COMMENTARY

Forging Local Level Partnerships to Make Health Programs Possible

Rita C. Salain

Over the past several decades, a tremendous reservoir of experience and expertise has developed with regard to the role and importance of community planning and partnership development through which concerted actions to improve the health of rural residents can take place. In this commentary, I attempt to summarize some of this accumulated knowledge and experience and identify some of the critical steps toward meaningful community health action to improve the health of rural people, rural access to healthcare, and rural health program development.

In rural communities, if a primary care physician decides to re-locate to another town or close his/her practice, the community's healthcare options may become drastically limited over night. The same is true if a rural hospital closes or limits needed services because of financial distress. Both of these scenarios place an increased strain on public health providers in the area as well as the other private health providers. In communities with limited resources, one provider making a change impacts all the other providers, families, and individuals. Rural healthcare systems are fragile. Events that affect the ability of rural communities to provide quality healthcare vary, but most rural communities face a similar set of access to care barriers, which include financial, geographic, educational, cultural, and language.

In many rural communities, however, high-quality health services are available and thriving. The difference between a strong, high-quality primary care system and a system that fails in rural communities is often based on whether or not the community has local leadership dedicated to understanding and preserving healthcare that is appropriate and meets most of its citizens' needs. The success of most healthcare systems in rural communities hinges on community leaders who are willing to work together to identify needs, find resources, and invest their time and talent in solving healthcare access problems. Often rural health leadership includes working with adjoining communities to plan and deliver health services.

Creating a successful healthcare system in a rural community goes beyond the leadership of one person. Success depends on rural stakeholder collaboration and commitment. The events that prompt the formation of a partnership among stakeholders vary, as do the methods by which rural communities take action. A small community health planning group could be formed and charged with investigating and defining the problems. The group could be self-appointed or appointed by county or municipal government leaders, community physicians, the hospital, the board of health, etc. A coalition of local leaders or an appointed task force or partnership might be charged with finding outside help or consultation.

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Regardless of how the group comes together to develop and maintain the most effective community health planning group, communities will need to identify appropriate constituents as stakeholders, agree on a governance structure that will make diverse participation possible, and explore ways individuals can work together to sustain rural health initiatives over time.

Importance of Stakeholder Support

Several years ago, a colleague from south Georgia asked me why some communities attract all kinds of resources while others

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—with as much need—do not. My response was that communities with a demonstrated track record of working well together typically receive more attention and help than communities without a history of collaboration. Since all resources are finite, governments, corporations, and foundations prefer to invest funds where a successful outcome is more certain. For this reason, opportunities are limited for communities without a community health partnership, health and civic leadership, or a history of rural health development, including networks or other rural health collaborations. The rationalization for this thinking is that there will always be more communities with "need" than resources to meet those needs, and thus, assistance should be invested in areas where there is need *and* the probability of success. Technical support and resources should be invested when a legitimate community-based group asks for help, but the onus belongs to the rural community leaders to ensure that investments will be prudent and useful. Fundamentally, the responsibility for change rests on the shoulders of community leaders and stakeholders who are willing to invest their time, talent, and resources in work to improve health status in their community.

Stakeholders can be defined as "a person or group with a direct interest, involvement, or investment in something, e.g. the employees, stockholders, and customers of a business concern."[1] Not only does having stakeholder support make a community health planning group more attractive to funding agencies, but stakeholder support also helps ensure plans and proposals are relevant, appropriate, and acceptable. Having various stakeholders participating is important in reducing potential duplication and ensuring that problems and solutions are fully defined. In addition, stakeholders should provide accountability and broaden community support.

Across rural communities, the particular stakeholders needed to define and solve problems will vary based on the specific health problem being addressed, the proposed solution(s), etc. At times, a broad-based community group comprised of civic leaders, citizens, physicians, nurses, other business leaders, and elected or appointed officials will be appropriate. Often, input from disadvantaged groups (e.g., the uninsured; poor, minority populations) is crucial to understanding the nuances of the problem and for developing appropriate solutions.

In many cases, the formation of stakeholder groups is guided, in part, by program requirements for funding. For example, if a rural community is applying for a primary care operational subsidy from the federal government [e.g., to become a Federally Qualified Health Center (FQHC)], federal regulations specify that the majority of the organization's governing board members must be users of the service. That is a condition for receiving such a grant.

Many public and philanthropic grant programs have specific requirements. Often, these requirements involve defining and engaging stakeholders. For some, positions on governing boards will be required, while others might suggest the type of local guiding group necessary to become successful applicants. Some local health programs, such as county boards of health, specify who appoints board members, how many can be appointed, the length of their terms, and the professional background or credentials board members must have. This is an important area of local policy, and rural citizens should be sure they understand it.

Contact the Office of Rural Health

To begin, groups formed to address health access problems should request assistance from their respective state Office of Rural Health. These offices, now in every state, are great places to ask for help, and some have resources to plan and solve health status or health system problems. State ORHs are supported in part by federal resources matched with state funds. A list of ORH directors and phone numbers is available on the federal Office of Rural Health Policy (ORHP) Web page (http://ruralhealth.hrsa.gov/funding/50sorh.htm) or by calling 301-443-0835.

Other helpful groups might include hospital associations, medical or family practice associations, universities, associations representing county commissioners, public health officials, foundations as well as other specific health interest groups. The ORH staff should have relationships with many of these groups and be able to connect you with others who can help. Most ORHs work to be a one-stop resource and will help find and broker technical assistance and consultation from a variety of state, federal, association, and foundation groups. Your ORH can connect rural leaders with resources, ideas, people, and tools.

Constituent Identification: Who Should Be Included as Part of the Stakeholder Group?

Depending on the situation or health system problem, a full spectrum of rural health providers, users of health services, civic leaders, representatives of groups experiencing disparate health access or health outcomes, faith leaders, business leaders, and social service providers might initially be convened to address specific health system problems. There are diverse opinions on how to identify the constituents necessary to develop a rural health service program and when to invite these participants, Opinions about who to invite range from issuing an open invitation to selecting a handful of opinion leaders whose influence will be required to make change.

Issuing an open invitation to interested parties works best when a clear statement of the need exists along with specific working parameters, the time commitment required, and the projected timeline. Including specific expectations in the open invitation helps stakeholders determine if they will participate. Clear expectations of involvement, group direction, and a planned way to use stakeholder input are crucial components of successfully developing and maintaining health programs and health assets, as well as being important in keeping a broad-based group engaged.

Depending on the program to be developed, there are times when smaller groups might work better initially. For example, a group of physicians and staff might form as physicians recognize they are providing care to a growing portion of uninsured people. The physicians might notice they have fewer privately insured clients. They might identify that they need help managing coding, billing, and collections from public insurers (Medicaid and Medicare). They may ask for help in assuring that any patient eligible for a program is made aware of it and helped to enroll. They may first coalesce as a small, invited group to clearly define the problem. Later they might seek assistance in defining the problem more broadly—how the growing number of uninsured is impacting the hospital, emergency medical services (EMS), public health, etc. They could then form a larger group to research and quantify the problem, craft potential solutions, and/or develop additional resources. They might ask for help from their Office of Rural Health (ORH). The physicians might seek assistance with improving practice management or developing a Rural Health Clinic.

This example can also be viewed as a potential problem to retaining primary care physicians in a community. As the problems are identified more fully, it becomes clear that the growing number of uninsured is a community-wide problem (as well as a national one). The initial group might broaden to include—in addition to the original physician group—nurses, a hospital administrator, public health leaders, hospital board members, mental health providers (if any), EMS providers, pharmacists, and other concerned stakeholders. As this group grows, it will be important to include the voices of the people who are the major users of services or those who are most in need, (i.e., those who have no insurance, those eligible for but not enrolled in programs, and those with limited income, etc.).

The importance of group diversity may not always be apparent. For example, several years ago while working with a large group of medical providers, hospital administrators; cancer survivors; and public health, business, civic, and faith leaders in a rural region formed a coalition to improve cancer screening, detection, diagnosis, and appropriate treatment. After months of coalition meetings, one of the medical leaders asked why the faith community was at the table. One minister retorted, "Who do you think people call as soon as they get the diagnosis that they or a family member has cancer?" The faith leaders in that coalition made key contributions to the work and opened doors for screening where the need was great.

Representatives of disadvantaged groups almost always need to be at the health service development table, regardless of the eventual governance structure adopted by the group. Disadvantaged people might not be included at an entrepreneurial health table or with a group convened to improve the technical components of managing an efficient, effective primary care practice, for example. If, however, the issues to be solved deal with improving access to health services, full community participation can significantly benefit the planning process.

The *timing* of invitations is also important. It typically does not work to invite representatives of the uninsured, poor, or the underinsured *after* key decisions have been made. Too often, groups make the mistake of waiting until key decisions have been made to invite other representatives to the table. A serious consequence of delayed inclusion is that the newly invited individuals will not have the historical perspective of the group's planning and thinking, nor will they have the ease of association and rapport, all of which have been building since the group was formed. Ground rules how the group functions are formed early in the process, thus making it harder for new members to understand the group's informal rules. Delayed inclusion can also cause new members to be hesitant in offering opinions, which in turn, might lead to false conclusions about the new member's willingness to actively participate.

Including as many stakeholders as possible from the beginning reduces the likelihood of criticism that key decisions were made without sufficient input from key groups who will use the planned health services. If a group finds they need to add members later in the process, they should provide a comprehensive orientation to new members, including where the group is in their thinking, planning, and studying of options.

Deciding Which Corporate Structure Will Make Diverse Stakeholder Participation Possible

Each community health planning group will need to agree on a governance structure for themselves. When considering an appropriate corporate structure for the group, form should follow function and necessity. Several corporate structures might work well. Sometimes groups form an informal board, task force, or coalition. Over time, the group might decide to form a 501(c)(3) or another corporate model. Other times, groups form and decide the work can be handled without formal incorporation. That same group might decide that by-laws and operating procedures will be useful and that appointing an organization to serve as the fiscal agent is prudent. Some groups might attach to existing organizations, such as hospitals.

The group should adopt a structure that facilitates collaboration and productivity. Even when the corporate structure is prescribed by a funding partner, the execution of that structure is largely in the hands of the community leaders. A good way to ensure a full spectrum of stakeholder participation is to specify diversity in the corporate structure (i.e., prescribe a 'balanced' group with all viewpoints represented) and to be vigorous in assuring diverse opinions, experience, and expertise are invited and respected.

Sustaining Health Service Initiatives

Being able to sustain a program or a new service once it is up and running is often a challenge. In addition to developing a program that provides high-quality health services and has a system for referring patients to accepting specialists when necessary, the group must make sure the new program or service exhibits efficient management, can demonstrate effectiveness, can be sustained, has broad community acceptance, and is seen as an important economic component in the community.

Ensuring Efficient Management

One of the first steps toward sustainability for a primary care or programmatic service is to ensure managerial efficiency. For example, if the health services to be provided are covered by insurance (i.e., Medicaid, Medicare, or private insurance), the providers must be properly enrolled as a provider. Staff must know how to code, file, and collect payment for services delivered. This is not easy in the rapidly changing health insurance market. Efficient practice and program management is essential.

The North Carolina Office of Rural Health pioneered the development of publicly supported practice management technical assistance to improve retention of primary care providers. Several states in the southeast (Alabama, Arkansas, Georgia, Louisiana, South Carolina, and Texas) now provide or broker primary care practice management services developed as a part of the Robert Wood Johnson Foundation's (RWJF) Southern Rural Access Program. The practice management component of that Program was modeled after the successful work of the RWJF *Practice Sights* initiative of the early 1990s, incorporating lessons learned from that project. The RWJF National Program Office for that initiative was directed by Jim Bernstein and his colleagues in Raleigh. The Southern Rural Access Program is phasing out now, but several states intend to continue offering practice management support. The Office of Rural Health in most states can advise if free or low-cost rural practice management assistance is available.

Evidence of Effectiveness

Another key component of sustainability is assuring that the service developed is effective and efficient and, thus, warrants being sustained. To make this case, a program evaluation is required. Armed with key information on effectiveness, cost, and utility, the next step is to find a long-term funding partner. This is more easily accomplished with unbiased, supportive data, and a clear description of what was done, for whom, by whom, at what cost, and to what end or outcome. Not every effort will require a funding partner, but many will.

Securing Financial Support

Sustaining health services in many rural communities still requires securing long-term funding. Because of the disproportionate percent of rural people who are uninsured or under insured, often additional resource support must be found. Funding might be found by securing a direct federal grant (generally not a long-term strategy), foundation gifts or grants, private donations, state funding, or local support for services. Many counties or parishes support the hospital, EMS, the public health department, public mental health services, and some invest in the retention and recruitment of primary care providers. Working with like-minded organizations in adjacent and or nearby communities is also a very effective way to support services by spreading costs and sharing resources.

Action Steps

The following steps, or similar ones, are generally thought of as community health system development, community encouragement, etc. There are a variety of approaches, both formal and informal, that can be used to develop a rural health action plan. Rural community groups are not alike, so steps, catalysts for change, and resources will vary.

- A rural community leader, clinician, or health administrator becomes aware of a health problem that needs to be addressed.
- A small group (or groups) is (are) formed to investigate the problem.
- Problem(s) are researched, information is shared and the group begins to investigate solutions.
- The group, based on the information gathered (i.e., specific data), decides that the health status or system problem is one they have the will to address, and they then begin to develop a plan for how to deal with the problem.
- Clinical leadership is brought together (if not already present) to participate in planning and solution development.
- The local group, including clinicians and other health providers, asks for information, support, data, technical assistance, facilitation expertise, etc., from the ORH, other technical assistance providers or other associations, foundations, or corporations—to help define the most significant problems and search for resources.
- The group forms a larger, multi-disciplinary, planning group charged with developing a strategic plan for health. The plan will ideally include short- (one-to-three year) and long- (five- to-ten year) term goals and specific measurable objectives. The plan can include working with other organizations in adjacent counties or parishes, and, at times, a regional initiative will form.
- The group either forms a specific governance structure or works with an existing structure (i.e., rural hospital, not-for-profit) to develop and implement the plan and provide frequent feedback to the community.
- The plan is put into action.
- The group collects specific data, evaluates the results and resources invested, and shares that data.
- The group continues to work the plan, make necessary changes, engages in strategic planning, forms additional partnerships, and continues the quest to secure and find resources to improve health status.

Broad Community Use of Services

Important to sustaining health services is for all the community to use local health services. The civic, business, faith community, and other opinion leaders must use health services in the community. Citizen leaders should not by-pass local health services. Rural providers must have a strong mix of insured clients to help carry the disproportionate load of self-pay, Medicaid, and Medicare patients they serve. Medicaid and Medicare often require deep fee discounts (sometimes below the cost of providing services). As a reassurance to all—healthcare providers should make it clear that they are formally linked with other regional providers and have referral agreements with other facilities and specialists when required.

Healthcare and the Economy as a Sustaining Factor

Another key to sustainability is for rural civic and government leaders to understand that health services are one of the most useful, sustainable economic engines in a rural community. Healthcare is big business. According to the National Coalition on Health Care in 2003, "the United States spent 15.3% of its Gross Domestic Product (GDP) on healthcare."[2]

Health services bring money into the community from the state and federal government (Medicaid and Medicare). Rural health dollars "roll over" about 1.5 times in the community. In many rural communities, the healthcare sector accounts for ten to 20% of all jobs in the community,[3] and health sector jobs often pay well and are sustainable jobs. Many times the healthcare sector is the largest employer in the county or parish.

The federal Office of Rural Health Policy (ORHP) invested in helping community leaders understand the economic impact of the healthcare sector through funding support for the *Rural Health Works Program*,[4] managed and pioneered by the University of Oklahoma. The *Rural Health Works Program* is especially useful because standard employment data, gathered through the Census, is used to calculate the economic impact of the healthcare sector on the rural economy. The database (IMPLAN) is used to calculate the payroll of businesses engaged in health services, including public organizations and then calculate the economic impact of those jobs and dollars spent in the community. Other models are available to measure the economic impact of healthcare in the local economy. Some calculate the dollar value to the community of each primary care physician. Many hospitals can quantify their economic impact on the community.

Business leaders, civic leaders, economic development staff, and elected officials are more likely to help sustain, attract, and grow programs and encourage health businesses if health services are viewed as a part of the economic vitality of the community. In addition to the direct economic impact of health services, the significant difference health makes in family life (i.e., affecting one's ability to earn a living, decreasing morbidity, and helping people enjoy a higher quality of life) is universally understood.

Summary

The quintessential difference between most successful rural health programs and unsuccessful ones is local leadership. The ways in which a community invites, values, develops, nurtures, and supports the involvement of diverse stakeholder groups form an important part of the base for local rural health program success. Successful programs are initiated by local stakeholder groups who are committed to collaboration, have a working governance structure, a good understanding of their health and healthcare challenges, and a plan for sustainability. A key first step for rural community health planning is to contact one's local state Office of Rural Health. Most ORHs will provide information, guidance, and technical assistance. There are many challenges in rural health, but there are also great successes. North Carolina communities fare better than many because the North Carolina Office of Rural Health has demonstrated how effective state and local leadership work together to directly benefit rural communities and rural people. **NCMedJ**

REFERENCES

1 MSN Encarta dictionary; http://encarta.msn.com/dictionary_/stakeholder.html. Accessed January 2006.
2 The National Coalition on Health Care, Washington, DC 20005, Facts on the Cost of Health Care. Available at: www.nchc.org. Accessed 2004.
3 Capital Area Rural Health Roundtable, July 1997. HCFA/CMS, 1998.
4 Rural Health Works, Available at: http://www.ruralhealthworks.org. Accessed January 2006.