

Louisiana Rural Health Plan 2011-2015



Acknowledgements

This *2011 – 2015 Louisiana Rural Health Plan* was developed by the Louisiana Department of Health and Hospitals' Bureau of Primary Care and Rural Health, and is the product of numerous partnerships and collaborations throughout the State. The plan would not have been possible if it were not for the invaluable expertise, experience and commitment of a multitude of organizations, individuals, government officials, hospital providers, rural advocates and citizens who are dedicated to improving the quality of life, health and health care services for rural Louisianans.

To the many partners of the Bureau of Primary Care and Rural Health who continually step up to ensure that health and health care issues are representative of the needs and the desires of the residents of Louisiana, the state and its citizenry are grateful for your dedication, sacrifice and expertise.

To all who will continue to partner with the Bureau of Primary Care and Rural Health over the life of this plan to ensure timely and accurate implementation, as well as guidance and benchmarking, please accept our gratitude in advance for your time, energy and resources.



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Bureau of Primary Care and Rural Health Mission Statement:

“To improve the health status of Louisiana residents in rural and underserved areas by building health systems’ capacity to provide integrated, effective and efficient health care services.”

Background

Louisiana is located in the Southern region of the United States, bordered to the west by Texas, to the north by Arkansas, to the east by Mississippi, and to the south by the Gulf of Mexico. The state is divided into 64 parishes, which are similar geo-political units to counties. Louisiana is ranked 31st in terms of size in the United States, and covers 43,562 square miles. The 2010 estimated population for Louisiana was 4,533,372 people – with 1,152,634 people living in rural Louisiana. Baton Rouge is Louisiana's state capital. The state's largest cities are New Orleans, Baton Rouge and Shreveport. According to the U.S. Census Bureau, 62 percent of the state's population is white, 31 percent is African-American, 3 percent is of Hispanic origin and 3 percent is of other origin.

According to the U.S.D.A. Economic Research Service, the average per-capita income for all Louisiana residents in 2008 was \$36,091, although rural per-capita income lagged at \$29,698. Estimates from 2009 indicate a poverty rate of 21.8 percent exists in rural Louisiana, compared to 16.2 percent in urban areas of the state. Data collected in 2000, reported that 32.6 percent of Louisiana's rural population had not completed high school, while 22.7 percent of the urban population lacked a high school diploma.

The state's principal agricultural products include seafood (Louisiana is the largest producer of crawfish in the world, supplying approximately 90 percent), cotton, soybeans, cattle, sugarcane, poultry, eggs, dairy products and rice.

Industry generates chemical products, petroleum and coal products, food processing and transportation equipment and paper products. Tourism is also important to the State's economy.

The Port of South Louisiana, located on the Mississippi River between New Orleans and Baton Rouge, is the largest-volume shipping port in the Western Hemisphere and fourth-largest in the world. In addition, it is the largest bulk cargo port in the world.

State government in Louisiana is similar to other states in that the state is struggling with a sluggish economy, coupled with a growing demand for public support of health and social services. Louisiana is different from most states in that Louisiana and its people have a recent history of having been negatively impacted by natural disasters, hurricanes, floods, as well as the Deep Water Horizon oil spill in the Gulf in 2010.

The residents of Louisiana have a wide variety of hospitals in the state to meet the needs of a very diverse population. Located in the rural parishes and communities are small rural hospitals, critical access hospitals and acute care hospitals. Additionally, the State of Louisiana operates the "public" hospital system, which provides care to those who are uninsured, under-insured, as well as patients who have health insurance. There is at least one public hospital in each of the nine state regions – thus providing local access for a majority of the citizenry. The state also has three medical schools with dedicated hospitals. Additionally, the urban areas of the state are served by a number of large private hospital systems.

Demographic data for Louisiana, as compared to the United States, is shown on the following page.



*Louisiana and United States: Selected Demographics

*Louisiana data is 2008 - 2009; the U.S. data is 2009.

	Louisiana #	Louisiana %	US %
Distribution of Total Population by Federal Poverty Level			
Under 100%	1,002,000	23%	20%
100-138%	368,900	8%	8%
139-250%	885,200	20%	21%
251-399%	794,200	18%	19%
400%+	1,334,100	30%	32%
Population Distribution by Age			
Children 18 and under	1,199,900	27%	26%
Adults 19-64	2,636,800	60%	61%
65+	547,700	12%	13%
65-74	297,100	7%	7%
75+	250,600	6%	6%
Population Distribution by Race/Ethnicity			
White	2,725,300	62%	65%
Black	1,378,900	31%	12%
Hispanic	146,800	3%	16%
Other	133,400	3%	7%
Population Distribution by Metropolitan Status			
Metropolitan	4,533,372	75%	84%
Non-Metropolitan	1,152,634	25%	16%

*Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the U.S. Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements) and U.S. Economic Research Service, State Fact Sheet, Louisiana

<http://www.ers.usda.gov/StateFacts/> accessed July 2011

Chart Notes:

Population and demographic data are based on analysis of the Census Bureau's March 2009 and 2010 Current Population Surveys (CPS; Annual Social and Economic Supplements) and may differ from other population estimates published yearly by the U.S. Census Bureau. U.S. and state population data displayed on this site are restricted to the non-institutionalized, civilian (not active duty military) population; state data represents two-year averages.

"Other" includes Asian-Americans, Pacific Islanders, American Indians, Aleutians, Eskimos and persons of "Two or More Races." These groups have been combined due to their small populations in many states which prevent meaningful statistical analyses of the groups individually. Persons of Hispanic origin may be of any race; all other racial/ethnic groups are non-Hispanic.

Metropolitan Statistical Area must include at least one city with 50,000 or more inhabitants, or a Census Bureau defined urbanized area of at least 50,000 inhabitants and a total metropolitan population of 100,000 or more (75,000 in New England). See U.S. Census Bureau, www.census.gov.

Persons in poverty are defined as those living in "health insurance units" with incomes less than 100 percent of the Federal Poverty Level (FPL) as measured by the U.S. Department of Health and Human Services' (HHS) poverty guidelines. Health insurance units are related individuals who would be eligible as a group for "family" coverage in a health plan. The federal poverty guideline for a family of four in the 48 contiguous states and D.C. was \$21,200 in 2008 and \$22,050 in 2009. The U.S. Census Bureau produces simplified, but very similar versions of federal poverty guidelines called "poverty thresholds." For more information on measures of poverty, see the detailed description provided by HHS at <http://aspe.hhs.gov/poverty/faq.html>.

As the state health agency in Louisiana, DHH has many varied responsibilities. DHH has been working to improve access to health care services in rural and urban areas across the State for many years. Prior to the late 1990s, the Office of Primary Care and the Office of Rural Health operated separately. The current configuration, combining the Office of Primary Care and the Office of Rural Health, was done to strengthen the work and highlight the priority on rural health and primary care.

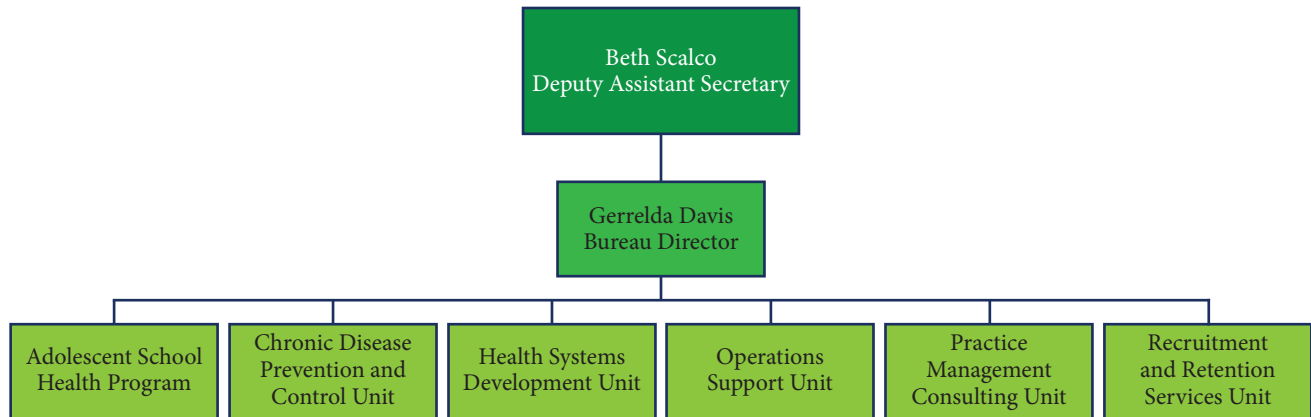
The Bureau of Primary Care and Rural Health (BPCRHR) is a unit of state government, organizationally located within the Louisiana Department of Health and Hospitals' (DHH) Office of Public Health (OPH). The seasoned staff of the BPCRHR are respected both within the Department and throughout the State for their expertise and hard work, as well as their credibility, diligence and ability to grasp rural issues. In addition, the staff are able to find solutions that benefit the citizens living in rural Louisiana; providers practicing in rural areas; and providers who serve the underserved populations living in non-rural areas.

Technical assistance is provided to communities statewide, 85 federally qualified health centers (FQHCs), physician practices, 115 rural health clinics (RHCs), 27 critical access hospitals (CAHs), as well as 38 small rural hospitals.

Through its work with organizations across Louisiana, the BPCRHR is committed to developing strong community partnerships and integrated primary care services to reduce health disparities and improve health. Additionally, the BPCRHR works to support effective clinical practices, health care organizations and workforce development initiatives to ensure a sustainable health care system that provides access to needed health services for all.



Office of Public Health - Bureau of Primary Care and Rural Health



The BPCRHR provides services through six organizational units or programs, as depicted above. These units and programs include the Adolescent School Health Program, the Chronic Disease Prevention and Control Unit, the Health Systems Development Unit, the Operations Support Unit, the Practice Management Consulting Unit and the Recruitment and Retention Services Unit. Together, these units and programs provide a continuum of services to establish, enhance and sustain health care services for all Louisiana residents. Units and programs work together to support the rural health delivery system. Staff and resources from all the units are included as assets in the Louisiana Rural Health Plan. The main functions of the BPCRHR units and programs, outlined below, is to work collaboratively to support access to health services for rural citizens.

The Chronic Disease Prevention and Control Unit administer programs related to the State's chronic disease initiatives to reduce the burden of asthma, diabetes, heart disease and stroke and to help control the use of tobacco. In addition, through the Chronic Disease Prevention and Control Unit, BPCRHR is responsible for developing and publishing the Behavioral Risk Factor Surveillance Systems (BRFSS) for Louisiana.

The Health Systems Development Unit provides strategic planning, needs assessments, group facilitation and resource development to create community support and to ensure the success of health care development projects. Federal resources help support this work, through the U.S. Department

of Health and Human Services' Health Resources and Services Administration (HRSA), including the Office of Rural Health Policy (ORHP), the Medicare Rural Hospital Flexibility (FLEX) Program and the Small Rural Hospital Improvement Program (SHIP). This unit also works directly with RHCs and FQHCs by providing technical assistance and other support. In prior years, this unit also administered the State-funded Community-based and Rural Health Program (CBRHP) Grant. Effective in Fiscal Year 2011, funding for the CBRHP was eliminated due to budget limitations.

The Operations Support Unit manages and administers State budget appropriations, line item appropriations, budgets for federal and philanthropic grants and any other ancillary budgets administered and/or received by BPCRHR.

The BPCRHR also developed and makes available a Practice Management Consulting Unit. This unit provides market analyses, feasibility studies, patient flow analyses and medical records review. Medicaid and insurance billing technical assistance is also offered, as well as training on medical coding to promote better financial performance, enhanced quality of care and better patient health outcomes for primary care providers in rural and underserved areas.

The Recruitment and Retention Services Unit, partially supported by the federal HRSA, provides incentives for physicians and other practitioners to work in underserved areas. The unit reviews and

recommends designations of Health Professional Shortage Areas (HPSAs) and administers the J-1 Visa Waiver Program, the State Loan Repayment Program for health care providers, state initiatives for the National Health Service Corps Program and the Primary Care Office grant. The unit works in conjunction with Med Job Louisiana, Louisiana's state funded professional recruitment service, managed by the state's Area Health Education Centers (AHECs).

In March 2011, the BPCRHR assumed responsibility for the Adolescent School Health Program, which administers the state's School-Based Health Center (SBHC) investments. SBHCs were started in Louisiana in 1990, when policymakers became concerned about the high morbidity and mortality rates of adolescents and children. At that time, the Legislature requested that OPH determine the feasibility of opening SBHCs. Subsequently, the Adolescent School Health Initiative was enacted in 1991, and DHH was authorized to facilitate and encourage the development of comprehensive SBHCs in public schools. The program's organizational move under the direction of the BPCRHR has focused on further development, financial stability and efficiency of operations of the SBHCs, along with the strengthening of primary care and behavioral health integration. At this time, there are 65 SBHCs in 28 parishes, serving 109 public schools and providing services to more than 32,000 students.

Additionally, the BPCRHR offers health information services to health facilities, organizations and providers in the following areas:

- Develops economic impact studies (IMPLAN) analyzing the financial and employment influence of a business, or facility on its community, with special emphasis on the health care industry and its components;
- Collects and disseminates demographic, economic, health and social indicators gathered according to geographical boundaries (state, parish, zip code, place, census tract and radius);
- Maps services, locations, clients, competition, and quality of life indicators that illustrate current and potential market reach;
- Provides health service market analyses that combine all the elements mentioned above to create an overview of the community's access to health care;

- Provides technical assistance through workgroups and advisory committees, grant application documentation, proposal development, identification of potential collaborators, letters of support and the reviewing of grant applications; and
- Disseminates information to constituents through the use of a LISTSERV. LISTSERV activities include providing constituents and other interested parties with updated information regarding proposed and actual changes to health care delivery systems; information regarding new and/or revised regulations regarding patient care; educational opportunities for rural providers and their staffs; and funding opportunities through specific initiatives.

Health information services are utilized internally to expand responses, enhance information and enrich presentations. These services are especially useful to health entities seeking assistance in economic development, grant support, business planning and feasibility of service expansion.

Success of the BPCRHR is dependent on strong partnerships with state, federal, regional and local organizations. Through collaboration and information sharing, the support and services provided by the BPCRHR and their partners directly assist primary care and rural health organizations and community leaders to better understand what is required to develop and sustain health care solutions.

The BPCRHR focuses on the primary and preventive health care needs of both rural and urban underserved areas and is funded and supported by multiple federal agencies, as well as State government. The BPCRHR receives grant funding and manages responsibilities required for funds from three federal agencies within the U.S. Department of Health and Human Services, i.e. the HRSA; which includes funds from the Bureau of Health Professions, Bureau of Primary Health Care and Office of Rural Health Policy (ORHP); the Centers for Disease Control and Prevention (CDC); and the Centers for Medicare and Medicaid Services (CMS). State funds appropriated to the BPCRHR are managed according to the parameters established by the Legislature and DHH.

Planning Processes to Improve Rural Health in Louisiana

In 2002, the Louisiana State Legislature passed a bill (Act 162) that impacted health care in Louisiana's rural and urban underserved communities. Essentially, this bill reiterated and emphasized historical functions of the State Office of Primary Care and Rural Health, later renamed the Bureau of Primary Care and Rural Health. In addition, that bill mandated the BPCRHR to develop and implement a strategic plan that outlined an approach for increasing access and improving the quality of care in Louisiana's rural and underserved areas.

The BPCRHR was also required to publish a rural health plan by the federal ORHP at the beginning of the FLEX Program in 2000, and an update or revision of the plan was required in 2007. For the revised rural health plan, the ORHP urged states to create a plan that would serve as a roadmap for using FLEX and other grant funds to support CAH facilities; CAH-eligible hospitals; and the communities they serve in a strategic way designed to support rural health care broadly. Partners and rural providers from throughout the state gave input, and that information has been included in the Louisiana FLEX Program, other grant proposals, as well as in preparation of this plan.

The planning process for the 2011-2015 Louisiana Rural Health Plan began during the spring of 2010, through a series of strategic planning sessions with the

CAHs across the state to review existing services and grant objectives. In the spring of 2011, the BPCRHR made the determination to broaden the rural health plan to meet not only the requirements of the FLEX grant, but also to provide necessary reporting to the state Legislature and the Secretary of DHH. To ensure input was received from a broad array of participants, the BPCRHR began planning for three community and one partner input forums.

This report is the product of the four planning sessions conducted in June 2011; numerous discussions among BPCRHR staff, management and advisers; as well as a review of the rural health literature; specific provisions of the Affordable Care Act (ACA); federal guidance; changes in the Louisiana Medicaid Program; and economic, health and demographic data and reports and plans made by sister organizations within the DHH.

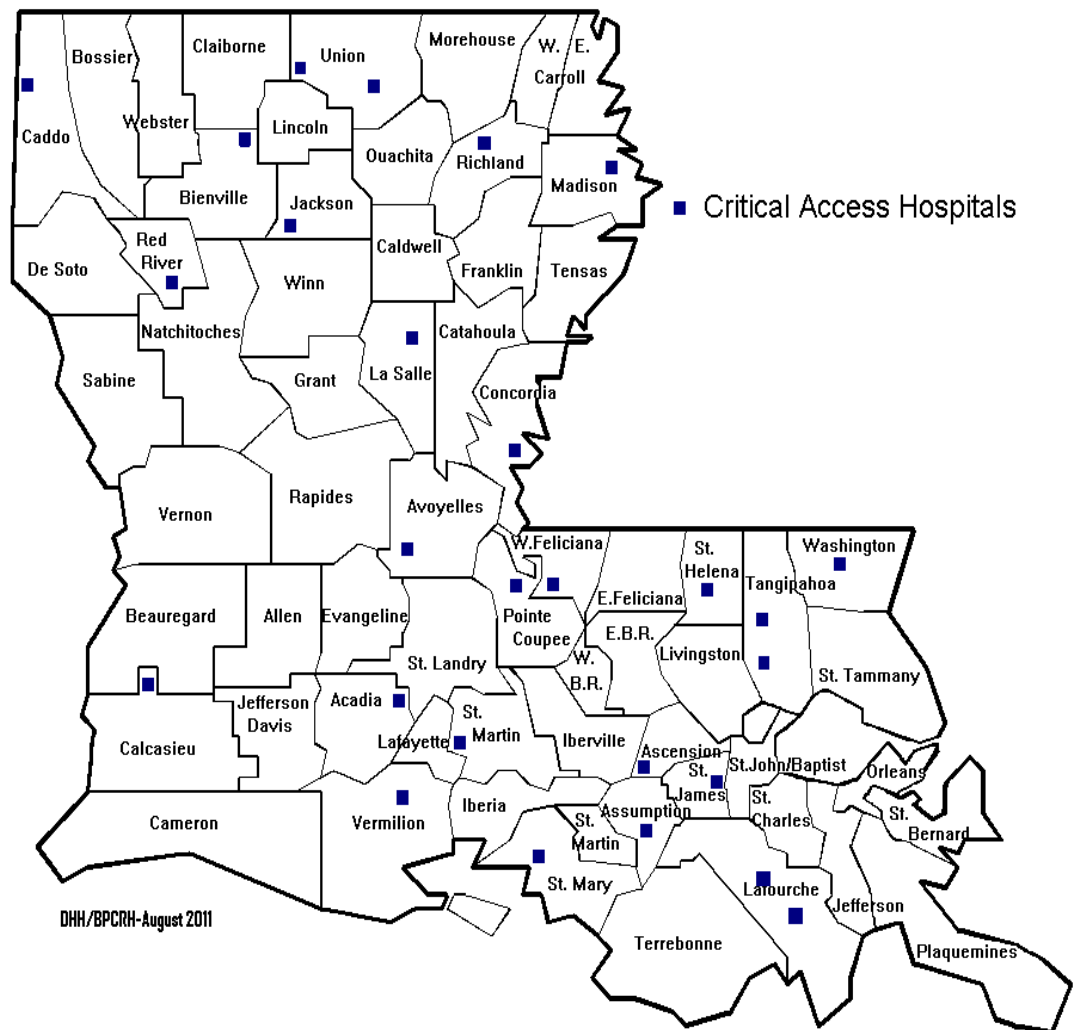
Some of the recommendations included in the plan are administrative and some are time and environmentally sensitive. The health landscape in rural Louisiana is not unlike that in other states in that many communities and parishes are struggling with a poor economy, with more and more people being unemployed and uninsured and with more people needing access to publicly supported health and social services.



Critical Access Hospitals and the FLEX Program

The federal Balanced Budget Act of 1997 created the FLEX Program to assist CAHs in improving access to health services in rural communities. The BPCRHR administers the FLEX Program in Louisiana and from the start has recognized the unique opportunities of working with and through partners, capturing the flexibility, spirit and intention of the FLEX Program. The BPCRHR works directly with rural hospitals and community leaders on conversions to CAH status, as well as working to help form rural health networks; strengthening the internal fiscal management of the hospitals; and improving the quality of care delivered. As required by the FLEX grant, the BPCRHR continues to work with the Louisiana Emergency Response Network (LERN) and the local emergency medical services (EMS) to ensure services are available, appropriate and integrated. Community forum feedback indicated that there was a great deal of confidence in the statewide EMS systems, their integration and the services they provide.

The BPCRHR has worked to help communities sustain the rural health infrastructure by strengthening CAHs and maintaining necessary access to health care for rural residents.



To date, Louisiana has 27 hospitals designated as CAHs, with three more hospitals potentially interested and considering conversion. Several other small, rural hospitals are now interested in conversion, but are no longer eligible because the necessary provider provisions are no longer available to states.

The CAH Leadership Council is composed of CAH administrators and provides direct input to the FLEX Program on what works well for them, and what else is needed in terms of health information technology, quality improvement, business systems consulting and other aspects of the program. The CAH Leadership Council is active and engaged and the FLEX Program is strengthened through their commitment.

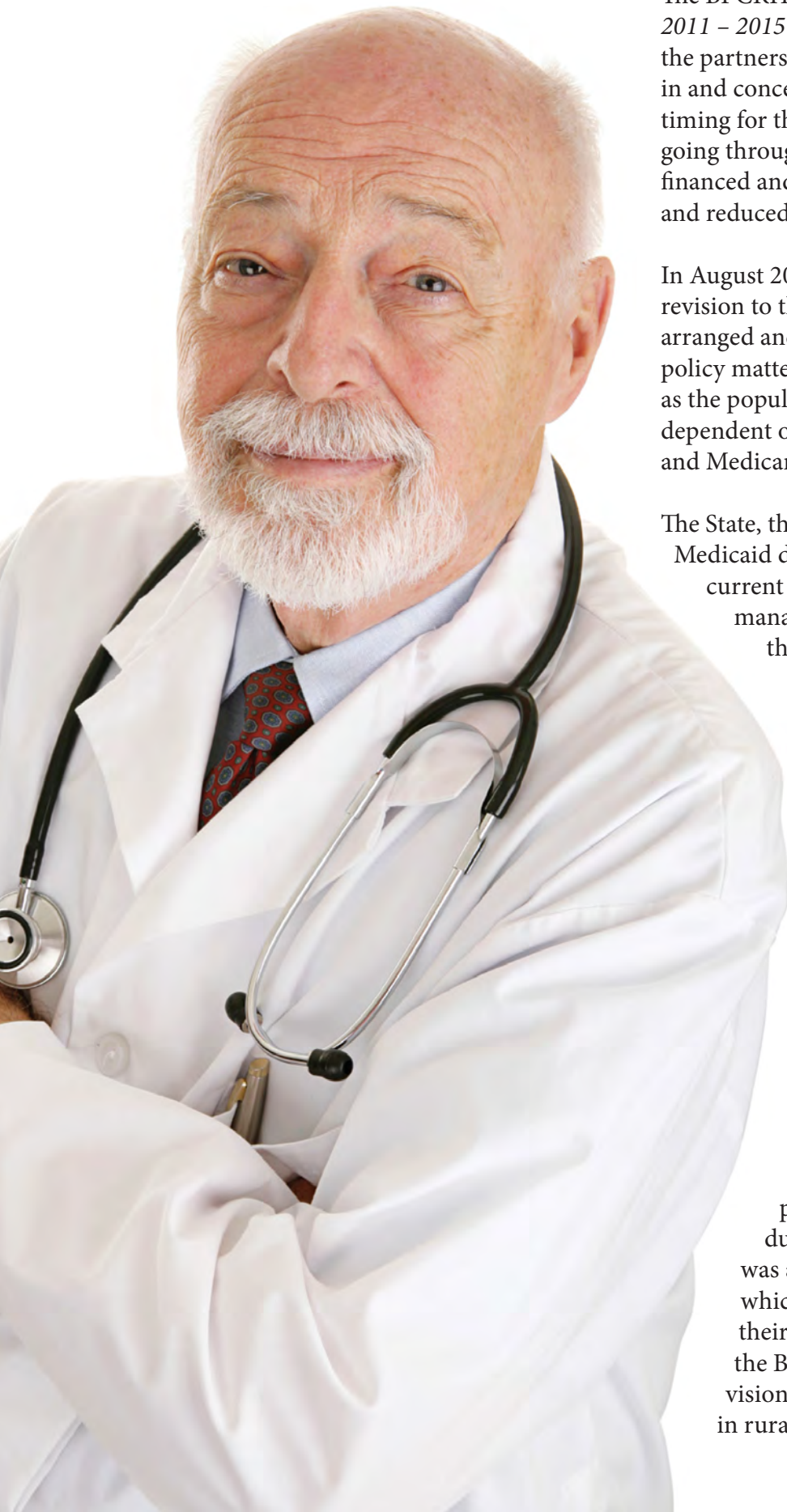
Purpose of the Rural Health Plan

The FLEX Program requires the BPCRHR to publish a rural health plan, as does the Louisiana Legislature. The Secretary of the DHH requested input from the BPCRHR and the rural health community because changes are being made, by necessity, in the health system and health service financing in Louisiana. This plan is intended to meet the requirements for the FLEX Program, the Legislative requirement and to provide input to the DHH Secretary as requested.

This plan allows the BPCRHR to focus on a strategic direction for rural health and facilitates the development and delivery of health services in rural Louisiana. This plan, as implemented, also strengthens partnerships among rural providers, as well as the partnerships the BPCRHR has nurtured with rural communities, other State-level partners, and federal government funders and supporters.



Developing the *2011-2015 Louisiana Rural Health Plan*



The BPCRHR decided to broaden the required *2011 – 2015 Louisiana Rural Health Plan* to include all the partners, providers and interested parties working in and concerned about rural health in Louisiana. The timing for this planning was fortuitous, as the state was going through major changes in how health care was financed and delivered due in part to the poor economy and reduced State revenues.

In August 2011, Louisiana was planning a major revision to the way Medicaid services were delivered, arranged and paid for in the state. Medicaid payment policy matters greatly to Louisiana's rural providers, as the population in rural communities is much more dependent on public payers, including Medicaid and Medicare.

The State, through DHH, proposed to transform Medicaid during the next year, moving away from the current fee-for-service system and more effectively managing Medicaid enrollees' health care through the implementation of a coordinated care network model of care (Bayou Health).

This new delivery system is financed with State and federal Medicaid funds, and became operational statewide in June 2012. Each network underwent a thorough readiness review before it could begin providing services to Medicaid recipients.

Against this backdrop, the BPCRHR assembled a leadership team from within the office to plan how to gain direct and meaningful input for the Louisiana Rural Health Plan from community leaders, community providers and others. The BPCRHR wanted to hear from statewide partners, as well as share any lessons learned during the community input sessions. This was accomplished through input sessions in which the BPCRHR asked partners directly what their organizational priorities were and how the BPCRHR could assist them in achieving their vision for improving the health of people living in rural Louisiana.

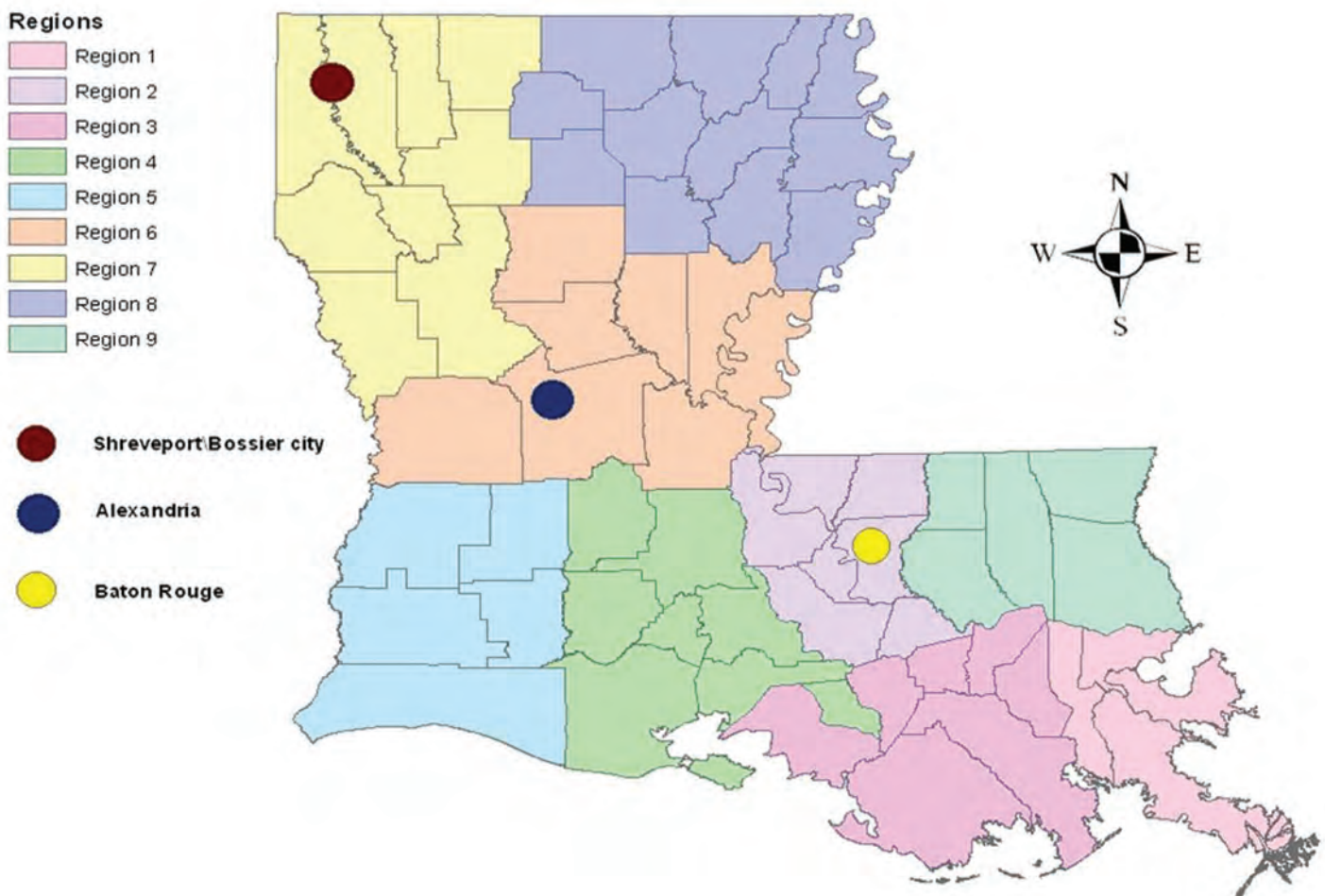
Participation in the Rural Health Planning Process - Community Meetings

The BPCRH team planned and convened three (3) community input sessions in different regions of the state and used email lists and other mechanisms to invite a wide array of leaders potentially interested in providing input into the *2011 – 2015 Louisiana Rural Health Plan*. The three community sessions were held in convenient locations and conducted in the late afternoon and early evening to afford providers the opportunity to participate without having to close their practices early.

The target audience for each region was community and civic leaders, health providers and others interested in improving health in rural Louisiana. The North Louisiana AHEC assisted the BPCRH with logistics and invitations. The sessions were convened as follows.

- June 13, 2011 – Shreveport/Bossier City (north Louisiana)
- June 14, 2011 – Alexandria (central Louisiana), and
- June 15, 2011 – Baton Rouge (south Louisiana)

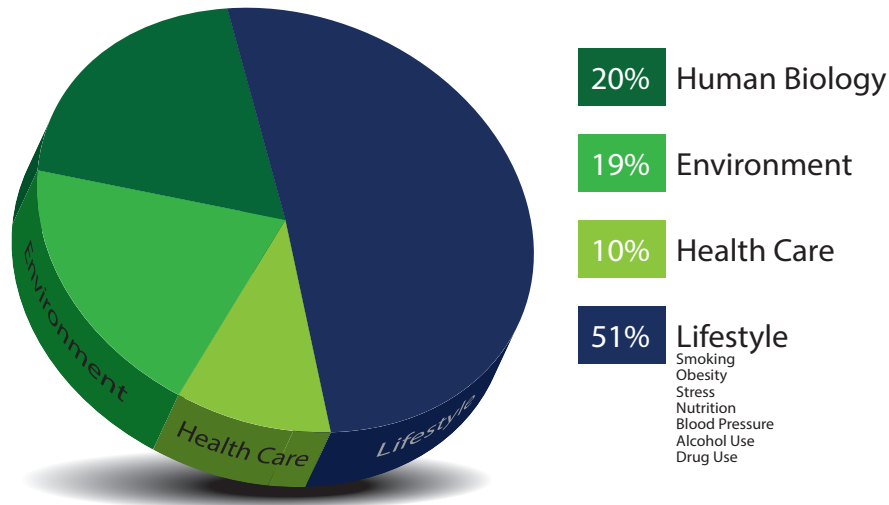
Locations of Community Input Sessions



Structure of Community Sessions

Each of the input sessions utilized the same format. After introductions of all participants, a brief opening presentation was used to set the stage for the planning and to call attention to the purpose of the sessions. Participants were assured by the BPCRHR staff that they would receive a survey to provide additional input after the session; a copy of the *2011 – 2015 Louisiana Rural Health Plan*; and most importantly, that their input would be used to formulate the plan.

Factors Influencing Health Status



Source: Green, Larry, and Ottoson, Judith, *Community and Population Health*, eighth edition, page 364

Demographic data was discussed to help set the stage for reflection and planning. (See demographic information in the “Background” section.) For perspective, Louisiana was compared with the United States. Demographic and income data were used to describe the major vital and social statistics of the population. In addition, infant mortality data was reviewed because it is a sensitive indicator of the health status and health system of an area.

The Louisiana BRFSS data was presented, as many of the factors influencing health are directly related to behavior, which is noted in the graph. The Louisiana BRFSS reports are available on the BPCRHR website at www.dhh.la.gov/BRFSS. The primary purpose of the Louisiana BRFSS is to provide population estimates for chronic diseases and risk factors for Louisiana populations.

Data from the BPCRHR’s *2008 Louisiana BRFSS* was presented to highlight the health of Louisiana residents related to health behavior, health

insurance and access. The BRFSS, established in 1984 by the CDC, is a state-based system of health surveys conducted over the telephone that collects information on health risk and behaviors, e.g. lifestyle, access to health care and chronic diseases and injuries. The BPCRHR is responsible for ensuring that the survey is conducted correctly and the information and data are published.

The 2008 Louisiana BRFSS data revealed the following:

- Louisiana consistently ranks near the bottom in most rankings for health indicators and public health indicators. These rankings do not necessarily relate to the quality of care, but are more related to long-term persistent poverty. For example, according to the United States Department of Agriculture, 24 parishes are defined as persistent poverty parishes, which means 20 percent of the population has been below the poverty level for 30 years, or more;

- Lack of health insurance generally translates to a lack of receiving recommended preventive health screenings;
- Louisiana ranks last among states, territories and DC in terms of the percent of women who have had a Pap smear test; and
- Smoking in Louisiana is higher than in the United States; however, Louisiana is making progress with reducing smoking (20.5 in LA vs. 18.3 in the US).

According to unpublished data from the 2009 Louisiana BRFSS, the following was highlighted:

- In 1995, 24 percent of Louisiana adults reported being told that they have high blood pressure by a health professional. In 2009, 35 percent of the respondents reported having high blood pressure, which is nearly a 50 percent percentage increase;
- The state level for obesity among adults has steadily increased since 1995 and has been consistently higher than the national average (33.9 percent statewide vs. 27.2 percent nationally in 2009);
- Nearly half (47 percent) of the respondents without a high school education reported being without health insurance and households with an annual income less than \$25,000 (49 percent) reported being without health insurance; and
- The percentage of smokers in Louisiana has declined over the past 14 years but the rate has remained higher than the national average (22.1 percent statewide vs. 17.9 percent nationally).

There has been an increase in self-reported leisure time and physical activity among Louisiana adults from 65.1 percent in 1996 to 71.4 percent in 2009. In addition, there has been an increase in moderate or vigorous exercise among Louisiana adults from 35.4 percent in 2001 to 41.2 percent in 2009. However, Louisiana residents still fall below the national average of leisure time and physical activity (75.8 percent) and moderate or vigorous exercise (50.6 percent).

After data were presented, the purpose for convening the planning sessions was reviewed, and

participants were asked to reflect and provide input about what issues or resources had to be addressed to improve the health and quality of life for people living in rural Louisiana.

Even though health provider participants varied at each session, the concerns and issues raised were remarkably similar. Participants were encouraged to share their thoughts about what the BPCRHI should do in the coming year(s) to assist rural health providers to meet the health care needs of rural people.

Attention was paid to ensuring every participant had multiple opportunities to speak, if desired. Each participant was encouraged to discuss issues that helped and hindered them in providing health services to the rural population. Active participation was a part of every session. Providers noted that the health care environment is very stressful, with more complex information coming out daily. Participants voiced concerns with keeping up with information, ever-changing regulations and requirements, as well as changes in payments and eligibility. These changes are exacerbated by the growing demands of many patients who need more services, yet have fewer resources. The dynamic environment has never been more challenging.

As participants discussed issues, circumstances, policies and resources, their comments were posted on the walls around the room so everyone could easily see what had been discussed. All suggestions were transcribed into a list of topics. After thorough discussion, topics were outlined, and participants reviewed the topics to ensure their input was accurately reflected.

Participants then used these topics for priority setting. All participants (except BPCRHI staff) were given eight (8) votes to cast to gauge the relative priority of each topic. Participants were asked not to affix more than three (3) votes to any one topic, or they must vote for at least three (3) priorities. The votes were counted, and participants were asked to review the outcome. If there were questions or concerns raised, they were discussed. Following this step, the BPCRHI staff thanked participants, and assured them they would receive a copy of the report, as well as another opportunity to provide additional input via a survey. Meetings were then adjourned.



Priority Topics from Community Sessions

From the three (3) community sessions, priority topics were reviewed and categorized. The priority topics are listed in the chart on pages 14 - 17. Following each numbered priority, specific action steps suggested during the community provider's session are noted and the participants are listed.

Emergency medical services (EMS) were not identified as a priority throughout the community sessions. In each session, BPCRHR staff mentioned the importance of local EMS, as the services are a major component of the rural health system. The ability of local emergency medical companies to respond quickly and appropriately in emergencies is crucial. The BPCRHR has spent considerable resources and time working with EMS over the past years. When asked during the planning sessions about EMS, the consensus was that EMS was working quite well. The BPCRHR will continue to work with rural EMS to improve and sustain the quality of rural EMS.

During the month of August 2011, a link to a survey was emailed to all the people who participated in the three (3) community input forums and to members of the BPCRHR's Listserv. The survey was a recapitulation of the information gathered from the community input forums and provided forum participants an opportunity to share additional thoughts on their original ideas, as well as to provide new thoughts and ideas. For those who did not participate in one of the community input forums, the survey provided an overview of the 10 major topic areas discussed, as well as a list of the subtopics. Non-participants were asked to prioritize each of the "subtopics" according to their ideas of need within their communities. Also, "non-participants" were afforded the opportunity to include ideas and insights along with their responses. The survey was posted on the BPCRHR website for further input.



Priority Topic

1. Prepare rural providers to help them remain viable and available to meet the health needs of people living in rural Louisiana

Help Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs) and other rural hospitals prepare for ICD-10 conversion, starting with mock conversions

Help position rural providers to be effective partners and players in the Accountable Care Organization (ACO) environment

Work with rural providers to recognize and use new opportunities effectively, like health information technology (HIT), electronic health records (EHRs) and ACOs, to fully take advantage and benefit rural populations

Assist CAHs with excellent consults geared to today's health issues, e.g. consultations available through the Delta States Project, etc.

Provide leadership, assistance and education with Medicaid plans, especially the Bayou Health Plans and other methods, to reduce Medicaid expenditures by representing rural provider's views and explaining the impact on rural people

Educate providers about what services, programs and resources are available

Provide technical assistance to CAHs, RHCs, FQHCs, and SBHCs regarding medical homes (work with Louisiana Health Care Quality Forum to get started)

Hire a full-time staff person to focus on this work

Help physicians, RHCs, CAHs and small hospitals prepare for International Classification of Diseases, revision 10 (ICD-10)

Prepare for and learn about Accountable Care Organizations. Ensure education is presented widely, disseminated and posted

Help rural primary care providers take full advantage of resources available through HIE and other HIT resources

Help find and develop other resources to assist

Focus technical assistance and other support to help providers adopt and make the transition to ICD-10

Help rural providers with Bayou Health development and rollout

Priority Topic
2. Support collaboration and network development
Develop opportunities for collaboration and learning among RHCs, FQHCs, CAHs, small rural hospitals, public health units (PHUs), etc., on for example, the Rural Health Network development, etc.
Develop models, opportunities, and incentives for collaboration at the parish and community level, e.g., networks
Support FQHC, RHC and CAH collaboration and coordination to strengthen the rural health care system
Increase focus on oral health (dental) for children, as this is a major access barrier for children
Use existing rural health organizations to house and manage PHU services (privatization), such as WIC, family planning, Medicaid eligibility workers This will benefit rural residents and rural providers and help meet the state's objective of privatization of services
3. Increase supply of rural health providers
Increase supply of mental health providers and explore the use of other credentialed professionals for providing care and being reimbursed
Increase the supply and distribution of primary care providers, including medical doctors (MD), Doctor of Osteopathic Medicine, (DO), Physician Assistants (PA), Nurse Practitioners (NP), and Certified Nurse Midwives (CNM)
Focus on PA, NP and the CNM pipeline (produce more), retain more and recruit more for rural Louisiana Start now
Expand Med Job Louisiana program to include additional health careers
Support the development of a workforce plan for rural communities; find resources to fund the development of a plan
4. Expand access to behavioral health services in rural Louisiana
Work with DHH and rural providers on a system that works for people with serious or unmanaged mental illnesses (Over reliance on the Physician Emergency Certificate allowance to hold patients for 72 hours leads to unnecessary admits and depletes resources available to other patients)
Focus resources and development on outpatient mental health issues and services
Contract with (address reimbursement) rural health providers (privatization) to provide outpatient mental health services

Priority Topic
5. Develop educational materials and programs for patients
Develop educational programs and materials for patients regarding using Medicaid benefits (responsibilities and how to use benefits)
Develop help for seniors to make informed Medicare, Part D selections
Educate patients about using health services and how choices impact their health
6. Strengthen and expand School-Based Health Centers (SBHCs)
Develop SBHC policies, including staffing standards, referrals and billing procedures
Expand, solidify, clarify and strengthen SBHCs to help providers meet more needs of children
Target and focus on SBHC development as a way to engage children in health improvements
Continue to expand, support and fund SBHCs
7. Expand assistance to improve the quality of care provided in rural Louisiana
Explore methods to more effectively measure quality and patient satisfaction with services
Educate and develop programs to incentivize providers to provide the highest quality care, e.g. provide the type of care they “want” to provide. Change the conversation Find models
Find models and demonstrate ways to align quality care with reimbursement
8. Recognize and publicize the economic impact of the health sector and provide technical assistance to attract resources
Help find resources for planning, development and building rural health replacement facilities
Maintain the practice management consulting team and expand to assist with ICD-10 work
Calculate, promote and disseminate information about the economic impact of the health sector, as the economic engine it is

Priority Topic

9. Educate DHH and other legislative and administrative policymakers in Louisiana about the needs of rural communities

Provide leadership, assistance and education with Medicaid plans, e.g. Bayou Health Plans, and other provider reimbursement changes, by representing the views of the rural providers and its impact on rural people

Educate inside DHH about the impact the Bayou Health Plans, Medicaid cuts and other changes (e.g. closures and consolidations of PHUs and outpatient mental health services) have on rural providers, and ensure rural providers stay in the information loop

10. Expand access to prenatal care in rural areas for pregnant women

Find ways to provide incentives and assistance to rural providers to offer prenatal care, such as help with malpractice, EHRs, etc.

Investigate and develop prenatal care services in rural communities with ties (referral agreements) to delivering hospitals and providers

Note: This priority topic has been included in this report to reflect that it occurred as a concern in each of the three Community Input Forums. Although prenatal care is not within the purview of the BPCRHR, the BPCRHR is committed to collaborating with the appropriate units within DHH responsible for prenatal services. As a collaborative partner, the BPCRHR will assure that prenatal concerns of rural residents are articulated.



Participation in the Rural Health Planning Process - Partner Session

The fourth session was a partner session designed for BPCRHR partners to provide input into the content of the *2011 – 2015 Louisiana Rural Health Plan*. The meeting was held in Baton Rouge on June 17, 2011, and was attended by BPCRHR's strategic partners.

The BPCRHR Director, Gerrelde Davis, opened the meeting by welcoming participants and introducing the DHH Deputy Secretary, Kathy Kliebert. The Deputy Secretary began the meeting with an overview presentation. In preparation for this partner meeting, the DHH Secretary and Deputy Secretary were provided the priorities derived from the three (3) community input sessions.

The Deputy Secretary's presentation and opening comments set the stage for a productive partner session. The state's major strategies were highlighted, including the explanation that the community care networks (Bayou Health) are a method to increase the effectiveness of the Medicaid program, while reducing costs and eliminating duplication. The Deputy Secretary shares DHH's commitment to ensuring rural residents maintain access to health services.

After opening comments and emphasizing the importance of the *2011 – 2015 Louisiana Rural Health Plan* to DHH and Louisiana, the Deputy Secretary agreed to answer questions. She acknowledged the work the State is engaged in to resolve major funding and resource challenges. Before responding to questions, the Deputy Secretary addressed an issue from the community input session regarding the closing of parish PHUs. She clarified that no PHUs had been closed, except for one site in Orleans Parish; however, services had been curtailed in several rural parishes due to budget cutbacks.

The Deputy Secretary noted some PHUs had been consolidated and the schedule of services severely cut back, but these sites were not closed. Comments reinforced the need for continuous communication with communities about when services will be available and where, especially in rural parishes where transportation difficulties are prevalent. As one partner cited, when clients arrive at a PHU that does not appear to be open at that moment, to that

client, the unit is closed and services needed were not provided. More and continuous information about where public health services are available and at what times is needed within every rural parish.

The medical director of the DHH Louisiana Medicaid Program, Dr. Rodney Wise, was present for the opening portions of the meeting and he clarified how Medicaid pays for prenatal care and delivery services. This question was raised during community input sessions. Additionally, the State led infant mortality reduction efforts through the Medicaid program, as approximately 70 percent of the births in Louisiana are paid by Medicaid.

Partners asked how rural safety net providers can become sites for services, such as WIC, family planning and Medicaid eligibility, when schedules for the PHUs are scaled back. Other questions about closures, cuts in services, and notices about hearings and planning were discussed. Partners were specifically concerned about how PHU closures were being managed and about changes and shifts in behavioral health services. The specific discussions and topics were somewhat time sensitive; however, the opportunity for rural providers to help DHH meet the service demand while DHH is working to reshape the public health system are relevant and inform this plan. For that reason, some questions and responses are provided here.

Question: Is anyone tracking how or if public health clients are going anywhere else for care when they are referred?

Response: The DHH OPH is scheduled to develop a system to track public health clients to determine where they are going for care, how they are being referred and if they get to where they are referred.

Question: How was the distribution handled for the Regional Behavioral Health Forums?

Response: These were organized very quickly, and the distribution was not done well for the first one, held on June 16 in Baton Rouge. Since these forums were of major interest to the partners, the schedule will be posted on the BPCRHR Web page and sent out as an email alert.

The role of rural hospitals in behavioral health includes keeping behavioral health clients safe and stable until they can receive the level of care needed. This is very difficult, given the present lack of a system and payment mechanisms to support seriously mentally ill people. The BPCRHR director encouraged the group to review the behavioral health waivers posted on the DHH website.

Question: With the State's infant mortality rate (IMR) increasing, and with the State's desire to improve pregnancy outcomes, how can DHH incentivize prenatal care in rural areas? Are prenatal care visits and the delivery billed together for Medicaid as a global fee, or can it be broken out to facilitate prenatal care being provided in rural communities?

Response: Prenatal care visits can be billed by visit, with the delivery billed separately, as well as the post-partum visit billed separately.

After those clarifications and discussions, the meeting was opened to partner input. Several partners had met the previous day to give input on Louisiana's Community Transformation Grant (CTG), a major grant opportunity made available through federal funding. The BPCRHR was selected by the DHH Secretary to lead the state in that significant effort.

Staff from every program within the BPCRHR participated in the partner discussion and priority review. The three (3) community sessions, as well as the partner session, were attended by representatives of the Louisiana Hospital Association and the Louisiana Rural Health Association. CAH representatives, primarily chief executive officers of CAHs, actively participated in every session as well. There was also active participation from FQHCs at each session.

BPCRHR partners participating in the session included:

- Louisiana Hospital Association
- Louisiana Rural Health Association
- Louisiana Primary Care Association
- Louisiana Public Health Institute
- Area Health Education Centers
- Med Job Louisiana
- Rapides Foundation
- Rural Hospital Administrators
- Rural Health Clinic CEOs
- FQHC Administrators
- Louisiana Health Care Quality Forum

The partner session was intended to review input received from the three (3) community sessions and to discuss partners' strategic priorities to improve the rural health system and the health of rural Louisianans. The purpose in reviewing partners' priorities was to identify work that could be strengthened by the BPCRHR assisting their organizations. Partners also gave input about the work the BPCRHR is currently doing that should be continued.

The partner discussion was rich, with multiple threads tying the BPCRHR work to the work of the organizations represented. Potential strategies, as well as cautions and inputs from the partners, are below.

The Louisiana Hospital Association (LHA), represented by their rural health liaison, began the discussion. LHA priorities and focus include:

- Hospital reimbursement: Louisiana receives one of the highest percentages in the nation of disproportionate share hospital funds (known as DSH), but most all of the DSH funds go to the charity or public hospitals, with very little going to other member hospitals or rural hospitals. When the Affordable Care Act (ACA) is implemented, much of the DSH funds will no longer be available, and so LHA is focused on how to make that up, as well as other reimbursement issues at a national level;
- Working with rural hospitals to stay afloat and help hospitals prepare for:
 - * ICD-10 conversion;
 - * ACOs through ACA;
 - * Louisiana Bayou Health;
 - * HIT, including meaningful use, selecting the right EHR; and
 - * Working with rural members and the BPCRHR to clarify how hospitals fit within the entire community system of care.

The Louisiana Rural Health Association (LRHA) is working with its members to prepare for:

- ICD-10 conversion;
- ACOs, through ACA;
- Louisiana Bayou Health;
- HIT, including meaningful use, selecting the right EHR;
- Helping rural communities develop competitive FQHC proposals; and

- Advocating at the state and federal levels for rural providers and rural communities in health reform and managed care negotiations, and working with the BPCRHI to conduct practice management seminars and technical assistance seminars for grant writing.

The Louisiana Public Health Institute (LPHI) is continuing to work with communities to improve health. The LPHI representative noted that to really know how the health care system is doing, one must know how the community is doing. Health care is a marketplace, and too many rural markets in Louisiana are not doing well. It is important to align incentives with what the State wants to encourage. There must be broader bridges built between health and health outcomes. From the LPHI perspective, whenever data are provided, the data must be provided by race and by parish, as there are significant racial and geographic disparities in Louisiana. Using total rates masks significantly poorer outcomes and disparities for African Americans and rural people.

The Louisiana Health Care Quality Forum (LHCQF) is working to assist primary care providers meet the meaningful use standards set through the ACA. The Forum representative noted that funds are still available to help primary care providers choose an electronic health record that works well. The Forum is especially interested in assuring that rural providers receive all the help available to them. Providers should contact the Forum directly.

An Area Health Education Center (AHEC) participant challenged participants to take steps now to prepare Louisiana to find and train people to become managers for Bayou Health, ACOs and medical homes. Another workforce asset many states are using (not including Louisiana) is Community Health Workers (CHW). CHW have proven effective in many rural communities, used with a variety of health conditions and diseases to increase access to care and help patients navigate complicated health systems. Currently, Louisiana does not have a payment mechanism to support CHW in the Medicaid program. Some states reimburse through Medicaid for CHW services. Louisiana should consider this workforce option and find resources to help hire and train Community Health Workers.

Community Health Workers (CHW) can be effective helping people navigate the complicated health system and in helping people learn about available services. In some states, CHW work as health educators.

Potential next steps include:

- Find models that work in various settings, with various populations and disease conditions to replicate;
- Investigate how to recruit and train CHW;
- Investigate the Baylor, Texas CHW model;
- Investigate other Medicare and Medicaid chronic disease models. (The federal ORHP has recently released a study on CHW); and
- Investigate how to fund a CHW program.

The Rapides Foundation priorities are focused on parishes in Central Louisiana; however, the Foundation is concerned about health and health services in the entire state. The Rapides Foundation likes to support state priorities. Rapides' priorities and concerns include:

- How will the state communicate with providers and clients about Bayou Health?
- How will people know what they need to know? There needs to be a strong communication strategy that helps information flow in all directions;
- Providers, businesses and citizens want to help improve health and need to know how and to be informed about processes; and
- Workforce issues, especially retention and recruitment of primary care providers.

The Louisiana Primary Care Association (LPCA) priorities are to continue to make Community Health Centers, also known as FQHCs, strong and resilient contributors to improving access to health care and improved health for underserved populations. At this point, the LPCA is working with members to:

- Expand access to primary care services through FQHC expansions and developing new organizations, when required;
- Work in collaboration with the BPCRHI, other providers and organizations to develop networks of services; and
- Prepare for how the safety net will change with more people covered by health insurance, as is the promise with the ACA. How is Louisiana preparing, and how is rural, underserved Louisiana, in particular, getting prepared?

Several rural hospital administrators participated in the partner meeting and expressed the following significant concerns:

- EHRs, HIT and how hospitals, clinics and physicians' offices will meet the meaningful use standard required;
- The future and how ACOs will evolve. Will they include rural providers?
- Ensuring and measuring quality of care;
- Health information technology and other technology conversion issues;
- Helping provider-based RHCs and independent RHCs select and effectively use an effective EHR;
- Helping private providers make a good selection of a useful, affordable EHR system; and
- From a rural hospital standpoint: health professional training programs; the BPCRHR and other state agencies must focus on producing more mid-level providers, e.g. nurse practitioners, physician assistants and certified nurse midwives. Rural hospitals will require these providers to continue providing necessary services.

The group then discussed how the BPCRHR can help partners meet their objectives over the coming years. The following comments were recorded in response to the question, **"How can the BPCRHR help?"**

These responses reflect what the BPCRHR can do to help, as well as what partner participants identified as important work for the BPCRHR to continue.

According to the responses, the BPCRHR should:

- Continue to share information;
- Continue to work directly with partners;
- Continue to model the behavior required in rural Louisiana to strengthen collaboration and cooperation. The BPCRHR and partners want to encourage more collaboration in the future, as collaboration will strengthen health services. One example of how the BPCRHR leads effectively is through the example of the recent work with the CTG. The BPCRHR is the lead organization and has encouraged partnerships and partners to actively participate in the development of a CTG proposal. In fact, many of the partners participated in a meeting the day before with the BPCRHR, as they prepared for submission of the proposal. The focus of the CTG work is rural Louisiana, as that is where the burden of disease is most acute and profound;

- The BPCRHR should provide data by state, by parish and by region. Data should always be provided by race and totals;
- Partners expressed a strong desire for the BPCRHR to continue its leadership in helping develop effective community health assessments, as rural hospitals, FQHCs and other organizations rely on these assessments to include in proposals, guide services and other work;



- The BPCRHR works with statewide and regional partners and through that work leverages resources effectively. That strategy is considered a major strength. The BPCRHR does not only work with other organizations because of hiring freezes or other state government imperatives, but rather the BPCRHR does it as a distinct, strategic method to get work done. The BPCRHR management style in working with others helps to build the capacity of partners and is more effective. The BPCRHR works directly with partners as a choice and in a focused way to support partner organizations and strengthen assets. This way of working is considered a very effective business strategy. Because of this way of working, partners do not feel compelled to compete with the BPCRHR for resources and not competing is helpful. Knowing the BPCRHR will share resources and information and provide contractual funds, makes working with the BPCRHR productive. Trust is built, and when there is trust, much more gets accomplished. This strategy is consistently employed by the BPCRHR and recognized as helpful and smart. The BPCRHR builds strong, strategic partnerships resulting in reliance, partnership and wise rural health investment;
- Practice management is a major service that must be continued. Feedback was strong about

its effectiveness. Rural Louisiana providers rely on the BPCRHR's practice management services. An example of how the practice management program helps is by assisting entities to comply with CMS correct coding initiatives. Currently, Louisiana has 370 billing coders certified through the Association of Rural Health Professional Coders, to help reduce billing errors and help the entities become sustainable. The BPCRHR practice management service is credited with helping them get ready for certification. The Practice Management Consulting Program staff is consistently recognized for their professionalism and assistance and support. Feedback on consultations is positive and recognized as excellent;

- The BPCRHR provides notification of funding opportunities consistently and this should continue. Not only do they notify eligible communities and partners, but they also support others in securing competitive resources, including supplying data and other resources;
- The *Community-based Rural Health Program* Grants have been administered by the BPCRHR for several years. These state-supported grants to communities are important to rural Louisiana, and communities rely on these. This funding is critical; however, in FY 2011-12, funding for the CBRHP was not appropriated due to budget limitations;
- The BPCRHR should review the Maternal and Child Health, Title V; five-year needs assessment and plan, as well as the *Oral Health State Plan*. These, and other State plans, should inform this State Rural Health Plan. BPCRHR managers should review these proposals to determine how

the work of other DHH organizational units can align with the BPCRHR's work, resulting in more benefits for rural Louisiana. These plans should ideally fit and reinforce each other. The CTG and the input provided should reinforce the work of this Louisiana Rural Health Plan. The CTG will focus on changes in weight, changes in proper nutrition, changes in physical activity, changes in tobacco use prevalence, changes in heart disease prevalence and changes in stroke prevalence in rural parishes;

- According to an administrator of a network of rural hospitals, one of the major programs for reducing infant deaths and improving pregnancy outcomes is the Nurse-Family Partnership (NFP) Program. NFP is a national model which works well in rural Louisiana, according to the administrator's experience. She commented that NFP is an excellent program with compelling outcomes, evidenced-based, cost-effective when compared with the cost of poor pregnancy outcomes, and it is a program that rural Louisiana can use and expand, since the program is already being used effectively in some parts of the State. The BPCRHR has recently begun working with the NFP program and is learning more about the program and ways to improve coordination of services.

The partner session concluded with assurance from BPCRHR leaders that partners' input would be reflected in the *2011 – 2015 Louisiana Rural Health Plan*; partners would receive a copy of the plan; and partners would have another opportunity for input via a survey.

Other Considerations and Future Focus

Many topics were reviewed and considered during the planning sessions, as well as through staff discussions with rural providers. The following issues were raised through discussions, observations or research, but are not clearly reflected in the priorities from the partner or community sessions. These issues must be addressed.

The first of these issues is the clear racial disparities in health outcomes and access to health services. Data were not provided by race during the planning sessions, which was a shortcoming. Disparities in health outcomes are stark in Louisiana, especially when comparing African American (or black) outcomes with white outcomes. Presenting data totals only masks real differences by race and geography. Differences must be understood and taken into account to be resolved. The BPCRHR is committed to using data by race and to learning more about the impact of race as it relates to stress, poverty, health behaviors, access to health care, use of health services

and health outcomes. This is a serious area for study and understanding and will be undertaken with care. Rural health providers and leaders could also benefit from workshops or information designed to help all become familiar with and understand more about the impact of race and discrimination on health behaviors and health outcomes.

A clear example of the differences in outcomes by race is Louisiana’s infant mortality rate. The infant mortality rate is an especially sensitive indicator of the health of women and infants, as well as access to health services and public health practices. The following chart shows the great disparity in infant outcomes by race. (Providing data by race was a suggestion made during the partner session.) United States rates are reported as Total, Non-Hispanic White (White); and Non-Hispanic Black (Black).

2007 Infant Mortality Rates, per 1,000 Live Births				
	Total	White	Black	Other
Louisiana	9.0	6.2	13.8	1.9
United States	6.75	5.6	13.3	

Sources: Louisiana Center for Health Statistics, 2007; CDC, Infant Mortality Statistics, 2007 Period Linked Birth/Infant Death Data Set.

Two additional issues the BPCRHR will be addressing in the future include:

- The aging population in Louisiana will have a direct and definitive impact on the way rural health care is delivered. Seniors and their access to health care services will be reviewed, as the BPCRHR moves forward. Rural Louisiana communities will need better access to services targeted to the elderly, or disabled. These services include primary care, nursing homes, palliative care, hospice and home health. These

important services and needs of the elderly or disabled, must be considered and integrated into the rural health system; and

- HIT and EHRs – these crucial areas are very important to rural health providers, and there is considerable trepidation. The BPCRHR needs to maintain or strengthen resources and attention in these areas.

These two issues are ongoing and will move to the forefront over time.

Objectives of the *2011-2015 Louisiana Rural Health Plan*

From the four June 2011 planning sessions, and with consideration of the economic reality in DHH and Louisiana, the BPCRHR re-examined its mission, program objectives and considered how to best shape the work, align resources and develop new assets to accomplish the objectives of the *2011 – 2015 Louisiana Rural Health Plan*. BPCRHR staff reviewed the DHH Title V, Maternal and Child Health needs assessment, and the Oral Health State Plan to identify opportunities for the BPCRHR to create synergy with others in DHH, increase access to services for people living in rural areas and improve health status.

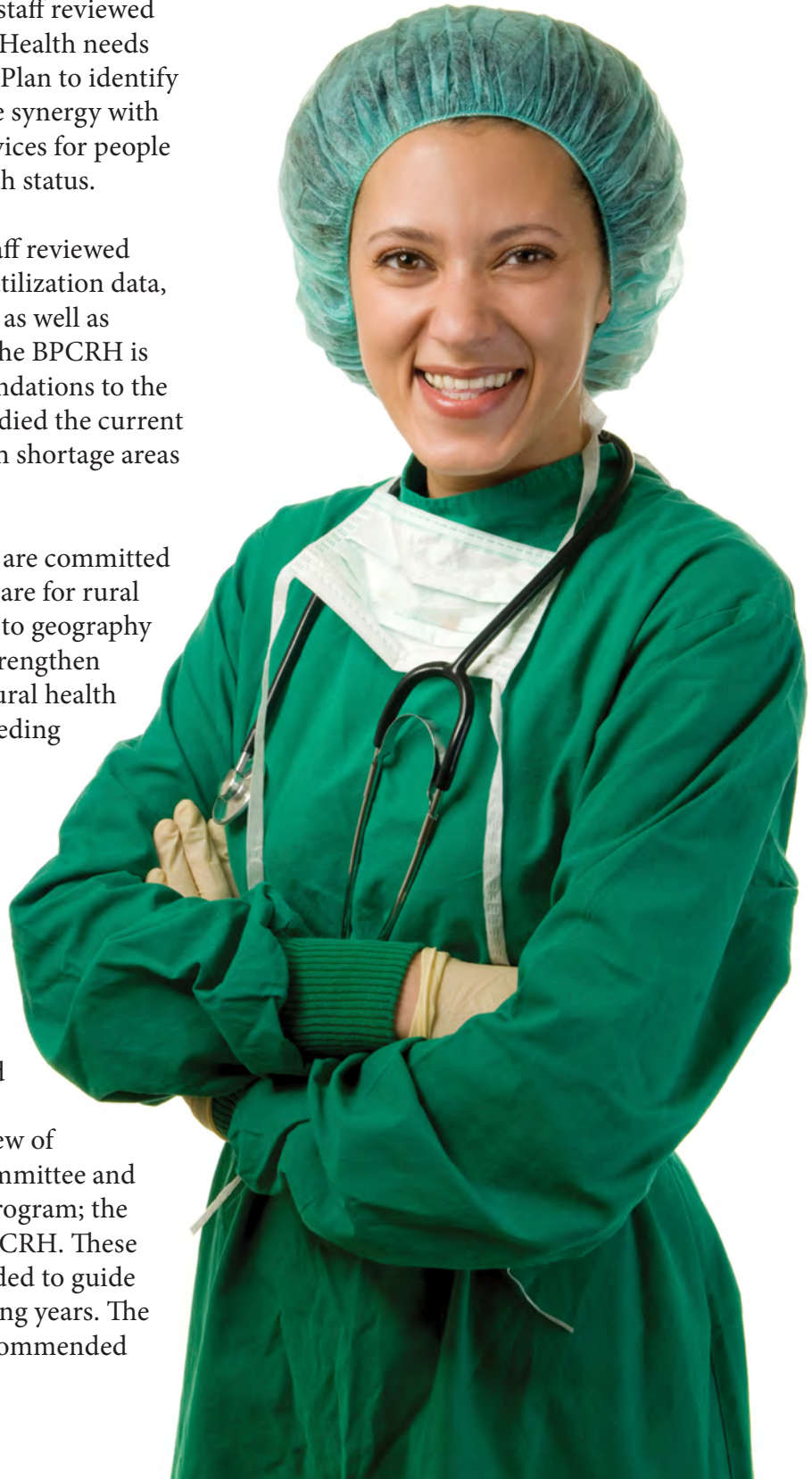
To formulate this plan, the BPCRHR staff reviewed health outcomes data, health service utilization data, U.S. Census data, BRFSS information, as well as demographic and economic data. As the BPCRHR is also responsible for making recommendations to the HRSA regarding HPSAs, they also studied the current primary care, dental and mental health shortage areas for this plan.

DHH, the BPCRHR, and their partners are committed to increasing access to quality health care for rural people, eliminating disparities related to geography and race, as well as to continuing to strengthen essential rural health providers. The rural health planning process highlighted areas needing attention, strategic development and refinement for the coming years.

Objectives:

The objectives of the *2011 – 2015 Louisiana Health Plan*, along with focused attention and shared resources, will assist with meeting the BPCRHR mission. From input provided during the community and partner input forums; as well as research; review of the priorities of the CAH advisory committee and the grant programs managed by the program; the following priorities were set by the BPCRHR. These overall objectives are broad and intended to guide the work of the BPCRHR over the coming years. The objectives align with the priorities recommended

by the participants in the June 2011 planning process and take into account the requirements of the FLEX Program. Based on these objectives, the following work plan was developed:



Objective 1: Prepare rural providers to help them remain viable and available to meet the health needs of people living in rural areas

	Activities	Dates	Funding Program	Unit Staff	Outcomes	Measures
1	Support educational opportunities for rural providers for financial and operational improvement and expansion and enhancement of services: a) Provide direct funding to hospitals for training, supplies; enhancement of HIT, EMS, etc.; b) Provide Coding Certification courses; and c) Fund trainings, conferences and technical assistance through LHA, LRHA, and vendors	2011-2015	FLEX; SHIP; SORH; PCO a)\$347,293 b)\$130,000 c)\$35,000	Health Systems Development Unit; Practice Management Consulting Unit	Providers will have certified coders on staff. Providers will enhance financial, operational and clinical practices.	# of providers meeting each phase of HIT requirements # of certified coders trained # of provider staff trained

Objective 2: Support collaboration and network development efforts of rural providers to strengthen the health system, eliminate duplication and build capacity

	Activities	Dates	Funding Program	Unit Staff	Outcomes	Measures
1	Support the continuum of care across primary care providers, hospitals, EMS and other community providers: a) Support the development of new clinics and services in underserved areas (e.g., mock rural health clinic certification surveys, grant writing workshops, feasibility studies); b) Engage and inform state partners, providers and key stakeholders on major rural health issues	2011-2015	FLEX; SHIP; SORH; PCO a) In-Kind b) In-Kind	Health Systems Development Unit; Practice Management Consulting Unit	Communities will receive information and assistance to start and expand health care services. Providers will receive timely, consistent information on policies, regulation changes and funding opportunities.	# of technical assistance encounters with providers and communities # of entities receiving LISTSERV updates # of listserv updates sent
2	Support the inclusion of EMS services into local, regional and statewide systems of care and in the trauma system through support of the Louisiana Emergency Response Network, Bureau of Emergency Medical Services, and the Louisiana Ambulance Alliance.	2014-2015	FLEX (In-Kind)	Health Systems Development Unit	Rural communities will become integral participants in the statewide trauma system.	Louisiana will have an accredited CEU and nurse trauma trainer.

Objective 3: Increase the supply of rural health providers

	Activities	Dates	Funding Program	Unit Staff	Outcomes	Measures
1	Promote preceptor participation in the Student/Resident Experiences and Rotations in Community Health (SEARCH) program as a recruitment strategy for primary care, nursing and allied health students	2011-2015	PCO; SEARCH	Recruitment & Retention Unit	More students/residents will gain experience working in rural communities	# of new rural preceptors added to the SEARCH program
2	Encourage the recruitment and retention of primary care, dental and mental health professionals in rural areas by providing knowledge of rural incentive loan repayment programs and incentives	2011-2015	PCO	Recruitment & Retention Unit	Increased use of State Loan Repayment Program, National Health Service Corp., Conrad 30 and other recruitment programs by rural providers Health professionals participating in recruitment programs will stay six (6) months past the end of their service commitments	# of providers, associations, etc. receiving information on programs # of providers serving rural communities # of providers remaining in rural Louisiana after the end of their service commitments

Objective 4: Expand access to behavioral health services in rural Louisiana

	Activities	Dates	Funding Program	Unit Staff	Outcomes	Measures
1	Support statewide implementation of Bayou Health (Coordinated Care Networks) and the coordinated system of care (CsoC) through provider education about these programs	2011-2015	SORH	Health Systems Development Unit; Practice Management Consulting Unit	Improved delivery and continuum of care in behavioral health in rural communities	Implementation of Bayou Health and CsoC programs statewide # of Bayou Health and CsoC meetings attended and held

Objective 5: Develop patient education materials and programs

	Activities	Dates	Funding Program	Unit Staff	Outcomes	Measures
1	Educate providers on guidelines and recommendations of the NHLBI, National Asthma Education and Prevention Program (NAEPP)	2011-2015	FLEX; LA Asthma Management & Prevention Program \$4,000	Health Systems Development Unit; Chronic Disease Prevention & Control Unit	Improved delivery and continuum of care for asthma patients in rural communities	# of trainings provided by trained asthma educators
2	Continue smoking cessation awareness campaign targeted to rural and low socioeconomic populations	2011-2014	Tobacco Control Program	Chronic Disease Prevention & Control Unit	A 5% decrease in smoking prevalence among rural and low socioeconomic populations	% rural residents who smoke
3	Continue Tobacco Control campaigns for reducing secondhand smoke exposure and expansion of Project HEAL to critical access hospitals	2011-2014	Tobacco Control Program; FLEX \$11,000	Health Systems Development Unit; Chronic Disease Prevention & Control Unit	A 5% decrease in exposure to secondhand smoke among rural and low socioeconomic populations	% rural residents exposed to secondhand smoke Six (6) additional CAHs will become "smoke-free campuses"

Objective 6: Strengthen and expand school-based health centers

	Activities	Dates	Funding Program	Unit Staff	Outcomes	Measures
1	Support financial, programmatic, and quality assurance training for SBHCs	2011-2015	SORH	Adolescent School Health Program; Practice Management Consulting Unit; Health Systems Development Unit	Increase sustainability of SBHCs	Billing and collection revenue amounts

Objective 7: Expand assistance to improve the quality of care provided in rural Louisiana

	Activities	Dates	Funding Program	Unit Staff	Outcomes	Measures
1	Support educational opportunities and special projects that assist rural providers to implement best practices in patient care and utilization of quality reporting and evaluation systems	2011-2015	FLEX; SHIP; SORH	Health Systems Development Unit	Providers will meet new reporting and participation requirements in state and federal policies	# of CAHs participating in multi-state benchmarking system (e.g. Hospital Compare/ MBQIP, QHI)

Objective 8: Recognize and publicize the economic impact of the health sector and provide technical assistance to attract resources

	Activities	Dates	Funding Program	Unit Staff	Outcomes	Measures
1	Provide Internet-accessible IMPLAN studies for the State and each parish that providers and communities can use to educate their local, state and federal officials on the economic impact of the health sector	2011-2015	SORH	OPH Health Improvement Support Unit	IMPLAN studies will be completed for 19 additional parishes	List of IMPLAN studies available on the DHH website

Objective 9: Educate DHH and other legislative and administrative policymakers in Louisiana about the needs in rural communities

	Activities	Dates	Funding Program	Unit Staff	Outcomes	Measures
1	Purchase Nielson Claritas Data Information System to set baseline measurement of chosen health indicator	2011-2013	FLEX \$10,000	Health Systems Development Unit; OPH; Health Improvement Support Unit	Baseline data on selected health factor to address in Medicare project Use data to examine health outcomes and consumer demand for tobacco cessation products	Purchase of system baseline measurement report Total expenditures and percentage rates



Conclusion

This *2011 – 2015 Louisiana Rural Health Plan* builds on the work of small rural hospitals, CAHs, rural FQHCs, primary care physicians, RHCs, PHUs, the State's AHEC network, many providers and advocates, as well as the work of DHH's BPCRHR staff. The depth and the amount of input received through the three (3) June 2011 community meetings, as well as the June partner meeting, along with comments received as part of other planning work led by the BPCRHR, helped make this plan relevant.

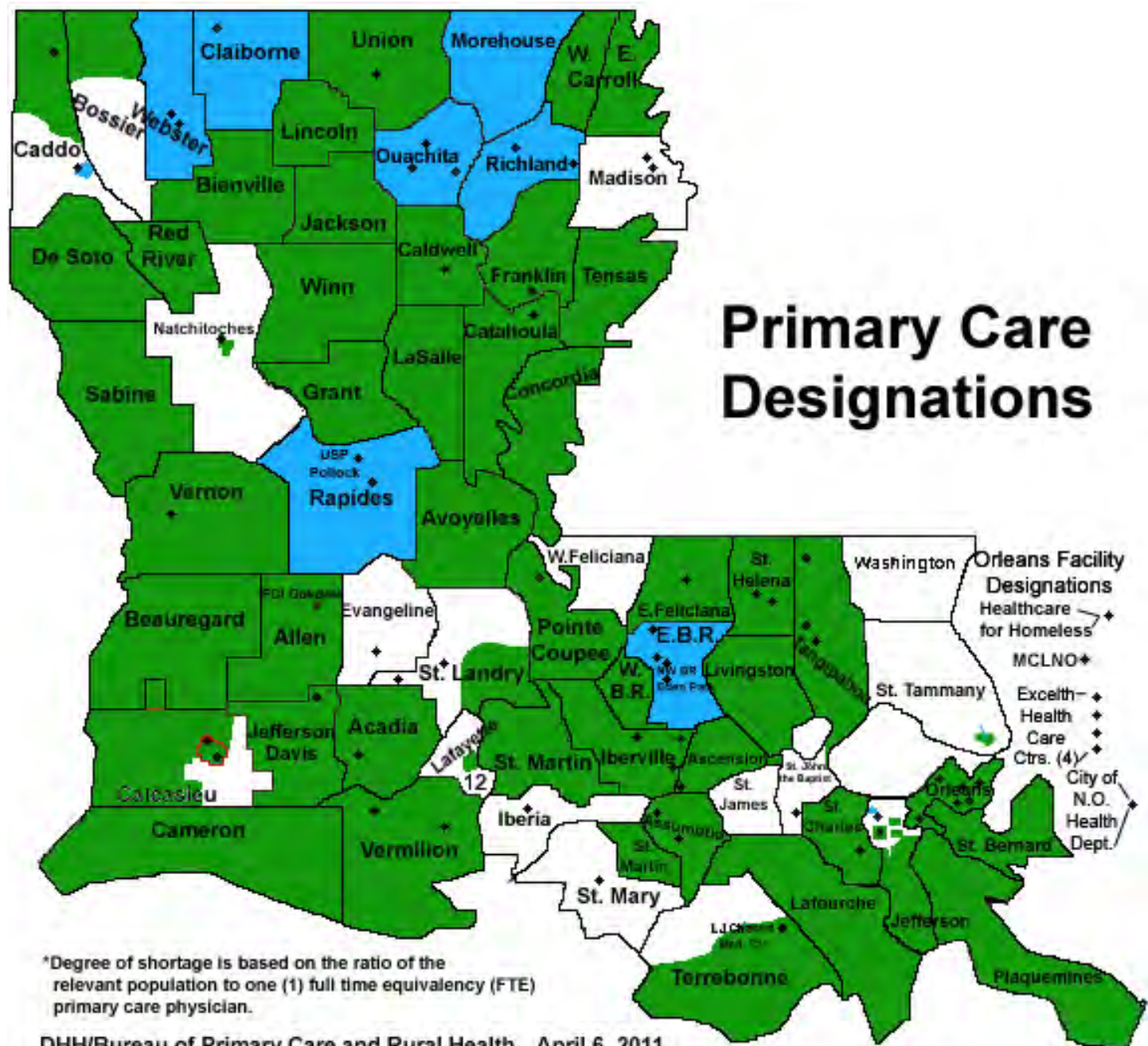
The work described in this plan, and the monitoring and evaluation of the strategies, as well as the activities implemented, requires associations, individuals, providers, agencies and civic leaders to continue to participate and collaborate in the fundamental work of increasing and ensuring access to quality health care for rural Louisianans. Collaboration and focus are essential to eliminating disparities related to geography and race, as well as to continuing to strengthen the work of rural health providers.

This rural health planning process highlighted areas in need of attention, strategic development and refinement for the coming years. Needs and resources

were identified and examined. Collaboration is the method the BPCRHR has successfully used in the past, and is the method upon which the BPCRHR depends on for the implementation of this plan. The June 2011 community and provider forums brought many individuals and groups to the table to discuss rural health in Louisiana. This plan reflects that broad diversity of experience and uses input taken directly from those sessions.

A high degree of collaboration, resource identification, resource development and focused work are required now to move forward. The BPCRHR invites active participation in the implementation of the work described in this plan. The success of this plan is contingent upon continued engagement, and partners providing direct input into the work, the progress, as well as the identification of future problems and development of solutions. Many challenges were identified in the planning process. The environment is full of opportunities, as well as significant concerns. Only through collaboration, focus and vigilance will the important work described in this *2011 – 2015 Louisiana Rural Health Plan* be accomplished.





HPSA DESIGNATIONS LEGEND:

- Geographic Designation
- Population Group Designation
- Facility Designation

