

Nebraska Rural Health Advisory
Commission's

Annual Report
and
Rural Health
Recommendations

As provided through the
Nebraska Rural Health Systems and
Professional Incentive Act

December 2014

**Nebraska Rural Health Advisory Commission
November 2014**

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**Nebraska Rural Health Advisory Commission's
Annual Report
of the
Nebraska Rural Health Systems and Professional Incentive Act
December 2014**

**EXECUTIVE SUMMARY
and
RECOMMENDATIONS**

- The Rural Health Systems and Professional Incentive Act, passed in 1991, created the Rural Health Advisory Commission, the Nebraska Rural Health Student Loan Program and the Nebraska Loan Repayment Program.
- The thirteen (13) members of the Rural Health Advisory Commission are appointed by the Governor and confirmed by the Legislature.
- The Rural Health Advisory Commission's statutory duties include, but are not limited to, establishing state-designated shortage areas, awarding rural student loans and loan repayment to eligible health professionals, and preparing recommendations to the appropriate bodies to alleviate problems in the delivery of health care in rural Nebraska.
- The Nebraska Rural Health Student Loan Program provides *forgivable* student loans to Nebraska medical, dental, physician assistant, and graduate-level mental health *students* who agree to practice an approved specialty in a state-designated shortage area.
- The Nebraska Loan Repayment Program assists rural communities in recruiting and retaining primary care health professionals by offering state matching funds for repayment of *health professionals'* government or commercial educational debt.
- As of August 2014, there are 107 rural incentive program recipients practicing under obligation in Nebraska.
- The Nebraska Loan Repayment Program has a 92 percent success rate of recipients completing their practice obligations.
- The Nebraska Rural Health Student Loan Program buyout rate has dropped from an average of approximately 50 percent in 1998 to the current average of 17.0 percent.
- Based on county population, the rural health incentive programs currently impact over 800,000 people¹ living in Nebraska in underserved areas by providing them access to health care professionals.

¹ Based on county populations.

- According to studies on the economic impact of rural health care, “One primary care physician in a rural community creates 23 jobs annually. On average, 14 percent of total employment in rural communities is attributed to the health sector.”²
- The importance of the state-funded rural incentive programs is reflected in comments received from recipients.
 - *“...providing compensation to those who practice in under-served areas in rural Nebraska...improves the level of care to those served in these areas.”*
 - *“This program has made moving to a rural area a viable option...”*
 - *“The rural incentive program has been a tremendous help to me...and will benefit the local community. ...I have been able to make...substantial principal payments on my student loans. This means that I have a greater capacity to reinvest in and update the practice...”*
 - *“I wouldn’t trade living out here for nothing...”*
 - *“We had never considered setting up practice anywhere other than the Omaha area. When the opportunity came up for a position in rural Nebraska we...initially blew off the idea. We then looked more into the benefits of working in a smaller community and the Nebraska rural incentive program. This program was definitely a factor in the decision. We never knew how much our family would love this small town life!”*

² Doeksen, G.A., St. Clair, C. F., and Eilrich, F.C. “Economic Impact of Rural Health Care.” National Center for Rural Health Works, www.ruralhealthworks.org, September 2012.

Nebraska Rural Health Advisory Commission's

RECOMMENDATIONS

- Maintain and expand funding for the Nebraska rural health incentive programs (student loan and loan repayment).

Nebraska was one of the leaders nationally when these state-funded rural incentive programs were initiated; however, funding has not kept pace with the demand. In addition, the rural incentive programs have expanded due to increases in the amount of the awards and the inclusion of more specialties without additional funding. The state appropriation, award amounts, and health professions eligible for the rural incentive programs all need to be expanded due to increasing educational debt and demand for all health professions.

- Develop a comprehensive plan for the recruitment and retention of health professionals.
- Support the development and operation of the Nebraska Health Care Workforce Center.
- Encourage rural stakeholders to participate in health care workforce studies.
- Enhance the interdisciplinary training opportunities between primary care providers and mental health professionals.
- Identify and seek private and public funds to develop an integrated rural health system that includes at a minimum primary care practitioners, critical access hospitals, and behavioral health services.
- Develop and implement more flexible Medicaid and private insurance reimbursement policies that would address transportation and travel costs. Consideration should also be given to increasing or beginning reimbursement for telehealth/telemedicine services.
- The educational medical centers in Nebraska should emphasize interdisciplinary training and a team-oriented approach to delivering health care services.
- The Office of Rural Health should seek funding to develop integrated health networks.
- Both public and private payers should be encouraged to change their reimbursement policies so that the investments for the essential infrastructure (e.g., care coordinators and data analysis) for patient-centered medical homes can be developed.
- The work of the LR 422 Workgroup as they develop an ideal model for health care delivery in the next 15 years should be supported.
- After successful system improvements at the local and regional levels, the Nebraska Office of Emergency Medical Services in the Division of Public Health should organize a

broad based coalition that includes representatives from key EMS organizations, local ambulance services, hospital administrators, hospital personnel, physicians, state and local public officials, and others for the purpose of developing a state EMS plan.

- The Nebraska Office of Emergency Medical Services should continue to assess local EMS services and encourage innovative models that make the system more effective and efficient.
- The Nebraska Hospital Association should work with the Nebraska Congressional delegation to allow all hospitals that own or manage EMS ambulance units to receive cost-based reimbursement. (Currently, only hospitals that own or manage EMS units that are 35 miles from another unit can receive cost-based reimbursement.)
- Develop and implement pilot projects to evaluate new models of in-home care, telemedicine, and home monitoring technology.
- Assess the feasibility of providing public transportation at least in some regions of the state.
- Establish a “team approach” training program for present health care providers and provider facilities to train medical teams that can provide care for the at-risk elderly population.
- Use health information technology to assess patient needs and support treatments at multiple points of care.
- Develop training initiatives for providers related to the aging patient (e.g., pharmacy modifications and appropriate treatment of the elderly trauma patient).
- Expand the number of health professionals (e.g., geriatric nurses, certified nursing assistants, and mental health professionals) who are better able to provide care for older patients.
- With staff from the Department of Health and Human Services, identify best practices in advanced rural telehealth network models that could be duplicated in other areas of the state.
- Promote and encourage the use of telecommunications for consultations, education, and electronic health information delivery to and from homes, hospitals, and other health care providers.
- Promote the development of strong telecommunications linkages between public health departments, area hospitals, and other health professionals to address district-wide, regional, and statewide health needs.

- Support the use of electronic health records (EHR) technology by all health care providers and share patient information through health information exchanges.
- Develop standardized protocols for all reporting, transmitting, and the exchange of all health care data.
- Develop the capacity in state agencies so they can send and receive important patient information that providers with certified EHRs are required to transmit and receive.

History

The Rural Health Systems and Professional Incentive Act (the Act) was passed in 1991 creating the Rural Health Advisory Commission, the Nebraska Rural Health Student Loan Program, and the Nebraska Loan Repayment Program. (State of Nebraska employees are not eligible to receive benefits under the rural incentive programs.)

Rural Health Advisory Commission

The Rural Health Advisory Commission is a governor-appointed commission consisting of thirteen members as follows: (1) the Director of Public Health of the Division of Public Health or his or her designee and another representative of the Nebraska Department of Health and Human Services; and (2) eleven members appointed by the Governor with the advice and consent of the Legislature. These eleven members include one representative of each medical school located in the state involved in training family physicians, one physician in family practice residency training, one rural physician, one rural consumer representative, one rural hospital administrator, one rural nursing home administrator, one rural nurse, one rural physician assistant, one rural mental health practitioner or psychologist licensed under the requirements of section 38-3114 or the equivalent thereof, and one rural dentist. (*NE Revised Statutes Section 71-5654*)

The purpose of the Commission is to advise the Nebraska Department of Health and Human Services – Division of Public Health, the Legislature, the Governor, the University of Nebraska, and the citizens of Nebraska regarding all aspects of rural health care and to advise the Nebraska Office of Rural Health regarding the administration of the Rural Health Systems and Professional Incentive Act. (*NE Revised Statutes Section 71-5655*)

By statutory authority the Commission has the following powers and duties: (1) advise the Nebraska Department of Health and Human Services – Public Health Division (department) regarding the development and implementation of a state rural health policy; (2) advise the department and other appropriate parties in all matters relating to rural health care; (3) serve as an advocate for rural Nebraska in health care issues; (4) maintain liaison with all agencies, groups, and organizations concerned with rural health care in order to facilitate integration of efforts and commonality of goals; (5) identify problems in the delivery of health care in rural Nebraska, in the education and training of health care providers in rural Nebraska, in the regulation of health care providers and institutions in rural Nebraska, and in any other matters relating to rural health care; (6) *prepare recommendations* to the appropriate bodies to alleviate the problems identified; (7) advise the department regarding the Rural Health Systems and Professional Incentive Act; (8) designate health profession shortage areas in Nebraska; and (9) select recipients of financial incentives available under the Act. (*NE Revised Statutes Section 71-5659*)

Nebraska Rural Health Student Loan Program

In 1979, the State of Nebraska began awarding low-interest loans to medical students who agree to practice in shortage areas. Due to legislative changes over the years, the Nebraska Rural Health Student Loan Program now awards *forgivable* student loans to Nebraska medical, dental,

physician assistant, and graduate-level mental health students who agree to practice an approved specialty in a state-designated shortage area. Approved specialties are defined as follows: medical and physician assistant students must agree to specialize in family practice, general surgery, general internal medicine, general pediatrics, obstetrics/gynecology, or psychiatry; dental students must agree to specialize in general practice, pediatric dentistry, or oral surgery; and mental health students must be enrolled or accepted for enrollment in a training program that meets the educational requirements for licensure by the Department of Health and Human Services for “licensed mental health practitioner” or “licensed psychologist”.

The Nebraska Rural Health Student Loan Program is for Nebraska residents attending graduate college in Nebraska. Student loan recipients receive a forgivable educational loan while they are in training in exchange for an agreement to practice in a state-designated shortage area the equivalent of full-time for one year for each year a loan is received. The number and amount of student loans are determined annually by the Rural Health Advisory Commission based on state funding.

Dental students were added to the Nebraska Rural Health Student Loan Program in 2000 and graduate-mental health students were added in 2004. In 2000, the Legislature also passed legislation that increased the maximum amount of student loan awards for medical and dental students to \$20,000 per year. The maximum amount of physician assistant student loans was increased to \$10,000 per year. When graduate-level mental health student loans were added in 2004, the maximum amount of a student loan for a doctorate-level mental health student was set at \$20,000 per year and for a master-level mental health student, it was set at \$10,000 per year. Since 2009, the Rural Health Advisory Commission has awarded student loans at the maximum amount of \$20,000 for doctorate-level students and \$10,000 for full-time master-level students.

Nebraska Loan Repayment Program

In 1994, the Nebraska Legislature appropriated funding for the Nebraska Loan Repayment Program for health professionals willing to practice in a state-designated shortage area. Initially only physicians, nurse practitioners, and physician assistants practicing one of the defined primary care specialties, clinical psychologists, and master-level mental health providers were eligible for loan repayment. In 1998, pharmacists, occupational therapists, physical therapists, and dentists were added to the program. The approved specialties are the same specialties defined under the Nebraska Rural Health Student Loan Program listed previously.

The Nebraska Loan Repayment Program requires community participation in the form of a local match and a 3-year practice obligation for the health professional. Communities must do their own recruiting, using the availability of the loan repayment program as a recruitment and retention tool. Once a health professional is recruited a local entity and the health professional must submit loan repayment applications to the Rural Health Advisory Commission.

State-Designated Shortage Areas

The Rural Health Advisory Commission has the responsibility of establishing guidelines and identifying shortage areas for purposes of the Nebraska rural incentive programs for the primary care specialties defined in the Act. Every 3 years a statewide review of all the shortage areas is

completed. If changes occur in an area during the years between the statewide reviews, the community may request a shortage area designation from the Commission. Any data or information submitted for review is verified by the Nebraska Office of Rural Health and University of Nebraska Medical Center – Health Professions Tracking Services. If the area meets the guidelines for state designation, the Commission may designate it.

In 2014, the Rural Health Advisory Commission approved new guidelines and shortage areas for Occupational Therapists (OT) and Physical Therapists (PT). The process of collecting full-time equivalency (FTE) data for OTs and PTs was started by the Department of Health and Human Services and the University of Nebraska Medical Center, Health Professions Tracking Services in 2012. It took a little over a year to collect and analyze the data. The new OT and PT shortage areas were approved as of July 1, 2014, after a 30-day public comment period.

Criteria for the federal and state designations differ and are used for different federal and state programs. Nebraska Office of Rural Health staff can assist with the data requirements and benefits of the various shortage area designations and incentive programs. Guidelines for the state-designated shortage areas and the current federal and state shortage areas are posted on the Nebraska Office of Rural Health webpage.

While the Nebraska rural incentive programs primarily focus on *rural* shortage areas Federally Qualified Health Centers (FQHCs) may request to be designated as state-designated shortage areas for family practice and/or general dentistry. As a state-designated shortage area, FQHCs may then qualify for benefits under the state incentive programs in addition to *federal* health professional incentive programs.

The Nebraska Office of Rural Health works to maximize state funds for areas not eligible for the benefits under the federal incentive programs due to practice area or practice specialty eligibility. Health professionals who are practicing in a federal Health Professional Shortage Area (HPSA) and are eligible are encouraged to apply first for the National Health Service Corps (NHSC) Loan Repayment Program or the *new* NHSC Nebraska State Loan Repayment Program (NHSC SLRP) before applying for the Nebraska Loan Repayment Program. Depending on the availability of federal funds, the NHSC will often times award loan repayment to health professionals based on the HPSA score. When higher HPSA scores are needed to qualify, there is a greater demand for the Nebraska Loan Repayment Program because Nebraska HPSA scores tend to be lower compared to other areas nationally.

New as of September 1, 2014, the Department of Health and Human Services, Office of Rural Health was awarded a 4-year grant for the National Health Service Corps *State* Loan Repayment Program (NHSC SLRP). This program has the same criteria as the NHSC Loan Repayment Program except a match from the community is required and health professionals can practice in any federal Health Profession Shortage Areas without regard to HPSA scores. The Nebraska Office of Rural Health is using the NHSC SLRP to complement the Nebraska Loan Repayment Program. For additional information about the NHSC SLRP, contact the Nebraska Office of Rural Health.

Analysis of the Rural Incentive Programs

Chart 1 on page 9 shows graphically the number of rural incentive recipients by program receiving payments by fiscal year. The current fiscal year (FY2014-15) shows awards as of November 1, 2014. It is anticipated that the Rural Health Advisory Commission will obligate all of the funds for FY2014-15 at their November 2014 meeting and move approximately 10 more applicants to the waiting list for a total of 14 applicants on the waiting list for loan repayment. It should be noted that 5 of the 14 applicants will not begin practice until FY2015-16.

Several factors influence the number of incentive recipients each year. These factors include the amount of state funds available, the amount of each individual incentive award, and the educational level of the recipients. As one commission member stated, *“of all the programs, these are the most successful and the money comes back many times over.”* The demand for the rural incentive programs remains high and total student loan debt is continuing to rise each year. Based on the current loan repayment recipients’ applications the average student loan debt for a physician is \$187,665 and for a dentist is \$226,515.

Chart 2 on page 10 shows the budget amounts by source for each fiscal year. Comparing Charts 1 and 2 demonstrates the direct relationship between funding and the number of incentives awarded by the Rural Health Advisory Commission. Beginning July 1, 2013, the Legislature transferred \$1.5M from the Department of Health and Human Services cash fund and moved it to the Rural Health Incentive Fund. Cash spending authority was granted to use \$500,000 of this money for each of the next two years (FY2013-14 and FY2014-15) for the state match for loan repayment. In addition, the Legislature authorized spending authority for the local match funds in the same amount as the state match. (This is essential for the loan repayment program because this program requires a 50-50 state and local match.)

Beginning in FY2009-10, the Rural Health Advisory Commission began awarding student loans and loan repayment at the maximum levels of \$20,000 or \$10,000 per year depending on the educational level of the recipient. This resulted in fewer awards but assisted rural communities in being able to compete with larger communities to recruit and retain health professionals.

Chart 3 on page 11 shows the dollar amount of rural incentive awards by program by fiscal year. Student loans are awarded by the Rural Health Advisory Commission in June prior to the beginning of each fiscal year; therefore student loans are projected for fiscal years beyond FY2014-15.

Loan repayment awards are made at each Rural Health Advisory Commission meeting as applications are received and state funds are available. Loan repayment requires a 50-50 local-state match and cash spending authority to spend the local match. Based on the number of loan repayment applications received as of November 1, 2014, it is anticipated that the Rural Health Advisory Commission will award 6 applicants loan repayment at the November meeting and move 10 applicants to the waiting list.

Chart 4 on page 12 gives another perspective to the loan repayment awards. Since loan repayment requires a 50-50 state-local match, Chart 4 shows the funding impact of loan repayment awards by fiscal year. The increase “bump” beginning in FY2013-14 is the addition of the cash funds transferred to the rural incentive cash fund.

The Nebraska Loan Repayment Program requires a 3-year practice obligation so when the Rural Health Advisory Commission awards loan repayment the obligation of funds is projected over the 3-year practice obligation. Loan repayment awards being made in FY2014-15 will impact the rural incentive program budget in FY2015-16, FY2016-17, and FY2017-18; hence the future budget obligations shown on Chart 4.

Charts 5 and 6 on pages 13 and 14 show the number of recipients by profession by fiscal year for the Nebraska Loan Repayment Program and Nebraska Rural Health Student Loan Program; respectively. While more medical professionals use the loan repayment program than the other eligible health professionals, the Nebraska Rural Health Student Loan Program has been a good program for dental students interested in rural practice.

Unlike the Nebraska Loan Repayment Program, student loan recipients do not have to find a local agency to match the state loan repayment funds and they can be self-employed and still receive forgiveness of their rural incentive student loans. Due to the number of qualified *medical* students applying for the Nebraska Rural Health Student Loan Program in 2014, the Rural Health Advisory Commission was able to award 8 out of the 14 student loan awards to medical students.

Table A on page 15 shows the number of student loan awards issued each year from FY2005-06 through FY2014-15. Since FY2005-06, the Rural Health Advisory Commission has awarded an average of 7 new student loans and 9 continuation student loans per year. New student loan awards are based on the quality of applicants each year and the likelihood that the applicant will return to a rural shortage area to practice.

Prior to 1998, buyout rates for student loans averaged about 50 percent. Given four years of medical school and at least three years of residency training, a medical student loan recipient will not be available to practice in a shortage area for up to seven or more years. To improve the success rate of recipients fulfilling their practice obligations, administrative changes were implemented in 1998 to remind student loan recipients of their practice obligation. Then in 2007, the Rural Health Advisory Commission recommended a legislative change to reduce the buyout rate for student loan recipients from 24% simple interest from the date the loan was received to 150% of the principal plus 8% at the time of default. During the most recent 5-year period (FY2006 – FY2010), for which data are available, the buyout rate has dropped to an average of 17.0%.

Table B on page 16 provides a summary of the Nebraska Loan Repayment Program from 1994 through 2014. Since 1994, 483 health professionals have participated or are participating in the Nebraska Loan Repayment Program. Ninety-two percent (92%) of loan repayment recipients have completed their practice obligation or are currently serving their practice obligation. Less than 8% of loan repayment applicants have defaulted on their practice obligation. As of

November 2014, there are 91 *loan repayment* recipients in practice under obligation in rural or underserved areas of Nebraska with more to be added as awards are made and contracts are signed.

The map on page 17 shows the practice location of rural incentive recipients as of August 2014 and includes the Legislative District outlines. At that time 107 licensed health professionals were in practice under obligation.

Summary

As a result of both the rural incentive programs, as of August 2014, there are 107 licensed health professionals in practice under obligation providing access to health care services for over 800,000 people living in Nebraska. These two rural incentive programs (student loans and loan repayment) are the only state-funded programs of this type to encourage health professionals to practice in state-designated shortage areas. The only limitation to these programs is the level of the state appropriation.

CHART 1
Nebraska Rural Incentive Programs
 Number of Recipients Receiving Payments by Program by Fiscal Year

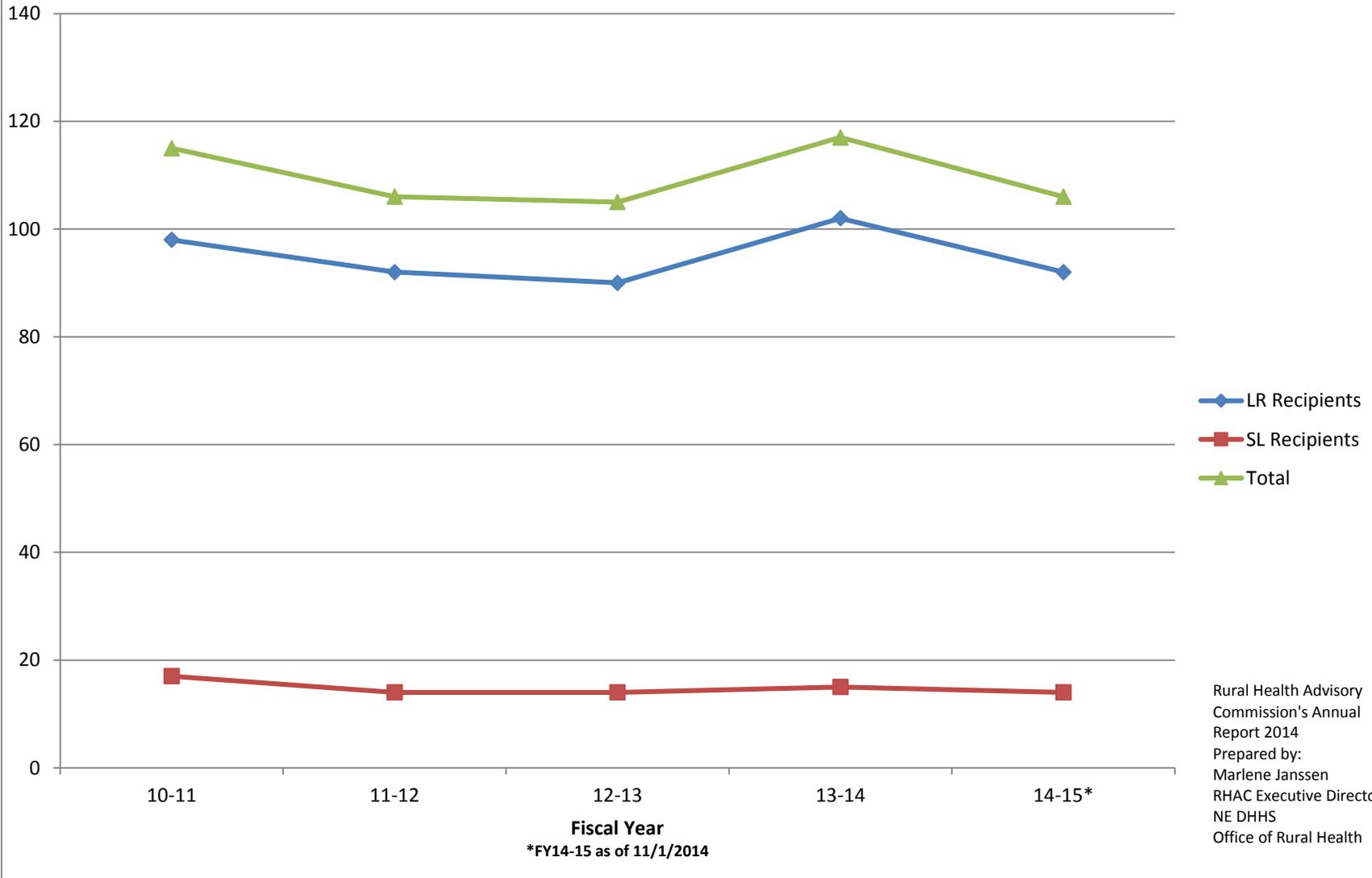
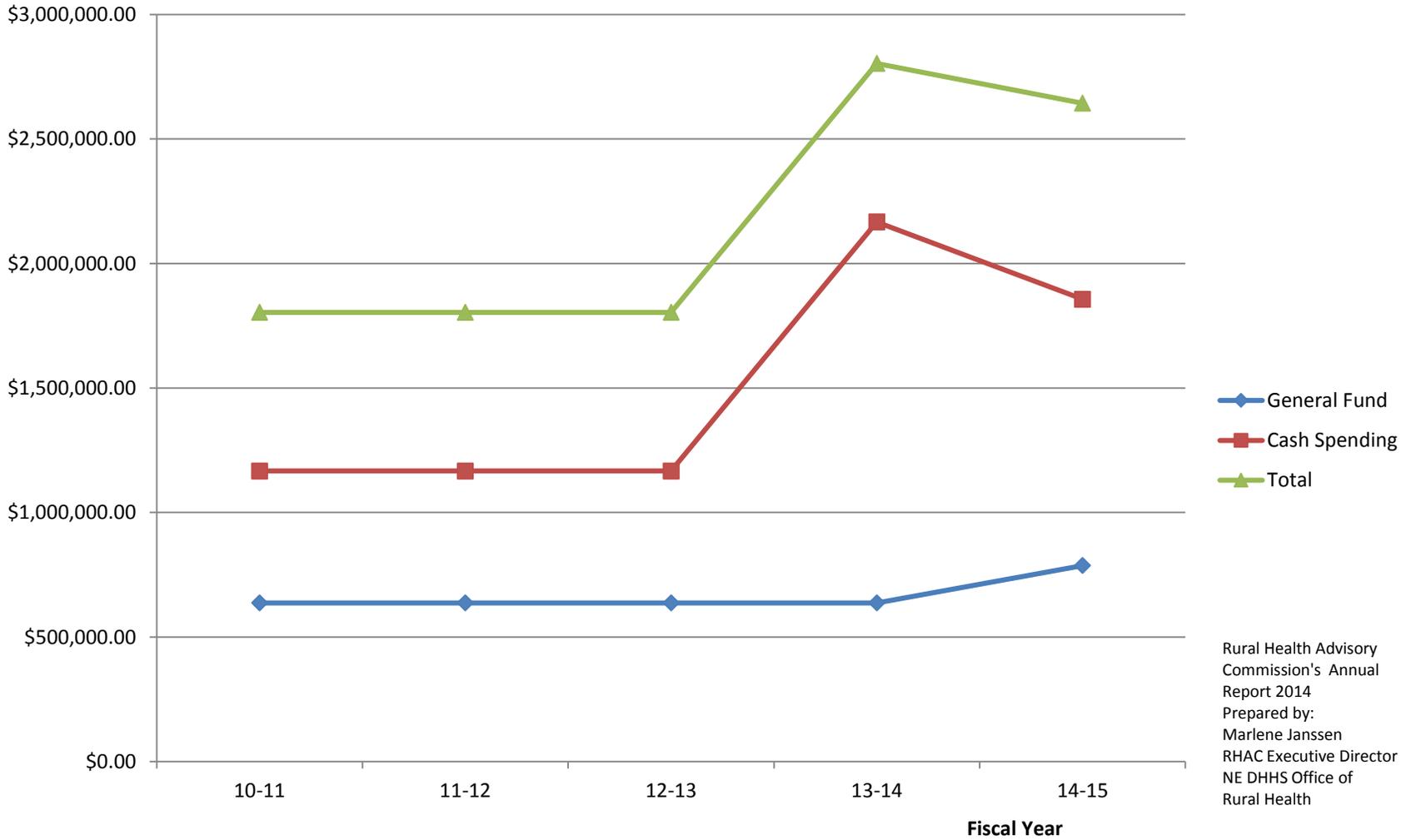


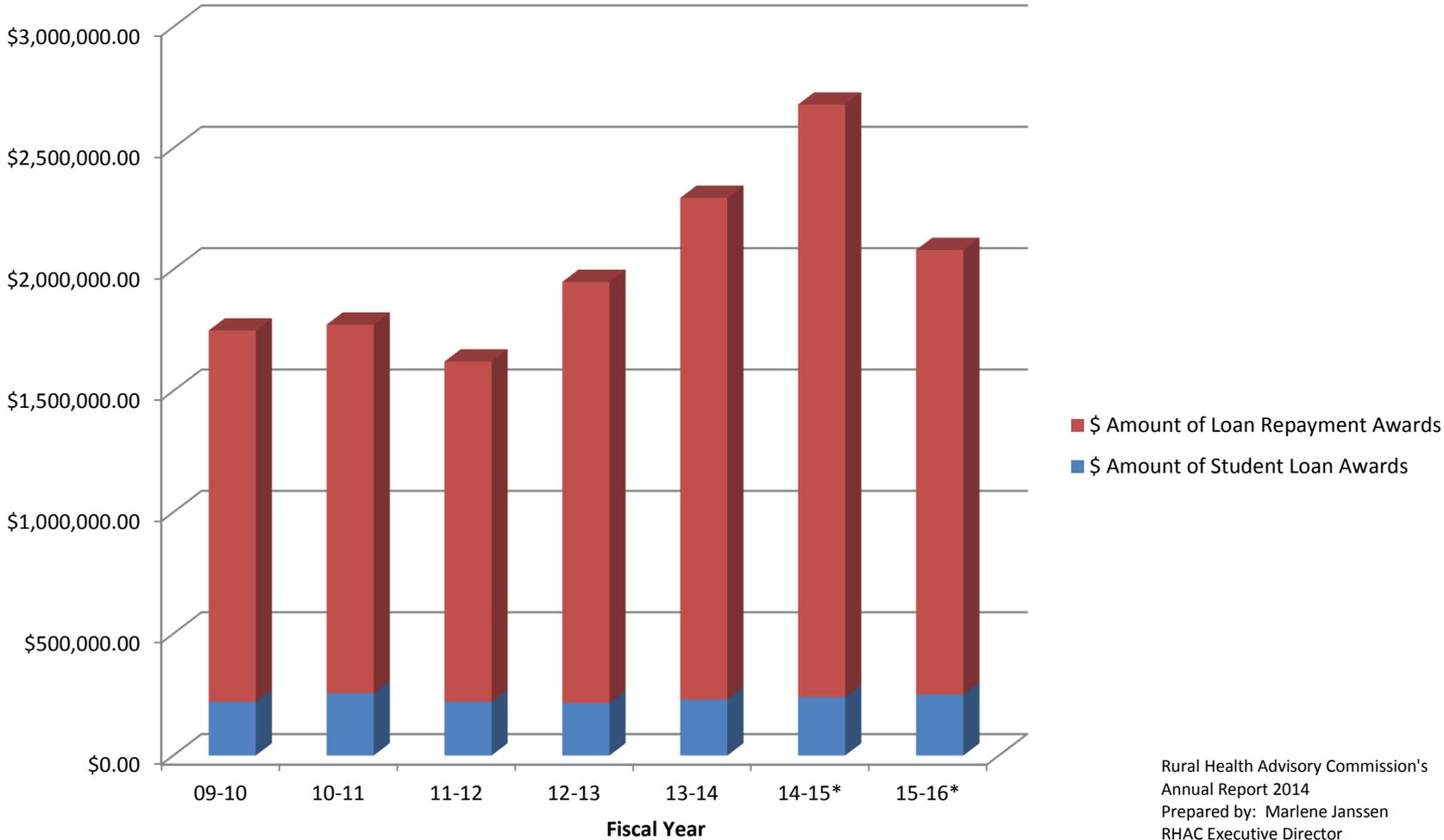
Chart 2
Nebraska Rural Incentive Programs
State Budget Appropriation By Source By Fiscal Year



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 NE DHHS Office of
 Rural Health

FY14-15 cash spending authority reduced by DHHS, no longer needed for Merck cash

CHART 3
Nebraska Rural Incentive Programs
\$ Amount of Rural Incentive Awards by Program by Fiscal Year

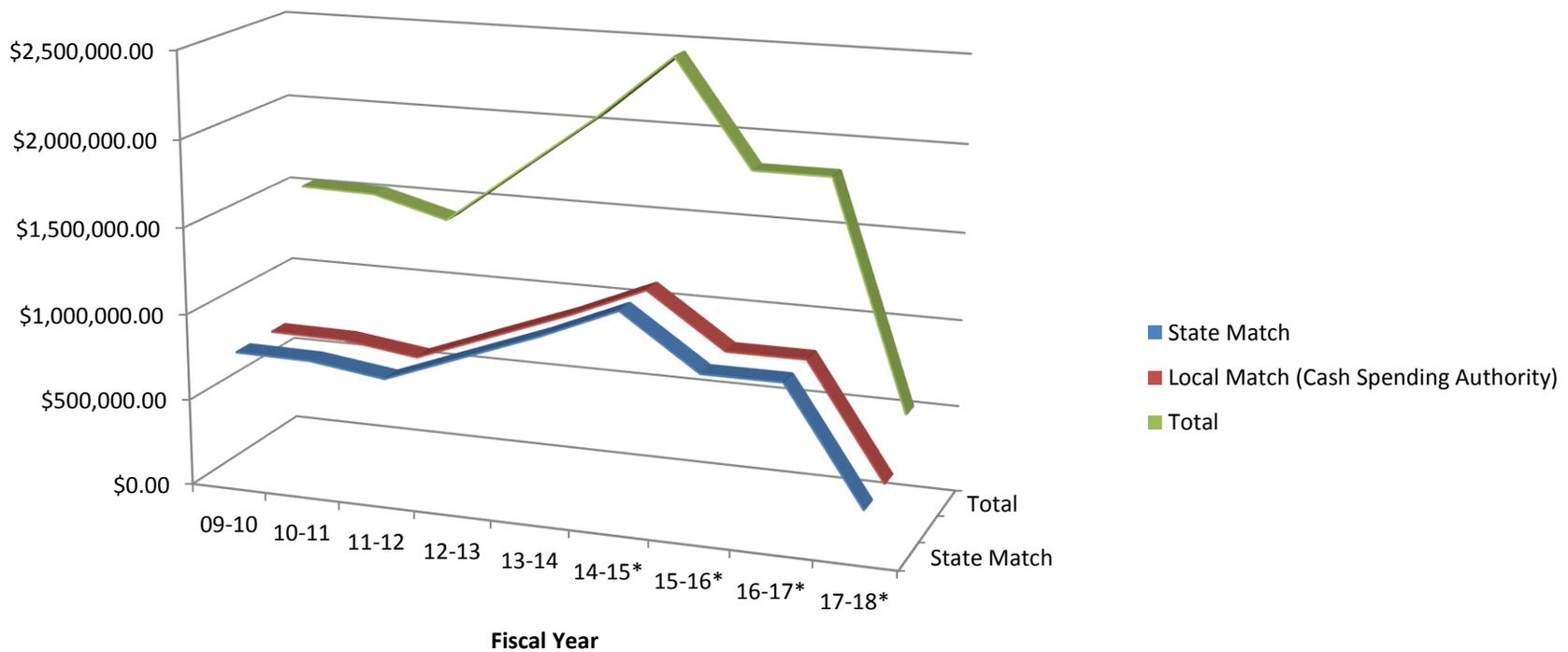


(*LR is a 3-year program, FY2014-15 through FY15-16 shows *current* LR obligations. SL awards are projected for FY15-16 & FY16-17.)

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CHART 4 Nebraska Loan Repayment Program \$ Amount of Awards by Contribution Source by Fiscal Year

(Note: Loan Repayment requires a 50-50 State & Local Match. Cash Spending Authority is needed for the Local Match)



Note: Loan Repayment requires a 3-year practice obligation
 *FY14-15 is based on current & expected LR awards
 *FY15-16 through FY17-18 are based on current obligations.

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CHART 5
Nebraska Loan Repayment Program
Awards by Profession by Fiscal Year

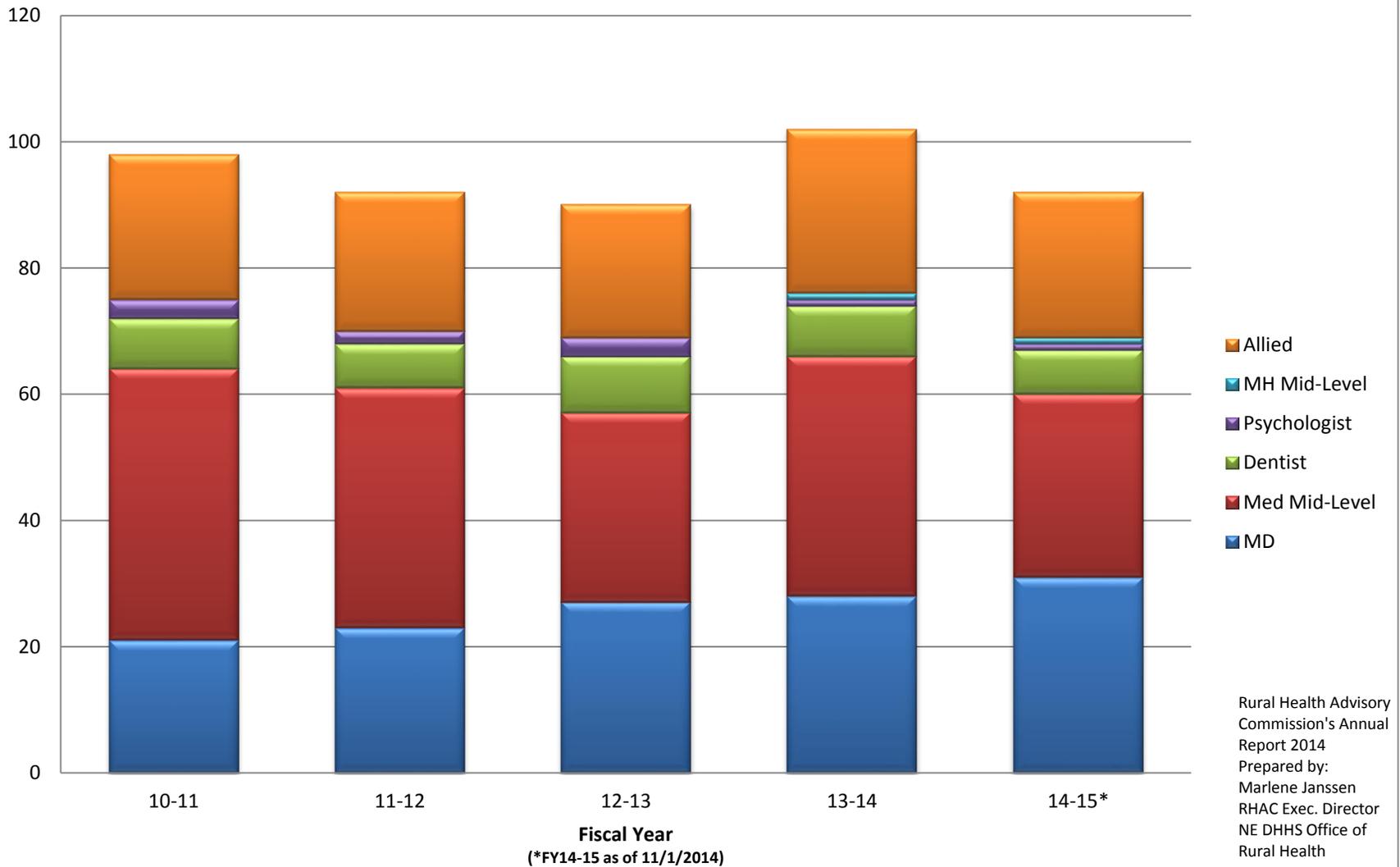


CHART 6
Nebraska Student Loan Program
Student Loan Recipients by Profession by Fiscal Year

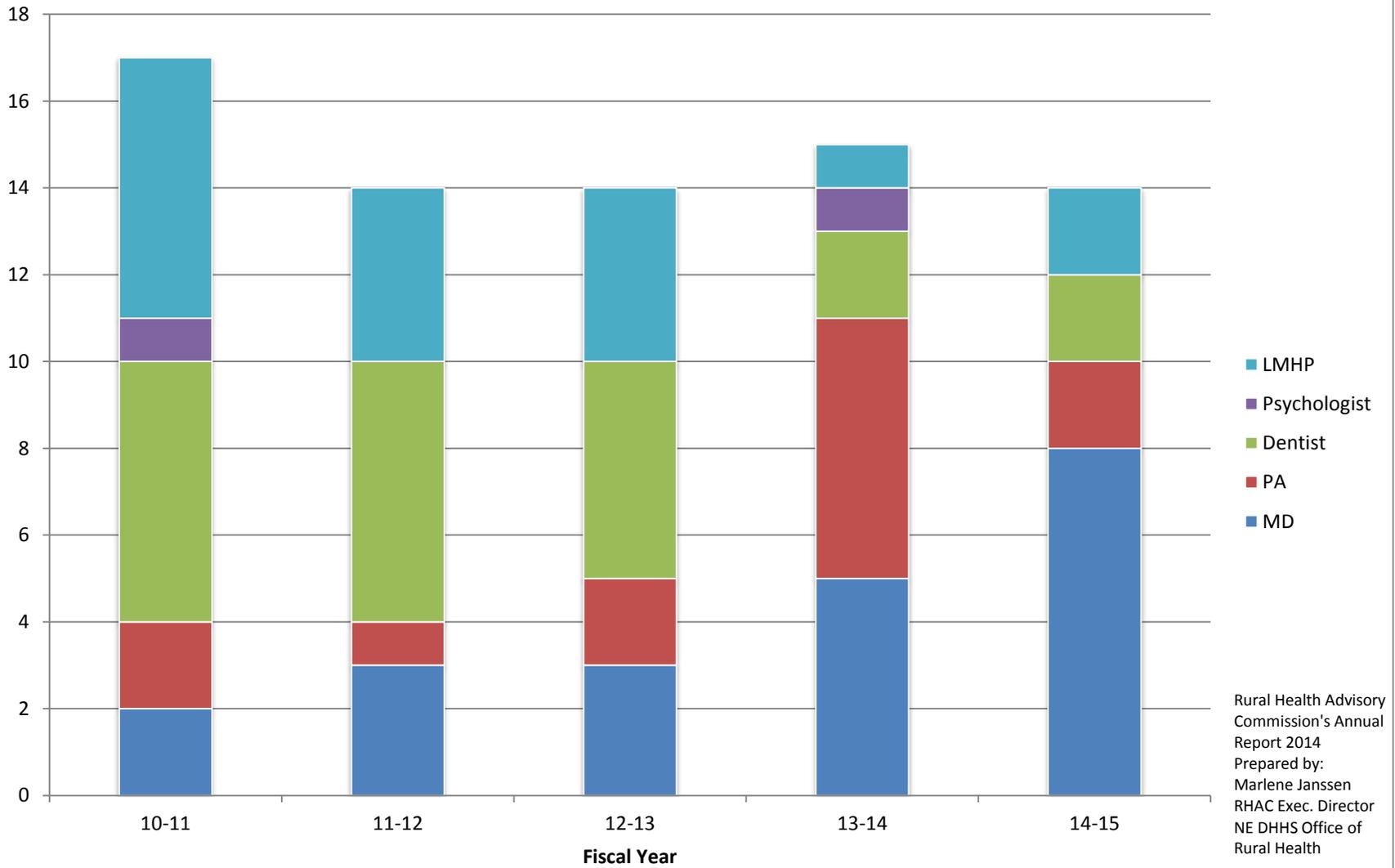


TABLE A
Nebraska Rural Health Student Loan Program
Number of Student Loans by Type & Outcome By Fiscal Year
(Duplicate Counts (1))

Fiscal Year	Total Amount Awarded	Student Loan Awards			In Training As of 2014 (2)	Outcomes As of 2014				
		New	Continuation	Total		In Practice Forgiveness	Completed Practice	Partial Forgiveness/ Buyout	Contract Buyout	Buyout Rate (3)
2005-06	\$341,250	10	14	24	0	3	16	2	3	12.5%
2006-07	\$341,250	6	16	22	1	3	12	2	4	18.2%
2007-08	\$236,250	6	9	15	2	3	6	2	2	13.3%
2008-09	\$227,500	7	7	14	4	3	3	0	4	28.6%
2009-10	\$220,000	6	7	13	6	4	0	1	2	15.4%
2010-11	\$255,000	7	10	17	7	7	0	1	2	NA
2011-12	\$220,000	6	8	14	7	6	0	0	1	NA
2012-13	\$215,000	8	6	14	10	3	0	0	1	NA
2013-14	\$230,000	11	4	15	15	NA	NA	NA	NA	NA
2014-15	\$240,000	7	7	14	14	NA	NA	NA	NA	NA
								5-Year Average Buyout Rate		17.0%

Footnotes:

1. Student loan recipients may receive up to four annual loans. This means a recipient will be counted as "New" the first year and then as "Continuation" in subsequent years. Summing the "Total" student loan awards over several years will result in duplication of individuals receiving awards.
2. "In Training" means in school, residency, or provisionally licensed.
3. "Buyout Rate" is the number of recipients who buyout their contracts without ever practicing a primary care specialty in a shortage area divided by total student awards for each year. Buyout rates are not applicable for 2010-2014 since most recipients are still in training.

Historical Notes:

- * In 2000, dental students became eligible to apply for the Nebraska Rural Health Student Loan Program. The maximum student loan award amount was increased to \$20,000
- * In 2004, graduate-level mental health students became eligible for the Nebraska Rural Health Student Loan Program.
- * In 2009, the Rural Health Advisory Commission began awarding student loans at the maximum amounts: \$20,000 for doctorate level students and \$10,000 for full-time master's level students.

TABLE B

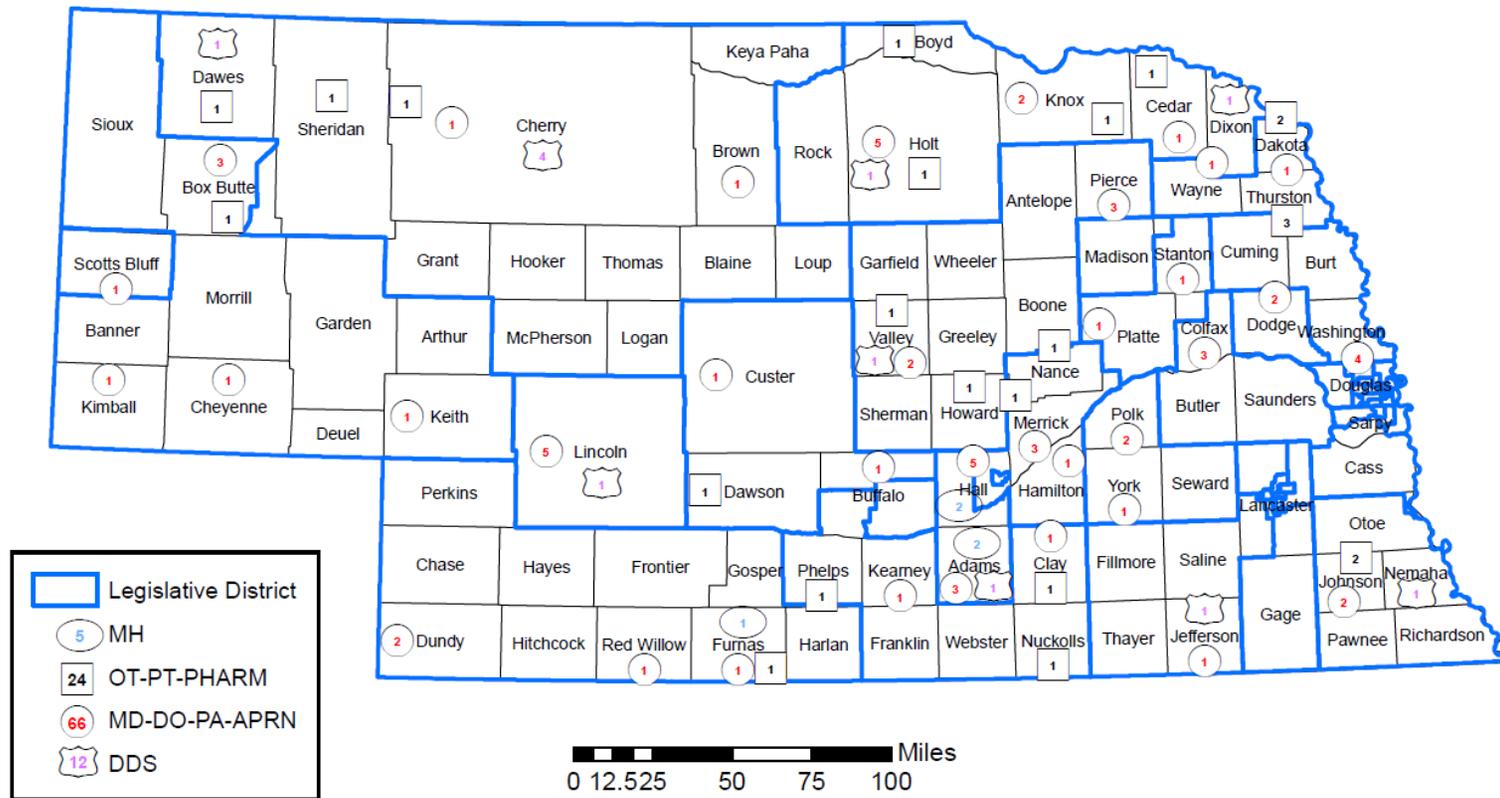
**Nebraska Loan Repayment Program
Number of Awards by Status
1994-2014**

Status	Awards
In Practice Under Obligation as of 11/2014	91
Completed Practice Obligation	351
Default	37
Other	4
Total	483

Nebraska's Rural Incentive Programs

Rural Health Student Loan and Loan Repayment Programs

[107] Obligated Health Care Providers as of August 2014



Source: Rural Health Advisory Commission
 DHHS - Nebraska Office of Rural Health
 August 2014

Cartography: Clark Sintek | Community & Regional Planning Intern | DHHS
 For: Marlene Janssen | Exec. Director, Rural Health Advisory Commission
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Rural Health Advisory Commission's Rural Health Recommendations

Background and Purpose

In the past few years the health care system has undergone dramatic changes. While many of these changes create new opportunities for both rural providers and communities, they have also led to significant challenges. Some of these challenges include new reimbursement systems, which may lead to lower revenue streams for rural providers, innovative delivery models that may result in greater consolidation and loss of local control, and the adoption and use of electronic health records. In addition, many traditional challenges still remain such as the shortages of various types of health professionals, more hospitals with very low or negative margins, lack of public transportation, and fragmented delivery systems.

The passage of the Rural Health Systems and Professional Incentive Act in 1991 authorized the Rural Health Advisory Commission (RHAC) to develop a series of recommendations regarding the direction of state rural health policy. These recommendations should address the problems in the delivery of rural health care, the education and training of health professionals, the regulation of rural health providers and institutions, and other factors that impact rural health care. The recommendations are prepared annually and submitted to all appropriate government agencies and bodies, including the Governor, the State Legislature, and the Department of Health and Human Services.

Vision Statement

In preparing the recommendations, the RHAC developed the following vision statement to serve as a guide for the direction of rural health policies:

“All of the people in rural Nebraska have access to a high quality, affordable, and integrated health care services that meets all of their physical and mental health needs.”

This vision implies that people in rural Nebraska have access to health care services. It is recognized that not all services can or should be provided locally, but needed services should be reasonably accessible to all rural residents. This vision also implies that the health system should focus on keeping people healthy. This system should not merely treat illness but should be patient-centered and provide comprehensive wellness and support services. Finally, the Commission strongly believes that rural communities should be responsible for designing a system that best meets their needs. While communities should seek advice from outside experts, local communities should identify their needs and establish priorities for the delivery of health care services.

Recommendations

The recommendations discussed below will help strengthen and transform the rural health delivery system. These recommendations will improve both the efficiency and effectiveness of

the system and produce better physical and mental health outcomes, higher quality of health care services, and a more integrated and coordinated system of care. In this report, the recommendations are focused on the following areas: (1) Workforce Issues and the Health Professional Incentive Programs, (2) Behavioral Health Issues, (3) Rural Integrated Delivery Systems, (4) Emergency Medical Services, (5) Long-term Care Services, (6) and Communication and Information Technology Systems.

I. Workforce Issues and Health Professional Incentive Programs

By 2020, the total number of primary care physicians, physician assistants, and nurse practitioners is expected to increase nationwide, but the supply will not be adequate to meet the growing demand for primary care services. The demand for services is expected to increase due to the expanding aging population, the growth in total population, particularly in urban areas, and to a lesser extent the expanded insurance coverage under the Affordable Care Act. The imbalance between supply and demand has a significant impact on rural areas where many older physicians are nearing retirement age and will need to be replaced. In addition, the rising level of student debt and lower reimbursement rates make rural areas less attractive to new physicians. The demand for primary care practitioners in urban areas is expected to increase sharply because of a growing population base, expanded insurance coverage, and new models of care (e.g., Accountable Care Organizations) which emphasize a greater use of primary care and prevention services. The expanded use and recruitment of primary care practitioners in urban areas will magnify the shortages in rural areas.

While many rural areas face challenges in the recruitment and retention of physicians, physician assistants and nurse practitioners, the supply of other health professionals such as dentists, pharmacists, mental health practitioners, physical therapists, and occupational therapists is also inadequate to meet the need. Most rural hospitals, physician clinics, and nursing homes are forced to pay a nationally competitive wage rate in order to attract these health professionals to their communities. However, the reimbursement rates allowed by Medicare and other third-party payers are often based on local costs, which may not be sufficient to pay these competitive rates.

Although Nebraska has benefited from the federal National Health Service Corps loan repayment program, recent cutbacks in funding have greatly reduced the number of qualified shortage areas. As a result, Nebraska has relied on the state-funded student loan and loan repayment programs to encourage health professionals to practice in state designated shortage areas. Since the inception of the loan repayment program, a total of 453 eligible health professionals have or are practicing in shortage areas with a default rate of only 11 percent.

Recommendations

1. Maintain and expand funding for the Nebraska rural health incentive programs (the student loan and loan repayment programs).
2. Develop a comprehensive plan for the recruitment and retention of health professionals. In this plan, future needs as well as the projected pool of potential health care

professionals would be identified. This plan would also establish priorities for future funding levels for the Health Professional Incentive Programs and include potential changes that would make these programs more attractive to health professionals in Nebraska.

3. Support the development and operation of the Nebraska Health Care Workforce Center so that it can serve as a central depository for state health workforce data. The Center would also conduct studies to assess future workforce shortages and suggest proactive solutions and innovative models of care.
4. Encourage rural stakeholders to participate in health care workforce studies.

II. Behavioral Health Issues

Background:

There has been a chronic shortage of behavioral health professionals in rural Nebraska for many years. The shortages of personnel include psychiatrists, psychologists, licensed mental health practitioners, nurses, alcohol and drug abuse counselors, and others. Currently, only three counties (Douglas, Sarpy, and Lancaster) are not designated as state mental health professional shortage areas, nine counties are partially designated, and 81 counties are designated as shortage areas.

The shortage of behavioral health professionals has a serious impact on access to and the quality of health care services. It also creates more stress for primary care providers because a relatively high percentage of their patients consult them about a mental health problem. However, the majority of the patients with diagnosable mental disorders appear under a different diagnosis. With the pace of physician care practice (e.g., 4 or 5 patient visits an hour), the primary care physician is under a great burden to diagnose the mental health disorder correctly in every encounter.³

Even if an accurate diagnosis is made, it may be difficult to make an appropriate referral because there is a lack of integration between these two systems. This problem can be overcome by integrating mental health professionals into the primary care setting. The rationale for this model is that many rural patients are resistant to accepting the stigma of a mental diagnosis and a referral to a separate mental health organization. Also, most patients prefer to receive their behavioral health care from their family physician.⁴ In addition, untreated mental health problems result in the greater use of health care services. For example, depressed patients use three times more health care services and have seven times more emergency room visits.⁵ However, the lack

³ Institute of Medicine (1996). *Primary Care: America's Health in a New Era*. Washington, D.C.: The National Academies Press

⁴ Mims, S. (April 6, 2006). *Integrated Health Care: Involving Primary Care Physicians in the Continuum of Care*. Presentation at the WNC Symposium on Mental Health and Substance Abuse. Asheville, NC.

⁵ *Ibid.*

of mental health professionals and the cultural differences in their training may create barriers that make implementation challenging.

There are some other promising strategies. For example, telepsychiatry has been used effectively in Nebraska and in other states. In this model, psychiatrists can be used by the primary care provider to confirm the diagnosis and provide treatment options. Although this modality is currently underutilized, fewer resources are needed and the patient does not need to travel for a referral.

Recently, the University of Nebraska Medical Center began training nurse practitioners and physician assistants with a specialty in psychiatry. Currently, 31 are practicing in rural Nebraska, but many more are still needed.

Recommendations:

1. Enhance the interdisciplinary training opportunities between primary care physicians, physician assistants, nurse practitioners, and mental health professionals.
2. Identify and seek private and public funds to develop an integrated rural health system that includes at a minimum primary care practitioners, critical access hospitals, and behavioral health services.
3. Develop and implement more flexible Medicaid and private insurance reimbursement policies that would address transportation and travel costs. Consideration should also be given to increasing or beginning reimbursement for telehealth/telemedicine services.
4. Maintain or increase state incentives for providers practicing in rural areas, including:
 - a. Providing supportive services and training to present workers
 - b. Maintaining competitive reimbursement rates
 - c. Supporting increased incentives for rural practice.

III. Rural Integrated Health Care Systems

Many of the current health care delivery models are not designed to serve adults with chronic conditions, individuals with behavioral health needs, or those with long-term care needs. For example, the delivery of physical, behavioral health, and long-term care services often lead to costly and poor outcomes such as avoidable hospitalizations and unnecessary institutionalization.

While these problems plague both rural and urban populations, many rural residents have many of the social and medical vulnerabilities that make the need for integrated care critical. For example, rural populations tend to be older, poorer, and have limited access to transportation. While the need for integrated care is greater, it is often more difficult to integrate care in rural communities because access to primary care, specialist care, hospital care, and related non-

medical supportive services is more variable. In addition, problems of scale limit the feasibility of investing in needed infrastructure, such as information technology and workforce.⁶

Fortunately, there are some new models of care that show considerable potential. One of these models is the patient-centered medical home model. In this model, a physician's clinic provides care that is accessible, continuous, timely, patient-centered, and coordinated. There is an emphasis on preventive services (e.g., mammograms, cholesterol and blood pressure screenings, and up-to-date immunizations). With this model, there is also an incentive to work closely with behavioral health providers, public health professionals, and long-term care support services. Several patient-centered medical home clinics are developing in Nebraska, but new revenue streams are needed to build the capacity that will make these models successful. Limited funding for pilot projects has also been provided by the DHHS Division of Public Health to encourage local public health departments to collaborate with patient-centered medical home clinics on diabetes prevention programs and using community health workers to work with patients with chronic disease about making behavioral changes (e.g., physical activity and nutrition). Additional pilot projects need to be developed, and guided by the following principles:

- An integrated system should be developed from the “bottom up” and should be guided by a comprehensive planning process that involves health care providers, community leaders, and consumers.
- Although all integrated rural health systems will have many common characteristics, diverse approaches are necessary because of the differences in the needs of the population, the economic characteristics of the area, and the local culture.
- All integrated systems should foster cooperation, collaboration, and integration of services and activities, including innovative technology such as telecommunications.
- All integrated systems should be evaluated based on the Triple Aim (better health outcomes, better quality of health care services, and lower per capita costs).

Recommendations

1. The educational medical centers in Nebraska should emphasize interdisciplinary training and a team-oriented approach to delivering health care services.
2. The Office of Rural Health should seek funding to develop integrated health networks.
3. Both public and private payers should be encouraged to change their reimbursement policies so that the investments for the essential infrastructure (e.g., care coordinators and data analysis) for patient-centered medical homes can be developed.

⁶ Eileen Griffen and Andrew Colburn, “Integrated care Management in Rural Communities,” Working Paper #54, Maine Rural Health Research Center, University of Southern Maine, May 2014.

4. The work of the LR 422 Workgroup as they develop an ideal model for health care delivery in the next 15 years should be supported.

IV. Emergency Medical Services (EMS)

Emergency medical services are an essential and often unrecognized component of the rural health care system. The goal of the EMS system is to provide a coordinated, timely, and effective response to medical emergencies. These services are essential in rural areas because of the distances between population centers and the need to transport patients from hospitals and nursing homes in small communities to larger facilities. Although emergency services/skills are essential, many challenges exist in small communities. These challenges will only intensify as the demand for health care services expand because of a growing elderly population, more chronic illnesses, and new technological innovations.

One of the major challenges is to recruit and retain volunteers who are interested in becoming EMTs and paramedics. Some of the major factors contributing to this problem are: (1) the work is often emotionally stressful and burnout may occur, (2) the compensation and benefits are low or non-existent for volunteers, (3) it is difficult to maintain coverage during the day because many volunteers work out of town and/or employers may not allow EMTs to miss work, and (4) the training and educational requirements are considered excessive by some volunteers.

Another challenge is the lack of research and data about the effectiveness of the EMS system and patient outcomes. Although some states, including Nebraska, are collecting EMS performance data (e.g., length of time to reach destination), major gaps still exist and the analysis of the data is very limited. Without the widespread adoption of improved communication systems and health information technology that will allow the exchange of patient information across the continuum of care, it will be very difficult to evaluate the quality and performance of the EMS system related to patient outcomes.

According to a recent report by the Institute of Medicine, the lack of knowledge about the quality of EMS services results from the lack of nationally agreed-upon measurements of EMS quality, no nationwide standards for the training and certification of EMS personnel, no accreditation of institutions that educate EMS personnel, and virtually no accountability for the performance of EMS systems.⁷

Finally, the EMS system is difficult to change because of the fragmentation and lack of coordination between pre-hospital providers. In Nebraska, it is not uncommon for multiple EMS agencies to serve the same population center. For example, Thayer County has eight ambulance units to serve 5,317 residents. Many of these EMS units are not able to communicate effectively with one another, although new communication technology can alleviate most of the problems. Adopting new communication systems would allow hospital emergency room personnel to better treat the patient or transport the patient to a tertiary facility.

⁷ Institute of Medicine (2006). *Emergency Medical Services at the Crossroads*. Washington, D.C.: The National Academies Press.

To improve coordination and communication among EMS providers and between EMS providers and other health care services (e.g., hospitals), a new vision is needed. This vision needs to take into account the overlapping EMS roles and responsibilities that include health care, public health, and public safety. This new vision and the strategic initiatives to achieve the vision need to consider which entity or entities should lead this effort and ultimately assume responsibility and accountability for the performance of EMS care. Consideration should also be given to identifying the strengths and weaknesses of regionalization and what standards need to be established to evaluate the quality and performance of the EMS system. In Nebraska, no public or private entity is responsible for the scope, authority, and operation of local EMS systems. Finally, it will be critical to identify potential local, state, and federal funding sources, existing and new incentives, and reimbursement policies to make the EMS system more effective and efficient.

Recommendations

1. After successful system improvements at the local and regional levels, the Nebraska Office of Emergency Medical Services in the Division of Public Health should organize a broad based coalition that includes representatives from key EMS organizations, local ambulance services, hospital administrators, hospital personnel, physicians, state and local public officials, and others for the purpose of developing a state EMS plan. The plan should address roles and responsibilities of various public and private entities, assess the strengths and weaknesses of regional models and the coordination of large and small EMS units, and identify measures that can be used to evaluate the quality and performance of local ambulance visits and the state EMS system. The coalition should recommend an entity at the county or regional level that would be responsible for EMS services in the area.
2. The Nebraska Office of Emergency Medical Services should continue to assess local EMS services and encourage innovative models that make the system more effective and efficient.
3. The Nebraska Office of Emergency Medical Services and Office of Health Statistics should develop a data management plan with the assistance of experts of the DHHS Epidemiology and Informatics Unit and external partners. The plan should identify the essential data elements, develop a guideline for data dictionary and databases, data utilization protocols that are needed for EMS performance and improvement in addition to public health emergency preparedness and public health surveillance such as syndromic surveillance, injury surveillance and cardiovascular disease surveillance.
4. The Nebraska Hospital Association should work with the Nebraska Congressional delegation to allow all hospitals that own or manage EMS ambulance units to receive cost-based reimbursement. (Currently, only hospitals that own or manage EMS units that are 35 miles from another unit can receive cost-based reimbursement.)

V. In-Home Care and Long-Term Institutional Care Services

In rural Nebraska, the percentage of the population over 65 years of age is 17.6 percent as compared to 11.1 percent in urban areas. With an older population, rural areas have a higher proportion of chronic illnesses and need for all types of health care services. Despite a greater need for services, access to these services is limited by the lack of public transportation, an inadequate supply of health care providers, limited in-home support services, and inadequate resources to pay for these services. Access to home health and in-home services vary considerably across the state. Although long-term institutional care services (i.e., skilled nursing care and assisted living care) are generally available, these services are more expensive and many of these facilities receive a significant proportion of their revenues from Medicaid. In addition, all critical access hospitals have swing beds which provide long-term care support.

While it is critical to have an adequate supply of long-term care beds, it appears that there is an imbalance between institutional care and in-home care. New technology and greater support services would allow a greater share of the aging population to remain in their own homes for a longer period of time and would reduce costs.

Recommendations

1. Develop and implement pilot projects to evaluate new models of in-home care, telemedicine, and home monitoring technology.
2. Assess the feasibility of providing public transportation at least in some regions of the state.
3. Establish a “team approach” training program for present health care providers and provider facilities to train medical teams that can provide care for the at-risk elderly population.
4. Use health information technology to assess patient needs and support treatments at multiple points of care.
5. Develop training initiatives for providers related to the aging patient (e.g., pharmacy modifications and appropriate treatment of the elderly trauma patient).
6. Expand the number of health professionals (e.g., geriatric nurses, certified nursing assistants, and mental health professionals) who are better able to provide care for older patients.

VI. Communication and Information Technology Systems

Electronic technologies are transforming the rural health delivery system and they have the potential to expand access to services, improve quality of care, and provide clinical and managerial data that will support informed decision-making. For example, electronic health records have already been implemented by most hospitals and the majority of physician clinics.

While these data are now generally used for internal decisions, in the future they will be shared among all providers. New technology has improved the quality of care through e-ICUs, remote EKG readings, teletrauma, e-pharmacy, telebehavioral health, telemedicine access to specialty care (e.g., cardiologists), and home monitoring systems. Unfortunately, most of these new technologies are greatly underutilized because of payment policies, lack of training, and practice cultures.⁸

Recommendations

1. With staff from the Department of Health and Human Services, identify best practices in advanced rural telehealth network models that could be duplicated in other areas of the state.
2. Promote and encourage the use of telecommunications for consultations, education, and electronic health information delivery to and from homes, hospitals, and other health care providers.
3. Promote the development of strong telecommunications linkages between public health departments, area hospitals, and other health professionals to address district-wide, regional, and statewide health needs.
4. Support the use of electronic health records (EHR) technology by all health care providers and share patient information through health information exchanges. It is going to be very important that all Health Information Exchanges (HIEs) communicate and share data so support should be given to the Nebraska Health Information Initiative (NeHII). They are the prominent HIE in the state and, with proper support, can be a valuable partner with patients and providers in the sharing of patient data and the development of a complete electronic patient record. They can also become the ideal conduit to share data with public health and other state and federal agencies.
5. Develop and use of standardized protocols for all reporting, transmitting, and the exchange of all health care data.
6. Develop the capacity in state agencies so they can send and receive important patient information that providers with certified EHRs are required to transmit and receive.

Conclusion

The health care environment is changing rapidly and these changes are having a dramatic impact on the rural health system. These recommendations attempt to bridge some of the major gaps during this transition. While there are many new opportunities to help achieve the Commission's vision (e.g., new incentives to build integrated models of care, new data that can be used to improve quality and health outcomes, and new technologies to expand access to care), many

⁸ "The Future of Rural Health," The National Rural Health Association, 2013, pp. 18-20.

major challenges remain. Some of these challenges include a shortage of health professionals, more consolidated networks which could threaten local control of health services, and lower reimbursement rates which makes it more difficult to build integrated care models. However, by working together and moving quickly, communities have the opportunity to reshape their health system to produce better health outcomes, better quality of health care services, and a more efficient, cost-effective system.