped from an average of 50% prior to 1998 to an average of 22%. This is due to administrative changes that were implemented in 1998-99.
- Dental students were added to the Nebraska Student Loan Program in 2000 by the Legislature. Since then, 29 dental students have been awarded student loans. Of the 21 dental student loan recipients that have graduated, 81% have received at least some forgiveness of their student loan, with most still in practice under obligation.
- Graduate-level mental health students were added to the Nebraska Student Loan Program in 2004. Mental health students must be enrolled in a training program that meets the educational requirements for Licensed Mental Health Practitioner or Licensed Psychologist. As of August 1, 2010, 24 graduate-level mental health student loans have been awarded. Of the 11 mental health student loan recipients that have left school or graduated, 82% are in practice receiving forgiveness.

Nebraska Loan Repayment Program

- In 1994, the Nebraska Legislature appropriated funding for the loan repayment program for health professionals willing to practice in a state-designated shortage area. Initially only physicians, nurse

practitioners, and physician assistants practicing one of the defined primary care specialties, clinical psychologists, and master's level mental health providers were eligible for loan repayment. In 1998, pharmacists, occupational therapists, physical therapists, and dentists specializing in general dentistry, pediatric dentistry, or oral surgery were added to the program. The Nebraska Loan Repayment Program requires community participation in the form of a local match and a 3-year practice obligation for these health professionals.

- Since 1994, 372 health professionals have participated or are participating in the Nebraska Loan Repayment Program.
- Over 90% of loan repayment recipients complete the 3-year practice obligation.

Because of these two rural incentive programs, there are over 90 licensed health professionals currently in practice, under obligation, providing access to health care services for over 700,000 people (based on county population) living in Nebraska. These two rural incentive programs (student loans and loan repayment) are the only state-funded programs of this type to encourage health professionals to practice in state-designated shortage areas. The level of state appropriations each year enables us to identify the number of incentive program recipients.

The annual report can be found on the Nebraska Office of Rural Health website at www.dhhs.ne.gov/orh under Rural Health Advisory Commission.

REMINDER: Local agencies should not provide Form 1099s to health professionals receiving payments under the Nebraska Loan Repayment Program. Funds received by health professionals under this program are no longer included in gross income as per Public Law 111-148, Section 10908. □

Shining Star Award nomination

The Nebraska Hospice and Palliative Care Partnership (NHPCA) is proud to announce it is seeking nominations for the 2011 Shining Star Award.

The Shining Star Award recognizes an individual, group or organization that has done outstanding work in the leadership of end-of-life care in their community or statewide.

Nominees should have illustrated outstanding leadership in the promotion of end-of-life services; raised awareness of or educated others on end-of-life

issues; developed a new program; or developed or completed outstanding work in an end-of-life coalition.

The recipients of this award will receive recognition at NHPCA's annual banquet on April 19, 2011.

Nominations will be accepted through March 4.

Depending on the number of nominations, more than one award may be given.

For a nomination form, e-mail Jennifer@nehospice.org. Please submit nominations no later than **March 4, 2011**. □

Rural jobs tied to rural health

By John L. Roberts, MA

Executive Director, Nebraska Rural Health Association

What we learned in Washington, DC:

Eleven people from the State of Nebraska attended last month's National Rural Health Association's Rural Health Policy Institute. We talked with Nebraska's Congressional Delegation about health care reform, both the good and the bad. The reality is that the Reform Bill and its implementation will and should be scrutinized and, hopefully, improved. This will happen, in hundreds of ways, over the next decade or so, with or without new faces elected to Congress.

I for one hope we don't "throw the baby out with the bathwater" and repeal reforms such as:

- Take away insurance from tens of millions of hard working Americans.
- Allow health insurers to deny children health insurance because of pre-existing conditions.
- Take away from small businesses tax credits covering up to 50% of employee premiums.
- Allow insurers to put a "lifetime cap" on how much insured healthcare you can receive.

I believe rural communities need both public and private sectors to:

- Assure that we have reasonable access to care in local rural communities.
- Stop wasting money on unnecessary procedures with payments driven by the amount of care provided, not the quality of that care.
- Stop unjustifiable differences in what Medicare pays for care in one region versus another.
- Incent providers to keep patients healthy and coordinate their overall care.

The last election was about huge government deficits and the creation of jobs. The stage is now set for a hard tug of war between job creation and deficit reduction. As politics and policies compete after the election, we who care about rural health must speak up. We must say more often and more powerfully: **"rural health care equals rural jobs."**

And not just in health care. People know that rural health means rural jobs in health care. People know that businesses are influenced in their relocation decisions by what health care is available locally. But many people don't consider a major third effect.

Our country needs rural hospitals, doctors and other caregivers to do more, to do better and do it for less. This is a reality driven by an aging population and the need to be competitive globally. But for rural America, where our state, federal and private sector health care dollars are spent, also matters.

Jobs, in good part, depend on the export of goods and services. The point here is that, in terms of job creation, rural health care is a major export of rural communities. Rural health providers are very much like a manufacturer or any other exporter because the health care provided to local residents is, more often than not, paid for by dollars from outside the community.

Yes, rural health dollars may have started as insurance premiums and taxes in the community, but they only come back if there are local health care providers there to attract them. The economic impact of exports on jobs does not depend on where the goods or service are consumed. It depends on where the money comes to pay for them.

All of us who care about rural health understand the critical connection between rural health and rural economic development. We need to make sure that message is clear. We who care about rural health must be heard—that the total impact of rural health is as much to keep and grow rural jobs, as it is to provide critically important health care locally.

For more information, e-mail John Roberts - jroberts@mwhc-inc.com. □

Suicide prevention resources:

Nebraska State Suicide Prevention Coalition:
www.suicideprevention.nebraska.edu

Nebraska Rural Response Hotline:
(800) 464-0258.

Together for Kids and Families: early childhood mental health

By Lynne Brehm, Molly Clark, Jen Gerdes and Barb Jackson

The relationship between a young child and his or her parents can be key to the child's optimal growth and development and his or her early childhood mental health (ECMH).

Since 2002, a work group in Nebraska has provided an action plan for the state in this critical area. The plan grew out of the 2001 Governor's Symposium on Early Childhood Mental Health, which drew attention to the increasing interest in the social-emotional health of infants and young children as a foundation for healthy development and school readiness.

Paula Zeanah and Julie Larrieu, leading researchers in infant mental health, define ECMH as "the young child's capacity to experience, regulate and express emotions, form close and secure relationships, and explore the environment and learn" (Tulane Institute of Infant and Early Childhood Mental Health, 2010).

The importance of improving practices that promote young children's social, emotional, and behavioral health is emphasized in several reports. In *A Public Health Approach to Early Childhood Mental Health* (2009-10), Joan Patterson explains that, "...infants, toddlers, and preschoolers can, and do, experience significant mental health problems." She describes several determinants of mental health in young children between the ages of birth and 5, including the quality of early relationships, biological factors, the mental health of parents and caregivers, the social environment, and poverty.

In the article, *Promoting Children's Emotional and Behavioral Health* (2010), the authors state that children who are emotionally healthy are more likely to enter school ready to learn and succeed, to be physically healthy, and to lead productive lives.

Nebraska's Early Childhood Comprehensive Systems Grant (Together for Kids and Families), and the five-year State Infrastructure Grant (SIG) for children's mental health and

substance abuse from SAMHSA were key grants that continued the momentum generated by the governor's symposium. Among the accomplishments of SIG was the development of curricula for health care providers to improve screening and referral of young children for social-emotional development concerns.

Another effort was the Central Nebraska Early Childhood Mental Health System of Care (CNEC) in Hastings, developed to identify and address the needs of young children with mental health challenges and their families in a seven-county rural area.

In 2005, Lifespan Health Services was awarded a one-year perinatal depression grant which supported the development of materials for women and their families as well as tools and curricula for providers. These resources can be found at <http://www.dhhs.ne.gov/lifespanhealth/pcah.htm>.

In addition the first Nurturing Healthy Behaviors grants provided funds for mental health consultation in child care settings based on the use of the Teaching Pyramid Model and Positive Behavior Intervention and Supports (PBIS). With these complementary efforts underway, Together for Kids and Families (TFKF) Mental Health Work Group focused on implementation of the Teaching Pyramid Model within early care and education settings. More information can be found at: <http://ectc.education.ne.gov/partnerships/ecmh/pbs.htm>.

In 2010, the TFKF Mental Health Work Group began to refocus its efforts around early childhood mental health. This group consists of several individuals across the state from a variety of disciplines who are working on systems issues related to early childhood mental health in Nebraska. The current efforts of the group are focused on reaching the goal of having the early childhood social, emotional and behavioral health needs of Nebraska's children met.

The Mental Health Work Group has two focus areas: Community Capacity Building and Workforce/Caregiver Development. The two

Continued on page 8

strategies of this group are:

- To assist communities to develop and enhance an effective system of care to support the social, emotional, and behavioral health needs of Nebraska's young children.
- To build the capacity of individuals who interact with young children to support social, emotional, and behavioral health.

Nebraska faces three primary challenges in this work including lack of workforce and informal caregivers (e.g. parents, extended family) with knowledge and skills related to infant and early childhood mental health; lack of monetary resources to support social and emotional screening and mental health services for infants and young children; and a need for consensus across disciplines about the definition of infant and/or early childhood mental health.

With continued discussion and collaboration, we are confident there will be systems level changes that will have positive impacts on the mental health outcomes of Nebraska's youngest children.

For more information about Together for Kids and Families visit: <http://www.hhs.state.ne.us/LifespanHealth/Together-Kids-Families.htm> □

References

Drake, A. (2007). Early Childhood Mental Health: A Report to Nebraska March 2002. Children's Mental Health Coalition for the Advancement of Children's Mental Health, 1.

Nemours Health and Prevention Services Strategic Plan. (2010). Promoting Children's Emotional and Behavioral Health. Nemours Health & Prevention Services, 2.

Patterson, J. (2009-10). A Public Health Approach to Early Childhood Mental Health. Healthy Generations: Center for Leadership Education in Maternal and Child Public Health, 2.

Zeanah, P., Larrieu, J. (2010). Infant Mental Health. Tulane Institute of Infant and Early Childhood Mental Health, 1.

Nebraska outreach to returning military

By Marilyn Mecham

Interchurch Ministries of Nebraska has joined other local and national organizations in working to ensure that our troops are returning safely and reintegrating successfully back into their families and their communities. We have found that there are many needs to be addressed within the military community in our state. Because we recently deployed the largest guard and reserve units in our history (over 1,300), and a large number of veterans are returning to our communities.

Through the support of the Nebraska DHHS, Office of Rural Health, and SAMHSA, IMN has developed an Outreach Program under the leadership of Danielle Sodergren. Along with designing training and developing services, Danielle attends deployment and reintegration briefs for returning military and families, sharing information about available resources and providing care packages to help them continue contact with family members.

We saw the need to equip communities to support those serving in the military, both while they are deployed and once they return home. IMN therefore hosted two reintegration workshops with speakers from faith communities, mental

health agencies, and veterans' organizations.

Also provided in these workshops was a packed "resource kit" that contained cutting edge information about mental health, suicide prevention, and reintegration. Two more workshops will be scheduled in 2011, one in central Nebraska and one in the Scottsbluff area.

While there are many different needs to be addressed, of special concern is the risk of suicide for our Nebraska military personnel. According to the Department of Defense, once every 36 hours a service member commits suicide. For the second year in a row, the U.S. military has lost more troops to suicide than it has to combat in Iraq and Afghanistan. Interchurch Ministries of Nebraska is now working with the Nebraska State Suicide Coalition and military organizations to prevent suicides by offering QPR (Question, Persuade, and Refer) Gatekeeper training, as well as other resources.

If you would like more information about the QPR training, the library of resources at IMN, or other services for military personnel and their families, contact Danielle Sodergren at Interchurch Ministries of Nebraska, (402) 476-3391, or e-mail-im50427@windstream.net. □

Accountable Care Organizations (ACOs): are they good for rural?

By David Palm

The Affordable Care Act passed in March of 2011 created Accountable Care Organizations (ACOs) as a way to control health care costs, enhance the coordination of care, and improve the overall health of the population in a community. ACOs will be implemented beginning on January 1, 2012, as an optional method for receiving payment under the Medicare program. An ACO will be held accountable for its performance and rewarded for improving the quality and coordination of care and controlling costs.

Although ACOs will receive fee-for-service reimbursement, they will be responsible for meeting yet to be defined quality standards and will be eligible for a certain percentage of the shared cost savings. ACOs will probably have different organizational frameworks, but they will include hospitals, physicians, and other providers (e.g., mental health professionals, public health agencies, etc.).

Three ACO Scenarios

In a recent article published in the *Journal of Rural Health*, MacKinney, Mueller, and McBride examine the potential impact of ACOs on rural providers and communities. They describe three possible scenarios for ACOs to impact the service delivery system in rural communities. In the **best-case** scenario, rural providers will initially collaborate to form rural networks that will improve care coordination and control costs. Once the rural network is operating effectively, they will initiate mutually beneficial collaboration with distant and large health care systems. These larger systems will become "sensitive" partners, resulting in more healthy and vital rural communities.

In the **intermediate** scenario, collaborations between rural and urban providers will generally occur by chance or necessity without a thoughtful planning process or consideration of the long-term needs of rural people and places. In this case, rural and urban health disparities will persist. In the **worst-case** scenario, urban health systems will use their financial strength and market dominance to leverage market share from rural providers. In this case, rural

provider shortages will substantially increase and rural hospitals could become "band-aid stations." These changes will diminish access to quality health care services, declining health status, and a decrease in the economic vitality of rural communities.

The article authors believe that rural providers and communities can influence these scenarios, but they must act immediately to influence area ACO development. Failure to take action will invite urban providers to fill the void.

ACO Competencies

The authors note that past research has identified several ACO competencies, which include (1) leadership, (2) an organizational culture of teamwork, (3) an information technology infrastructure for population management and care coordination, (4) an infrastructure for monitoring, managing, and reporting quality, (5) the ability to manage financial risk, (6) the ability to receive and distribute payments, (7) resources for patient education and support, (8) physician engagement and leadership, (9) non-profit local ownership, and (10) the capacity to manage high cost and high risk patients.

They also identify several challenges or barriers to rural ACO development. These barriers include:

- Rural provider autonomy – several rural independent physician practices and small hospitals make it difficult to develop an integrated delivery system with a unified mission. However, collaboration and close alignment are essential if rural providers wish to negotiate with urban systems from a position of strength.
- Rural practice design – a larger percentage of rural physicians work in small independent practices, but ACOs, other payers, and patients will demand redesigned practices that have tools such as care management and interoperable information technology.
- Low rural volumes – an ACO is required to have at least 5,000 Medicare beneficiaries, which means that several rural providers from a relatively large geographic area will need to

Continued on page 10

to generate savings, but many rural providers already have low costs and it will be difficult for efficient providers to find new savings.

- Urban motivations – Rural providers need to identify the factors that motivate urban providers to be “rural-focused.” Some of these factors may include: (1) scope of influence, (2) control, (3) large profit margins, (4) quality and patient satisfaction, and (5) physician satisfaction.
- Urban provider cost structure – although costs in rural hospitals are lower than urban hospitals, the key factor is the additional or marginal cost attributable to a particular service. An urban hospital may prefer the patient to receive care in a large hospital because the marginal cost may be lower and the profit may be higher.
- Legal and regulatory barriers – the ACO concept requires that extensive contractual and/or legal agreements be developed. In urban areas, many of these agreements already exist, but they may not exist in rural areas. They

must be carefully written to avoid violating antitrust laws.

- Rural leadership experience – Because many rural providers are independent and leadership training opportunities are often more limited, rural leaders must be developed, because it is critical to overcoming the ACO barriers.

The authors conclude that ACOs are rapidly developing across the country and it is important for rural providers to be proactive and begin preparing for ACO development. The first step is to build a collaborative network with other rural providers and then negotiate with larger urban systems. Although rural areas face significant barriers, the best-case scenario can be achieved with strong leadership and a unified mission.

Questions about this article should be addressed to Dave Palm at david.palm@nebraska.gov. □

*A. Clinton MacKinney, Keith Mueller, and Timothy McBride, “The March to Accountable Care Organizations,” *The Journal of Rural Health*, Vol. 27 (2011), pages 131-137.

First endowed chair at SAHP

James Temme, associate director of radiation science technology education in the University of Nebraska Medical Center’s School of Allied Health Professions (SAHP), has been appointed to an endowed faculty chair. Temme, a native of Petersburg, Nebraska, has been appointed to the Charles R. O’Malley Chair for Radiation Science Technology Education.

The endowed faculty chair -- the first in the SAHP -- was made possible through the generosity of the Charles R. O’Malley Charitable Lead Trust through the New York Community Trust. Trustees worked with the University of Nebraska Foundation to establish the chair.

“We are tremendously grateful to everyone who made the endowed chair a reality for the school,” said Kyle Meyer, Ph.D., associate dean

of the SAHP. “This marks a transformational milestone for the school.”

Temme said being appointed to a chair is one of the highest honors a faculty member can receive.

“This generous gift will have a considerable impact on promoting the development of the radiation science technology education division,” he said. “The endowed chair enables faculty to explore innovative ways to improve education and bolster research in the radiation sciences.”

Graduates of the program assist radiologists and other health care professionals in diagnostic imaging and radiation therapy.

For more information, contact Vicky Cerino, UNMC Department of Public Relations, vcerino@unmc.edu □

Nebraska Statewide Telehealth Network: expanding technology and ideology

By Laura Meyers

With the recent focus by the federal government on increasing broadband capabilities throughout the nation, a great number of sites across the U.S. are in the process of either initiating or expanding their telehealth capabilities. The Nebraska Statewide Telehealth Network, one of the first comprehensive networks in the nation, is no exception.

Working with nearly \$1.3 million in federal grant funding between 2008 and 2012, the NSTN has been able to strengthen the technological infrastructure of the Network. The NSTN has replaced aging and obsolete cameras with high definition equipment in 38 sites; expanded tele-emergency capabilities to nearly every hospital in Nebraska; implemented network monitoring software and is now beginning to implement peripheral equipment. This equipment will allow for clinical consults that require a stethoscope or otoscope as well as provide handheld cameras to tele-emergency sites for use in wound examination.

One of the most important technological upgrades may well be the expansion of telehealth to physician offices, allowing specialists to provide medical consultations directly from their own clinics to any site in Nebraska. The NSTN hopes that by placing equipment directly into these offices, specialists will begin to incorporate telehealth into their culture, seeing the telehealth patient as just another patient to care for in the daily schedule. UNMC is taking this one step further by beginning to look at ways to integrate telehealth into physician training programs.

While all of this is exciting, the NSTN also realizes that technology can only do so much to move the Network forward. Long-term success depends upon expanding not only technology but also ideology. This will also depend on the NSTN's ability to envision the future, overcome barriers, enhance physician buy-in and ownership, influence lawmakers and partner effectively with others in the state and nation

that are moving forward.

During 2010, as part of the effort to enhance decision making capabilities, the NSTN expanded the Governing Committee to include representation from hospitals, health departments and mental health centers across the state. This new Committee provides a better cross section of members, helping to ensure that those the NSTN serves have a voice in its destination. In addition, several member sites were added, including the Nebraska Department of Health & Human Services.

The NSTN continues to work with Public Service Commissioner and USAC Board Member Anne Boyle and the FCC to permanently grandfather sites at risk of losing funding. Governing Committee members have entered into formal discussions with the Veterans Administration to determine the best ways to connect these networks to better serve veterans who are sometimes hundreds of miles away from the nearest VA facility. The goal of these discussions is for Nebraska to serve as a beta site for a structure that can be replicated nationwide. Trauma coordinators across the State are discussing how tele-emergency may improve a trauma patient's clinical outcomes. The NSTN continues to consider alternate formal structures that may enhance the ability to remain financially stable and even move towards greater financial independence. And, meetings are taking place with surrounding states to look at regionalization opportunities and the strength regionalization would provide in the future.

The NSTN is a medium, much like a phone line, that facilitates organizations working together to enhance the availability of care to rural Nebraskans. However, it is also much more than that. It is a vehicle that has the potential of changing the way we deliver health care, helping Nebraska to continue supporting the rural way of life.

For more information, e-mail Laura Meyers - laurameyers@charter.net. □

McCook Community Hospital named in top 100 Recovery Act projects

McCook's Community Hospital was named in the "100 Recovery Act Projects That Are Changing America." Community Hospital was selected among all federal agency American Recovery and Reinvestment Act (ARRA) projects nationwide.

The Community Hospital Association secured \$17 million in Recovery Act funding to expand its facility to better serve the needs of the McCook community and surrounding area. An additional \$15 million Rural Development community facility guaranteed loan was financed through Thayer County Bank of Hebron, Nebraska which represents a group of Independent Community Banks in Nebraska that teamed up to provide the guaranteed financing.

McCook Community Hospital is a Critical Access Hospital that provides acute inpatient and outpatient care, skilled nursing, emergency medicine, surgery, obstetrics and delivery, diagnostic facilities, pharmacy and rehabilitation services. The Hospital offers two rural health clinics, an outpatient services center, home health and hospice programs, visiting specialists, sleep study and orthopedic clinics. With this project expansion, the hospital plans on recruiting an additional general and orthopedic surgeon. All local orthopedic trauma patients now have to be transferred or diverted at least 70 miles for treatment. The improvements to McCook's Community Hospital will enhance both the quality and delivery of care to those it serves.

This expansion has already created 300 construction jobs. Full-time employees and jobs at the hospital exceed 215.

"We feel honored and privileged to be named among the Top 100 Recovery Act projects," said Community Hospital President and Chief Executive Officer Jim Ulrich, Jr. "Through this project we are investing in the future of healthcare and the region we serve. The new patient and surgery wings along with continued staff and technology development will enable

us to continue on our journey to excellence and fulfill our mission of providing for the healthcare needs of our region through quality, efficient, and patient-centered care."

The hospital serves the 11,500 residents of Red Willow County as well as residents of Frontier, Furnas, Hayes and Hitchcock counties in Nebraska; and Cheyenne, Decatur and Rawlins counties of Kansas.

Including McCook's Community Hospital Association, Nebraska funded six hospitals statewide through ARRA dollars totaling more than \$40 million. Rock County Hospital of Bassett received nearly \$77,000; Memorial Community Health Inc. of Aurora \$6.7 million; Fillmore County Hospital in Geneva \$12.6 million, Warren Memorial Hospital Foundation in Friend \$149,000 and Providence Medical of Wayne \$3.5 million. Non-ARRA funds in federal fiscal year 2010 were provided to Pender Community Health Care of Pender, with nearly \$14 million awarded through disaster funds. Recently completed hospital projects funded in 2008 and 2009 include Dundy County Hospital in Benkelman, Brodstone Memorial Hospital of Superior, Community Medical Center of Falls City and Chadron Community Hospital in Chadron. □

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.

NOSORH honors U.S. Senator Ben Nelson

The National Organization of State Offices of Rural Health (NOSORH) awarded its 2010 Legislator of the Year Award to U.S. Senator Ben Nelson (D-Nebraska).

NOSORH was created in 1995 to serve as an influential voice for rural health concerns and promote a healthy rural America through state and community leadership. The organization presents its Legislator of the Year Award each year to recognize outstanding legislators for their work on, and support of, rural health initiatives that address identified national healthcare needs. Those selected have introduced or supported legislation that addresses an identified rural health need or issue; made a special effort to effect change in rural health policy; and/or demonstrated leadership in the rural community.

Recruiting and retaining healthcare professionals is arguably the biggest issue facing rural and frontier America. Several incentive programs have been introduced at the federal and state level to help communities address this need—including healthcare professional loan repayment programs.

Sixteen states have authorized state-funded loan repayment programs to date. While these programs have been successful in attracting healthcare professionals to rural and frontier communities, recipients of state-funded loan repayment awards historically have paid federal income tax on

whatever awards they received. Federal and hybrid loan repayment programs, on the other hand, have imposed no federal tax burden on the recipient.

Senator Nelson introduced legislation which effectively eliminates the federal income tax burden for state-funded loan repayment award recipients. The bill, which was passed as Section 10908 of the Patient Protection and Affordable Care Act in March 2010, became retroactive for awards received after December 31, 2008.

“As a result of this much-needed tax relief, healthcare professionals practicing in rural and underserved areas of these 16 states will have additional money to apply to their educational debt,” noted Dennis Berens, director of the Nebraska Office of Rural Health, in the nomination of Senator Nelson. “Rural and underserved communities in all 16 states will also benefit because these healthcare providers will have more money to support the local economy.”

NOSORH presented Senator Nelson with this award at the Annual Rural Health Institute on January 26, 2011, in Washington, DC.

For additional information, please contact NOSORH Executive Director Teryl Eisinger at teryle@nosorh.org or (586)739-9940 or NOSORH Communications Coordinator Bill Hessert at billh@nosorh.org or (814)308-8697. □

MARK YOUR CALENDARS

Nebraska Rural Health Advisory Commission Meeting

February 25, 2011 - 1:30 p.m. - Lincoln, NE

NRHA Rural Medical Educators Conference

May 3, 2011 - Austin, TX

Annual NRHA Conference

May 3-6, 2011 - Austin, TX

Nebraska Rural Health Advisory Commission Meeting

Friday, June 17, 2011, 1:30 p.m., Lincoln, NE

NRHA Quality and Clinical Conference

July 20-22 - Rapid City, SD

CRHC Coding and Billing Workshop

September 21, 2011 - 9:00 a.m. - 4:00 p.m.

Younes Conference Center -- Kearney, NE

2011 Annual Nebraska Rural Health Conference

September 21-22, 2011 - Kearney, NE

Younes Conference Center - www.RuralHealthWeb.org

Nebraska Rural Health Advisory Commission Meeting

During the Rural Health Conference (TBA)

Younes Conference Center -- Kearney, NE

NRHA Rural Health Clinic Conference

September 27-28 - Kansas City, MO

NRHA Critical Access Hospital Conference

September 28-30 - Kansas City, MO

Nebraska Rural Health Advisory Commission Meeting

Friday, November 18, 2011, 1:30 p.m., Lincoln, NE

Nebraska's REC grant funding available

Wide River Technology Extension Center (TEC), Nebraska's Regional Extension Center, would like to announce that our grant funding has recently been broadened to allow us to assist Nebraska primary care physicians, **free-of-charge**, in meeting meaningful use requirements. Specialty providers - we recently expanded our services to work with you as well. To see if your clinic qualifies for our services, contact us right away. You may be eligible for incentive payments or reimbursements of \$44,000 from Medicare or \$63,750 from Medicaid to offset the cost associated with implementing an EHR.

We will work with your practice to achieve:

- Successful electronic health record implementation
- Meaningful use
- CMS incentives (We assist to ensure you receive the maximum incentive)

Currently, we are assisting over 250 providers to help ease the transition to EHRs. If you would like to contact any of our current clients as references, we have an ever-growing list available upon request.

The time to sign up for the free-of-charge services will be ending very soon. Primary

care physicians (family medicine, internal medicine, OB/GYN and pediatrics) must sign an agreement with us by March 18, 2011 to receive the promotional pricing offer. To obtain the official agreement, complete the form located at www.widerivertec.org/home/partnerwithus.aspx.

For additional information, references or to receive an agreement via e-mail, contact us at 476-1700 or info@widerivertec.org.

Also, you're invited to attend this educational event hosted by Wide River TEC:

E-Health Forum and Vendor Lab
Tuesday, March 8, 2011, 9 am - 4 pm
Embassy Suites, La Vista - Omaha

This event is designed to engage, motivate and educate attendees regarding meaningful use and the clinical value of using health information technology. Hands-on demonstrations from vendors will be available throughout the event.

To view the full agenda and registration details, go to www.widerivertec.org/home/events.aspx.

For more information, contact Jennifer Rathman at Jrathman@Widerivertec.org. □

New Affordable Care Act rules to fight healthcare fraud

On Mon Jan 24, HHS announced new rules authorized by the Affordable Care Act which will help stop healthcare fraud. "Thanks to the new law, CMS now has additional resources to help detect fraud and stop criminals from getting into the system in the first place," CMS Administrator Donald Berwick, MD, said. "The Affordable Care Act's new authorities allow us to develop sophisticated, new systems of monitoring and oversight to not only help us crack down on fraudulent activity scamming these programs, but also help us to prevent the loss of taxpayer dollars across the board for millions of American healthcare consumers."

Specifically, the final rule:

- Creates a rigorous screening process for providers and suppliers enrolling Medicare, Medicaid, and CHIP.

- Requires new enrollment process for Medicaid and CHIP providers.
- Temporarily stops enrollment of new providers and suppliers.
- Temporarily stops payments to providers and suppliers in cases of suspected fraud.

For more information:

- The full text of the press release issued on Mon Jan 24 is available at <http://www.HHS.gov/news/press/2011pres/01/20110124a.html>.
- A copy of the regulation is available in the *Federal Register* at www.OFR.gov/inspection.aspx or www.archives.gov/federal-register/news.html
- A factsheet on the new rules can be found at www.HealthCare.gov/news/factsheets □

4. HEALTH CARE. From a community perspective, it is so much more than medical care, health insurance, etc. How do we get the COMMUNITY into the discussion and decision making opportunities in today's world. What is health and what does care mean?

Part of the answer may be found in a dual discussion about health and health care. During my 20 years working in rural health, we have talked mostly about health care, which equated to medical professional shortages, hospitals, clinics, mental health needs, etc. We talked about the need to help our citizens and residents

get the health care they deserved and needed, but we seldom talked about health. Health means that I, the individual, must no longer abdicate my personal health responsibility to others. It means I must decide the right lifestyle to live, the right foods to eat and the way all the aspects of my life connect to make me a healthy person. I do all of this in community(ies).

Isn't it time that we all, health care professionals and citizens, sat down and identified what will be best for the communities that we live and work in? Rural communities may have an advantage because of our smallness and our connectedness. Let's make 2011 a time to focus on community and its role in our lives. □

Critical Access Hospitals to receive free comparative data reports

Beginning in April 2011, the Centers for Medicare & Medicaid Services will make available free hospital-specific comparative data reports for critical access hospitals (CAHs) nationwide. The report – known as PEPPER, or the “Program for Evaluating Payment Patterns Electronic Report” – provides hospital-specific data statistics for Medicare discharges at risk for improper payments. Hospitals can use the data to support internal auditing and monitoring

activities. PEPPER is the only free report comparing a CAH's Medicare billing practices with other CAHs in the state, MAC or FI (Medicare Administrative Contractor or Fiscal Intermediary) jurisdiction, and nation.

CMS has contracted with TMF Health Quality Institute to develop and distribute the reports, which were previously available only for short- and long-term acute care hospitals. The PEPPERs will be distributed via a MyQualityNet secure file exchange on or about Mon Apr 25. (MyQualityNet is a secure site accessible from the www.QualityNet.org; CAHs must have a QualityNet account in order to receive their PEPPER.) The PEPPER files will be sent to the hospital's QualityNet administrators and to QualityNet user accounts with the PEPPER recipient role. CAHs may work with their Quality Improvement Organization if they do not have a QualityNet administrator account.

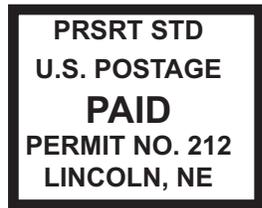
For more information, including the PEPPER distribution schedule, a sample of the PEPPER for CAHs, and information about QualityNet accounts, visit www.PEPPERresources.org. CAH staff are also encouraged to join the email list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities. □

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 hot-
line 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**



ACCESS

Nebraska Office of Rural Health
Nebraska Department of Health & Human Services
Division of Public Health
P.O. Box 95026
Lincoln, NE 68509-5026
(402)471-2337

Address Service Requested

25-48-00

ACCESSory Thoughts

Community Matters

**Dennis Berens, Director
Nebraska Office of Rural Health**

I have used these words before in this column, but it seems appropriate to address them again to begin 2011. I believe we must focus on community if we are to take advantage of our new opportunities and challenges.

What exactly is a community? What is the role of a community in addressing health and health care issues? Not easy to answer either question.

I believe that, to be a member of any community, a person must be willing to risk for the other members. Without a willingness to risk you cannot have trust, and without trust you cannot have reliable, dependable relationships. Under that definition, we are each involved in many communities, and those operate on a continuum of risk levels.

If you agree with my definition of community, we can begin to address some new ways of looking at health and health care. Community members care for each other and are willing to

risk for each other -- at least a little. If you accept that premise, let's look at the following ideas:

1. ACOs -- accountable care organizations -- could become ACCOUNTABLE COMMUNITY ORGANIZATIONS that work to identify the health and health care needs and opportunities in each community and bring health professionals and residents together to create a local model.
2. PHRs -- personal health records -- could be thought of as POPULATION HEALTH RECORDS that identify the uniqueness of rural places and incorporate that into health and health care activities at a community level.
3. MEDICAL HOME. What about the COMMUNITY HOME that all of us live in? Whom do we depend on to help us understand health issues? Who takes us to appointments when we cannot make it alone? Who helps us in our homes with the needs that a system cannot or will not address?

Continued on page 15