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FINAL PRINT  
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# ACCESS

Newsletter of the Nebraska Office of  
Community and Rural Health,  
Nebraska Department of Health & Human Services,  
Division of Public Health  
for all rural health stakeholders  
**Issue 70, August 2013**

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## What dental workforce numbers are saying

by David Howe

SORH Contracted Rural Writer

The old saw that “numbers can be deceiving” may come to mind for a casual observer looking at workforce numbers compiled in a recent report prepared by the University of Nebraska Medical Center.

Using data from the UNMC Health Professions Tracking Service workforce survey, the report found that the total number of dentists practicing in Nebraska increased from 1,017 in 2008 to 1,028 in 2012, a gain of 11 dentists over that four-year period. While that didn't quite keep pace with population growth, it works out to only a 2.85 percent decline in number of dentists per 100,000 population in Nebraska—not exactly an “Oh, my!” number.

But the response from Dr. Kim McFarland, DDS, MHSA, a faculty member in the University of Nebraska Medical Center's Dental College, isn't so sanguine. The 2.85 percent fewer dentists per 100,000 population in Nebraska doesn't begin to tell the story.

“I think distribution of dentists across the state is the more important question,” says McFarland, a co-author of the aforementioned UNMC Center for Health Policy report last spring. “I'm more concerned about the distribution (of dentists in the state) than ratios,”

she adds. It's a national issue, not just specific to Nebraska, she says.

Some of the troubling numbers from the UNMC Health Professions Tracking Service (HPTS) in the oral health access report include:

- The number of dentists older than 60 has risen by nearly 40 percent in Nebraska since 2008, bringing the percent of Nebraska's practicing dentists who are 60 or older to about 40.
- About 40 percent of the state's dentists are practicing in rural areas, which is roughly proportional to the 40 percent of the state's population that is rural. But, dentists practicing in rural areas tend to be older than their urban counterparts, according to McFarland. So the percentage of dentists older than 60 may be greater than 40 percent in rural areas, according to McFarland.
- While the state is not in crisis yet, McFarland says, she sees a potentially more sobering situation looming just a couple of years from now—around 2015. That's the “high water mark,” when the state will see a major share of dentists older than 60 begin to retire, she says.
- About 20 rural counties in Nebraska have

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Department of Health & Human Services

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no dentist. Those counties, historically, have never had a dentist, according to McFarland. The problem is, about 30 counties have only one or two dentists, she continues. If dentists in some of those counties are not replaced when they retire, the result could be several counties next to each other without a dentist .

- The HPTS survey shows that slightly more than half the dentists in Nebraska are practicing part-time. However, McFarland believes that number may overstate part-time practices a bit. Possibly, because of the way the question was worded, some respondents may have interpreted the question to mean how much of their practice is with patients in the chair, rather than their total practice responsibilities that include insurance forms and other administrative chores.
- McFarland also expects a rise in demand for dental services as more people obtain health insurance coverage. The American Dental Association has estimated that up to 5 percent more children will have dental insurance by 2018.

When dental access is lacking, hospital emergency rooms become the default, more costly source of care, according to McFarland. There are two million dental visits to emergency rooms nationally every year, she says.

So, what's the answer?

McFarland believes that more emphasis is needed on recruitment efforts in dental practices. Putting just four or five more dentists in Nebraska's rural areas each year could help avoid a crisis in rural dental care access in the state, she says. "Nebraska needs to be positioning itself for the future. We can't really turn on a dime in terms of these workforce issues." The turnaround from recruiting a dental student to that student practicing is about 10 years, she says.

So, long-term, rural dentists nearing retirement need to be thinking about their legacy—who will replace them, she says.

They need to "come up with a legacy plan," McFarland says.

That might mean, for example, identifying outstanding high school students in their communities and thinking about "packaging" what it would take to attract new providers to a rural community—child care, is just one example.

It isn't only the health care benefit of having a dentist in the community. McFarland says research shows that a dental practice has about \$1.2 million in economic impact annually in the community where it's located.

Legacy plans by rural dentists might best be achieved with the help of promotional efforts led by an organization such as the Nebraska Dental Association, McFarland suggests.

Dental students recruited from rural areas, studies show, tend to return to rural areas to practice, McFarland says. It may not be the same area where they grew up, but a similar area, she adds. The tendency for rural recruits to return to rural areas to practice is even greater among female dentists, according to McFarland. HPTS survey numbers show that about 20 percent of the dentists in Nebraska are female.

Rural recruitment holds greater potential for addressing rural dental workforce shortages than expansion of class sizes in Nebraska's two dental colleges, in McFarland's view. Without new construction, dental schools are "basically maxed out" in terms of space, she says. And even if the dental colleges were expanded, the shortage of dental faculty would probably be a limitation to graduating more dentists. "To think we are going to create more spots in dental school, I just don't think that's going to happen."

Other measures to address Nebraska's oral health workforce issues mentioned by McFarland and the UNMC report include:

- Exploring the potential of other workforce models that have been implemented in other

*Continued on page 3*

states may help to alleviate future shortages. For example, the Dental Health Aid Therapists (DHAT) program has been implemented in Alaska and introduced in Minnesota. DHATs are indirectly supervised by a dentist who is not practicing in the same community, and they provide dental screenings, take X-rays, apply sealants, and conduct extractions and restorations.

- Utilizing practice sites for pediatricians, family physicians, nurses, and nurse practitioners for delivery of preventive dental care. McFarland points out that dental hygienists can obtain a Public Health Authorization Permit, which enables them to provide such services in settings such as a public school without the supervision of a dentist. Only about 75 dental hygienists in Nebraska have that permit.

A U.S. Department of Health and Human Services initiative titled, Healthy People 2020, sets out 10-year goals for health promotion and disease prevention. That initiative includes a number of objectives relating to oral health. While Nebraska meets some of those oral health objectives, others will require improvement in access to oral health. And for still other objectives laid out in that initiative, the state currently lacks an oral health surveillance system for gathering the information that can provide guidance on where and how to make changes to meet those objectives, note the

authors of the UNMC report on access to oral health care in Nebraska.

Some examples of oral health care data that Nebraska lacks include the proportion of the population with untreated dental decay among children 3 to 5 years old and 13 to 15 years old. Nor is such data available for adults 35 to 44 years old, 65 to 74, and 75 or older. Other holes in dental care data collection include the proportion of school-based health centers that include such care as dental sealants and topical fluoride,

Addressing dental workforce issues goes beyond good oral health. Authors of the UNMC report on oral health access in Nebraska cite the U.S. Surgeon General oral health report, which states that “. . . oral health can't be differentiated from general health and is essential for well-being.”

Oral health is too often overlooked in discussions of general health, McFarland says. You can't really have a discussion about general health without recognizing its linkages to oral health, McFarland says. “We (dental professionals) are the Rodney Dangerfield to healthcare,” she adds, referencing the comedian whose trademark remark was that he received no respect. □

<sup>1</sup> Chandak, A., McFarland, K.K., Nayar, P., Deras, M., Stimpson M.P., Access to Oral Health Care in Nebraska. Omaha, NE: UNMC Center for Health Policy, 2013.

## MARK YOUR CALENDARS

### CRHC Billing & Coding Workshop

September 18, 2013

Younes Conference Center - Kearney, NE

### 2013 Nebraska Rural Health Conference

September 18 and 19, 2013

Younes Conference Center - Kearney, NE

### Nebraska Rural Health Advisory Commission Meeting

Thursday, September 19, 2013, 6:00 p.m.

Kearney, NE

### Nebraska Rural Health Advisory Commission Meeting

Friday, November 22, 2013, 1:30 p.m.

Lincoln, NE

## Rural Health Advisory Commission updates

By Marlene Janssen, DHHS Health Program Manager and RHAC Executive Director

In the 2013 legislative session, the Legislative Appropriations Committee proposed a \$500,000 increase in the availability of funds for the state's two rural incentive programs: The Nebraska Rural Health Student Loan Program, and the Nebraska Loan Repayment Program. This proposed legislation was ultimately passed by the Legislature and signed by the Governor.

This legislation allows the Rural Health Advisory Commission to spend an additional \$500,000 per year on new awards under the two rural incentive programs. At its June 21, 2013, meeting, the commission interviewed 22 rural health student loan applicants and awarded 13 new student loans and three continuation loans.

The Nebraska Rural Health Student Loan Program provides student loans to Nebraska residents attending medical, physician assistant, dental, or graduate-level mental health programs in Nebraska. Doctorate-level student loan recipients receive \$20,000 in student loans for the year and master's-level students receive up to \$10,000 in student loans for the year.

Rural health student loan recipients sign a contract with the State of Nebraska that requires them to practice in a state-designated shortage area the equivalent of full time for one year for each year they receive a student loan in order to receive *forgiveness* of their loans. For recipients that renege on their practice obligation, there is a buyout provision that requires repayment of 150 percent of the principal at 8 percent interest at the time of default.

While the Nebraska Rural Health Student Loan Program is for certain health professional *students*, the Nebraska Loan Repayment Program is for certain *licensed* health professionals. The following health professionals are eligible for the Nebraska Loan Repayment Program: physicians, physician assistants, and nurse practitioners practicing one of the primary care specialties of family practice, general internal medicine, general pediatrics, general surgery, OB/GYN, or psychiatry; general dentists, pediatric dentists, oral surgeons, licensed mental health practitioners,

psychologists, occupational therapists, physical therapists, and pharmacists. Loan repayment requires the recipient to practice in a state-designated shortage area for three years and requires a local entity in the community to match the state funds.

The Rural Health Advisory Commission approved 23 loan repayment applicants for up to \$20,000 each in state funds per year. Loan repayment awards are based on the recipient's practice time in the shortage area, government and/or commercial student loan balances, and the amount of local funds the local entity is willing to match. A minimum practice time of 20 hours per week is required to be eligible for loan repayment and the benefits are reduced for less than full-time practice. Loan repayment recipients along with the local entities must sign a contract with the State of Nebraska.

### State-Designated Shortage Areas

The Rural Health Advisory Commission approved the new state-designated shortage areas went into effect July 2, 2013, after the public comment period. Every three years the commission does a statewide review of all of the state-designated shortage areas. If a change in health professionals practicing in an area occurs between the statewide review periods, the community may request that the commission re-evaluate the area. If the area meets the shortage area guidelines the commission may approve the request.

The new shortage areas are posted on the Nebraska Office of Community and Rural Health's website. These shortage areas, which are not the same as the federal shortage areas, are used for the Nebraska rural incentive programs. Any Nebraska rural health incentive program recipient currently in practice or having applied when the area was a shortage will be grandfathered in if the shortage area designation changes for that site.

Information about the Rural Health Advisory Commission is posted on the Nebraska Office of Rural Health's website at [www.dhhs.ne.gov/orh](http://www.dhhs.ne.gov/orh). You may also contact Marlene Janssen at (402)471-2337 or [marlene.janssen@nebraska.gov](mailto:marlene.janssen@nebraska.gov) for additional information. □

## 2013 annual Nebraska Rural Health Conference

By Melissa Beaudette, Conference Coordinator

Mark your calendars for this year's annual Nebraska Rural Health Conference which is scheduled for Wednesday and Thursday September 18 and 19, 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, health care, health information technology, the medical home model, behavioral health care, and EMS.

This year's first keynote speaker is Guy Masters. He is a senior vice president with The Camden Group. With 20 years of health care experience, Mr. Masters focuses on strategic, business, and service line planning, and business advisory and competitive positioning strategies for hospitals/health systems, physicians, and payers. He has developed HMOs, PPOs, IPAs, MSOs, PHOs, medical groups, and direct contract relationships with employers. Mr. Masters has written more than 80 articles on health care trends, strategic and business planning, financial forecasting, managed care strategy, and physician-hospital integration.

The next keynote presentation will be by Hall of Fame Speaker LeAnn Thieman. LeAnn's story of being "accidentally" caught up in the Vietnam Orphan Airlift in 1975 engages and inspires people. An ordinary person, she struggled through extraordinary circumstances and found the courage to succeed during her daring adventure of helping to rescue 300 babies as Saigon was falling to the Communists. LeAnn's penetrating conversations and expertise have been featured around the globe on BBC, NPR, PBS, FOX News, Newsweek magazine's Voices of the Century issue, and countless radio and TV programs. LeAnn's 15 books have inspired, motivated, and changed the lives of millions of readers. It began with *This Must Be My Brother*, her incredible Operation Babylift story. After it was featured in *Chicken Soup for the Mother's Soul*, LeAnn became one of Chicken Soup's

most prolific writers.

Her devotion to 30 years of nursing made her the ideal co-author of *Chicken Soup for the Nurse's Soul*, which hit the New York Times Bestseller list. Her latest, *SelfCare for HealthCare, Your Guide to Physical, Mental and Spiritual Health* is a dynamic component of her transformational SelfCare for HealthCare initiative. LeAnn is among fewer than 10 percent of expert speakers worldwide to have earned the Certified Speaking Professional designation and in August 2008 she was inducted into the National Speakers Association's Speaker Hall of Fame.

Again, please mark your calendars for September 18-19, and go to the Nebraska Rural Health Association website [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). □

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**Questions? Need help? Contact [Ann.Larimer@Nebraska.gov](mailto:Ann.Larimer@Nebraska.gov), (402) 471-2337.**

## Quality of care in Critical Access Hospitals

by David Palm

Administrator, Office of Community and Rural Health

A recent article published in the April 3, 2013, *Journal of the American Medical Association* (JAMA) has questioned the quality of care provided in Critical Access Hospitals (CAHs). This study compared mortality rates for Medicare beneficiaries admitted to Critical Access and non-Critical Access Hospitals between 2002 and 2010. This study used data from Medicare fee-for-service patients admitted to acute care hospitals across the country with acute myocardial infarction (AMI), congestive heart failure, and pneumonia. According to the study, CAHs had mortality rates comparable with those of non-CAHs in 2002, using a composite mortality across all three conditions. However, between 2002 and 2010, mortality rates increased 1.0 percent per year in CAHs but decreased 0.2 percent per year in non-CAHs. The study concluded that by 2010, CAHs had higher mortality rates as compared to non-CAHs (13.3 percent vs. 11.4 percent). The patterns were similar when each individual condition was examined separately.

The authors of the study identified several possible explanations for these differences. One explanation was that CAHs are not required to participate in federal efforts to collect and publically report quality performance data while all hospitals over 50 beds are required to report these data. Another possible explanation is that CAHs as a group may not be able to invest in new technology, especially for conditions related to AMI. Finally, the authors also speculated that some of the differences in the patient population such as higher poverty and/or unemployment rates may account for some of the changes in the observed outcomes.

The findings from this study have been widely challenged. For example, Laura Redoutey, President of the Nebraska Hospital Association, stated in a *Lincoln Journal Star* editorial that one of the reasons for the higher mortality rates in some CAHs is that they may keep patients who are too sick to transfer and need stabilization. She noted that most CAHs

admit only heart attack patients who are both critical and have an order not to resuscitate, which tends to leave CAHs with patients who are sicker. The vast majority of other heart attack patients who require treatment are transferred to a larger hospital.

Researchers at the University of Minnesota Rural Health Research Center have also challenged the results. These researchers identified some serious data issues. For example, hospitals were classified as small if they had 1-99 beds, whereas CAHs are limited to a maximum of 25 beds. As a result of this inaccurate measurement of bed size, it is likely that there is an overestimate of excess mortality associated with CAH status. They also emphasize that some older, sicker patients choose to remain in the CAH rather than being transferred to a large tertiary facility. It is part of patient-centered care and these choices should be respected.

Finally, the researchers challenged the assumption that CAHs do not publically report on quality data because there is no mandate to do so. The researchers emphasized that even though CAHs are not required to report quality improvement data, about 80 percent do publically report on inpatient quality measures. In fact, in Nebraska, all of the 65 CAHs report these data, and the Office of Community and Rural Health, the Nebraska Hospital Association, CIMRO of Nebraska, and the CAH Network Coordinators track these data on a quarterly basis. Although some trend data have been collected, more time is needed to thoroughly analyze the results. These findings will be shared in a future newsletter.

In conclusion, there are several serious problems with the JAMA study. As Laura Redoutey stated in her editorial, Nebraskans should continue to have trust and confidence in their rural hospitals.

Although there were some serious methodological issues and errors in the JAMA study, more studies are needed to find ways

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## Margaret Brockman to join the OCRH

Margaret Brockman joined the Office of Community and Rural Health (OCRH) on July 1, 2013. Margaret has an extensive background in the health care service area. Prior to her current position, she worked as a program specialist – physician services for the Division of Medicaid and Long-Term Care. While in this position, she was responsible for managing several contracts, administering the Nebraska Medicaid Physician Services Program, and coordinating the patient-centered medical home pilot project.

Her previous experience includes serving as an adjunct faculty instructor for graduate nursing courses at Nebraska Wesleyan University, administering the managed care workers compensation program for Blue Cross/Blue Shield of Nebraska, and becoming the founder and owner of a private case management and health and wellness consulting firm.

In the OCRH, she will be responsible for managing the Medicare Rural Hospital Flexibility grant and the Small Hospital Improvement grant. She will also work with other staff in the OCRH to assist small communities in developing long-term solutions to their health problems. □

## Quality of Care *continued from page 6*

to improve the quality of care in both rural AND urban hospitals. Many improvements have already been made in the quality of care and patient safety, but more work needs to be done.

Questions about this article should be directed to Dave Palm, the Administrator of the Office of Community and Rural Health, at (402) 471-0146 or david.palm@nebraska.gov □

<sup>1</sup> Karen E. Joynt, E. John Oran, and Ashish K. Jha, "Mortality Rates for Medicare Beneficiaries Admitted to Critical Access and Non-Critical Access Hospitals, 2002-2010," JAMA, April 3, 2013, Vol. 309, No. 13, pp. 1379-1387.

<sup>2</sup> Laura Redoutey, "Rest of the Hospital Story," Lincoln Journal Star, April 14, 2013, p. D-10.

<sup>3</sup> "University of Minnesota Rural Health Research Center/FLEX Monitoring Team Response to 'Mortality Rates for Medicare Beneficiaries Admitted to Critical Access and Non-Critical Access Hospitals, 2002-2010- published in JAMA, April 3, 2013,' www.flexmonitoring.org, April, 2013.

<sup>4</sup> Laura Redoutey, op. cit.

## Multi-state National Health Service Corps retention collaborative

By Thomas Rauner, Primary Care Office Director

Nebraska and 10 other states are involved in a two year study focused on the retention of selected health care professionals in primary care, mental health, and dental health who are participating in the National Health Service Corps (NHSC) and the state loan repayment programs. The purpose of the study is to project the anticipated retention rates and identify those critical factors that are most likely to influence these professionals to remain in their communities. This information can then be used to help communities and clinics develop successful retention strategies.

This study has been led by Dr. Don Pathman from the Sheps Center for Health Services Research at the University of North Carolina. He is a former NHSC physician and an experienced researcher who has published

several articles on this topic. Thomas Rauner from the Office of Community and Rural Health is the project director for this collaborative.

In the first year of the study, over 1,500 health care professionals were surveyed. This survey included a stratified sample of representative data at the national level, as well as state representative sample sizes.

The findings from the study showed that the retention rates for the Nebraska Loan Repayment Program were equal to or exceeded the rates for all of the other states. In addition, the survey responses indicated that the anticipated retention rates for the Nebraska Loan Repayment Program at five years was more than double the NHSC program (65 percent for the Loan Repayment Program and

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25 percent for the NHSC program).

Another key finding was that the anticipated retention rate for the NHSC Loan Repayment Program is significantly longer than the NHSC Scholarship Program. This finding was consistent with the Nebraska Loan Repayment Program and the Nebraska Student Loan Program. The respective rates for these Nebraska programs are 70 percent and 36 percent by the end of year one and 35 percent and 13 percent at the end of five years.

The results of the surveys also indicated that several structural design factors were associated with anticipated retention. These factors accounted for 19 percent of the anticipated retention at the end of five years and included: (1) clinicians older than 29, (2) were non-Hispanic White, (3) have children, (4) grew up and/or trained in states where they serve, (5) lived in rural areas in Nebraska, (6) practiced in rural health centers (clinics), and (7) practiced in mental health and substance abuse facilities.

The retention rates were also influenced by the clinicians' experiences in their practice and their communities. Some of the factors included:

(1) overall satisfaction with the practice, (2) the practice administrator, (3) the salary/income for the practice and access to specialist consultants for patients (4) a sense of belonging to the community, (5) a happy spouse, (6) a lack of concern about personal safety by the family, (7) the service program and contact with and support from the program. The factors in this category accounted for 27 percent of the anticipated retention at the end of five years.

The entire report is available on the Nebraska Office of Rural Health's website: [http://dhhs.ne.gov/publichealth/Documents/Multi-State%20NHSC%20Retention%20Collaborative%20Final%20Report\\_Nov%205%202012.pdf](http://dhhs.ne.gov/publichealth/Documents/Multi-State%20NHSC%20Retention%20Collaborative%20Final%20Report_Nov%205%202012.pdf). You are also encouraged to share your comments with us.

In the second year of the Multi-State/NHSC Retention Collaborative, a web-based longitudinal retention management system will be developed by the North Carolina Foundation for Advanced Health Programs. This system will gather information from clinicians and clinical site administrators about retention measures. Future newsletter articles will report on the second year study findings. □

## A rural dentist's experience with the State Incentive Programs

By Jesse Carr, D.D.S.

My name is Jesse Carr and I am a dentist in West Point, Nebraska, a town of approximately 3,400 people and this is my story of how I came to be a *rural* dentist.

I knew at a very young age that I wanted to be a dentist someday. An unfortunate basketball incident during a second grade recess left my upper two front teeth fractured. This led to numerous visits to my hometown dental clinic over several years. While multiple fillings, a root canal, and eventually a crown and veneer would be enough to shy most people away from the dentist, it intrigued me. Most kids my age were afraid to go to the dentist. I did not have this reaction because of the quality of care I received. The office as a whole really made me feel comfortable, and I knew I wanted to be able to help people like

that someday.

Growing up in Seward, which had a population of about 5,500 people at the time, I came to appreciate the benefits of small-town living. My friends and I could ride our bikes to the pool on the west side of town and to Plum Creek to fish on the east side of town, all in one day. While growing up, I learned that word travels fast in a small town. While some people may be uneasy about the idea of everyone knowing their business, I feel it makes people more accountable for their actions.

As a senior in high school, things fell into place for me when I was chosen to participate in the UNMC Rural Health Opportunities Program (RHOP). RHOP is a partnership program between UNMC and Wayne State and Chadron State Colleges and offers

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recipients automatic acceptance into UNMC. As an RHOP student, I was awarded an undergraduate scholarship by Wayne State College.

As a sophomore in dental school, I began talking with a family friend, Dr. Shawn Kralik, who had also grown up in Seward. Shawn had graduated from dental school a year or two before me and began his practice in West Point by purchasing a dental practice from a retiring dentist. From this conversation, I found out that I could practice dentistry in a rural Nebraska town, have access to the outdoors with great hunting and fishing close by, and it was less than a two-hour drive from my hometown of Seward. Some might picture a small town dental office as an old building with old equipment, but this office was far from that. There were intraoral cameras, a Biolaze laser, and a Cerec machine. There were plans in the works to get ScanX digital radiography and to go completely paperless with electronic billing and charts. I would also have the opportunity to become part of a busy two-person practice as the second dentist.

Shortly after talking seriously about this future opportunity in West Point, I found out about the **Nebraska Rural Health Student Loan Program**. This program offers certain health professional students, who are Nebraska residents and attending college in Nebraska, *forgivable* student loans. The student is required to practice in a state designated shortage area the equivalent of full time for one year for each year he/she receives a loan.

At the time I applied for the Nebraska Rural Health Student Loan Program, West Point, which is in Cuming County, was a state-designated dental shortage area. After looking over the list of counties and towns, I felt confident that even if the opportunity in West Point did not work out, I would be able to find another rural Nebraska town that would be a good fit for me. The student loan recipient may choose a shortage area practice site up to 18 months prior to being eligible to practice. Since state-designated shortage areas are reviewed

every three years, it is possible that an area that was a shortage area when the student applied for the student loan may not be a shortage area when the student loan recipient is ready to begin practice.

At that point in my life, with the student loan totals adding up, I was beginning to realize how valuable this program is to a student. The average dental student graduates with about \$200,000 of student loan debt. Looking at all these facts, it was a no brainer for me to apply for the Nebraska Rural Health Student Loan Program. I was awarded student loans by the Rural Health Advisory Commission for my junior and senior years of dental school which allowed me to reduce my other government student loans.

At the conclusion of dental school, I had completed all of my requirements to graduate, passed all the board exams for my license, and I felt very fortunate to have a contract signed to practice dentistry in West Point. Over the next two years while fulfilling my requirement to the Nebraska Rural Health Student Loan Program by practicing in a shortage area, I learned about another program called the Nebraska Loan Repayment Program.

**The Nebraska Loan Repayment Program** is an incentive program *for certain licensed health professionals* to assist them in paying off their commercial and/or government educational loans. This program is a recruitment tool that can be used by communities in state-designated shortage areas to *recruit* health care professionals or, as in my case, to *retain* health care professionals.

The Nebraska Loan Repayment Program application process includes having a local entity submit a “community application” and the health professional submit the “health professional application with documentation of loan balances.” If approved for loan repayment by the Rural Health Advisory Commission, the health professional must practice three years in the shortage area and may receive up to \$40,000 (local and state match) per year in loan repayment. Again, I was fortunate to apply and

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be accepted into this program.

My obligation to the Nebraska Loan Repayment Program ended on June 30, 2013. After five years of practicing dentistry in West Point, I look back and feel very grateful that these two programs helped me start a life here. I am in the rural Nebraska town that I envisioned many years ago. I met my wife, who is from West Point, in this rural Nebraska town, and we plan on raising our kids in this rural Nebraska town. The two rural incentive programs not only led me to a great Nebraska community with a great dental office, but also provided me with \$95,000 of state

money to help pay off student loan debt. It goes without saying how important that money has been. I would definitely recommend any future health care professional or current health care professional even thinking about practicing in a rural Nebraska community to learn about these programs. I encourage you to at least take the time to look at the list of shortage areas because you may be able to find your “West Point.”

For information about the Nebraska rural incentive programs, contact Marlene Janssen, Nebraska Office of Community and Rural Health, (402) 471-2337, or marlene.janssen@nebraska.gov □

## A medical home “under construction” by SERPA

by David Howe

SORH Contracted Rural Writer

With their promise of taming rising health care costs and enhancing quality of care, the terms “patient centered medical homes” and “accountable care organizations” carry cachet.

But, what about actually putting such a “structure” together?

True, there are key standards that a patient centered medical home (PCMH) and an accountable care organization (ACO) must meet for accreditation. But a stock blueprint and availability of “materials” waiting there on the shelf for construction may be another matter.

That’s the sense one gets from visiting with Dr. Bob Rauner, the medical director for Southeast Rural Physician Alliance’s ACO (SERPA-ACO). This Nebraska rural health care network represents just one example of a PCMH and an ACO “under construction.” SERPA, which began with about 70 southeast Nebraska rural physicians, now includes an ACO with nine clinics located across the state

As medical director for SERPA-ACO, Rauner is responsible for coordinating SERPA’s journey toward becoming a PCMH and an ACO. Start-up financing help is coming from a special \$2.1 million Medicare loan. The loan was granted last January.

Despite the “southeast” in its name, SERPA’s nine clinic locations stretch all the way from

Bellevue in eastern Nebraska to McCook in the southwestern part of the state. Growing pains of creating an ACO involving rural providers are made all the more challenging by the need to bring together such geographically scattered clinics, Rauner says. Face-to-face meetings are important in the process. SERPA’s other clinics are in David City, Geneva, Hastings, York, Lexington, Broken Bow, and Kearney.

To explain the relationship between the PCMH and an ACO under SERPA’s model, Rauner uses this analogy: View the PCMH as a “house” and view the ACO as the “neighborhood” or wider medical community. Specialists, other providers and hospitals outside of SERPA are the “neighborhood.”

SERPA is developing its PCMH model based on criteria that consist of the following four components, according to Rauner:

- 1. Access.** Patients must be seen when needed, with providers on call at all times. That helps avoid emergency room or urgent care visits for care that can be given more appropriately and often less expensively by the primary care provider. “Access is big,” Rauner says.
- 2. Continuity.** A patient sees the same provider over time, who is familiar with that patient’s conditions and medical history. Providers in the clinic can work together as a team. This aspect of a PCMH “is probably the most

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underappreciated,” Rauner says. “It’s huge.” The benefits include prevention of duplicate testing and patients being more inclined to follow their physicians’ advice because regular contact with their physicians helps build trust in their physicians.

**3. Comprehensiveness.** Clinics within SERPA have personnel with an overview of each patient to make sure that the patient is accessing the right care at the right time. The convenience of care at one location encourages patients to get the care they need, with less duplication and less conflicting care, Rauner points out.

**4. Coordination.** Each clinic has a care coordinator to help keep patients compliant, making sure they are following medication instructions, keeping immunizations current, and receiving proper screening—all part of disease registries followed by the clinics. This aspect of a PCMH makes electronic medical records essential, according to Rauner. “We picked those nine clinics (in SERPA) for a reason.” That’s because they all have EMRs. “I don’t think you could make it work without that,” he says.

The SERPA model is on the “cutting edge,” but also faces some major challenges. For example, SERPA providers include physicians, physician assistants, and nurse practitioners, but no other types of providers, such as ophthalmologists, cardiologists, or psychiatrists at this time. “We may expand to include others,” Rauner says. “We’re interested in adding a behavioral health component, but don’t have the funds to support that yet.”

What about when care from providers outside of SERPA is needed? “We can tell you where (in the “neighborhood”) we think you should go,” Rauner says. Medicare claims data on providers outside the SERPA system are, in part, a guide to those recommendations that SERPA providers make to their patients.

At the same time, patients are free to pass up those recommendations in favor of their own choice of providers. “We are not the gatekeeper” to where patients can go, he adds. “Patients get to vote with their feet.”

Meeting conditions of the no-risk Medicare

loan is based on “only those patients who stay with us,” Rauner continues. However, even if a patient goes outside SERPA for a portion of his or her care, that patient figures into the Medicare loan incentive calculus as long as the bulk of that patient’s care comes from SERPA providers, according to Rauner.

That’s not the same arrangement you might find in other versions of PCMHs and ACOs, Rauner points out. Some versions, for example, might be set up along a “silo” structure that ties together primary care physicians, specialists, and hospitals as one organization from which patients obtain all of their care within that organization, Rauner explains. And, charges for all services provided in the treatment of an illness may be consolidated into one bill sent to the patient under such an arrangement.

In SERPA’s case, patients are billed separately, rather than receiving a consolidated bill.

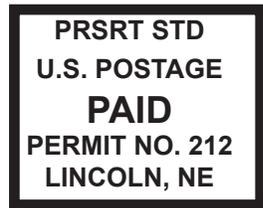
The larger the percentage of patients who participate in a PCMH, the more doable the model is, says Rauner, simply because too few patients participating in it makes it difficult to cover costs of building that model.

And, to make an ACO workable, he continues, many believe 5,000 Medicare patients are a minimum. Some think it may be closer to 20,000, he adds. The numbers are a challenging hurdle for a rural ACO, Rauner says, adding this: “ACOs need a minimum number of patients, because the payment is based on cost savings spread out over a population. If the population is too small, your payment could be wiped out by just a few bad chance outcomes.”

SERPA, with its nine clinics, has 10,000 to 11,000 Medicare patients, which represent about 20 percent of its total patient population, according to Rauner.

Yet another challenge in this Medicare-based effort is bringing together all the different payers—payers such as insurance companies and Medicaid. “We are in the process of meeting with the other payers,” Rauner says.

The aforementioned \$2.1 million Medicare loan is to be paid out over 18 months “. . .to



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cover three years of infrastructure costs that we will presumably pay back with savings we achieve for Medicare,” Rauner explains.

“Any savings we get we have to pay off the loan first. If we don’t do what we say we’ll do, we have to pay it back,” says Rauner. Savings are the amount by which SERPA’s average Medicare Parts A and B costs per Medicare patient falls below the national average for Medicare patients. Part D drug costs are not part of the comparisons.

If savings exceed the amount of the loan, the gain is shared between SERPA and Medicare.

There are also Medicare quality targets that must be met, Rauner says. Those include numerous measures for patient satisfaction, quality measures such as admission/readmission, health information technology, and quality improvement measures such as percent of patients in whom factors such as blood pressure and cholesterol are controlled.

Health care providers wishing to become PCMHs and ACOs must meet standards set by an accrediting agency. Several such accrediting organizations are: the National Committee for Quality Assurance, JCHOA (formerly the Joint Commission on Accreditation of Health Organizations and now called Joint Commission) and Nebraska Medicaid PCMH Tier I & II. SERPA will be using the Nebraska Medicaid PCMH criteria.

“You can’t just paint a name on your door” and call yourself a PCMH or an ACO, Rauner says. You have to open the door and make it a “home.” □