

# ACCESS

Newsletter of the Nebraska Office of Rural Health,  
Nebraska Department of Health & Human Services,  
Division of Public Health  
for all rural health stakeholders  
**Issue 66, May 2012**

## contents

- **2012 Rural Health Conference** (page 3)
- **Rural health calendar** (page 4)
- **Tracking health professionals** (page 5)
- **Swapping health ideas** (page 8)
- **Panhandle health care model** (page 10)
- **Rural health grants** (page 11)
- **Rural health leadership** (page 12)

## IMPORTANT NOTICE

The *ACCESS* newsletter, along with our library of back issues, has been available for several years on the Web at [www.dhhs.ne.gov/orh](http://www.dhhs.ne.gov/orh).

We have been asked to publish all newsletters in electronic-only versions. We are asking you to now subscribe to our electronic newsletter. To be notified when a new issue is available, please go to [http://dhhs.ne.gov/Pages/newsletters\\_access.aspx](http://dhhs.ne.gov/Pages/newsletters_access.aspx) 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 prefer, send your e-mail address to [Ann.Larimer@nebraska.gov](mailto:Ann.Larimer@nebraska.gov), and we will do this for you. Please e-mail Ann with any questions.

## A partnership to up the level of care for military veterans in Nebraska

by David Howe  
SORH Contracted Rural Writer

Good Samaritan Hospital at Kearney and Veterans Affairs have their sights set on stepping up healthcare services a notch for Nebraska's military veterans.

They're doing it through a partnership leveraged by the Nebraska Statewide Telehealth Network.

This pilot project, the first of its kind, intends to link Good Samaritan's Richard Young Hospital in Kearney and Veterans Affairs healthcare services in delivering behavioral healthcare to veterans. If that works out as hoped, similar partnering between non-VA and VA providers in the state might be expanded to other medical services for veterans, according to Dale Gibbs, Director of Outreach and Telehealth Services at Good Samaritan Hospital in Kearney, and Dr. Ahsan Naseem, psychiatrist at the VA in Lincoln.

Under the pilot project, the VA telehealth network will be linked to Good Samaritan's Richard Young Hospital in Kearney by the Nebraska Statewide Telehealth Network. Eventually--if the pilot is successful and connections are expanded--all non-VA providers around the state who are linked by the Statewide Telehealth Network could, in turn, be linked to the VA telehealth network.

Hypothesizing how that might work under the agreement, Gibbs uses the example of a veteran with behavioral health problems who goes to a small rural Nebraska hospital emergency room. The physician at that hospital might, through

*Continued on page 2*

the aforementioned tie-in with the VA, be able to determine in consultation with VA providers a course of treatment locally, rendering an ambulance trip to Omaha unnecessary.

The overall goal is to make healthcare available closer to home for veterans whenever possible, Gibbs explained. Information Technology personnel at Good Samaritan Hospital and at the VA are working out system compatibility issues and security to ensure against crossover of sensitive information between the VA's and Good Samaritan Hospital's telehealth systems, Gibbs said.

The partnership has been 1½ years in the making, with a lot of encouragement from the Nebraska Department of Health and Human Services, Public Health, State Office of Rural Health, according to Gibbs.

The first order of business under the Good Samaritan Hospital-VA agreement is to target veterans who are already patients at Richard Young Hospital, Dr. Naseem said. The system under the agreement is designed to smooth the transition for veterans being discharged from Richard Young Hospital, he explained. Through the Statewide Telehealth Network, providers at Good Samaritan Hospital and the VA can work as a team to consult and develop a follow-up treatment plan or transition to another facility for a veteran being discharged from Richard Young Hospital in Kearney. Calling it a "coordinating tool," Dr. Naseem said, "We're using it (Good Samaritan/VA telehealth linkup) more as a means of facilitating care."

It's to ensure that a veteran being discharged from the hospital doesn't drop out of the system. One "big reason" a patient relapses, Dr. Naseem said, is that the patient "doesn't follow up or gets lost in the system." Avoiding that outcome is the initial focus of the pilot agreement for now, he said.

A feature that Gibbs sees under the agreement with the VA is that some veterans may not be fully aware of services available to them from the VA. If a veteran comes to a non-VA provider, the connection between that

provider and the VA could lead to connecting that veteran with VA healthcare services he or she might not otherwise have accessed. And, that could result in reduced cost of care for that veteran, Gibbs added.

"Mental healthcare is the biggest (medical) need of vets," Gibbs said. "So we decided we would try this."

But, as previously noted, success with delivering behavioral healthcare to veterans under the VA-Good Samaritan Hospital agreement may pave the way for other medical services to veterans. Twenty-two types of specialty care—everything from hearing loss to urology—are provided by rural VA clinics, according to Dr. Naseem. Possibly, some of those kinds of care could be provided in the future to veterans at non-VA facilities that are closer by than VA facilities for those veterans. It all depends on how well the pilot project works out.

As Dr. Naseem put it: "Good Samaritan is that first step in developing such a bridge, and we hope to widen that bridge." For now, behavioral healthcare is the focus of the pilot project. More veterans are coming back from combat zones, Dr. Naseem said. Those vets and an aging population of Vietnam vets represent a large healthcare need.

"We (VA) would like to extend ourselves" in partnering with non-VA providers in coordinating care for veterans, he added. "Now, we have an opportunity to do it, using the technology we have at hand. I, for one, am appreciative of working with Mr. Gibbs to move this forward."

Gibbs said, "It just makes sense that we do a lot more collaboration with the VA."

## The 2012 Nebraska Rural Health Conference

Will be held *September 19 and 20, 2012*  
At the Younes Conference Center in Kearney  
For more information, contact:  
Melissa Beaudette  
mbeaudette@mwhc-inc.com

## 2012 Annual Nebraska Rural Health Conference

This year's annual Nebraska Rural Health Conference scheduled for Wednesday and Thursday September 19 and 20, at the Younes Conference Center in Kearney Nebraska.

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

This year's keynote speaker, Michael E. Frisina is an internationally recognized leadership expert, speaker, and author. He has developed leaders and organizational teams worldwide. Every year he speaks to national and international healthcare organizations, non-profit organizations and audiences as diverse as engineers to organ procurement organizations. His work in healthcare leadership, safety, and quality has been recognized by The Joint Commission in its publication, "Doing the Right Things Right." He is the author of *Influential Leadership – Change Your Self, Change Your Organization, Change Health Care*.

Additional keynote speakers will be Brock Slabach, Senior Vice President of the National Rural Health Association and Jeff Ellis, Spencer Healthcare Strategies. Brock will report on the latest from Washington D.C. on health care reform and Jeff will discuss "From Competition to Collaboration: A New Vision for Rural Health Networks."

"We are pleased to bring back an old friend to the State of Nebraska, A. Clint MacKinney, MD, MS. Dr. MacKinney is a member of the Rural Policy Research Institute Health Panel and has served on national committees for the Institute of

Medicine, the Department of Health and Human Services, the American Academy of Family Physicians, and the American Medical Association," noted John Roberts of NeRHA. In his capacity as a rural health advocate, Dr. MacKinney writes and presents nationally. Dr. MacKinney's professional interests include rural health system design, healthcare value, physician and administration relationships, physician payment, rural health policy, and population-based healthcare.

Mark your calendars for September 19-20, 2012 and go to the Nebraska Rural Health Association web site [www.nebraskaruralhealth.org](http://www.nebraskaruralhealth.org) for more information as the conference continues to be developed. For more information regarding sponsorship or being an exhibitor contact the conference coordinator, Melissa Beaudette at (402)421-7995 or [mbeaudette@mwhc-inc.com](mailto:mbeaudette@mwhc-inc.com). □

### **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**

# SAVE THE DATE!

September 19 will be  
an all day CRHC  
Coding and Billing  
Workshop

## Nebraska Rural Health Association

### 2012 Annual Conference

September 19 and 20, 2012

Younes Conference Center

Kearney, Nebraska

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

NeRHA is now accepting **Nebraska Rural Health Association Award Nominations!**

Each year, the Nebraska Rural Health Association honors people who have contributed to rural health-care through leadership at its annual conference. These awards recognize individuals and organizations who take on leadership roles in healthcare and their communities. Prior to each annual conference, the NeRHA solicits nominations for three awards and your input is very valuable to us! For a 2012 awards nomination form and more information, please visit:

<http://nebraskaruralhealth.org/events/annual-conference-webinars/> -- or contact **Melissa Beaudette** at the e-mail address above.

## MARK YOUR CALENDARS

### **Pediatric CBRNE (Chemical Biological Radiological Nuclear Explosives) Conference**

May 30-31, 2012 - LaVista Embassy Suites, Omaha, NE

For more information, contact Barbara Dodge  
(402) 552-3101 or visit [www.nemsa.org](http://www.nemsa.org)

### **Nebraska Rural Health Advisory Commission Meeting**

Friday, June 22, 1:30 PM - Lincoln, NE

### **2012 Summer Nebraska EMS Association Conference**

July 14-15, 2012

Younes Conference Center - Kearney, NE

For more information, visit [www.nemsa.org](http://www.nemsa.org)

### **CRHC Billing & Coding Workshop**

September 19, 2012 - all day

Younes Conference Center, Kearney, NE

### **2012 Nebraska Rural Health Conference**

September 19 and 20, 2012

Younes Conference Center - Kearney, NE

### **Nebraska Rural Health Advisory Commission Meeting**

Thursday, Sept. 20, 6:00 p.m., Kearney, NE

### **NRHA Rural Health Clinic Conference**

September 25-26, 2012 - Kansas City, MO

### **NRHA Critical Access Hospital Conference**

September 26-28, 2012 - Kansas City, MO

### **Nebraska Rural Health Advisory Commission Meeting**

Friday, November 30, 1:30 PM - Lincoln, NE

### **National Rural Health Day 2012**

November 30, 2012

<http://celebratepowerofrural.org/>

### **2013 Nebraska Rural Health Conference**

September 18 and 19, 2013

Younes Conference Center - Kearney, NE

## Tracking health professionals in Nebraska

The University of Nebraska Medical Center, College of Public Health, Health Professions Tracking Service (HPTS), was established in 1995 to document the retention of Nebraska's physicians.

Since that time, HPTS has surveyed Nebraska physicians annually and physician practice locations semi-annually. The combined physician and practice location responses have enabled HPTS to link physician and practice location data together in a relational database producing data that few states can match. The comprehensive approach identifies practicing physicians, practice specialties and practice locations (primary and satellite) throughout the State of Nebraska.

Examples of the important work made possible by the results of the surveys are:

- *"A Critical Match" Nebraska's Health Workforce Planning Project.* The report can be found at: <http://www.unmc.edu/rural/documents/NebraskaWorkforceProjectFinal091509.pdf>
- State and Federal Shortage Area designations for the State of Nebraska, DHHS, Office of Rural Health: [http://dhhs.ne.gov/publichealth/Pages/hew\\_orh\\_samaps.aspx](http://dhhs.ne.gov/publichealth/Pages/hew_orh_samaps.aspx)
- Contact information for the Nebraska Health Alert Network (HAN). The HAN website is: [http://dhhs.ne.gov/publichealth/Pages/han\\_hanindex.aspx](http://dhhs.ne.gov/publichealth/Pages/han_hanindex.aspx)
- *The Nebraska's Behavioral Health Workforce – 2000 to 2010* report. The report can be found at: [http://www.unmc.edu/bhecnc/docs/Final\\_Report\\_BHWorkforceAugust1.pdf](http://www.unmc.edu/bhecnc/docs/Final_Report_BHWorkforceAugust1.pdf)
- *The Nebraska – 2012 Combined Behavioral Health Assessment and Plan* (SAMHSA Uniform Block Grant Application FY 2012-2013). [http://dhhs.ne.gov/behavioral\\_health/Documents/NE-FINAL-SAMHSA-UniformBlock-GrantApplication2012-13.pdf](http://dhhs.ne.gov/behavioral_health/Documents/NE-FINAL-SAMHSA-UniformBlock-GrantApplication2012-13.pdf)

The completeness of the HPTS data is directly linked to the survey responses of all physicians and practice locations. HPTS data are used by the State Office of Rural Health (SORH) to identify state and federal shortage areas for purposes of the Nebraska rural incentive programs and several federal

programs.

### State Designated *Medical Shortage Areas*

How are state designated medical shortage areas identified? Approved medical specialties, as defined in the Rural Health Systems and Professional Incentive Act (Nebraska Revised Statutes, §71-5650 to §71-5670), include family practice, general practice, general internal medicine, general pediatrics, general surgery, obstetrics/gynecology, and psychiatry. Psychiatry/Mental Health, oral health, and allied health shortage areas will be discussed in later articles. The Rural Health Advisory Commission (RHAC) is responsible for establishing the shortage area guidelines and approving the state-designated shortage areas.

The RHAC, with assistance from the Nebraska HHS, PH, State Office of Rural Health, has developed the methodology for defining state-designated, health professional shortage areas through working with professional associations, local communities, state law makers, government agencies (federal, state, and local), and interested parties. According to the Nebraska Rural Health Systems and Professional Incentive Act, "...in making such designations the commission shall consider, after consultation with other appropriate agencies concerned with health services and with appropriate professional organizations, among other factors: (1) the latest reliable statistical data available regarding the number of health professionals practicing in an area and the population to be served by such

Continued on page 6

**For Shortage Area designations and more information on the Incentive Programs, go to our website:**

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

practitioners; (2) inaccessibility of health care services to residents of an area; (3) particular local health problems; (4) age or incapacity of local practitioners rendering services; and (5) demographic trends in an area both past and future.” (Nebraska Revised Statutes, §71-5665.)

Physician records supplied by the UNMC-HPTS are used to determine medical shortage areas. HPTS provides approximately 3,250 physician records to the SORH. After these records are sorted and truncated so only rural physician records are left, the SORH normalizes practice hours per week to a 40-hour work week. The objective is to have one record for each physician practicing in a particular county. SORH ends up with approximately 700 physician records and 13 data fields, out of the 51 data field HPTS sends to the state office.

SORH prepared physician data are then put into an ACCESS data base where programs are run to generate full-time equivalency (FTE) reports by county by physician specialty. Family practice shortage areas require data from other sources in addition to the FTE data. County population is obtained from the latest Census estimates along with county population age 65 and over and poverty data. The Vital Statistics office also provides the SORH with infant mortality rates and low birth weight rates by county.

Once all of the county data for determining family practice shortage areas are entered, counties with populations equal to or greater than 15,000 are excluded because these counties are not eligible to be designated as state-designated *family practice* shortage areas. Next county populations to family practice FTE ratios are calculated. Ratios equal to or exceeding 2,000/1 or counties with no family practice physician coverage are highlighted. These counties meet the first criteria for being designated as a state-designated family practice shortage area.

Counties with population to family practice FTE ratios between 1,500/1 up to 1,999/1 may still meet the family practice shortage area guidelines if they have one or more high-need indicators. High-need indicators for state-

designated family practice shortage areas include: (1) the proportion of the population that is 65+ ranks in the highest quartile of the state; (2) the proportion of the population below the poverty level ranks in the highest quartile of the state; (3) the infant mortality rate ranks in the highest quartile of the state; (4) the low birth weight rate ranks in the highest quartile of the state; (5) more than half of the area's physicians are over 60 years old; or (6) the area is a frontier area (fewer than six persons per square mile).

Population to specialty physician FTEs are calculated for the other medical specialties but these state shortage areas are based on this ratio. There are no high need indicators for medical specialties except for family practice.

A statewide review of state-designated shortage areas is completed every 3 years. If a change occurs in the county between the statewide review years, the community can submit a request and documentation of the change to the Rural Health Advisory Commission through the SORH. Office staff submits the information to HPTS to be verified and then reports it to the Rural Health Advisory Commission. If the county meets the guidelines the commission approves the county as a shortage area and identifies the effective date of the change.

While the Nebraska State Office of Rural Health is not the only user of HPTS data, this information is critical in the designation process for health professional shortage areas both at the state and federal level. So when a professional receives a survey form in the mail or a telephone call from the HPTS staff, we ask each to respond with accurate information. This input is very important!

Continued on page 7

## **Suicide prevention resources:**

Nebraska State Suicide  
Prevention Coalition:  
[www.suicideprevention.nebraska.edu](http://www.suicideprevention.nebraska.edu)

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

## Federal Primary Care Shortage Area Designations

The Nebraska State Office of Rural Health contains the Primary Care Office, which also uses the HPTS physician data to determine federal primary care health professional shortage areas. In order to determine a federal primary care shortage area one needs to know the full-time work status at each practice location, primary care specialty (family practice, general internal medicine, general pediatrics and obstetrics and gynecology), serving a federal obligation (National Health Service Corps or J1 Visa Waiver) and work address for geocoding practice location. These and other items collected by the HPTS are necessary to upload into the Federal Office of Shortage Designation geographic information software program which is used to define federal shortage area designations.

Using such a robust dataset of primary care provider information, the Office of Shortage Designation is able to act more quickly on our shortage area designation requests as there is no doubt regarding the accuracy of the data compared to national databases. Federal designations may be submitted at any time and once an area is designated it must be reviewed every three years to determine if it still qualifies. There are a number of different types of federal primary care shortage area designations which can be submitted. In Nebraska the criteria for which most primary care designations qualify are rational geographic areas (counties), tribal facilities, federally funded community health centers, Medicare Certified Rural Health Clinics and correctional facilities. The most recent listing of federal primary care health professional shortage areas are listed on the Nebraska HHS, Office of Rural Health website ([http://dhhs.ne.gov/publichealth/Pages/hew\\_orh.aspx](http://dhhs.ne.gov/publichealth/Pages/hew_orh.aspx)).

The primary impact that health care providers and communities will feel from these primary care state and federal shortage area designations will be from the incentive programs which help attract and retain health professionals to rural and urban underserved areas. The most

recent maps of primary care providers serving in shortage areas demonstrates that 95 (state programs as of September 2011) were serving a student loan or loan repayment obligation.

In addition to the incentive programs there are a number of other federal programs which have a significant impact in Nebraska. For instance the HPTS data is used to aid in the designation of Governor Designated Eligible Areas for Medicare Certified Rural Health Clinics (which areas are eligible to retain their RHC status), federal Medically Underserved Populations (this creates areas eligible for a CHC status), Medicare Bonus Payments in geographic HPSAs, eligibility for many federal primary care training programs and private foundation grants. For more information, contact Marlene Deras, HPTS, (402) 559-2972; Marlene Janssen – Nebraska Rural Incentive Programs (402) 471-2337; or Thomas Rauner – Federal Incentive Programs (402) 471-2337. □

## Mark your calendars National Rural Health Day *Celebrating the Power of Rural!*

November 15, 2012

**Nearly 59.5 million people – about one in five Americans – live in rural areas. These community-minded people possess a selfless, "can do" spirit that has helped our country grow and thrive.**

- **Rural communities are wonderful places to live and work**
- **Surprising things are happening in Rural America**
- **Being a rural healthcare provider offers tremendous opportunities**
- **Health care in rural America is unique**

**For more information on Nebraska's efforts, contact Melissa Beaudette at the Nebraska Rural Health Association at: [mbeaudette@mwhc-inc.com](mailto:mbeaudette@mwhc-inc.com)**

## Media and health swapping ideas on how to better inform citizens

By David Howe  
SORH Contracted Rural Writer

Few topics occupy a bigger share of our economy and play a bigger role in how well we live than healthcare. Yet, one of the biggest challenges the media and the healthcare industry face is giving citizens balanced, accurate, easily understood information they need for decisions about their care and public policy affecting how that care is paid for.

That prompted healthcare industry officials and local news media to hold a series of panel discussions last fall, on how the two could work together to better serve the health information needs of citizens.

Planning is underway for another series on media/healthcare relations for this coming fall, with final choices for topics yet to be made.

Dialogue coming out of last fall's panels, conducted in conjunction with the Nebraska Hospital Association and the University of Nebraska-Lincoln College of Journalism and Mass communications, was only a starting point, the way Allen Beermann sees it. He helped organize those panel discussions.

Two major lessons came out of those discussions, said Beermann, Executive Director of the Nebraska Press Association. "We learned that, by and large, there is fairly significant interest (in coming together to better serve citizens' health information needs)." Second, those panel discussions affirmed that lots of work lies ahead for the news media and the health organizations in providing citizens with an understanding of healthcare delivery systems, rapidly changing healthcare technologies, and the public policy issues they spawn, particularly with respect to the Patient Protection and Affordable Care Act of 2010.

The challenges are especially great for small to mid-size news organizations, which lack personnel and other resources to provide definitive coverage of such specialized, complicated subject matter, according to Beermann.

Two Nebraska daily newspaper journalists who served as panelists last fall expressed that concern. Editor Kent Warneke of the Norfolk Daily News and Managing Editor Mike Konz of the Kearney Hub each said his staff size was too small to assign a staff member solely to healthcare. Covering healthcare's many aspects—scientific, political,

emotional, technological—is a "real challenge" for smaller publications, Warneke said. "The challenge is to get beyond scratching the surface."

Both journalists see value in continuing to explore ideas on how healthcare providers and organizations can help smaller news organizations leverage their resources to provide the healthcare coverage their readers need.

When it comes to understanding issues such as healthcare reform and the uncertainties surrounding it, Beermann said, "Most people (citizens) say, 'I quit.' And that's sad." That's why he sees a need for both the media and healthcare interests to continue the dialogue initiated in last fall's panel discussions.

Nebraska Hospital Association Executive Director Laura Redoutey agrees that last fall's health industry-media probing for ways the two can help each other should be continued. She, like Beermann, helped organize last fall's series of panels.

She would like to see more public involvement in the back and forth between journalists and healthcare interests. "The telehealth network didn't work as well as we had hoped. I don't think it was 'Joe Public' who watched it," Redoutey said.

With the benefit of experience from last fall's panel series, it might be possible to find ways to involve the public to a greater degree for more interaction between it and the panel members, she added.

In Nebraska, she said, her sense is that when it comes to rural health care, most rural residents are relatively knowledgeable about "access points" for their care. So many procedures that once meant a trip to Lincoln or Omaha for rural residents are now available closer to home for them. However, the same can't be said of citizens' knowledge about who pays for care and how it's paid for, according to Redoutey.

Beermann made a similar point. He said he's seen confusion even between Medicaid and Medicare by some citizens. Payers and payments are an area requiring more attention from the news media and the healthcare industry, he added. And, that includes the insurance industry. "We can't keep insurance out of it (panel discussions)," he said.

He and Redoutey see the Affordable Care Act as a major public information challenge for the media, not only because it's voluminous, complex,

*Continued on page 9*

and controversial, but because of uncertainties expected in the aftermath of whatever way the U.S. Supreme Court rules in the challenge to the law's constitutionality.

The first series of panel discussions taught that very few staffers at most newspaper and broadcast organizations are "up to speed" on the Affordable Care Act, Beermann said. By way of example to make his point, he asked: How many people understand what insurance exchanges are and how they work?

Where can the media go for answers that cut through legalese, offer balanced interpretation of specialized terminology, and provide accurate, balanced analysis of how issues will impact their audiences? Beermann sees finding answers to questions like that as an important role for this fall's series of panel discussions.

Managing Editor Konz at the *Kearney Hub* said it's not always easy to anticipate which healthcare event or issue in a steady stream of healthcare developments will turn out to have merited extensive coverage. An alert that allows a newsroom to make a more informed judgment about how many resources to allocate to coverage of a particular healthcare development might be one way healthcare providers and health organizations could help journalists better serve their audiences, he said.

Reporters and editors have to be comfortable that their sources of information are legitimate and, "most of all, fair," Beermann said. With the "slightest hint" that it's not balanced, it "hits the trash can," he added.

Redoutey at the Nebraska Hospital Association believes a proper goal for the media/healthcare panel discussions is to identify sources of healthcare information that are legitimate, legal, and fair.

If the healthcare industry can help the media understand the issues, the media can then translate what that means to citizens in the communities they serve, said Jessica Kennedy, Director of Communications at the Nebraska Hospital Association.

Redoutey agreed: The idea is to help editors and reporters with the information they need to develop "a local perspective," she said.

Kennedy said she understands that journalists at many news organizations don't have the time they need to read and analyze all of the information required for in-depth articles on

health issues. They do a good job of reporting such events as a new hospital addition in the community, or a new local health or wellness program. But, she added, many news organizations are hard-pressed to stay abreast of healthcare legislation and regulations, and then turn that information into easily understood articles on how their audiences will be impacted. "Where can they (media) get information to know what questions to ask? That (point) just really stuck with me," she added, reflecting on comments she heard at last fall's discussions.

The Nebraska Hospital Association doesn't receive many questions from the news media about complex health policy issues, according to Redoutey. She and Kennedy believe that developing ongoing, informal exchanges of information between the media and healthcare organizations might help foster more trust and understanding between the media and healthcare interests.

Redoutey, Kennedy, and Beermann believe that continuing media/healthcare panels to address challenges they've raised here would be beneficial.

Konz at the *Kearney Hub* said he has "no idea" of who made up the audience of the panel he was on last fall, but added: "If people in healthcare were listening and know that journalists can't know everything, then it was a success." He believes the panels are worth continuing.

Warneke's response to the question of continuing media/healthcare panels is emphatic: "The answer to that is a definite yes." While he personally found the discussions helpful in understanding healthcare's political and regulatory issues on the state and national levels, he's not sure how other journalists value those discussions. He, too, wasn't sure who comprised the panel audience last fall.

He speculated that it might be helpful to have one of the panels consist solely of journalists, who focus on how healthcare interests could more effectively help the media with healthcare coverage.

"We had just one go-around, and it was successful," Beermann said of last fall's panels. While he favors continuing with two more panels this fall, he noted this caveat: "These things cost money." There are meals, transportation costs, hotels, and other expenses. "Fortunately, we had people who did that for us (covered their own expenses last fall)." But, that may not always be possible in the future, he said. □

## The future health care model in the Panhandle

By Dr. Todd Sorenson, CEO of Regional West Medical Center

Rural regions of the United States offer some unique health care challenges, and some advantages as well. Perhaps the most significant of our challenges is the slow decline in population that is occurring in rural parts of the country not blessed with one of a few natural endowments, including mountains, sea coasts, dense forests, and large deposits of fossil fuels (former Israeli Premier Golda Meir is said to have observed that "...Moses led my people around the Sinai for 40 years and managed to settle in the only place without oil.") While I see terrific beauty in the rural parts of our state despite the absence of these "advantages," it is important for rural health care providers to recognize the impacts of de-population that we have already seen, and to consider the likely impacts of this trend on our collective futures.

We face many of the same health care challenges as our urban colleagues, including a seriously defective payment mechanism and shortages of skilled workers, including nurses, technicians, therapists, and physicians, especially primary care physicians. These shortages tend to be augmented for rural communities because many of the skilled providers we need have spent most of their lives in urban environments and may be reluctant to take a chance on the countryside. In fact, they may even be a little intimidated by the prospect of life in a small town, though one rarely hears them admit to that!

So the models of health care we envision for the future need to be built with these considerations in mind: (1) because of the (probably long-term) population trends, we need to encourage rural residents to seek health care as close to home as possible; and (2) we need to develop some new care models that will provide greater rewards to care givers, so they will be attracted to rural settings and will be inclined to stay there once they have arrived.

These two issues may have a common solution. The dominant payment system in the United States is fee-for-service, which creates perverse incentives for providers to focus on seeing as many patients as they can. And because the fee schedules established for providers, driven most powerfully by the Medicare Resource-Based Relative Value Scale (RBRVS), disproportionately reward primary care

providers for seeing patients with uncomplicated problems, the very people who need the doctors' attention the most frequently have the most difficulty getting it. This system drives dissatisfaction for both patients and providers, so new models may need, at their base, a new and innovative way to compensate primary care providers for their services.

Many interesting ideas have been proposed, but the one that, in my view, offers the most potential for rural communities is the Patient-Centered Medical Home (PCMH). It can be challenging to create a true "Medical Home" for patients, but where this concept has been developed, it has resulted in sometimes dramatic improvements in both patient satisfaction and provider satisfaction. This is the most important characteristic of the PCMH in the context of this article, because it could, at the same time, help with recruitment and retention of rural providers and, by improving patient satisfaction, encourage patients to stay home for their health care.

A practice designed around the concept of the medical home uses a variety of practitioners to care for patients with a wide range of problems in a team-oriented manner. But because physicians currently can be reimbursed only for care provided in face-to-face encounters with their patients, some cooperation from payers will be necessary to make this feasible. One of the most encouraging developments to have arisen from our perceived national healthcare crisis is that participants in healthcare, from purchasers (employers, governments, and individuals), to payers (insurance companies, self-funded employers, governments, and individuals), to providers, to patients, have been more willing to engage in substantive conversations about solutions that may enable the changes we need so badly.

I believe that we are living through what will come to be recognized as a truly unique period in our nation's history. While there is reason to be concerned about the outcomes, and skeptical that such a monstrous system can be positively influenced, there are thousands of very talented people focused on just that issue. If it can be done anywhere in the world (and we are by no means alone in the world in our need to improve healthcare), I think it can be done in the United States. □

## The evolution and future of Certified Rural Health Clinics

By Janet Lytton, CRHC Consultant

The RHC program began in 1978 with Public Law 95-210 and continues to certify clinics in the rural and healthcare shortage areas across the U.S. Currently there are approximately 3,500 Independent and Provider Based Rural Health Clinics nationally, of which there are approximately 50% of each type.

The most asked questions are “What is the future of the RHC program?” or “are there going to be RHCs in the future?” The current reimbursement for an IRHC and a PBRHC of a >50 bed hospital is \$78.54 and there is no cap on the reimbursement rate for PBRHCs of <50 bed hospitals. A clinic that is contemplating RHC status should complete a feasibility to determine the impact in reimbursement. This is most advantageous for clinics that have significant Medicaid utilization or area provider based clinics for a hospital of less than 50 beds. They don't have a cap on the reimbursement rate. The federal government is committed to patients having access to healthcare. There are many new concepts “floating” around which include the “medical home” and “Affordable Care Organization.” RHCs should learn about these and perhaps be a part of these healthcare delivery systems.

The National Association of Rural Health Clinics is continuing to advocate for an increased capped rate to be comparable to the FQHC rate. All RHCs must be engaged with our local senators and representatives in order to assure the RHC program continues to provide access to healthcare for the patients in the rural and underserved areas.

For more information, contact Janet Lytton at [info@rhdconsult.com](mailto:info@rhdconsult.com) □

## Rural Health Services Outreach Grants for Nebraska

Rural health providers across the nation, including Nebraska, will receive more than \$10.4 million to provide direct health care services to their communities. The funding announced May 4, 2012 by HHS Secretary Kathleen Sebelius will be used to meet a broad range of health care needs in rural areas, from health promotion and disease prevention to expanding oral and mental health services.

“Access to quality and affordable health care should not be determined by where you live,” said Secretary Sebelius. “These grants are a continuation of our effort to ensure that rural providers are able to meet the needs of their communities.”

Each of 70 grantees will receive approximately \$450,000, over a 3-year project period, to address the needs of a wide range of population groups including, but not limited to, low-income families and individuals, the elderly, pregnant women, infants, adolescents, minorities and individuals with special health care needs. Funding is distributed through HHS' Health Resources and Services Administration (HRSA), the primary federal agency for improving health care access for people who are uninsured, isolated or medically vulnerable.

“Rural areas face unique issues and challenges,” said HRSA Administrator Mary Wakefield, Ph.D., R.N. “But that makes them ideal for developing innovative solutions and creating models that can be replicated elsewhere. As rural communities forge these systemic improvements, they set an example for the delivery of high quality health care regardless of where one lives across the United States.”

The list of grant recipients includes the following two sites in Nebraska: Public Health Solutions in Crete (contact: M. Jane Ford Witthoff, 402/826-3880, <http://www.phsneb.org/>) will receive \$450,000; Nebraska Association of Local Health Directors in Kearney (contact: Laura D. Meyers, 308/293-0623, <http://www.nalhd.org/contactus.html>) will receive \$450,000. Please check their websites for more information on these grants. □



## 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

### Rural Health Leadership

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

I got to thinking about the concept of leadership when I started reviewing the 2010 Census of Nebraska. We have 12 counties with fewer than 1,000 people in each. We have only 29 communities with populations above 5,000 people, and the number of communities with populations of fewer than 600 people continues to grow – to 431 by my count.

It hit me that these sparsely populated areas have been able to sustain themselves in ways that urban areas may not understand. They must have a leadership model that needs to be understood and appreciated. What is it?

For 22 years I have been traveling the roads of Nebraska offering our Office's assistance to providers, community leaders and citizens. I have discovered the following leadership traits in the rural areas of Nebraska:

1. Leaders are grounded in the needs of the community. They are altruistic, not self-serving.
2. Leaders are often pioneers in finding creative approaches to issues in their community.
3. Leaders take risks and often make personal sacrifices to help their communities.

4. Leaders inspire others to work together in meeting goals. They also help to train other leaders.
5. Leaders work often in uncertainty and ambiguity.
6. Leaders are persistent.
7. Leaders are great collaborators and know how to bring people together.

In addition, these are people of vision. They understand that what was "was" and that they must work toward a vision that will sustain the communities that they live in. Often they find themselves in a lonely position because they see beyond what many other community members see. Thank them for it.

Most of us who work in rural health, whether in government or in our communities, know that it is a thrilling and a challenging adventure. We are trying to ensure that our families, friends and communities have the health and health care needed for us to stay in our chosen community. To all of you, I say THANK YOU.

Farmers are now putting this year's seeds in the ground and hoping for a great crop in fall. Rural health leaders are also planting seeds of hope/vision/and care in their communities. Work with them to nurture and care for those seeds. Our communities are dependent on the efforts of all of us. □

A handwritten signature in black ink, appearing to read "Dennis Berens".