

- 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,

prevention and health educational resources as close to home as possible, and at a reasonable cost. However, there is a lack of agreement regarding the role of telehealth applications, the use of mid-level providers, the definition of acceptable travel distance for health care, and more. Rural stakeholders within each community must grapple with and come to consensus on the following fundamental questions:

- Should Virginia aim to replicate urban models of care in rural settings? Should rural areas expect to have available the same type and scope of services as are available in large metropolitan areas? In many rural areas, neither the local economy nor the population base can adequately support an urban model of health care. If this is indeed the desired outcome, then economic development must become the number one priority and primary solution to improving rural health and rural health care systems. Taken to its natural conclusion, this would ultimately change the face of rural in Virginia.
- On the flip side, should Virginia aim to develop and/or model innovative approaches that will meet the health care needs of rural residents while trying to maintain and preserve rural culture? What sacrifices, if any, are acceptable to rural stakeholders in order to maintain and preserve rural culture?

Improving rural health requires innovative, creative and integrative strategies that address both individual health-related behaviors and the many social determinants of health. It is imperative for any planning effort to think beyond health care services to the more multifaceted social conditions that impact health. Any discussion about how to improve the health status of a population group, whether rural or non-rural, must acknowledge the unequivocal link between individual health behaviors and health status. The negative effects of poor health behaviors outweigh the positive effects of acute and preventive health care services. There is clearly a need to promote health education, prevention and wellness strategies, as well as parental and personal responsibility. However, the goal of improving the health status of any population group cannot be adequately addressed without consideration of the social determinants of health (SDOH) and their distribution in the population. These social determinants include:

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| ▪ Socioeconomic status | ▪ Working conditions |
| ▪ Culture | ▪ Built and physical environments |
| ▪ Discrimination | ▪ Social support and capital |
| ▪ Housing | ▪ Health care services |
| ▪ Transportation | ▪ Healthy child development |
| ▪ Food Security | ▪ Democratic participation |

Additional contributors include income, gender, ethnic and cultural norms, educational and employment opportunities and community history. In Virginia and across the nation, these SDOHs are inequitably distributed by race/ethnicity, socioeconomic status and geography. SDOHs affect health by determining behavioral options, levels of stress exposure and exposure to environmental threats across the lifespan. Strategies for mitigating illness and improving individual health can only succeed if they are developed within the context of their broader social framework.

Performance and quality improvement must be central to rural health care services. Quality health care services and health status, as well as the quality of life for rural residents, are core goals of the VA-RHP. All planning efforts must be aimed at improving the ability to define, measure and compare performance and quality improvement. Actions and resources must also align with these improvements. Virginia’s rural health infrastructure will benefit from an established and agreed upon definition of quality. The definition

recommended by the VA-RHP Quality Workgroup and utilized in this plan comes from the Institute of Medicine’s (IOM) report from 2001 and is as follows:

“Quality healthcare is the provision of appropriate services to individuals and populations, that are consistent with current professional knowledge, in a technically competent manner, with good communication, shared decision-making and cultural sensitivity.

Quality healthcare is evidence based; increases the likelihood of desired health outcomes; and addresses six aims: safe, effective, patient-centered, timely, efficient, and equitable – using a systems approach to continuously improve clinical, operational, and financial domains.”¹⁵

This workgroup also recommended the adoption of the six aims for health care quality as objectives for this core definition (taken from the same IOM report). The IOM suggests that services be Safe, Timely, Effective, Efficient, Equitable, and Patient (or Community) Centered (STEEEP).

Aim	Definition
Safe	Avoiding injuries to patients from the care that is intended to help them
Timely	Avoiding waits and sometimes harmful delays for both those who receive and those who give care
Effective	Providing services based on scientific knowledge (evidence-based) to all who could benefit and refraining from providing services to those not likely to benefit (avoiding under-use and over-use, respectively)
Efficient	Avoiding waste, including waste of equipment, supplies, ideas, and energy
Equitable	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status
Patient-centered	Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions

Unfortunately, the IOM definition is predominantly health care services oriented. As Virginia continues to examine rural health in a more comprehensive way, it is imperative that quality be examined in terms of performance improvements and in relation to improvements to health and the quality of life. Virginia’s rural areas are diverse and there is significant variability in health status, as well as in performance and quality improvement measures. Virginia must develop a system to compare these differences, both between clusters of rural communities and localities, as well as in comparison with statewide and national population-based indicators.

Rural health must be examined at local, regional and statewide levels. Although many rural localities face similar challenges, Virginia’s rural areas also have characteristics that set them apart from one another. For example, the Shenandoah Valley region is faced with challenges that are very different than those faced on

¹⁵ Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. The Quality of Health Care in the United States. Washington, D.C.: National Academy Press, 2001.

the Eastern Shore. There are no “one-size fits all” solutions that can be applied to all rural communities and regions. There is a need to explore and be sensitive to local and regional conditions.

Rural residents must play a critical role in determining the needs and the strategies for improving the rural health infrastructure. Local communities must take on the primary responsibility for addressing community needs, determining desired models of care, securing resources, as well as the stewardship of such resources. The advancement of community responsibility and ownership is a necessary element in addressing rural community health improvement. However, Federal, State and local governments must also do its share to ensure the availability of a quality rural health infrastructure.

Collaborations and partnerships are necessary for leveraging resources, strengthening the service delivery system and rural health infrastructure, and reducing systems fragmentation. Although local prerogatives must be respected, it is imperative that collaborations and partnerships be developed in rural areas where there is a shortage of manpower and resources. The health system in rural areas must strive for a greater integration of primary care with mental/ behavioral health, EMS, dental/oral health, telehealth, women’s health services, preventive care and health promotion and health education.

A better alignment of funding sources will assist in targeting resources. Federal, State and private resources must be channeled to support projects that are consistent with the recommendations set forth by the VA-RHP.

Models of care and pilot projects that center on community planning and engagement are essential. A broad recurring strategic theme in many of the VA-RHP recommendations is the need to: (1) establish a global vision for rural Virginia; (2) identify related target needs, e.g., major gaps in community needs and identifiable health inequities; and (3) address these issues through the development of community-oriented demonstration projects that build on existing assets. Demonstration or pilot project should have a platform of substantive community participation; clearly identified leadership; demonstrated, multi-party collaboration; a reasonable probability for successful project implementation; and an evaluation strategy. Since there are insufficient resources to support community engagement in all rural areas simultaneously, the greatest return on investment may be from building new projects in communities that have a demonstrated history of collaboration. With that said, it is also important to note that some level of attention must also be directed toward identifying and working with disadvantaged communities that lack the social and economic infrastructure required to engage in large-scale collaborative projects. Frequently, these are the communities with the greatest need for improvements in health and the health care services infrastructure.

Health plays a critical role in sustaining and developing strong rural communities. Rural health is a necessary component of community health and economic development, in that the availability of a healthy workforce is critical in attracting employers. In addition, health service providers (hospitals, community health centers, nursing facilities, pharmacies, home care agencies and others) are oftentimes the major employers in many rural communities. The related expenditures generated by these providers have significant direct and indirect community impacts (i.e., economic multiplier effects). There is a need to clearly articulate the relationships between health, health services and the economic well-being of rural communities. Additionally, there is an undeniable connection between employment (a key social determinant of health) and improved health status. Presently, the linkages between organizations and individuals interested in health, and those interested in economic development, are underdeveloped. Greater understanding and communication between these groups need to be fostered.

Decision-making must be based on, and supported by, accurate and available data, research, timely analysis, and critical thinking. The development of strategies to improve rural health must begin with

data-driven assessments and recommendations. One of the key objectives of the VA-RHP planning process is to ensure that findings and strategies are based on accurate and quality data, and to make recommendations that further enable data-driven and evidence-based decision-making. While the State has multiple data sources, many of these existing data sources are not set up in such a way as to allow analyses by rurality.

Fundamental Building Blocks for Virginia’s Rural Health Care System

There are no universal solutions to the difficult challenges of improving rural health. Notably, there are substantial variations of actual and perceived needs, resources and organizational capacity among communities. These variations are paralleled by significant differences in both overall health status and chronic disease morbidity across rural regions, and are affected by factors such as the extent of “rurality”, seasonality, socioeconomic conditions, the availability of transportation, community history, and associated culture and attitudes.

It is easy to say that rural residents should have ready access to all of the identified services and that referral linkages to more specialized providers and facilities should be in place. However, in many cases neither the local capacity nor the referral resources and linkages are adequate. Priority must be given to establishing the following identified building blocks and securing the resources necessary for their sustainability.

The following set of foundational services and resources were embraced by all stakeholders who participated in the VA-RHP development process. These are not intended to limit the available health care services provided in rural areas, but to serve as a basis for the scope of services that should be provided.

Outpatient, Medical, Surgical, Obstetrical Services

Examples of providers include allopathic and osteopathic physicians and other health professionals to include physician assistants, nurse practitioners, certified advanced practice nurses, school nurses and midwives.

- Primary Care
 - Family Medicine
 - Internal Medicine
 - Pediatrics
 - Obstetrics and General Gynecology
- General Surgery (full-time in most rural hospitals but part-time in some, generally with particular emphasis on outpatient surgery, including endoscopy)
- Orthopedics (full-time in some rural hospitals, at least part-time in most, but this is highly variable by size of service area and service planning requires service-area-specific assessment).
- Other Limited Specialty Services

Emergency/Urgent Care Services

- Mobile Emergency Medical Services (ambulance services, emergency medical technicians, paramedics, and communications systems)