Building Blocks for Healthy Rural Communities
Guidelines and Foundational Services
Maine Rural Health Action Network

Introduction

What are the fundamental or foundational, building block services for healthy rural communities? Defining core health services to which rural people should access, has been considered by a significant number of local, state, and national rural health leaders for many years. Yet, simply identifying services is not enough. They need to be considered within the context of other factors that can shape the delivery system, as well as the overall health of rural communities. While there is a need for flexibility, given the great differences in rural environments, a lack of reasonable common ground and unifying agreement can impede progress.

The Hypothesis

The hypothesis of this paper is that greater consensus can be built around foundational principles, guidelines, and services, and that the concepts, when more universally applied, can lead to reduced fragmentation of efforts, better align resources, increase accountability, more assured access to services, and improvements in rural health.

What the Paper Presents

The paper has two sections, which can stand alone, but which are best viewed in combination. The first section provides a combination of principles and guidelines for simultaneously considering rural health and access to services. The second section outlines a set of foundational, or building block, health services that should be readily available within rural communities or reasonable regional clusters of communities.

The paper presents several ways of reflecting on rural needs and foundational services. It:

- Supports the assessment of community needs and access to care, consideration of current and innovative delivery models, and the alignment workforce planning. In addition, this foundation supports critical discussions of cost, quality, and the sustainability of services.
- Suggests a common touchstone that can be used by communities, rural health providers, advocates, and health-related organizations, as well as local, State, and Federal agencies when assessing access to services.
- Offers concepts that can guide collaborative discussions and actions, reduce fragmentation of efforts, and better align funding streams.
- Links services, delivery models, and financing strategies to consideration of social determinants of health, personal health behaviors, public health strategies, and community economics.
- Sets out goals for access to basic services and establishes a counterpoint to any assumptions that rural people do not deserve access to fundamental services, just because they live in rural communities.
- Promotes community engagement in determining the scope and priority of local or regional services.
- Provides the potential basis for the development of standards and processes to improve organizational and public accountability for access, quality, costs, and payment for services.

The latest version of Building Blocks for Healthy Rural Communities: Guidelines and Foundational Services was developed in 2018-2020 by the Maine Rural Health Action Network.[1] Although recently updated, it builds on more than eighteen years of consideration by several states and organizations. The concept of Fundamental Building Blocks has evolved from previous discussions 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 was based on the positions developed in the other locations. The current version also incorporates consideration of the American Hospital Association's Report of the Task Force on Ensuring Access in Vulnerable Communities—November 2016.[2] This proposed set of Foundational Health Services is believed to be the most highly vetted set of core rural services currently available.[3]

Limitations

- This concept paper is not a plan for achieving community-specific or topic-specific goals. It basically sets the stage and says, "If you are planning for rural health or rural health services, administering or governing health-related organizations, or acting with governmental responsibilities these are factors that you should be considering. They represent important context, as well as the needs and the meaningful expectations of rural people."

- The set of Building Blocks does not include all services to which rural residents should have access. Out-of-area access is critical (e.g., for services that cannot be provided locally, including advanced specialty care). Nonetheless, while this paper does note the need to assure appropriate referrals, it only addresses those services that should be highly accessible to clusters of rural communities.[4]

- The model does not specify, or mandate, the exact scope of services, how they will be delivered or in what settings. Rather, it makes clear that there are a variety of appropriate settings, models of care and approaches to financing and staffing, as well as ways to use supportive technology. In some settings, the goals will be aspirational and the realities of local or regional conditions may limit ready access.

- 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 there is an adequate and aligned workforce, the roles 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 foundational services, which should be integral to discussions of these other considerations.

[1] The Maine Rural Health Action Network is a volunteer group of rural stakeholders representing health professionals, businesses, philanthropy, education, who have met regularly for over two years to develop pragmatic, actionable steps and advocate for their implementation in order to address Maine's growing rural health crisis. See Appendix A for a list of Rural Health Action Network members.

[2] Several developmental documents quote liberally from each other without specific citations, as does this version.

[3] See Appendix B for a summary of the evolutionary stages of the Building Blocks.

[4] The fundamental services can and should be modified based on evidence that defines relationships between service delivery models, travel times, access, utilization rates, and clinical outcomes.

Principles and Guidelines

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

Principles

- 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. For the services that are provided, all services should be delivered within known quality parameters.

- Given rural Maine's aging population, special consideration needs to be given to how the rural elderly, as they age in place, can access services without having to move from their communities for basic care.

- The economic viability of rural Maine and most rural communities 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. Furthermore, 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.

- Even though access to some services may be considered foundational, for many communities, near-by access may be aspirational, but not feasible. Every community (or cluster of communities) will not be able to have ready access to all services. Collaboration among clusters of rural communities and the development of regional strategies will be critical to developing rural-appropriate models of care that will assure the highest levels of appropriate access (e.g., for obstetrical and emergency medical services).

- In the face of the challenges of allocating resources, the status of foundational services should be considered when setting priorities for access.

- Payment policies and models for financing health services are dominant driving forces that define or in stronger terms often dictate, the scope services that will be received, as well as how they can be provided. Influence comes from all insurance providers, managed care programs, and governmental programs (e.g., Medicare and MaineCare). If there is consistent application of the concept of foundational or essential rural services, it will be easier to hold payers accountable for assuring adequate payments for these services.

General Considerations

- Governmental agencies use multiple definitions to identify rural areas or populations. Nationally, and even across states, "rural" means different things in different geographic and/or population contexts. For example, in Maine, rural Somerset County is very different that rural Androscoggin County; and both of these areas of rural Maine are very different than rural western Kansas. These differences are often critical for understanding the nature of rural health. Geography and population density influence the sustainability of many services (e.g., obstetrical/delivery services).

- There are tremendous financial resources in the current system and additional funding that may be obtained as the State accesses more of its options, such as funding to address issues related to opioids or for demonstration projects. There are also considerable resources represented by the time of volunteers working across hundreds of not-for-profit organizations. These resources can have greater impact if fragmentation and duplication of efforts are reduced.

Heath Versus Health Services

- In general, rural residents are poorer, older, sicker, and have more chronic illness than non-rural residents. They often have high levels of substance abuse and mental illness. In rural communities, smoking, obesity, substance abuse, and other public health problems cause or significantly exacerbate poor health status and compel higher costs.

- 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.[5]

- It is estimated that as much as 80% of individual health status is determined by non-health care factors. In addition to considering SDH, there is a range of other factors from basic genetics to a host of individual behavioral choices that negatively affect health status.

- When considering how resources can be applied and priorities set, it is important to consider the interplay between improving community health and efforts to address access to services.

- 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.

Guidelines for Delivering Services

- 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, such as EMS providers, including community paramedics) 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). The list of foundational services includes several examples of delivery options.

- The scope of services and the delivery locations may sometimes conflict with the community's overall interests. Limited populations and demand for services may result in adverse competition, underutilized and costly programs, and less sustainable health service delivery systems. For example, free standing outpatient urgent care clinics may compromise the sustainability of primary care practices. Addressing these possibilities require openness and community engagement.

- Delivery of services, reimbursement and regulatory systems should facilitate providers working to the full extent of their licenses.

[5] Section XIII, provides an overview of fundamental public health services, many of which are associated with addressing the Social Determinants of Health and another non-health services factors influencing individual and population health.

- Health services should be provided equitably. Across the nation, there are inequities, caused by variables such as ethnic, racial, or gender biases, that should not be tolerated.

- 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 will not be physically located in a rural setting, but the services will still be accessible.

- As consideration is given to assuring that clusters of rural communities have adequate access to services, workforce pressures must be considered. If staffing is not available, even the most appropriate services cannot be delivered. Rural communities face considerable challenges in recruiting and retaining a workforce necessary to deliver services.
    - Workforce development strategies and investments (which are often long-term) must consider rural needs and be aligned with the models of care that will be necessary. Discussions about educational strategies and expanding the pools of professionals, often get ahead of adequate consideration of the models of care. For example, there is a big difference between building a staffing strategy that delivers dental care to children in school settings, by using advanced dental hygienists supported by telehealth, and a strategy based on training more dentists and trying to create incentives to have them move to rural areas. While both approaches may be meaningful, investments should be weighed against rural realities.

<u>Responsibilities and Caveats</u>

- Communities and 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 currently available or otherwise obtainable resources (e.g., grant funding or expanded state support). There is community responsibility, not just health organization responsibility, and certainly not just State responsibility, although the State *shares* overall responsibility for addressing the needs of rural people. Different clusters of communities may take different approaches to addressing community needs; there are multiple models for supporting collaboration. Communities and clusters of communities that are unwilling or unable to engage in local planning will be at increasing risk.

- Community-driven evolutionary change, innovations, and willingness to invest resources may move local expectations beyond the foundational services that are identified. More expanded services should be carefully evaluated, and choices should be data-driven, with an emphasis on both *value* and sustainability. Community expectations beyond foundational services may change the dialogue with payers.

- 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 for these entities to expend energy and allocate resources beyond an essential focus on sustaining day-to-day operations and even survivability. 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.

- To engage in discussions, set local priorities and develop actions steps, many communities will need support from State and other governmental entities, as well as private support from non-local organizations, such as philanthropies and multi-provider/hospital health systems.

- The deteriorating financial position of most rural hospitals increasingly challenges their ability to address unmet community health needs; and, an increasing number of hospitals are at risk of decline, or even failure. Given the likelihood of increasing financial pressures, not only on hospitals but other health organizations, community engagement and collaboration take on heightened importance when addressing needs.

Foundational Building Block Services

For All Services

Rural health systems 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. [6] The term "Value" is frequently used to describe access, efficiency, cost, and quality. In all cases, consideration should be given to the effective, affordable, and sustainable ratio of providers to the populations served. Although there is a gauntlet of challenges to achieving these goals, agreement on goals can focus the initiatives and decisions needed to move closer to meeting the needs of its rural people and their communities.

I) Primary Care, Emergency Medical Services, and Urgent Care—the Essential Core of Rural Health Care Systems

A) Comprehensive 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 use disorder services, and basic oral health services. Comprehensive primary care also includes several of the essential public health services noted in Section XIII.

1) **Primary Medical Care**

May be provide through a mix of:

(a) Family Medicine
(b) Internal Medicine
(c) Pediatrics
(d) Obstetrics and General Medical Gynecology
    (i) In communities where there are no readily accessible delivery services, essential primary care access includes pre-natal and post-natal care, as well as support for securing necessary referral relationships for deliveries.

2) **Mental Health Services and Substance Use Disorder Services**

(a) Crisis intervention, diagnosis, primary outpatient treatment, prevention, and referral, including services for adults, children, adolescents, and families
(b) Recovery communities that support outpatient treatment (which may include residential settings)
(c) When care exceeds local capacity (e.g., the need for specialized inpatient treatment), referral mechanisms to outpatient and inpatient mental health and substance use disorder providers in other communities, with referrals back to local community's outpatient providers.

3) **Oral Health Services**

(a) Preventive dental services including prophylaxis, appropriate use of fluorides, dental sealants, oral health education, and oral health promotion activities
(b) Basic restorative treatments

[6] 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.

(c) Referral mechanisms to more specialized services (orthodontics, more complex restorative care, oral surgery, and prosthodontics, e.g., crowns

B) **Emergency Services**

1) Emergency services to evaluate and/or treat medical conditions that require immediate and unscheduled medical care and can include observation services

(a) Services include the integration of all systems for treating time-sensitive illnesses and injuries including Trauma, Stroke, ST-elevation myocardial infarction (STEMI), pediatrics, Burns, Obstetrics, and other emergencies

(b) Access to services may be provided through a combination of:

(i) Mobile emergency medical providers—EMS (ambulance services—including air-ambulance services, emergency medical technicians, paramedics, and in more limited ways police officers)

(ii) Hospital emergency departments

- In the future, options for care may include alternative models for providing emergency services in hospitals that do not have beds, including consideration of Community Outpatient Hospitals.

(iii) Telehealth linkages

(iv) Other emergency support such as automatic external defibrillators in public settings

C) Urgent Care Services

1) Urgent Care services where timely intervention is appropriate and desired by patients and families, but where the services do not require immediate and unscheduled medical care

(a) Services may be provided in various settings including outpatient practices, hospitals (including services provided in emergency departments) and other urgent care programs, such as offered by Community Health Centers.

II) **Other Primary Services**

Although not within the definition of primary care, Primary Services extend to several other services, such as primary care-associated support services (as noted below), general surgery, appropriate inpatient facilities, associated health education and health promotion, and care coordination

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A) **Primary or Core Specialty Services**

1) General Surgery

(a) Full-time in many rural hospitals but increasingly part-time, with predominant emphasis on outpatient surgery (including colonoscopies)[7]; and must include coordinated referral services

2) Orthopedics

(a) Full-time in some rural hospitals, at least part-time in many, but appropriateness is highly variable based on the size of service area; and must include coordinated referral services

B) **Inpatient Hospital Services**

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

1) Basic inpatient care consistent with the mix of primary care, general surgery, obstetrics and gynecologic services that are locally supportable; and, where possible, orthopedics and other specialty services (with all services provided within documented quality standards)[8]

[7] In many communities, this is trending to part-time, no-call-coverage, outpatient-only general surgery.

[8] 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.

2) Services may include skilled nursing services provided in swing beds (SNF services may alternatively be provided in other community settings, as noted below). Definitive inpatient mental health and substance abuse services, as well as physical rehabilitation programs may be provided in some communities (e.g., as part of Critical Access or other hospitals) but these inpatient services are not considered core services that should be available within all clusters of rural communities.[9]
3) 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 local delivery systems that do not rely on the availability if inpatient beds (e.g., a "Community Outpatient Hospital").
4) Whether or not inpatient services should be included in a community health system and the scope of services have traditionally been community decisions. In many places the decision is increasingly a made by a non-local corporate entity that controls the local hospital. The decision processes should be transparent and open to community discussion.

III) **Support Services** (consistent with local physician and non-physician provider services, as well as services provided through telemedicine connections)
1) Diagnostic and Treatment Services
(a) Diagnostic Imaging (with local or remote interpretations)
(b) Basic laboratory services (local drawing, with local or remote interpretations)
(c) Pathology
(d) Anesthesia (anesthesiologists or nurse anesthetists)
(e) Therapeutic services (e.g., OT, PT, RT, speech, and audiology
(i) Recruiting physical, occupational, and speech therapists is often very difficult. Difficulties with staffing can compromise the ability to provide basic support for providers, full scope home care and Skilled Nursing Services.)

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

V) **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*.

VI) 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. Nonetheless, 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.)

VII) 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.

[9] With adequate reimbursement and regulatory changes, in some cases it may be possible to repurpose underutilized hospital space to expand inpatient access for mental health, substance use disorders, and SNF care, as well as inpatient hospice programs.

VIII) **Home Health Services and Hospice Care*[10]**

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

1) Other support services may be necessary to meet the conditions necessary to treat patients in their homes.
2) Home health will increasingly be supported by telemedicine technology.
3) The use of community paramedics is increasing being considered to add capacity to deliver some home services.
4) Given the needs for adequate utilization to sustain a facility, inpatient hospice services will not be readily available within all clusters of rural communities. Services will often require regional approaches.

IX) **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.

C) Given the needs for adequate utilization to sustain a facility, SNF and Nursing Facility services will often require regional approaches.

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

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

1) Like SNF services, given the needs for adequate utilization to sustain a facility, Assisted Living Services and other forms of residential care will often require regional approaches.

XI) **Pharmacy Services***

A) Prescription drugs and consultations for providers, as well as associated adverse risk screening and consumer education related to the appropriate use of medications

1) In many settings, access may need to be provided by remote pharmacies and pharmacists.
2) Pharmaceuticals may need to be delivered by mail.

XII) **Eye Care Services***

1) Optometry and Optical Services
2) Ophthalmology (which can be a limited physician specialty as identified above) is not expected to be available locally or in small clusters of rural communities.

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

Public Health Services and Educational Support are often provided in various settings as components of comprehensive primary care, or by other community organizations in a variety of settings. Nonetheless, there is always a need for more developed and more focused State and community initiatives. Public health and educational initiatives are frequently, substantially, underfunded, while still being essential to improving population health.

[10] 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.

The following services and strategies were originally based on the CDC's often referenced Ten Essential Public Health Services. [11] Expanded strategies include at least the following, *with priorities varying* according to the characteristics of communities in each rural cluster:[12,13] In addressing rural health, it is unequivocally true that given increasing challenges to having adequate access to even fundamental acute services, the aspects of public health and education that address prevention of disease become more critical.

Services that should be provided and topics that should be considered include:

A) Access to food and nutrition services 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.)
    1) Opiate Education (MPHA)
C) Programs to assure safer prescribing of opioids for pain (CDC)
D) Domestic/child violence prevention, intervention, and the identification and treatment of Adverse Childhood Events (ACEs)
E) Teenage pregnancy prevention (and as necessary, teenage maternal and child support)
F) Other personal health risk prevention strategies, such as
    1) Immunizations
        (a) Including strategies to mitigate hesitancy toward vaccines
    2) Nutrition services
        (a) Including Obesity Prevention (MPHA)
    3) Blood lead screening and lead exposure mitigation
    4) Smoking cessation support Fund for a Healthy Maine: Fund Tobacco First (MPHA)
        (a) Including strategies to address vaping
    5) Motor vehicle safety (CCD)
    6) Suicide prevention
    7) Screening of patients for high blood pressure and making blood pressure control a quality improvement goal (CDC)
    8) Increasing cancer prevention and early detection (CDC)
    9) Oral Health education and preventive care (also included under comprehensive primary care)
        (a) Including support of community water fluoridation
G) Climate Change
    1) For example, the effects of a warmer climate on the spread of ticks and Lyme Disease as well as the effects on agriculture and food supplies
H) Other environmental protection issues Environmental Health, (MPHA)
    1) Including clean air and clean water (including drinking water), as well as mitigation of the risks from toxic chemicals
        (a) Clean Drinking Water (MPHA)
I) Immigrant and migrant health
J) Occupational health/work risk exposure with special emphasis on agriculture-related risks
K) Managing the interface with Zoonotic Diseases
L) Sanitation
M) Communicable disease prevention and treatment
N) Gun Safety/Violence prevention

[11] The Center for Disease Control's, Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994.
[12] Maine Public Health Association notations and links indicate MPHA's current policy priorities and coalition work.
[13] Center for Disease Control (CDC) references are from the CDC website

O) Bioterrorism and pandemic disease prevention and mitigation strategies
P) Support services for individuals with disabilities
    1) Additional support for families who have children with mental, behavioral, or developmental disorders (CDC)
Q) Housing
R) Transportation
    1) Transportation services include both medical and personal transportation to allow patients to access care at hospitals and other health care facilities.
S) Access to a competent public health workforce
    1) Including public health nursing (MPHA)
T) Public health leadership and policies
    1) Development of multi-community public health strategies for clusters of rural communities
    2) Appropriate public health policy, laws, regulations, and enforcement
U) Rural health research, including epidemiology and surveillance
V) Other population-based services such as, vital records, enrollment for insurance, and collection of used pharmaceuticals

XIV) 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[14]

[14] Plan for Improving Rural Health in Maine, 2008

Appendix A
Maine Rural Health Action Network Members

The Maine Rural Health Action Network is a volunteer group of rural stakeholders representing health professionals, businesses, philanthropy, education, who have met regularly for almost two years to develop pragmatic, actionable steps and advocate for their implementation in order to address Maine's growing rural health crisis. Current members include:

- **Arthur Blank**, President and CEO, Mount Desert Island Hospital
- **Nicole Breton**, Director, State Office of Rural Health, Oral Health and Primary Care, Maine CDC
- **Jeff Brown**, Principal, Safer Healthcare LLC
- **Andrew Coburn**, Professor Emeritus and Senior Fellow, Maine Rural Health Research Center, University of Southern Maine
- **Charles Dwyer**, Senior Program Officer, Maine Health Access Foundation
- **Rick Erb**, President, Maine Healthcare Association
- **John Gale**, Senior Research Associate, Population Health and Health Policy, University of Southern Maine
- **Morgan Hynd**, Director, The Bingham Program
- **Thomas Judge**, Executive Director, Lifeflight Foundation
- **Laurie Kane-Lewis**, Chief Executive Officer, DFD Russell Medical Center
- **Carol Kelly,** Management Director, Pivot Point, Inc.
- **Kevin McGinnis,** Rural EMS Advisor, National Association of State EMS Officials
- **Maureen O'Connor**, Director of Resource and Member Development, Maine Primary Care Association
- **Diana Prescott**, Clinical Psychologist, Hampden Psychological Consultation, PLLC
- **Jonathan Sprague**, President, Rocky Coast Consulting, LLC

In addition to input from members the RHAN has sought and continues to seek, substantial additional input from a wide range of Maine's health and social service leaders.

Appendix B
Fundamental Health Services and Associated Relationships
The Building Blocks of Strong Rural Health Systems

Through more than eighteen years, the concept of a core services to which rural people living in clusters of communities should access, has been highly vetted by a significant number of local, state, and national rural health leaders. The most recent version was developed in 2019. The evolution has come in several steps.

The Genesis in Pennsylvania and Migration to Ohio

In 2001 and 2002, the Pennsylvania Office of Rural Health (located at Penn State University) outlined services that the Office believed should be considered by any State Office of Rural Health (SORH) when developing the SORH's business plan. This assessment was then used by the Ohio Office of Rural Health (located within the Ohio Department of Human Services) for similar SORH planning.

The 2003 Maine Rural Health Association

In 2003, the outline of services was shared with the Maine Rural Health Association. After considerable discussion, the MRHA re-crafted the core elements to create the June 2003 paper, "Fundamentals of Rural Health." This paper was distributed to all MRHA members, to many organizations such as hospitals and community health centers, to the Governor, all state legislators, and to Maine's congressional delegation.

The 2008 Virginia Rural Health Plan

In 2007-2008, the MRHA paper was integrated with the Institute of Medicine's report: "Quality Through Collaboration: The Future of Rural Health". After additional discussion by the work group creating the Commonwealth of Virginia's statewide Rural Health Plan, a similar "fundamentals" section was incorporated. The most notable addition was to define primary care as the integration of primary medical care, basic behavioral health, and basic oral health.

The 2008 Plan for Improving Rural Health in Maine

In 2007-2008, the "fundamentals" content of the Virginia Rural Health Plan was shared with a Rural Health Work Group creating the "Plan for Improving Rural Health in Maine." After further modifications, particularly additional stress on the need to integrate services, as well as the need for flexibility and community responsibility, the Work Group included the "fundamentals" as Appendix C of the Maine Plan). The Plan was published by the Maine Center for Disease Control and Prevention and the Office of Rural Health. In 2011, It was abolished by anew Governor.

The 2012 North Carolina Rural Health Plan

Between June 2011 and June 2012, the State of North Carolina, developed a Rural Health Plan, using a multidisciplinary advisory committee to its Office of Rural Health and Community Care. This advisory committee used the Maine "fundamentals" as the basis for a similar section in the North Carolina RHP.

The National Rural Health Association

From mid-2012 to February 2013, the National Rural Health Association developed a policy statement on the "Future of Rural Health". During this process, NRHA reviewed the "fundamentals" section of the North Carolina Plan. While addressing many other points, pages 8-16 of the NRHA paper, "Core Concepts and Principles of Rural Health Services", includes the "fundamental or building block" services that had been considerably vetted in the other venues.

Maine Rural Health Action Network

In 2018-2019, the Fundamentals paper was rewritten to incorporate the American Hospital Association's Report of the Task Force on Ensuring Access in Vulnerable Communities—November 2016 and additional input from a multi-disciplinary group of rural stakeholders working together as the Maine Rural Health Action Network,