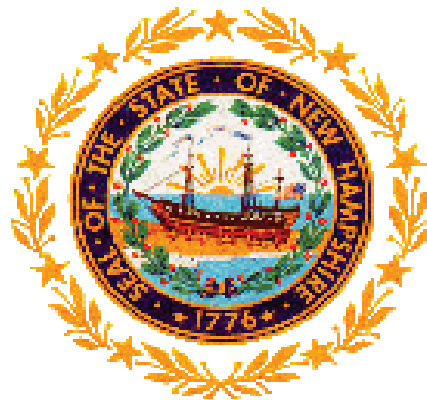


Annual Report on the Health Status of Rural Residents and Health
Workforce Data Collection to
New Hampshire Health and Human Services Oversight Committee

Calendar Year 2019



Rural Health and Primary Care Section
Bureau of Public Health Systems, Policy and Performance
Division of Public Health Services
Department of Health and Human Services

February 21st, 2020



INTRODUCTION

The Department of Health and Human Services, Division of Public Health Services, Bureau of Public Health Systems, Policy and Performance, Rural Health and Primary Care (RHPC) Section includes the Primary Care Office (PCO) and the State Office of Rural Health (SORH); under which the Medicare Rural Hospital Flexibility Program (Flex), which supports the Critical Access Hospitals and the Small Rural Hospital Improvement Program (SHIP), the State Loan Repayment Program (SLRP) and the Health Professions Data Center (HPDC) exist. The mission and function of the Rural Health and Primary Care section is to support communities and stakeholders that provide innovative and effective access to quality health care services with a focus on the low income, uninsured, and Medicaid populations of New Hampshire. In order to achieve this, RHPC focuses efforts on the following goals:

- Access - To increase access to quality health care services for rural and underserved populations
- Quality - To improve the quality of care provided at Critical Access Hospitals and Rural Health Clinics.
- Sustainability – To improve financial and operational outcomes of Critical Access Hospitals and Rural Health Clinics.
- Workforce – To quantify and increase the number of health care providers serving rural and underserved populations.

In 2008, the NH State Office of Rural Health (SORH) was established in RSA 126-A:5, XVIII(a) to

1. Link rural health and human service providers with state and federal resources;
2. Seek long-term solutions to the challenges of rural health;
3. Increase access to health care in rural and underserved areas of the state;
4. Improve recruitment and retention of health professionals in rural areas;
5. Provide technical assistance and coordination to rural communities and health organizations;
6. Maintain a clearinghouse for collecting and disseminating information on rural health care issues and innovative approaches to the delivery of health care in rural areas;
7. Coordinate rural health interests and activities; and
8. Participate in strengthening state, local, and federal partnerships.

Following the establishment and charges of the SORH, HB 1692 (Chapter 114, 2010) authorized the SORH to collect and organize data regarding the current and anticipated supply of health care professionals who make up the state's primary care workforce and the current and anticipated demand for primary care services in the future by planning and budgeting for a NH Health Professions Data Center to collect this data.

RSA 126-A:5, XVIII(c) requires that the State Office of Rural Health (SORH) submit a report on or before December 1, 2019, and annually thereafter to the speaker of the house of representatives, the senate president, the governor, the oversight committee on health and human services established under RSA 126-A:13, the chairs of the house and senate executive departments and administration committees, the chairs of the house and senate policy committee having jurisdiction over health and human services, and the commission on primary care workforce issues established by RSA 126-T:1, on the health status of rural residents, incorporating current data from the Bureau of Health Statistics and Data Management.

In 2019, RSA 126-A:5, XVIII-a was amended to include that the SORH shall receive and collect data regarding surveys completed by participating licensees pursuant to RSA 317-A:12-a, RSA 318:5-b, RSA 326-B:9-a, RSA 328-D:10-a, RSA 328-F:11-a, RSA 329:9-f, RSA 329-B:10-a, RSA 330-A:10-a, and RSA 330-C:9-a. Annual reports submitted by the SORH shall incorporate aggregate data and information on current and projected primary workforce needs and the participation rate on surveys completed by clinicians.

All reports produced by the RHPC can be found on the Department's Rural Health and Primary Care Section website publications page <https://www.dhhs.nh.gov/dphs/bchs/rhpc/publications.htm>. They include the State Loan Repayment Program reports, Primary Care Needs Assessments and Health Professions Data Center reports.

SUMMARY OF ACTIVITIES FOR CALENDAR YEAR 2019

Health Status of Rural Residents

New Hampshire (NH) is one of the oldest states in the country; it was originally a land grant in 1623 and became a state in 1775. With its 1,300 lakes and ponds, 40,000 miles of river and 18 miles of seashore NH is the 45th largest state at 190 miles long and 70 miles wide. NH is bordered by Canada on the north and by Massachusetts on the south. On the east is the Atlantic Ocean and Maine and on the west is Vermont. New Hampshire's scenic rivers, mountain ranges, lakes and agricultural lands define the state's culture and geography but also create physical boundaries and barriers to the resources that improve health. The topography lends itself to difficult driving and long distances between places, particularly for rural residents. Access to primary and specialty medical, oral, behavioral

health care can be a significant challenge due to New Hampshire's geographical location and landscape.

Over 37% of the population and 84% of the landmass in New Hampshire is considered rural;¹ most of the land area lies north and west of the capital Concord. The majority of New Hampshire towns are considered rural, with non-rural areas located in the south east and south central regions and primarily rural areas in the western, central and northern sections. The White Mountain National Forest separates the northernmost rural section of the state, which consists of Coos County. Coos County, known as the North Country, has the largest landmass of any county but the smallest population by county. The three (3) most urban or metro areas are Manchester, Nashua and Concord, all located in the state's southern tier where the majority (53%) of the population lives. NH's population is disproportionate as density increases from North to South. Population density ranges from 20 people per square mile in Coos County to 775 people per square mile in the Greater Nashua region.²

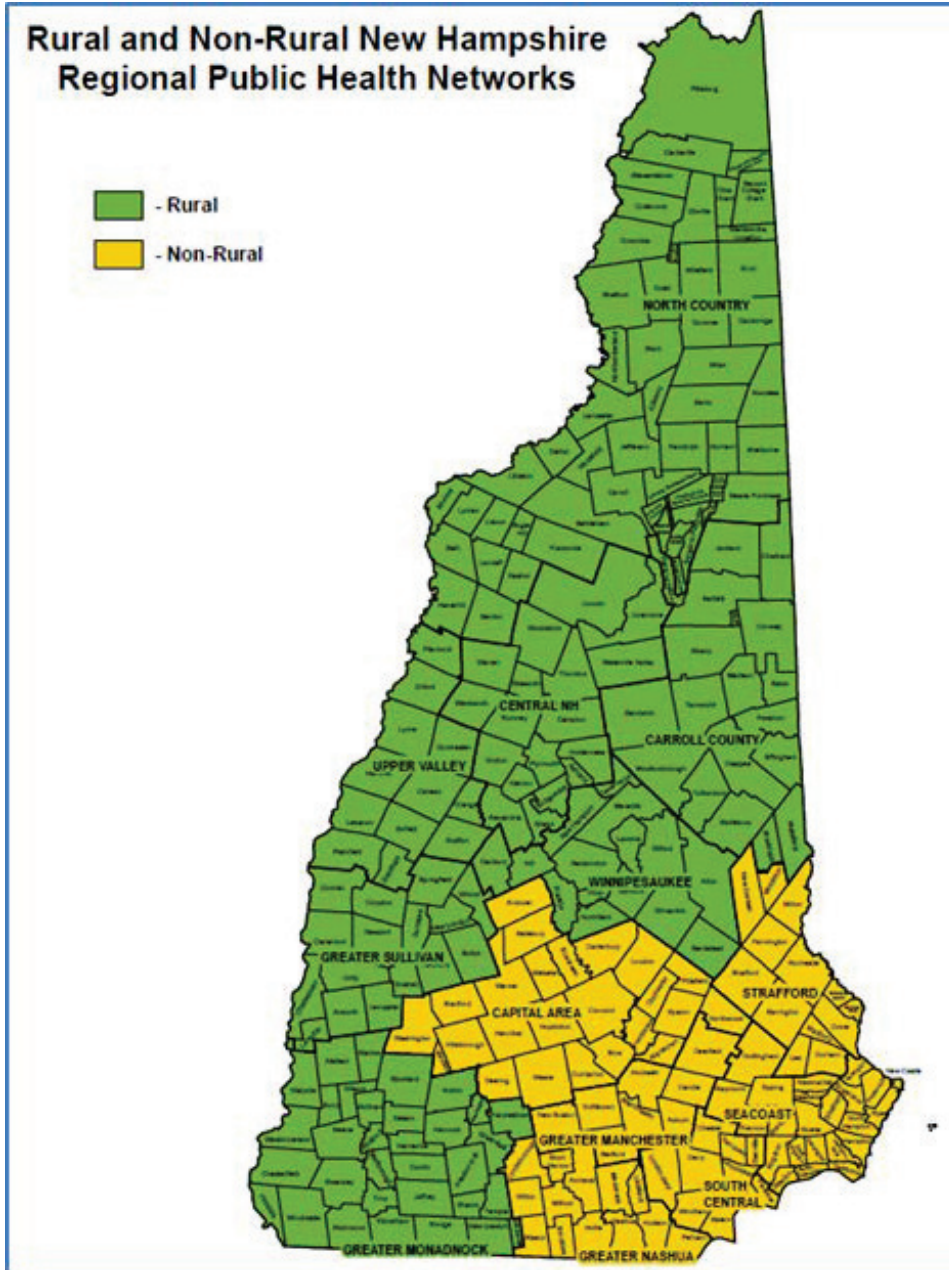
In July 2013, the NH DHHS, through the Bureau of Drug and Alcohol Services (BDAS) and Division of Public Health Services (DPHS) established a strategic partnership to align multiple regional and local public health partnerships into one integrated system. The Regional Public Health Networks (RPHNs), a network of 13 NH regions, integrates multiple public health initiatives and services into a common network of community stakeholders for communities with comparable public health issues and priorities in order to improve health outcomes specific to these regions. In place of counties or other geographically defined areas, DPHS, including RHPC, uses these RPHNs when reporting on geographic areas of the state. This ensures both consistency and use of NH-appropriate definitions. RHPC defines rurality for RPHN using population and population density measures (Figure 1). RPHNs with a population of 100,000 or less and with a population density of 150 people per square mile or less are considered rural. RPHNs that don't meet these criteria are categorized as non-rural. The Greater Nashua RPHN has the highest population and population density in NH with 223,563 residents and 457 people per square mile, while North Country - which has the largest land mass of the RPHNs - is the least densely populated Region with only 18.4 people per square mile.³

¹ Economic Research Service, United States Department of Agriculture, 2017 New Hampshire State Data. Retrieved on 10/09/2018 from <https://data.ers.usda.gov/reports.aspx?ID=17854>; Division of Forests and Lands, New Hampshire Department of Natural and Cultural Resources. Retrieved on 10/09/2018 from <https://www.nhdf.org/reports/forest-statistics>.

² New Hampshire State Plan on Aging. Bureau of Elderly and Adult Services, DHHS. October 2015 – September 2019. Retrieved on 10/09/2018 from <https://www.dhhs.nh.gov/dcbcs/beas/documents/stateplan.pdf>.

³ United States Census Bureau. Census of Population and House and Geography Division. Prepared by indexmundi. Retrieved on 10/11/2018 from <https://www.indexmundi.com/facts/united-states/quick-facts/new-hampshire/population-density#map>.

Figure 1.



The indicators chosen for this report are a subset of the indicators we use to measure the health status of rural residents. The Division of Public Health services is currently updating their entire system for reporting population health data (NH Health WISDOM). Because we have limited resources until the new system is available, we chose a subset of key health indicators from the NH State Health Report made available through WISDOM and visualized. The subset is made up of demographic data, select health behaviors data and select health outcomes data.

The data was compiled by the Bureau of Public Health Statistics and Informatics at the NH Department of Health and Human Services. Data included in this report comes from the following sources:

Vital Records – Division of Vital Records Administration (DVRA), a division of the New Hampshire Department of State. DVRA is responsible for recording births, deaths, marriages, and divorces. Datasets utilized include

- Birth Certificates: 2010-2019 maternal smoking rate
- Death Certificates: 2009-2018 youth suicide, deaths from poisonings

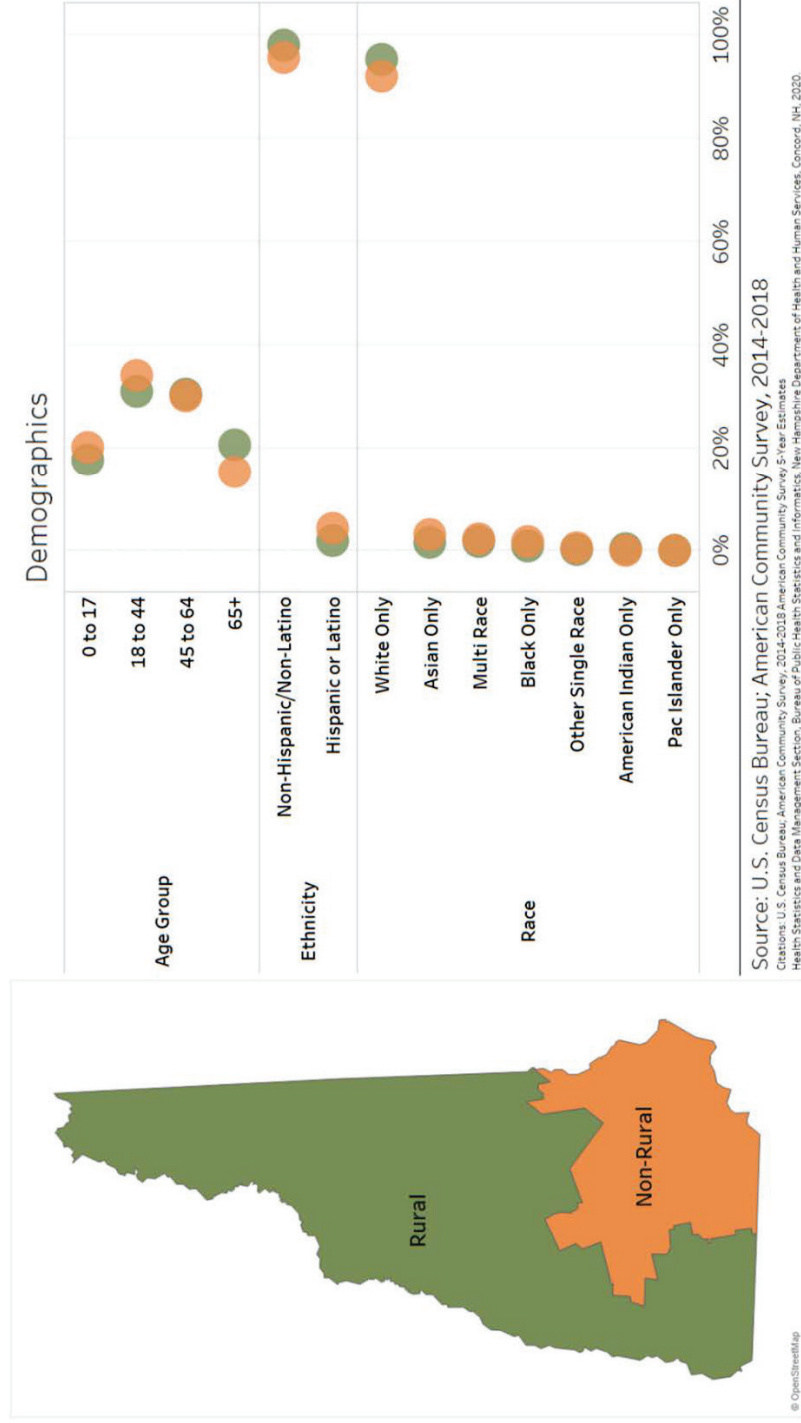
BRFSS - The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project between all of the states in the United States (US) and participating US territories and the Centers for Disease Control and Prevention (CDC). The BRFSS is administered and supported by CDC's Population Health Surveillance Branch, under the Division of Population Health at the National Center for Chronic Disease Prevention and Health Promotion. The BRFSS is a system of ongoing health-related telephone surveys designed to collect data on health-related risk behaviors, chronic health conditions, and use of preventive services from the noninstitutionalized adult population (≥ 18 years) residing in the United States. This dataset utilizes

- 2017 data for asthma, diabetes, binge drinking, smoking, lack of health insurance, poor mental health, poor physical health, high blood pressure, and high cholesterol

American Community Survey (ACS) - The American Community Survey (ACS) is an ongoing survey by the U.S. Census Bureau. It regularly gathers information previously contained only in the long form of the decennial census, such as ancestry, citizenship, educational attainment, income, language proficiency, migration, disability, employment, and housing characteristics. The Census Bureau randomly sample addresses in every state, the District of Columbia, and Puerto Rico. This dataset utilizes

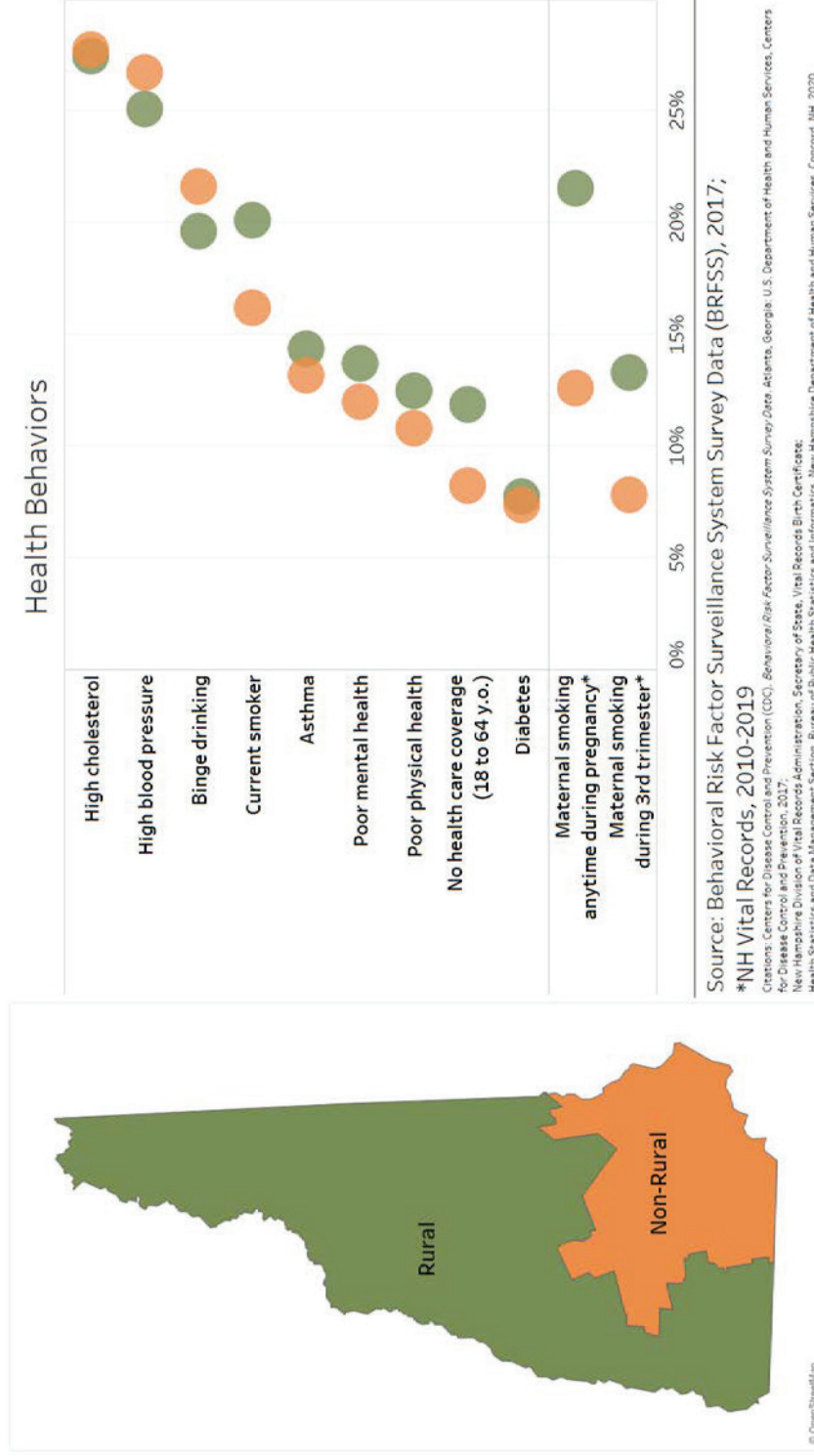
- 2014-2018 data for race, ethnicity, and age group distribution

Figure 2.



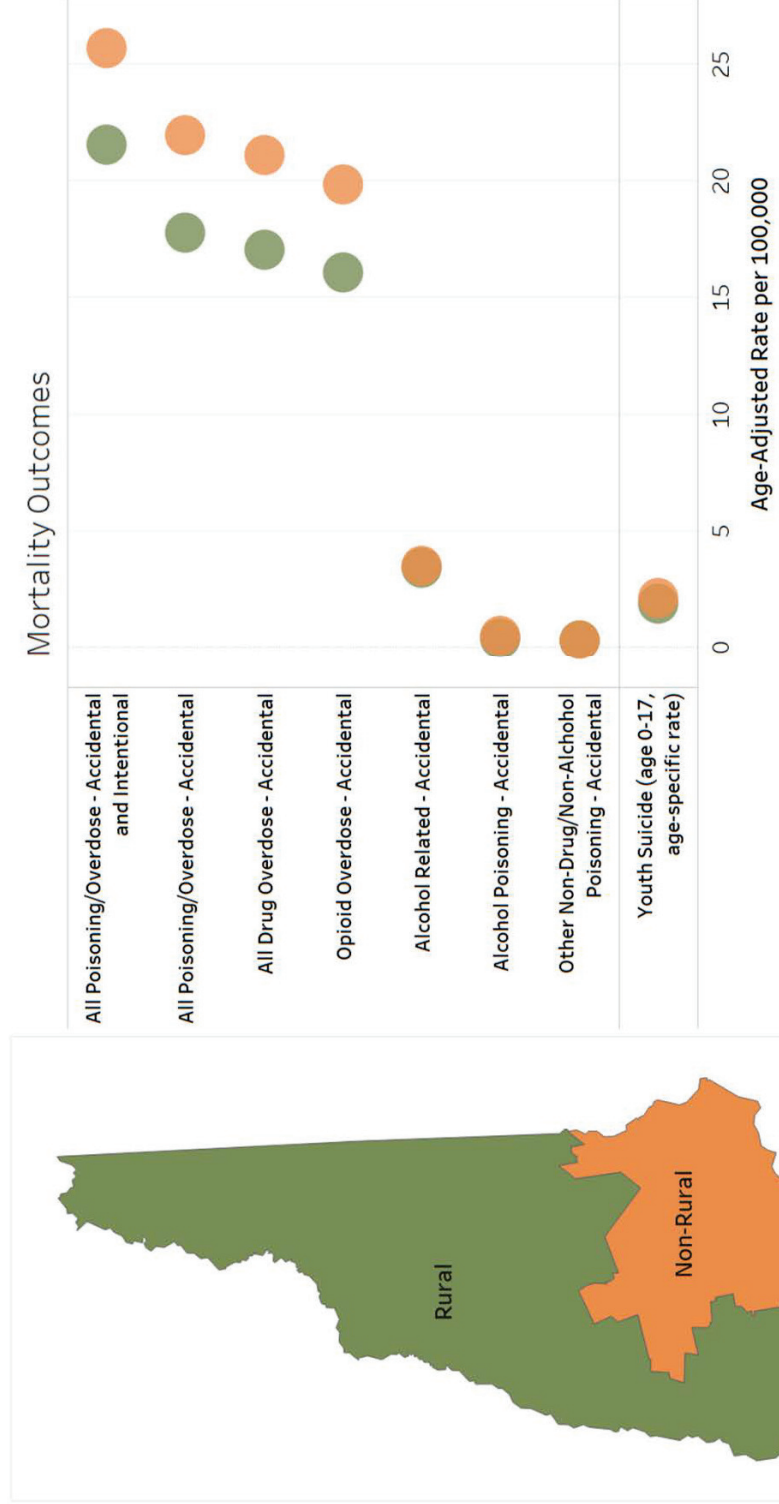
Non-rural and rural NH is demographically similar when comparing race and ethnicity statistics. Because NH as a whole is predominantly White, there are negligible non-White racial differences in population between rural and non-rural regions. While the greatest statistical difference in race between rural and non-rural NH is visible in the White-only indicator in Figure 2 above, it is only by 3 percent (95.3% v. 92.1%). Surprisingly, rural and non-rural NH are also statistically similar in population age, with the greatest difference found in those 65+ years old (20.7% and 15.4%, respectively).

Figure 3.



As illustrated in Figure 3 above, rural and non-rural NH differences in health behaviors are most notable for smoking and health care coverage. BRFSS data indicates a 4% difference in the rate of rural and non-rural current smokers (20.1% v. 16.2%); however, when examining maternal smoking during pregnancy, the differences appear more significant. While 13.3% of maternal smoking anytime during pregnancy was reported in rural NH compared to 7.8% by their non-rural counterparts, the greatest gap in smoking between rural and non-rural exists for smoking during the 3rd trimester, where approximately 9% more rural residents reported this health behavior (21.5% v. 12.6%). Slightly more rural residents (11.8%) reported no health care coverage compared to non-rural residents (8.2%).

Figure 4.



Source: NH Vital Records, 2009-2018

Citations: New Hampshire Division of Vital Records Administration, Secretary of State, Vital Records Death Certificates; Health Statistics and Data Management Section, Bureau of Public Health Statistics and Informatics, New Hampshire Department of Health and Human Services, Concord, NH, 2020.

Consistent with the national trend, accidental and intentional overdoses for drugs, including opioids, are slightly higher in non-rural NH than in rural NH (*average* (\bar{x}) = 4%) as seen in Figure 4 above. Also of note are the insignificant differences between rural and non-rural NH when considering alcohol related deaths and youth suicide.

Health Professions Data Center

Since the amendment to RSA 126-A:5, XVIII passed in July 2019, only one (1) provider type, physician assistants has relicensed with the Division of Health Professions under the Office of Professional Licensure and Certification (OPLC).

Physician Assistant Response Rate

Of the 903 physician assistants (PAs) due to renew their license, 837 renewed (92.7%), reducing the percentage of NH-licensed PAs by just over 7 percent since 2018. Table 1 contains the response rate statistics for calendar year 2019. This includes the number of licensees who completed the survey, the number who completed the opt-out form, and the number who did not complete the survey requirement (survey or opt-out form), defaulting.

Table 1: Physician Assistant (PA) Response Rate Data for 2019

Relicensed PAs	Number	% of Relicensed PAs
Total Physician Assistant License Renewals	837	
Licensees who Fulfilled the Survey Requirement	810	96.8%
Completed the Health Professions Survey	795	95.0%
Completed the Opt-Out Form	15	1.8%
Did not Fulfill the Survey Requirement	27	3.2%

Administrative Rules Update

Health Status of Rural Residents

No update.

Health Professions Data Center

New administrative rules, He-C 801, were approved by the Joint Legislative Committee on Administrative Rules (JLCAR) and were effective with an amendment on May 7th, 2019. The rule establishes the requirements for the collection of health care provider data by the State Office of Rural Health’s Health Professions Data Center and the purpose of data collection (http://gencourt.state.nh.us/rules/state_agencies/he-c800.html).

The Administrative Rules will be amended, annually, to reflect the current iterations of the Health Professions Survey.

In addition to the new DHHS administrative rule, each participating licensing board is required to promulgate rules requiring licensees to fulfill the survey requirement – completion of the Health Professions Survey or completion of the opt-out form - as a condition of license renewal.

Five of the eight participating health professions licensing boards have formally adopted survey rules: the Board of Medicine, the Board of Nursing, the Board of Mental Health Practice, the Board of Alcohol and Other Drug Use Professionals, and the Board of Psychologists. The administrative rules process has commenced for the Board of Dental Examiners and will conclude prior to the anticipated 2021 survey implementation. The remaining two boards, the Boards of Allied Health Professionals and Pharmacy, are slotted to enter the administrative rules process two years after full implementation with primary care-associated licensing boards, in 2024.

Program Updates

Health Status of Rural Residents

NH Health WISDOM, the data portal for the Division of Public Health Services, is undergoing a major technical transition. The application used for the last seven years to calculate and produce data charts and maps in the portal, IBM Cognos, has numerous limitations and fails to meet WISDOM's growing needs. Four years ago, the Bureau of Public Health Statistics and Informatics initiated an RFP to analyze and determine the best application for the portal requirements. The findings from the RFP narrowed the choices down to two tools with the final selection of Exaptive.

The WISDOM team started the transition over to Exaptive and completed 50-75% of the project, when NH DHHS started exploring an enterprise business intelligence (EBI) application solution. Senior management reviewed the direction of WISDOM and determined the best long-term plan was to cease Exaptive development and to start using the newly selected EBI visualization tool, Tableau.

Due to limited resources, the strategy during the transition to Exaptive, and subsequently Tableau, was to limit creating new Cognos charts in WISDOM and updating only select datasets to allow the team to focus on the transition to the new EBI application. All efforts are focused on transitioning quickly over to Tableau in June 2020.

Once live, the new WISDOM application will provide modern interactive visualizations. The data will have the latest up-to-date data, and include new features such as providing rural and non-rural data filtering.

Health Professions Data Center

Rural Health and Primary Care (RHPC) has been working closely with the Office of Professional Licensure and Certification (OPLC) to establish one set of administrative rules for each health professions licensing board to approve and formally adopt. Because the original survey legislation in 2017 authorized named health professions licensing boards to adopt rules for their respective licensees, the administrative rules process

commenced for all but one (Board of Dental Examiners) of the participating boards in prior to the 2019 amendment. Although the legislative amendment expanded the 2017 survey legislation by mandating participation by all named licensing boards and requiring completion of the survey or opt-out form as a condition of license renewal, the administrative rules were crafted to cover the expanded legislative language. As a result, five of eight licensing boards had entered the administrative rules process before the 2019 amendment passed. As mentioned above, the Board of Dental Examiners is currently in the process of an administrative rules change to include the survey requirement and the rules are expected to be formally adopted prior to implementation in 2021.

In 2019, RHPC targeted efforts to better streamline the survey process and reduce inefficiencies by improving access to provider data and creating consistent survey notification language.

The OPLC and RHPC are working on an MOU to grant the Health Professions Data Center (HPDC) manager FTP site access to the Health Professions Division provider records. Direct access to provider data fields used to create the respondent panels and pre-populate the surveys will improve survey implementation efficiency. The current method of data retrieval requires requests to multiple OPLC entities, creating a bottleneck, which slows down survey activation and the implementation process. With direct access to provider data, OPLC staff will be removed from the data retrieval process, increasing process efficiency.

In order to implement the survey requirement into the license renewal process, RHPC works closely with the eGov Web Services Division of the Department of Information Technology (DoIT). The Web Services Division provides provider data to the HPDC and manages the survey page on every license renewal page for participating providers. In order to keep the survey specific workload to a minimum for DoIT, HPDC has crafted consistent survey notification language to be used for each participating provider. Once FTP site access is granted to the HPDC manager, DoIT will only be responsible for replacing the old survey link with the new link on each of the participating provider type renewal pages.

FUTURE PLANS

Health Status of Rural Residents

Under the RHPC, the Primary Care Office (PCO) coordinates with the Bi-State Primary Care Association (BSPCA) and Sections in the Division of Public Health Services (DPHS), which includes Maternal and Child Health and Public Health Statistics and Informatics, to collect primary care data for the statewide Needs Assessment. New to this collaboration will be the NH Integrated Delivery Networks (IDNs), developed in accordance with NH's Delivery System Reform Incentive Payment Demonstration

Waiver (DSRIP); and the Division for Behavioral Health (DBH). The NH PCO and aforementioned partners will convene prior to the end of the budget period to discuss the upcoming Needs Assessment Report, due June 30. As part of the Needs Assessment, our shortage designation contractors at Community Health Institute/John Snow, Inc. (CHI/JSI) collect and analyze data from targeted-area surveys and the following state and national databases:

- Uniform Data System (UDS)
- All Payer Claims Database (APCD)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Hospital Discharge data
- NH TEMSIS (Trauma Emergency Medical Services Information System)
- WISDOM
- American Community Survey (ACS)
- Social Vulnerability Index (SVI)
- Vital records
- Health Professions Data Center

The PCO submitted the last Needs Assessment Report in May 2016, which highlighted population disparities in access to care and gaps in the data sources. Access to healthcare services underlies many of the observed rural/non-rural disparities underscored in the Needs Assessment.

Once the new WISDOM data system is available, where possible, all data will be able to be viewed as rural versus non-rural according to the definition by Public Health Region. The RHPC will then create a Rural Health dashboard in Tableau that will link to the WISDOM system but contain rurally relevant indicators for: basic demographics, health status, morbidity rates, mortality rates, health care access, social determinants, and environmental determinants. The link for the rural dashboard will be on our section website and also used for future annual reports. This data will be updated at least annually but as often as the datasets change.

Health Professions Data Center

While physician assistants are the only provider type to renew their license since the 2019 legislative amendment passed, all other provider types in the legislation, aside from dentists and dental hygienists, will renew their license in 2020 and participate in the survey requirement.

Workforce reports with aggregated provider data will be developed annually for each participating provider type that relicenses together in one given year; and bi-annually for each participating provider type that relicenses all licensees in two years (see Appendix A).

Reports will be developed in Tableau and hosted on the RHPC website. The report will include the following workforce sections: response rate; practice status; demographics; capacity - sites and hours, and specialty; distribution; access – payment and wait time; recruitment - education/training; retention – years in practice, NH ties, and anticipated capacity; and rural associations. For an example of report format and content, please see the 2018 Physician Workforce Report (<https://public.tableau.com/profile/danielle.weiss#!/vizhome/2018PhysicianWorkforceReport/TableofContents>).

We anticipate rich, comprehensive workforce data will improve healthcare access planning and workforce assessment and will ultimately lead to:

- Federal shortage designations, which brings providers and grant funding to underserved areas of the state;
- Strengthened recruitment/retention initiatives including scholarships, loan repayment, and waiver programs;
- The expansion of existing educational programs and employment training programs; and
- Stronger emergency preparedness.

As mentioned above, analysis considerations will include rural associations, which will help RHPC to further delineate significant regional differences for indicators suggesting a disparity in health care access, such as accepted payers and availability of sliding fee scale policies, wait time, and retention of providers.

In addition to releasing workforce reports, periodically, RHPC will educate and provide ongoing consultation on the HPDC and the state of the health care workforce in NH to internal and external parties, including the health professions licensing boards, to ensure a complete collaborative approach to identifying and addressing health professions workforce challenges.

HPDC work will be supported by a data analyst; a new position to be funded by recent legislation (HB 4, Laws of 2019) and anticipated to be filled in 2020. The new employee will work closely with the Health Professions Data Center Manager, who will guide their work to ensure reporting requirements outlined in the statute are met.

Appendix A

List of Provider Surveys as of December 2019	License Renewal Cycles
Alcohol and Drug Counselor Licensure Survey <ul style="list-style-type: none"> ▪ Licensed Alcohol and Drug Counselors (LADCs) ▪ Master Licensed Alcohol and Drug Counselors (MLADCs) 	Biennially, 4/1-6/30
APRN Licensure Survey	Biennially, rolling renewals by birthday
Dentist Licensure Survey	Biennially on even years, 2/1-4/30
Dental Hygienist Licensure Survey	Biennially on odd years, 2/1-4/30
Mental Health Practitioner Licensure Survey <ul style="list-style-type: none"> ▪ Licensed Independent Clinical Social Workers (LICSWs) ▪ Licensed Clinical Mental Health Counselors (LCMHCs) ▪ Marriage and Family Therapists (MFTs) ▪ Pastoral Psychotherapists (PPs) 	Biennially, rolling renewals by initial license day
Physician Licensure Survey	Biennially; 50% of licensees on even years, 50% of licensees on odd years
Physician Assistant Licensure Survey	Annually, 10/1-12/31
Psychologist Licensure Survey	Biennially, 4/1-6/30