

	<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

and revised as necessary or as required.”¹² The 2000 SRHP was guided by an advisory group called the Critical Access Taskforce (CAT) and had the following six core goals:

1. Ensure access to hospitals and other health services for residents in rural Virginia;
2. Facilitate the number and quality of rural health networks on a local and regional basis;
3. Create an efficient administrative infrastructure to guide and oversee the state’s CAH program;
4. Educate and assist rural hospitals desiring to convert to CAH status to ensure their sustainability and to promote quality of care;
5. Ensure a regulatory framework supportive of the creation of CAHs; and
6. Educate the Virginia General Assembly and members of the Virginia Hospital and Healthcare Association about the Flex program and CAH designation in order to help them make informed policy choices.

The development of this updated Virginia Rural Health Plan (VA-RHP) occurred in three distinct phases.

Phase One. In December 2004, the OMHPHP partnered with the Virginia Rural Health Association to begin the planning process for updating the 2000 plan. Approximately 50 partners from across the Commonwealth attended the planning meeting. Participants first discussed recurring rural health issues¹³. These included:

<ul style="list-style-type: none"> ▪ Availability of population characteristics and utilization data <ul style="list-style-type: none"> ○ Disease distribution ○ Disease burden ○ Health outcomes 	<ul style="list-style-type: none"> ▪ Availability of an inventory of rural health resources / programs <ul style="list-style-type: none"> ○ Workforce distribution ○ Community infrastructure / programs ○ Telemedicine ○ Transportation ○ Prescription drug availability ○ Mental health ○ Dental ○ Specialty ○ Allied health ○ Lay provider programs ○ Health literacy and early intervention ○ Long-term and elder care ○ English versus other languages/migrants ○ Volunteers ○ Interns, students, service learning
<ul style="list-style-type: none"> ▪ Ability to leverage resources <ul style="list-style-type: none"> ○ Opportunities and incentives for collaboration that would improve both the number and quality of services offered ○ Cultural competency ○ Opportunities to tie the impact of health care into rural economic development 	
<ul style="list-style-type: none"> ▪ Resource inequities <ul style="list-style-type: none"> ○ Reimbursements ○ Healthcare workforce distribution, recruitment and retention 	
<ul style="list-style-type: none"> ▪ Lack of consensus on a definition of rural 	
<ul style="list-style-type: none"> ▪ Health care reform 	
<ul style="list-style-type: none"> ▪ Title I and VI requirements 	
	<ul style="list-style-type: none"> ▪ Effectiveness of programs
	<ul style="list-style-type: none"> ▪ Loan repayment and J1-Waiver programs

¹² The Virginia General Assembly, Legislative Information System. *Code of Virginia*. Retrieved on August, 2008 from: <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+32.1-122.07>

¹³ University of Virginia, School of Nursing, Rural Health Care Research Center – Community Outreach. Retrieved on September, 2008.

Participants then discussed barriers to the provision of care in rural areas, concerns about current rural health care services and questions to be considered¹⁴. These included:

Barriers to the Provision of Rural Health Care	Concerns about Rural Health Care Services	Questions to Consider
<ul style="list-style-type: none"> ○ Lack of specialty care ○ Low health literacy ○ Lack of available and affordable health care services for indigent residents ○ High rate of illiteracy ○ Overutilization of emergency rooms as health clinics 	<ul style="list-style-type: none"> ○ Need to identify gaps in primary care services ○ Need to identify where citizens go for primary care services ○ Need to clearly identify the demographics of rural populations and understand the aging population in rural areas ○ Need to address dental/oral and mental/behavioral health, chronic diseases, utilization of telehealth applications and the emerging immigrant populations 	<ul style="list-style-type: none"> ○ Are there restrictions on the acceptable/preferred definition of rural? ○ How broad or narrow should the definition of rural be? ○ What work has been done with Centers for Medicare & Medicaid Services (CMS) to reduce discrepancies in the definition of rural for reimbursement purposes? ○ What other agencies or organizations are concerned with the rural/urban divide?

After an enthusiastic start, for a variety of reasons, the momentum for the planning process was lost and an updated rural health plan never came to fruition. In 2007, the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) Office of Rural Health Policy (ORHP) required all states that participated in Flex to revise their original SRHP. By program guidance, states were urged to create a revised SRHP that would be a roadmap toward using grant funds to support CAH facilities, CAH eligibles, and the communities they serve in a strategic fashion that helps support rural health care delivery broadly and that builds on the success of past Flex-supported efforts. Virginia was among the states required to revise its original SRHP.

Phase Two. In July 2007, the OMHPHP organized a Rural Health Strategic Planning Summit. This Planning Summit served two purposes: (1) to strategize and plan for upcoming rural health activities (particularly the upcoming Flex grant activities) and (2) to revive the SRHP planning process, adding new stakeholders and providing greater structure. It was at this Planning Summit that four workgroups were established to work on updates to the VA-RHP.

In order to strategize and plan for the upcoming Flex grant activities during the Planning Summit, stakeholder input was obtained regarding the following four areas: 1) development/implementation of rural health networks, 2) support of existing CAHs and eligible hospitals, 3) improving quality of care, and 4) improvement and integration of EMS. The following were the findings related to these four areas:

¹⁴ University of Virginia, School of Nursing, Rural Health Care Research Center – Community Outreach. Retrieved on September, 2008 from: <http://www.nursing.virginia.edu/Research/rhrc/community>

<p>Development/ Implementation of Rural Health Networks</p>	<ul style="list-style-type: none"> ▪ Rural areas need reliable communications ▪ There is a need to document the tele-communications infrastructure in rural VA as it relates to healthcare providers/healthcare systems ▪ There is a need to understand how well we are connected to each other ▪ These is a need to understand the existing infrastructure and to examine where there are gaps 	<ul style="list-style-type: none"> ▪ There is a need to grow the culture of information sharing ▪ There is need to understand existing resources and capacity ▪ There is a need to develop strategies to get at root causes of problems
<p>Support of Existing CAHs and Eligible Hospitals</p>	<ul style="list-style-type: none"> ▪ There is a need to ensure access to specialty care and to develop seamless integration (getting people to the specialist) ▪ There is a need for EMS training at the advanced and finance level ▪ There is a need for technology support (i.e. tele-radiology, tele-pharmacy and tele-radiology) ▪ There is a need for legislative changes ▪ There is a need to conduct a workforce/economic development study for rural healthcare and to tie this into strategic planning efforts 	<ul style="list-style-type: none"> ▪ These is a need for assistance with health care workforce issues ▪ These is a need to address the cost of insurance and liability ▪ There is a need to address staffing issues in small rural hospitals , looking at physicians vs. nursing ▪ There is a need for a person to provide information technology support among the CAHs
<p>Improving Quality of Care</p>	<ul style="list-style-type: none"> ▪ There is a need to improve quality within the rural health infrastructure ▪ There is a need to conduct an analysis among rural hospitals to assess current quality and performance ▪ There is a need to further develop electronic medical records ▪ There is a need to implement learning sessions around quality, workforce, performance, etc. 	<ul style="list-style-type: none"> ▪ There is a need to develop a rural oriented training for quality improvement ▪ There is a need to have routine quality meetings to keep stakeholders informed and up to date
<p>Improvement and Integration of EMS</p>	<p><i>Improve staffing</i></p> <ul style="list-style-type: none"> ▪ There is a need for focused recruitment campaigns ▪ There is a need for funding to bring experienced providers into rural areas and areas of need ▪ There is a need to provide incentives to providers to bring them into rural areas ▪ There is a need for mentoring programs 	<p><i>Coordination and Collaboration</i></p> <ul style="list-style-type: none"> ▪ There is a need to strategically place EMS in areas needed ▪ There is a need for real time documentation of the availability of locations and resources ▪ There is a need for automatic mutual aid ▪ There is a need for coordination of training

	<ul style="list-style-type: none"> ▪ There is a need for staff leasing/job sharing ▪ There is a need for consolidation of services ▪ There is a need for grant funding to fund physicians <p><i>Integration of information</i></p> <ul style="list-style-type: none"> ▪ There is a need to sharing information between EMS and hospitals ▪ There is a need for more advanced information ▪ There is a need for a greater activation of services 	<p><i>Trauma</i></p> <ul style="list-style-type: none"> ▪ There is a need for team and system development (bring focus of trauma back to rural communities) ▪ There is a need for coordination of training ▪ There is a need for better transportation
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The Planning Summit also resulted in providing a wealth of additional information about health-related needs, issues and priorities in rural Virginia. The following were identified as necessary for improving rural health:

- A seamless continuum of care that integrates all partners and healthcare providers.
- A greater focus on health promotion programs.
- Greater coordination of health care resources.
- EMS to be a reliable and integral part of the continuum of care.
- Ability to link EMS with hospital discharge data to more effectively examine outcomes.
- Quality indicators that are more relevant to small rural hospitals and to Virginia’s rural areas.
- Greater access to health information.
- CAH hospitals to have electronic medical records.
- More stakeholder involvement in Virginia’s rural health planning process, including those representing mental/behavioral and dental/oral health, long-term care, local government officials and rural residents.
- A study of the current Medicaid reimbursements rates and financial health care market structure for small rural hospital facilities and rural EMS agencies.
- Financial management training for small rural hospitals and other rural health care facilities.
- A study of the prevalence of substance abuse and domestic violence in rural areas and the development of prevention and early intervention initiatives to address these issues.
- A statewide database that shows bed availability in real-time for certain medical problems in order to increase efficiency of services.
- A more effective and integrated network system and the ability to share best practices.
- The development of comprehensive community health directories.

- Better data regarding rural health disparities/inequities, including what disparities/inequities exist and where they are most prevalent.

Phase Three. The work of developing recommendations for the updated VA-RHP was divided among four workgroups: access, quality, workforce and data/rural definitions. Although there are many contributing factors to rural health and health care, it was recognized that these four were the top priorities for the first update to the VA-RHP. Each workgroup:

- Was comprised of prominent subject matter experts, community leaders, government and private organizations and advocates.
- Met at least three times from August 2007 to February 2008
- Was informed that the purpose of the updated VA-RHP is to provide a three-to-five year action plan targeted towards the advancement of health and health care services in rural areas, with the ultimate goal of strengthening the overall current and future rural health infrastructure.
- Was informed that the VA-RHP is not to solely focus on the CAH structure because it is imperative to take a broader examination of the rural health infrastructure that is inclusive of both CAH and non-CAH rural localities.
- Was given a particular focus and charge:
 - *Access Work Group* – Examined rural health care access issues related to primary care, specialty care, emergency medical services, and mental and dental health care in order to make recommendations for improving health care access.
 - *Quality Work Group* – Examined rural health care quality issues in order to make recommendations for quality improvement efforts and/or activities.
 - *Data and Rural Definitions Work Group* – examined available rural health data and identified data gaps in order to make recommendations for future data collection efforts and/or activities. This workgroup was also tasked with coming to consensus on a working definition of rural in Virginia (see Appendix C).
 - *Workforce Work Group* – Examined available resources and issues in order to make recommendations for improving the health care workforce in rural Virginia.
- Met independently, but shared meeting notes and summaries across groups.
- Agreed on a set of ten core guiding principles for improving rural health in Virginia.
- Agreed on a set of foundational building blocks for rural Virginia; thereby laying the vision for a rural health infrastructure.

Core Guiding Principles for Improving Rural Health in Virginia

Successful rural health systems hinge on a set of shared core expectations regarding fundamental services. To ensure long-term progress toward assuring strong, healthy and viable rural communities, stakeholders must be willing to ask and address some very difficult questions. These include things like What are the priorities? Who is responsible? How much will it cost? What do we want rural Virginia to look like?

There is strong consensus that all rural residents should have access to affordable and quality treatment,