State Flex Program Core Competencies for State Flex Program Excellence Guide

Updated October 2022

National Rural Health
Resource Center

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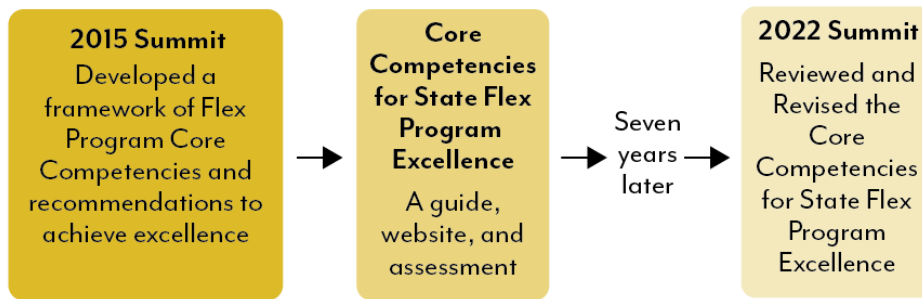(218) 727-9390 | info@ruralcenter.org | www.ruralcenter.org

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Background

In 2015, The National Rural Health Resource Center (The Center) convened a group of experienced State Office of Rural Health (SORH) Directors, Flex Program coordinators, rural health leaders, and staff from the Federal Office of Rural Health Policy (FORHP), Rural Quality Improvement Technical Assistance (RQITA), and the Flex Monitoring Team (FMT) to develop a framework of Medicare Rural Hospital Flexibility (Flex) Program core competencies and recommendations to achieve excellence in state Flex Programs. Given the numerous changes in health care since 2015, the Technical Assistance and Services Center (TASC) program felt it was time to meet again in 2022, this time virtually, to review, discuss, and suggest updates to the 2015 Core Competencies for State Flex Program Excellence Guide. The aim was to:

- Review the current core competencies for relevance in today's health care environment.

- Intentionally look at the events, trends, issues, and expectations of the current and emerging health care environment to determine competencies the state Flex Programs need to help rural communities in their states.

- Based on information gathered during discussion, determine what core competencies are necessary for the emerging rural health care environment.

- Establish a living document of suggested initiatives, actions, and measures that will be updated and utilized to achieve program excellence.

- Update the existing self-assessment for a state Flex Program to capture assets and opportunities for improvement on the identified core competencies.

Using this approach and the guidance and insight from Flex Program experts around the nation, the 2022 Flex Core Competency Guide was developed. A list of participants is included as Appendix A.

Development Timeline

2015 Summit	Core Competencies for State Flex Program Excellence		2022 Summit
Developed a framework of Flex Program Core Competencies and recommendations to achieve excellence	A guide, website, and assessment	Seven years later	Reviewed and Revised the Core Competencies for State Flex Program Excellence

Purpose

This 2022 Guide offers anyone who manages and/or works on the Medicare Rural Hospital Flexibility (Flex) Program the opportunity to complete a competency self-assessment, identify areas of proficiency, recognize opportunities for improvement and development, and to use the Guide to understand and gather insight into what determines proficiency and how it can be developed. Tips, tools, and resources are also included in the Guide to provide additional background and support.

This Guide lays out the 10 core competencies of an effective and impactful Flex Program, including:

- Developing Leadership and Workforce
- Managing the Flex Program
- Planning Strategically
- Managing Information and Evaluation
- Building and Sustaining Partnerships
- Understanding Policies and Regulations
- Strengthening Quality Reporting and Improvement
- Improving Financial Sustainability
- Understanding the Current and Future Health Care Environment
- Addressing Community Needs

Suggestions for developing or strengthening these competencies are presented throughout the guide with links to examples and resources.

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How to Use the Core Competencies

It is suggested that state Flex Program staff start using this 2022 Guide by first reading to understand what each competency is and what proficiencies are related to each competency. After reading the Guide, it is suggested that a state Flex Program complete the Core Competencies Self-Assessment. The assessment tool can serve as a baseline towards understanding the state office's competency in key skills and knowledge necessary to fully manage, develop, and implement the Flex Program. The assessment should be taken from the perspective of the state Flex Program as a whole, and not as an individual person and their own proficiencies and competencies. After reading the Guide and completing the assessment, each core competency described in the Guide can be referenced to better understand and develop proficiency in the skills and knowledge.

It should be noted that with any competency, TASC and their team of experts can provide technical assistance to state Flex Programs. For additional support, discussions, or technical assistance, please contact TASC via phone at 877-321-9393 or email at TASC@ruralcenter.org. For more information on TASC, please review the Introduction to TASC section of the Flex Program Fundamentals Guide.

Flex Program Partner Organizations

Throughout the 2022 Guide, federally funded organizations that specifically support state Flex Programs are referenced, including:

Federal Office of Rural Health Policy (FORHP) – FORHP is part of the Health Resources and Service Administration (HRSA), U.S. Department of Health and Human Services (DHHS). FORHP advises the Secretary of DHHS and works to increase access to care for underserved people in rural communities through grant programs and public partnerships. They manage and administer the Flex Program nationally.

Flex Monitoring Team (FMT) – FMT assesses the impact of the Flex Program on rural hospitals and communities nationally and the role of the states in achieving overall program objectives. FMT creates,

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hosts, and develops the Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS) database and develops state and national reports covering all Flex Program components.

National Rural Health Resource Center (The Center) – The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities and provides technical assistance, information, tools, and resources for the improvement of rural health care. It serves as a national rural health knowledge center and strives to build state and local capacity.

Technical Assistance Services Center (TASC) – TASC, a program of The Center, provides support, resources, and technical assistance to all Flex Programs addressing all core competencies described in this guide. TASC also provides critical access hospital (CAH) and other rural provider information, tools, and education.

Rural Quality Improvement Technical Assistance (RQITA) – RQITA's goal is to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of FORHP quality initiatives, which are focused on quality measure reporting and improvement. RQITA supports state Flex Programs by providing Medicare Beneficiary Quality Improvement Project (MBQIP) tools and resources, technical assistance, training, and education.

Getting Started & Glossary of Terms

Each **competency** is briefly described, followed by specific **proficiencies** that make up the competency and descriptions on how to develop the competency.

Competency

The ability and/or knowledge required to successfully complete a state Flex Program activity or project.

Proficiency

The skills or expertise necessary to excel at a competency

Below are a few more terms to get started:

Proficiency Development – The act of making progress in the skills and expertise necessary to excel at a competency.

Activity – Skills and knowledge in practice that provide examples of a proficiency.

Best Practices – What state Flex Programs are doing to support competencies.

Rural Providers - For the purposes of this document rural providers include rural hospitals, rural clinics, emergency medical services (EMS), and their associated boards.

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10 Core Competencies of an Effective and Impactful Flex Program

Developing Leadership and Workforce

Managing the Flex Program

Planning Strategically

Managing Information and Evaluation

Building and Sustaining Partnerships

Understanding Policy and Regulations

Strengthening Quality Reporting and Improvement

Improving Financial Stability

Understanding the Current and Future Health Care Environment

Addressing Community Needs

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Developing Leadership and Workforce

Proficiencies:

- Understand the crucial role of leadership in producing rural provider excellence

- Employ basic methods and strategies for supporting and enhancing leadership in state Flex Programs, as well as rural hospitals and clinics

- Ensure a sustainable state Flex Program workforce, through effective hiring, onboarding, training, retention activities, and succession planning

- Employ strategies to help rural providers hire and retain needed staff and workforce

- Develop a relationship with leadership at each CAH in the state

The Flex Program and CAHs rely on leadership and a skilled workforce to advance program goals and deliver high-quality, high-value care for patients. High turnover challenges many state Flex Programs and CAHs. However, with strong leadership, planning, data collection, analysis, and a focus on workforce development, program goals can be set, advanced, and achieved.

Leaders set direction by building and communicating a common and inspiring vision. Leadership has the strongest relationship to organizational outcomes and value, including for state Flex Programs and CAHs. State Flex Programs are funded to serve as leaders in addressing CAH needs related to quality improvement, financial and operational improvement, population health, EMS. The Small Rural Hospital Blueprint for Performance Excellence and Value – State Flex Program Companion Resource, The Leadership Fundamentals Video Series, and the State Flex Program Staff Sustainability Guide and Toolkit should be reviewed for more in-depth information and tips leadership development.

In addition to leadership, trust is fundamental to the success of an organization and partnerships. Trust is established through open communication, integrity, and follow-through. It takes time to build trust.

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Through trusting relationships and strong leadership, state Flex Programs can engage and maintain partners and foster collaboration and innovation to advance the goals of the national Flex Program.

Leadership Development

Proficiency Development

Maintaining the health care workforce is necessary to provide access to quality health care in rural areas. Ideally, rural health care organizations will employ enough health care providers to meet the needs of the community. The health care providers should have adequate education and training; understand the value of cultural competency, diversity, equity, and inclusion[1]; and hold appropriate licensure or certification. When facilities promote coordination between health professionals and place them in roles where their skills can be used to their best advantage, patients will receive the best possible care.[2] While the Flex Program does not have a goal focused specifically on workforce, none of the Flex Program goals can be achieved without an adequate and skilled rural provider workforce.

Prior to Medicaid expansion and COVID-19, the U.S. had a health care worker shortage. Since that time the shortage has escalated and is even more pronounced in rural areas. The federal government, states, communities, and health care organizations have put programs and incentives in place to help recruit and retain staff. However, no immediate solutions can fill the gap between current supply and demand. As Flex Programs move forward during this severe health care worker shortage, it is essential

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[1] Additional information about health equity efforts can be found in the Health Equity Roadmap
[2] Rural Healthcare Workforce Overview - Rural Health Information Hub

to leverage rural health care workforce programs, funding, tools, and best practices developed by stakeholder organizations. Examples include:

- RHIhub presents strategies for optimizing the use of health professionals in rural areas
- The National Academy for State Health Policy's Case Study: How Indiana Addresses its Health Care Workforce Challenges which focuses on leadership, data, and cross-agency collaboration and identified strategies to address needs
- The Rural Recruitment and Retention Network (3Rnet), a web-based hub posting jobs in rural and underserved areas throughout the country.

State Flex Programs should participate in local, state, and national workforce discussions and consult their rural providers directly to be aware of the greatest issues and concerns to communicate to state and local policy makers and educational institutions.

Leaders set direction by building and communicating a common and inspiring vision.

Since many rural providers have similar challenges, state Flex Programs can support workforce development through facilitating peer-to-peer learning and sharing lessons learned and best practices. This can be accomplished by including stories as a part of regular Flex Program communications; encouraging networking, hosting in-person or virtual sharing between CAHs and other partners; and building formal processes to document and share experiences.

Similarly, state Flex Programs are encouraged to share lessons learned and best practices with each other. The annual FORHP Flex Program Reverse Site Visit is a great opportunity for learning and sharing with other Flex Programs. Other opportunities for state Flex Program networking include other national and regional conferences focused on rural health and CAHs, such as the National Rural Health Association (NRHA) Rural Health Clinic Critical Access Hospital Conference and the National Rural EMS and Care Conference.

Managing the Flex Program

Proficiencies:

- Describe the national Flex Program overall goals and program areas, and areas of focus within your state
- Utilize the template work plan and cooperative agreement writing resources to build your program
- Utilize electronic submission methods required by FORHP (i.e., Electronic Handbooks System (EHBs), grants.gov, and Performance Information and Management System (PIMS)
- Monitor project progress, contracts, and expenditures throughout the program year
- Utilize process measures to assess program progress
- Utilize short-, interim- and long-term outcome measures to assess program impact and plan for the future
- Maintain a relationship with your FORHP PO and provide regular program updates
- Understand and review contractor activities, reports, and invoices in a timely manner and follows-up on questions and missing or delayed items

Managing the cooperative agreement is one of the primary responsibilities of state Flex Programs and includes: budgeting, cooperative agreement application writing and submission, maintaining a relationship with the FORHP Project Officer (PO), working with partners, information management, and reporting. State Flex Programs should be aware of the cooperative agreement requirements, goals, and timelines as stated in the Flex Program Funding Guidance.

Managing the Flex Program

Proficiency Development

TASC, as well as other Flex Program partners, facilitate different learning opportunities with information related to each of the proficiencies above. These include TASC 90 webinars, TASC Virtual Knowledge Groups (VKGs), learning collaboratives and small group meetings. These webinars are recorded and made available on the TASC website. Additionally, TASC publishes a monthly newsletter where updates, resources and upcoming events are shared. As with many of the other competencies, maintaining a relationship with your federal Project Officer (PO) is important to managing a Flex Program.

Each year, new funding guidance is released which requires either: 1) a comprehensive and competitive cooperative agreement application (usually every 3-5 years) or 2) a Non-competing Continuation (NCC) application (in all interim years). If program changes and/or budget adjustments are needed during the cooperative agreement year, the funding guidance should be used to determine changes in direction and possible next steps in consultation with your PO.

All state Flex Program applications must have:

- Reports on progress, program changes, and project plans
- A detailed current and future work plan template, including baseline measures and targets (see Information and Evaluation)
- Project plans and activities that address the primary components of the Flex Program in narrative form, including:
    o CAH Quality Improvement (required)
    o CAH Operational and Financial Improvement (required)
    o CAH Population Health Improvement (optional)

- o Rural EMS Improvement (optional)
- o CAH Designation (required if requested)
- Budget justification narrative
- Position descriptions
- Biographical sketches/resumes

A well-written Flex Program funding application reflects positively on the program overall. It serves as documentation for past accomplishments and current activities, as well as a detailed guide for project plans moving forward. It is a critical tool for program continuity, should Flex Program staff changes occur during the cooperative agreement funding cycle. Since the Flex Program focuses primarily on the needs of CAHs, it is important that state Flex Programs have a strong working knowledge of CAHs and rural health care systems. This knowledge and understanding should be reflected throughout the funding application.

There are many resources to support Flex Program cooperative agreement application writing. If you have never submitted a proposal for HRSA funding, consider starting with reviewing HRSA's tips on How to Write a Strong Application. Cooperative agreement application writing resources specific to the Flex Program are also on the TASC website.

All HRSA grants are submitted electronically using EHBs or through grants.gov. It is important that staff submitting the application are familiar with the submission tools and deadlines. Meeting the submission deadline is imperative, as late submissions are not funded.

After the funding award is issued, all state Flex Programs should read the Notice of Award (NoA) issued by FORHP to identify their FORHP PO and Grants Management Specialist (GMS). The NoA should be reviewed closely to identify any terms and conditions associated with the funding. All reporting requirements should also be reviewed. State Flex Programs should keep track of required deadlines associated with the funding award including:

- Submission of the Federal Financial Reports (FFRs)
- Submission of Unobligated Balance (UOB)/Carry-over Requests, which are due prior to January 30th using HRSA's EHBs. These should be discussed prior to submission with your PO
- Submission of PIMS measures (see Information and Evaluation), due 60-day post project period end using HRSA's EHBs
- Submission of the End of Year Report (see Information and Evaluation) using HRSA's EHBs
- As your program year goes on, monitor project progress and expenditures (including contracts) so there is no unobligated balance at the end of the cooperative agreement program year. Consult with your PO when you anticipate an unobligated balance to discuss your ideas before acting

FORHP POs can respond to questions about project plans and the program guidance overall, as well as project questions. FORHP POs provide program updates during the cooperative agreement year.

Regular contact with the PO ensures that HRSA is well-informed of project activities and can assist with program needs in a more-timely manner.

Most state Flex Programs contract with other organizations to access additional expertise, staff, time, and resources needed beyond what is available internally. These contracts provide training, financial assessments, quality improvement initiatives, etc. Contracts may be with hospital associations, state agencies, universities, non-profits, consulting firms, independent consultants, and others. Since state Flex Programs are responsible for these contracts, they should have a strong working knowledge of the contractor, their roles, responsibilities, and requirements of contractual relationships. In depth contracting guidance can be found in The Grant Project Life Cycle, A Grant Subcontract Management Guide.

The Flex NoA should be reviewed closely to identify any terms and conditions associated with the funding.

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Contractual requirements are typically mandated by the parent organization of the state Flex Program. It is imperative that state Flex Programs understand such requirements prior to identifying and building a contractual relationship. These requirements may determine the size or type of contracts available, contracting process, need for competitive application process, and the timeline needed to execute a contract.

When establishing a formal relationship with a contractor, remember, the contractor is working for and on behalf of the state Flex Program and utilizing federal funding. Contractors can provide expertise to support decision making but they are not the final decision-maker. More on what to look for in a contractor can be found in [The Grant Project Life Cycle, A Grant Subcontract Management Guide](.).

Any contract established with an outside vendor should include a timeline for services, reporting requirements, and targets or intended outcomes. The contract should require the contractor to report both activity outputs and outcomes. Outputs and outcome measures should be defined in advance and should be reported in a way that they can be easily tracked and reported by the Flex Program to FORHP or other stakeholders. These outcomes will be directly reflected in the PIMS measures. Having these requirements predefined will support Flex Program management.

Open communication is key to any successful relationship. Before establishing a contract, discuss communication expectations, needs, and limitations. It is not unusual for state Flex Programs to receive requests from FORHP, TASC, FMT, and RQITA for information and updates. Inform your contractor of this and build the expectation for such communication into the contract.

Planning Strategically

Proficiencies:

- Clearly defined mission, vision, and values for the state Flex Program
- Understand the changing needs and opportunities for the state Flex Program to improve financials, quality of care and health outcomes of communities
- Identify how program activities are linked between rural community needs and mission, vision, and values of the state Flex Program
- Utilize a comprehensive framework[*] to focus and maintain stability of organization direction
- Regularly assess strategic progress of goals related to needs
- Utilize process measures and short-, interim- and long-term outcome measures to assess program progress and plan for the future

Planning ought to be purposeful, active, and relevant, with input from key stakeholders such as internal staff, rural provider leaders and staff, the state hospital association, quality improvement partners, and the state rural health and clinic organizations. Flex Program strategic planning should be completed to align with the New Competing Continuation application that occurs every three to five years. The plan should include a vision, mission, and values as well as goals and objectives. The plan should be reviewed quarterly, and adjustments made with each non-competing continuation application or during the cooperative agreement year with FORHP approval.

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[*]Additional information about the Baldrige Framework, one option for a comprehensive framework, can be found here

Planning Strategically

Proficiency Development
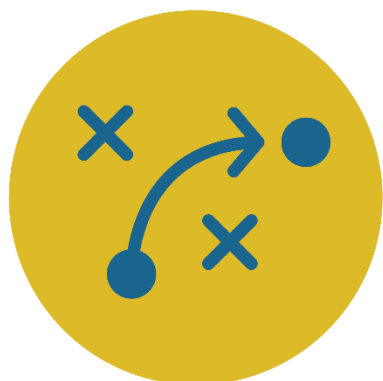
Within your organization, determine an approach for strategic planning. Examples of strategic planning models include basic strategic planning model, issue-based model, and alignment model.[3] The basic model is well suited for Flex Programs that are beginning their strategic planning journey. The steps are to create a mission, vision, and values; identify strategies, measures, and action plans; and monitor and update the plan. Issue-based strategic planning starts with a SWOT analysis (strengths, weaknesses, opportunities, and threats), inclusion of stakeholders who can identify issues and goals, review of/updating the mission, vision, and values, developing action plans and measures, and regular monitoring. Those to consider for inclusion are staff from: State Office of Rural Health (SORH), hospital association, quality improvement network/quality improvement organization (QIN/QIO), CAHs (especially the C-Suite), state and local EMS, public health, accounting firm specializing in rural provider financials, as well as others. The alignment model is based on using evaluation findings to identify what is working, where change is needed, and adjusting plans to make changes and make improvements.

For any of the models, consider using an outside facilitator, tools, and templates so strategic planning stays on track and impartially engages all participants. The most beneficial thing about using an outside facilitator is the staff can fully participate in the process, making use of their knowledge and experience base. Regular, quarterly review of the plan is important. Systems thinking is also helpful to understand how various critical success factors in rural provider and state Flex Program performance

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[3] Read more about strategic planning processes here

can be incorporated into a strategic plan. Success factors are then managed to produce sustainable high-performance outcomes. Systems approaches are most effectively implemented with the use of systems frameworks, like those found in the [Baldrige framework](#), [Small Rural Hospital Blueprint for Performance Excellence and Value](#), and [Small Rural Health Blueprint for Performance Excellence and Value – State Flex Program Companion Resource,](#) which include a broad range of quantifiable goals that measure and communicate progress.

Needs assessments support strategic planning and program planning. These can be scheduled and included in program operations (e.g., annually or at the end of each cooperative agreement cycle in preparation for the next cycle); targeted at certain topics or more broad-based; completed using a survey, questionnaire, interviews, and/or focus groups; and conducted by internal staff or contractors. The findings from needs assessments should be included in the Flex Program strategic planning process. More information on needs assessments can be found in the [Community Health Needs Assessment Toolkit](#)[4] and on [RHIhub](#).

Flex Program strategic planning should be completed to align with the Competing Continuation application.

Other resources to support strategic planning include: CAHs' community health needs assessments (CHNA), tools accessible through TASC (e.g., SWOT analysis findings; CAH QI and financial data such as that available from the [FMT](#) and through the [Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS)](#) makes it easy for CAH executives, state Flex Coordinators, and federal staff to explore the financial, quality, and community-benefit performance of CAHs.

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[4] Although Flex funding cannot be utilized to complete CHNAS, Flex funding can be utilized to support activities that are a result of CHNA findings or support capacity building of CAHs to effectively complete CHNAs to identify and met community needs.

Managing Information and Evaluation

Proficiencies:

- Utilize a framework for program evaluation

- Tell the story of the state Flex Program's impact and direction to various audiences

- Understand evaluation basics and definitions

- Utilize SMART goals based on needs

- Access and analyze data for decision making

- Ensure data reporting deliverables built into contractual agreements with consultants

- Utilize process measures and short-, interim-, and long-term outcome measures to assess program progress and plan for the future

- Describe measurable outcomes about the state Flex Program's activities that demonstrate impact

State Flex Programs are required to submit an annual report, PIMS, and program outcomes within the work plan to FORHP through the EHBs. To do this, your program needs to have a system in place to collect primary data about your program and often access secondary data to supplement these data to report outcomes. Data collection should be ongoing, reflected in the strategic plan and work plan, and tied to each program goal, objective, measure, and intended outcome as described in your state Flex Program funding application, as well as PIMS.
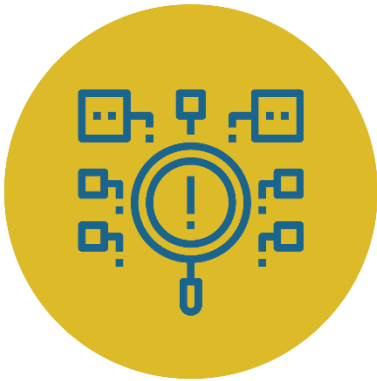
Managing Information and Evaluation

Proficiency Development

When creating the Flex Program Work Plan, objectives should be SMART (specific, measurable, attainable, relevant, and times sensitive) so you can determine whether objectives have been met. A sample SMART objective for quality improvement may be, "All CAHs will meet or exceed 95% quality compliance across all emergency department transfer communication (EDTC) measures for two consecutive quarters by 2024." Consider utilizing a logic model to provide a systematic and visual presentation of the relationships among Flex resources, activities, and desired results.

Goals for the Flex Program are defined in the NOFO as:

1) Show and improve quality of care
2) Stabilize finances and maintain services
3) Adjust to address changing community needs
4) Ensure patient care is integrated throughout the health care delivery system

Once objectives are set, measures should be created that align with objectives. There are different types of measures:

1) Process measures quantify operational functions, such as the time it takes to process an invoice, on-board or engage a CAH, or implement a new policy or procedure;

2) Output measures are products or services delivered and that the Flex Program has control over, such as the number of workshops, technical assistance support encounters completed, and staff trained;

3) Outcome measures identify a consequence or result that can be attributed to one or more intervention or activity. Outcome measures typically reflect a change, such as those related to quality of care, finances and operations, recruitment and retention, and community health

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status. Example outcome measures are the number of CAHs who improve their days revenue in accounts receivable or improve a quality metric that can be attributed to the work of the Flex Program. The Performance Management/Program Evaluation Guide provides more details and samples on creating objectives and measures.

Program evaluation can be completed at any time during the funding cycle; however, programs that excel build it into project plans using a continuous improvement approach such as lean or the plan, do, study, act (PDSA) method to make incremental or continuous change throughout the project period (See QI below). Lean is a practice that evaluates how an organization utilizes its resources and provides methods, tools, and processes for identifying and eliminating anything that is waste or non-value added. Lean[5] is founded on two basic principles: respect for people, and continuous improvement. For example, if you are hosting a CAH financial workshop, conduct a pre-test or pre-workshop operations assessment. These can be followed up with a post-test or a post-workshop assessment sometime from two to four months following an education/intervention asking how participants put the learnings into practice/changed operations. If the workshop is one activity in a series of activities to improve hospital finances, gather baseline data from each participating CAH at project start and the same data at project end and/or after hospitals have been able to put the activity into practice. If participants report no change during the evaluation, additional inquiry may be needed and/or adjustments to project plans may be warranted.

Data collection should be ongoing, reflected in the strategic plan and work plan, and tied to each program goal, objective, measure, and intended outcomes.

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[5] More information on lean and PDSA methods can be found in the Medicare Rural Hospital Flexibility Performance Management/Evaluation Guide.

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State Flex Program activities completed through contractual arrangements must also be evaluated. All contracts should include language reflecting reporting requirements, data submission requirements and format, and timelines based on objectives, measures, intended outcomes, and deliverables. Contractor reporting and timelines should align with Flex Program reporting requirements, needs, and timelines. Limit reporting using text formats such as PDFs or Word documents as they are inefficient and cannot be easily aggregated throughout the project period. More information and guidance can be found in the Grant Project Life Cycle: A Grant Subcontract Management Guide.

Some state Flex Programs use spreadsheets to track program evaluation data while others also use databases such as TruServe to monitor and track Flex Program outputs and outcomes. State Flex Programs should identify, implement, and use tools and systems that suit the needs of the program.

Evaluation reporting to program stakeholders should be included in Flex Program activities. This includes PIMS reporting, which is part of the Flex management process as indicated above. Reporting supports overall program transparency and development, stakeholder buy-in, engagement, and accountability.

Building and Sustaining Partnerships
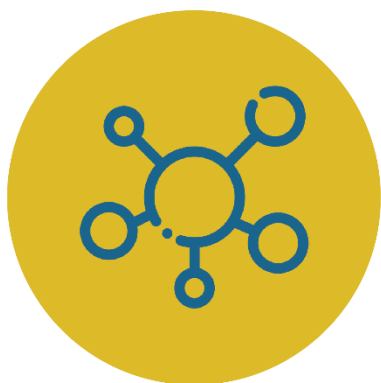
Proficiencies:

- Develop or maintain relationships with each rural provider through routine visits to each hospital and clinic
- Host and participate in local and state partner meetings to discuss issues impacting rural health with well-developed facilitation skills
- Engage with other state Flex Programs to identify promising practices and troubleshoot similar challenges
- Regularly convene meetings with rural providers on relevant Flex Program areas
- Regularly convene peer to peer sharing with rural providers on relevant Flex Program areas
- Develop and maintain collaborative relationships with state associations representing various provider types to foster regular communication on new programs, policy and regulatory changes, and opportunities for collaboration

Strong partnerships lead to more informed and engaged stakeholders and ultimately increased program impact and outcomes. State Flex Programs remain vital because of the web of relationships developed and maintained within communities, providers, networks, states, regions, and nationally. As the health care system changes and staff turnover occurs, it is imperative that state Flex Programs have the skills, capacity, and commitment to build and sustain partnerships, new and old, to support rural providers and rural stakeholders.

A partnership is an arrangement between two or more individuals, groups, or organizations working together to achieve common goals. Partnerships are developed over time and typically support the sharing of resources, knowledge, skills, ideas, and/or costs. Partnerships are key to the success of the Flex Program. They allow for the leveraging of skills and resources, decreasing duplication of efforts,

increasing overall impact and reach, and providing comprehensive approaches to opportunities and challenges.

Building and Sustaining Partnerships

Proficiency Development

Developing partnerships requires spending time getting to know state and local rural health care leaders and advocates. State Flex Programs should become familiar with their work and priorities. Periodic face-to-face meetings are imperative for building and sustaining partnerships and trust. State hospital associations, state rural health associations, state EMS office and associations, regional rural health networks, QIN/QIO, and local public health are all examples of organizations to build partnerships.

When combined with successful leadership, networking can be a powerful tool to advance rural health care systems. Networking enables providers and communities to leverage resources, expertise, and capacity to increase access to health care and improve health care performance and quality while lowering costs. Networking can lead to new relationships, partnerships, and knowledge sharing. Networks can be an effective way for rural health care organizations and leaders, including state Flex Programs, to utilize limited resources to their advantage.

As your state Flex Program networks in both formal and informal relationships, consider the identified opportunities and challenges in relation to the goals of your program. Take actionable steps to leverage resources, build upon existing networks and partnerships, and further develop others. The state Flex Program should play the role of introducing stakeholders and shining the spotlight on common goals, strengths, and opportunities. Do not assume service providers, partners, or networks are aware of each other.

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Effective communication is foundational to all relationships and developing partnerships. It begins with understanding what you are trying to communicate and translating information in a way that meets your audience's needs. This requires knowing the audience: who needs what information, by when, in what format, and for what purpose. Ask stakeholders and partners about their communication preferences and communicate accordingly. In addition, ask your audience for feedback on your communications: style, format, clarity, frequency.

State Flex Programs are often charged with convening groups of stakeholders to share information or ideas; enable peer-to-peer learning; build or sustain partnerships; strategically plan; make decisions; and complete activities. To be effective, facilitators must be objective and neutral. An effective facilitator fosters an energized, productive, inclusive, and participatory environment. While there are many approaches and processes used for facilitation, the best facilitators are prepared and have experience using different facilitation methods and techniques.

When combined with successful leadership, networking can be a powerful tool to advance rural health care systems.

Since many CAHs have similar challenges, state Flex Programs can facilitate peer-sharing, share lessons learned, and best practices. This can be accomplished by including stories as a part of regular Flex Program communications; encouraging networking, in-person or long-distance sharing between CAHs and other partners; and building formal processes to document and share experiences. Similarly, state Flex Programs are encouraged to share lessons learned and best practices with each other. The annual FORHP Flex Program Reverse Site Visit, VKG webinars, TASC 90s and learning collaboratives are great opportunities for learning and sharing with other Flex Programs, as are other national and regional conferences focused on rural health and CAHs, such as the NRHA Critical Access Hospital Conference and the National Rural EMS and Care Conference.

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Partnerships are often developed to leverage resources. Local, state, regional, and federal resources can be leveraged to advance Flex Program goals. The first step is awareness of resources and then partnering to identify common goals or objectives to determine the best use of resources. Resources may be in the form of expertise (e.g., QI or staff in other Flex Programs), training opportunities, or funding. It is important for state Flex Programs to familiarize themselves with current and emerging resources, such as: the Small Rural Hospital Improvement Grant Program (SHIP), Rural Healthcare Provider Transition Project (RHPTP), Delta Region Community Health Systems Development Program (DRCHSD), the Rural Health Network Development Planning grants, and other state and private foundation funding. RHIhub has information on many resources that may be of interest to state Flex Programs. The key is to not operate in a bubble or recreate the wheel; reach out to your peers, learn, share best practices, develop joint strategies, resources, and tools.

Understanding Policies and Regulations

Proficiencies:

- Recognize and communicate how policies and legislation affect rural providers

- Develop a relationship with CMS regional representative

- Follow e-mail list serves and participate in national rural calls and listening sessions

- Develop relationships with state hospital, health, and EMS association staff with expertise in policy and regulations

- Maintain relationships with risk managers at CAHs

Health policy, rules, and regulations have a profound impact on programs, operations, services, reimbursement, and systems. State Flex Programs need to have an in-depth understanding of the policies and regulations governing the Flex Program, as well as a basic understanding of the policy-making process and other policies and regulations affecting rural providers. While state Flex Programs do not need to be experts in all aspects of the rural health landscape, having a basic understanding of key components will: 1) allow state Flex Programs to better understand rural provider challenges and opportunities and develop strategies to address them, 2) communicate more effectively with program partners, 3) access resources and expertise when needed, 4) educate others about rural communities and rural providers, and 5) anticipate and prepare for health system changes.

Understanding Policies and Regulations

Proficiency Development

It is important that state Flex Programs have at least a basic understanding of the legislation that established the Medicare Rural Hospital Flexibility (Flex) Program, the new and changing regulations, and to be aware of any future changes. This aids in understanding the potential impact of proposed or new legislation that may affect CAHs, other rural health providers, and the communities they serve and to communicate such impacts to stakeholders in a clear and concise manner. Some of the major legislation impacting the Flex Program includes:

- Balanced Budget Act of 1997 (BBA)
- Balanced Budget Refinement Act of 1999 (BBRA)
- Benefits Improvement and Protection Act of 2000 (BIPA)
- Medicare Prescription Drug, Improvement and Modernization Act of 2003
- Medicare Improvements for Patients and Providers Act of 2008
- American Recovery and Reinvestment Act of 2009
- Patient Protection and Affordable Care Act of 2010
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

You can find an overview of the Flex Program in the History of the Medicare Rural Hospital Flexibility Program section of the Flex Program Fundamentals.

Before a small rural hospital can be designated as a CAH, it needs to meet specific bed limits, geographic requirements, and Conditions of Participation. It must pass a survey through state certification or accrediting organization. Once designated, CAHs must meet and continue to meet the CMS Conditions of Participation (CoPs). These health, safety, policy, and procedure standards support quality improvement and protecting the health and safety of patients. An overview of CAHs can be found on RHIhub.

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To stay up to date on new and changing regulations, state Flex Program staff should maintain regular participation in the CMS Rural Open Door Forum and the TASC 90 webinars. Additionally, it is important to maintain a relationship with the state's CMS Regional Office Rural Health Coordinator as well as the CAH quality and risk managers.

Strengthening Quality Reporting and Improvement

Proficiencies:

- Understand QI and process improvement principles
- Analyze state and hospital-specific data in MBQIP reports from FMT to identify opportunities for QI at the State and rural provider levels
- Determine best practices in quality reporting and QI principles based on the needs of rural providers
- Describe the purpose of MBQIP
- Understand each MBQIP measure, the purpose, and overall data collection method
- Direct MBQIP reporting and QI resources to rural providers

A core component and goal of the Flex Program is to support CAHs with quality improvement (QI). HRSA defines QI as "systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups."[6] To accomplish this, state Flex Programs must understand QI principles, resources, and trends to support CAHs in advancing QI. This includes administering the Medicare Beneficiary Quality Improvement Project (MBQIP) and supporting other rural providers, such as EMS, with QI.

Strengthening Quality Reporting and Improvement

Proficiency Development

As the health care system shifts to a value-based model and becomes increasingly data driven, the requirement to have QI hardwired into health care operations is evident. While state Flex Programs are not expected to be quality improvement experts, they should have a basic understanding of QI principles to best support and work with project partners, develop project plans, implement MBQIP, establish QI initiatives, and report program outcomes. They should also know how and where to access QI technical expertise, such as RQITA.

The process of QI is continuous. Activities or processes within a health care organization contain two major components:

1) What is done (what care is provided)
2) How it is done (when, where and by whom care is delivered)

Improvement can be achieved by addressing either component. The greatest QI impact is achieved when both are addressed at the same time.

Two suggested methods or philosophies to support quality improvement and process improvement are Lean or the plan, do, study, act (PDSA) method. Both focus on process and are considered methods for continuous improvement. Continuous improvement is the systematic and ongoing effort to discover and improve services, processes, or products. Lean is one of the most common methods used in all industries, including health care, to make process improvements. The PDSA method is used to test and make decisions about a change. It fosters continuous improvement and is ongoing.

Data are the cornerstone of QI because if you cannot measure it, you cannot improve it. Data are used to describe how well current processes and systems are working and to document performance improvement. State Flex Programs need to be familiar with quality data sources, where to access the data and how to use the data to develop program activities, prioritize program resources and support rural providers in their QI efforts. This includes data available through the FMT's MBQIP reports, CAHMPAS, other state or national data sets, and internal data. FMT creates quarterly MBQIP reports for each state and each CAH. These reflect CAH data, state CAH data, and national CAH data. The MBQIP reports are accessed through the FORHP's NIH data portal and should be shared with CAHs as they become available. Access to the portal is gained by contacting your state's PO. CAHMPAS is a web-based data query tool with quality, financial, and community benefit data for trend analysis and download. Quality measures can be selected and graphed with state and national comparisons. For more details see the Step-by-step CAHMPAS Guide.

Quality reporting is for internal use and decision making at a CAH, as well as for public use, benchmarking, and research. Internal reporting is the process by which health care providers capture quality data for their own tracking purposes, often by way of the electronic health record. Public reporting is the process through which internal health care provider quality data is made available to the public through a third party. State Flex Programs should be aware of CAH quality reporting including an awareness of reporting processes for: MBQIP, electronic clinical quality measures (eCQMs), and QIN-QIO. State Flex Programs should also encourage and support through regular communications about upcoming deadlines and providing any technical assistance needed for CAHs in reporting data.

The Medicare Beneficiary Quality Improvement Project (MBQIP) is administered by state Flex Programs. It was launched by FORHP in 2010 with the goal of improving the quality of care provided in CAHs by increasing quality data reporting by CAHs and then driving quality improvement activities based on the data. MBQIP provides an opportunity for individual hospitals to look at their data, compare their results against other CAHs, and partner with other hospitals around quality

improvement initiatives to improve outcomes and provide the highest quality care to every patient. State Flex Programs can support CAHs with this aim through technical assistance, training, education, and peer to peer learning both for reporting and improvement.

The MBQIP measure set is intended to reflect the services and priorities of CAHs as well as the priorities of the Centers for Medicare and Medicaid Services (CMS). The MBQIP Fundamentals Guide for State Flex Programs provides information on the history and basics of MBQIP with links to resources and additional support materials. It is essential reading for state Flex Program Coordinators and quality staff. Current domains within MBQIP include:

Data are the cornerstone of QI because if you cannot measure it, you cannot improve it.
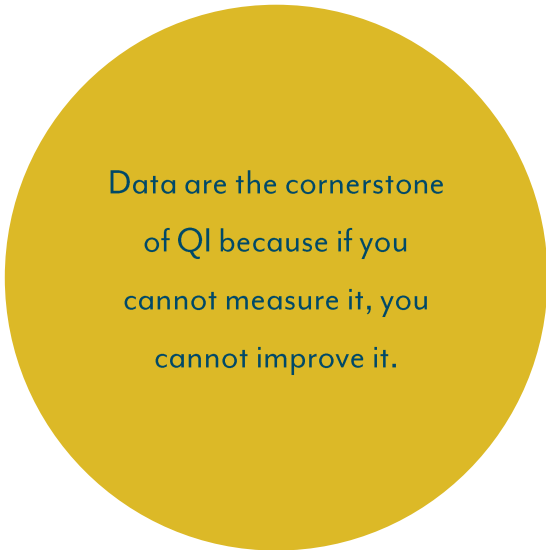
- Patient Safety/Inpatient
- Patient Engagement
- Care Transitions
- Outpatient

MBQIP reporting deadlines are updated monthly on the TASC website in the MBQIP Data Reporting Reminders. Some measures are submitted by CAHs through CMS or the Centers for Disease Control and Prevention (CDC) data reporting portals, while others are submitted directly to the state Flex Program. It is important for state Flex Programs to understand these processes by reviewing the MBQIP Fundamentals Guide for State Flex Programs. Flex Programs can access MBQIP technical assistance, tools, resources, data and reports for internal and CAH use through resources at TASC, RQITA, FMT, and contractors. Other state Flex Programs are good resources for learning and sharing. RQITA publishes an MBQIP Monthly that should be used by Flex Programs and shared with CAHs.

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Improving Financial Sustainability

Proficiencies:

- Recognize the basic concepts of CAH and rural health clinic (RHC) payment

- Understand how CAH financial data are reported, analyzed, and acted upon

- Describe what each of the most important CAH financial measures means, and how each affects the hospital's overall financial performance

- Explain the basic concepts of value-based payment for rural providers

- Analyze a rural hospital's financial performance over time and identify hospitals in financial crisis and in danger of closing

- Understand the basic strategies for improving the financial performance of rural hospitals and clinics

Sustainable financial performance of rural providers is essential for both the day-to-day operation as well as for needed investments in technology, infrastructure, and staff. The Flex Program and CAH designation was established and remains in place because of the financial vulnerability of small rural hospitals. CAH financial and operational improvement is one of the required program areas of the Flex Program.

Changing market forces and payor reimbursement have been challenges for decades. Market forces continue to evolve and contribute to financially stress small rural hospitals. This financial distress has led to the closure of numerous rural hospitals while several hundred are currently classified as financially distressed. Similar to QI, state Flex Programs are not expected to be financial and operational improvement experts. However, state Flex Programs should have a basic understanding of financial and operational improvement principles to best support project partners, serve as a resource, develop project plans, establish, and implement initiatives, share best practices, and report program

outcomes. They should also know how and where to access financial and operational technical expertise, such as TASC, and access and use financial data, such as CAHMPAS.

Improving Financial Stability

Proficiency Development

Medicare and Medicaid regulations, reimbursement, incentives, billing codes and private payer (insurance) contracts are complex. Rural provider financial improvement is often dependent on access to financial expertise both within and outside the facility. For many CAHs, finances and operations extend beyond the hospital as they may offer a multitude of services within the continuum of health care services such as clinic(s), skilled nursing, swing bed, behavioral health, specialty services, and ambulance. Additionally, Medicaid policy and reimbursement differs from state to state as does workforce and other policies and support efforts (e.g., ability to hire physicians, physical plant standards, minimum staffing requirements, workforce training subsidies). At the local level, access to local tax subsidies is another factor. Regardless of differences, Flex Programs and their rural providers need to be aware of policy and reimbursement changes and their impact. Meanwhile, the state Flex Program needs to be able to support rural providers towards financial and operational improvement by following effective business processes and utilizing an efficient revenue cycle management system.

For the past several decades, the U.S. health care system has been characterized by poor quality, increasing costs, and decreasing access to care with declines in key indicators of population health. Despite efforts to make improvements, barriers to improvement persist. Much of this is attributed to it being a volume driven system: the more medical procedures performed, the more revenue produced. In contrast, the developing system is based on value: quality, patient experience, cost, and population health and a shift from acute and emergency department care to outpatient and primary care. While large hospitals have started the move to value-based reimbursement, most CAHs and other rural

providers are still in the initial stages. More information on value-based reimbursement can be found in the [Rural Hospital Toolkit for Transitioning to Value-based Systems](#).

Common financial and operational improvement concepts and terminology that state Flex Programs should be familiar with are cost-based reimbursement, revenue cycle management, and CAH financial indicators. There are acknowledged financial improvement strategies that can support improvement in these areas. All of these concepts, and more, are described in the [Small Rural Hospital and Clinic Finance 101](#) manual which is strongly suggested reading for all state Flex Program Coordinators. More in-depth information on revenue cycle improvement can be found in the [Revenue Cycle Webinar Series](#) as well as [RHIhub](#).

In 2012 and 2018, the FORHP and TASC worked with FMT, trusted financial experts, and other Flex Program partners to identify 10 high priority, CAH financial indicators. Each of these is described in the [Small Rural Hospital and Clinic Finance 101 guide](#). Like QI, it is nearly impossible to plan for and drive improvements in CAH finances and operations without data. Additionally, financial and operational improvement can be supported using process improvement methodologies described above in QI, such as PDSA and lean. Both methods focus on process and continuous improvement. CAH financial data are available through [FMT](#), [CAHMPAS](#), benchmarking tools such as [Quality Health Indicators](#), and potentially in collaboration with state hospital associations. The CAH Financial Distress Index is also available in CAHMPAS. Data can be collected and analyzed for an individual CAH, a cohort of CAHs, or statewide. Findings should be used for program planning, development, and to determine if state Flex Program activities are resulting in their intended outcomes.

> State Flex Program needs to be able to support rural providers towards financial and operational improvement.

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State Flex Programs may not have the expertise on staff to fully support rural providers in their financial and operational improvement efforts. It is recommended that state Flex Programs have access to financial experts for advice and to help develop statewide financial improvement strategies. Such experts can be found in hospital consulting firms, the Healthcare Financial Management Association (HFMA), as well as through TASC and its cadre of expert advisors. FMT is another important source of research information and data on CAH finances. They have a library of financial information on CAHs and periodically publish research reports and special studies on the topic and manage CAHMPAS.

Understanding the Current and Future Health Care Environment

Proficiencies:

- Understand the interconnection of various provider types (i.e., hospitals, clinics, LTC, EMS, behavioral health, etc.)

- Develop and maintain collaborative relationships with state associations representing various provider types to foster regular communication on new programs, policy and regulatory changes, and opportunities for collaboration

- Foster CAH participation in local and statewide public health initiatives

- Engage with public health, rural health care providers, rural community stakeholders, and EMS to prepare for emergencies impacting rural health

- Encourage rural providers to have up-to-date emergency response plans that are reviewed at least annually and communicated to all local and state partners

- Describe the future health care environment, drivers for change, and the opportunities for rural providers

- Understand how quality of care, hospital operations and finances, patient and employee engagement, community collaboration, and health outcomes interrelate to drive the future of rural health care

- Share new models of care information, resources, and outcomes to rural providers and key stakeholders

- Help hospitals and rural health clinics understand the need to participate in community-based, comprehensive

- approaches to emergencies

- Identify the varying needs of independent and system-affiliated CAHs, and CAHs with provider-based RHCs, LTC, or owned ambulance agencies

Given the goals and role of the Flex Program, the role and services provided by CAHs, RHCs, and EMS, and the population health needs of rural communities, it is imperative that state Flex Programs have a general understanding of the health system. This includes having basic knowledge of: 1) the various roles and classification models of the types of hospitals, clinics, EMS, and long-term care (LTC) facilities prevalent in rural America and 2) the rapidly evolving health care payment models, as payors increasingly pay for value and outcomes rather than for procedures. This understanding enables state Flex Programs to participate in discussions and planning to serve as a rural "voice" to ensure rural needs are met. The COVID-19 pandemic highlighted the need to orchestrate a coordinated response to rural emergencies. The Flex coordinator can be a key partner in rural emergency planning, given the broad scope of their program responsibilities. Pressures are being felt in rural areas as the population ages, costs increase, and payors look for opportunities to decrease health care costs. A broad comprehension of the health care environment is crucial to understanding how various health and social service providers can work together in rural communities to improve the health of populations.

Understanding the Current and Future Health Care Environment
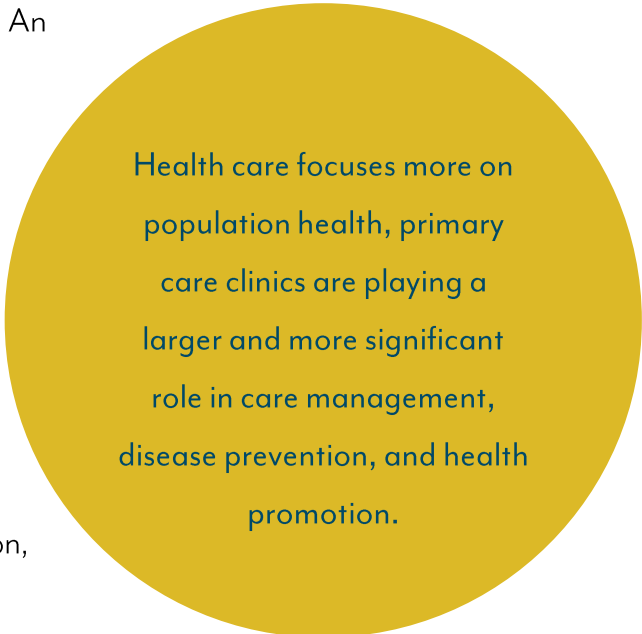
Proficiencies Development

State Flex Programs spend significant time developing and implementing initiatives targeted at CAHs. It is imperative to develop a relationship with each CAH as each has unique circumstances. In the past, CAH volume was heavily driven by acute care patients; however, this has shifted to swing bed services, outpatient services, rehabilitation services, emergency departments, and urgent care clinics. Additionally, CAHs often have other health care service entities within their organization: clinics, LTC, home care, EMS, pharmacies, assisted living, etc.

State Flex Programs can help CAHs transition into value-based systems, population health models, and future opportunities through education, network support, facilitation of new partnerships, and

technical assistance. For example, leadership understanding of the new models and transition strategies are crucial and require a great deal of education. CAHs may also need to develop partnerships with other community service providers, as well as participate in either networks or larger health systems to participate in emerging models. Public health concepts are important in managing the health of populations, presenting opportunities for hospital-public health collaboration. As CAHs move into new value models, they will increasingly reach out to state Flex Programs for assistance in the transition. The movement to value will be more rapid in some states, but ultimately all CAHs need to find a place in the emerging systems.

The new payment systems are emerging in different ways. An Accountable Care Organization (ACO) provides reimbursement to a group of providers (usually hospitals and/or clinics) to provide services to a group of 5,000 or more Medicare recipients. When care is provided at a lower cost with high quality, the savings are split between the Medicare program and the providers. This model requires new partnerships and effective care management, ready use of patient data and financial metrics, chronic disease management, wellness, prevention, and accurate coding and billing practices.

Health care focuses more on population health, primary care clinics are playing a larger and more significant role in care management, disease prevention, and health promotion.

Medicaid ACOs are also emerging across the U.S., with services to Medicaid recipients being managed by groups of providers. Early state results have demonstrated both cost savings and good quality and are expected to be used in a growing number of states. In addition, third party insurance providers are forming ACO-like models to contract with groups of health providers and are expected to shift a majority of their business to value-based models in the next few years.

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An alternative global budget payment model is being used by rural hospitals in Pennsylvania and Maryland. The Maryland model was designed under a CMS waiver and launched in 2014 and in 2019 PA initiated their global budget model program. This model uses global budget payments and aligns incentives for providers to deliver value-based care while changing the local health care delivery system to better meet community needs.

In 2021, the Rural Emergency Hospital (REH) model was established as a new provider type that went into effect on January 1, 2023. "The REH model will offer the opportunity for current CAHs and rural prospective payment systems hospitals with fewer than 50 beds to convert to REH status to furnish certain outpatient hospital service in rural areas, including emergency department and observation service."[7] Like CAH designation, an REH has specific operating requirements with a unique payment methodology. State Flex Programs will be engaged in the conversion of REH status by interested facilities.

Many CAHs are already participating in new models of care. State Flex Programs should be familiar with and understand these new models of care and their outcomes. State Flex Programs should serve as a resource to program stakeholders and should develop state Flex Program plans to foster innovation and alignment with new models.

As health care focuses more on population health, primary care clinics are playing a larger and more significant role in care management, disease prevention, and health promotion. CAHs, particularly their outpatient departments, clinics, or RHCs, will progress prominently as the hub of primary care in rural communities, coordinating care, and promoting health and wellness with an eye toward population health and preventable hospitalizations. State Flex Programs need to be aware of the strengths, weakness, and policy changes impacting these care providers because they are increasingly the drivers of health care in the community. LTC, which includes a different level of care than care

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[7] Additional information about the REH Model can be found here

provided in skilled nursing facilities (SNFs), are common in rural areas as rural populations tend to be older and desire to receive care in their communities. Some CAHs own and operate a LTC facility as they allow for patients and their families to have their needs met close to home, addressing a community need, though sometimes at a financial expense to a CAH. State Flex Programs need to be aware of the strengths and challenges facing LTC facilities, which are a vital part of rural communities and often a CAH referral source or transfer site.

EMS is a critical part of the health care team. EMS provides pre-hospital care, works with hospital emergency departments, serves as part of trauma and transfer teams, and is part of care coordination and follow-up. As EMS roles and responsibilities evolve, state Flex Programs need to be aware of such changes to plan, engage, and communicate the impact with rural communities and CAHs.

The future of EMS includes the potential for new provider types and reimbursements, integration, and regionalization. RHIhub and the National Emergency Medical Services Information System (NEMSIS) have an extensive list of resources on the EMS system, challenges, and opportunities. The Rural Community Ambulance Agency Transformation Toolkit offers ambulance agency leaders the opportunity to assess the readiness of their agency in moving from volume to value in their agency's culture and operations.

Community Paramedics are a new and evolving EMS provider type. They are also known as community emergency medical technician (EMT) due to the limited number of paramedics in some rural areas/states. Community Paramedics/EMTs are intended to serve as full-time providers with an expanded scope of practice that includes elements of primary care, public health, disease management, care coordination, mental health, and/or oral health. State Flex Programs should stay abreast of this new provider type because of its potential impact on access to EMS, care coordination, population health, rural health systems and the continuum of care. State Flex Programs should regularly visit the Community Paramedic website, state and local resources, discussions, and webinars.

The [Roles of EMS in the Transition to Value webinar](#) has great insights and resources related to the role EMS can play in the transition to value.

While the health care system shifts to a value-based environment that includes social determinants of health (SDOH), rural communities continue to struggle to meet the behavioral health needs of their residents. Behavioral and mental health services are being integrated into primary care settings and across the continuum of care, though significant access issues persist.

The U.S. is experiencing a severe shortage of behavioral and mental health providers coupled with lack of or limited payment reimbursement methodology. The workforce shortage is more evident in rural areas where distances and wait times are longer. As the health system changes and primary care becomes the center for one's health and well-being services, care coordination between traditional primary care and behavioral and mental health services will continue to evolve. State Flex Programs need to be aware of related policy and rule updates, opportunities, reimbursement changes, and new provider types and services that affect rural communities. For example, CAHs and clinics are increasingly using telemedicine to increase access to behavioral and mental health services for their patients. During the COVID-19 pandemic, reimbursement, access, and acceptance of tele-mental health expanded significantly, the impact and permanence of this is yet to be determined.

New ideas, models, systems, and stakeholders in the health care marketplace will evolve. Examples include the increasing development and roles of artificial intelligence (AI) in health care decision-making, telemedicine, specialty services, and devices. New players such as Walmart, Amazon, CVS, and Walgreens are collaborating on ideas related to insurance, health promotion, technology, telemedicine, and care coordination. Remote monitoring and hospital-at-home models emerged during COVID-19 and their on-going use seems likely. While it is not essential to stay abreast of every emerging idea in health care, a general awareness of the market will help state Flex Programs stay engaged and bring new ideas and concepts to discussions with rural health stakeholders and providers.

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Addressing Community Needs

Proficiencies:

- Understand the SDOH and how they impact the current and future health care environment
- Recognize and invest in health equity, inclusion, and diversity to impact the current and future health care environment
- Analyze data from CHNAs, CAHMPAS, and other sources to identify opportunities for addressing community needs
- Utilize CHNAs and other data sources to identify opportunities for rural provider collaboration on population health improvement
- Understand interventions that are impactful in addressing community needs

Health care services, such as those provided at CAHs and RHCs, are intended to meet the health needs of their communities. Health needs can be determined using a variety of factors including demographic data, social and economic status, physical environment, clinical care, health behaviors, and health outcomes. It is important for state Flex Programs to understand the community needs of CAH and RHC service areas to develop or leverage program activities in support of health system development, community engagement, and population health improvement.

There are multiple ways to understand community needs of CAHs and RHCs. Researching secondary data is crucial for the service areas of CAHs and RHCs. This is essential in determining SDOH and other needs of the community CAHs and RHCs serve. Using the County Health Rankings to find county specific data and doing some visual representation is helpful. CAHMPAS also has many other helpful tools to discover disparities around the SDOH. To gain greater insight into individual CAH community

needs, conducting a CHNA is helpful. Keep in mind that a CHNA is a formal, systematic process that identifies and analyzes needs and assets. For CAHs, this drives local planning, decision making, and programs. Review rural health assessments conducted by the state's Office of Rural Health for further information.

Addressing Community Needs

Proficiency Development

The World Health Organization defines SDOH as, "the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development, agendas, social norms, social policies, and political systems."[8]

Increasingly, SDOH are being recognized as key factors contributing to health inequities. Addressing SDOH is fundamental to increasing quality and access to health services and decreasing costs.

State Flex Programs should be familiar with SDOH, the role that SDOH play in population health and value-based health care, and how health and community programs and services are changing to include and address SDOH. State Flex Programs should use and convey this knowledge to prepare CAHs to participate in current and future state, regional, and local health system planning.

"Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position."[9] It is important for state Flex Programs to understand their organization's approach to health equity and how this approach can impact their work with rural care providers and communities. This may include encouraging CAHs to identify and address policies, procedures, environment, and practices that

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[8] Social determinants of health (who.int)
[9] Health Equity | CDC

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further perpetuate health inequity. With the advent of value-based payment models, care coordination, electronic health records, and the COVID-19 pandemic, the need to invest in, address, and require health equity has emerged as a national priority.

Many rural communities are diverse and changing. CAHs are the primary source of health care in many rural communities. They play a central role in addressing health equity, diversity, and inclusion. Understanding of the drivers of inequities can assist rural providers in meeting the health care needs of their community and individual patients. Presentations, webtools and documents on the value, importance, and impact of health equity are increasingly available. Recommended resources can be found in the Center's Health Equity Collection.

Population health serves as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three stages:

1) Distribution of specific health statuses and outcomes within a population
2) Factors that cause the present outcomes distribution
3) Interventions that modify the factors to improve health outcomes

Although these three aspects of population health are interconnected, they lead to different operational strategies. It is important that state Flex Programs and CAHs recognize the need for strategies that address both aspects with the resources available related to your state's priorities. Health outcomes are the product of social and environmental factors, personal behavior, genetic disposition, health equity, and access to available high quality health services. As such, collaboration is required among those who influence the drivers and resisters to achieving excellent population health. Population health is increasingly incorporated into quality, operational, and financial performance improvement initiatives, and value-based care initiatives. Population health is an important concept for state Flex Programs to understand and communicate. To aid in the creation and movement toward wellness through population health strategies, The Center has created an

interactive Population Health Toolkit. This toolkit is a public information source to understand population health and access assessments and a web-based database for acquiring health data specific to a location.

CHNAs have been conducted by CAHs and other rural health organizations for decades. Often the assessments were used to obtain grant funds, guide physical plant improvements, or guide service development or expansion. The Affordable Care Act established requirements for hospitals wishing to maintain non-profit or 501(c)(3) status including conducting a CHNA and developing a related implementation strategy at least once every three years. Although state Flex Programs cannot directly fund CHNAs, they can provide technical assistance and support CAHs in addressing needs and priorities specified in completed CHNAs.

Population health is increasingly incorporated into quality, operational, and financial performance improvement initiatives, and value-based care initiatives.

"Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention, and detection and control of infectious diseases. Overall, public health is concerned with protecting the health of entire populations."[10] Public health is an important resource both locally and at the state level to support QI, care coordination, population health improvement, emergency preparedness, and collaboration. Public health agencies often collect, analyze, and report on the health needs of the communities they serve through a Community Health Improvement Plan (CHIP). This information can be used by state

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[10] What is Public Health? | The CDC Foundation

Flex Programs and CAHs in planning and to align findings with CAHs' CHNAs. State Flex Programs should be familiar with the roles and responsibilities of public health in their counties and state as they have established relationships within communities and around the state that can be excellent for collaboration.

Conclusion

The contents in the guide discuss the core competencies identified by SORH Directors, Flex Program coordinators, rural health leaders, staff from the Federal Office of Rural Health Policy, the National Rural Health Resource Center, Rural Quality Improvement Technical Assistance, and the Flex Monitoring Team to foster state and national program excellence. Application of the proficiencies related to the competencies will lead a state Flex Program toward improvement of rural hospital financial and quality performance, population health and value-based payment models.

This guide identifies tools and resources currently available or that need to be developed to support those competencies. It is suggested that state Flex Program staff begin by reading the guide to understand each competency and the proficiencies related.

Completion of the Core Competencies Self-Assessment (from the prospective of the state Flex Program as a whole, and not an individual member of the team) is the suggested next step. Once specific areas where most opportunity is identified, TASC and our team of experts can provide technical assistance and resources to state Flex Programs.

For additional support, discussions, or technical assistance, please contact TASC via phone at 877-321-9393 or email at TASC@ruralcenter.org.

This guide will be continuously updated by TASC. Furthermore, through Summit participant recommendations and feedback shared by state Flex Programs, FORHP, TASC, FMT, and other Flex Program partners, TASC will continue to develop technical assistance, education, and other means of support to state Flex Programs in building and maintaining core competencies and knowledge.

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Appendix A

Summit Participants

The Summit participants consisted of nationally recognized rural hospital and clinic field experts, including SORH leaders, Federal Office of Rural Health Policy staff, rural health consultants, Flex Program staff, and Flex Program partners. The 2022 Core Competency Summit Participants included the following field experts:

- John Barnas, Executive Director, Michigan Center for Rural Health, Flex Program
- Caroline Bell, Program Coordinator, National Rural Health Resource Center (The Center)
- Sally Buck, Chief Executive Officer, The Center
- Tahleah Chappel, Program Officer, Federal Office of Rural Health Policy (FORHP)
- Nicole Clement, Program Specialist, The Center
- Karen Davis, Rural Health Policy Specialist, RHIhub, University of North Dakota
- Lisa Davis, Director, Pennsylvania State University, Flex Program
- John Gale, Co-Principal Investigator, Flex Monitoring Team, University of Southern Maine
- Nick Galvez, Flex Coordinator, North Carolina Department of Health and Human Services, Flex Program
- Patricia Gayle, Program Coordinator, The Center
- Kiona Hermanson, Program Coordinator, The Center
- Terry Hill, Senior Advisor, The Center
- Wanda Hilton, Flex Coordinator, Iowa Department of Public Health, Flex Program
- Debra Laine, Program Specialist, The Center
- Megan Lahr, Principal Investigator, Flex Monitoring Team, University of Minnesota
- Tori Leach, Program Officer, FORHP
- Dorothy Marcello, New York State Department of Health, Flex Program
- Kathryn Miller, Flex Coordinator, University of Wisconsin, Flex Program
- Tracy Morton, Director of Population Health, The Center

- Kristin Reiter, Co-Principal Investigator, Flex Monitoring Team, University of North Carolina at Chapel Hill
- Chris Salyers, Director of Programs and Evaluation, National Organization of State Offices of Rural Health (NOSORH)
- Stephanie Sayegh, Flex Coordinator, Idaho Bureau of Rural Health and Primary Care, Flex Program
- Laura Seifert, Program Officer, FORHP
- Caleb Siem, Program Specialist, The Center
- Rochelle Spinarski, Report Writer, Rural Health Solutions
- Natalia Vargas, Program Officer, FORHP
- Dawn Waldrip, Flex Coordinator, Georgia Office of Rural Health, Flex Program
- Karla Weng, Senior Program Manager, Rural Quality Improvement Technical Assistance (RQITA), Stratis Health