Medical Care Advisory Committee
Meeting Minutes
Thursday, December 14, 2023

The Medical Care Advisory Committee (MCAC) met on Thursday, October 19, 2023, from 3 p.m. to 5 p.m. CST at the Bess Dodson Walt Branch Library in Lincoln, Nebraska. The meeting was held in person and virtually.

MCAC members in attendance: Karma Boll, Vietta Swalley, Shawn Shanahan, Frank Herzog, Dr. Jessica Meeske, Amy Nordness, Kelly Weiler, Staci Hubert.

DHHS employees in attendance: Matt Ahern, Jordan Himes, Joe Wright, Nikkola Bales, Nate Watson, Dr. Elsie Verbik, Meagan Horne,

Members of the public in attendance: Deb Esser, Cindy Kadavy, Jina Ragland, Dr. Julie Fedderson, Kelsey Arends, Sarah Sjolie, Jeff Stafford, Erica Anderson, Nancy Laughlin-Wagner, Paula Stapleton, Dr. Christopher Elliott, Mikayla Wicks, Leonor Fuhrer.

MCAC members not in attendance: Felicia Martin, Jason Gieschen, Jason Petik, Kenny McMorris, Melanie Davis, Michaela Call.

I. Openings and Introductions

The meeting was called to order by Karma at 3:03 p.m. CST.

- The Open Meetings Act was made available for attendees.

II. Review and Approval of October 19, 2023, Draft Minutes

Karma asks for a motion to approve the minutes. Frank requested a change to his statement regarding nursing homes, as the drafted statement was generic. This statement has been expanded to include other responsibilities that nurse aides undertake.

- Shawn moves to approve the minutes and Vietta seconds. The motion passes.

III. Medicaid and Long-Term Care (MLTC) Business Updates

Enrollment Updates:

Jordan: Due to a limitation in our system, we had to capture the enrollment numbers in a different way than usual. An email was sent to the executive board regarding this limitation.

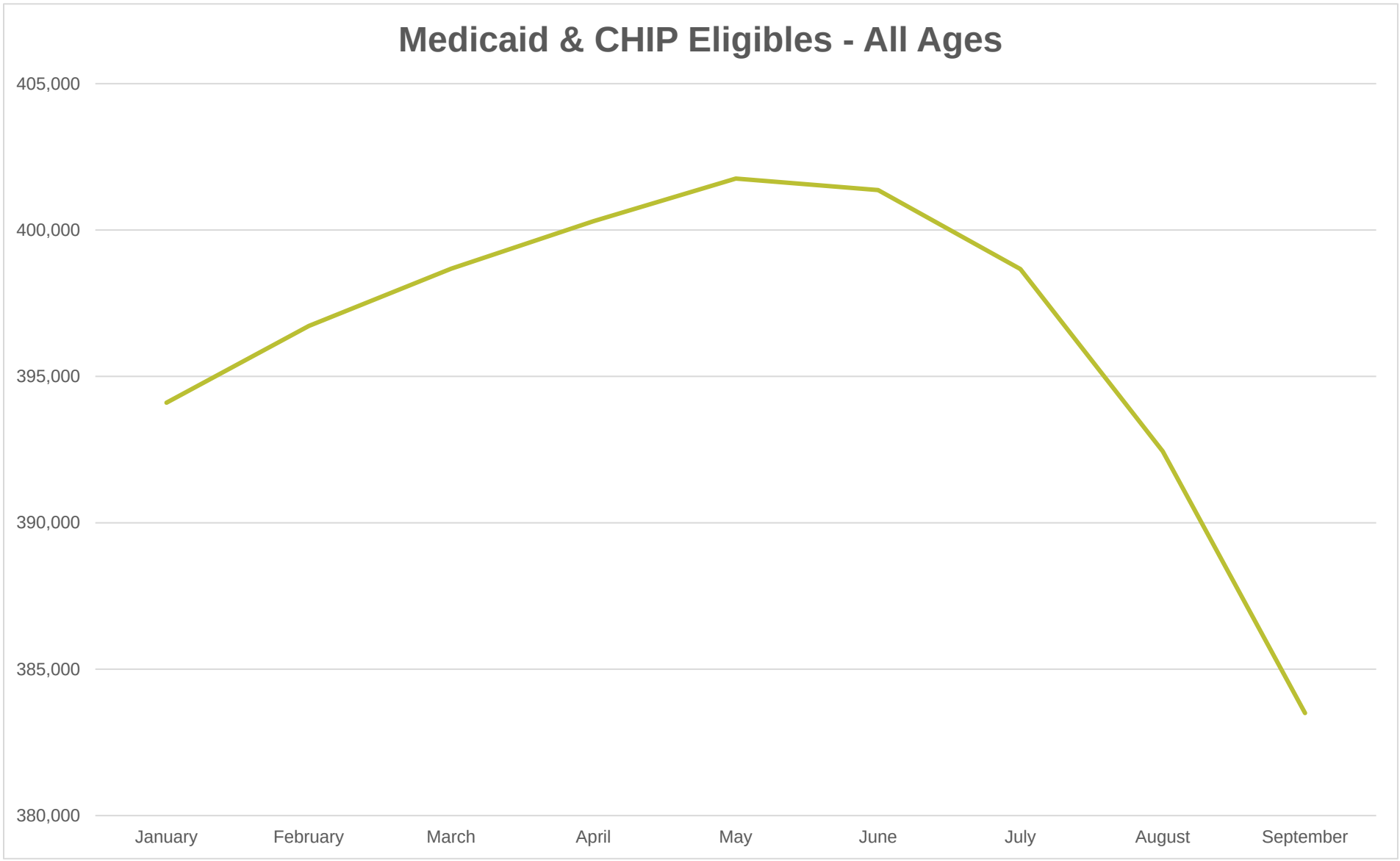
The data itself should remain relatively the same, you will just find a difference in the grouping of numbers. We presented you with the same type of data in the past. We are working with our data team to make sure that the data remains consistent going forward. Because of the inconsistencies from last month, we included the full year of data that we could pull in the handout today. This way, you can have a full view of the enrollment numbers. You will find that Medicaid enrollment by month remains relatively the same. It has declined very slightly. Additionally, Medicaid and CHIP eligibles are shown on the graph and their trajectory over the last year. As we anticipated, we are seeing a decline in membership due to the renewal process. We have not seen much out of the ordinary, though we will discuss this more as we move on. I apologize that we have had to pull the numbers in different ways. I hope this update provides clarification for everyone.

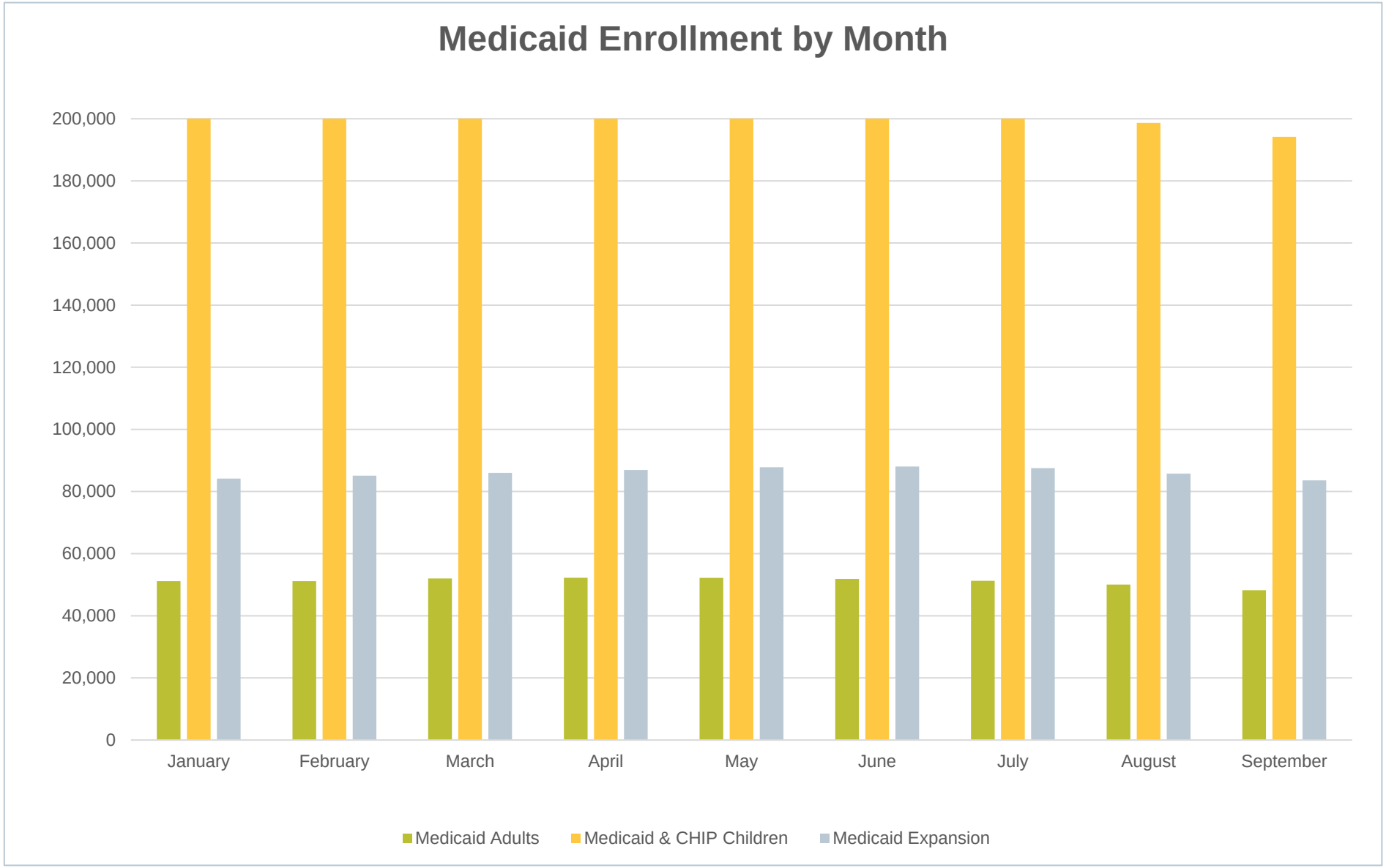
- Karma: Thank you, Jordan. We will have a brief executive committee after this meeting to address the data pull going forward.

MCAC Enrollment Update

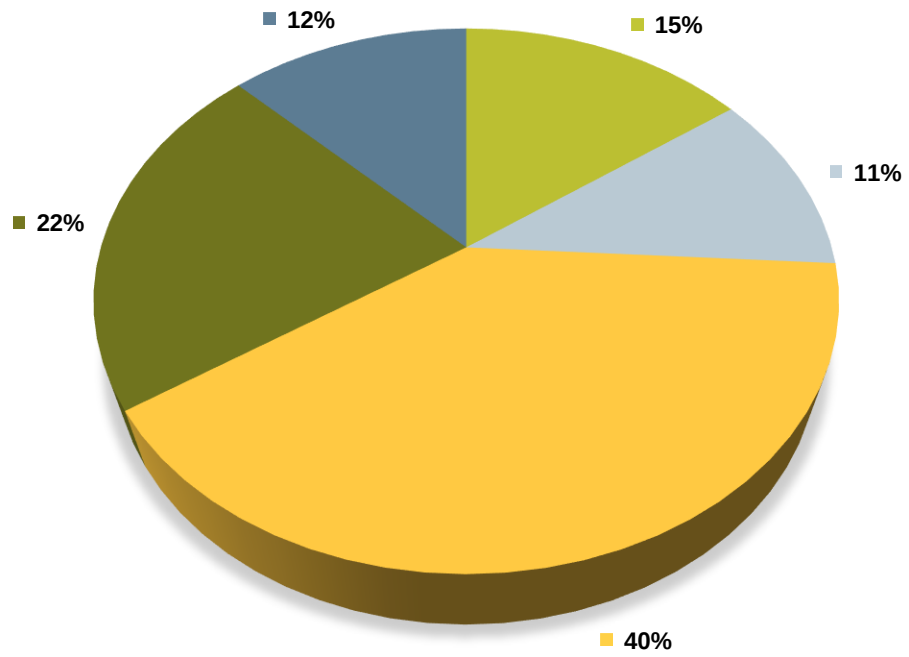
January 2023 – September 2023

Eligibility Group	January	February	March	April	May	June	July	August	September
Medicaid Eligibles - Aged/Blind/ Disabled	57,286	58,131	58,210	58,212	58,382	58,337	58,206	57,948	57,483
CHIP	43,779	43,951	43,669	43,572	43,605	43,665	43,299	42,744	42,037
Medicaid Children	157,712	157,964	158,789	159,342	159,741	159,464	158,402	155,954	152,143
Medicaid Expansion	84,166	85,088	86,005	86,954	87,819	88,035	87,520	85,763	83,597
Other Adult	51,159	51,592	52,007	52,220	52,211	51,866	51,240	50,031	48,242
Total Medicaid & CHIP Members	394,102	396,726	398,680	400,300	401,758	401,367	398,667	392,440	383,502


Medicaid & CHIP Eligibles - All Ages
405,000
400,000
395,000
390,000
385,000
380,000
January
February
March
April
May
June
July
August
September


Medicaid Enrollment by Month
200,000
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
January
February
March
April
May
June
July
August
September
Medicaid Adults
Medicaid & CHIP Children
Medicaid Expansion

Medicaid Enrollment - September 2023



COVID-19 Public Health Emergency (PHE):
Nate: We are over halfway through the unwind, which is the reintroduction of the regular Medicaid eligibility rules. If you are found non-eligible in your renewal month, then you will be disenrolled from your Medicaid coverage and be offered different options available to you. This could be through someone's employer as well as what may be available through the federal marketplace. There are often individuals who are just over the income limit. These individuals will often be eligible for a plan on the marketplace at little to no cost. Our goal throughout this is that individuals not covered through us, particularly children, are covered by someone else so they can continue to receive medical coverage. If you look at our total enrollment count, it continues to decline as, again, we expected. The last figures we released were just under 360,000 for current member enrollment.

Now, it is just over 354,000 after adding the new month of data. There are two pathways to viewing enrollment numbers. You can go by individual member numbers or by household numbers. Household can be a useful metric if you understand the one limitation of this data. Households can vary widely by members; we will use parents and minor children for this example. If at least one member of that household has been found ineligible for any reason, that household is marked as being disenrolled. It could be the case, for example, that a household of a mom and two children has the mom disenrolled, but the children are still enrolled in Medicaid. The household would still be marked disenrolled, as it is an "all-or-nothing" metric.

At the time of renewal, we currently are finding that 67% of members continue to be enrolled. This is fewer than what we originally estimated. Initially, we thought only 10-20% of individuals would be disenrolled. However, as we said at the time, this was our best, educated guess. This was informed by talking to our peers across the country in other Medicaid programs. The 1/3rd of individuals currently being disenrolled can be due to a variety of reasons. It continues to be the case that, about half the time, we did not have enough information. There are cases where we ask the family to provide additional information and we do not receive it. We continue our above-and-beyond-normal outreach to address this.

The other thing I will say as we continue to ask for your help through the unwind is that we have a lot of people who don't get back to us for instances we completely understand. Take, for example, an adult of working age who is not disabled. They know that their life circumstances have changed, whether it be getting a new job, getting a raise, or more. They may be sure that they are no longer eligible, so why would they go through the trouble of filling out paperwork when they already know the answer? These individuals have the choice to not fill out our paperwork. However, there are instances where people think they are no longer eligible, but they might be. If you have minor children in your house, people may not know that their children can be found eligible even if the parents are found ineligible. The income limit for children to get Medicaid is much higher than their parents. Again, even if their parents are no longer eligible,

their children may very well be eligible. We are trying to get the message out regarding this messaging.

- Vietta: I see a lot of this messaging coming through. At the Santee Health Center, it helps us know what we need to pay for so we can use our PRC dollars to pay for Medicaid services. We are trying to stay on top of this and are working hard with the families.
    - Nate: Thank you for doing this, Vietta. Additionally, if you look at the total number of individuals who have been disenrolled as part of the unwind, it is around 70,000. If you see our total enrollment, it has not fallen by 70,000. You will notice it has fallen by roughly half that amount. There have been 70,000 members who have been disenrolled, but a net loss of around 36,000. This tells us a couple of things. First, we know that we have new people enrolling who were not on Medicaid. Next, we have people re-enrolling. Unlike insurance, Medicaid is always open. Under Medicaid, you can apply any day of the week. There is no harm in applying. The greatest harm is not applying. When we see people apply, it can sometimes be because they didn't get information in by their initial renewal date. We understand people's lives are busy, and getting paperwork to the government is probably not their top priority. Later, something will come up for these individuals, like going to the pharmacy and attempting to get the medication they need. Or, unfortunately, they will show up to the emergency room and not have coverage. We just want people to know this, and if you continue to help us get the word out that Medicaid is always open, it will be of great help. Even if we can't avoid a gap in coverage for some individuals, we can at least get people back on Medicaid. We do everything we can to get people as much coverage as they are entitled to so they can get the care they need and not be stuck with a giant bill they cannot pay.
- Jordan: For those who work with members, we have resources to share, specifically with child eligibility and reminding parents to update their information. We have a new one-pager in English and in Spanish on our Preparing to Renew Medicaid website, we have a social media campaign coming soon that you are welcome to post to your social media. Concerning the Unwind, MLTC conducted our first paid social media campaign and found a considerable amount of success on Facebook and Instagram. We're currently exploring extending these advertisements through the end of the unwind to reach these members. If you'd like any of these resources, please reach out to me or anyone else on the team and we will be happy to send these materials over to you.
- Karma: Nebraska took the path of following its normal cadence in the unwind. Would you mind explaining this with the unwind?
    - Nate: Yes. Normally, Medicaid members get their eligibility reviewed annually. This was the case from the mid-1960s to 2019. These reviews have restarted this year. The review depends on your renewal month. It's like updating the plates you get on your vehicle, as Medicaid typically conducts the annual

renewal in the same month as the initial approval. We decided to go with our normal cadence when conducting reviews. On March 1, we started reviewing the renewal months of April and May. This means March will be the last month of the Unwind review process. Some states were allowed a lot of flexibility from the federal perspective. We thought it would make a lot more sense to not disrupt people's lives by mixing up renewal dates. In keeping the normal cadence, we need to think about our staff. In future years, if we suddenly jumble renewal reviews up, it will mess the process up forever. There are some natural bubbles, meaning months with more people. Bubbles we have noticed are in August, September, and October. If you remember, we started adult expansion on October 1, 2020. Given this start date, the initial months saw many individuals sign up for adult expansion. These months tend to have around 40,000 members each being reviewed. The months coming up have 18,000 to 22,000 people being reviewed. We are a bit behind due to these bubbles and staffing challenges. Our current staff is doing a great job getting through the renewals. Another reason why we are behind is because we doubled the amount of time members had to respond to us. We want to avoid instances of people getting kicked off Medicaid due to not having enough time to respond. The federal time limit for renewal response is 15 days. We have given members 30 days to respond. Again, we would much rather give people the time they need to send in their paperwork. Consequently, when you double the amount of time to respond, you receive more cases. We are proud of allowing more time for members to respond. We put the members first because it's so much better for them to avoid pointless fear, angst, legal processes, and more. It's also better for us and keeps our priorities in the right place. We do fully anticipate being able to get through this bubble and the next couple of months since these months are slower in terms of the number of new cases up for review. Some states prioritize cases differently, but we decided that the right way to treat our members and our staff is to operate under the normal cadence.

- Vietta: CMS sent a notice out to states saying that some were reporting a large number of ineligibles. I didn't see Nebraska affected by this.
    - Nate: Correct, we didn't receive one of those letters from CMS.
- Vietta: We are also a small enough state to monitor everything. I'd say our numbers are very low in terms of losing coverage.
    - Nate: I appreciate you calling this out. Yes, we've had a 1/3rd of people disenrolled, and half of those disenrolled are due to procedural determination, but some states have as many as 96% of procedural determinations. We're on the good side of the middle in terms of procedural determinations. We feel good about where we're at since we do everything we can to get a hold of people. We're trying very hard to get the message out and let people know their options if they miss their 30-day period. Our goal is to help the people we serve and give

them one less thing to worry about.

- Vietta: I have a very good state contact person in Hastings in case we ever have issues with Medicaid applications. If we ever have issues with recertification, they help us with the issue. We want to say thank you for giving us support.
    - Nate: Thank you. We often don't hear the good, so thank you again.
- Karma: It looks like 1/3rd of members are being disenrolled. About half of them didn't provide enough information. There's also still the appeal process available to them. Are there many appeals now?
    - Nate: Good question. I don't have the precise number in front of me, but the trend I've seen is that the number of appeals is below average. You do need to discount the three years that no one lost coverage, years where we barely saw any appeals. But, if you look at a comparable period from 2016-2019, we are still below the historical trends. We are just not seeing a lot of appeals. We do see some people reach out and are seeing the occasional mistake. We are human and acknowledge our errors. Our error rate is remarkably low compared to other states. The last figure I saw was that our error rate is four times lower than average. We prioritize this, especially at the front line. I can't say enough about our excellent field staff. Our social service workers, those in our call centers, and others have the toughest jobs. I mean it when I say I don't know how they're able to keep up the great work with the volume we are seeing. They are fantastic.
        - Matt: I will also add that we do a lot to partner with managed care organizations to engage them and have them reach out to their members. They ensure that their members get their contact information in and educate them about the unwind. This process has been a group effort and is a unique permission through the unwind process that we've been able to take advantage of. They are a great partner. Other community partners are also helpful.
        - Jeff: To throw in an example of this, the state was great to work with in terms of helping us create guidelines. Between Nebraska Total Care and UnitedHealthcare, we put around a million dollars into these informative campaigns.

MCO Contract Update:

Matt: The managed care organization contracts are full steam ahead through the January 1 start. One of the broader changes that we've discussed is integrating dental into the managed care organizations rather than their being an entirely separate dental benefit manager. One of the big indicators we've been ramping up is building the dental network for each MCO and getting the critical providers in and under contract. This ensures access to our members and has been a huge focus. The MCOs have been quite collaborative in terms of streamlining the credentialing process for dental providers, having them get on the same page in terms of prior authorizations and expectations, which is unique. This process has gone very well. We've been

going through the readiness review as well. There was a large inflow of documents as well as back-and-forth conversations about every policy and contract requirement we've been reviewing and approving. This has been a large undertaking and has been moving along well. Everything is on track, and I think we are doing well. We have been working on data sharing from the dental benefits manager to make sure everyone is ready to go with care and case management operations on day one to ensure a smooth transition. Everything is going very well. I am happy to answer any questions people may have.

IV. Project Discussion

Karma: As we usually discuss, we want to see if we can move these projects forward to make a difference for Nebraskans on Medicaid.

Dental Student Reimbursement:

Dr. Meeske: Both Creighton and UNMC College of Dentistry are credentialed with all three MCO plans, I believe. This was a big goal since the last time we met. I want to thank the MCOs for reaching out to the dental schools and getting this over the finish line. I also want to mention that, to my understanding, I learned this week that Central Community College, which houses one of our dental hygiene programs in the state, is not currently signed up with any plan. We must get the hygiene schools on board. Not only are they a safety net provider for the state in terms of seeing patients, doing cleanings, preventative care sealants, and more, but if you're not able to teach a dental hygiene student how to work with patients on Medicaid and how to navigate the processes and the system, we will not be able to graduate future hygienists into the Nebraska workforce that know how to work with Medicaid members. I know that Nebraska Total Care has a plan to reach out to the director of Central Community College, but I'm looking at other ways to harp on the importance of our efforts. The main concern the director of Central Community College is having is the hurdles in place for dental credentialing.

Another aspect I want to address is that the Nebraska Dental Association (NDA), in collaboration with the MCOs, had a big dental Medicaid update session. It took place around December 10. We had a great turnout. We had 185 people who either attended in person or virtually. We had the MCOs speak, talk about what was coming, and address their credentialing process. We invited all the stakeholders to this session. We also had a lot of public health workers in the room. It was a great way to address the dental community to what some of the changes are and encourage them to participate. The Thursday before this meeting, the ADA and the NDA did a dental boot camp at each of our dental schools with third- and fourth-year dental students. We had a great turnout for this event. My staff and another Medicaid-providing dentist from Colorado engaged with dental students on the importance of taking care of Medicaid patients when they get out of school.

The last two things I want to let you all know is LB358, which is the bill for the 25% fee increase for dental providers, is out of committee. NDA is strategizing how to get this bill on the floor for debate so we can see it over the finish line. The final item I will announce is that we will sponsor a bill for dental loan repayment. I floated this idea to the NDA legislative council. They said that this is something we need to do this year, so we had a lobbyist write a bill. We now have a draft, and that bill will be introduced in the first weeks of the legislative session. Once we have a bill

number, I will update the group with it. We need a loan repayment for dentists that isn't based on geography, but instead is based on how much Medicaid you see. The parameters of this are not set, but the idea is out there, and it has a physical note. We have moved this forward since the committee got started.

- Karma: Congratulations, you've gotten great traction on this. This is a great update, thank you.
    - Dr. Meeske: We're getting the bill introduced, which is step one. It may take a couple of years to get it through. You all might be hearing from me because, as we formulate a strategy on LB358 if we can get a priority bill sponsor, we may ask advocates for a better dental Medicaid program to help us make phone calls or send emails to senators. I have a list of those who have advocated in the past when we had the legislative hearing. If this is something you are willing to do, I would love for you to reach out to me by email.
- Jordan: I am reading a question from Deb. She asked if there would be more discussion on the dental codes that have been proposed.
    - Matt: I believe that this hearing is scheduled. We want all the feedback we can get through the public hearing process. We will be looking forward to feedback there.

Nursing Home Staffing:

Frank: Since our last meeting, the 60-day response period for the CMS proposed nursing home staffing rule ended on November 6th. I have a question about this. When we talked about this a couple of months ago, DHHS hadn't responded but they were thinking about it. Is there any update on this and did you submit a response?

- Matt: We did not.
    - Frank: Have you received any other insight into the responses so far from the Feds?
        - Matt: I haven't seen anything come back from the Feds. What was anticipated is that after the feedback was received, we might anticipate receiving something back within a year. But I'm not sure, and there's no set timetable.
- Frank: Thank you, Matt. One of the other questions I have for you is about when we discussed the transparency of ownership and final approval. This period started, I believe, in February or March. The final rule was announced in November. My question is if this is a typical period of implementation between the end of the response period to the final rule. Is this something for the staffing that we will need to wait a year to hear about?
    - Matt: It's likely to be over a year, especially since it's a significant and impactful proposed change.
- Frank: Meanwhile, here in Nebraska, I feel we have a severe shortage of nursing staff.
    - Matt: The reality is that it is harder to hire on all fronts. Staffing is a concern on every front. We want to make sure we have enough people to care for those in nursing homes and be able to hire enough to support the nursing homes. I know we feel constricted on all fronts.

- Frank: The last time we spoke, we discussed the differences between rural and urban areas. While there is a clear difference between rural and urban areas and the need for nurse aides versus the need for nurses, to be able to satisfy the needs of the nurses in the rural areas it is particularly difficult since there aren't many around there. However, I think nurse aides could assist with this shortage. They can be trained in a couple of months. The position may be more attainable than getting an overall increase in nurses. Courses can be offered in high school, junior college, and more to help those in rural areas become nursing aides. I think anything we do to encourage this can go a long way.
    - Karma: From my experience in a rural community, they were having a problem getting nurse aides. I became a certified instructor so I could do training for CNAs and long-term care facilities. What you suggest could be a solution.
        - Frank: What is the requirement for hours needed to train a CNA?
            - Karma: Personally, I put in a couple of weeks' worth of training into a class, full-time. It depends on the level of nurse aides. This can open a career pathway for many in rural areas.
        - Frank: I agree. For example, it opens the door for farm families looking for extra income.
            - Karma: Yes, I see a lot of creative work schedules to cover the needs of facilities that hire clinical staff. Long-term care facilities will need to do the same.
        - Frank: I see that Cindy sent a message saying that 76 hours is the amount of time needed to train a nurse aide. Thank you.

Maternal and Newborn Health:
Karma: The team that I'm working with on this project met on November 30. Shawn, Staci, Amy, and Dr. Esser joined our work group given her long-standing interest in maternal and newborn health. One of the topics we discussed today was the speaker we will introduce later. I am happy to see the MCOs present to listen to this presentation on collaboration. Some of the other things we talked about in terms of objectives are leveraging aid from around the community, like initiatives. Quite a few of us attended the Maternal Health Symposium in September. There was a lot of good information there. It shows we need to work together. MCOs are talking about aligning and potentially building CP II codes to get early identification for pregnancy. We need to know this vital information in the first trimester. To do that, we need to find people and get them enrolled earlier in Medicaid. Once we get them enrolled, there's a wealth of support and resources for those individuals.

One of the other items we discussed is the unbundling of OB services. With bundled OB, you do not get the first lab draw. We need to capture this earlier, and overall unbundling may be helpful. Dr. Verbik and I have worked together in the past on this. We know Missouri did this and have made great headway after unbundling OB. There are some initiatives underway on the ONAF form which is the state form that has been present for years. Trying to simplify this to some extent and adopt it across all three MCOs so the doctors only have one form to deal with is important. We have a meeting with the Nebraska Hospital Association to see if there are some ways, they can help us

with early identification. They aren't so sure that in the hospital setting it will be the quickest way to pick up on someone being pregnant. But there was some good dialogue that came from that call. NHA said there may be some ways they can assist, like substance abuse disorder since it also affects pregnant women. We also discussed the MCOs and the value-added benefits. Leveraging this as incentives and doctors sharing it when people come to the office helps get people engaged and enrolled. Amy provided us with an excellent article on providers being frustrated with trying to find good, accessible data on pregnancy and outcomes.

- Amy: I think we need some clarity on where we need to go to find information. Are we looking at the right things, is there a separate distinction between research and data? It seems that if there is a research question, it's a process that takes a lot longer. Maybe there needs to be data available.
    - Karma: Yes, the provider community is looking where things are most available. March of Dimes has decent data, but the research may be lacking. The provider community is looking to see if they can make this research more available.

Other Potential Projects:

Karma: I want to offer this time to see if there is anything you all have thought of that you believe would make a worthwhile project. Does anyone have any suggestions for educational topics? If you do, share them with me or Jordan. Seeing no other suggestions at this time, we will proceed with the guest speakers.

V. Educational Discussion: Maternal Health – Nebraska Children and Families

Shawn: I am grateful to be here in person. I also want to thank the MCOs for joining us today. I serve on this committee, and I am also an executive director of development in community health. My interest in Medicaid, as well as maternal health, comes from my adoption of two state-ward children who were on Medicaid during their tenure. When I joined this group and this committee came up, it was of personal passion since I spent 25 years as a state child welfare director with Heartland Family Service. I found myself unemployed when the reform fell through. Then, I became the executive director of United Way for ten years. My background has allowed us to do some innovation and new ideas with the personal passion of creating change for many higher levels of care for children and families, as well as figuring out how to partner with our community. When I joined this committee, the group said, "Could you come and speak about the initiatives you started in Fremont?" I invited my dear friends from the Nebraska Child and Families Foundation to join us today.

In Fremont, we had a community health assessment and found some alarming statistics for Dodge County. In response, we put together a community collaborative that's funded by the Nebraska Children and Families Foundation, some local funds, and some local philanthropy funds. Each of our community partners also identified what they could do to be part of the solution. We started simply and asked how we could help families outside the walls of a hospital. It all started with community collaboration, collecting local data, and statistics, identifying gaps, and more.

It took around two years to develop a great network of relationships and partnerships to where we had trust and could start to move the needle. We have an OB/GYN nurse that we've placed in our OB/GYN clinic. She works part-time in the birthing unit and part-time in the OB/GYN clinic. We

also use foundation funds to pay for her position. Our community benefit report shows this as an investment in the community. Our nurse and our social worker complete the assessments. We connect the mom and the family to community resources that we have through the coalition. Then, we can provide car seats, baby items, pack-n-plays, and more. This is all from the funding. We fund the positions and then the coalition funds the business partners and nonprofit partners. We can connect moms with resources for housing and basic needs.

At the time of birth, we have in-home services with Nebraska Methodist Health System in Fremont. We also launched a pilot project knowing Medicaid provides three visits for in-home services. We wanted to provide more than that and include a social worker during the visit. We do this with funding from the hospital foundation, allowing us to go into the homes for up to 90 days as needed. In-home, we use the Humpty Dumpty assessment and chart through the EMR. The pilot for the in-home has been ongoing since 2021, officially launching in 2023. We met with the moms and families in the hospital before they were discharged so we could give them a meal option. The moms we serve are identified as “at risk.” We use the assessments that Nebraska Children and Family Services put in place like prior CPS involvement, substance abuse, depression, homelessness, and more.

In 2023, we served 16 at-risk families with an average of four visits. We only had one out of the 16 that turned into a CPS case. We also had no injuries to the children, and they all had proper sleeping arrangements. This great work is happening in Fremont as well as across the state in different ways and collaborative efforts. We have brought our friends to tell you about other initiatives. I will now turn it over to Leonor and Mikayla.

- Leonor: Thank you for having us today. I work for the Nebraska Children and Families Association as an Assistant Vice President of Community Response. In my past life, I was a community collaborative coordinator in Norfolk. This is where I met Shawn. Speaking to our prior conversation, I was also a CNA as a college student, thinking I would be a nurse at the time, and used to work in a nursing home.
- Mikaela: I am an Associate Vice President of Medical Pathways at Nebraska Children and Families Association. In the last ten years, I worked at DHHS in child welfare as a case worker.
- Leonor: We are looking to reduce entry into the child welfare system through community collaboration, bringing together partners and lived experiences to shape what we can provide with support to the community. The community knows best what they can provide for a family to keep them from having to enter child protective services and more. The biggest aspect is in the integration of services and support. How do communities come together to share information? How can services maximize their capacity, their funds, and more? Bringing together partners to talk about what we can do best together for those in our community is vital.

  We do have a long-term vision for this project. It has been more than 15 years in the making. We hope to identify and support solutions to reduce barriers to community-based prevention efforts. We look to raise awareness of what is working and what is not to promote a community-based model around prevention. We know that Nebraska is taking the lead and successful prevention efforts work. Nebraska is a highlight across the nation. We aim to bring together local, state, and national partners to develop a new strategy

around prevention. We also work to make sure communities in Nebraska have support and opportunities. To do this, we have a process of collective impact, bringing people together to collaborate, like learning how to maximize support and services. We are putting together a community response system with central navigation, and a central access point that can connect people to further support and resources. We utilize evidence-based practices that we can rely on. The outcomes are increasing protective factors, looking at family well-being, stability, and what opportunities they have after receiving services and support. Across Nebraska, we have several community collaboratives that serve as hubs. Some areas are uncovered, but the approach is meant to be "no wrong door." Whatever area a family or person gravitates to will be met with the resources and support they need. For example, my area in Norfolk isn't exactly covered, but naturally rural areas and young people will gravitate to where they feel most comfortable and have connections to support, whether it be informal or formal. When they come to these communities, they can receive services. It will follow them home; they don't have to come to the hub to receive the services and support.

- Mikaela: I want to add that in one of our offices, we have a markerboard filled with the state of Nebraska's resources and location. The map is filling every day and it's unbelievable the number of hubs we have compared to seven years ago.
- Leonor: There is a lot of infrastructure that goes into these community collaboratives. This includes steering teams that are made up of different multisector and lived experience partners. There are also work groups that tackle different initiatives. There's so much that goes beyond the landscape of the tangible connections you can make. The communities have developed a great infrastructure. We have an initiative called the Connected Youth Initiative, which is a statewide system change network to improve outcomes for unconnected youth and young adults in Nebraska.
- Shawn: I asked Leonor to discuss this since I know we have members from across the state who serve on this committee. I want them to know that there may be a collaboration within their area, and they should reach out to them so we can continue to gather preventative work and prenatal care across the state.
- Leonor: No wrong door access is possible due to multisector partnerships. This means private and public partners as well as those with lived experiences. We have schools represented, health, law enforcement, DHHS, social workers, behavioral health, dentists, and more that sit across the table with one another and help each other. The most important piece is hearing the family and youth voice which helps shape the prevention system. We also have many referral sources. If you do go to a clinic and find out that your child is underweight and you have access to acquiring food, the family should automatically be referred to by the clinic or provider to central navigation. There are many ways to help. Sometimes the central navigator is housed within the hospital, other times they are referred to. The point is that there are so many different access points for families, so the services provided are maximized. With access points, families can be referred to more services. We also have coaching to root on the families, walk with the families to appointments, and more. There are also assessments. As Shawn mentioned, it can help paint a bigger picture. If anything, I want you to remember the numbers 402-227-5842 and 308-280-8383. This is how families can be connected to any statewide support or central navigation. If any families text HELP to both numbers, they will get connected to a central navigator closest to them. Regarding our impact numbers, you can see that 6,000 children were serviced

through central navigation. We do have some communities that are new and gathering their data on how to track cases, so this number may be even higher. Local prevention strategies also help impact. Our annual report is being compiled as we speak.

- Karma: You say multiple initiatives are happening across the state. Do you capitalize on that knowledge and initiatives that they may have that could be plugged and played in other places across Nebraska?
  - Leonor: Absolutely. Not only are there local networks, but there are also statewide networks. We do this in various ways. We do in-person training with central navigation coordinators, local leaders, and more for a multiple-day brainstorming and solutions session. We also have a monthly convening call. It invites anybody from across the state who provides services and support. We are also inviting those with lived experiences. We also have interpretation during those calls since they have grown so much. We also have a narrow-scoped call with coordinators. There are various ways we stay connected and informed
- Jeff: Have you worked with any of the MCOs? Have you partnered with any of the safety net hospitals? What opportunities do you see coming down the road with using community health workers? How can Nebraska Medicaid help support? And how can we jump-start this in January? You can answer these at the end.
  - Shawn: I will help address these questions at the end of the speech. Fremont has a pilot launching in January.
  - Karma: Additionally, if there is a Medicaid member, there are value-added benefits that can be supported through the MCOs.
  - Leonor: The MCOs have been a huge partner, especially on the local level, for the collaboratives. There have been baby showers, diaper drives, and more. It's been a fantastic partnership.

- Mikaela: I primarily have a responsibility with prenatal plans of safe care. As a brief background, the Comprehensive Addiction and Recovery Act (CARA), was updated in 2016. A lot of the weight of this act goes on child welfare's shoulders. One of the biggest changes instituted in the 2016 update was the removal of the word "illegal" in front of substance abuse due to the opioid epidemic. What was required at that time was for a plan of safe care to be developed for the infant, mother, and any additional family in the home to address their needs. There's also a monitoring system reporting back on how many infants are affected by substance use, how many have plans of safe care, and how many have referrals to appropriate sources and resources in their community. There's also a requirement that healthcare providers notify the child welfare system in the state of those infants being born. As this was developing, I was with the department.

  Now, there are new notification pathways. It allows for the hospital or medical provider to notify without any personally identifiable information that an infant was born, the specific substance used, and if the mom was in treatment or prescribed an opioid during pregnancy. The plans for safe care are also used to address the household. We do ask that hospitals make a plan of safe care for families affected by substance abuse and have it forwarded to the child's pediatrician to follow up on concerns. There is a template on the department website for the plan of safe care, but it doesn't always need to be utilized. When I worked on this project, I got stuck on the fact that we were not helping prenatally. It

didn’t sit right with me.

Therefore, we started looking into ways to find women struggling with substances during their pregnancy. Through some technical assistance with the National Center on Substance Abuse and Child Welfare (SAMHSA), we created prenatal plans of safe care. With child welfare, you need to wait until a baby is born to intervene. Now, we are moving upstream with prevention. What prenatal plans of safe care do is allow families to have a network built up before the birth event. Partnerships across providers increase the empowerment of the woman and the family, knowing they have the support of the community so they can make decisions for themselves and their children. This is not something that is required federally. It may eventually be added, but we felt strongly that we needed to take this step for Nebraska and the families that we serve. What we did was develop a binder that these women get with different tabs. It has a plan of safe care, allowing the woman to develop the plan prenatally. It asks various questions like those related to breastfeeding, who watches the baby in outpatient treatment, mental health questions, and more. Within this binder is also contact information for moms to list everyone they are in contact with. Next, there are consent and release of information forms. Families need to know what they consent and release to. Child resources are also included. There are resources prenatally and post-partum. There’s also a section for appointments and after-visit summaries. We think it’s very important to put certificates and accomplishments in there. We want to focus on the positives for the moms going on this journey. We also have a section for notes and additional information.

Hastings and North Platte have launched their prenatal plan of safe care binder. We had a re-launch in the Spring who came to an event and showed she was using the binder. I also want to talk about our local-level structures. Hastings and North Platte were identified by the number of children aged 0-5 who were removed due to parental substance abuse. We know that Lincoln and Omaha have a multitude of resources, so we wanted to pilot these in places that didn’t have resources as readily available. The binders show what is specifically available in their community. It shows what is available with a quick drive or phone call. We worked with the community coordinator and the collaborations that Leonor talked about. We brought community members together who we thought would be interested in this project and identified gaps and barriers.

Through this process, we discovered that many professionals weren’t talking to each other about the services available. These relationships have been built and allow for better resource sharing. I do want to say each group went through these binders and we changed the language to make it appropriate for each community. These binders can also be handed out to the father. Anyone taking care of the infant can have a binder of their own. The binder system is a creator-interaction-awareness system. The creators are those who have the binder and can help identify women and families struggling with substance abuse. The interaction piece comes from those who don’t have binders to hand out, but they can help fill out and update information. We want them to be aware that the binder is in the community. Awareness is for those who refer families to creators who hand out binders.

Law enforcement participation, especially in Hastings, has been a big help in the awareness field. They can help us identify when someone is using substances, is pregnant, and can do a warm handoff to a central navigator or a women’s resource center. We have also connected with school districts, homeless shelters, and more. Dr. Verbik helped us engage with all three of the MCOs to be part of our group. We have a core group

that discusses implementation, and we also have an MCO partner who works in the area and attends our local meetings.

In January 2024, we will start collaborating with our partners in Dakota County and working on implementation. We want it to be a word-of-mouth kind of system. For example, Hastings has had conversations with their colleagues in Grand Island. We want to be very intentional with the fact that these binders are tailored to the locations of the recipients. This is why it's been so important to work with the collaborators.

- Member of the public (did not self-identify): You're talking about primary care providers and MCOs exchanging information. Does HIPAA provide any obstacles that prevent the identification of these people?
    - Mikayla: The communities that develop their own MOUs that the organizations who partner with us are willing to sign. It goes through their legal departments. Sometimes it is a warm handoff to inform people of resources. It is voluntary on the patient's part. Physicians have brought this up as well as community resource partners. We're looking at different ways to go about that. With Hastings and North Platte specifically, the MOU they have has worked thus far.
- Member of the public (did not self-identify): What does MOU stand for?
    - Matt: Memorandum of understanding. It's like a contract or agreement.
- Member of the public (did not self-identify): Are you saying it's impossible for a hospital to sign an agreement with a medical provider that allows them to exchange information without the consent of individual patients?
    - Shawn: No.
    - Jeff: When you have the patient at the center, you aren't going around them, you're going straight through them the way it is intended. The member is at the center.
    - Mikayla: The pregnant individual has the power to inform whoever they want that they have this binder and what that means to them. We give talking points in the binder for them to explain to their OB/GYN why they have the binder. Another aspect of this is pediatrician interviews. When a mom is going in to find a pediatrician for their new baby, make sure the pediatrician is willing to work with you as their parent knowing that you have a history or are currently struggling with substance abuse. There is a section of consent and releases that we give the parents copies of so they know who can talk to whom.
- Jeff: What can we do to support you starting in January?
    - Leonor: With the MCOs, there are definite partnerships on a local level. We invite MCOs on our calls to come and present to our central navigators.
        - Jeff: One of the things that I am most proud of is that we had a common external problem with COVID-19. It taught us to collaborate.
            - Leonor: I can speak for my experience at a local level. During the Public Health Emergency, we partnered with our health department and our MCOs on a forum of information regarding

the vaccine to help people make an informed decision. We also partnered with interpretation and an opportunity to ask questions with the experts.

- Jeff: It's fantastic knowing we have monthly calls and collaboration.
    - Mikayla: We do have members from the Department of Public Health and Medicaid and Long-Term Care in our meetings as well. I've been asking who I need to meet with to make sure people are supported. Having a local connection to the meetings is equally important.

- Karma: When I was talking about the maternal health and child initiative that we're working on, identifying the mothers early, especially during the first trimester, is so important. Getting them enrolled in Medicaid early and informing them of resources will help tremendously.
    - Jeff: There have been conversations amongst the MCOs to find out ways we can help before we even know which MCO a pregnant mother ends up with. We know they will end up with one of the three, so why not find a way to collaborate to aid them?
- Shawn: Some great things are coming out of the coalitions, including federal funders. I think we are onto something with community collaboratives and central navigators. It's part of the movement with community health workers. You need to have central navigation that can pull together all the right partners. You also need expertise in each sector to drive and create change. The community health worker is a key piece in changing our health outcomes across the state. I've been very transparent about the challenges of community health workers. I keep challenging our amazing partners and wanting the MCOs to keep sticking around with our coalitions. Join every community coalition going on so we can figure out how to make social change. We need education, awareness, and opportunities for community health workers to learn the system.

  Six months in, we have served 159, and all of them had two or more Z codes. The primary Z codes are housing, medical supplies, pharmaceutical needs, and access to insurance and Medicaid providers. Again, we are very fortunate. We were one of the partners with NHA, a funded position through UHC that we will pilot in January. We will have a full-time person in our ED who will be an actual hospital employee to get rid of the barriers and releases. We are super excited. I can't say enough great things about community collaboratives. To have change, you need to figure out how to do it collectively.
    - Karma: In Nebraska, we come together. I'm not surprised that we may be leading the nation on this initiative. The fact that we are pioneering this concept is fantastic. In Nebraska, we are pioneers. Other states could learn from this.
        - Jeff: There is no reason why Nebraska could not be the first in the country on this kind of initiative.
            - Shawn: MCOs, keep funding and work with your local hospitals and community health workers.
- Dr. Elliott: Dr. Verbik has gotten us into meetings with NHA. This morning, we heard

about your program. It's amazing. Do you have a lot of stats regarding the Z code claims?

- Shawn: What we have figured out is that we can note what the Z code is. We work with the nurses and physicians who enter the Z codes. What we're missing is closing the loop of the outcome.
  - Leonor: We are working on this as well. How can we ensure what we do is followed up on? We are prioritizing this as we speak. We want this to be client-facing.
  - Mikayla: In Douglas County, they are working on the implementation of Healthy Grow through the United Way. Specifically, it's for medical providers. The family is then linked to resources and support then the loop is closed. When they go back to the provider, the provider can ensure they are connected to the resource.

- Karma: To the extent of MCOs, they often have a piece we can't our hands on, which is Clinical Outcome Data.
  - Dr. Elliott: I'm so glad you have the information with the MCOs. Don't hesitate to reach out.
    - Mikayla: Absolutely. We take every opportunity we can for the MCOs to explain what they do best. I do welcome the MCOs to come to our statewide calls. If you can encourage local partners to come, it will be well received.
- Jeff: Thank you for this presentation. It's a mixed feeling. How have I not been dosed with this information? But I'm also optimistic. I know we can do this. We can give MLTC a model that complies with the federal guidelines. How can we pick out the pieces that will be sustainable? Can we go to our friends in the foundation and our funders?
  - Shawn: I agree on funding.
- Sarah: I have the honor of partnering with Mikayla on the Health Grow project she was discussing. I would love to see the advocates in the room team up and work on having kids screened for social needs. On January 1, the joint commission is requiring all hospitals to screen for social needs. Now that it is a required standard of care, how do we lift it in the next season of the legislature? How can we get it on the radar? If there is a work group that pops up concerning an integrated approach to SDoH screening and connection to resources, I'm happy to volunteer.
  - Karma: Thank you, and I will hold you to this.
- Matt: Dr. Meeske did have to leave, but she asked me to convey her appreciation and thoughtfulness of these efforts.
  - Shawn: If anyone wants to form a committee, I will take it on.
    - Nate: You do have the ability to make a subcommittee. We can help with the administrative support.

VI. Discussion of New Members and Vacant Positions

Karma: The executive committee will meet before the January MCAC meeting. There are terms on the committee to look over. We will be prepared to discuss the change in leadership. Dr.

Nordness will take over as the chair, and we will be looking for a co-chair. Please let me or Jordan know if you are interested in this role.

- Jordan: And if there's interest in applying, please do.

VII. Confirm the Next Meeting Time and Location

Karma: The next meeting will be held on January 18th in Omaha.

VIII. Open Discussion

No items were brought to the floor for open discussion.

IX. Adjournment

Shawn makes a motion to adjourn which is seconded by Vietta at 5:07 p.m. CST.