Best Practices & Success Stories

A Guidebook for Medicare Rural Hospital Flexibility Program Coordinators

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INTRODUCTION

Who is this guidebook for?

This guidebook is primarily for those who work on the Medicare Rural Hospital Flexibility (Flex) Program. Flex Coordinators (as they are known), and other staff working on the Flex Program, are charged with supporting improvement in rural health care, including Critical Access Hospitals (CAH), across the United States.

This guidebook is written especially for those who are relatively new to the Flex Program. It's designed to help them learn from one another about responding to local conditions and resources. It defines the major Flex Program components and offers lists of program activities, best practices, and success stories.

How this guidebook came to be

Even with the wonders of the internet, it can be difficult to connect with and learn from colleagues in other states. This guidebook draws on the experiences and advice of some of the more experienced Flex Coordinators. It distills their experiences and provides practical strategies and advice to help their fellow Flex Coordinators succeed in managing a state Flex Program.

At a 2009 forum, leaders from a cross section of successful Flex Programs identified factors and strategies that lead to Flex Program success. (The forum was convened on July 23 to 24, 2009 in Rockville, MD.) The meeting was facilitated by staff from the Technical Assistance and Services Center (TASC), a program of the National Rural Health Resource Center, and staff from the Office of Rural Health Policy (ORHP) and Flex Monitoring Team were in attendance. Forum participants were chosen by ORHP.

How can this guidebook be helpful?

The guidebook reflects the **best practices** and **success stories** identified by Flex Program staff who willingly shared their experience and made recommendations and suggestions for their fellow Flex staffers in each of the major Flex Program components:

- Forming community partnerships
- Building health networks
- Strengthening CAH financial capacity
- Improving the quality of patient care
- Adopting health information technology (HIT)
- Improving and integrating emergency medical services (EMS)

This guidebook is designed to

- Suggest tactics and solutions that have worked well for other Flex Coordinators
- Provide food for thought about planning, projects, and grant proposal preparation
- Identify helpful resources
- Highlight major Flex Program responsibilities

> Please note that the guidebook contains ideas and suggestions, not a list of requirements. We encourage you to customize the support you provide to meet the needs of your individual state.

What are Flex Coordinators' primary responsibilities?

Initially, the Flex Program was designed to assist small rural hospitals at risk of closing, due largely to financial distress. The first charge was to help these facilities gain designation as CAHs. This designation brings cost-based reimbursement to small rural hospitals, resulting in greater financial stability for many of them. By 2009, more than 1,300 CAHs had been designated.

Now the Flex Coordinator's job involves bringing together many different people and organizations to work together to support the state Flex Program, as well as the state's CAHs and their communities. As one Flex staffer put it, "The role of Flex is to be a convener and liaison between local, state, and national rural health groups, all the while maintaining a neutral position." The job duties are broad and far-reaching. There are no step-by-step prescriptions for the work. However, Flex coordinators currently focus on:

- Supporting quality and financial improvement initiatives
- Supporting health system development and community engagement
- Integrating and supporting EMS
- Developing resource networks and cultivating partnerships
- Educating staff and providers in rural hospitals
- Helping to bring needed health care providers to rural areas
- Fostering the integration of services to improve continuity of care and avoid duplication
- Supporting the adoption of HIT

The advantage—and the chief difficulty—of a Flex Coordinator's job is the flexibility of the assignment. Each Flex Coordinator's job is to identify the strengths and challenges faced by their state's rural health care providers and to set goals to build state and local capacity. However, the methods used will almost inevitably vary by state and region.

Some Flex Programs have up to 16 people on staff, while others are limited to a single person. Some Flex Coordinators have been on the job for many years, while others have only just begun. Flex Programs are located at universities, state departments of health, or private, non-profit organizations and some contractually delegate the work to networks, hospital associations, or consultants.

FORMING COMMUNITY PARTNERSHIPS

Why are community partnerships important to rural health care?

Community involvement leads to more-informed citizens and greater community support for local health care providers. Partnerships formed with organizations and individuals in the local community, as well as partnerships between communities and health care providers, are essential to the success of rural hospitals.

Examples of Flex activities to encourage community partnerships

- Community economic impact assessments
- Community health needs assessments
- Community health planning
- Community wellness initiatives

There are at least three benefits to these activities. One, the community gains information about its health status and health needs. Two, Flex Coordinators demonstrate a commitment and interest in the community's health. And three, Flex Coordinators begin developing relationships and trust, which are essential to the success of a Flex Program.

Best practices in forming community partnerships

- Spend time getting to know leaders at both the state and local levels. Face-to-face meetings are imperative.
- Consider joining committees within the state that will provide useful contacts.
- Explore the possibility of integrating Flex Program funding with other sources to support program activities such as the ORHP Small Rural Hospital Improvement Grant Program (SHIP), the Rural Health Network Development Planning Grant, and state and private foundation funding.
- Consider helping to link CAHs with schools, public health agencies, and economic development sectors, which will help build community infrastructure and community support.
- Communicate constantly. Set up communication tools, such as an electronic newsletter, host conference calls or webinars on a regular basis, and utilize other online teaching tools for education and group alignment.

- Conduct follow-up surveys and phone calls rating the success of the communication tools, and pay attention to feedback and recommended changes.
- If you try something that doesn't work, admit it up front, seek feedback, and try something else based upon that feedback.

"It takes time to build partnerships. Create opportunities for partnerships to grow. Often, you have to take the lead and do the work because partners may not be as committed as you are. Admit when you don't know, ask questions for clarification, and be receptive to feedback. ***Partnerships are keys to success.*** *Go to the table willing to share and learn."*

Community partnership success story

Community partnerships aid CAH infrastructure

The Idaho Flex Program has established local community partnerships between the CAH, residency program, and University to aid in the recruitment and retention of physicians in the CAH setting. Idaho's Flex Coordinator partnered CAH residency programs with universities to develop and implement a tool (the Community Apgar Questionnaire) to identify community-specific strengths and challenges related to the recruitment and retention of family physicians. Although this program is in the early implementation stage, the project has been extremely well received. (For more information, visit www.healthandwelfare.idaho.gov)

BUILDING HEALTH NETWORKS

Why are networks useful in rural health care?

Networks are an important tool for saving money and expanding access to resources such as medical information, telecommunications, and emergency services. Networks build purchasing power and provide greater access to education. They also can provide a critical mass for increasing leverage with vendors and suppliers. Networks are most successful when they provide obvious value for their members.

One method Flex Coordinators use to work with health care leaders is to take advantage of networks and other cooperative working relationships. Some state programs even require every CAH in their state to participate in some type of health care network.

Types of networks

The classification of a network determines the type of goals and scope of partnership. Networks are often classified as either vertical or horizontal, depending upon the types of members that are involved. Vertical networks are generally made up of organizational members of different types and sizes. An example of a vertical network would be CAHs, a large tertiary care center, several clinics, and one or two long-term care facilities. Horizontal networks, on the other hand, are made up of organizations of a similar type and size.

A classic example of the horizontal model is a network made up of multiple CAHs, such as the Illinois Critical Access Hospital Network, which consists of more than fifty members. Networks can be formally incorporated or unincorporated, community based or business oriented, large or small. Configurations and purposes vary widely. In essence, networks are a tool to cooperatively address a rural health challenge. They require resources, time to grow, and strong leadership in order to be successful.

Examples of Flex activities that benefit from network structures

- Patient transfer agreements between facilities
- Quality or performance improvement initiatives
- Health information technology applications
- Referral arrangements
- Specialty service agreements
- Communication of information
- Education and resource sharing
- Peer support meetings

Best practices in building health networks

- Look for partnerships that already exist. For example, there may be a number of rural hospital networks already operating in your state. Maximize resources and avoid duplication by enhancing these network relationships rather than reinventing them.
- Seek help from rural liaisons that represent health systems in your state. They can be a helpful resource.

> *"Be proactive: Don't wait, ask questions, form relationships as soon as you begin. Take the time to get out into your state and talk with others—a lot! Go to regional and national meetings to learn and meet others."*

- As a Flex Coordinator, play the role of introducing neighbors and shining the spotlight on common goals. Don't assume local service providers are aware of each other or know how to work together.
- Consider forming a Flex Program advisory council consisting of representatives from CAHs, clinical care, public health, educational institutions, EMS associations, and so on. A diverse cross section of members will provide meaningful input about community needs and will advance members' understanding of rural health matters.
- It takes time to build trust, so look for easy wins and first steps, and try to articulate a larger vision. Forcing your ideas on participants won't work; they'll need ownership and buy-in as well as clearly articulated reasons for networking.
- When you bring participants together, allow them time to identify their problems and work out cooperative solutions. This encourages them to rally to the cause at hand and act as a team.
- Consider using an experienced, neutral facilitator who can help participants find common ground.
- Identify and then support network leaders. Leadership has been identified in several research studies as the most critical variable for network success.
- Use teleconferencing media when possible to save on travel expenses and encourage broad participation.

- Encourage networks to be ready to respond quickly when funding becomes available. Keep them informed of potential funding opportunities.
- Consider setting aside Flex funding each year to finance network-related initiatives for CAHs. This will encourage CAHs to see networks as a problem-solving tool.

Network success stories

Build CAH shared expertise
The Illinois Flex Program has developed the Illinois Critical Access Hospital Network with more than 50 CAH members. The purpose of the network is to build CAH-shared expertise and education on the topics of nursing, pharmacy, business office tasks, finances, HIT, and quality through a variety of communication tools and educational workshops.

Network member hospitals also use a free online quality-improvement scorecard application. They share data to determine best practices to improve patient care quality and services. (For more information, visit www.icahn.org.)

Encourage horizontal and vertical networks
To build strong community health networks, the Pennsylvania Flex Program encourages both horizontal and vertical integration of networks. The Pennsylvania State Rural Health Plan encourages regionalization of services in order to:

- Improve health information technology use in CAHs and their communities
- Improve continuity of patient care and services
- Assist with community health improvement activities

By using vertical and horizontal networks, the Pennsylvania program is able to bring together both different- and same-size organizations to accomplish Flex Program goals and leverage resources. (For more information, visit www.porh.psu.edu.)

STRENGTHENING CAH FINANCIAL CAPACITY

How can Flex Coordinators strengthen CAH financial capacity?

With the majority of eligible facilities now designated as CAHs, Flex Coordinators can provide education and tools to help CAHs improve their business practices and performance to strengthen financial capacity. An emphasis on linking quality to improved financials will prove especially beneficial for the challenges CAHs face with adopting HIT and coping with the economic recession.

Examples of Flex activities to support financial health

- Financial analyses
- Charge master reviews
- Cost report reviews
- Workshops on coding and billing for CAH chief financial officers and their billing staff

Best practices in strengthening CAH financial capacity

- Consider promoting a framework in the CAH environment that connects behavior, quality, and performance improvement to improved financial outcomes, such as Balanced Scorecard, Studer, Lean Management, and Baldrige Criteria frameworks.
- Develop a basic understanding of CAH finances and reimbursement. Flex Coordinators do not have to be experts, but it's important to understand and articulate the major concepts.
- Educate CAH leaders about appropriate financial performance analysis tools and systems. Contact TASC for assistance in this area, or possibly turn to a trusted accounting source.
- Encourage CAHs to utilize the Flex Monitoring Team's financial reporting and analysis procedures available at www.shepscenter.unc.edu/cah/.
- Offer technical assistance in business and financial performance to CAHs, and identify practices that may hinder the financial stability of CAHs.

"Never assume you understand the needs of CAH leaders until you have worked closely with them."

CAH financial capacity success story

Utilize online trainings
Hometown Health University (HTHU), offered by the Georgia Flex Program, provides an interactive, user-friendly training, certification, and education program. The program operates a variety of online platforms for hospital financial employees. HTHU does a successful job of training hospitals to identify the link between behavior, quality, and performance improvement to the "bottom line."

HTHU topics include patient financial services; management and leadership skills; clinical staff compliance (including JCAHO compliance); and materials and practice management. The program is open to the public and can easily be used by other states. (For more information, visit www.hthu.net.)

IMPROVING THE QUALITY OF PATIENT CARE

Why is improving quality of care important?

Patient safety initiatives and comprehensive quality improvement programs can save lives and prevent patient suffering due to medical errors. Improved quality of care may also reduce costs. Improving health care quality is one of the Flex Program's most important goals. More Flex funding has been spent in this area than in any other.

Examples of Flex activities to support quality of patient care

- Hospital Compare reports
- Performance improvement education
- Peer reviews at CAHs
- Multiple hospital quality projects

Best practices for improving the quality of patient care

- Make use of technical assistance and consultant services available through contracts with your state Quality Improvement Organization (QIO).
- Connect with the local hospital association or state QIO to find others who understand and support the need for rural health care quality.

"Involve CAH quality leaders in program development; don't assume you understand their needs."

- Learn about hospital quality-improvement efforts that are already in use and have track records, such as the Institute for Healthcare Improvement's 5 Million Lives Campaign or the Centers for Disease Control (CDC) Infection Control campaign.
- Promote CAH quality reporting to national databases, such as Hospital Compare.
- Provide public recognition for CAH accomplishments in quality reporting and quality measurement through newsletters, web site stories, press releases, and quality awards.
- If you ask for quality data reporting, keep your requests to a minimum, since CAHs must respond to multiple quality-reporting initiatives.

"Make an effort to learn about best practices in other states before reinventing the wheel."

- Convene CAH quality coordinators to share information, learn from one another, and join a state quality network.
- Set up Performance Improvement (PI) workshops on topics such as board and senior leadership education, quality process improvement, and staff management. PI education and support can positively affect quality outcomes.
- Keep track of progress. If you don't document quality improvement, it didn't occur.

Quality of patient care success story

Create a Quality Network
Colorado has a statewide CAH Quality Network, thanks to the combined efforts of its Rural Health Center and CAH quality directors. Members gather to share information, network, and set and meet objectives. They publicly acknowledge quality-performance results and promote successful quality-improvement methods. As a result of this network, all CAHs have:

- Participated in infection reporting
- Standardized wristband and code-call programs
- Participated in a statewide 5 Million Lives Campaign (a national effort to provide safe care for each patient by instituting six quality-improvement practices within hospitals)
- Increased the number of CAHs reporting Medicare quality measures

These efforts are due in part to on-site quality and performance improvement programs at individual hospitals, facilitated by state Flex Program staff and support from Colorado's QIO. (For more information, visit www.coruralhealth.org.)

ADOPTING HEALTH INFORMATION TECHNOLOGY (HIT)

What are the challenges of adopting HIT?

HIT is becoming an essential part of health care operations. Cost savings, quality performance, and patient satisfaction are all improved by the use of HIT. Incentives and penalties for the adoption and implementation of HIT have been tied to requirements for "meaningful use" of electronic health records. However, HIT is a relatively new aspect of hospital management in rural areas.

Adopting HIT is a big challenge for the following reasons:

- It calls for technical expertise
- It tests an organization's workflow processes
- It tests an organization's ability to handle change
- It calls for up-front capital, which, despite federal financial incentives, may not be available to CAHs and other rural hospitals.

Given these challenges, networks and partnerships are crucial to HIT success, as a way to combine manpower and dollars. Flex Coordinators' connections at state and local levels are also important.

HIT Regional Extension Centers, which are currently being identified by the U.S. Department of Health and Human Services' Office of the National Coordinator for Health Information Technology, will offer resources and technical assistance. (For more information, visit http://healthit.hhs.gov/portal/server.pt?open=512&objID=1335&mode=2&cached=true)

Examples of Flex activities to support HIT

Flex Coordinators may help CAHs implement HIT with these steps:

- CAH readiness assessment for HIT
- HIT implementation and adoption road maps
- HIT strategic planning
- Work flow analysis
- Network development for shared funding and purchasing
- Co-op models for sharing HIT workforce

Best practices for adopting HIT

- Encourage HIT networking among CAHs to enable access to shared expertise, negotiate discounts, and improve efficiency.
- Raise awareness of HIT value through webinars and other forms of education for CAH leaders and staff. For example, educate them about incentives and reimbursement opportunities linking HIT and quality. Include both local and national perspectives on HIT adoption.
- Offer a presentation on the link between HIT, quality performance, and financial health. (For example, electronic health records enable accurate prescription dosage, possibly lowering operating costs, bringing about a positive medical outcome, and resulting in a satisfied and loyal patient.)

"Make sure CAH needs drive your program development process. This is best accomplished by conducting a statewide needs assessment survey. Be aware that HIT needs and statuses change often, so be flexible and driven toward progress."

- Use available funds to hire a consultant with experience in rural HIT to conduct readiness assessments or to help with HIT strategic planning.
- Make sure HIT models are affordable and reflective of the size and scope of services offered at CAHs.
- Partner with local schools and colleges to promote rural HIT as a career choice.
- Participate with other HIT initiatives in your state to make sure rural is represented.
- Identify sources of reliable HIT technical assistance, including HIT Regional Extension Centers, consultants, and universities.
- Encourage broadband access for every CAH. With broadband speed, HIT is much more appealing as a tool and more likely to be utilized.

HIT adoption success stories

Offer different kinds of support
The Arizona Flex Program has offered support at several different points on the HIT spectrum: readiness assessments, work flow analyses, and start-up funding for CAHs willing to implement electronic health record systems. Arizona has worked with pharmacists in four CAHs to implement a medication reconciliation project. (For more information, visit http://www.azflexprogram.com/.)

Minimize Flex administrative work
HIT networks can minimize administrative time for the Flex Program while helping to enhance HIT adoption and use. In Idaho, a network disburses funding for CAHs to support IT staff education and develop regional plans for connectivity and data sharing between hospitals. Experienced network directors who are reliable and accountable can facilitate projects that are straightforward and easy to administer. (For more information, visit http://healthandwelfare.idaho.gov/Health/RuralHealthandPrimaryCare/CriticalAccessHospitalsandFlexProgram/tabid/407/Default.aspx.)

Identify CAH readiness
The North Dakota Flex Program developed a CAH-specific "Electronic Medical Record (EMR) Get Ready" initiative offering customized readiness assessments with an appropriate EMR road map for each facility. Each participating facility received technical assistance via teleconference with a consultant team and attended a daylong HIT workshop. A summary report of this initiative will be used to guide other CAHs, networks, state legislators, and the state HIT director to assist statewide efforts in moving toward the development of Health Information Exchange (HIE). (For more information, visit http://ruralhealth.und.edu/projects/flex/.)

IMPROVING & INTEGRATING EMERGENCY MEDICAL SERVICES (EMS)

What are the challenges faced by rural EMS?

Rural EMS, vital to the safety and health of rural citizens, faces several challenges that Flex Program staff must be aware of:

- Recruitment and retention of rural staff. The work is difficult, the hours are long, and the pay is often low. It's not unusual for Emergency Medical Technicians to serve on a volunteer basis, making it harder to implement staff planning and quality-performance measures.
- Although rural EMS leaders tend to be passionate about the services they provide, leaders tend to lack essential financial and business management skills.
- EMS and hospital staff can have difficulty communicating, adversely affecting quality of patient care.
- Rural hospitals lacking trauma designation may not have access to patients (and related income) delivered by ambulance services.

Flex activities to support EMS

- Leadership training
- Quality-improvement initiatives
- Recruitment and retention tools
- Business management training courses

Best practices for improving and integrating EMS

- Learn EMS terms, designations, and criteria.
- Work to implement accessible, cost-effective continuing education and evaluative measures for rural EMS agencies and emergency department directors. Remember that Flex funding is often available for education and evaluation.
- Conduct online workshops that focus on topics such as the roles and responsibilities of EMS medical directors or basic business skills in EMS.

"Medical directors are key links between EMS and CAHs."

"EMTs and paramedics are typically not trained in business management, so one Flex coordinator is conducting a train-the-trainer program on management and medical director training "

- Translate regional or national hot topics in EMS into local action.
- Explore state departments of health's EMS division, which can be a helpful resource and a useful partner in meeting the EMS needs of rural citizens.
- Collaborate with the state department or public health to help CAHs obtain and maintain trauma designation.

EMS success stories

Partner with public health
The Colorado Flex Program has created collaborative partnerships with EMS agencies, provided resources and training to EMS medical directors, and supported and funded statewide Emergency Medical Technician recruitment and retention.

Colorado reports, "Our partnership with the state department of public health has been key; it's enabled us to participate as a contractor in our state's hospital preparedness programs and assist with distributing supplies, equipment, and training to EMS agencies and hospitals. We've been able to strengthen our presence in the EMS community and have a significant impact on quality of care and patient safety in emergency services." (For more information, visit www.coruralhealth.org.)

Be a driving force for change
Similarly, the Kansas Rural Health Options Project (KRHOP) has conducted statewide EMS planning, trauma trainings, medical director trainings, and community assessments. The integration of public health, primary care, and EMS, particularly in rural and remote environments, is the most effective way to ensure access to critical health care services.

KRHOP strives to integrate physicians into all aspects of the EMS system, such as dispatch protocols development, quality and performance improvement, and education and training. As a result, KRHOP has developed credibility among the state's EMS community and is seen as a driving force for change. (For more information, visit http://www.krhop.net/.)

CONCLUSION: THE ESSENTIALS

No matter which state Flex Program you are a part of, there are four essentials to your work: education, communication, partnerships, and evaluation. Whether you are addressing HIT or EMS, quality of care or finance, you'll want to keep the following elements in mind.

Education

- First, educate yourself—about your state's health care concerns, about the basics of health care issues, about the key players in health care. And you need to do more than learn from books and sites. It's essential that you get out and meet people and get to know how they see their jobs and their problems.
- For all Flex Coordinators, there is no substitute for face-to-face interaction with CAH administrators and staff as a means to understanding a CAH's problems.
- Second, educate others about opportunities for improvement; about tools, resources, and skills; and about the Flex Program. As one Flex Coordinator said, "The Flex Program can be difficult to understand for people just learning about it." In addition to the information presented in this guidebook, you can find material about the program on TASC's Web site at http://www.ruralcenter.org/tasc.
- When seeking consulting services, Flex Coordinators recommend consultants who are already familiar with the Flex Program or with the challenges of rural health care in general. To make the most of consulting services, Flex Coordinators suggest finding a consultant whose methodology meets the appropriate intervention.
- For instance, "process" consultants specialize in facilitating groups to deal with issues involving processes and group dynamics rather than tasks. This methodology works well for people who are aware of their needs and are open to learning new skills or changing behaviors.
- "Expert" consultants offer specialized skills and advice that a group has been previously unaware of and typically do not address group dynamics or skill development. Some Flex Coordinators find that it can be more cost-effective to help people learn the skills they need than to pay repeatedly for expert advice.

- Finally, you'll want to be aware of the many resources available to support rural health care improvement, from funding sources to consultants to technical assistance centers and associations.

Communication

- Ongoing communication is another essential aspect of your work. Web sites, newsletters, e-news, press releases, and even telephone calls and personal visits keep your Flex Program connected with all stakeholders. These methods can also be useful to keep stakeholders in touch with one another.

Partnerships

- Whether you are addressing HIT challenges or helping a CAH figure out how to measure quality performance, networks and partnerships are essential to improvement in rural health care.
- Partnerships encourage the sharing of resources and expertise, and networks make this possible on a long-term basis. This guidebook offers examples of ways to build these essential relationships. As one Flex Coordinator says, "Structure your program so that CAHs can learn to work together and learn from one another. Encourage creativity and innovation amongst partnerships."

Evaluation

- Evaluation and feedback help not only to determine what is going well (or not) but also to demonstrate that you are paying attention and giving weight to the concerns of health care groups in your state.
- Find ways to get regular feedback on your performance, such as with some phone calls or a survey. You might try using a Balanced Scorecard or Logic Model framework for evaluation.

Contacting other Flex Programs

A current list of Flex Coordinators and other Flex staff is available on the TASC Web site at http://www.ruralcenter.org/tasc/statecontact.php. Also, please explore the State Flex profiles that are posted on the TASC Web site at http://www.ruralcenter.org/tasc/profiles.php. These profiles not only contain contact information for Flex staff but also provide current activities, success stories, and significant achievements in each of the 45 State Flex Programs.

Flex Program participants included:

- Arizona Rural Hospital Flexibility Program, Flex Program Director, Alison Hughes
- Colorado Rural Health Center, Executive Director, Lou Ann Wilroy
- Georgia State Office of Rural Health, Director of Hospital Services, Patsy Whaley
- Idaho Office of Rural Health and Primary Care, Director, Mary Sheridan
- Illinois Critical Access Hospital Network, Executive Director, Pat Schou
- Kansas Department of Health and Environment, Office of Local and Rural Health, Director, Chris Tilden
- Pennsylvania Office of Rural Health, Critical Access Hospital Coordinator, Larry Baronner
- University of North Dakota Center for Rural Health, Program Director/Interim Co-Director, Marlene Miller
- University of Minnesota, Flex Monitoring Team, Ira Moscovice
- University of North Carolina at Chapel Hill, Flex Monitoring Team, Mark Holmes
- University of Southern Maine, Flex Monitoring Team, Andy Coburn
- University of Southern Maine, Flex Monitoring Team, John Gale
- HRSA Office of Rural Health Policy, Director, Tom Morris
- HRSA Office of Rural Health Policy, Hospital State Division Director, Kristi Martinsen
- HRSA Office of Rural Health Policy, Flex Program Coordinator, Steve Hirsch
- HRSA Office of Rural Health Policy, Flex Program Project Officer, Jennifer Chang
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- National Rural Health Resource Center, Community Specialist, Kami Norland