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**An Update
on the Development of a
Rural Health Plan for
Virginia**

November 7, 2007

Guidelines for Rural Health Plan Development

- A Statewide Rural Health Plan (SRHP) for Virginia that will lead to improvements in health (not just to improvements in the delivery of services)
- A SRHP to support ways to continue to enhance and improve the ability of critical access hospitals (CAHs) and other small rural health hospitals to meet existing and emerging health care needs

Guidelines for Statewide Rural Health Plan Development

- It is anticipated that the Plan will be a “living” document that will be revisited yearly to:
 - (1) examine progress of activities
 - (2) examine ongoing appropriateness of Plan
 - (3) determine whether modifications are needed

Guidelines for Rural Health Plan Development

- The Plan must include goals and objectives for the future with measurable outcomes
- It will incorporate several of the following considerations:
 - Support of existing CAHs and Eligible Hospitals
 - Development and Implementation of Rural Health Networks
 - Improvement and Integration of EMS Services
 - Improvements in the Quality of Care

Guidelines for Rural Health Plan Development

- The Plan will be used to provide a cohesive and concise portrait of rural health and the needs to various local, State and Federal stakeholders, partners and rural citizenry. It is meant to guide, (but is not limited to):
- - Government officials
 - Government agencies
 - Grantors/Funding programs
 - Local and state partners
 - National organizations

Guidelines for Plan Development

- The target is a relatively **Concise** Plan (with associated appendices, cross-references, and hyperlinks)
- **Community Sensitive**, while also recognizing State priorities
- **Practical** while offering some inspiration
- **Actionable** with recommendations that target some short-term actions that can be implemented recognizing constraints on resources
- **Readable**, not so overwhelming that it will not be used, and
- **Directive** to not just short-term actions, but long-term results.

Guidelines for Rural Health Plan Development

- The “Horizon” for the Plan is 3-4 years, although many trends and implementation steps are likely to have longer-term timeframes.
- There are four Work Groups:
 - Quality (Paul Crews)
 - Access (Howard Chapman)
 - Workforce (Karen Guye)
 - Rural Definition/Data (Ken Cook)

Guidelines for Rural Health Plan Development

- Build on good work done in Virginia, on data and informational resources that exist (studies, reports, data compilations), and work-in-progress, and then to integrate findings and recommendations; not to “reinvent the wheel”.
- The core of the Plan will be drafted by the end of the year, but there will be some spill-over to January.
- Two to three public meetings to solicit additional comments

Some Principal Guiding Points

Coming Out of the Initial Access, Quality, and Workforce Work Group Meetings

- **Need for Sensitivity to the Social Determinants of Health**
 - Many of the most significant factors determining the health status of a population are grounded in social and economic influences.
 - A goal of improving the health status of rural populations cannot be adequately addressed without consideration of poverty levels, race, ethnic background, education, employment, cultural, community history, and other demographic and socioeconomic factors.

Some Principal Guiding Points

- **Building a Guiding Vision for the Fundamental Components of Rural Health Systems**
 - Identification of a framework of fundamental health services and public health relationships that should be available or reasonably accessible to residents of rural communities or clusters of communities
 - Institute of Medicine's 2005 report, Quality Through Collaboration, The Future of Rural Health advocates the availability of a set of fundamental services as an element of "quality".

Some Principal Guiding Points

- The concept of “fundamental” services is not meant to be prescriptive in setting an upper limit
- Rather, the intent is to define a target for a minimal foundation for strong rural delivery systems development

Some Principal Guiding Points

- **Supporting the Role of Rural Residents in Determining Rural Needs and Strategies**
 - Strong emphasis on assuring community buy-in and support for rural health improvement strategies
 - Support for communities engaging in the assessment of community needs, setting priorities, and in the development of community-oriented strategies
 - “Community Responsibility” rather than approaches that dictates “from the top down” solutions to problems defined by non-rural folks-from-away.

Some Principal Guiding Points

- **Reducing Fragmentation**

- Rural areas are more likely than urban area to lack the financial **and** non-financial resources needed to invest in addressing multiple problems simultaneously.
- Rural areas must concentrate on reducing fragmentation and duplication which can lead to less than optimal use of limited resources.

Reducing Fragmentation/Improving Integration

- The rural health systems should functionally integrate physical, behavioral, oral, and public health services
- Economic, regulatory, policy, and legal incentives and other mechanisms should be identified to reduce or eliminate fragmentation

Some Principal Guiding Points

- **Developing a Data Base and Processes for Analyzing Data**
 - To address access, quality and workforce issues within or across various regions of Virginia we must have a data base that supports the identification of disparities in health and rural resources
 - State has multiple good resources for data, there is a need to be better able to aggregate and access rural-specific data.

Some Principal Guiding Points

- **Identifying and Piloting Models for Community Planning and Engagement**
 - Models for community and regional engagement around access, quality, and workforce issues should be identified (to the extent that successful models exist in Virginia or elsewhere)
 - Good ideas needs to be transferred
 - Expanded use of pilot projects should be supported particularly where there is likelihood that the outcomes will result in knowledge that could benefit other rural Virginia communities.

Some Principal Guiding Points

- There are insufficient resources to support expanded community engagement in all rural areas at the same time. The greatest return on investment may be from building new projects in communities that demonstrate some history of collaboration among multi-parties.
- However, additional attention is also warranted to working with some **interested** communities to develop their “community readiness” and the community **leadership** necessary to engage in projects.

Some Principal Guiding Points

- **Linking Rural Health to Sustaining and Developing Strong Rural Communities**
 - There is a need to more clearly articulate the relationships between health and health services, and their economic impacts on rural communities.
 - In addition, there is a need to simultaneously highlight the connection between employment and improved health status (a key social determinant of health).

Thoughts on Quality

- Establishing a “working definition” of “quality” and then refining it to meet the need for discussion in Virginia.
- It is proposed that we start with the definition used by the Institute of Medicine in its 2005 report Quality Through Collaboration, The Future of Rural Health. This definition was adopted by the IOM in 1990 and is widely recognized nationally. The definition states:

Quality

- *“Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”*
- **But**, the IOM definition generally addresses “quality of care” and health services. As previously noted, these factors are critically important but do not fully reflect the full scope of “quality” considerations that are fundamental to improving rural health.

Quality

- This IOM definition also notes six IOM's aims for health care quality: that services be Safe, Timely, Effective, Equitable, and Patient- or Community-Centered (STEEP).
- There needs to be sensitivity to what citizens might define as quality versus what professionals might use as a definition.
- Very Open to Suggestions

Work Force Issues

- The concept of workforce planning needs to be much broader than just focusing on primary care needs (and within primary care broader than just focusing on physician needs)
- There needs to be emphasis, not only on the needs of hospitals, but also needs in other settings such as community health centers and long-term care facilities, within patients' homes, and for EMS providers.

Workforce

- Greater emphasis needs to be placed on engaging communities in the development of the workforce necessary to provide fundamental services. Communities (not just the hospitals or community health centers) need to “own” more of the responsibility for workforce development including recruitment and retention, as well as the continuing education and re-education of place-committed community residents.

Workforce

- Many strategies being discussed are the same strategies that other states will be using. A particular challenge is to determine what Virginia can do to specifically address its needs.
- Greater emphasis needs to be placed on how Virginia's academic institutions can be "incentivized" to address rural needs.
- Consideration should be given to approaches to expand, while also reducing the competition for, clinical training sites.

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