National Organization of
State Offices of Rural Health

NOSORH

State Office of Rural Health Manual for New Employees

October 2016

NOSORH
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www.nosorh.org

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INTRODUCTION

Welcome! Congratulations on your position with the State Office of Rural Health (SORH). We are pleased you are now a member of the rural health family! The National Organization of State Offices of Rural Health (NOSORH) is the membership organization for all fifty State Offices of Rural Health. NOSORH is here to help you in your role to increase the capacity of State Offices to improve health care in rural America through leadership development, advocacy, education, & partnerships.

NOSORH works with SORHs and other rural health stakeholders to develop programs and support activities that strengthen each state's ability to:

- Improve access to quality health care;
- Expand the rural health workforce;
- Reduce health disparities;
- Strengthen rural hospitals and clinics;
- Broaden the reach of health information technology and telehealth services; and
- Enhance rural emergency services.

NOSORH strives to:

- Cultivate the next generation of SORH and community leaders;
- Strengthen the technical assistance capacity of SORHs;
- Facilitate partnerships that spur the development of rural health-related activities;
- Foster the exchange of rural health-related information and best practices; and
- Provide a collective voice on rural health issues.

We want to share a few resources from NOSORH with you.

NOSORH Website

NOSORH's web address is www.nosorh.org. Some areas are for NOSORH Members only. Your access code for these materials is:

Username: pinetree
Password: 50sorh

You can find all past meeting materials on the website along with all recorded webinars.

NOSORH Educational Exchange Program

Any NOSORH member may request travel scholarships to meet with another SORH to learn about a topic of importance to that member's SORH. Scholarships support travel which enable a NOSORH member to link with a mentor or peer at another SORH who will help that member develop or enhance his or her expertise and leadership skills; adopt a promising practice; and/or improve their program management or strategic planning/implementation effectiveness.

Visit the NOSORH website for additional details: https://nosorh.org/educational-resources/travel-scholarships/

NOSORH Regional Representatives

Each Region is assigned 2 NOSORH representatives on the Board of Directors. Reach out to your Regional Representative to discuss what committees to become involved with based on your areas of interest. Regional Reps act as a NOSORH ambassador to link NOSORH with SORH staff and partners. Let us know if you plan to attend any national meetings so we can introduce you in person. Regional Reps are resources to support you along with the current NOSORH Board of Directors, listed below.

NOSORH Regional Representatives	
Region A	
Cathleen McElligott Massachusetts Office of Rural Health Phone: (413) 586-7525 Email: cathleen.mcelligott@state.ma.us	Mike Mallon (effective Jan. 2017) Virginia Office of Rural Health Phone: (804) 864-7432 Email: Michael.mallon@vdh.virginia.gov
Region B	
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Region C	
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Region D	
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NOSORH Executive Committee	
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National Rural Health Association, State Office Council, Chair	
John Barnas, Executive Director Michigan Center for Rural Health Phone: 517-432-9216 Email: john.barnas@hc.msu.edu	

NOSORH Liaisons	
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Policy	**Flex**
Lisa Davis Pennsylvania Office of Rural Health Phone: 814-863-8214 Email: lad3@psu.edu	Jody Ward, Flex Coordinator North Dakota Center for Rural Health Phone: 701-858-6729 Email: jody.ward@med.und.edu
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National Rural Health Day

NOSORH sets aside the third Thursday of every November to celebrate National Rural Health Day. National Rural Health Day is an opportunity to:

- "Celebrate the Power of Rural" by honoring the selfless, community-minded spirit that prevails in rural America,
- Bring to light the unique healthcare challenges that rural citizens face; and
- Showcase the efforts of rural healthcare providers.

This year, National Rural Health Day (NRHD) is on November 17, 2016. In past years the day's efforts have received attention from the President of the United States, from media outlets and nearly two-thirds of governors have declared National Rural Health Day in their states. Please utilize the key messages about the power of rural to bring attention to the good work being done on behalf of rural communities across the nation.

- **Rural communities are wonderful places to live and work. Great things are happening there.**
- **Rural America's health professionals, hospitals, and clinics are dedicated to delivering high-quality and innovative care to underserved Americans.**
- **Collaboration is crucial to address the barriers that remain.**

NOSORH has many resources available to help you with your National Rural Health Day efforts. Please contact Ashley Muninger if you have any questions. In addition, more information on National Rural Health Day can be found at https://nosorh.org/calendar-events/nrhd/

TruServe

In conjunction with the University of North Dakota, NOSORH offers a web-based performance measures tool called TruServe. TruServe is a web-based tracking system that allows organizations to conveniently monitor and report progress. Each state enrolled in TruServe has a customized web page used for tracking performance measures and other activities. TruServe allows you to capture the activities of staff; information later used to provide detailed and accurate reports for staff, the organization, funders, decision makers, legislators and others. Information within TruServe is available at all times and provides the ability to generate reports, maps, charts, and more with a few clicks. For more information on TruServe please contact Matt Strycker and visit www.truserve.org.

NOSORH Newsletters

NOSORH produces 2 newsletters to inform SORHs. The Branch is sent the first week of the month and offers news on NOSORH and partners' activities, promising practices and resources. The second newsletter, Roots, is sent in the middle of the month and provides news on the people from NOSORH and SORH. NOSORH strives to feature the work and leadership of each SORH throughout the year. We look forward to you sharing your work with your SORH colleagues. Please let Paige Law, NOSORH's Information Assistant, know if you do not receive these newsletters.

Committees

NOSORH convenes committees to provide learning opportunities, plan programs and services and to advise the organization on how best to meet SORH needs. Committee activities are planned by State Offices of Rural Health for State Offices of Rural Health. They are a great place to learn more about policy, get involved with the organization on a national level and to link with other State Offices of Rural Health throughout the year. We encourage you to join a committee. More information on each committee can be found here: https://nosorh.org/nosorh-members/nosorh-committees/.

NOSORH Committees

- The **Awards Committee** is responsible for developing Awards criteria to recognize SORH efforts during the NOSORH annual meeting. The Committee shall also evaluate and select the awardees and make arrangements for securing appropriate recognition symbols.
- The **Communications Committee** oversees development of National Rural Health Day and other materials to communicate information on NOSORH and State Offices of Rral Health.
- The NOSORH **Development Committee** cultivates relationships; identifies and obtains resources; and develops and implements programs and activities that strengthen NOSORH's organizational capacity and position the organization as the national leader in providing technical assistance to State Offices of Rural Health.
- The **Educational Exchange Committee** supports and enhances the leadership of state offices of rural health through education and training assistance.
- The **Finance Committee** reviews NOSORH budget at least annually to help develop appropriate procedures for budget preparations and to check consistency between the budget and NOSORH strategic plan.
- The **Flex Committee** provides the State Office of Rural Health perspective on policy issues and serve as a link between State Offices of Rural Health and others implementing the Rural Hospital Flexibility Program including the Federal Office of Rural Health Policy and the Technical Assistance and Services Center.
- The **Policy Committee** shall be responsible for tracking Policy issues of interest to NOSORH and coordinating Policy communication and educational activities for the organization.
- The **Joint Committee on Rural Emergency Care (JCREC)** is a group of organizations working together to improve the quality of care in rural and frontier communities.
- The **Rural Health Clinic Committee (RHC)** provides technical assistance and education to State Offices of Rural Health that are interested in providing technical assistance to RHCs and safety net providers, like Free and Charitable Clinics.
- The **Policy Program Monitoring Team (PPMT)** Committee ensures proactive scanning and assessment of policy and program changes to ensure positioning of SORH leadership to improve rural health.

Upcoming Events

Throughout the year NOSORH offers deep dive educational programs or "Institutes" on topics such as grant writing or working with rural health clinics. Webinars are typically offered monthly on topics identified by our SORH led Educational Exchange Committee. Each year NOSORH holds a meeting in every region of the country and an annual meeting. You can find out about upcoming events on our website at https://nosorh.org/calendar-events/.

Staff

If you have questions regarding NOSORH, please contact any of us; we would be pleased to spend time with you! We look forward to working with you!

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What is rural health?

According to the Federal Office of Rural Health Policy website, up to 25 percent of U.S. residents reside in rural areas. Compared with urban populations, rural residents generally have higher poverty rates, have a larger elderly population, tend to be in poorer health, and have higher uninsured rates than urban areas. Correspondingly, rural areas often have fewer physician practices, hospitals, and other health delivery resources. These socioeconomic and health care challenges place some rural populations at a disadvantage for receiving safe, timely, effective, equitable, and patient-centered care. Rural healthcare consists of Critical Access Hospitals (CAHs), Certified Rural Health Clinics (RHCs), Federally-Qualified Health Clinics (FQHCs), EMS organizations and other providers dedicated to communities they serve.

Defining the Rural Population. There are two major definitions of "rural" that the Federal government uses, along with many variants that are also available.

U. S. Census Bureau definition identifies ***two types of urban areas:***

- Urbanized Areas (UAs) of 50,000 or more people;
- Urban Clusters (UCs) of at least 2,500 and less than 50,000 people.

The Census does not actually define "rural." "Rural" encompasses all population, housing, and territory not included within an urban area. Whatever is not urban is considered rural.

The White House Office of Management and Budget (OMB) designates counties as Metropolitan, Micropolitan, or Neither. A Metro area contains a core urban area of 50,000 or more population, and a Micro area contains an urban core of at least 10,000 (but less than 50,000) population. All counties that are not part of a Metropolitan Statistical Area (MSA) are considered rural.

The Federal Office of Rural Health Policy (FORHP) accepts all non-metro counties as rural and uses an additional method of determining rurality called the Rural-Urban Commuting Area (RUCA) codes. Like the MSAs, these are based on Census data, which is used to assign a code to each Census Tract. Tracts inside Metropolitan counties with the codes 4-10 are considered rural. More information on RUCA codes can be found on the FORHP website.

Some states also have a state definition of rural.

Collaboration is needed to address the barriers that remain. State Offices of Rural Health, rural healthcare providers and other rural health stakeholders continue to foster partnerships that improve the health status of the communities they serve. Critical Access Hospitals make up 30% of acute care hospitals but receive less than 5% of total Medicare payments to hospitals. More than 60% of CAH revenue comes from government payers. All payment reductions to Medicare or Medicaid have an immense impact on CAHs' ability to provide access in rural communities. Emergency medical services are mostly volunteer dependent but are vital in rural America where 20 percent of the nation's population lives and nearly 60 percent of all trauma deaths occur. Rural workforce education and training programs are needed to help recruit, retain and increase the number of well-qualified medical providers for rural veterans. Federally Qualified Health Centers, CAH's and other health providers in rural areas are working with their local communities to design health delivery systems designed specifically for the population they are serving. In many cases they may be the only source of primary care in a community.

What is a SORH?

State Offices of Rural Health (SORHs) have a rich history of creating partnerships, developing programs and providing resources and technical assistance that help each state address the healthcare needs of its rural citizens. All 50 states maintain a State Office of Rural Health. In 1987, the United States Congress identified a significant health care trend affecting many rural communities. Many rural hospitals were closing due to financial constraints. In response to this increasing compromised access for rural residents, the Congress created the Federal Office of Rural Health Policy in 1987 and the State Offices of Rural Health (SORH) grant program in 1991. Administered by the Federal Office of Rural Health Policy, this program enables rural America's communities to sustain and strengthen their health care systems through creation of collaborative partnerships that support rural health development.

State Offices of Rural Health by Organizational Type

The State Offices of Rural Health differ substantially according to the unique nature of each State. The program grants are flexible and allow each State to determine the most appropriate location for its office with adequate consideration of their state-specific needs and preferences. Currently, there are 37 offices located in a State Agency, 10 offices within a University system and 3 offices operating as not-for-profit entities. 36 offices are co-located with the State Primary Care Offices (PCOs).

Although each one varies in terms of size, scope and organization, they all share one common purpose: to help rural communities within their state build effective healthcare delivery systems. SORHs accomplish this by:

- Collecting and disseminating health-related information;
- Coordinating state rural health resources and activities;
- Providing technical assistance;
- Encouraging the recruitment and retention of health professionals; and
- Strengthening state, local, and federal partnerships.

SORH Grant

Authorizing legislation provides that each SORH must conduct the following activities:

(1) Establish and maintain within the state a clearinghouse for collecting and disseminating information on:
   (A) rural health care issues;
   (B) research findings relating to rural health care; and
   (C) innovative approaches to the delivery of health care in rural areas;
(2) Coordinate the activities carried out in the state that relate to rural health care, including providing coordination for the purpose of avoiding redundancy in such activities; and
(3) Identify federal and state programs regarding rural health, and provide technical assistance to public and nonprofit private entities regarding participation in such programs.

The legislation also allows that each SORH may:

- Conduct activities pertaining to the recruitment and retention of health care professionals to serve in the rural areas of their states: and
- Provide sub-awards and contracts to public and non-profit organizations to carry out SORH activities.

Program Objectives

1. Collect and disseminate information.

SORHs are the focal point and clearinghouse for rural health within their state. They collect and receive information about rural health issues, research findings and innovative approaches for the delivery of health care in rural areas from a wide variety of sources and disseminate that information through a variety of means to rural partners and stakeholders that can benefit from or utilize the information.

SORHs must list and discuss the various activities that will accomplish this objective. Examples include utilization of website (hits, requests etc.), list serves, print or electronic newsletters and updates, webinars, promotion of Rural Health Information Hub (RHIhub) and Gateway websites and any other methods used to collect and disseminate information.

2. Coordinate rural health care activities in the state in order to avoid redundancy.

SORHS are the state rural health focal point and are to be aware of rural health activities occurring within state and coordinates such activities in order to avoid duplication of effort and inefficient utilization of limited resources. SORHs engage in state level activities and are a voice for the rural perspective. The SORH also strengthens partnerships and fosters communication and collaboration among rural health partners and stakeholders at the local, state, federal and national level.

SORHs must list and discuss the various activities such as participation or attendance at various rural health partner and stakeholder groups, boards, conferences, meetings and any other methods used to coordinate rural health activities. SORHs are required to annually attend three partnership meetings: 1) FORHP Regional, 2) National Rural Health Association, and 3) the National Organization of State Offices of Rural Health.

Activities pertaining to recruitment and retention of the rural health workforce must be included this section.

Examples of Rural Health Partners / Stakeholders
HRSA: Federal Office Rural Health Policy (FORHP), National Health Service Corps (NHSC), Bureau of Primary Health Care (BPHC), Bureau of Health Workforce (BHW) & Office of Regional Operations (ORO).

Federal Offices: Center for Medicare and Medicaid Services (CMS), Veterans Administration (VA) Office of Rural Health, U.S. Department of Agriculture (USDA), Centers for Disease Control (CDC) and Health Information Technology (HIT) exchanges.

State: Public Health Departments, Primary Care Associations, Medicaid Offices, Hospital Associations, Emergency Medical Services, Rural Health Associations, Quality Improvement Networks, Hospital Engagement Networks, Primary Care Offices and Regional Extension Centers and State Health Information Exchanges National Associations: Rural Recruitment and Retention Network (3RNet), National Organization of State Offices of Rural Health (NOSORH), National Rural Health Association (NRHA), American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), National Association of Rural Health Clinics (NARHC), American Hospital Association (AHA), and National Association of Community Health Centers (NACHC).

3. Provide technical assistance (TA) to public and non-profit private entities.

As a result of knowledge gained from the collection and dissemination of rural health information and coordination of rural health activities among partners and stakeholders, the SORH identifies federal, state and non-governmental (i.e. coalitions, networks, trusts, foundations) rural health opportunities (i.e. grants, programs, proposals, loans, training) and provides TA to public and non-profit entities regarding how to participate in or apply for such opportunities. Informational or educational TA on rural health related regulations, policies, and best practices may also be provided. The volume, intensity and diversity of TA provided vary among SORHs, correlating primarily with the degree of state rural need and the capacity of SORH to provide specialized TA. TA may be provided by third-party (i.e. contractor) or non-SORH staff as long as SORH will be directly involved in funding, planning, or coordinating the TA.

SORHs must discuss the various types of direct TA activities they provide as well as the types of clients to whom they provide TA.

FEDERAL, NATIONAL, STATE AND LOCAL PARTNERS

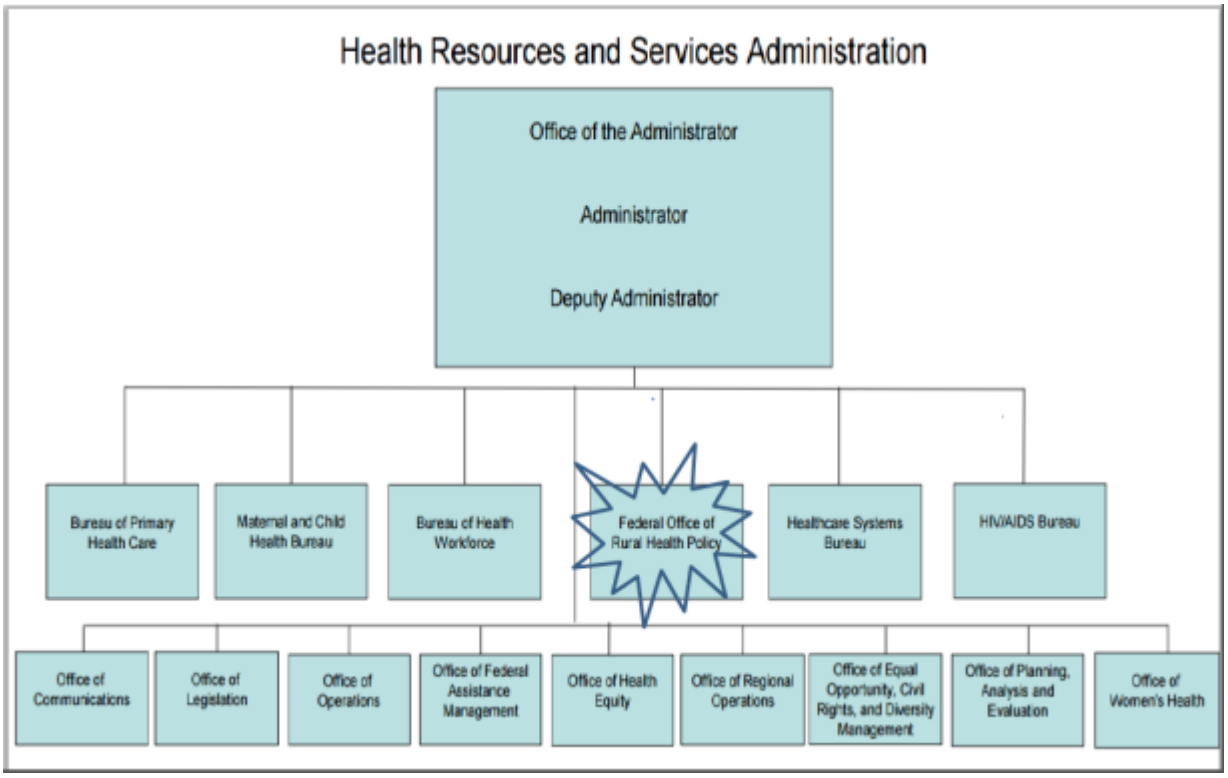
State Offices of Rural Health achieve success, with limited resources, by collaborating with others to address rural health goals.

FEDERAL PARTNERS

Federal Office of Rural Health Policy

The Federal Office of Rural Health Policy (FORHP) coordinates activities related to rural health care within the U.S. Department of Health and Human Services. Part of the Health Resources and Services Administration (HRSA), FORHP has department-wide responsibility for analyzing the possible effects of policy on residents of rural communities. Created by Section 711 of the Social Security Act, FORHP advises the Secretary on health issues within these communities, including the effects of Medicare and Medicaid on rural citizens' access to care, the viability of rural hospitals, and the availability of physicians and other health professionals.

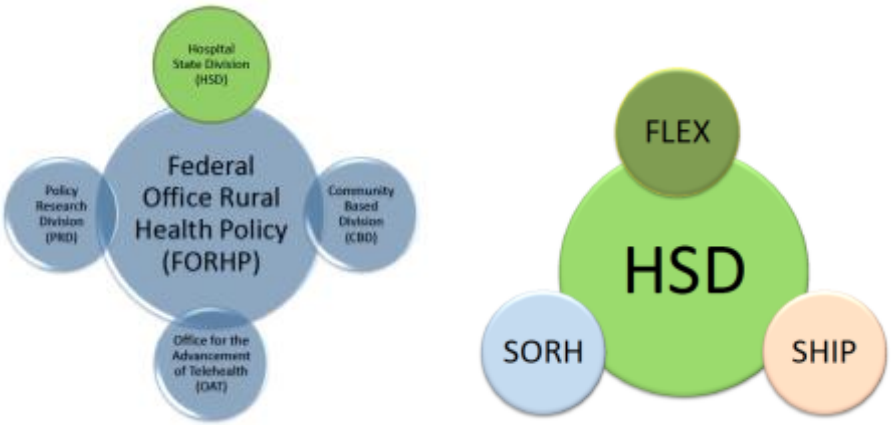
FORHP administers grant programs designed to build health care capacity at both the local and State levels. These grants provide funds to 50 State Offices of Rural Health (SORH) to support on-going improvements in care, and to rural hospitals through the Medicare Rural Hospital Flexibility Grant (Flex). Through its community-based programs, FORHP encourages network development among rural health care providers; upgrades in emergency medical services; and places and trains people in the use of automatic external defibrillators. FORHP also oversees the Black Lung Clinics grant program and the Radiation Exposure Screening and Education grant program. While these efforts are not solely focused on rural health issues, many of the populations affected reside in rural areas.



FORHP Structure

FORHP programs are organized in four divisions:

- The Community-Based Division (CBD) grant programs provide funding to increase access to care in rural communities and to address their unique health care challenges. Most of CBD's programs require community organizations to share resources and expertise using evidence-based models of care in networks of two or more health care services providers.
- The Hospital-State Division supports grants and activities for State Offices of Rural Health and support and technical assistance to small rural hospitals, including CAHs.
- The Policy-Research Team coordinates policy work impacting rural providers and beneficiaries, as well as fund research and analysis of key policy issues facing rural.
- The Office for the Advancement of Telehealth promotes the use of telehealth technologies for health care delivery, education, and health information services, and provides funding for telehealth grants and resource centers.



FORHP Program Coordinators

Program coordinators provide leadership and perform administrative and oversight activities that contribute towards the overall success of the grant program. They are responsible for preparation of grant guidance and coordination of the grant application, review and funding processes. Any questions related to the processing of the application, should be directed to the Program Coordinator.

Program	Coordinator
State Offices of Rural Health (SORH) Program	Suzanne Stack sstack@hrsa.gov
NOSORH Cooperative Agreement	Keith Midberry kmidberry@hrsa.gov
Medicare Rural Hospital Flexibility (Flex) Program	Sarah Young syoung2@hrsa.gov
Small Rural Hospital Improvement Program (SHIP)	Bridget Ware bware@hrsa.gov
Flex Monitoring Team (FMT) Program	Omy Boulote obouloute@hrsa.gov
Technical Assistance and Services Center (TASC)	Mike McNeely mmcneely@hrsa.gov
Rural Quality Improvement Technical Assistance (RQITA)	Yvonne Chow ychow@hrsa.gov

FORHP Project Officers

Project Officers carry out the day-to-day work on the three Hospital State Division grant programs and are the main point of contact for SORH, SHIP and Flex questions from grantees. Building a collegial relationship with Project Officers is an important activity for SORH leaders. Project Officers can be wealth of information and support to SORH in addition to the role they have for oversight and award of funds. The FORHP project officers want SORH to understand that if the grantee submits a budget revision or carry over requests, the Project Officer should be copied in any correspondence to the Grants Management Office. If grantees have questions about the review of their application, how the grant funds can be used, potential changes to their program, or changes in staffing, they should contact their Project Officer. Project Officers provide technical assistance to the states by providing FORHP and other updates, organize regular regional conference calls and facilitate with the planning of regional meetings.

Federal Office of Rural Health Policy
Hospital State Division

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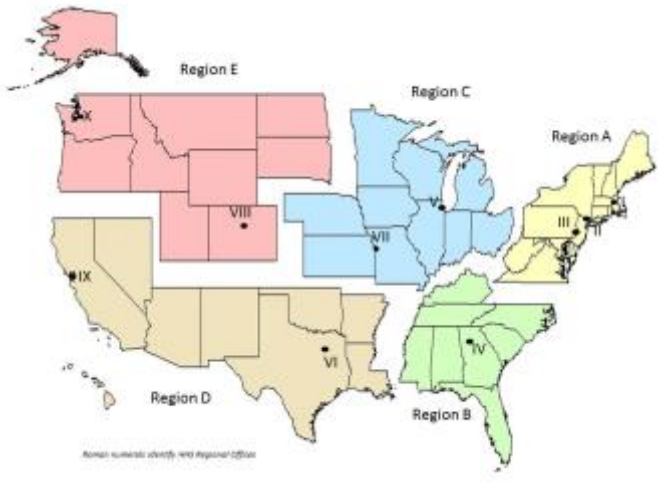

SORH Project Officers

Region A (13 States)	**Keith Midberry**	**(301) 443-2669**	kmidberry@hrsa.gov
	Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia		
Region B (8 States)	**Suzanne Stack**	**(301) 443-4043**	sstack@hrsa.gov
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Region C (10 States)	**Victoria Leach**	**(301) 945-3988**	vleach@hrsa.gov
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Region D (9 States)	**Keith Midberry**	**(301) 443-2669**	kmidberry@hrsa.gov
	Arkansas, Louisiana, Oklahoma		
	Victoria Leach	**(301) 945-3988**	vleach@hrsa.gov
	Arizona, California, Hawaii, Nevada, New Mexico, Texas		
Region E (10 States)	**Suzanne Stack**	**(301) 443-4043**	sstack@hrsa.gov
	Alaska; Colorado, Idaho, Montana, North Dakota, Oregon; South Dakota; Utah, Washington, Wyoming		

HRSA Office of Regional Operations

The goal for rural health for the Health Resources and Services Administration (HRSA) Office of Regional Operations (ORO) is to improve the access to quality health care services in rural areas, enhance information exchange, and support rural HRSA grantees and stakeholders.

Common service offerings include:

- ORO will establish, renew and strengthen strategic partnerships with HRSA's Office of Rural Health Policy, Federal partners and rural health organizations to identify and optimize opportunities for rural engagement.
- ORO will engage rural health organizations in each region to assess needs, share resources, and provide technical assistance to address disparities, access to care, and improve their ability to successfully apply for HRSA funding.
- ORO will identify and report critical groundlevel communications and information learned through rural activities to inform agency operations, decision-making, and allocation of resources.

Region 1 (CT, ME, MA, NH, RI, VT)
Jeff Beard (Acting), Regional Administrator (617) 565-1460

Region 2 (NJ, NY, PR, VI)
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Region 3 (DE, DC, MD, PA, VA, WV)
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Region 8 (CO, MT, ND, SD, UT, WY)
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Region 9 (AZ, CA, HI, NV, AS, CNMI, FSM, Guam, Marshall Island, Republic of Palau)
CAPT John Moroney, Regional Administrator (415) 437-8090

Region 10 (AK, ID, OR, WA)
Sharon Turner, Regional Administrator (206) 615-2059

CMS – Rural Health

The **Centers for Medicare & Medicaid Services** (**CMS**) is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, and clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments. The Centers for Medicare & Medicaid Services (CMS) have ten Regional Offices (ROs) reorganized in a Consortia structure based on the Agency's key lines of business: Medicare Health Plans Operations, Financial Management and Fee For Service Operations, Medicaid and Children's Health Operations, and Quality Improvement and Survey & Certification Operations. Each regional office has a rural health consultant, listed below.

Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)		
Rick Hoover	rick.hoover@cms.hhs.gov	(617) 565-1258
Region 2 (New Jersey, New York, Puerto Rico, Virgin Islands)		
Miechal Lefkowitz	miechal.lefkowitz@cms.hhs.gov	(212) 616-2517
Region 3 (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, WV)		
Patrick Hamilton	patrick.hamilton@cms.hhs.gov	(215) 861-4097
Region 4 (Alabama, Florida, Georgia, Kentucky, Mississippi, N. Carolina, S, Carolina, TN)		
Lana Dennis	lana.dennis@cms.hhs.gov	(404) 562-7379
Region 5 (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)		
Christine Davidson	christine.davidson@cms.hhs.gov	(312) 886-3642
Region 6 (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)		
Becky Peal-Sconce	becky.pealsconce@cms.hhs.gov	(214) 767-6444
Region 7 (Iowa, Kansas, Missouri, Nebraska)		
Claudia Odgers	Claudia.odgers@cms.hhs.gov	(816) 426-6524
Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming)		
Lyla Nichols	lyla.nichols@cms.hhs.gov	(303) 844-6218
Region 9 (AZ, CA, HI, NV, AS, CNMI, FSM, Guam, Marshall Island, Republic of Palau)		
Neal Logue	neal.logue@cms.hhs.gov	(415) 744-3551
Region 10 (Alaska, Idaho, Oregon, Washington)		
Theresa Cumpton	Teresa.Cumpton@cms.hhs.gov	(206) 615-2387

Many SORH maintain regular contact with their CMS office to stay informed about emerging issues, regulatory changes or other information which may impact rural providers. CMS also holds regular conferences calls called “Open Door Forums” on issues of interest to SORHs. The list includes:

- Special Open Door Forums
- Ambulance Open Door Forum
- Disability Open Door Forum
- End-Stage Renal Disease and Clinical Laboratories Open Door Forum
- Home Health, Hospice & Durable Medical Equipment Open Door Forum
- Hospitals Open Door Forum
- Low-Income Health Access Open Door Forum
- Medicare Beneficiary Ombudsman Open Door Forum
- Pharmaceutical, Pharmacy, and Device Manufacturers Open Door Forums
- Physicians, Nurses and Allied Health Professionals Open Door Forum
- Rural Health Open Door Forum
- Skilled Nursing Facilities/Long-Term Care Open Door Forum

Visit the CMS website to be notified when the next open door forums are scheduled - http://www.cms.gov/OpenDoorForums/.

NATIONAL PARTNERS

Rural Health Information Hub

The Rural Health Information Hub, formerly called the Rural Assistance Center (RAC), is a product of the U.S. Department of Health and Human Services' Rural Initiative and was established in December 2002 as a rural health "information portal." RHIhub helps rural communities and other rural stakeholders access the full range of available toolkits, programs, funding, and research that can enable them to provide quality healthcare to rural residents.

SORH often utilize or encourage constituents in their states to utilize the trained resource specialists available through RHIhub. RHIhub specialists staff a toll free phone line, ready to answer questions and be a resource to your technical assistance work and support for your state partners. These specialists can be reached by dialing 1-800-270-1898. RHIhub resources are featured in NOSORH's monthly newsletters. Find out more at https://www.ruralhealthinfo.org/.

National Rural Health Association

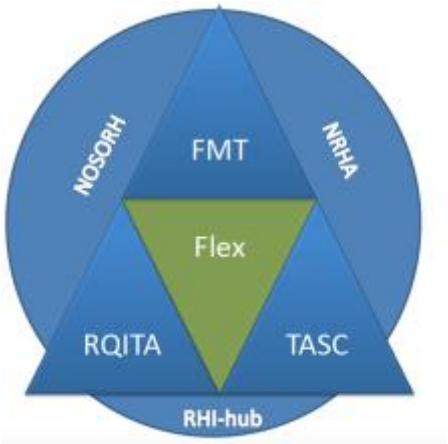
The National Rural Health Association (NRHA) is a national nonprofit membership organization with more than 20,000 members. The association's mission is to provide leadership on rural health issues. NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health. SORH benefit from attending their annual meetings and receiving policy information. More information can be found online at http://www.ruralhealthweb.org/.

Rural Health Research Centers and Analysis Initiatives

The Federal Office of Rural Health Policy (FORHP) currently funds seven rural health research centers and three rural health policy analysis initiatives. In previous funding cycles, FORHP has also funded individual researchers and other research centers. See projects currently in progress by all centers. The Research Gateway provides easy and timely access to research and findings of the FORHP-funded Rural Health Research Centers, 1997-present. The goal of the Research Gateway is to help move new research findings of the Rural Health Research Centers to end users as quickly and efficiently as possible. SORH use the Research Gateway to orient themselves to specific rural health facts and findings.

Current Research Centers & Areas of Expertise

- Maine Rural Health Research Center
  Health Insurance and the Uninsured, Long Term Services and Supports, Rural Health Clinics (RHCs), Mental Health, Substance Abuse
- North Carolina Rural Health Research and Policy Analysis Center
  Medicare, Medicaid and S-CHIP, Health Care Financing, Health Policy
- North Dakota and NORC Rural Health Reform Policy Research Center
  Health Policy, Health Services, Frontier health, Workforce
- RUPRI Center for Rural Health Policy Analysis
  Health Policy, Medicare, Medicare Advantage (MA), Health Insurance and the Uninsured, Health Services
- Rural and Underserved Health Research Center
  Substance Use Treatment, Primary Care, Emergency Department Access
- Rural Telehealth Research Center
  Telehealth, Health Information Technology, Technology
- South Carolina Rural Health Research Center
  Health Disparities, Minority Health, Health Services
- Southwest Rural Health Research Center
  Health Insurance, Maternal and Child Health, Aging, Diabetes, Substance Abuse
- University of Minnesota Rural Health Research Center
  Quality, Health Information Technology, Health Services
- WWAMI Rural Health Research Center
  Workforce, Health Services



Flex Monitoring Team

The Flex Monitoring Team is a performance monitoring resource for state Flex programs, Critical Access Hospitals, States, and Communities. The Rural Health Research Centers at the Universities of Minnesota, North Carolina-Chapel Hill, and Southern Maine (the Flex Monitoring Team), are the recipients of a 5-year cooperative agreement award from the Federal Office of Rural Health Policy to continue to monitor and evaluate the Medicare Rural Hospital Flexibility Grant Program (Flex Program). The monitoring project is assessing the impact of the Flex Program on Critical Access Hospitals and their communities and the role of states in achieving overall program objectives. SORH tap into the FLEX Monitoring team for reports on hospital financial and quality performance and to identify emerging issues impacting CAH. More information can be found at www.flexmonitoring.org.

Technical Assistance and Services Center

Technical Assistance and Services Center (TASC) has provided information, tools and education to critical access hospitals (CAHs) and to 45 state Flex Programs to improve quality, finances, operations, health system development and community engagement. TASC is a key partner of all forty-five FLEX programs and has a rich cadre of resources to support SORH. More information can be found at www.ruralcenter.org/tasc.

Rural Quality Improvement Technical Assistance

Rural Quality Improvement Technical Assistance (RQITA) is a cooperative agreement with the Federal Office of Rural Health Policy (FORHP) implemented by Stratis Health. The purpose of RQITA is to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of FORHP quality initiatives such as Flex programs, Small Health Care Provider Quality Improvement grantees, critical access hospitals (CAHs), and other rural providers. Through RQITA, technical assistance is provided in the following areas: data collection and analysis, understanding measure specifications, benchmarking and target setting, developing and implementing efficient and effective improvement strategies, and tracking the outcomes of quality improvement efforts.

Consortium of Telehealth Resource Centers

Telehealth Resource Centers (TRCs) have been established to provide assistance, education and information to organizations and individuals who are actively providing or interested in providing medical care at a distance. Their charter from the Office for Advancement of Telehealth is to assist in expanding of the availability of health care to underserved populations. More information can be found at http://www.telehealthresourcecenter.org/.

STATE PARTNERS

Area Health Education Centers (AHEC)

Area Health Education Centers enhance access to quality health care, particularly primary and preventive care, by improving the supply and distribution of healthcare professionals through community/academic educational partnerships. SORHs often partner with AHEC to achieve rural health workforce development goals.

National AHEC Organization – www.nationalahec.org

Search the RHIhub website (https://www.ruralhealthinfo.org/) for success stories, publications, and links to AHEC organizations.

State Primary Care Associations (PCAs) and State Primary Care Offices (PCOs)

State Primary Care Associations (PCAs) and State Primary Care Offices (PCOs) are some of the SORHs most important partners. Operating through grant funds authorized by Section 330 of the Public Health Services Act, PCAs and PCOs are administered by the Bureau of Health Workforce in the Health Resources and Services Administration (HRSA). PCAs and PCOs are charged with the responsibility of building appropriate relationships and collaborating in support of primary health care delivery to underserved populations.

Other responsibilities of PCAs and PCOs are to gather data and document the effects of such programs as CHIP and welfare reform on underserved populations, locate communities and specific populations that do not have access to primary and preventive care, and identify populations with significant health disparities. This information assists in the development of programs that will enhance preventive and primary care to all populations.

Primary Care Associations (PCAs)

PCAs are private, non-profit membership associations that support and assist Bureau of Health Workforce programs and other providers of preventive and primary care to underserved groups. On behalf of Health Centers, PCAs bring together organizations and individuals to build coalitions and support the strengthening and improvement of primary care.

Primary Care Offices (PCOs)

PCOs are located within state health agencies or other sectors of state government that have primary responsibility for supporting and expanding access to health care. Unlike PCAs, PCOs work exclusively toward the enhancement of primary health care within the state. PCOs operate under cooperative agreements with the Office of State and External Affairs in BPHC. BPHC's goals are the expansion of primary care access and the elimination of health disparities guide PCOs' activities. The state cooperative agreements behind the management of PCOs are particularly helpful in promoting collaboration between the private, local, State and Federal levels. PCOs' primary responsibilities are tailored according to state-specific needs and available resources. PCOs conduct research in an effort to understand state and community needs and problems. Studies and other information enable PCOs to improve their methods and strategies for supporting underserved communities, addressing access barriers, and improving poor health outcomes and disparities across population and areas.

LOCAL PARTNERS

Critical Access Hospitals

A Critical Access Hospital (CAH) is a hospital certified under a set of Medicare Conditions of Participation (CoP), which are structured differently than the acute care hospital CoP. Some of the requirements for CAH certification include:

- Having no more than 25 inpatient beds;
- Maintaining an annual average length of stay of no more than 96 hours for acute inpatient care;
- Offering 24-hour, 7-day-a-week emergency care;
- And being located in a rural area, at least 35 miles drive away from any other hospital or CAH (fewer in some circumstances).

The limited size and short stay length allowed to CAHs encourage a focus on providing care for common conditions and outpatient care, while referring other conditions to larger hospitals. Certification allows CAHs to receive cost-based reimbursement from Medicare, instead of standard fixed reimbursement rates. This reimbursement has been shown to enhance the financial performance of small rural hospitals that were losing money prior to CAH conversion and thus reduce hospital closures. CAH status is not ideal for every hospital and each hospital should review its own financial situation, the population it serves, and the care it provides to determine if certification would be advantageous.

The Medicare Rural Hospital Flexibility Program (Flex Program) was created by the Balanced Budget Act of 1997 and is intended to strengthen rural health care by encouraging states to take a holistic approach. The purpose of the Flex Program is to provide support for CAHs for quality improvement, quality reporting, performance improvements, and benchmarking; designating facilities as critical access hospitals; and the provision of rural emergency medical services. Through these activities the Flex Program ensure residents in rural communities have access to high quality health care services. State Flex funding for this three-year project period will act as a resource and focal point for strategic planning in the following program areas with an emphasis and priority on quality and financial and operational improvement:

1. Quality Improvement (required)

2. Financial and Operational Improvement (required)

3. Population Health Management and Emergency Medical Services Integration (optional)

4. Designation of CAHs in the State (required if requested) 5. Integration of Innovative Health Care Models (optional)

For support on the Flex Program, contact The Rural Health Resource Center Technical Assistance Service Center - http://www.ruralcenter.org/tasc

Community Health Clinics (aka Federally Qualified Health Centers - FQHCs)

Federally qualified health centers (FQHCs) include all organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must:

- Serve an underserved area or population
- Offer a sliding fee scale
- Provide comprehensive services
- Have an ongoing quality assurance program
- Have a governing board of directors

There are many benefits of being an FQHC. For FQHCs that are PHS 330 grant recipients, the biggest benefit is the grant funding. For new starts, funding up to $650,000 can be requested. Other benefits include:

- Enhanced Medicare and Medicaid reimbursement
- Medical malpractice coverage through the Federal Tort Claims Act
- Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program
- Access to National Health Service Corps
- Access to the Vaccine for Children Program
- Eligibility for various other federal grants and programs

CMS Federally Qualified Health Centers Center - https://www.cms.gov/center/fqhc.asp

Overview of the FQHC Program - https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers

Fact Sheet - https://www.cms.gov/MLNProducts/downloads/fqhcfactsheet.pdf

HRSA “The Health Center Program” http://bphc.hrsa.gov/

FQHC Member Association – National Association of Community Health Centers (NACHC) - http://www.nachc.com/

Rural Health Clinics

A Rural Health Clinic is a federally qualified health clinic certified to receive special Medicare and Medicaid reimbursement. CMS provides advantageous reimbursement as a strategy to increase rural Medicare and Medicaid patients' access to primary care services.

The National Association of Rural Health Clinics (NARHC) is the only national organization dedicated exclusively to improving the delivery of quality, cost-effective health care in rural under served areas through the Rural Health Clinics (RHC) Program. More information can be found at www.narhc.org.

CMS Rural Health Clinics webpage - https://www.cms.gov/center/rural.asp

RHC Resources for SORH - https://nosorh.org/member-resources/toolkits/

RESOURCES BY TOPIC

Community Health Workers

Community Health Workers (CHWs) are frontline public health workers who have a close understanding of the community they serve. RHIhub has designed a toolkit to help you evaluate opportunities for developing a CHW program and provide resources and best practices developed by successful CHW programs. The toolkit is made up of several modules. Each concentrates on different aspects of CHW programs. Modules also include resources for you to use in developing a program for your area.

- Module 1: Introduction to Community Health Workers
  An overview of community health workers and their roles.
- Module 2: Program Models
  Elements of differing models for CHW programs.
- Module 3: Training Approaches
  Available training materials and procedures for CHWs.
- Module 4: Program Implementation
  Building a program from the bottom up.
- Module 5: Planning for Sustainability
  How to ensure your CHW program functions properly.
- Module 6: Measuring Program Impacts
  Methods that allow you to measure the effectiveness of your program.
- Module 7: Disseminating Best Practices
  Letting other people know what you have done with your program.
- Module 8: Program Clearinghouse
  Examples of and contacts for successful CHW programs

At a 2015 NOSORH Regional meeting, information on community health workers was shared in the Montana Frontier Community Health Care Coordination Demonstration Grant. The presentation can be found here: https://nosorh.org/wp-content/uploads/2015/01/FCHIP-Care-Coordination-Community-Health-Worker-Program-Heidi-Blossom.pdf

Community Paramedicine

Community paramedicine (CP) is an emerging healthcare profession. It allows **paramedics** and emergency medical technicians (EMTs) to operate in expanded roles to provide healthcare services to underserved populations.

RHIhub has prepared a topic guide that can be found here:
https://www.ruralhealthinfo.org/topics/community-paramedicine

The National Association of Emergency Medical Technicians (NAEMT) has a great webpage with links to resources (on the left column), including a toolkit that is a collection of useful documents from various sources and the “knowledge center” link that has a lot of material as well. http://www.naemt.org/MIH-CP.aspx

Other resources can be found in the EMS section below.

Working with Vulnerable Hospitals

States across the nation are experiencing an increase in hospital closure. The North Carolina Rural Health Research Program (NCRHRP) reports that more than 100 rural hospitals have closed their doors to patients in need of inpatient services from 2005 through 2015. Closure rates show no sign of slowing with 12 hospitals closing since January of 2016. The National Rural Health Association reports that 673 additional hospitals are vulnerable and could close. Of these, approximately 200 are at high risk for closure. In cooperation with FORHP, NOSORH

has prepared the *State Office of Rural Health Roadmap for Working with Vulnerable Hospitals*. This document is filled with resources to assist SORH in identifying vulnerable hospitals to provide technical assistance. More information can be found on the NOSORH website at https://nosorh.org/working-with-vulnerable-hospitals-and-communities/

Leading Change

Leading Change: Best Practices in Technical Assistance for Rural and Frontier Health-Care Organizations in a Time of Transformation is a toolkit designed to meet the specific needs of rural and frontier health service organizations and the capacity building organizations that offer technical assistance to facilitate change.

The toolkit was developed by the National Network for Rural and Frontier Capacity, consisting of the National Center for Frontier Communities, the University of New Mexico Office of Community Health, the National Organization of State Offices of Rural Health, and the State Offices of Rural Health in Hawaii, South Carolina, Pennsylvania, Ohio, and Montana.

The entire toolkit can be found at http://frontierus.org/wp-content/uploads/2015/10/Leading-Change-Toolkit.pdf

Rural Health Clinics

The NOSORH Rural Health Clinic (RHC) Committee began in 2009 as a task force to assess what types of support SORHs were providing for RHCs. The task forced evolved into the RHC Committee in 2013 to focus on providing education for SORHs that are interested in providing technical assistance to RHCs and safety net providers. The committee began by surveying SORHs to understand the amount and type of technical assistance that was provided to RHCs. Since then, the Committee has used this information to help produce four modules:

Module 1: An Introduction to the Rural Health Clinic Program
Module 2: Learning About Certified Rural Health Clinics
Module 3: Helping SORHs Make Decisions About Providing Technical Assistance and Support to Rural Health Clinics
Module 4: Helping Rural Health Clinics Work Effectively with Other Key Rural Health Providers
Module 5: Rural Health Clinic Performance Measurement and Quality Improvement
Module 6: Incorporating Behavioral Health Services in the Rural Health Clinic

Veterans

NOSORH created an informative tool and “How-To” manual to support SORHs in addressing the health care needs of rural veterans. The guide includes:

- Information about rural health initiatives of the Veterans Health Administration (VHA)
- Key Questions to identify state-specific challenges for rural veterans on health issues
- Statistical data/facts about the health care needs of rural veterans
- Recent published literature related to the health care needs of rural veterans
- Information about the work of individual SORH related to addressing the health care needs of rural veterans
- Information on organizations engaging in veterans' health issues and their roles
- Potential solutions and best practices for addressing health care needs of rural veterans
- List of suggested activities SORHs may engage in to address the health care needs of rural veterans

You can find this toolkit and others on the NOSORH website at https://nosorh.org/member-resources/toolkits/.

KEY TOPIC STATEMENTS

Over the years, NOSORH gauges the most prominent health issues facing rural communities and identifies state and regional variations of those issues. As a result, NOSORH prepared a series of statements on these issues, which are included in the following narrative along with a few resources for addressing these priorities.

The following priorities were established then and have continued and will likely be priorities for the years ahead.

- ✓ Expand the rural healthcare workforce;
- ✓ Offer accessible, quality health care to the uninsured and underinsured;
- ✓ Reduce oral and behavioral health disparities in rural communities;
- ✓ Enhance the delivery of rural emergency medical services;
- ✓ Improve the status of small rural hospitals; and
- ✓ Invest in, and expand the reach of, health information technology.

The priorities are described in the following narrative along with some recommendations for action on each of the position statements which follow.

Statement on Expanding the Rural Healthcare Workforce

The shortage of healthcare workers in rural communities is the greatest rural health issue facing America today. While about 20 percent of the American population – approximately 61 million people – live in rural areas, only about nine percent of all physicians[1] and 12 percent of all pharmacists[2] practice in rural communities. Rural areas average about 30 dentists per 100,000 residents, while urban areas average approximately twice that number.[3] Shortages of nurses (both registered nurses and licensed practical nurses) and allied health professionals also abound.

This shortage is only expected to worsen as the demand for healthcare workers nationwide grows faster than the supply over the next several years. Consider the following:

- ✓ Overall, the Bureau of Health Professions projects that there will be a 33 to 44 percent increase in demand for physicians and a 41 percent increase in demand for RNs between 2000 and 2020.[4] Unfortunately, supply is not expected to keep up with demand; projections indicate there will be a shortage of approximately 200,000 physicians and 800,000 RNs in the United States by 2020.[5]

- ✓ The Bureau of Labor Statistics projects that between 2000 and 2010, an additional 1.2 million (50 percent increase) nursing aides, home health aides, and persons in similar occupations will be needed to (a) cover the projected growth in long-term care positions and (b) replace departing workers. However, the pool from which such workers have traditionally been drawn – mainly women between the ages of 25 and 50 without post-secondary education – continues to shrink.[6]

- ✓ The cost of medical education has reached unprecedented levels. According to the Association of American Medical Colleges (AAMC), the average medical school debt of students from the class of 2007 was $139,517; approximately 75.5 percent of those students graduated with a debt load of at least $100,000.[7] Given these reports, it should be no surprise that most choose to enter a subspecialty with a salary of $300,000 as opposed to primary care with a salary of $120,000.[8]

- ✓ The average cost to replace a critical care RN is $64,000 and the cost to replace an RN on a medical surgical unit averages $42,000, including recruitment, orientation, and non-productive time.[9]

- ✓ According to the Bureau of Health Professions, there is an acute shortage of pharmacists in the U.S. In February 1998, there were 2,670 unfilled full and part-time positions in the U.S. as compared to 6,920 in February 2000. Adding to this, enrollment rates in U.S. schools of pharmacy declined during this period.[10]

As those living in rural communities already know, a shortage of healthcare workers has a profound impact in a variety of ways: decreased access, which has a profound impact on quality of care; increased stress in the workplace; increased medical errors; increased workforce turnover/decreased retention rates; and increased healthcare costs. The projected national trends will only exacerbate the impact of rural health workforce shortages that currently exist.

State Offices of Rural Health have a rich history of developing partnerships; creating, delivering and managing programs; and providing resources and technical assistance that help meet the healthcare needs of rural Americans. Therefore, these organizations can play an important role in addressing these challenges. However, new rural healthcare policies and programs and additional funding are crucial if states are expected to address rural health issues and concerns as effectively as possible.

For that reason, NOSORH supports the creation and funding of programs and activities that expand the technical assistance capacity of State Offices of Rural Health. In terms of expanding the rural health workforce, funding for this improved technical assistance capacity could be used to:

- ✓ Increase the recruitment and retention of health professionals in rural communities;

- ✓ Develop equitable reimbursement and pay models/systems for primary care physicians;

- ✓ Work with institutions of higher learning, workforce training programs and state agencies to develop a greater understanding of rural health workforce development issues and create educational opportunities that expand the rural health workforce;

- ✓ Identify cross-credentialed profession models and work with allied health groups on implementation;

- ✓ Develop and implement community-based training programs that increase the number of students from rural communities entering health professions; and

- ✓ Improve workforce data collection in order to generate and analyze standardized data.

NOSORH is particularly supportive of programs and activities which enable State Offices of Rural Health to address the following recommendations made by the National Advisory Committee on Rural Health and Human Services:

- ✓ Stabilize current levels of primary care providers in rural areas through tax credits and incentive pay, particularly those in rural HPSAs and MUAs. Such incentives should be offered to both new and existing rural practitioners (Recommendations 89-13, 94-04).

- ✓ Increase and target funding for the U.S. Department of Health and Human Services' Health Professions Programs, with special priority given to programs that prepare

individuals for primary care, rural practice or practice with other underserved groups. Preference should be given to programs that provide clinical experiences in rural and other underserved areas; link rural clinicians and the faculty of teaching institutions; have curricula which address the health needs of rural and other underserved individuals and the health systems serving them; or weigh admission criteria to favor rural, underserved and/or disadvantaged/minority applicants (Recommendations 91-24, 91-27).

- ✓ Encourage more training of "mid-level" and allied health professionals for rural communities (Recommendation 01-13).
- ✓ Require that training programs receiving graduate medical education funding have rural training sites (Recommendation 01-17).
- ✓ Seek authorization and funding which allows pharmacists to be eligible for the National Health Service Corps (Recommendation 06-02).

Statement on Improving Rural America's Access to Health Insurance

Providing access to quality, affordable health care is one of the most significant issues facing the American healthcare system today. Despite government-funded "safety net" programs such as Medicare, Medicaid and the State Children's Health Improvement Program, approximately 45.7 million Americans – 15.3 percent of the U.S. population – still lack health insurance.[1] Nearly 8.1 million of those without insurance are children.[2]

This lack of insurance is especially worrisome in rural communities, whose residents are generally poorer, older and less healthy than their urban counterparts – factors that directly influence the adequacy of health insurance coverage and access to health care.[3] Because of the diverse geographic, demographic, social and economic structures of rural communities, the health and economic status of people living in remote rural counties (those not adjacent to urban counties) can even differ substantially from rural residents who live closer to large urban areas.[4] For example:

- ✓ Approximately 21.9 percent of residents in remote rural counties are uninsured, compared to 17.5 percent in rural counties adjacent to urban counties and 14.3 percent in urban counties.[5]
- ✓ Only 59 percent of workers in remote rural counties are offered employer-sponsored health insurance (compared to 69 percent in urban counties), and less than half of workers in remote rural counties are covered by their employers (compared to nearly 60 percent in urban areas). Two factors are primarily to blame for this phenomenon – workers in remote rural counties typically earn lower wages than urban workers, and residents of remote rural counties are more likely to work for smaller businesses.[6]
- ✓ Residents of remote rural areas also are more likely to be uninsured for longer periods of time; their chances of being uninsured for an entire year are a third greater than residents of urban counties.[7]

There is also growing evidence that rural residents with health insurance have coverage that pays less of their healthcare expenses, forcing them to pay a greater percentage of their healthcare costs – a commonly accepted definition of "underinsured." Consider the following:

- ✓ Ten percent of rural residents rely on the individual policies as opposed to employee-sponsored/group policies for their health insurance. On average, individual market plans

cover 63 percent of medical costs, compared to 75 percent covered by group insurance plans. Half of individual market plans cover just 30 percent of healthcare expenses.

- ✓ Thirty-five percent of rural residents with health insurance lack dental coverage (compared to 29 percent of urban residents). As a result, rural residents are 50 percent more likely than urban residents to report never going to the dentist.

- ✓ The rural privately insured are more than 50 percent more likely to have no drug coverage.

- ✓ Total annual healthcare expenses per person for non-metropolitan residents are 18 percent greater than annual healthcare costs for residents of metropolitan areas. When viewed as a percentage of household income spent on healthcare expenses, a two-person household in a non-metropolitan area would spend 20 percent of their income on healthcare expenses, compared to 13 percent for a similar metropolitan household.

- ✓ Out-of-pocket costs for rural, privately covered residents are about 10 percent higher than urban residents, suggesting the health benefits of rural residents are less comprehensive.[8]

Despite an array of healthcare differences between urban and rural communities, the ultimate health status of rural people has as much to do with the availability of health insurance – and the type of coverage available – as anything else. Quite simply, those who lack health insurance (or those with coverage which requires them to pay more out-of-pocket expenses) are less likely to seek the healthcare services they may need, thus worsening the health status and increasing the chronic conditions that exist among those individuals. Therefore, there is a need to improve rural Americans' access to quality, affordable healthcare – and to do so in a way that takes into account the diverse geographic, demographic, social and economic structures of rural America.

State Offices of Rural Health have a rich history of developing partnerships; creating, delivering and managing programs; and providing resources and technical assistance that help meet the healthcare needs of rural Americans. Therefore, these organizations can play an important role in helping make quality health insurance more accessible to these individuals. For this to occur, rural healthcare policies and programs – and the funding which supports these policies and programs possible – are critical if states are expected to address this rural health issue as effectively as possible.

For that reason, NOSORH supports the funding of programs and activities which expand the technical assistance capacity of State Offices of Rural Health **to meet the healthcare needs of rural Americans. In terms of increasing access to quality, affordable health care, NOSORH recommends:**

Parity and equity in health insurance coverage for all Americans regardless of geographic location.

National health reform efforts which ensure real access to health care for all Americans with a full range of healthcare options. Any reform efforts should encourage community integrative models of health care that foster collaboration between safety net providers and small rural hospitals.

The creation of health insurance community ratings models which take into account the unique economic issues in rural communities.

The establishment of health insurance programs which serve small rural employers and offer incentives to provide employer-sponsored health insurance.

Insurance plans which support a wide range of healthcare services and delivery options, including mental and behavioral health and tele-health services, among others.

Managed care plans, including Medicare Advantage which are structured so that they address the unique characteristics of rural communities.

Statement on Improving the Status of Small Rural Hospitals

Rural hospitals provide essential healthcare services to nearly 54 million people in the United States, including nine million Medicare beneficiaries.[1] These hospitals typically serve as the healthcare "hub" of the community, offering residents access to a continuum of healthcare services and providers in one location. They also are frequently one of the largest, if not the largest, employers in the community – meaning the financial stability of a small rural hospital has a tremendous influence on its community's economic health.

As is the case with most hospitals, small rural hospitals depend largely on Medicare reimbursements to compensate them for services they offer; however, those with attached nursing homes can be equally dependent on Medicaid. Unfortunately, these hospitals face enormous fiscal challenges as reimbursement rates for these services decline – especially rural hospitals, which suffer from lower Medicare margins due to their smaller size; more modest assets and financial reserves; and higher percentage of Medicare patients since rural populations are typically older than average urban populations.[2]

As reimbursement rates for services decrease, many rural hospitals find themselves eliminating critical healthcare services just to remain financially solvent; in some instances, they are even forced to close their doors. A host of other pressures – a sustained shortage of healthcare workers; healthcare liability premiums and health information systems that drive costs higher; limited capital to renovate or replace aging facilities – only make the situation worse. Therefore, there is a need to offer programs and services that enable rural hospitals to reduce/eliminate these risks and remain vital components of their communities

Several programs in recent years have sought to reduce the incidence of service reductions and hospital closures. Perhaps none of these programs has been more significant than the Medicare Rural Hospital Flexibility Program (Flex Program), which was established as part of the Balanced Budget Act of 1997. The Flex Program gives small rural hospitals the opportunity to apply for designation as a Critical Access Hospital (CAH) – a designation which allows them to receive cost-based reimbursement from Medicare and operate under Medicare Conditions of Participation that are more flexible than acute care hospitals. As a result, the hospital's financial performance and their ability to meet the healthcare needs of their community are improved greatly.[3] CAHs may not have more that 25staffed beds and must be located in a rural area (or an area that is treated as rural) that is at least 35 miles from another hospital or at least 15 miles from another hospital in mountainous terrain or areas with only secondary roads); or be certified before January 1, 2006 by the state in which they are located as a necessary provider of healthcare services.[4]

As of January 2009, 1,298 facilities in the United States had been certified as a CAH.[5] Various surveys indicate that the benefits to the communities in which the CAHs are located have been substantial. For example, a 2007 survey of 381 CAH administrators indicated that the critical access hospitals actively monitor the health and health system needs of their communities, engage with other community organizations and stakeholders to address those needs and provide services (often free) for patients and other provider organizations in the community that enhance access to care.[6] Another 2007 survey of administrators whose CAHs were undergoing facility replacements indicated that those enhancements led to tangible improvements in hospital performance and customer satisfaction and greater success in physician/staff recruitment and retention.[7] Given these benefits, more small rural hospitals may want to explore the possible advantages of securing a CAH designation.

State Offices of Rural Health have a rich history of developing partnerships; creating, delivering and managing programs; and providing resources and technical assistance that help meet the healthcare needs of rural Americans. Therefore, these organizations can play an important role in helping small rural hospitals address the challenges they face. For this to occur, rural healthcare policies and programs – and the funding which supports these policies and programs possible – are critical if states are expected to address this rural health issues as effectively as possible.

For that reason, NOSORH supports the funding of programs and activities which expand the technical assistance capacity of State Offices of Rural Health **to meet the healthcare needs of rural Americans. In terms of bolstering the status of small rural hospitals, NOSORH recommends the following:**

- ✓ Small rural hospitals should not be penalized on receiving health information technology grants because they receive cost-based reimbursements.
- ✓ Expand cost-based reimbursement for small rural hospitals with up to 50 beds.
- ✓ Create funding incentives for building and renovating small rural hospitals. These should be grant programs, not loan programs.
- ✓ Support programs that provide Medicaid cost-based reimbursements to critical access hospitals similar to the Medicare cost-based reimbursements.
- ✓ Restore necessary provider provisions for all small rural hospitals.
- ✓ Review statutory definitions and interpretations of what constitutes a hospital for distance requirement purposes.
- ✓ Review guidance on Small Hospital Improvement Programs regarding direct costs for program, personnel, and indirect costs to better meet the needs of SORHs in their efforts to both maximize project funds and still provide administrative support for running the program.

Statement on Reducing Behavioral Health Disparities in Rural Communities

According to statistics provided the National Institute of Mental Health, mental illness/mental health disorders are prevalent both domestically and abroad. In the United States alone, an

estimated 26.2 percent of adults (individuals age 18 or older) suffer from a diagnosable mental health disorder in any given year – approximately 57.7 million people, based on 2004 estimates from the U.S. Census Bureau.[1] Many people suffer from more than one mental health disorder at a given time; nearly half (45 percent) of those with any mental health disorder meet criteria for two or more disorders, with severity strongly related to comorbidity.[2] Suicide in and of itself poses a major public health risk, ranking as the 11th leading cause of death in the United States in 2005.[3]

The burden of mental illness on overall health and productivity in the United States and throughout the world has long been underestimated. Data attained through the Global Burden of Disease Study, conducted in 2005 by the World Health Organization, the World Bank and Harvard University, reveal that mental illness (including suicide) accounts for more than 15 percent of the burden of disease in established market economies worldwide – more than the disease burden caused by all cancers combined.[4] Mental health disorders are the leading cause of disability in the U.S. and Canada for persons age 15-44,[5] with major depression being the leading cause of disability worldwide among persons age 5 and older.[6]

Nearly 60 million Americans living in rural and frontier areas suffer from mental health issues; in fact, the prevalence of mental illness, substance abuse and related disabilities is equal to, or greater than, those found in urban settings.[7] For example, suicide rates in the U.S. for males 15 years and over increase as counties become less urban. The greatest variation is in the western United States, where the rate for most rural counties is nearly 80 percent greater than the rate in urban areas.[8] However, a shortage of and more limited access to healthcare providers, reduced rates of health insurance coverage and lower healthcare provider reimbursement rates have created even greater behavioral/mental health issues for rural Americans. For example:

- ✓ In 2003, 74 percent of all federally designated mental health professional shortage areas were located in rural counties.[9]
- ✓ Ninety percent of psychologists and psychiatrists and 80 percent of masters-level social workers work in metropolitan areas.[10]
- ✓ Fifty-five percent of all U.S. counties have no practicing psychiatrists, psychologists or social workers; all of those counties are rural.[11]
- ✓ Sixty-five percent of rural Americans get their behavioral health care from their primary care provider.[12]

Given the prevalence of mental health disorders and their public health impact, it should come as no surprise that addressing mental health-related issues is identified as one of the ten highest priority health issues in Healthy People 2010.[13] It should also come as no surprise that, given the disparities that currently exist in behavioral/mental health services provided in rural communities, there is a need to improve the quality of, and increase access to, behavioral/mental healthcare services for rural Americans.

State Offices of Rural Health have a rich history of developing partnerships; creating, delivering and managing programs; and providing resources and technical assistance that help meet the healthcare needs of rural Americans. Therefore, these organizations can play an important role in addressing these challenges. At the same time, however, new rural healthcare policies and programs – and additional funding to support those policies and programs – are critical if states are expected to address these rural health issues as effectively as possible.

For that reason, NOSORH supports the creation and funding of programs and activities that expand the technical assistance capacity of State Offices of Rural Health **to meet the behavioral healthcare needs of rural Americans. NOSORH is especially supportive of programs and activities that enable State Offices of Rural Health that address the following recommendations made by the Annapolis Coalition and the National Advisory Committee on Rural Health and Human Services:**

- ✓ Develop a national plan for responding to the severe shortage of behavioral health professionals in rural areas (National Advisory Committee). Any plan should call for the implementation of systematic recruitment and retention strategies at the federal, state and local levels and should include a "grow-your-own" approach (Annapolis Coalition).

- ✓ Define and support the development of a mid-level behavioral health workforce that ensures adequate access to services. (Annapolis Coalition)

- ✓ Increase the relevance, effectiveness and accessibility of rural behavioral health education and training programs which offer specialized curricula and rural-specific training opportunities (Annapolis Coalition).

- ✓ Increase Federal funding for behavioral health training programs which encourage the use of Federally-funded clinics, hospitals in underserved areas and other rural healthcare providers (National Advisory Committee).

- ✓ Support the distribution and use of technology which enhances the training of rural behavioral health professionals and delivers tele-mental health services to rural populations (Annapolis Coalition).

- ✓ Enhance the infrastructure available to support and coordinate behavioral health services by expanding active collaboration among rural service providers, consumers and state and Federal agencies and among different systems. (Annapolis Coalition)

Statement on Reducing Oral Health Disparities in Rural Communities

There has been a growing awareness of the connection between a person's oral health status and their general health and well-being. In 2000, then-U.S. Surgeon General David Satcher released a groundbreaking report, *Oral Health in America: A Report of the U.S. Surgeon General,* that addressed the role that good oral health plays in the overall health of Americans. The report noted that "safe and effective measures" already existed to prevent the most common dental/oral health diseases; however, because of the "profound and consequential" oral healthcare disparities that existed, not all Americans knew about or practiced appropriate oral health promotion measures. Not surprisingly, residents of rural communities have been among those most affected by oral healthcare disparities. Consider the following:

- ➢ Nationally, 48 million people live in 4,048 dental Health Professional Shortage Areas (HPSAs).[1] Ninety-four percent of all whole-county dental HPSAs and 67 percent of partial county dental HPSAs are rural U.S. counties.[2]
- ➢ Rural adults are significantly more likely than non-rural adults to have untreated dental decay (32.6 percent compared to 25.7 percent).[3]
- ➢ Rural residents are less likely to have dental insurance and are less likely to have access to fluorinated water supplies than their urban counterparts.[4]

A position paper released in 2001 by the American Dental Hygienists Association highlighted these key points:

- Dental caries (cavities) are the most common chronic disease affecting 53 percent of 6-8 year olds and 84 percent of 17 year olds.[5]
- Fourteen percent of adults aged 45-54 and 23 percent of adults aged 65-74 have severe periodontal disease.[6]
- Research has identified periodontal disease as a risk factor for heart and lung disease; diabetes; premature, low-birth weight babies and a number of other systemic diseases. Also, routine oral health exams can uncover symptoms of diabetes, osteoporosis and low bone mass, eating disorders and HIV.[7]

As a result of this increased awareness, a greater emphasis has been placed on improving the oral health status of Americans in the past decade. In 2003, then-U.S. Surgeon General Richard Carmona issued a *National Call to Action to Promote Oral Health*. Based on the findings of the 2000 *Oral Health in America*, the *National Call to Action* sought to expand plans, activities and programs that promoted oral health, prevented disease and reduced health disparities.[8] *Healthy People 2010* also identified oral health as one of its 28 focus areas.[9] Given the significant impact of these health disparities, there is a need to improve the quality of, and increase access to, oral healthcare services in rural communities.

State Offices of Rural Health have a rich history of developing partnerships; creating, delivering and managing programs; and providing resources and technical assistance that help meet the healthcare needs of rural Americans. Therefore, these organizations can play an important role in addressing these challenges. At the same time, however, new rural healthcare policies and programs – and additional funding to support those policies and programs – are critical if states are expected to address these rural health issues as effectively as possible.

For that reason, NOSORH supports the creation and funding of programs and activities that expand the technical assistance capacity of State Offices of Rural Health **to meet the oral healthcare needs of rural Americans. NOSORH is especially supportive of programs and activities that enable State Offices of Rural Health to address the following oral health recommendations made by the National Association of Rural Health:**

Increase Access to Oral Health Care:

- ✓ Place more emphasis on loan repayment and scholarships for oral health providers, especially those willing to serve in rural and underserved communities.

- ✓ Dental schools should create a residency or externship requirement for dental students to increase their practical experience and their service to rural and underserved communities.

- ✓ Allow foreign-trained dental students who complete their residency in the U.S. to obtain U.S. licensure in return for work in underserved areas.

- ✓ Create and fund capital improvement programs and increase support for public health infrastructures that enhance the delivery of rural oral healthcare services.

- ✓ Provide dental schools and residency programs with financial incentives to rotate students and faculty through private practices and health centers in rural areas.

- ✓ Increase federal support to community health centers which integrate oral health care more fully.

Reimbursement for Rural Oral Health Services:

- ✓ Expand Medicaid coverage so it makes oral health services a mandatory service for eligible adults; require Medicaid to cover preventive and basic restorative oral health care, not just emergency care; include transportation as a covered ancillary service; and require Medicaid reimbursement for oral health screening and treatment during pregnancy.

- ✓ Add dental services as a rural health clinic reimbursable service and allow rural health clinics to contract with local providers for these services.

- ✓ Provide Medicare reimbursement for dental care.

- ✓ Encourage oral health care within school-based clinics and within programs aimed at low-income children such as Head Start.

Oral Health Training Programs:

- ✓ Encourage applications from students with rural backgrounds and those with demonstrated service to underprivileged and minority populations.

- ✓ Emphasize serving as a safety net provider in the training of oral healthcare providers

- ✓ Increase dental student rotations through rural settings and create rural residency/externship programs

- ✓ Require family practitioners, pediatricians and mid-level providers to have oral health assessment training.

- ✓ Make scholarships available for practicing dentists, dental hygienists and students to do fellowships in geriatric oral health care.

Rural Oral Health Research:

- ✓ Develop and assess strategies for improving rural oral health services.

- ✓ Synthesize rural-specific data from existing public and private sources.

- ✓ Conduct a comprehensive study of the functions and utilization of allied health professionals, differences among state practice acts and the supply of personnel in these fields, in order to explore the expanded use of such as dental assistants, hygienists, and mid-level/allied health providers

- ✓ Study, catalogue and promote the adoption of best practices among state practice acts that enhance the rural oral health care workforce

- ✓ Study the issue of licensure reciprocity for dentists.

Oral Health in Rural America Fact Sheet
https://nosorh.org/wp-content/uploads/2013/08/Oral-Health-Fact-Sheet-and-Resources.pdf

To assist SORHs in their efforts, NOSORH has compiled many helpful resources for SORHs on our website, including:

- National Network for Oral Health Access
- Rural Assistance Center Rural Oral Health Toolkit
- Creating State and National Partnerships to Improve Rural and Frontier Oral Health
- Recruiting and Retaining Oral Health Providers in Rural Communities: Successes from Idaho and Iowa webinar
- How to Add or Expand Dental Services webinar
- Fundraising and Development 101 for Health Centers and Safety Net Clinics webinar

Statement on Enhancing Emergency Medical Services in Rural Communities

Emergency Medical Services (EMS) encompasses the initial stages of the emergency care continuum. EMS includes emergency calls to 9-1-1; the dispatch of emergency personnel to the scene of an illness or trauma; and the triage, treatment and transport of patients by ambulance and air medical service. Not surprisingly, EMS plays an especially critical role in rural areas of the United States – although only 20 percent of the nation's population lives in rural areas, it is where nearly 60 percent of all trauma deaths occur.[1] Moreover, the death rate in rural areas is inversely related to population density. Consider the following:

- ✓ The relative risk of a rural victim dying in a motor vehicle crash is 15 times higher than in urban areas, after adjusting for crash characteristics, age and gender.[2]
- ✓ Injury-related deaths are 40 percent higher in rural communities than in urban areas.[3]
- ✓ Eighty-seven percent of rural children who are victims of severe trauma do not survive to reach the hospital.[4]
- ✓ While nearly 85 percent of U.S. residents can reach a Level I or Level II trauma center within an hour, only 24 percent of residents living in rural areas have access within that time frame.[5]

Since 2001, NOSORH has worked with a broad range of partner organizations to address the greatest challenges facing EMS providers in rural communities. The challenges are many, but have been categorized into three major areas:

- ✓ *Recruitment and Retention:* Surveys of state EMS directors and local ambulance directors consistently rank recruitment and retention of personnel as the greatest challenge for EMS services.[6] Not only are these services scrambling to find personnel, but they also are struggling with a largely volunteer workforce for whom it is often difficult to maintain the necessary skills to appropriately treat patients who have complex and life-threatening medical needs. Reliance on a volunteer-based system (nearly 80 percent of EMS personnel in rural areas are volunteers compared to 33 percent in urban settings[7]), a shortage of leadership expertise and salaries that are generally less than other healthcare personnel contribute to the problem.

- ✓ *Reimbursement and Financing:* Rural EMS faces the problem of high fixed costs for a system with a low volume of patient transports, which presents a significant challenge in creating and/or maintaining a system that is sustainable. Limited or no local tax support,

inadequate reimbursement and high costs for equipment purchase and maintenance are significant concerns.

- ✓ *Restructuring and Coordination of Services:* According to the 2006 IOM report, *Emergency Medical Services at the Crossroads*, EMS systems have been developed haphazardly across the country; as a result, "…there is now enormous variability in the design of EMS systems among states and local areas.[8]" Fragmented care, disparities in response times, a lack of national quality measures, a lack of disaster preparedness, negative professional stereotypes and a limited evidence base for EMS practices are issues that must be addressed.

State Offices of Rural Health have a rich history of developing partnerships; creating, delivering and managing programs; and providing resources and technical assistance that help meet the healthcare needs of rural Americans. Therefore, these organizations can play an important role in addressing these challenges. In recent years, NOSORH has worked closely with the Office of Rural Health Policy (ORHP), the National Association of State EMS Officials (NASEMSO), the National Rural Health Association (NRHA), the National Highway Traffic Safety Administration (NHTSA) and others to improve rural EMS. With growing recognition of the crucial role played by EMS within the rural healthcare "safety net," SORHs are well-positioned to play a key role in a dialogue that ultimately should result in better integration of EMS into the rural healthcare delivery system. At the same time, however, new rural healthcare policies and programs – and additional funding to support those policies and programs – are critical if states are expected to address these rural health issues as effectively as possible.

For that reason, NOSORH supports the creation and funding of programs and activities that expand the technical assistance capacity of State Offices of Rural Health**. In terms of enhancing Emergency Medical Services in rural communities, NOSORH supports:**

- ✓ Increased visibility of emergency and trauma care within the Federal government, including support for the Federal Interagency Committee on EMS, the NHTSA Office of EMS and the National EMS Advisory Council, as well as a greater emphasis of rural EMS in the U.S. Department of Health and Human Services, including the Health Resources and Services Administration (HRSA) and the Centers for Medicare and Medicaid Services. This should involve:
  - ➢ Inclusion of ORHP on the Council on Emergency Medical Care, which provides input to Emergency Care Coordination Center in the HHS Office of the Assistant Secretary for Preparedness and Response, to ensure a rural voice in federal emergency preparedness and emergency care planning.
  - ➢ Restoration of federal funding for the HRSA EMS-Trauma Program, including sufficient "set aside" funding for rural EMS to support state-based efforts to enhance rural EMS and to re-establish a national Rural EMS and Trauma Technical Assistance Center.
  - ➢ A requirement to include pre-hospital providers in any Federally-funded Health Information Technology/Health Information Exchange (HIT/HIE) projects to ensure continuity of emergency care across the healthcare delivery continuum.
  - ➢ Inclusion of ambulance services in Federally-funded healthcare quality improvement programs.
  - ➢ Development of an EMS reimbursement methodology that includes readiness costs and permits payment without transport.

- ✓ Development of an EMS leadership model to strengthen EMS medical direction and ambulance service management nationwide.
- ✓ Adoption by states of nationally-recognized EMS education program accreditation standards.
- ✓ Development of evidence-based, model pre-hospital care protocols for the treatment, triage and transport of time-sensitive injuries and illnesses.
- ✓ Systematic efforts to increase quality and safety for EMS air and ground transports.

Resources from the National Rural EMS Conference 2016

A list of Emergency Medical Services (EMS) Resources was presented by the National Rural Health Resource Center at the Joint Committee on Rural Emergency Care (JCREC) meeting held in conjunction with the NOSORH Annual Meeting. A copy of the presentation can be found here:

https://nosorh.org/wp-content/uploads/2016/09/Rural-EMS-Resources-TASC-Nicole-Clement.pdf

All citations and additional resources can be found on the NOSORH website.

Acronyms

3R Net	National Rural Recruitment and Retention Network
ACF	Administration for Children and Families
ADAP	AIDS Drug Assistance Program
AHA	American Hospital Administration
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
APA	American Psychological Association
ARC	Appalachian Regional Commission
ASPE	Assistant Secretary for Planning and Evaluation
ATF	Bureau of Alcohol, Tobacco, and Firearms
ATSDR	Agency for Toxic Substances and Disease Registry
BBA	Balanced Budget Act of 1997
BBRA	Balance Budget Refinement Act
BCRS	Bureau of Clinician Recruitment and Services
BHPr	Bureau of Health Professions
BIA	Bureau of Indian Affairs
BIPA	Benefits, Improvement, & Protection Act of 2000
BLCP	Black Lung Clinics Program
BPHC	Bureau of Primary Health Care
CAH	Critical Access Hospital
CAP	Community Access Program
CARE	Comprehensive AIDS Resources Emergency
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHC	Community Health Center

CHGME	Children's Hospitals Graduate Medical Education
CIO	Chief Information Officer
CISS	Community Integrated Service Systems
CMS	Centers for Medicare and Medicaid Services
CQ	Center for Quality (HRSA)
CSG	Council for State Governments
CSHCN	Children with Special Health Care Needs
DASH	Deputy Assistant Secretary for Health
Delta	Delta State Rural Development Network Grant Program
Denali	Denali Commission
DHHS	Department of Health and Human Services
DIR	Division of Independent Review
DOC	Department of Commerce
DOE	Department of Energy
DoED	Department of Education
DOI	Department of Interior
DOJ	Department of Justice
DOL	Department of Labor
DOT	Department of Transportation
DOT	Directly Observed Therapy
DRA	Delta Regional Authority
DSH	Medicare Disproportionate Share Hospital
EEOC	Equal Employment and Opportunity Commission
EIS	Early Intervention Services
EMA	Eligible Metropolitan Areas
EMSC	Emergency Medical Services for Children
EPA	Environmental Protection Agency
FAA	Federal Aviation Administration
FCC	Federal Communications Commission

FDA	Food and Drug Administration
FDIC	Federal Deposit Insurance Corporation
FEC	Federal Exchange Commission
FEMA	Federal Emergency Management Agency
FESC	Frontier Extended Stay Clinics
FHWA	Federal Highway Administration
FI	Fiscal Intermediary
FIMR	Federal and Infant Mortality Review
FLEX	Medicare Rural Hospital Flexibility Grant Program
FMFIA	Federal Mangers Financial Integrity Act
FOH	Federal Occupational Health
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Center
FTC	Federal Trade Commission
FTE	Full-Time Equivalency
FY	Fiscal Year
GAO	Government Accounting Office
GHPC	Georgia Health Policy Center
GLMA	Gay and Lesbian Medical Association
GME	Graduate Medical Education
GMS	Grants Management Specialist
GPO	Government Printing Office
GPRA	Government Performance and Results Act
HAB	HIV AIDS Bureau
HEAL	Health Education Assistance Loans
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPDB	Healthcare Integrity and Protection Data Bank
HMO	Healthcare Management Organization

HOPWA	Housing Opportunities for Persons with AIDS
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HSB	Health Systems Bureau
HUD	Department of Housing and Urban Development
IGA	Intergovernmental Affairs
IHS	Indian Health Services
IME	Indirect Medial Education
INS	Immigration and Naturalization Services
IOM	Institute of Medicine
IRS	Internal Revenue Services
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LBGT	Lesbian, Gay, Bi-Sexual, and Transgender Populations
LEAP	Lower Extremity Amputation Prevention Project
LTHC	Long Term Care Hospital
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MA	Medicare Advantage (aka Medicare Part C)
MA-PD	Medicare Advantage Prescription Drug
MBQIP	Medicare Beneficiary Quality Improvement Project
MCTAC	Managed Care Technical Assistance Center
MDH	Medicare Dependent Hospital
MedPAC	Medicare Payment Advisory Commission
MMA	Medicare Modernization Act
MUA	Medically Underserved Area
MIPS	Merit-Based Incentive Payment System
PPACA	Patient Protection and Affordable Care Act
NAC	Rural Health and Human Services National Advisory Committee
NACHC	National Association of Community Health Centers
NACRHHS	National Advisory Committee for Rural Health and Human Services

NADO	National Association of Development Organizations
NCCC	National Center for Cultural Competence
NCHS	National Center for Health Statistics
NEA	National Endowment for the Arts
Network Planning	Network Development Planning Grant Program
Network	Network Development Grant Program
NGA	National Governor's Association
NHSC	National Health Service Corps
NHTA	National Highway Traffic Safety Administration
NID	National Institute of Dental Care and Craniofacial Research (NIH)
NMDP	National Marrow Donor Program
NOSORH	National Organization of the State Offices of Rural Health
NPI	National Provider Identifier
NPRM	Notice of Proposed Rural Making
NRDP	National Rural Development Partnership
OA	Office of the Administrator
OAT	Office for the Advancement of Telehealth
OCR	Office of Civil Rights
OFAM	Office of Federal Assistance Management
OFP	Office of Family Planning
OGM	Office of Grant Management
OIG	Office of the Inspector General
OIT	Office of Information Technology
OL	Office of Legislation
OMB	Office of Management and Budget
OMH	Office of Mental Health
OMPS	Office of Management and Program Support
OPA	Office of Population Affairs
OPDIV	Operating Division

OPE	Office of Planning and Evaluation
OPM	Office of Personnel Management
OPR	Office of Performance Review
ORHP	Office of Rural Health Policy (updated to FORHP)
OSHA	Occupational Safety and Health Administration
Outreach	Rural Health Care Services Outreach Grant Program
OWH	Office of Women's Health
PART	Performance Assessment Reviewing Tool Prospective Payment System
PCA	Primary Care Association
PCC	Poison Control Centers
PCO	Primary Care Organization
PFC	Partnership for Children
PFFS	Private Fee-for-Service
PHP	Public Health Preparedness
PHS	Public Health Service
PPO	Preferred Provider
PPS	Perspective Payment System
PQRI	Physician Quality Reporting Initiative
PSC	Program Support Center
QIO	Quality Improvement Organization
QulC	Quality Interagency Coordination
RAC	Rural Assistance Center
RAED	Rural Automatic External Defibrillator
RESEP	Radiation Exposure Screening and Education Program
RHC	Rural Health Clinic
RHN	Rural Health Network
RHRC	Rural Health Research Center
RHWKS	National Center for Rural Health Works
RRC	Rural Referral Center

RUCA	Rural Urban and Commuting Areas
RUPRI	Rural Policy Research Institute
RWCA	Ryan White Care Act
SAMHSA	Substance Abuse and Mental Health Services Administration
SBA	Small Business Administration
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCHPQI	Small Health Care Provider Improvement Grant Program
SEARCH	Student/Resident Experiences and Rotations in Community Health
SEC	Security Exchange Commission
SMRF	State Medicaid Research Files
SNF	Skilled Nursing Facility
SORH	State Offices of Rural Health
SPRANS	Special Projects of Regional and National Significance
SRDC	State Rural Development Councils
SSA	Social Security Administration
Treasury	Department of Treasury
TRHCA	Tax Relief and Health Care Act of 2006
USDA	United States Department of Agriculture
USMBHC	US.-Mexico Border Health Commission
VA	Department of Veteran's Affairs
VBP	Value Based Purchasing
VICP	Vaccine Injury Compensation Program
WIC	Women, Infants, and Children
WWAMI	Washington, Wyoming, Alaska, Montana, Idaho Research Center