

Creative Common Sense

Many Lives, One Healthy Vision

K. Lynn Gallagher, JD
Quality of Life Director, SW New Mexico
Former Secretary, New Mexico Department of Health

Phillip L. Polakoff, MD, MEnvSc, MPH
Founder/CEO, A Healthier WE



Written By:

*K. Lynn Gallagher JD
Quality of Life Director - Southwest New Mexico
Former Secretary, New Mexico Department of Health*

*Phillip L. Polakoff MD MEnvSc MPH
Founder/CEO - A Healthier WE
Consulting Professor - Stanford University School of Medicine
Affiliated Scholar - Stanford University Bill Lane Center for the American West
Member - New England Journal of Medicine Catalyst Council*

Acknowledgments:

*Dennis Berens MA
Chief Rural Strategist – A Healthier WE
Past Director Nebraska State Office of Rural Health,
Former President, National Rural Health Association & NOSORH*

*Steve Raskin MD FACC
Chief Cardiology Advisor – A Healthier WE
Clinical Professor of Medicine Emeritus, University of California, San Francisco*

*John Langefeld MD
Chief Medical Advisor - A Healthier WE*

*Joe Evans PhD
Chief Behavioral Health Advisor - A Healthier WE
Professor, UNMC*

*June Sargent
Chief Impact Officer – A Healthier WE*

*David Angelson MMedSci PhD
Research Director - A Healthier WE*

*Vlad Chaloupka
Director of Photography - A Healthier WE*

A Healthier WE - a 501(c)3 non-profit organization dedicated to addressing critical issues in rural health

CREATIVE COMMON SENSE

“Many Lives, One Healthy Vision...”

By: K. Lynn Gallagher, JD, Quality of Life Director in SW New Mexico and Former NM Department of Health Secretary
and
Phillip Polakoff, MD, CEO A Healthier WE and Consulting Professor Stanford University School of Medicine

“Everyone wants to change the world, but nobody wants to change himself.” Leo Tolstoy

Background

Rural America offers unique advantages by way of landscape, culture, tradition, and adaptability. The challenges are complex and are often associated with proximity, isolation, and scarcity. Rural Americans are forced to adapt and overcome the chronic culture of “all talk with no action” and the triangulation of federal funding that permeates the fixed mindset of those in the highest levels of government. Many great examples exist that showcase this adaptability, readiness, and innovative spirit collectively working to improve the lives of their citizens from the inside out rather than the topside down.

Several of these great examples come from New Mexico, a state with a little more than 2 million residents, a population density of 15 people per square mile, and whose overall state budget equals ~\$7.6 billion that is heavily dependent on oil and gas revenues. Many small communities in New Mexico flourish in some of the most wonderful ways and unlikely partners. For example, Cuba, New Mexico is a village in the Northwest part of the state with approximately 761 people with one U.S. Highway linking them to the urban Albuquerque area. Like many other rural New Mexico communities, Cuba residents experience high incidents of health disparities like obesity, heart disease, and diabetes. In 2009, the village partnered with the University of New Mexico’ Prevention Research Center and various of other partners to create the ‘Step Into Cuba’ Alliance whose goal is to “promote physical activity through development of sidewalks, paths, trails, social support, and opportunities for lifestyle change.”

Another such example located in Santa Rosa, New Mexico, Guadalupe County, population of approximately 4,300, facing similar negative health disparities and geographic limitation in access to modern healthcare. In 2011, a partnership among county, city, non-profit and for-profit partners, and the hospital foundation, brought state-of-the-art healthcare to the community by replacing a very old, very antiquated hospital built in 1952 with a 10 bed LEED certified hospital, complete with emergency department, decontamination unit, heliport, anchored with a public health office, medical and dental offices. This collaboration among local partners allowed for rapid improvement to infrastructure and the overall health of a community.

Rural community’s creative common sense and resiliency abound, but still, rural Americans die at an alarmingly high rate. What is it really going to take to improve the health of rural America? It is certainly going to take more than the current complicated, rhetoric filled, top-down

approach. Fixing this broken system needs consistent relationship building, passion, purpose, follow through, and a spirit of broader collaboration. Changing large systems and their structures requires a drastic shift in behavior and ideology. Values and beliefs in core levels of citizens, within government organizations, among local leadership, and among impacted individuals is also needed.

Most people want to see positive changes, but what we have learned seems to be that nobody wants to be the ONE to do the changing OR TO BE CHANGED. The COVID-19 pandemic has taught us much about changes to our health and healthcare system in times of crisis. During the last eighteen months, America has seen rapid, widespread focus on health innovation and expansions in telemedicine, enhancements of healthcare payment models, and broader sharing of health information. These innovations have been long sought and hard to come by until now for many reasons. As an example, the use of the many forms of telecommunication, like telehealth, which has been piloted at the University of New Mexico through the Project ECHO® program, a telecommunication model program that links expert-level resources to organizations and communities around the world. This program has worked strategically using technology to prove positive health outcomes. Funding for these programs has been hard to anticipate and largely privatized. But because of the COVID-19 pandemic, today, telehealth and telemedicine options are multiplying exponentially as a direct result of the immediate need for service provision at arm's length to thousands of isolated people. The adage "where there is a will, there is a way" seems appropriate to this discussion when you add "where there is an emergency, there is a way." How then do we modify our response to change the way we look at health improvement away from the knee-jerk person centric solution to predictable system problem-solving approach?

Moving forward

The modern public health system has been greatly influenced by similar reactive, knee-jerk health interventions. Urban areas experiencing large-scale sanitation limitations and disease outbreaks have received the greatest attention and shaped how the public health system of today tracks data, mitigates risk, and mobilizes funding. Rural communities have been impacted in equal measure (if not greater) by these same diseases and sanitation concerns but typically received little to no attention, largely due to their sparse population densities and frequent movement of people. Anyone who has ever watched an episode of the Waltons or Dr. Quinn Medicine Woman knows that prior to the medical and healthcare advancements of the 1940s, people in rural communities relied upon country docs for their health needs and had to travel many miles to larger urban communities for more advanced care.

The end of WWII brought a rural focus from the Executive and Legislative branches of government culminating with the passage of the Hill-Burton Act in 1945, which created health care financing in locations where hospitals and clinics were needed and provided opportunities for broader physician relocation into underserved areas.

This initial focus of improving rural infrastructure not only created around 6,800 facilities in 4,000 communities but also brought decades more of attention to complex health and healthcare issues in rural communities at the federal level. Fast forward more than seventy-five years to the same conversations in the same communities but with larger population and health implications. The challenges facing rural communities is growing not decreasing, despite early interventions and policy changes at local, state, and federal levels. It seems that being an expert at the problem has not meant that we are an expert at the solution. In theory, bringing healthcare solutions from the outside into rural communities should have had a domino effect of vastly improving health outcomes in those areas. Even with the expansion and overhaul in the 70s of the Hill-Burton Act to the much more expansive Public Health Service Act and more federal legislation and attention with the creation of the Office of Rural Health Policy in 1987 to specifically advise on rural policy and hospital/healthcare access, what we have experienced are steady declines in health and in health systems over the last 50 years in rural and frontier regions of America.

Lessons Learned

What have we learned? Healthcare and healthcare infrastructure, although important, have little to do with improved health outcomes. New Mexico, for example, has led the nation in alcohol-related illness, injury, and death with little change in over three decades. Does that mean healthcare interventions have failed to reduce alcohol-related illness and death? On the contrary, it means that the approach in rural communities needs to shift from reactive downstream decision making to upstream, proactive approaches to prevention. As noted above, rural Americans continue to be more likely to die of heart disease, obesity, cancers, and unintended injury than others in more urban settings. Add to that list the rapid increase in mental and behavioral health concerns and it's staggering to think of the numbers of lives being lost in areas with little to no population density.

While the World Health Organization defines health "as a state of complete physical, mental, and social well-being, [free from illness or injury]," health in a rural setting encompasses more. Included in that definition for rural health must be a consideration of the social determinants ("constructs" or "elements" if you will) and the specific behaviors, traditions, culture, safety, connectedness, proximity, and capability that intersect to impede health outcomes. In America, urban versus rural health comes down to values, beliefs, and their related behaviors, environment, and access. Urban health disparities exist because of crime, limited outdoor spaces for exercise, poor air quality (pollution), large socio-economic differences, high risk behaviors (excessive alcohol, unsafe sex, illicit drugs). Rural disparities exist because of outside system developments, lack of needed information provided in a culturally appropriate way as well as poverty, social isolation, education gaps, negative health behaviors (smoking, obesity, seat belts, despair), fewer healthcare options, lack of fiscal attention at the federal level. In addition, the failure to build solid relationships that help rural residents feel comfortable dealing with an outside solution when they want one.

Call to Action

How then do we help rural American citizens bridge the many gaps and bring about positive improvements in their health and overall quality of life? Resources matter. Community, regional, state, multi-state, and the nation matter. For the most part, the federal government focuses its broadest attention on urban areas where the ROI metrics are easier to identify (driven by a paradigm of size over person). Competitive federal funding and grant opportunities typically force smaller, rural communities out of the running because they cannot compete with function and form of larger health systems. The U.S. population living in rural areas has experienced a steady decline year over year since the 1990s with .82% decline according to the 2020 U.S. Census data. Rural community leaders have long since done more with less and are tired and frustrated at the voluminous requirements and immense red tape required for federal funding. As we see people moving out of rural communities in steady numbers, we will need to quickly move the needle toward a healthier rural America. Creating a structurally competent system that listens to the voices of those closest to the problem is critical—from the bottom up. Pioneering approaches to funding opportunities, building cross-cultural leadership who focus on the needs [at] the community level instead of [for] the community level, and expanding “pipeline” strategies to train and retain young people in their communities who enter the healthcare workforce. For example, utilizing programs in telehealth like Project ECHO® from greater capacity to learn and teach healthcare providers using technology to keep them living and thriving in their rural place. Expanding residency programs and adjusting licensing requirements to allow for locations that historically have not supported the creation of residency programs, using larger clinical based learning and telecommunication to meet the specific needs of physician education requirements. Larger medical school program partnerships with local community colleges and universities to bring the learning to the people by creating satellite learning centers in general medicine. Further expanding the use of paraprofessionals and community health workers and providing greater payor options for such services. New Mexico was among the first to expand the use of Community Health Workers, who are boots on the ground support and who know their neighbors. Community Health Workers speak traditionally appropriate languages and teach culturally appropriate content.

Another area where we need to reframe the conversation is around health, health financing and healthcare payment models to better support upstream, measurable, behavior changing health outcomes at the community level. When the Affordable Care Act was signed into law in 2010, it created the Innovation Center attached to the Centers for Medicare and Medicaid Services, which ultimately should have been created at the community level first to accurately identify needs versus assumptions. It was, however, an important initial component to shifting federal leadership decision and policymaking toward community driven decision and policy making. The goal of the Innovation Center is to build capacity at the local level and then to shift to the federal level for community-centered healthcare delivery systems, however it seemed way too complicated and far removed to work for many rural places. The idea was to create design, pre-test, and test grants that could be awarded at local levels so that every American is afforded the most essential health and health services using a community and evidence-based approach.

Figure 1 and Figure 2 below which come from the CMS publication, “State Innovation Models Initiative: General Information” show the states who were awarded Design, Pre-Testing, and Testing grants between 2013-2014 in both Round 1 and Round 2 of CMS funding opportunities:

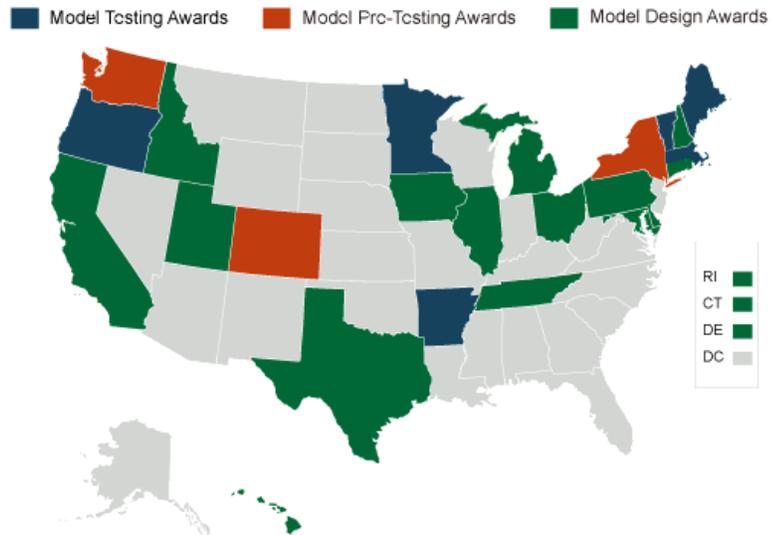
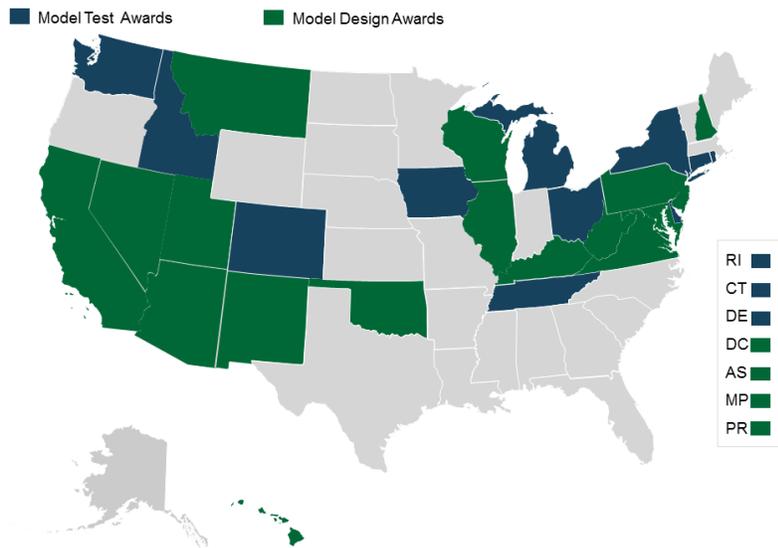


Figure 1 Round 1

Source: Centers for Medicare & Medicaid Services



Source: Centers for Medicare & Medicaid Services

Figure 2 Round 2

The CMS Innovation Center awarded approximately \$300 million in Round One to 25 states to design or test innovative health care payment and service delivery models. Thirty-two awardees (28 states, three territories, and the District of Columbia) received \$660 million in Round 2 funding to design, support, and implantation of their state innovation model plans. According to CMS, “Award recipients engage a diverse group of stakeholders, including public and commercial payers, providers, and consumers, to develop or implement a state innovation plan. The state’s innovation plan outlines its strategy to use all available levers to transform its health care payment and delivery system through multi-payer reform and other state-led initiatives.”

Because the United States spends more money on healthcare than any other country in the world, CMS models its process under the triple AIM, which is driven by a 3-prong approach that will:

- Improve patient care.
- Reduce healthcare costs.
- Improve population health.

This federal funding process again seems disconnected with the best methods for helping local, rural communities achieve breakthrough success because at a glance the opportunity avails itself to a local solution by local stakeholders, however, the result is that once again funding is provided to and supported at the locations with the largest population densities (even when those locations have areas considered “rural” defined as mere geography rather than a more realistic idea of rural identified above). While the desire to create a local approach is intended, the result is status quo. Looking at the summary of outcomes from this work, as could have been predicted, the progress is slow and hard to determine even though the overwhelming result is that states are committed to removing barriers and improving payor options. That is why with \$130 Billion in ARPA funds at stake, now is the time to activate a bottom up rather than top-down approach and truly build a new normal so that 100% of our rural families thrive rather than just survive.

Conclusion

Rural communities operate, process, live, understand, and feel things differently than larger urban communities. To see lasting change in these underserved areas, we need to envision a new system where: 1) governments seek the voice and need at the community level instead of for the community level; 2) funding opportunities require flexibility in their scope to be applicable to the intricate needs of rural communities; 3) insurance payment models need overhauling with input from rural stakeholders; 4) workforce development opportunities need to take a local or regional focus at their nexus of rural communities; 5) rural community stakeholders need to be brought to the table of discussions earlier and frequently; and 6) stop the single-minded one size fits all approach to improving health outcomes and let the problem guide the funding in a richer more measurable way.

It's time to swing the pendulum in a new direction and take time to listen to the needs of those seeking services and supports, bring together equitable stakeholders, and understand the problems facing rural Americans with new insight, new passion, with a new perspective. It's going to take creative common sense to truly change the paradigm and fulfill the WHO's definition of 'health'. The sooner we can move from opportunity to possibility and shift our focus FROM the rural community TO the rural community- that is when the magic will happen, and rural health will improve.

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*“In these times, if ‘I’ is replaced by ‘We’
even illness becomes wellness”*

Contact Information:

Phillip L. Polakoff, MD, MEnvSc, MPH
Founder/CEO A Healthier WE
plp@sbcglobal.net
510-508-9216

K. Lynn Gallagher JD
Quality of Life Director - Southwest New Mexico
Former Secretary, New Mexico Department of Health
klglawnm@gmail.com



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www.healthierruralamerica.org