

State of Nebraska Rural Health Advisory Commission

# Annual Rural Health Recommendations

March 2013

**Rural Health Advisory Commission  
September 2012**

**Name / Affiliation**

**Appointment Designation**

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Rural Mental Health Practitioner

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Omaha, NE

Family Practice Resident

**Rural Health Advisory Commission**  
**September 2012**  
**(continued)**

**Name / Affiliation**

**Appointment Designation**

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# RURAL HEALTH ADVISORY COMMISSION

## Annual State Rural Health Recommendations

As per §71-5659 NE Revised Statutes

### **Vision Statement:**

***All rural Nebraskans have access to a dynamic, integrated health and health care system meeting all of their physical and mental health needs.***

In the face of the changing local, state, and national health care environment, the Nebraska Rural Health Advisory Commission (RHAC) has drafted the following 2013 state rural health policy recommendations, as required by statute, to present to the Governor, the Legislature, the Nebraska Department of Health and Human Services, and the citizens of our State.

Each year, the Rural Health Advisory Commission considers the past, current, and future health care access and utilization issues our state's rural communities and residents are or will be facing. We focus on our communities because we believe that our communities matter to their citizens and to all of us who live in this State. One of the most important priorities every community must address is the health and health care accessibility for their residents.

The number of primary care providers in the State continues to decrease despite the State's increasing need. These needs are even more prevalent in our rural areas, where providers must do more with fewer resources and support than their urban counterparts. Many health care providers begin their educational journey with the dream of returning to the rural areas in which they were raised. Sadly, this goal many times remains unattained due to the many difficulties facing providers in rural areas. Lower reimbursement, longer hours, and more commitments are there to rudely greet the new rural provider, along with ever increasing levels of student debt.

The rural health incentive programs serve to eliminate one of the major barriers in retaining and attracting young providers to return to their underserved rural areas. These programs play a vital role in providing continued access to health care in some of the most rural areas of the State. With a default rate of less than 12% (meaning that 88% of recipients fulfill their obligation to practice in a rural or underserved area), the tremendous success of these programs is instantly recognizable through the benefits to the community in health care and positive economic impact.

*“Student debt has been increasing at a rate much higher than inflation, and many graduates are facing huge debt loads of greater than \$200,000. As recently reported, total student debt in this country now amounts to more total dollars than America's total credit card debt! This alone is swaying people away from primary care medicine in general, regardless of practice location. The student loan repayment programs not only serve to place providers in rural and underserved areas, but also help in attracting students to pursue primary care fields from the very beginning of training. If I am honest, I must question whether I myself, would have chosen primary care without the reassurance of these types of loan repayment programs. Along with my fellow classmates, I have begun to look for the practice location where I can make the greatest*

*contribution to my home state. Many of us have roots in small, rural towns, and have turned back to those roots, because of the sense of home they provide. The loan repayment offered by these programs allows all of us who have ever had a dream of returning to a small rural community as a family practitioner, the opportunity to do so without the burden of mounting debt.” – Zach Frey, M.D., former RHAC member*

The Rural Health Advisory Commission has developed the following recommendations crafted from a researched perspective and with the knowledge that it will take partnerships between communities, between communities and their governments, between communities and their health professionals, and all of the other partners who have a stake in the rural places and people of our State. The issue is *access* to health and health care, and we respectfully ask your partnership in helping our rural communities to have that access.

## **Recommendations:**

### **I. Incentive Programs for Rural Health Professionals**

- A. The Rural Health Advisory Commission (RHAC) strongly advocates for maintaining financial support of the state’s incentive programs (student loans and loan repayments) for statute identified rural health professionals. The Commission also supports the continued assessment of health care provider shortages, especially primary care physicians listed in the Rural Health Systems and Professional Incentive Act: family practice and general surgery, physician assistants, pharmacists, advanced practice nurses, dentists, licensed mental health professionals (LMHPs), psychologists, psychiatrists, and physical and occupational therapists. We also support alternative incentives to remove barriers in recruitment and retention of these health care providers. Since 1994, 416 health professionals have or are participating in the Nebraska Loan Repayment Program with over 91% completing their practice obligation.

For the last few years, the National Health Service Corp (NHSC) loan repayment program benefited a number of rural practitioners in the state. This program has now changed its qualification criteria in such a way that many underserved areas of Nebraska no longer score high enough to qualify for the incentives. The State of Nebraska needs to increase the funding for the state incentive programs to offset the loss of funding from the NHSC program. A relatively small amount of General Funds is used for these programs not only to increase access to health care services but also create new jobs in the communities.

- 1. a. The Commission encourages the continued support, utilization and enhancement of the present rural health incentive programs managed by the Nebraska Office of Rural Health.
- b. The Commission strongly encourages maintaining the current state general funds appropriation level for the coming biennium budget for the incentive programs, (student loans and loan repayments) which would include replacing and enhancing

the \$250,000 in Merck settlement money with state general funds. (FY2011-12 was the last year of the Merck Settlement cash of \$250,000.)

2. a. The Commission recommends that affected/invested stakeholders participate in health care workforce studies and meet with, or communicate to, the Commission a review of their findings; and then to work at the creation of an encompassing strategy and work plan to address identified workforce shortages.
- b. The Commission supports the development and operation of the Nebraska Healthcare Workforce Center that would be the trusted source of data related to current and future workforce shortages so that proactive solutions to resolving the shortages could be developed.

## **II. Behavioral Health Services:**

Behavioral health care in rural Nebraska continues to be a major concern for the Rural Health Advisory Commission. There continues to be a shortage of mental health providers in most rural areas which results in many problems, including the fact that rural Nebraskans must drive long distances for treatment. The Commission supports and provides incentives for community based behavioral health providers. The Commission encourages an integrated health delivery system such as the medical home model that addresses both medical and mental health needs and resources. The Commission realizes the importance of the continued need to recruit behavioral health providers and recognizes the importance of retaining providers who are presently serving rural areas. The Commission supports the development of resources and reimbursements that can help assure the recruitment and retention of behavioral health providers to Nebraska.

A. Community based mental health workforce issues should be addressed through:

1. Maintaining or expanding funding for current state incentive programs for behavioral health workers including:
  - a. supporting legislative efforts to maintain and strengthen present programs,
  - b. assessing and developing alternative funding sources, and
  - c. working with existing workforce development programs and resources.
2. Evaluating present provider reimbursement issues and developing recommendations to update payment models.
3. Supporting an integrated, new innovative model of care utilizing present behavioral health or medical providers in new roles and systems.

B. Medicaid reimbursement for behavioral health providers in rural areas needs to be addressed through:

1. Reasonable reimbursement incentives for behavioral health providers practicing in rural areas.
2. Support and update payment reimbursement models for unique rural issues including:

- a. transportation and travel costs;
  - b. payment reimbursements for integrated services including new project models; and
  - c. payment issues to support the use of telehealth services or other electronic means of telemedicine.
3. Evaluating present Medicaid reimbursement issues and offering recommendations, as appropriate.

### **III. Integrated Service Delivery and Training Systems**

The Rural Health Advisory Commission supports the creation of a sustainable unified reimbursement model to help advance health care system integration for rural communities and individuals. This model would be developed by a group of professional inclusive stakeholders. We believe the most effective health care delivery model of the future will include:

- A. Integrated networks;
- B. Professional collaboration (in some communities this may include: school nurses, caregivers, skilled nursing facilities, public health officials, dentists, home nurses, mental health professionals, parents, consumers, teachers, day care providers, community activists, civic organizations, blood bank organizations, chiropractors, physical therapists, pharmacists, advanced degree nurses, physician assistants and physicians, to name a few);
- C. Patient centered medical home model of care delivery or other proven rural provider model; and
- D. Community involvement.

The Commission encourages all in-state health professional education programs to include training experiences in rural areas to assist providers in understanding the navigation and delivery of care in rural parts of our state.

The Commission continues to predict a rural health provider shortage for the foreseeable future. We invite continued thoughtful solutions and strategies to address statewide distribution, education/training and access to health care for all of our State's residents. This prediction is based on a large number of retiring health professionals, the expansion of insurance coverage, and decreased number of Medicare providers which will increase the demand for health care services at all levels and of all professions.

### **IV. Rural Emergency Medical Services**

While progress has been made towards integrating rural EMS, the industry still has important goals to achieve the recommendations made in the 2006 Institute of Medicine report, "The

Future of Emergency Care”. The report proposed that future EMS efforts focus on emergency health care delivery in a manner that is area focused, coordinated and accountable. Those efforts will involve EMS working with multiple systems in all arenas, including local, state and federal levels to "enable continuous communication and enhance the benefits of overall system integration, including better and safer patient care."

Failure to integrate EMS into local systems of care and into regional and national networks is likely to result in ongoing deterioration that further limits availability and access to advanced EMS care in rural and frontier areas, Nels Sanddal, longtime EMS researcher and Manager of Trauma Systems with the American College of Surgeons (ACS), asserted. But integration is only one component in the future viability of rural EMS.

“I don’t think the EMS volunteer model is sustainable over the long run for a variety of reasons,” commented Sanddal. “The economy has driven more working people to larger communities. Younger people still living in small communities often commute and are unavailable during daytime hours. And employers are reticent to allow an employee to leave work when they realize transports may take that employee away for several hours.”

Twenty percent of EMS leaders in the NCRHR-PAC report were uncertain of their ability to maintain future service and 8 percent were labeled "frankly pessimistic." They indicated that volunteer recruitment would likely be the largest deciding factor.

"The need for pre-hospital care in small communities continues to be recognized and met by local residents and local officials who stepped up when market-based solutions were not available," the report concludes. "In a significant number of areas, however, the ability of community volunteers to provide emergency services is being stretched to the breaking point and requires new creativity. Consolidation of local services to benefit recruiting and to increase run volume and revenue must be considered. Although rural volunteer EMS grew locally from local need, the need to work together with other EMS agencies or other health care providers in systems of care is inevitable and offers options to maintain these important services."

The Commission Recommends:

- A. The development of a state wide EMS system to support a comprehensive program for pre-hospital care, ranging from in-home care, trauma to national emergency preparedness.
- B. Research and identify models of a statewide critical patient care transport system addressing inter-facility advanced life support transport of patients from rural hospitals to a more appropriate advanced level of care.
- C. Study the feasibility of developing a statewide program to utilize the skills of “Out of Hospital Emergency Care Providers” within their scope of practice to provide care in partnership with other health care providers to patients living in their homes or other

facilities in their community. The foundation of this study would be the Community Para-Medicine model.

- D. The Commission recognizes the need to develop and pass legislation designating a governmental entity or oversight body at the local level to assure pre-hospital care will be provided at the local level.

## **V. Rural Communication and Information Technology Systems**

The Commission encourages the continued improvement of telecommunications technology across all areas of the state to support the sharing of health information in a patient information secured environment. Emphasis needs to be given to assuring that the bandwidth of the telecommunications infrastructure is adequate to meet all of the health care needs in the state.

- A. The Commission recommends that the Nebraska Department Health and Human Services work with advanced rural telehealth network models to identify best practices that can be duplicated in other areas of the state.
- B. The Commission strongly encourages the use of telecommunications for consultations, education, and electronic health information delivery to and from homes, hospitals and other health care providers.
- C. The Commission recommends development of strong telecommunications linkages between public health departments, area hospitals, and other health professionals to address district-wide, regional, and statewide health needs.
- D. The Commission supports the use of electronic health record (EHR) technology by all health care providers and the secure sharing of patient information through health information exchanges. Even though some of these exchanges have already been developed, alternative systems need to be explored to ensure that the best systems are in use and that those systems are designed in such a way that the business model that funds them is truly financially sustainable.
- E. The Commission strongly encourages the use of standardized protocols for all reporting, transmitting and the exchange of all health care data.
- F. The Commission also recommends that state agencies develop the capacity to send and receive important patient information that certified EHRs are required to transmit and receive.

## **VI. Rural Quality**

The Rural Health Advisory Commission supports efforts to improve the quality of health

care provided in rural areas. The Institute of Medicine (IOM) report entitled, “Quality through Collaboration: The Future of Rural Health” outlines an excellent agenda for achieving this goal. The Affordable Care Act (ACA) also calls for the development of a National Healthcare Quality Strategy to be developed. This strategy may have a significant impact on the quality efforts of all providers, especially those in rural areas. The Commission believes that Nebraska is in a position to be a leader in the implementation of this agenda, once it is defined. It also supports the efforts of health care providers (physicians, health departments, home health, Advance Practice Nurses, dentists, mental health providers, etc.) to join the Nebraska Coalition for Patient Safety and participate in the reporting of adverse events and “near misses” as defined by the Coalition as reportable events

A. To achieve this higher quality standard, the RHAC will:

1. Testify and provide additional information to the Legislature and appropriate subcommittees about the need for health care delivery changes.
2. Identify the additional primary care needs/solutions for the next 10 years in all health care professions in order to provide satisfactory health care to rural Nebraska residents.
3. Promote continued research into utilizing, developing, and applying rural health care models in rural health settings.

B. Recommendations:

1. Encourage developing partnerships with local businesses to provide health care clinics for the underserved, uninsured, under insured, chronic illness cases, and returning war veterans.
2. Encourage and support Universities and Colleges in establishing rural residency programs within rural health care systems. Rural residency programs should include medical, nursing, dental, mental health, pharmacy, business schools, public health, occupational health, rehabilitation students and other graduate schools that contribute to rural health.
3. Encourage apprenticeship/internships in collaboration with health clinics in rural areas from business, public health, law, information technology (IT), and marketing students.
4. Encourage and provide financial incentives to support telehealth medicine.
5. Encourage and provide financial incentives for rural health care providers to continue involvement in Quality Improvement Organization programs.

6. Promote and reward broader case management concepts that increase Registered Nurse services for the underinsured, uninsured, vets, etc. in rural Nebraska.
7. Encourage and support the medical home concept for high end users of emergency rooms for health care services and hospital re-admissions.
8. Support and reimburse the use of local public health departments in developing and sustaining medical homes for high end users of medical services.
9. Encourage and provide financial support to home health departments in providing follow care and education to elderly who are not home bound. Support research and models that promote the use of home health departments for those patients not home bound.

## **VII. Strengthening Rural Health Services by Improving Access to Affordable Health Care**

Many additional health disparity issues continue to be found in our rural communities. The recruitment/retention of providers, the maintenance of facilities, loss of population, and the cost of care/drugs for lower income patients are but a few issues facing rural Nebraska.

A. The Commission recommends:

1. The creation of a new, proven, payment template for an integrated network service model. (This totally integrated model should be designed to help providers transition from pilots to successful integration.)
2. Review of the opportunities for Nebraskans to obtain health care insurance coverage through the Health Insurance Exchanges created by the national health reform legislation.
3. Highest consideration should be giving to providing access to and payment assistance for the needed health care for all rural Nebraskans. This should be done with the cooperation of governments at all levels. It may include increased use of community health care workers such as, community paramedics, nurse centers, and mid-level practitioners, using existing local public health departments, and evidence-based health-care practices.

## **VIII. Rural Managed Care and Reimbursement**

The Commission believes that reimbursements of health services provided drive the successful models for health care delivery within our state; therefore:

- A. The Commission supports the development of a Medicaid rural “Primary Care Team” model, with attractive reimbursement, for those providing all primary care services to

rural communities (Medical, Dental, Behavioral Health, etc.).

- B. The Commission recommends that the Legislature fund potential new rural care delivery models and assist with a rural impact study to identify outcomes.

## **IX. Veterans Care**

The majority of soldiers returning from the wars come from our rural communities, which often lack the needed professional health care providers to assist them with the many injuries they may have received. Steps must be taken to make sure that these soldiers, who have served their country so well, are able to receive the care they need and deserve as close to their home as possible.

Presently 28 percent of all Veterans live in rural America and since 2006, the number of Veterans utilizing the Veteran's Administration (VA) Health Care system has increased by 15 percent. Twenty-six (26) percent of these patients are over the age of 75 years. This strain on the VA health care system will continue over the next few years and present challenges to access and increase the use of private emergency care systems.

According to the VA Office of Rural Health, the access to health care services is limited by the distance to care, limited transportation options, the lack of specialty care and rural providers, a poorer, sicker and older population, the lack of mental health providers, and lack of understanding by the veteran.

The VA Medical System has increased the utilization of rural providers and has started new rural clinics, but access still remains limited and the understanding of access avenues is still lagging behind other medical resources such as Medicare and Medicaid.

It is recommended that the Rural Health Advisory Commission work with the Department of Health and Human Services, the local rural health departments, interfaith ministries, and the VA Office of Rural Health to develop a comprehensive program to educate and enhance veterans' access to care in Nebraska, especially in the area of mental/behavioral health.

Issues to be included may be:

- A. A liaison between the Veterans Administration and rural health care services needs to be created to better serve all veterans and their families living in rural areas.
- B. VA contracts are difficult for primary care clinics, hospitals, and long-term care facilities to obtain causing veterans in rural areas to be moved away from their homes for long-term care. If veterans choose to stay in rural areas close to their home, they do not receive the benefits other veterans in more populated areas receive.

- C. The liaison created between the Veterans Administration and rural health care providers should work to outsource long-term/short-term in-house rehabilitation to centers in the veteran's respective communities. The outsourcing could also occur with mental health providers who could be educated through the Veteran's Administration outsourcing liaison concerning specific issues veterans may encounter (i.e., post-traumatic stress disorder).
- D. Veterans' health benefits need to be reviewed to determine how they may better be distributed in rural areas while using cost-saving measures. One way this could be accomplished would be adjust veterans' benefits to more closely mirror Medicare benefits while at the same time, making them more available to all veterans in all communities.

## **X. Elderly**

With the decline of services and population in the rural areas, the elderly population is facing an ever increasing-challenge in obtaining medical and home health care. Caseworkers are no longer individuals from the community the elderly can trust, relate to, and count on for answers. Many health issues require a specialist who may be over 50 miles away. Many small villages and communities do not have public transportation to assist the elderly in getting too much-needed appointments.

Issues to address include:

- A. The technological requirements from government entities to complete applications and request information online can be an impossible request for elderly citizens who do not have computers and do not have a caseworker in their community to visit or call for assistance. Agencies providing assistance to obtain health care to include Medicare and Medicaid need to make available liaisons between the elderly and the agencies to bridge the gap created by technology. Lack of these much-needed liaisons can be life threatening.
- B. A review through Pharmacy Board needs to be initiated to find a way to supply medications that are being destroyed that have orders and are clearly labeled to Medicaid recipients. It would also be beneficial to supply these unused medications to individuals who fall in the donut hole or do not have Part D coverage. The thousands of dollars of waste caused by this regulation could be used to better assist our elderly population.
- C. Look into creating a system where healthy Medicaid recipients assist elderly or disabled Medicaid recipients' needs in the rural areas such as transportation to doctor's appointments as a condition to receiving Medicaid assistance.
- D. An open dialogue needs to be created and sustained between the Medical Director's Association and the long-term care survey process in the State of Nebraska. The focus of survey must be to provide the best care possible for the elderly of Nebraska. The best

avenue to achieve this would be a collaborative process versus a punitive process. One example of this being; when nursing facility residents receive orders for multiple drug therapy from their physicians, nursing homes are being given deficiencies for an unnecessary drug therapy tag. Physicians should not be afraid to write the best therapies for their clients and facilities should not be put in the middle of the doctor/patient plan of care.

"Access to health care" is not a simple provider office, especially for the rural elderly. This "Access" includes:

- Recognition of need for prevention and treatment of medical care
- Transportation to and from a facility
- Appropriate type of provider and testing
- Sharing of information through IT to multiple providers
- Opportunity for appropriate treatment options and medications
- Monitoring of the treatment and or post hospitalization care
- Reimbursement for the providers and health care facility

Elderly patients tend to be sicker, less mobile, and have less available income. Providers now face less reimbursement for their care and many are restricting their practices to the total number of Medicare beneficiaries being treated on a daily basis. This triad of issues is restricting access to appropriate health care services.

The Nebraska Rural Health Advisory Commission recommends the following:

- A. Establishment of a "team approach" training program for present health care providers and provider facilities to train medical teams to provide and care for the at risk elderly population in Nebraska.
- B. Encourage local rural health departments to hire care coordinators to identify local patients and assist local providers about available resources such as internet access for health care programs and remote "virtual visits" by home health and providers.
- C. Allow and train primary care providers, dentists, mental health providers, pharmacists, paramedics, etc. to utilize telemedicine as a reimbursable medical care modality for all levels of care including emergent, nursing home, and personal residence visits.
- D. Develop training initiatives for providers specific for the elderly including such topics as nursing home medical treatment guidelines, pharmacy modifications for the elderly, treatment of the elderly trauma patient etc.

- E. Assist the workforce in the retention and the recruitment of health care providers for all aspects of care including dental, mental health, social services, transportation (EMS), etc.