

2016 Rural Provider Leadership Summit Report

Strategies for Rural Provider Engagement in Transitioning to Value-based Purchasing and Population Health

August 10, 2016



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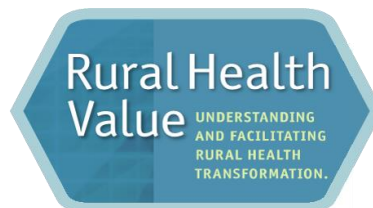
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PREFACE

With the support of the [Federal Office of Rural Health Policy \(FORHP\)](#), the [National Rural Health Resource Center \(The Center\)](#) developed this report to assist rural hospital leaders in engaging rural health providers in the transition to value-based purchasing and population health. This report is designed to help rural hospital leaders and providers during the transition. First, the report describes issues and opportunities related to engaging rural providers in value models. Second, it provides key strategies that rural hospitals may deploy to overcome challenges and engage providers in value-based models and enhance medical staff collaboration. Third, the report highlights success stories and lessons learned that were shared by the panelists during the summit. The report is also intended to assist state Medicare Rural Hospital Flexibility (Flex) Programs and State Offices of Rural Health (SORH) by offering timely information to develop tools and educational resources that support their hospitals and networks as they transition to population health.

The information presented in this paper is intended to provide the reader with general guidance. The materials do not constitute, and should not be treated as, professional advice regarding the use of any particular technique or the consequences associated with any technique. Every effort has been made to assure the accuracy of these materials. The Center and the authors do not assume responsibility for any individual's reliance upon the written or oral information provided in this guide. Readers and users should independently verify all statements made before applying them to a particular fact situation, and should independently determine the correctness of any particular planning technique before recommending the technique to a client or implementing it on a client's behalf.

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INTRODUCTION

The landscape of health care delivery and payment has been undergoing change at a rapid pace. In early 2015, the US Department of Health and Human Services (HHS) announced bold goals for moving payment of health care services to models based on quality and value. The goals aim for 90 percent of fee-for-service Medicare payments to be linked to value by 2018, and HHS has worked to develop a private public partnership with private payers, health plans and Medicaid programs to move in the same direction with payment connected to quality and population health.¹

Emerging payment models such as accountable care organizations (ACOs), patient centered medical homes (PCMH) and the new provider [Quality Payment Program \(QPP\)](#), place primary care providers at the center of reimbursement structures. Payment under these models is linked to the provision of lower cost and higher quality care. It is crucial for any health care organization to engage providers who are engaged in quality improvement and redesigning care delivery for efficiency and effectiveness.

Rural health care organizations, in particular critical access hospitals (CAHs), rural health clinics (RHCs) and federally qualified health centers (FQHCs) may be distinctly challenged by delivery and payment reform. The cost-based payment structures for these organizations, which have been so important to preserving access in many rural communities, do not align with the new fee-for-service based quality and value incentive programs. This misalignment of incentives, paired with tight resources, workforce challenges and communities that are often poorer, sicker and older, leaves rural health care organizations and the communities they serve at risk of being left behind.

Rural hospitals are facing unprecedented changes and challenges. More than 70 rural hospitals have closed since 2010², and another 600-plus are at risk of closure.³ Cuts to traditional Medicare and Medicaid reimbursement, increased reporting requirements related to quality, use of electronic records and new payment models that deemphasize inpatient care have rural challenged the financial viability of many rural hospitals.

During a time when rural provider input and leadership is critical to rural health system survival and success, there are increasingly high rates of frustration and burn-out among health care providers. *For purposes of the Summit and this*

¹ [CMS Fact Sheet on Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume.](#)

² [NC Rural Health Research Program: 76 Rural Hospital Closures: January 2010 – Present](#)

³ [Ivantage Health: Rural Hospital Closures Predicted to Escalate](#)

summary, 'provider' is defined as clinicians providing direct health care services - such as physicians, advance practice nurses, paramedics or physician assistants. Providers who are feeling effects of burn-out, including a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment⁴ are unlikely to be effective and engaged leaders. These factors have led to the concept of a 'quadruple' aim, where improving the work life of health care providers is aligned with the more traditional 'triple aim' focusing on quality, patient experience, and lower cost.⁵ When crafting and implementing strategies to engage rural providers, health care leaders need to be mindful of the stressors and challenges already in place, and aim to be part of the solution in improving work-life of care providers rather than adding an additional layer of requests and frustration.

PURPOSE AND PROCESS

As part of the 2016 work plan, the Technical Assistance and Services Center (TASC) for the Flex Program, a program of the National Rural Health Resource Center (The Center), hosted a Rural Provider Leadership Summit in Bloomington, Minnesota on May 23 – 24, 2016. The purpose of the Summit was to identify strategies for rural provider engagement in transitioning to value-based reimbursement systems.

The objectives for the two half-days of facilitated conversation focused on:

- Identifying issues and challenges related to engaging rural providers in value models
- Identifying and prioritizing strategies and actions rural hospitals can take for engaging rural providers in value and population health initiatives and enhancing medical staff collaboration
- Sharing examples of successful models and identifying resources to support implementation

⁴ Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med.* 2012;172(18):1377–1385.

⁵ Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med* 2014; 12:573–6. doi:10.1370/afm.1713

RURAL PROVIDER LEADERSHIP SUMMIT ATTENDEES

The Summit participants, included representatives of critical access hospitals, rural ACOs, physicians, state Flex Programs, SORHs, universities, quality and rural health network leaders. The panel also included representatives from FORHP, a rural foundation, emergency medical services and community paramedics. The 2016 Rural Provider Leadership Summit participants include the following field experts (Refer to Appendix A for contact information).

- John Barnas, Michigan Center for Rural Health
- Barbara Berner, University of Alaska Anchorage, School of Nursing
- Ray Christensen, MD, University of Minnesota Duluth, Gateway Family Health Clinic
- Morgan Fowler, Marcum & Wallace Memorial Hospital
- Kathy Johnson, Dynamic Advantage
- Paul Kleeberg, MD, Aledade
- Paul Krause, MD, Caravan Health/National Rural Accountable Care Organization (ACO)
- Leslie Marsh, Lexington Regional Medical Center
- Joe Mattern, MD, Washington Rural Health Collaborative, Jefferson Healthcare
- Mike McNeely, Health Resources and Services Administration, Federal Office of Rural Health Policy
- Melinda Merrell, South Carolina Office of Rural Health
- Toniann Richard, Health Care Collaborative of Rural Missouri
- Maggie Sauer, Foundation for Health Leadership and Innovation
- Karla Weng, Stratis Health
- Gary Wingrove, Mayo Clinic Medical Transport

Summit Facilitators

- Sally Buck, The Center
- Tracy Morton, The Center
- Kami Norland, The Center

FRAMEWORKS TO SUPPORT RURAL PROVIDER LEADERSHIP

To help set the stage for the discussion, Summit participants reviewed two frameworks related to identification and implementation of strategies:

- 1) The [Performance Excellence Blueprint](#), a system-based approach modeled after the Baldrige Framework for Performance Excellence
- 2) A resource from Rural Health Value: "[Physician Engagement – A Primer for Healthcare Leaders](#)"

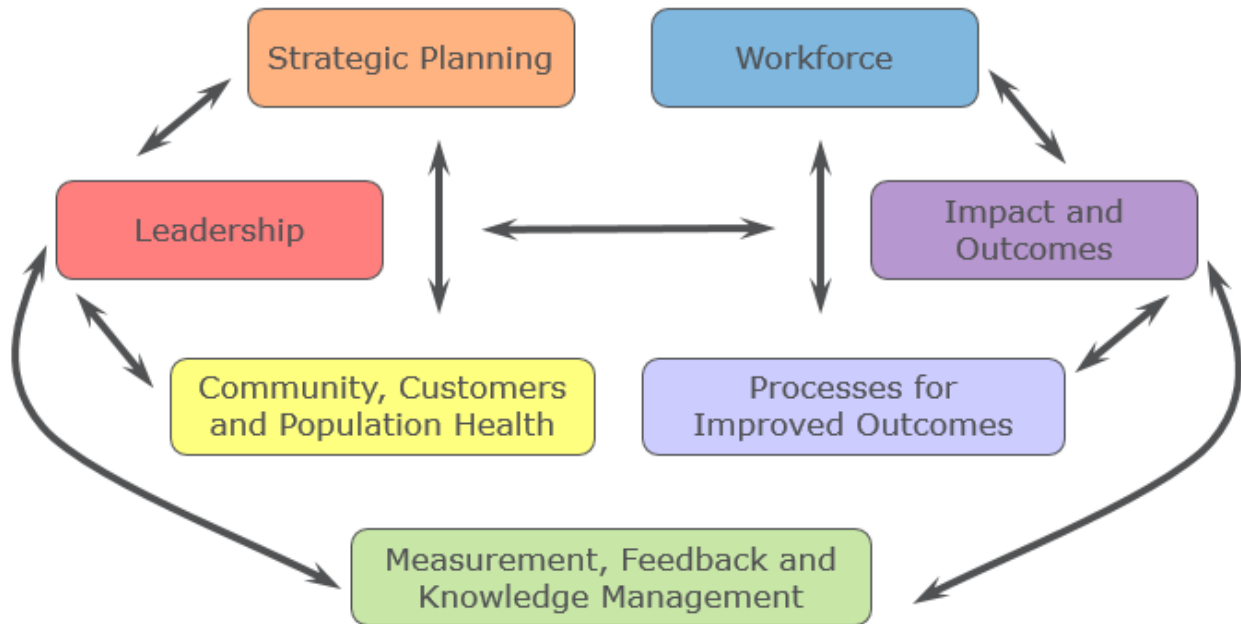
The Center has long encouraged adoption of a systems-based approach modeled after the Baldrige Framework for Performance Excellence in managing hospital complexities and striving towards excellence in quality and safety. The [Performance Excellence \(PE\) Blueprint](#) provides a proven approach towards managing the crucial elements of organizational excellence desperately needed in this rapidly changing health care environment. This comprehensive approach, which includes the ability to measure and show value, can also help hospitals frame the essential components of provider engagement. The PE Blueprint outlines seven key areas for rural providers to consider when developing a strategic plan for provider engagement. The seven categories include the following.

- Leadership
- Strategic planning
- Community, customers and population health
- Workforce
- Impact and outcomes
- Processes for improved
- Measurement, feedback and knowledge management

The seven categories in the Blueprint are not separate, but rather are interdependent. Figure 1 demonstrates the key inter-linked components of the PE Blueprint and how the seven components are intertwined to impact the quality of care, financial performance and overall operations.

Figure 1.

Performance Excellence Blueprint



Modified from [Baldrige Framework](#)

The PE Blueprint enables organizations to measure predicted outcomes. Results in all seven categories are measured regularly, and the information is fed back to hospital leaders for ongoing improvement. Generally rural hospitals are not short of information; rather they have so much information they often struggle to sort the important strategic information from the less important.

The [Physician Engagement Primer](#), developed by Dr. Clint MacKinney, part of the [Rural Health Value](#) team at the RURPI (Rural Policy Research Institute) Center for Rural Health Policy Analysis, identifies key categories of organizational culture related to physician engagement: governance, education, compensation and use of data. The primer also identifies specific tactics leaders of health care organizations should consider to improve physician engagement including development of a shared vision, nurturing of physician leaders, identifying effective communication strategies and structuring meetings and discussions to promote active physician involvement.

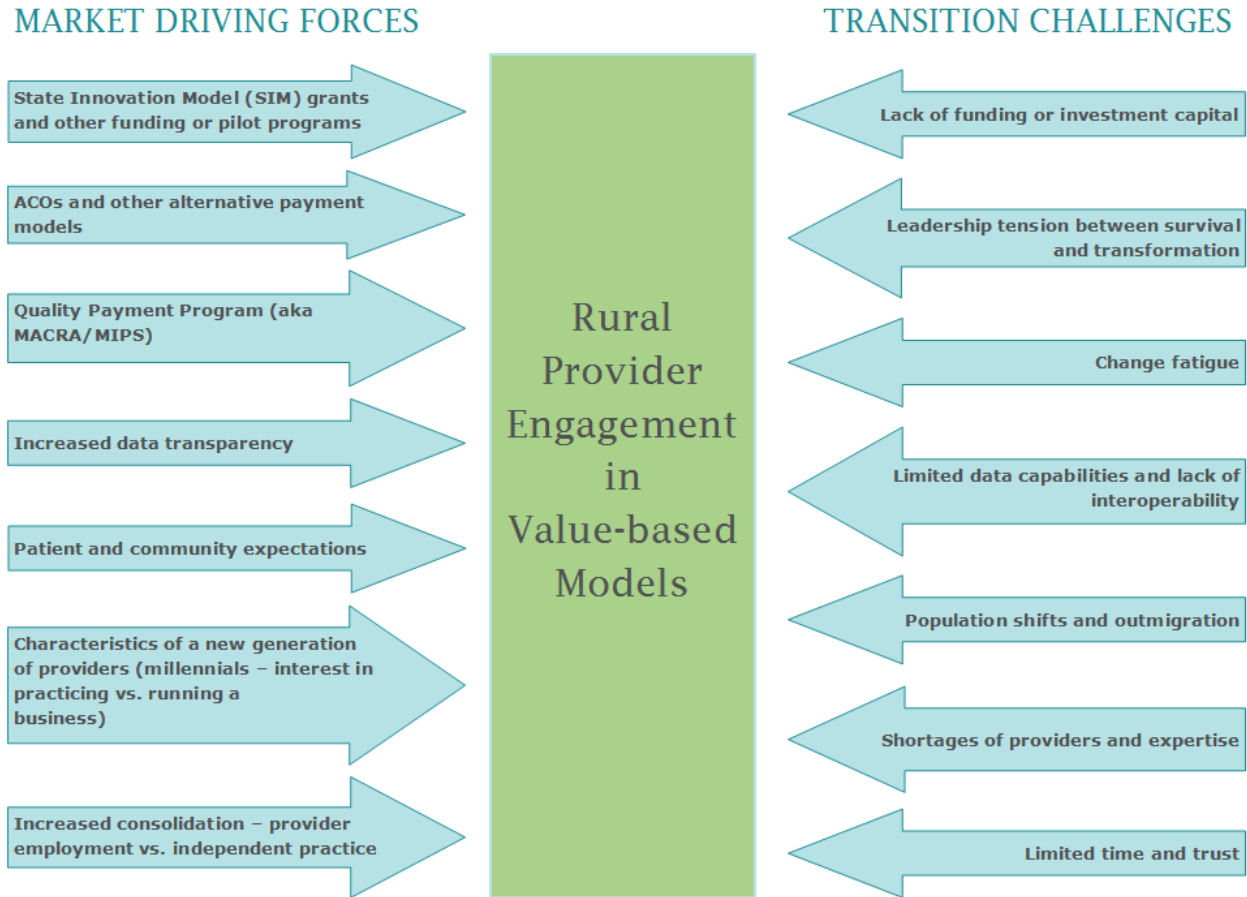
Throughout the Summit discussion, participants paused and referenced these two frameworks as a touchpoint to help ensure key areas had not been overlooked.

MARKET DRIVING FORCES AND TRANSITION CHALLENGES

As rural hospitals move into value-based models and begin developing population health strategies, there are a number of events that have happened recently that impact the transition for rural hospitals at the same time that unique challenges exist for small, rural facilities. To help frame the discussion, Summit participants began by reviewing the driving forces and challenges related to engaging rural providers in the value-based models. Although each rural hospital and community has its own unique combination of opportunities and challenges, the figure below summarizes the common themes identified for provider engagement (Figure 2).

Figure 2

Market Driving Forces and Transition Challenges



RURAL PROVIDER ENGAGEMENT STRATEGIES TO TRANSITION TO VALUE

Summit participants brainstormed, grouped and prioritized a wide variety of strategies to help guide rural providers in understanding the movement to value. The top five strategies, in priority order, follow:

1. Create a shared vision of value and understand the role of providers in the transition

Hospital leaders need to be willing to invest time and resources to help provide education on the changing health care environment, and facilitate discussions that lead toward a shared vision of value: improve health, smarter spending and better care. Providers, particularly, primary care physicians, need to be a key part of the discussion from the start as they will be the drivers and conveners of care in this transition towards value.

“This is something that has to start and grow - it’s not going to happen overnight. We all have to own it.”

It is recommended for providers of all types to communicate challenges, strengths and opportunities with hospital administration to work together for success in this changing environment.

2. Examine various models and approaches towards value

Hospital leaders should actively seek funding opportunities and resources to support development and implementation of value-based strategies and engage providers in determining the most feasible model to address the unique needs of their community. The Center for Medicare and Medicaid Innovation (CMMI) supported programs such as the [ACO Investment Model \(AIM\)](#), and in many parts of the country [State Innovation Model \(SIM\)](#) implementation provide low-risk funding as a learning ground to test strategies and programs. Other opportunities may include local foundations, health plans, [HRSA – FORHP funding](#) (Health Resources and Services Administration Federal Office of Rural Health Policy) and [Grants.gov](#). [The Rural Health Information Hub](#) (RHIhub) is an excellent source for identification of funding opportunities, ideas and information to support development of funding applications. Hospital leaders may also want to encourage providers to participate in technical assistance programs available such as the [Transforming Clinical Practice Initiative](#) through joining a Practice Transformation Network or the [Comprehensive Primary Care Plus](#) model. Participating in educational webinars, conferences and networking

opportunities with other organizations and associations to glean best practice examples may also be advantageous.

3. Invest in provider leadership (time, money and education)

Investment in provider leadership goes beyond financial reimbursement. Every practice has a thought leader(s); work to identify their interests and passions and identify ways to develop and align those pursuits with a shared vision of value.

“An employed physician does not equal an engaged physician”

For example, supporting attendance at conferences that focus on the changing health care environment, fostering development of skills related to team-based care and providing opportunities to network with other provider leaders are all means to investing in provider engagement that go above and beyond paying for their time. Hospital leaders will be well served by investing time in developing trusting relationships with providers, listening to and acting on needs, challenges and suggestions when appropriate, and supporting meaningful opportunities for participation in hospital governance.

4. Partner with others to capture and share data

Several Summit participants shared stories relating to the critical role of capturing and sharing data to engage providers. Access to claims data that providers gain when joining an ACO has been cited as eye-opening, since it provides a fuller picture of the scope and costs of services their patients receive.

“You have to share data shamelessly with everyone - even the public”

“Data provides the platform for the discussions on how to improve care”

Data can provide the platform for discussions on how to improve care and lower costs, but for that to happen it needs to be shared frequently and broadly, not just with providers, but with all staff that provide patient care. Data should be shared as appropriate with other community providers

including aging services, behavioral health, emergency medical services, public health and social services. Key data for rural hospital to collect include, but are not limited to: Medicare Beneficiary Quality Improvement Program (patient safety, patient engagement, care transitions, outpatient care), Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), meaningful use of electronic health records, key financial performance indicators, emergency medical needs, community health status and needs. Fostering trusting relationships by sharing data can also support improved communication and transitions of care processes across community care team members.

5. Develop collaborative relationships and connect community resources to address patient needs

There is growing recognition that many of the factors that impact illness and health care spending are outside of the scope of traditional health care. Mental and behavioral health needs, socio-economic factors and an individual's habits and behaviors all have significant impact on a patient's well-being and their ability to improve health or manage chronic illness. A key component of value-based payment models is evaluation metrics that measure the health of a population, thus it is becoming even more critical to provide support and opportunities for providers to help address socio-economic factors and lifestyle that negatively impact population health. Strategies that include development of relationships and processes to easily connect patients to community resources such as behavioral and/or social service programs can not only help improve care for patients – but can also help engage providers by allowing them a means to help address the non-medical challenges that impact patient health and outcomes.

“You have to listen to what people have to say – what are their concerns, what are their ideas?”

In addition to the top five strategies prioritized above, Summit participants identified the following strategies (not prioritized) that may further support provider engagement efforts:

6. Redesign operational processes for value and population health

A focus on improving efficiency and effectiveness in hospital processes can set the stage for implementation of strategies that expand to include a focus on value and improving community health. For example, use of [Lean](#)

[methods](#) can help eliminate waste, improve productivity and patient care. Improvement teams that engage providers in a focus on quality and patient safety can build capacity for success in new payment models, which typically include a component related to performance on quality metrics.

7. Develop skills and organizational capacity for team-based care

Defining roles and distributing tasks across team members to reflect skills, abilities and credentials can increase the ability of providers to improve care, and can help reduce provider stress and frustration. In the [Implementation Guide for developing Continuous and Team-Based Healing Relationships](#), the Safety Net Medical Home Initiative highlights the need to establish organizational support for care delivery teams accountable for the patient population as a critical step of transforming care. Patient needs are often best met by a team of health care professionals working together to address the medical and behavioral health needs of patients while addressing socio-economic issues that may exacerbate health issues. Patients also should be supported in helping to manage their own chronic illnesses and stress levels which have a major impact on patient outcomes.

8. Seek opportunities for collaboration and synergy with other providers and organizations

Identify and participate in rural networks, membership organizations or other affiliations that offer opportunities to interact with other professionals facing similar challenges. Networks and affiliations can provide opportunities to share resources and implement strategies that may not be feasible by an individual organization, and can help aggregate patients, and address technology or support needs for participating in alternative payment models.

“We need to get to ‘*our patient*’ not ‘*my patient*’.”

Nearly all the success stories shared by participants during the Summit included some aspect of banding together to help support leadership and improve health care access and value. This may include bringing together providers across multiple organizations and/or communities to discuss strategies and challenges. Providers who coordinate, communicate and network effectively with one another demonstrate greater strength and vitality within their rural organization and community as new insights are gleaned, evidenced-based strategies are discussed or purchasing power is combined.

9. Tell your story

Open sharing of successes and challenges can support engagement at a provider and community level, as well as encourage and inspire other rural hospitals and providers and help influence policy and rulemaking. Seek opportunities to regularly share information about your organization's value related activities with providers, local media, community groups and at local, state and national conferences.

10. Advocate for rural payment policies that adequately address rural community needs

Policies and regulations that impact care delivery and reimbursement are undergoing significant change as federal and state programs shift to value-based models. Ask providers for their input, and help be a voice for their thoughts and concerns. Get to know your local legislators and congressional representatives, invite them to your facility to see and hear about the impact their policy decisions can have.

“Where are the cinders that you blow on to make the fire happen?”

It is critical for rural voices to be advocating for policies that make sense, and submitting formal comments about the impact of new regulations on rural health care organizations. Participation in advocacy organizations such as national and state associations or professional organizations such as state hospital or provider associations can be avenues to provide input into healthcare policies and regulations. FORHP is also charged with advising other HHS Agencies in regards to the impact of policy and regulations on rural providers and communities. FORHP keeps a [current list of rural related policy announcements](#), with weekly updates.

RURAL EXAMPLES OF TRANSITION TO VALUE

Success Stories and Lessons Learned Shared by Summit Panelists

Create and promote a shared vision toward value

Health Care Collaborative (HCC) of Rural Missouri, a network of Federally Qualified Health Clinics (FQHCs) has served as a platform for discussion regarding what is best for the health of their local community, and a structure for collective action to

address needs. Although competition still exists, the network has allowed local hospitals leaders a forum for exploring opportunities to increase value, without having to shoulder all of the risk. For example, recognizing a lack of capacity to serve behavioral health needs, the HCC Network was able to hire a psychiatrist and lease services back to the local hospitals in addition to increasing access at the FQHC clinic sites - something none of the organizations would have been able to do on their own.

Invest in Provider Leadership

Caravan Health (formerly the National Rural ACO) works with more than 14,000 rural providers. A medical director has been selected for each of their 23 ACOs. At a recent event focused on provider leadership across the organization, instead of scheduling formal educational sessions, they brought them together with no formal agenda, but rather had in-person discussions focused on the topics they wanted to address – fears, obstacles, and successes. Just getting leaders together can be an effective means of empowerment and providing education.

Seek out and take advantage of opportunities that offer funding to support transformation

The Michigan Center for Rural Health, which provides leadership for two Medicare ACOs in rural Michigan, cites the [AIM funding](#) (ACO Investment Model) from CMS as transformational for the 17 communities involved. One of the most rewarding aspects has been seeing people begin to think differently about how they deliver care. Many recognized the need for change, but needed a push to get them started. Taking advantage of the AIM opportunity has been viewed like a ‘scholarship’ to support learning how to operate in the value-based models that are coming.

Capture and share data

Aledade uses ACO data from CMS with their affiliated practices to better understand where patients are seeking care, what patients are at highest risk, prioritization for chronic care management, and understanding costs. Access to the CMS data gives providers and opportunity to get a handle around what is valuable – or not. For example, in West Virginia Aledade used the CMS ACO data to profile cost and quality of different cardiology groups, and provided that information to their primary care providers. Rather than tell physicians which cardiology groups to use – they gave them information that wasn’t previously available to help them make their decisions about referrals.

Develop relationships and connect community resources to address patient needs

Like many Critical Access Hospitals, Jefferson Healthcare in Port Townsend Washington, was challenged with access to mental health services in their rural community. Primary care and mental health services were in silos, and the local community mental health agency had struggled with frequent staff and leadership turnover. Nearly two years ago, hospital leadership approached the board of the mental health agency and asked to be involved in the selection process of the new Executive Director, sending a message of partnership, leadership support, and potential financial resources through possible shared services. They have since hired a shared psychiatrist position, and have worked towards integration of services and the ability to fast track patient identified at highest risk into appropriate services. The partnership has been so successful they are currently recruiting for a second shared provider.

RURAL PROVIDER LEADERSHIP: TOOLS AND RESOURCES

At the end of the Summit, participants considered the provider engagement strategies for rural hospitals in the transition to value and identified existing and future resources for rural hospitals to deploy to support the implementation of these strategies. The broad list of resources identified by participants is included in Appendix B. A number of federally supported programs, technical assistance programs and tools were identified that are responding to the transition to value and relate to provider engagement. In addition a variety of associations and training programs were recommended. Finally, the participants discussed recommended resources to provide better support to rural hospitals. These recommended resources could be supported or created by state Flex programs, State Offices of Rural Health, rural health networks, technical assistance providers, policy makers and funding agencies to provide better support to rural hospitals.

CONCLUSION

Rural health providers, particularly those in primary care will be at the heart of the new value-based purchasing and population health management systems. Summit panelists identified key strategies to help critical access hospitals, health networks and Flex programs focus their efforts on provider engagement and help lead their communities towards improved health, better health care and smarter spending.

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APPENDIX B: RURAL PROVIDER LEADERSHIP TOOLS AND RESOURCES

Existing Resources

The following are suggested resources from the participants that are currently available to support rural hospitals in implementing the key strategies in provider engagement. The list includes federally supported tools and resources.

- [Agency for Healthcare Research and Quality](#) – quality measurement tools and resources for health care providers professionals
- [American Academy of Family Physicians](#)
- [American Hospital Association](#) – education forum
- [Baldridge Performance Excellence Criteria](#)
- City level data
- Claims data
- [Clinic assessment](#) (e.g. Colorado Rural Health Center tool)
- CMS Innovation Center
 - [ACO Investment Model \(AIM\)](#),
 - [Transforming Clinical Practices \(TCPI\)](#)
 - [Comprehensive Primary Care Plus \(CPC+\)](#)
- [County health rankings and roadmaps](#)
- Community collaboration integration between primary care and public health ([Practical Playbook](#))
- [Communitycommons.org](#)
- [Community Paramedic](#) (program handbook and college access to the curriculum)
- [Community Paramedicine Insights Forum](#) (archived streaming video of US only CP programs)
- [Critical Access Hospital Financial Pro Forma tool](#)
- [Federal Office of Rural Health Policy, Rural Health Network grants](#)
- [Flex Monitoring Team](#)
- [Health information exchange and associated electronic tools](#)
- [Institute for Healthcare Improvement - team delivery model and leadership](#)
- [International Roundtable on Community Paramedicine](#)
- [Johns Hopkins trainings](#)
- [LEAP-Learning from Effective Ambulatory Practices](#)
- [Medicare Beneficiary Quality Improvement Program \(MBQIP\)](#)
- [National Quality Forum](#) - quality measures
- [National Conference of State Legislatures](#)
- [National Rural Health Association](#)

- Network development – [National Cooperative of Health Networks Association](#) and Rural Health Innovations – [Network Technical Assistance](#)
- Physician leadership programs
- [Population Health Portal](#)
- [Quality Health Indicators \(QHi\)](#)
- Resiliency training
- [Rural Health Models and Innovations](#) and Rural Health Value - [profiles of innovation](#)
- [Rural Health Information Hub](#)
- [Rural Health Value](#)
- [Small Rural Hospital Transitions Project](#)
- [Stanford Medicine Self-Management Program for chronic diseases](#)
- [State Rural Health Associations](#)
- [State Offices of Rural Health \(SORH\)](#)
- The [Florence Prescription](#) book and culture change challenge
- [Technical Assistance and Services Center for the Medicare Rural Hospital Flexibility Program](#)
- [Training for care coordination and health coaches](#) – rural model

Needed Resources

These resources were identified by the participants to provide better support to rural hospitals with provider engagement in the transition to value. They could be supported or created by state Flex programs, State Offices of Rural Health, rural health networks, technical assistance providers, policy makers and funding agencies to provide better support to rural hospitals.

- Access to claims data (currently only available with ACO participation for Medicare FFS)
- Affordable leadership coaching
- Best practice maps for successes
- Common data platform to share data
- Cost modeling/ROI resource
- Data repository and analysts
- Education focusing on leadership skills
- List of existing rural ACOs with a basic summary of where they are on their journey
- New funding sources
- Patient and caregiver involvement in the change to value
- Portal to share best practices
- Rural Physician Leadership Training (Promote team participation, Follow-up following team training, Over 1-2 years, Data/quality, Community)

- SRHT project expansion
- Strategies for engagement of civic/faith organizations
- Truly inter-operable health records for data sharing
- Training on using data (at pop. Level)