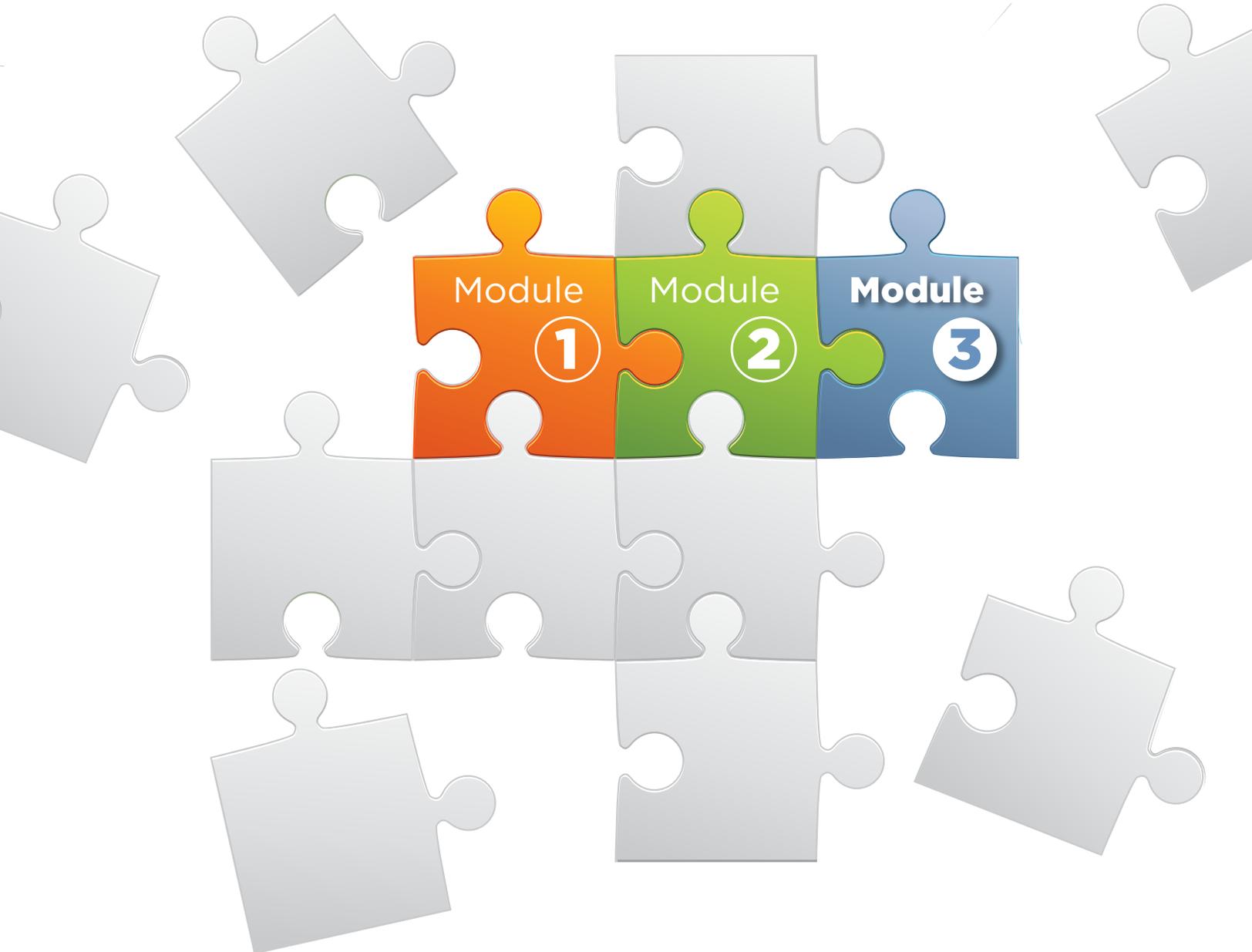




Module 3

**Helping SORH Make Decisions
about Providing Technical
Assistance and Support to
Rural Health Clinics and Other
Rural Primary Care Providers**

**Rural Health Clinic Technical Assistance
Educational Series**



MODULE 3



Helping SORHs Make Decisions about Providing Technical Assistance and Support to Rural Health Clinics and Other Rural Primary Care Providers

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MODULE 3

Helping SORH Make Decisions about Providing Technical Assistance and Support to Rural Health Clinics and Other Rural Primary Care Providers



Target Audience and Objectives

This module is designed primarily for State Office of Rural Health (SORH) directors and team members interested in development and implementation of technical assistance for rural primary care providers including Rural Health Clinics (RHCs). Although RHCs are central in this module, general business principles are applicable to most primary care provider types. Some content may be appropriate to share with partners, stakeholders and/or community members. Objectives for this module include:

1. To understand the core principles of technical assistance and their application.
2. To provide information, ideas and suggestions to help SORH determine their capacity to provide technical assistance and the process to determine appropriate services to meet identified needs within the rural primary care practice.
3. To provide information, ideas and suggestions to help SORH develop a basic technical assistance services strategy to rural primary care providers with the available bandwidth and expertise of the SORH team.
4. To outline the benefits to SORH for providing technical assistance to RHCs and other rural primary care providers.
5. To outline opportunities for SORH to provide technical assistance to rural primary care providers.

Within the rural healthcare landscape, a major area of interest and concern is whether communities have the primary care infrastructure required to expand services to the millions of rural citizens who are aging, uninsured and/or underinsured. Rural primary care

providers in general serve an “older, sicker, poorer population.” According to the USDA¹, 19% of the rural population is 65 years or older.

Suggested Resource Materials and Background Reading:

[*Introduction to the Rural Health Clinic Program \(Rural Health Clinic TA Project Educational Module 1\)*](#), NOSORH, 2019

[*Learning about Rural Health Clinics \(Rural Health Clinic TA Project Educational Module 2\)*](#), NOSORH, 2019

Rural Health Information Hub [*Am I Rural?*](#)

[*National Association of Rural Health Clinics \(NARHC\)*](#)

[*Tiered Technical Assistance Program*](#)
(NOSORH)

[*Rural Health Clinic Center*](#), Centers for Medicare and Medicaid Services

[*Apply to Become an NHSC Site*](#),
National Health Services Corp

[*A Quick Guide for Rural Health Clinics Applying for NHSC Site Approval, Health Resources and Services Administration, May 2010*](#)

[*SORH RHC Technical Assistance Survey, June 2019*](#)

[*Strengthening Nonprofits: A Capacity Builder's Resource – Delivering Training and Technical Assistance*](#) (2010), Compassion Capital Fund

The Rural Health Research Gateway reported in November of 2018 that rural America had a poverty rate of 16.9% vs 13.6% in urban.² For those who have been uninsured and/or underinsured for an extended period of time, there is possibility of an increased need for preventive care and screenings, as well as for diagnosis and treatment of chronic diseases and other health issues. This care is typically managed by primary care providers.

In rural communities the concern is even more acute as rural America does not have the number and distribution of primary care providers needed. Following the 2010 Census, the Federal Office of Rural Health Policy (FORHP) definition of rural included approximately 57 million people, about 18% of the population and 84% of the land area of the U.S.³

Rural Healthy People 2020⁴

(<https://srhrc.tamhsc.edu/rhp2020/index.html>)

“Rural Healthy People 2020’s goal is to serve as a counterpart to Healthy People 2020, providing evidence of rural stakeholders’ assessment of rural health priorities and allowing national and state rural stakeholders to reflect on and measure progress in meeting those goals. The specific aim of the Rural Healthy People 2020 national survey was to identify rural health priorities from among the Healthy People 2020’s (HP2020) national priorities.”

—Abstract from that survey Rural Healthy People 2020: New Decade, Same Challenges⁵ was created.

This document as well as the [June 2019 SORH RHC TA Survey](#) are used in the following pages to inform the development and implementation of technical assistance services a State Office may provide to RHCs and other rural primary care providers. RHCs are a valuable part of the healthcare safety net in rural America. Unlike FQHC’s, RHCs do not receive federal operational subsidies/grants. However, RHCs and other rural primary care providers do provide access to primary care for Medicaid and Medicare beneficiaries, to people with private health

insurance and to the uninsured. Many use a sliding fee scale or discounted fee schedule to assure people who live in poverty can still receive access to quality primary care.

Because of the value of the RHCs and their rural primary care counterparts, SORH are working harder than ever to provide assistance and capacity building to these providers to remain sustainable and continue to function as an integral part of the safety net system.





SECTION 1:

To understand the core principles of technical assistance and their application.

A. Defining Rural Primary Care Providers

The American Association of Family Practitioners (AAFP) defines primary care in four domains. This module focuses on domain #2 Primary Care Practice – “A primary care practice serves as the patient’s first point of entry into the health care system and as the continuing focal point for all needed health care services. Primary care practices provide patients with ready access to their own personal physician, or to an established back-up physician when the primary physician is not available.

Primary care practices *provide health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses* in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.).

Primary care practices are organized to meet the needs of patients with undifferentiated problems, with the vast majority of patient concerns and needs being cared for in the primary care practice itself. Primary care practices are generally located in the community of the patients, thereby facilitating access to health care while maintaining a wide variety of specialty and institutional consultative and referral relationships for specific care needs. The structure of the primary care practice may include a team of physicians and non-physician health professionals.”⁶

Rural primary care providers include but are not limited to CMS certified Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs)/ Community Health Centers (CHCs), independent clinicians, and practices, free and charitable clinics and other primary care providers serving rural communities. Additional examples of services generally provided in the primary care settings include well visits and physicals; immunizations for children and adults; management of chronic conditions; coordination of care with specialists;

basic women’s health (including PAP smears); treatment of acute illness, injuries and the like.⁷

The following pages define technical assistance and discuss rationale for SORH to explore the provision of meaningful technical assistance.

B. Defining Technical Assistance

The Compassion Capital Fund (CCF), administered by the U.S. Department of Health and Human Services, is a “grant program [that] helps grassroots organizations increase their effectiveness and enhance their ability to provide social services to low-income individuals. [Their] goal is to strengthen the role of organizations in their ability to provide social services to low-income communities.”⁸

CCF inspired the National Resource Center to create the *Strengthening Nonprofits: A Capacity Builder’s Resource Library* assist with the continuation of CCF’s capacity building work.”⁹

One of the resources developed is *Strengthening Nonprofits: A Capacity Builder’s Resource – Delivering Training and Technical Assistance*. Although the resource was last updated in 2010, this resource library remains a strong tool for understanding training and technical assistance delivery. The resource helps us differentiate between training and technical assistance:

“Training is delivered in small or large group settings (seminars, workshops, and courses) and designed to teach key concepts related to a particular topic. When should you use training rather than individualized technical assistance?

Trainings can be a better value for your money and provide opportunities for valuable peer-learning. In the long term, trainings open the door to building a community of practice among the organizations you serve. If you assess several organizations in



your community and find a common need, training, rather than individual technical assistance, will be the most efficient and effective method to address that specific need.”¹⁰

“Technical assistance (TA) is the process of providing targeted support to an organization with a development need or problem.” It is commonly referred to as consulting. TA may be delivered in many different ways, such as one-on-one consultation, small group facilitation, or through a web-based clearinghouse.

TA is one of the most effective methods for building the capacity of an organization. By including TA in a capacity building project, you make the capacity building much more likely to create change. According to some, 10 percent of what gets learned in training is applied on the job, while 95 percent of what is coached gets applied on the job. Technical assistance is this coaching.”¹¹

The descriptive definitions above provide a strong foundation to build a strategic technical assistance program. To ensure a robust technical assistance program, begin development by adhering to the definition above and then incorporate each of the “Core Principles” listed below.

Core Principles of Technical Assistance

While each TA engagement will vary in duration, topic, form, and structure, it should be shaped using the following principles:

- **Collaborative.** Work jointly with the organization's staff to identify underlying needs and long-term goals of the capacity building engagement.
- **Systematic.** Use a systematic approach when providing TA, such as the approach outlined in the next section.
- **Targeted.** Determine what areas of the organization have the greatest need and where TA will have the greatest impact. Target your efforts at those areas.
- **Adaptive.** As the TA provider, you must remain adaptive throughout the engagement. Be flexible

according to the needs of the beneficiary organization.

- **Customized.** Respond to the unique needs of each beneficiary organization by designing and delivering tailored TA engagements.
- **Asset-based.** Organizations, like people, can more easily build on strengths than develop brand new competencies. Every organization has its own unique pool of resources and relationships from which it can draw, and TA should help the organization identify, engage, and leverage the assets that exist.
- **Accountable.** Create a mutual agreement such as a memorandum of understanding and draft a work plan that outlines specific actions and responsibilities.
- **Results-driven.** Identify measures that indicate improvements in management practices or organizational performance and track those measures to prove that the TA had real, measurable results.¹²

While both training and TA have their merits, TA better lends itself to rural business models with its characteristic customizable nature and organization specific attributes. The merits of training should not be diminished however, the focus of this module is technical assistance.

Technical Assistance programs do not have to be complicated or expensive, but they must demonstrate the principles above. SORH may face challenges including funding, bandwidth and availability of resources as they development and implement a technical assistance program. A robust and impactful technical assistance is possible when following the core principles.

C. Rationale for SORH to Provide Technical Assistance

The State Office of Rural Health Grant guidance stipulates that SORH grantees provide TA in addition to a few other requirements. This reason alone should encourage development of



a TA program. Whether provided by internal team members or if the TA is contracted to an outside vendor, these services are a requirement of the grant.

Other than being a grant requirement, there are many reasons why a State Office should provide TA services to rural primary care providers. Many rural providers do not have the resources to commit to professional development for their teams. In the rapidly changing healthcare landscape, on-going, in-depth capacity building is critical to the success and sustainability of rural providers.

Currently, SORH across the nation provide varying levels of TA to RHCs and other rural primary care providers. Some are interested in developing more expertise and increasing the TA available to their rural providers; some are actively working to develop their internal expertise; some leverage partnerships with other SORH to increase availability of TA; while others tap into the services of outside vendors to provide assistance services. This interest in assisting rural primary care providers comes at a critical time in the evolving health care landscape.

SECTION 2:

To provide information, ideas and suggestions to help SORH determine their capacity to provide TA and the process to determine appropriate services to meet identified needs.

A. How does a SORH determine its capacity to provide technical assistance?

As previously mentioned, there is considerable variation in the scope, type and depth of TA offered by SORH to rural primary care providers. Because of the interest of many SORH and the expertise of some, nearly a decade ago NOSORH embarked on a project to help SORH either begin providing TA, consultation, referral or increase the amount and scope of TA provided.

This work began in mid-2009, when NOSORH asked SORH to describe the type of TA they provide RHCs, topics covered, and tools used. Ten SORH provided the information requested and agreed to provide guidance to the project. These states were providing significant TA to RHCs and were donating their time

and expertise to help guide the development of TA modules to help other SORH develop TA and training resources.

Since that time, the need for and provision of TA has grown exponentially. Annually, NOSORH surveys SORH to determine TA provided to RHCs. The June 2019 SORH RHC TA Survey was expanded to include a few broader questions to incorporate all rural primary care providers. This survey had 36 responses from 31 states. Of the respondents, 50% provide some TA to RHCs at least weekly with an additional 18% providing services at least monthly.

Eighty-five percent of SORH responding to the survey fund TA services through the State Offices of Rural Health Grant and approximately 71% use Flex funds. Most states reported using a combination of funding depending on the TA recipient and type.



Table 1 below reflects the SORH reported types of TA provided to RHCs and other rural primary care provider types:

	SORH STAFF PROVIDE TA	CONTRACT TO PROVIDE TA	DO NOT PROVIDE TA	NEED RESOURCES AND/OR EDUCATION TO PROVIDE TA	TOTAL RESPONDENTS
How to start an RHC	71.43% 20	14.29% 4	14.29% 4	17.86% 5	28
Regulatory and Legislative Changes	74.07% 20	14.81% 4	11.11% 3	14.81% 4	27
Health Information Exchanges	18.52% 5	33.33% 9	44.44% 12	11.11% 3	27
Electronic Medical Records	17.86% 5	25.00% 7	39.29% 11	32.14% 9	28
Health Equity	53.85% 14	11.54% 3	23.08% 6	26.92% 7	26
Telehealth	57.14% 16	25.00% 7	10.71% 3	32.14% 9	28
Other Health Information Technology	32.00% 8	28.00% 7	36.00% 9	20.00% 5	25
Primary Care Medical Homes	42.86% 12	21.43% 6	25.00% 7	32.14% 9	28
Accountable Care Organizations	29.63% 8	22.22% 6	44.44% 12	25.93% 7	27
Value Based Care (CMS Quality Payment Program (MACRA) and Merit-based Incentive Payment System)	25.00% 7	35.71% 10	10.71% 3	57.14% 16	28
Quality Improvement	59.26% 16	44.44% 12	11.11% 3	18.52% 5	27
Population Health	75.00% 21	32.14% 9	7.14% 2	14.29% 4	28
Billing/Coding/Documentation	27.59% 8	58.62% 17	10.34% 3	24.14% 7	29
Leadership	40.74% 11	25.93% 7	37.04% 10	14.81% 4	27
Cost Reports	17.86% 5	50.00% 14	28.57% 8	14.29% 4	28
Reimbursement	39.29% 11	32.14% 9	21.43% 6	28.57% 8	28
Compliance (Conditions of Participation)	58.62% 17	31.03% 9	17.24% 5	17.24% 5	29
Mock Surveys	39.29% 11	17.86% 5	35.71% 10	25.00% 7	28



CONTINUED

**Table 1:
Types of Technical Assistance Provided to RHCs and Other Rural Primary Care Providers**

	SORH STAFF PROVIDE TA	CONTRACT TO PROVIDE TA	DO NOT PROVIDE TA	NEED RESOURCES AND/OR EDUCATION TO PROVIDE TA	TOTAL RESPONDENTS
Project Management (including but not limited to Grant Management, Innovation Projects, Transformation, etc.)	51.85% 14	14.81% 4	37.04% 10	14.81% 4	27
EMS	52.00% 13	44.00% 11	12.00% 3	16.00% 4	25
Substance Use Disorders/Opioids	42.86% 12	32.14% 9	21.43% 6	35.71% 10	28
Recruitment and Retention	78.57% 22	28.57% 8	7.14% 2	7.14% 2	28
Data Collection and Analysis	48.15% 13	37.04% 10	18.52% 5	14.81% 4	27
Community Development	53.57% 15	14.29% 4	21.43% 6	32.14% 9	28
Rural/Urban Collaborations	40.74% 11	14.81% 4	33.33% 9	22.22% 6	27
Grant Writing	62.96% 17	14.81% 4	14.81% 4	25.93% 7	27





Table 2 below reflects the identified top rural priorities from Rural Healthy People 2020: New Decade, Same Challenges. Keep in mind this information was obtained through a survey completed by rural residents across the country.

Table 2:
Types of Technical Assistance Provided to RHCs and Other Rural Primary Care Providers

Table 2 Selection as a “Top 10” Rural Healthy People 2020 Priority, Nationally and by Census Region

Priorities	Overall		West		Midwest		South		Northeast	
	No.	%	No.	%	No.	%	No.	%	No.	%
Access to quality health services	926	76.3	138	81.2	374	74.2	325	74.9	72	82.8
Nutrition and weight status	661	54.5	80	47.1	286	56.8	232	53.5	52	59.8
Diabetes	660	54.4	79	46.5	275	54.6	241	55.5	53	60.9
Mental health and mental disorders	651	53.6	81	47.7	280	55.6	229	52.8	53	60.9
Substance abuse	551	45.4	72	42.4	235	46.6	190	43.8	46	52.9
Heart disease and stroke	550	45.3	74	43.5	241	47.8	182	41.9	46	52.9
Physical activity and health	542	44.7	70	41.2	244	48.4	180	41.5	36	41.4
Older adults	482	39.7	71	41.8	188	37.3	175	40.3	39	44.8
Maternal, infant, and child health	449	37.0	57	33.5	188	37.3	166	38.3	34	39.1
Tobacco use	429	35.3	53	31.2	188	37.3	139	32.0	39	44.8
Cancer	428	35.2	55	32.4	174	34.5	162	37.3	35	40.2
Educational and community-based programs	400	33.0	60	35.3	162	32.1	146	33.6	31	35.6
Oral health	381	31.4	47	27.7	174	34.5	132	30.4	21	24.1
Quality of life and well-being	327	26.9	46	27.1	132	26.2	119	27.4	26	29.9
Immunizations and infectious diseases	324	26.7	43	25.3	139	27.6	113	26.0	24	27.6
Public health infrastructure	315	26.0	46	27.1	129	25.6	110	25.4	25	28.7
Family planning and sexual health	278	22.9	38	22.4	113	22.4	101	23.3	22	25.3
Injury and violence prevention	265	21.8	36	21.2	110	21.8	89	20.5	26	29.9
Social determinants of health	258	21.3	35	20.6	115	22.8	87	20.1	18	20.7
Health communication and health IT	257	21.2	38	22.4	105	20.8	85	19.6	22	25.3

Interestingly, many of the topics identified in Table 2 above are “clinical” in nature and related to the “business” of healthcare while many of the topics identified by SORH are more “operational” in nature. There should be balance between the types of topics in order to offer a robust TA program.

As the tables above outline, there is no shortage of opportunities to provide TA. As a SORH weighs opportunities and options, questions to consider might include:

1. What is the best fit for current and/or future SORH staffing?
2. Should we offer services with in-house team members or should these services be contracted to outside resources?

3. Might there be better return on investment (ROI) to contract services while building internal capacity?

These questions should be thoroughly explored before making any decisions. The NOSORH Technical Assistance Director can provide guidance and, by request, can come alongside the SORH as a thought partner while developing these basic TA strategy parameters. Further, the [Tiered Technical Assistance Program](#) can provide necessary guidance and momentum to develop an in-depth TA strategy for the SORH while providing support to the SORH and its stakeholders as the SORH builds internal capacity.



B. How does a SORH determine the level of need of rural primary care providers?

Determining the level of need of rural primary care providers may be accomplished in several ways.

1. Establish a relationship where the SORH is the “trusted advisor” of the rural provider. In this instance, needs will arise organically.
2. Develop and implement an outreach strategy informing all rural providers of services provided by the SORH. Direct marketing of services offered.
3. Offer to assist with completion of a Community Health Needs Assessment or other community driven process.
4. Develop a survey to be completed by direct service providers with questions focused on need and areas where TA is most needed.



SECTION 3:

To provide information, ideas and suggestions to help SORHs develop a basic technical assistance services strategy to rural primary care providers with the available bandwidth and expertise of the SORH team.

A. How does the SORH determine level of internal team expertise?

Once a SORH determines it will provide TA services and has generally determined need of rural primary care providers they will serve, the SORH must evaluate the internal level of expertise necessary to meet the identified need.

As previously mentioned, the SORH RHC Technical Assistance Survey is repeated annually. For 2019, the scope of the survey was broadened to include other rural primary provider types aligning with the NOSORH Strategic Priorities. The [2019 Survey Summary results](#) are included in the Resources section of this module and on the NOSORH website. A copy of the full survey is also posted on the NOSORH website. SORH are encouraged to review the summary results.

The survey results may serve as a foundation for determining the areas of expertise that might be needed to provide a robust TA program. Keep in mind that development of a TA program is a marathon not a sprint. Have realistic expectations of what the SORH can and should provide. It is better to start

small and slow, increasing services at a thoughtful, reasonable pace. Do not institute an area of TA until its sustainability is assured.

Building in-state SORH TA capacity is the preferred and recommended approach. This is the preferred path for SORH to pursue for many reasons including:

- Many important primary care resources and relationships are state based
- There is such variation among states in the rural primary care landscape
- HRSA has at least two points of contact in each state for primary care development, i.e. the SORH and the Primary Care Office (PCO)
- Many states also have a state primary care association (PCA)
- Some states have a state rural health clinic association (RHCA)

The economic impact of developing and maintaining services must be acknowledged. States may be eligible to apply for resources from DHHS, FORHP and other offices within HRSA that could expand



SORH capacity specifically in the primary care space. While some SORH might be able to build TA programs within their current capacity, some SORH might need to consider hiring new team member(s). If a SORH decides to hire new team member(s), consideration must be given to the type of staff/level of expertise to hire, the onboarding/education process, the marketing of services, whether or not to charge for services and if so, how much. These answers should be based on the TA strategy and its implementation.

Some SORH that are currently providing TA started their service by hiring seasoned practice management consultants experienced with RHC requirements, making the consultants immediately available to the RHCs. Other SORH started by assigning RHC work to staff with field experience, such as those who work with Critical Access Hospitals (CAHs), staff who have a strong fiscal or healthcare billing background (or knowledge), or staff with clinical expertise.

SORH have learned that keeping the skills of team members working with RHCs and other rural primary care providers honed and current is imperative. Providing TA teams with learning opportunities and providing flexibility to learn, grow and be available to rural primary care providers is essential.

NOSORH provides several opportunities to strengthen the TA bench within SORH. Basic assistance is provided as a benefit of the membership. Effective January 1, 2020, NOSORH also offers the [Tiered Technical Assistance Program](#) which allows for an individualized opportunity to meet the needs of RHCs and rural primary care providers while building capacity within the SORH. This [Tiered Technical Assistance Program](#) may be project specific or a deeper dive into the development and implementation of a customized TA strategy. Additional information regarding the Tiered Technical Assistance Program can be found in the Resources section of this module.

B. Who might a SORH partner with to ensure rural primary care providers receive needed assistance?

It is well established that partnerships make rural health work possible on many levels. Provision of TA is one of those areas that lend itself to partnership. Earlier in this module, the SORH RHC TA Survey data as well as the table from Rural Healthy People 2020 provided insight into potential topic areas of needed TA. With those in mind, here are a few potential partner types to consider as a SORH develops a TA strategy:

Type I: Communication and Advocacy for Rural Primary Care Providers

- National Association of Rural Health Clinics (NARHC)
- National Rural Health Association (NRHA)
- State Rural Health Associations
- State Rural Health Clinic Associations

Type II: Development and Compliance (Regulatory)

- Deeming Entities
- Financial Feasibility Consultants
- Licensure Specialists (state level and national level) ■ NARHC

Type III: Existing Practices — Operational Sustainability

- **Financial**
 - Financial Consultants
 - Rural IT Specialists
 - Coding & Billing Specialists
 - Education for Coders & Billers
- **Administrative**
 - Human Resource Specialists
 - Board Education Specialists
 - Communications/Marketing Specialists
- **Clinical**
 - Quality Improvement Specialists
 - Recruitment/Retention Specialists
 - CME Specialists
 - Credentialing & Enrollment Specialists



■ Information Systems

- Electronic Health Record Specialists
- Broadband
- Telehealth Capacity Specialists

■ Other

- Grant Finding & Writing Specialists
- Network Development & Management Specialists
- Population Health/Health Equity Specialists
- Affiliation Specialists (larger health systems)

NOSORH has established strategic partnerships through the years and may have information to help in the search for potential TA partners. The NOSORH Technical Assistance Director can provide guidance and, by request, can come alongside the SORH as a thought partner while developing these basic TA strategy parameters.

C. When is the appropriate time to provide technical assistance?

The current precarious economic situation in many rural communities makes **now** a compelling time to start work designed to enhance RHC and primary care service sustainability. There may be federal resources through HRSA or other partners to assist with primary care development, network development and/or primary care workforce development.

For rural communities to benefit from these federal and other resources, the SORH must be fully engaged. A SORH can open doors for RHCs and other rural primary care providers. Development of a SORH TA program for rural primary care providers can begin with an introduction. The needs of RHCs have been documented through the NOSORH RHC Survey for many years. Opportunities exist for building capacity, resources and creative, thoughtful work.

SECTION 4:

To outline the benefits to SORH for providing technical assistance to RHCs and other rural primary care providers.

Benefits to SORH and rural areas of the state it serves are not difficult to identify when providing TA to RHCs and other rural primary care providers. As healthcare reform was implemented and as a result of the economic and job environment in many rural communities, RHCs are vital to the rural healthcare infrastructure.

By definition, RHCs are primary care practices located in medically underserved rural areas. Developing avenues to provide TA to strengthen the sustainability of these and other essential rural safety net providers might be a priority activity in states where little TA has been offered in the past. Helping communities understand opportunities and available resources is a pressing and ongoing issue. Adding RHC and other rural primary care provider development and sustainability possibilities to the

SORH TA portfolio is important and may be extremely beneficial for the state. Understanding and clearly explaining differences and similarities between RHCs and FQHCs, for example, is a subject some SORHs help rural healthcare providers, stakeholders and communities understand.

Some states have a long history of providing assistance to RHCs and other rural primary care providers. The North Carolina Office of Rural Health and its founding director, Jim Bernstein, were instrumental in the drafting of Public Law 95-210 legislation (which created the Rural Health Clinic Program) and then working with Congress to get the law passed in 1977. The legislation had two central goals. The first was to **improve access** to primary health care in rural and underserved communities



and the second to **promote a collaborative model of health care delivery** using physicians, nurse practitioners and physician assistants. This wording defined a primary care practice model that Jim Bernstein and others thought would work and would demonstrate long-term sustainability.

They were right. Today, RHCs continue to provide access to high quality primary care throughout rural America using the practice model first described in the legislation. The requirement that RHCs must use advanced practice practitioners, i.e. physician assistants and nurse practitioners, helped solidify those provider types, have grown their scope of practice through the years and helped extend primary care to vulnerable populations — primarily rural Medicaid and Medicare beneficiaries.

Other benefits of providing TA to rural primary care providers include but are not limited to:

- It is the right thing to do. Every person should have access to quality primary healthcare close to home.
- Development of TA is possible through the flexibility of funding sources, problem solving, SORH leadership and creative thinking.
- Providing TA makes business sense for a SORH. This helps meet grant requirements and is a natural fit with the work of the office. Rural practices need the help, rural care delivery provides an effective,

efficient model for providing primary care and so the need and the opportunity to assist makes a compelling argument to provide TA.

- TA provides the opportunity to facilitate relationships between providers and other state agencies such as licensure to increase access to care in rural communities.
- Rural primary care providers are local businesses. Health services dollars are desperately needed in rural communities. Helping these providers is helping rural development and the rural economy and may help keep jobs local.
- The SORH has reason to become involved in rural communities. In turn, rural providers and rural communities get a conduit into the state. State officials may grow to see communities and primary care providers from a big-picture perspective and begin to think about what else these rural primary care providers might do to help the state meet objectives, i.e. immunizations, pneumococcal vaccination, cancer screening, diagnosis and treatment of chronic diseases, etc.
- Retention of primary care providers in rural communities is imperative to access and the overall wellness of a community. The SORH develops resources and provides TA services that help the sustainability of these providers which allows for more successful recruitment and retention overall.





SECTION 5:

To outline opportunities for SORH to provide technical assistance to rural primary care providers.

A. Where might a SORH find user friendly, cost effective resources for rural primary care providers that they might share?

Should funding be a concern, there are several cost-effective TA resources with specific focus on RHCs. General business practice guidance might be gained from these resources for other rural primary care providers, as well.

There are quite a few TA resources available at little or no cost to RHCs. Most of these resources are provided through the FORHP or some other bureau, the Centers for Medicaid and Medicare (CMS) or through Cooperative Agreements with national partners such as NOSORH.

Not all rural primary care providers are aware of these available TA resources. A positive, helpful step for SORH may be to promote these resources to RHCs and other rural primary care providers. Module 2 in this RHC Education series outlined these nationally available resources; the list below highlights some of these. For more information, consult Module 2 or follow the links below.

Technical Assistance Resources

Federal Office of Rural Health Policy: The Federal Office of Rural Health Policy (FORHP) provides direct support to several organizations that in turn assist Rural Health Clinics. The [FORHP website](#) contains links to assets and provides helpful RHC information. The [Resources](#) web page provides information about the rural health work provided by FORHP and their strategic partners.

National Association of Rural Health Clinics

(NARHC): RHC technical assistance calls and the listserv maintained by NARHC are valuable assets. RHCs and SORH are encouraged to sign up for the listserv and conference calls by visiting the FORHP or NARHC websites. The NARHC homepage provides an invitation and prompts for signing up to the NARHC listserv. Archived conference call information is available, as is information and links for calls conducted from July 2008 through the present.

In addition, NARHC offers a training called the **Certified Rural Health Clinic Professional (CRHCP) Course** that is designed to teach participants the operation and management of a successful RHC. This comprehensive course is offered to Directors, Consultants, Clinic Administrators & other RHC leaders. Upon course completion & attainment of an 80% or higher exam score, you will earn a CRHCP certification. For more information on the CRHCP Course [click here](#).

There are other resources available through NARHC; the website provides links to those.

National Rural Health Association: The National Rural Health Association (NRHA) is a national nonprofit membership association made up of diverse individuals and organizations that share the common bond of an interest in rural health. For NRHA members, assistance is available via the NRHA annual meeting and a fall RHC educational meeting. For information about dues, membership benefits and RHC resources visit the NRHA website.



Rural Health Information Hub: RHHub provides a list of frequently asked questions for RHCs and links to various websites and documents useful to existing RHCs, practices considering becoming an RHC or SORH staff interested in learning more about the RHC program.

National Health Service Corps: RHCs may become eligible for recruitment and retention assistance from the National Health Service Corps (NHSC) either through loan repayment or the assignment of an NHSC scholar. State Primary Care Offices (PCOs) should be able to provide information about how RHCs might be eligible for assistance through the NHSC. SORH and RHCs should visit the website for additional information.

Centers for Medicare and Medicaid Services (CMS): One of the features of the CMS website is its **Rural Health Clinic Center**, which links users to a plethora of RHC - related regulations; the RHC legislation itself; information about billing, enrollment, CMS manuals, payment manuals; and many other links, resources and topics. The website also provides free information, technical support and assistance. SORH should know the CMS site exists and what information is available so they can refer RHCs to the CMS page for TA resources.

RHC Fiscal Intermediaries (FI) and **Medicare Administrative Contractors** (MAC) should also provide free consultation and TA to RHCs. Contact them for additional information as types and levels of assistance provided may vary.

If SORH staffing bandwidth is a concern, NOSORH offers a wide range of direct TA and TA capacity building development assistance for its members and their stakeholders. Contact NOSORH Technical Assistance Director for additional information.

B. What should a SORH know?

When beginning development of a TA strategy, SORH should carefully consider several questions:

- What is the overall need and in which topic areas?
- What is the overall team member bandwidth availability to address the determined TA need?
- What is the current team member skill level/expertise in the topic areas of need?

What is the current team member bandwidth to take on additional workload (individually)?

- What are possible other/outside resources to contract/collaborate with to meet identified need?

Reach out to the NOSORH Technical Assistance Director for assistance and/or as a thought partner in the early phases of TA strategy development.

During consideration of the questions outlined above, keep in mind the following basic list of possible TA topics as decisions regarding these services are considered.

Type I: Communication and Advocacy

■ Communication and Promotion

- Distribution of information via website, email or newsletter
- NOSORH RHC Education Modules and other resources
- SORH one-pager (who we are and what we do)
- SORH resources
- RHC conferences or workshops
- TA conference calls and/or webinars
- Site visits to RHCs or potential practices
- Membership support for NARHC or state RHC Associations
- RHC program promotion or marketing to non-RHC primary care practices
- Point of contact for RHC issues and questions

■ Advocacy or Education

- Advocacy at the local, state or national level
- Work with state survey agencies (see Module 2)
- Work with Medicaid on reimbursement issues
- Facilitation with other state agencies or offices

Type II: Development and Compliance

(Regulatory)

■ Decision to Apply, Survey and Certify

- Economic impact analysis
- Financial feasibility study
- Assistance with conversion to RHC
- Data analysis for eligibility
- Designation issues
- Mock survey
- Policies and Procedure Manual
- Ownership decisions
- Biennial RHC evaluations
- Medicare enrollment
- Change of ownership
- Post-survey plans of correction
- Qualitative assessment
- Quality Assessment and Performance Improvement (QAPI)\Projected interim cost report
- Emergency preparedness

Type III: Existing Practices – Operational Sustainability

■ Fiscal

- Financial Policies and Procedures
- Budgeting
- Accounting Systems
- Billing Systems
- Coding
- Managing Accounts Receivable
- Fee Schedules
- Sliding Fee Scales (or discounted fee schedules)
- Cost reports

■ Administrative

- Personnel Policies and Procedures
- Staffing
- Organization Chart
- Position Descriptions
- Management and/or leadership skills
- Strategic Planning
- Marketing, outreach
- Staff training – various
- Ownership, governance
- Board training
- Biennial RHC Evaluations

■ Clinical

- Quality Improvement
- Best practices
- Coding practices
- Documentation practices
- Provider relations
- Provider recruitment and retention
- Continuing education
- Credentialing
- RHC Provider enrollment

■ Information Systems

- Health Information Technology
- Broadband availability and affordability
- Patient registration, eligibility
- Patient appointments
- Electronic Health Records
- Telehealth capacity (medical and behavioral health)
- Practice Management

■ Other

- Consortium or network development, management
- Pharmacy assistance programs
- Migrant, seasonal farm workers
- Health Equity
- Population Health (including aging, Veterans, etc.)
- Grant development

C. What should a SORH do?

Reasons why SORH develop and provide TA services to RHCs and other rural primary care providers are compelling, as is the concern and difficulty of the work. The benefits of providing TA are provocative and reveal a deep level of thought and work that is and may be invested by SORH in developing, fielding, building and maintaining a robust TA program.

The difficulty of hiring or re-assigning team members, developing expertise and then providing and evaluating the quality of the TA services provided are daunting tasks. The level of need expressed by the RHCs (see Module 2) and the considerable thought many SORH have invested in developing, expanding or maintaining the level of assistance provided is clear.

Simple steps and suggestions follow for SORH wanting to begin providing assistance to rural primary care providers including RHCs:

Suggested Steps to Consider when Developing a TA Program

1. Develop a mailing list of RHCs from the CMS list posted on the CMS website or from the State Medicaid office as well as other rural primary care providers.
2. Send an introductory letter to providers. Provide overview information about the SORH, contact information and invite them to use the SORH website. In the letter, include information about the FORHP supported services available through the NARHC and provide a link to the FORHP and NARHC websites. Link them with the RHIMHub. Read the first three RHC Education modules again. Read specified sections from the [Starting a Rural Health Clinic: A How-to Manual](#). Despite its age, it remains a solid resource for SORH and stakeholders alike.
3. Schedule an introduction and orientation meeting with the State Licensure and Survey staff.
4. Ask for an orientation session with the PCO staff (if not part of the SORH). Ask them what help they provide RHCs and other rural primary care providers. How do they assist eligible practice locations to become NHSC sites, for example, do they help develop a sliding fee scale? Are they interested in developing a small rural primary care provider/RHC work group to determine what could be easily offered to these providers that would help retain primary care services? What are their recruitment activities? Learn about potential loan repayment programs (both state and federal).
5. Review the Summary Results of the 2019 SORH RHC TA survey and share results with other state partners.
6. Develop a workplan for RHC workshop, rural primary care workshop or assistance service

expansion. Develop a business plan/strategy for these services. Ask NOSORH for basic assistance and consider joining the Tiered Technical Assistance Program for more in-depth, customized assistance such as strategy development and implementation.

7. Review which SORH provide TA services and then ask NOSORH for educational exchange and/or mentoring resources to work with a fellow SORH.

Consider contracting directly with NOSORH and/or fellow SORH for faculty for RHC workshops, rural primary care workshops, or for help educating you and your team. The NOSORH Team as well as fellow SORH are willing to assist with education, developing expertise, as well as advising on staffing. Each member is committed to helping SORH succeed with this primary care work. Contact the NOSORH Technical Assistance Director with questions or for additional information.

8. Review your Flex budget and determine how provider based RHC support fits with Flex objectives.
9. Develop an evaluation plan to accompany the business plan/strategy. Think about how to move forward, as well as how to determine if the investment made in RHC services is meeting the objectives set.
10. Start small. Take the first step. Do something. Take action.

It is possible that SORH can develop other TA services, education or outreach initiatives for rural primary care providers without large investments in staff time or direct funds. For example, every SORH could develop and maintain a mailing list (or e-mail list) of these providers. The [CMS list](#) of RHCs discussed in Module 2 is available by state and updated periodically. SORH might use the [CMS list](#) to contact all the RHCs in the state to introduce themselves, provide information about the SORH website as well as offer to include RHCs in education offered by the SORH, SORH home institutions and/



or partner training. SORHs might provide information in the initial contact letter or e-mail about the free resources outlined earlier in this module and in Module 2, particularly the listserv and TA calls offered by FORHP through [NARHC](#).

SORH can assist with strengthening the safety net of rural primary care providers by assisting RHCs. SORHs should recognize RHCs as partners in improving and increasing access to quality primary care for rural residents and make connections for RHCs with other state, regional and federal partners.

The amount and scope of TA and outreach provided to RHCs by SORHs is wide ranging as reflected in the SORH RHC TA Survey results. For example, 68% of the SORHs responding to the survey note they provide TA at least monthly to RHCs in their state, while 88% of the respondents state they provide assistance to RHCs by distributing information via email.

The RHC survey (see Module 2 and the [SORH RHC Survey Summary results](#) posted on the NOSORH website) identified RHC TA needs. Some SORH already providing TA to RHCs noted they needed additional resources, especially when practices were developing their RHC. For example, RHCs needed assistance with data analysis for eligibility, shortage area designation aid and help with the state survey agency. These are services SORH could develop fairly easily by working with the state PCO and by developing rapport with the state survey agency staff. Results of the SORH RHC TA survey are provided to inform SORH what colleagues in other states are doing to assist RHCs or their future plans. The results also help inform the work of NOSORH Technical Assistance and the Primary Care Committee (formerly the RHC Committee).

Conclusion

As previously stated, the current precarious economic situation in many rural communities makes **now** a compelling time to start work designed to enhance RHC and primary care service sustainability in rural areas. There may be federal resources through HRSA and/or other sources to assist with primary care development, network develop and/or primary care workforce development.

For rural communities to benefit from these federal and other resources, SORH must be fully engaged. SORH may open doors and build relationships for RHCs and other rural primary care providers. Starting to develop TA services to these providers can begin with an introduction. The needs of RHCs have been documented through the NOSORH RHC Survey for many years. Opportunities exist for building capacity, resources and creative, thoughtful work.

Most importantly, start. Start small. Take the first step. Take action.





SORH Self-Assessment

The information and questions below provide a 4 step process intended to help State Offices of Rural Health determine what role they should (or should not) play in providing technical assistance for rural primary care providers and communities. SORHs should understand that their role may need to change over time, depending on the technical assistance needs of the rural providers and communities. This assessment is meant to provide a general guide for discussion and framework for articulating the technical assistance role of the SORH.



Fundamental Questions For SORH Consideration

Recommendation: If any answer to these questions is no, it is recommended that the SORH should have NO role in technical assistance to rural primary care providers and communities.



1. Does the SORH know the needs and vulnerabilities of rural primary care providers in the state?
2. Does the highest level of leadership to which the SORH reports support the technical assistance role — with both financial and human resources — of the SORH and provision of those services?
3. Does the SORH or its partners have an invitation or existing relationship with the rural primary care provider and/or the community which to build the technical assistance effort? If no, how difficult might it be to establish?
4. Is there at LEAST a .10 FTE available from the SORH to champion the development of a TA strategy.



Questions To Determine Role Of The SORH

Recommendation: SORH team members should utilize these questions to consider the capacity they (and their partners) have to respond to the needs of rural primary care providers and communities. They should be fully vetted before proceeding with any effort.

1. Will the SORH be available as a resource to all rural primary care providers and communities? In the event of multiple target communities how will these be prioritized?
2. Are travel funds available from the Office budget(s) to support SORHs team members to travel to identified rural communities? How much travel funding is available?
3. Are there Office funds available to support contractors or partners to provide additional expertise? How much? What is the timeline for being able to disseminate these funds?
4. What is the additional available FTE of SORHs team member(s) for supporting or working directly with the provider and/or community? e.g. staff for travel, meeting coordination, logistics, preparation of materials?
5. Is there at least one other partner willing to engage? e.g. hospital associations, primary care associations, rural health associations, universities, AHEC, Cooperative Extension, economic development authority, county commission.
6. What resources can partner offer? e.g. FTE of staff, expert consultants, funding to support travel to the rural primary care providers or community.
7. Is there a “sanctioned” community focal point for the technical assistance? e.g. an advisory committee appointed by the county commission, a community development agency, or hospital employee?
8. Does the community already have an achievable goal for the technical assistance effort?
9. Has a simple project plan including a goal for addressing the needs of been adopted by community and a TA team?
10. Is there an Memorandum of Understanding (MOU)/ Business Associates in place for the SORH, the provider organization, the community and/or any needed partners and contractors to achieve the project plan?

SORH Self-Assessment



Utilizing the chart below, consider the questions for consideration and identify a descriptive role for your SORH to adopt

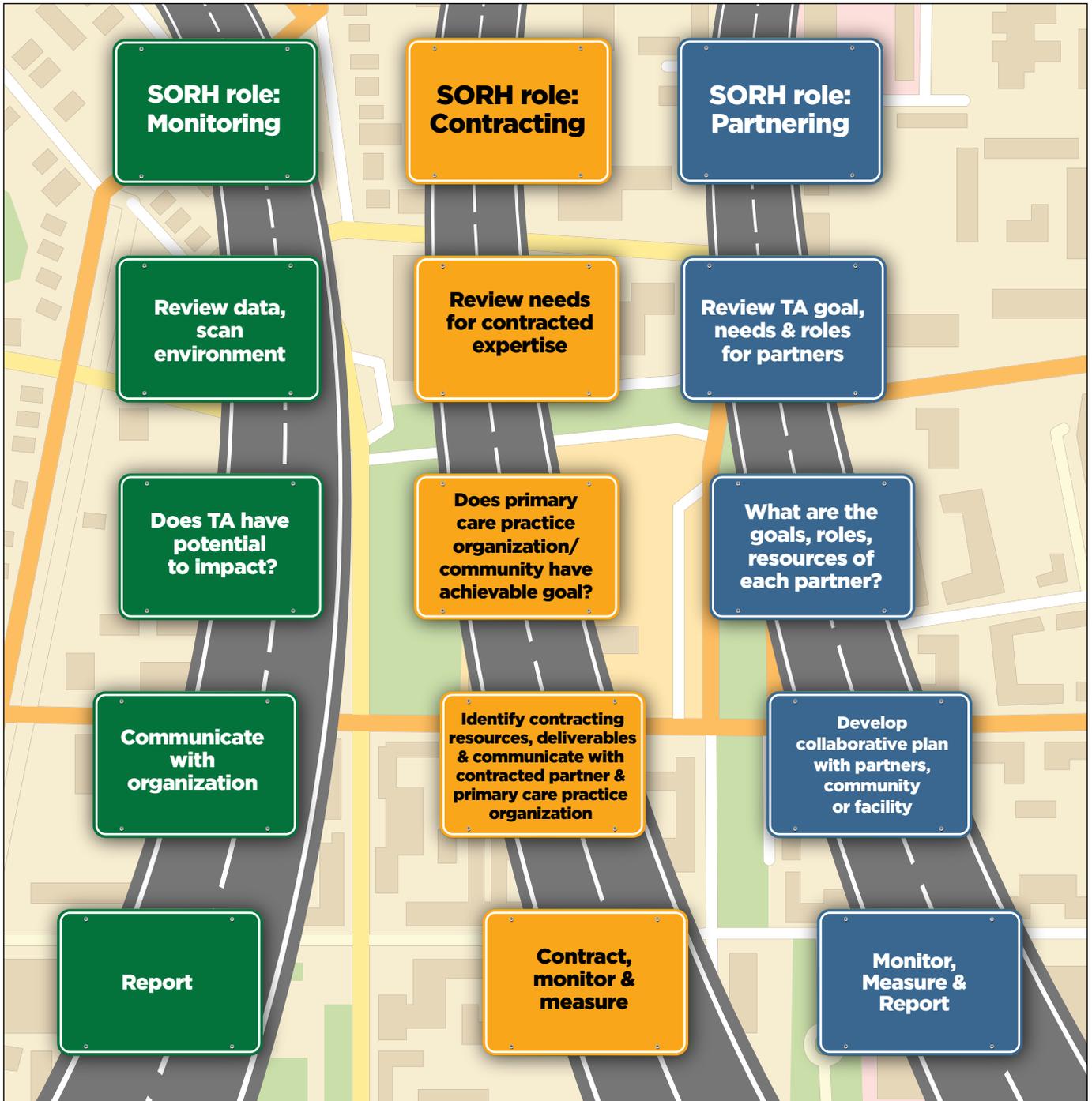
With answers to these questions SORH can consider one of three general roles. This delineation of roles is a general guide to determine the type of TA the SORH might consider given existing capacity

SORH/partner available resource	Which Role?	Types of TA
.10 FTE and no other budget	Monitoring — SORH has limited staff, budget and partner resources to allocate. SORH can utilize one of the resources described in the road map on page 22. This is a simple role to periodically review data and disseminate information as appropriate to rural primary care providers, community, partners or other organizations.	<ul style="list-style-type: none"> ◆ Financial Indicators ◆ Quality Indicators ◆ Provider Production Indicators ◆ Community Engagement Indicators
.25 FTE and some SORH budget for contracting and travel	Contracting — SORH has staff and budget resources from Flex, SHIP or other funds which may be utilized to hire contracted expertise to provide information or education to support more than one provider organization or community. SORH activities include travel and meetings with the community and ensuring appropriate contract development and management.	<p>Monitoring</p> <ul style="list-style-type: none"> ◆ Ensure financial and operational resources are available (e.g. benchmarking reports, contract for expertise) ◆ Encourage community stakeholder education
.50 FTE and some budget and partners	Partnering — SORH has resources, a partnership with at least one organization with expertise and resources to offer the rural primary care provider organization and community. There should be a specific community/organization contact dedicated to a community and/or practice organization identified goal. SORH activities include facilitation, participation in a collaborative community effort and may include an educational role.	<p>Contracting</p> <ul style="list-style-type: none"> ◆ Offer stakeholder education on leadership & changing systems ◆ Encourage community stakeholder education and engagement ◆ Assess community health needs ◆ Evaluate health care resources ◆ Develop a community plan

SORH Self-Assessment



SORH Delineation Map — Use this map to understand the role of the SORH and as a guide for the decisions and activities which must be made by SORH, provider practice organizations, communities, partners and contractors who are supporting the technical assistance efforts.



RESOURCES

[Strengthening Nonprofits: A Capacity Builder's Resource – Delivering Training and Technical Assistance](#) (2010), Compassion Capital Fund National Resource Center administered by HHS

[NOSORH 2019 SORH RHC TA Survey](#)

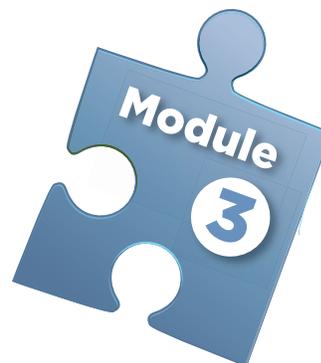
SurveyMonkey results

[NOSORH Tiered Technical Assistance Program](#)

[Starting a Rural Health Clinic: A How-to Manual](#), HRSA

[CMS Rural Health Clinic Center](#)

[CMS RHC Fact Sheet](#)



SOURCE REFERENCES

¹ USDA: <https://www.usda.gov/media/blog/2018/12/20/rural-aging-occurs-different-places-very-different-reasons>

² Rural Health Research Gateway: <https://www.ruralhealthresearch.org/assets/2200-8536/rural-communities-age-income-health-status-recap.pdf>

³ Federal Office of Rural Health Policy: <https://www.hrsa.gov/rural-health/about-us/definition/index.html>

⁴ Rural Healthy People 2020: <https://srhc.tamhsc.edu/rhp2020/index.html>

⁵ Survey — Rural Healthy People 2020 — New Decade, Same Challenges: <https://srhc.tamhsc.edu/rhp2020/bolin-et-al-2015-the-journal-of-rural-health.pdf>

⁶ American Association of Family Practitioners (AAFP): <https://www.aafp.org/about/policies/all/primary-care.html>

⁷ Comprehensive Primary Care: <https://comprehensiveprimarycare.com/what-exactly-is-primary-care/>

⁸ Compassion Capital Fund (CCF) — administered by HHS: <https://www.acf.hhs.gov/ocs/resource/asset-initiative>

⁹ Compassion Capital Fund (CCF) — administered by HHS: https://www.acf.hhs.gov/sites/default/files/ocs/delivering_tta.pdf; page 3

¹⁰ Compassion Capital Fund (CCF) — administered by HHS: https://www.acf.hhs.gov/sites/default/files/ocs/delivering_tta.pdf; page 4

¹¹ Compassion Capital Fund (CCF) — administered by HHS: https://www.acf.hhs.gov/sites/default/files/ocs/delivering_tta.pdf; page 12

¹² Compassion Capital Fund (CCF) — administered by HHS: https://www.acf.hhs.gov/sites/default/files/ocs/delivering_tta.pdf; page 13