

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 63, August 2011

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Taking rural ambulance service beyond “oxygen, IV, and driving”

by David Howe

STEMI is a term that appears headed for marquee attention among rural ambulance services.

This acronym describes a type of heart attack where an artery is completely blocked. Virtually all of the heart muscle supplied by that artery starts to die, as opposed to heart attacks caused by partial blockages.

While elapsed time from symptom onset to treatment is obviously critical for all heart attacks, it's particularly critical for patients suffering a STEMI, which stands for “ST segment elevation myocardial infarction.”

Most big-city ambulance services are equipped for diagnosis of a patient's type of heart attack while en route, enabling transport directly to a hospital that can be ready and waiting with the generally preferred intervention—heart catheterization, in the case of STEMI. Even the emergency room can be bypassed in favor of saving critical time, when every minute counts—not just for STEMIs, but also for certain other types of heart attacks.

However, less than 16% of Nebraska's 66 critical access hospitals (CAHs) who responded to a recent survey said they are served by rural rescue units equipped with 12-lead EKGs that permit diagnosis of STEMI heart attacks, according to State EMS Physician Medical Director Dr. Donald Rice. And only about half of those—7½%—are served by ambulance services

able to transmit the results to the receiving medical facility while en route, either by cell phone or secure Internet, for interpretation, according to Dr. Rice.

He's scheduled to make a presentation on this topic at the Nebraska Rural Health Association annual conference in Kearney this September.

The projected payoff: STEMI-capable rural ambulance services are able to bypass the local hospital and go directly to a hospital with a heart catheterization lab—where, ideally, the cath lab can be ready and waiting. No time is lost in an emergency department, connecting the 12-lead EKG or performing blood testing to confirm a heart attack before instituting appropriate intervention.

Even more critical minutes can be lost by having to wait for transfer approval if that treatment isn't available at the site and no pre-existing transfer agreements are in place, according to Rice.

The national standard for heart attack intervention is 90 minutes from when the ambulance picks up the patient until treatment. Dr. Rice said the 90-minute standard is subject to review as part of the protocol for EMS. Should the standard be based on starting the clock when the patient first began experiencing symptoms, he asked, rather than from the time the ambulance picked up the patient? In some rural areas of the

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Department of Health & Human Services



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state, much of that 90 minutes is eaten up just getting to the patient and then transporting the patient to the hospital.

But, just how much of a payoff is there in terms of lives saved and quality of life saved by equipping rural ambulances with the ability to determine en route if the patient is having a heart attack and if it's a STEMI?

Those are among questions that may be answered largely by data being collected for analysis by Dr. Rice and others through an arrangement with the Beatrice Fire and Rescue Service that serves Gage County, for which Dr. Rice also serves as Medical Director. Other EMT records, such as e-NARSIS (Nebraska Ambulance Rescue Service Information System) data will be part of the statewide analysis.

He and his professional colleagues and organizations will review the data and develop recommendations for the protocol and standards for rural ambulance services in conjunction with the state EMS Board for approving or amending STEMI response.

Beatrice Fire and Rescue EMTs are equipped and trained with the ability to not only attach 12-lead EKGs and transmit results for diagnosis of STEMI to Lincoln's BryanLGH hospital, but have paramedics onboard who are qualified to read the EKGs and make that determination, as well.

The 12-lead EKG results offer about 60% reliability for diagnosing STEMI heart attacks, according to Dr. Rice. However, Beatrice Fire and Rescue is also equipped with something called ACI-TIPI (Acute Cardiac Ischemia Time Insensitive Predictive Instrument). That mouthful name describes an instrument that enhances the accuracy of STEMI diagnosis to 75% to 80%, Dr. Rice added. It does that by bringing additional personal history of the patient into the equation for prognosis of the patient's status.

But how much does it all cost?

The tab for the 12-lead EKG, ACI-TIPI and other related equipment can come to \$30,000 or more per ambulance, according to Dr. Rice.

And, only a paramedic or higher can be certified to interpret the results with that equipment for diagnosing a STEMI or other acute coronary syndrome in the field. That was the cost per ambulance for the Beatrice Fire and Rescue, a rural ambulance service that makes more runs annually than many rural ambulance services.

What about those ambulance services who only make a few cardiac calls annually?

A 12-lead EKG can cost as little as \$4,000. Any first responder, from a basic EMT on up, can be trained and licensed to attach the 12-lead EKG. Cost of training may range from the \$100s to a couple of thousand dollars, according to Dr. Rice. "Teaching people how to do it is not expensive," he said. Training can be done in a couple of half-day sessions, he added.

A rural ambulance service could then be equipped with a rugged laptop computer to transmit 12-lead EKG results by secure Internet from the field to a facility with medical personnel qualified to interpret the results, which could eliminate critical delays in getting appropriate treatment to the patient.

That's the route the Hebron and Deshler EMT squads took. They may make only a few runs annually that involve heart attacks, according to Wayne Kugel, Rescue Captain of the Hebron Volunteer Fire and Rescue Department. They can transmit the results to the hospital in Hebron or St. Elizabeth Medical

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

Center in Lincoln.

Does it save time for those patients? “Absolutely,” answered Dr. Timothy Sullivan at the hospital in Hebron. “It saves probably a good 12 to 15 minutes.” That’s the time it would otherwise take just to attach the 12-lead EKG at the hospital, not counting time to read the results and then order thrombolytic drugs from the pharmacy and administering them before transferring the patient to St. Elizabeth Medical Center. Most emergency heart patients are transferred to St. Elizabeth Medical Center from the hospital in Hebron, he said.

EMS Program Administrator Dean Cole in the Nebraska Department of Health and Human Services said efforts are underway to see if there are sources of grant funding to help rural ambulance services cover the cost of adding

equipment and training to transmit 12-lead EKG results from the field. He looks at the collection and application of data from the Beatrice Fire and Rescue Service’s 12-lead EKG experience and a recent Critical Access Hospital STEMI Survey as a resource to pursue grant money to implement a statewide rural STEMI plan in 5 years.

Even for an ambulance service making only a few runs annually that involve heart attacks, the investment in equipment and training has to be balanced against improving chances of saving a life. What’s that life worth? And, what about saving quality of a life? For example, Dr. Rice asks, what’s it worth to have a farmer be able to continue farming instead of being sidelined by a badly damaged heart, with an oxygen tank in tow, for lack of timely intervention?

For survivors with extensive heart muscle damage, “quality of life is terrible,” he said. □

The Medicare Beneficiary Quality Improvement Project

By Dave Palm

The Medicare Beneficiary Quality Improvement Project (MBQIP) is a voluntary project aimed at Critical Access Hospitals (CAHs) across the nation. The purpose of the project is to improve the quality of care in CAHs by applying a rural appropriate system of measurement and comparisons. This project will also provide an opportunity to share best practices from CAHs in Nebraska and other states.

The project has three phases for reporting common measures. In the first phase, which begins in September of 2011, all CAHs will submit all of the Hospital Compare sub-measures for pneumonia (e.g., initial antibiotic received within six hours of admission) and heart failure (e.g., adult smoking cessation advice/counseling). The second phase will begin in September of 2012. In this phase of the project, the CAHs will report on all of the outpatient Hospital Compare measures such as was aspirin given on arrival and the median time to transfer to another facility for acute coronary intervention. As part of this phase, CAHs will also report the results of a patient satisfaction survey called Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The HCAHPS survey asks discharged patients to answer questions about their hospital stay. These questions include communication with nurses and doctors, discharge

information, and the overall rating of the hospital.

The final phase begins in September of 2013 and includes two reporting areas. The first area involves the verification of medication orders within 24 hours and the second area includes measures related to outpatient emergency department transfer communication (e.g., vital signs, medication-related information, and procedures and tests completed).

There are several benefits to participating in the project. One of the benefits is the opportunity to compare the quality of each CAH with others across the nation. It will also help to improve the overall quality of care and learn about “cutting edge” best practices in a more timely manner. Finally, since it is a voluntary program, it provides an opportunity for CAHs to prepare for the pay-for-performance environment.

At this point, 57 of the 65 Nebraska CAHs have agreed to participate in the project. Nationally, it is estimated that over 600 CAHs will be involved in the project. According to Dave Palm, the Coordinator for the Critical Access Hospital Program in Nebraska, this response from CAHs in Nebraska demonstrates great leadership and the desire of Nebraska CAHs to continually improve the quality of care.

For more information, please contact Dave Palm at (402) 471-0146 or david.palm@nebraska.gov. □

Critical Access Hospitals and Quality

By John L. Roberts, M.A., Nebraska Rural Health Association

In a national study that examines the quality of care at critical access hospitals (CAHs) in rural areas of the U.S., two Harvard School of Public Health (HSPH) researchers found that CAHs have fewer clinical capabilities, lower quality of care, and worse patient outcomes compared with other hospitals. The researchers found that patients admitted to a CAH for heart attack, congestive heart failure, or pneumonia were at greater risk of dying within 30 days than those at other hospitals. The article was titled "Quality of Care and Patient Outcomes in Critical Access Rural Hospitals." The study appears in the July 6, 2011, *Journal of the American Medical Association (JAMA)*. The study shows that despite more than a decade of policy efforts to improve rural health care, substantial challenges remain.

In this study, data was collected from 1,268 CAHs across the U.S. For all three conditions studied—AMI, HF and pneumonia—CAHs had lower performance on Hospital Quality Alliance (HQA) measures (Hospital Compare) than non-CAHs and had higher 30-day risk adjusted mortality rates (2008-2009 data). The authors of this report identified the following as factors that might contribute to these findings:

- CAHs have less access to capital and fewer health care professionals in their communities, including specialists, which results in their facing equal or greater challenges in delivering high quality care (Nebraska is improving the use of telehealth system to provide services such as clinical consultations to patients in rural communities).
- CAHs were located in counties with a lower median income than non-CAHs and served a higher proportion of Medicare patients (the elderly typically have multiple chronic conditions which may affect outcome, income level may impact an individual's ability to follow prescribed care such as prescriptions, travel to a tertiary center for ongoing outpatient care, etc.).
- Patients in the study that were admitted to

CAHs tended to be older and had a higher incidence of diabetes and depression, and were more likely to be transferred to another acute care hospital (even if they died at the hospital to which they were transferred, the death was attributed to the CAH for the purposes of this study).

- CAHs had fewer clinical resources and were less likely to have intensive care units, cardiac catheterization capability or the ability to perform surgeries. (it would not be feasible for CAHs to have cardiac catheterization capability or intensive care units comparable to the units in larger, urban hospitals; one purpose of the CAH program is to stabilize and transfer when appropriate to a tertiary hospital).
- Patients admitted to CAHs were less likely to be transferred to a hospice than patients admitted to non-CAHs (appropriate utilization of hospice and end-of-life discussions may be helpful).
- CAHs did have comparable nursing staffing levels to non-CAHs.

Two reactions to the report. First, I think that the report misses the boat by not recognizing that there are some fundamental differences between CAH hospitals and non-CAH hospitals. The most major difference is that the CAHs exist in smaller rural markets with much less availability of physicians, specialist physicians and advanced clinical capabilities (such as cardiac catheterization labs). Also, critical access hospitals are focused on keeping only those patients that can be treated safely in a smaller hospitals and transferring the more acutely ill patients to larger hospitals. In the JAMA study, patients that were transferred to a larger hospital were excluded from some of the analysis. My conclusion to this methodology is that there needs to be more study on what constitutes "rural relevant" measures to determine what constitutes high quality in critical access hospitals.

The HRSA Office of Rural Health Policy (ORHP), which funds the Medicare Rural

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Hospital Flexibility Program, has implemented several programs to support quality improvement in CAHs. ORHP has funded 45 State Flex Programs to implement a wide range of quality initiatives targeted to CAHs, including projects with state Quality Improvement Organizations and networks supporting quality improvement and hospital staff training in quality improvement techniques. ORHP created a new initiative this year, the Medicare Beneficiary Quality Improvement Program, working with State Flex Programs to provide CAHs with technical assistance and additional resources to improve patient care. CAH reporting and benchmarking of quality data are an integral part of the initiative.

Second reaction - Where is JAMA's consistency in articles regarding quality of care? One article, published in the Journal of the American Medical Association last year by Clemens Hong, notes the difficulty of separating the context of primary care of the underserved from the quality of care. This is a landmark article, painstakingly difficult to complete, and it concluded that "greater proportions of underinsured, minority, and non-English-speaking patients were associated with lower quality rankings for primary care physicians."

So what happened between last year, when

patients made the difference in quality, and this year when it was location of the hospital? Why would a comparison of hospitals with the most and least in any number of dimensions be a good comparison, other than to demonstrate the inequities of U.S. health spending designs?

Why would we expect anything else when care in rural areas involves consistently some of the most complex populations with the least access to care and the lowest concentrations of health care resources and workforces? Why do sophisticated researchers, reviewers, and editors maximize the context of care sometimes (in 2010) and minimize it at other times (in 2011)? Is it perhaps because they fail to comprehend the importance of the patient and the context of care? The article in JAMA prominently notes that critical access hospitals, those that are found in rural communities, have fewer resources. Any reader can understand that this could be a problem with regard to health care delivery.

Perhaps that's because the system is designed to spend uniformly less on health care across rural America.

(For more information, see the Minnesota Rural Health Research Center/FLEX Monitoring Team, go to www.flexmonitoring.org Web site for their response to the JAMA Report.) □

2011 Annual Nebraska Rural Health Conference

Blazing New Trails...Reaching New Heights is the theme for this year's Nebraska Rural Health Conference scheduled for Wednesday and Thursday September 21 and 22, 2011 in Kearney, NE at the Younes Conference Center.

The annual conference provides a forum to address rural health issues and to develop and promote effective solutions at the local, state and national levels. This year the conference will cover key issues ranging from national trends impacting rural health, such as workforce shortages, emerging challenges and opportunities in rural health, Affordable Care Act, HIT, and

behavioral health in rural Nebraska.

One of this year's keynote speakers is Scott Burton. Scott brings humor and humanity to healthcare. A stand-up comic and world-class juggler, Scott recounts his yearlong cancer battle with a refreshingly honest and engaging sense of humor. The patient perspective is shaped by every facet of the healthcare system. Scott shows how keeping a human touch not only opens the door for the intangible healing needed when facing chronic disease, but the intangible healing and grace we all need in our lives every day. His is not a story about cancer; it

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is a story of life!

Another keynote speaker will be Charles Fluharty, President and CEO of the Rural Policy Research Institute. With the 2010 Census results now released, redistricting and reapportionment in each state will offer new rural challenges. The continuing impacts of the global recession on federal, state, and local budgets will further fray the already fragile safety net in many rural communities. The current federal budget, and discussions regarding next year's funding will mean significant reductions in federal support for rural programs, including health and human services. This will be the new "normal," and creative rural re-alignment of scarce public, private, and philanthropic resources must be developed. Rural health sector impacts will be

significant, and this session will frame those dynamics, explore the future challenges and opportunities for rural communities, and address the growing importance of Regional Rural Innovation.

Sponsors and exhibitors are a critical part of bringing the conference to care providers at a reasonable cost, and we appreciate them. Please consider sponsoring or being an exhibitor at the 2011 conference. For additional information, contact Melissa Beaudette at mbeaudette@mwhc-inc.com or (402)421-7995.

Please mark September 21-22, 2011 on your calendar, and go to the NeRHA Web site www.nebraskaruralhealth.org for registration, exhibit, and sponsorship information. Watch for more news on the NeRHA web site at <http://www.nebraskaruralhealth.org>. □

MARK YOUR CALENDARS

Veterans Workshop

August 26- Scottsbluff

Contact Danielle Sodergren - (402) 476-3391
mdsodergren@hotmail.com

CRHC Coding and Billing Workshop

September 21, 2011 - 8:00 a.m. - 5:00 p.m.

Younes Conference Center - Kearney, NE

2011 Annual Nebraska Rural Health Conference

September 21-22, 2011

Younes Conference Center - Kearney, NE

www.RuralHealthWeb.org

Nebraska Rural Health Advisory Commission Meeting

Thursday, September 22, 2011, 6:00 p.m.

Holiday Inn Convention Center - Kearney, NE

NRHA Rural Health Clinic Conference

September 27-28, 2011 - Kansas City, MO

NRHA Critical Access Hospital Conference

September 28-30, 2011 - Kansas City, MO

Veterans Workshop

October 7 - Columbus

Contact Danielle Sodergren - (402) 476-3391
mdsodergren@hotmail.com

2011 PHAN Annual Conference

October 13-14, 2011

Midtown Holiday Inn - Grand Island, NE

Veterans Workshop

October 21 - Papillion

Contact Danielle Sodergren - (402) 476-3391
mdsodergren@hotmail.com

Nebraska Rural Health Advisory Commission Mtg.

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

Nebraska Department of Health and Human Services
220 South 17th Street - Lincoln, NE

National veterans awareness campaign

The National Hospice and Palliative Care Organization (NHPCO) recently announced that the Nebraska Hospice and Palliative Care Association's Jennifer Eurek, CSW, has been appointed as the Central Plains Regional Representative for the We Honor Veterans Campaign.

The We Honor Veterans campaign is a collaboration of NHPCO and the Department of Veterans Affairs (VA) to help improve the care Veterans receive from hospices and palliative care providers. The national campaign will provide tiered recognition to organizations that demonstrate a systematic commitment to improving care for Veterans. These "Partners" will assess their ability to serve Veterans and, using resources provided as part of the campaign, integrate best practices for providing end-of-life care to Veterans into their organization.

"All hospices are serving Veterans but often aren't aware of that person's service

in the armed forces," said J. Donald Schumacher, NHPCO president and CEO. "Through We Honor Veterans we are taking a giant step forward in helping hospice and palliative care providers understand and serve Veterans at the end of life and work more effectively with VA medical facilities in their communities."

Eurek's region includes North Dakota, South Dakota, Minnesota, Iowa, Nebraska, Kansas, Missouri, Texas, New Mexico, and Arizona. Her responsibilities are to provide technical assistance for hospices that are We Honor Veterans Partners, assist in developing collaborative partnerships between community hospices and VA facilities, and extend the reach of the We Honor Veterans campaign.

Visit www.wehonorveterans.org or www.nehospice.org to learn more, or contact Jennifer@nehospice.org □

SAVE THE DATE!!



*September 21 will be
an all day CRHC
Coding and Billing
Workshop*

**2011 Annual Conference
September 21st & 22nd, 2011
Younes Conference Center
Kearney, NE**

**For more information contact the Nebraska Rural Health Association,
Melissa Beaudette: (402) 421-7995 or mbeaudette@mwhc-inc.com**

Nebraska Rural Health Association Award Nominations

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

Integrated Rural Healthcare Award

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

Outstanding Rural Health Practitioner Award

The Outstanding Rural Health Practitioner Award recognizes an individual that is a direct service provider who provides direct patient care such as physicians, nurses, physician assistants, nurse practitioners, and others. This individual must exhibit outstanding leadership in bringing and/or improving health services in rural Nebraska. Factors taken into consideration include providing outstanding care; collaboration and multi-

disciplinary teamwork; involvement in the community; involvement in education; and lasting contribution to the rural health care system.

Rural Health Achievement Award

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

Rural Health Consumer Advocate Award

It is important to recognize that rural health care delivery systems will survive only with the involvement of rural consumers. This award honors an individual consumer, who is not an employee in the health care or health insurance industry, for active participation within his or her community and/or region regarding rural health service delivery issues. For example, the award winner may have testified to the state or national legislature on rural consumers' health care needs or made lasting contributions to rural health care in their community, region, or state. The nominee should be current on rural consumer health care issues and must have shown leadership in community and education regarding health care changes, needs, or improvements. Awards will be presented at the annual Nebraska Rural Health Conference September 16, 2010. Fill out and return the nomination form now.

Please select the award for which you are nominating an individual or team:

Integrated Rural Healthcare Award

Outstanding Rural Health Practitioner Award

Rural Health Achievement Excellence Award

Rural Health Distinctive Consumer Advocate Award

Nominee Name: _____

Address / City / State / Zip: _____

Phone (Office): _____ (Home): _____

Nominee's Organization: _____

Areas (towns, counties) affected by Nominee's Work: _____

Please describe the nominee's contribution to rural health care, accomplishments and the significance of this person's work. A biographical sketch should be attached. You may also attach news articles and other documentation to support this nomination.

Name of Person/Organization Submitting Nomination: _____

Address/City/Zip: _____

Email Address: _____ Phone: _____

Awards will be presented at the Nebraska Rural Health Conference - Thursday September 22, 2011

Deadline for Nominations: August 19, 2011

All applications **must** be postmarked by this date. Late nominations will not be considered for awards.

Mail completed applications to: Nebraska Rural Health Association / 310 Glenhaven Dr / Lincoln, NE 68505

Or email to mbeaudette@mwhc-inc.com

Rural Health Advisory Commission update

The Nebraska Rural Health Advisory Commission is a governor-appointed commission with statutory powers and duties. The thirteen members of the Rural Health Advisory Commission (RHAC) include the Director of the Department of Health and Human Services' (DHHS) Division of Public Health (or his or her designee), one representative appointed by the Director of the DHHS, one representative of each medical school located in the state involved in training family physicians, one physician in family practice residency training, and, from rural areas of Nebraska, one physician, one dentist, one consumer representative, one hospital administrator, one nursing home administrator, one nurse, one physician assistant, and one mental health practitioner or psychologist.

The purpose of the RHAC is to advise the DHHS, the Legislature, the Governor, the University of Nebraska, and citizens of Nebraska regarding all aspects of rural health care. Some of the statutory duties of the RHAC include identifying problems in the delivery of health care, in the education and training of health care providers, and in the regulation of health care providers and institutions in rural Nebraska and prepare recommendations to the appropriate bodies to alleviate the problems identified. The RHAC also has the duty of designating state-designated health profession shortage areas in Nebraska and selecting recipients of financial incentives available under the Rural Health Systems and Professional Incentive Act (the Act). The Nebraska Office of Rural Health is responsible for the administration of the Act with the advice and consultation of the commission.

Each year in June, members of the RHAC interview applicants for the Nebraska Student Loan Program. The Nebraska Student Loan Program provides medical, physician assistant, dental, and graduate-level mental health students educational loans up to

\$20,000 per year that are forgiven if the recipient practices in a state-designated shortage area the equivalent of one year for each year he/she receives a loan. These loans are only available to Nebraska residents attending graduate school in Nebraska. This year the RHAC interviewed 12 applicants and offered student loans to 9 of those applicants. In addition to the 9 "new" student loans the RHAC also approved 7 continuation student loans.

Besides the Nebraska Student Loan Program, the RHAC approves applications for the Nebraska Loan Repayment Program. The Nebraska Loan Repayment Program is for certain licensed health professionals, requires a "local entity match," and a 3-year practice obligation in a state-designated shortage area. The Nebraska Loan Repayment Program assists health professionals in repaying their government or commercial educational loans.

Health professionals eligible for loan repayment include physicians, physician assistants, and nurse practitioners practicing one of the following primary care specialties: family practice, general internal medicine, general pediatrics, general surgery, obstetrics and gynecology, or psychiatry; dentists practicing one of the following specialties: general dentistry, pediatric dentistry, or oral surgery; psychologists, licensed mental health practitioners, pharmacists, occupational therapists, and physical therapists. The amount of loan repayment the health professional may receive depends on his/her educational debt, the amount of local matching funds the local entity is willing to provide, and the practice time spent in the shortage area. The maximum amount of loan repayment for physicians, dentists, and psychologists is \$40,000 per year (\$20,000 from the local entity and \$20,000 from the state) for all other professions it is \$20,000

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per year (\$10,000 from the local entity and \$10,000 from the state).

At the June meeting, the RHAC approved 12 new loan repayment applications and moved 2 loan repayment applications to the waiting list because the health professionals will not begin practice until 2012. There are 81 loan repayment recipients in practice in shortage areas in Nebraska. Applications for the Nebraska Loan Repayment Program are accepted year round and may be submitted up to 18 months prior to the health professional being eligible to practice.

A local entity needs to provide the local matching funds to the state funds and monitor

the loan repayment recipient's practice in the shortage area. The health professional cannot monitor his/her own practice nor provide the local match. There is an application form for the local entity to complete along with the health professional's application.

Minutes of past Rural Health Advisory Commission meetings are posted on the Office of Rural Health website after the commission approves them at www.dhhs.ne.gov/orh.

For more information about the commission, state-designated shortage areas, or the rural incentive programs, please contact Marlene Janssen at the Office of Rural Health, (402) 471-2337. □

For Shortage Area designations and more information on the Incentive programs, go to our Web site:

<http://www.dhhs.ne.gov/orh/>

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



CRHC Coding and Billing Workshop

September 21, 2011
8:00 a.m. - 5:00 pm.
Younes Conference Center,
Kearney, Nebraska



Achieving Meaningful Use

By Rita Luongo, TCHS

For the past four years, Thayer County Health Services has been converting all patient health information into a digital format for their electronic health records (EHR). When asked for an update on their EHR, Joyce Beck, CEO for TCHS replied, "We are very excited because later this summer, Thayer County Health Services (TCHS) will attest to meaningful use of our EHR to the federal government. This achievement will likely make us the first hospital in Nebraska to accomplish this goal."

What is meaningful use? Meaningful use is the term used by the federal government to determine the level in which a healthcare provider is electronic with their EHR. Starting in 2011, meaningful use is the key in determining if a healthcare provider meets the qualifications for incentive payments from Medicare and Medicaid. These incentive payments are being used by the federal government to encourage healthcare providers to move forward in converting their health information over to an EHR. Over the next five years there will be a gradual introduction of what constitutes meaningful use and its associated requirements. During this time, three phases will be used by providers in accomplishing meaningful use. The first phase begins in 2011, and the next two phases will take effect before 2015.

Phase 1, which begins this year, has several requirements associated with it. To be considered meaningfully using a certified EHR system, healthcare provider must meet all of them. Some of the requirements are fairly simple while others require a significant investment of time and training to implement. Key requirements are:

- Physicians are using Computerized Physician Order Entry (CPOE)
- Allergies patients have to prescription drugs are being tracked.
- Smoking status of patients who are at least 13 years old are being recorded.
- Electronically verification of insurance eligibility for patients.
- A copy of a patient's health records are pro-

- vided to patients when requested.
- Implementation of at least five decision support routines in important areas of your practice.

Beck further stated, "EHR systems do not achieve these benefits merely by transferring information from paper format to a digital format. An EHR system can only deliver its benefits when the information contained in it are standardized and structured in a uniformed way. Just as bank ATMs use a uniformed format, the 'meaningful use' approach will also require EHR systems to be standardized."

Beck further stressed that, "Besides being a financial benefit, having a certified EHR will provide a safer environment to provide care to patients. The adoption of health information technology (HIT) nationwide will ultimately lead to improved quality of healthcare and increased patient safety. This is because it will allow doctors access to a patient's complete health picture and provide better care coordination between providers. Already we have seen benefits from using our EHR system. Since its implementation there have been fewer medication errors and less duplicate tests ordered. When patient information is able to be shared among providers it results in a savings of time and money for both healthcare providers and their patients."

For more information, contact Rita Luongo at rluongo@tchsne.org. □

Suicide prevention resources:

Nebraska State Suicide Prevention Coalition:

www.suicideprevention.nebraska.edu

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

Healthcare: the hunt for better understanding

by David Howe

Is the healthcare industry falling short of telling the public what it needs to know about such matters as patient safety, new services and technologies, healthcare priorities, and how to obtain the best care?

Are the news media holding up their end of the bargain in pressing for the answers the public needs from the healthcare industry so that citizens can make informed decisions about what they should expect from their healthcare providers?

Questions like those have led to formation of a five-panel series on healthcare topics. Panel discussions will be linked interactively through the Nebraska Statewide Telehealth Network among 80 hospitals and 19 public health sites in Nebraska this fall. The public is invited to attend at those sites which will try to accommodate as many as their telehealth room capacities permit.

The first panel will be convened September 15 and the last on December 1 (see accompanying schedule).

The mix of panel participants will vary according to the panel topic, with each panel having at least four members, each noted for expertise related to the topic. Panelists over the course of the series will include healthcare professionals, administrators, in-state and out-of-state media, legislators, and health service organizations.

Panel organizers want to generate light, not heat.

“My goal would be to have a conversation—not a debate,” said Nebraska Hospital Association President Laura Redoutey, one of the organizers.

“We all know there are differing opinions,” said Allen Beermann, another panel series organizer. “We hope to be able to leave the politics out of it.” Not everyone knows where to go, whom to go to, and how to get the health information they need. Hopefully, the panels will generate some answers to those questions for citizens, said Beermann, Executive Director of the Nebraska Press Association. “We think

we have a variety of panelists who can do that.”

The organizers see this series as an opportunity for healthcare providers and the media to be candid about what they need from each other to best serve the health information needs of the public.

Nationally acclaimed health journalist Trudy Lieberman is coordinating with organizers that include Beermann and Redoutey. Lieberman will be joining the University of Nebraska-Lincoln College of Journalism and Mass Communication as a guest lecturer at the College this fall. Together, they have identified panel topics and panel members, based on contacts in their respective fields of expertise.

Lieberman will facilitate the panel discussions. Over her 43 years as a journalist, this Nebraska native has among her credentials a long career at Consumer Reports, specializing in insurance, healthcare, and healthcare financing. She was recently a director of the health and medical reporting program at the Graduate School of Journalism at City University of New York. Among her many other credentials as a health journalist, she has garnered more than 20 national and regional reporting awards and other honors. She is a contributing editor to the Columbia Journalism Review, where she blogs about healthcare and retirement at cjr.org, and is a fellow at the Center for Advancing Health, where she blogs at preparedpatientforum.org.

Panel planners chose the series title, “Tackling Health Care: Improving Access to Useful Information.”

The organizing partnership hopes the panel discussions will “. . .inform healthcare professionals, journalists, policymakers, and citizens about the U.S. healthcare system: its strengths, its weaknesses and potential changes and reforms.”

While Medicaid and Medicare are part of the discussion in a couple of panels, issues

Continued on page 13

relating to health insurance companies are not a centerpiece of the panel series, according to Beermann. Coverage and competition among health insurance companies might be an appropriate topic for a followup round of healthcare panels, he said.

He sees the panels as an opportunity for healthcare providers and the media to sit down at the same table in a setting that lets them talk to each other in a way that focuses on how they can best serve the public.

Are there situations in which the media may be wary of whether providers make positive image-building information a higher priority than information that puts the public's interest first? Conversely, are providers sometimes suspicious that the media are mainly interested in issues of a more dramatic nature—conflict and healthcare failures?

Lieberman, with a long career in health reporting, noted that reporters often have an agenda different from that of healthcare professionals. "Hospitals and providers need to understand what we (journalists) do." For instance, in the event of medical errors, "the public needs to know about those things," she said. "Many times, that's in the public interest."

At the same time, it's important for reporters to know how the healthcare system works, she added. Journalists need to be trained in critical thinking skills, she said. Asked about the need for specialized journalism training for covering the healthcare field, Lieberman responded that there is a trend toward specialized journalism in fields such as healthcare.

Information generated by the panels will become topics for articles by journalism students in the courses that Lieberman will be teaching at UNL this fall. Those articles will be available to the media.

Of course, the media will be invited to cover the panel discussions. Additionally, the proceedings will be videotaped for editing and broadcast through various outlets, including the Nebraska Educational Television Network, according to the organizing partners.

The general public will be invited to sit in on the panel discussions. However, details on how the public will be accommodated are still being worked out, owing to limited space at the 80 hospitals and 19 public health sites to which the discussions will be aired via the Nebraska Statewide Telehealth Network.

Lieberman said, "It's important that these (panel discussions) are going to be open to the public all across the state." She sees it as an "unprecedented opportunity to learn from many experts all across the state."

The format, as currently planned, will be introduction of panel members and discussion among them for the first 45 minutes, followed by 30 minutes in which the audience in Lincoln and at remote sites will be able to ask questions of the panel members and panel members will be able to ask questions of the audience.

Yet to be decided is if or how questions for panel members from the public will be solicited in advance to initiate interactive discussion.

Redoutey at the Nebraska Hospital Association expects that the biggest payoff from these panel discussions will come after the public has had time to digest publication and broadcast of the proceedings in the months following the series. The topics are especially important within the context of healthcare reform and state and federal fiscal challenges, she said. □

Panel Topics and Dates

3-4:15 p.m. Central Time, 2-3:15 p.m. Mountain Time

Originating from St. Elizabeth Regional Medical Center and delivered to all hospitals on the Nebraska State Telehealth Network and to most public health district offices. Call your closest site to reserve a space. Seating is limited.

Sept. 15—Health Care Payment in a Market Economy.

Sept. 29—How Can We Better Protect Our Patients?

Oct. 20—What Are the Real Politics of Medicare and Medicaid?

Nov. 3—Dealing with Death and Dying?

Dec. 1—What Else Makes and Keeps People Healthy?

Brain injury reminders

The Nebraska Brain Injury Association hope you are having a safe and healthy summer. This time of year brings lots of summer-time activities, and we start gearing up for back-to-school sports and activities as well. At the Nebraska Brain Injury Association, we know that the benefits of sports and physical activity far outweigh the risks, and we want to remind everyone of ways to protect your kids from head injuries while they're sporting, playing, and having fun.

Concussions are brain injuries, even though most of them occur without loss of consciousness and don't always show up on CT scans or MRIs. They can be caused by a blow to the head, or just by forceful movement of the head itself from a hard hit to the body or fall. ANY sport can cause a concussion, not just football. Children and teenagers are more likely to get concussions and take longer to recover than adults. Research shows having had one concussion makes an individual more likely to have another. A second concussion to a brain that's not fully recovered can have catastrophic effects, or even result in death.

Should we just lock our kids up and only let them out of the house in full body armor and helmets to protect them? Sometimes we'd like to. But education and prevention serve as second best, and more realistic alternatives.

A minute or two to think about safety can save living a lifetime with brain injury. Use all the available protective gear required for your sport or activity including helmets and padding. Make sure equipment is in good condition and working order. Always have adult supervision for young children and encourage the buddy system when kids are out playing on their own.

Though concussions are serious, the good news is that about 80% of all brain injuries are mild and most of these heal within days or weeks if precautions, especially decreased activity, are taken.

Signs and symptoms of concussion:

- Dazed and confused
- Blurred vision
- Headache
- Nausea
- Poor balance
- Ringing in ears
- Noise and/or light sensitivity
- Irritability
- Short-term memory loss or disorientation to time, place, and situation
- Fatigue, sluggishness

If these symptoms persist, you should see a physician who can refer you to specialists in brain injury.

Did you know that the Nebraska Unicameral passed a Concussion bill that will become law a year from now? In 2012, all coaches in youth sports run by schools, city leagues, and non-profit groups will be required to receive education and training regarding concussion and sports. They will be required to prohibit any youth suspected of having had a concussion from returning to play for that game and for future play until cleared by a mental health care professional (physician, athletic trainer, neuropsychologist, or other individuals certified, licensed, or registered to provide medical treatment). Students, parents, and guardians will also receive education about concussions as a part of this legislation.

For more information on Brain injury contact the Nebraska Brain Injury Association at <http://www.biane.org/>. □

Wide River TEC Reaching Milestones

- 90 Percent of Rural Providers in Nebraska are Working Towards Electronic Health Records
 - Omaha Doctors Among First in Nebraska to Receive Meaningful Use Medicare Incentive
- Wide River Technology Extension Center (TEC), the designated Regional Extension Center (REC) for Nebraska, has had an eventful past few months and has reached a milestone recently. Since obtaining the initial grant in February of 2010, Wide River TEC has begun working with over 700 providers in Nebraska's clinics and critical access hospitals to assist them in becoming meaningful users of electronic health record (EHRs).

Wide River TEC is working to have an impact in rural Nebraska. Recent enrollment statistics show that 90.1% of eligible primary care providers in rural Nebraska have enrolled with Wide River TEC and are now working toward implementation and meaningful use of an EHR.

"To know that we are reaching rural Nebraska at such a high percentage is outstanding. I am proud that this grant, aimed to help small, rural providers, is achieving its goal to the fullest extent in our state," said Todd Searls, Director of Wide River TEC.

A major challenge to rural health care providers' implementation of an EHR system is the complexity associated with system selection and adoption. A lack of familiarity about EHR systems in general and about specific systems may discourage or delay EHR system adoption. Wide River TEC has staff with the experience and capacity necessary to assist healthcare providers with the task of modernizing their practices with certified EHRs. By utilizing EHRs, providers can offer higher quality, safer care and create tangible improvements to their practices, allowing them to make better clinical decisions, provide more coordinated care and increase efficiency in their offices.

On July 19, Omaha family medicine physicians Dr. Mark Woodruff and Dr. William Weeks were recognized by Nebraska's Lt. Governor, Rick Sheehy and Wide River TEC for their leadership in the transition to EHRs. Drs. Woodruff and Weeks, of Southwest Family Physicians, are among the first physicians in the state to successfully attest and certify Meaningful Use of their EHR system as part of the Medicare EHR Incentive Program.

"Patient care has improved dramatically. We have seen greater efficiencies in accessing records both in and outside of our office," said Dr. William

Weeks. "Our staff and providers were unified in making this a success. It's really a great example of how common vision, goals and teamwork can achieve this huge accomplishment in our small medical practice."

The Centers for Medicare & Medicaid Services (CMS) awards providers an incentive payment as part of the Medicare and Medicaid EHR Incentive Programs. Drs. Woodruff and Weeks are among the first physicians in the country to each receive an initial \$18,000 Medicare EHR incentive payment from CMS. Eligible professionals and hospitals receive financial incentives when they demonstrate meaningful use of a certified EHR. Provider payments can amount to \$44,000 through Medicare or \$63,750 through Medicaid over the life of the initiative.

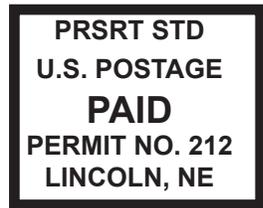
"It may seem like a small thing, but never losing a chart, never looking for a chart, never having to wait for a chart, never fighting over a chart and therefore always having immediate access to any and all patient information is a tremendous time saver and stress reliever," noted Dr. Mark Woodruff. "EHRs make me more confident that important information about the patient is not slipping through the cracks."

This is the first year doctors are eligible for incentives. The incentive dollars were authorized as part of the 2009 economic stimulus also known as the American Recovery and Reinvestment Act.

Wide River TEC would also like to announce they are hosting an event at Western Nebraska Community College in Scottsbluff on August 24. You're invited to attend the upcoming Meeting Meaningful Use Summit and Vendor Lab. This event will focus on EHRs and meeting Meaningful Use.

- Meeting Meaningful Use Summit and Vendor Lab; Wednesday, August 24, 2011, 9 am to 4 pm (MDT); Western Nebraska Community College, John N. Harms Advanced Technology Center, Scottsbluff, Nebraska
- James F. Parks and Nancy Ross, Box Butte General Hospital, will deliver the keynote presentation, Meaningful Use: The Journey from The Dull Edge to the Bleeding Edge.
- To view the agenda, registration information and all 21 vendors exhibiting, <http://www.widerivertec.org/home/events.aspx>. Registration closes August 19!

For more information, call Wide River TEC: (402) 476-1700. □



ACCESS

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ACCESSory Thoughts

COMMUNITY MATTERS

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

Community Matters is more than a nice set of words with a dual meaning. It is a reality and a frame that we must do a better job explaining and advocating for these days. Rural may matter to us, but does it matter to the rest of the state/country? Does your community matter today? Do we really know the difference between our rural myths and our rural realities, resources and opportunities? Do we really understand our strengths and can we see where rural can lead?

I believe that for most of us these issues are really matters of the heart (our Mores). It would be wonderful if we could transform those feelings into strategies and actions that have a sense of urgency tied to a large amount of knowledge. Logic needs a frame and we need to create a frame that tells the rural health and health care story with all the values that we hold dear.

We must ensure that Community Matters for the sake of its members, our citizens, and for the sake of our nation and world.

The great thing about a community is that communities need their members to be involved if they are to remain sustainable. I think they also want their members to participate in public life as a way to improve the health and health care of their fellow citizens. Why, because they want action, they want to see growth and improvement. Underlying all the strategies employed in health and community development models is also the assumption that people have a right to participate in public affairs that affect their lives. What affects us more than our individual health and the health care system we need at times to help us.

I truly believe that communities want to be better, healthier, more economically viable and safer for their neighbors, friends, family and themselves. Please take some time to help transform your community by explaining why communities matter and framing the health and health care issues in a resource positive vs. a resource negative only frame. Communities matter because every member matters and we all have matters that need to be addressed. □