

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 68, November 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.

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How to quit running in place

by David Howe
SORH Contracted Rural Writer

"Getting off the hamster wheel," was referenced more than a couple of times at the September Nebraska Rural Health Conference in Kearney.

Finding ways to beat back healthcare costs and raise quality of care rather than continuing on the path of increasing health care costs is the quest. And, that quest will only be intensified in the future. That was an overall conference theme.

But how to meet that challenge?

Dr. Clint MacKinney was one of the speakers tasked with shedding light on the answer to that question.

This physician and Deputy Director at the RUPRI Center for Rural Health Policy Analysis at the University of Iowa, sees the answer in new models of care delivery leading to a transition from "fee-for-service" to "value-based purchasing" of healthcare. The latter embodies the seemingly counter-intuitive pairing of lower cost and higher quality of care.

MacKinney told his Kearney audience that opportunities lie within that challenge. Capturing those opportunities will require risk-taking from rural providers, he said. "But, you will need to be smart about it."

As an example that cost and quality don't necessarily travel in parallel, he cited a study that shows some states with the highest spending per Medicare beneficiary (\$7,000-\$9,000) rank in the lowest tier of healthcare quality, while some of the lowest spending states (\$5,000-\$6,000 per beneficiary) rank in the upper range of states for quality. (Nebraska, at about

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\$6,000 in Medicare spending per beneficiary, ranks near the top tier of states for quality.)

“I have heard people say, ‘You can’t assess value in healthcare.’ I say, ‘Baloney,’” he told the conference audience. “This (ability to measure and improve quality) is the reason we are being forced to change,” he added, citing the triple aim of better care, better health and lower cost.

Using a bit of humor to characterize where this country’s healthcare finds itself, MacKinney alluded to this Winston Churchill quotation: “You can always count on Americans to do the right thing—after they’ve tried everything else.” What hasn’t been working, MacKinney said, includes fee-for-service (the more you do, the more you’re paid, regardless of the outcome). Nor have other measures succeeded, such as self-policing for quality, he added.

Within the past two years, MacKinney said, a concept called Accountable Care Organizations (ACOs) has begun to attract attention as an avenue to a low-cost, high-quality sustainable care system.

ACOs feature a coordinated network of providers with shared responsibility for providing high quality and low cost care to their patients, he explained. These organizations couple risk-based provider payment with healthcare delivery system reform, according to MacKinney.

The Centers for Medicare & Medicaid Services (CMS) implemented ACOs to help doctors, hospitals, and other healthcare providers better coordinate care for Medicare patients. “Everybody is writing about it (ACOs),” MacKinney said. “Anyone who thinks this concept won’t continue to expand, I think, is wrong.”

As of August 2012, there were 174 Medicare ACO programs, according to MacKinney, with more than 5 percent (2.5 million) of Medicare beneficiaries in those programs.

Two ACO programs are Shared Savings and Advanced Payment Demonstration.

The Medicare Shared Savings Program is intended to reward ACOs that lower their growth in healthcare costs, while meeting performance standards on quality of care, according to CMS. Medicare pays fee-for-service, then shares any gains with providers at the end of three years. “Suboptimal quality” reduces the percent of shared gains. Success requires excellent care and low cost, according to MacKinney.

Unlike the Shared Savings program, the Advanced Payment ACO is a demonstration program, developed by the Center for Medicare & Medicaid Innovation (CMMI) to further help organizations participating in an ACO Shared Savings Program.

Only two types of organizations participating in an ACO Shared Savings Program are eligible for the Advanced Payment Demonstration, according to MacKinney: 1. Facilities with no inpatient facilities and less than \$50 million in annual revenue, and 2. Critical Access Hospitals with less than \$80 million in annual revenue.

Under the Advanced Payment Demonstration, the ACO with 5,000 Medicare enrollees receives an upfront fixed payment of \$250,000, an upfront payment of \$36 per enrollee, and a monthly payment of \$8 per beneficiary for 18 months, according to MacKinney.

The ACO receives about \$1.15 million in new money under the Advanced Payment Demonstration program, in addition to fee for service, MacKinney noted. That’s the total of the upfront \$250,000; upfront \$36 per enrollee (\$36 x 5,000) for \$180,000; and \$8 per enrollee per month for 18 months for \$720,000 (\$8 x 18 months x 5,000).

That upfront money or loan of \$1.15 million—to help an ACO become established—is to be paid back by future cost-savings that providers earn under the ACO system. “If there is not enough shared savings to pay back the loan, and the ACO

remains a good faith participant for three years, the loan is forgiven,” MacKinney said.

“The ACO must have a minimum of 5,000 enrolled Medicare beneficiaries only—not Medicaid or other payers,” he added. “These are patients who get the majority of their care from a primary care doctor associated with the ACO.”

One problem for Critical Access Hospitals in this program is that many of them may not have 5,000 Medicare patients, MacKinney said.

Transition from fee-for-service to value-based purchasing, by whatever means, may be like having one foot on the dock and the other in the boat for some providers, MacKinney acknowledged. For example, what’s to be done

with that new hospital wing or the new MRI scanner that could be rendered redundant by collaboration, networking and coordinated care with other providers?

There are things that can be done right now, he suggested. They include:

- Negotiate with third party insurers to pay for quality (funding for ACO infrastructure).
- Aggressively apply for value-based demonstrations and grants.
- Begin implementing processes designed to improve healthcare value.
- Move organizational structure from hospital-centric to patient/community-centric.
- Assess potential collaborations to provide the full continuum of care. □

Nebraska Rural Health Association presents Awards for Outstanding Rural Health Achievement

Awards for Outstanding Rural Health Achievement were presented at the 2012 Nebraska Rural Health Association held in Kearney on September 19, and 20, 2012. The Nebraska Rural Health Association takes pride in recognizing individuals who take leadership roles and who make a difference in healthcare in rural Nebraska.

“There are a few things more gratifying than the approval and recognition of our peers for a job well done,” said Janelle Ali-Dinar, Nebraska Rural Health Association 2013 President Elect. “That’s why it is an honor to recognize these people for their work in the rural healthcare field.”

The 2012 award recipients were:

- **Outstanding Rural Health Practitioner Award** – Dr. Steven Nagengast, Lincoln
- **Outstanding Rural Health Achievement Award** – Rebecca Rayman, Columbus
- **Outstanding Rural Health Achievement Award** – Dennis Berens, Lincoln

The **Outstanding Rural Health Practitioner Award** recognizes an individual who is a direct service provider and who has exhibited outstanding leadership, care, and collaboration in improving health services in rural Nebraska. Those eligible for this award are individuals who provide direct patient care.

This year the award goes to **Dr. Steven Nagengast** of Lincoln, Nebraska. Currently Dr. Nagengast visits hospitals in Auburn, Nebraska City, Crete, Syracuse, Osceola and Lincoln. Dr. Nagengast has demonstrated over and over again his commitment to rural Nebraska by his actions. He brings the best of medical and surgical care delivered in a kind and unassuming manner, putting his patients and their families at ease. Dr. Nagengast also enthusiastically shares his knowledge and experience with healthcare trainees and new staff. He is a patient and kind mentor for all healthcare team members.

He willingly travels to rural hospitals for emergency surgical care as well as scheduled surgical cases. One snowy night he returned to Auburn for an emergency surgical procedure on an elderly gentleman. Dr. Nagengast said, “It is much easier and more comfortable for me to drive in the snow than for him to make the trip in an ambulance.” Joe Lohrman, CEO of Annie Jeffrey Hospital and NeRHA president said, “Dr. Nagengast is willing to go the extra mile for the patients he serves and has never left a facility abandoned or without surgical coverage,

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ensuring patients will have care close to home.”

Dr. Nagengast is a compassionate and humble man. He visits with all patients in an unhurried and understanding manner, never leaving questions unanswered or confusing for the patient or their family.

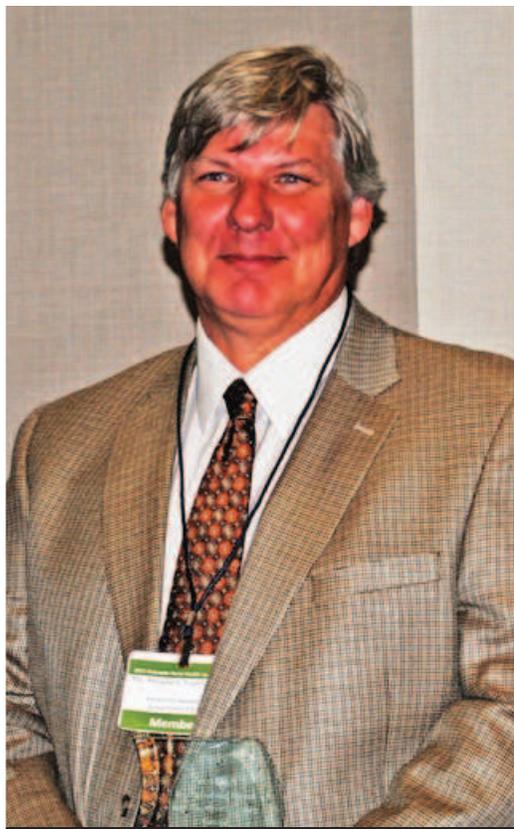
The **Outstanding Rural Health Achievement Award** recognizes individuals for leadership and noteworthy initiative in promoting the development of community-oriented, rural healthcare delivery.

This year the award goes to **Rebecca Rayman** of Columbus. Rayman is the Executive Director of East-Central District Health Department and of the Good Neighbor Health Center. Her leadership and initiative in promoting the development of community oriented rural healthcare delivery is without parallel.

As an outgrowth of her dedication to serving the community health needs in the three-county Columbus area, Rayman started the Health Department from a paper start in November of 1998 and became its first Executive Director. She not only tackled funding, office space, hiring staff, ordering equipment, establishing policies and procedures, garnering partnerships, tailoring programs to needs, and setting quality standards, but also oversaw rapid growth of the department so that now it is the third largest health department in the state from a fiscal and encounter status.

In April 2003 Rayman became the Executive Director of the Good Neighbor Community Health Center. Again, she established a new entity from nothing – all to serve low-income patients with nowhere else to turn. Rayman’s tireless work to significantly impact the health

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Dr. Steven Nagengast



Rebecca Rayman



Dennis Berens



status of the underserved has made a lasting difference in the East-Central District. In 2011, Good Neighbor Community Health Center served nearly 6,000 patients, providing high quality primary healthcare in a culturally-competent way, addressing issues of low income and utter poverty, little to no health insurance, and a higher incidence of chronic disease.

Rayman was made Vice Chair of the 2011 establishment of a statewide Primary Care Association for community health centers to support the quality and help grow that number of health centers in Nebraska. The Health Center Association of Nebraska is the newest association of its kind in the U.S. Her leadership and contributions to the Health Center Association of Nebraska have led to tremendous achievements in its first year.

The **Outstanding Rural Health Achievement Award** also went to **Dennis Berens**. Since 1990, Berens has been the Coordinator/Director of Nebraska's Rural Health Office in Lincoln, with responsibility for improving the state's rural health care. In July of this year, Berens made the decision to step down from that position but his work will leave a lasting legacy.

After getting his undergraduate and graduate degree from Concordia College in Seward, in 1971, Berens went to work as a teacher and athletic director at local schools. He continued teaching for 10 years. Berens then took a position as co-publisher of the town's only newspaper, *The Seward County Independent*, became open in 1976, he took the job and remained there for the next 14 years. In his role as co-publisher, Berens became more conscious than ever of the plight of America's rural communities and the need to preserve them as a precious, living resource. While at the paper, Berens chaired several Chamber of Commerce committees, became a member of county, district, and state advisory boards, and in 1995 helped establish the Nebraska Main Street program, which is dedicated to

preserving Nebraska's small towns.

As a result of his efforts in rural economic development, Berens' work came to Nebraska Governor Kay Orr's attention. In 1990, she offered him the post of Coordinator at the Nebraska Department of Health's Office of Rural Health. He took the job, perceiving the great need for better rural health care and seizing the chance to do something about it. He was instrumental in forming the Rural Response Partnership—a consortium of public and nonprofit groups that provided a network of mental health services to rural residents, in response to the continuing rural crisis brought on by the fall crop prices (due to worldwide abundance of food) and hence in land values, and to natural disasters such as the long drought that afflicted Nebraska during the 1990's and continues to this day.

Perhaps the largest program Berens has worked on is the Nebraska's Critical Access Hospital Program—a category of hospitals initiated in 1997 under the federal Medicare Rural Hospital Flexibility Program, providing for hospitals with two dozen beds or less, and geographically far from a major hospital, to realize cost savings through flexibility in staffing and other means.

He served as President of the National Organization of State Offices of Rural Health in the 1990s, and of the National Rural Health Association (NRHA) in 2010. In addition to serving on NRHA committees and presenting at educational conferences, Berens is a member of the National Rural Health HIT Coalition and has served on the National EMS/Trauma Advisory Board for Health Resources and Services Administration. In 2007 he facilitated the creation of the National/International Community Health and Emergency Cooperative, which created the Community Paramedic Curriculum and Program.

For more information about the awards, contact: Melissa Beaudette, Nebraska Rural Health Association, mbeaudette@mwhc-inc.com. □

National Rural Health Day

By Dave Palm, Administrator
Director, Office of Community and Rural Health

The second annual National Rural Health Day will be celebrated on Thursday, November 15, 2012. This day provides an opportunity to showcase rural health practices, providers, and communities.

The rural health care delivery system is composed of a variety of health care professionals, including physicians, physician assistants, mental health professionals, nurses, pharmacists, EMS volunteers, etc., as well as organizations such as hospitals, nursing homes, and mental health centers. These health professionals and organizations are major economic drivers in the community and provide high quality affordable health care services. This dual role not only creates new jobs, but it also greatly improves the health of individuals who live in rural communities.

This year, the Office of Rural Health will spotlight rural student loan recipients and those health professionals participating in the loan repayment program, for their commitment to serving rural communities. We hope that rural communities will consider celebrating National Rural Health Day by making individuals aware of some innovative service or model, recognizing a single or several rural health professionals, or highlighting important local rural health issues. □

MARK YOUR CALENDARS

National Rural Health Day 2012

November 15, 2012

<http://celebratepowerofrural.org/>

Nebraska Rural Health Advisory Commission Meeting

November 30, 1:30 p.m. - Lincoln, NE

Rural Multiracial and Multicultural Health Conference

December 4-6, 2012 - Asheville, NC

National Rural Health Policy Institute

February 4-6, 2013 - Washington, DC

Annual National Rural Health Conference

May 7-10, 2013 - Louisville, KY

Rural Medical Educators Conference

May 7, 2013 - Louisville, KY

Rural Quality and Clinical Conference

July 17-19 - Chicago, IL

2013 Nebraska Rural Health Conference

September 18 and 19, 2013

Younes Conference Center - Kearney, NE

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

Sparing the fruit-bearing branches from Congressional budget loppers

By David Howe
SORH Contracted Rural Writer

Rural healthcare providers have a positive story to tell. And, it's important that this story be told to a Congress that's waving budget loppers at many rural healthcare programs.

That might be one way of summing up Brock Slabach's message to the Nebraska Rural Health Conference in Kearney in September.

Medicare Dependent Hospitals, Low-Volume Hospital Adjustment, and a moratorium on the Sequestration Growth Rate (SGR) formula (physician fee cut), to name a few, are among a number of programs that hang in the balance, the National Rural Health Association's Senior Vice President for Member Services told his Kearney audience. A number of "Medicare extenders" have expired or are set to expire, he said, citing numerous programs that are critical to maintaining rural residents' access to healthcare.

So, what about the positive story that rural healthcare needs to tell? One example mentioned by Slabach was this: A study on the relevance of rural healthcare done in 2012 showed that the average cost of care per rural Medicare beneficiary was 3.7 percent less than the cost per urban beneficiary. That amounts to a \$2.2 billion annual saving, according to Slabach.

And, why is that? Rural has had a reliance on a primary care model for healthcare delivery, versus a specialty model found in many cities, Slabach speculated. "Rural" has been doing medical homes in this primary care mode all along--in fact "before 'medical home' was cool," he added.

The 3.7 percent lower cost takes into account all of the "special payments" that are included in federal rural hospital funding (Medicare Dependent Hospitals, Critical Access Hospitals, Low Volume Hospital Adjustment, etc.). It points to higher quality and lower cost of care, according to Slabach. "So, what sense does it make to cut those provisions?" he asked.

The message: "Rural" is not the problem in healthcare, Slabach said. Cutting rural healthcare funding is not the answer to our country's deficit, he added.

Rural healthcare's message to Congress is "value," he said, citing the following measures from a Rural Hospital Strength Index, in support of that message:

- Rural hospital performance on CMS Process of Care measures is on par with urban hospitals.
- Rural hospital performance on CMS Outcomes measures is better than urban hospitals.
- Rural hospital performance on Hospital Care Qual-

ity Information from the Consumer Perspective inpatient experience survey measures is better than urban hospitals.

- Rural hospital performance on price and cost efficiency measures is better than urban hospitals.

Among other data Slabach highlighted for his conference audience in support of the value story that rural healthcare has to tell were these:

- The mean total wait time in a rural emergency department is approximately half as long as the wait in an urban emergency department (29 minutes vs 56 minutes.)
- The mean wait time to see a physician in a rural emergency department is nearly 2.5 times less than the wait in an urban emergency department (98 minutes vs 247 minutes).
- More than 50 percent of all emergency department visits to critical access hospitals were categorized as low acuity cases.

Another part of that message is that rural patient access is a benefit to the community economically as well as healthwise. "We need to be telling the story of what's important in rural communities," Slabach advised.

Noting that approximately 25 percent of America's population is rural, Slabach pointed out that only 9 percent of physicians are practicing in rural areas, where the population tends to have poorer health than its urban counterpart.

He also reminded that many members of Congress—especially newly elected ones, and their aids (many of those only in their 20s) will not understand or even be aware of rural healthcare programs.

But the challenge for rural healthcare interests doesn't end there, Slabach said. Congress is challenging rural healthcare providers to "come up with something different" in rural areas. That includes crafting "workable models for the future," he said. It means "taking appropriate risks," he said. "We have to be willing to talk openly. . . that there may be better ways of doing things."

A theme throughout the Rural Health Conference was that major changes in what will be required of healthcare are coming, especially in rural healthcare. And those changes will involve a shift from fee-for-service to value-based purchasing of care—a shift of risk from patient and payer to provider. And, that shift will propel providers toward structures with more networking, coordination and collaboration, according to Slabach.

That will require rural providers to understand their market—where their patients are going for health services and why, Slabach said. □

Nebraska Rural Response Hotline

By Marilyn Mecham

Severe drought throughout Nebraska, 333,000 acres burned by wildfires, and livestock herds decreased due to hay shortage have negatively impacted farmers and ranchers throughout the state in the past few months. Nebraska Rural Response Hotline staff responded to an increase in crisis calls in the third quarter, 1,157 calls compared to 1,112 in the second quarter and 1,275 calls in the first quarter.

The calls and personal contacts came from all 93 counties in Nebraska. Services provided include mental health counseling vouchers, legal advice, financial counseling, and emergency assistance. Farm and ranch clinics were held in Norfolk, Valentine, Fairbury, and Kearney. Issues included foreclosure sale procedures and notices, oil pipeline easement contracts, water dispute, appeal rights, contempt proceedings, damages claims, conservation easements, fraud investigation, acreage purchase, zoning ordinance variances, intentionally defective trusts, as well as succession and estate planning, drought relief, bankruptcy/workouts, and pipeline issues.

While the clinics focus on corporate farming issues, the mental health counseling services address personal and family issues. During the third quarter 686 counseling vouchers were distributed by hotline staff. The intensity and complexity of the needs presented continue to increase. Some of the recent issues raised and addressed include:

- Rape
- Domestic abuse
- Alcoholism
- Child dealing with juvenile diabetes
- Forced separation of family
- Fourteen-year old daughter missing and found murdered; older brother is struggling with it.
- Elderly man stole items from Wal-Mart so he

could return them in order to buy his wife's medication.

- Husband died suddenly and left behind two young children
- Young girl scared of her dad because of domestic violence
- Attempted suicide
- Teenager made a threat on internet, also paranoia issues
- Teenager caught at school with prescription painkiller
- Military family struggling with reintegration
- Financial impact of drought

The Nebraska Rural Response Hotline, through Interchurch Ministries of Nebraska, was established in response to the farm crisis of the 1980s. For almost 30 years the services provided have met the on-going needs of farmers, ranchers, and their families. Currently hotline staff members are responding to more requests for services for children and young people. Disasters like the drought, previous ice storms and tornadoes, as well as economic downturns influence the comprehensive nature of the calls.

For more information about the Nebraska Rural Response Hotline, call (800) 464-0258. □

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**

State designated allied health shortage areas

By Marlene Janssen, Nebraska Office of Rural Health
Marlene Deras, UNMC Health Professions Tracking Services

The Nebraska Office of Rural Health (ORH) and the University of Nebraska Medical Center, Health Professions Tracking Services (HPTS) have been cooperatively writing a series of articles concerning state and federal shortage areas. In previous issues of ACCESS we have focused on medical and dental shortage areas. In this installment, the focus is on **allied health professions**. Psychiatry/Mental Health will be discussed in a future edition of Access.

Only healthcare professions that are eligible for federal and/or state incentive-type programs have shortage areas designated for the specialty. Approved **allied health** specialties, as defined in the Rural Health Systems and Professional Incentive Act (Nebraska Revised Statutes, §71-5650 to §71-5670), include **pharmacists, occupational therapists, and physical therapists**. The National Health Service Corps programs do not include these disciplines; hence, there are not federally defined shortage areas for these allied health professionals.

The Rural Health Advisory Commission, with assistance from the ORH, developed the methodology for defining state-designated, health professional shortage areas through working with professional associations, local communities, state lawmakers, 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.)

The commission's shortage area guidelines generally use county-level, full-time equivalency

(FTE) data when it is available. In the case of occupational therapists (OT) and physical therapists (PT), FTE data are not available. The best statewide county information available for OTs and PTs is the Department of Health and Human Services' (DHHS) licensure database. Licensure data report the number of OTs and PTs licensed in the county. Most health professionals use their home address when applying for a license not their work address; therefore the number of OTs or PTs in a given county using the licensure database does not necessarily reflect the number of OTs or PTs *practicing* in the county. The commission recognized the limitation of using the DHHS Licensure database and set the population to PT or OT ratios for shortage area designation lower.

OTs and PTs TO BE SURVEYED: At this time, DHHS is providing funding to HPTS to survey OTs and PTs. Through this survey, HPTS will be able to collect full-time equivalency data for these health professionals. This will allow the RHAC the ability to revise the guidelines for designation of OT and PT state-designated shortage areas and use county FTE data instead of county of residence data to calculate the population to health professional ratios. *The first mailing of the OT and PT survey is scheduled to go out in November 2012.*

The University of Nebraska Medical Center's HPTS, was established in 1995 to document the retention of Nebraska's physicians. Since that time, HPTS has grown and surveys many of the healthcare professions, including pharmacists beginning in 2000.

In August 2012, PTs and OTs were added to the HPTS survey process. HPTS will mail surveys to licensed PTs and OTs this fall. The requested information is consistent with the information requested of the other professions HPTS surveys; including demographic, educational, and practice location information. Most importantly, the survey is designed to capture the information of all licensed PTs and OTs regardless of professional status – *active status* (clinically active, managerial, educational, research, etc.) or *inactive status* (retired, working in another field, inactive – personal,

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Shortage areas *continued from p. 9*

disabled, no longer located in Nebraska, etc.)

After HPTS has added the survey responses to the database, surveys will be forwarded to PT and OT *practice locations*. Practice location surveys are sent to confirm the facility name, telephone number, address and most importantly, the licensed PTs and OTs practicing at the facility. This survey process, which includes both the professionals and practice locations, has proven successful with other healthcare professions and has provided the most complete workforce information available.

The completeness of the HPTS data is directly linked to the survey responses of all PTs, OTs and practice locations.

FTE data for pharmacists is supplied to the ORH by the HPTS and is used to determine state-designated pharmacist shortage areas. After these records are sorted and truncated so only *rural* pharmacist records remain, the ORH normalizes practice hours per week to a 40-hour work week. The objective is to have one record for each pharmacist practicing in a particular county. ORH prepared pharmacist data are then entered into an ACCESS database where programs are run to generate FTE reports by county.

Data from other sources are gathered in addition to the FTE data for pharmacists and the DHHS licensure data for OTs and PTs to determine shortage area designations. County population is obtained from the latest Census estimates along with county population age 65 and over, poverty data, and population per square mile. The percentage of special education students by county is acquired from the Nebraska Department of Education.

To be declared a state-designated pharmacist shortage area the population to pharmacist FTE ratio must be 1700:1 or greater *or* if the county has a population to pharmacist FTE ratio at or between 660/1 – 1699/1 and a high need indicator. There are 2 high need indicators for pharmacists: (1) the population 65 and older ranks in the highest quartile of the state or (2) if more than half of the area's pharmacists are over 60 years old. Counties or parts of counties within a 25-mile radius of Lincoln or Omaha will not be designated as a pharmacist shortage area.

The current guidelines for OT or PT shortage areas state that if there is no Occupational Therapist

(Physical Therapist) in the county or if the population to OT (PT) ratio equals or exceeds 5000/1 the area will be designated as a shortage area. A county may be designated if the population to OT (PT) ratio is at or between 4500/1 – 4999/1 and at least one of the following high need indicators is present: (1) the area is a frontier area (fewer than six persons per square mile); (2) the proportion of the county population 65 and older ranks in the highest quartile of the state; (3) the proportion of the county Special Education students to the student population ranks in the highest quartile of the state; or (4) the proportion of the county population below the poverty level ranks in the highest quartile of the state. Counties or parts of counties within a 50-mile radius of Lincoln or Omaha will not be designated as OT or PT shortage areas.

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 ORH uses HPTS data for the designation of health professional shortage areas, ORH is not the only user of HPTS data. The results from this survey are used by multiple agencies for workforce planning, development, and projection of future needs. So when you receive a survey form in the mail or a telephone call from the HPTS staff, please respond with accurate information. Your input is very important!

For more information contact: Marlene Janssen, Nebraska Rural Incentive Programs, (402) 471-2337; or Marlene Deras, HPTS, (402) 559-2972. □

Suicide prevention resources:

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

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

The economic impact of Critical Access Hospitals

By Dave Palm, Administrator
Office of Community and Rural Health

With funding from the Office of Rural Health, the Nebraska Center for Rural Health Research prepared a study that analyzed the economic impact of Critical Access Hospitals (CAHs) on Nebraska's economy.¹ The 2009 report uses National IMPLAN model software to predict changes in overall economic activity as a result of changes (e.g., spending) in the health care sector.

Based on the application of the National IMPLAN model, the following results were reported:

- One job created in a Critical Access Hospital in Nebraska would lead to the creation of another 0.43 job in other sectors of the state's economy.
- One dollar of income earned in a Critical Access Hospital in Nebraska would lead to another \$0.31 of income earned in other sectors of the state's economy.
- The overall job creation due to the 65 Critical Access Hospitals in Nebraska (directly and indirectly) is estimated at 12,026 jobs, which accounts for 6.2% of the state's total employment created by the health care sector.
- The overall income earned due to the 65 Critical Access Hospitals in Nebraska (directly and indirectly) is estimated at \$468.93 million, which accounts for 5.7% of the state's total income created by the health care sector.
- The overall spending due to the 65 Critical Access Hospitals in Nebraska (directly and indirectly) is estimated at \$1.35 billion, which accounts for 6.7% of the state's total economic output created by the health care sector.

Implications

The results of this study confirm the role of CAHs as an economic driver in their local communities and regions. In addition to creating jobs and stimulating spending, these hospitals provide access to high quality health care services. They also found that the overall death rates in counties with CAHs dropped by

47 percent between 2009 and 2009. The most notable declines occurred for heart disease and stroke where the corresponding age-adjusted death rates decreased by 26 percent and 41 percent.

This complete study can be found on the Office of Rural Health web site at http://dhhs.ne.gov/publichealth/Pages/hew_orh.aspx. Many individual county profiles can be found on the Nebraska Rural Health Works website at <http://www.unmc.edu/rural/NeRHW>. □

¹ Li-Wu Chen, et al., "The Economic Impact of Critical Access Hospitals on Nebraska's Economy, 2009," Nebraska Center for Rural Health Research, University of Nebraska Medical Center, June, 2012.

**For Shortage Area
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[http://dhhs.ne.gov/publichealth/
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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**
- **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