

# Virginia's State Rural Health Plan



Supporting Rural Health through Community Engagement and Action

2013

**Purpose:**

*The Virginia State Rural Health Plan (VSRHP) is a three to five year action plan with the objective of enhancing health care systems throughout rural communities. The plan provides an analysis of current health status in rural areas and presents practical strategies for improving health outcomes by broadening development in areas in addition to delivery of health care services.*

**Goal:**

*The goal of the VSRHP is to strengthen the current and future rural health infrastructure in Virginia.*

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# 2013 Virginia Rural Health Plan

## October 8, 2013

### Executive Summary

*We envision a time when all Virginians value rural Virginia not solely for its beauty, cultural variety, and history, but also for the health of its residents.*

This vision represents the hope, intention, and commitment of hundreds of people who value rural Virginia and who contributed to this 2013 Virginia Rural Health Plan. They offered their ideas through survey, conference, telephone interviews, and meetings held in different regions of the state. This Plan focuses on key health problems and identifies six objectives and associated actions intended to address those problems.

The key health conditions identified for this Plan include the following:

- *Obesity and associated behaviors and diseases*, including nutrition, physical activity, diabetes, cardiovascular disease, and early mortality
- *Mental and behavioral health*, including depression, substance abuse, and a range of acute and chronic mental health issues
- *Oral health*, including self-care, preventive and restorative treatments
- *Cancer*, including prevention, early detection and treatment
- *Perinatal issues*, including low birth-weight, infant mortality, spacing between births, and abortion
- *Lung disease*, including COPD and other conditions related to smoking or occupational exposure

Six objectives were also identified in conjunction with a vision statement and several proposed actions that would help to achieve those objectives. The six objectives and accompanying visions are:

1) **Health Outcomes:** Organize locally to identify and address priority health conditions  
*Vision: Rural localities organize to target priority health concerns and take actions that make measurable improvements in health outcomes for these priority concerns.*

2) **Healthy Communities:** Increase awareness, engagement, and coordination among an expanded base of stakeholders to address the social determinants of health (SDOH) and promote healthy and equitable communities  
*Vision: Rural health stakeholders engage local, regional, and state policymakers to consider health and health equity in their long-term planning and day-to-day decisions.*

3) **Access to Health Care:** Reduce barriers and improve rural health care delivery  
*Vision: Rural health communities and stakeholders value, demand, and receive access to quality health care services where language, culture, equipment, facilities, or logistics—including, issues with mobility, such as the inability for an individual to get up on an exam table—are not*

*barriers. Distance from providers and language and cultural differences are no longer barriers to receiving high quality health services.*

4) **Individual Empowerment:** Support community members with education, incentives, and resources to facilitate healthy choices for themselves and their families

*Vision: Virginia's rural residents have the knowledge, institutional support, and resources to make informed decisions that promote healthy families.*

5) **Workforce Development:** Increase the number of providers and develop the appropriate scope of practice needed by the local population

*Vision: Rural communities have sufficient well-trained, culturally and linguistically diverse, and competent health care providers working at the appropriate scope of practice. Rural communities' workforce accurately reflects the diversity of its community. Health care providers that receive federal funding adhere to the guidelines of the National Standards for Culturally and Linguistically Appropriate Services in Health Care.*

6) **Advocacy:** Advocate for rural health policies that promote sustainability for rural health goals and institutions

*Vision: Federal and state policies support Virginia's rural health infrastructure.*

## Introduction to the 2013 Virginia Rural Health Plan

*“The plan is nothing; planning is everything.” -Dwight D. Eisenhower*

Credited to Dwight D. Eisenhower, this statement means that thinking and acting strategically in the face of challenges is essential, but a plan that does not allow for adaptation to changing conditions is useless. Having a plan does not mean that it will be enacted; rather, building and sustaining the resources and capabilities needed to succeed must be part of an ongoing planning process. Finally, the publication of a plan, as important as this is, is not a marker of success; success will be in how well these actions accomplish their goal of improving rural health.

With this in mind, this 2013 Rural Health Plan for Virginia intends to accomplish a number of goals:

- Bring widespread attention to current and anticipated rural health issues and needs
- Capture the ideas, commitment and energy of rural health stakeholders around the Commonwealth
- Motivate participation among a wide range of such stakeholders to enact the Plan’s actions
- Identify key strategic objectives and actions that will sustain ongoing accomplishments and fill gaps in ways that improve the health of the residents of all of Virginia’s rural communities
- Encourage partnerships between community, academic, government, business, and other resources
- Recruit and organize diverse stakeholders to collaborate effectively, bringing together effective partnerships addressing priority topics
- Identify descriptive evaluation processes and measures that are community-based and participatory to enable members to determine progress/improvements

The Plan also is *not* certain things:

- It is not intended to be an encyclopedia of all that is and should be done to ensure healthy rural communities.
- It is not intended to supersede local planning and other ongoing health initiatives.<sup>1</sup>
- It is not a reason for avoiding acting on other needs and opportunities that arise during the period in which this Plan is relevant.

It is easy to mistake action for accomplishment. The 2013 Rural Health Plan needs to be guided by thinking about how what is intended to ensure healthy outcomes actually *achieves* those outcomes. This Plan is a call to action that will require reflection, adaptation, and engagement of a broad and highly diverse set of stakeholders, including new partners and resources. It also requires continuing advocacy and commitment and an ability to prioritize resources towards the areas of greatest need.

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<sup>1</sup> For instance, Virginia’s hospitals have been conducting community health needs assessments, which will yield data that may be invaluable in addressing local community concerns.

## How This Plan Was Developed

The strategic actions in this plan are based on rural health stakeholders' input, gathered in 2012 and 2013. Rather than basing these recommendations on national or state reports, the objectives and actions reflect the real “experts,” individuals who work daily with communities in rural Virginia. Stakeholder input was gathered in five ways:

The [Virginia Rural Health Association \(VRHA\)](#) conducted an **online survey** in August of 2012. This survey served as a preliminary engagement tool to identify priority issues in rural health across the Commonwealth. Over 800 people responded to the survey.

The **2012 Virginia Rural Health Action Conference**, co-sponsored by the Virginia Rural Health Association, the [Virginia Public Health Association](#), and the [Virginia Department of Health \(VDH\)'s Office of Minority Health and Health Equity \(OMHHE\)](#), was held on October 8 and 9. This conference included open-space collaboration where over 120 attendees worked in small groups to identify innovative solutions for priority issues in rural health. This was an opportunity for rural health professionals to network and to look at issues from different avenues, then focus on one issue that they cared most about.

In-depth **interviews** allowed key leaders, many of whom worked on the 2008 plan, to offer lessons from the previous planning process and concrete suggestions for the 2013 Virginia Rural Health Plan in confidence. Two dozen such interviews ensured diversity of insight by reaching out to many sectors and disciplines from around the Commonwealth.

**Five regional listening sessions** allowed issues and solutions pertaining to such themes as access to care, the Affordable Care Act (ACA), advocacy and leadership, and workforce development to be recognized by different regions. Goals of the regional meetings were to gather recommendations based on the experiences and perspectives of regional rural health advocates, to better understand regional priorities for rural health, and to encourage dialogue and networking among the many sectors and agencies involved in the health of rural residents. Meetings were held in Winchester, Lebanon, Tappahannock, Onley, and South Hill. About 70 individuals participated in the regional meetings in total.

Finally, an **Advisory Council** consisting of representatives of the OMHHE, the Virginia Rural Health Association, and the Virginia Public Health Association (VaPHA), worked with the staff of the Institute for Environmental Negotiation, University of Virginia, to combine and synthesize all of this input into the Plan that you see here. This oversight committee reviewed regional issues on a broad level and submitted the health plan draft to present to the Virginia Department of Health.

## History of Virginia's Rural Health Plans

Virginia is charged by State Code section § 32.1- 122.07 to establish a State Rural Health Plan (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.”

Virginia developed its first SRHP in 2000. The 2000 SRHP focused on the:

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

The development of the 2008 plan began during a 2007 statewide rural health strategic planning session with over 40 prominent partners. Virginia sought to develop a 3-5 year plan that would:

- Provide a comprehensive analysis of health in rural area
- Develop practical strategies that will lead to improvements to sustain long-term sustainability of rural health, not just to improvements in the delivery of services that may be a more short-term perspective
- Remain an active collaborative effort among various partners

The 2008 plan was divided into four broad topic areas, each represented by a stakeholder driven workgroup.

- Access Work Group - examined rural health care access issues related to primary care, specialty care, Emergency Medical Services (EMS), 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
- Workforce Work Group - examined available resources and issues in order to make recommendations for improving the health care workforce in rural Virginia

## Key Achievements of the Previous Period

The focus of the 2008 Virginia Rural Health Plan was to develop a formalized operational framework to assist in bolstering partnerships, leveraging resources, and providing an avenue for advisory expertise. The previous plan also set 48 separate goals; 42 of which were completed or are ongoing. Several key achievements are listed below.

- Councils were established (Quality, Workforce, Access, and Data and Rural Definitions) to address specific goals of the Rural Health Plan and building a framework to examine issues. The councils conducted and published several surveys to better understand conditions and challenges in the state.
- The Virginia Rural Health Data Portal was developed and launched, providing information on statewide rural health outcomes. This tool has been used widely by health care professionals, nonprofit organizations, and individuals pursuing grant funding.
- A compendium of Best Practices and models of care in rural Virginia were published.
- Annual Rural Health Summits were coordinated and hosted, including a rural EMS Summit.
- Several state health plans were updated, including Virginia's statewide dental/oral health plan and the Rural Obstetrical Report.
- Travel grants were provided to rural areas to allow individuals to attend conferences and seminars focusing on health care quality issues.
- The development of retention incentives was advocated for in order to encourage providers to remain in rural areas. Outreach was expanded to students and relationships were fostered with Virginia's medical schools and community colleges.
- A statewide system for health care was promoted in conjunction with the Virginia Telehealth Network.

*“Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”*

*-Preamble to the Constitution of the World Health Organization.*



## 2013 Rural Health Plan Mission

To inspire and guide Virginians to improve the health of residents of Virginia's rural communities

## 2013 Rural Health Plan Vision

*Vision: We envision a time when all Virginians value rural Virginia not solely for its beauty, cultural variety, and history, but also for the health of its residents.*

We envision a rural Virginia where...

- People of all ages lead healthy lives.
- Everyone has access to clean water and clean air.
- Everyone has access to the social, economic, educational and community resources and opportunities that are necessary for good health.
- Outdoor spaces are safe, inviting, exciting places that provide every resident access to trails, parks, rivers, and lakes as well as developed recreation facilities.
- Health care providers choose to live in rural Virginia because of the commitment of rural residents and community leaders to good health, the outstanding quality of life, and their deep connection to community and place.
- Every resident is health literate.
- Every resident, regardless of age, gender, ethnicity, impairments, or socio-economic status, has access to high quality, affordable health care.
- Primary and secondary schools integrate healthy learning and behavior within their curriculum, nutritional programs, and outdoor landscape and activities.
- Community leaders account for health and health equity in all areas of planning.

## Guiding Values and Principles

Everyone living in rural Virginia has a right to the opportunity to lead a healthy life.

Everyone in rural Virginia sees a role for themselves in this Plan, and everyone in rural Virginia is served by this Plan.

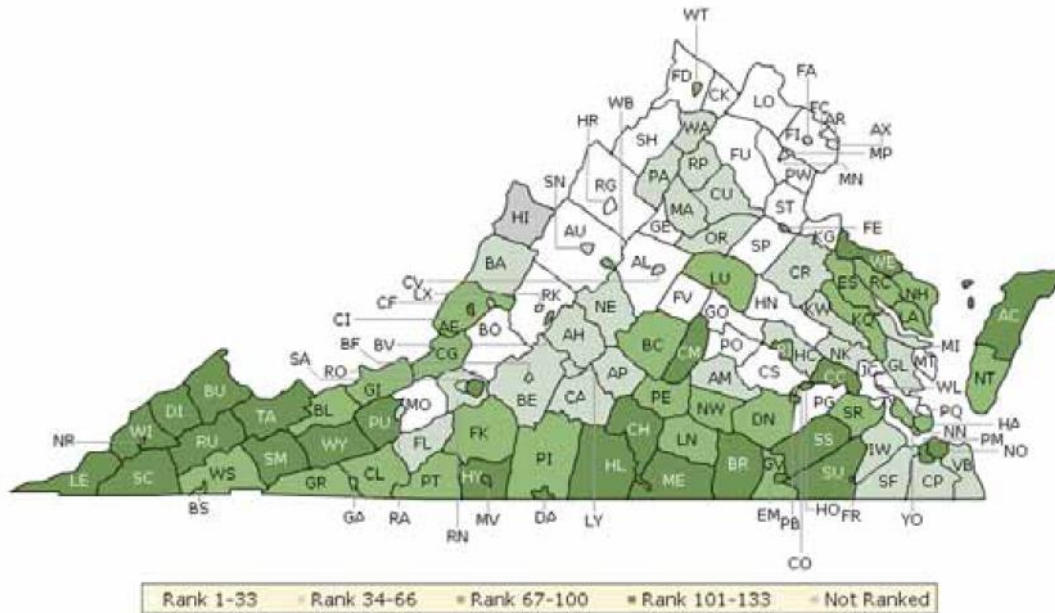
Stakeholders own this plan – it will be successful with active leadership and participation by a diverse cross-section of citizenry, public officials, and providers.

Health equity, defined as achieving the highest level of health for all people, is a fundamental consideration of every element of the Plan and is integrated into all aspects of the Plan.

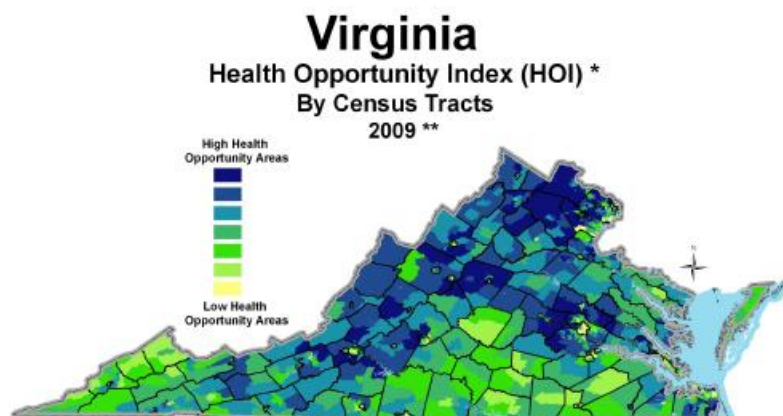
## Rural Health Status

The Rural Health Plan seeks to improve health opportunities and health outcomes in rural Virginia, and seeks to reduce disparities between rural and urban, regional, racial, and other population groups. The Rural Health Councils and other organizations working towards these goals have readily available data from many sources.

Rural areas of Virginia have some of the most significant disparities in health outcomes and SDOH compared to other states in the nation. The [2013 County Health Rankings](http://www.countyhealthrankings.org) showed the rural southwest, south side, northern neck, and eastern shore regions to be some of the least healthy areas of the state in terms of morbidity and mortality ([www.countyhealthrankings.org](http://www.countyhealthrankings.org)):



The Virginia Department of Health's [Virginia Health Equity Report 2012](#) reported on a range of health disparities and SDOH by census tracts, documenting the importance of examining health at a local level. The report introduced a Health Opportunity Index (HOI) that comprised social, economic, and environmental determinants of health. Not surprisingly, the areas of rural Virginia with poor health outcomes also have low health opportunities.



Organizations can measure their progress through the two indices above, or through other reports and data sources. The [Virginia Rural Data Portal](#) continues to serve as a user-friendly source for a variety of Virginia-specific health related information. Similarly, the [Weldon Cooper Center](#) offers Virginia data on demographics, economics, workforce, and policy. Regional recommendations, such as the Southwest Virginia Health Authority's [Blueprint for Health Improvement and Health-Enabled Prosperity](#), provide useful guidance. Other important sources of regional recommendations and data include community health needs assessments, often available through public health districts and community hospital systems. [Healthy People 2020](#) contains detailed information and suggested benchmarks for health outcomes and opportunities for health.

## **Key Objectives and Priorities for Action**

Each of the following key objectives is chosen to reflect the needs identified through the 2012 Survey, 2012 VRHA Conference, 2013 regional listening sessions, and 2013 interviews. These objectives and proposed actions also provide a clear agenda for the new Rural Health Councils. Each objective contains actions intended to *grow AND sustain*; that is, to meet unfulfilled needs while maintaining gains achieved during the previous plans' enactment.

**1) Health Outcomes: Organize locally to identify and address priority health conditions**

**2) Healthy Communities: Increase awareness, engagement, and coordination among an expanded base of stakeholders to address the SDOH and promote healthy and equitable communities**

**3) Access to Health Care: Reduce barriers and improve rural health care delivery**

**4) Individual Empowerment: Support community members with education, incentives, and resources to facilitate healthy choices for themselves and their families**

**5) Workforce Development: Increase providers and develop the appropriate scope of practice**

**6) Advocacy: Advocate for rural health policies that promote sustainability for rural health goals and institutions**

## **Overall goals of the 2013 Rural Health Plan**

*Vision: We envision a time when all Virginians value rural Virginia not solely for its beauty, cultural variety, and history, but also for the health of its residents.*

The following six goals represent the intention of the Plan:

1. Bring widespread attention to current and anticipated rural health issues and needs
2. Capture the ideas, commitment and energy of rural health stakeholders around the Commonwealth
3. Motivate participation in enacting the Plan's actions among a wide range of such stakeholders
4. Identify key strategic actions that will sustain ongoing accomplishments and fill gaps in ways that improve the health of the residents of all of Virginia's rural communities
5. Encourage partnerships between community, academic, government, business, and other resources
6. Recruit and organize diverse stakeholders to collaborate effectively, bringing together effective partnerships addressing priority topics

## Objective 1) Health Outcomes: Organize locally to identify and address priority health conditions

*Vision: Rural localities organize to target priority health concerns and take actions that make measurable improvements in health outcomes for these priority concerns.*

Key health conditions identified for this Plan include the following:

- *Obesity and associated behaviors and diseases*, including nutrition, physical activity, diabetes, cardiovascular disease, and early mortality
- *Mental and behavioral health*, including depression and substance abuse as well as other acute and chronic mental health issues
- *Oral health*, including self-care, preventive and restorative treatments
- *Cancer*, including prevention, early detection and treatment
- *Perinatal issues*, including low birth weight, infant mortality, and maternal health
- *Lung disease*, including conditions related to smoking or occupational exposure

These key health conditions were selected through synthesis of stakeholder input, starting with results of the 2012 VRHA online survey and Rural Health Action Conference. Participants at the five regional meetings and individual interviewees were presented the results, and asked if the list accurately reflected their region or organization. Their comments included the need to add lung disease, which had not been on the survey. There were also consistent calls to bring prenatal health higher in the priority list.

<p>Survey results: Top health issues</p> <ol style="list-style-type: none"> <li>1. Obesity (56.6%)</li> <li>2. Diabetes (37.7%)</li> <li>3. Depression and anxiety (33.6%)</li> <li>4. Poor physical health (25.2%)</li> <li>5. Oral health (20.2%)</li> <li>6. Heart disease (20.0%)</li> <li>7. Cancer (17.7%)</li> <li>8. Other (16.7%)</li> <li>9. Poor mental health days (14.8%)</li> <li>10. Teen pregnancy rate (14.7%)</li> <li>11. Sexually transmitted infections (10.1%)</li> <li>12. Hypertension (13.3%)</li> <li>13. Infant deaths (5.0%)</li> <li>14. Low birth weight (4.3%)</li> </ol>	<p>Survey results: Top health behaviors</p> <ol style="list-style-type: none"> <li>1. Diets high in fats and sugars (61.2%)</li> <li>2. Physical inactivity (53.9%)</li> <li>3. Alcohol abuse / excessive drinking (43.3%)</li> <li>4. Smoking / tobacco usage (42.0%)</li> <li>5. Prescription drug abuse (36.5%)</li> <li>6. Illegal drug use (36.3%)</li> <li>7. Unprotected sexual encounters (21.0%)</li> </ol>
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The U.S. Department of Health and Human Services named mental health coverage an “Essential Health Benefit”. A clear disparity exists between mental health benefits and medical and surgical benefits. Given the socio-economic standing and isolation of many of Virginia’s rural constituents, short term mental health maintenance, focused on acute depression and anxiety related to life circumstances, is as important to overall preventative health as nutritional education and programs promoting physical activity.

One clear message about the 2013 Plan’s approach to health conditions is that health behaviors and health outcomes should be considered together. SDOH include: socioeconomic status, discrimination, housing, physical environment, food security, child development, culture, social support, health care services, transportation, working conditions, and democratic participation. Fostering conditions that encourage and support healthy personal choices and behaviors is essential to the prevention and management of these key health conditions. The goals for the Health Outcomes objective focus on achieving measureable progress towards reducing the burden of priority health conditions.

This Plan urges greater emphasis on building coalitions for prevention, management of chronic diseases, and coordination of services. Coalition building is a central facet of improving care in rural communities. It facilitates sharing of resources and avoiding duplication of services. Collaboration among different providers, agencies, and sectors can be time consuming and presents unexpected challenges. Strong and agile leadership, committed volunteers, and skill-building are important features of successful coalitions.

*“Chronic disease needs to be managed more effectively and efficiently to reduce costs.”<sup>2</sup>*

*Strategy 1.1 Using local data, such as hospitals’ community health needs assessments or health departments’ public health assessments and an authentic community-driven process, identify top priorities by region or locality (depending upon scale of effort) to address priority health conditions*

*Strategy 1.2 Set benchmark goals for program processes and/or outcomes related to priority health conditions*

- a. Use [Healthy People 2020](#) or local data source for benchmark measures
- b. Incorporate the [\(HOI\)](#) to identify health disparities

*Strategy 1.3 Identify, design and implement programs focused on priority health conditions*

- a. Collaborate with other sectors to find helpful resources such as evidence-based program designs and expertise in different areas
- b. Plan program evaluation before implementation

*Strategy 1.4 Evaluate programs: collect and analyze data*

- a. Conduct formative evaluation of process
- b. Conduct evaluation of outcomes

*Strategy 1.5 Share successes and lessons learned*

*Virginia Specific Ideas*

- Provide fluoride treatments in schools

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<sup>2</sup> All unattributed quotations, unless otherwise noted, in the 2013 Virginia Rural Health Plan come from participants in the 2012 survey, 2012 conference, interviews, or public meetings.

## **2) Healthy Communities: Increase awareness, engagement, and coordination among an expanded base of stakeholders to address the SDOH and promote healthy and equitable communities**

*Vision: Rural health stakeholders engage local, regional, and state policymakers to consider health and health equity in their long-term planning and day-to-day decisions.*

*“Individual health responsibility is inextricably linked to society’s health responsibility. Ultimately, our success in achieving more equitable opportunities to be healthy and reducing health inequities requires strong, action-oriented partnerships with the Commonwealth’s stakeholders.”*

*- [Virginia Health Equity Report 2012](#)*

The SDOH are those inter-related social and economic factors that influence health. The World Health Organization defines SDOH as "complex, integrated, and overlapping social structures and economic systems that include the social environment, physical environment, and health services; structural and societal factors that are responsible for most health inequities. SDOH are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices."

Healthy communities involve nearly every sector in providing environments where people can live not just without disease, but with a high quality of life. Economy, education, ecology, and culture are all integral to healthy communities. This holistic approach acknowledges the interconnectedness of the many social determinants of health. In order to address those social determinants and to build widespread understanding of SDOH at different scales, one must engage a broader set of stakeholders than has traditionally been concerned with or even thought to be associated with health. Since SDOH include housing, jobs, education, income, social support, access to health resources like food, physical activity, and transportation, addressing these factors means engaging those who shape and enact policy in these areas.

*“The equitable access to green spaces and exercise facilities that cater to the geographically isolated [is a huge issue].”*

Awareness of the significance of these factors is growing throughout rural Virginia and the nation as a whole, not only within the health professions but in fields of planning, architecture and landscape architecture, food policy, and recreation.

For example, economic wellbeing is a vital part of a healthy community. There is a reciprocal relationship between health and economics; for instance, priority health conditions such as obesity-related diseases, mental/behavioral or substance abuse issues, or dental problems can lower worker productivity or prevent an individual from entering the work force. On the other hand, a strong economy creates revenue for localities to build health facilities and programs, and increases income for residents to have better access to healthy products and services and reduced levels of stress related to basic survival. Higher income also reduces the impact of stress, poor nutrition, violence, and substance abuse on pregnancy outcomes (e.g. Fetal Alcohol Syndrome,



low birth weight, premature births). It is also important to ensure that economic well-being is accessible to all community residents in order to address historic inequitable access to such resources, which is at the root of health inequities.

*“Economics, education, and health are a braid; one can’t do one without the others.”*

*Strategy 2.1 Engage many sectors of community to understand their role in building healthy communities, and the role of health to the wellbeing of their institutions*

- a. Partner with businesses, civic organizations, and public institutions to contribute to this effort

*Strategy 2.2 Use inclusive, consensus-building processes to plan and implement physical and social initiatives that benefit target populations in a community*

- a. Ensure diverse community members from every segment of the community are involved in program design and implementation
- b. Involve multiple sectors of organizations
- c. Increase community capacity to identify needs and advocate for meeting their needs

*“I would like to see what is called ‘creative cooperation,’ where diverse groups work together and every partner understands their role.”*

*Strategy 2.3 Evaluate effects of healthy communities initiatives*

- a. Assess changes to built and social environments based on results of healthy communities projects
- b. Measure and analyze effects on overall health and social indicators
- c. Measure effects across population subgroups to evaluate reduction in disparities

*Strategy 2.4 Promote healthy aging at home*

- a. Address transportation and mobility for the elderly and individuals with disabilities
- b. Develop programs to provide social interaction and support for the elderly, and people with disabilities, and provide supportive services for caregivers of the elderly
- c. Promote life-long physical activity and exercise programs specific to the needs of the elderly
- d. Address food security and nutrition concerns of the elderly
- e. Promote medication safety and adherence through patient education, drug take-back programs, and pharmacy programs

*Strategy 2.5 Promote economic development and job creation*

- a. Encourage collaboration between economic and health stakeholders to work together toward mutual goals of a healthy workforce and families as well as a healthy environment

*Strategy 2.6 Support education resources that promote health*

- b. Allocate resources to school facilities and curricula that promote health

- c. Engage community partners in providing extracurricular health-oriented opportunities for students
- d. Address the economic value of clean air, water, and other environmental conditions

*Strategy 2.7 Allocate health care resources to community-based professionals whose focus is wellness and disease prevention*

- a. Increase community-based health services through public health and other community-oriented organizations
- b. Increase school-based health professionals
- c. Engage businesses in hiring occupational health professionals who promote health among employees

*Virginia Specific Ideas*

Suggestions to improve nutrition, physical activity, and healthy aging in rural Virginia:

- Nutrition
  - Create Farm-to-table programs
  - Expand Farmers markets accepting SNAP (food stamp) benefits
  - Promote teaching children and adults about cooking and other food production
  - Promote teaching healthy eating to churches to promote to their congregation
  - Expand community gardens and greenhouses to teach gardening and provide a place for residents to grow their own food
  - Increase backpack food programs to increase kids' food security
  - Create health fairs and other events to model healthy eating and lifestyles
  - Enact local and state policy development to eliminate food deserts
  - Create local food policy councils
  - Promote school meals and vending guidelines
  
- Physical Activity
  - Build sidewalks and crosswalks to improve walkability
  - Change attitudes and address community violence to make outdoor recreation more attractive
  - Teach kids and adults about no-cost physical activities
  - Ensure access to community fitness centers with low fees where applicable
  - Promote free fitness facilities
  - Promote the model of the Health and Outdoor Recreation Strategic Plan (in development for Southwest Virginia)
  
- Healthy Aging
  - Encourage pharmacy programs to synchronize medication refill cycles and improve packaging with easy-to-read instructions
  - Increase mobile clinic sites accessible to the elderly

### **3) Access to Health Care: Reduce barriers and improve rural health care delivery**

*Vision: Distance from providers and other problems with language, cultural or other access are no longer barriers to receiving high quality health services.*

*“People have to go to Tennessee, North Carolina, or West Virginia a lot of times or three hours to Roanoke for service.”*

Significant barriers continue to limit rural residents’ access to health care services. Personal factors include language, culture, education level, health literacy level, insurance status, finances, and access to transportation. Optimal health services may not be available nearby, and many rural residents report driving several hours to access specialty care or even primary care. Even safety net providers in rural communities can have unintentional barriers, such as income limits in free and sliding scale clinics that exclude people who need such services but whose income may just fall over the limit. Patients with Medicare or Medicaid may find that local providers do not accept these insurance types.

*“To reduce the effects of distance as an inhibiting force in our society’s ability to realize its economic and social aspirations.”<sup>3</sup>*

Transportation across long distances has been identified as a significant challenge in rural Virginia. Rather than thinking of travel distance alone as the issue and providing more roads and/or vehicles as the solution, a broader definition of transportation planning is necessary. Telehealth is part of that broader definition, allowing the utilization of telecommunication technologies to deliver health-related services; telehealth joins the list of improvements in rural transportation infrastructure as appropriate objectives.

Mental or behavioral health conditions bring additional barriers to care (besides shortages of mental health professionals and services), including gaps and disorganization among services for this population, and stigma related to these conditions. Many rural residents with mental health conditions are reluctant to seek services due to societal stigma around mental illness and addiction. Clinical providers and services in greatest need include psychiatrists, child psychiatrists, geropsychiatry, medical drug detoxification and residential recovery programs, and acute psychiatric inpatient services.

Dental care access is a pressing need for children and adults in rural Virginia. Oral disease can lead to life-threatening illnesses such as heart disease. A shortage of dental professionals in rural areas is compounded by health insurance that does not cover dental care or is not accepted by dentists. Rural communities may have unique challenges including geography, education, economics, and culture. When preventive dental care is inaccessible, dental problems often cause pain and decay, prompting visits to the emergency department and tooth extractions. Dentists as well as patients feel frustration over this lack of preventive care.

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<sup>3</sup> “Facing Virginia’s Transportation Challenges,” Vol. 84, No. 5, November 2008. *The Virginia News Letter*, by Alan E. Pisarski.

The seven CAHs in the state face uncertain futures due to policy and reimbursement shifts. Rural emergency medical systems confront shortages of skilled volunteers and equipment. Charity-based health care, such as Remote Area Medicine (RAM) clinics, can be helpful in the short-run but bring only superficial solutions to complex problems of access in rural areas. Telehealth capacity continues to grow in rural Virginia, but in the next years several challenges need to be addressed.

*“Telehealth resources haven’t been quickly implemented in the area because the learning curves for training how to use the equipment is perceived to be so large that the physicians don’t believe they have enough time even to learn it.”*

*Strategy 3.1 Identify population groups at risk of inadequate access to care under current models of care and under the changes related to the ACA*

- a. Reach out to rural veterans through the Virginia Wounded Warriors Program and other organizations providing assistance to veterans

*Strategy 3.2 Develop and disseminate resources for providing culturally and linguistically appropriate care for targeted population groups appropriate to each region or locality*

- a. Train providers in importance of and the effective use of qualified interpreters, with a minimum of 40 hours of training from a reputable course provider that equips interpreters with skills in cultural competency and skills for providing linkages and referrals to support services

*Strategy 3.3 Assess needs for and develop technical assistance to rural health organizations making changes in care delivery or administrative structures*

- a. Encourage communities around CAHs to support hospital usage and activities
- b. Provide community engagement technical assistance to CAHs according to their assessed needs

*Strategy 3.4 Strengthen telehealth services for mental health and dental care, health education, specialists, diagnostics, and other areas of rural shortages*

- a. Assess barriers to adopting telehealth technology, and develop solutions that will lower barriers
- b. Develop and pilot test new applications of telehealth technology in rural populations
- c. Develop peer networks of vocal champions for telehealth
- d. Incorporate telehealth training into health career training programs (e.g., dental schools, hygienist training) and continuing education for current providers
- e. Establish loan repayment programs for providers using telehealth services in rural underserved areas
- f. Address low reimbursement rates for telehealth services on the “transmission” side where the patient is located
- g. Seek solutions to enhance interoperability of telehealth systems, e.g., Veterans Administration (VA)– Community Based Outreach equipment and VDH system
- h. Integrate telehealth with smart data from phones and mobile applications that allow hospitals to have the ability to interface with the data

- i. Improve rural telecommunications infrastructure for telehealth systems and mobile devices such as from ambulances to hospitals

*Strategy 3.5 Develop dental health clinical services and education programs for key populations*

- a. Assess resources and needs in communities for dental care delivery model – i.e., stationary vs. mobile clinic, teledentistry vs. on-site dentist
- b. Collaborate with school systems to develop plans for providing dental services through rural schools
- c. Develop and implement dental health education curriculum for rural schools
- d. Assess other vulnerable populations for dental care access, such as nursing homes and community residents with disabilities

*Strategy 3.6 Build and partner with local coalitions for health access, including multidisciplinary and multi-sector teams*

- a. Develop resources, including communication and leadership skills, to help local and regional health-related coalitions grow stronger
- b. Assist volunteer-centered organizations to build skills specific to managing volunteers
- c. Enhance coalition-building aimed at serving rural residents with mental and behavioral health problems

*Strategy 3.7 Promote access to a continuum of mental health services*

- a. Develop a plan for enhancing networks of mental health services in rural communities
- b. Address the lack of inpatient facilities for patients with substance abuse or other mental health needs
- c. Engage health care providers and communities in reducing stigma associated with mental illness
- d. Promote models of care that combine physical and mental health care
- e. Expand telehealth services for mental health

*Strategy 3.8 Increase services to prevent and treat substance abuse*

- a. Assess the availability of a continuum of services for substance abuse prevention, treatment, and recovery in localities and regions
- b. Hold summit meetings to discuss and address gaps in substance abuse services
- c. Develop community-wide collaboratives that include schools, aimed at preventing substance abuse in youth
- d. Expand the Prescription Monitoring Program to be used by more providers and to list prescriptions filled in other states, especially states adjacent to Virginia
- e. Advocate for substance abuse programs as not just a health issue, but an economic issue that affects businesses and labor
- f. Develop drug court programs in more rural counties
- g. Address safety issues for health care providers related to prescription drug abuse
- h. Develop and/or strengthen prison and substance treatment re-entry programs

*Strategy 3.9 Ensure access to health services for the elderly and individuals with disabilities*

- a. Increase rural end-of-life and palliative care services, including supportive housing
- b. Educate providers, patients, and families about management of pain and other symptoms for individuals living at home or in long-term care facilities
- c. Increase health professional training opportunities to improve person-centered care for the elderly or have a disability, to include appropriate pain management
- d. Increase access to home modifications, assistive technology, “smart home” technology, and in-home nursing care to enable aging-in-place
- e. Increase access to affordable housing and in-home supports
  - Increase rural access to hospice services and palliative care services for those individuals facing end-of-life
  - Provide or expand education to individuals and families in care-giving methods that enhance functioning in collaboration with local Centers for Independent Living and other organizations (Note: the CILs are charged by State Code with providing education and advocacy for individuals with any disability and their families. Collaboration with them, and other related organizations would maximize efforts by all.)
  - Create or, as indicated, expand respite care programs to support caregivers

*Strategy 3.10 Improve access to transportation*

- a. Promote the allocation of resources to rural public transportation services
- b. Engage community coalitions in creating local resources to increase access to transportation for health care and other services
- c. Improve access to transportation for the elderly and individuals with disabilities

*Virginia Specific Ideas*

- Implement the Patient Centered Medical Home model in primary care practices
- Utilize the Geisinger model of insurance reimbursement for bundled services, aim to improve efficiency and health outcomes
- Initiate hospital based programs to reduce readmissions: transition coaches (nurses) for patients with disease at high risk for readmission, such as pneumonia and COPD; telephone follow-up in first 30 days after discharge
- Create group care models for pregnancy, obesity, heart disease, diabetes
- Utilize mobile clinics at sites where underserved populations tend to go
- Create intensive outpatient psychiatric program for those who are elderly, based at rural hospital
- Incorporate telepsychiatry and mental health services into primary care offices
- Expand teledentistry to allow hygienists to treat patients without a dentist on site
- Implement school based dental programs to educate children, provide preventive care, and assess needs for dental treatments
- Create a program similar to Project Lazarus, a program out of North Carolina, aiming to reduce accidental overdose deaths for users of narcotic medications
- Pilot a program (e.g., Eastern Shore and Tangier Island) to initiate a Statewide Telehealth Network to deliver Mental Health care

- Create a network of primary care sites where generalist and specialty providers can rotate through; mobile *providers*, as opposed to mobile *clinics*
- Utilize models such as Harrisonburg, which has a history of strong multi-sectoral health collaboration among universities, hospitals, providers, and other nonprofit organizations

#### **4) Individual Empowerment: Support community members with education, incentives, and resources to facilitate healthy choices for themselves and their families**

*Vision: Virginia's rural residents have the knowledge, institutional support, and resources to make informed decisions that promote healthy families.*

*"It is almost impossible to address any issues in isolation and to be effective. We have to begin honest conversations with our fellow Virginians about choices and lifestyle issues."*

To address most of the priority health problems in rural Virginia, individuals must have sufficient resources and support to be able to make healthy choices for their personal behavior on an everyday basis. Knowledge of health behavior alone is insufficient for enacting healthy choices; individual, interpersonal, organizational, and community norms, and values as well as broader public policies all shape individuals' and families' abilities to make such choices. The context in which people live provides them with the resources to make the best decisions for their health. Those resources are the SDOH operating within that context.

Self-efficacy and family-efficacy refer to beliefs about one's own power and capacity to make positive changes. Beyond individuals and families, social and material support from organizations, communities, and policies provides environments in which healthy choices are easier to make, thus changing the SDOH and providing opportunities for healthier outcomes. For instance, knowledge and intent to eat a healthy diet and exercise may be insufficient in a community where healthy foods and recreational facilities may be unaffordable or inaccessible. Whether healthy foods and recreational facilities are affordable or accessible are SDOH that can be realigned to meet the needs of people living in communities.

*"Given the importance of community involvement and personal choice, engaging, educating, and empowering the community is essential."*

Social and cultural factors in rural Virginia can also increase risks for unhealthy behavior in some populations. Many rural communities have social norms that support unhealthy eating, physical inactivity, tobacco use, and other substance use. Health behavior risks including, persistent poverty, low educational attainment, addictions, domestic violence, and incarceration, can span generations. In some regions there are high numbers of children being raised by their extended families or foster parents, often due to drug abuse, child abuse, or incarceration. Caregivers too ill or family members with disabilities often set aside their own self-care needs to focus on others. Even positive attitudes may have challenges: a strong work ethic may lead to the notion that "If I can work, I'm well," that leads to avoidance in seeking health care until symptoms become intolerable. The variety of social determinants of health, as outlined in this paragraph, impact the way health decisions are made, but are the ingredients in the context in which people live that are the most changeable.

*"We need activities that promote mental, spiritual, and social wellbeing."*



Individual health behavior problems overlap with the social determinants of health. The concerns may be identified within several main areas:

- Poor nutrition (diet knowledge, food access, income)
- Insufficient physical activity (knowledge, outdoor and exercise access)
- Alcohol, tobacco and substance abuse
- Risky sexual behaviors
- Violence, especially intimate partner violence and child abuse

The Rural Health Plan aims to promote health-seeking behaviors by individuals and families. These include improving the risky health behaviors listed above, and also include a variety of behaviors that can add to quality and longevity of life.

*Strategy 4.1 Engage whole communities in identifying and implementing strategies to change local culture associated with key personal behaviors*

- a. Engage community institutions (e.g., schools, hospitals, service agencies)
- b. Engage businesses and other employers
- c. Provide opportunities for lifelong learning about health and healthy behaviors
- d. Provide programs to train parents and caregivers and other role models to model healthy behavior for children
- e. Develop and provide more respite care programs to support caregivers
- f. Use new technology to share resources, best practices, feature successful groups, and improve communication and technical assistance

*Strategy 4. Make education and information about health widely accessible at home and at community locations*

- a. Develop partnerships with public libraries to develop a reliable resource for health support
- b. Leverage the public school system to transmit information about healthy living, possibly through after school activities
- c. Provide sufficient education about basic health care for de facto health care providers such as teachers, secretaries and administrators filling the gap of the shortage of school nurses
- d. Use school cafeterias to promote healthy eating, highlighting local foods

*Strategy 4.2 Incorporate a focus on healthy personal behaviors into health care services, through cross-training or hiring health educators, health coaches, or similar personnel*

*Strategy 4.3 Develop messaging and social marketing about healthy personal behavior appropriate for target population groups*

*“Education about the role of self-care in health status and environmental factors that lead to lifestyles that are detrimental to health need to be addressed.”*

*Strategy 4.4 Support the growth of social networks and support structures to provide practical and social support to individuals striving to make healthier choices*

- a. Focus on health issues that respond to group care (prenatal, heart disease, obesity)
- b. Foster partnerships with faith based communities (e.g., Faith in Action, parish nursing)

*Strategy 4.5 Have Virginia students graduate with a basic knowledge of health information, including nutrition, exercise, anatomy, and reproductive health*

*“Develop the desire in people to be a life-long learner.”*

*Strategy 4.6 Develop community facilities and infrastructure fitness facilities and spaces for outdoor recreation, healthy food retailers, gardens, and substance-free events, where making healthy choices is easy*

*Strategy 4.7 Institute a range of support actions for caregivers that promote self-care*

*Strategy 4.8 Promote adherence to medication*

*“Education regarding prevention (through exercise, physical activity, and proper nutrition) can save citizens from many illnesses and disorders as well as save taxpayers billions!”*

#### *Virginia Specific Ideas*

- Increase health care training for caregivers - have primary care physicians and staff (social workers, front desk managers, nurses) provide the family and the caregivers information on self-care and how caregiver self-care will ultimately benefit the patient
- Seek to have more behavioral health consultants hired in primary care offices so that caregivers can be seen while the person with the disability or illness is being seen by the physician
- Change adult day health care regulations so that more people can utilize these facilities and so that they can be more easily accessible to rural residents
- Educate first responders about early signs of caregiver stress and have a list of local providers who they can refer these caregivers to within the community
- Develop patient navigators (mandated in the ACA) to help people connect with insurance and insurance exchanges
- Incorporate medication dispensing systems in the home in conjunction with mobile applications that people can use with smart phone technology
- Build on success of health care coaches who conduct telephonic follow-up telephone interviews 30 days after release from hospitals
- Improve synchronization of medication refill cycles and improved packaging with easy to read instructions
- Train students to work with adults learning to use basic technology for health information, connectivity, and socialization
  - Pilot: Develop a pilot partnership at the Highland Medical Center
- Incorporate aspects of Program of All-Inclusive Care for the Elderly (PACE) programs

- Develop a “Parent University” to educate, improve lifestyle choices, and show parents where to find resources (food, transportation, clinics, and recreation centers)
  - Programs would include stress management, vaccinations, nutrition and meal planning, exercise, and behavioral health
- Incorporate models of chronic disease self-management, similar to those developed by Stanford University, to expand on the success of the VA and Senior Connections
- Consider creating a statewide Rural Council, similar to the federal Rural Council

## **5) Workforce Development: Increase providers and develop the appropriate scope of practice**

*Vision: Rural communities have sufficient well-trained, culturally and linguistically diverse, and competent health care providers working at the appropriate scope of practice.*

Rural communities are striving to achieve health care workforces with adequate numbers as well as an appropriate mix of training and specialization, but needs can vary by region. The increased access to health insurance and other parts of the ACA will likely increase the demand for health care workers, as will the continued demographic shifts in rural Virginia towards older populations. But a large proportion of rural primary care providers are approaching retirement age with few young doctors to fill their ranks.

Loan repayment and J-1 visa programs are important sources of recruitment to rural facilities, but are insufficiently funded and have insufficient numbers, respectively. Pay in rural facilities may be lower than in urban areas, and health care professionals may perceive rural communities to have fewer amenities for themselves and their families.

There is a lack of racial and ethnic diversity among health care providers and health system administrators, making these workers less reflective of the rural communities they serve. Many rural leaders express concern about continued outmigration of talented youth who see few professional opportunities in their hometowns, while beneficial programs like Area Health Education Centers (AHEC) lose funding.

There is widespread agreement that health care professionals are not yet able to practice to the full extent of their license. Limitations of practice due to institutional regulations or lack of training opportunities cause significant inefficiencies in the delivery of health care. Evidence supports the extended practice of professionals like pharmacists, in managing chronic disease treatments; dental hygienists, in establishing autonomous practices; and registered nurses, in taking lead roles in the patient-centered medical home model. New dental therapist licensure programs, like those in Minnesota and Alaska, are being considered in other states.

Increasing credential requirements are also of concern in rural areas, where average educational attainment can be lower than urban areas, and numbers of individuals with advanced degrees are low. For example, the requirement of a Masters in Social Work to administer the popular PACE can be a barrier to establishing the program.

Health care workforce development is also community economic development, and should involve business sectors as well as health and education.

Rural areas with Health Professional Shortage Area (HPSA) or Medically Underserved Area / Population (MUA/P) designations may be eligible for assistance to recruit and retain health care workers.

*Action 5.1 Promote the recruitment and retention of health care professionals in rural areas*

- a. Identify job positions forecast to have increased shortages
- b. Engage rural communities in partnering with health care institutions to recruit and retain health care workers
- c. Actively recruit workers with diverse backgrounds
- d. Advocate for increased loan repayment programs and J-1 visa programs
- e. Assess needs of the families of workers, such as employment for a spouse and education options for children
- f. Provide financial incentives to decrease overhead costs for private practices in rural areas

*“It is important to consider that you not only have to attract the workers, but you need to attract their families.”*

*Action 5.2 Develop community “Growing Our Own” programs that encourage individuals of diverse backgrounds to pursue careers as health care providers and health care leaders*

- a. Increase awareness of the need, preparation, and possibilities for hometown health careers
- b. Create a common message on health careers and a strategy including career fairs, mentors, and other programs starting at the Head Start level
- c. Foster awareness of medical opportunities among middle and high school guidance counselors so youth take the right science classes (e.g., biology, chemistry)
- d. Develop partnerships between local technical schools and larger universities

*Action 5.3 Seek appropriate and monitored increases in the scope of practice and licensure*

- a. Identify and change regulations and policies that are barriers to working at an optimal level by license
- b. Identify health care job positions that are difficult to fill, and evaluate whether the license and degree requirements create a barrier
- c. Review the scope of practice regulations, especially for nurse practitioners and family practitioners
- d. Increase the utilization of collaborative practice agreements
- e. Support opportunities for pharmacists to monitor/manage chronic diseases, especially those that are medication-intensive
- f. Increase the use of physician assistants and nurse practitioners
- g. Encourage programs that allow nurses to practice as well as teach or continue their education
- h. Support a transition toward inter-profession patient teams and increase cross-training of providers, so limited health care providers could serve a variety of functions in rural communities
- i. Address licensure issues to allow providers to work across state lines
- j. Consider licensure for Certified Nursing Assistants (CNAs)/Licensed Practical Nurses (LPNs) to perform fluoride treatments in clinics
- k. Consider authorization for hygienists to offer fluoride varnish and routine cleaning without supervision by a dentist

- l. Assess the need for certification and oversight of school personnel who provide health services

*Action 5.4 Explore health care workforce training models that are high quality and accessible to rural residents*

- a. Identify opportunities to increase health training programs in rural communities
- b. Develop and increase health care professional training at the high school level
- c. Use schools for continuing education night classes for current providers (address need for bachelors degrees for nurses)

*Action 5.5 Identify areas and populations in which trained lay health educators can fill gaps in care*

- a. Study the effects of lay health educator programs on the community health outcomes and on the lay health educators themselves

*Action 5.6 Engage academic health and medical institutions to increase rural clinical rotations, rural curricular content, and partnership with rural health institutions*

*Action 5.7 Promote collaboration between and among health professions*

- a. Promote curricular changes to increase inter-professional team education models
- b. Offer continuing education on effective inter-professional team collaboration and communication, especially associated with hospitals and patient-centered medical homes
- c. Develop clinical experiences or preceptorships that team nursing and medical students together

*Action 5.8 Support EMS*

- a. Remove unnecessary formal requirements in favor of competency-based criteria
- b. Identify training programs that can supply rural communities with adequate numbers of well-trained personnel, whether volunteer or paid
- c. Refine organizational EMS territorial agreement scopes so they are complementary
- d. Promote coordination of EMS services with hospitals

*Action 5.9 Review the process and data sources for applying for designation as a HPSA or MUA/P*

*Virginia Specific Ideas*

- Incorporate HOSA-Future Health Professionals activities in high schools ([www.hosa.org](http://www.hosa.org))
- Conduct “Stay” interviews with current employees to assess what keeps them working there
- Introduce EMS para-medicine programs to fill need for personnel
- Initiate education benefits for rural providers’ children
- Utilize “Choose Virginia” partnership to recruit rural physicians
- Create new residency program in rural emergency department
- Create scholarships to cover travel expenses for rural health professions students
- Introduce mentoring programs to connect local health care workers with high school students

- Promote college loans to local students, to be forgiven if student returns to work in community
- Increase dual enrollment programs for high school students to get college credit
- Partner with Chamber of Commerce young professionals group that presents to high schools about professional opportunities
- Evaluate the effectiveness of the state partnering with national rural recruitment network
- Increase incentives for housing, educational benefits for providers' children, loan repayment
- Advocate increased number of J1-Visa slots
- Increase the number of rural residencies
- Increase rotations from the medical schools for rural areas
- Develop a statewide database of regional opportunities
- Increase the participation in the Medical Reserve Corps

## **6) Advocacy: Advocate rural health policies that promote sustainability for rural health goals and institutions**

*Vision: Federal and state policies support Virginia's rural health infrastructure*

*"The Rural Health Plan should help shape public policy, especially as it relates to government responsibility (maintaining health, safety, and welfare)."*

Many elements of rural health, particularly those that involve reimbursement for services by insurance companies and state and federal programs, depend on policies that go beyond any one locality's scope of influence. Rural health stakeholders must communicate with policy makers in government, businesses, and other sectors to advocate for favorable policies and resource allocation.

*"Get people in the Golden Crescent to understand ... that rural Virginia provides a lot to all of Virginia- food, ecology, unacknowledged, unpaid-for benefits. All rural areas flow to urban areas and many flow to the Chesapeake Bay."*

As of 2013, the ACA is in the process of bringing about major changes in the ways that health care is financed and delivered in the U.S. Many of the most important provisions, including individual mandates to have health insurance and the expansion of Medicaid to cover more low-income individuals, have not yet been implemented. There is widespread uncertainty about how these and other reforms will affect rural providers, patients, employers, and others. As a result, the needs and focuses of policy advocacy may shift during the years of this Plan and rural health advocates will need to pay continuing attention to health policy at the national and state levels.

*"Getting rid of the Critical Access designation for rural hospitals ... would be potentially devastating to us because of preferential reimbursement from Medicare."*

*Strategy 6.1 Ensure the sustainability of CAHs and other rural health providers through advocacy for:*

- a. Continued CAH designation (at the federal level)
- b. Optimal rates of reimbursement for Medicare and Medicaid
- c. Providing education for CAHs and rural health clinics about how to maintain fiscal viability and quality
- d. Increasing the bargaining ability of CAHs
- e. Processes for state-contracted Managed Care Organizations to automatically qualify a Medicare-qualified hospital
- f. Processes for state-contracted Managed Care Organizations to automatically credential providers that accept Medicaid



*Strategy 6.2 Promote the expansion of Medicaid in Virginia through the ACA*

*“Some of the hospitals won’t make it without Medicaid expansion.”*

*Strategy 6.3 Advocate for the reallocation of Medicaid to a community-based case management model*

*Strategy 6.4 Advocate for strong public health schools around the state*

*Strategy 6.5 Advocate for additional resources to improve rural transportation infrastructure*

*Strategy 6.6 Train stakeholders from communities and organizations to communicate effectively with policy makers*

*Strategy 6.7 Seek regulation to contain the rising cost of medical education*

*Strategy 6.8 Present the Plan at town hall meetings across the state*

## Appendix

## Rural Definition

There are multiple and conflicting definitions for designating a place to be rural. The 2008 Rural Health Plan initiated an intensive process to evaluate different models for defining rurality, and to select a model based on Virginia’s unique characteristics. The Isserman definition of rural was selected, and remains the Rural Health Plan’s preferred method for designating rural counties.

**Isserman<sup>4</sup> Definition:** Counties are classified as (1) rural, (2) mixed rural, (3) mixed urban, and (4) urban. A rural county is one in which the county’s population density is less than 500 people/square mile, and 90 percent of the county population is in a rural area or the county has no urban area with population of 10,000 or more. An urban county is one in which the county’s population density is at least 500 people per square mile, 90 percent of the county population lives in urban areas, the county’s population in urbanized areas is a least 50,000 or 90 percent of the county population. A mixed rural county is one, which meets neither the urban nor the rural county criteria, and its population density is less than 320 people per square mile. A mixed urban county is one which meets neither the urban nor the rural county criteria, and its population density is at least 320 people per square mile.

**Isserman Rural and Urban Geographical Classification Summary<sup>5</sup>**

Rural			
Accomack County	Cumberland County	Lancaster County	Prince Edward County
Alleghany County	Dickenson County	Lee County	Rappahannock County
Amelia County	Essex County	Louisa County	Richmond County
Appomattox County	Floyd County	Lunenburg County	Rockbridge County
Bath County	Fluvanna County	Madison County	Russell County
Bedford County	Franklin County	Mathews County	Scott County
Bland County	Giles County	Mecklenburg County	Shenandoah County
Brunswick County	Goochland County	Middlesex County	Smyth County
Buchanan County	Grayson County	Nelson County	Southampton County
Buckingham County	Greene County	New Kent County	Surry County
Caroline County	Greensville County	Northampton County	Sussex County
Carroll County	Halifax County	Northumberland County	Tazewell County
Charles City County	Highland County	Nottoway County	Westmoreland County
Charlotte County	Isle of Wight County	Orange County	Wise County
Clarke County	King and Queen County	Page County	Wythe County
Craig County	King George County	Patrick County	Norton city
Culpeper County	King William County	Powhatan County	

<sup>4</sup> Isserman, A. M. (2005). In the national interest: Defining rural and urban correctly in research and public policy. *International Regional Science Review*, 28(4), 465-499

<sup>5</sup> Center for Rural Health Policy, Education and Research

Mixed Rural			
Albemarle County	Dinwiddie County	Henry County	Rockingham County
Amherst County	Fauquier County	Montgomery County	Spotsylvania County
Augusta County	Frederick County	Pittsylvania County	Warren County
Botetourt County	Gloucester County	Prince George County	Washington County
Campbell County	Hanover County	Pulaski County	Suffolk city
Mixed Urban			
Chesterfield County	Stafford County	Covington City	Lexington City
James City County	Bedford City	Emporia City	Martinsville City
Loudoun County	Buena Vista City	Franklin City	Radford City
Roanoke County	Clifton Forge City	Galax City	Staunton City
			Waynesboro City
Urban			
Arlington County	Charlottesville City	Harrisonburg City	Poquoson City
Fairfax County	Chesapeake City	Hopewell City	Portsmouth City
Henrico County	Colonial Heights City	Lynchburg City	Richmond City
Prince William County	Danville City	Manassas City	Roanoke City
York County	Fairfax City	Manassas Park City	Salem City
Alexandria City	Falls Church City	Newport News City	Virginia Beach City
Bristol City	Fredericksburg City	Norfolk City	Williamsburg City
	Hampton City	Petersburg City	Winchester City

## Resources

Implementing the objectives in the Virginia SRHP requires many resources. Many projects start with documenting needs, partnering with other organizations, and applying for funding. There are many other organizations that could be listed, but the following resources provide a place to start.

### Data Sources for Rural Health Programs

Organization	Focus of data
Centers for Disease Control and Prevention <a href="http://www.cdc.gov">www.cdc.gov</a>	Healthy Communities program planning resources
Welden Cooper Center for Public Service <a href="http://www.coopercenter.org">www.coopercenter.org</a>	Virginia data including demographics, workforce, economics, and policy
Healthy People 2020 <a href="http://www.healthypeople.gov">www.healthypeople.gov</a>	National benchmarks for health indicators
County Health Rankings <a href="http://www.countyhealthrankings.org">www.countyhealthrankings.org</a>	County-level data on health outcomes and determinants of health
Virginia Department of Health and Office of Minority Health and Health Equity <a href="http://www.vdh.virginia.gov">www.vdh.virginia.gov</a>	Health statistics, disparities, health care licensure, much more
Virginia Rural Health Resource Center and Virginia Rural Health Data Portal <a href="http://www.vrhrc.org">www.vrhrc.org</a>	Health, demographic, and economic data for localities in Virginia
Voices for Virginia's Children <a href="http://www.vakids.org">www.vakids.org</a>	Data on children's health, education, and families
Healthy Appalachia Institute <a href="http://www.healthyappalachia.org/">www.healthyappalachia.org/</a>	Health blueprint and other resources specific to southwest Virginia
Virginia Workforce Connection <a href="http://www.vawc.virginia.gov">www.vawc.virginia.gov</a>	Employment data by industry and region
Virginia Health Workforce Development Authority <a href="http://www.vhwda.org">www.vhwda.org</a>	Job and training data on health professions
Virginia Rural Health Association <a href="http://www.vrha.org">www.vrha.org</a>	Conferences, newsletters, and other sources of up-to-date information on rural health issues and opportunities for education and funding
Hospitals' Community Health Needs Assessments	Required report from nonprofit hospitals; available through individual hospitals
Public health districts' Mobilizing for Action Through Planning and Partnerships (MAPP)	Public health strategic planning report; available through some <a href="#">health districts</a>

Potential Collaborators

Organization	Focus area
YMCA <a href="http://www.vaymca.org">www.vaymca.org</a>	Physical activity, youth development
Virginia Cooperative Extension <a href="http://www.ext.vt.edu">www.ext.vt.edu</a>	Nutrition, family development, youth development, agriculture, community development, natural resources
Virginia Rural Health Resource Center <a href="http://www.vrhrc.org">www.vrhrc.org</a>	Virginia's clearinghouse for local, state and national rural health information lists rural organizations
Veterans Affairs <a href="http://www.va.gov">www.va.gov</a>	Programs for military veterans and their families
Virginia Association of Free and Charitable Clinics <a href="http://www.vafreeclinics.org">www.vafreeclinics.org</a>	Resources and advocacy for free and other clinics that serve uninsured and underserved Virginians
Virginia Community Healthcare Association <a href="http://www.vacommunityhealth.org/">www.vacommunityhealth.org/</a>	Resources for existing and aspiring community health centers
Rural Assistance Center <a href="http://www.raonline.org/states/virginia.php">www.raonline.org/states/virginia.php</a>	Lists organizations serving rural Virginia
Virginia Department of Housing and Community Development <a href="http://www.dhcd.virginia.gov/">www.dhcd.virginia.gov/</a>	Partners with communities to build safe, affordable, and prosperous communities
Virginia Tech Community Design Assistance Center <a href="http://www.cdac.arch.vt.edu/">www.cdac.arch.vt.edu/</a>	Assists communities with improvements to built and natural environments
Virginia Farm to Table <a href="http://www.virginiafarmtotable.org/virginia-farm-to-table-plan/">www.virginiafarmtotable.org/virginia-farm-to-table-plan/</a>	Promotes farming, food access, and nutrition
Alliance for Healthier Virginians <a href="http://www.eatsmartmovemoreva.com/nutritioninfo.html">www.eatsmartmovemoreva.com/nutritioninfo.html</a>	Partnership of many diverse organizations seeking to advance nutrition and wellness
Medical Reserve Corps <a href="http://www.medicalreservecorps.gov">www.medicalreservecorps.gov</a>	Local volunteer groups that help with emergency response and other health needs
HOSA – Future Health Professionals <a href="http://www.hosa.org">www.hosa.org</a>	Promotes high school students to pursue careers in health professions
HealthmapRx <a href="http://www.healthmaprx.org">www.healthmaprx.org</a>	Works with employers and communities to implement pharmacist-led chronic disease management, based on “The Asheville Project”
Patient-Centered Primary Care Collaborative <a href="http://www.pcpsc.net">www.pcpsc.net</a>	Promotes strong primary care and medical home models
National Committee for Quality Assurance <a href="http://www.ncqa.org">www.ncqa.org</a>	Patient-centered medical home model

## Funding Sources

Funding source	Focus areas
Virginia Health Care Foundation <a href="http://www.vhcf.org">www.vhcf.org</a>	Primary health care access for underserved populations
Centers for Disease Control and Prevention <a href="http://www.cdc.gov">www.cdc.gov</a>	Healthy Communities grants
Virginia Rural Health Association <a href="http://www.vrha.org">www.vrha.org</a>	Lists funding resources
Virginia Foundation for Healthy Youth <a href="http://www.vfhy.org">www.vfhy.org</a>	Healthy choices, tobacco use, and obesity in youth
Health Resources and Services Administration (HRSA) <a href="http://www.hrsa.gov">www.hrsa.gov</a>	Rural hospitals and clinics, telehealth
Rural Assistance Center <a href="http://www.raconline.org/states/virginia.php">www.raconline.org/states/virginia.php</a>	Lists funding and other resources
The Grantsmanship Center <a href="http://www.tgci.com/funding/cfs.asp?statename=Virginia&amp;statecode=VA">www.tgci.com/funding/cfs.asp?statename=Virginia&amp;statecode=VA</a>	Lists community foundations and the geographic areas they serve
Grants.Gov <a href="http://www.grants.gov/">www.grants.gov/</a>	Centralized site for federal grants to organizations
Robert Wood Johnson Foundation <a href="http://www.rwjf.org">www.rwjf.org</a>	Variety of health program grants
Surdna Foundation <a href="http://www.surdna.org">www.surdna.org</a>	Promotes sustainable communities initiatives
PNC Foundation <a href="http://www.pncsites.com/pncfoundation/">www.pncsites.com/pncfoundation/</a>	Focus on sustainability, diversity, early childhood education, and economic development
Presbyterian Committee on the Self-Development of People <a href="http://www.presbyterianmission.org">www.presbyterianmission.org</a>	Projects managed and led by oppressed or disadvantaged groups

## Interviewees

The following individuals generously volunteered their time for individual interviews with the staff of the Institute for Environmental Negotiation, University of Virginia.

Derek Burton, project manager | SWVA Behavioral Health Board; president, Virginia Rural Health Association

Howard Chapman, program development director | Tri Area Community Health

Michele Chesser, senior health policy analyst | Joint Commission on Health Care

David Cockley, health administrator | James Madison University

Ken Cook, director of technical assistance | VRHRC

Ruth Cox, chair | Planning District-3 Substance Abuse Coalition

Terry Dickinson, executive director | Virginia Dental Association

Jeanette Filpi, hospital administrator | Pioneer Community Hospital, Patrick County

Juliana Fehr, FACNM coordinator, nurse-midwifery | Shenandoah University, Division of Nursing

Pat Foutz, administrator | Bath County Hospital

Roger Hofford, M.D., program director, family medicine residency | Carilion Roanoke/Salem

Janet Jeter, community health ambassador | Three Rivers Health District

Debra Jones, extension specialist | Virginia State University

Susannah Lepley, program director | Blue Ridge AHEC, Virginia Medical Interpreters Collaborative

David Nutter, economic development specialist | VT Office of Economic Development

Beth O'Connor, executive director | Virginia Rural Health Association/Virginia Rural Health Resource Center

Marcia Quesenberry, co-director | Healthy Appalachia

Rosa Rouch, community health ambassador | Three Rivers Health District

Mike Royster, director of programs | Institute for Public Health Innovation; board member, Virginia Rural Health Association

Regina Sawyer, executive director | Appalachia Agency for Senior Citizens, Inc.

Tyler Sanders, community health ambassador | Three Rivers Health District

Suzanne Sheridan, executive director | Rockbridge Area Free Clinic

Robert Stephens | Suffolk Community Action Coalition

Nancy Stern, executive director | Eastern Shore Rural Health System, Inc.

Sarah Jane Stewart | Virginia Health Care Foundation

Joyce Turner, community health ambassador | Lenowisco Health District

Mark Vanover, director of operations | Dickenson Community Hospital

Wendy Welch, executive director | Southwest Virginia Graduate Medical Education Consortium

Peggy Whitehead, executive director | Blue Ridge Medical Center

Kathy Wibberly, director | Mid-Atlantic Telehealth Resource Center, UVA Telehealth Center



## Acronyms in this Plan

Affordable Care Act (ACA)  
Area Health Education Centers (AHEC)  
Certified Nursing Assistants (CNAs)  
Chronic obstructive pulmonary disease (COPD)  
Critical Access Hospital (CAH)  
Emergency Medical Services (EMS)  
Exchange Visitor (J) non-immigrant visa (J-1 Visa)  
Health Opportunity Index (HOI)  
Health Professional Shortage Area (HPSA)  
Licensed Practical Nurses (LPNs)  
Medically Underserved Area / Population (MUA/P)  
Program of All-Inclusive Care for the Elderly (PACE)  
Social determinants of health (SDOH)  
State Rural Health Plan (SRHP)  
Veterans Administration (VA)  
Virginia Department of Health Office of Minority Health and Health Equity (OMHHE)  
Virginia Public Health Association (VaPHA)  
Virginia Rural Health Association (VRHA)