NOSORH

National Organization of
State Offices of Rural Health

SORH Topical Proficiencies Guide

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Introduction

With the success of the SORH Core Proficiencies, NOSORH is excited to share with you the SORH Topical proficiencies; a series of rubrics and self-assessment tools for individual State Offices of Rural Health (SORH) to evaluate their current level of effort and develop a strategy for building internal capacity on unique focus area of SORH. Topical proficiencies recognize that SORH operate at varying levels of capacity and SORH should decide for themselves which topical proficiencies that they wish to assess. For instance, your office may focus on many Workforce efforts but be limited in your Primary Care Integration capacity — therefore, you may opt to focus only on the Workforce self-assessment at first.

Topical proficiencies are formatted similar to the first four Core rubrics of Grants Management, Information Dissemination, Organizational Capacity. For more information on how to use the Proficiencies rubrics and self-assessment, please refer back to the **SORH Proficiencies Guide**. If you still have questions, please see the **SORH Proficiencies FAQ** or contact NOSORH staff.

Self-Assessment Tool

The self-assessment tool provides SORH with a numerical measure of the level of SORH capacity. The self-assessment tool is built from the Target Areas within each rubric. There are three levels of capacity for each of the elements which comprise every element and a Not Applicable option: Needs Improvement, Competent, and Proficient as defined below:

Needs Improvement — identifies an area in which the office can strategically create improvement plans to build their internal capacity

Competent — the ability to complete tasks that meet the requirements of the SORH in a way that is universally accepted by peers as the norm

Proficient — when the expectations of completing tasks exceed the norm, allowing for innovation and pace-setting strategies for the office

Structure: The self-assessment tool has been built on the Qualtrics electronic survey system. Each Target Area is a separate page within Qualtrics. Definitions and explanations of some elements are visible in the survey by hovering over the choice with your cursor. Each element has a "N/A" option, which should be used to skip those elements which the SORH does not choose to assess.

Scoring: Scoring is done by Target Area, with an aggregate score provided overall for the rubric and one for each Target Area. If a SORH opts out of scoring an area with an "N/A" response, those elements are removed from the scoring criteria, to avoid a false low score.

NOTE: ***The SORH proficiencies are designed to provide a framework in assisting a SORH in developing greater internal capacity. However, the description of proficiency should not be misconstrued to supersede any requirements of a State Office of Rural Health set forth by federal or state regulations, or requirements as a grantee of the Federal Office of Rural Health Policy.***

Target Area I: Health Professions Workforce

Self-Assessment Link

Rationale: The NOSORH Proficiencies workgroup envisions that this workforce capacity rubric will be used by SORH who are engaged with the development and/or the recruitment and retention of a strong rural health workforce in their state. Some SORH may have incorporated a detailed workforce strategy into their SORH, Flex, or Primary Care Office workplans. The components of this rubric acknowledge that: a) the capacity of SORH vary widely, b) efforts to partner must be aligned with the rural needs of each state, and c) some partnerships may be a higher priority than others. These variables may fluctuate within the state over different periods of time.

Throughout the components of this rubric, the target level for partnerships varies based upon the consensus about the role of SORH and priorities provided by the Educational Strategy Committee. The peer group considered that partnerships with Primary Care Associations, Departments of Labor, international medical graduate programs and state workforce tax incentive programs are a lower priority than partnerships with Primary Care Offices, Area Health Education Centers, loan repayment programs and other health profession training programs.

None of the components of this rubric should be construed as a requirement of the Federal Office of Rural Health Policy (FORHP) or supersede any directive provided by a Federal Project Officer. SORH may opt to only self-assess their office on certain components of this rubric, selecting the 'N/A' option in the self-assessment.

5.1. Partners

This category relates to the key partners that a SORH may engage with to accomplish their workforce goals. Some of these programs may be housed within your current infrastructure. If your SORH does manage one of these other offices, it is likely that your office will rate as Proficient in that category.

5.1.1. Engagement with the state's Primary Care Office (PCO) — the extent to which the SORH engages with the designated PCO. For states that are co-located, consider how well the workplans are aligned across similar activities.

5.1.2. Engagement with the state's network of Area Health Education Centers (AHEC) — the extent to which the SORH engages with the Area Health Education Centers, either at the statewide or regional level. For states that are co-located, consider how well the workplans are aligned across similar activities.

5.1.3. Engagement with the state's Primary Care Association (PCA) — the extent to which the SORH engages with the state's designated Primary Care Association.

5.1.4. Engagement with the state's Department of Labor (DOL) — the extent to which the SORH engages with the state's DOL.

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1. Partners			
1. Engagement with the state's Primary Care Office (PCO)	SORH has a point of contact at the PCO and disseminates relevant information on their behalf	SORH conducts regular meetings with the state PCO and disseminates relevant information on their behalf	SORH and PCO develop joint strategies to assess and address workforce needs in the state using available data from the PCO
2. Engagement with the state's network of Area Health Education Centers (AHEC)	SORH has a point of contact at the AHEC program office and with each regional office, and disseminates relevant in-formation on their behalf	SORH and AHEC office collaborate to develop workforce programs that improve the supply and distribution of the rural health workforce	SORH operates as an AHEC program office or regional site, or has a formalized MOU with the AHEC system to improve the supply and distribution of the rural health workforce
3. Engagement with the state's Primary Care Association (PCA)	SORH does not have a point of contact and/or regularly engage with the PCA	SORH conducts regular meetings with PCA and disseminates relevant in-formation on their behalf	SORH and PCA collaborate to strategically target facilities that would benefit from available resources
4. Engagement with the state's Department of Labor (DoL)	SORH does not have a point of contact for the state's DOL and/ or disseminate relevant infor-mation on their behalf	SORH has a point of contact at the state's DOL and disseminates relevant in-formation on their behalf	SORH partners with DOL to strategically allocate resources targeted at rural communities

5.2. Programs

This section references a variety of state and federal programs that are available to support the development and recruitment and retention of a strong rural health workforce. While not an exhaustive list, these core programs provide a strong background for engaging with workforce efforts occurring across the state.

5.2.1 Knowledge of the state's loan repayment programs (e.g., NHSC, SLRP, etc.) — the extent to which the SORH is aware of various loan repayment opportunities that are available from federal, state and local organizations. This includes National Health Service Corps (NHSC), federal and state-funded State Loan Repayment Programs (SLRP), and similar.

5.2.2. Knowledge of health professions training programs in the state and their relationship to rural communities. — the extent to which the SORH is aware of health professions training programs. If the level of effort is varied across the pipeline, a SORH may consider engagement primarily with those trainings that confer degrees and residency programs, including: College of Medicine, College of Pharmacy, College of Nursing, College of Social Work, etc.

5.2.3 Engage with the state's Rural Recruitment and Retention Network (3RNet) member — the extent to which the SORH engages with the state-specific 3RNet member, not the 3RNet parent organization. If the office is co-located, consider how the program is used to compliment other efforts of the SORH.

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5.2.4. Knowledge of the state's international medical graduate programs (e.g., J-1/Conrad 30) — the extent to which the SORH is aware of the international medical graduate opportunities that can help to fill existing workforce gaps.

5.2.5. Knowledge of the state's workforce incentive programs (e.g., tax incentives, etc.) — the extent to which the SORH is aware of state-specific workforce incentive programs such as: preceptor tax credits or payments and student tuition reductions.

2. Programs			
1. Knowledge of the state's loan repayment programs (including NHSC, SLRP, etc.)	SORH has a point of contact for loan repayment programs within the state and disseminates relevant information to rural constituents	SORH provides assistance to providers and sites that currently participate, or are interested in participating, in loan repayment programs	SORH is responsible for one or more components of the state's loan repayment programs through a formalized agreement and provides staffing or other office resources in support of them.
2. Knowledge of health professions training programs in the state and their relationship to rural communities	SORH has a point of contact with health professions training programs in the state and disseminate relevant information to rural communities	SORH engages regularly with key stakeholders to strategically identify needed health professions training programs to fill rural gaps	SORH has a formal method of monitoring and tracking individuals in health training programs and reporting on their practice in rural areas
3. Engage with the state's Rural Recruitment and Retention Network (3RNet) member	SORH funds membership and/or conducts regular meetings with state 3RNet member and disseminates relevant information on their behalf	SORH serves as the 3RNet member, either independently or jointly through a formalized partnership	Through a formal needs' assessment process, 3RNet resources are strategically targeted to facilities with the greats unmet need
4. Knowledge of the state's international medical graduate programs (including J-1, etc.)	SORH does not have a point of contact for the state's international medical graduate programs and/or disseminate relevant information	SORH has point of contact for the state's international medical graduate programs and disseminates relevant information to rural communities	SORH provides assistance to providers and facilities interested in using the state's international medical graduate programs
5. Knowledge of state's workforce incentive programs (tax incentives, etc.)	SORH does not have a point of contact for state workforce incentive programs and/or disseminate relevant information	SORH is aware of state workforce incentive programs that enhance recruitment and retention of rural healthcare providers	SORH educates individuals in the state on the available workforce incentive programs for rural providers and links them to available programs

5.3. Support

There are a number of ways in which a SORH might support the workforce activities that are occurring within their state. When considering the "support" elements of this topical proficiency rubric, a SORH may consider other programs located in the office (PCO, AHEC, etc.). However, be certain to consider how these overlapping programs are leveraged together in a way that reduces duplicated efforts and targets resources to the highest need.

5.3.2. Conducting an environmental scan annually of workforce activities — whether formally or informally, the extent to which the SORH is monitoring and scanning workforce initiatives in the state. It is appropriate to consider how the office is able to leverage workforce data provided by the PCO.

5.3.2. Identification of community need and linkages to available resources — the extent to which the SORH is able to articulate community needs and provide linkages to existing resources that can address specific community needs. It is appropriate to consider how the office is able to leverage the needs assessments conducted by other reputable sources (Maternal and Child Health, PCO, etc.) as a mechanism of identifying need.

5.3.3. Coordination of activities between workforce partners in the state — the extent to which the SORH is involved with assisting in the coordination of rural health workforce activities in the state. If your office only focuses on a certain aspect of the broad rural health workforce spectrum, consider this in light of those efforts that your office elects to focus on.

5.3.4. Monitoring of emerging health professions and their role in the healthcare landscape — the extent to which the SORH monitors the various emerging health professions within their state, and the impact they have on the rural health landscape. This may be an entirely new health profession (Community Health Worker, Community Paramedic, etc.) or it could be a change to the licensing for some (e.g., expanded prescribing for nurse practitioners).

5.3.5. Knowledge of local and/or state workforce advisory committees/ workgroups — recognizing that it's not feasible for the SORH to serve on or be aware of all statewide and local groups collaborating on workforce activities, this element recognizes the need for continuous engagement at some level. When considering the breadth of possible workforce activities occurring, only consider those groups which align to the workforce strategies the SORH elects to undertake.

3. Support			
1. Conducting an environmental scan annually of workforce activities	SORH reviews the workforce needs of rural communities as workforce issues arise	SORH conducts an informal scan of workforce activities in the state on an annual basis	SORH formally scans the workforce activities in the state on an annual basis with a process for tracking
2. Identification of community need and linkages to available resources	SORH does not assist in identifying community workforce needs	SORH is able to identify community need and link to available workforce resources to address gaps	SORH develops, individually or through partnerships, a guide of available workforce resources for state constituents that is updated on a regular basis
3. Coordination of activities between workforce partners in the state	SORH is aware of the workforce partners in the state but does not have a regular form of communication	SORH engages regularly with workforce partners to stay abreast on their efforts and reduce duplication of efforts	SORH and partners conduct a joint workforce needs assessment and strategy, on a reoccurring basis
4. Monitoring of emerging health professions and their role in the healthcare landscape	SORH has an informal method of learning about emerging health professions, in their state or nationally	SORH monitors, individually or with partners, the landscape for emerging health professions both in their state and nationally	SORH educates others on the emerging health professions in the state or nationally
5. Knowledge of lo-cal and/or state workforce advisory committees / workgroups	SORH identifies and can articulate the purpose of the local and state-based workforce advisory committees or workgroups	SORH is a member of at least one local or state-based workforce advisory committee or workgroup	SORH coordinates at least one state-wide advisory committee or workgroup focused on rural health needs of the state

Target Area 2: Communicating SORH Impact

Self-Assessment Link

Rationale: The NOSORH Proficiencies workgroup envisions that this assessment will be for SORH that plan, analyze, communicate and disseminate information on the impact of their rural-focused activities. The key elements contained herein should not be construed as a requirement of the Federal Office of Rural Health Policy, or supersede any directive provided by a federal Project Officer. This rubric, and its elements, should be viewed in collaboration with the SORH core proficiency of Information Dissemination. As a topical rubric, completion of the associated self-assessment is optional based on the priorities of the Office. In addition, SORH may choose to self-assess the target area but may opt to only assess their office on certain elements by selecting the 'N/A' option in the self-assessment instrument.

6.1. Planning

The first step in being able to communicate the impact of a SORH is to have a plan for what is to be communicated in the long-term. This initial phase of planning ensures that the office is working to capture the necessary data it will take to communicate their impact collectively.

6.1.1. Office has a method of identifying the target audience for impactful communications— the extent to which the SORH is able to articulate the differences between key target audiences for communications of SORH impact.

6.1.2. Office tailors communication tools for a particular audience — the extent to which the SORH is able to recognize the differences in communicating impact with the various target audiences.

6.1.3. Office has a method for planning the general message and content — the extent to which the SORH creates a plan for the general message and content of the communications. The plan doesn't have to be written as a template, but rather a SORH can be competent or proficient if they build this into their planning process.

6.1.4. Office has a data collection plan that supports the planned message and content — the extent to which the SORH has a written plan to capture data that supports the planned general message and content. At a minimum, the data collection plan should include the measures to be captured and how often, where it should be stored and how, and the responsible party.

1. Planning			
1. Office has a method of identifying the target audience for impactful communications	SORH has limited knowledge in the process of identifying target audiences	SORH has a general knowledge in the process of identifying target audiences, and can articulate the differences between the target audiences of their state	SORH has the expertise to provide technical assistance to rural stakeholders in the process of identifying target audiences and in articulating the differences between target audiences

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1. Planning (continued)			
2. Office tailors of communication tools for a particular audience	SORH has limited knowledge in tailoring communications tools to a particular target audience	SORH has a general knowledge in the process of tailoring communication tools to a particular target audience	SORH has the expertise to provide technical assistance to rural stakeholders in the process of tailoring communication tools to a particular target audience
3. Office has a method for planning the general message and content	SORH has limited knowledge in planning of general messaging and content development for communication tools	SORH has a general knowledge in the planning of general messaging and content development for communication tools	SORH has the expertise to provide technical assistance to rural stakeholders in the planning of general messaging and content development for communication tools
4. Office has a data collection plan that supports the planned message and content	SORH has a limited knowledge in the development of a data collection plan to support the planned message and content	SORH has a general knowledge in the development of a data collection plan that supports the message and content	SORH has the expertise to provide technical assistance to rural stakeholders in the development of a data collection plan to sup-port their planned messages and content

6.2. Analysis

The analysis of available data, both qualitative and quantitative, can range in its level of complexity based upon the capacity of a SORH. Some offices may have the capacity to run data in SPSS, SAS or Tableau. Other offices may only be able to utilize Microsoft Excel in order to conduct an analysis. In the self-assessment of this section, consider the capacity of your SORH and recognize that each element can be incorporated regardless of analytic platform.

6.2.1. Office can articulate their funding sources, and financial or in-kind investments within the state

— the extent to which an office has a plan for analyzing their rural investments in the state, aligned to the needs of rural communities. To be proficient, a SORH should be able to calculate and articulate the Return on Investment (ROI) of their programs.

6.2.2. Office has a method of analyzing data at an appropriate level for rural populations

— the extent to which the office can stratify their analysis at an appropriate 'rural' level, based on the needs of their rural communities. In instances of low numbers, this may mean combining multiple years of data (trending) or combining multiple communities into a target population or service area. To be competent, a SORH would use the appropriate rural definition for the level of data available (e.g., census tract data uses RUCA, county-level data uses RUCC, etc.) To be proficient, a SORH should further divide (stratify) the data by a level that identifies specific needs of rural communities in the state.

2. Analysis			
1. Office can articulate their financial and in-kind investments within the state, by funding source	SORH can articulate how and where funding and in-kind investments are allocated	SORH can articulate how and where funding and in-kind investments are allocated, and the outcomes of all associated projects	SORH can identifiy a Return on Investment (ROI) collectively, and for individual programs, of the office.

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2. Analysis (continued)			
2. Office has a method of analyzing data at an appropriate level for rural populations	SORH can articulate how and where funding and in-kind investments are allocated	SORH can articulate how and where funding and in-kind investments are allocated, and the outcomes of all associated projects	SORH can identify a Return on Investment (ROI) collectively, and for individual programs, of the office.

6.3. Communication and Dissemination

This category relates to the way in which the SORH communicates their 'value', as determined by the qualitative and quantitative data they've collected and/or analyzed. These elements should be considered in coordination with those from the Information Dissemination rubric, to ensure that communication reaches the target populations in the appropriate format. For these elements, a "communications tool" can be a variety of methods; it could be a simple 2-page report or an advanced, interactive dashboard. The 'appropriate' type of tool is relative to your individual SORH.

6.3.1. Office has a communication tool for educating key stakeholders

— the extent to which a SORH has a tool to communicate their impact. To be competent, the SORH should be able to talk globally about the programs and the impact to the state as a whole. To be proficient, the SORH should be able to stratify their tool to their predefined areas of need in the state.

6.3.2. Office communication tool incorporates standards for visualization

— this element recognizes that SORH must follow all organizational standards when developing communications tools, but that there are additional standards that should be considered. Industry standards, such as being ADA-compliant, must be considered. To be competent, SORH should be compliant with all organizational requirements; while proficient should additionally incorporate industry standards.

3. Communication and Dissemination*			
1. Office has a communications tool for educating key stakeholders	SORH has limited knowledge in tailoring communications tools to a particular target audience	SORH has a general knowledge in the process of tailoring communication tools to a particular target audience	SORH has the expertise to provide technical assistance to rural stakeholders in the process of tailoring communication tools to a particular target audience
2. Office communications tool incorporates standards for visualization	SORH does not have a communications tool for educating key stakeholders	Communications tool is used as a resource to educate key stakeholders on the impact of funding and programmatic outcomes across all FORHP-funded activities.	Communications tool educates key stakeholders on the impact of all FORHP-funded efforts of the office, dividing existing boundaries based upon similarities

*Please refer to SORH Proficiencies rubric **"Information Dissemination"** for more information and requirements related to communication and dissemination.

Target Area 3: Primary Care Integration

Self-Assessment Link

Rationale: The NOSORH Proficiencies workgroup envisions that this primary care integration rubric and accompanying self-assessment will be used by SORH who are engaged with the development and/or strengthening of the rural primary care safety net providers in their state, with a focus on integrating primary care services to address a more comprehensive approach to the wellness needs of their patients. The key components of this rubric should not be construed as a requirement of the Federal Office of Rural Health Policy (FORHP) or supersede any directive provided by a Federal Project Officer, or other federal, state or local requirements. SORH may opt to assess their office on certain components of this rubric based on the goals of the office; selecting the 'N/A' option in the self-assessment will opt a SORH out of a particular component.

In general, elements within this target area are rated based on a consistent scale. Those who indicate "needs assistance" have a limited knowledge and/or don't have a connection to a technical assistance (TA) partner. To be "competent", SORH should have a general understanding of the topic and have a connection to a TA partner, as needed. The "proficient" category assumes that a SORH has the expertise to deliver TA themselves on the specified topic.

7.1. Integrating services in Primary Care

This category relates to the ability of a SORH to assist a primary care clinic that is attempting to integrate additional healthcare services into their practice setting. The process and requirements for integrating services will vary some by state; please be sure to consult your local regulations to ensure your primary care clinics are prepared to become integrated for all public insurers and to negotiate rates with private insurers.

7.1.1. Clinic compliance with requirements for implementation of integration activities — the extent to which a SORH can assist primary care clinics with the infrastructure needed to integrate services. This may include the technological, physical, or staffing infrastructure necessary to integrate services.

7.1.2. Integration of behavioral health services into primary care — the extent to which the SORH is able to assist primary care clinics with the integration of behavioral health services. Behavioral health is defined here as a combination of mental health and substance abuse services.

7.1.3. Integration of oral health services into primary care — the extent to which the SORH is able to assist primary care clinics with the integration of oral health services. This does not have to mean an on-site dentistry but may include the application of fluoride varnish treatments for pediatric patients.

7.1.4. Integration of other specialty services into primary care — the extent to which the SORH is able to assist primary care clinics with the integration of other specialty services, other than behavioral and oral care.

7.1.5. Utilization of telehealth to expand patient access to care — the extent to which the SORH is able to assist primary care clinics with the adoption of telemedicine services in a compliant and sustainable manner.

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1. Integrating Services in Primary Care			
1. Clinic compliance with requirements for implementation of integration activities	SORH maintains limited knowledge of the needed clinic infrastructure to successfully integrate non-traditional primary care services into a primary care setting and/or doesn't have a connection to a technical assistance partner.	SORH has a general understanding of the needed clinic infrastructure to successfully integrate non-traditional primary care services into a primary care setting and has a connection to a technical assistance partner, as needed.	SORH has the expertise to deliver the technical assistance necessary for developing a sustainable clinic infrastructure that supports successful integration efforts.
2. Integration of behavioral health services into primary care	SORH maintains limited knowledge of successfully integrating sustainable behavioral health services into the primary care setting and/or doesn't have a connection to a technical assistance partner.	SORH has a general understanding of successfully integrating sustainable behavioral health services into the primary care setting and has a connection to a technical assistance partner, as needed.	SORH has the expertise to deliver the technical assistance necessary for the successful integration of sustainable behavioral health services into the primary care setting.
3. Integration of oral health services into primary care	SORH maintains limited knowledge of successfully integrating sustainable oral health services into the primary care setting and/or doesn't have a connection to a technical assistance partner.	SORH has a general understanding of successfully integrating sustainable oral health services into the primary care setting and has a connection to a technical assistance partner, as needed.	SORH has the expertise to deliver the technical assistance necessary for the successful integration of sustainable oral health services into the primary care setting.
4. Integration of other specialty services into primary care	SORH maintains limited knowledge of successfully integrating other sustainable specialty services into the primary care setting and/or doesn't have a connection to a technical assistance partner.	SORH has a general understanding of successfully integrating other sustainable specialty services into the primary care setting and has a connection to a technical assistance partner, as needed.	SORH has the expertise to deliver the technical assistance necessary for the successful integration of other sustainable specialty services into the primary care setting.
5. Utilization of telehealth to expand patient access care	SORH maintains limited knowledge of implementing a successful, sustainable telehealth service lines in a primary care practice and/or doesn't have a connection to a technical assistance partner or their TRC.	SORH has a general understanding of implementing a successful, sustainable telehealth service line into a primary care practice, has a connection to a technical assistance partner as needed, and has a relationship with their TRC.	SORH has the expertise to deliver the technical assistance necessary for implementing a successful, sustainable telehealth service line into a primary care practice, connecting clinics with their TRC and state telehealth network (if applicable).

7.2. Population health in primary care

This category relates to the ability of a SORH to undertake a data-driven decision-making and program planning approach with primary care clinics. Primary care clinics should utilize their available data to identify the needs of their patients, leveraging results in refining internal processes and procedures. Clinics should target the development of partnerships and relationships based on the analysis of their data (e.g., agreements with cardiologist office if a high number of patients have heart disease).

7.2.1. Clinic participation in appropriate value-based payment programs — the extent to which the SORH is able to assist primary care clinics in identifying and participating in appropriate value-based payment programs. This should include a variety of reimbursement models for Medicare, Medicaid and private insurers.

7.2.2. Analyses and interpretation of available health outcomes data — the extent to which the SORH is able to assist primary care clinics in the analysis and interpretation of health outcomes data captured from their patient records. This may include the identification of trends, monitoring high utilizers of emergency services, or more.

7.2.3. Leveraging of health outcomes data to improve primary care services and processes — the extent to which the SORH is able to assist primary care clinics in using their analyzed data to make informed decisions about their patient population. Results of the analysis should be used to refine internal processes and procedures. For instance, if there is a high rate of "no show" appointments and low medication adherence, a process for reminder phone calls may be a solution. A proficient SORH should be able to assist the clinic in undergoing a continuous change model based upon their available data.

7.2.4. Collaboration with other healthcare organizations to improve continuity of care — the extent to which a SORH is able to assist primary care clinics in developing partnerships with other healthcare organizations to improve the continuity of care based upon health needs of the population. These agreements should be based upon available data and benefit large numbers of the patient population. For instance, if a high number of patients have existing heart conditions, then a formal partnership with a Cardiologist might be a solution.

7.2.5. Leveraging funding from multiple sectors to address identified population health needs — the extent to which a SORH is able to assist primary clinics to engage in multi-sector partnerships that provide funding in meeting population health needs. This may be incorporated into existing community health needs assessments efforts or may be a separate undertaking with other community partners. For the purpose of this element, population health needs are those that are identified for the majority of the patient population.

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2. Population Health in Primary Care			
1. Clinic participation in appropriate value-based payment programs	SORH maintains limited knowledge of appropriate value-based payment programs available for rural primary care providers and/or does not have a connection to a technical assistance partner.	SORH has a general understanding of appropriate value-based payment programs available for rural primary care providers and has a connection to a technical assistance partner, as needed.	SORH has the expertise to deliver technical assistance necessary for implementing appropriate value-based payment programs with rural primary care providers
2. Analysis and interpretation of available health outcomes data	SORH maintains limited knowledge of analysis and interpretation of health outcomes data and/or does not have a connection to a technical assistance partner.	SORH has a general understanding of analysis and interpretation of health outcomes data and has a connection to a technical assistance partner, as needed.	SORH has the expertise to deliver appropriate technical assistance necessary for analysis and interpretation of available health outcomes data.
3. Leveraging of health outcomes data to improve primary care services and processes	SORH maintains limited knowledge of using health outcomes data to improve primary care services/ processes and/or does not have a connection to a technical assistance partner.	SORH has a general understanding of using health outcomes data to improve primary care services/processes and has a connection to a technical assistance partner, as needed.	SORH has the expertise to deliver appropriate technical assistance necessary for using health outcomes data to improve primary care services and processes.
4. Collaboration with other healthcare organizations to improve continuity of care	SORH maintains limited knowledge of collaboration between healthcare organizations to improve continuity of care and/or does not have a connection to a technical assistance partner.	SORH has a general understanding of collaboration between healthcare organizations to improve continuity of care and has a connection to a technical assistance partner, as needed.	SORH has the expertise to deliver appropriate technical assistance necessary for improving continuity of care across multiple healthcare organizations.
5. Leveraging funding from multiple sectors to address identified population health needs	SORH maintains limited knowledge of available funding from other sectors that can address identified population health needs and/ or does not have a connection to a technical assistance partner.	SORH has a general understanding of available funding from other sectors that can address identified population health needs and has a connection to a technical assistance partner, as needed.	SORH has the expertise to deliver appropriate technical assistance necessary for leveraging funds across multiple sectors to address identified population health needs beyond the clinic walls.

7.3. Social determinants in primary care

This category relates to the health behaviors, physical environment, and social and economic factors that influence an individual's health outcomes. Unlike "population health" these factors are unique to each individual patient and require a variety of strategies that are tailored to each patient.

7.3.1. Screening, analysis and interpretation of social determinant data — the extent to which the SORH is able to assist primary care clinics in adopting social determinants screening tools into clinic protocols; enabling them to analyze and interpret results in identifying contributing factors for individual patients.

7.3.2. Identifying and coordinating with health and human services supports for patients — the extent to which a SORH is able to assist primary care clinics in identifying and coordinating with local health and human services partners. These should include support for housing, transportation, food, education, income and workforce readiness, etc. Clinics should utilize current reimbursable models (if available) in the state, which may include social workers, community health workers, community paramedics, home health nurses, and more.

7.3.3. Adoption of policies and procedures that promote equitable access to primary care services — the extent to which the SORH is able to assist primary care clinics in adopting policies and procedures that promote equitable access to primary care services. Dependent upon the clinic size and resources this may look differently. At a minimum, all clinics should evaluate their hours of operations to accommodate working individuals and require cultural competency training for all staff. Those with greater resources may incorporate more advanced policies, such as ensure leadership and providers are representative of the patient population being served.

7.3.4. Collaboration with non-traditional/ non-healthcare partners to address inequities that may negatively impact health outcomes in the community — the extent to which a SORH is able to assist primary care clinics in fully integrating with non-traditional and/or non-healthcare partners to address inequities for individual patients. For instance, this could include the development of a free ride sharing program to reduce transportation barriers and not limited to healthcare appointments.

3. Social Determinants in Primary Care			
1. Screening, analysis and interpretation of social determinant data	SORH maintains limited knowledge on the screening, analysis and interpretation of social determinants data, and/or does not have connection to a technical assistance partner	SORH has a general understanding on the screening, analysis and interpretation of social determinants data and has a connection to a technical assistance partner	SORH has the expertise to deliver appropriate technical assistance for screening, analysis and interpretation of social determinants data
2. Identifying and coordi-nating with health and human services supports for patients	SORH maintains limited knowledge of existing federal, state, and local health and human services pro-grams available to support rural communities.	SORH has a general under-standing of existing health and human services programs available to support rural communities and can connect primary care clinics with program con-tacts/partners, as needed.	SORH has the expertise to deliver appropriate technical assistance necessary for proactively connecting primary care clinics with health and human services program contacts/partners at the local, state and, federal levels.

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3. Social Determinants in Primary Care (continued)			
3. Adoption of policies and procedures that promote equitable access to primary care services	SORH maintains limited knowledge of the policies and procedures that promote equitable access to primary care services and/or does not have a connection to a technical assistance partner	SORH has a general understanding of policies and procedures that promote equitable access to primary care services and has a connection to a technical assistance partner, as needed.	SORH has the expertise to deliver appropriate technical assistance necessary for adopting policies and procedures that promote equitable access to primary care services
4. Collaboration with non-traditional/ non-healthcare partners to address social determinants of health	SORH maintains limited knowledge of non-traditional, non-healthcare partners to help address social determinants of health and/or does not have a pro-gram contact/ partner to connect with primary care clinics.	SORH has a general understanding of non-traditional, non-healthcare partners to help address social determinants of health and/or can connect primary care clinics with program contacts/partners.	SORH collaborates with non-healthcare partners to address social determinants of health and connect available resources with rural primary care stakeholders.

Next Steps

NOSORH would like to thank the State Office of Rural Health for their participation in assessing their office's capacity in these topical areas. Results from the self-assessment will be made available every other year, alternating with the Core proficiencies. These results will be made available in a Benchmarking Report that will be accompanied by resources that SORH can use in building their own capacity, starting in early 2021. NOSORH will also use the results from the self-assessment to plan breakout sessions during the Annual Meeting and to drive new resource development through the appropriate NOSORH committees.

Having trouble getting started? NOSORH is here to help! If you or your office would like to conduct the proficiencies self-assessment in a facilitated discussion or would like to dig in deeper, contact the NOSORH Education and Services Director.

NOSORH

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