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MARCH 2022

An Inventory of State Flex Program Population Health Initiatives for Fiscal Years 2019-2023

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PURPOSE

This brief responds to interest from State Flex Programs (SFPs) and other Critical Access Hospital (CAH) stakeholders about the range of population health initiatives proposed and implemented across the Flex Program by summarizing the population health initiatives proposed by each of the 45 SFPs. We also identify the output/process and outcome measures described by the SFPs in their applications and program materials, as well as the organizations serving as their partners in this work. This brief serves as a companion to our initial brief, *Evaluating State Flex Program Population Health Activities*, which provides a high-level overview of SFP population health activity, highlights promising population health strategies, reviews issues related to monitoring the outcome of SFP population health activities, and explores opportunities to align SFP population health activities with the Health Resources and Services Administration's Healthy Rural Hometown Initiative.[1]

BACKGROUND

The Medicare Rural Hospital Flexibility (Flex) Program funds initiatives to improve the health of rural communities under Program Area 3: Population Health. The goal of this optional Flex program area is to build capacity of Critical Access Hospitals (CAHs) to achieve measurable improvements in the health outcomes of their communities.[2,3] Based on the Flex Program Structure for Fiscal Years (FY) 2019-2023, State Flex Programs (SFPs) may propose initiatives in one or more of the three population health activity areas.[3] The activity areas for population health are laid out in the FY2019 Notice of Funding Opportunity[2] and the Medicare Rural Hospital Flexibility Program Structure for FY 2019-2023.[3]

3.1 Support to assist CAHs in identifying community and resource needs

This category includes assessment and planning activities to support CAH population health initiatives for Activity Category 3.2 and develop targeted interventions for Activity Category 3.3. The purpose is to connect facilities and organizations with tools and resources to identify their strengths and needs and support their population health initiatives. Potential activities include encouraging CAHs to complete the Population Health Readiness Assessment; using the assessment results to assist in building capacity; offering community health needs assessment (CHNA) trainings; and evaluating CHNAs and implementation plans prepared by CAHs to inform planning for population health cohorts.

3.2 Assist CAHs with building strategies to prioritize and address unmet needs of the community

Based on the results of their Population Health Readiness Assessment and CHNAs, CAHs can design community action plans to address the needs of their communities. With a focus on engaging patients, partners, and communities, tax–exempt (501(c)(3)) CAHs are required to implement strategy plans to address priority needs identified through their CHNAs. While publicly-owned CAHs are not required to conduct CHNAs or implement strategy plans to address local needs, SFPs can encourage them to engage in population health planning and participate in CAH population health cohorts. Suggested activities include sharing resources and tools to inform population health action planning for a cohort of CAHs; supporting CAHs to create population health action plans through workshops, conferences, or CAH network meetings; providing training and TA on interventions to address priority needs and common chronic health issues; partnering with stakeholders to develop community health programs; facilitating collaboration between CAHs and community stakeholders; and evaluating implementation and progress of action plans.

3.3 Assist CAHs with engaging community and public health experts and addressing specific health needs

This activity category seeks to build on information collected through CHNAs, develop implementation plans, and build ongoing engagement between CAHs, local public health leaders, and community stakeholders to address local concerns to support CAHs in developing and implementing population health strategies. Suggested activities include facilitation of ongoing collaboration between CAHs and community stakeholders to support implementation of chronic care management programs; substance use prevention, treatment, and recovery strategies; mental health services; and programs to address public health, wellness, and the social determinants of health.

APPROACH

The Flex Monitoring team reviewed the 2019 State Flex Applications to inventory and categorize projects proposed under each sub-activity of Program Area 3 and other program areas to identify complimentary population health-related initiatives. We also reviewed the FY 2020 Non-Competing Continuation (NCC) Applications and FY2019 End of Year Reports to assess the continuation of these activities in 2020, as well as any potential new or revised activities. We summarized the types of activities and coded them thematically to identify trends. In addition to describing the specific activities proposed by each SFP, we described the process/output and outcome measures proposed by SFPs for their activities.

REFERENCES

1. US Department of Health and Human Services. *Rural Action Plan.* US DHHS;2020 September. Accessed December 30, 2021. https://www.hhs.gov/sites/default/files/hhs-rural-action-plan.pdf
2. Federal Office of Rural Health Policy. *Medicare Rural Hospital Flexibility Program Notice of Funding Opportunity FY 2019.* U.S. Department of Health and Human Services, Health Resources and Services Administration; 2019. HRSA-19-024, CFDA No. 93.241. Accessed July 19, 2021. *https://grants.hrsa.gov/2010/Web2External/Interface/Common/EHBDisplayAttachment.aspx?dm_rtc=16&dm_attid=e215d1f4-efe3-4bec-8d29-05b24290b235*
3. Federal Office of Rural Health Policy. *Medicare Rural Hospital Flexibility Program Structure for FY 2019-2023.* U.S. Department of Health and Human Services, Health Resources and Services Administration; 2018. Accessed May 21, 2021. https://www.ruralcenter.org/content/flex-program-funding-guidance

		Summary of State Flex Program Population Health Initiatives, FY 2019-2021	Output/Process Measures	Outcomes Measures	Partners
Alabama	3.1	Support population health readiness assessments (PHRAs)/ action plan development Conduct biannual Recommendation Adoption Process (RAP) interviews	# assessments distributed # results shared	# CAHs completing PRHA	TASC
	3.3	Provide CAHs with diabetes educational materials produced by the Chronic Disease Division of the Alabama Department of Public Health (CCD-ADPH)	# educational materials distributed	# education material distributed to CAHs	CCD-ADPH
Alaska	3.1	Support CHNA completion, identify common health priorities, assess alignment with statewide goals in CHNAs	# CHNA resources distributed # TA provided	# CHNA implementation plans that target community needs	None
	3.2	Share CHNA successes and challenges Analyze CHNAs and identify collective issues for cohort planning with a focus on substance use disorders (SUDs), social determinants of health (SDOH), and behavioral health Support action plan development Improve care coordination through real-time information sharing	# CHNA successes/ challenges shared # priorities identified # action plans developed # CAHs participating in real-time sharing	# CHNA implementation plans that target community needs	Alaska State Hospital and Nursing Home Association
	3.3	Promote involvement with Healthy Alaskans 2020 and Alaska Healthcare Transformation Project Help implement Community Cafés to understand and plan for future initiatives	# CAHs updated on statewide initiatives # CAHs assisted with Community Cafes	# CHNA implementation plans that target community needs	
Arizona	3.1	Identify common needs and alignment with state-level health priorities Provide training, TA, or other activities to support CAHs in addressing priorities	# reports # meetings #webinars # trainings	Increase # CAHs receiving TA for CHNA-based or other community health activities	AZ First Responders ADHS-SAMHSA/ISA Evaluator and Health Educator
	3.2	Prioritize and address unmet community needs through CHNA summaries, training, and TA	# meetings # reports # TA	# CAHs receiving TA for CHNA-based or other community health activities	
	3.3	Community coalition meetings to identify strategies to address health priorities and develop evaluation plans to measure impact	# meetings # trainings # projects # TA	# CAHs implementing CHNA-based community health activities	
California	3.3	Analyze CHNAs and identify collective issues for cohort planning Provide training, TA, and networking opportunities. Cohorts will focus on behavioral health, substance abuse, access to healthcare, homelessness Support 1-3 hospital projects and monitor progress Support Rural Trauma Team Development Course	# CHNA analysis # cohort(s) # hospital specific projects- baseline measures, contracts, progress reports and final report # trainings	Identify collective health improvement issues and build cohorts for activities Hospital project measures TBD Hospital project webinar and best practice summary	

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Colorado	3.1	Analyze CHNAs and identify collective issues for cohort planning Encourage CAHs to complete PHRAs Invite CAHs with high readiness scores to participate in the CO Rural Sustainability (CORS) Network	# CHNAs in past 3 years #/% PRHAs completed #/% CAHs eligible for network	None	None
	3.2	Develop and facilitate the CORS Network, support action plan development for integrated chronic care management programs Evaluate action plans using the Recommendation Adoption Process (RAP)	# action plans % communities who score ≥ 4 on RAP	None	None
	3.3	Facilitate CORS Network implementation of chronic care management programs through peer learning calls, workshops, network meetings, and 1:1 coaching calls Complete a virtual process map of each facility's Chronic Care Management (CCM) clinical workflow as part of a gap analysis Analyze monthly hospital and clinic QHi reports and compare to national benchmarks	# peer calls # participants in network # 1:1 coaching calls	all cause readmissions # patients with controlled high blood pressure # patients with Hemoglobin A1c Poor Control (>9.0%) medication reconciliation post discharge	SMEs
Florida	3.1 & 3.3	Host webinar to promote rural health collaboration focused on nutrition support and smoking cessation Fund a project with the Big Bend Rural Health Network to assess the population health capacity of 2 CAHs most impacted by Hurricane Michael and provide education Ensure CAHs engage in FL DOH Mobilizing for Action through community health improvement planning	Participation in webinar and FL DOH community improvement activities	CAH participation in the FL DOH community health improvement process	North Highland Consulting, AHE, Big Bend Rural Health Network
Georgia	3.3	Assist CAHs in identifying behavioral health priority areas and create an action plan to address the priorities through SME led webinars and regional workshops with live hands-on training and forums to build community partnerships	Participation in visioning meeting shared strategic plan webinars online support training; regional meeting sharing meeting summary report	Increase training or education in six action areas per hospital by at least one member.	HomeTown Health LLC, SMEs
Hawaii	3.1	Develop community status reports	# community status reports	None	None listed
	3.2	Provide CHNA TA as requested	# requests/year	None	None listed
	3.3	Conduct Pilinaha/THRIVE sessions to help rural communities identify environmental and social conditions that impact health and strategies to improve those conditions	# community sessions/year	Community measure TBD # sites exceeding the state median	None listed
Idaho	3.2	Path to Value Project- educational webinars and TA to share strategies and best practices, develop action plans, and assist in implementation Four projects implemented with clear goals and tracking of key metrics: diabetics with elevated A1C > 8 (2 CAHs), adults 25-60 with pre-diabetic risk factors (1 CAH), pre-hypertensive adults age 30-60 (1 CAH)	Participation in webinars # action plans # TA	# CAHs implementing at least 1 Flex-funded population health improvement initiative	Rural Health Innovations (National Rural Health Resource Center)

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Illinois	3.1	Support CHNA completion and maintain statewide CHNA database Conduct community outreach projects to support population health and community needs	Database maintained Best practices, outcomes, replicable programs shared # projects funded	# of baseline community needs assessments	SMEs
	3.2	Develop and implement rural community health worker model Expand current health coaching program associated with local university and partnership with CAHs	Course curriculum, staff, office space, and travel funded Instructor, course materials, travel funded	None	SMEs
	3.3	Coordinate statewide workshop for local coalitions on SUD strategies, MAT protocols and mental health Develop and/or expand current behavioral health services in rural communities Establish clinically integrated networks specific to rural communities targeting SDOH	CAH participation, resources, and telehealth inventory # CAHs funded to initiate/expand coalitions # resources, toolkits, and best practice for networks	1) # CAHs implementing behavior health services 2) # CAHs participating in clinically integrated networks	SMEs
	5.1	Develop and pilot a skilled nursing navigator (SNN) program to improve care transitions, length of stay, and overall quality outcomes and reduce Medicare spending through reduction of readmissions and urgent care visits	Protocols, job descriptions, resources, and toolkits developed. # pilot sites	1) Improve care transitions: # CAHs participating in SNN program 2) Identify, pilot, replicate one innovative model annually- # pilot sites	SMEs
Indiana	3.2	Create program to address Substance Use Disorder (SUDs) Provide educational training that champions will take back to each hospital	# internal CAH champions # communities committed SUD and MH included in activities	None	Valiant Health
Iowa	3.1	Assess support needed by CAHs to complete their CHNAs Determine top health needs in each region Assess Community Benefit (CB) reports to determine CB spending by CAHs and ID CAHs with low CB spending	Needs assessment report Assessment of CAH CHNAs Assessment of CB spending	# CAHs in Iowa needing assistance with CHNA-HIP process	Contractor, Iowa HC Collaborative
	3.2	Develop toolkit and TA program to assist CAHs to build strategies to promote and address priority needs	Toolkit and TA program developed	# CAHs utilizing toolkit and receiving TA to build strategies to address priority/ unmet needs	Iowa Healthcare Collaborative
	3.3	Develop toolkit and TA program to assist CAHs to engage with community stakeholders and public health experts to address specific health needs Finalize a strategic plan to address opioid use disorder (OUD) prevention, treatment, and recovery Provide funding	Toolkit and TA program developed # CAHs funded	# CAHs utilizing toolkits and receiving TA to engage community stakeholders and public health experts to address health needs	Iowa Healthcare Collaborative OUD work: Stroudwater

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Kansas	3.1	Support CAHs in developing and updating CHNAs and implementation plans	# CAHs developing CHIPs	None	KHERF, KDHE
	3.2	Conduct analysis of available CAH and community data to identify top community diagnoses Assist CAHs in developing strategies to address identified needs	Analysis completed # CAHs with actionable plans	None	KHERF, WSU, SMEs
	3.3	Convene conversations with community and statewide partners to address specific needs in communities with a potential focus on mental health transportation Support hospitals participating in the Healthy KS Hospital Initiative, promote best practices in the implementation of population health workplace wellness activities	# events # participants# # strategies developed # participating CAHs CAH feedback	Improve community health indicators keyed to community needs TBD	KHERF, SMEs
Kentucky	2.4	Host CAH Substance Abuse Project Summit to address issues in CAH communities	CAH participation	None	State and local stakeholders
	3.1	Assess CAH's population health readiness and provide education on the transformation to population health	# CAHs trained CAH participation in a population health activity	None	None
	3.2	Develop and facilitate at least 3 rural health networks to address unmet needs in communities, share population health improvement efforts, and provide education	CAH network participation	# CAHS participating in Flex-funded population health improvement projects	None
	4.3	Provide mental health first aid trainings to CAH communities	# trainings	None	None
Louisiana	3.3	Epidemiologist to assess CAH chronic disease management/prevention capacity Identify CAH training needs and service gaps with LA Department of Health (DOH) and Center for Disease Control (CDC) population health grant programs Assess CAH participation in opioid use trainings/programs	Baseline of CAH chronic disease management/ prevention services Training/support needs CAH participation	# CAHs with chronic disease management or prevention services # opioid prescriptions in Louisiana	Epidemiologist CDC and LA DOH LA DOH
Maine	3.1	Contract with 1-2 CAHs to identify lead provider(s) to become Advanced Life Support in Obstetrics (ALSO) trainer(s) and certify hospital staff- CAH(s) will develop business and sustainability plan	# contracts # trainings # CAH staff trained/ certified	Develop infrastructure for ALSO	SMEs
	3.2	Recruit CAH leaders to serve on the Value-Based Payment (VBP) workgroup and create a five-year project plan for population health improvement utilizing VBP contracting Engage community stakeholders and state/local public health experts in planning the implementation timeline for years 2-5 of the VBP population health projects Establish performance measures and tracking methods	Charter committee formed and charter developed Yrs 2-5 timeline developed 1-2 performance measures identified	Increase # new CAH VBP contracts	iVantage, Network Facilitator, Maine QIO/QIN

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Michigan	3.1	Update collective issues/trends identified in population health management needs assessment and bi-annual CHNA analysis Work with Blue Cross Blue Shield (BCBS) Peer Group 5 Pay-for-Performance Program to establish population health champions in all CAHs	# updates # population health champions	# CAHs with population health champions	None BCBS
	3.2	Encourage completion of PHRAs	# PHRAs completed	Build population health capacity with CHNAs (measured by PHRA)	None
Minnesota	3.1	Encourage completion of PHRA (Due to COVID-19-related demands on CAHs, Stratis Health used available data to complete a rural hospital assessment instead of PHRAs)	# PHRAs/assessments completed	None	State and local stakeholders
	3.2	Build CAH Leadership Capacity and Community Ownership: Up to 10 CAHs will form two cohorts to address issues such as chronic care management and SDOH Year 1 cohorts will design change package, develop intervention strategy, and identify population health champions Year 2-5 cohorts will participate in Leadership and Organizing for Action program.	# CAHs invited to join cohort	None	None
	3.3	Path to Value: up to six CAHs will form cohort focused on care coordination and integrated care model Year 1 CAHs will identify community resources and needs Year 2-3 cohort will build community relationships Year 4-5 CAHs will develop strategic plan with community	# CAHs invited to join cohort # action plans # progress/success videos	TBD based on cohort focus MN Path to Value website: https://www.ruralcenter.org/rhi/path-to-value/mn	Rural Health Innovations
Mississippi	3.1	Provide TA to CAHs to complete PHRAs Identify collective issues and trends to inform activities Conduct RAP interviews	# communities assessed # PHRAs completed	# CAHs completing PHRAs	None
	3.2	Provide CHNA trainings	# CAHs participating	Increase awareness of community health needs through CHNAs	SMEs
	3.3	Provide diabetes education curriculum to community health workers employed by CAHs	# CAHs participating # CAHs utilizing strategies # participants	# CAHs building chronic care infrastructure	SMEs
Missouri	3.1	Provide education to CAHs on population health strategies to control cost and improve care Assess where CAHs fall on population health maturity scale and provide TA to address barriers Develop population health learning action network	# trainings # CAHs participating # assessments completed and distributed to CAHs	Awareness of community health needs measured by CHNA completion	None

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Missouri	3.2	Provide TA to identify CAH priorities and advance strategies to address priorities Provide education on prevention and health promotion strategies for population health management	# CAHs identifying priorities # trainings; CAHs participating; participants	CAH placement on population health maturity scale	SMEs
	3.3	Identify CAHs to work on priorities from 3.2	# CAHs identified	Improve CAH staff's population health management clinical skills	SMEs
	5.1	5.1: Identify model to address transportation needs	# survey responses CAH's interests and needs	# CAHs participating in innovative model	None
Montana	3.1	Support completion of CHNA and implementation plans Maintain data hub, which displays priority needs and community resources by hospital and public health department Update State Rural Health Plan	# implementation plans State Rural Health Plan	# CAHs completing CHNA implementation plans # communities participating in MT Flex activities	MORH
	3.2	Provide education and TA to CAH leaders and board members on community dissemination and implementation of action plan Encourage CAHs to use data hub to identify resources and collaboration opportunities	Content developed TA delivered Action plans identified Data hub use evaluated quarterly	None	MORH
	3.3	Six programs: Community Access to Mental Health First Aid Resources Trauma Systems and Hospital Preparedness Program CAH worksite wellness projects (WWP) Rural Train the Breastfeeding Trainer and Critical Access Certified Lactation Program NCC: Resiliency training for CAH staff NCC: Obstetrics and Maternal Support (MOMS) program	# trainings; events, participants; resource guides published and distributed # surge test # CAHs participating # staff certification scholarships; CAHs hosting training	# CAHs implementing evidence-based programs and policies for worksite wellness CAH competency in providing breastfeeding support	Rural Hospital Improvement Coordinator (RHIC) DPHHS DPHHS
Nebraska	3.1	Year 1-Conduct a PHRA in select CAHs and develop hospital profiles; Years 2-5 form a care coordination team that includes community partners to implement action plan addressing high priority needs such as SDOH, improved quality, and coordinated care Organize full-day Population Health Summit to educate CAHs about value-based purchasing and population health Analyze CHNAs and implementation plans and develop appropriate recommendations	# CAHs completing hospital profile # CAHs attending Future TA needs identified	Determine outcome measure appropriate to the population health interventions planned Examples: improve health outcomes, decrease inappropriate emergency department use, increase referrals to primary care, reduce readmissions, improve chronic care management	National Rural Health Resource Center Stroudwater UNMC
Nevada	3.1	Provide education to CAHs on population health strategies to control cost and improve care Assess where CAHs fall on population health maturity scale and provide TA to address barriers Develop population health learning action network	# copies distributed Ongoing data collection # rural county population health profiles # data requests completed	# statewide and rural health stakeholders receiving Ninth Edition of Nevada Rural and Frontier Health Data Book	None

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Nevada	3.2	Provide education to CAHs on population health strategies to control cost and improve care Assess where CAHs fall on population health maturity scale and provide TA to address barriers Develop population health learning action network	# copies distributed Ongoing data collection # rural county population health profiles # data requests completed	# statewide and rural health stakeholders receiving Ninth Edition of Nevada Rural and Frontier Health Data Book	None
	3.3	Based on statewide and community need and resource assessments facilitate the development of a 1) statewide and 2) community-level rural population health improvement strategy plans for rural communities, program leaders and state policymakers	Statewide and community population health improvement strategy plan	Facilitate development of a rural community health improvement plan (CHIP) based on statewide rural population health needs and resource assessment	None
North Carolina	3.1	CAHs complete PHRAs Provide RHC education and TA for development of preventive/ wellness care Discuss with DHHS global budgeting options for CAHs Share community profiles with 20 CAHs Develop action plan for Population Health Profiles. UNC Sheps Center student to conduct research project Develop and support Primary Care Rural Health Network Maternal Health Project assessing effect of maternity unit closures on maternal morbidity and other outcomes	Compare 2018 readiness scores to 2019 and develop project plans for 2021 cycle # presentations and TA Final report/ recommendations # profiles reviewed with leadership teams Report on analysis/ trends Final report with recommendations # webinars/meetings	# CAHs receiving population health recommendations based on CHNAs # market demographic assessments for CAH RHCs # CAHs capable of implementing global budget payment for state, federal and private payers	Contractor TBD; NC Hospital Association, DHHS, consultants
North Dakota	3.1	Provide CHNA training and TA to understand IRS reporting requirements and best practices Track completed CHNAs and implementation plans for population health planning	# CAHs participating in training and TA # CHNA reports and implementation plans linked to CRH CHNA webpage	Increase CAH capacity for implementing population health initiatives reflective of needs identified	None
	3.2	Support up to 3 CAH regional population health activities or projects- interested CAHs must complete PHRA Facilitate collaboration with CAH/RHCs and statewide partners Offer training for development of chronic care management services and care coordinator role	# CAHs proposals; # CAHs ready to implement a project; # and focus of completed projects # participants; # CAHs represented	# RHC/CAHs supported to develop chronic care management services	SMEs
	3.3	Facilitate virtual learning network using Project ECHO platform focused on behavioral health, substance use disorder/pain management Provide funding for subject matter experts (SMEs) and educational materials and supplies related to advance care planning and palliative care	#-CAHs/#-RHCs, #- CHCs; and total # of participants # CAHs and total # participants	None	SMEs, Project ECHO

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Oklahoma	3.1	Develop and distribute an annual stakeholder needs assessment Provide CHNA training to non-profit CAHs on IRS reporting requirements and best practices Facilitate CHNA process through three community meetings (per hospital) to present economic, demographic, and health data Develop CHNA annual report which maps CHNAs, summarizes findings, and describes priorities adopted by each facility	# annual assessments # participating CAHs # CHNAs completed with Flex assistance	None	Eide Bailey
	3.2	Assist communities in developing action plans to prioritize needs identified in CHNAs MPH students to develop implementation/evaluation plan for participating communities Interview CEOs for best practices in implementing action items and highlight in quarterly newsletter	# action plans # CAH implementation/ evaluation plans # CEOs interviewed	# not-for-profit CAHs that implement action items because of the CHNA process	OSU Master of Public Health Program
Oregon	3.1	Develop Health Status Service Area Profiles (HSSAP) and Areas of Unmet Health Care Need reports Create interactive map of all CHNAs and Community Health Improvement Plans	# reports distributed and accessed online	None	None
	3.3	Host an Annual Forum on Aging in Rural Oregon to facilitate CAHs partnership with Local Public Health Authorities (LPHAs), Coordinated Care Organizations (CCOs) and community stakeholders Provide SME training on how to align CHNAs and address regional aging needs	# CAH, LPHAS and COO participating # webinars	Increase regional collaboration/programming between CAHs, CCOs and LPHAs to address CHNA priorities on aging	SMEs and OR Hospital Association
Pennsylvania	3.1	Expand PORH website to include population health resources, links, and data for CHNA research and preparation	# CAHs utilizing resources	None	None
	3.3	CAHs participating in the PA Rural Health Model (RHM) will develop transformation plans that target chronic disease prevention and management Cohorts will build best practices and activities to manage COPD and include in training platform- Additional focus areas include congestive heart failure, diabetes. SDOH, substance use disorder and behavioral health	# CAHs participating; # transformation plans	Fund CAH cohort Flex activities to support RHM participants' transformation plans Increase CAH participation in RHM	PA DOH, PA Rural Health Redesign Center, Quality Insights
South Carolina	3.1	Provide trainings on IRS reporting requirements and best practices for CHNA Perform assessment of CAH communities' unmet health needs and identify root causes and distribute report to CAHs and stakeholders Provide Community/Population Health training Encourage participation in statewide initiatives Facilitate stakeholder collaboration to address unmet needs via Rural Health Networks and Learning & Doing Collaborative	# CAHs participating # assessments; # assessments distributed # staff; 3 CAHs	Increase awareness of community health needs to improve population health Support community health initiative development to address unmet healthcare needs Facilitate statewide and local strategic planning around SDOH, health indicators, and root causes	SMEs- Iron Sharpens Iron

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South Dakota	3.3	Year 3- Collaborate with state epidemiologist to identify cohort of CAHs with similar health challenges identified in state needs assessment Year 4 – Work with cohort communities, stakeholders, and public health experts to address a specific health need Year 5- Gather CAH/community data on the identified population health activity	None	# CAHs addressing a common community health need	State epidemiologist
Tennessee	3.1	Create Population Health Profiles (PHP)	# profiles completed	Increase awareness of community health needs to improve population health	iVantage, TN Hospital Association
	3.2	Provide TA for GAP analysis of PHPs and action plans development to bridge the gaps- Diabetes and access to mental health services identified as top priority areas	# GAP analysis completed		iVantage, TN HA, Chartis Center for Rural Health
	3.3	Facilitate Population Health Engagement Network to identify health disparities and unmet needs- CAH will identify Community Health Engagement Liaison to develop chronic disease management program	CAH attendance; #/% CAHs participating annually in pop health improvement projects	TBD based on projects	iVantage, TN HA, Chartis Center for Rural Health
	5.1	Develop Clinical Integrated Network (CIN) in 6 rural counties to enhance care coordination for value-based programs- Focus on Medicare programs (chronic and transitional care management and annual wellness visits) and Medicaid programs (chronic disease management, reduction of avoidable ED utilization and hospital admissions)	# new FQHC added to CIN #/% CAHs participating annually in population health improvement projects	Expand CIN Pilot to include 1 additional FQHC Other measures TBD based on project	TN Hospital Association
Texas	3.1	Year 4-5 – Offer CHNA education opportunities, compile completed CHNAs, assist and encourage completion of PHRA and share results Activities will align with a funding mechanism supported through value-based purchasing	None	Increase awareness/ knowledge of community needs to improve population health # CAHs assisted in completing PHRA and share results	None noted
Utah	3.1	Update CAH Population Health Management Needs Assessment; update and distribute Community Health Profiles; encourage completion or reassessment of PHRA; provide training in analyzing data to implement community benefit activities	PHMN Assessment; # profiles, # profiles shared; # PHRAs completed; # trainings	Increase average population health readiness score	Health Systems Support Staff
	3.2	Provide TA and share best practices with CAHs interested in addressing unmet needs; maintain funding opportunity database and proactively connect CAHs to opportunities	# TA contacts and recipients Database updated weekly and CAHs informed	None	SMEs, Health Systems Support Staff
	3.3	Host annual Rural Hospital Administrators Summit to connect CAHs to resources, assist implementation of community benefit activities, and improve community coalition Provide resources/training to leaders on coalition building and mobilization of resources for community benefit	Attendance # resources # trainings	None	SMEs, Health Systems Support Staff

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Vermont	3.1	Standardize CHNAs by identifying approved templates to use for 2020-21 CHNA cycle	Identify CHNA templates # CAHs using template	# approved template used 2021-22 CHNA cycle	None
	3.2	Cohort will identify strategies to address at least one SDOH in their community with priorities to include transportation, housing, food, and economic insecurity	# CAHs with funds and plans to address ≥1 SDOH # CHNA aligned action plans	# CAHs with funds and plans to improve at least one SDOH measure	None
	3.3	Identify hospitals with greatest mental health (MH) needs; create action plans to reduce wait time for all patients seeking psychiatric care, particularly involuntarily admitted MH patients waiting for transfer or admission	# CAHs participating	# CAHs that have ED wait times <48 hours for MH # CAHs that reduce total days in ED for MH	DMH, VAHHS, VPQHC, and Community MH Agencies
	3.3	Facilitate Population Health Engagement Network to identify health disparities and unmet needs- CAH will identify Community Health Engagement Liaison to develop chronic disease management program	# CAHs participating	TBD based on projects	iVantage, TN HA, Chartis Center for Rural Health
Virginia	3.1	Host Population Health 101 webinar Conduct strategic planning calls with CAHs to determine priority areas and action steps based on CHNA summary Host community conversations to discuss strategic solutions Produce Community Calendar, highlighting 12 topics identified during strategic planning and share best practices, resources, and programs that address the issue, and honor a community champion Update Rural Health Plan	# PPT and resources distributed # CAHs with priority areas and action steps to implement projects	# CAHs participating in Flex funded measurable population health activities	VDH Population Health Division, Healthy VA, VA Hospital and Healthcare Association
Washington	3.2 & 3.3	Build capacity for CAHs to engage with community stakeholders, build projects to address a specific health issue and succeed in meeting measurable goals and targets Add information gathered from activities to CAH Informational Dashboard Provide TA	# projects, quarterly updates # peer evaluations of dashboard and priority data #TA	# CAHs actively collaborating with community on population health improvement activities # CAHs reporting measurable improvement in ≥1 determinant of health	Contractor TBD
	5.1	Rural Palliative Care Initiative: Develop and provide education to 20 CAHs; include leaders, frontline staff, and community Opioid Work Group and Network will meet monthly to share information Provide resources and support to 3 CAHs with opioid HRSA grants	Training developed; # sites trained; Measurable change in provider confidence # hours/month contributed to workgroup	# sites trained in palliative care	None
West Virginia	3.1	Develop National Diabetes Prevention Programs (NDPP) with CAH owned RHCs and provider-based clinics to identify and treat persons with pre-diabetes including those with high cholesterol and high blood pressure TA provided through CAH Network	None	None	WVHA, CAH Network, WV Division of Health Promotion and Chronic Disease, WVU

		Summary of State Flex Program Population Health Initiatives, FY 2019-2021	Output/Process Measures	Outcomes Measures	Partners
Wisconsin	3.3	Obesity Reduction Project awards funding to address root causes of obesity in three CAH communities with high obesity rates Substance Abuse Community Pilot Project funds one CAH with a high rate of SUD and a high population to mental health provider ratio; CAH identifies patients in the ED who may have substance use disorder and provides transport to a treatment program using a local cab company Outreach to Farmers and their Families Program offers in-home or on-site preventive health screenings, health coaching, and referrals	# TA; # CAHs funded # participants # interventions; final report. # pilot projects; final report # pilot projects completed # assisted	# CAHs reporting improvement of contributing factors to chronic disease in their communities	Rural Health Initiative
Wyoming	3.1	Support CAHs in identifying community and resource needs Provide pandemic TA	# CAHs completing CHNA # TA	# CAHs supported with identifying community and resource needs	NRHRC SMEs
	3.2	Assist CAHs in building strategies to prioritize and address unmet needs of the community	# action plans completed # population health scholarships awarded	# CAHs assisted with building strategies to address unmet community needs	NRHRC SMEs
	3.3	Partner with community stakeholders and public health experts to address specific health needs- Three CAHs are establishing a diabetes prevention program and nine people received Community Interpreter International certification	# community focus groups conducted to complete CHNAs % CAHs receiving funds for pop health	# CAHs assisted with engaging community/ public health experts and address specific health needs	NRHRC SMEs

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This report was completed by the Flex Monitoring Team with funding from the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS), under PHS Grant No. U27RH01080. The information, conclusions, and opinions expressed in this document are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.