

State Flex Program Core Competencies for State Flex Program Excellence



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Purpose

This guide offers anyone who manages and/or works with the Flex Program the opportunity to complete a competency self-assessment, identify areas of proficiency, recognize opportunities for improvement and development, and gather insight into what determines proficiency. 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.

How to Use the Core Competencies

It is suggested that state Flex Program staff should:

1. Read this guide to understand each competency and what proficiencies are related to each competency.
2. 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.
3. Reference each core competency to better understand and develop proficiency in the skills and knowledge.

It should be noted that with any competency, TASC and their team can provide technical assistance to state Flex Programs. For additional support, discussions, or technical assistance, please contact TASC via phone at 800-997-6685 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 Partners

Throughout the 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 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, 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 hospitals (CAH) and other rural providers with 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.

Proficiency

The skills or expertise necessary to excel at a competency.



Competency

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



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

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

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

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

10 Core Competencies of an Effective and Impactful Flex Program



Developing Leadership and Workforce



Understanding Policies and Regulations



Managing the Flex Program



Strengthening Quality Reporting and Improvement



Planning Strategically



Improving Financial Stability



Managing Information and Evaluation



Understanding the Current and Future Health Care Environment



Building and Sustaining Partnerships



Addressing Community Needs



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. While high turnover is a challenge for many state Flex Programs and CAHs, strong leadership can help ensure program goals are still achieved.

Leaders set direction by building and communicating a common, inspiring vision. Leadership has the strongest relationship with organizational outcomes and value, including 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, and EMS. [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 for leadership development.

In addition, trust is fundamental to the success of organizations and partnerships. Trust is established through open communication, integrity, and follow-

through. It can take time to build trust but by building relationships and strong leadership, state Flex Programs can engage and maintain partners which fosters collaboration and innovation to advance the goals of the national Flex Program.

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. Health care providers should have adequate education and training 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.

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. Ideally, rural health care organizations will employ enough health care providers to meet the needs of the community. When facilities place health care professionals in roles where their skills can be used to their best advantage, patients will receive the best possible care.¹

The U.S. has been experiencing a health care worker shortage for decades and these shortages are 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 to leverage rural health care workforce programs, funding, tools, and best practices developed by collaborating organizations.

Examples Include:

- Rural Health Information Hub [RHlhub](#) 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 areas throughout the country 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.

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:

- Maintaining regular Flex Program communications with CAHs and other partners.
- Discussion and collaboration with other state Flex Programs during the Reverse Site Visits and other Flex Program networking events.
- Attending national and regional conferences focused on rural health and/or CAHs like the National Rural Health Association (NRHA) Rural Health Clinic and Critical Access Hospital Conference.



¹ [Rural Healthcare Workforce Overview - Rural Health Information Hub](#)



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 Data Collection Platform (DCP))
- 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 Project Officer and provide regular program updates
- Understand and review contractor activities, reports, and invoices in a timely manner and follow-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](#).

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 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 five years) or 2) a Non-Competing Continuation (NCC) progress report (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:

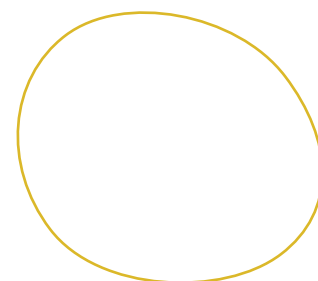
- Reports on progress, program changes, and project plans
- A detailed current and future [work plan template](#), including baseline measures and targets (see Information and Evaluation)
- Project plans and activities that address the primary components of the Flex Program in narrative form, including:
 - CAH Quality Improvement (required)
 - CAH Operational and Financial Improvement (required)
 - CAH Population Health Improvement (optional)
 - Rural EMS Improvement (optional)
 - CAH Designation (required if requested)
- Budget justification narrative
- Position descriptions
- Biographical sketches/resumes

Each application or progress report should reflect the current status of CAHs and rural health care in the state and the program plan to address challenges. A well-written Flex Program funding application or progress report 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.

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; progress reports are submitted through HRSA's Electronic Handbook ([EHBs](#)) and new funding applications are submitted 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. If you have questions about when to submit documents, reach out to your PO.

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 30 days after FFR due date using HRSA's EHBs. Discuss these with your PO prior to submission
- Submission of an annual performance report, due 90 days after post project period into Salesforce Data Collection Platform (DCP)
- 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. 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. FORHP POs provide program updates during the cooperative agreement year.

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](#).

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, the contracting process, the need for a 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 established by the State Flex program. The contract should require the contractor to report on 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 contributors. These outcomes will be directly reflected in your annual end-of-year report to FORHP. 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 framework¹ 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

¹ Additional information about the Baldrige Framework, one option for a comprehensive framework, can be found [here](#)

Planning ought to be purposeful, active, and relevant, with input from key community leaders 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 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 (NCC) application or during the cooperative agreement year with FORHP approval.

Proficiency Development

Within your organization, determine an approach for strategic planning. While there are many strategic planning models available, 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
- Monitor and update the plan.

If Flex Programs have started with a basic model, they can begin to adopt additional models like issue-based strategic planning or alignment-based strategic planning. Issue-based strategic planning starts with a SWOT analysis (strengths, weaknesses, opportunities, and threats), including community collaborators who can identify issues and goals, review of/updating the mission, vision, and values, developing action plans and measures, and regular monitoring.

Additionally, staff from the following will help guide strategies:

- State Office of Rural Health (SORH)
- Hospital association
- Quality improvement network/quality improvement organization (QIN/QIO)
- CAH leadership
- State and local EMS
- Public health agencies
- Accounting firm specializing in rural provider financials
- Any other relevant partners or community members who understand the rural health care landscape.

The alignment model is based on 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 that 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 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](#), 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 Toolkit²](#) and on [RHlhub](#).

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.

2 Although Flex funding cannot be utilized to complete Community Health Needs Assessments (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 meet 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, NCC, and program outcomes to FORHP. Your program needs to have a system in place to collect primary 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 in DCP.

Proficiency Development

When creating the [Flex Program work plan](#), objectives should be SMART (specific, measurable, attainable, relevant, and time 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."

See graphic on next page.



SPECIFIC

All CAHs achieving 95% compliance on EDTC measures

MEASURABLE

Compliance rate of at least 95% over 2 quarters

ACHIEVABLE

Use baseline data to determine if the measure is achievable prior to setting the measure

RELEVANT

EDTC measures are core MBQIP measures, so this is relevant to quality improvement

TIME-BOUND

The deadline for this goal is two quarters by the end of 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 Notification of Funding Opportunity ([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:

- **Process measures:** Measure that determines if the steps in the project are proceeding as planned. For example, developing a survey instrument or completing a training.
- **Outputs:** Measure that an activity occurred, a stepping stone used to move forward. For example, the number of meetings, education programs, or webinars provided.
- **Outcome:** Measurable change resulting from an activity or series of activities. Outcomes can be short-term, intermediate, and long-term. Example: Revenue Cycle Management project
- **Outcome Evaluation:** Assessing the short- and long-term results of a project to measure the changes that occurred. Projects often produce outcomes that may be unexpected and efforts at prevention, particularly in community-based initiatives, can be difficult to measure. Flexibility is key.

Example: Revenue Cycle Management project

OUTCOMES

Short-Term Outcomes

Effects occurring more immediately, typically within the first year.

Examples:
reduced registration errors as a percent of total registrations or increased percentage of point-of-sale collections

Intermediate Outcomes

Effects that occur in the first 1-2 years.

Examples:
reduced percentage of claims denied, increased percentage of denied claims re-billed, improved clean claims rate

Long-Term Outcomes

Effects that occur after 3 years.

Examples:
improved days' net revenue in accounts receivable (CAHMPAS), greater days cash on hand (CAHMPAS), improved current ratio (CAHMPAS)

[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 ideally build evaluation 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. Lean³ 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 does not add value. Lean 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.

Some state Flex Programs use spreadsheets to track program evaluation data while others also use databases 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 contributors should be included in Flex Program activities. Reporting supports overall program transparency and development, community buy-in, engagement, and accountability.

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



³ More information on Lean and PDSA methods can be found in the [Medicare Rural Hospital Flexibility Performance Management/Evaluation Guide](#).



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 contributors and ultimately increase 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 collaborators.

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.

Proficiency Development

Developing partnerships requires spending time getting to know state and local rural health care leaders and advocates such as state hospital associations, state rural health associations, state EMS offices and associations, regional rural health networks, Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs), and local public health departments. 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.

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.

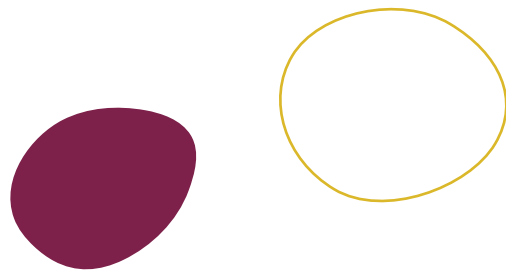
As your state Flex Program networks in both formal and informal relationships, consider the identified opportunities and challenges in relation to the goals of your program. Take actionable steps to leverage resources, build upon existing networks and partnerships, and further develop others. The state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

Effective communication is foundational for 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 information, by when, in what format, and for what purpose. Ask partners about their communication preferences and communicate accordingly. In addition, ask your audience for feedback on your communications: style, format, clarity, frequency.

State Flex Program coordinators often convene groups of community leaders and collaborators to share information or ideas; enable peer-to-peer learning; build or sustain partnerships; strategically plan; make decisions; and complete activities. An effective facilitator must be objective, neutral, and foster an energized, productive, and participatory environment while utilizing different facilitation methods and techniques.

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 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.

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.



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

It is important for state Flex Programs to familiarize themselves with current and emerging resources, such as:

- [Small Rural Hospital Improvement Grant Program \(SHIP\)](#)
- [Rural Healthcare Provider Transition Project \(RHPTP\)](#)
- [Delta Region Community Health Systems Development Program \(DRCHSD\)](#)
- [Rural Hospital Stabilization Program \(RHSP\)](#)
- [Rural Health Network Development Planning grants](#)
- State and private foundation funding
- [RHIhub](#)
- [Targeted Technical Assistance for Rural Hospitals Program \(TTAP\)](#)
- [Rural Emergency Hospital \(REH\) TA Center](#)
- [National Organization for the State Offices of Rural Health \(NOSORH\)](#)
- [Rural Residency Planning and Development Technical Assistance \(RRPD TA\) Center](#)
- [Rural Communities Opioid Response Program Centers of Excellence \(RCORP COE\)](#)
- [Flex Monitoring Team \(FMT\)](#)
- [Rural Quality Improvement and Technical Assistance \(RQITA\) Resource Center](#)

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 Centers for Medicare and Medicaid Services (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.

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 leadership and community members 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 \(MACRA\)](#)

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 [RHlhub](#).

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 Quality Improvement (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). QI is a structured approach to continuously improving patient care in health care settings and being able to see an impact of these changes over time. 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 agencies, with QI. For more information about Quality Improvement, please review the [Quality Improvement Workbook](#).

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.

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](#) 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:

- Global Measures
- Patient Safety
- Patient Experience
- Care Coordination
- Emergency Department

MBQIP reporting deadlines are updated on RQITA's 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](#). 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.

The process of QI is continuous – it starts with tracking and reporting data but needs to move into action to improve outcomes. 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 is the cornerstone of QI because if you cannot measure it, you cannot improve it. Data is 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. Critical Access Hospital Measurement and Performance Assessment System ([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 Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs). State Flex Programs should also ensure regular communication with their CAHs to make sure data is reported correctly by the deadline; this also allows the opportunity to provide technical assistance to hospitals.

Data is the cornerstone of QI because if you cannot measure it, you cannot improve it.





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

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 financial stress in 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](#).

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 differ 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. State 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.

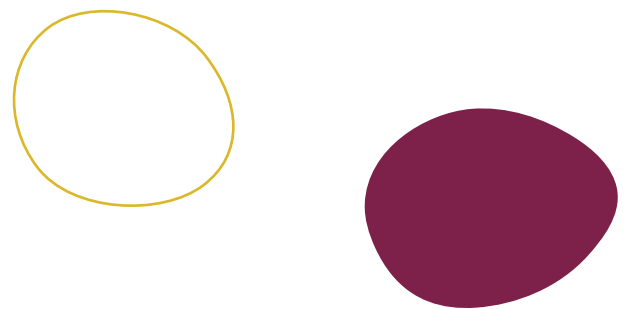
For the past several decades, the U.S. health care system has been characterized by poor quality, increasing costs, and decreasing access to care with declines in key indicators of population health. Despite efforts to make improvements, barriers to improvement persist. Much of this is attributed to 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 these concepts, and more, are described in the [Small Rural Hospital and Clinic Finance 101](#) guide 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 Management Best Practices Guide](#).

FORHP and the Flex Program partners have identified 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 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, and through collaboration with state hospital and rural health 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 Programs may not have the expertise on their 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, long term care (LTC) facilities, 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 leaders, 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 partners
- 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 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 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 payers look for opportunities to decrease health care costs.

A broad understanding 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.

Proficiency 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, long-term care facilities (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 requires 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 high

quality care is provided at a lower cost, 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.

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 have formed ACO-like models to contract with groups of health providers and are expected to shift a majority of their business to value-based models over the next few years.

Global budget payment models—where hospitals receive a set, pre-determined annual budget — are 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,”⁴ per the Rural Health Redesign Center. 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.

4 Additional information about the REH Model can be found [here](#)

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

As health care focuses more on population health, primary care clinics are playing a larger, 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, weaknesses, and policy changes impacting these care providers because they are increasingly the drivers of health care in the community. Long-term care (LTC) facilities, which include a different level of care than care 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 an LTC facility as this allows 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. 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 review state and local resources, discussions, and webinars.

While the health care system shifts to a value-based environment that includes a focus on health-related social needs, rural communities strive 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.

New ideas, models, systems, and community collaborators 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. Private industries are collaborating on ideas related to insurance, health promotion, technology, telemedicine, care coordination, remote monitoring, and hospital-at-home models. 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 partners and providers.





Addressing Community Needs

Proficiencies

- Understand the health-related social needs (HRSN) and how they 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 need

Health care services are intended to meet the health needs of their communities. Health needs can be determined using a variety of factors including community data, 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 health-related social needs and other needs of the community CAHs and RHCs serve. [CAHMPAS](#) has many helpful tools for health-related social needs. To gain greater insight into individual CAH community needs, conducting a CHNA is helpful; a CHNA is a formal, systematic process that identifies and analyzes needs and assets. Keep in mind that while CHNAs are beneficial, Flex Programs cannot fund these as they are a federal requirement for non-for-profit

hospitals by the Internal Revenue Service to satisfy community benefit for tax exemption status. Outside funding will need to be gathered from another source if the hospital is seeking assistance with the CHNA. For CAHs, the CHNA drives local planning, decision making, and programs. The findings are informative to the state Flex Program and can guide Flex work.

Proficiency Development

State Flex Programs should be familiar with HRSN, the role that these needs play in population health and value-based health care, and how health and community programs and services are changing to include and address HRSN. 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.

CAHs are the primary source of health care in many rural communities. They play a central role in addressing access to health and the opportunities that create health. Understanding the assets that support health

and the barriers to obtaining health can assist rural providers in meeting the health care needs of their community and individual patients.

Population health serves as a strategic platform to improve the health outcomes of a community, 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, and access to available high quality health services. As such, to improve community health outcomes, collaboration is required among those who influence drivers and resisters to achieve 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.

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.

While clinical health care is focused on caring for disease prevention, treatment, and management in individuals, public health focuses on encouraging healthy lifestyles, disease and injury prevention, and controlling infectious disease in groups of people. 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 Flex Programs and CAHs in planning and aligning 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.

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



Conclusion

This guide identifies tools and resources currently available or that need to be developed to support the core competencies for state Flex Program excellence.

The details provided on the proficiencies serve as specifics for knowledge and skill attainment by state Flex Programs and their partners. After reading this guide, completion of the [Core Competencies Self-Assessment](#) is the suggested next step; this assessment should be completed from the perspective of the state Flex Program as a whole, and not an individual member of the team. Once specific areas for improvement are identified from the self-assessment, TASC and its team of experts can provide technical assistance and resources to state Flex Programs through individualized assistance.

For additional support, discussions, or technical assistance, please contact TASC via phone at 800-997-6685 or email at TASC@ruralcenter.org.