Indiana State Rural Health Plan

July 2011

Submitted by

Affiliated Service Providers of Indiana, Inc.

Acknowledgements

The Indiana State Rural Health Plan represents the voices of many who seek to provide Indiana's rural citizens with exceptionally high quality, affordable, and accessible health care. Dozens of administrators and community network representatives provided insight and data through survey and interview processes that informed the primary themes of this document that will serve as a starting point for planning and forward movement in rural health care within Indiana.

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Executive Summary

The Indiana Rural Health Plan is a living document that captures the economic, workforce, and health care needs of counties served by Indiana's critical access hospitals. Indiana's rural populations are at the center of multiple forces that can work in concert to improve and sustain health. Indiana is fortunate to have established partnerships on a statewide level that are keenly focused upon issues of workforce development, quality service delivery, patient safety, emerging telehealth connectivity, data gathering and analysis, training, and collaboration.

Through a review of secondary sources as well as through a dual survey process of key rural health leaders and statewide organizations addressing rural health care, the current plan establishes five directives to be addressed in its work plan. These include (1) support collaborative solutions to issues of rural health service quality and access, (2) provide equitable and accountable funding strategies for appropriate projects resulting in improved care and/or provider accountability for rural citizens, (3) utilize existing expertise already working on rural health issues to the greatest degree possible, (4) aid in accountability of clinical practice and financial acumen of rural providers, and (5) act as a conduit of accurate information to and from critical access hospitals, rural providers, training experts, and state policy makers.

Indiana continues to be challenged by shifts in demographic composition, loss of employment, an uneven distribution of health care professionals, and shifts in payer mix for service providers. Yet, Indiana's rural health care providers remain dedicated to serving their communities, developing skills, and remaining financially viable. Through technology, creativity, collaboration, efficiencies of scale, and improved training and education, rural health care providers remain resilient in the face of these challenges.

To support rural providers and their constituent consumers, the Indiana State Office of Rural Health has formed a Flex Advisory Committee and a Rural Roundtable to enhance multi-disciplinary communication, project collaboration, and efficiencies through integrative approaches. Further, Flex funding processes are responsive to the identified needs of Critical Access Hospitals as recorded through survey and focus group data. The process is objective and accountable and aligned with categories of funding. The resulting work plan for the current funding year fits within the parameters of the five state plan directives, relates directly to wider national initiatives, and fits well within the overall goals for the State Office of Rural Health as informed by rural stakeholders.

Movement toward an integrated system of care is especially challenging in rural areas as many essential services *(*e.g., hospital and physician services, behavioral health, dental care, and EMS services) are not available in many small communities. As a result, it is critical to develop linkages with providers in other communities and to use the technology as effectively as possible. The State Office of Rural Health maintains interest and support for emerging technologies and models of cooperation that bring high quality coordinated and culturally sensitive care to Indiana's rural populations while supporting viable revenue streams for providers. The Indiana Rural Health Plan is a catalyst for forward movement of initiatives and collaborations in place within the state.

Indiana State Rural Health Plan

Forward

A snapshot of the state of Indiana's health provides a picture of a general population that ranks above the national BRFSS medians on smoking prevalence, obesity, diabetes, and asthma. In addition, Hoosiers are less likely to participate in early detection testing. See **Figure 1** below.

Figure 1. State Rankings, BRFSS 2008& 2009 Comparison

Current Smokers 2008 data		**Current Smokers 2009 data**		**Obesity based on bmi 2008 data**		**Obesity based on bmi 2009 data**		**Ever told you have diabetes 2008 data**		**Ever told you have diabetes 2009 data**		**Told you currently have asthma 2008 data**		**Told you currently have asthma 2008 data**	
%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank
26	2	23.1	5	26.9	23	29.9	14	9.5	12	9.3	14	9.2	19	9.1	18
National Median 18.3		**National Median 17.9**		**National Median 26.6**		**National Median 26.9**		**National Median 8.2**		**National Median 8.3**		**National Median 8.7**		**National Median 8.8**	

Source: Behavioral Risk Factor Surveillance System Indiana Statewide Survey Data, 2008; CDC BRFSS Website, 2011.

Indiana's trends generally coincide with those of the nation in terms of upward and downward movement. However, Indiana continues to exceed the national median on all of the measures listed above. Two conditions that could be preventable are smoking and obesity. Indiana ranks tenth in the nation in the consumption of tobacco with an annual consumption of 78.9 million packs. The state also ranks 35th in terms of smoke-free air laws (McMillan, 2010). Tobacco use and obesity contribute heavily to the other conditions on the list.

The Kaiser Family Foundation State Health Facts for Indiana (2011) revealed higher birth rates for teens, higher infant mortality across all race/ethnicity groups, lower overall life expectancy, and higher child mortality than the national average. Clearly, the health of Indiana's citizens is at risk.

Indiana has 122 hospitals, 38 of which are located in rural areas (North Carolina Rural Health Research and Policy Analysis Center, Dec. 2008). The state has 35 hospitals currently identified as Critical Access Hospitals (April, 2009). There are 61 Rural Health Clinics in Indiana (Kaiser, 2010), and 19 Federally Qualified Health Centers provide services at 86 sites in the state (Kaiser, 2008). Most Hoosiers have some form of health insurance coverage, although 13% of the state's residents lack any health insurance (Kaiser, 2011).

Physician Access

Nationally, Indiana ranks 35th in overall primary care provider rate according to the Area Resource File (2006). **Figure 2** shows the counties with the best and worst access to Indiana's physicians. Marion County which contains Indiana's capital tops the list. Its access score is 1.6

times as high as that of the second-ranked county, Vanderburgh County, and more than two times as high as all but four counties. Marion County's primacy shows that access to physician care is very unequally distributed across Indiana. Indiana counties with the worst access to physician care are listed at the bottom of **Figure 2**. Posey County in southern Indiana has the worst access to physicians, followed by four other counties located along the Ohio River: Switzerland, Ohio, Perry, and Spencer counties. The poor access in some of these counties is mitigated to some extent by physicians in other states. Only two of the 10 counties with the worst physician access, Benton and Newton counties, are located in the northern portion of the state. They are part of a vast area along the Illinois border that has also been identified as a Health Professional Shortage Area according to the criteria of the U.S. Department of Health and Human Services.

Figure 2. Counties with Best and Worst Physician Access.

Rank	County	
	The Best	
1	Marion	1.00
2	Vanderburgh	0.64
3	Hamilton	0.632
4	Monroe	0.538
5	Hancock	0.525
6	St. Joseph	0.500
7	Allen	0.482
8	Boone	0.466
9	Hendricks	0.462
10	Tippecanoe	0.455
	The Worst	
83	Ripley	0.051
84	Benton	0.048
85	Sullivan	0.046
86	Newton	0.037
87	Crawford	0.018
88	Spencer	0.018
89	Perry	0.018
90	Ohio	0.010
91	Switzerland	0.005
92	Posey	0.000

*The higher the score, the better the access. Source: Purdue Center for Regional Development (2010).

Rural Indiana

Indiana represents a mix of major metropolitan areas with concentrations of industry and commerce. Sixty percent of Indiana counties (55 of 92) are located in rural or non-metropolitan areas. Twenty-six (26) of the 55 rural counties in Indiana are partially or completely medically underserved or have shortages of health professionals. This designation indicates that residents in certain rural areas have fewer physicians than urban areas and a higher rate of unemployment, poverty rates, and population over the age of 65 years.

The challenges of health professional shortages are amplified in rural Indiana given the elevated rates of tobacco use, obesity, diabetes, and hypertension. These rates are directly linked to higher rates of cancer and heart disease in rural versus urban counties. While these all-too common

health problems can be improved through increased physical activity and improved nutrition, the barriers associated with rural living, such as limited sidewalks, fitness centers, walking trails, as well as lower socio-economic status make access to these resources a challenge.

The health of Indiana's rural residents and their access to quality health care, public health services and preventive health programs differ from urban residents. These statistics are no surprise given the current economic climate and the rising cost of health insurance. The number of uninsured and underinsured residents has increased and is causing more individuals to turn to the Indiana Medicaid program and safety net providers for basic health services, which places a financial strain on these already-stressed programs.

Social Determinants of Health

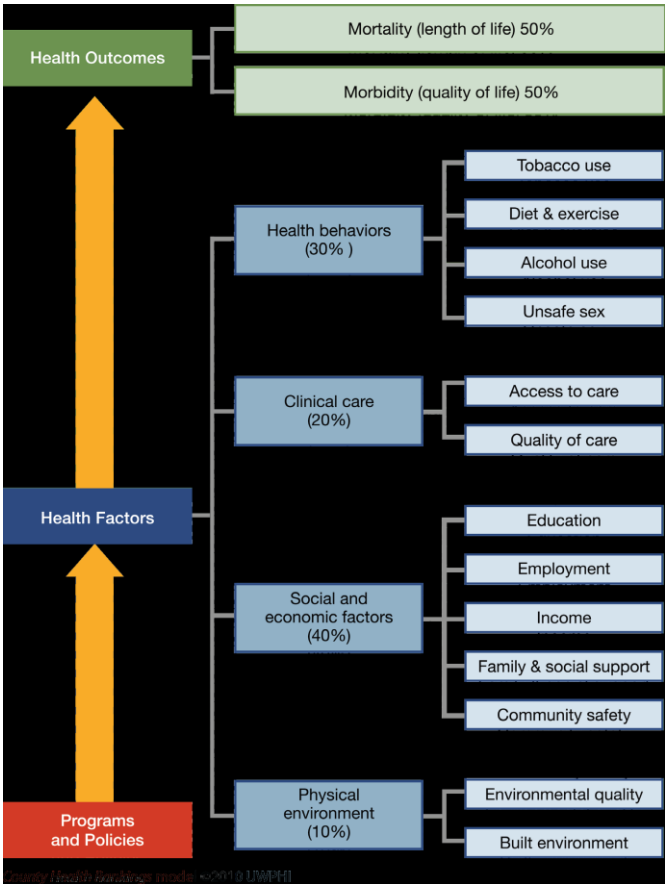
Social determinants of health are factors in the social environment that contribute to or detract from the health of individuals and communities. These factors include, but are not limited to the following:

- Socioeconomic status
- Transportation
- Housing
- Access to services
- Discrimination by social grouping (e.g., race, gender, or class)
- Social or environmental stressors

Social determinants of health have repeatedly been found to be associated with heart disease and stroke. These factors work either directly to affect the burden of chronic diseases and their risk factors, or indirectly, through their influence on health-promoting behaviors. In considering the status of rural Indiana at this time, all of the determinants are operating against Indiana's rural citizens.

Rural Hoosiers are at a greater disadvantage due to higher prevalence of each of these chronic issues, plus greater unemployment, further distances to treatment, lower income, lower levels of education, aging patterns, lower levels of insurance coverage and a shortage of health care workers. In 2010, the University of Wisconsin Population Health Institute published **County Health Rankings 2010.** Multiple factors were considered in developing the rankings. The following graphic depicts the elements that interact with health factors and their distribution across the community. This interplay of factors and community programs and policies produce health outcomes.

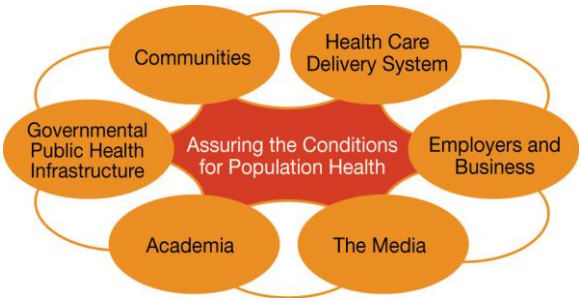
Figure 3. Components of Health Outcomes.



Source University of Wisconsin, 2010.

The types of community programs and policies could be generated from the following community stakeholders.

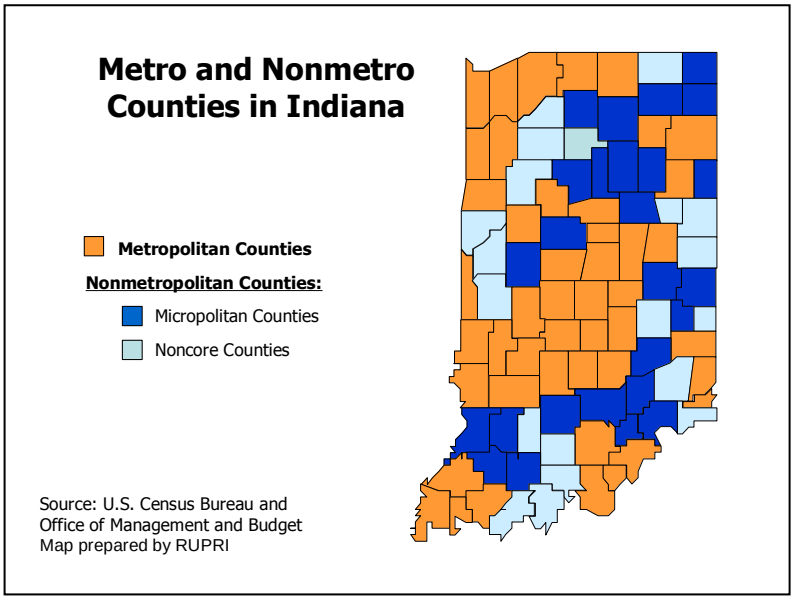
Figure 4. Community-based Programs and Policies Designed to Alter the Distribution of Health Factors within the Community.



Source: Institute of Medicine, 2002

Within Indiana specifically, disparities exist between rural and urban environments because of the interaction of these factors. The map below separates metropolitan and non-metropolitan counties within the state.

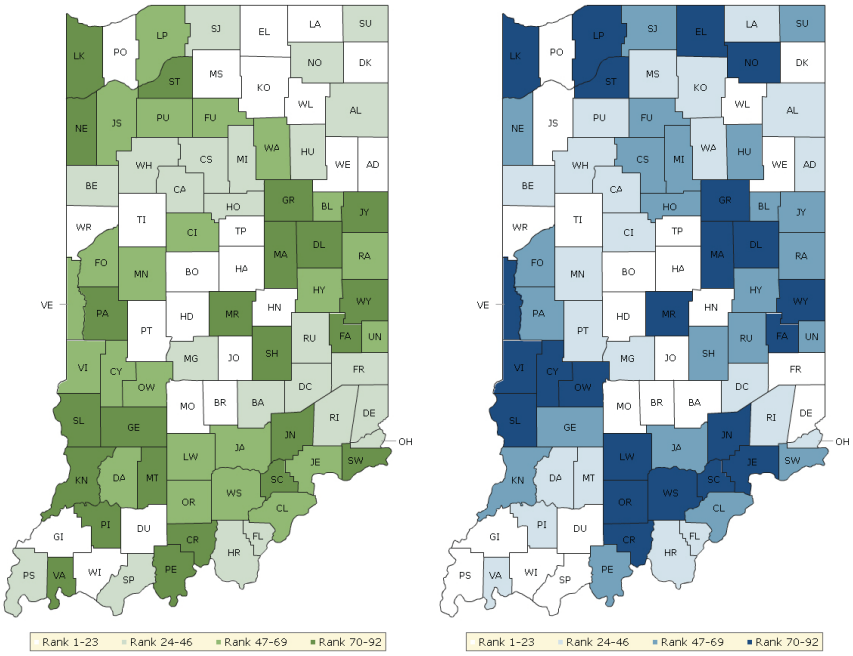
Figure 5. Metro and Nonmetro Counties in Indiana



With the variable of rural and urban counties in mind, the state's health disparities become clearer when looking at rankings of health outcomes and health factors.

Figure 6. Maps of Indiana County Health Outcomes and Health Factors Rankings.

Health Outcomes **Health Factors**



Source: University of Wisconsin Population Health Institute. *County Health Rankings 2010*

An alternative method of examining the rankings is through the following list. Asterisks identify rural counties.

Figure 7. Health Outcomes and Health Factor Rankings of Indiana Counties.

Health Rank	Health Outcomes	Rank	Health Factors	Health Rank	Health Outcomes	Rank	Health Factors
1	Hamilton	1	Hamilton	47	Jasper	47	Huntington*
2	Hendricks	2	Hendricks	48	Daviess *	48	Newton
3	Dubois *	3	Warrick	49	Wabash*	49	Howard
4	Boone	4	Boone	50	Fountain *	50	St. Joseph
5	LaGrange *	5	Dubois *	51	Clinton *	51	Shelby
6	Warrick	6	Hancock	52	Montgomery*	52	Perry *
7	Whitley	7	Monroe	53	Randolph *	53	Randolph *
8	Marshall *	8	Wells	54	Jefferson *	54	Cass *
9	DeKalb *	9	Johnson	55	Blackford *	55	Henry *
10	Wells	10	Brown	56	Fulton *	56	Jackson *
11	Putnam	11	Whitley	57	Pulaski *	57	Union *
12	Tippecanoe	12	Spencer *	58	Owen	58	Blackford *
13	Brown	13	Porter	59	Clark	59	Fulton *
14	Tipton	14	Warren *	60	Washington	60	Knox *
15	Adams *	15	Jasper	61	La Porte	61	Fountain *
16	Porter	16	Gibson	62	Union *	62	Steuben *
17	Monroe	17	Dearborn	63	Vermillion	63	Clark
18	Elkhart	18	Tippecanoe	64	Henry *	64	Jay *
19	Gibson	19	Tipton	65	Orange *	65	Miami *
20	Warren *	20	Bartholomew	66	Lawrence *	66	Parke *
21	Johnson	21	Posey	67	Jackson *	67	Rush *
22	Hancock	22	DeKalb *	68	Clay	68	Switzerland*
23	Kosciusko *	23	Franklin	69	Vigo	69	Greene
24	Carroll	24	Ohio	70	Shelby	70	Orange *
25	Dearborn	25	Marshall *	71	Vanderburgh	71	Delaware
26	Ripley *	26	Harrison	72	Newton	72	Sullivan
27	Franklin	27	Carroll	73	Parke *	73	Noble *
28	Posey	28	Clinton *	74	Wayne *	74	Lawrence *
29	Huntington *	29	Putnam	75	Jay *	75	Elkhart
30	White *	30	Vanderburgh	76	Knox *	76	Jefferson *
31	Decatur *	31	Wabash *	77	Grant *	77	La Porte
32	Steuben *	32	Morgan	78	Greene	78	Vigo
33	Allen	33	Benton	79	Madison	79	Scott *
34	Bartholomew	34	Adams *	80	Marion	80	Wayne *
35	Benton	35	Daviess *	81	Delaware	81	Clay
36	Ohio	36	Ripley *	82	Jennings *	82	Owen
37	Noble *	37	Floyd	83	Crawford *	83	Washington
38	Cass *	38	Kosciusko *	84	Lake	84	Grant *
39	Harrison	39	Allen	85	Fayette *	85	Vermillion
40	Morgan	40	White *	86	Perry *	86	Crawford *
41	Miami *	41	Pike *	87	Sullivan	87	Marion
42	St. Joseph	42	Pulaski *	88	Pike *	88	Jennings *
43	Floyd	43	Martin *	89	Martin *	89	Madison

44	Spencer *	44	Decatur *	90	Switzerland*	90	Fayette *
45	Rush *	45	Montgomery*	91	Starke *	91	Starke *
46	Howard	46	LaGrange *	92	Scott *	92	Lake

Source: University of Wisconsin Population Health Institute. *County Health Rankings 2010*

The following chart shows the rural county rankings as they appear in quartiles, demonstrating the distribution of rural counties as they relate to health factors and health outcomes.

Figure 8. Quartile Distribution of Rural Counties: Health Outcomes and Health Factors.

	Quartile 1 Rankings 1 - 23	Quartile 2 Rankings 24-46	Quartile 3 Rankings 47- 69	Quartile 4 Rankings 70-92
Health Outcomes	7	10	15	14
Health Factors	4	14	17	11

A recent Robert Wood Johnson report (March, 2010) identified Indiana as ranking 47th in State Public Health Budgets; 50th in HRSA dollars received in FY 2009; and 48th in CDC dollars allocated in FY 2009. Indiana struggles to meet the health needs of its citizens under these constraints. Adding to low levels of economic support is job loss within the state. Indiana has lost 209,800 manufacturing jobs since 2000. Over the same span, the actual number of net jobs lost/ gained in all categories in the state totaled 136,500. This means the state has been losing factory work faster than enterprises can add jobs in the service economy (www.indy.com, April 2009). Elkhart County, Indiana, has become a symbol for job loss in the current US recession, with unemployment in that county exceeding 18%.

The current economic picture nationally and within the state have created a shift in payor mix for Indiana's CAHs complicated by a recent 5% reduction in Medicaid reimbursement to hospitals for outpatient and inpatient hospital services. These conditions add pressure to hospital operations that must rely on sound fiscal leadership and economies of operations to maintain access to hospital care for Indiana's rural populations.

Background and Purpose

The purpose of the Indiana Rural Health Plan is to provide a map for improving the health of Hoosiers through a more accessible, efficient, and accountable system of service delivery and Flex funds spending. The plan is divided into six sections. **Section One** identifies some of the major health and economic concerns of Indiana's rural population. **Section Two** describes Indiana's Critical Access Hospitals, their impact and necessary support systems. **Section Three** discusses the need for health workforce development and retention in Indiana's rural areas. **Section Four** explains the Flex proposal development process, reviews recent CAH statistics, and summarizes the findings of the planning process leading to the focus of the Indiana State Rural Health Plan. **Section Five** addresses the major themes and the associated activities that will support the evolution and sustainability of high quality, affordable rural health care in Indiana through the efforts of the State Office of Rural Health and its partners. **Section Six** provides a brief summary and direction for the future.

Process for Developing the Plan

The development of the Flex-related sections of the Indiana State Rural Health plan evolved through two primary approaches. The key stakeholders involved in the plan included the CEOs of Indiana's Critical Access Hospitals and the members of the Indiana Rural Roundtable, a group of diverse rural medical stakeholders convened as follow-up to the Rural Health Plan of 2009. Affiliated Service Providers of Indiana, Inc. served as the facilitative body for the plan, under the direction of Ann Alley, Director, Primary Care Office, Public Health and Preparedness Commission, Indiana State Department of Health.

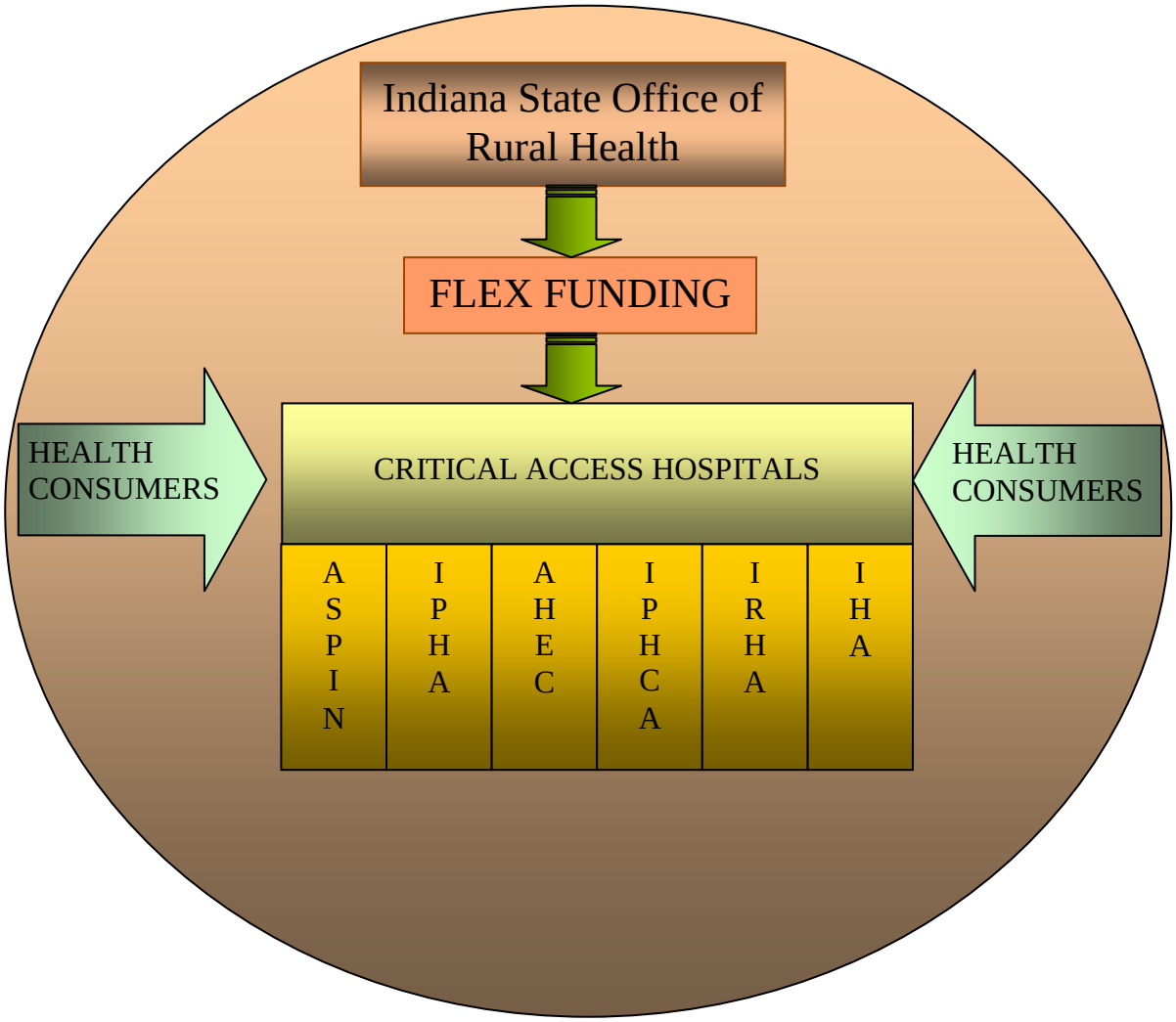
The CEOs of Indiana's thirty-five critical access hospitals were invited to submit responses to an electronic survey that captured current-state health care issues within the context of a depressed economy and increasingly vulnerable consumers of medical care, along with their assessment of the largest issues facing the critical access hospitals, with potential solutions. The survey instrument is included in Appendix A. Outcome data is presented and discussed in Section Four of this plan. The survey was fundamentally a repeat of the survey conducted in 2010, with the additional goal of being able to track changes within the one-year time span.

The Rural Roundtable meets quarterly. The group members with their respective organizations are found in the chart below. Additional members are expected to be recruited as the group continues to respond to rural health issues.

Indiana Rural Round Table Members 2011	
Ann Alley	Director, Primary Care Office, Public Health Preparedness Commission, Indiana State Department of Health
Don Kelso	Indiana Rural Health Association
Cindy Large	IRHA, Flex Coordinator for Indiana
Kathy Cook	Affiliated Service Providers of Indiana, Inc.
Jerry King	Indiana Public Health Association
Phil Morphew	Indiana Primary Health Care Association
Rick Kiovsky	Indiana AHEC
Becky Royer	Health Care Excel
Spencer Grover	Indiana Hospital Association
Gina DelSanto	Indiana Workforce Development
Brittany Knick	State Office of Rural Health
Anna Barrett	Traumatic Brain Injury Association of Indiana
Carole Kacius	Indiana University School of Medicine Dept. of Public Health

Figure 9 below demonstrates the supportive relationship of these stakeholders to the success of the Critical Access Hospitals

Figure 9. Indiana State Rural Health Plan Stakeholder Field.



This document summarizes existing research, statistics, previous health planning work, and knowledge gained through reports, plans, surveys, and interviews to create a comprehensive, living document that will serve as a foundation for current and future planning. It is hoped that its strategies and recommendations will lend information and support for the combined efforts of policymakers, health care providers, educational institutions, the Office of Rural Health, professional associations, and other stakeholders to improve the health of Indiana's rural population.

Vision

The primary goal of the Indiana Flex Plan is for Indiana to become a leader in supporting rural health providers and in providing rural citizens with the quality and performance improvement support needed by critical access hospitals.

A healthy rural Indiana will result from the provision of funding, performance improvement support, and collaborative problem-solving for sustainable solutions to support Indiana's Critical Access Hospitals and their key stakeholders.

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University of Wisconsin Population Health Institute. *County Health Rankings 2010.*

Section I. A Picture of Indiana's Rural Population

Indiana's Rural Demographics

Indiana is in the Great Lakes region of the United States, with shoreline on Lake Michigan. The state is located in the Corn Belt, and most years has almost half of its cropland devoted to corn. Residents of Indiana are known as Hoosiers, which is also the team name for Indiana University athletic teams. Indiana covers 35,867 square miles, with a 2008 estimated population of 6,273,900 people with approximately 28% living in non-metropolitan areas.

Figure 10. Population Distribution by Metropolitan Status Indiana and US

Population Distribution by Metropolitan Status, Indiana (2008-2009), U.S. (2009)				
	IN 2008 #	IN 2009 #	IN %	US %
Metropolitan	4,499,200	546,600	72%	84%
Non-Metropolitan	1,774,700	1,774,500	28%	16%
Total	6,273,900	6,423,113	100%	100%

Notes: Non-Metropolitan includes both respondents living in non-metropolitan areas and areas not classified in either category.
Percentages may not sum to 100% due to rounding effects.
For more details, see "Notes to Demographic and Health Coverage Topics Based on the CPS" at http://www.statehealthfacts.kff.org/methodology.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007, 2008, 2009. Current Population Survey (CPS: Annual Social and Economic Supplements)

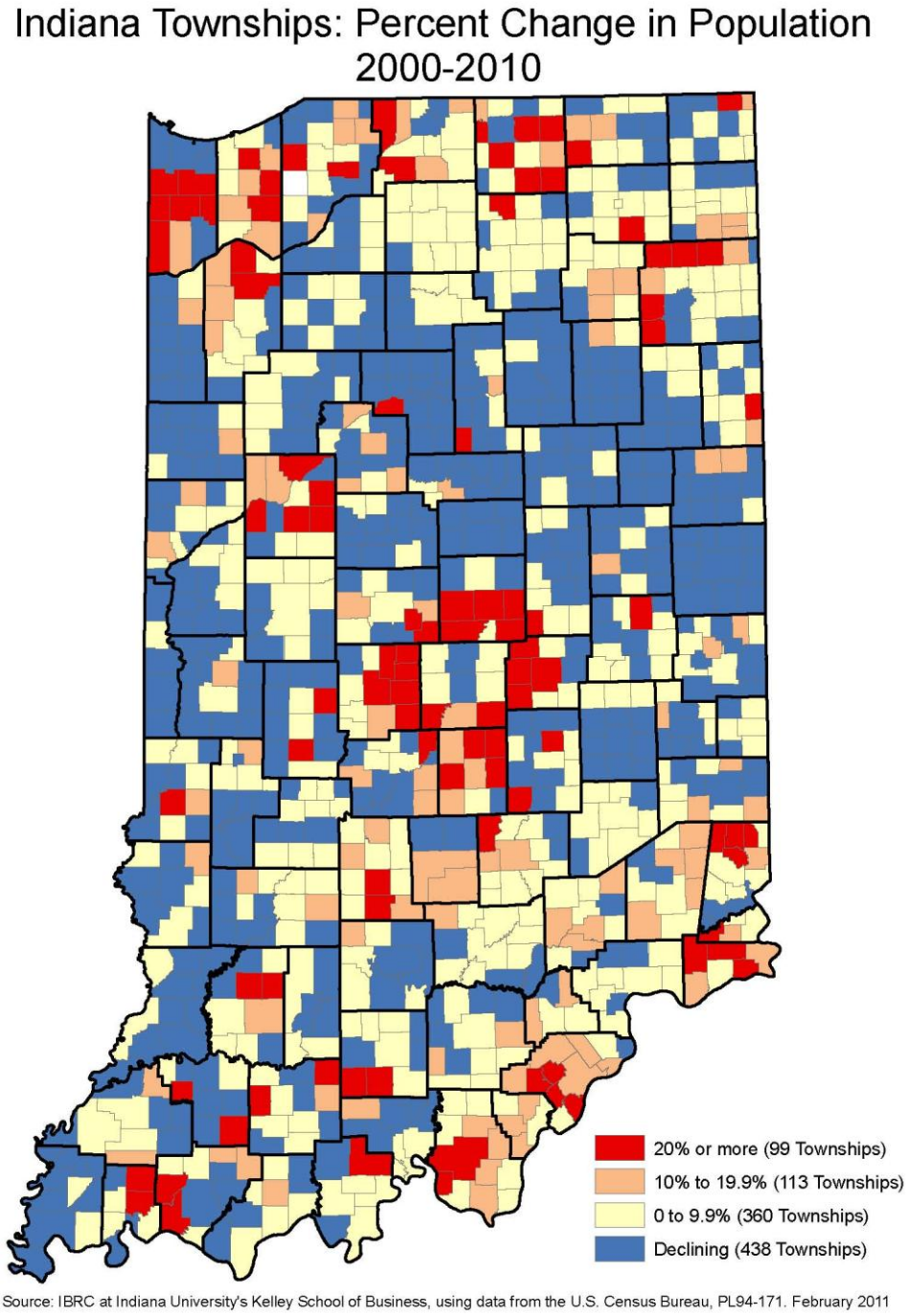
Definitions: **Metropolitan Statistical Area** must include at least one city with 50,000 or more inhabitants, or a Census-Bureau defined urbanized area of at least 50,000 inhabitants and a total metropolitan population of 100,000 or more (75,000 in New England). For more information, visit the Census Bureau website at http://www.census.gov/population/www/estimates/aboutmetro.html
NSD: Not Sufficient Data

Indianapolis, the capital, is located in the central part of the state. The state's largest cities are Indianapolis, Fort Wayne, and Evansville. According to the U.S. Census Bureau, 87.8% of the state's population is white, 9.2% is African-American/Black, 1.5% is Asian, 0.3% is American Indian, and 5.5% is of Hispanic/Latino origin[2].

The average per-capita income for all Hoosiers in 2009 was $36,620. According to the USDA Economic Research Service (2011) a poverty rate of 14.1% exists in rural Indiana, compared to a 14.5% level in urban areas of the State. These figures demonstrate an increase in poverty for both classifications over 2008 levels which were 13% and 12.6% respectively.

The following map represents percent change in population across Indiana from census data in 2000 to that in 2010. Notable population losses fell within primarily rural areas, with highest growth centered in counties surrounding the capital of Indianapolis.

Figure 11. Percent Change in Population, 2000-10.



Source: U.S. Census Bureau, Census 2000 and 2010 Census Redistricting Data Summary File

Current Economic Picture

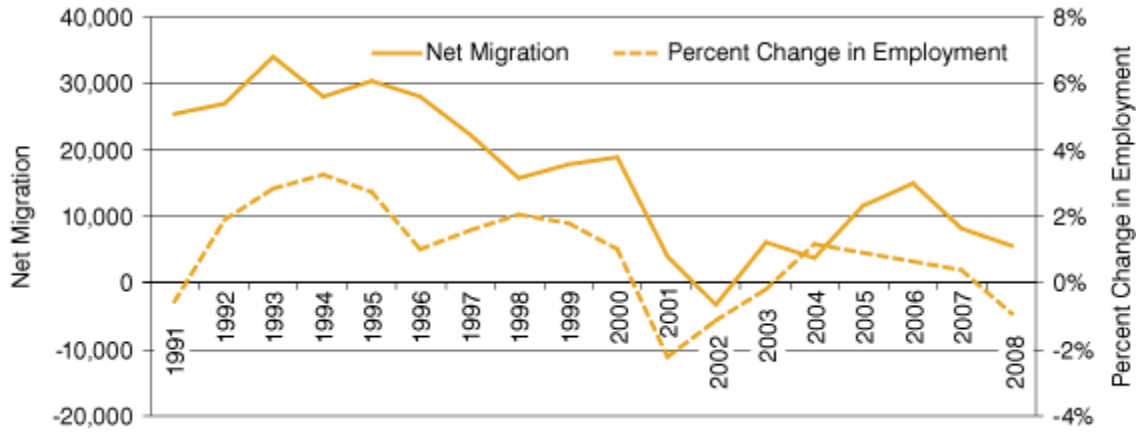
"The patterns of demographic change in rural America are often complex and subtle, but their impact is not. We see it in persistent poverty and diminished community capacity in declining rural communities, and in strained infrastructure, pressed institutions, and rising housing costs in growing communities." (Carsey Institute, 2006).

Employment Change and Migration

Figure 12 traces Indiana's annual net migration between 1991 and 2008 along with the annual percent change in the state's total nonfarm employment. Over this period, the two variables tended to move together with shifts in the rate of employment change generally signaling a similar shift in the level of net migration.

For instance, Indiana's greatest employment boom in recent years occurred between 1993 and 1995 when jobs increased by roughly three percent a year. In total, Indiana added 230,000 jobs over this period. These are also the top years for in-migration with an average annual net movement into the state of 31,000 residents. The state continued to add jobs throughout the decade but at a more modest pace. These lower rates of employment growth were accompanied by lower levels of net in-migration.

Figure 12. Indiana's Annual Percent Change in Employment and Net Migration, 1991 to 2008.

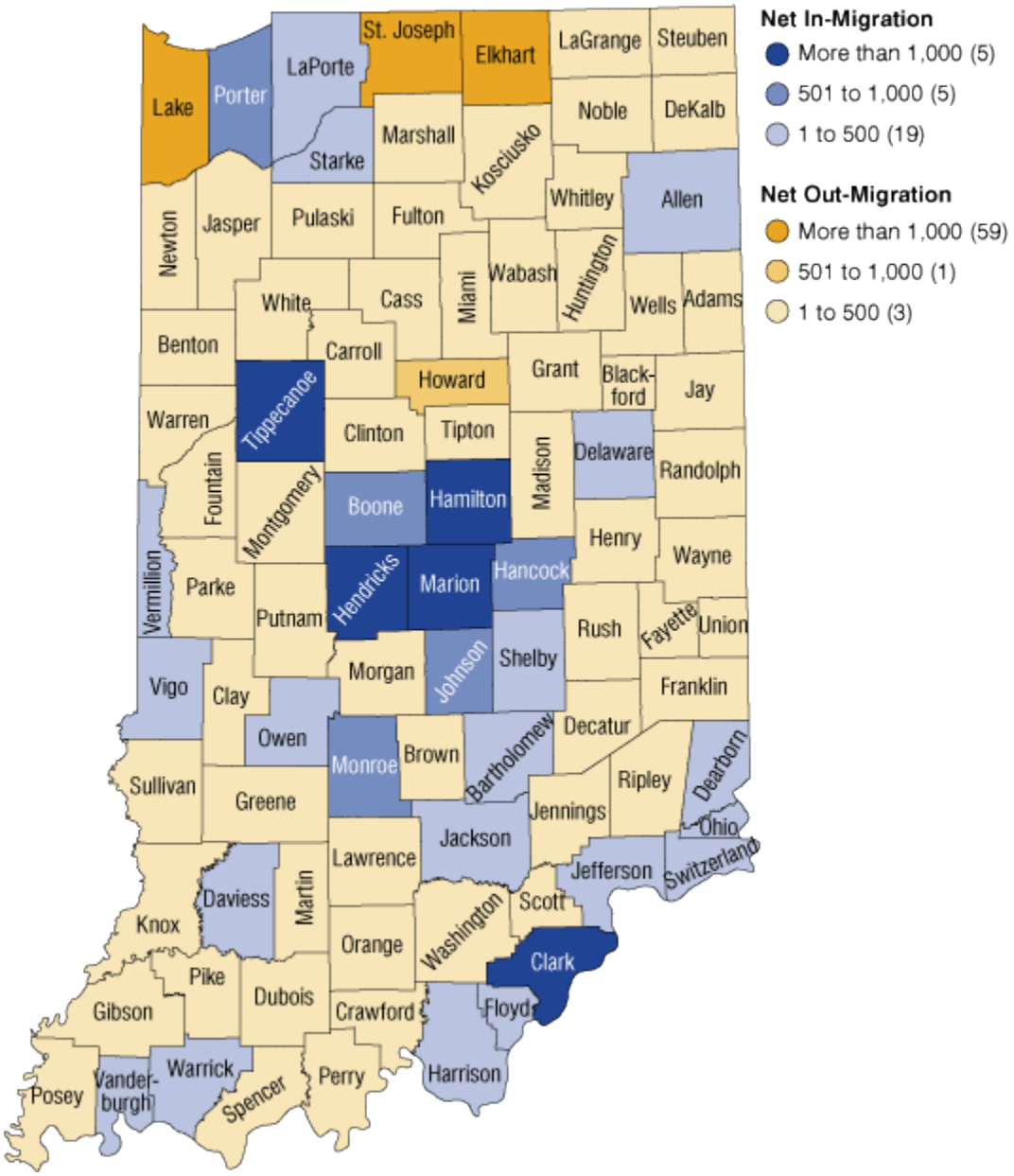


Sources: U.S. Census Bureau, Moody's Economy.com, Bureau of Labor Statistics

This fairly strong association between changes in employment and migration is important to understand given the current economic downturn. Recently released data from the U.S. Census Bureau documents the fact that largely rural counties lost the greatest proportion of their populations through migration. For example, Pike County in southwestern Indiana lost more than 2% of its population through net migration in 2009. A net outflow of residents accounted for more than a 1.5% population decline in White, Parke, and Crawford counties. Note that migration differs from overall population change, as it pertains only to population shifts into the state and out from the state. Natural increases and decreases in population due to births and

deaths are also considered in population change. The following map (**Figure 13**) illustrates the percent of population change in each county that was due to net migration.

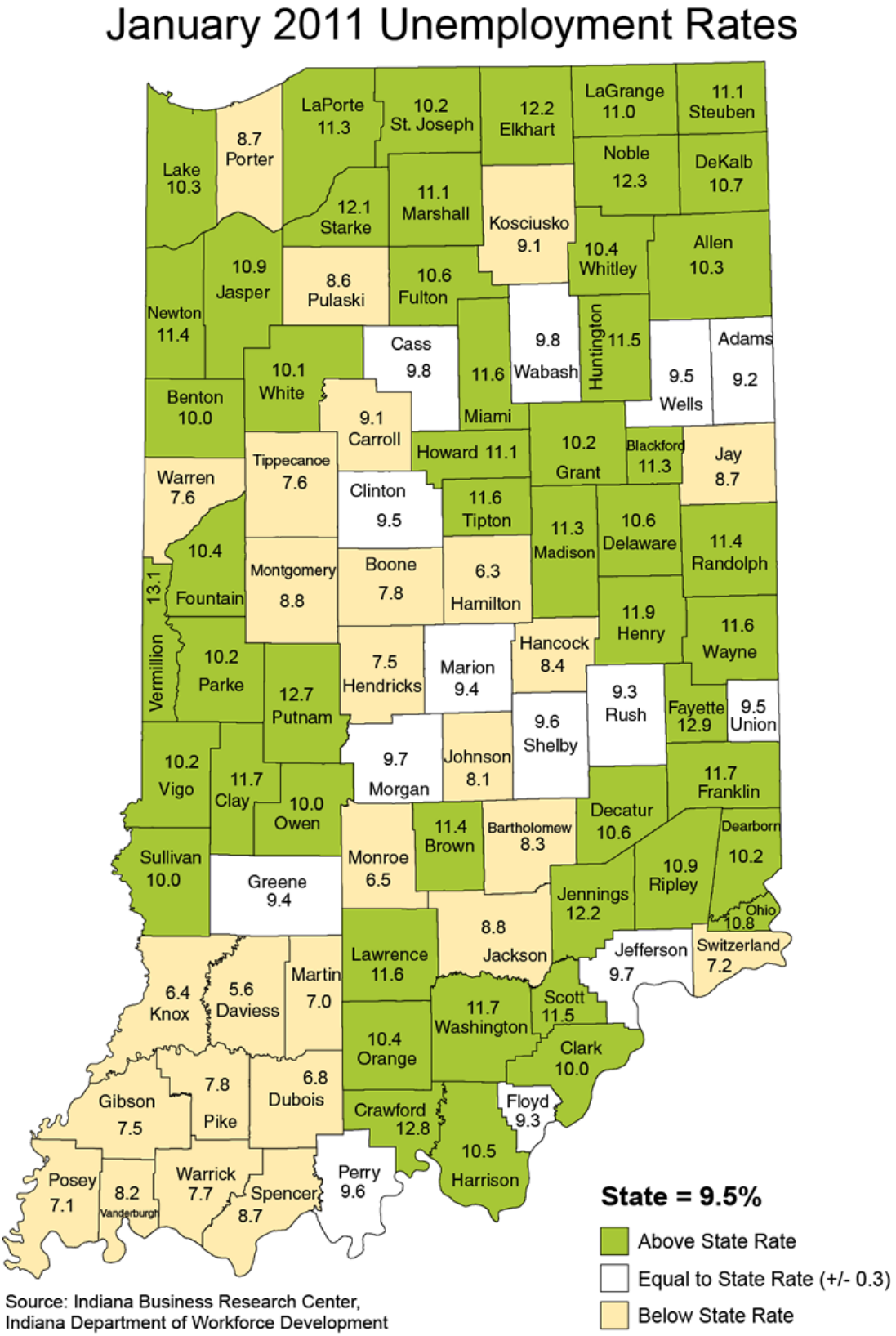
Figure 13. Net Migration by County, 2009.



Source: Indiana Business Research Center, using U.S. Census Bureau data

Indiana, like much of the nation, has seen heavy job losses In fact, between May 2008 and May 2009, Indiana lost 156,000 jobs, which exceeds the state's greatest decline during the previous recession (132,600 jobs lost between May 2000 and July 2003).According to the Kaiser Foundation, employment in Indiana is rebounding However, this is not occurring evenly across the state. (See **Figure 14**.)

Figure 14. Indiana Unemployment Rates by County, January 2011.



Indiana has not escaped the recent national economic downturns. The following table includes the counties in which Critical Access Hospitals are located, comparing unemployment statistics from June of 2008 through January 2011. These figures were prepared in cooperation with the U.S. Bureau of Labor Statistics and have been adjusted to the current population survey for use in allocating federal funds. Although gains in employment are apparent, these counties continue to have unemployment rates higher than the state and national averages.

Figure 15. Unemployment Rate and Population Shifts in Indiana County Locations of Critical Access Hospitals

County Location of Critical Access Hospital	Rate June 2008	Rate June 2009	Rate June 2010	Rate January 2011	Unemployment Change in % from June 2010 to January 2011	Population Shift in % 2000 – 2009
Adams	5.5	14.8	10.0	9.2	- 8%	**+1.9**
Blackford	7.2	15.5	12.6	11.3	- 10.3%	**-7.1**
Clay	7.3	13.1	10.6	11.7	+10.4%	**-0.1**
Clinton	5.1	11.6	10.1	9.5	- 6%	**+1.5**
Decatur	6.1	13.2	10.6	10.6	No Change	**+2.1**
Fulton	5.9	12.7	10.6	10.6	No Change	**-1.2**
Gibson	5.3	9.4	8.2	7.5	- 8.5%	**+0.8**
Greene	6.3	8.7	9.3	9.4	+1.1%	**-2.1**
Harrison	5.6	9.7	8.3	10.5	+26.5%	**+9.4**
Jasper	5.3	9.5	10.3	10.9	+6%	**+9.2**
Jay	5.5	12.1	9.2	8.7	-5.4%	**-3.2**
Jennings	6.2	13.6	11.1	12.2	+9.9%	**+1.8**
LaGrange	6.7	15.8	11.1	11.0	-1%	**+6.6**
Lawrence	6.8	13.0	11.0	11.6	+5.5%	**-0.2**
Madison	6.6	11.4	11.6	11.3	-2.6%	**-1.5**
Marshall	6.3	13.5	10.6	11.1	+4.7%	**+3.9**
Miami	7.4	16.5	11.4	11.6	+1.8%	**-.02**
Orange	5.6	10.5	10.6	10.4	-1.9%	**+1.3**
Perry	5.1	10.1	9.5	9.6	+1%	**-0.5**
Pulaski	5.3	11.1	8.8	8.6	-2.3%	**-1.0**
Putnam	7.2	11.4	11.2	12.7	+13.4%	**+2.3**
Randolph	6.9	12.3	11.1	11.4	+2.7%	**-6.2**
Ripley	5.6	10.7	10.4	10.9	+9.6%	**+3.4**
Rush	5.8	10.5	9.7	9.3	-4.1%	**-5.9**
Scott	6.4	13.5	11.3	11.5	+1.8%	**+2.9**
Steuben	6.4	14.9	11.5	11.1	-3.5%	**+1.1**
Sullivan	7.3	9.9	10.6	10.0	-5.7%	**-2.7**
Tipton	7.0	16.3	10.9	11.6	+6.4%	**-4.1**
Vermillion	6.8	11.9	12.4	13.1	+6.5%	**-3.7**
Wabash	7.3	13.8	10.7	9.8	-8.4%	**-6.9**
Warren	3.8	11.8	9.2	7.6	-11%	**+0.9**
Warrick	4.9	7.9	8.1	7.7	-4.9%	**+11.7**
Washington	6.9	13.2	9.4	11.7	+24.5%	**+1.9**

White	4.9	11.0	9.9	10.1	+2%	**-7.2**
US Overall	**5.7**	**9.7**	**9.5**	**9.0**	**-5.3%**	
Indiana Overall	**5.7**	**10.6**	**10.1**	**9.5**	**-5.9%**	+2.5%
CAH Counties Overall	6.1	12.2	10.4	10.5	+1%	+.27%

Source: Indiana Department of Workforce Development
*Source: U.S. Census Bureau, 2000 Censuses of Population (corrected), and 2009 county estimate files. January 2011 Unemployment Rates from Indiana business Research Center, Indiana Department of Workforce Development. Retrieved from http://www.ers.usda.gov/Data/Population/PopList.asp?ST=IN&LongName=Indiana

The counties served by a Critical Access Hospital have unemployment rates higher than the rest of the state and are less likely to increase in population.

Other Measures of Economic Distress

In March 2010, the Indiana Institute for Working Families completed *The Status of Working Families in Indiana, 2009* which was a comprehensive report on the economic challenges facing low-income, working families in Indiana. *The Status of Working Families in Indiana: 2010 Update* is the 8th annual publication of the annual Status report and uses the best available data from the 2009 U.S. Census Bureau to update the data contained in the Institute's 2009 Status report. This 2010 report analyzes Indiana's economic conditions and its effects on Hoosier workers and their families. To reference the 2009 report, visit: www.incap.org/iiwfRandP.html. Hoosier workers and their families are toiling to stay afloat while the effects of the national recession linger on. Among the report's most significant findings, data from the 2009 U.S. Census Bureau's Current Population Survey shows:

- One in three Hoosiers are now low-income—that is they earn less than 200 percent of the Federal Poverty Guidelines (FPG) ($36,620 for a family of three in 2009). These individuals, despite their best efforts, are struggling to meet their most basic needs.

- Hoosier incomes have declined over the decade. In 1999, the median household income in Indiana was $50,896. By 2009 the median household income had fallen 15 percent to $44,305.

- Hoosier workers continue to earn a median wage lower than the average American and have throughout the past decade. Workers in Indiana earned 96 cents for every dollar earned by the average worker.

- Unemployment and underemployment have increased and have disproportionately affected Indiana's African-American and Hispanic workers. African-Americans have an unemployment rate of 18.7 percent and underemployment rate of 25.5 percent. While Hispanics have an unemployment rate of 17.3 percent and underemployment rate of 35.5 percent.

- National long-term unemployment—lasting longer than 26 weeks—is at its highest level since 1948. Long-term unemployment continues to plague Hoosier workers as Indiana's

economy remains weak—58 percent of unemployed Hoosier workers have exhausted their 26 weeks of benefits in 2009.

- With each additional level of educational attainment, Hoosier workers are less likely to be unemployed, underemployed, and working part-time for economic reasons. Workers with a Bachelor's degree or higher are weathering this recession better than workers with lower levels of educational attainment.

- Poverty is more prevalent in Indiana than in the U.S., as 1 in every 6 Hoosiers lives below the Federal Poverty Guideline - $22,050 for a family of four in 2009.

It is estimated that 16.2% of Indiana families are food insecure. Food insecurity is defined as the ISDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members; limited or uncertain availability of nutritionally adequate foods. Based on national averages, about 29% of food insecure individuals are above 185% of the poverty line and are typically ineligible for most food assistance programs (Nord, Coleman-Jensen, Andrews, & Carlson, 2010). Indiana counties in which Critical Access Hospitals are located reflect an overall 16.7% food insecurity rating, higher than the state average. This can have significant impact on health. Another measure of economic distress is the number of children receiving free and reduced lunches in the state. The data in **Figure 11** are overall figures for Indiana in 2009. It appears that the number of children in poverty is increasing over time.

Figure 16. Indiana Welfare Statistics in 2009.

Welfare Statistics in 2009			
	Number	**10 Year Change**	**10 Year Percent Change**
TANF Families	34,097	1,360	4.2%
Food Stamp Recipients	311,036	11,157	3.7%
Total Lunch Recipients	436,945	160,547	58.1%
Free Lunch	346,885	128,304	58.7%
Reduced Fee Lunch	90,060	32,243	55.8%

Source: Indiana Family and Social Services

Age

Population projections released by the Indiana Business Research Center (IBRC) at Indiana University's Kelley School of Business (2011) portray big changes on the horizon in the size, geographic distribution, and age composition of Indiana's population.

Labor Force

A potential labor shortage may hinder economic development efforts across much of Indiana over the next twenty years, according to new projections issued by the IBRC. Population in the prime working ages of twenty-five to fifty-four can be expected to shrink in seventy-three of

Indiana's ninety-two counties between 2000 and 2020. This twenty-five to fifty-four age range could be considered the most economically productive in the entire life span, since labor force participation is typically highest at these ages. A large share of the population under age twenty-five is still focusing on education, while at age fifty-five and older, the impacts of early retirement and disability result in lower labor force participation rates.

The relatively few counties that can be expected to gain population in the twenty-five to fifty-four age group are concentrated mainly in the center of the state, near Indianapolis. The ten-county Indianapolis Metropolitan Statistical Area (metro) is expected to gain approximately 86,000 people in the twenty-five to fifty-four age group in the twenty years after 2000, while the rest of the state will lose 140,000. Even within the metro area, change in this age group will be geographically uneven, with strong growth in Hamilton, Hendricks, and Johnson counties overcoming a large loss in Marion County. In addition to Marion, six other counties primarily located in the northwestern corner of the state are expected to lose more than 5,000 people in the prime working ages over the twenty-year period.

Losses in the twenty-five to fifty-four age group would likely reduce the labor force in the impacted areas, unless labor force participation rises substantially among the older population, or those under twenty-five. Keeping older workers active in the labor force could have multiple benefits for Indiana and the nation, but increased participation at younger ages would probably have a negative effect on educational attainment.

While job opportunities in the Indianapolis metro may exercise a pull on people in the prime working ages, most counties across the state would inevitably experience a decline in this age group even if all county borders were closed and no migration were permitted. The large baby boom generation outnumbers subsequent generations in most counties, and this uneven age structure is responsible for much of the decline in the prime working ages through 2020.

Elderly

The entry of Baby Boomers into the traditional retirement age of sixty-five will also transform the state. **Figure 17** depicts the changing population shares in two age groups at opposite ends of the age spectrum: under fifteen and sixty-five or older. By 2035, Indiana is expected to have more residents age sixty-five or older than those under fifteen. At the beginning of the projection period, about one in eight Hoosiers had reached their sixty-fifth birthday. This proportion was expected to remain stable through 2010, but it will climb steadily after that point, reaching 21 percent in 2040. The population share under fifteen, by contrast, remains relatively stable throughout the entire projection period.

Figure 17. Population Share, 2000 to 2040.

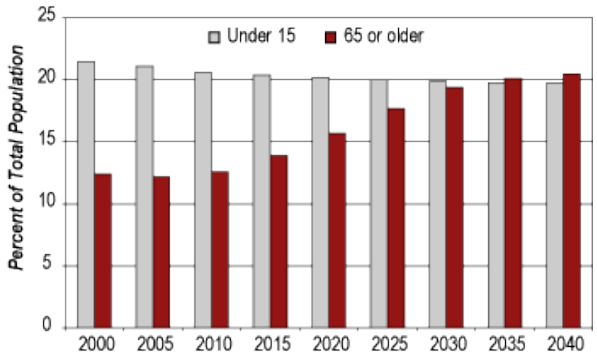


Figure 18 compares the projected median ages of populations within Indiana counties containing critical access hospitals with state and national figures. **Figure 18** graphically demonstrates that counties covered by Indiana's critical access hospitals are home to older and faster aging populations.

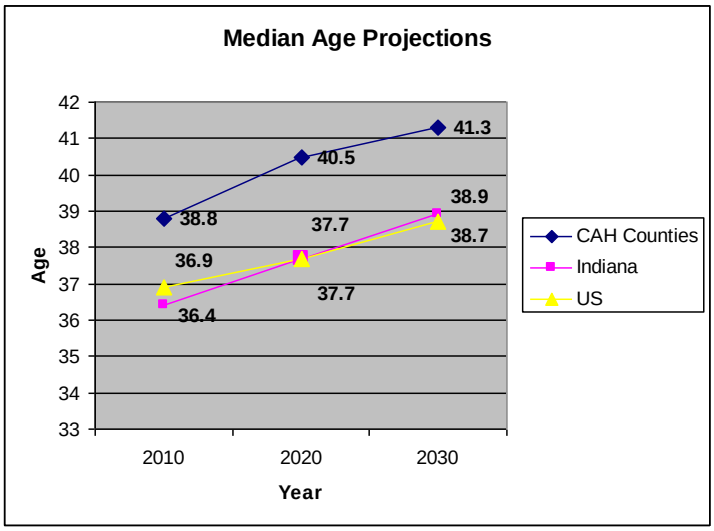
Figure 18. Comparison of Projected Median Age of Populations in CAH Counties.

County Location of Critical Access Hospital	Median Age 2010	Median Age 2020	Median Age 2030
Adams	33.5	33.3	**33.0**
Blackford	41.5	43.3	**43.7**
Clay	38.1	39.7	**41.1**
Clinton	36.5	37.4	**37.9**
Decatur	38.1	40.2	**40.0**
Fulton	40.5	42.2	**42.7**
Gibson	39.1	39.8	**41.4**
Greene	40.5	42.1	**43.0**
Harrison	39.4	42.1	**44.4**
Jasper	36.7	38.5	**39.5**
Jay	38.7	40.1	**38.7**
Jennings	36.7	38.7	**39.7**
LaGrange	30.8	32.1	**32.5**
Lawrence	41.4	43.6	**44.2**
Madison	39.9	41.2	**41.9**
Marshall	36.3	38.4	**38.7**
Miami	39.8	41.8	**41.9**
Orange	39.2	41.2	**41.7**
Perry39.6	39.6	41.6	**44.7**
Pulaski	40.6	43.4	**46.0**
Putnam	36.7	38.6	**39.8**

Randolph	41.1	42.5	**42.7**
Ripley	37.8	39.4	**39.8**
Rush	40.8	42.8	**41.2**
Scott	37.6	40.9	**42.7**
Steuben	37.6	38.7	**39.9**
Sullivan	38.3	40.6	**42.2**
Tipton	41.8	44.4	**45.0**
Vermillion	41.3	43.1	**44.4**
Wabash	39.5	38.7	**39.3**
Warren	41.1	43.5	**45.3**
Warrick	39.5	40.9	**42.7**
Washington	38.2	40.8	**42.4**
White	40.2	41.2	**40.8**
US Overall	**36.9**	**37.7**	38.7
Indiana Overall	**36.4**	**37.7**	38.9
Critical Access Hospital Counties Overall	38.8	40.5	41.3

Source: Indiana Business Research Center, IU Kelley School of Business

Figure 19. Graph Comparing CAH Counties, Indiana, and US Projected Median Ages.



In general, Indiana is close to trend with United States median age statistics. The rural counties served by critical access hospitals include a population that is older and will be aging faster than the average, increasing the likelihood of medical care needs.

Persons with Disabilities

The presence of citizens with disabilities poses added considerations in terms of adaptive communities, specialized education and specialists in health care. Persons with disabilities may

require more support for activities of daily living and find employment to be a great challenge in rural communities.

Indiana is home to a greater percentage of persons with disabilities than is true of the United States as a whole, 12.7% vs. 12.1% respectively. The following statistics indicate the social and economic status of non-institutionalized people with disabilities in the United States, using data from the 2008 American Community Survey (ACS), and summarized within the **2008 Disability Status Report: Indiana** published by the Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics.

Age: In 2008, the prevalence of disability in Indiana was:

- 12.7 percent for persons of all ages
- 0.8 percent for persons ages 4 and under
- 5.7 percent for persons ages 5 to 15
- 6.5 percent for persons ages 16 to 20
- 11.6 percent for persons ages 21 to 64
- 27.3 percent for persons ages 65 to 74
- 49.7 percent for persons ages 75+

Gender: In 2008, 13.0 percent of females of all ages and 12.4 percent of males of all ages in Indiana reported a disability.

Hispanic/Latino: In 2008, the prevalence of disability among persons of all ages of Hispanic or Latino origin in Indiana was 6.7%.

Race: In 2008, the prevalence of disability for working-age people (ages 21 to 64) was: 11.3 % among Whites 14.5 % among Black / African Americans 4.8 % among Asians, 28.3 % among Native Americans, and 13.8% among persons of other race(s).

Employment: In 2008, the employment rate of working-age people (ages 21 to 64) with disabilities in Indiana was 39.8%, with 25.2% working full-time/full-year, and 10.3 % of unemployed people with disabilities actively looking for work.

Annual Earnings: In 2008, the median annual earnings of Indiana's working-age people with disabilities working full-time/full-year were $33,600.

Annual Household Income: In 2008, the median annual income of Indiana households with working-age people with disabilities was $36,700.

Poverty: In 2008, the poverty rate of working-age people with disabilities in Indiana was 25.5 percent.

Supplemental Security Income: In 2008, 15.5 % of working-age people with disabilities were receiving SSI payments in Indiana.

Educational Attainment: In 2008, the percentage of Indiana's working-age people with disabilities with only a high school diploma or equivalent was 37.4%; with only some college or an associate degree was 28.3 %; with a bachelor's degree or more was 9.9%. This leaves approximately one-fourth of the population without a high school education.

Veterans Service-Connected Disability: In 2008, the percentage of working-age civilian veterans with a VA-determined Service-Connected Disability in Indiana was 15.9%.

Health Insurance Coverage: In 2008, 80.5 %of working-age people with disabilities in Indiana had health insurance.

Major Causes of Death

Based upon Indiana's Mortality Report of Leading Causes of Death the following illnesses are contributing heavily to loss of life in Indiana.

Figure 20. Leading Causes of Death: Indiana Residents, 2006 and 2007.

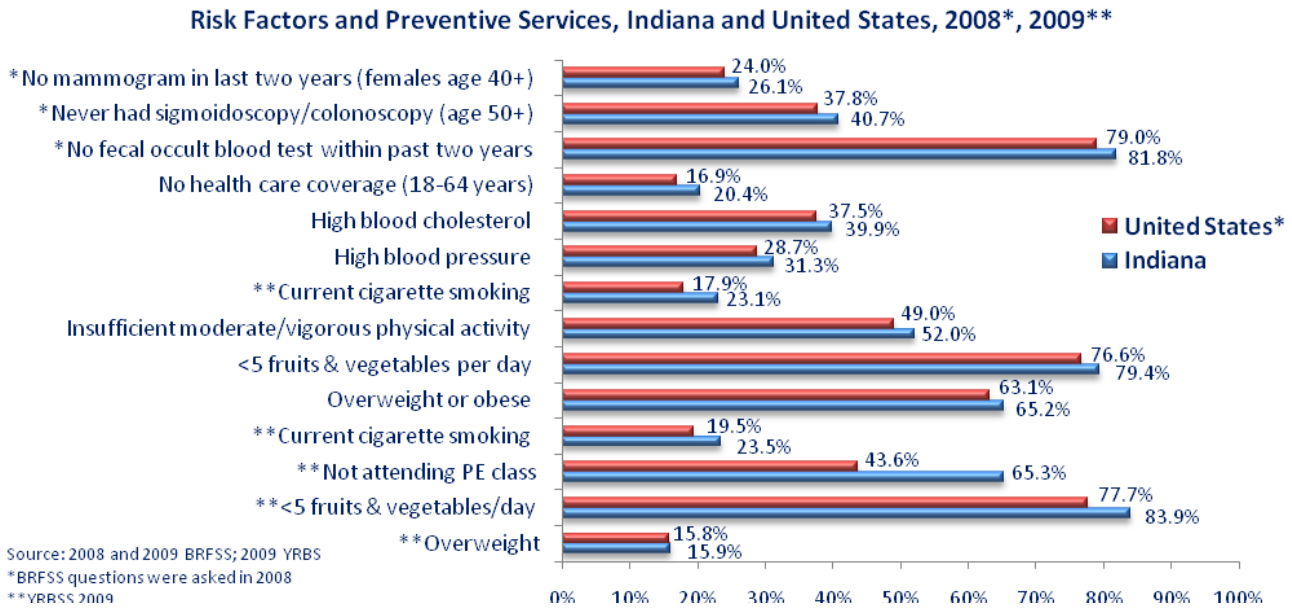
Cause of Death	Male 2006	Male 2007	Female 2006	Female 2007	Total 2006	Total 2007
Heart disease	7,105	6,835	7,191	6,880	14,296	13,715
Acute Myocardial Infarction	4,929	1,850	4,230	1,424	9,159	3,274
Stroke	1,263	1,148	1,961	1,853	3,224	3,001
Chronic Lower Respiratory Disease	1,585	1,584	1,695	1,640	3,280	3,224
Cancer	6,705	6,707	6,167	6,043	12,872	12,750
Diabetes	804	727	875	837	1,679	1,564

Source: Indiana State Department of Health www.in.gov/isdh

These deaths are disproportionately represented in rural areas. The Age-Adjusted Death Rate for all Hoosiers in 2006 was 845.12 per 100,000. The average Age-Adjusted Death Rates for Hoosiers living in the thirty-four rural counties in which a Critical Access Hospital is located was 859.35 per 100,000. Regarding 2007 statistics, heart disease accounted for 25.5% of all deaths; and cancer accounted for 23% of all deaths. Chronic lower respiratory disease was the third leading cause of death for total and white residents; stroke was the third leading cause of death for black residents. Diabetes was the fourth leading cause of death for black residents.

These deaths could be related to the poor scorecard that Indiana has with regard to prevention of chronic disease. See **Figure 21** below.

Figure 21. Risk Factors and Preventive Services, Indiana and United States.



Rural Population Summary

Indiana as a whole reflects economic distress as expressed in job losses, lower levels of net migration, high rates of home foreclosures and food stamp participation. The state's population is aging, and the state as a whole is not expected to gain or retain a high infusion of young people in the near future. Indiana's rural citizens are likely to be older and to die of chronic diseases so prevalent in the state. They are poorer and less likely to have sufficient insurance coverage.

Implications for health providers in Indiana's rural counties are that economic conditions are contributing to difficult decisions within families in terms of choosing healthy food, undertaking preventive health care options, and buying all prescribed medications. The population is older and with a prevalence of higher rates of disability and chronic disease; they will require higher levels of care with greater sophistication of service array. These multiple factors increase the likelihood of more frequent critical health incidents requiring emergency services which will increase the burden for Indiana's critical access hospitals. The effect of this burden intensifies as those seeking treatment at CAHs become increasingly dependent on Medicaid, Medicare and charity care—none of which allows a hospital to recover all of its cost for service provided.

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Section II. Providers of Care: Critical Access Hospitals, FQHCs, CHCs

The Medicare Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program (Flex Program), created by Congress in1997, allows small hospitals to be licensed as Critical Access Hospitals (CAHs) and offers grants to States to help implement initiatives to strengthen the rural health care infrastructure. To participate in the Flex Program, States are required to develop a rural health care plan that provides for the creation of one or more rural health networks, promotes regionalization of rural health services in the State, and improves the quality of and access to hospital and other health services for rural residents of the State. Consistent with their rural health care plans, states may designate eligible rural hospitals as CAHs.

CAHs must be located in a rural area or an area treated as rural; be more than 35 miles (or 15 miles in areas with mountainous terrain or only secondary roads available) from another hospital, or be certified before January 1, 2006 by the State as being a necessary provider of health care services. CAHs are required to make available 24-hour emergency care services that a State determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e., for the reasonable costs of providing inpatient, outpatient, and swing bed services).

The legislative authority for the Flex Program and cost-based reimbursement for CAHs are described in the Social Security Act, Title XVIII, Sections 1814 and 1820, available at http://www.ssa.gov/OP_Home/ssact/title18/1800.htm.

Indiana's Critical Access Hospitals

Currently, 35 Critical Access Hospitals are certified in Indiana. Based upon data supplied by the Flex Monitoring Team in their publication *Community Benefit Activities of Critical Access Hospitals, Non-Metropolitan Hospitals, and Metropolitan Hospitals: National and Indiana Data* (Race, Gale, & Coburn, 2010), Indiana Critical Access Hospitals outperform both non-metropolitan and metropolitan hospitals in twelve measures:

1. Has a long-term plan for improving the health of the community
2. Provides adult day care
3. Provides home health services
4. Has a mission statement that includes a focus on community benefit
5. Provides support for community building activities
6. Makes financial contributions, provides in-kind support, or participates in fund-raising for community programs not directly affiliated with the hospital
7. Uses health status assessments to identify unmet needs, excess capacity, or duplicative services in the community
8. Works with other providers to collect, track, and communicate clinical and health information across cooperating organizations
9. Community outreach

10. Health fairs
11. Health screenings
12. Immunization programs

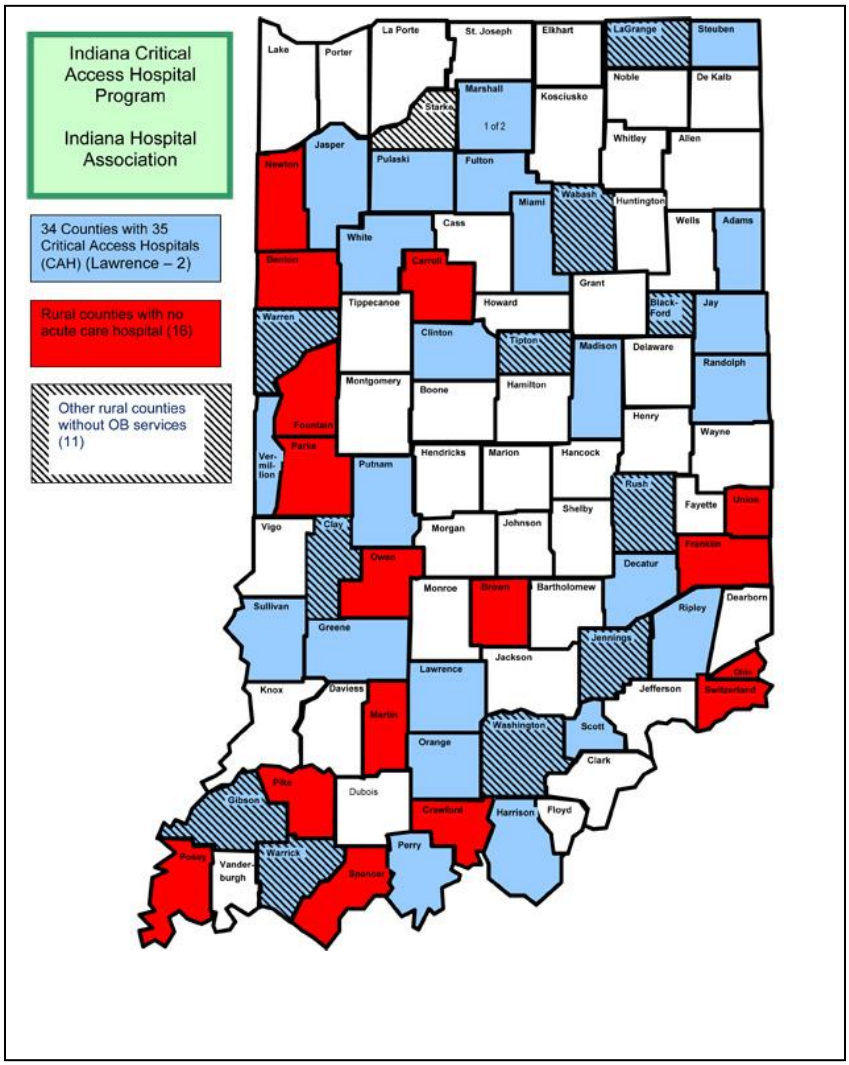
It is obvious that Indiana's Critical Access hospitals are sensitive to the needs of the community and see themselves as members of the communities that they serve. There are no non-certified CAHs that receive funding under the Small Rural Hospital Improvement Grant Program. Currently, 33 of the 35 CAHs within Indiana receive funding through the Small Rural Hospital Improvement Grant Program. The office has been reaching out to the non-participating CAHs and is hopeful 34 hospitals will participate in the upcoming year. The sustained interest in the Small Rural Hospital Improvement Grant program indicates the strength of relationships between SORH and the CAHs. The following chart lists Indiana's Critical Access Hospitals, their locations, and number of beds.

Figure 22. List of Critical Access Hospitals, Locations, and Number of Beds (2011)

Name	City	State	Zip	Beds
Adams Memorial Hospital	Decatur	Indiana	46733	25
Bremen Community Hospital of	Bremen	Indiana	46506	24
Cameron Memorial Community Hospital	Angola	Indiana	46703	25
Decatur County Memorial Hospital	Greensburg	Indiana	47240	25
Dukes Memorial Hospital	Peru	Indiana	46970-1698	25
Gibson General Hospital	Princeton	Indiana	47670-1043	25
Greene County General Hospital	Linton	Indiana	47441-9457	25
Harrison County Hospital	Corydon	Indiana	47112	25
Indiana University Health Bedford Hospital	Bedford	Indiana	47421	25
Indiana University Health Blackford Hospital	Hartford City	Indiana	47348	15
Indiana University Health Paoli Hospital	Paoli	Indiana	47454-0499	25
Indiana University Health Tipton Hospital	Tipton	Indiana	46072	25
Jasper County Hospital	Rensselaer	Indiana	47978	25
Jay County Hospital	Portland	Indiana	47371-1322	25
LaGrange Hospital (Parkview)	LaGrange	Indiana	46761	25
Margaret Mary Community Hospital	Batesville	Indiana	47006	25
Perry County Memorial Hospital	Tell City	Indiana	47586	25
Pulaski Memorial Hospital	Winamac	Indiana	46996	25
Putnam County Hospital	Greencastle	Indiana	46135	25
Rush Memorial Hospital	Rushville	Indiana	46173	25
Scott Memorial Hospital	Scottsburg	Indiana	47170	25
St. Mary's Warrick Hospital	Boonville	Indiana	47601	25

St. Vincent Clay Hospital	Brazil	Indiana	47834-2675	25
St. Vincent Dunn Memorial Hospital	Bedford	Indiana	47421	25
St. Vincent Frankfort Hospital	Frankfort	Indiana	46041	25
St. Vincent Jennings Community Hospital, Inc.	North Vernon	Indiana	47265	25
St. Vincent Mercy Hospital	Elwood	Indiana	46036	25
St. Vincent Randolph Hospital	Winchester	Indiana	47394	25
St. Vincent Salem Hospital	Salem	Indiana	47167	15
St. Vincent Williamsport Hospital	Williamsport	Indiana	47993-0215	16
Sullivan County Community Hospital	Sullivan	Indiana	47882	25
Wabash County Hospital	Wabash	Indiana	46992	25
Union Hospital Clinton	Clinton	Indiana	47842-0349	25
White County Memorial Hospital	Monticello	Indiana	47960	25
Woodlawn Hospital	Rochester	Indiana	46975	25

Figure 23. Critical Access Hospital Locations, Counties with No Hospitals



Source: Indiana Hospital Association 2009

Performance Data

Comparative data on the financial condition and performance of hospitals is beneficial to the hospitals and to the SORH office. The most current available financial comparison data is from calendar year 2008. Below are the performance dimensions and indicators that reflect how Indiana performed compared to the rest of the nation.

Profitability indicators measure the ability of the organization to generate the financial return required to replace assets, and meet increases in services demands.

- Total margin- the control of expenses relative to revenues
- Cash flow margin- the ability to generate cash flow from providing patient care services
- Return on equity- the net income generated by equity investment (net assets)

Figure 24. CAH Return on Equity

	% total margin	% cash flow margin	% return on equity
US	3.64	5.98	9.96
IN	4.05	10.09	8.15

Source: Flex Monitoring Team. 2009

Liquidity indicators measure the ability of an organization to meet its cash obligations in a timely manner.

- Current ratio- the number of times short-term obligations can be paid using short-term assets
- Days cash on hand- the number of days an organization could operate if no cash was collected or received
- Days revenue in accounts receivable- the number of days it takes an organization to collect its receivables

Figure 25. Critical Access Hospital Liquidity Indicators

	Current ratio	Days cash on hand	Days revenue in accounts receivable (lower is better)
US	2.25	58.65	59.08
IN	2.42	48.63	61.04

Source: Flex Monitoring Team, 2009

Capital structure indicators measure the extent to which an organization uses debt and equity financing.

- Equity financing- the percentage of total assets financed by equity
- Debt service coverage- the ability to pay obligation related to long-term debt, principal payments, and interest expense
- Long-term debt to capitalization- the percentage of total capital that is debt

Figure 26. Critical Access Hospital Capital Structure Indicators

	Equity financing	Debt service coverage	Long-term debt to capitalization
US	61.44	3.25	26.23
IN	59.78	3.33	28.55

Source: Flex Monitoring Team, 2009

Revenue indicators measure the amount and mix of different sources of revenue

- Outpatient revenues to total revenues- the percentage of total revenues that are for outpatient revenues
- Patient deductions- the allowances and discounts per dollar of total outpatient revenues
- Medicare inpatient payer mix- the percentage of total inpatient days that are provided to Medicare patients
- Medicare outpatient payer mix- the percentage of total out-patient charges that are for Medicare patients
- Medicare outpatient cost to charge- outpatient Medicare costs per dollar of outpatient Medicare charges
- Medicare revenue per day- the amount of Medicare revenue earned per Medicare day

Figure 27. Critical Access Hospital Revenue Indicators

	Outpatient revenues to total revenues	Patient deductions	Medicare inpatient payer mix	Medicare outpatient payer mix	Medicare outpatient cost to charge	Medicare revenue per day
US	67.99	34.04	74.52	34.63	0.49	1545
IN	76.21 44.82	44.82	67.73	33.13	0.37	1603

Source: Flex Monitoring Team, 2009

Cost indicators measure the amount and mix of different types of costs

- Salaries to total expenses- the percentage of total expenses that are labor costs
- Average age of plant- the average age in years of the fixed assets of an organization
- FTEs per adjusted occupied bed- the number of full-time employees per each occupied bed

Figure 28. Critical Access Hospital Cost Indicators

	Salaries to total expenses	Average age of plant	FTEs per adjusted occupied bed
US	44.35	10.33	5.62
IN	44.46	7.75	5.09

Source: Flex Monitoring Team, 2009

Utilization indicators measure the extent to which fixed assets are fully occupied

- Average daily census swing-SNF beds- the average number of swing-SNF beds occupied per day
- Average daily census acute beds- the average number of acute care beds occupied per day

Figure 29. Critical Access Hospital Utilization Indicators

	Swing-SNF beds	Acute beds
US	1.64	4.43
IN	1.70	8.71

Source: Flex Monitoring Team, 2009

Indiana will use hospital specific data to target areas of concern and launch quality improvement initiatives.

The SORH understands the importance of CAH financial feasibility, not only for the hospital, but the community as well. SORH will work with CAH financial experts to provide training opportunities for CAH CEOs and CFOs. Information concerning cost reporting, allocated costs, variable costs, and CAH economics will be disseminated to the CAHs. Indiana also recognizes the importance of CAHs participating in the CMS Hospital Compare program. The SORH has taken steps to increase the number of CAHs reporting to Hospital Compare and increase the number of core measures reported.

Indiana continues to encourage and support the Hospital Compare submission of data. In Indiana, 29 of the 35 CAHs in 2009 reported data to Hospital Compare on at least one inpatient process of care measure for 2009 discharges (**Figure 30**). The Indiana participation rate of 82.9% was higher than the national rate of 71.9%. The Indiana rate remained unchanged from 2007 to 2009.

Figure 30. CAH Participation in Hospital Compare in Indiana and Nationally 2005-2009.

	# % participating				
	2005	2006	2007	2008	2009
Indiana	24 (66.7%)	25 (71.4%)	29 (82.9%)	29 (82.9%)	29 (82.9%)
National	678 (53.4%)	812 (63.1%)	892 (69.1%)	914 (70.3%)	943 (71.9%)

Source: Flex Monitoring Team, 2009

Figure 31. Hospital Compare Results for 2008 and 2009 Discharges for CAHs in Indiana and Nationally.

	Measure	**Indiana % of CAH patients receiving recommended care (n=29 both years)**		**National Percent of CAH patients receiving recommended care**	
		2008	**2009**	**(n=918) 2008**	**(n= 933) 2009**
AMI	Aspirin at arrival	88.90%	93.2%	90.60%	92.1%
	Aspirin at discharge	92.20%	96.6%	88.60%	90.2%
	ACEI or ARB for LVSD	93.20%	95.1%	84.80%	87.4%
	Smoking cessation advice	96.20%	93.8%	80.80%	89.7%
	Beta blocker at discharge	94.40%	96.7%	88.50%	90.5%
Heart Failure	Discharge instructions	76.20%	82.4%	71.30%	75.5%
	Assessment of LVS	87.40%	89.0%	80.00%	82.7%
	ACE inhibitor or ARB for LVSD	86.90%	89.3%	83.80%	84.7%
	Smoking cessation advice	88.20%	94.1%	83.30%	85.6%
Pneumonia	Pneumococcal vaccination	86.10%	89.3%	82.70%	85.9%
	Blood culture prior to first antibiotic	89.10%	88.6%	90.70%	92.0%
	Smoking cessation advice	88.90%	91.5%	83.00%	86.2%
	Initial antibiotic(s) within 6 hours	95.00%	95.8%	94.40%	95.0%

	Most appropriate initial antibiotic(s)	87.10%	86.7%	86.90%	87.4%
	Influenza vaccination	77.60%	86.9%	79.90%	83.1%
Surgical Care Improvement	Preventative antibiotic(s) 1 hour before incision	90.10%	94.4%	88.40%	91.6%
	Received appropriate preventative antibiotic(s)	95.00%	96.5%	94.70%	96.0%
	Preventative antibiotic(s) stopped within 24 hours after surgery	85.70%	87.7%	86.50%	91.2%
	Doctors ordered blood clot preventative treatments	86.90%	86.2%	87.70%	88.6%
	Received blood clot prevention treatment 24 hours pre/post surgery	84.70%	84.1%	86.00%	87.7%

Source: Flex Monitoring Team, 2009; 2011

The quality measures cited above indicate that on 17 of the 20 measures, Indiana's CAHs improved when comparing data from 2008 to 2009. Indiana performs better on 75% of the measures when compared to national performance percentages.

Critical Access Hospitals Summary

Indiana's Critical Access Hospitals provide a tremendous contribution toward the health and well-being of the citizens of their respective counties and in some cases for those of neighboring rural counties without hospitals of their own. Clearly, the ability of Indiana's Critical Access Hospitals to generate cash flow from providing patient care services is more constrained and has in all likelihood deteriorated due to increased economic distress within the counties they serve. Yet, the ability of these hospitals to efficiently collect receivables and to manage cash is laudable. Lean staffing as measured by FTEs per adjusted occupied bed is demonstrated.

Indiana's CAH administrators are dedicated to quality performance and improvement as demonstrated by their participation in data collection efforts and ongoing training and technical assistance efforts. A continuation of support for data coordination, financial expertise development, information management for forecasting, and informed management decision-making will continue to be necessary as these hospitals cope with the changing landscape of the state economy, workforce, population trends, technology and aging physical plants. Collaboration and networking will continue to be key to their viability.

Indiana's Community Health Centers

Indiana has State-Funded Community Health Centers which receive operating monies from tobacco settlement funds received by the state, and Federally Qualified Health Centers (FQHC). The FQHCs are funded primarily through the Bureau of Primary Health Care (BPHC), part of the US Department of Health and Human Services, and they may also receive state money from the tobacco settlement. In total, there are 48 Community Health Centers in Indiana, 19 of which are FQHCs.

The Centers are public or private not-for-profit organizations that provide some or all of the following services depending on the need and support within the specific local Indiana community:

- Primary medical care
- Diagnostic laboratory and radiological services
- Preventive services including: prenatal and perinatal services, cancer and other disease screenings, well child services, immunizations against vaccine-preventable diseases, screenings for elevated blood lead levels, cholesterol testing, etc.
- Eye, ear and dental screening for children
- Voluntary family planning services
- Preventive dental services
- Emergency medical services
- Pharmaceutical services as appropriate to the particular Center
- Referrals to other providers of medical and health-related services including substance abuse and mental health services
- Patient case management services, including referral, follow-up, and eligibility assessment for and gaining access to Federal, State, and local support and financial programs for various medical, social, and related services
- Enabling services including outreach, transportation, translation, etc.
- Education about health services availability and appropriate use.

Community Health Centers are characterized by five essential elements that differentiate them from other providers:

- They must be located in or serve a documented high-need community. Designations, each with its own specific criteria, include Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs), and Health Professional Shortage Areas (HPSAs).
- They must provide comprehensive primary care services, as well as supportive / enabling services such as translation and transportation that promote access to care;
- Their services must be available to all residents of their service areas regardless of income status, with fees formally adjusted for patients' ability to pay;
- They must be governed by a Community Board that includes a majority of members who are Center patients ("consumers"); and,
- They must meet specific performance and accountability requirements for administrative, clinical, and financial operations.

The following data summarizes the contributions of the FQHCs and State-funded community health centers in meeting the health needs of Indiana. The most recent data available is from 2008.

Federally Qualified Health Centers and Community Health Centers

*****Data provided by the Indiana Primary Health Care Association. Retrieved April 11, 2011 from http://www.indianapca.org/aboutchcs/factsandfigures.html.

The Health Care Need in Indiana
(Estimated State Population, 2007-08: 6,376,792)

Estimated Persons < 133% Poverty:	1,428,000
Estimated Uninsured Persons:	734,600
Estimated Homeless Persons:	7,395

Availability of Services (2008)
(Based on responses from all Federally Qualified Health Centers and State-Funded Centers)

Total Number of Persons Served by All Responding Primary Health Care Sites:	399,560
Total Number of Persons Served by FQHCs:	216,079
Persons Enrolled in Medicaid (Dec. 2008):	766,500
Persons Enrolled in Medicaid Served by Responding Primary Health Care Sites:	142,210
Uninsured Persons Served by Responding Primary Health Care Sites:	132,052

Indiana's Federally Qualified Health Centers 2009 Summary
(19 FQHCs at time of data collection) Source: HRSA Unified Data Report Data as of 5/12/10

Funding Sources	
Private Pay	$10,315,202
Medicaid	$58,100,206
Medicare	$6,876,072
Self Pay	$35,634,233
Other Public Payor	$822,507
Grants under Sec. 329/330/340 of the Public Service Act	$21,996398
State	$19,601,075
City/County	$2,066,773
Private Foundations	$5,530,020
Donations/St, local indigent /Other	$5,138,935
Other non-patient revenue	$4,595,522
TOTAL FUNDS	**$170,676,943**

Patient Income Levels	
At/Below Poverty	107,018
101 – 150% Poverty	23,571
151 – 200% Poverty	6,833
200% + Poverty	7,022
Unknown	71,635

TOTAL	**216,079**

Insurance	
Medicaid	87,335
Medicare	11,052
Uninsured	89,134
Other	28,137
Unknown	421
TOTAL	**216,079**

Race & Ethnicity	
White, Non-Hispanic	111,222
Black, Non-Hispanic	48,951
Hispanic, All Races	39,237
American Indian	321
Asian/Pacific Islander	2,526
Unknown	13,822
TOTAL	**216,079**

Patient Age	
0 – 14 Years	73,795
15 – 19 Years	17,506
20 – 44 Years	78,189
45 – 64 Years	38,118
65 And Over	8,471
Unknown	0
TOTAL	**216,079**

*Indiana's State-Funded-Only Health Centers 2008 Summary**

*Three centers did not provide 2008 data; therefore, their 2007 data was included.

Funding Sources	
Private Pay	$1,826,010
Medicaid	$4,152,364
Medicare	$1,677,245
Private Insurance	$2,591,641

Grants under Sec. 329/330/340 of the Public Service Act	$0
State	$5,220,535
City/County	$992,027
Private Foundations	$421,887
Donations/Other	$1,359,939
Other Public	$139,218
TOTAL FUNDS	**$18,380,866**

Patient Income Levels*	
At/Below Poverty	20,279
101 – 150% Poverty	11,577
151 – 200% Poverty	6,293
200% + Poverty	7,481
Unknown	105,677
TOTAL	**151,307**
* Please note: not all State-funded-only health centers provided complete patient income information.	

Insurance	
Medicaid	54,875
Medicare	27,334
Uninsured	42,918
Other	56,204
Unknown	2,150
TOTAL	**183,481**

Race & Ethnicity	
White, Non-Hispanic	95,293
Black, Non-Hispanic	45,099
Hispanic, All Races	28,234
American Indian	104
Asian/Pacific Islander	891
Unknown	13,860

TOTAL	**183,481**

Patient Age	
0 – 14 Years	59,370
15 – 19 Years	16,887
20 – 44 Years	46,999
45 – 64 Years	41,090
65 And Over	15,644
Unknown	3,491
TOTAL	**183,481**

It is clear that these health centers meet a huge need for primary and preventive care in the state. Community Health Centers (CHCs) are a major component of America's health care safety net, providing high quality primary health care to low-income citizens, the uninsured, and other vulnerable populations. Indiana's 48 Community Health Centers serve as "health care homes" for residents in more than 50 of the 92 counties in Indiana.

Section III. The Need for Health Professionals

Note: The following workforce information is an excerpt from an **Issue Brief: Indiana's Health Professions Workforce Shortages & Maldistribution** (2007), by the Workforce & Workforce Development Subcommittee of the Indiana University Health Care Reform Study Group.

"The impending health care and human services workforce shortage is a national concern that is growing more urgent every day. The U.S. Department of Labor's Bureau of Labor Statistics (BLS) predicts that health care and social assistance will be the fastest growing industry.[1] Between 2006 and 2016, a high percentage of growth is projected for a broad range of health and human services occupations in non-metropolitan counties: the need for personal and home care aides will increase by 50.6 percent; medical assistants will increase by 35.4 percent; and pharmacy technicians will increase by 32.0 percent.[2] The Committee has noted over the years that the presence of a skilled workforce is the foundation for further development of a quality health and human services delivery system. Rural areas, in particular, are in need of more qualified workers across the full range of health and human services professions to provide adequate services for their citizens. Meeting service needs will also help economic development, by keeping stable jobs in rural communities.

As people born in the baby boomer generation retire and leave the workforce, the available pool of health and human services workers will shrink, since fewer people were born during the successive years.[3] The lack of an adequate workforce is magnified in rural areas because the elderly population is growing more rapidly in rural than in urban areas.[4] With an influx of baby boomers retiring to rural areas, rural America is experiencing a disproportionately large and growing elderly population—a population that often needs more health care and human services, which places a greater demand on the workforce. Compounding this problem is an out-migration of talented youth from some rural areas in search of broader educational and job opportunities.[5] In the face of expected workforce shortages, maintaining a qualified workforce that can adequately meet the needs of the community poses some challenges for many rural areas.[6]

Shortages in Indiana

Many communities across the state experience a shortage of health professionals in most disciplines from medical assistants to medical doctors. Many of the communities with the most serious shortages also experience the most poverty and the poorest health status. These communities increase the health care cost in our state because the individuals in those communities tend to wait to access healthcare until it is urgent and tend to access healthcare in the most expensive and least effective way -- through hospital emergency rooms. The costs incurred in this fashion are often covered by Medicaid, resulting in an increased tax burden, or remain uncompensated to the hospitals, resulting in unavoidable shifting of costs, which increases medical premiums for businesses and their employees. These medically underserved communities, which suffer from health professional shortages, can exist anywhere, but tend to be concentrated in rural communities and urban inner city areas where there are economically disadvantaged individuals. Despite the poverty in these areas that may make the communities appear unattractive to some health professionals, there are many strategies to recruit students to practice in medically underserved communities[7]. Evidence shows that the strongest predictor of

where a health professional will practice is where that health professional came from, validating the supposition that those who practice in medically underserved communities are most likely to have come from underserved populations. However, evidence also shows that students from underserved backgrounds are less likely to enter higher education and health professions training programs than their economically advantaged counterparts, unless they are equipped to overcome the educational and financial barriers that they face [8,9].

The supply of health professionals varies greatly based on certain geographic, demographic and socioeconomic factors resulting in a mal-distribution of health professionals across the state of Indiana. Health professionals are more likely to be concentrated in areas of economic affluence and less likely to be concentrated in areas where the population is less dense. These are also areas where the population has higher proportions of low income and racial and ethnic minorities [10-14]. Medically underserved populations suffer disproportionately from poorer health status and higher health care costs because of their lack of access to primary and preventive care. These disparities are due to many factors, but are certainly due in part to lack of health coverage and an insufficient numbers of providers. Disparities are most prevalent in Indiana's urban inner cities and rural areas."

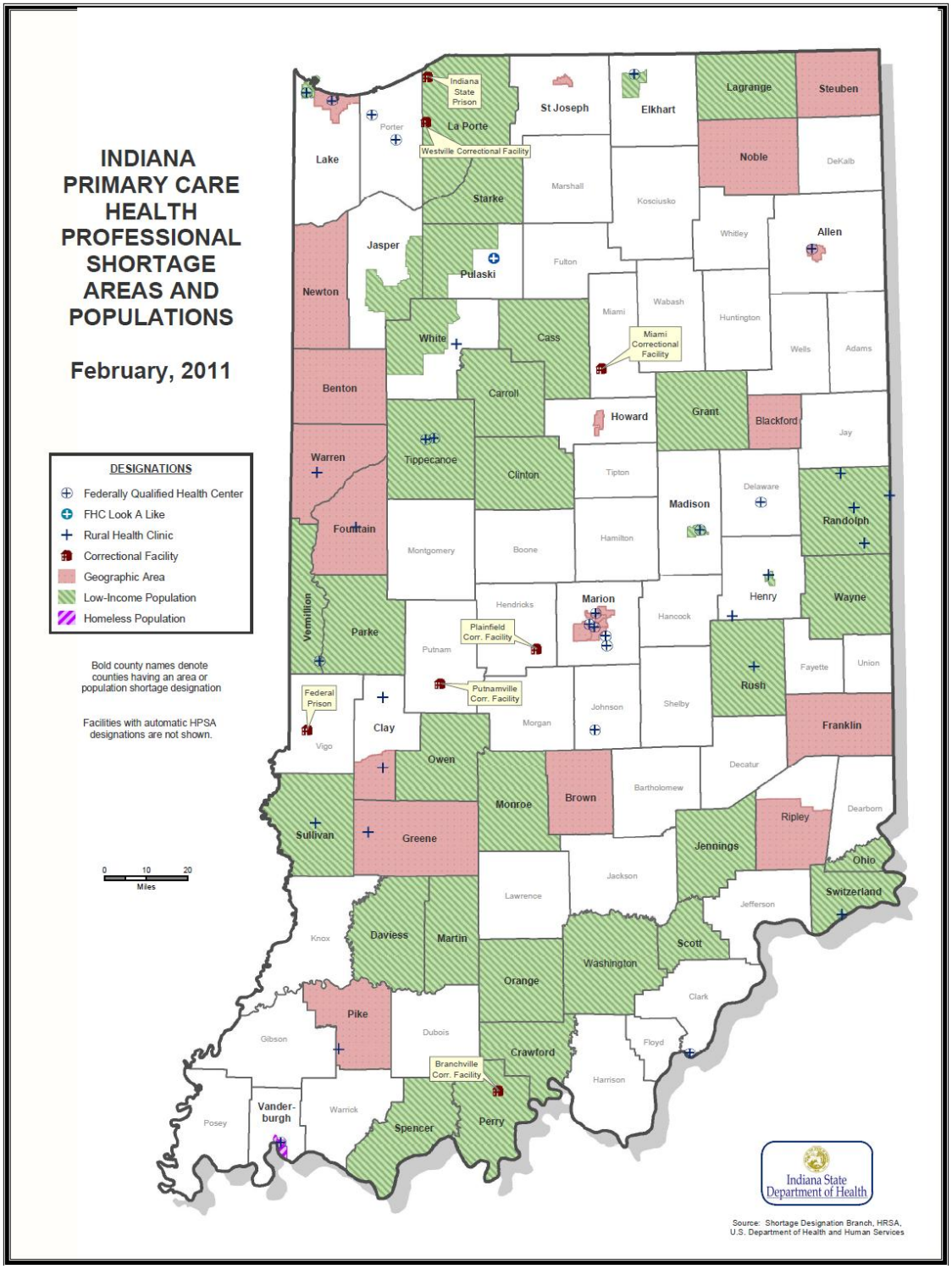
A review of information provided by the Workforce and Workforce Development Subcommittee of the Indiana University Health Care Reform Study Group (2007) cited current levels of primary care physicians and non-physician clinicians in each county as a rate per 100,000 inhabitants in 2005. The thirty-four Indiana counties and their levels of primary care physicians and non-physician clinicians are averaged in the table below and compared with the averages of counties comprising Metropolitan Statistical Area center counties.

Figure 32. Comparison of Prevalence of Clinician Types in CAH Counties to MSA Centers.

Clinician Type	CAH Counties	MSA Centers
Family Medicine Physician	417	**1273**
General Int. Med. Physician	91	**809**
Gen. Pediatric Physician	77	**490**
Osteopathic Physician	91	**511**
Prim. Care Physician Assistants	10	**56**
Nurse Practitioners	127	**864**
Total	**813**	4003
Rate per 100,000 (2005)	**813/34 =** 24	**4003/16 =** 250

Within Indiana many primary care health professional shortage areas and populations exist. See **Figure 33** below.

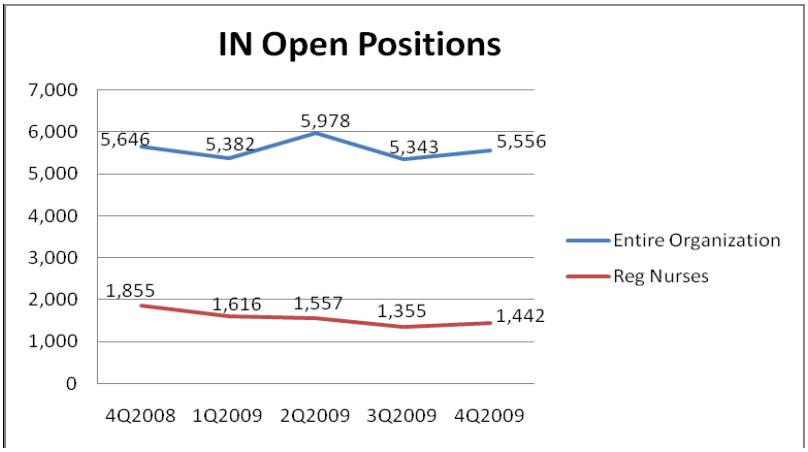
Figure 33. Indiana Primary Care Health Professional Shortage Areas and Populations



In addition, information supplied through the Indiana Hospital Association indicated sixteen counties within Indiana that have no acute care hospital and eleven counties without obstetrical services, demonstrating keen shortages of even basic clinical services in those rural counties.

According to the Indiana Hospital Association (IHA) Benchmarking Survey (2009, 4th quarter), 2009 ended with a rise in total open healthcare positions in Indiana. Registered nurses comprised the largest number of open positions with 1,442 openings. Still lower than in the same quarter of 2008, the number of open RN positions in fourth quarter 2009 was 6% higher than it was in the previous quarter. Imaging, Pharmacists, Occupational Therapist and Lab open positions saw a significant boost in fourth quarter 2009 while Respiratory Therapist open positions stayed relatively the same. Physical Therapist was the sole position that experienced a decrease in the fourth quarter of 2009. The graph below shows the change in open positions according to the Indiana Hospital Survey.

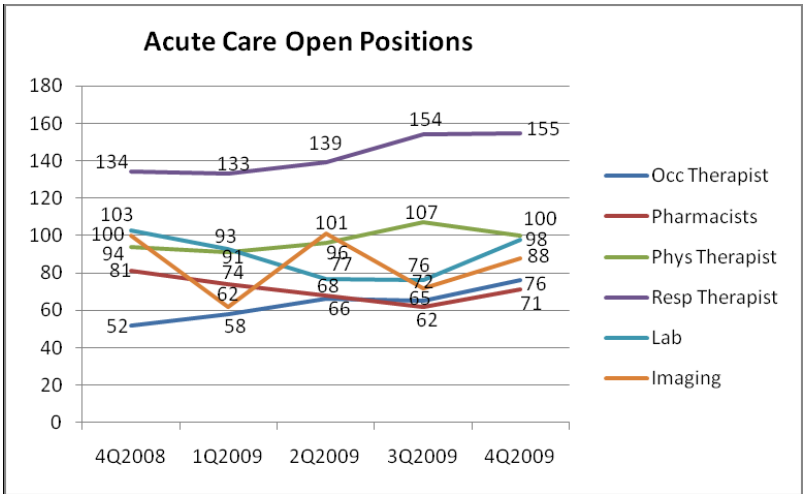
Figure 34. Open Positions, All Hospitals 2009.



Source: Indiana Hospital Association Benchmarking Survey Report, 2009

The following graph examines all open positions among reporting hospitals in the IHA survey (4th quarter, 2009).

Figure 35. Acute Care Open Positions, All Hospitals 2009.



Source: Indiana Hospital Association Benchmarking Survey Report, 2009

The Behavioral and Mental Health Professionals Re-Licensing Report for 2004 & 2006 (2010) indicated that based upon surveys received, counties with the largest populations tended to have the most mental health professionals and the highest ratios per 100,000 population. All Indiana counties had at least one mental health professional. Seven counties lacked even one social worker. Forty-six counties (50.0%) did not have a marriage and family therapist who responded to the survey. Thirteen counties (14.1%) did not have a mental health counselor who responded to the survey. Twenty counties (21.7%) did not have other mental health professionals who responded to the survey.

The number of mental health professionals licensed in Indiana has slightly decreased from 2004 to 2006. Most mental health professionals were white, non-Hispanic, female, and in the 45-54 age group. Most of their professional time was spent in social work activities followed by mental health counseling activities. The top three practice areas were general mental health, mood disorders, and anxiety disorders. Over four-fifths of the psychiatric and mental health nurse respondents were actively working as psychiatric mental health nurses in Indiana. Almost all were female, white, and non-Hispanic/Latino. Over two-thirds provided patient care as a registered nurse. Their major activities included psychopharmacological interventions and clinical supervision/education. Less than three-fifths anticipated retiring in ten or more years. There is a need to train, recruit and retain more mental health professionals actively working in Indiana.

The number of some specific types of professionals appeared to have declined in 2006 compared to 2004. In addition, many mental health professionals are reaching the retirement age, especially marriage and family therapists. Also, the data clearly shows a gender and minority gap in the workforce, which could have an impact on the patient population who seek help from mental health professionals.

Health Professional Summary

Indiana's health care workforce is lacking in rural areas. Recruitment and retention are essential activities for most providers. Not only does Indiana need sufficient coverage of medical providers from many disciplines who are able and willing to work with citizens from rural counties, but those providers must be highly skilled and comfortable with the lifestyle that rural communities provide.

Efforts to provide rural rotation experiences are underway. Indiana's Area Health Education Centers are actively working across the state to develop an interest and vision among Indiana's young people to promote the pursuit of health-related careers and eventual practice in Indiana's underserved areas. Further, they actively recruit candidates for training that match the demographic characteristics and culture of persons in underserved communities. Supporting health care workforce development activities and connecting existing efforts with providers seeking health care workers is essential. Creating connections between needed specialists and needy communities are key efforts in developing Indiana's health care workforce.

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Section IV. Flex Funding

The Medicare Rural Hospital Flexibility (Flex) Program was established by the Balanced Budget Act of 1997. The purpose of the program is to help rural communities preserve access to primary and emergency health care services by:

- Enhancing emergency medical services;
- Improving health care quality and performance; and
- Promoting rural health networks and community development

Flex grants help rural health care providers and rural communities respond in a comprehensive, collaborative, and more effective fashion to major changes affecting the rural health system and rural communities. Local and regional partners are encouraged to work together to assess their environments and community needs and to plan and implement strategic responses to improve rural health care delivery. Grants are available for activities ranging from planning through implementation, with an emphasis on activities leading to measurable outcomes.

Flex Program Work Plan

The Flex Program Work Plan provides a detailed description of the Indiana Flex Program for year one, including program/project overview, needs assessment, proposed activities, and measures (outcome and process). The goals, objectives, strategies, activities (inputs), staffing needs, responsibilities, outcome measures (outputs) both qualitative and quantitative, timeframes for program/project start and completion, and overall outcomes are outlined in the tables and narrative provided. As required, the Work Plan outlines in detail each activity's relationship with one or more of the four core areas of the Flex Program.

- Flex Core Area 1 – CAH Support for Quality Improvement
- Flex Core Area 2 – CAH Support for Financial and Operational Improvement
- Flex Core Area 3 – CAH Support for Health System Development and Community Engagement
- Flex Core Area 4 – Facilitate CAH Conversion of Small Rural Hospitals to CAH Status

A proposed five-year plan with Program timeframes for each anticipated Program activity is documented.

Work Plan Goals and Objectives

The goals and objectives of the Program have been designed around the Flex core areas for the Rural Hospital Flexibility Program 2010- 2015 and were adopted by the Flex Committee in an attempt to meet the needs of rural health care providers and ultimately those of rural residents in Indiana.

<u>Program Goal 1:</u>
Core Area 1: Provide CAH Support for Quality Improvement (QI)

- Develop a statewide data reporting and sharing system via a secure portal for data exchange.

- Support CAHs in building upon a multi-hospital quality improvement project involving hospital readmissions targeting chronic diseases to increase patient safety and quality of care
- Increase access to care for specialty and subspecialty services through telehealth initiatives.

Program Goal 2:

Core Area 2: Provide CAH Support for Operational and Financial Improvement

- Support CAHs with planning and implementing evidence-based strategies for improving financial performance.

Program Goal 3:

Core Area 3: Provide CAH Support for Health System Development and Community Engagement

- Develop and expand use of electronic tools and e-learning to enhance communication, training and education, and interaction among CAHs in Indiana to increase access to health care services by residents in Indiana.

Program Goal 4:

Core Area 4: Facilitate Conversion of Small Rural Hospitals to CAH status

- Facilitate conversion of small rural hospitals to CAH status in accordance with federal and state regulation as needs arise among Indiana rural hospital providers.

Assumptions in Work Plan Goal Development

The goals of the Indiana Flex Program were developed with the assumption that the initiatives and projects will benefit rural CAH providers throughout the state of Indiana. Specifically, it is assumed that by implementing the initiatives and projects, participating rural CAH providers would have access to resources, services, and programs that they otherwise would not have. Examples of outcomes expected once these resources, services, and programs are applied include:

- Improved operational efficiency of rural CAH providers
- Improved connectivity of rural CAH providers and communities
- Increased utilization of Health Information Technology and videoconferencing capabilities
- Provision of education programs developed specifically to meet the needs of rural CAH providers and communities
- Increased ability to meet Information Technology needs of rural CAH providers through group purchasing and service agreements
- Development of self-sustaining programs that add value to rural CAH providers and organizations

It is assumed that an infusion of resources, services, and programs will enhance the quality of provided services, thereby making rural CAH providers more competitive and their services more attractive to local patients. Although these assumptions were made, the SORH based programming and direction with the aid of practitioners. It has also been assumed that, by receiving funds through the HRSA Flex Program Grant, rural Indiana CAH providers will be

able to enhance the overall clinical and financial performance of their hospitals, thereby creating a positive impact upon the rural communities they serve.

Figure 36. Projected Impact of the Indiana Flex Program, 2010-2015.

	Flex Core Area 1	***Flex Core Area 2***	***Flex Core Area 3***
I.	**Statewide CAH Benchmarking Program** Clinical data and outcomes	**Statewide CAH Benchmarking Program** Financial data and operational outcomes	**Statewide CAH Benchmarking Program** Educational training and support
II.	**Statewide CAH Quality Program** Project #1 CAH Readmissions Clinical data and outcomes	**Statewide CAH Quality Program** Project #1 CAH Readmissions Financial data and operational outcomes	**Statewide CAH Quality Program** Project #1 CAH Readmissions Educational training
	Statewide CAH Quality Program Project #2 TeleStroke Network Telemedicine Network Clinical data and outcomes	**Statewide CAH Quality Program** Project #2 TeleStroke Network Telemedicine Network Financial data and operational outcomes	**Statewide CAH Quality Program** Project #2 TeleStroke Network Telemedicine Network Educational training
III.	**CAH Educational Programs** Quality (clinical) Leadership	**CAH Educational Programs** Quality (financial) Leadership/BOD HIT	**CAH Educational Programs** HIT
IV.	**Videoconferencing & E-learning Program** Years 2 – 5 Phase 2 E-learning/virtual education	**Videoconferencing & E-learning Program** Years 2 – 5 Phase 2 E-learning/virtual education	**Videoconferencing & E-learning Program** Years 1 – 5 Phase 1 Videoconferencing/virtual meetings
V.	***Flex Core Area 4 - Facilitate Conversion of Small Indiana Rural Hospitals to CAH Status (2011 – 2015)*** to facilitate appropriate conversion of small rural hospitals to CAH status in accordance with federal and state regulation. SORH will provide resources as needs arise. Currently, no CAH conversions are anticipated.		

Current Flex Projects

CAH Readmission Project

The objective of supporting CAHs in implementing a quality/patient safety project focused on reducing avoidable readmissions through improvements in discharge processes. Site visits were conducted with each of seven participating hospitals to review CHF/PM readmission rates and strengths and weaknesses of current discharge processes. Project activities center on shift-to-shift communication, patient reconciliation tools, timely sharing of patient discharge information patient education/health literacy, collaborative partnerships among providers, and the use of personal health records. Technical assistance is being provided to assist CAHs with change implementation. Utilization, length of stay, and financial data are being collected as indicators of change.

Benchmarking/State Portal Project

The Indiana Flex benchmarking initiatives will be tracked through the *Medicare Beneficiary Quality Improvement Project*. The State Office of Rural Health will begin using the *Center*

Activity Tracking System (CATS) for reporting performance improvement measures to HRSA as well as tracking at least 10 additional statewide measures focused on current Flex projects. The SORH will continue to look into options and needs for statewide reporting into a statewide portal. Additionally CAHs will be trained on the submission of data to *Hospital Compare*.

Medicare Beneficiary Quality Improvement Project (MBQIP)
Baseline data was established for this project with support from Health Care Excel, the Indiana QIO. The goal of this project is to increase participation in Hospital Compare to improve publicly available data and to motivate CAHs to implement related quality improvement initiatives.

Telehealth Network Project
This project supports the continued development of the Indiana Statewide Rural Health Network (InSRHN) TeleStroke Network Project and its objectives: (1) to deliver specialty services statewide through telehealth focusing on stroke, and (2) to implement evidence-based practice guidelines for stroke care by partnering with the American Heart Association and the Indiana QIO to implement the *Get with the Guidelines* for stroke care. This model can be expanded in terms of membership and/or adapted for other medical conditions.

CAH Educational Programs Project
Funding for this initiative supports major educational events, a newsletter, technical assistance, and evaluation activities throughout the year aimed at hospital quality improvement and/or operational and financial improvement.

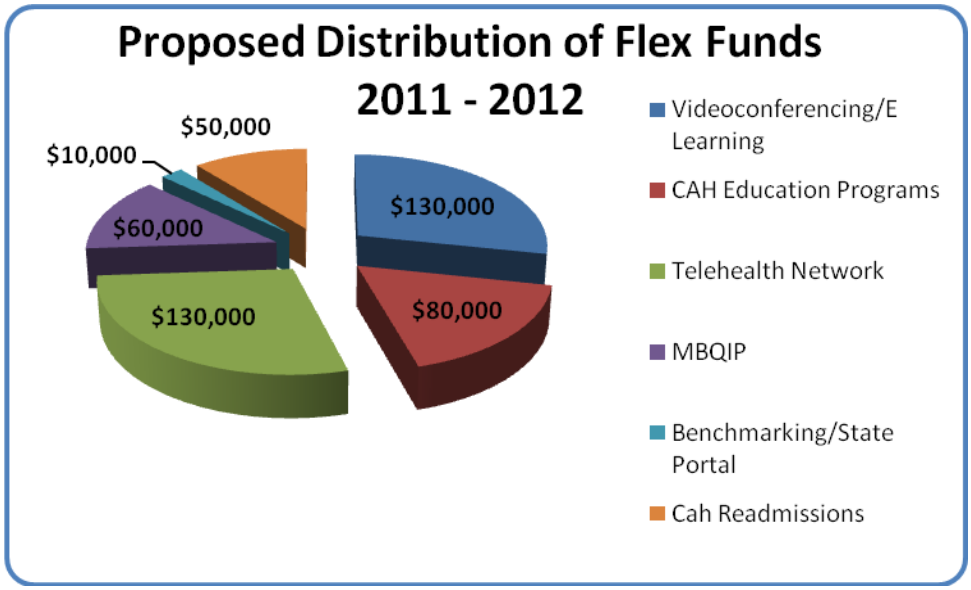
Videoconferencing and E-Learning Project
The objective of this project is to create a statewide rural videoconferencing platform for CAHs to use for meeting, training, and educational opportunities. The first phase of this project, establishing the videoconferencing bridge has been accomplished through the purchase of a 12-port Tandberg Codian bridge and the connection of six pilot CAH locations to that bridge. Next, equipment for the continued development of the network must be obtained and installed. Then group purchasing of existing online courses will occur. Partnerships with the Indiana University Department of Public Health will allow access to a learning management system for continuing education records management.

CAH Conversion
No conversions are in process at this time.

Flex Funding Summary

Flex funding for FY 2011 addresses core areas of national concern formulated into statewide approaches to address the health needs of Indiana's rural communities. **Figure 37** shows the proposed distribution of Flex funds for the year.

Figure 37. Flex Funds Distribution 2010 - 2011.



Hospitals to be served through Flex funding

Through the selected programs and projects, all thirty-five CAHs will benefit. Over the five year Flex grant period, initiatives will be phased in using a sequence that serves the priorities of the Flex constituencies and results in meaningful absorption and change.

The Indiana Rural Health Association is also providing a platform for technology use applicable to these efforts as it was the lead applicant in a grant funded by the Federal Communications Commission's (FCC's) Rural Health Care Pilot Program in 2007. Since that time IRHA has begun building a 100 megabit fiber network to all 35 critical access hospitals as a consortium partner in the Indiana Telehealth Network. This dedicated broadband can be used for multiple purposes including telemedicine, health information exchange, distance education and training, public health surveillance, emergency preparedness and trauma system exchange development. In addition, IRHA was the lead applicant in a HRSA Outreach Network Grant that is creating telemental health within rural areas of Indiana. These combined resources, along with the SORH's dedicated portal form a strong foundation for the use of Flex funding to utilize broadband applications and secure a videoconferencing bridge to benefit all CAHs.

The Indiana **Rural Health Plan/Flex Grant Logic Model** included below shows the connections between program inputs, outputs and outcomes expected as a result of the efficient use of Flex funds as proposed.

Figure 38. Rural Health Plan/Flex Grant Logic Model

Rural Health Plan Themes	Flex Grant Core Areas	Baseline	Inputs	Outputs	Outcomes
1. Support Collaborative solutions to issues of rural health services quality and access. 2. Provide equitable and accountable funding strategies for appropriate projects resulting in improved care and/or provider accountability for rural citizens. 3. Utilize existing expertise already working on rural health issues to greatest degree possible. 4. Aid in accountability of clinical practice and financial acumen of rural providers. 5. Act as conduit of accurate information to and from Critical Access Hospitals, rural providers, training experts, and state policy makers.	1.Support for Quality Improvement 2. Support for Operational and Financial Improvement 3. Support for Health System Development and Community Engagement 4. Facilitate Conversion of Small Rural Hospitals to CAH status	Current State Extent of the Problem Need for change	a. Data Gathering b. Reporting c. Increased Measurement d. Protocol Development e. Research f. Materials/product development g. Equipment/ Technology or other Training h. Implementation of EBP i. Assessment of need j. Collaborative Agreements	a. Increased reporting b. Change as result of training c. Increased data available d. Greater utilization of HIT/EHR e. Increased collaboration with other CAHs f. Increased efficiency g. Increased revenue h. Increased access i. Infection control j. Reduced chronic admissions	a. Increased knowledge b. Improved health of constituents c. Increased internal efficiency d. Improved networking e. Increased transparency f. Increased resources g. Increased capacity h. Habit change i. Social change
		Baseline Measures	**Input Measures**	**Output Measures**	**Outcome Measures**
		Waiting List Wait Times Repeat Admissions Accidents Culture Surveys Follow up Services Health Record Issues Documentation Issues Communication Issues	Level of participation Amount and type of assistance Activities to promote positive change Training activities and level of participation Connectivity ratings	Extent of the change against baseline	Impact of change on defined issue Dissemination of improved processes

Full-time Flex Program Coordinator

In order to successfully implement the Flex-funded CAH activities, the SORH has hired a full-time Flex Coordinator, Cindy Large, who will be responsible for overseeing implementation of the Flex strategies and activities prescribed in the work plan within the identified time period.

Flex Advisory Committee

The SORH has convened a Flex Advisory Committee comprised of a diverse group of CAH leaders, rural health care experts, key stakeholders, and others. The mission of the Flex Advisory Committee is to support efforts to improve and sustain the quality of care provided by CAHs to ensure that Indiana rural citizens receive appropriate care in their communities. The SORH and Flex Coordinator will draw upon the expertise and experience of the Flex Advisory Committee and CAH leaders to identify the needs and challenges of Indiana's rural CAH providers and the communities they serve, develop methods for addressing these needs and challenges, and implement additional activities as identified that will benefit the overall needs of the Indiana CAHs.

Figure 39. Flex Advisory Committee, 2010-2011.

Committee Member Name	Title	Organization
1. Ann Alley	Director	Indiana State Office of Rural Health Flex Advisory Committee Chairperson
2. Brad Dykes	CAH, CEO	Bedford Regional Medical Center
3. Brad Smith	CAH, CEO	Rush Memorial Hospital Indiana Hospital Association Council on Rural
4. Hicham Rahmouni	IT Specialist	Richard G. Lugar Center for Rural Health
5. Spencer Grover	Vice President	Indiana Hospital Association
6. Becky Sanders	Network Development Director	Indiana Rural Health Association
7. Cindy Large	FLEX Coordinator	Indiana Rural Health Association
8. Julie Liersch	VP of Clinical Services	Jasper County Hospital
9. Deb Rasper	CAH, CEO	St. Vincent Mercy
10. Dennis Weatherford	CAH, CEO	Putnam County Hospital
11. Don Kelso	Executive Director	Indiana Rural Health Association
12. Jim Miller	Special Projects Coordinator	Indiana Rural Health Association
13. Matt Serricchio	Asst. Network Dev. Dir.	Indiana Rural Health Association
14. Emmett Schuster	CAH, CEO	Gibson General Hospital
15. Gregg Malott	CAH, CFO	Pulaski Memorial Hospital
16. Jerry King	Executive Director	Indiana Public Health Association
17. Joe Biggs	Executive Administrator	Richard G. Lugar Center for Rural Health
18. Stephanie Long	CEO	White County Memorial Hospital
19. John Alley	CAH, CEO	Woodlawn Hospital
20. Brittany Knick	Manager	State Office of Rural Health
21. Marilyn Custer-Mitchell	CAH, CEO	Wabash County Hospital
22. Ann Yates	Director of Nurrsing	St. Vincent Mercy Hospital
23. Andrea Koontz	R.N., D.O.N.	Community Hospital of Bremen
24. Trish Niswonger	Dir. Of Inpatient Services	St. Mary's Warrick Hospital
25. Rebecca Royer	QIO, Dir. Clinical Services /Ops	Health Care Excel and Consulting, Inc.
26. Tim Putnam	President/CEO	Margaret Mary Community Hospital
27. Scott Graybill	CAH, CEO	Community Hospital of Bremen
28. Mary Minier	COO, CCO	White County Memorial Hospital
29. Diane McKinney	Vice President	Decatur County Memorial Hospital
30. Kathy Lewis	Dir. Ed., Quality, & Compliance	IU Health Bedford Hospital
31. Sam Mishelow	EVP, President	Meyer-Najem; IRHA Board
32. Jeanette Huntoon	Chief Executive	Logansport Memorial Hospital

Most Flex Committee members volunteered while others were referred by the community. Members are experts in rural Indiana health care representing Indiana CAHs, the SORH, associations and other rural-serving entities. The Committee's input and direction will be accommodated by the Flex Coordinator and the SORH through meetings, minutes, and written recommendations. The Flex Advisory Committee is charged with helping to update the Indiana Rural Health Plan and advising the Flex grant application at least annually. This 32-member committee has a diversified rural background, predominantly representing the Indiana CAHs, and will serve as a support and resource for the Flex Program.

The Indiana Flex Advisory Committee meets a minimum of three times a year via face-to-face meetings or conference calls, to be facilitated by the SORH/Flex Coordinator who will be responsible for insuring implementation of statewide Flex program and initiatives. During these meetings, Flex Program goals, strategies, and activities will be discussed, and the SORH/Flex Coordinator will provide direction to the committee members regarding tasks that must be accomplished in order to successfully complete the initiatives/activities described in this grant application. In addition, concerns and obstacles will be identified and strategies will be developed to address and overcome these issues.

Expected Benefits from Flex Program Activities

Increase in Access to Quality Health Care Services
It is anticipated that rural communities and residents will experience increased quality of care services and more stable access to rural health care services as a result of Flex Program initiatives. This will occur through combined efforts across diverse issues, resulting in economies of scale, resource sharing, and shared programs. A few of the potential health care system improvements that may occur as a result of network activities include:

- Implementation of quality improvement initiatives
- Implementation of best practices and evidence-based practice guideline for chronic disease management
- Reduction in readmission rates
- Access to needed specialty and subspecialty services in their communities
- Health Information Technology (HIT) resources, collaborative purchasing, and utilization
- Education and training for CAH leadership, management, and health care professional staff
- Education accessibility for rural communities and residents

In addition, the activities of the Flex Program will enable rural health providers to leverage the resources needed to create economies of scale, improve access to health care services, and ultimately improve the health and well-being of Indiana's rural residents.

While the ***design*** of the Indiana Flex Program will positively impact rural health providers, it is anticipated that urban and suburban health care providers may lose patients as a result of improvements in the rural health care delivery system. However, it is believed that shifts in health care utilization will be small in comparison to the overall business of a large hospital or

clinic. Conversely, these same changes in health care utilization will result in a substantial positive impact for rural health care providers.

It is clear that those CAHs participating in and benefiting from the Flex Program initiatives are able to obtain advantages that otherwise would be unavailable. These advantages include:

- Strengthened collaborative efforts among rural health providers in Indiana
- Access to resources to strengthen rural health care delivery resulting in higher expectations regarding performance improvement initiatives among CAHs
- Structured environment for statewide networking opportunities for CAHs that would otherwise be impossible
- Improved employee and physician satisfaction scores

As a result of the Flex Program initiatives, it is anticipated that Indiana's rural CAH providers will establish a more efficient and cost-effective rural health care system that will ensure their sustainability. Accordingly, if these rural health care providers are cost-effective, they will remain viable locations for the provision of high quality health care services for years to come; ultimately improving the quality of life for Indiana's rural residents.

The Flex program will strengthen the ability of Indiana's rural health providers to serve their respective rural communities by providing needed services, products, and programs that they would otherwise not be able to access due to financial and staffing limitations. Examples of potential services, products, and programs that could be purchased and/or implemented through efforts of the Flex Program include:

- Mandatory annual training/education via electronic communication methods
- Increased ability to attend meetings and/or educational programs via electronic modalities
- Participation in rural health quality programs focusing on disease processes identified as a statewide improvement area
- Access to specialists and subspecialists, while keeping patients in their own communities
- Development of collaborative agreements that enable the provision of virtual training, meetings, and webinars.
- Reallocation of time formerly spent in travel to meetings toward patient and management-centered activities
- Collaborative agreements among network members to develop joint training programs and performance improvement measures

In addition, by convening the Flex Program user groups, each participating CAH organization will have the opportunity to draw upon the expertise of the other CAHs or organizations. Lastly, the Flex Program initiatives develop and nurture affiliations with other rural providers, state associations, and universities, creating opportunities for CAHs individually and collectively to expand the types and quality of services they provide.

Resources and Capabilities

Collaborations
Key stakeholders include both rural health care providers and organizations that serve CAHs throughout the state of Indiana. These key stakeholders bring statewide and national resources to support successful outcomes of Indiana's Flex Program. The collaborative seeks to:

- Provide support, resources, technical assistance, and expertise necessary for successful program implementation
- Provide knowledge regarding the needs and challenges faced by rural health care providers in Indiana as they pertain to quality improvement activities and the skills to address these needs and challenges
- Participate in Flex Program meetings and/or conference calls as needed
- Provide meeting space for meetings, as deemed appropriate
- Dedicate staff time to assist with successful implementation of Flex Program activities

Below is a listing of stakeholders that have committed to Indiana's Flex Program activities with a description of the organization, the skills, knowledge, and expertise they bring, and the ways in which they add value to the Flex Program.

Indiana Rural Health Association (IRHA): IRHA was founded in 1997 as a not-for-profit corporation for the purpose of improving the health of all rural citizens in Indiana. The mission of IRHA is to enhance the health and well-being of rural populations in Indiana through leadership, education, advocacy, collaboration, and resource development. In keeping with the organization's mission, IRHA has historically implemented projects and programs that are beneficial to rural health care providers and the patients that they serve. Given the previously established relationships and prior collaborative history with CAHs and other statewide rural health organizations in Indiana, IRHA is well positioned to support the SORH and the Flex activities proposed within this application, as well as to meet and exceed Program requirements and expectations. IRHA is supportive of the Indiana Flex Program and has provided a letter of support regarding the proposed Flex initiatives.

Indiana Hospital Association (IHA): A state and regional organization representing 166 Hoosier hospitals and health systems, IHA works to provide leadership, representation, and services in the common best interests of its members as they promote the improvement of community health status. IHA is supportive of the Indiana Flex Program and has provided a letter of support regarding the proposed Flex initiatives.

Health Care Excel, Indiana Quality Improvement Organization (QIO): Health Care Excel (HCE) is recognized as one of the most experienced health care utilization management and quality improvement organizations in the United States. Given Health Care Excel's expertise regarding health care quality improvement activities, the organization's extensive collaborations with SORH and Indiana CAHs, as well as their commitment to the Flex Program activities, it is anticipated that the organization will prove a formidable partner that will help ensure successful quality improvement activity implementation. HCE is supportive

of the Indiana Flex Program and has provided a letter of support regarding the proposed Flex initiatives.

Critical Access Hospitals (CAHs): There are 35 CAHs in the state of Indiana. These small rural hospitals that have 25 beds or less and are located in rural areas of the state of Indiana provide access to needed services for rural residents. The participation of these hospitals in the Flex Program will provide needed combined services that will benefit Indiana's rural communities. The responsibilities of the CAHs participating in the Flex Program are:

- Participation in program meetings and/or conference calls as requested
- Dedicate staff time to assist with successful implementation of program activities
- Provide a portion of staff time as an in-kind contribution(s) to help ensure successful implementation of Program activities

Informing Future Efforts

The Flex Advisory Committee determined that it would be beneficial to repeat the initial Critical Access Hospital survey distributed in years 2009 and 2010 to begin to collect longitudinal data on CAH issues and performance. ASPIN conducted the survey electronically in May of 2011. The information gathered served several purposes. First, the hospitals collectively establish an overall picture of the impact of the economy on human resources, funding, and services within their areas. Next, the survey identified areas of greatest concern, issues of vulnerable populations, current benchmarking and statistical reporting mechanisms, level of telehealth involvement, and training needs. In addition, the survey identified primary unmet community healthcare needs and requested input regarding the ways that Flex program might be able to respond to those unmet needs. The full survey instrument is included in Appendix A.

Critical Access Hospital Survey Outcomes – May 2011

The following section summarizes the results of Indiana State Department of Health Survey of Critical Access Hospitals. Input provided by the CEOs of the Critical Access Hospitals established an up-to-date snapshot of emerging health needs in our state in response to demographic, administrative, and economic shifts, as well as defined categories of need for Flex funds.

Responses

The survey was distributed electronically to CEOs of all thirty-five of Indiana's critical access hospitals. The survey was divided into three sections with an electronic link to each section in order to allow for internal forwarding to subject matter experts in Human Resources, Administration, and Finance. It was therefore the responsibility for each hospital to complete three separate surveys. Not all hospitals completed all surveys. The completion rate for the Administration survey was 43% (15 of 35 reporting); the rate for the Finance surveys was 54% 19 of 35 reporting); and the rate for Human Resources was 49% (17 of 35 reporting). Responses are summarized in the aggregate in the following paragraphs around themes of workforce, effects

of the external economy, data management and technology, training needs, interaction with local health departments, and unmet community health care needs.

Issues of Greatest Concern

The CEOs of the participating Critical Access Hospitals identified issues of greatest concern from their administrative perspective. These are ranked as follows:

1. Recruiting/Retaining Physicians
2. Financial Performance
3. Health Care Reform Impacts
4. (tied ranking)
    - Reimbursement
    - Recruiting/Retaining Nurses
    - Electronic Medical Records
    - Patient Safety

These issues fall into two primary categories: Workforce and Financial.

Workforce Issues

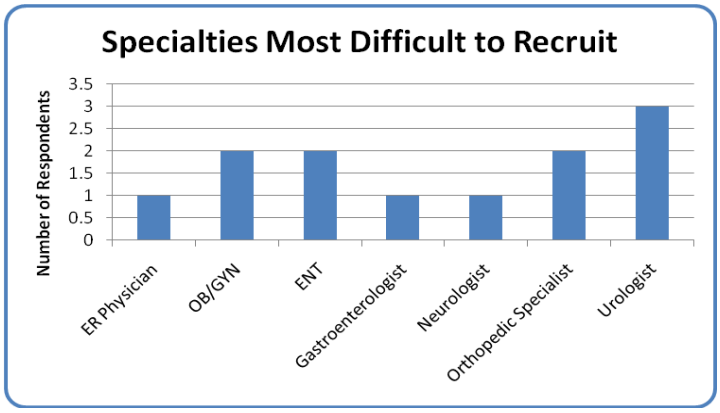
The critical access hospitals are experiencing from one to seven full-time positions open at each critical access hospital on a weekly basis; a range of from zero to ten part-time positions are typically available. It was indicated that it could take months to fill open positions. The positions hardest to recruit are primary care physicians, pharmacists, nurses, and specialty care physicians. See **Figure 40** below that compares the recruitment difficulty of four positions over time. In 2011, the ability to fill pharmacy positions was indicated as difficult by 50% of survey respondents. It appears that nursing positions are more easily filled now than in the past. This may be due to downsizings in some organizations that create skilled workforce availability for others.

Figure 40. Positions Most Difficult to Recruit, 2009 to 2011.

Position	Yes – Difficult to Recruit in 2009	Yes – Difficult to Recruit in 2010	Yes – Difficult to Recruit in 2011
Nurses	44%	32%	**38%**
Primary Care Physicians	76%	54%	**62%**
Adv. Practice Nurses	96%	10%	**25%**
Specialty Care Physicians	**68%**	**42%**	**38%**

Of the specialty care physician positions, the ones most difficult to fill are summarized below.

Figure 41. Specialties Most Difficult to Recruit, 2011.



Some hospitals have had to resort to reductions in force as a response to economic downturn. In 2010, six hospitals reported reductions of an average of 24 persons, slightly higher than the reported 20 persons in 2009. In 2011, two respondents acknowledged reductions in force averaging 20 individuals each.

Effects of External Economy

Plant closings, downsizings, and/or business failures have had staggering impacts on Indiana's rural communities. Forty-three percent (43%) of survey respondents indicated that within the last year, downsizings have continued with both manufacturing and small business losses. Hospitals are also noticing reductions in health coverage and higher deductibles in response to budget cuts among existing employers. In many cases, employees with chronic conditions cannot pay the annual deductibles that often reach the $5,000 per year range. The economy in these rural areas is not rebounding; the impact of recession continues.

By averaging payer mix responses from all hospitals, an aggregate picture of current-state payer mix was developed and graphed in Figure 37. According to 2011 survey respondents, Medicaid accounted for a range of between 4 and 43% of patient receivables; Medicare accounted for a range of 9-57% of patient receivables; Commercial insurance created from 28.4 to 41% of patient receivables; Uninsured/Self payers ranged from 3.5 to 11.9%; and Charity accounted for between 1 and 8% of hospital patient billings. It is clear that the CAHs represent varying levels of payer complexities depending upon local economy and demographic mix.

Figure 42. Average Payer Mix of Critical Access Hospitals, 2011.

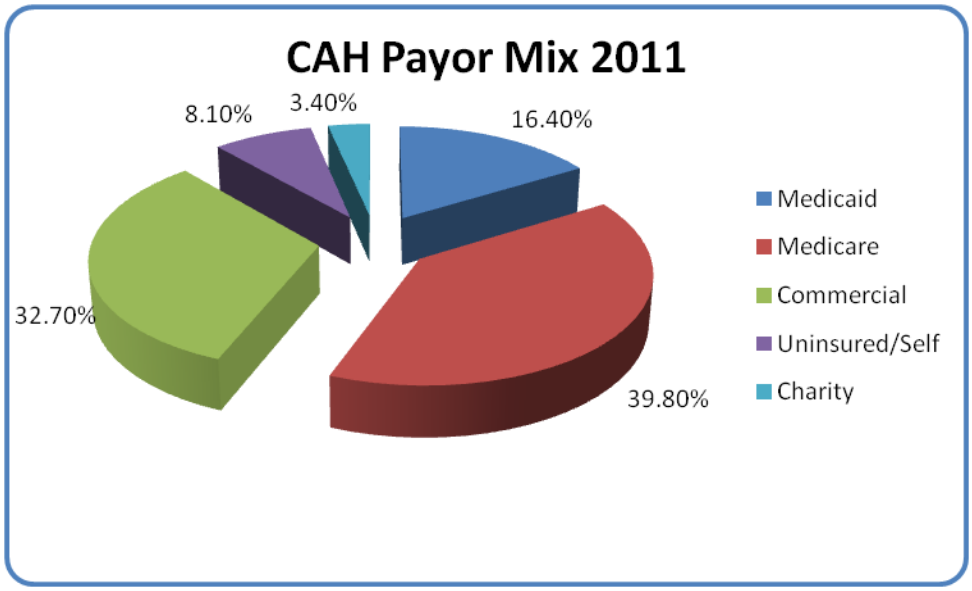


Figure 43. Comparison of Payer Mix 2009 through 2011.

Payer	2009 Survey Data	2010 Survey Data	2011 Survey Data
Medicaid	14%	12%	16.4% (20/35)
Medicare	44%	41%	39.8% (16/35)
Commercial	32%	28%	32.7% (15/35)
Uninsured/Self	7%	12%	8.1% (13/35)
Charity	3%	3%	3.4% (10/35)

It appears that Medicaid is a growing revenue source, as is commercial insurance. However, these statistics may not represent the group as a whole. Please note the number of responses included in the averages viewed in parentheses.

A majority of the hospitals responding to the survey (57%) indicated that funds to their facilities were reduced primarily due to Medicaid payment reductions. Reductions cited ranged from $30,000 to $300,000. Additional changes in revenue appear to be coming from adjustments in payer mix.

A minority of hospitals responding to the survey (20%) have taken on new services in response to needs of their communities. Examples include providing assistance in the opening of a FQHC, creating a position to facilitate the linkage of underserved/underinsured individuals to health resources, and the adding of a specialty physician practice for oncology. Hospitals are continuing to discontinue services in order to remain viable. Examples cited by survey respondents include a discontinuation of obstetric delivery and nursery services, EMS, and durable medical equipment, and the closure of physician offices.

Concern for vulnerable populations and ways to best serve them also was in evidence. The CEOs collectively supplied the following unduplicated list of vulnerable populations that are present in their areas. This is not a ranked list. The diversity in the identified populations underlines the variety of needs in CAH communities.

- Latino Community
- Growing Medicaid populations
- Families with very limited resources/working poor
- Amish population
- Elderly
- Persons with multiple chronic diseases
- Uninsured
- Underinsured
- Persons with Behavioral Health Needs
- Children
- Non-English Speaking Populations

Meeting the needs of these vulnerable populations requires high levels of resource utilization as well as specialized support systems. The following comments are paraphrased qualitative responses from CAH CEOs regarding the impact that serving the vulnerable populations has on the hospital's resources. The comments are not rank-ordered and may represent issues cited by more than one hospital.

> *Patients wait too long to receive care. When they finally receive care, it is often for major procedures that are very costly. They oftentimes can't meet the deductible and we have to write-off a significant portion of the bill as uncollectible.*
>
> *Patients without primary care access use services that are very expensive like ER.*
>
> *Greater demand is being put on us to serve all with increasing costs and declining reimbursement. At some point we can no longer afford to meet all needs.*
>
> *We need to provide services in a manner that integrates effectively with unique cultures.*
>
> *Lack of transportation in rural areas inhibits ability to keep appointments, see specialists, and have medications filled.*
>
> *School nurses report that nutrition is a predominant issue as well as meeting needs of diabetic and asthmatic children.*
>
> *We frequently have issues transferring behavioral health patients for appropriate treatment.*

It appears that initiatives related to cultural competency, rural community health transportation, and prevention of chronic disease are especially needed in the rural areas.

Data Management and Technology

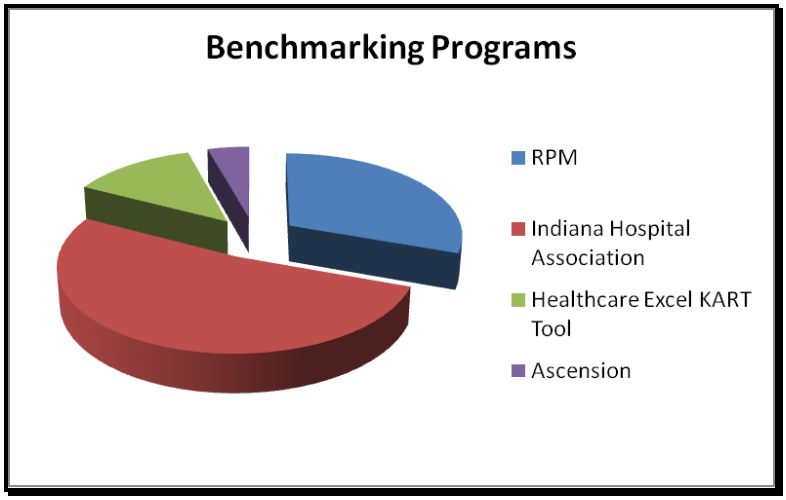
The survey identified that most (87%) of responding critical access hospitals submit data to Hospital Compare through the U.S. Department of Health and Human Services. Further, responders indicated that they submit between one and seven data sets.

In addition, most (85%) share statistics with other outside entities. The following is an unduplicated list of entities mentioned. Hospitals that are part of a larger network are less sure of where data is submitted annually, as it is done centrally by the network.

- Healthcare Excel
- Indiana Hospital Association
- St. Vincent Health
- JCAHO
- Anthem Hospital Quality Program
- CMS
- Leapfrog
- Indiana Rural Health Association
- Rural Performance Management
- Alliant Management, Inc.
- KART
- Press Ganey

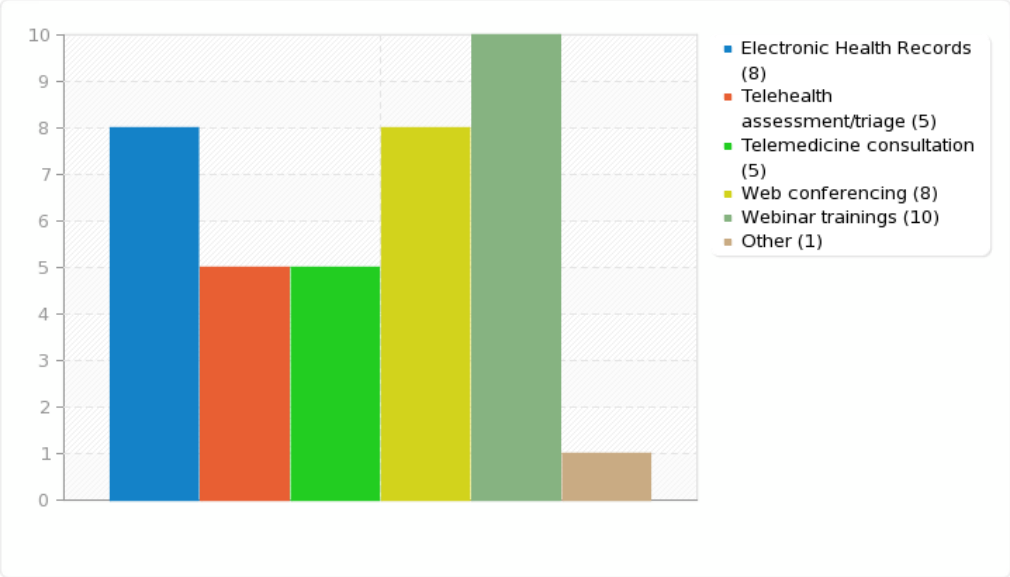
The hospitals also participate in various benchmarking programs. Most submit data to the Indiana Hospital Association the Indiana Rural Health Association/RPM system, and Healthcare Excel Kart Tool.

Figure 44. Benchmarking Entities Reported by CAHs, 2011.



Various technological applications are in place in the hospitals. The applications in greatest evidence were related to webinar trainings, web conferencing, and electronic health records. Telemedicine applications in use continue to demonstrate increases.

Figure 45. Technology Use, 2011.



Survey respondents were asked to identify barriers to greater telehealth/telemedicine use. This question invited respondents to check all that apply, creating multiple answers per respondent. The following table shows the frequency of issues selected from 2009 through 2011 surveys.

Figure 46. Barriers to Telehealth/Telemedicine Goals for Critical Access Hospitals.

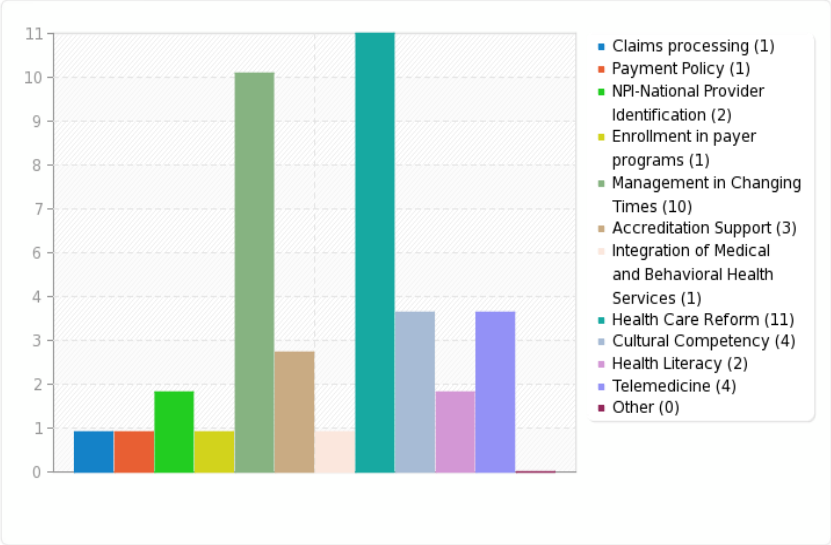
Barrier	# indicating the barrier 2009	# indicating the barrier 2010	# indicating the barrier 2011
Financial	13	12	**9**
Staff Time for Implementation	9	5	**6**
Bandwidth	6	2	**2**
Billable Rates	6	7	**5**
Staff Training Support	6	7	**7**
IT Support	4	6	**4**
Connectivity	4	1	**4**
FCC Match	2	0	**2**
Board Support	1	1	**0**
No barriers	**1**	**3**	**1**

It appears that the mechanical aspects of incorporating technology are being solved, although the staff and financial issues remain significant along with a need for ongoing IT support. Six of the 2011 respondents identified a lack of physician support as an additional barrier.

Training Needs

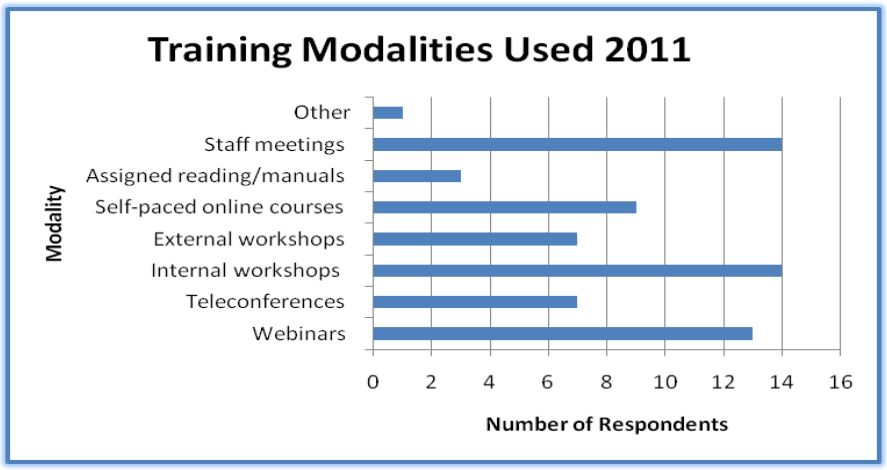
The training topics most needed by the critical access hospitals are summarized in the following table. Health Care Reform training led the list for both the 2009 and 2010 surveys. The 2010 survey also identified Management in Changing Times, Accreditation Support, Cultural Competency, and Telemedicine as significant training needs.

Figure 47. Training Topics Most Needed by Critical Access Hospitals, 2011.



Training modalities most used by the critical access hospitals include staff meetings, internal workshops, self-paced online courses, and webinars. It appears that modalities that require little travel and minimal time away from the workplace are favored. The following graph demonstrates the types of modalities used as indicated by survey respondents. The modality cited in the "Other" category pertained to vendor-specific equipment and products.

Figure 48. Training Modalities in Use in Critical Access Hospitals, 2011.

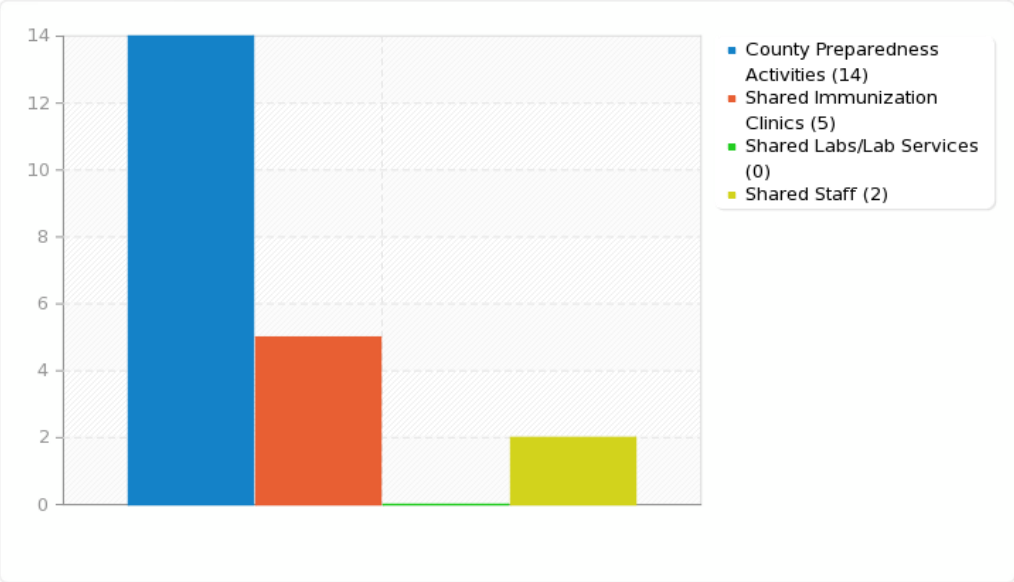


Approximately 12% of responding hospitals indicated that they currently maintain training contracts with outside entities. CareLearning was named as a provider with mandatory and voluntary course offerings in web-based formats. Overall annual training budgets shared by participating respondents ranged from $5,000 to over $2,000,000.

Interaction with Local Health Departments

In general, the survey results discovered that the critical access hospitals do not interact to a great degree with local health departments. The most often-cited affiliations fell under the categories of preparedness activities and shared immunization clinics.

Figure 49. Interaction with Local Health Departments, 2011.



Unmet Community Health Care Needs

In answer to a request for the top three unmet health care needs in their respective communities, twenty-two different needs were identified. The top needs identified were primary care access, weight management support, behavioral health care, cardiac specialty care, transportation, OBGYN care, and care for the underinsured. **Figure 50** below summarizes the needs identified.

Figure 50. Primary Unmet Health Care Needs Cited by Critical Access Hospitals.

Community Need	Number of Respondents Identifying
Timely Access to Primary Care	5
Weight Management Support	4
Behavioral Health Care	4
Specialty Care - Cardiac	3
Transportation	2
Specialty Care - OBGYN	2
Care for un/underinsured	2
Specialty Care - Pulmonary	1
Specialty Care - Ortho	1
Specialty Care - Oncology	1
Specialty Care - Dermatology	1
Specialty Care - GI	1
Assisted Living/Intermediate Care for Seniors	1
Diabetes Support	1
Wellness Education/screening	1
Preventative Services	1
Local Lab Services	1
Tobacco Cessation Support	1

Besides identifying issues, respondents were asked to supply potential solutions. The following table summarizes the issues and solutions suggested.

Figure 51. Unmet Needs and Suggested Solutions Provided by Critical Access Hospitals.

Issue	Suggested Solution
Wellness/Screening	a. Establish a mobile clinic that travels to rural communities b. Create more funding for hospitals to provide screenings
Obesity/Nutrition	a. Support education for diet and exercise, provide incentives for wellness b. Obesity/fitness/nutrition programs for children c. Exercise education for adults
Transportation	In-depth study of needs
Primary Care Access	Rural training opportunities, Rural recruitment assistance, loan repayment support
Behavioral Health	Increase number of available beds
Specialty care	Recruitment support, telemedicine support
More community programs for disease management	Development of better community follow-up systems

The Indiana Office of Rural Health has formed a Flex Committee to meet quarterly. With this group in place and work plans from subsequent Flex and grants and other funding sources, the State Office of Rural Health will move forward to meet the needs of the Critical Access Hospitals and their respective communities.

Key Stakeholder Input from Indiana's Rural Roundtable

A second set of data was gathered through a survey process conducted with executives currently participating on the Indiana Rural Roundtable convened by Ann Alley, the Director of the Indiana State Office of Rural Health. This group meets quarterly to exchange information, network, and collectively begin to address universal healthcare needs affecting rural Indiana. These leaders provided information regarding gaps in health care viewed from their perspectives and tied their information to the ways in which their organizations support the efforts of Indiana's critical access hospitals.

The Indiana Rural Roundtable is viewed as a coalition to bring forward information and collaborative solutions to address rural health needs. It is also meant to streamline duplication and uneven distribution of information. Moving forward, those represented within the Rural Roundtable will apply energy to shared concerns through powerful collaborations for diversified funding, program development, and statewide models of care, technical assistance, and growth among entities concerned with the health care of rural citizens. The Indiana State Office of Rural Health relies upon these entities to identify needs, review models, and to attempt creative resolution of issues of care in rural areas.

The following individuals and their respective organizations are represented on the Rural Roundtable:

Figure 52. Rural Roundtable Participants, 2010 – 2011.

Name	Organization
Ann Alley	State Office of Rural Health
Don Kelso	Indiana Rural Health Association
Matt Serricchio	Indiana Rural Health Association
Cindy Large	Flex Coordinator
Kathy Cook	Affiliated Service Provi1ders of Indiana, Inc.
Martha Levey	Affiliated Service Provid1ers of Indiana, Inc.
Phil Morphew	Indiana Primary Health Ca1re Association
Rick Kiovsky	Indiana AHEC
Jerry King	Indiana Public Health Association
Spencer Grover	Indiana Hospital Association
Rebecca Royer	Indiana Healthcare Excel
Anna Garrett	Brain Injury Association of Indiana
Gina DelSanto	Indiana workforce Development
Brittany Knick	State Office of Rural Health Manager
Carole Kacius	IU School of Medicine Dept. of Public Health

In May of 2011, a survey was emailed to Roundtable members. A copy of the survey questions is included in Appendix A. What follows is a summary of the responses to the survey.

Rural Roundtable Survey Response Summary (7 Respondents)

Question 1: From your perspective, what are the major barriers facing rural health care **consumers** in Indiana and what solutions would you recommend to address these issues?

Issue	Proposed Solution
Access to Primary Health Care	a. Indiana Access Plan provides a discussion of leading factors influencing local access b. Telehealth c. Examine credentialing requirements d. Remove disincentives for rural practice e. Increase reimbursement for Medicare/Medicaid f. Mental health integration
Competing demands for attention (Economy, employment, costs of items) push down health care as a priority	a. Encourage displaced workers (unemployed) to enter training for health care careers
Access to specialty care	a. Encourage more individuals from rural population to enter training to become providers to rural populations. b. Telehealth
Perception that rural health care is of less quality	a. Use students to help deliver needed health promotion programs to the community b. Share CAH quality data with local communities
Rural population may not relate openly with a provider because they don't want to seem unknowledgeable.	a. Increase provider skill in relating to rural populations. b. Develop a statewide health literacy program for local communities to conduct.
Lack of insurance coverage/sufficient funds to pay for services and/or deductibles	a. Offer financial incentives to improve wellness b. Support statewide smoking ban c. Access to safe exercise environments d. Use educational technology to educate consumers regarding disease and health access

Question 2: From your perspective, what are the major barriers facing rural health care "**providers**" in Indiana and what solutions would you recommend to address these issues?

Issue	Proposed Solution
Lack of Primary Care Providers	a. Robust, sustainable recruitment program b. Create alternative training/delivery options c. Expose more students to providers in rural settings

	d. Partner with health insurance companies to support pilot projects to help students understand the value of working in rural health e. Lower medical school costs f. Increase number of open slots in medical schools
Inadequate network of local specialty care	a. Increase number of medically underserved areas and populations to create FQHCs b. Include inter-professional education to help develop teams to address community health issues c. Develop stronger linkages between providers and local residency programs and other training programs
Insufficient number of physicians accepting Medicaid	a. Restructure Medicaid reimbursement for telehealth services b. Decrease number of federal regulations
Slim business margin makes it difficult to manage uncompensated care	a. Provide incentives to encourage providers such as tax breaks, differential reimbursement, debt re-payment, funding to key preceptors
Communication gaps/cultural barriers with foreign-trained physicians	a. Assess the needs of local providers to determine their needs – training, resources, etc. b. Assign a established physician as a mentor to foreign trained physicians
Poor patient adherence	a. Increase patient education b. Provide walk-in clinics c. Integrate mental health services in primary care d. Develop a statewide health literacy program for local communities to conduct.

Question 3: How does your organization currently identify unmet community health care needs?

- Survey (3)
- Direct discussion with constituents (4)
- Research (4)
- First-hand knowledge (3)
- Secondary data (3)

Question 4: How does your organization currently address the needs of vulnerable populations?

- Support for community health centers
- Provision of technical assistance and training (5)
- Advocacy efforts (3)
- Emergency preparedness activities (2)
- Workforce development programs such as J2 Waivers, National Health Service Corps
- Partnerships with other organizations (4)
- Community-based student learning opportunities drawing from vulnerable populations
- Input from diverse group of board members
- Grant funds that provide added technology, education, collaboration (3)

Question 5: How does your organization currently support Indiana's Critical Access Hospitals?

- Flex Funding (2)
- Networking (2)
- Use of best practices
- Education (3)
- Advocacy (3)
- Board Education regarding CAHs (2)
- Board recruitment to include CAH representation

Question 6: Does your organization support the Rural Health Priorities listed below?

Rural Health Priority	Activity
Access to Quality Healthcare	a. Continuing Education for professionals b. IU Center for Workforce Studies workforce reports c. Advocacy d. Community development e. Shortage designation f. Efforts to improve viability of rural hospitals g. Work with Rural Health Clinics, Critical Access Hospitals, and Community Mental Health Centers to improve services h. Participate in study groups, pilot projects i. Manage grant to improve access to behavioral health care for veterans and families
Heart Disease and Stroke	a. Participation on Indiana Stroke Prevention Task Force b. Leadership in Stroke Network
Diabetes	a. Participation on ISDH Diabetes Advisory Board b. Education at sponsored training events c. Manage Project ICE Grant – Integrated Care through Education d. Conduct pilot telemedicine diabetes groups
Mental Health /Disorders	a. Continuing education/evidence-based care training b. Participation on Indiana Integrated Care Alliance Committee c. Grants to expand telemedicine use d. Performance improvement reporting for behavioral health network
Oral Health	a. Serve on oral health taskforce b. Support health fairs c. Annual conference education segment
Tobacco Use	a. Provide members with information from Indiana Tobacco Prevention and Cessation Program b. Involvement with ITPC c. Grant funds to expand statewide tobacco education

	d. Years of supporting webinars, conference calls, process improvement regarding screening e. Development of online course addressing tobacco use and mental illness f. Integration of tobacco information into Certified Recovery Specialist curriculum
Substance Abuse	a. Support health fairs b. Annual conference education segment c. Provide continuing education for clinical staff
Educational &Community-Based Programs	a. K-12: prevention clinic b. Workshops on nutrition, weight management, stress management and fitness for WorkOne clients c. Participated in Indiana Coalition for Healthier Rural Community focusing on access to care and tobacco cessation d. Participation in Community Health Engagement Program to increase meaningful research e. Hosted multiple programs f. Conducts training for clinicians and community
Maternal, Infant & Child Health	a. K-12: Focus on Health b. Participation on Indiana Perinatal Network Advisory Board
Nutrition & Overweight	a. K-12: Charting Calories/ Discovery Digestive System b. K-12: Nutrition and Exercise c. Support health fairs d. Provided numerous education offerings e. Developed online course addressing nutrition and diabetes
Cancer	a. Continuing education
Public Health Infrastructure	a. K-12: Introduction to careers in public health b. Collaboration with IUPUI School of Public Health on numerous community projects
Immunization & Infectious Disease	a. K-12: STDs/STIs Myths Facts First Aid and Blood b. Continuing education c. Support health fairs d. Dissemination of information regarding immunizations e. Hosted conference call on improving immunization rates f. Participation on Indiana Immunization Coalition Board
Injury & Violence Prevention	a. Annual conference education segment b. Partnership with companies like Pioneer Seed Corn to improve farmer safety
Family Planning	
Environmental Health	
Other Contributions: Internships, Research, Service Learning	

This small group of respondents representing less than half of the Rural Roundtable members generated a number of proposed solutions to rural health needs and demonstrated that they actively work to make positive change in provider skills, workforce expansion, organizational effectiveness, and health information dissemination. Collaboration was repeatedly mentioned as supportive of increased impact and creative solution development. These organizations are involved in multiple collaborations and are well-known to each other, serving as a rural nucleus and forum for knowledge transfer and systems change. The outcome of this survey will serve as a foundation for further discussion within the group.

Data from both the Critical Access CEO survey and the Rural Roundtable reinforce one another. For example, issues of workforce recruitment and retention are presented through both surveys. The increasing importance of health information technologies to fill gaps in specialist care was identified in both. The need for continuing education for clinical practitioners and business leadership is recognized by all. As communities face economic hardship and high-need populations, the need for collaboration and creative solutions becomes even more evident.

Section V. Moving Toward a High Performance Rural Health Care System

The Indiana State Office of Rural Health

Established in 1992, the State Office of Rural Health (SORH) is located in Indiana State Department of Health's (ISDH) Primary Care Office (PCO). The mission of the SORH is to enhance the growth of public health services, funding sources, and educational opportunities for every rural Hoosier. The SORH lost its director in July of 2009 and will not be able to offer a state employee position to the replacement rather; a contractual position has been created. A full-time FLEX Coordinator position has been contractually created and is half funded with the SORH grant. The SORH operates with the Director of the PCO and a Grants Manager who serves as the SHIP Project Director as well as supporting general SORH activities. Additional operational and programmatic support is provided by the Office of Primary Care Manager through underserved area designation activities affecting National Health Service Corps placements in rural areas, the ISDH Finance Department that provides accounting and financial management of the SORH grant fund, and the ISDH Contract Division that assists contract execution through the state process. The PCO Director currently oversees the SORH, Flex, and SHIP programs. The PCO Contracts and Grants Manager administers the SHIP program for the office. The state program meets the program requirements of the authorizing statute.

The SORH operates within the PCO and as such is able to leverage its federal and state funds in a more effectively to better serve all Indiana rural residents. Complementary--internal partners and programs within the PCO include the J-1 Visa Waiver Program, State Funded Programs for Community Health Centers, State Loan Repayment Program, National Health Service Corps, Shortage Designations, Trauma, Injury Prevention, and Spinal Cord and Traumatic Brain Injury Research.

External Partners

The SORH works with external key partners to address rural health needs. These external partnerships broaden the SORHs capacity to enable core and additional statutory functions aimed toward improving access to health care and addressing health deficits.

- 35 Critical Access Hospitals
- Indiana Rural Health Association (IRHA)
- Indiana Hospital Association (IHA)
- Affiliated Service Providers of Indiana, Inc. (ASPIN)
- Richard G. Lugar Center for Rural Health
- Emergency Nurses Association (ENA)
- Indiana Statewide Rural Health Network (InSRHN)
- Area Health Education Center Program (AHEC)
- Telehealth Advisory Consortium (TAC)
- Indiana Health Information Exchange (IHIE)
- Indiana Primary Health Care Association (IPHCA)
- Indiana Department of Homeland Security
- Indiana Criminal Justice Institute (ICJI)

- Indiana Trauma Task Force
- Health Care Excel (HCE)
- Bowen Center for Health
- Indiana Bioterrorism and Preparedness Task Force
- Indiana Rural Health Association (IRHA)
- Indiana Hospital Association (IHA)
- Emergency Nurses Association (ENA)
- Indiana Statewide Rural Health Network (InSRHN)

The SORH's primary and collaborative partner is the IRHA. The office provides state, FLEX and SORH funds in support of the annual IRHA Rural Conference, various publications, and workshops. Through IRHA the SORH provides rural residents of Indiana the latest perspectives on local, state, regional, and national rural health initiatives. IRHA facilitates communication via site visits to CAHs for the purpose of determining individual technical assistance needs and community perspectives. This year the SORH is contracting with IRHA to provide a full-time FLEX Coordinator who will aid the fledgling FLEX Advisory Committee that was formed in August of 2009. Through IRHAs expertise, the SORH is increasing its reach into the CAHs and other rural serving entities. To accomplish this, IRHA is implementing data collection and evaluation activities to monitor and modify, as needed program planning, implementation, and evaluation efforts to assess progress toward the desired outcomes among rural health centers.

The SORH and the Indiana Hospital Association (IHA) have a productive working relationship which allows SORH to stay abreast of hospital insider concerns and opportunities. IHA holds a "Council on Rural" for all chief executive officers of CAHs and rural hospitals. At each of these meetings, SORH staff present findings on the most recent events and on assistance provided by SORH. IHA uses data collected by ISDH and SORH to address the needs of CAHs. IHA serves as a financial information warehouse and has shared information with other rural partners, including the SORH, IRHA, and CAH staff.

The **Lugar Center** for Rural Health has evolved as a tripartite partner in the areas of health care delivery, telemedicine and workforce development. Recently the SORH has partnered with the Lugar Center for Rural Health on telehealth and telemedicine projects. Other telehealth/telemedicine partners include TAC and IHIE.

The SORH began working with **ASPIN** to explore behavioral and mental health issues pertaining to rural Hoosiers and has evolved into a rural health planning partner. ENA and the Indiana Trauma Task Force continue to enable the office to stay up to date on issues pertaining to emergency care and trauma system development. Indiana's Governor established a formal Trauma Committee by executive order this year. Partnerships have been established among SORH, AHEC, IPHCA (3RNet), and the Bowen Center for Health. AHEC and IPHCA represent the workforce recruitment and retention arm of Indiana, while the Bowen Center provides workforce research.

The **InSRHN**, a subsidiary organization of IRHA, and SORH are working to meet rural health network needs. These needs include increased financial viability and sustainability among Indiana's rural healthcare providers that will ensure access to care for rural residents; increased access and use of Health Information Technology among Indiana's rural health care providers; increased connectivity among Indiana's rural health care providers that will enable the sharing of resources, services, implementation and participation in education programs, and increases in

quality improvement activities among Indiana's rural health care providers. InSRHN had its first Board Retreat on February 12, 2009.

IPHCA has assisted the Primary Care Office (PCO) with developing clinical, governance, administrative, and financial standards for community health centers, 11 of which are designated as rural health clinics. IPHCA will assess the centers once standards are formally adopted in 2009, a final report of findings will be submitted.

SORH and the PCO continue to capitalize on the opportunities present in local collaborations. IPHCA is assisting with community health center and local health department collaborations. IPHCA assists the PCO with providing data and support for National Health Service Corps activities, for health professional shortage area/medically underserved populations area designations, and J-1 visa waiver applications.

IPHCA is the 3RNet entity in Indiana. **3RNet is** made up of organizations such as State Offices of Rural Health, AHECs, Cooperative Agreement Agencies and State Primary Care Associations. These not-for-profit organizations help health professionals locate practice sites in rural and underserved areas throughout the country. Grant monies will be used to ensure outreach to rural providers.

The PCO/SORH is assessing how future state and federal resources should be deployed using medically underserved areas (MUAs), health professional shortage areas and both internal and publicly available data sets as components of an evaluation. The PCO, ISDH Geographic Information System (GIS) specialists, IPHCA and the SORH have formed a workgroup and will engage other community and federal partners once an access plan on the basis of the evaluation is drafted. Recommendations from this workgroup will be presented to the state health commissioner for her determination of where programmatic resources could be posited based on a geographically displayable definition of need, accessibility and health status.

In addition to ensuring a broad base of expertise to advise the direction of the program, the Indiana SORH is committed to the utilization and collection of data for assisting decision making and grants management. Every grant managed by the Indiana State Department of Health (ISDH) focuses on at least one of four health initiatives established by State Health Commissioner. The health initiative met through the SORH grant is the collection of data to promote ISDH's Data Driven Initiatives and Policies. The data collected through SORH initiatives will be disseminated to ISDH, as well as to rural health partners and will be posted on SORH's website for the public.

State Matching Fund Support

State funds pay for the time the PCO Director and Contract Manager devote a total .4 FTE to the SORH and Flex Programs ($82,670) which strengthens state and local partnerships as a result of the programs the PCO oversees. In addition, state funds provide resources ($889,500) to rural health clinics through the Richard Lugar Center for Rural Health and Hoosier Uplands which, in addition to eight other clinics serve 46,000 rural patients a year. Grant funds for these rural health centers are awarded based on state funding criteria. The Indiana Rural Health Plan is a living document that captures the economic, workforce, and health care needs of counties served by Indiana's critical access hospitals. The needs assessment processes used informed the SORH regarding areas that can be addressed through Flex funding and set the tone for the office's future

collaborations. Indiana's rural populations are at the center of multiple forces that can work in concert to improve and sustain health. Indiana is fortunate to have established partnerships on a statewide level that are focused on issues of workforce development, quality service delivery, patient safety, emerging telehealth connectivity, data gathering and analysis, training, and collaboration.

Movement toward an integrated system of care is especially challenging in rural areas as many essential services (e.g., hospital and physician services, behavioral health, dental care, and EMS services) are not available in many small communities. As a result, it is critical to develop linkages with providers in other communities and to use the technology as effectively as possible. The SORH maintains interest and support for emerging technologies and models of cooperation that bring high quality coordinated and culturally sensitive care to Indiana's rural populations while supporting viable revenue streams for providers.

Through a review of secondary sources as well as through a dual survey process of key rural health leaders and statewide organizations addressing rural health care, the Plan establishes five directives to be addressed in its work plan. These include (1) support collaborative solutions to issues of rural health service quality and access, (2) provide equitable and accountable funding strategies for appropriate projects resulting in improved care and/or provider accountability for rural citizens, (3) utilize existing expertise already working on rural health issues to the greatest degree possible, (4) aid in accountability of clinical practice and financial acumen of rural providers, and (5) act as a conduit of accurate information to and from critical access hospitals, rural providers, training experts, and state policy makers.

Within these broad directives, the goals of the various funding bodies that support the work of the State Office of Rural Health are assured. In addition, the goals are in alignment with Flex Goals, the Healthy People 2020 Goals, and the Ten Essential Public Health Services. The following graphic demonstrates the interplay of these initiatives. The impact of the development of the Indiana Rural Health Plan and the distribution of Flex funding in the current year is in alignment with local and national priorities. The Indiana Rural Health Plan is a catalyst for forward movement of initiatives and collaborations in place within the state through integration of programmatic goals, cross-discipline training, information exchange, and partnership development.

The following graphic demonstrates the ways in which all efforts undertaken by the State Office of Rural Health are complementary in terms of moving the focus areas of funders and stakeholders forward through its various initiatives.

Figure 53. Goals Integration.

State Rural Health Plan Theme	State Rural Health Plan Goal	Flex Core Areas	Healthy People 2020/Rural Healthy People 2010 Goal Alignment	Public Health Essential Services Alignment
1. Support collaborative solutions to issues of rural health services quality and access.	**Coordination of rural health resources and activities Statewide.**	**Support for Health System Development and Community Engagement** Statewide CAH Quality Program for CAH Readmissions	HP 1, 2, 3, 4 RHP 1 - 12	3, 4, 5, 7, 8

2. Provide equitable and accountable funding strategies for appropriate projects resulting in improved care and/or provider accountability for rural citizens	**Provision of technical assistance.** Provides contract management oversight to all partners receiving rural health funding through SORH, FLEX and SHIP. Is the fiscal agent for the HIT-CAH grant.	**Support for Operational and Financial Improvement** Statewide CAH Reporting Program	HP 1, 2, 3, 4 RHP 1-12	4, 5, 9, 10
3. Utilize existing expertise already working on rural health issues to greatest degree possible.	**Provision of technical assistance.** Support rural health partners as needed.	**Support for Health System Development and Community Engagement** Statewide CAH Educational Programs	HP 2, 3, 4 RHP 1, 2, 3,	1, 4, 8, 9, 10
4. Aid in accountability of clinical practice and financial acumen of rural providers**.**	**Provision of technical assistance.** Support rural health partners as needed.	**Support for Quality Improvement** Statewide CAH Reporting Program Statewide CAH Quality Program for CAH Readmissions	HP1,2, 3, 4 RHP 2-12	1, 2, 3, 5, 6, 8, 9, 10
5. Act as conduit of accurate information to and from Critical Access Hospitals, rural providers, training experts, and state policy makers.	**To improve collection and dissemination of information.**	**Support for Health System Development and Community Engagement** Statewide Videoconferencing and e-learning Program	HP 1, 2, 3, 4 RHP 1 - 12	1, 3, 4, 5, 6, 8, 10

The Indiana Rural Health Work Plan for 2011-2012 creates movement across 5 key themes identified through survey processes. These themes include:

a. Support collaborative solutions to issues of rural health services quality and access.
b. Provide equitable and accountable funding strategies for appropriate projects resulting in improved care and/or provider accountability for rural citizens
c. Utilize existing expertise already working on rural health issues to greatest degree possible.
d. Aid in accountability of clinical practice and financial acumen of rural providers.
e. Act as conduit of accurate information to and from Critical Access Hospitals, rural providers, training experts, and state policy makers.

This plan is meant to be a working document that will expand and contract as work is completed and new projects added under each theme. For example, the project column contains a minimum set of projects to be accomplished, however, new ones can be added as issues emerge or are resolved. In this way, this year's work plan essentially provides input for that of the following year.

Alignment with Wider Initiatives

Healthy People 2020 Goals
All rural initiatives developed and/or supported through the Indiana State Office of Rural Health are in support of the four primary goals outlined in **Healthy People 2020** which provides a 10-year agenda for improving the nation's health.

Healthy People 2020 strives to identify nationwide health improvement priorities, increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress. It also provides measurable objectives and goals that are applicable at the national, state, and local levels. Its aim is to engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge. In addition, the initiative seeks to identify critical research, evaluation, and data collection needs. **Healthy People 2020** established four overarching goals:

1. Attain high quality, longer lives free of preventable disease, disability, injury, and premature death;
2. Achieve health equity, eliminate disparities, and improve the health of all groups;
3. Create social and physical environments that promote good health for all;
4. Promote quality of life, healthy development, and healthy behaviors across all life stages

Rural Healthy People Goals
The **Rural Healthy People 2010** report is intended to inform constituents regarding current rural health conditions and provide insights into possible methods to improve rural health conditions. The report is a companion to **Healthy People 2010**, and identifies ten areas of health concern especially prevalent in rural areas. These include: (1) access to insurance, (2) access to primary care, (3) access to emergency medical services, (4) heart and stroke, (5) diabetes mellitus, (6)

mental health and mental disorders, (7) oral health, (8) tobacco use, (9) substance abuse, (10) maternal infant and child health, (11) nutrition and overweight, and (12) cancer. These are issues noted in surveys of Critical Access Hospitals and statewide associations as ones that are of great concern in Indiana at this time. The updated version, **Rural Healthy People 2020** has not been released as of this writing.

The Essential Public Health Services

The Essential Public Health Services (1994)[3] provide a fundamental framework by describing the public health activities that should be undertaken in all communities. The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. This steering committee included representatives from US Public Health Service agencies and other major public health organizations.

The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems. The Indiana Office of Rural Health relates these ten essential services to its efforts.

1.	Monitor health status to identify and solve community health problems.
2.	Diagnose and investigate health problems and health hazards in the community.
3.	Inform, educate, and empower people about health issues.
4.	Mobilize community partnerships and action to identify and solve health problems.
5.	Develop policies and plans that support individual and community health efforts.
6.	Enforce laws and regulations that protect health and ensure safety.
7.	Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8.	Assure competent public and personal health care workforce.
9.	Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10.	Research for new insights and innovative solutions to health problems.

Rural Health Work Plan Summary

The impact of the development of the Indiana Rural Health Plan and the distribution of Flex funding in the current year is in alignment with several national priorities, notably those that support improved emergency medical care through training regarding trauma response, through support for telehealth expansion to meet specialist demand in emergency care, and through careful assessment of rural health care needs and focus on removing disparities in care and access. The Indiana Rural Health Plan is a catalyst for forward movement of initiatives and collaborations in place within the state.

References

Public Health Functions Steering Committee, Members (1994). The ten essential public health services. Retrieved August 18, 2009, from http://www.cdc.gov/od/ocphp/nphpsp/essentialphservices.htm

U.S. Department of Health and Human Services. (2010).*Healthy People 2020.Retrieved from www.healthypeople.gov*.

VI. Summary

Previous Sections of this plan have described many barriers and challenges to delivering health care services in rural Indiana. For example, in some areas there is not a sufficient supply of health professionals to care for complex and chronic populations. Also, most areas have lost revenue because of challenging economic times. Finally, most areas have not developed a well-coordinated and integrated health care delivery system offering medical homes and team approaches to service delivery.

A rural integrated health system is based on the following assumptions:

1. An integrated system requires accurate data, planning, communication systems, and methods applicable to the needs of specific geography and populations.
2. Multiple and diverse approaches are necessary because of the differences in the needs of the population, the economic characteristics of the area, and the local culture.
3. Integrated systems should foster cooperation, collaboration, and integration of services and activities, including innovative technology such as telecommunication.
4. Although the planning of an integrated system should begin at the community level, the collaborative network must be expanded to include other hospitals, physician and dental clinics, pharmacies, EMS units, nursing homes, behavioral health services, and public health services in a region. It must also extend to regional and urban centers because rural patients need the specialized services offered in larger communities.
5. All integrated systems should develop performance measures based on the six quality aims (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity) that were developed by the Institute of Medicine (2005) to evaluate the overall performance of each health care delivery system.
6. An integrated system should focus on both population health and personal health.

Providers in rural Indiana communities often practice independently of one another. This lack of coordination is frequently the result of previous practice models and of poor communication. It is magnified by the shortage of health professionals and frequent referrals or transfers to providers in larger communities. As a result, many patients and families must navigate unassisted across different providers and care settings. The lack of communication and clear accountability for a patient among multiple providers may lead to medical errors, waste, and duplication of care (Shih, Davis, Schoenbaum, Gauthier, Nuzum, & McCarthy, 2008).

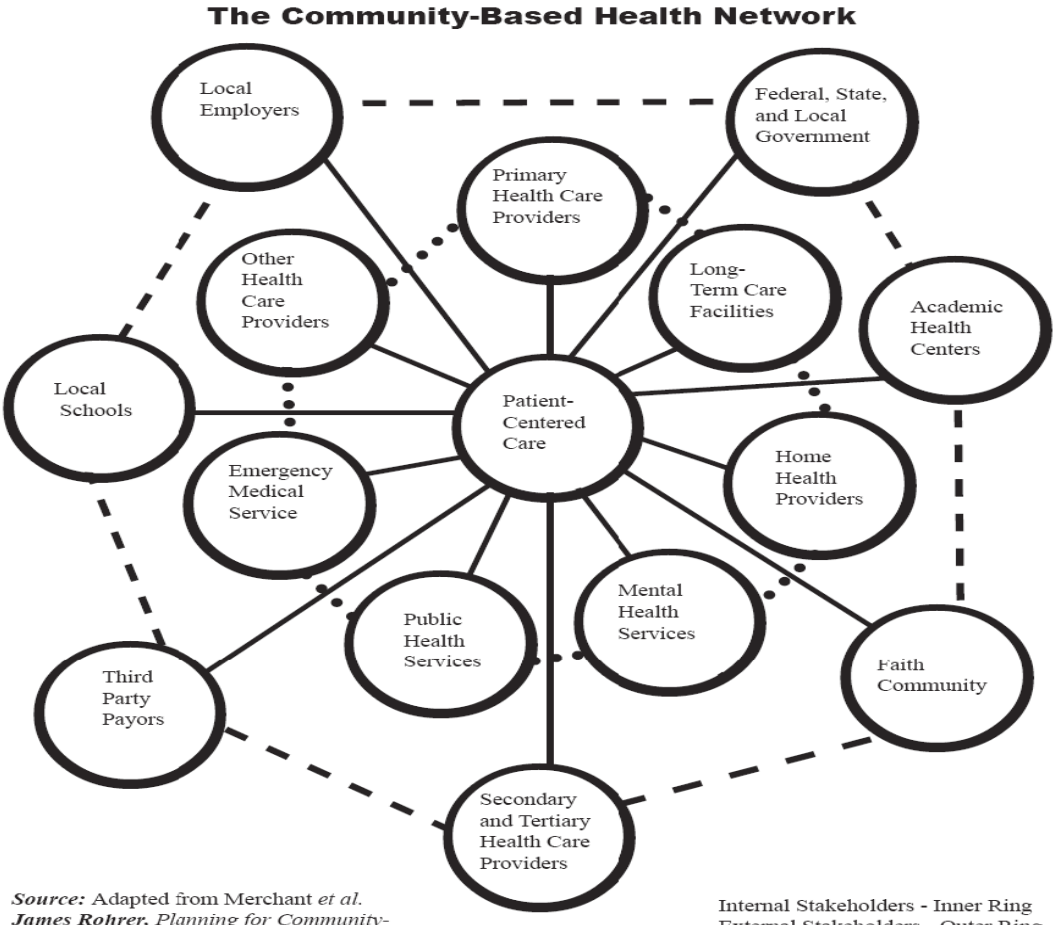
According to the Commonwealth Fund Commission on a High Performance Health System (2008), there are six attributes of an ideal health care delivery system. These attributes are:

1. Patients' clinically relevant information is available to all providers at the point of care and to patients through electronic health records.
2. Patient care is coordinated among multiple providers, and transitions across care settings are actively managed.
3. Providers (including nurses and other members of care teams) both within and across settings have accountability to each other, review each other's work, and collaborate to reliably deliver high-quality, high-value care.

4. Patients have easy access to appropriate care and information, including after hours; there are multiple points of entry to the system; and providers are culturally competent and responsive to patients' needs.
5. There is clear accountability for the total care of patients.
6. The system is continuously innovating and learning in order to improve the quality, value, and patients' experiences of health care delivery.

A system with these attributes is likely to be more achievable in rural areas for many reasons. Rural health care systems are smaller and can be coordinated more quickly. Rural providers are generally more knowledgeable about and more familiar with their patients. Some emerging systems of care have the potential to achieve this ideal because of excellent leaders, existing associations, and cooperative alliances capable of guiding the development of these new delivery systems within the state of Indiana.

Figure 54. The Community-Based Health Network.



Source: Adapted from Merchant *et al.* ***James Rohrer,*** *Planning for Community-Oriented Health Systems* (Washington, D.C.: American Public Health Association, 1996).

It is clear that community health and health care are influenced by multiple institutions and influences upon a given community. Indiana's rural populations are at the center of multiple forces that can work in concert to improve and sustain health. Indiana is fortunate to have established partnerships on a statewide level that are keenly focused upon issues of workforce development, quality service delivery, patient safety, emerging telehealth connectivity, data gathering and analysis, training, and collaboration.

Movement toward an integrated system of care is especially challenging in rural areas as many essential services *(*e.g., hospital and physician services, behavioral health, dental care, and EMS services) are not available in many small communities. In addition, the needs of each community are unique. The challenge to planning is to provide sufficient latitude for individual communities to find relevant and effective solutions to address the special populations and unique demographics present within their service areas. As a result, it is critical to develop linkages with providers in other communities and to use the technology as effectively as possible. The State Office of Rural Health maintains interest and support for emerging technologies and models of cooperation that bring high quality coordinated and culturally sensitive care to Indiana's rural populations while supporting viable revenue streams for providers.

References

Institute of Medicine (2005). *Quality Through Collaboration: The Future of Rural Health.* Washington, DC: The National Academies Press.

Shih, A., Davis, K., Schoenbaum, S., Gauthier, A., Nuzum, R., & McCarthy, D. (August 2008). *Organizing the U.S. Health Care Deliver System for High Performance.* New York, NY: The Commonwealth Fund.

The Medicare Rural Hospital Flexibility Steering Committee (2008).*Nebraska Rural Health Plan.*

Appendix A – Survey Forms

1. Critical Access Hospital Survey 2011
2. Statewide Associations Focus Group Survey

Appendix A

Indiana State Department of Health Survey of Critical Access Hospitals (2011)

The Critical Access Survey is divided into five sections that can be forwarded as distinct survey links. In this way, each hospital CEO may forward a link for a given section to a key informant most able to respond accurately to that section. The CEO is primarily responsible for assuring that all sections are completed in a timely manner.

Section 1 – Administrative

1A. Name of Organization:

2A. Rank your organization's greatest concerns as you look forward to the next two years Please number each box in order of preference from 1 to 15.

Health Care Reform Impacts
Reimbursement
Recruiting/Retaining Physicians
Expansion of Services
Rules and Regulations
Financial Performance
Recruiting/Retaining Nurses
Strategic Planning
Succession Planning
Information technology
Electronic Medical Records
Telemedicine
Patient Safety
Health Outcomes
Other

3A. If you selected "Other" in the previous question, please list it here.

4A. What vulnerable populations require special considerations regarding care in your facility? Please identify.

5A. How does meeting the needs of the population listed above affect your services? Please explain.

6A. Do you currently submit data to Hospital Compare through the U.S. Department of Health and Human Services?

- Yes
- No

7A. If yes to the above question, how many data sets do you submit?

8A. Do you share statistics with other outside entities?
- Yes
- No

9A. If yes to the above question, list those entities.
- Entity One
- Entity Two
- Entity Three
- Entity Four
- Entity Five

10A. How is data transmitted to the outside entities?
- Entity One
- Entity Two
- Entity Three
- Entity Four
- Entity Five

11A. Check all benchmarking systems to which your organization provides data
Please choose all that apply:
- IRHA/RPM/Performance Management Institute benchmarking tool
- Indiana Hospital Association
- Healthcare Excel KART Tool
- Other:

12A. What are the three primary unmet community healthcare needs of citizens in your community?

13A. How can the FLEX Program assist in addressing these needs? List one strategy for each concern cited above.

14A. In what ways do you interact with the local health department? Choose all that apply.
- County Preparedness Activities
- Shared Immunization Clinics
- Shared Labs/Lab Services
- Shared Staff

15A. What, if any, Health Information Technology devices do you currently use? Choose all that apply.
- Electronic Health Records
- Telehealth assessment/triage
- Telemedicine consultation

- Web conferencing
- Webinar trainings
- Other:

16A. What are the barriers to your telehealth/telemedicine goals? Choose all that apply.

- None
- Financial Constraints
- FCC Match
- Connectivity
- Bandwidth
- Staff training/support
- Board Support
- IT Support
- Billable Rates
- Staff time for implementation
- Lack of physician support

17A.Please provide additional comments here.

Section 2 – Financial

1F. Name of Organization:

2F. What is your payor mix (by percentage, total should equal 100%)?

- Medicaid
- Medicare
- Commercial
- Uninsured/Self
- Charity

3F. Has local funding been cut to your facility?

- Yes
- No

4F. If local funding has been cut, estimate the extent from each source.
Please choose all that apply and provide a comment:

- State Dollars:
- County Dollars:
- Other:

5F. Has your organization taken on new services due to local government spending reductions?

- Yes
- No

6F. If yes to the previous question, which services has your organization added or expanded?

7F. Has your organization discontinued any services due to changes in funding?
● Yes
● No

8F. If yes to the above question, which services were eliminated?

9F. Have plant closings, downsizings, and/or business failures in your communities impacted your hospital's payor mix since July 2009?
● Yes
● No

10F. If yes to the previous question, list each company and estimated job losses since July 2009.
Please choose all that apply and provide a comment:
● Company One (jobs lost)
● Company Two (jobs lost)
● Company Three (jobs lost)
● Company Four (jobs lost)
● Company Five (jobs lost)

11F. Please provide additional comments here.

Section 3 – Human Resources

1H. Name of Organization:

2H. What is your overall personnel turnover rate expressed as FTEs?

3H. Has your organization conducted a recent RIF due to economic trends since July 2009?
● Yes
● No

4H. If yes to the above question, how many FTEs were released?

5H. On average, how many full-time positions are open in a given week?

6H. On average, how many part-time positions are open in a given week?

7H. What essential positions are hardest to recruit?
Please choose all that apply:

- Nurses

- Primary Care Physicians
- Advanced Practice Nurses
- Specialty care MDs
- Pharmacists
- Psychiatric Nurses

8H. If Specialty MDs was checked above, please specify.

9H. What types of training resources are most often used by staff at your facility? Check all that apply.
Please choose all that apply:
- Webinars
- Teleconferences
- Training workshops (internal)
- Training workshops (external)
- Self-paced online courses
- Assigned reading/manuals
- Staff meetings
- Other:

10H. From which of the following training topics would your organization most benefit?
Please choose all that apply:
- Claims processing
- Payment Policy
- NPI-National Provider Identification
- Enrollment in payer programs
- Management in Changing Times
- Accreditation Support
- Integration of Medical and Behavioral Health Services
- Health Care Reform
- Cultural Competency
- Health Literacy
- Telemedicine
- Other:

11H. Do you currently have contracts with third party organizations for staff training?

If the answer is yes to Question 10, please complete Questions 12, 13, 14, and 15. If no, you may skip to Question 16.

12H. Please identify the third party organization(s).

13H. Are these trainings:
All Mandatory ___yes ___no
All Voluntary ___yes ___no

Mixture of Mandatory and Voluntary ___yes ___no

14H. Are these trainings:
Traditional Face-to-Face ___yes ___no
Web-based (webinars or teleconference) ___yes ___no
Online courses ___yes ___no

15H. Please provide an estimate of total training budget for your facility.

16H. Please provide additional comments here.

Appendix A

Rural Roundtable Survey for Indiana Office of Rural Health State Plan

Organization:
_____Date:_____

1. From your perspective, what are the major barriers facing rural health care **"consumers"** in Indiana and what solutions would you recommend to address these issues?

2. From your perspective, what are the major barriers facing rural health care "**providers"** in Indiana and what solutions would you recommend to address these issues?

3. How does your organization currently identify unmet community health care needs?

4. How does your organization currently address the needs of vulnerable populations?

5. How does your organization currently support Indiana's Critical Access Hospitals?

6. Does your organization support the Rural Healthy Priorities identified in Rural Healthy People 2010 listed below? Check all that are a focus and briefly list the activities you conduct that support each priority.

_____Access to Quality Healthcare
Activity:_____
_____Heart Disease and Stroke
Activity:_____
_____Diabetes
Activity:_____
_____Mental Health & Mental Disorders
Activity:_____
_____Oral Health
Activity:_____
_____Tobacco Use
Activity:_____
_____Substance Abuse
Activity:_____
_____Educational & Community Based Programs
Activity:_____
_____Maternal, Infant & Child Health
Activity:_____
_____Nutrition & Overweight
Activity:_____
_____Cancer
Activity:_____
_____Public Health Infrastructure
Activity:_____
_____Immunization & Infectious Disease

Activity:_____
_____Injury & Violence Prevention
Activity:_____
_____Family Planning
Activity:_____
_____Environmental Health
Activity:_____

Please return to Martha Levey (mlevey@aspin.org). Thank you for your input.

Appendix B – Work Plans

1. Goals Alignment Framework
2. Indiana State Office of Rural Health Work Plan

Appendix B – Goals Alignment Framework

Goals Alignment Framework

Rural Health Plan Themes

1. Support collaborative solutions to issues of rural health services quality and access **2.** Provide equitable and accountable funding strategies for appropriate projects, resulting in improved care and/or provider accountability for rural citizens **3.** Utilize existing expertise already working on rural health issues to greatest degree possible **4.** Aid in accountability of clinical practice and financial acumen of rural providers **5.** Act as conduit of accurate information to and from Critical Access Hospitals, rural providers, training experts, and state policy makers

Healthy People 2020 Goals

Attain high quality, longer lives free of preventable disease, disability, injury, and premature death

Achieve health equity, eliminate disparities, and improve the health of all groups

Create social and physical environments that promote good health for all.

Promote quality of life, healthy development, and healthy behaviors across all life stages

1. Provide CAH Support for Quality Improvement (QI)

2. Provide CAH Support for Operational and Financial Improvement

3. Provide CAH Support for Health System Development and Community Engagement

Flex Goals

4. Facilitate Conversion of Small Rural Hospitals to CAH status

Flex Projects

7. Conversion of Small Rural Hospitals to CAH Status

1. CAH Readmissions Quality Project

2. Benchmarking/ State Portal Project

3. MBQIP Project

4. Telehealth Network Project

5. CAH Educational Programs Project

6. Videoconferencing

2011 - 2012 Budget Period Plan and Performance Measures

Core Function (1): Collection and Dissemination of Information

Objective:
1. Collect and disseminate information concerning rural health.
2. Provide up to date education, alerts and communication through several mediums
3. Provide a forum through which partners will focus on rural issues and participation as appropriate for individual missions, including healthcare delivery, education, workforce development and public health support.

Product/Service/Activity:
1. Update and distribute the Rural Health Plan through ASPIN ($30,000.)
2. Sponsor the IRHA conference ($30,000);
3. SORH staff will attend regularly scheduled partner meetings and will continue to convene the Rural Health Round Table that more directly focuses partners on rural issues.

Projected Progress:
1. The plan will be distributed electronically to the public and partners
2. IRHA will host a conference for its 1600+ members.
   IRHA's Annual Conference brings together physicians, nurses, pharmacists, public health professionals, and other rural health practitioners and advocates with residents of rural communities. Practitioners from the field and national experts discuss current topics, as well as share the experiences of others in public health and rural health care delivery, along with the latest information regarding the start-up and on-going management of rural health care delivery models.
3. Meeting attendance will present funding opportunities, research, and policy updates

Process Measures:
1. The plan will provide updated rural health pertinent statistics, analyses, and intervention strategies that will be distributed to partners and the public electronically and via its website and those of partners. The State has restricted marketing and communication expenditures and requires they be the exception when disseminating information.
2. Develop a multi-partner collaboration with a rural focus including internal partners the Chronic Disease Division, Immunization Division, the Cancer Registry, and the Division of Physical Activity and Nutrition.
3. 465 individuals attended the 2010 IRHA Annual Conference; therefore, the turnout for the 2011 event is expected to be strong as well. It will be conducted over 2 days in June and will include 2 keynote speakers, five concurrent session tracks, networking opportunities, poster presentations, and exhibits and displays by leading health care providers and vendors. Tracks for the 2011 conference will be similar to last year's, i.e. quality improvement, health information technology, clinical education, leadership initiatives, and emergency/disaster preparedness.

Projected Qualitative Impacts:

1. Indiana's rural health profile and strategies for improvement will educate rural residents and elevate rural issues in the state.
2. Common projects with will convey consistent messages through websites, webinars, and gatherings and deploy resources in areas of greatest need. Multiple affiliations will keep rural health on the agenda of important components of health care delivery and economic development.
3. IRHA Annual Conference attendees will make new connections, acquire new information that will be useful to their health care endeavors.

Core Function (2): Coordination of Rural Health Resources & Activities Statewide-

Objective:

1. Use webinars (ISDH and IRHA capabilities) for educational activities.
2. Assess CAH/RHC needs and distribute funds accordingly.
3. SORH attendance at meetings, participation in research informing resource distribution.
4. Increase rural resident access to health care.

Product/Service/Activity:

1. Webinar topics of interest to CAHs and RHCs will be aired.
2. ASPIN will investigate and document CAH needs through a survey and by supporting the FLEX Advisory Committee meetings.
3. SORH will analyze the impact of new rules for shortage area designations, examine the effect of J-1 Visa Waiver determinations on rural providers, and increase rural participation in the state loan repayment program.
4. Fund Hoosier Uplands 3 rural health clinics and the Lugar Center for Rural Health with state matching funds ($889,500.)

Projected Progress:

1. Create and air a webinar of interest
2. Include survey/meeting results in the Rural Health Plan Update that will inform future funding distribution.
3. Use state resources for activities in # 3 above. The designation analysis will be based on when/if a new rule is issued. Partners will be used to advise the J-1 process and to market the state loan repayment program.
4. The rural community health centers and rural health clinics will provide health care to residents on a sliding fee scale.

Process Measures:

1. A webinar experience will be evaluated for effectiveness.
2. Resources will be deployed according to documented need.
3. State resources will be distributed in concert with rural needs.
4. CHCs and RHCs have become increasingly critical in rural areas as population seeking care has increased.

Projected Qualitative Impacts:
1. Webinars will become a new, efficient way to bring rural partners together.
2. Rural health providers will become more informed, be assisted in quality improvement projects and improve their overall health care delivery.
3. Access to health care in rural areas will be improved.
4. The health status of rural residents will improve.

Core Function (3): Provision of Technical Assistance-

Objective:
1. Use resources to assist rural providers become certified for meaningful use of EHRs.
2. Assist rural providers and residents with questions about underserved/health professional shortage area designations and programs for which they are prerequisite.
3. Discover and prioritize areas for technical assistance

Product/Service/Activity:
1. The SORH will contract ($30,000) with the Regional Extension Service, I-HITEC to provide on-site workshops for CAHs in preparation for meaningful use of electronic health records.
2. The Office of Primary Care will provide information and assistance.
3. The SORH Manager, ($55,000) will visit CAHs and RHCs and help prepare databases and analyses needed to distribute and track funding, subcontractor performance and research informing rural issues.

Projected Progress:
1. At least 10 hospitals will be assisted on site. Video-tape sessions for webinars. Hospital staff will be able to see his/her function in context and relative to what is being required by the EHR use standard.
2. Approximately half of the designations will be rural.
3. The SORH Manager will organize and track assistance and outcomes for all subcontractors and beneficiaries, CAHs and RHCs.

Process Measures:
1. The workshops feature analysis of the current state of EHR use within the participating hospital and education on each of the 24 objectives that hospitals must meet in Stage One.
2. Rural designations will increase.
3. The SORH will deliver resources based on informed need and best practice.

Projected Qualitative Impacts:
1. 10 additional hospitals will be better prepared to institute EHRs.
2. Indiana will be able to attract additional providers to practice in rural, underserved areas.
3. Rural serving organizations will be better prepared to improve the health of residents.

Additional Function (4): Encourage Recruitment and Retention of Health Professionals in Rural Areas-

Objective:
1. Increase and retain our "home grown" health care professionals who may serve in a variety of rural care settings.
2. Increase rural recruitment and retention activities in Indiana

Product/Service/Activity:
1. Fund AHEC's annual conference ($19, 825.)
2. ARRA and PCO projects benefitting rural health due to collaboration with AHEC and, primary care office; IPHCA: recruitment and retention site determination for National Health Service Corps.

Projected Progress:
1. The Meeting brings together Indiana AHEC Program Statewide Staff and Advisory Board Members; health professions workforce development stakeholders including K-12 schools, higher education, hospitals and community-based healthcare providers, public health officials, government agencies, minority health partners; and high school students from underserved communities from Indiana who are interested in a career in healthcare (expected attendance 175).
2. Additional funding available for recruitment and retention of health professionals dedicated to rural areas.

Process Measures:
1. Students and professionals will share learnings and unique rural medical practice experiences and receive information pertinent to attaining and maintaining health care delivery in rural settings.
2. Increase rural providers in health professional shortage areas through the J-1 Visa Waiver Program, State Loan Repayment Program, and National Health Services Corps recruitment of health professionals.

Projected Qualitative Impacts:
1. Students and medical residents will see the benefits of a rural practice.
2. Rural Indiana will receive quality care by qualified health professionals.

Additional Function (5): Participate in Strengthening State, Local and Federal Partnerships-

Objective:
1. Participate in education and planning efforts with IRHA and the Indiana Primary Health Care Association
1. Strengthen knowledge of other state programs through federally offered means.

Product/Service/Activity:

1. Meet monthly: Rural Health Roundtable: Includes IRHA, Indiana Public Health Association, Indiana University, Indiana Hospital Association, Health Care Excel, Indiana Primary Health Care Association, and ASPIN.
2. Host the Region C State Offices of Rural Health Meeting.

Projected Progress:
1. Rural Health Roundtable members meet to share data and discuss common projects.
2. The meeting will be held in August and will have a peer to peer presentation format

Process Measures:
1. Members of the Round Table will collaborate on one or more projects.
2. The Region C meeting will have all 10 states participate—both attending and presenting.

Projected Qualitative Impacts:
1. Projects will be designed and implemented to benefit rural residents.
2. States will increase their knowledge of other state's approaches to rural programming and understand how to employ them to their advantage in their home settings.