

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 67, August 2012

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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.

We have been asked to publish all newsletters in electronic-only versions. We are asking you to now subscribe to our electronic newsletter. To subscribe, please go to 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, and we will do this for you. Please e-mail Ann with any questions.

Panhandle Network powered up for lightning-fast health data

by David Howe
SORH Contracted Rural Writer

Rural Nebraska Healthcare Network's fiber optic network is now "lit up."

The last connection in the 750-mile loop of fiber optic cable linking this Panhandle group of nine critical access hospitals, 32 clinics and Regional West Medical Center in Scottsbluff was completed in May. Most of the facilities have already become operational on the network.

"By the end of the summer, we should have everyone passing information back and forth (on the fiber optic network)," said Jim Parks, Chief Operating Officer at Box Butte General Hospital in Alliance. Parks is among those who have been involved in the fiber optic network since its genesis under a FCC grant and private matching funds from the Rural Nebraska Healthcare Network (RNHN) a couple of years ago.

Hospitals and clinics in the RNHN can now electronically transmit radiological images, electronic records, and other digital information among themselves and elsewhere around the country in a tiny fraction of the time it took with the T1 lines they were using before, according to Parks.

For those interested in the technical aspects, each hospital and clinic has a 25 megabit/second connection into and out of the fiber optic network--about 15 times faster than the 1.5 megabit/second T1 lines that the fiber optic network replaces. A radiological image can now be zipped to another hospital in the network or to facilities in Denver or Omaha in

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Network *continued from p. 1*

several seconds, according to Parks. Digital mammography files, which he describes as “absolutely huge,” couldn’t be moved without the fiber optic network, he said.

Personnel in the RNHN’s clinics and hospitals need no special training in advance of using the network. It is “totally seamless,” Parks said. The only thing users will notice is a much faster transmission speed.

The fiber optic network, which has a total capacity of 2 gigabytes, delivers not only more speed but more capacity and more reliability than the former T1 lines, he pointed out. “There’s just going to be no down time. . . we’ve had no issues at all.” It’s a circular loop, with each hospital and clinic in the network having fiber in and fiber out. An accidental severing of the cable by a construction crew or farmer, for example, still leaves the other connection to the clinic or hospital available. Only in the unlikely event that cable is severed at the same time on both the outgoing and incoming side of the facility would service be interrupted, Parks explained.

The fiber optic network’s capacity offers still-to-be realized full potential, Parks noted. The RNHN is still learning, considering that it has been “live” only a couple of months. “Now that we know we have this, we are starting to look for (even more) ways we can use it,” he said.

Some possibilities, he acknowledged, are remote monitoring of intensive care patients in a critical access hospital by a regional hospital and consultations between doctors in the RNHN facilities and doctors at hospitals in, say, Omaha or Denver—or, for example, at the Mayo Clinic. Consultations within the state are less problematic than consultations between doctors in different states because of interstate licensing and credentialing issues, Parks pointed out.

“Where it (fiber optic capacity) will really work is for mental health,” he said. A mental health therapist can provide counseling from remote sites to patients at any of the hospitals in the RNHN. Also, fiber optic’s capacity is a

major plus to easily handle audio/video for health education presentations to remote sites, Parks noted. The larger capacity of the fiber optic network over that of a T1 line allows those and other data-intensive applications to be conducted simultaneously.

Readers may remember an earlier article in this newsletter explained that funding for construction of the RNHN’s fiber optic network came from a \$19 million Federal Communications Commission Rural Health Care Pilot Project grant, plus a required \$2 million matching fund from the RNHN. That \$2 million was raised by RNHN’s sale of a portion of the network’s capacity to a private organization, the Zayo Group, which in turn is marketing its share of the network capacity to such users as a telephone company for TV service to small towns, Parks said.

Parks said the fiber network construction was completed without using all of those funds. With money left over, the RNHN purchased a block of high speed public Internet access that will have a great portion of the cost subsidized by USAC (Universal Service Administrative Company) funds. “This can then be sold to the RNHN members at a greatly reduced rate. This is a 15-year contract, so the price is locked in for that period of time,” Parks continued.

“We (RNHN) have the same bandwidth as someone sitting in the middle of Omaha.” And from there, the RNHN can link to other health facilities with fiber optic capability. “It gets them (RNHN hospitals and clinics) to anywhere in the outside world.”

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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

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The network also has fiber spur connections into Denver, Colorado, and Omaha, which offer redundant paths out of the network. In addition, the network replaced its copper T1 connections into the Nebraska Statewide Telehealth Network with a fiber connection between Scottsbluff and Grand Island, according to Parks.

Without the fiber network in the Panhandle as the RNHN's porthole to other fiber bandwidths, the RNHN would have service limited to the speed of the T1 lines it was using before.

In yet another wrinkle, the RNHN hopes to

market some of its purchased Internet bandwidth to eastern Nebraska hospitals. It's bandwidth RNHN was able to lock in under a 15-year contract at 1/10th the cost of Internet bandwidth on the commercial market, according to Parks. "We can sell them (eastern Nebraska hospitals) some of the bandwidth that the RNHN has locked in," Parks said. That will help defray the RNHN's cost of that purchased Internet bandwidth.

So far, Parks said, there have been no major problems with the network, only the challenges of finding ways to capitalize on all of the potential the network has to offer for serving the Panhandle population. □

2012 Annual Nebraska Rural Health Conference

by Melissa Beaudette

Mark your calendars for 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."

The next two 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 healthcare 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 (RUPRI) 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. 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.

Again, please mark your calendars for September 19-20, 2012 and go to the Nebraska Rural Health Association website 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. □

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 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 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

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 p.m. - Lincoln, NE

National Rural Health Day 2012

November 15, 2012

<http://celebratepowerofrural.org/>

2013 Nebraska Rural Health Conference

September 18 and 19, 2013

Younes Conference Center - Kearney, NE

Report from the Medicare Payment Advisory Commission

By Dave Palm

Director, Office of Public Health

The Medicare Patient Advisory Committee issued a report to Congress in June, 2012. A major section in this report addressed several rural health issues, including: (1) rural Medicare beneficiaries' access to care, (2) rural providers' quality of care, (3) special rural Medicare payments, and (4) the adequacy of Medicare payments to rural providers. The report also presented a set of principles that are designed to guide the expectations and policies concerning rural access, quality, and payments.

The report concluded that access to care for Medicare beneficiaries was no longer a major concern. After examining the use of health care services, the report concluded that despite lower physician-to-population ratios and difficulties of recruiting physicians to practice in rural areas, beneficiaries in urban and rural areas used comparable amounts of health care in every service that was examined. The report did find significant differences in the use of services across regions of the country (e.g., South versus Midwest), but only small differences between rural and urban beneficiaries within regions (i.e., rural use is high when urban use is high and rural service use is low when urban use is low). The report also found that patient satisfaction levels between rural and urban areas was similar even though some beneficiaries have to travel "outside their area to obtain care".

When the quality of care between rural and urban providers was considered, no major differences were found. However, the Commission did find that rural hospitals as compared to urban hospitals do not perform as well on most process measures and on condition-specific, 30-day mortality rates, which is consistent with the findings from other studies.

With regard to payment, the report concluded that, "in general, the adequacy of fee-for-service payments to rural providers do not differ systematically or significantly from the adequacy of urban providers' payments." This finding reflected payments to physicians, hospitals, skilled nursing facilities, and home

health agencies. In previous reports, however, the Commission has raised concerns about the adequacy of payments to primary care physicians in both rural and urban areas.

The Commission's report also included a set of principles to guide future policies. These include:

Access: All beneficiaries, whether rural or urban, should have suitable access to health care services. However, equitable access does not necessarily mean equal travel times for all services or that all services are available locally.

Quality: Expectations for quality of care in rural and urban areas should be equal for nonemergency services rural providers choose to deliver. By contrast, emergency services may be subject to different quality standards to account for different levels of staff, patient volume, and technology between urban and rural areas. Quality metrics should be reported by even the smallest hospitals, and all hospitals should be expected to practice evidence-based medicine.

Payment: The Commission does not agree with some of the "special payments" (such as cost-based reimbursement for critical access hospitals) that have been enacted by Congress.

- Payments should be targeted toward low-volume isolated providers – that is, providers that have low patient volume and are at a distance from other providers.
- The magnitude of special rural payment adjustment should be empirically justified. That is the payments should increase to the extent that factors beyond the providers' control increase their costs.
- Rural payment adjustments should be designed in ways that encourage cost control on the part of providers.

Implications: The findings in this report are likely to be considered by Congress, but it does not mean that policy changes will be made. Some of the conclusions in this report have already been challenged by the National Rural Health Association. In addition, some rural health research centers are considering preparing a response. As these responses are developed, we will summarize them in future newsletters. □

Going beyond classroom walls at UNMC's Dental College

By David Howe
SORH Contracted Rural Writer

It isn't enough to say the University of Nebraska Medical Center's College of Dentistry trains dentists and dental hygienists. It's that, plus much, much more.

Through a variety of programs, the College takes teaching and services beyond classroom walls and into the midst of Nebraska's rural areas and into the heart of urban centers, mostly in person but sometimes via telehealth networks. These programs include the students' involvement in dental care for underserved children and adults as well as assessment and care for the elderly in nursing homes.

Dr. David Brown says it's all part of a commitment to having dental care no more than a 90-minute drive away from all Nebraskans, helping meet the dental care needs of underserved children and adults, teaching dental students to coordinate with other health professions and fulfilling the college's obligation to be a part of the general health safety net for the state. Brown is executive associate dean and professor in the Department of Oral Biology in the Dental College.

During the past year, alone, the College has served 12,443 children through its various programs such as Dental Day, Panhandle Dental Days, the Dental Sealant program and affiliations with public health clinics. Those figures are from the National Children's Oral Health Foundation annual report.

Children's Dental Days brings about \$250,000 of services to about 500 Nebraska children each year at no cost to them. Through a national program called SHARING (Student Health Alliance Reaching Indigent Needy Groups), the Dental College provides about \$150,000 of services to about 400 adult patients each year, at no cost to the patients, Brown said. The Dental Sealant program, run by the Dental Hygiene Department, provides free treatment for about 2,500 children across the state each year.

The statewide classroom

Each summer, the College's juniors enter a "statewide classroom" through "extramural rotations." They leave the Lincoln campus in the summer following their junior year to spend hands-on time in dental practices around the state, applying what they learned in the classroom. The program not only helps fulfill the College's educational mission but helps bring dental healthcare to underserved children and

adults throughout the state, Brown explained. For participating practitioners who volunteer as preceptors, it's an opportunity to maintain a stronger relationship with their profession, he noted.

The extramural program began about 35 years ago with dental students spending one day observing how a private practice is conducted. Since then, this program has blossomed into the current rotation where students complete two two-week blocks – four weeks total – at one of about 50 different private and public dental practices at various sites around the state. Starting next year, the extramural rotation program will be expanded to two three-week blocks at participating private and public non-profit practices. At least one of each student's rotations must be in a public health clinic. Students can complete the rotation any time after their junior year, Brown said.

Public health clinics working with the Dental College include Federally Qualified Health Centers and local health departments. Examples of such partners are: CAPWN (Community Action Partnership of Western Nebraska), Community Health Center in Norfolk, Good Neighbor Community Health Department in Columbus, and the public health departments in Lincoln.

Partnerships with professionals

Students practice under the supervision of dentists in private and public practices, applying what they've learned in the classroom, Brown explained. It's different from simply going some place to volunteer for a day and (then) "we'll never see you again," Brown said.

On average, a student is seeing six to eight patients a day during the rotation. "Service learning" is the philosophy behind this program, he added. Local clientele have dental needs, and the dental college has need for students to learn, he added.

Emphasis is on Medicaid patients. Though students work more slowly than the dentists under whose supervision they work, their involvement enables the practice to serve more Medicaid patients than would otherwise be possible.

"The motivation (for participating dentists) is not money," Brown explained. It's a chance for volunteer preceptors to become acquainted with new techniques being taught in the Dental College and an opportunity to maintain a closer association with the College. "Preceptors often are looking for a change

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of pace and an opportunity to teach,” he said.

Under “Enhanced Medicaid” payment in this program, a slightly larger Medicaid reimbursement rate provides for a small portion of the payment to be allocated to the Dental College. That money, in turn, covers the cost of the College’s programs that serve the dual purpose of educating dental and dental hygiene students and providing dental care to underserved patients, according to Brown.

A five-year HRSA (Health Resources and Services Administration) grant, now in its second year, is paying students’ cost of transportation and lodging for their multi-week rotations at the aforementioned 50-some sites around the state.

Making use of technology for telehealth

Telehealth technology is an integral part of the extramural program. Through either a dedicated line or the Nebraska Statewide Telehealth Network at participating sites, students gain experience in doing consultations with professors back at the Dental College. Starting with the 2013 rotation schedule, a student will be able to select a patient with whom he or she can go through the telehealth process, Brown explained.

The Dental College began using telehealth more than 10 years ago in conjunction with efforts to recruit and train dental hygiene students from western Nebraska. Before that, Brown pointed out, “. . .we were not successful in getting our graduates to move to the Panhandle.” Students recruited and trained in the Panhandle are more inclined to practice in western Nebraska after graduation, he added. That’s what led to the Dental College establishing a dental hygiene program at CAPWN in Gering with funding from Nebraska’s Tobacco Settlement a little more than 10 years ago.

The question was: How could lectures be provided to the far end of the state? The answer lay in distance learning technology.

Over the course of the years, adoption of telehealth as a tool of the Dental College has been meshed with the extramural program and other efforts by the College. That technology — now refined to mainly a laptop with the right programs on it and an intra-oral camera — has been added to various public health sites. Some in private practices already have the equipment, he said.

One goal is to promote telehealth technology in rural communities. The more the College involves students in telehealth, Brown said, the more students will see telehealth as part of the practice of dentistry.

Doing “grand rounds” via telehealth

One of the latest applications of telehealth in dentistry is “community grand rounds” where a rural practitioner presents an interesting case to the Dental College through telehealth. Students and faculty are in the audience. “It’s a teaching tool for the students at the College,” Brown said. It’s also a two-way learning process between rural practitioners and the Dental College.

He described several examples of grand rounds based on cases brought to the attention of the Dental College by rural practitioners. One was a victim of a gunshot wound to the face who lost teeth and suffered other damage and had not received proper follow-up care.

Another case involved a patient with a congenital metabolic disorder that manifested itself in malformation of the patient’s teeth. Yet another case that was a focus of grand rounds via telehealth involved a cancer patient who was having difficulty maintaining tooth structure because of radiation therapy.

Grand rounds are another way “to foster the concept that this (telehealth) is part of dental health nowadays,” Brown said.

Looking into the future, he speculated, “I see us relying more and more on these programs (in the Dental College) as part of the educational process.” He also sees the Dental College relying increasingly on volunteer preceptors.

“The College tries to choose its outreach programs carefully in order to maximize the effectiveness and efficiency of its programs to provide service learning opportunities for students and services to underserved populations,” he said. “In this way, the college tries to meet not only the strategic plan goals of UNMC but also its obligations to the profession and the state.” □

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

http://dhhs.ne.gov/publichealth/Pages/hew_orh.aspx

Citizen health care system thoughts

By Dennis Berens

For more than 20 years I have been intrigued by the many health care delivery and payment models found around the world. This July, I had the opportunity to visit Germany and learn something about their system. Why Germany? They are the place where the U.S. Social Security model came from. I also was able to talk with citizens and providers from France, Denmark, Australia and Greece. (The following comments are from citizens of those nations and may not be entirely factual.)

Germany: The nation has a mandatory national health insurance system, covered in large part by a Value Added Tax of about 14 percent. People who make more than 50,000 Euros per year may take out a private health care insurance plan, but they cannot decide later to return to the national insurance system unless their income falls below 50,000 Euros. Hospitalization and physicians payments are covered. If you get a prescription, you will pay 5 Euros for each. If you go to the hospital, it will cost you 10 Euros per day for the food during the first 28 days of hospitalization.

The citizens I talked to all said they liked their system of care -- BUT. They wondered how their nation will be able to sustain this present type of coverage. They also are concerned about how to pay for mental and dental care in an aging society.

France: Visits to the doctor cost 1 Euro under this national health insurance plan. Prescriptions cost 4 Euros each, but that is refundable to the patient from the government health program. Again, the people I talked to think the system is great – BUT. They are concerned about how the nation will continue to pay for this level of care in the near and distant future.

Greece: The people I talked to about Greece's national model of care said it is under great stress along with the rest of the nation's economy. Doctors are leaving their practices, and citizens often have to pay for private nursing and may have to bring their own food to the hospital. Cost is a huge issue now and growing. How to pay for this system now and in the future is of great concern.

Australia: The citizen couple that I met talked about how care was very adequate and the payment model seems to be working, but they

were also concerned about the future of the Australian system.

Denmark: I was fortunate to meet with a medical doctor in residence and his nurse wife. The doctor noted that he will not incur debt from his medical education and that he will have credentials to practice in all of Scandinavia. He was surprised that not many U.S. doctors make house calls as he does and will be doing. Military veterans can go to any provider for care in Denmark, and the doctor I met is being well trained in the national electronic health care model. He was also interested in our EMS model and how it works in rural areas. The big issue for this physician family is the concern about the sustainability of Denmark's health care system in the future.

What I think I see emerging is a new evolutionary health care model that internationally may be more focused on sustainability and a "human centric" design. All the people I talked to about health care were concerned about how to care for their family, friends and neighbors. Issues of shared responsibility and new partnership roles between people and their governments are now being discussed in all the nations referred to above.

The important role for all of us now is to sit down and talk about our common needs. Nebraskans are well suited to have this important discussion about care models that can work and be sustainable. □

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

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 three awards and your input is very valuable to us.

Outstanding Rural Health Practitioner Award

The Outstanding Rural Health Practitioner Award recognizes an individual who is a direct service provider and 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 healthcare system.

Rural Health Achievement Award

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

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

- 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 attach a description of 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 September 20, 2012

Deadline for Nominations: August 24, 2012

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

Dental Shortage Areas

Dental shortage area designations are a collaborative process between the Nebraska Office of Rural Health (ORH) and the University of Nebraska Medical Center, Health Professions Tracking Service. The ORH has contracted with the University of Nebraska Medical Center, College of Public Health (CoPH), Health Professions Tracking Service (HPTS), since 2000 to document the location and retention of Nebraska's dentists. Since that time, HPTS has surveyed Nebraska dentists annually. The dentists' responses have enabled HPTS to link dentists and practice location data together in a relational database. The comprehensive approach identifies practicing dentists, practice specialties and practice locations (primary and satellite) throughout the State of Nebraska.

Shortage area criteria differ according to programs and the entities approving the shortage areas. For example, there are currently 11 federal dental Health Professional Shortage Areas (HPSA) and 68 "automatically designated" facilities compared to 50 counties or partial counties that are state-designated general dentistry shortage areas. In addition, the state-designated pediatric and oral surgery shortage areas include counties or parts of counties outside a 50-mile radius of Lincoln and Omaha.

Federal dental HPSAs are determined using data from the HPTS. The Nebraska Primary Care Office, within the ORH, analyzes the data according to the criteria specified and submits the request to the U.S. Department of Health and Human Services, Office of Shortage Designation.

State-designated dental shortage areas also begin with data from the HPTS. Using guidelines established by the governor-appointed Rural Health Advisory Commission (RHAC), the ORH analyzes the data and submits the results to the RHAC for approval.

Since HPTS data are used for federal and state shortage area designations, the completeness of the data is extremely important. HPTS data are directly linked to the survey responses. Even if your data has not changed, confirmation that the information on your survey is correct is essential.

State-Designated Dental Shortage Areas

In this section of the article, the focus is on the specific criteria used to identify state-designated **dental** shortage areas. Psychiatry/Mental Health and allied health shortage areas will be discussed in later articles and medical shortage areas were discussed in the previous issue of the **ACCESS** newsletter. Approved **dental** specialties, as defined in the Rural Health Systems and Professional Incentive Act (Nebraska Revised Statutes,

§71-5650 to §71-5670), include general dentistry, pediatric dentistry, and oral surgery. The Rural Health Advisory Commission (RHAC) is responsible for establishing the shortage area guidelines and approving the state-designated shortage areas.

The Rural Health Advisory Commission, with assistance from the ORH, 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 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 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.)

Active general dentists, pediatric dentists, and oral surgeons' records supplied by the UNMC HPTS are used to determine medical shortage areas. HPTS provides approximately 1,020 records to the ORH. After these records are sorted and truncated so only rural dentist records are left, the ORH normalizes practice hours per week to a 40-hour work week. The objective is to have one record for each dentist practicing in a particular county. ORH ends up with approximately 500 records and 18 data fields down from the 54 data fields HPTS provides.

ORH prepared dental data are then put into an ACCESS data base where programs are run to generate full-time equivalency (FTE) reports by county by dental specialty. Determining *general dentistry* shortage areas requires data from other sources in addition to the FTE data. County population is obtained from the latest Census estimates along with county population aged 55 and over, poverty data, and county population per square mile, which is used to calculate "frontier" areas. Frontier areas are defined as fewer than six persons per square mile. As per the RHAC guidelines for dental shortage areas, counties or parts of counties within a 50-mile radius of Lincoln or Omaha will not be designated.

Once all of the county data for defining family practice shortage areas are entered, county

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populations to general dentist FTE ratios are calculated. Ratios equal to or exceeding 3,000/1 or counties with no general dentistry coverage are highlighted. These counties meet the first criteria for being designated as a state-designated family practice shortage area.

Counties with population to general dentist FTE ratios between 2,500/1 up to 2,999/1 may still meet the general dentistry shortage area guidelines if they have one or more of the high-need indicators. High-need indicators for state-designated general dentistry shortage areas include: (1) the proportion of the population that is 55+ 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; or (3) the area is a frontier area.

In addition to the rural areas that meet the state-designated general dentistry shortage area guidelines, the Rural Health Advisory Commission will also consider service areas designated as *federal* general dentistry Health Professional Shortage Areas (HPSA) for purposes of the Nebraska rural incentive programs. The clinic or community that is a federal general dentistry HPSA must request the state-designation from the Rural Health Advisory Commission and the commission must then approve the request.

Due to the lack of pediatric dentists and oral surgeons practicing in rural Nebraska, the Rural Health Advisory Commission defines these shortage areas as “counties and parts of counties outside a 50-mile radius of the cities of Lincoln and Omaha.”

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 ORH. ORH 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 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 you receive a survey form from HPTS in the mail or a telephone call from the HPTS staff, please respond with accurate information. Your input is very important!

Federal Dental Health Professional Shortage Area Designations

The Primary Care Office uploads the Health Professional Tracking Service data and Medicaid

information into the federal Office of Shortage Designation geographic information software program (ASAPS) used to define federal shortage area designations. In Nebraska, we primarily use facility, geographic and Medicaid population designations to define federal dental health professional shortage areas. Each of these designation types incorporate slightly differing designation criteria which is cumbersome to explain but is available at: <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/dentalhpsacriteria.html>

The most common types of facilities in Nebraska which receive an “automatic” federal dental health professional shortage area designation are Community Health Centers, Indian Health Services and Medicare Certified Rural Health Clinics. In order for a facility to have a federal “automatic” designation it must meet the guidelines of the National Health Service Corps program by complying with their program requirements. The major requirements of a NHSC site is to see everyone regardless of their ability to pay by using a sliding fee schedule, being culturally competent, being part of an integrated health care delivery system and accepting all forms of public and private insurance. The National Health Service Corps (NHSC) program requirements may be found on their web site at: <http://nhsc.hrsa.gov/sites/becomenhscapprovedsite/index.html>.

Geographic and Medicaid population designations are also used frequently in Nebraska to denote areas with a shortage of general and pediatric dentists. The major factors used in dental designations are: a population to dentist ratio of 5,000 to 1, dentists in a 40 mile contiguous area who are over utilized, excessively distant, or inaccessible to the population. In Nebraska we incorporate Medicaid provider data into the determination process because most national studies demonstrate an uneven dental care delivery to Medicaid and low income patients.

Currently the number of dental practitioners receiving federal loan repayment is somewhat limited because most practices in Nebraska are private for profit sites which do not meet the National Health Service Corps program requirements mentioned earlier. We continue to use the Health Professions Tracking Service to assist in federal shortage area designations and providing guidance on dental health workforce needs in Nebraska. A map of Nebraska federal dental shortage area designations is available on our web site at: <http://dhhs.ne.gov/publichealth/Documents/HPSA%20DDS%202012.pdf>

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Department of Health & Human Services



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