

*Arkansas Department of Health  
Office of Rural Health and Primary Care  
State Rural Health Plan, 2015-2020*



Arkansas Department of Health

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# Acknowledgements

The *Arkansas State Rural Health Plan, 2015-2020* was created by the Arkansas Department of Health's Office of Rural Health and Primary Care as well as partners from the Arkansas Department of Health (Emergency Medical Services, Trauma and Preparedness & Response Sections), Arkansas Highway and Transportation Department, Arkansas Hospital Association, Community Health Centers of Arkansas, Office of Health Information and Technology, University of Arkansas for Medical Sciences (College of Health Professions, College of Medicine, Center for Dental Education and Regional Programs). This collaboration includes input from partners across Arkansas representing health systems and providers, rural health clinics, EMS and trauma, health information exchange, state agencies, and academic institutions.

Appreciation is extended to the numerous individuals and organizations who have worked tirelessly in developing a collaborative workplan that will have an impact on eliminating health disparities in rural Arkansas. If you or your organization would like to join efforts in implementing our state's plan, we invite you to participate.

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# Background

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## Introduction

The Medicare Rural Hospital Flexibility Grant Program, hereafter known as FLEX, was authorized by Section 4201 of the Balanced Budget Act (BBA) of 1997, (Public Law 105-33) and was reauthorized by Section 405 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, (Public Law 108-173).



The FLEX Grant Program helps sustain the rural health care infrastructure and fosters a growth of collaborative rural delivery systems across the continuum of care at the community level to maintain access to high quality care for rural Medicare beneficiaries. This is accomplished through the designation and support of small rural hospitals referred to as Critical Access Hospitals (CAHs), the creation of rural health networks and strengthened community development, integration of emergency medical services (EMS) into the health care system, and improvement in the quality of care provided to those served by this program.

In 1998, the Arkansas Department of Health (ADH) Office of Rural Health and Primary Care (ORHPC) convened rural health care stakeholders from across the state to create rural health networks, promote regionalization of rural health services in the state, and improve access to hospitals and other services for rural residents. The result was a rural health plan establishing a statewide FLEX Grant Program. In order to continue development of a system of rural health care, the FLEX Grant Program requires states to update and revise their plan on a continual basis. Arkansas's Rural Health Plan in 2008 was published as a revision to the initial plan written in 1998.

Workplan goals and objectives for the Arkansas FLEX Grant Program are developed based on an assessment of needs for the state's CAHs, need for improved quality health care services in rural communities and the availability of partners with the ability to assist with addressing identified needs. Population groups to be served include residents in rural communities identified with the greatest need, including those who are uninsured or underinsured.

Arkansas's FLEX Grant Program works with key partners including the Arkansas Hospital Association, Quality Improvement Organizations, Health Information Exchanges, Rural Health Network groups, Rural Health Associations and others to increase the quality of healthcare services to all Arkansans. The establishment and preservation of these partnerships enables the ORHPC FLEX Grant Program to

accomplish the activities specified in its work plan to target underserved rural populations and address the barriers to service in the state of Arkansas.

## **Purpose**

In accordance with Arkansas's FLEX grant work plan to maintain an updated rural health plan, the *Arkansas State Rural Health Plan, 2015-2020*, provides a roadmap for improving health care in the rural and medically underserved areas of our state. Released by the ORHPC, this State Plan with accompanying Workplan reflects efforts being conducted by federal, state and local partners. This collaboration includes input from partners across Arkansas, representing health systems and providers, rural health clinics, EMS and trauma, health information exchange, state agencies, and academic institutions.

The Workplan included in the *Arkansas State Rural Health Plan, 2015-2020* contains a set of goals, objectives and strategies with five year targets designed to allow our partners to collaboratively improve the health of rural Arkansans. This Workplan consists of goals, objectives and strategies used to measure progress in four priority areas:

- 1) Access and Quality of Care to Health Care Services
- 2) Trauma System and Emergency Medical Services (EMS)
- 3) Networks
- 4) Facilities and Workforce.



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# State Profile

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While Arkansas is a rural state, it is important to note there are many definitions of rural. Each definition emphasizes different criteria such as commuting patterns, population size and population density. For the purposes of this plan, we used the 1999 U.S. Census Bureau definition of rural. In this definition, rural is defined as those counties in Arkansas that are identified as non-metropolitan statistical areas (MSA) and have a population of less than 50,000.<sup>1</sup>

## Geography

- Arkansas is the 32nd largest state with an area of more than 53,000 square miles and a population of more than 2.9 million people.<sup>2</sup>
- Since the 2010 Census, current population estimates (2013) show that the rural population is declining and the urban population is increasing.<sup>3</sup>
- Sixty-two of the state's 75 counties meet the U.S. Census Bureau's definition of rural.<sup>2</sup>
- As of 2010, forty-four percent of the population lives in non-metropolitan or rural counties compared to the nation (19 percent). Arkansas has a greater percentage of rural people than the nation throughout the last century.<sup>3</sup>

## Demographic

- The median age in the U.S. is 37.5 years, while the state's median age is 39.8 years. Rural areas in Arkansas have a median age of 41.5 years.<sup>3</sup>
- Of the state's population:
  - 79.9 percent is Caucasian
  - 15.6 percent is Black/African-American
  - 6.9 percent is of Hispanic/Latino origin (2013).<sup>4</sup>
- From 2000-2010, Arkansas's Hispanic population more than doubled, increasing from 87,000 to over 186,000.<sup>2</sup>
- Nine Arkansas counties had more than 10 percent of their population identifying as Hispanic.
  - Three of the ten were counties located in urban areas (Benton, Sebastian and Washington counties).
  - Of the six rural counties, all but one county (Bradley) was in the western half of the state.<sup>3</sup>

## **Education**

- Arkansans are less likely to have high school diplomas as well as two-year and four-year college degrees.<sup>3</sup>
- Arkansas ranks 44th nationally in the percentage of adults age 25 and older with high school diplomas and 49th in the percentage of people with college degrees (2010).<sup>3</sup>
- Nationwide, nearly 31 percent of adults had a college degree compared to only 14 percent of rural Arkansans and 25 percent of urban Arkansans (2010).<sup>3</sup>

## **Health Literacy**

- Arkansas has approximately 820,000 adults with low health literacy. This is 37 percent of the adult population.<sup>5</sup>
- Arkansas has a high proportion of people in groups that are more likely to have low literacy. Groups with low health literacy include people who are age 65 and over, blacks and other minorities, people who live in rural areas, people who have no health insurance and those who covered by Medicare/Medicaid, people with less than a high school education, and people who live in poverty.<sup>5</sup>
- Nationwide, experts estimate that only 12 percent of adults in the U.S. have proficient health literacy, while 53 percent have Intermediate health literacy.<sup>5</sup>

## **Income & Employment**

- Rural Arkansans report higher rates of poverty than those living in urban areas.<sup>3</sup>
- Arkansas's overall poverty rate is estimated at 19.6 percent compared to 16 percent for the nation. Arkansas ranks among the ten states with the highest poverty rates (2012).<sup>3</sup>
- Rural areas of Arkansas have even higher rates of poverty.
  - Lowest poverty rate is 9.7 percent in Saline County.
  - Highest poverty rate is 39.0 percent in Phillips County.
  - In Arkansas's Delta, one in four persons live in poverty (2012).<sup>3</sup>
- Close to one-third of Arkansas children under the age of 18 live in poverty.<sup>5</sup>
- Although the earnings per job increased at a faster rate in rural areas of Arkansas, there remains a persistent gap between rural earning increases per job (2.1 percent) and urban earning increases per job (0.7 percent) from 2007-2012.<sup>3</sup>

- Employment in Arkansas has not reached pre-recession employment levels.
  - Declined by 2.6 percent between 2007-2010 (U.S. 3.8 percent).
  - Increased by 2.1 percent between 2010-2012 (U.S. 3.8 percent).<sup>3</sup>



- Although average earnings per job have increased between 2007 and 2012, there are fewer jobs in rural areas of the state, and many rural households have low and declining household incomes.<sup>3</sup>

## Health Status

- Arkansas ranks 48th in overall health, only Mississippi and Louisiana rank lower.<sup>5</sup>
- An average of 64.5 primary care physicians per 100,000 people practice in rural Arkansas compared to 139 physicians per 100,000 people in urban areas.<sup>3</sup>
- As of 2012, there are four rural counties (Lincoln, Izard and Poinsett) which had less than 20 primary care physicians (per 100,000 people), including Cleveland County which did not have any primary care physicians.<sup>3</sup>
- In 2012 every county in Arkansas had over 50 percent of their adult population classified as either overweight or obese.<sup>3</sup>
- Elderly people 75 years and over made up 7.7 percent of the rural population and 5.6 percent of the state's total population, presenting unique challenges for rural areas where health services are already strained in some counties.<sup>3</sup>

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# Planning Process

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## Steps

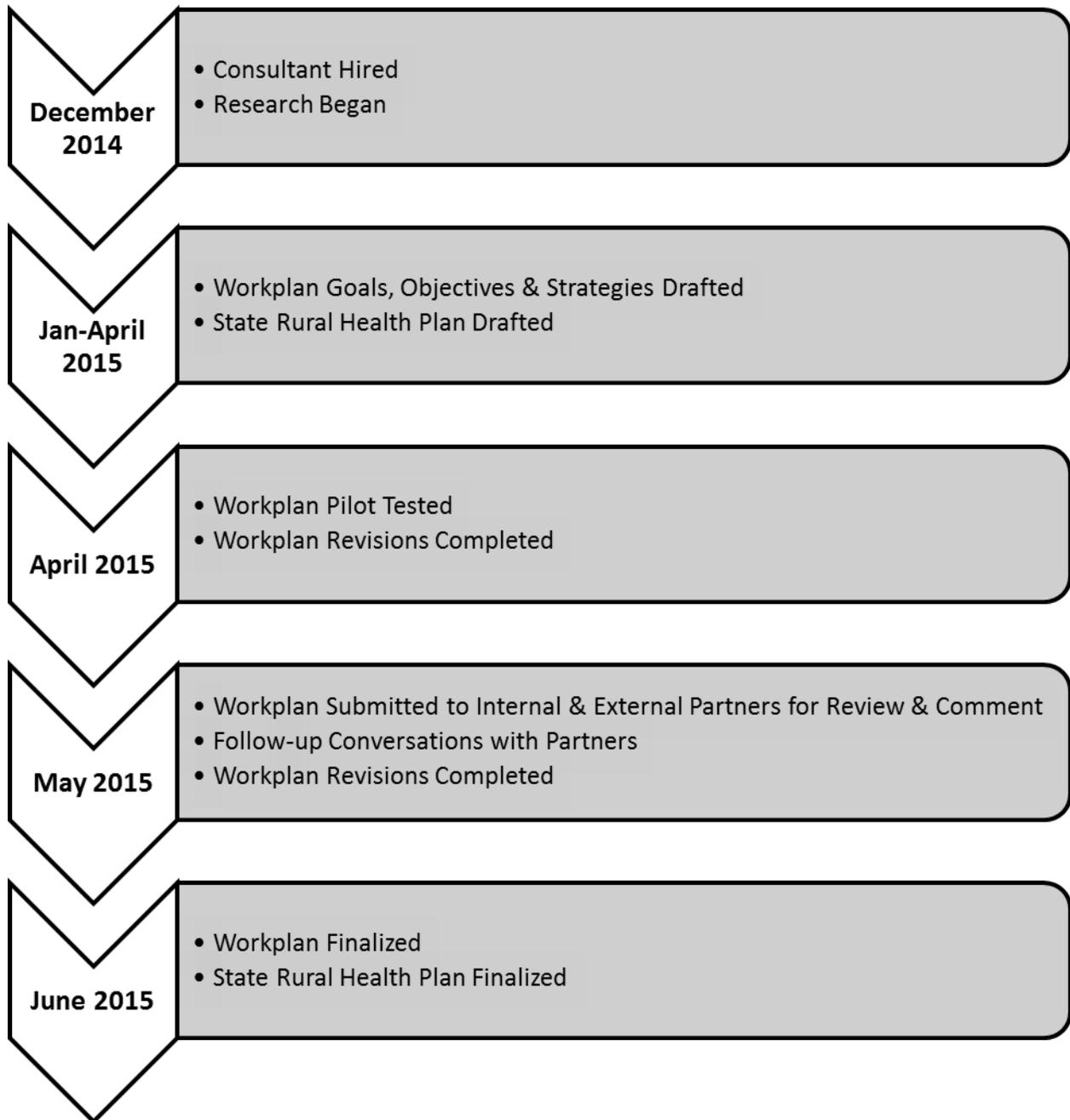
In December 2014, the ADH-ORHPC contracted with a public health consultant to assist in the research and development of documents related to the five-year state rural health plan, as well as provide guidance on collaborating with ORHPC internal and external partners. To determine priority areas for the Workplan, background research was conducted and rural health best practice plans from other states were reviewed. Additionally key partners from Arkansas were identified, their plans were reviewed, and conversations began regarding rural health activities occurring in the state.

Based on best practice research, plans from other states, and statewide partner plans, the ADH-ORHPC identified four priority areas and developed goals in each of these areas. After consulting with partners and stakeholders, SMART objectives and strategies were developed and included in the Workplan.

In April 2015, the ADH-ORHPC conducted a pilot test with six (6) external partner organizations using Survey Monkey in order to strengthen the draft workplan prior to soliciting comment from federal, state and local partners. Based on comments and lessons learned from the pilot test, the Workplan was further revised.

In May 2015, the ADH-ORHPC began disseminating the Workplan using Survey Monkey to 26 external and internal partners to collect comments and input from federal, state and local partners. Of the 26 contacts who received the Survey Monkey invitation, 12 people responded (46 percent response rate). The Workplan was circulated among partners to serve as a catalyst for highlighting activities the rural health partners were coordinating (or planning to coordinate) around the state.

Because partner agencies conduct a vast number of activities and programs around the state, partners were encouraged to provide additional input, objectives and/or strategies in the comment sections for the Workplan utilizing Survey Monkey. The input and suggestions submitted by the partners provided an opportunity for the ADH-ORHPC to have additional conversations with partners in an effort to further revise the Workplan. In reviewing partner comments and suggestions from Survey Monkey, it became apparent partners were unaware of activities occurring across the state, thus highlighting a need for follow-up communication between partners as well as opportunities for collaboration. With the publication of *Arkansas State Rural Health Plan, 2015-2020*, the ADH-ORHPC is hopeful partners will collaborate as appropriate with those who have similar goals thereby, enhancing collaboration and communication.



### **Plan Overview**

The Workplan for the *Arkansas State Rural Health Plan, 2015-2020* has four priority areas, each with an accompanying goal. Additionally, these goals each have objectives with measureable targets, baselines and strategies. In some instances, measureable targets and baselines for objectives are still to be determined. A few partners currently are conducting needs assessments and/or will be adjourning meetings in the near future. SMART objectives identified as “to be determined” may be further revised once additional information is provided by partners.

<b>Arkansas State Rural Health Plan, 2015-2020</b>	
<b>Priority Area</b>	<b>Goal</b>
Access & Quality of Care to Health Care Services	Enhance access to quality health care services by addressing unmet needs and barriers to services for rural Arkansas residents.
Trauma System & Emergency Medical Services (EMS)	Enhance the statewide trauma system and emergency medical services.
Networks	Strengthen rural health networks by enhancing technology, funding, collaborative partnerships and public information/education.
Facilities & Workforce	Support of existing rural hospitals.

### **Priority Area Rationale & Barriers**

#### **Access & Quality of Care to Health Care Services**

The goal in the first priority area is to enhance access to quality health care services by addressing unmet needs and barriers to services for rural Arkansas residents. To eliminate health care disparities and improve the quality of years lived, access to quality health care must be a focus for public health in Arkansas. Because of lack of access to care, those less likely to receive needed services include: women, older members of racial and ethnic minorities, poorer, less educated, or uninsured. The Institute of Medicine (IOM) defines access to health care as “the timely use of personal health services to achieve the best health outcomes”.<sup>6</sup> In order to be accessible, health care needs to be:

1. Available: This includes prompt diagnosis and treatment of illnesses, as well as, early preventive care available to persons living in rural Arkansas.
2. Affordable: This includes coverage for basic health insurance and adjusted out of pocket costs for those with low incomes.
3. Appropriate: This includes primary care professionals and specialists who have overcome cultural and linguistic barriers to provide the best patient care possible.

In January of 2014, Arkansas became the first state to offer the “Private Option” health care coverage under the Affordable Care Act (ACA). The Arkansas Private Option (APO) extends health care coverage to lower income persons with the goal of being able to improve access to health care without expanding Medicaid. Under the current plan, subsidized insurance is provided to persons with an income up to 138 percent of the federal poverty level. Reflecting greater poverty in Arkansas, a higher percentage of adults in rural areas (7.3 percent) were approved eligible in 2014 compared to those in urban areas (5.6 percent). Additionally, for those living in the Delta this rate rose to 8.6 percent (1 in 12 adults). Of the five counties that had rates exceeding 10 percent, all were in the Delta.<sup>3</sup>

For those in rural areas, having the availability to different transportation options often makes the difference in access to health care. For low-income, elderly and disabled individuals, access and availability to transportation is crucial because they often have greater health care needs. When transportation options are available, the rates of hospitalization and nursing home admittance are lower, thus keeping health costs down.<sup>7</sup>

## Trauma System & Emergency Medical Services (EMS)

The goal in the second priority area is to enhance the statewide trauma system and emergency medical services. According to the American College of Emergency Physicians, in 2008 Arkansas had the worst system of emergency care compared to other states. Until 2009, Arkansas was one of three states without a trauma system and the only one without a designated trauma center.<sup>8</sup>

In recent years, the Trauma System Act in Arkansas was passed by the Arkansas legislature. This act provided funding to implement our state’s trauma system. As of June 2015, Arkansas had 70 designated trauma centers throughout the state.<sup>9</sup> The number of trauma centers is expected to grow in the future.

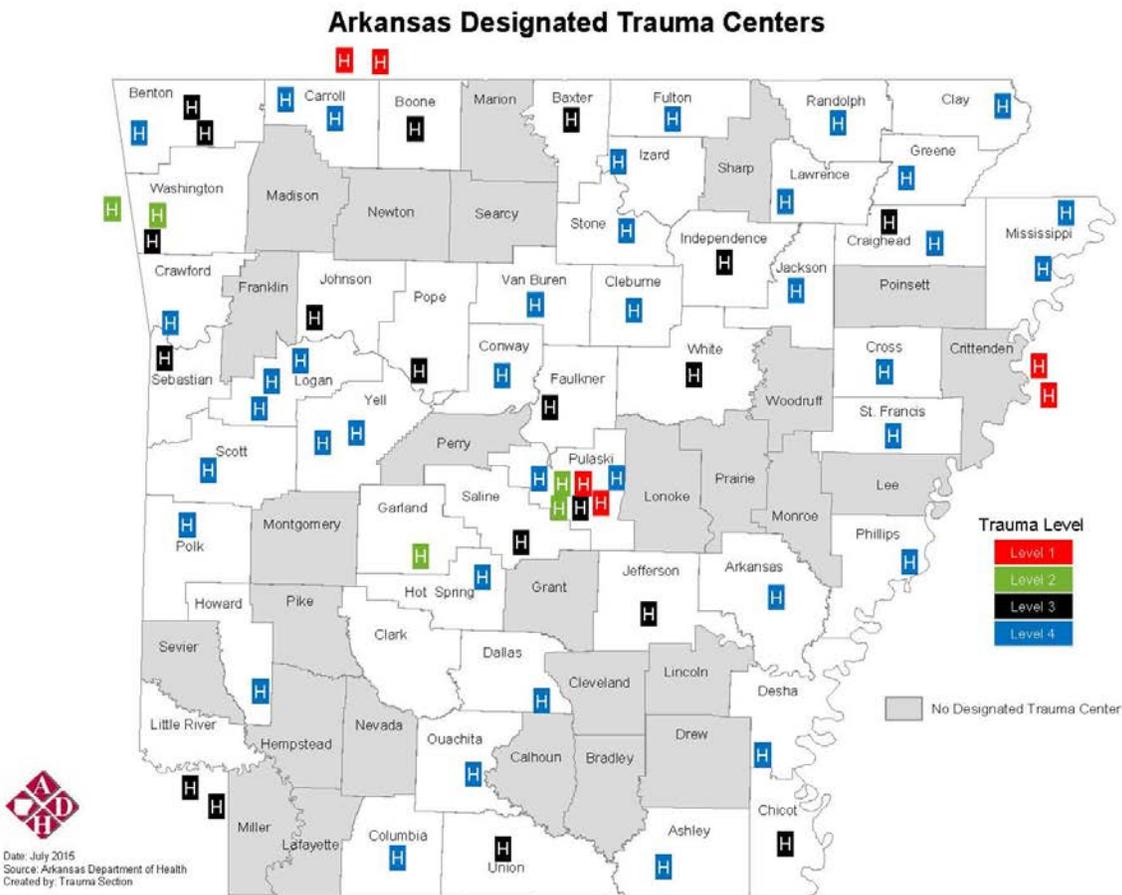
For a hospital to become a trauma center, it must make additional commitments to provide immediate care for those with life threatening injuries. These rigorous commitments are not part of a hospital’s usual requirements for licensure. For a hospital to be designated as a trauma center, it must have physicians, nurses, and support personnel with specific training and experience in the care of injured patients. Additionally, these trauma centers have equipment and systems in place to evaluate and stabilize critical trauma victims.

There are different levels of trauma centers based on capability and capacity. A Level I trauma center is the highest level while a Level IV trauma center is the lowest level. The higher the trauma level, the more severe the injury a hospital can handle. It has been shown that a system with various levels of trauma centers have better outcomes than those systems with only a few higher level trauma centers.

Arkansas's Trauma System includes four levels of trauma centers and is based on these best practice models. As of June 2015, there is a network of 70 trauma centers serving Arkansas:

- ✓ 6 are Level I trauma centers
- ✓ 6 are Level II trauma centers
- ✓ 19 are Level III trauma centers
- ✓ 39 are Level IV trauma centers.<sup>9</sup>

Some of the hospitals in Arkansas's trauma system are actually out of state, because they treat many people from Arkansas. These include hospitals in Memphis, Tennessee; Springfield, Missouri; and Texarkana, Texas.



Source: Arkansas Department of Health, Trauma Section, July 2015.

Emergency Medical Services (EMS) provide out of hospital medical care and transports patients for care, illnesses and injuries. The goal of EMS is to move the patient to the

next point of care, usually to a hospital's emergency department. There are currently 211 EMS services in the state.<sup>10</sup>

Access to EMS is critical for rural citizens but providing services is often challenging. Two of the most common challenges focus on geography as well as workforce. Because EMS units typically serve large sparsely populated areas, the distance they must travel means it takes EMS personnel longer to arrive at the scene of an emergency. This increased length of time impacts patient outcomes and survival rates. Another challenge continues to be the dependence on volunteer ambulance crews. Due to the low call volume in rural areas, it is often cost-prohibitive to operate with paid personnel. Even though the call volume may be low, personnel are still on-call regularly, participate in time-consuming patient transfers and must keep skills and certifications up to date.

## Networks

The goal in the third priority area is to strengthen rural health networks by enhancing technology, funding, collaborative partnerships and public information/education. Health Information Technology (HIT) is the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing and use of health care information, data, and knowledge for communication and decision. Health Information Exchange (HIE) provides the capability to electronically move clinical information between disparate health care information systems to facilitate access to and retrieval of clinical data, thereby helping to provide safer, timely, efficient, effective, equitable patient-centered care.

In 2009, Arkansas began applying for federal funding to develop strategic and operational plans for a statewide health information exchange. Arkansas's Office of Health Information Technology (OHIT) provides leadership for the development and implementation of a statewide health information exchange. OHIT's role is to coordinate the collaboration of health information technology planning, development, implementation, and financing; and plan the development and operation of the health information exchange, known as the State Health Alliance for Records Exchange (SHARE).

SHARE makes it possible for doctors and hospitals to share and retrieve health information using standardized electronic health records. Thus ensuring doctors, hospitals, clinics, insurers and pharmacies have the patient's complete medical information they need at the time and place they need it to provide the best possible treatment. Having access to a patient's complete medical history, lab tests, allergies, medications and other reports allows for a more informed decision about the patient's care plan.

As information technology improves, broadband connectivity has become a required infrastructure component. The lack of access to telecommunications infrastructure in a region such as the Delta, continues to serve as economic, educational and medical

barriers. These problems are particularly exacerbated in already distressed counties. Technology improvements in lower income areas can open doors to improving health care, educational opportunities, economic development and other areas.

The Statewide Interactive Compressed Video Network provides access to real-time, interactive education and training programs and video conferencing through all the University of Arkansas for Medical Sciences (UAMS) Regional Program Centers, plus more than 50 hospitals, community health centers, local health units, clinics, schools and universities. Medical consultations, consumer health education, and health professional training courses are extended to many areas of the state that would not otherwise have access. Many programs are streamed, allowing internet access to the programs. The entire network in Arkansas is based on industry standards, utilizing T1 transmission, with open architecture allowing for interoperability and scalability.

## Facilities & Workforce

The goal in the fourth priority area is support of existing rural hospitals. It isn't enough to focus on improving the health of an individual, infrastructure, network systems, or transportation. We must also focus on recruiting and retaining health professionals in rural Arkansas. Continued funding of programs that increase the number of health care professionals in an area will enable health care services to be provided and those areas more viable to live.

People who live in rural Arkansas find it difficult to obtain health care because there is a shortage of health care facilities in their communities. For example, 46 counties in Arkansas have only one hospital and 21 counties have no hospital.<sup>5</sup>

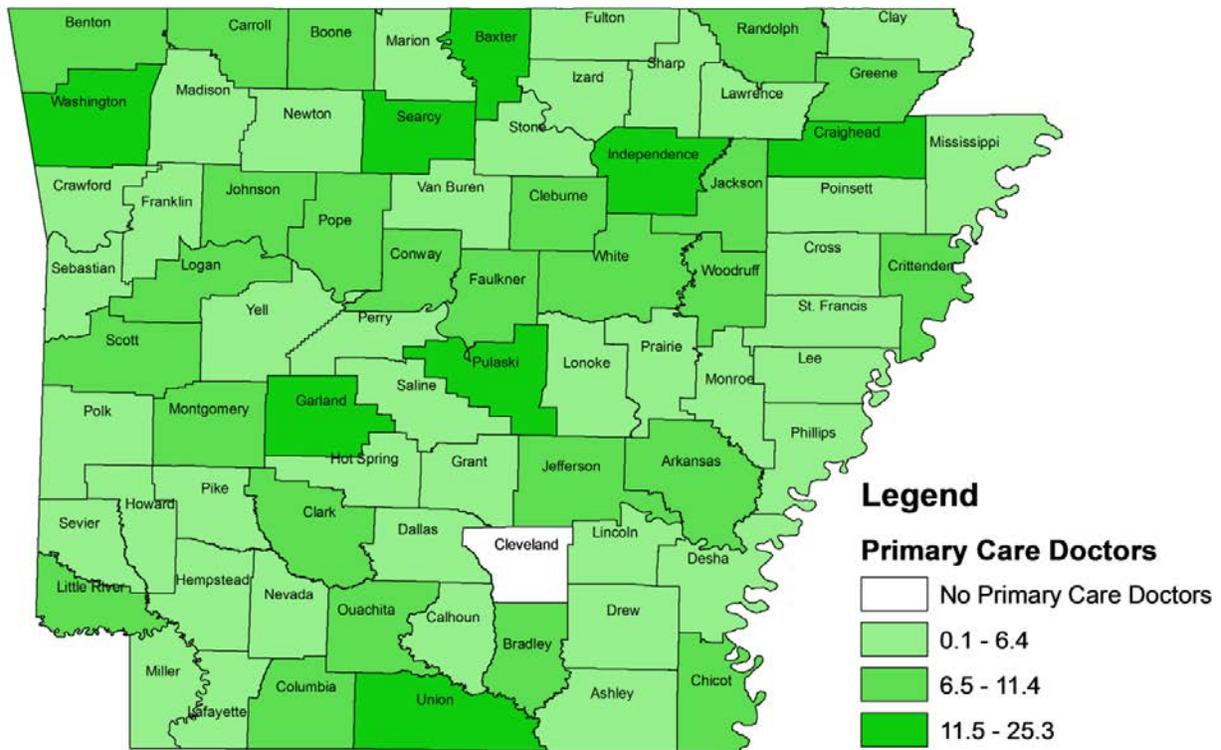
High quality health care service is dependent on the availability of health personnel in sufficient numbers to meet the public's needs. Particularly in rural and low socioeconomic areas, Arkansas is medically underserved. An area can be named as a primary care Health Professional Shortage Areas (HPSA) when there are 3,500 or more residents for every primary care doctor. The higher the HPSA score, the greater the shortage.<sup>5</sup>

According to the Health Resources and Services Administration (HRSA), HPSAs indicate that of Arkansas's 75 counties, 33 are currently designated as whole county primary care HPSAs, which is almost half of all 75 counties. Additionally, there are 53 whole county dental HPSAs and 68 whole county mental health HPSAs.<sup>11</sup>

Many of the rural counties in Arkansas have been named as Medically Underserved Areas (MUAs) by HRSA. Fourteen counties in Arkansas are designated as partial MUAs and only two counties have no MUA designation, Boone and Grant.

On average, Arkansas has 10.7 primary care doctors available per 10,000 people. On a county level, the primary care physician per 10,000 population range from a low of 0.7 per 10,000 population in Izard County to a high of 25.3 per 10,000 people in Pulaski

County. Cleveland County is the only county in the state that does not have a primary care physician.<sup>2</sup>



Source: Arkansas Department of Health, Health Statistics Branch, 2012

While there is a general shortage of primary care doctors in Arkansas, this is especially true in rural parts of the state. Primary care doctors can be doctors who work in general practice medicine, family medicine, internal medicine, pediatrics or obstetrics and gynecology. Overall, there are 867 residents in Arkansas for every one primary care doctor compared to 631 residents for every one primary care doctor in the U.S.

Through the FLEX program, small rural hospitals receive their Critical Access designation from the Centers for Medicare and Medicaid Services. The FLEX program was designed to improve rural health care access and reduce hospital closures. Of the 104 hospitals in Arkansas, 29 are Critical Access Hospitals.<sup>12</sup> Given the large proportion of rural elderly populations living in poverty, the lack of services often means those in need of services do not receive them.

Federally Qualified Health Centers (FQHCs), also referred to as Community Health Centers (CHCs), are local, nonprofit, community-owned health care providers serving low-income and medically underserved communities. Core services provided by Arkansas's 12 Community Health Centers with 102 sites include mental, dental, medical and pharmacy. The costs of care at CHCs rank among the lowest and reduce the need for more expensive in-patient and specialty care services, saving taxpayers millions of dollars.

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was enacted to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the use of non-physician practitioners such as nurse practitioners (NP) and physician assistants (PA) in rural areas.<sup>13</sup> Approximately 4,000 certified Rural Health Clinics (RHCs) nationwide provide access to primary care services in rural areas, including 76 Certified Rural Health Clinics located in Arkansas.<sup>14</sup>

# Workplan

## Workplan Priority Areas, Goals, Objectives & Strategies

Workplan Priority Areas for Arkansas State Rural Health Plan, 2015-2020			
Access & Quality of Care to Health Care Services	Trauma System & Emergency Medical Services (EMS)	Networks	Facilities & Workforce
<ul style="list-style-type: none"> <li>• Best Practices</li> <li>• Funding (Medicare, Medicaid, etc.)</li> <li>• Infrastructure</li> <li>• Policy &amp; Program Improvements</li> <li>• Telemedicine</li> <li>• Private Option</li> <li>• Transportation</li> </ul>	<ul style="list-style-type: none"> <li>• Provider Availability</li> <li>• Continuing Education</li> <li>• Data Management</li> </ul>	<ul style="list-style-type: none"> <li>• Health Information Technology (HIT)</li> <li>• Broadband</li> <li>• Networking &amp; Partnerships</li> <li>• Funding &amp; Mutual Agreements</li> <li>• Public Information/Education</li> </ul>	<ul style="list-style-type: none"> <li>• Community Health Centers (CHC)</li> <li>• Rural Health Clinics (RHC)</li> <li>• Critical Access Hospitals (CAH)</li> <li>• UAMS Regional Programs</li> <li>• Shortages</li> <li>• Recruitment, Retention &amp; Retirement</li> <li>• Continuing Education</li> </ul>

<b>GOAL 1 Enhance access to quality health care services by addressing unmet needs and barriers to services for rural Arkansas residents.</b>	
Objective 1	Increase the availability of health care services and sites (Community Health Center Access Points) in rural areas. (Target to be determined. Baseline: 2015, CHC website, 12 CHCs with 102 sites).
Strategies	Increase the number and expand capacity of Community Health Centers (CHC) to provide services in rural areas. CHC core service areas include: mental, dental, medical and pharmacy.
Objective 2	Continue supporting ongoing transportation efforts in rural communities through the availability of funding opportunities. (Target to be determined. Baseline 2014 Arkansas Highway & Transportation Department Public Transportation Directory, 177 public transportation providers across the state).
Strategies	Increase the number of rural public transit systems.
	Enhance services for rural intercity transit through the rural transit system.
	Improve the coordination of trips and increase the efficiency of rural public transit systems by contracting with human service agencies for transit service.
Objective 3	<b>By August 31, 2016, perform financial assessments for each of Arkansas' 29 Critical Access Hospitals (CAH). (Baseline: Data from these financial assessments will be used to establish a financial performance baseline for each CAH).</b>
Strategies	Develop and implement training for the overall improvement of operations and eliminating waste.
	Improve pursuit of grant funding for hospitals through increased awareness of ORHPC technical assistance and electronic dissemination of grant opportunities.
	Continue to partner with the United States Department of Agriculture (USDA) representative for the provision of state and federal support for capital needs.
	Improve accuracy of coding/billing for services in rural hospitals.
	Support Critical Access Hospitals (CAH) in quality and financial efforts.
Objective 4	<b>Improve the health care payment system. (Target &amp; baseline to be determined).</b>
Strategies	Study the impact of Private Option legislation originally passed in 2013 on rural Arkansans.
	Analyze the number of insured Arkansans as a result of the Private Option legislation passed in 2013.
	Advocate for fewer Medicare payment cuts.

<b>GOAL 2 Enhance the statewide trauma system and emergency medical services (EMS).</b>	
<b>Objective 1</b>	<b>By 2020, increase the number of hospitals designated for the inclusive statewide trauma centers to 76. (Baseline: June 2015, ADH Injury Prevention and Control Branch, Trauma Section, 70)</b>
Strategies	Continue to seek financial support for the statewide trauma system by pursuing grants and other opportunities.
	Educate the entities that are dealing with the stroke/STEMI (ST-segment Elevation Myocardial Infarction) issues about the statewide trauma system.
	Assist partners in organizing and identifying funding sources and with other technical assistance needs.
	Develop a comprehensive data management plan and system metrics using risk adjusted data for components of the trauma system.
	Improve the EMS registry.
<b>Objective 2</b>	<b>By 2020, conduct a needs assessment of EMS providers. (Baseline: 2016, ADH-EMS, 7000 EMS providers and 210 services)</b>
Strategies	Review rural EMS provider pay, attrition rates, and educational needs.
<b>Objective 3</b>	<b>By 2020, strengthen EMS medical direction by appointing a statewide EMS Medical Director for Ambulance Service. (Baseline: 2015, ADH-EMS)</b>
Strategies	Reduce the number and availability of EMS training programs across the state to improve EMS education and current pass rates in the training programs. Reducing the number and availability of programs will allow for more coordinated and streamlined efforts.
	Formulate a working group to establish standard job descriptions and oversight guidelines for EMS Medical Directors.
	Assess current national scope of practice for continuous update of EMS policy and identify opportunities for improvements.

<b>GOAL 3 Strengthen rural health networks by enhancing technology, funding, collaborative partnerships and public information/education.</b>	
Objective 1	By July 1, 2017, increase the adoption and use of health information to include connectivity to 4 Community Access Hospitals (CAH) and 3 Small Rural Hospitals (SRH) to strengthen rural health networks. (Baseline: 2015, Office of Health Information Technology (OHIT), 3 CAH and 1 SRH are live on State Health Alliance Records Exchange (SHARE))
Strategies	Increase adoption and use of health information technology. Increase the number of CAH's and SRH's connected to SHARE by 7.
	Increase awareness of available health information technologies through education and public relations. Hold two rural conferences in 2015-2016 and one webinar focused on rural health networks.
	Enhance the interoperability of the current health information technology system in rural areas by making patients' health care data available to Long Term Post Acute Care providers, Behavioral Health providers and others not eligible for Meaningful Use payments.
Objective 2	By 2017, increase collaborative partnerships among rural health stakeholders to strengthen rural health information technology networks by providing SHARE presentations and exhibits at 2 conferences and association meetings. (Baseline: Source-OHIT; Year and amount to be determined)
Strategies	Research successful model programs in other states.
Objective 3	By 2017, increase collaboration with rural health stakeholders to enhance support of rural advocacy ensuring that rural stakeholders are represented in SHARE user groups. (Baseline: 2015, OHIT, 0)
Strategies	Ensure rural hospitals are represented by at least one member on the following SHARE user groups: clinical, privacy/security and technical.

<b>GOAL 4 Support of existing rural hospitals.</b>	
Objective 1	By 2020, increase the number of primary care physicians residing in Arkansas counties with the lowest life expectancies to 11 per 10,000 citizens. (Baseline: 2012, Arkansas Center for Health Improvement, Arkansas Workforce Strategic Plan: A Roadmap to Change, 10 primary care physicians per 10,000 citizens)
Strategies	Work with UAMS Regional Programs to ensure a portion of family practice rotations are being conducted in rural hospitals and communities.
Objective 2	Proposed: Continue efforts to increase the number of qualified Arkansas resident applicants from every county within Arkansas, and in particular qualified applicants from rural and underserved communities in the state. (Baseline: 70.5% of Arkansas resident applicants accepted for admission to the 2015 entering freshman class have been designated by American Medical College Application Service (AMCAS) as being from "rural or underserved" communities in Arkansas.)
Strategies	Continue to seek collaborative partnerships to recruit health professionals to rural areas.
	Explore funding resources for the newly accredited General Practice Residency program which consists of 12 months of advanced dental education and residency rotations.
	Continue exploring ways to expand "grow your own" programs such as A Day In the Life, Medical Applications of Science for Health (MASH) and Community Health Applied in Medical Public Service (CHAMPS) in public schools across the state.
	Increase public awareness regarding shortage of allied health and health professionals.
	Increase rural practice incentives through scholarships and loan repayment programs for health professionals to stay in communities in Arkansas.
	Expand efforts to increase the qualified pool of Arkansas applicants to the UAMS College of Medicine
	Increase targeted recruitment, skills enrichment, mentoring and other support programs for college level pre-med students.
Objective 3	Offer continuing education support for providers serving in rural areas in Arkansas. (Target to be determined. Baseline #1: 2014, UAMS Regional Programs & UAMS Center for Distance Health via interactive video network, CME for 5,000 providers. Baseline #2; 2015, AHA, 95-100 programs offered.)
Strategies	Increase the number of health care professionals in rural Arkansas who obtain continuing education hours or enroll in training opportunities.
Objective 4	By 2018, continue to recruit health care professionals placed in rural Arkansas through National Health Service Corps (NHSC) scholarship and loan repayment programs and the Arkansas J-1 Visa/Conrad 30 program (Baseline: 2013, HRSA Bureau of Health Workforce, 127 NHSC Loan Repayment Applicants)
Strategies	Promote the NHSC scholarship and loan repayment programs and the Arkansas J-1 Visa/Conrad 30 program to organizations and communities to increase the program awareness.
	Assist the NHSC and interested parties with application questions and reviews to facilitate processing and support recruitment and retention efforts.
	Refer and assist interested J-1 Visa/Conrad 30 program individuals to proper entity to apply for available slots.
Objective 5	By 2018, continue the coordination of Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) designation process to ensure consistent and accurate assessment of underserved areas. (Baseline: 2014, 154 Whole County HPSAs (33 Primary Care,

	53 Dental, 68 Mental Health) and 59 Whole County MUAs, HRSA Bureau of Health Workforce)
Strategies	Establish and reevaluate HPSA scores for mental health, primary care and dental to identify underserved areas.
	Review MUAs and assess opportunities for new MUAs to increase overall number of MUAs.

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# Evaluation

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## *How Will We Evaluate the Impact of Our State's Plan?*

The goals, objectives, and strategies in *Arkansas State Rural Health Plan, 2015-2020* are collaborative in nature in that they have been developed through partner consultations and feedback. Throughout the entire process, evaluation will be central to the success of the plan, thus providing ongoing feedback and information to better understand and improve initiatives.

While the overall long-term goals will most likely take five or more years to see



significant improvement, the strategies developed for each of the objectives will result in short-term and intermediate outcomes within two to five years. These short-term outcomes focus on improving the infrastructure and identifying best practice models that support rural health in our communities.

Both quantitative and qualitative evaluation methods will be used. Because this plan relies on partners working and communicating together, the ORHPC will coordinate

with partner agencies and stakeholders in periodically keeping partners informed with progress and data updates.

In April 2015, the ORHPC released the *2015 Arkansas Primary Care Needs Assessment* as a companion piece to this state plan. This Needs Assessment contains a more detailed profile and statistical glance of primary care needs in rural Arkansas. The *2015 Arkansas Primary Care Needs Assessment* serves as a snapshot of current measurable indicators. It also identifies various needs that can be addressed through strategic planning, evaluation, and coordination with partnering agencies and stakeholders who have a similar interest.<sup>2</sup>

In addition to the quantitative methods available above, qualitative methods will be used to help describe and understand how best practice programs are developed and implemented. In some instances, the target and baseline information may need to be further developed for objectives. In these cases, the ORHPC may rely on qualitative data to assist in evaluating goals, objectives and strategies for each of the priority areas. These methods might include interviews with program developers and

community stakeholders to identify barriers, resources and lessons learned. As a result, indicators for measuring success and baseline data will be addressed as the goals and objectives evolve. By evaluating the goals and objectives throughout the course of the plan's implementation, the ORHPC will be able to refine target outcomes and strategies.

With a variety of evaluation approaches, the ORHPC will be able to disseminate statistical data alongside anecdotal information to diverse audiences such as health care providers, community members, and policy makers. By continuously evaluating progress, the ORHPC will also be able to provide more accurate and timely information to community stakeholders. This in turn will allow partners to more effectively adopt best practices and address issues that pose a problem for rural health in Arkansas.

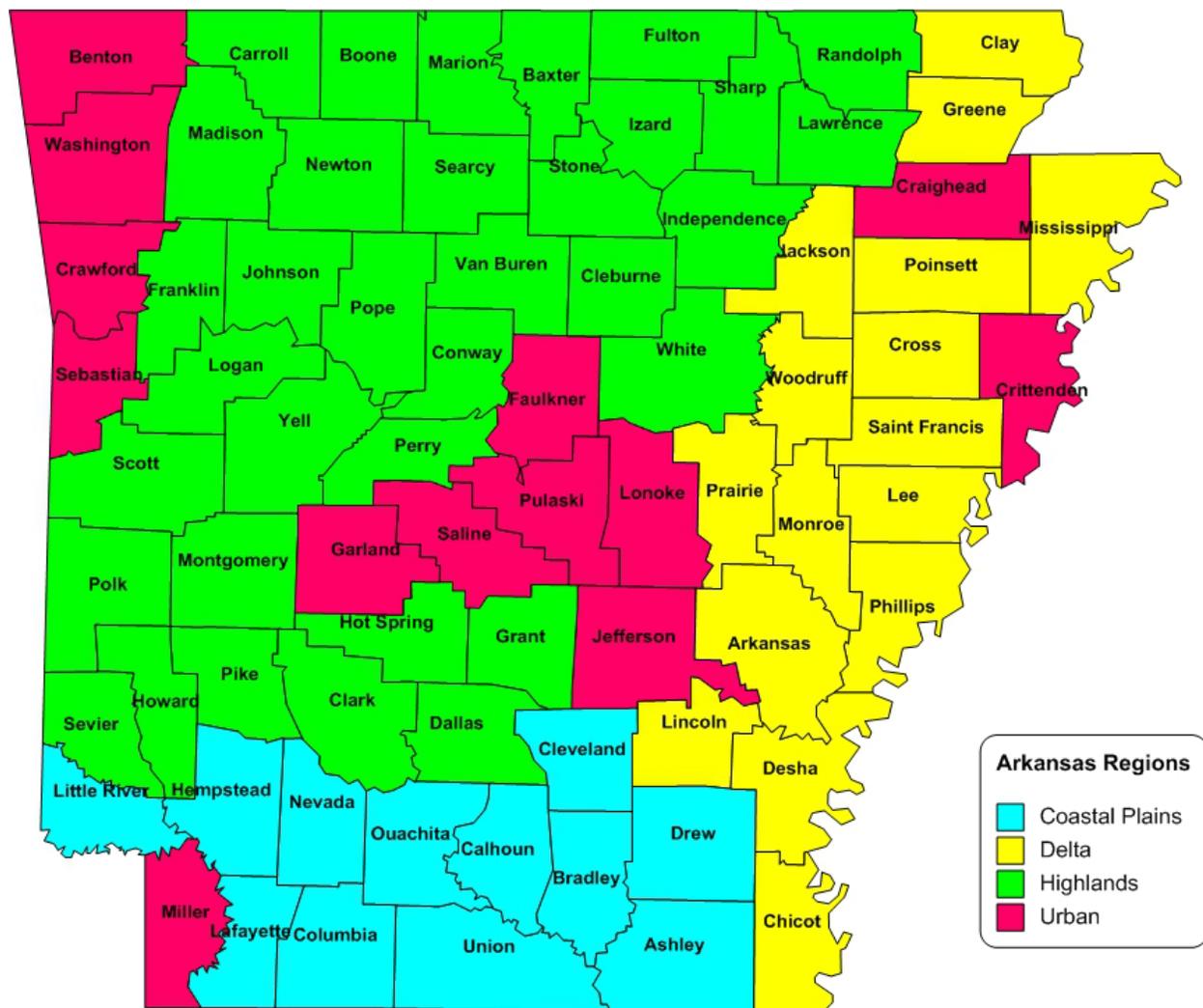
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## *Appendix*

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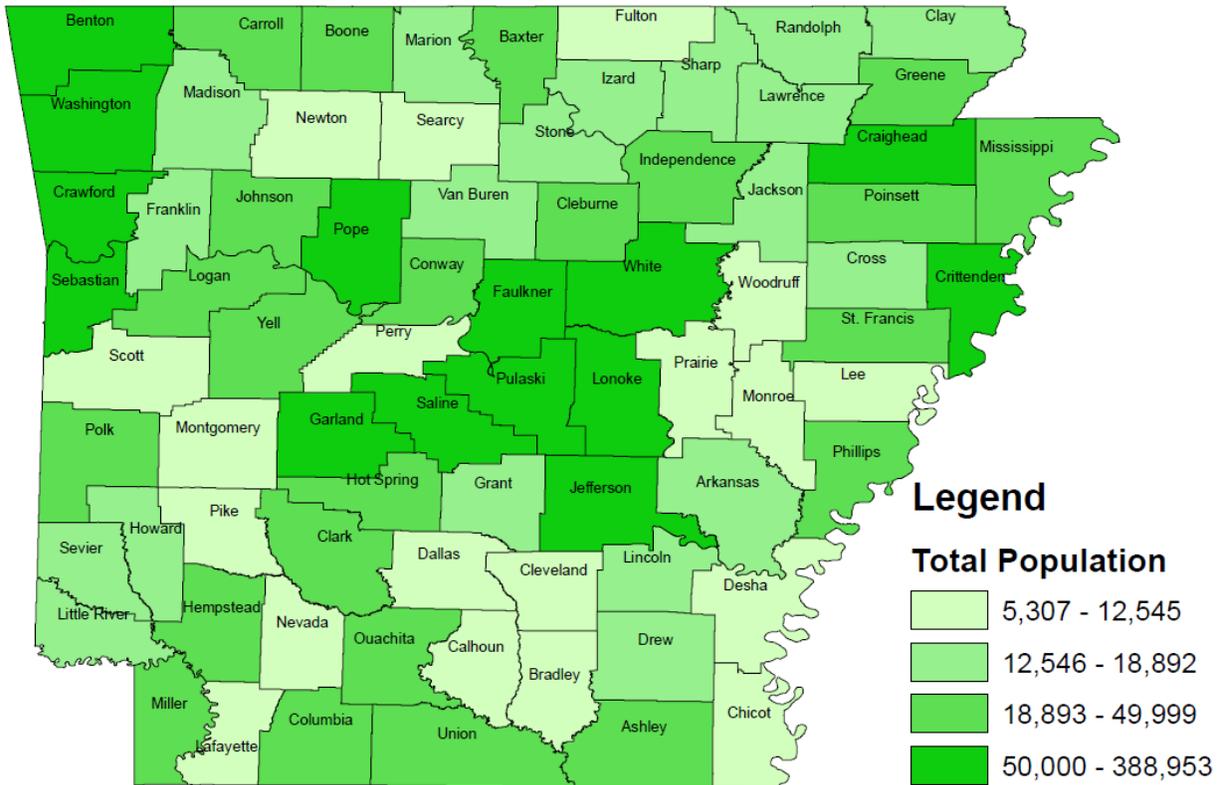
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## Rural Profile of Arkansas by Region



Source: University of Arkansas, Division of Agriculture, Research & Extension. *Rural Profile of Arkansas-2015, Social and Economic Trends Affecting Rural Arkansas*. Accessed June 25, 2015 from <https://www.uaex.edu/publications/pdf/MP-531.pdf>.

## Total Population of Arkansas



Source: U.S. Census Bureau, 2012.

## *Arkansas Rural Health Plan Partners*

AGENCY	DEPARTMENT, SECTION OR PROGRAM
<b>Arkansas Department of Health (ADH)</b>	<ul style="list-style-type: none"> <li>Emergency Medical Services (EMS)</li> <li>Office of Rural Health &amp; Primary Care (ORHPC)</li> <li>Preparedness and Response</li> <li>Trauma Section</li> </ul>
<b>Arkansas Highway Transportation Department (AHTD)</b>	
<b>Arkansas Hospital Association (AHA)</b>	
<b>Community Health Centers of Arkansas, Inc. (CHCA)</b>	
<b>Office of Health Information &amp; Technology (OHIT)</b>	
<b>University of Arkansas for Medical Sciences (UAMS)</b>	<ul style="list-style-type: none"> <li>College of Health Professions (COHP)</li> <li>College of Medicine (COM)</li> <li>Center for Dental Education</li> <li>Regional Programs</li> </ul>

## *List of Acronyms*

ACA	Affordable Care Act
AMCAS	American Medical College Application Service
ADH	Arkansas Department of Health
AHTD	Arkansas Highway and Transportation Department
AHA	Arkansas Hospital Association
AHEC	Area Health Education Centers
APO	Arkansas Private Option
CAH	Critical Access Hospitals
CC	Charitable Clinic
CDC	Centers for Disease Control and Prevention
CHAMPS	Community Health Applied in Medical Public Service
CHC	Community Health Center
EHR/EMR	Electronic Health Records/Electronic Medical Records
EMS	Emergency Medical Services
FLEX	Medicare Rural Hospital Flexibility Program
FQHC	Federal Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
HHI	Hometown Health Improvement (Arkansas Department of Health)
HPSA	Health Provider Shortage Area
HRSA	Health Resources Services Administration
IOM	Institute of Medicine
MASH	Medical Applications of Science for Health
MUA	Medically Underserved Area
MSA	Metropolitan Statistical Area
NHSC	National Health Service Corps
NP	Nurse Practitioner
OHIT	Office of Health Information Technology
ORHPC	Office of Rural Health & Primary Care (Arkansas Department of Health)
PA	Physician Assistant
RHA	Rural Hospital Association
RHC	Rural Health Clinic
SHIP	Small Hospital Improvement Program
SRH	Small Rural Hospital
SHARE	State Health Alliance for Records Exchange
USDA	United States Department of Agriculture
UAMS	University of Arkansas for Medical Sciences

## References

- <sup>1</sup> Health Resources and Services Administration – definition of rural. Accessed June 25, 2015 from [http://www.hrsa.gov/ruralhealth/policy/definition\\_of\\_rural.html](http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html).
- <sup>2</sup> Arkansas Department of Health Office of Rural Health and Primary Care. *Arkansas Primary Care Needs Assessment. April 2015*. Accessed June 25, 2015 from <http://www.healthy.arkansas.gov/programsServices/hometownHealth/ORHPC/Documents/PCONeedsAssessment.pdf>.
- <sup>3</sup> University of Arkansas, Division of Agriculture, Research & Extension. *Rural Profile of Arkansas-2015, Social and Economic Trends Affecting Rural Arkansas*. Accessed June 25, 2015 from <https://www.uaex.edu/publications/pdf/MP-531.pdf>.
- <sup>4</sup> U.S. Census Bureau: State and County QuickFacts. (2013) Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits. Last Revised: Thursday, 28-May-2015. Accessed June 25, 2015 from <http://quickfacts.census.gov/qfd/states/05000.html>.
- <sup>5</sup> Arkansas Department of Health. *Arkansas's Big Health Problems and How We Plan to Solve Them. State Health Assessment and Improvement Plan 2013*. Accessed June 25, 2015 from <http://www.healthy.arkansas.gov/aboutADH/Documents/Accred/ARHealthReportHealthProblems.pdf>.
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- <sup>9</sup> Arkansas Department of Health, Trauma Section. *Designated Trauma Centers* (June 16, 2015) link on website. Accessed June 25, 2015 from

<http://www.healthy.arkansas.gov/programsServices/injuryPreventionControl/TraumaticSystems/Pages/DesignatedTraumaCenters.aspx>.

<sup>10</sup>Arkansas Department of Health, Emergency Medical Services Section, June 2015.

<sup>11</sup>Arkansas Department of Health, Office of Rural Health and Primary Care, June 2015.

<sup>12</sup>Arkansas Hospital Association. *2014 Annual Report*. Accessed June 25, 2015 from <http://www.arkhospitals.org/archive/MiscPDFFiles/AnnualReport.pdf>.

<sup>13</sup>United States Department of Health and Human Services. Centers for Medicare and Medicaid Services. Rural Health Clinic. *Rural Health Fact Sheet Series*. August 2014. Accessed June 29, 2015 from <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf>.

<sup>14</sup>United States Department of Health and Human Services. Centers for Medicare and Medicaid Services. *Rural Health Clinic List*. (Casper Report 0006D February 17, 2015) Accessed June 29, 2015 from <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/rhclistbyprovidername.pdf#page=70>.