Building Blocks for Healthy Rural Communities
Assumptions, Guidelines, and Fundamental Services

Introduction

The following presentation of the Building Blocks for Healthy Rural Communities is based on: The Plan for Improving Rural Health in Maine—October 2008; the National Rural Health Association's "The Future of Rural Health" Policy Paper—February 2013; and the American Hospital Association's Report of the Task Force on Ensuring Access in Vulnerable Communities—November 2016, and updates developed by an interested group of Maine health professionals in 2018.[1]

The paper has two sections, which can stand alone, but which are best viewed in combination. The first section provides assumptions and guidelines for considering the challenges of rural health and rural health services. The second section outlines a set foundational or building block health services that should be readily available within local communities or reasonable regional clusters of communities. The hypothesis is that if sufficient consensus can be built around the assumptions, guidelines and suggested services; and if the principles can be more universally applied, the State will make much greater progress in addressing rural needs.

This paper is meant to be a touchstone for communities, rural health providers and advocates, and health-related organizations, as well as local and State governments. It is a tool that can be used to support collaborative discussions and actions that can improve the health of rural Maine. It can help to better define our individual and mutual accountability for assuring access to services, but also for protecting rural people and the essential character of our State.

The set of Fundamental Building Blocks does not include all services (e.g., advanced specialty care) to which rural residents should have out-of-area access. It only addresses those services that should be highly accessible to clusters of rural communities.[2] For the services that are provided, it is assumed that all services should be delivered within known quality parameters and that various models of care may be necessary to meet community needs and expectations. It is beyond the scope of this paper to consider the complex and daunting issues of financing care or other challenges, such as assuring that we have a sufficient workforce, the implications of large health systems, or the most desirable structure to assure public health services. While it does not address all issues, this paper articulates basic assumptions and fundamental services, which should frame the discussions of all these other considerations.

Assumptions and Guidelines

The building blocks for healthy rural communities can stand alone, but they can be better understood in the context of several parameters that shape community health.

- The definition of rural is highly variable among various organizations and governmental entities. Perceptions of "what is rural" are also variable, depending on different parts of the country.

[1] The concept of Fundamental Building Blocks has evolved from previous use in Maine, Pennsylvania, Ohio, Virginia, and North Carolina. The basic concepts are also expressed in the National Rural Health Association's Policy Paper on the Future of Rural Health, which included consideration of the positions developed in the other locations. All documents quoted liberally from each other without specific citations, as does this version.

[2] The fundamental services can be modified based on evidence-based studies of the relationships between travel times, access, utilization rates and clinical outcomes.

- Improving individual and community health goes far beyond providing services. It is estimated that as much as 80% of individual health status is determined by non-health care factors, which range from basic genetics to a host of individual behavioral choices that negatively affect health status.

- Social Determinants of Health (SDH) are critical contributors to health status and include such factors as: education, employment and working conditions, discrimination, availability of childcare, cultural and community history, and other factors such as housing, income, physical environment, and transportation. Observable health disparities across different population groups can frequently be attributed to these factors. Rural populations often lack resources to mitigate the negative effects of some of the social determinants of health; yet, it will not be possible to make significant improvements to the health of rural people without addressing these factors.

- In addition to considering the Social Determinants of Health, it is important to consider whether health services are provided equitably. Across the nation, there are inequities, caused by variables such as ethnic, racial, or gender biases, that should not be tolerated.

- Maine's rural residents, like rural people nationally, are generally poorer, older, sicker, and have more chronic illness, higher rates of substance abuse and mental illness, and greater barriers to access than non-rural residents. In rural Maine, smoking, obesity, substance abuse, and other public health problems cause or significantly exacerbate poor health status and compel higher costs.

- The concept of "population health" has become bifurcated. Many large health plans (whether insurance company or provider-based) seek to manage the health of their *insured* "populations". This concept of population health is much narrower than thinking about the health of a state or a cluster of rural communities. It is a notable challenge to assure adequate focus on the health of communities and not just on commercially insured populations. If the needs of all the population in rural areas are not considered, significant segments will be left behind; and it is likely that these segments will be the most disadvantaged.

- Given the day-to-day pressures on rural hospitals (and often their non-rural parent organizations) as well as other rural health organizations (such as Community Health Centers and nursing facilities), it is increasingly challenging to expend energy and allocate resources beyond an essential focus on sustaining current efforts. Thinking more broadly about a community's overall health and defining and implementing community initiatives to improve health status are notable challenges that Maine is not adequately addressing.

- Maine was once a state where the financial integrity of its rural hospitals was sufficient to support the hospitals' role as the go-to leaders to address unmet community health needs. This is no longer assured in too many communities in the face of financial decline—which has put many rural hospitals at considerable, increasing risks, even risks of failure.

- As consideration is given to assuring that clusters of rural communities have adequate access to services, workforce pressures must be considered. Rural Maine faces considerable challenges in recruiting and retaining a sufficient workforce to deliver services. Workforce development strategies and investments must consider rural needs and aligned with staffing the Fundamental Services. If staffing is not available, even the most appropriate services cannot be delivered; if you cannot staff it, you cannot do it.

Other Guiding Assumptions[3]

[3] Largely from the 2008 Maine Plan

Several additions assumptions guide consideration of which services should be available and how they might be provided.

- Rural residents should have access to treatment, prevention, and educational resources as close to their homes as possible, when services can be provided with acceptable quality and cost.

- Rural residents should be supported by fundamental services as they age in place and should not have to move from their communities for basic care.

- Direct clinical and associated preventive and educational services can be offered by a variety of providers (e.g., physicians, nurse practitioners, physician assistants, other advanced practice nurses, dentists, dental hygienists, midwives, and others) within varied organizational structures and in a variety of settings (e.g., hospitals, hospital-affiliated or private practices, community health centers, community mental health centers, schools, and alternative community settings such as churches). Delivery, reimbursement and regulatory systems should facilitate providers working to the full extent of their licenses.

- Increasingly, technology (e.g., telemedicine and associated broad band capacity) will play a role in assuring timely, efficient, and effective access. Some providers of services may not be physically located in a rural setting, but the services may still be accessible.

- The core set of integrated parts defines long-term service and systems development goals, not current conditions. There are gaps between realities and aspirations that define some of the State's challenges.

- Clusters of rural communities have the primary responsibility for determining workable models for rural health improvement and the scope of services to be delivered locally, within obtainable resources. There is community responsibility, not just health organization responsibility. Different clusters of communities may take different approaches to services. Communities and clusters of communities that are unwilling or unable to engage in local planning will be at increasing risk.

- Those that are willing to do the hard work need on-going State and private support from non-local organizations, larger health systems, and governmental entities. In the face of limited resources, it is important that discussions and investments are focused on the essential services.

- The economic viability of rural Maine is intimately linked to assuring adequate access to basic health care. It is not possible to sustain and to build local economies without a healthy workforce. It is not reasonable to think about attracting businesses in the absence of accessible basic services, nor is it reasonable to assume that such communities would be attractive to retirees. Local spending on health services and the jobs that are created are critical factors in Maine rural economy and may be pivotal in determining communities' futures. A deterioration of local health care can be a significant precursor of community decline.

- The identified Fundamental Services are not a limit on services that could be provided; rather, they serve as a guideline for the minimum services that should be provided or readily accessible. All foundational services will not be appropriate in every rural community; but reasonable access to services for the population of clusters of communities should be the basic expectation. Initiatives to develop regional strategies are consistent with this approach.

- Any limitations placed on community-driven evolutionary change should be very carefully considered in the context of community health and development, as well as community-defined expectations and the

willingness of communities to invest their resources. The development of services that go beyond those noted should be carefully evaluated and data-driven, with an emphasis on both *value* and sustainability.

Fundamental Building Block Services

I) For All Services

Maine's rural health system must provide a foundational, core level of health services within local communities or reasonable regional clusters of communities. The rural health system should functionally integrate physical, behavioral, oral, and public health services and concepts to achieve greater access, efficiency, and quality.[4] The term "Value" is frequently used to describe access, efficiency, cost, and quality. Although there is a gauntlet of challenges to achieving these goals, agreement on goals can focus the initiatives and decisions needed to more Maine closer to meeting the needs of its rural people and their communities.

II) Primary Care—the Essential Core of Rural Health Care Systems

Primary Care consists of comprehensive health services at the point at which people enter the health care system. Services include not only prevention, diagnosis and treatment of acute and chronic conditions, but the provision of a continuum of services that include preventive, diagnostic, palliative, therapeutic, curative, counseling, rehabilitative, and end-of-life services that are accessible, comprehensive and coordinated.

Comprehensive Primary Care is defined to include primary medical care, basic behavioral health and substance abuse services, and basic oral health services. Although not within the definition of primary care, Primary Services extend to several other services, such as emergency and urgent care services, primary care-associated support services (as noted below), general surgery, appropriate inpatient facilities, associated health education and health promotion, *and care coordination*.

A) Primary Medical Care

May be provide through a mix of:

1) Family Medicine
2) Internal Medicine
3) Pediatrics
4) Obstetrics and General Medical Gynecology
   (a) In communities where there are no obstetricians and/or delivery services, recommended primary care access includes local pre-natal and post-natal care, as well as support for securing necessary referral relationships for deliveries.

B) Mental Health Services and Substance Abuse Disorder Services

1) Crisis intervention, diagnosis, primary outpatient treatment, prevention, and referral, including services for adults, children, adolescents, and families
2) Recovery communities that support outpatient treatment
3) When care exceeds local capacity, referral mechanisms to outpatient and inpatient mental health and substance abuse providers in other communities, with referrals back to local community's outpatient providers

C) Oral Health Services

1) Preventive dental services including prophylaxis, appropriate use of fluorides, dental sealants, oral health education, and oral health promotion activities
2) Basic restorative treatment
3) Referral mechanisms to more specialized services (orthodontics, restorative care, oral surgery, and prosthodontics, e.g., crowns

[4] The concepts have evolved from previous use in Maine and use in Pennsylvania, Ohio, Virginia, and North Carolina. The basic concepts are now expressed in the National Rural Health Association's Policy Paper on the Future of Rural Health.

III) Primary Services

A) Emergency/Urgent Care Services
   1) Hospital emergency departments (including an appropriate scope of medical/surgical/mental health/substance abuse services, as well as triage and referral, with telehealth linkages)
      (a) This may include alternative models for providing emergency services in hospitals that do not have beds, including consideration of Community Outpatient Hospitals.
      (b) Services include health care services provided to evaluate and/or treat medical conditions that require immediate and unscheduled medical care and can include observation services.
         (i) The integration of all systems for time-sensitive illnesses and injuries (Trauma, Stroke, STEMI / Cardiac, pediatrics, Burns, OB and other emergencies
   2) Mobile emergency medical services—EMS (ambulance services, emergency medical technicians, paramedics, and communications systems)
   3) Other: automatic external defibrillator programs

B) **Primary or Core Specialty Services**
   1) General Surgery
      (a) Full-time in <u>many</u> rural hospitals but increasingly part-time, with predominant emphasis on outpatient surgery (including colonoscopies)[5]; and must include coordinated referral services
   2) Orthopedics
      (a) Full-time in <u>some</u> rural hospitals, at least part-time in <u>many</u>, but highly variable by size of service area; and must include coordinated referral services

IV) Other Limited Specialty Services

Other specialty-physician services are generally not considered to be "core" or fundamental services on a full-time basis in most rural communities. But they are often available at least on a part-time basis, and broader services may be appropriate and sustainable depending on local conditions. Telemedicine will play an increasing role in providing local access. (Note again that the expectation is that the quality of services will not be compromised when the services are provided in rural locations.)

V) Telemedicine/Telehealth

Telehealth is not a service unto itself; it is a mechanism for delivering services and for expanding access. Nonetheless, telehealth technology and providers who employ this technology will become increasing relevant to providing access to Primary, Specialty, and Home Health Care, as well as Emergency Services. Thus, this is listed as a fundamental building block.

VI) Inpatient Hospital Services

The sustainable range of inpatient services will vary by community but generally includes the following:

A) Basic inpatient care <u>consistent with the mix of primary care, general surgery, obstetrics and gynecologic services</u> that are locally supportable; and, where possible, orthopedics and other specialty services (with all services provided within documented quality standards)[6]
   1) Services <u>may</u> include skilled nursing services provided in swing beds (services may alternatively be provided in other community settings, as noted below), definitive inpatient mental health and

[5] In many communities, this is trending to part-time, no-call-coverage, outpatient-only general surgery.
[6] Increasingly CAHs have found it difficult to sustain delivery services. This does not remove the essential nature of pre-natal and post-natal care, included under primary care.

substance abuse services, as well as physical rehabilitation programs, but these inpatient services are not considered core services that should be available within all clusters of rural communities.

B) It is increasingly relevant to note that some clusters of rural communities will not be able to support inpatient care; in such cases, communities need to build linkages with hospitals that provide inpatient services, as well as to design delivery systems that do not rely on the availability if inpatient beds (e.g., a "Community Outpatient Hospital").

C) Whether or not inpatient services should be included in a community health system has traditionally been a community decision and in many places currently, the decision of a corporate entity not local to the community. Regardless of ownership issues, the financing and investment in community inpatient structures should be considered within the context of a limited amount of resources and the most appropriate placement of those resources to reduce costs and improve health and health systems

VII) Support Services (consistent with local physician and non-physician provider services, including inpatient services, as well as services provided through telemedicine connections)

A) Diagnostic and Treatment Services
   1) Diagnostic Imaging (Radiology) (local and/or remote-teleradiology access)
   2) Basic laboratory services
   3) Pathology (local or remote access)
   4) Anesthesia (anesthesiologists or nurse anesthetists)
   5) Therapeutic services (e.g., OT, PT, RT, speech, and audiology)

B) Care Coordination and Associated Social Services (which can often address some of the challenges of addressing the Social Determinants of Health)

VIII) **Referral Relationships**

A) Regional and statewide referral relationships, which may be formal or informal, are essential to enhancing locally available resources and broadening access *to the full spectrum of health care services needed for individuals in the community*.

IX) **Home Health Services and Hospice Care***[7]

A) Home health and hospice services, including nursing care and care attendants, and as appropriate, physical therapy, occupational therapy, speech therapy, durable medical equipment support—including use of telemedicine technology, and other support services, which can include homemaker services (Inpatient hospice services will not be possible in all locations.)

X) **Skilled Nursing Services and Nursing Facility Services***

A) Skilled nursing and nursing facility services can be provided in a variety of settings, including hospitals and nursing facilities; the care may vary between short-term skilled services in either a hospital of nursing facility and long-term care in a nursing facility.

B) Skilled nursing facility (SNF) resources may include hospital-based "swing-beds," particularly in critical access hospitals (CAHs).
   1) Where SNF care is provided in hospitals, it is important to consider the community implications, including the financial impacts of the interplay between hospital and non-hospital providers.

XI) **Non-acute, Assisted Living and Residential Care***

[7] Services marked with an asterisk were not included in the AHA Report but have been determined through other discussions to be fundamental to strong community health systems.

A) Supportive housing, both private and MaineCare funded, with associated assistance with meals, medications, and clinical services to maintain independence at a pre-nursing facility level of care

XII) **Pharmacy Services***

A) Geographic access to prescription drugs, as well as associated adverse risk screening and consumer education related to the appropriate use of medications.

XIII) **Eye Care Services***

1) Ophthalmology (which can be a limited physician specialty as identified above, but which is not expected to be available locally everywhere)
2) Optometry and Optical Services

XIV) **Broad Public Health and Educational Support***

Public Health and Educational Strategies are often provided as components of primary care practices, but very often there is a need for more developed and more specific State and community initiatives. Public health and educational initiatives are frequently substantially underfunded, while still being essential to improving population health. Strategies include at least the following, with priorities varying according to the characteristics of communities in each rural cluster:

A) Access to food, including access to fresh fruits and vegetables and other healthy food products to enhance the overall wellness and health of the population.
B) Patient, family, and community health education (Education is critical to all aspects of individual care and prevention, as well as to the broader community health.)
C) Domestic/child violence prevention and intervention
D) Teenage pregnancy prevention (and as necessary, teenage maternal and child support)
E) Immunizations and other personal health risk prevention strategies, such as
    1) Nutrition services
    2) Smoking cessation support
    3) Auto safety
F) Environmental protection issues
G) Immigrant and migrant health
H) Occupational health/work risk exposure
I) Sanitation and clean water supplies
J) Communicable disease prevention
K) Bio-terrorism and pandemic disease prevention and mitigation strategies
L) Support services for individuals with disabilities
M) Housing
N) Transportation (this service was included in the AHA report)
    1) Transportation services include both medical and personal transportation to allow patients to access care at hospitals and other health care facilities
O) Access to a competent public health workforce
P) Public health leadership and policies
    1) Development of multi-community public health strategies
    2) Appropriate public health policy, laws, regulations, and enforcement
    3) Rural health research

XV) Conclusion

It is easy to say that rural residents should have ready access to all the identified services and referral linkages to more specialized providers and facilities. However, in many cases neither the local capacity nor the referral resources and linkages are adequate. While community engagement will be essential, community resources will often be limited. It is in these cases where some of the hardest work will need to be done and where innovation will be required; preservation of the *status quo* will rarely be a positive option.

To "do more with less" is a meaningless and highly inappropriate charge. However, to "do the right things, in the right ways, in the right places, with the resources we can secure" is essential and it should be the philosophical underpinning of addressing the needs of rural people.