

The Virginia Rural Health Plan (2008)

Introduction

The Commonwealth of Virginia is dedicated to improving the quality of health and health care services for all Virginians. In July 2006, the Governor signed Executive Order 31⁵ establishing a Commission on Health Reform to:

- a. Identify and implement national best practices in health care at the state level in terms of access to care, improving quality and safety of care, providing long-term care, and addressing affordability of care;
- b. Work closely with the Joint Commission on Health Care to foster executive—legislative cooperation on health care issues;
- c. Strengthen long-term care;
- d. Form, with appropriate other stakeholders, working groups on the uninsured, quality and safety of care, health care workforce, and long-term care; and
- e. Examine other issues as appropriate.

This report served as a call to action for the Commonwealth, medical professionals, business and community leaders, advocates, policymakers, citizens, public health officials, providers and school leaders. Recommendations from this report were related to workforce, access, prevention, quality, long-term care, infant mortality, obesity, tobacco use and transparency.⁶ The recommendations, if implemented and funded appropriately, would likely increase the state's overall health ranking and ensure "a healthy future for all Virginians."⁷ Ultimately, this monumental report aimed at making Virginia one of the top ten healthiest states in the nation.

In December 2006, the Governor signed Executive Order 42 to strengthen the transparency and accountability of the healthcare system. This order mandated the following:

- a. **Health Information Technology** –The Commonwealth will work with health insurance providers or third party administrators to encourage these companies to use health information technology systems and programs that meet interoperability standards recognized by the Secretary of Health and Human Services as existing at the time the systems are updated or implemented. In exchanging information, patient privacy will be protected as required by law. The Commonwealth will build on the work of the Health Care Information Technology Council to leverage the potential of information technology to improve health care delivery.
- b. **Transparency of Quality Measurements** – In order to support assessment of the quality of care delivered by health care providers, the Commonwealth will encourage health insurance providers or third party administrators with which it contracts to implement programs measuring the quality of services supplied to their enrollees. The Commonwealth will play an active role in bringing

⁵ http://www.governor.virginia.gov/Initiatives/ExecutiveOrders/2006/EO_31.cfm

⁶ *Roadmap for Virginia's Health: A Report of the Governor's Health Reform Commission*, page 18-19.

⁷ *Roadmap for Virginia's Health: A Report of the Governor's Health Reform Commission*, page 3.

stakeholders, including representatives of patients, physicians, hospitals, long-term care providers, pharmacists, payers, and other appropriate stakeholders together to [develop] appropriate metrics for use in Virginia. Quality measurements will be developed in collaboration with similar initiatives in the private and public sectors.

- c. **Transparency of Pricing Information** – In order to support consumer knowledge concerning the cost of care, the State Employee Health Benefits Program will work with its third party administrator(s) to make available to enrollees in state-sponsored health insurance plans the prices paid to providers for health care procedures, drugs, supplies and devices. The Commonwealth will also participate with multi-stakeholder groups in developing information about the overall cost of services for common episodes of care and the treatment of common chronic diseases. Pricing information will be developed thoughtfully, using appropriate stakeholder engagement and consumer research.
- d. **Promoting Quality and Efficiency of Care** – The Commonwealth will examine appropriate opportunities to promote pay- for-performance in health care financing, consistent with its goals of maintaining access, a broad provider network, and quality health services. These efforts will especially focus on chronic disease management. We will also work with our federal and private sector partners to identify opportunities to improve the quality and safety of care across the board, with a particular focus on management of chronic diseases.⁸

In response to the national *Healthy People 2000* and now *2010* initiatives, the Virginia Department of Health (VDH) took the lead in identifying key focus areas and objectives that needed to be addressed in the Commonwealth. The overarching goals for the Healthy Virginians 2010 initiative are the same as those being advanced through the nationwide agenda: (1) increase the quality and years of healthy life and (2) eliminate health disparities. Out of the 28 focus areas and 467 objectives found in *Healthy People 2010*, there were 77 objectives within 24 focus areas that were deemed to be most important to Virginians. Some of those focus areas include:

- **Access to Quality Health Services:** Improving access to comprehensive, high-quality healthcare services.
- **Cancer:** Reducing the number of new cancer cases as well as the illness, disability, and death caused by cancer.
- **Diabetes:** Through prevention programs, reducing the disease and economic burden of diabetes, and improving the quality of life for all persons who have or are at risk for diabetes.
- **Educational and Community-Based Programs:** Increasing the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.
- **Environmental Health:** Promoting health for all through a healthy environment.
- **Family Planning:** Improving pregnancy planning, spacing and preventing unintended pregnancy.
- **Health Communication:** Using communication strategically to improve health.

⁸ Direct quotation from http://www.governor.virginia.gov/Initiatives/ExecutiveOrders/2006/EO_42.cfm

- **Heart Disease and Stroke:** Improving cardiovascular health and quality of life through the prevention, detection, and treatment of risk factors; early identification and treatment of heart attacks and strokes; and prevention of recurrent cardiovascular events.
- **Human Immunodeficiency Virus (HIV):** Preventing HIV infection and its related illness and death.
- **Immunization and Infectious Diseases:** Preventing disease, disability, and death from infectious diseases, including vaccine-preventable diseases.
- **Injury and Violence Prevention:** Reducing injuries, disabilities, and deaths due to unintentional injuries and violence.
- **Maternal, Infant, and Child Health:** Improving the health and well-being of women, infants, children, and families.
- **Mental Health and Mental Disorders:** Improving mental health and ensuring access to appropriate, quality mental health services.
- **Nutrition and Overweight:** Promoting health and reducing chronic disease associated with diet and weight.
- **Oral Health:** Preventing and controlling oral and craniofacial diseases, conditions, and injuries and improving access to related services.
- **Physical Activity and Fitness:** Improving health, fitness, and quality of life through daily physical activity.
- **Public Health Infrastructure:** Ensuring that Federal, Tribal, State, and local health agencies have the infrastructure to provide essential public health services effectively.
- **Respiratory Diseases:** Promoting respiratory health through better prevention, detection, treatment, and education.
- **Sexually Transmitted Diseases:** Promoting responsible sexual behaviors, strengthening community capacity, and increasing access to quality services to prevent sexually transmitted diseases (STDs) and their complications.
- **Substance Abuse:** Reducing substance abuse to protect the health, safety, and quality of life for all, especially children.
- **Tobacco Use:** Reducing illness, disability, and death related to tobacco use and exposure to secondhand smoke.⁹

Additionally, numerous boards, agencies and organizations have conducted studies, developed initiatives and advocated for funds to create and sustain quality health care services and systems in Virginia. The Virginia Board of Health is dedicated to the following priority public health issues:

- Prevention and control of chronic disease;
- Reduction of disparities in health care and health status;
- Improvement of Virginia’s public health infrastructure; and
- Improvement in the health and well-being of all Virginians.

⁹ Virginia Department of Health. *Healthy Virginians* 2010. Retrieved September, 2008 from: <http://www.vdh.virginia.gov/healthpolicy/HV2010/documents/FObj2010.PDF>

The VDH Office of Minority Health and Public Health Policy (OMHPP) is dedicated to identifying health inequities, assess their root causes, and addressing them by promoting social justice, influencing policy, establishing partnerships, providing resources and educating the public. The OMHPP promotes health equity and works to decrease and ultimately eliminate health inequities throughout the Commonwealth through the work of its two Divisions:

- *Division of Health Equity (DHE)* – Promotes a focus on social determinants of health and social justice, in addition to more traditional health promotion, as key strategies to eliminate health inequities that exist by socioeconomic status, race/ethnicity, geography, gender, immigrant status and other social classifications.
- *Division of Primary Care and Rural Health (DPCRH)* – Promotes health equity throughout the Commonwealth by improving access to quality care, supporting the development of models of care and addressing barriers related to rurality.

The Virginia State Office of Rural Health (VA-SORH), housed within the DPCRH, was established to create, fund and support quality and sustainable rural health care infrastructure throughout the Commonwealth. The VA-SORH is charged with:

- Fostering collaboration and leveraging resources across and within various levels of government, communities, and non-profit organizations;
- Collecting and disseminating information to stakeholders;
- Providing technical assistance;
- Assisting the coordination of rural health interests state-wide through assessment and planning efforts; and
- Supporting efforts to improve recruitment and retention of health professionals in rural areas.

The VA-SORH is presently responsible for managing the following federal Office of Rural Health Policy grant programs:

- State Office of Rural Health (SORH) Program;
- Small Rural Hospital Improvement (SHIP) Program;
- Medicare Rural Hospital Flexibility (FLEX) Program; and
- FLEX Critical Access Hospitals - Health Information Technology Network (CAH-HITN) Grants Program.

Despite these many efforts, Virginia and its citizenry continue to face challenges with health care infrastructure, particularly in rural areas. These challenges are exacerbated by the increasing number of uninsured, growing shortages of qualified health care professionals, skyrocketing health care costs, increasing demands for health care accountability and transparency, and the growing aging population (see Appendix C for a profile of rural Virginia).

The health care challenges facing rural Virginians are consistent with those facing rural residents across the nation. The Southwest Rural Health Research Center, located at the School of Rural Public Health at the Texas A&M University System Health Science Center, with grant support from the federal Office of Rural Healthy Policy developed *Rural Healthy People 2010: A Companion Document to Healthy People 2010*

(Volumes 1-3).¹⁰ As part of the development of these documents, in Spring 2001, national and state rural health experts identified the following top priorities for rural health¹¹:

Rural Priorities (identified by 15% or more)	Percent of Respondents (N=44)	
Access to health care (includes one or more of the following):		73%
Access to emergency medical services (EMS)	32%	
Access to health workforce	29%	
Access to health services (general)	29%	
Access to health insurance	26%	
Access to primary care	24%	
Mental health		49%
Oral health		41%
Educational and community-based programs		29%
Diabetes		26%
Injury and violence prevention		26%
Nutrition and overweight		21%
Public health infrastructure		21%
Tobacco		21%
Maternal, infant and child health		18%
Occupational safety and health		18%
Cancer		15%
Environmental health		15%
Heart disease and stroke		15%

Also, as part of the development of these documents, literature reviews were conducted about rural issues and disparities. The following is a summary of those literature reviews:

Access to Quality Health Services in Rural Areas (Insurance)	<ul style="list-style-type: none"> Persons living in nonmetropolitan areas are more likely to be uninsured than those in metropolitan areas – 20 percent versus 17 percent.
	<ul style="list-style-type: none"> Health insurance is a critical factor in determining timely access to health care. Persons without health insurance are less likely to have a “regular” or usual health provider, less likely to obtain preventive care, or to obtain needed tests and prescriptions.
	<ul style="list-style-type: none"> Access to health insurance has been identified by both national and state experts as a rural health priority, and access to quality health services was most frequently selected as a rural health priority in a survey of state and local rural health leaders.
Access to Quality Health Services in Rural Areas (Primary)	<ul style="list-style-type: none"> There are fewer physicians with the exception of family practitioners and general practitioners, in rural areas in all four regions of the nation.
	<ul style="list-style-type: none"> Only about 10 percent of physicians in America practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas.

¹⁰ Southwest Rural Health Research Center, Rural Healthy People 2010 Project. *Rural Healthy People 2010: A Companion Document to Healthy People 2010* (Volumes 1-3). Retrieved on August, 2008 from: <http://www.srph.tamhsc.edu/centers/rhp2010/publications.htm>

¹¹Taken directly from the Southwest Rural Health Research Center, Rural Healthy People 2010 Project. *Rural Healthy People 2010: A Companion Document to Healthy People 2010*.

Care)	<ul style="list-style-type: none"> As many as 12 percent of all hospitalizations may be avoidable and are disproportionately frequent among the poor and non-white populations.
Access to Quality Health Services in Rural Areas (EMS)	<ul style="list-style-type: none"> Emergency medical services is the umbrella term for a continuum of health services including pre-hospital medical services, emergency services provided at the hospital or health center, and the trauma system that often serves as the network of coordinated trauma care.
Access to Quality Health Services in Rural Areas (Long-term Care)	<ul style="list-style-type: none"> Approximately 75 percent of those over 65 suffer from at least one chronic illness.
	<ul style="list-style-type: none"> Nearly 22 percent of the nation’s elderly reside in rural areas.
	<ul style="list-style-type: none"> Rural elderly represent a larger proportion of the rural population than the urban population.
	<ul style="list-style-type: none"> The elderly in rural areas have access to fewer and a narrower range of long-term care services.
Maternal, Infant and Child Health in Rural Areas	<ul style="list-style-type: none"> Adolescent mortality is higher in rural areas in all four regions of the country.
	<ul style="list-style-type: none"> Infant mortality is higher in rural areas in the South and Western regions.
Mental Health and Mental Disorders in Rural Areas	<ul style="list-style-type: none"> A survey of state and local rural health leaders finds mental health and mental disorders to be the fourth most often identified rural health priority.
	<ul style="list-style-type: none"> The suicide rate among rural males is higher than among their urban counterparts across all regions of the nation.
	<ul style="list-style-type: none"> Among 1,253 smaller rural counties with populations of 2,500 to 20,000, nearly three-fourths of these rural counties lack a psychiatrist, and 95 percent lack a child psychiatrist.
	<ul style="list-style-type: none"> Access to mental health care and concerns for suicide, stress, depression and anxiety disorders were identified as major rural health concerns among state offices of rural health.
Nutrition and Overweight Concerns in Rural Areas	<ul style="list-style-type: none"> Nationally, rural areas have higher self-reported rates of adult obesity than urban areas, but there is considerable variation among men and women across the region.
The State of Rural Oral Health	<ul style="list-style-type: none"> Nationally, rural areas record higher rates of people 65 and older with total tooth loss than do their urban counterparts. Among the four regions, only in the Midwest is this rural rate exceeded by the small metropolitan counties.
	<ul style="list-style-type: none"> Shortages of dentists are much greater in rural areas in all four regions of the country.
	<ul style="list-style-type: none"> Dental visits within the past year tend to be lower among 18-64 year old people in rural areas than in urban areas across all four regions of the country.
	<ul style="list-style-type: none"> Dental shortages were identified as major rural health concerns among state offices of rural health.
Tobacco Use in Rural Areas	<ul style="list-style-type: none"> Rural adolescents (except in the Midwest) are more likely than their urban counterparts to smoke.
	<ul style="list-style-type: none"> Adult men and women in most rural counties, with some variation across the regions, are more likely to smoke than those in urban counties.
Educational and Community-based Programs in Rural Areas	<ul style="list-style-type: none"> School, worksite, health facility, and community-based health promotion, prevention and intervention programs reach large segments of the population; however, these programs may be less prevalent in rural than urban settings.
	<ul style="list-style-type: none"> Smaller employers – the mainstay of rural economies – are less likely than larger employers to offer health promotion and disease prevention programs.

	<ul style="list-style-type: none"> ▪ Rural areas may lack the readiness, resources, and technical expertise necessary to develop successful and sustainable educational and community-based programs.
Injury and Violence Prevention in Rural Areas	<ul style="list-style-type: none"> ▪ Age-adjusted injury and unintentional injury death rates are higher in rural areas than urban areas.
	<ul style="list-style-type: none"> ▪ Unintentional injuries are the fifth leading cause of death and are more prevalent in rural areas.
	<ul style="list-style-type: none"> ▪ Motor vehicles deaths and occupational injuries are higher in rural areas.
	<ul style="list-style-type: none"> ▪ The 40 percent of agricultural work-related fatalities accounted for by minors far outweighs the small percentage of minors in agriculture, eight percent.
Public Health Infrastructure	<ul style="list-style-type: none"> ▪ A majority (69 percent) of local public health agencies serve jurisdictions of less than 50,000 people.
	<ul style="list-style-type: none"> ▪ Public Health Infrastructure was identified as the 12th highest ranking rural health concern in a survey of rural stakeholders.
	<ul style="list-style-type: none"> ▪ Retaining and recruiting qualified public health professionals to serve in rural areas present barriers to strengthening the rural public health workforce.
	<ul style="list-style-type: none"> ▪ More non-metropolitan (41 percent) than metropolitan (26 percent) local public health agencies noted funding was their main challenge.

In spite of these varied and seemingly insurmountable challenges, the Commonwealth remains unwavering in its commitment to ensuring affordable, safe and high quality health care for all Virginians, including those in rural areas.

Background and Purpose

Authorized by section 4201 of the Balanced Budget Act of 1997 (BBA), Pub. L. 105-33 and reauthorized by Section 405 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173 (see Appendix A), all states that participate in the Federal Medicare Rural Hospital Flexibility (Flex) Grant Program, are required to develop a State Rural Health Plan (SRHP). The purpose of the plan is to provide for the: (1) creation of rural health network systems, (2) designation of Critical Access Hospitals, (3) support of CAH and other small rural hospital facilities, (4) integration of Emergency Medical Services (EMS) into an organized system of care, and (5) integration of quality and performance improvement.

As a grantee of the Flex program, Virginia was required by Federal regulations to develop a State Rural Health Plan (SRHP). Virginia developed its first SRHP in 2000. The 2000 SRHP focused on the:

1. Conversion of eligible hospitals to Critical Access Hospital (CAH) status and supporting these hospitals through the conversion process;
2. Identification of other potential hospitals that are eligible for CAH status and assisting with financial feasibility analyses;
3. Development of a taskforce to implement the Flex program; and
4. Development of administrative support for federal and state regulatory requirements of the plan.

As a result of the Balanced Budget Act of 1997, Virginia is also charged by State *Code* section § 32.1-122.07 (see Appendix B) to establish a SRHP. Under this section of *Code*, “The Commissioner shall develop and the Board of Health shall approve a rural health care plan for the Commonwealth...the plan shall be developed