Quality through collaboration in the United States

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Introduction

Why do we need health care in rural communities? Should we not foster efficiency by transporting these misguided persons who choose a rural life to urban centres where expertise and technology naturally occur? Regrettably, a positive response to this opinion is often heard in policy arenas in the United States.

Many of us have no desire to live in a city, and 20% of US citizens agree.1 It is clear that certain aspects of health care are provided with higher quality and greater efficiency in the community where people live.2 Examples include primary care, public health services, long term care, maternal/child services and initial care of time sensitive entities such as acute myocardial infarction, stroke and trauma. Response to these issues requires rural system development at three levels: purely local, local via technology and stabilisation with transport. Other ways of viewing system development include community level coalitions that collaborate across the continuum of care and regional systems linking communities with tertiary care providers.

When approached from a system development perspective, health care can contribute to rural social capital in many ways. By becoming an integral component of the community and intentionally participating in building a healthy community, the health care infrastructure provides an economic engine for community development. Health care can be effective, efficient and safe, providing predictable and consistent processes and outcomes reflecting high quality; it also improves the health status of the population being served. The goal of system development must be safe, timely, effective, efficient, patient- and community-centred and equitable care for individuals and populations.3

Following the release of the Institute of Medicine report on rural health care in the United States in 2004 (Quality Through Collaboration: The Future of Rural Health), the National Rural Health Association (NRHA) inaugurated a rural quality initiative based on the findings and recommendations contained therein. In that context, this report focuses on the requirement for reform of US health care and the rural response by the NRHA. The core question is “What makes rural health care work?” Exemplary programs and initiatives for improving rural health care are described. Success factors and conclusions derived from these examples are identified. Finally, potential mutually beneficial activities related to these findings between our organisations (National Rural Health Alliance and Association) are proposed.

Opportunities for improvement in the United States

Why was there a need for a quality initiative? The issues are too complex and extensive for full clarification in this document. Sadly, the United States lacks a health care system. We have evolved a financial and legal arrangement largely controlled by special interests with little attention to the interests of the public. This results in low national ratings for population health status along with counter-cultural efforts by committed individuals and organisations to provide good care for all despite the enormous financial and regulatory barriers that discourage such efforts. We are far behind other institutions in information technology, a situation exacerbated in rural areas (often lacking broadband access to the Internet) due to financial constraints and population density insufficient to generate profit for internet service providers. Rural facilities are commonly old, poorly maintained, unsafe and not conducive to effective and efficient patient-centred care, again largely due to financial constraints. Our health care is inefficient, wasteful, ineffective and, too often, unsafe.4 We rarely address continuity even for chronic conditions. We communicate poorly and are anything but patient-centred. Practice laws are inconsistent, defensive and dysfunctional. Although we actively practice economic rationing of care and prefer to ignore equity, patients and communities are generally not engaged in health care issues. Financial results consistently trump quality and safety.
Though this description seems demoralising, it clearly presents enormous opportunities for improvement. Fundamentally, vision and leadership must emerge that forces system development toward the objectives of care for all citizens and improving health status of the population. The IOM Quality Chasm series provides the conceptual framework; we must see health care as it must become rather than appending “fixes” to the existing non-system. Profit for large organisations such as pharmaceutical giants and the insurance industry must take a back seat to quality, safety, service, inclusion and population health status. Run-away profits and an insurance business model built on restriction of care for financial reasons must be drastically curbed; the market is not always the solution. System building must create structures and processes that work together across the continuum of care and are designed to produce desired health outcomes and are consistent with current professional knowledge.

With the appearance of the IOM rural report in 2004, the National Rural Health Association (NRHA) determined that a great opportunity had emerged for rural health care to lead the United States toward this new and improved paradigm of health care. In addition to improving care for rural Americans, we needed to broaden the discussion of quality from the hospital setting to the continuum of care (relevancy being a key consideration) and engage the “quality establishment” in this vastly more fruitful concept of quality. Health care reform could “percolate up” (rather than maintaining the failed expectation that it would “trickle down”) by converting the IOM report from concept into action in rural communities and engaging rural citizens in their health care. Rural people must expect and demand more from their health care infrastructure.

The NRHA quality initiative by definition addresses the five areas of concentration of the document on which it is based: population health at the community level, quality support structures, workforce issues, health care finance and information/communication technology. Using the report as the basis for strategy and action, we engaged in a number of activities. First, we endeavoured to familiarise the rural health care universe with the contents of the document and the opportunities it created for rural America. Second, we developed a web site (www.nrharural.org/quality) to provide information about the initiative and linkage to many quality tools relevant for rural settings. We initiated annual rural quality conferences, the third of which will occur in Kansas City in July 2007. We have published several documents demonstrating best practices occurring in rural settings and a manual for comprehensive rural demonstrations as recommended by the IOM. We have provided limited technical assistance and intend to intensify that effort as the program matures. We are actively engaged in efforts to develop relevant measures to reflect quality and its improvement in rural settings across the continuum of care.

As a result of these and other activities, we have seen enormous growth of energy, acceptance and activity around quality, representing a major departure from past behaviour. We have developed numerous active partnerships around rural health care improvement. There is recognition within the universe of rural health care that there is a genuine conceptual framework for rural quality built around collaboration, continuity, communication and community engagement. There is also general acceptance of the belief that rural providers can contribute and that rural health care can lead in improving the health of Americans. We have been accepted at the table as having legitimate input into the quality discussion in both Federal and private settings. Our expectation is that there will be increasing rural influence on health care policy as we generate data on the effectiveness of our approaches and that genuine reform of many of the problems described above can emerge as a result of our learning in rural settings.

Currently we are actively studying best practices for improving rural health care in the nation and will be publishing the findings soon. The intention is to create a set of much higher expectations among rural people as to the value and effectiveness of health care and to challenge tertiary care providers to relate to their rural service areas in much more creative and proactive ways. This effort will be described in more detail below. We are working with many partners in addressing the numbers, skills and distribution of the rural health care workforce. Advocacy for and information about reimbursement, financial management and information technology are components of all aspects of the initiative. Additionally, we are aggressively seeking to find a way to fund the rural demonstrations of community based comprehensive health care systems that incorporate all that is known about population based safe, timely, effective, efficient, patient-centred and equitable health care. We believe
this can profoundly influence health care policy if done well.\(^7\) After publication of our best practice “models that are working”, we will direct our energies toward implementation of said practices universally rather than as exceptional projects. We will marshal technical assistance to that end and we will assure that findings and results are published and communicated effectively in various venues. With good reason, we are most enthusiastic about the initiative. Now let us briefly visit just a few examples of rural health projects where best practices are occurring despite all the barriers we have mentioned, and which provide models for improvement across the nation.

**Exemplary rural health programs in the United States**

Our virtual journey takes us to four health care operations that are making a vastly positive difference for rural people, even in the existing dysfunctional reimbursement environment. The settings are very different. First we will examine a collaborative program for cardiac care initiated by a major tertiary care centre in Minneapolis, Minnesota for their rural service area. Then we will travel to New England where Vermont is undertaking an ambitious agenda of health improvement for this rural state. Then we drive south to Pennsylvania where rural Tioga County has evolved a county-wide coalition for improving health in the county. Finally we will stop in Seymour, Indiana where a consortium of providers is collaborating in a community initiated endeavour to better serve their rural population in three agricultural counties. Key factors enabling success of these examples will be outlined in the subsequent section of this document.

First contact with the heart program in Minneapolis occurred in Boston at a meeting of the American Heart Association where improving care for myocardial infarction with particular emphasis on hard-to-reach (read “rural”) patients was discussed. A cardiologist from a tertiary care centre described a collaborative program with 30 rural hospitals up to 400 kilometres away. When patients are identified in the rural emergency department, a process is activated for getting the patient to the cardiac catheterisation lab within critical time limits. Their results with 1300 patients demonstrate that rural people can have outcomes comparable to (and sometimes even better than) those available to urban dwellers. Usually in two or three days, these patients returned to their communities with normal cardiac function, participating in rehabilitation and a secondary prevention process. Such dramatic clinical success results from: effective communication; standard protocols across the continuum (rural community and emergency department, transportation system and tertiary care centre); trust; and a relentless focus on the patient. The reason rural patients sometimes experience better outcomes than urban patients is that activation of the system with a single call from the rural emergency department produces faster response than the arrival of a patient by ambulance in the tertiary care emergency department. Note that the helicopters are stationed in rural communities in the service areas rather than in the city in order to achieve this degree of speed.

Vermont has found itself at the forefront of health care reform in the United States for several years, in part because of a generally progressive environment and a legislature willing to address health care issues; ensconced in legislative authority one finds the Blueprint for Health. State resources are committed to this state-led approach to developing information systems and processes of care in hospital districts throughout the State and across the continuum of care. Currently in the pilot phase in two communities, notable success is being documented in developing information technology (using the Orion system) and in implementing the Care Model\(^8\) for care of non-insulin-dependent diabetes with plans to expand to other chronic illnesses. The collaborative relationship between the State Department of Health and local communities is exemplary. Diabetes is selected as the pilot entity because: it is epidemic in our overweight society; much is known about good care; and the gap between what is known and what is actually done is enormous, resulting in both deplorable quality and inordinately high costs.

In Tioga County, Pennsylvania, a broad healthy community coalition was originated fifteen years ago by a visionary leader of the local health system. Organisations included in this coalition include the university in the county, the principal hospital system, the community development organisation, the local health department and others. The State Department of Health (another example of a progressive State level entity like Vermont) is also a player in this sustained process. Community assessment is one
function of this organisational entity which boasts a formal Board of Directors, a clear purpose, broad “buy-in” and important practical and political linkages. Many volunteers participate in “workgroups with passion” to carry forward healthy community initiatives. The track record of the Healthy Tioga County Partnership clearly shows that it has earned its reputation as a model for the nation for community involvement in health.

The last example of a model that is working is in rural Indiana; Seymour serves three agricultural counties midway between two urban centres. As community awareness grew that many farm families and the growing Hispanic population lacked adequate health services, a movement emerged around the Community Foundation to develop services for the under- and un-insured residents of the service area. Community leaders, the local hospital and volunteers joined forces to create facilities and obtain grant funding for a community health centre. The collaboration among the new community health centre, the hospital and physicians (led by an extraordinary physician champion) has resulted in greatly improved health care for the community. A new oral health facility was recently opened by the community health centre to great fanfare (oral health is a major deficiency in rural communities). It is worthy of note also that Indiana enjoys a very active, progressive and effective Rural Health Association which helps create the environment for innovation at the community level. Community involvement, a collaborative spirit with a community focus and leadership by a physician champion merit special notice in this example.

**Key findings: what makes rural health care work?**

Obviously best practices assume many guises, but there are characteristics shared in all models (including many not described here) that provide our “lessons learned” and guide us toward a functional system of care for rural communities and our nations. In part, “It’s a matter of will” (Dr Tim Henry, visionary cardiologist, Minneapolis). Vision, leadership, collaboration and developing “systemness” are core ingredients of success, as are the ability to adapt to a constantly changing environment and to creatively apply available tools and resources. Community engagement, regional approaches as appropriate and decision making on the basis of real data and information are other “top ten” elements of effectiveness.

Program leaders identify many reasons for success, including:

- agreed protocols across the continuum
- relentless focus on the patient
- equally relentless attention to detail
- real-time communication and problem solving
- refusal to allow turf, money, competition and “politics” to divert attention from patient care
- always focusing energy on making things work within the system of care
- a single person passionately dedicated full time to making things work
- communication, communication, communication
- training in rural emergency departments and building trust between rural and tertiary providers
- a single sheet of data for both care and research that follows the patient via FAX
- focusing on improvement, never blame
- collaboration across the continuum
- mutual respect
- integration of transportation into the care process
- IT system that puts needed information “just a click away”.

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Collaboration must occur among providers, among disciplines within health care organisations, among non-provider segments of the community with a vested interest in a healthy community and between the provider and non-provider communities. Since discussing collaboration can sometimes seem intimidating, it is good to think and talk about “working together”.

Collaboration among a diverse group of partners is enhanced by:

- clear values and purpose, openly shared and consistently addressed
- commitment to open, clear, direct communication which is consistently “checked out” for agreement, disagreement or misunderstanding
- workgroups with passion for the task/topic
- assuring that the activities of the Partnership never adversely affect members
- consistent leadership
- commitment of community leadership, combined with provision of time for key staff to participate in Partnership activities
- all partners are substantively involved and their interests are addressed
- grant funding is aggressively pursued with the assistance of a capable grant writer
- facilitation of meetings in a way to foster trust
- savvy political involvement
- sharing with other partnerships nationally
- state environment supportive of Partnership operations and goals
- strategic planning as an integral Partnership function, individually and collectively
- partners tangibly invest in the partnership and see a return on that investment, creating a sense of ownership
- regular and frequent celebration of accomplishments and milestones.

These elements permeated all exemplary programs, and are presented as conceptual components of reforming and improving health care in all environments. They point to central themes including collaboration, continuity, communication, leadership and community involvement. It will be easier to implement them in a rural setting than in urban places because our need is great, we have experience with collaboration, we are of manageable scale and we can identify a denominator population.

**Proposed joint opportunities**

There are opportunities for synergy and collaboration between our national rural health organisations based on mutually agreed principles and goals. Already there is collaboration in the area of emergency medical services (EMS) and transport. Publishing around success factors for rural health, teaching and modelling effective communication and collaborative practices, fostering a community focus for improvement programs, developing innovative approaches to solving workforce problems, including all rural citizens in access to health care and focusing on continuity and health improvement are examples of potential synergy between Australia and the United States in rural health.

Dialogue smoothes the path to learning and synergy. We should purposefully share best practices, continue learning about EMS and work together for global improvement of rural policies and advocacy for rural people. The United States has a lot to learn from your knowledge and experience. The US version of NRHA can be instrumental in helping that to happen.
References


Presenter

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