RURAL HEALTH ADVISORY COMMISSION

NEBRASKA OFFICE OF RURAL HEALTH
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MINUTES of the

Rural Health Advisory Commission (RHAC)

Thursday, May 26, 2022

1:30 p.m. – 4:18 p.m.

Crowne Plaza & Younes Conference Center North
Bronze 5 Meeting Room
707 W. Talmadge Street
Kearney, NE

And virtual via Zoom:
https://us06web.zoom.us/j/84733371637?pwd=ZFMzTkpvc0U3TEsraElJbm0wWDR5QT09

1. **Call Meeting to Order; Open Meetings Act and Agenda Posted/Available for Download; Adopt Agenda; Approve Minutes from March 18th, 2022 Meeting**

Vice Chair Rebecca Schroeder, Ph.D. called the meeting to order at 1:35 p.m. with the following members present: Gary Anthone, M.D.; Sheri Dawson, R.N.; April Dexter, N.P.; Jessye Goertz; Michael Greene, M.D.; Jeffrey Harrison, M.D.; Lynette Kramer, M.D.; Rebecca Schroeder, Ph.D; Roger Wells, PA-C.

Guests in attendance: Nicole Carritt, MPH, UNMC; Julie Fedderson, M.D., CMO, United Healthcare; Jeff Stafford, United Healthcare; Todd Stull, M.D.

Vice Chair Schroeder announced that the meeting notice had been posted to the DHHS website and sent out via email and USPS on May 12, 2022.* Handouts, the open meetings act, and agenda were also posted on the DHHS website, with a link to these given on the agenda itself *(http://dhhs.ne.gov/Pages/Rural-Health-Advisory-Commission.aspx - under "Documents").* Additionally, the open meetings act and meeting agenda were posted outside the meeting room.

**Sent as usual to: NE Rural Hospital CEOs, NE Certified Rural Health Clinic Directors, NE Local Public Health Departments, NE Community Action Partners, NE Community Health Centers/FQHCs, NE Professional Associations/Organizations, NE State Senators, the Offices of the Governor and Lt. Governor, and other rural interested groups and parties.*

Roger Wells, P.A. moved to approve the May 26th, 2022 meeting agenda and Gary Anthone, M.D. seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Anthone, Dawson, Dexter, Goertz, Greene, Harrison, Kramer, Schroeder, Wells. ABSTAIN: None. EXCUSED: Fattig, Hunt, Wallman. Motion carried.

Lynette Kramer, M.D. moved to approve the March 18th, 2022 meeting minutes and Jessye Goertz seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Anthone, Dawson, Goertz, Greene, Harrison, Kramer, Schroeder, Wells. ABSTAIN: Dexter. EXCUSED: Fattig, Hunt, Wallman. Motion carried.

2. Administrative Items

Commission Member Update:
The position of Rural Dentist remains open. Parties interested in serving can apply via the application located here: https://governor.nebraska.gov/board-comm-req

In September, the following members are up for appointment/reappointment and must reapply if they wish to continue serving:

April Dexter – Amelia – (2017) – (Rural Nurse)
Martin L. Fattig – Auburn – (2004) – (Rural Hospital Administration)
Jessye A. Goertz – Brock – (2013) – (Consumer)
Lynette Kramer – Albion – (2018) – (Rural Physician)

3. Understanding Health Needs of Rural Nebraska

Julie Fedderson, M.D., CMO; and Jeff Stafford – both with United Healthcare (UHC) – spoke about the company's efforts to improve health outcomes in Rural Nebraska.

Dr. Fedderson is an internist by training and a hospitalist with UNMC who recently transitioned into her current role with UHC/Medicaid. She spoke about some of their projects and experiences in assessing the healthcare delivery system. They've seen Telehealth and teleconsultation filling in gaps for shortages of specialty MDs, behavioral health providers, and other providers. They're looking at how to leverage existing providers, but would also like to look at building other types of support; for example – an ARPN or nurse run clinic. Transportation is always an important consideration for rural areas, and NE Medicaid does offer transportation to get to visits. Bandwidth and Wi-Fi are also concerns. Dr. Fedderson mentioned it's great to have those telehealth options, but patients and providers need reliable internet to be able to access this. The issue becomes: how to make sure technology is available to those that need it. Looking at quality issues, rural areas have higher mortality in general. Data shows you what is there, but doesn't tell the whole story. They are considering the best approach in communicating about behaviors like smoking or immunization, tailored to the audience at hand (a particular community). Sometimes smaller practices are doing better on these metrics and UHC is getting in touch with them to find out why. Access to educational opportunities can also be an issue for rural providers. UHC is reaching out to make sure opportunities are equivalent. Keeping rural providers up to date maintains access to well-researched, evidence-based medicine for rural folks. Quality improvement projects are also important to fund and focus on rural areas. Considering traditional insurer-driven projects: they are asking how to do something different where the needs of the community are supported without using a claims-based model. Examples: support for community organizations that provide food, partnering with local health departments, etc. Ensuring equity is important. There are lower education levels and general socioeconomic status in rural areas, but rural areas are all unique. Geographic location and isolation produces its own issues. Once a specific lack of access is identified, UHC wants to ensure appropriate services are in place to produce successful outcomes. Public health is the main point. Looking at the late 2020 flu model (expected a high level of flu that year); they leveraged what local health departments were already doing and offered an incentive to create plans and educate people. There was ultimately a similar rate of flu vaccination that year despite a lapse in primary care visits, so they saw this as a success (Building Pathways). The following year they focused on COVID; this involved exchanging data to find where disparities were and then targeting the message to groups with

poorer uptake. By providing this data to local health department, they were able to determine which populations needed outreach/where there were cultural issues. Rural agricultural and farm families were identified as a group that needed outreach. They had members of the community speak out about importance of vaccination. Identified women of childbearing age as another group in need of more information. Used a repository with college of public health (vaxnebraska.org) publically available and full of data/resources. Now, they are extending investment into nontraditional partners. Dentistry is a real gap in Nebraska. There's a concerning decline in those who will take Medicaid patients, resulting in an erosion of outcomes in rural vs urban children (proactive care, cavity care, etc). Dr. Charles Craft from DHHS along with the local health departments designed a dental hygienist model to support what's already built but extend it further. They came up with a ramped up proactive model for areas experiencing a lack of providers. When individuals come in for dental work, they often talk about other health issues, which makes it a good opportunity to provide primary care access. Work as a full unit – UHC plus Medicaid partners (the other two MCOs have agreed to support this and other projects).

Jeff Stafford then spoke, remarking he was proud to have people working together. SDOH – fashionable, hard pressed to have a meeting without it being mentioned. COVID has made us think it's time to get outside of what have been some of our silos. Partnered pretty heavily with Creighton. MLTC wanted to see some pilots. Some of the effort was focuses on urban at least initially. Working to implement in a rural setting – will be a different looking solution. They would like to hear from folks what they're missing. Looking for more perspectives on how individual communities can be supported. Looking at nonprofits, also want to partner with schools and churches. It's not just about vaccines; it's about getting on the same page with what will work and educating more broadly/helping with access to care.

Dr. Fedderson then spoke again. When trying to determine where they could help, early days with COVID, people were doing so much basic healthcare related stuff that they didn't have the time to look at what would work for marketing, collecting and distributing data, etc. That's where UHC decided they could help (on the gathering of items) so the LHDs and providers can do what they do best rather than having to search and sort through for the most relevant materials. She mentioned the importance of developing different pathways (with local input) for Omaha/Lincoln vs these rural communities. SDOH project with Four Corners currently, is what we're doing in Lincoln/Omaha going to translate to here? Lexington - idea around chronic patients trying to maintain outpatient lifestyle. Building and sustaining workforce is another big area of consideration. Major economic impact of healthcare providers on a community. As an insurer, how do we support that? Back to the dental example, has been hard to get folks to support/retain. Can we build supports for that? Pay incentives? Continuing education/assistive technologies/EMRs. Getting tools they need to people.

Discussion of how dental is not typically covered by standard insurance but impacts physical health and is a gateway to talk to people about other health issues, how to sign up for Medicaid, why other preventative screenings are good, etc.

Lynette Kramer, M.D. then spoke about public health during COVID being inconsistent. One school was getting different messages from five different public health departments. Community health workers have been discussed a lot; would like to continue discussing and look at how to implement for some home based checkups. Again, this brings up the issue for workforce; is there anything insurance or Medicaid can do to support these projects? Transfer is one of the biggest issues they are seeing lately - lack of access, long wait times. Is there a way to support local and volunteer first responders? Also need to keep mental health high on the list. Spoke about how they are using telepsychiatry. Dr. Fedderson asked if they could implement a project in Dr. Kramer's county. Dr. Kramer said their RNs are doing transfers because of issues with access to EMS/paramedics (all volunteer).

Sheri Dawson, R.N. spoke up and said CMS/Medicaid has additional funding now for crisis calls and mobile crisis teams. She mentioned she could speak about this at the next Commission meeting. She also mentioned to Dr. Kramer that they're working on a bed registry.

Nicole Carritt, MPH; UNMC – Director of Rural Health Initiatives – presented next (see PowerPoint).

- Pipeline of health providers being newly trained will not make up for the amount retiring
- Importance of keeping people at home/in their communities as long as possible – how do we do that
- Housing different types of providers together so they are more aware of each other/building relationships/communities can attempt to recruit teams of health providers
- Let's ask what the issues are for providers in these rural areas and develop programs honed to address them. We know what the issues are on a broad level, but not specifically, and not specifically how to address them. Involve whole community.
- Bold Ideas – flipping the script
- Make sure students are having a good experience in rural clinicals
- Training programs in the community so they don't have to leave to be trained
- Kearney project – The American Rescue Plan Act of 2021 ("ARPA") funding; hope to have it open in Fall 2025 (up to 600 learners, doubles capacity)
- Communities need short-term housing for students
- Behavioral Health Education Center of NE also received some ARPA funding – how do we grow and support this workforce, ensure access for rural communities
- Real life scenarios for sim vans; what are the situations helpful to each community

4. Integrated Care

Todd Stull, M.D. presented next. Sheri Dawson, R.N. introduced him, stating that he would discuss implementation of integrated health, which was mentioned in the Commission's recommendations and at the last meeting.

Dr. Stull remarked that he hopes this is part of an ongoing series of discussions. Discussed behavioral components of physical problems and the importance of meeting people where they're at and continuing to learn and grow. Integrated care = collaborative care. Nebraska is in the bottom tier of states with primary care doctors co-located with behavioral health providers. According to a recent needs assessment survey, time and lack of referral options are top two barriers. When behavioral health providers are co-located in clinic, actual communication with providers improves drastically (within clinic includes telehealth). Main barrier for referrals is a lack of providers (either no provider or schedule is full). Follow up is better if the care is collaborative (providers in same location/associated with one another). Psychiatry and mental health are the most needed professionals to add or expand at clinical site. Cost and lack of available providers are top two barriers to adding mental health therapists on site. Half of providers said "maybe" or "yes" to being part of a pilot for these issues. Reverse integration – mental health providers hire pediatricians/ dieticians/etc. They are looking for feedback and want to develop programs. Dr. Stull would welcome an invite to provide updates to the Commission on progress of these and encouraged Commission members to reach out to him with any questions.

Jeff Stafford will be reaching with ways they can support.

Rebecca Schroeder, Ph.D. mentioned the Commission has been discussing integrated care for twenty years and that it's great to have an update.

A short break was taken and the meeting was called back to order at 3:37 p.m.

5. Rural Health Systems & Professional Incentive Act Program Updates

Review and Update State Shortage Area Guidance:
Rachael Wolfe explained that, as discussed at the last meeting, there would be a vote to remove the following wording from the existing shortage area guidelines, simplifying and clarifying the process:

REMOVE: "If the population to FTE ratio is greater than the population of the service area, the population of the service area will be entered as the ratio. The Rural Health Advisory Commission will review individual concerns about full employment of a service area."

Tom Rauner remarked that when there are no physicians, the ratio begins to count against the county, where a partial FTE would make the area qualify. This complicates the assessment process and penalizes counties without providers. He believes it was related historically to some prioritization criteria but is no longer effective for that purpose.

Lynette Kramer, M.D. moved to approve the removal of the language and Jessye Goertz seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Anthone, Dawson, Dexter, Goertz, Greene, Harrison, Kramer, Schroeder, Wells. ABSTAIN: None. EXCUSED: Fattig, Hunt, Wallman. Motion carried.

Review and Approve Updated State Shortage Areas:
This is the statewide assessment done every three years. The Commission gave initial approval for updated maps at the last meeting. A 30-day period of public comment followed the last meeting. The updated maps were posted on the website and emailed out to the following groups: rural health advisory commission members (RHAC), RHAC interested parties, student loan recipients with forgiveness or in training, loan repayment recipients and community contacts, NE rural hospitals, NE certified rural health clinics, NE professional organizations/associations, NE Public Health Departments, NE community action partnerships (CAPs), and Community Health Centers/FQHCs. After the Commission's approval, the new maps will replace the old ones on the website at the start of the State's new fiscal year (July 1, 2022).

Updates since the initial approval: Morrill County keeps its family medicine designation; Rock County keeps its pharmacy designation.

Comments: three letters were submitted and represented to the Commission.

Roger Wells, P.A. moved to approve the updated state shortage areas and Jessye Goertz seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Anthone, Dawson, Dexter, Goertz, Greene, Harrison, Kramer, Schroeder, Wells. ABSTAIN: None. EXCUSED: Fattig, Hunt, Wallman. Motion carried.

Update Policy to Allow Multiple Loan Repayment Awards in Certain Situations:
Five million in American Rescue Plan Act of 2021 ("ARPA") funding available to make full awards with no match requirement only to those providers whose contracts start 7/1/22 or later. The funds must be obligated by December 2024 and spent by December 2026. Proposal to use federal funds allocated with LB1007 to allow a new full award to be given to any qualified applicant who has already completed loan repayment so as to use all federal funds and expand access to the no match benefit. Any applicant would still need to be approved by the Commission, but this could help with retention.

"For as long as The American Rescue Plan Act of 2021 ("ARPA") funds are available, an award may be given to any qualifying provider regardless of status as a previous state loan repayment recipient or amount of prior award. These awards will be made at the discretion of the commission and for the purpose of retention."

Michael Greene, M.D. moved to add the above wording to the Commission's guidelines and Roger Wells, P.A. seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Anthone, Dawson, Dexter, Goertz, Greene, Harrison, Kramer, Schroeder, Wells. ABSTAIN: None. EXCUSED: Fattig, Hunt, Wallman. Motion carried.

Budget Update:
Ms. Wolfe then gave an update on the budget. Total obligated in FY2021-22 (ending in June) was about $1.7 million out of the total General Fund allotment of $2.18 million. This means a little over $400,000 will be carried over to next year.

Total currently obligated for FY2022-23 is $1.5 million out of the anticipated General Fund allotment, plus carryover, of around $2.6 million total. Just over $1 million remains to be obligated, and cash Spending Authority was increased sufficiently for FY2022-23.

Additionally, $5 million in ARPA funding has been made available for loan repayment with no match required. The "no match" stipulation is only allowable for contracts starting July 1st or later. The funds must be obligated by December 2024 and spent by December 2026. All new applicants and some approved applicants who had not yet been paid will be moved to this funding source, so $3.5 million is already obligated, with $1.5 million remaining.

This means there is $2.5 million unobligated for the fiscal year that begins in July; $1.5 million for no match awards, and $1 million for state loan repayment. The Federally-funded NHSC SLRP program would like to utilize some of these funds as match for doctorate level providers. ORH will likely get one support staff position to help manage the ARPA funds.

If the Commission would like to begin making student loan forgiveness awards again, there is need for more staff to manage the program. Each contract can take up to twelve years to complete between the initial award and the completion of the service obligation, plus more time spent on defaults as that program generally sees a much higher default rate. It could be beneficial to look at amending the existing statute to increase the maximum for student loan forgiveness awards, giving out a larger award later in schooling when providers are more likely to be committed to a certain area of practice.

Another amendment to consider would be to extend the "no match" awards past December 2026, at least for certain providers that have historically had difficulty getting community match, like behavioral health providers and dentists.

Lynette Kramer, M.D. asked about possibly increasing loan repayment awards; what is the history. Other members replied that it had been done before. Commission members requested the average student loan debt of current recipients and recent applicants be sent to them.

Rebecca Schroeder, Ph.D. stated that loan repayment is clearly the more successful program when compared to student loan forgiveness. She would like to see the "no match" option expanded for loan repayment recipients.

Michael Greene, M.D. asked what other states do. Tom Rauner replied that many rely on federal programs and put up match with state funds.

Roger Wells, P.A. mentioned that individuals do go to Kansas from Nebraska because Kansas pays off more of their loans. He wants to know if we should try to amend the current statute to increase maximum awards or do away with local match in certain situations.

Rachael Wolfe will make available documentation of average loan balances as well as average amounts other states award.

6. Rural Health Advisory Commission Recommendations

Commission members agreed not to discuss this item at this time as there had already been three speakers. Roger Wells, P.A. would like to bring a provider to discuss remote pharmacy and changes in rural pharmacy to the next meeting. This is associated with the recommendations insofar as it is an innovative item.

7. CLOSED SESSION

Lynette Kramer, M.D. moved to go to closed session for the purpose of review and discussion of accounts receivable, loan repayment program applications, and other confidential information, and for the prevention of needless injury to the reputation of the individuals at 4:08 p.m.

Roger Wells, P.A. seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Anthone, Dawson, Dexter, Goertz, Greene, Harrison, Kramer, Schroeder, Wells. ABSTAIN: None. EXCUSED: Fattig, Hunt, Wallman. Motion carried.

Rebecca Schroeder, Ph.D. announced that the Commission would go into Closed Session at 4:10 p.m.

There were no guests remaining.

8. OPEN SESSION

Jessye Goertz moved to go into Open Session at 4:15 p.m. and Michael Greene, M.D. seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Anthone, Dawson, Dexter, Goertz, Greene, Harrison, Kramer, Schroeder, Wells. ABSTAIN: None. EXCUSED: Fattig, Hunt, Wallman. Motion carried.

Jeffrey Harrison, M.D. moved to approve the loan repayment applications with estimated loan repayment start dates and loan repayment amounts as indicated or as determined by Office of Rural Health staff, based on issuance of license and/or loan documentation, practice time in the shortage area, and the availability of funds for the state match. Roger Wells, P.A. seconded the motion. Deb Stoltenberg initiated roll call vote. YES: Anthone, Dawson, Dexter, Goertz, Greene, Harrison, Kramer, Schroeder, Wells. ABSTAIN: None. EXCUSED: Fattig, Hunt, Wallman. Motion carried.

First Name:	Last Name:	Profession: (if you do not see your profession listed, you are not eligible for the Loan Repayment Programs)	Specialty: (if you do not see your specialty listed, you are not eligible for the Loan Repayment Programs)	Site 1 County:	State Award Amount:	SLRP Minimum Award Amount:	SLRP Maximum Award Amount:
Melissa	Schock	DDS/DMD	General Dentistry	Nance	$131,113.80		
Mikaela	Shaw	DDS/DMD	General Dentistry	Merrick	$90,000.00		
Rebecca	Lechner	Nurse Practitioner	Family Practice	Otoe	$90,000.00	$30,000.00	$60,000.00
Tracy	Ross	Nurse Practitioner	Family Practice	Otoe	$47,248.00		
Janice	Cunningham	Nurse Practitioner	Psychiatry	Adams	$50,698.00		
Shannon	Linton	Nurse Practitioner	General Internal Medicine	Buffalo	$31,500.00		
Cathrynn	Horacek	Occupational Therapist		Lincoln	$90,000.00		
Abigail	Sheets	Nurse Practitioner	Family Practice	Saline	$56,250.00		
Daniell	White	Nurse Practitioner	General Internal Medicine	Buffalo	$68,902.30		
Jamie	Schmeits	Nurse Practitioner	General Internal Medicine	Buffalo	$87,400.00		
Blake	Johnson	Physician Assistant	General Internal Medicine	Buffalo	$90,000.00		
Nicole	Walz	Physician Assistant	General Internal Medicine	Buffalo	$90,000.00		
Ann	Scott	Nurse Practitioner	General Internal Medicine	Buffalo	$90,000.00		
Rebecca	Beckler	DDS/DMD	General Dentistry	Hall	$180,000.00		
Amy	Nelson	Nurse Practitioner	General Internal Medicine	Adams	$84,175.00		
Tanner	Huckabee	Physician Assistant	General Internal Medicine	Buffalo	$90,000.00		
Mackenzie	Allen	Physician Assistant	General Internal Medicine	Buffalo	$90,000.00		
Taryn	Lienemann	Physician Assistant	General Internal Medicine	Buffalo	$47,000.00		
Sydney	Meyer	Physician Assistant	General Internal Medicine	Buffalo	$90,000.00		
Kelsey	Peterson	Nurse Practitioner	General Internal Medicine	Buffalo	$49,000.00		
Alan	Spanel	MD/DO	General Internal Medicine	Madison	$165,524.04		
Jenna	Hilker	Nurse Practitioner	Family Practice	Garfield	$90,000.00	$45,000.00	$90,000.00
Stephani	Thompson	Licensed Mental Health Professional		Lincoln	$90,000.00		
Krystal	Novotny	Registered Nurse (Bachelor's level or higher)		Valley		$35,862.78	$35,862.78
Robert	Nunns	Pharmacist		Fillmore	$90,000.00		
Molly	Cawley	DDS/DMD	Pediatric Dentistry	Douglas	$180,000.00	$100,000.00	$200,000.00
Kellie	Stone	Licensed Mental Health Professional		Adams	$90,000.00		
Mikayla	Wiese	Physician Assistant	General Internal Medicine	Adams	$36,583.34		
Johnna	Richter	Pharmacist		Dawson	$90,000.00		
Joseph	Ziemba	Licensed Mental Health Professional		Buffalo	$58,965.44		
Trisha	Goembel	Nurse Practitioner	Family Practice	Wayne	$90,000.00		
Beau	Fry	MD/DO	Family Practice	Holt	$180,000.00		

9. Review Current Federal & State Legislative Activities Impacting Rural Health

Roger Wells, P.A. remarked that he would email a report to Deb Stoltenberg to be distributed to the Commission members.

10. Public Comment

No guests remaining.

11. Adjourn

Lynette Kramer, M.D. moved to adjourn at 4:18 p.m., and no second is necessary. Deb Stoltenberg initiated roll call vote. YES: Anthone, Dawson, Dexter, Goertz, Greene, Harrison, Kramer, Schroeder, Wells. ABSTAIN: None. EXCUSED: Fattig, Hunt, Wallman. Motion carried.