NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Rural Health

2021 Rural Health Conference

Rural Resilience and the Road to Recovery

November 18th, 2021 | 9:00 am – 3:30 pm

Housekeeping

- Today's session will be recorded & posted to the ORH Rural Health Centers program website
- Please keep your lines muted when not speaking
- Submit questions in the chat box or use the raise hand feature during designated Q&A sections (click 3 dots on lower panel)
- Use the call-in feature to improve sound quality
  - This can be found in your event registration or if you click the ⓘ button on the top left
- Use the active speaker view for best view of panelists
- Take breaks as needed

Agenda

- Welcome & ORH Updates
  - Maggie Sauer
- Lead the Way in 5 Minutes a Day: Sparking High Performance in Yourself and Your Teams
  - Jo Anne Preston, Rural Wisconsin Health Cooperative

10:30 – 10:45 Break

- How Are You Prepared for What's Now and What's Next?
  - Michelle Rathman, Impact! Communications
- Integrated Care Panel Session
  - Lisa Tyndall, FHLI Center of Excellence for Integrated Care
  - Alysia Hoover-Thompson, High Country Community Health
  - Regina Dickens, Rural Health Group

12:30 -1:15 Lunch – Celebration of YOU

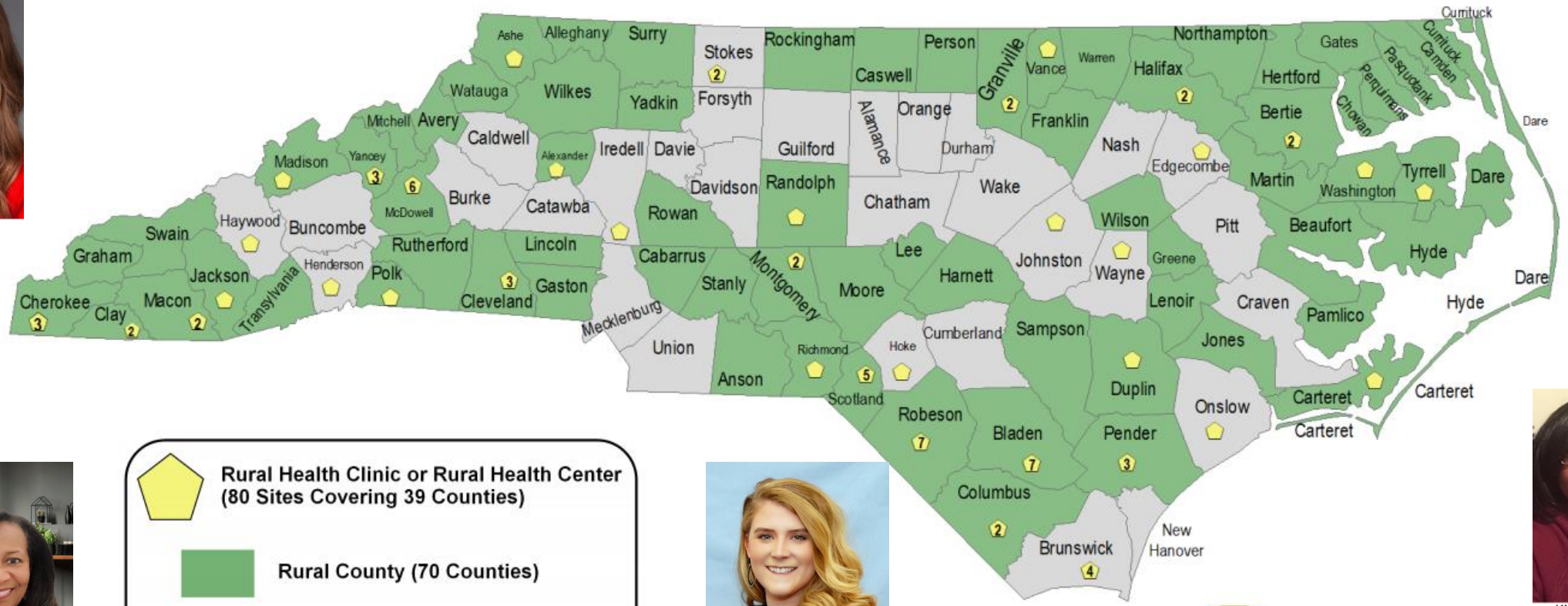
- Rural Health Clinic Best Practices and Benchmarks
  - Jonathan Pantenburg, Stroudwater Associates
- RHC COVID-19 Initiatives & FHLI CDC Funds
  - Shannon Chambers, SC Office of Rural Health
  - Carla Obiol, Foundation for Health Leadership and Innovation
- Closing
  - Victor Armstrong, DHHS Chief Health Equity Officer

Objectives

- Recognize how to spark high performance in yourself and your teams
- Understand roles that strategy, communication, advocacy, and vulnerability play in meaningful collaboration, innovation, and capacity building.
- Increase knowledge of benefits of Integrated Care in rural communities
- Recognize best practices and benchmarks for Rural Health Clinics
- Increase knowledge of COVID-19 initiatives for Rural Health Clinics

North Carolina Office of Rural Health
SFY 2020 Rural Health Clinic and Rural Health Center Sites

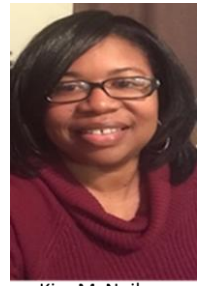
Caroline Collier- West



Dorothea Brock – Program Manager

Beth Blaise – South Central

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Rural Health



Kim McNeil - East

Thank you to our planning team!

- Carla Obiol, Foundation for Health Leadership and Innovation
- Katherine Parker Lucas, Hometown Strong
- Kevin Meese, Office of Rural Health
- Nick Galvez, Office of Rural Health
- Oluanda Green, NC Rural Center
- Renee Clark, Office of Rural Health
- Shawanda Fields, Office of Rural Health
- Brandon Washington, NC Community Health Center Association

NC Department of Health and Human Services

Office of Rural Health - Update

Maggie Sauer

November 18, 2021

CELEBRATING THE POWER OF RURAL

National Rural Health Day

Since 2011, the National Organization of State Offices of Rural Health, the 50 State Offices of Rural Health, and rural health stakeholders from across the country have set aside the third Thursday of November to celebrate National Rural Health Day (NRHD).

#POWEROFRURAL

CELEBRATING THE POWER OF RURAL
National Rural Health Day

National Rural Health Day (NRHD) is an opportunity to “Celebrate the Power of Rural” by honoring the selfless, community-minded spirit that prevails in rural America. NRHD showcases the efforts to address the unique healthcare challenges that rural citizens face today and into the future


Thank You!

NC COVID Relief Funds

NC Rural Health Centers and Rural Health Clinics (RHCs) make up a key part of the rural health care infrastructure and help address health equity gaps in medically underserved rural communities to improve health outcomes for rural residents.

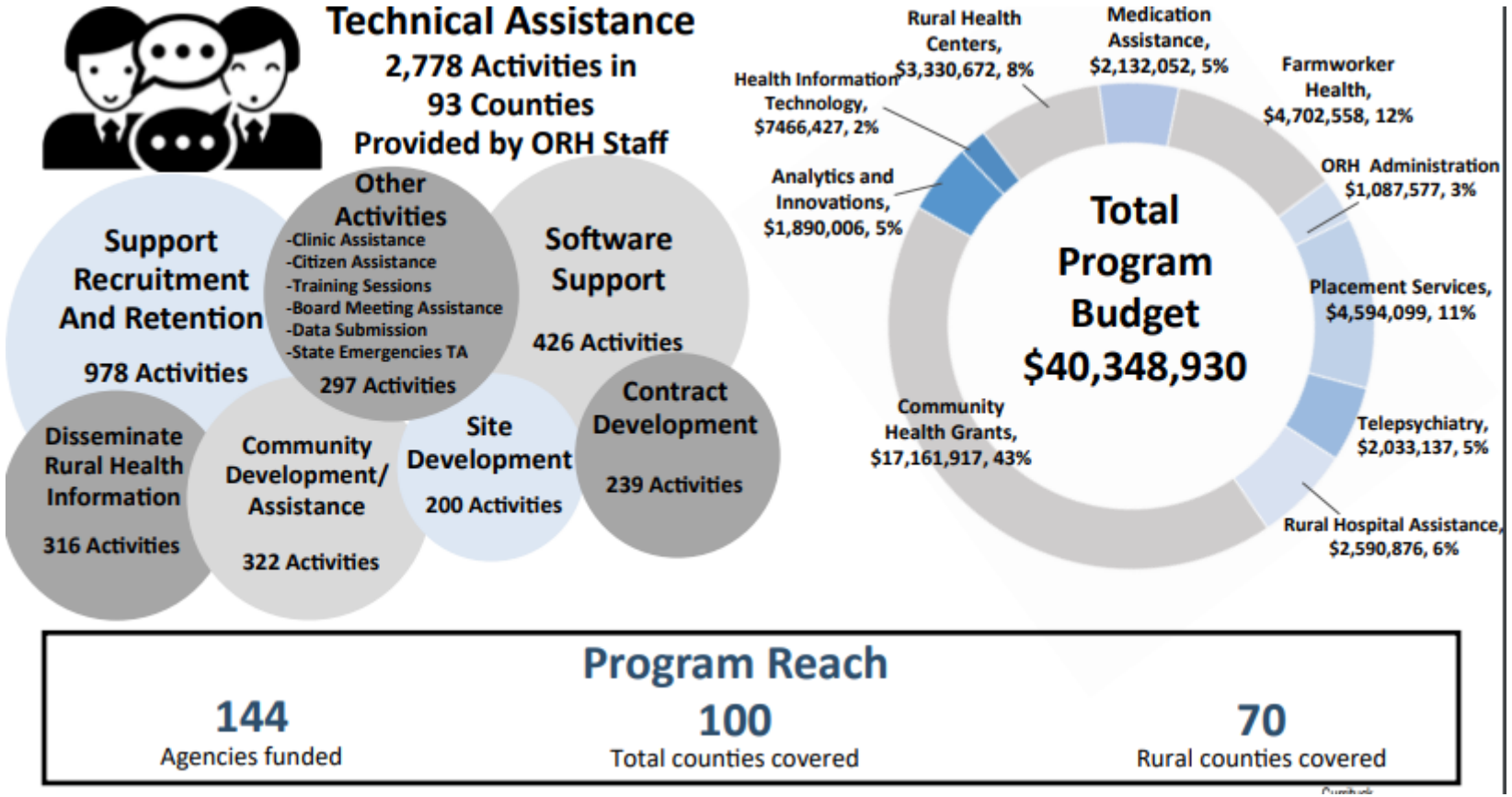
- Testing & Mitigation
- Ensuring Equitable Distribution of Vaccines in Rural Areas
- Building Vaccine Confidence

Office of Rural Health (ORH) & Mission

- First state office (1973) in the nation created to focus on the needs of rural and underserved communities
- ORH Mission Statement: The North Carolina Office of Rural Health (ORH) supports equitable access to health in rural and underserved communities.
- To achieve its mission, ORH works collaboratively to provide:
  - Funding
  - Training
  - Technical assistance
- For high quality, innovative, accessible, cost-effective services that support the maintenance and growth of the State's safety net and rural communities.
- <u>State Fiscal Year 2020 Office Facts:</u>
  - Administered 216 contracts
  - $33.9 million available grant funding from state, federal, and philanthropic sources
  - Returned 84% of its budget directly to NC communities
  - Provided 2,778 technical assistance activities
  - 72 staff (including temporary)

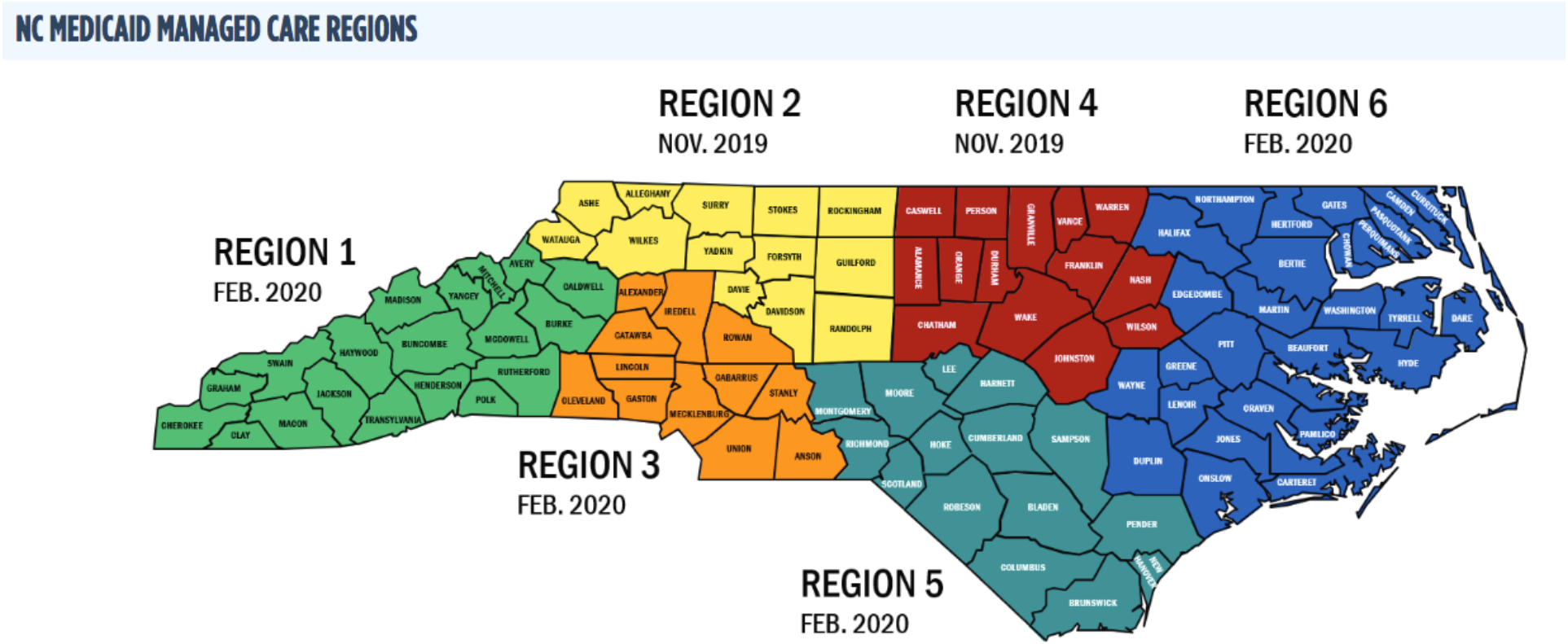
** While we do not provide direct care, our programs support numerous health care safety net organizations throughout North Carolina.

ORH Profile

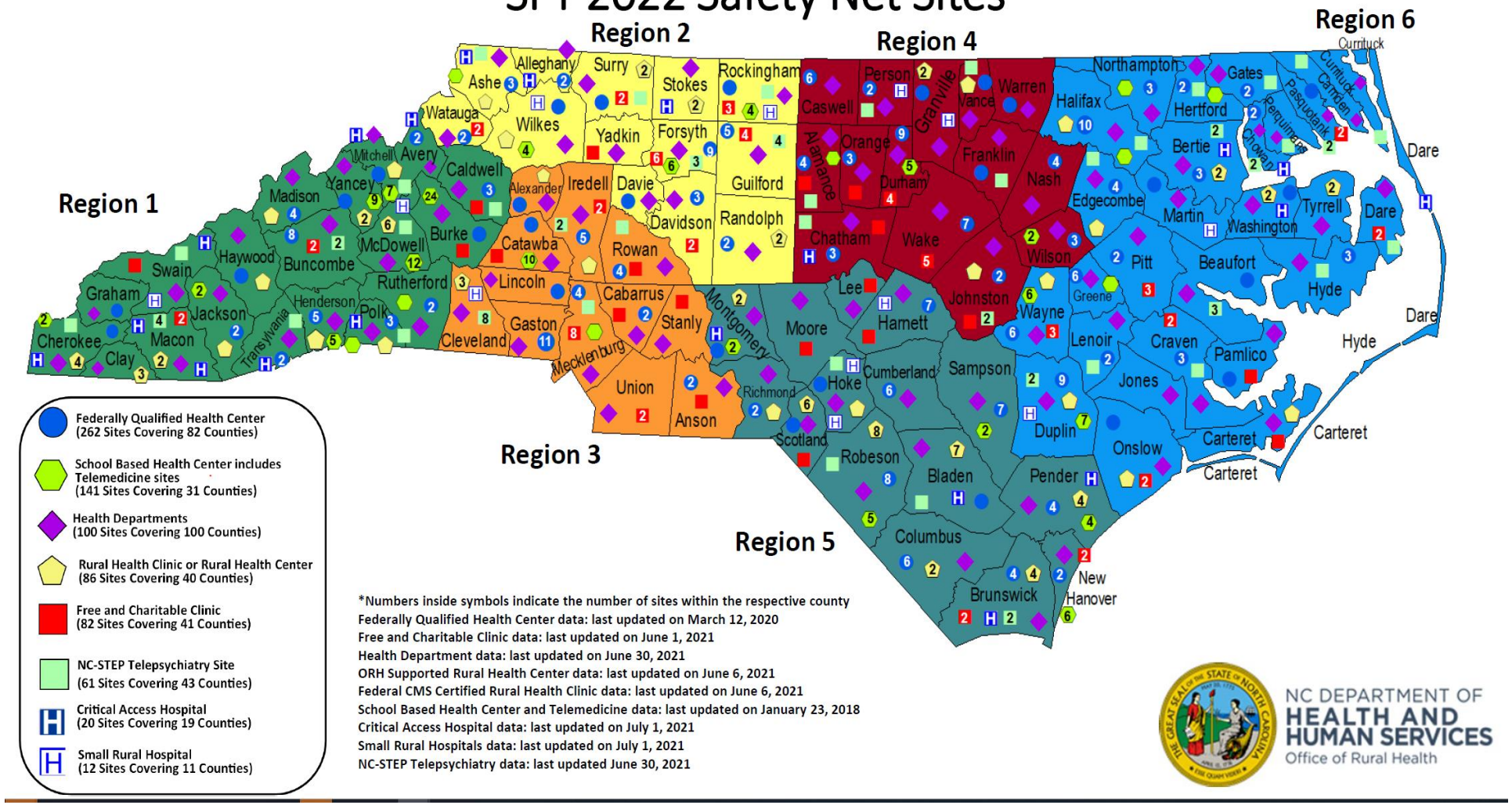


https://www.ncdhhs.gov/divisions/office-rural-health/office-rural-health-programs

NCORH Regional Approach



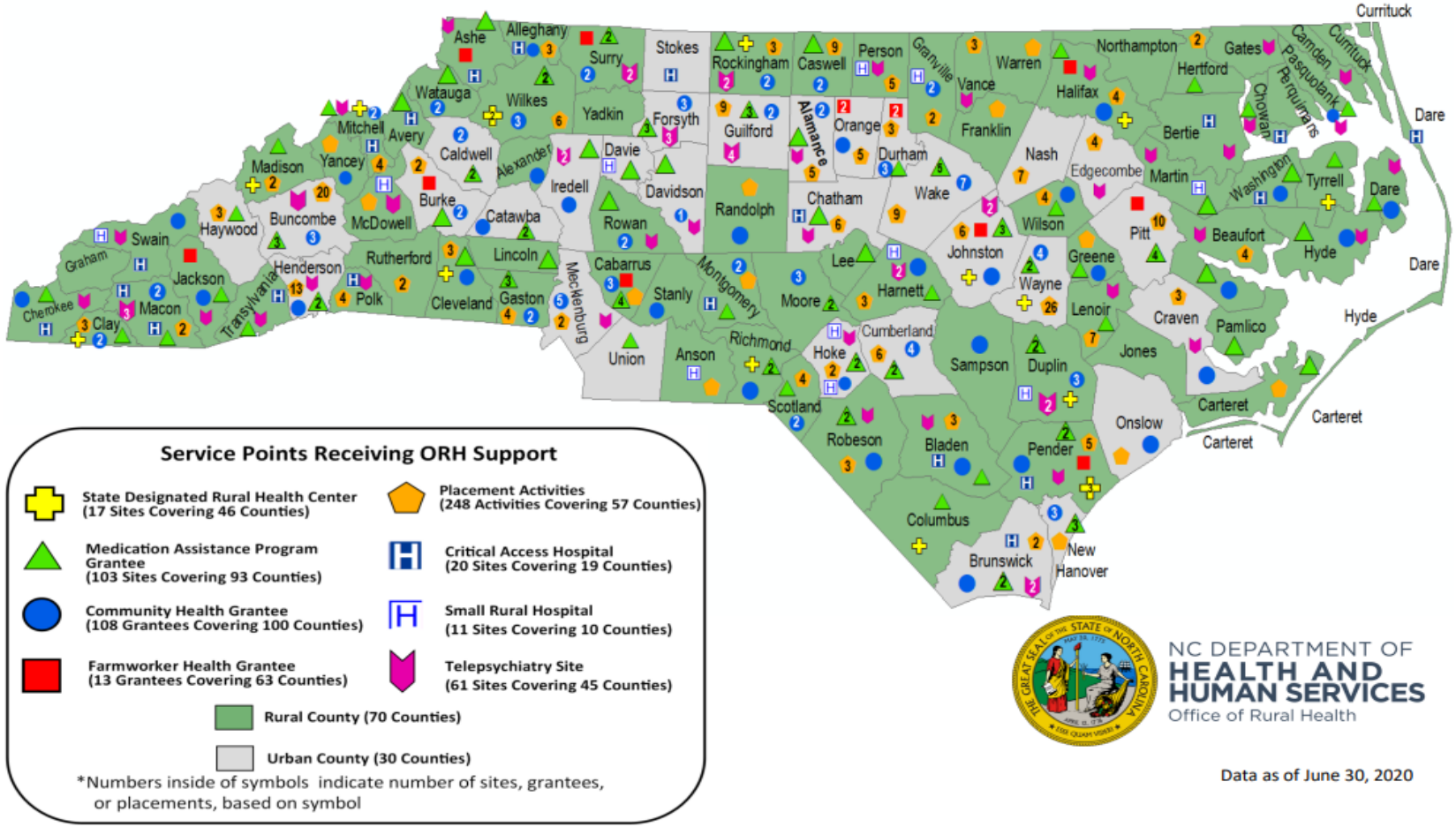
North Carolina Office of Rural Health
SFY 2022 Safety Net Sites



*Numbers inside symbols indicate the number of sites within the respective county
Federally Qualified Health Center data: last updated on March 12, 2020
Free and Charitable Clinic data: last updated on June 1, 2021
Health Department data: last updated on June 30, 2021
ORH Supported Rural Health Center data: last updated on June 6, 2021
Federal CMS Certified Rural Health Clinic data: last updated on June 6, 2021
School Based Health Center and Telemedicine data: last updated on January 23, 2018
Critical Access Hospital data: last updated on July 1, 2021
Small Rural Hospitals data: last updated on July 1, 2021
NC-STEP Telepsychiatry data: last updated June 30, 2021

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Rural Health

North Carolina Office of Rural Health
Service Points and Coverage Map
SFY 2020



Service Points Receiving ORH Support

- State Designated Rural Health Center (17 Sites Covering 46 Counties)
- Placement Activities (248 Activities Covering 57 Counties)
- Medication Assistance Program Grantee (103 Sites Covering 93 Counties)
- Critical Access Hospital (20 Sites Covering 19 Counties)
- Community Health Grantee (108 Grantees Covering 100 Counties)
- Small Rural Hospital (11 Sites Covering 10 Counties)
- Farmworker Health Grantee (13 Grantees Covering 63 Counties)
- Telepsychiatry Site (61 Sites Covering 45 Counties)
- Rural County (70 Counties)
- Urban County (30 Counties)

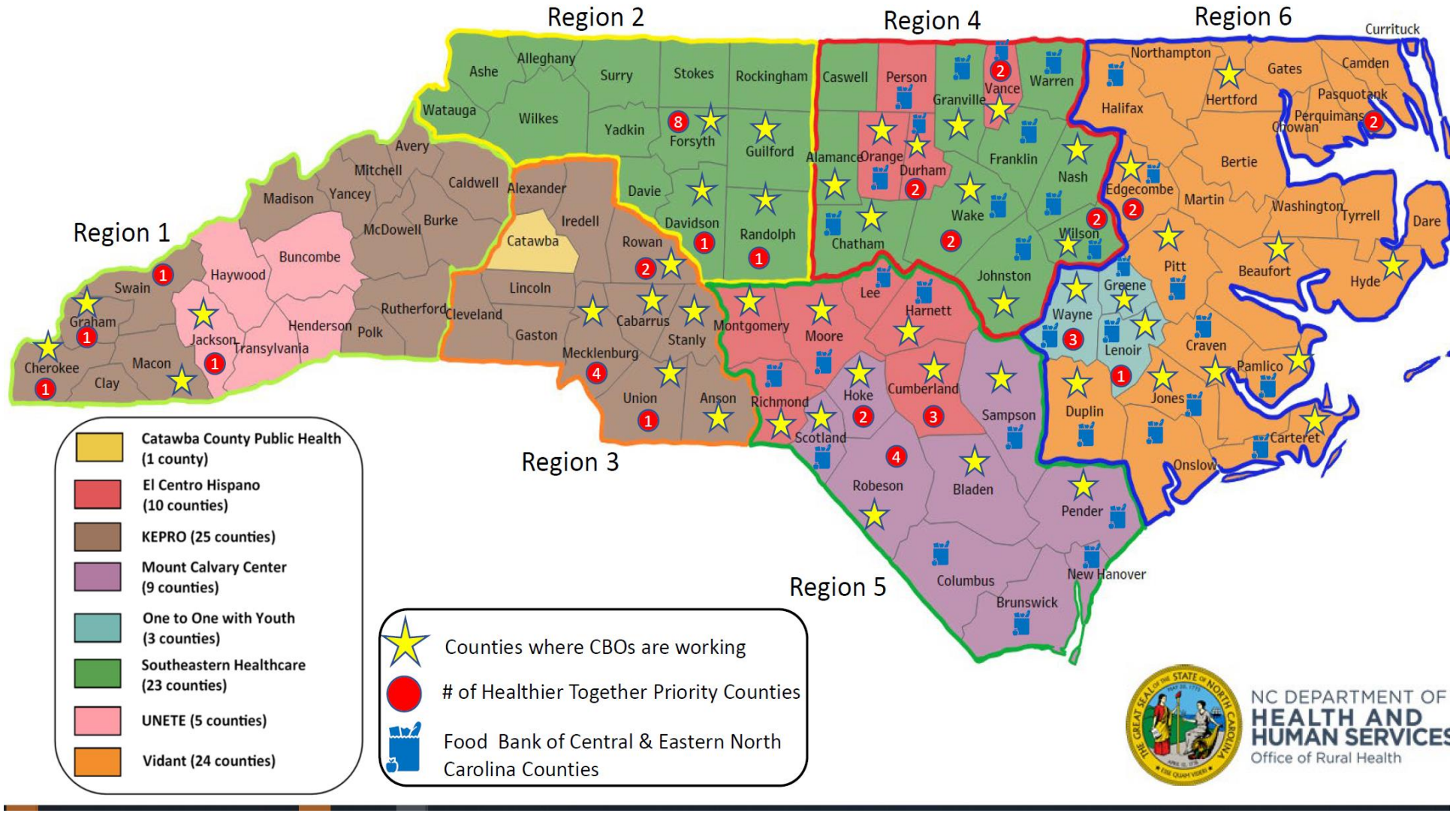
*Numbers inside of symbols indicate number of sites, grantees, or placements, based on symbol

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Rural Health

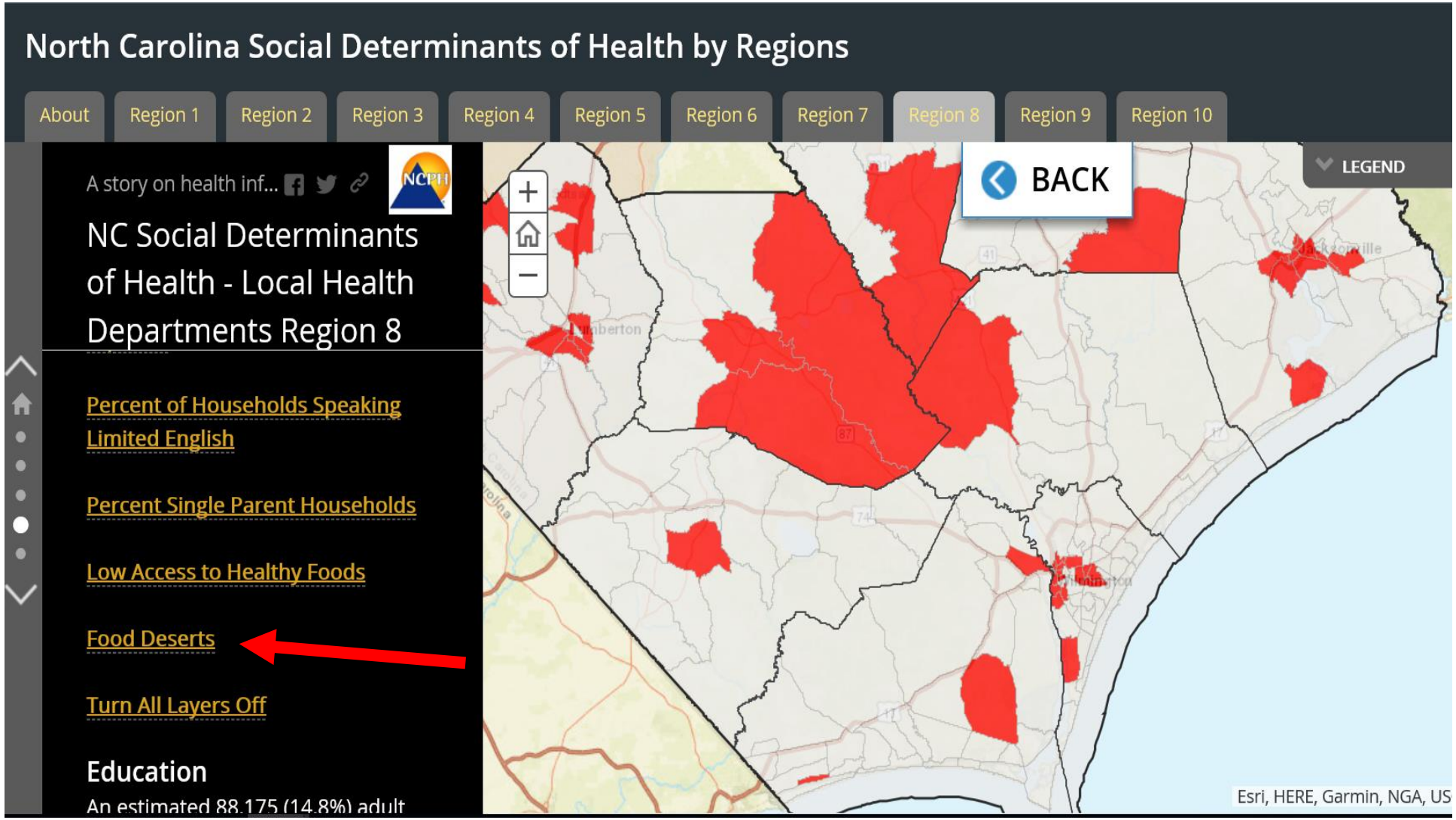
Data as of June 30, 2020

Programs at ORH

Community Health Worker Program

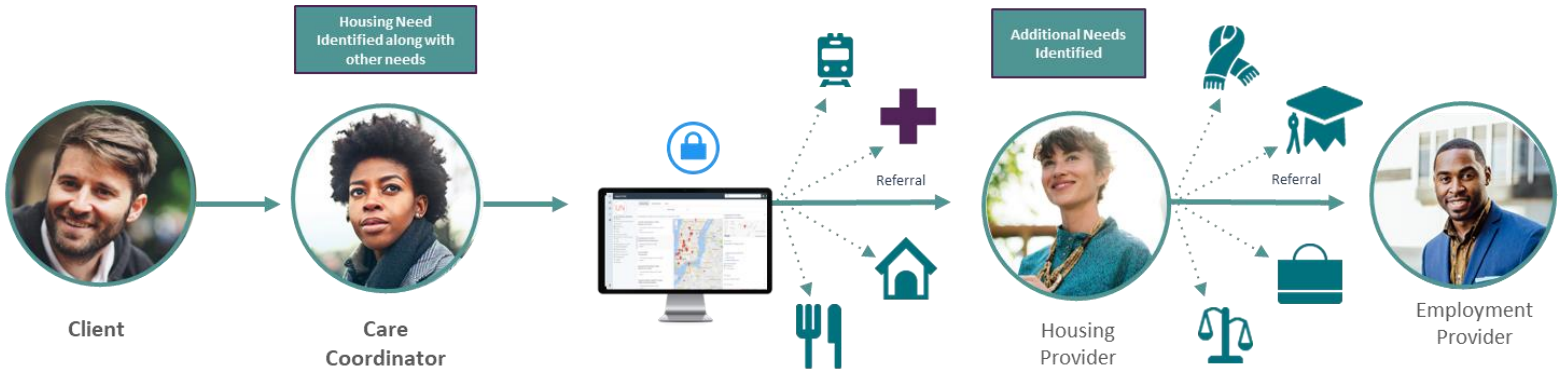


NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Rural Health


North Carolina Social Determinants of Health by Regions
About
Region 1
Region 2
Region 3
Region 4
Region 5
Region 6
Region 7
Region 8
Region 9
Region 10
A story on health inf...
NCPH
NC Social Determinants of Health - Local Health Departments Region 8
Percent of Households Speaking Limited English
Percent Single Parent Households
Low Access to Healthy Foods
Food Deserts
Turn All Layers Off
Education
An estimated 88,175 (14.8%) adult
BACK
LEGEND
Esri, HERE, Garmin, NGA, US

Statewide Resource Platform: NCCARE360

Network Model: No Wrong Door Approach



- **Investing in connections**: Statewide coordinated network to connect citizens, healthcare providers, and human service providers
- Strong **public-private partnership** to create foundation for healthy opportunities

Foundation for Health Leadership & Innovation
Moving people and ideas into action.
NCDHHS
United Way of North Carolina
NORTH CAROLINA 211
Expound
UNITE US

ORH COVID-19 Efforts

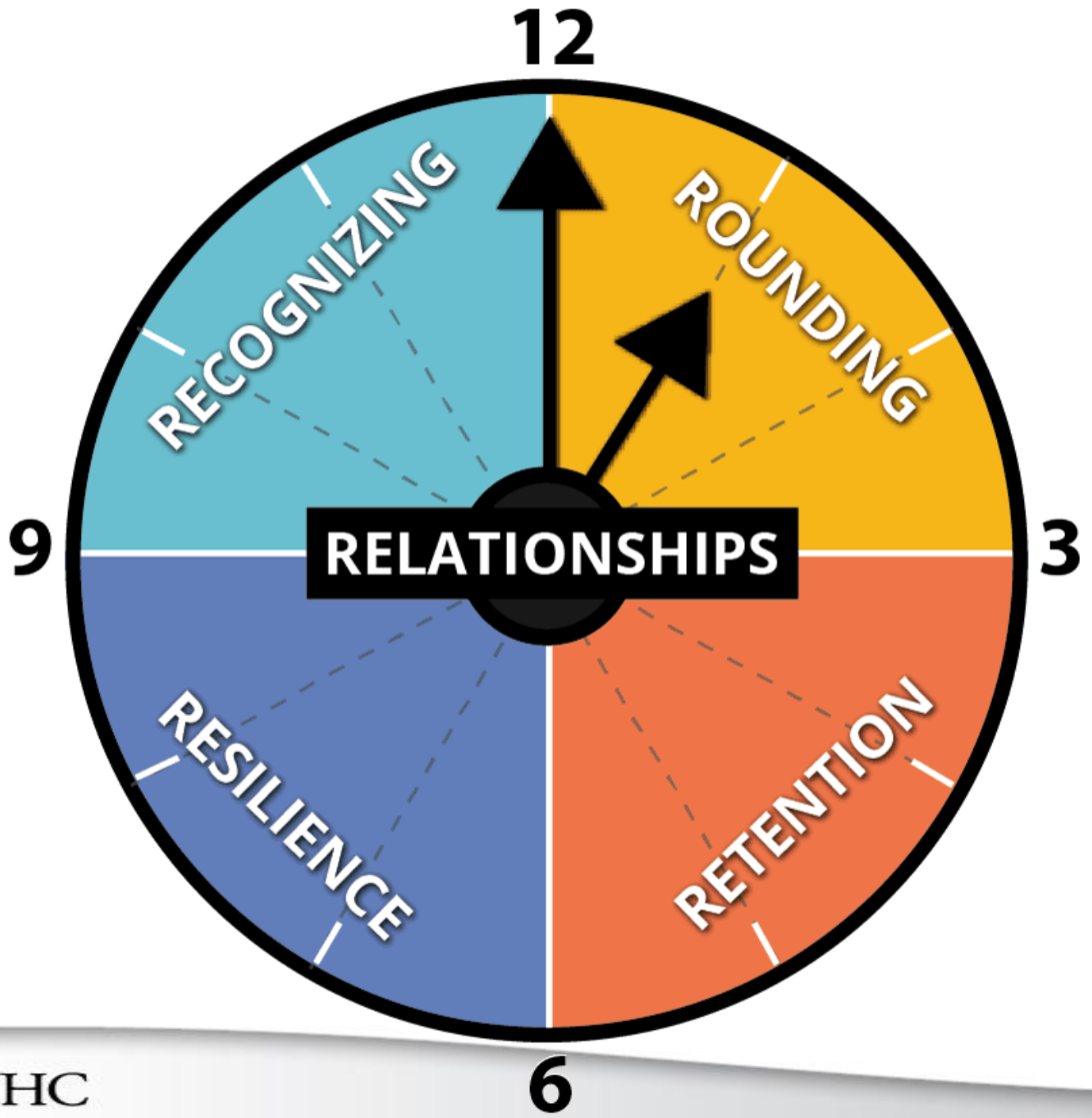
- Telehealth Technical Assistance
- Critical Hospital Assistance
- Community Health Worker and Support Services Program
- Migrant Farmworker Support
- Staffing Stakeholder calls
- NCDHHS Historically Marginalized Population
- Uninsured Portal
- Primary Care Survey
- CVMS support
- NCCARE 360 Support

Lead the Way in Five Minutes a Day:
Sparking High Performance in Yourself and Your Teams

Jo Anne Preston
RWHC Workforce & Organizational Development Sr Mgr

2021 Rural Health Conference
Rural Resilience and the Road to Recovery
North Carolina Office of Rural Health
November 18, 2021

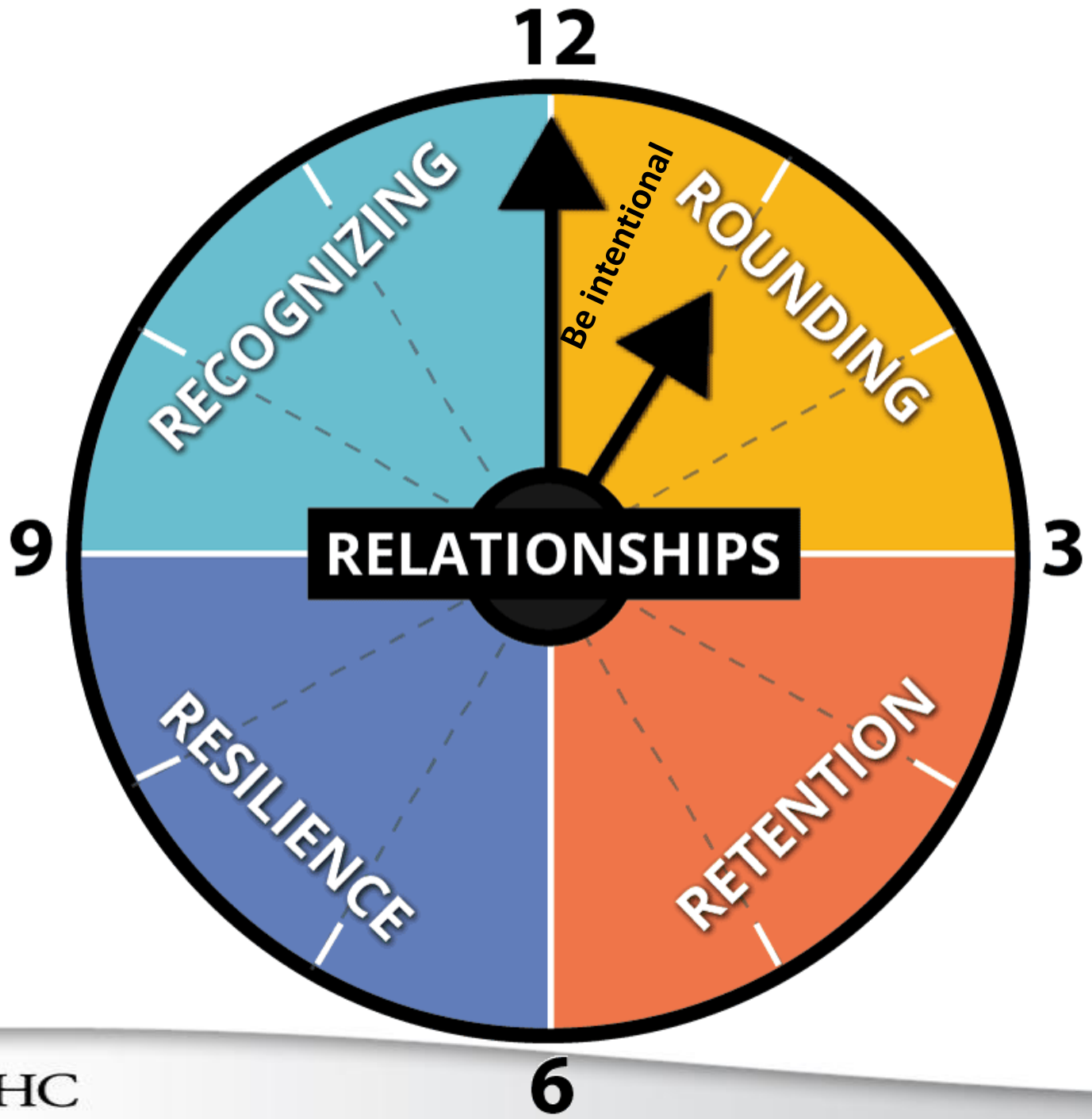
RWHC


12
RECOGNIZING
ROUNDING
9
RELATIONSHIPS
3
RESILIENCE
RETENTION
6

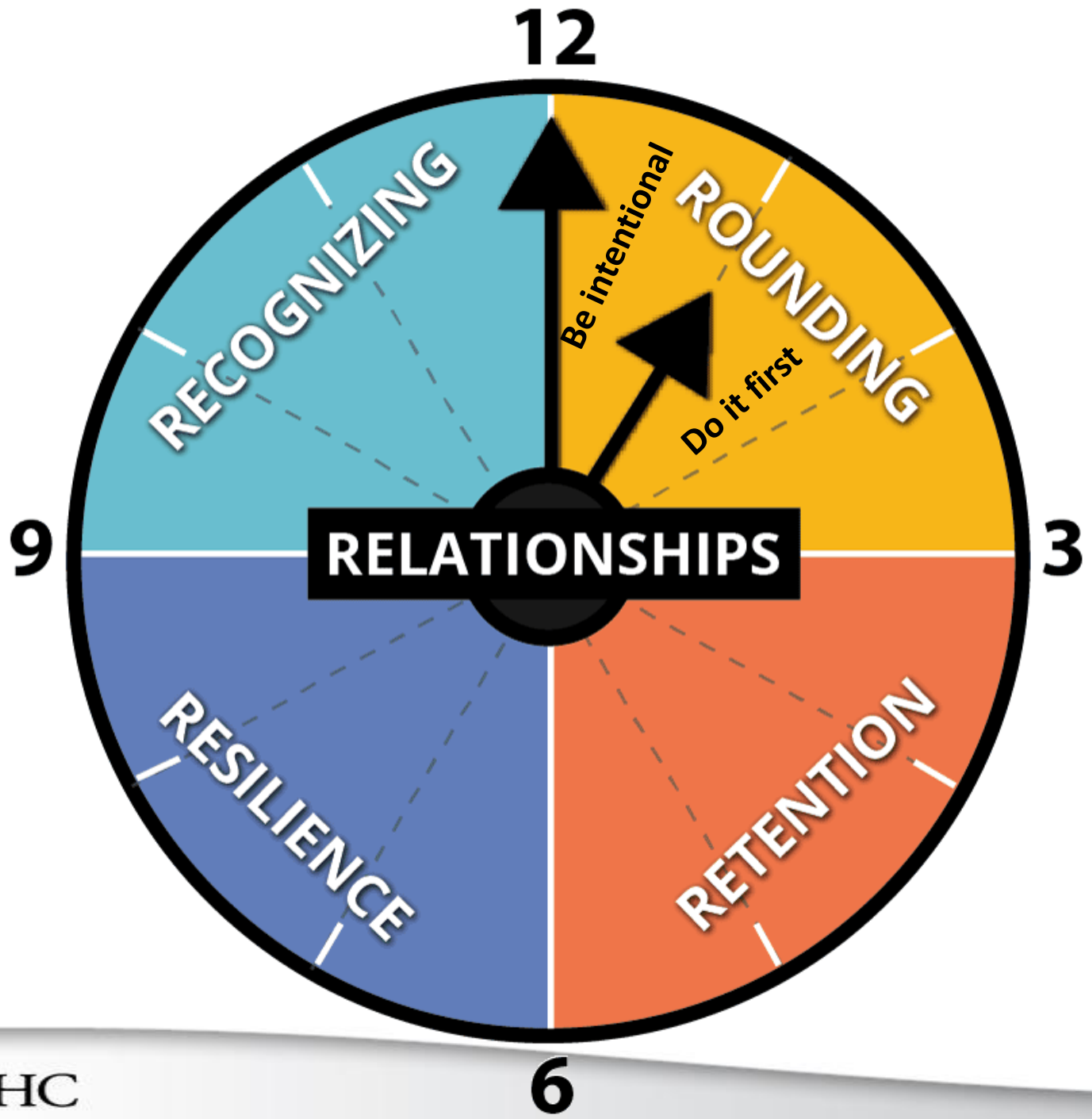
RWHC

ROUNDING

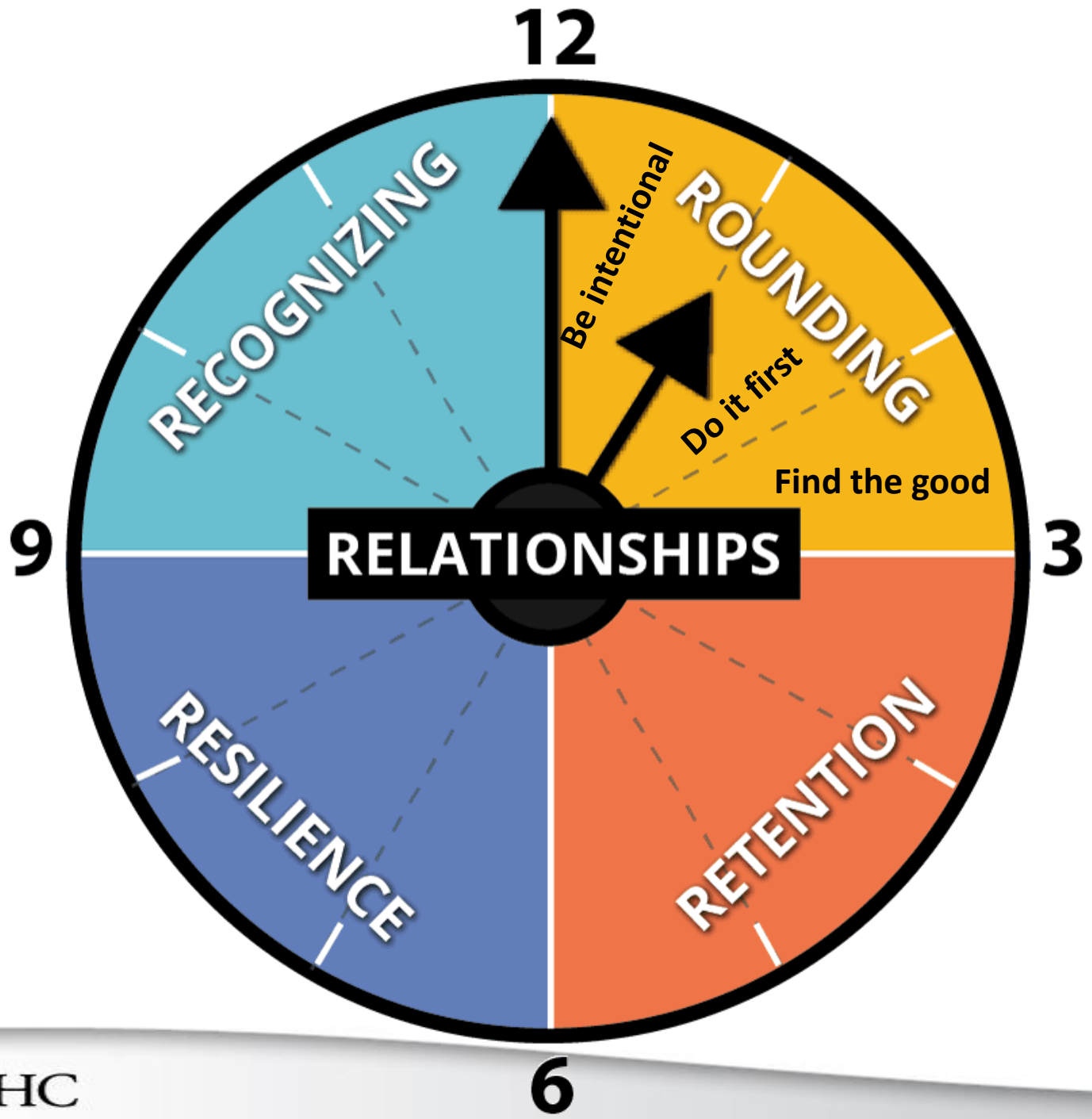
RWHC


12
RECOGNIZING
Be intentional
ROUNDING
9
RELATIONSHIPS
3
RESILIENCE
RETENTION
6

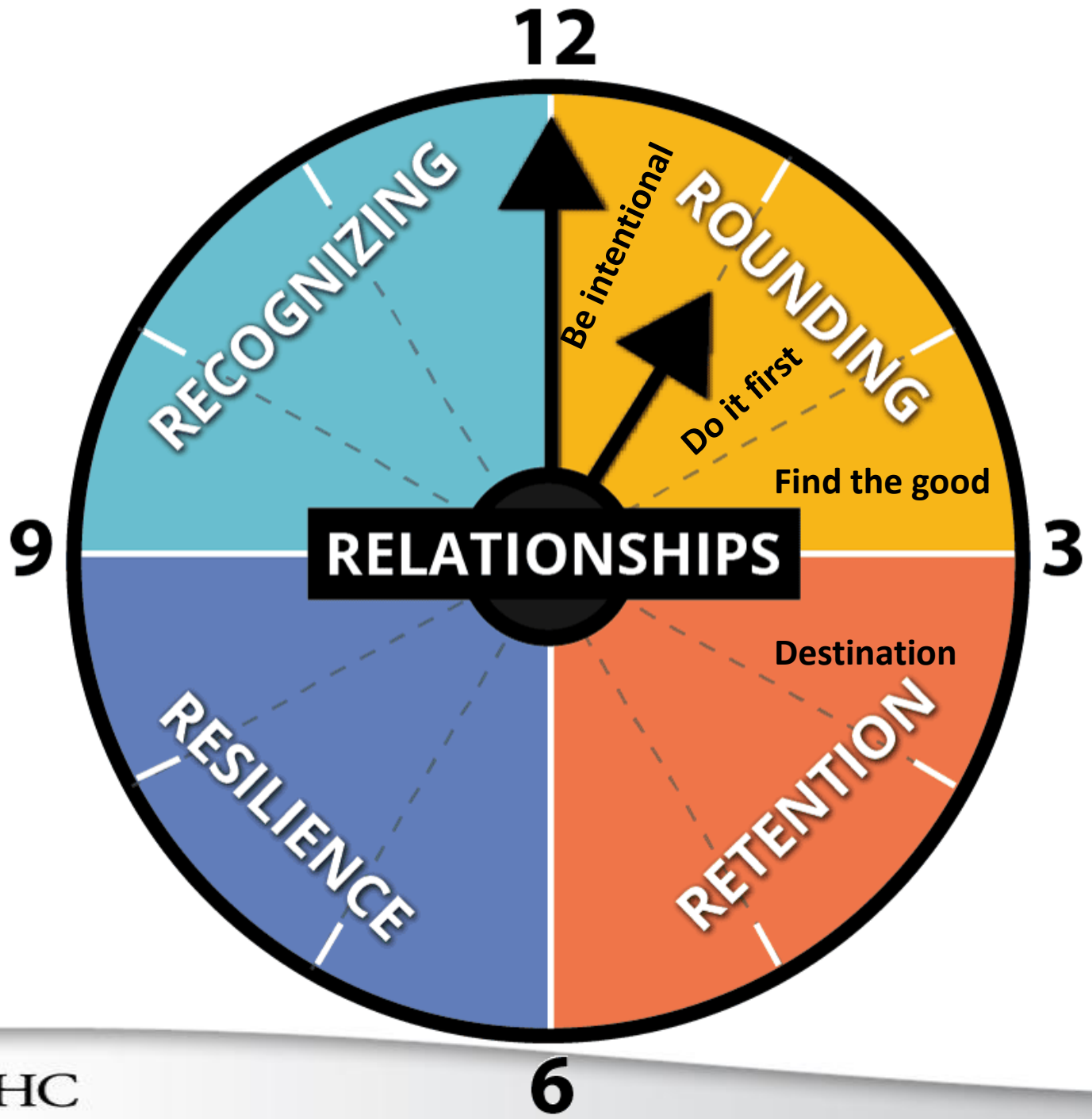
RWHC


12
9
3
6
RECOGNIZING
ROUNDING
Be intentional
Do it first
RELATIONSHIPS
RESILIENCE
RETENTION

RWHC


12
9
3
6
RECOGNIZING
ROUNDING
Be intentional
Do it first
Find the good
RELATIONSHIPS
RESILIENCE
RETENTION

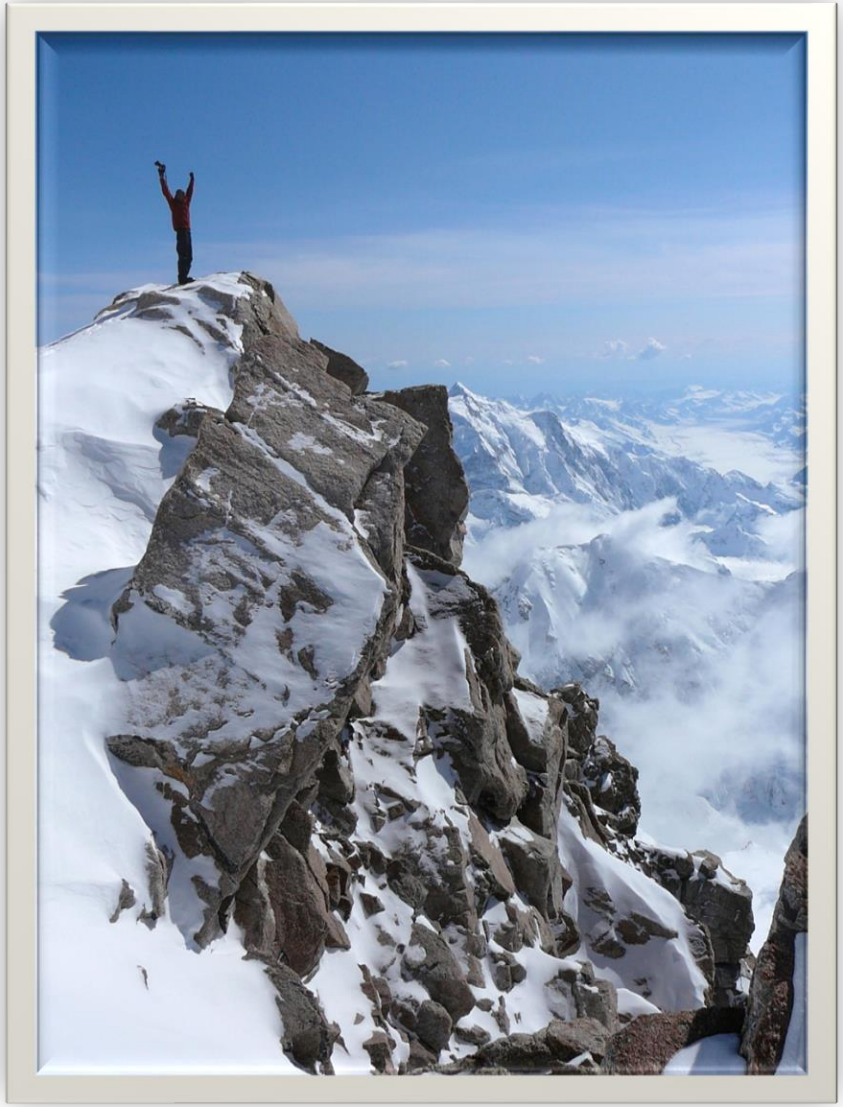
RWHC


12
9
3
6
RECOGNIZING
ROUNDING
Be intentional
Do it first
Find the good
RELATIONSHIPS
Destination
RESILIENCE
RETENTION

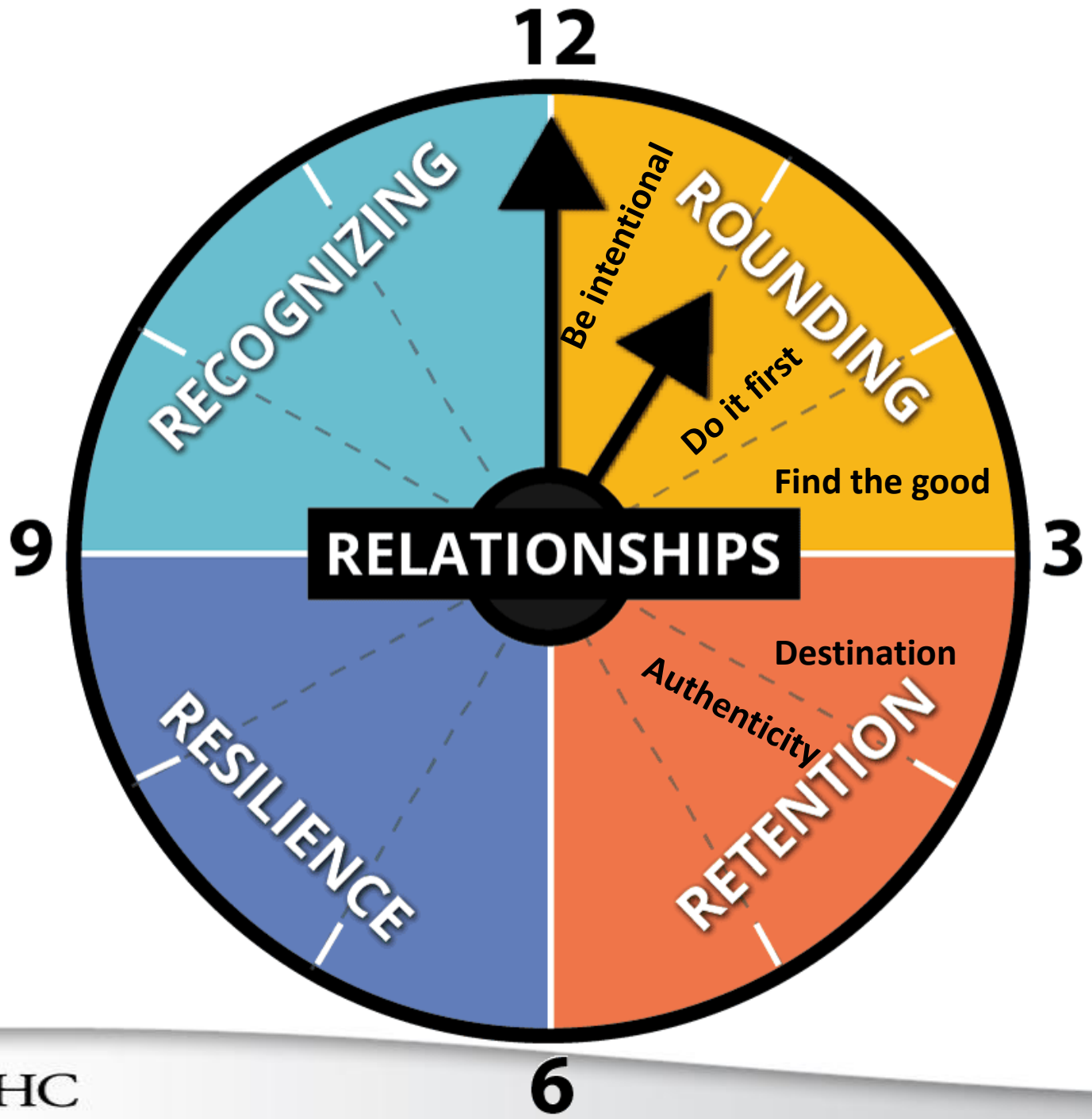
RWHC

RETENTION

Do people want to go where you are going?



RWHC

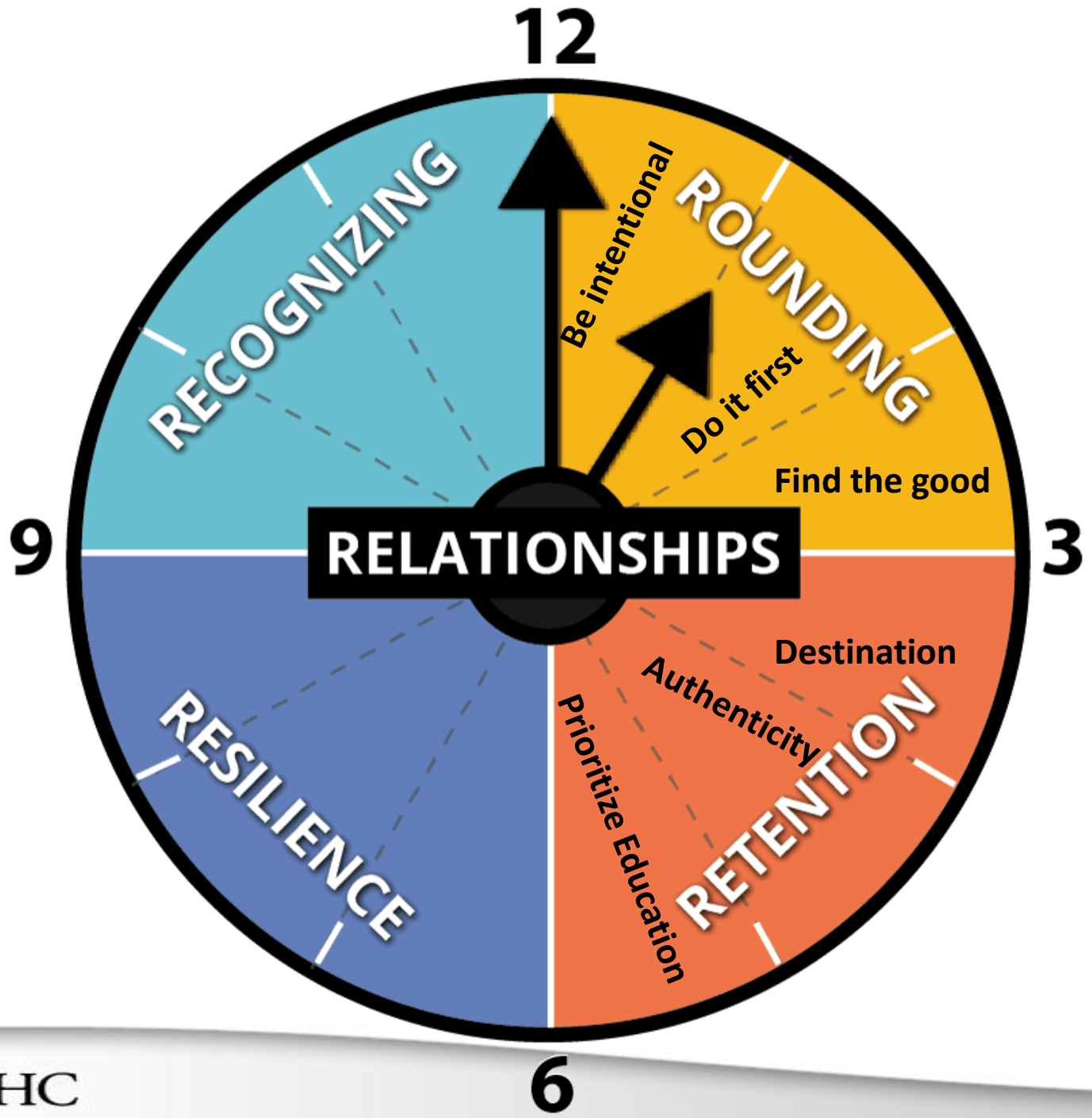

12
9
3
6
RECOGNIZING
ROUNDING
Be intentional
Do it first
Find the good
RELATIONSHIPS
RESILIENCE
RETENTION
Destination
Authenticity

RWHC

Leadership is "authentic self-expression that adds value" *Kevin Cashman*

Small Group Breakout discussion:

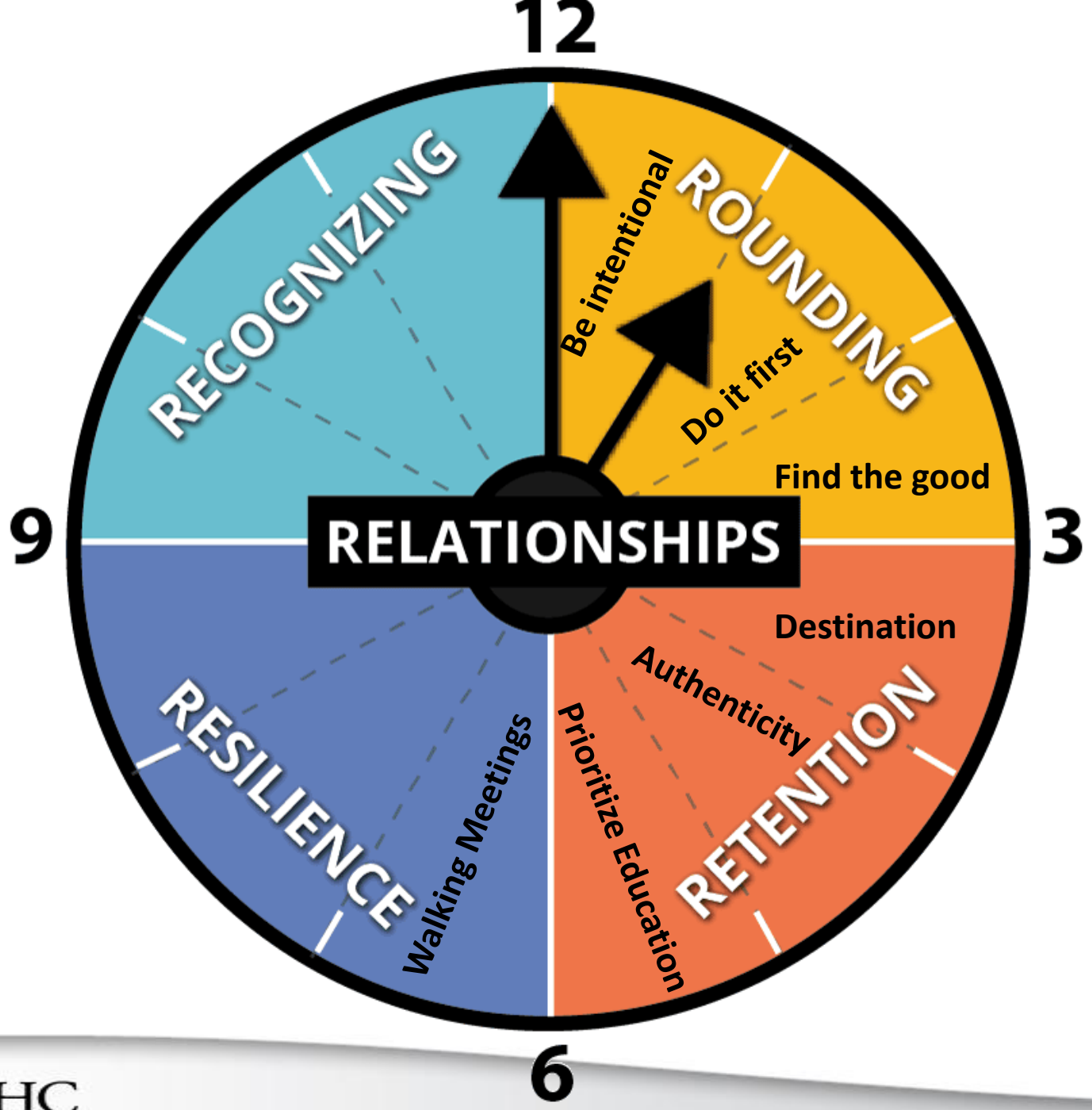
- Introduce yourselves
- Discuss in a round-robin sharing, 1-2 minutes per person:
  - What are some ways that you demonstrate "authentic self-expression" in the way that you lead? And,
  - How does this build others' trust in you?


12
9
3
6
RECOGNIZING
ROUNDING
Be intentional
Do it first
Find the good
RELATIONSHIPS
RESILIENCE
RETENTION
Destination
Authenticity
Prioritize Education

RWHC

RETENTION

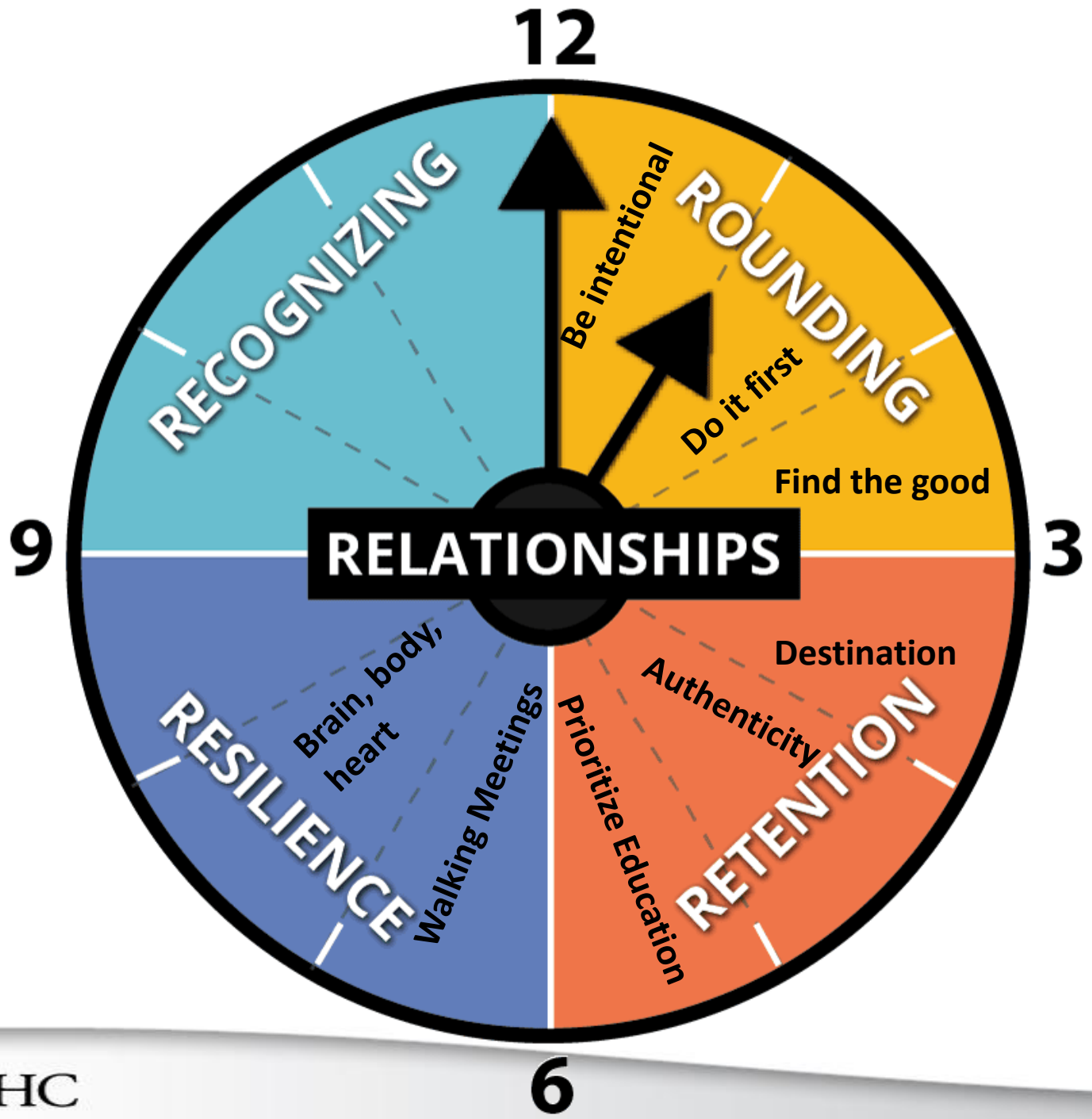
Are you a learning organization?


12
9
3
6
RECOGNIZING
ROUNDING
Be intentional
Do it first
Find the good
RELATIONSHIPS
Destination
Authenticity
RETENTION
Prioritize Education
RESILIENCE
Walking Meetings

RWHC

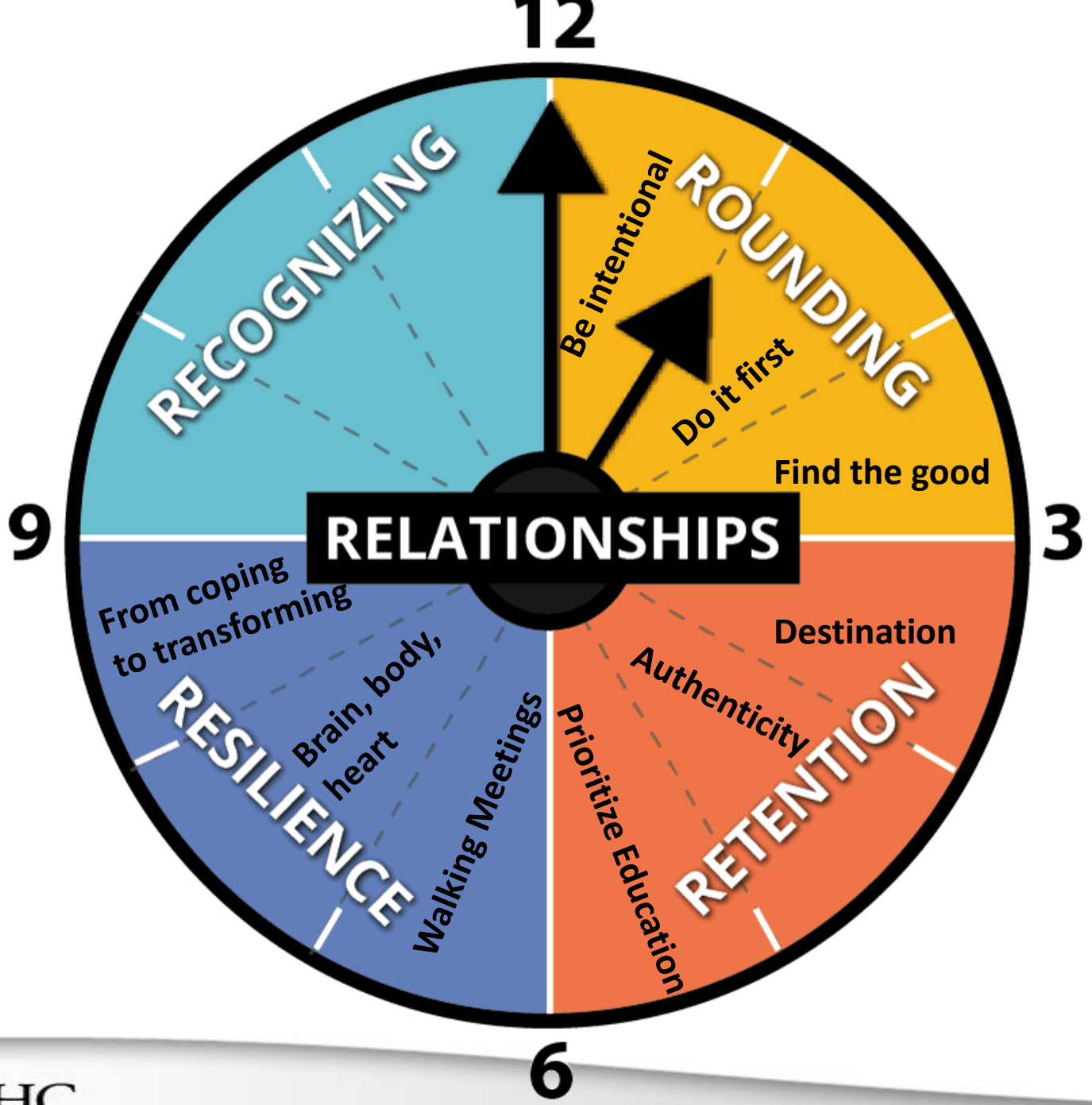
RESILIENCE

When can you walk, not just talk?


12
9
3
6
RECOGNIZING
ROUNDING
Be intentional
Do it first
Find the good
RELATIONSHIPS
RESILIENCE
Brain, body, heart
Walking Meetings
RETENTION
Destination
Authenticity
Prioritize Education

RESILIENCE

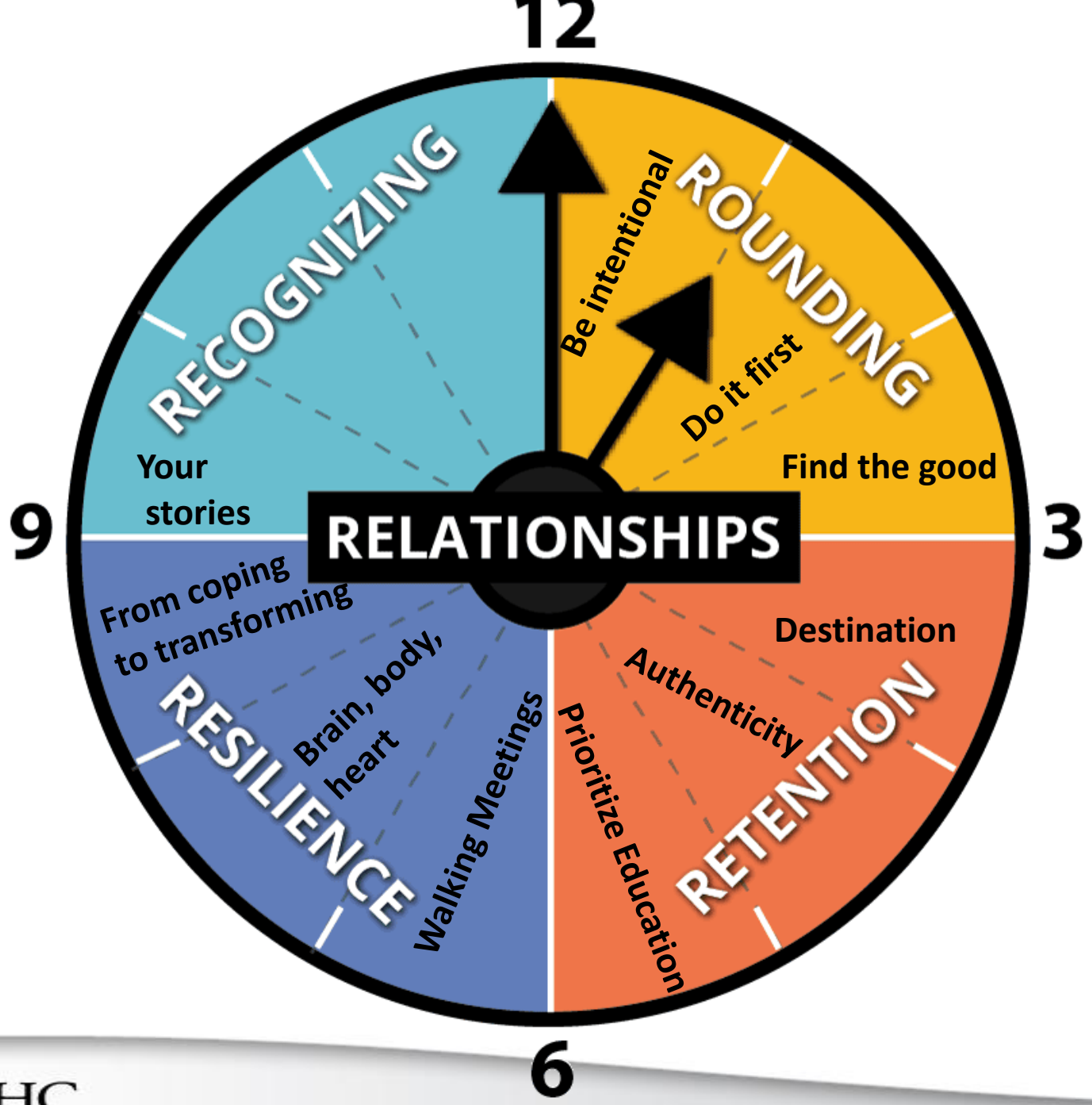
1. Move your body
2. Stimulate your brain
3. Engage your heart


12
9
3
6
RECOGNIZING
ROUNDING
Be intentional
Do it first
Find the good
RELATIONSHIPS
From coping
to transforming
RESILIENCE
Brain, body,
heart
Walking Meetings
Destination
Authenticity
RETENTION
Prioritize Education

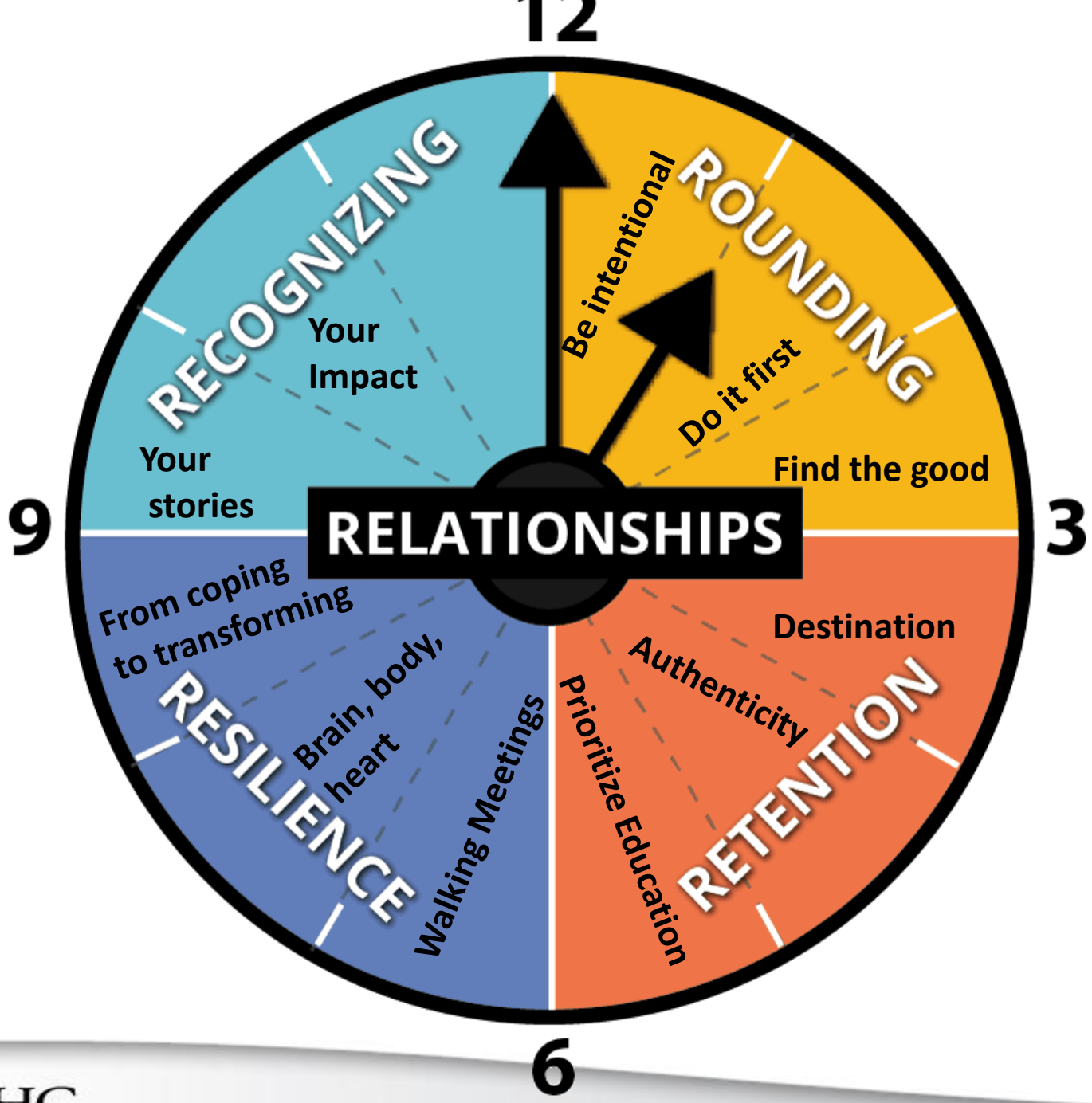
RWHC

RESILIENCE

- Center
- Enter
- Add Value

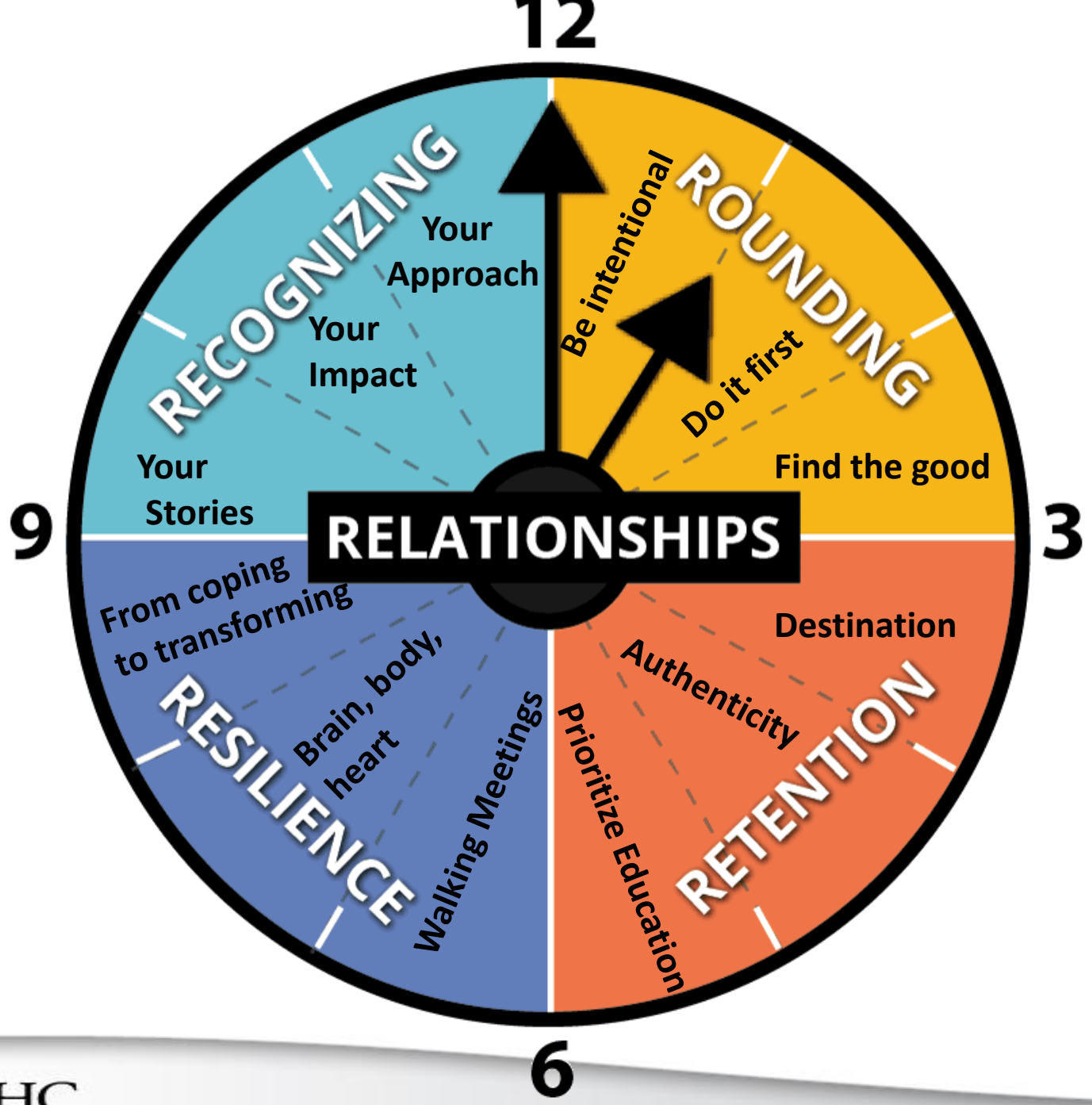

12
RECOGNIZING
Your stories
ROUNDING
Be intentional
Do it first
Find the good
9
RELATIONSHIPS
3
From coping to transforming
RESILIENCE
Brain, body, heart
Walking Meetings
Destination
Authenticity
Prioritize Education
RETENTION
6

Recognizing…


12
RECOGNIZING
Your Impact
Your stories
ROUNDING
Be intentional
Do it first
Find the good
9
RELATIONSHIPS
3
From coping to transforming
RESILIENCE
Brain, body, heart
Walking Meetings
Destination
Authenticity
Prioritize Education
RETENTION
6

Recognizing
Your Impact

RWHC


12
9
3
6
RECOGNIZING
Your Approach
Your Impact
Your Stories
ROUNDING
Be intentional
Do it first
Find the good
RELATIONSHIPS
RESILIENCE
From coping to transforming
Brain, body, heart
Walking Meetings
RETENTION
Destination
Authenticity
Prioritize Education

Recognizing
Your Go-To Approach

Does the
situation call for:

Acceleration?

Brakes?

Steering?

Lubricant?

Pay attention…

“The negative screams at us; the positive only whispers.”

Barbara Frederickson

Jo Anne Preston
Jpreston@rwhc.com
608-644-3261

GOT 5 MINUTES?
BUILD YOUR LEADERSHIP LEGACY!

RWHC

Resources

- Lead the Way in Five Minutes a Day: Sparking High Performance in Yourself and Your Teams, Jo Anne Preston
- http://www.rwhc.com/News/Leadership-Insights-Newsletter
- Duke Resilience Resources https://www.hsq.dukehealth.org/tools/
- Positivity, Barbara Frederickson
- The Zen Leader, and Resonate, Ginny Whitelaw
- Switch: How to Change When Change is Hard, Chip and Dan Heath
- No Ego, Cy Wakeman

Break until 10:45

How Are You Prepared for What's Now and What's Next?

Michelle Rathman

Impact! Communications

Are you prepared for what's now and what's next?

MICHELLE RATHMAN

Strategist / Speaker / Facilitator / Thought Partner

RURAL RESILIENCE & THE ROAD TO RECOVERY

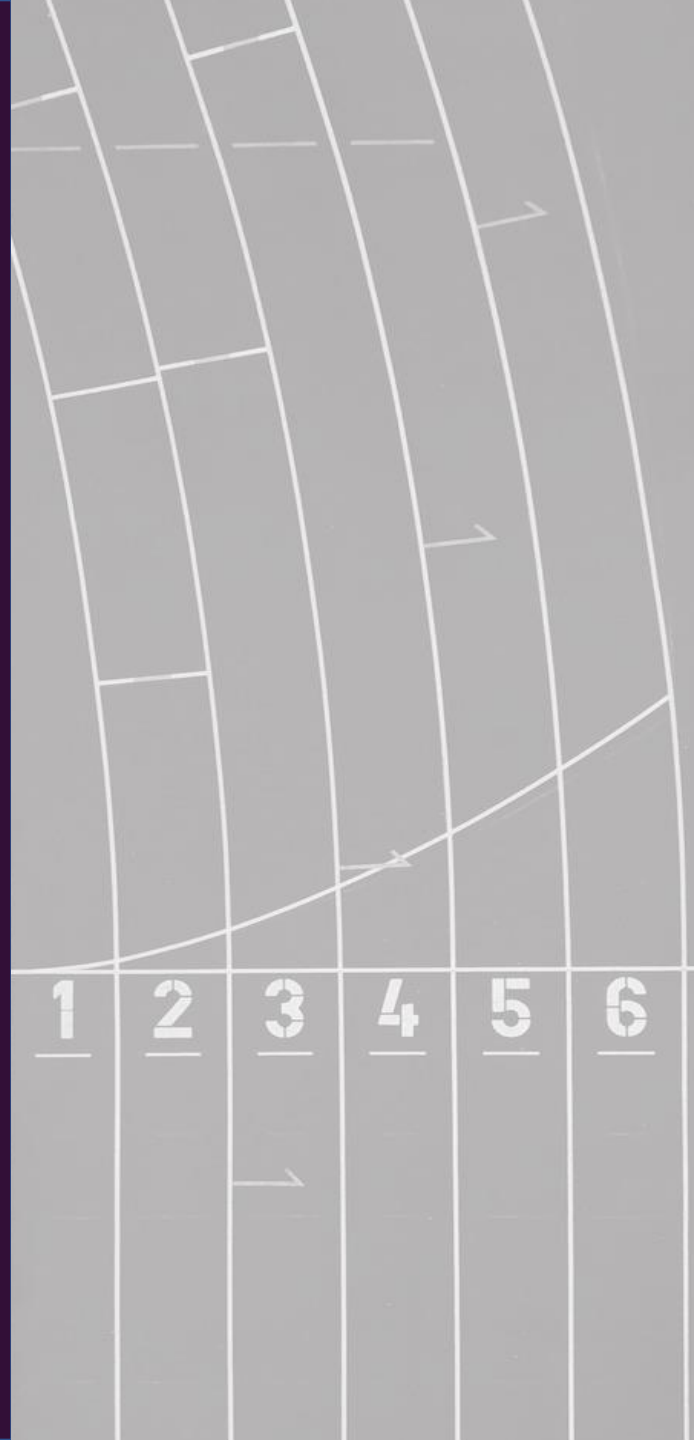
What's Now?

Where does your workforce stand?

Where will your organization land?

What's your plan to manage what's next?

Do you have a finish line in your sights?



Health Care in America is a Never-Ending Relay for Sustainability

- ✓ Still challenged with pre-pandemic industry burdens
- ✓ Continuing your quest to Identify the drivers for safety
- ✓ Working to improve organizational culture
- ✓ Removing the roadblocks to achieving High-Reliability
- ✓ Mustering up the courage to have the strategic conversations that accelerate change
- ✓ Preparing for leadership readiness
- ✓ Searching for resiliency in chaos
- ✓ **Recruitment for retention**


How do we manage population health without a workforce to do the hard and necessary work?

Opportunity.

The year **2020** was an urgent invitation to rethink our individual roles in the contribution of the population health disparities and inequities before us. (Reflection)

2021 further amplified the challenges and the opportunities to put what we learned during the previous year in action, and work to understand the big picture, putting into place the pieces we need to solve this gigantic puzzle. (Collaboration)

2022 is bigger than you and me and it begins with **COMMUNICATION, CULTURE & RESILIENCY.**

Established in 1989
impact! communications inc.
Proven Solutions for Health Systems & Hospitals

2021 Theme

4R's of the #PowerofRural

The way forward.
In your your hands?

Resiliency

How do you nurture it?

Put People First

Developing Talent on the Path to High-Reliability

(Think Retention)

The High Reliability Organization

HIGH RISK, DYNAMIC, TURBULENT,
YET OPERATE NEARLY ERROR-FREE…

even though human beings are involved.

Key Strength of an HRO

Commitment to Resilience

HROs are nimble, they have increased capacity for resourcefulness, they highlight the importance of communication, and encourage creative solutions to respond to unique problems.

Key Strength of an HRO

Commitment to Resilience

How do they get nimble?

HROs spend disproportionately on development (in addition to training*) for individuals and teams:

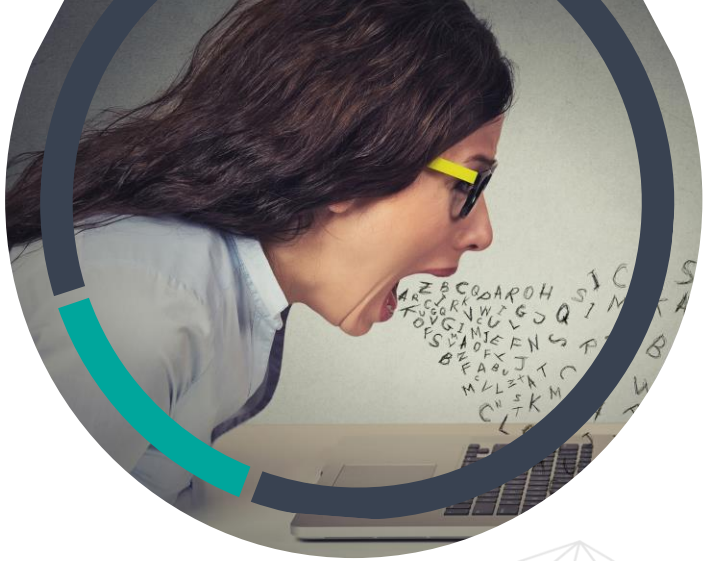
- Problem Solving
- Conflict Resolution
- Coping
- Rebounding
- Social Support
- Determination
- Adaptability
- Recuperability
- Hardiness

Developing Resiliency

Rebounding from setbacks and adversity when facing difficult situations. Specific development focused on:

- **Developing confidence under pressure**
- **Managing and handling crisis effectively and rationally**
- **Maintaining a positive attitude despite adversity**
- **Processing emotions after a setback**
- **Growing from negative experiences**
- **Conducting and constructing "Courageous Conversations"**
- **Using tools that will accelerate positive culture shifts**

EQi+JUST=HRO



Today, there is an unfortunate and growing belief that it is more important to say what is on our minds rather than be mindful of what we say and how we deliver our message.

Courageous vs. Confrontational

The difference between an emotionally intelligent conversation and one that is emotionally charged…everything.

You can be passionate without being punitive.

Strategy and Structure

Manage vs. Deal With

WHO?

Identify

WHY?

Pinpoint

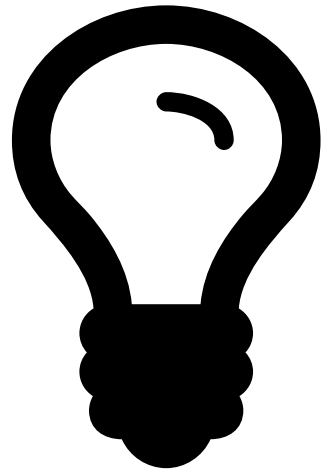
WHAT?

Result

WHO?

Identify someone you have or are currently experiencing conflict, broken communication or a difficult challenge. Think about a person with whom you would like to reset the relationship or set it on a better path to achieve a common goal.

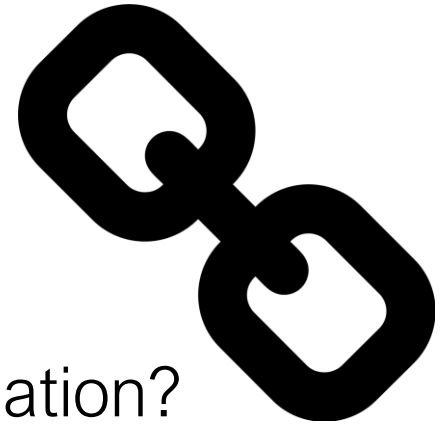
WHY?



Pinpoint the reason behind the conversation. Is it motivated out of…

- Guilt on your part
- Feeling of injustice or hurt
- Disappointment or confusion
- Frustration or a roadblock
- Fear or concern
- Growth and healing
- Accountability

WHAT?



What could be the result of the conversation?

- A new understanding or awareness
- Resolve of a situation or condition
- Moving beyond an issue or forgiveness
- Needed shifts in behaviors
- Improved situation or productivity
- Heightened safety and satisfaction

SHOULD or Shouldn’t?

BEING ASSERTIVE	DODGE	DO
RISK		
REWARD		

Be realistic and honest.

Relationships

How do you build and strengthen them?


Perform a comprehensive assessment
of interpersonal relationships on the team.

CULTIVATING CULTURE

Emotionally Intelligent Communicators

Commitment to Healthy Workplace Relationships

- Building strong-identity teams that apply their diverse skills and perspectives to achieve common goals.
- Gaining the confidence of trust of others through honesty, integrity, and authenticity.
- Developing and delivering multi-mode communications that convey a clear understanding of the unique needs of different audiences.
- Working collaboratively with others to meet shared objectives.

Commitment to Healthy Workplace Relationships

Deference to Expertise

"When it comes to patient and employee safety, quality and high-reliability, any member of the team, with the skills to best manage the situation at hand, can assume a leadership role."

Readiness

What's your process and who else will you invite to the table?

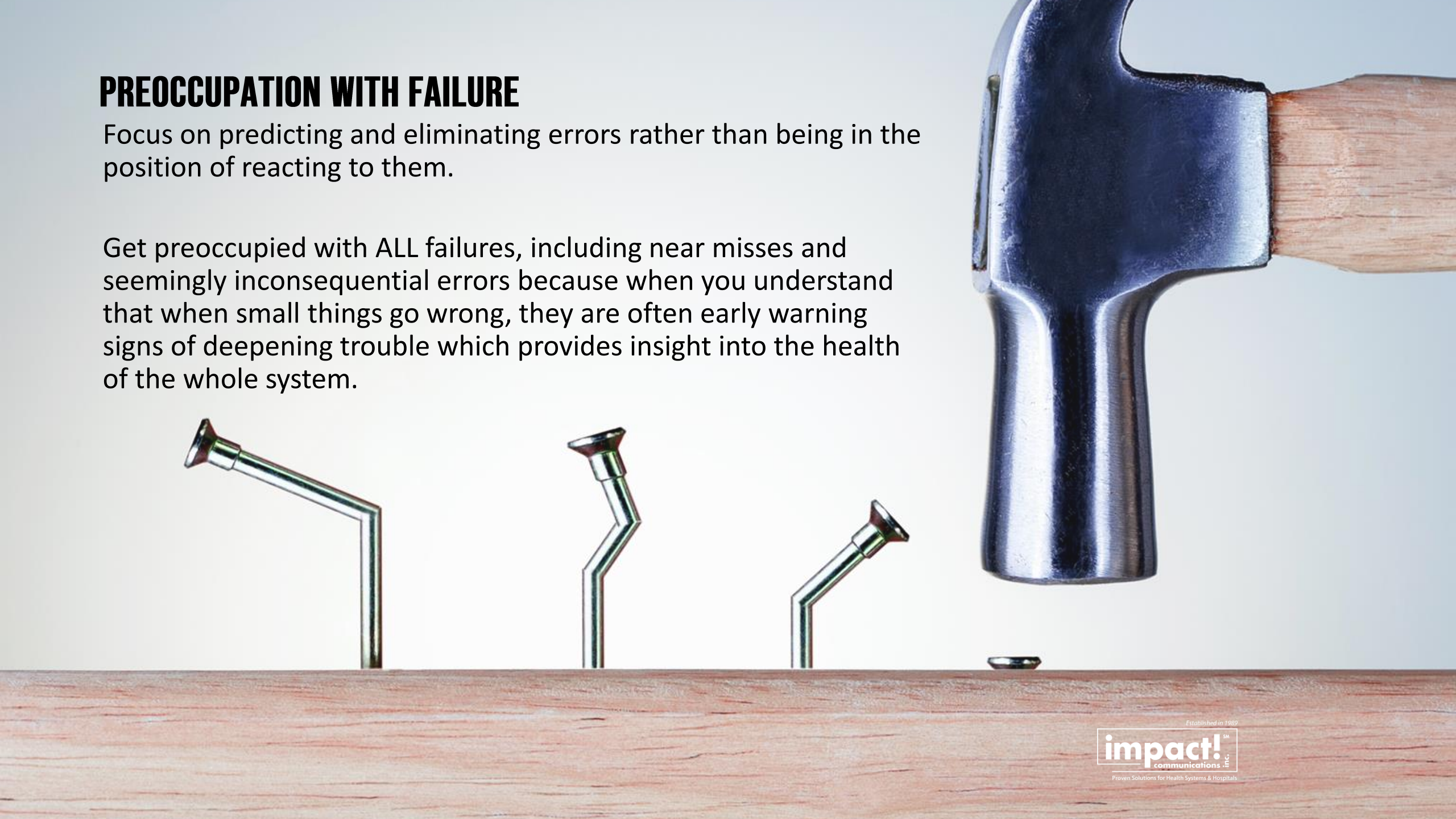
Readiness is a test of endurance.

- Preoccupation with Failure
- Reluctance to Simplify
- Sensitivity to Operations

PREOCCUPATION WITH FAILURE

Focus on predicting and eliminating errors rather than being in the position of reacting to them.

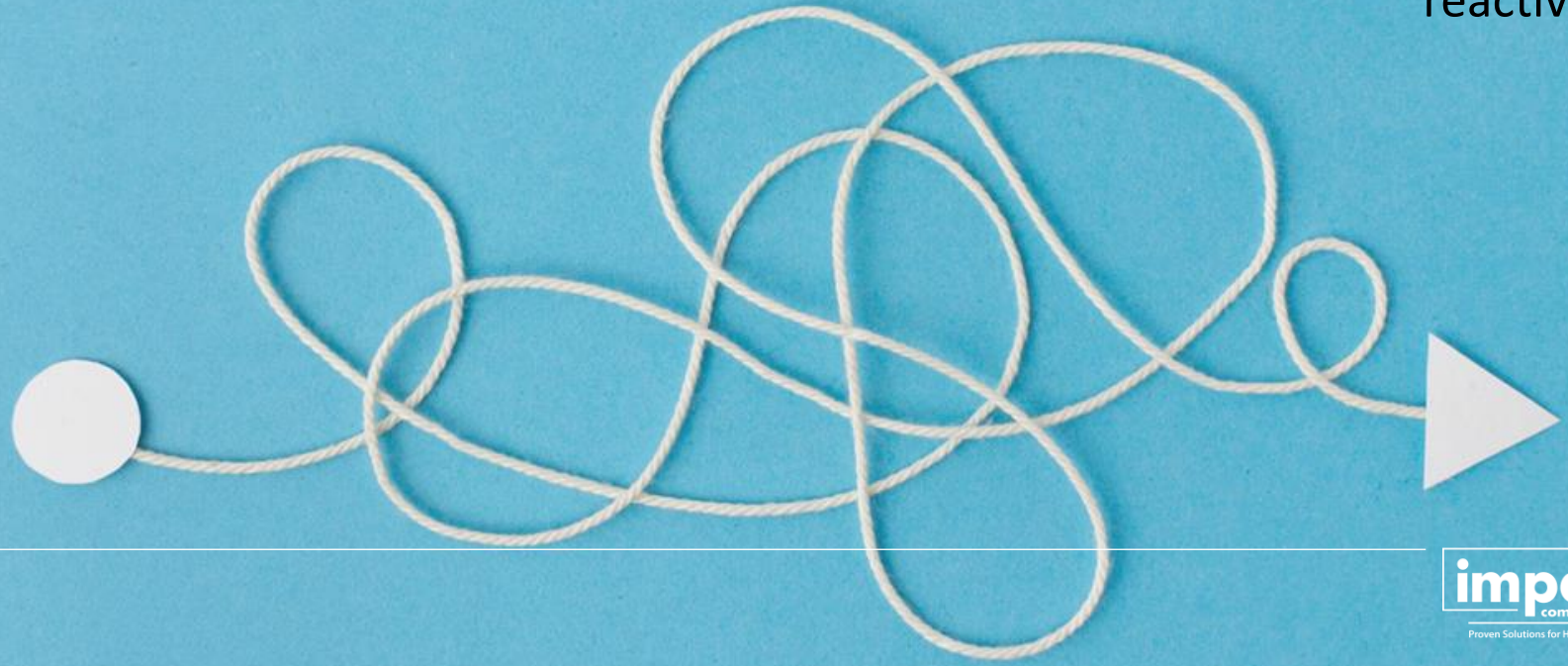
Get preoccupied with ALL failures, including near misses and seemingly inconsequential errors because when you understand that when small things go wrong, they are often early warning signs of deepening trouble which provides insight into the health of the whole system.



Reluctance to simplify

Resist the temptation to simplify to achieve a faster result. Invite in-depth and diverse checks and balances, adversarial reviews, and the cultivation of multiple perspectives.

Build systems and process solutions to prevent human error proactively even though being ‘reactive’ is human nature.



Sensitivity to operations

Everyone values organizing and collaborating to maintain heightened and sustained **situational awareness.**

Making sense of complex, high-quantity, and sometimes conflicting information to solve problems.

- Ask the right questions
- Acquire data from multiple sources
- Uncover root causes of difficult problems
- Champion ideas with courage

Sensitivity to operations

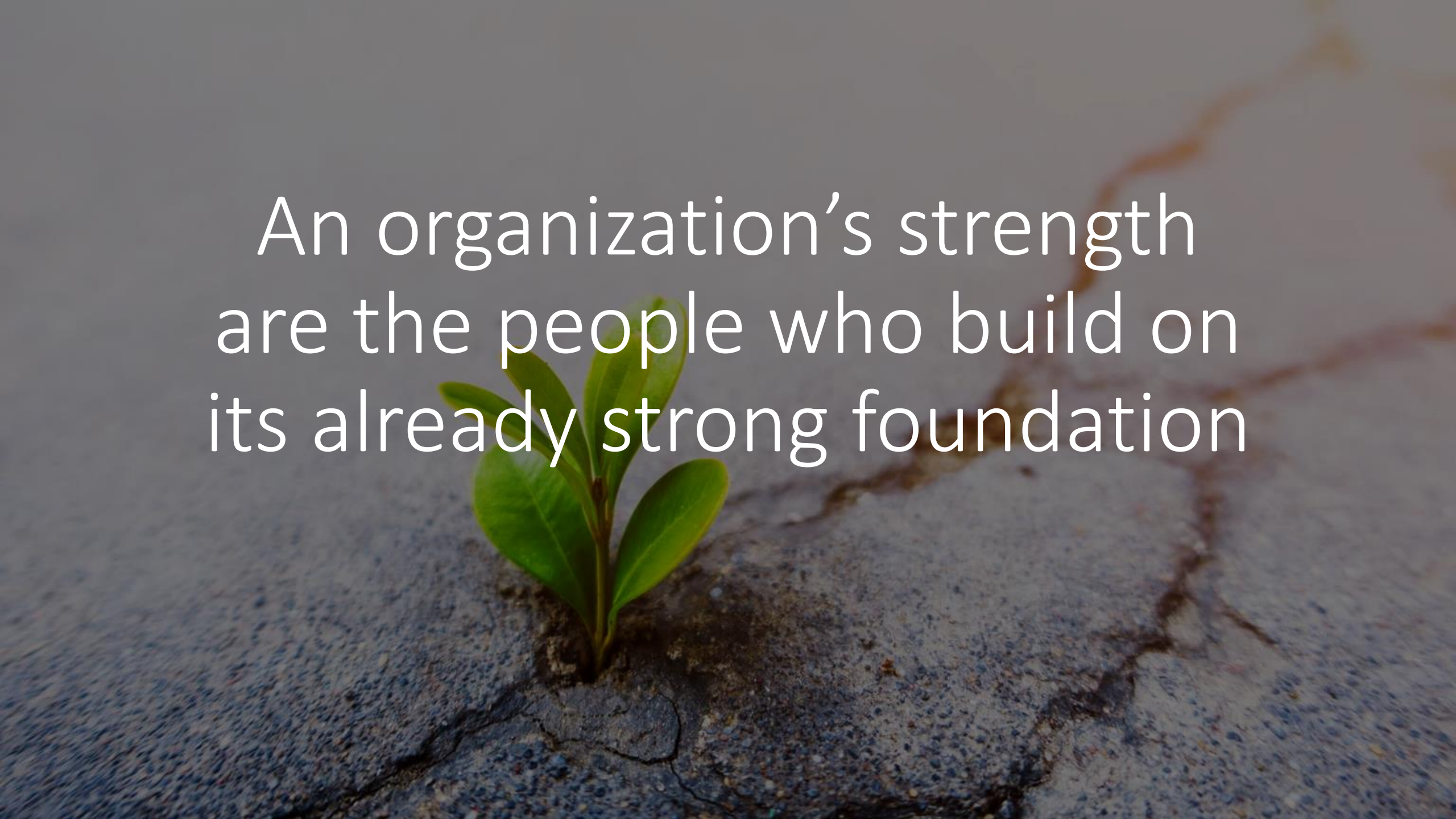
To be ready for what's next, answer these questions now:

1. What are conditions that might diminish situational awareness?

2. How do your teams (and you) practice mindfulness every day?


Resolve
Recruit & Retain


WORK
BALANCE
LIFE


An organization’s strength
are the people who build on
its already strong foundation


#PowerofRural
What's yours?

Material and Resource References

To inquire about having a skilled and certified facilitator for leadership development, administering and interpreting Emotional Intelligence Assessments, or for more information about the Impact! *Journey to High-Reliability s*taff leadership and team education sessions, contact:

Michelle Rathman
President & CEO
Impact! Communications, Inc.
Host of Rural Matters Podcast

p: 630.377.8101
m: 630.865.4439
e: michelle@doitwithimpact.com
w: doitwithimpact.com w: michellerathman.com

@MRBImpact

Recommended Leadership Development Tools:

- Emotional Intelligence Assessments as its resource for EQ-I 2.0 Assessments.
- StrengthsFinder 2.0

Integrated Care

Lisa Tyndall, PhD, LMFT
Regina Dickens Ed.D.
Alysia Hoover-Thompson, PsyD

National Definition of Behavioral Health and Primary Care Integration

Integrated care is “care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”

(Peek, 2013)

Benefits of Integrated Care in Rural Communities

- Improves "…availability, accessibility, affordability, and acceptability of behavioral health care for people in rural areas." (SAMHSA-HRSA)
- Enhances access, lifts stigma and promotes respect of human rights (WHO, 2008)
- Increases provider comfort with talking about behavioral health needs with patients
- Support of the BH provider also protects against PC provider stress and attrition (Miller-Matero et al., 2016)
- BHC helps connect the patients to community referrals and resources.

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath et al., 2013

Primary Care Behavioral Health Model

LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
s work:	
In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth un-derstanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Collaborative Care Model

Primary Care Behavioral Health Model

- Population based
- Goal is to improve and promote overall health within a population.
- BHC operates as a consultant and generalist – functional assessments.
- Team based with shared resources.
- Often a core model of a practice

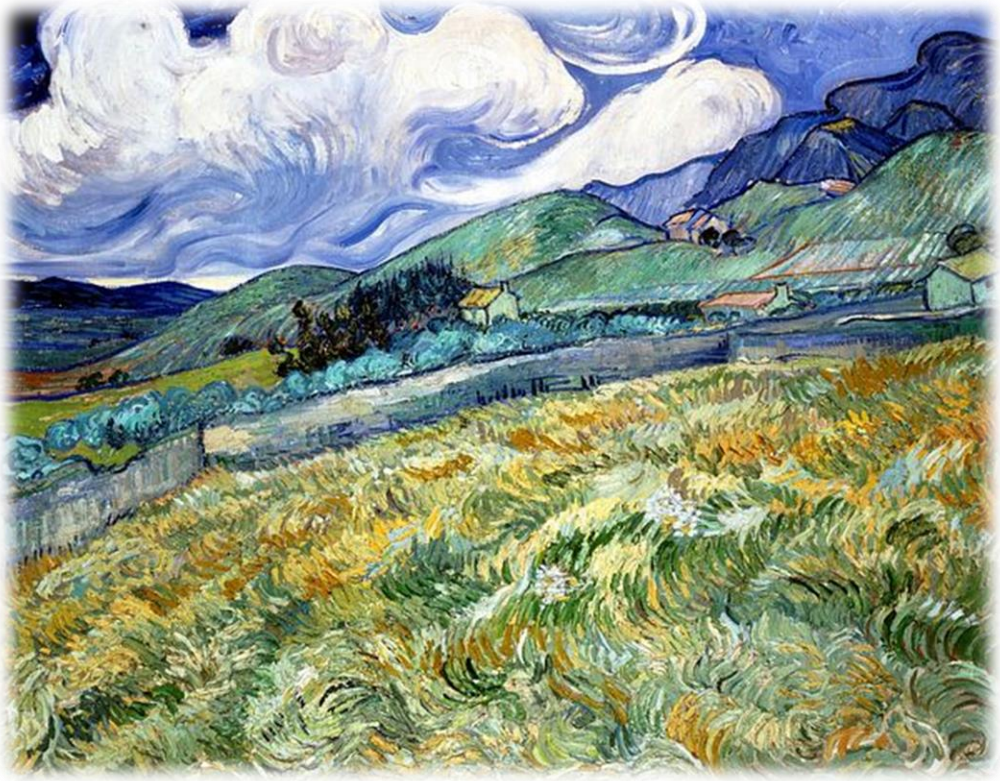
Collaborative Care Model

- Registry driven approach
- Collaboration between primary care, case manager & consulting psychiatrist
- Use of medication and visit algorithms
- Team based care
- Behavioral Activation and Problem Solving Treatment (PST)

Special Considerations of the Rural Based BHC

(Selby-Nelson, Bradley, Schiefer, Hoover-Thompson, 2018)

- Often stretched across multiple clinics
- Need increased sense of flexibility and heterogeneity in how they practice
- Need to work harder to balance the outpatient needs due to lack of referral places
- BHC may consider taking new patients and reverse hand-off to medical provider if needed
- Dual relationships, conflicting roles, and recognizing scope of practice.



Content resumes at 1:15

North Carolina Rural Primary Care Providers

Introduction to POND® Webinar

November 18, 2021

Lilypad®

Our Agenda

North Carolina Rural Primary Care Benchmarking Project Kickoff

01

Context

The relevance of rural primary care and RHCs

02

Taking Stock

North Carolina RHCs at-a-glance

03

POND®

Benchmarking system for rural primary care practices

04

20 Questions

Understanding RHC performance priorities

05

Next Steps

Building the POND database for North Carolina

Lilypad®

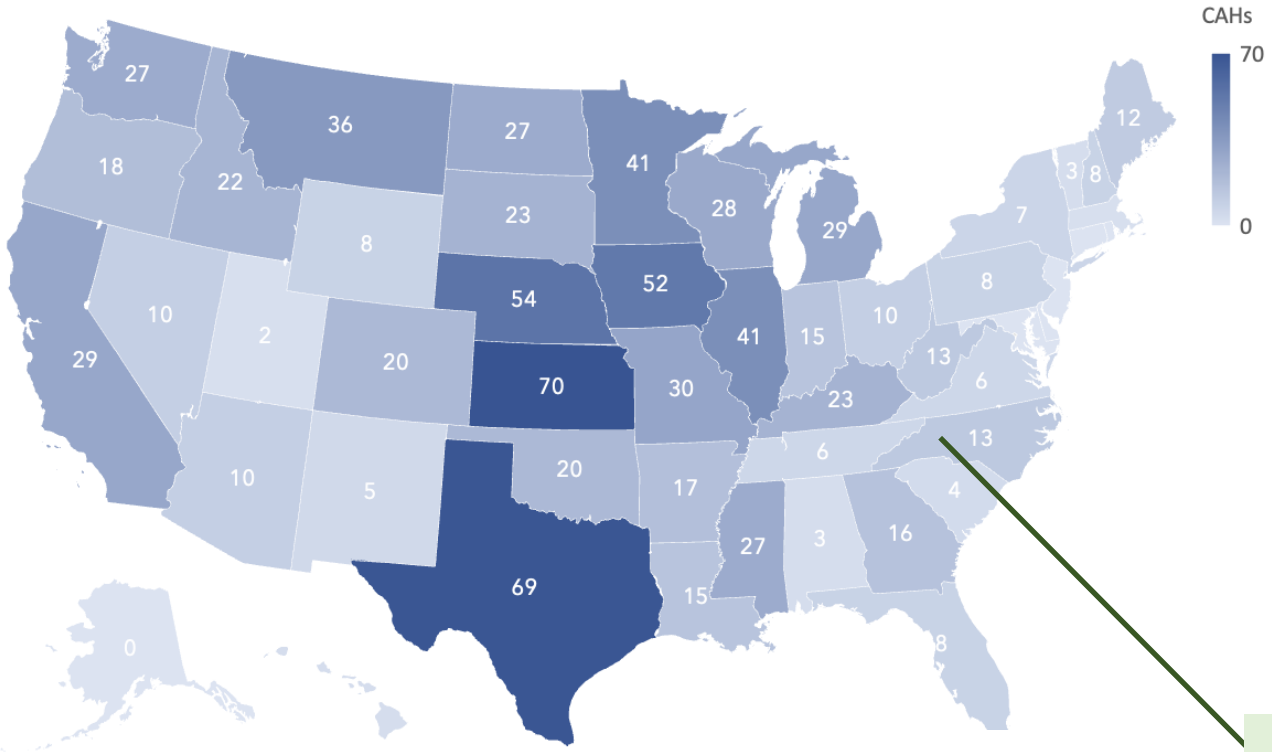
Context

The relevance of rural primary care and RHCs

Lilypad®

CAHs with Provider-based RHCs by State

Map A: State Comparison of CAHs that Own Provider-based Rural Health Clinics (2019)



890

In 2019, there were approximately **1,350** Critical Access Hospitals in the US. Among those organizations, **890** owned and operated at least one Provider-based Rural Health Clinic. Collectively, these CAHs owned **1,649** PB-RHCs. The distribution of PB-RHCs largely reflected the distribution of CAHs across rural America, with a large percentage of PB-RHCs located in the Midwest.

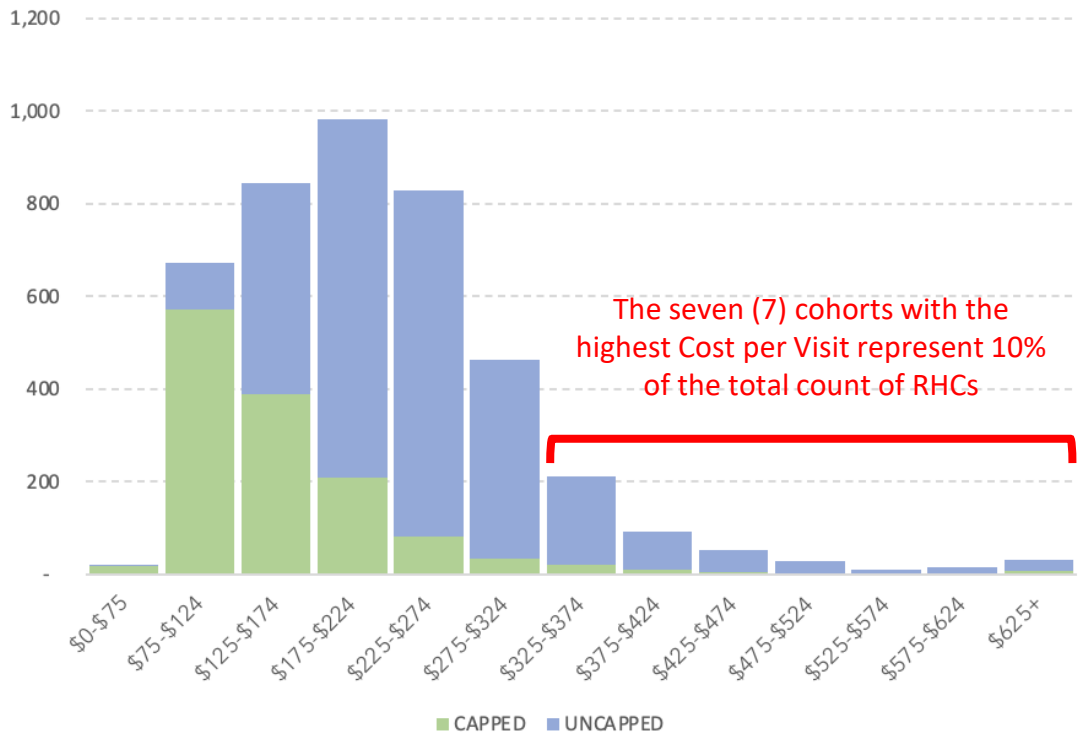
North Carolina has 13 CAHs with Provider-based RHCs Representing 45 of 72 RHCs (63%)

Lilypad®

Data Source: December 2020 Medicare Cost Report release for hospital and RHC fiscal year 2019; and December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.

RHC Cost Per Visit Rate Bands

Chart A: Distribution of Cost Per Visit Rate Bands for All RHCs (FY 2019)



90%

Chart A displays cohorts based on cost per visit rates calculated as Total Costs divided by Total Visits. We constructed 13 bands based on the cost per visit rates for all RHCs for FY 2019. This analysis includes all RHCs (Independent and Hospital-owned) and excludes those clinics whose Medicare cost reports contained material errors, omissions or irregularities (n=293). For each band we calculated its percentage of total RHCs.

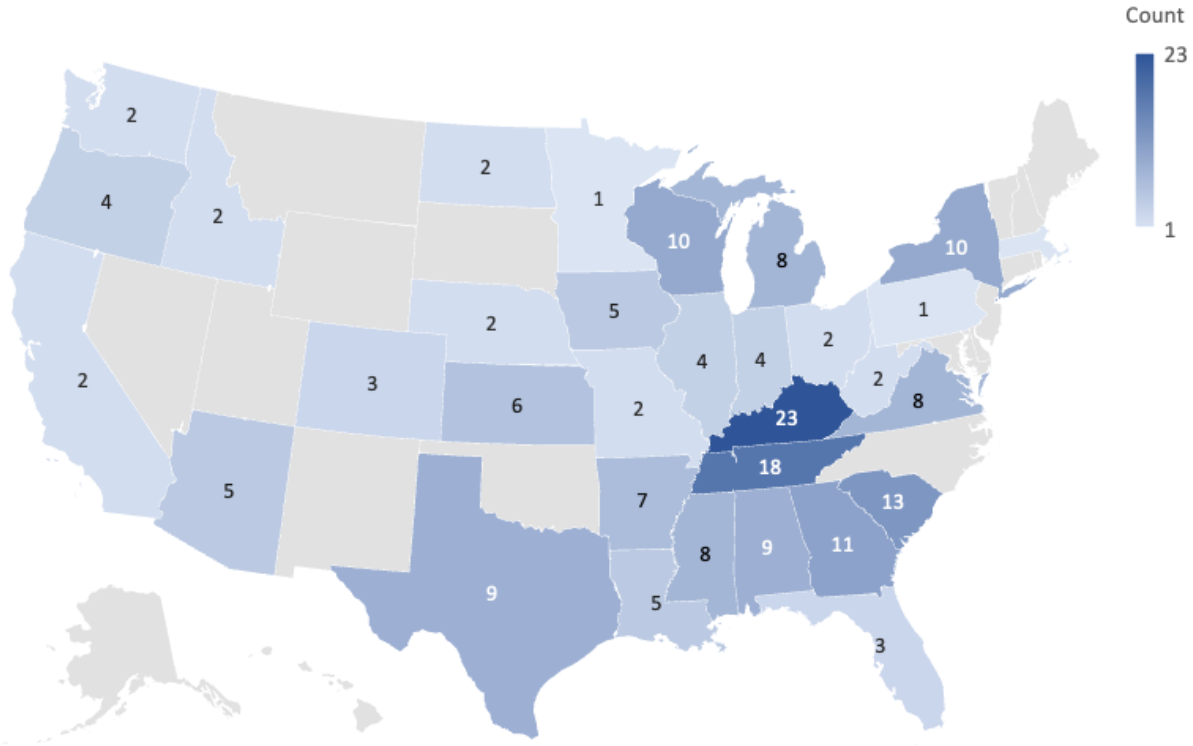
In FY 2019 for the 4,254 RHCs that had complete, reliable and traceable Medicare cost report submissions, **90%** of RHCs report a Cost per Visit rate lower than $325

Lilypad®

Data Source: December 2020 Medicare Cost Report release for hospital and RHC fiscal year 2019; and December 2020 CMS Provider of Services (POS) data file. Refer to the Data Management slide of this document for more details.

CYTD 2021 New Rural Health Clinics

Map A: State Comparison of Newly Certified Rural Health Clinics (CY 2021)



192

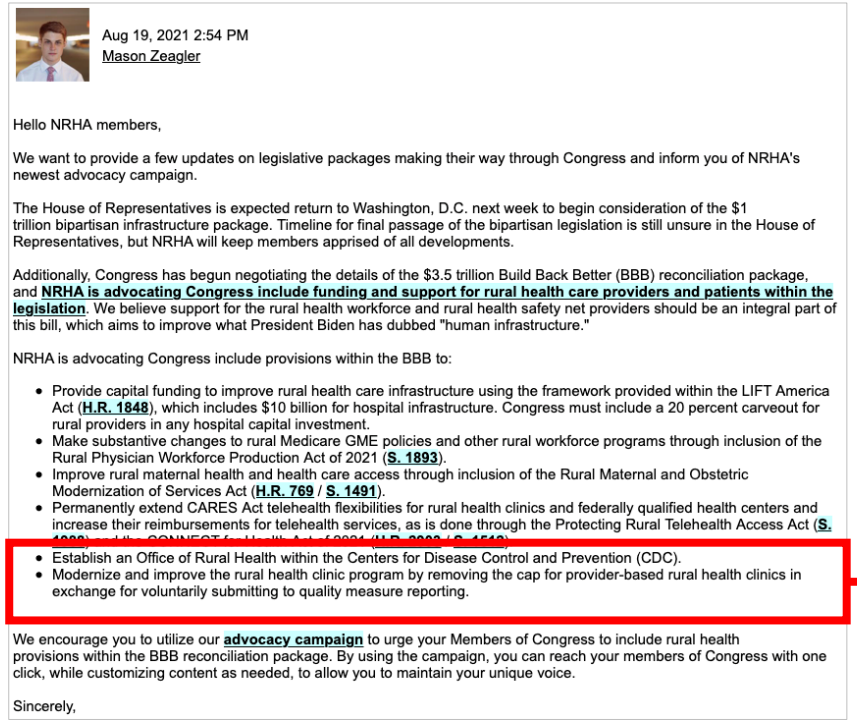
110 of the 192 RHCs are Provider-based while **21** RHCs are operated by hospitals with greater than 50 beds. **61** RHCs are Independent.

STATE	<50 CAH	<50 STAC	>50 STAC	IND
Kentucky	6	2	0	15
Tennessee	0	0	5	13
South Carolina	0	12	0	1
Georgia	0	6	3	2
New York	4	6	0	0

Lilypad®

Data Source: September 2021 CMS Provider of Services (POS) data file.

NRHA Grassroots Update



Aug 19, 2021 2:54 PM
Mason Zeagler

Hello NRHA members,

We want to provide a few updates on legislative packages making their way through Congress and inform you of NRHA's newest advocacy campaign.

The House of Representatives is expected return to Washington, D.C. next week to begin consideration of the $1 trillion bipartisan infrastructure package. Timeline for final passage of the bipartisan legislation is still unsure in the House of Representatives, but NRHA will keep members apprised of all developments.

Additionally, Congress has begun negotiating the details of the $3.5 trillion Build Back Better (BBB) reconciliation package, and **NRHA is advocating Congress include funding and support for rural health care providers and patients within the legislation**. We believe support for the rural health workforce and rural health safety net providers should be an integral part of this bill, which aims to improve what President Biden has dubbed "human infrastructure."

NRHA is advocating Congress include provisions within the BBB to:

- Provide capital funding to improve rural health care infrastructure using the framework provided within the LIFT America Act (H.R. 1848), which includes $10 billion for hospital infrastructure. Congress must include a 20 percent carveout for rural providers in any hospital capital investment.
- Make substantive changes to rural Medicare GME policies and other rural workforce programs through inclusion of the Rural Physician Workforce Production Act of 2021 (S. 1893).
- Improve rural maternal health and health care access through inclusion of the Rural Maternal and Obstetric Modernization of Services Act (H.R. 769 / S. 1491).
- Permanently extend CARES Act telehealth flexibilities for rural health clinics and federally qualified health centers and increase their reimbursements for telehealth services, as is done through the Protecting Rural Telehealth Access Act (S. [illegible]) and the CONNECT for Health Act of 2021 (H.R. [illegible] / S. [illegible])
- Establish an Office of Rural Health within the Centers for Disease Control and Prevention (CDC).
- Modernize and improve the rural health clinic program by removing the cap for provider-based rural health clinics in exchange for voluntarily submitting to quality measure reporting.

We encourage you to utilize our **advocacy campaign** to urge your Members of Congress to include rural health provisions within the BBB reconciliation package. By using the campaign, you can reach your members of Congress with one click, while customizing content as needed, to allow you to maintain your unique voice.

Sincerely,

Thursday, August 19, 2021 at 2:54 PM

"Modernize and improve the rural health clinic program by removing the cap for provider-based rural health clinics **in exchange for voluntarily submitting to quality measure reporting**."

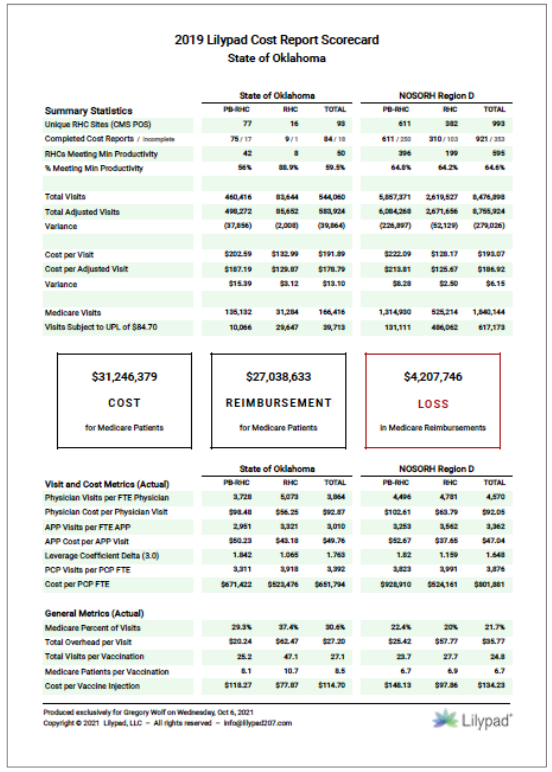
Lilypad®

Taking Stock

North Carolina RHCs at-a-glance

Lilypad®

North Carolina RHC Scorecard



2019 Lilypad Cost Report Scorecard
State of Oklahoma

Summary Statistics	State of Oklahoma PB-RHC	State of Oklahoma RHC	State of Oklahoma TOTAL	NOSORH Region D PB-RHC	NOSORH Region D RHC	NOSORH Region D TOTAL
Unique RHC Sites (CMS POS)	77	16	93	611	382	993
Completed Cost Reports / Incomplete	75 / 17	9 / 1	84 / 18	611 / 250	310 / 103	921 / 353
RHCs Meeting Min Productivity	42	8	50	396	199	595
% Meeting Min Productivity	56%	88.9%	59.5%	64.8%	64.2%	64.6%
Total Visits	460,416	83,644	544,060	5,857,371	2,619,527	8,476,898
Total Adjusted Visits	498,272	85,652	583,924	6,084,268	2,671,656	8,755,924
Variance	(37,856)	(2,008)	(39,864)	(226,897)	(52,129)	(279,026)
Cost per Visit	$202.59	$132.99	$191.89	$222.09	$128.17	$193.07
Cost per Adjusted Visit	$187.19	$129.87	$178.79	$213.81	$125.67	$186.92
Variance	$15.39	$3.12	$13.10	$8.28	$2.50	$6.15
Medicare Visits	135,132	31,284	166,416	1,314,930	525,214	1,840,144
Visits Subject to UPL of $84.70	10,066	29,647	39,713	131,111	486,062	617,173

$31,246,379	$27,038,633	$4,207,746
COST	REIMBURSEMENT	LOSS
for Medicare Patients	for Medicare Patients	in Medicare Reimbursements

Visit and Cost Metrics (Actual)	State of Oklahoma PB-RHC	State of Oklahoma RHC	State of Oklahoma TOTAL	NOSORH Region D PB-RHC	NOSORH Region D RHC	NOSORH Region D TOTAL
Physician Visits per FTE Physician	3,728	5,073	3,864	4,496	4,781	4,570
Physician Cost per Physician Visit	$98.48	$96.25	$92.87	$102.61	$93.79	$92.05
APP Visits per FTE APP	2,951	3,321	3,010	3,253	3,562	3,362
APP Cost per APP Visit	$50.23	$48.18	$49.76	$52.67	$37.65	$47.04
Leverage Coefficient Delta (3.0)	1.842	1.065	1.763	1.82	1.159	1.648
PCP Visits per PCP FTE	3,311	3,918	3,992	3,823	3,991	3,876
Cost per PCP FTE	$671,422	$523,476	$651,794	$928,910	$524,161	$801,881
General Metrics (Actual)						
Medicare Percent of Visits	29.3%	37.4%	30.6%	22.4%	20%	21.7%
Total Overhead per Visit	$20.24	$62.47	$27.20	$25.42	$57.77	$35.77
Total Visits per Vaccination	25.2	47.1	27.1	23.7	27.7	24.8
Medicare Patients per Vaccination	8.1	10.7	8.5	6.7	6.9	6.7
Cost per Vaccine Injection	$118.27	$77.87	$114.70	$148.13	$97.86	$134.23

Produced exclusively for Gregory Wolf on Wednesday, Oct 6, 2021

Lilypad

	Total MO RHCs		Regional Benchmarks
	72		
	Provider-based	*Independent*	
Count of RHCs	45 (63%)	27	1,223
Meeting Productivity	57%		65%
Cost per Visit	$255	$132	
Capped Rate Visits	16,725		
Physician Visits/FTE	2,965		3,744
APP Visits/FTE	2,398		2,750
Cost per PCP FTE	$730k		$632k

*Contributes to **$5.7 million** loss in potential Medicare reimbursements*

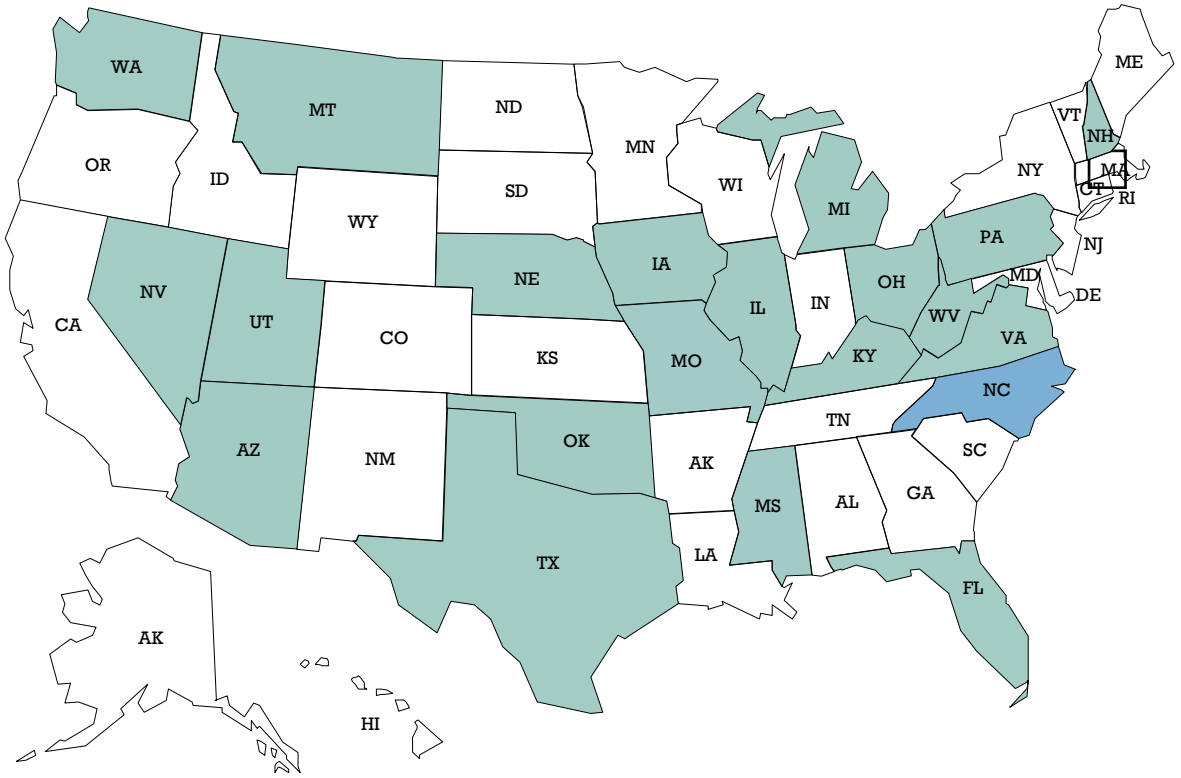
Lilypad®

POND®

Benchmarking system for rural primary care practices

Lilypad®

Our Current States

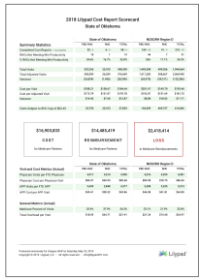


Lilypad®

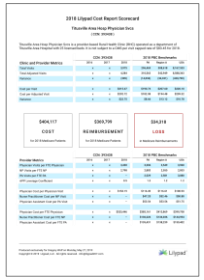
How Does It Work?

Advanced Analytics

State Scorecards

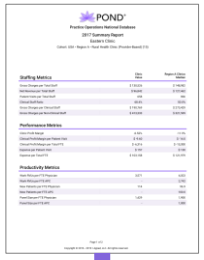


Clinic Scorecards

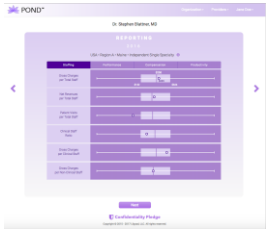


POND®

Clinic Scorecard



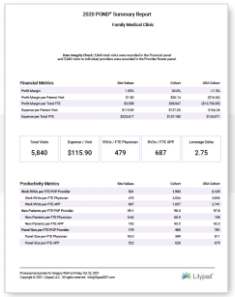
Interactive Tools



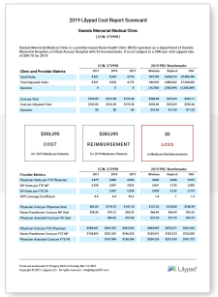
To gain access to these reports and tools the required data must be entered into the POND web application

Lilypad®

Our Reports



Lilypad's flagship report, the **POND Summary Report** includes RHC-specific financial, staffing, provider compensation, productivity and clinical metrics with customized peer group and national benchmarks.

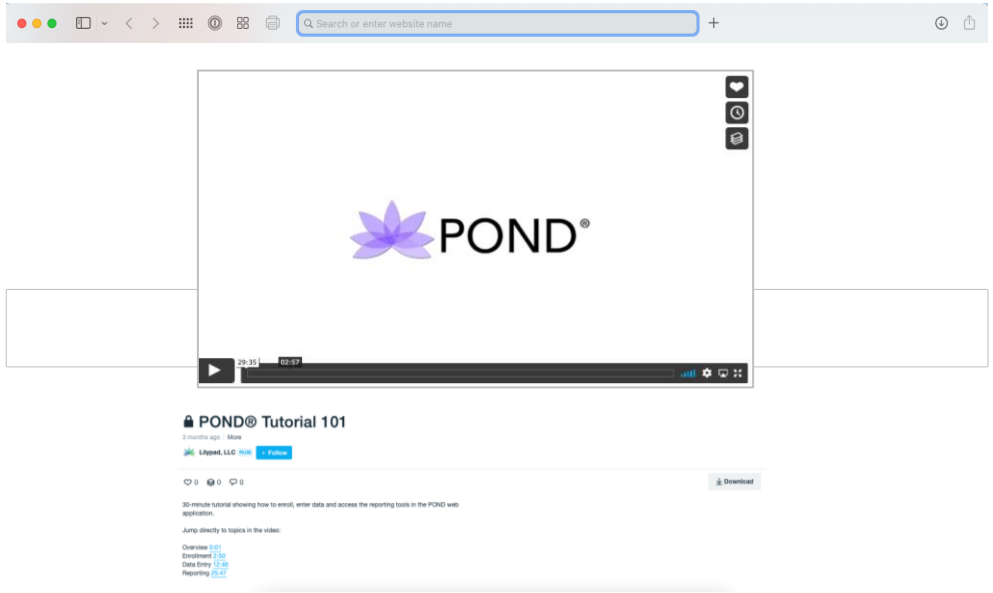


The **Cost Report Scorecard** includes multi-year trended volume, financial, cost and staffing ratios as well as state, regional and national benchmarks from all US RHCs based on current Medicare Cost Reports.

The **Site Audit** combines data from multiple public sources to provide summary statistics as well as a proprietary Medicare Cost Report integrity analysis and an evaluation of the out-of-pocket obligations for Medicare patients.

The **Lilypad Award Ranking Report** displays your RHC's annual performance in five weighted rural-relevant performance metrics according to the industry's only comprehensive RHC ranking and ratings program.

Online Training Tutorial



We created a simple 30-minute training webinar with chapters that enables viewers to watch how to enroll, enter data, generate reports and view benchmarks

https://vimeo.com/466246995/0ebde8b506

Lilypad®

20 Questions

Understanding RHC performance Priorities

Lilypad®

Why Hospital CFOs Should Use POND®

Focus on the Right Metrics

POND features the most relevant RHC financial, staffing, and provider metrics

Benchmark your Clinic(s)

POND is the only national database focused on small rural practices

Validate Provider Compensation Plans

POND provides RHC-specific compensation and productivity benchmarks

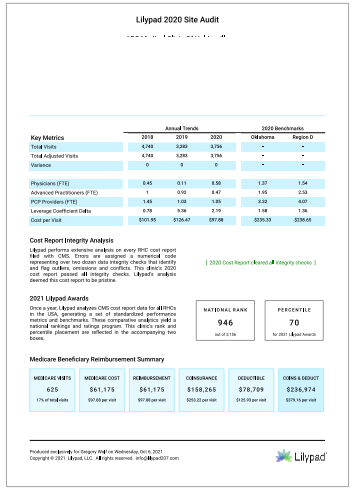
Evaluate RHC Performance

POND helps you elevate primary care in your hospital QI program

Access Peer Learning

POND is your ticket to collaborate with other CFOs who face similar challenges

RHC 20 Questions for Business Literacy


Lilypad 2020 Site Audit

Key Metrics

Annual Trends

2020 Benchmarks

Cost Report Integrity Analysis

2021 Lilypad Awards

NATIONAL RANK 946

PERCENTILE 70

Medicare Beneficiary Reimbursement Summary

MEDICARE VISITS 625

MEDICARE COST $61,175

REIMBURSEMENT $61,175

COINSURANCE $158,265

DEDUCTIBLE $78,709

CODING & DEDUCT $236,974

Lilypad

POND® Summary Report

1. **Why do visit volumes matter so much?**
2. What is the right mix of physicians and APPs?
3. Are our providers "busy"?
4. What is the difference between gross charges and net revenue?
5. How come our clinic does not make money?
6. What quality measures should we track?
7. Are our providers appropriately compensated?
8. Do we have the right number of support staff?
9. How can we control our cost per visit?
10. Why is important to track "new patients"?
11. **What is most important? Managing visits, revenue or expenses?**
12. What is the right mix of clinical and non-clinical staff?
13. What level of performance should we expect for quality measures?
14. How do we increase our profit margin per patient visit?
15. Should performance standards be different for PA and NPs?
16. How does patient panel factor into overall performance?
17. What is the best model to compensate physicians?
18. How does visit volume relate to Work RVUs?
19. Why are our productivity scores low?
20. Do we need to hire more providers?

Webinar A

Webinar B

Lilypad®

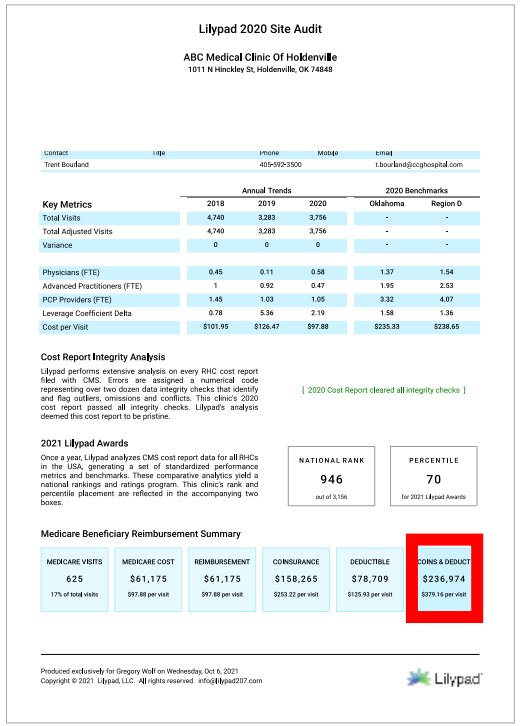
Gross Charges and Net Revenue

Gross Charges are the retail prices assigned to all medical services and procedures via the hospital or clinic Chargemaster

Net Revenue is the amount of actual income (dollars) generated by the hospital or clinic

Why does this matter for an RHC?

Gross Charges and Net Revenue



Lilypad 2020 Site Audit

ABC Medical Clinic Of Holdenville
1011 N Hinckley St, Holdenville, OK 74848

Contact	Title	Phone	Mobile	Email
Trent Bourland		405-592-3500		t.bourland@ccghospital.com

Key Metrics	Annual Trends 2018	2019	2020	2020 Benchmarks Oklahoma	Region D
Total Visits	4,740	3,283	3,756	-	-
Total Adjusted Visits	4,740	3,283	3,756	-	-
Variance	0	0	0	-	-
Physicians (FTE)	0.45	0.11	0.58	1.37	1.54
Advanced Practitioners (FTE)	1	0.92	0.47	1.95	2.53
PCP Providers (FTE)	1.45	1.03	1.05	3.32	4.07
Leverage Coefficient Delta	0.78	5.36	2.19	1.58	1.36
Cost per Visit	$101.95	$126.47	$97.88	$235.33	$238.65

Cost Report Integrity Analysis

Lilypad performs extensive analysis on every RHC cost report filed with CMS. Errors are assigned a numerical code representing over two dozen data integrity checks that identify and flag outliers, omissions and conflicts. This clinic's 2020 cost report passed all integrity checks. Lilypad's analysis deemed this cost report to be pristine.

[2020 Cost Report cleared all integrity checks]

2021 Lilypad Awards

Once a year, Lilypad analyzes CMS cost report data for all RHCs in the USA, generating a set of standardized performance metrics and benchmarks. These comparative analytics yield a national rankings and ratings program. This clinic's rank and percentile placement are reflected in the accompanying two boxes.

NATIONAL RANK	PERCENTILE
946	70
out of 3,156	for 2021 Lilypad Awards

Medicare Beneficiary Reimbursement Summary

MEDICARE VISITS	MEDICARE COST	REIMBURSEMENT	COINSURANCE	DEDUCTIBLE	COINS & DEDUCT
625	$61,175	$61,175	$158,265	$78,709	$236,974
17% of total visits	$97.88 per visit	$97.88 per visit	$253.22 per visit	$125.93 per visit	$379.16 per visit

Produced exclusively for Gregory Wolf on Wednesday, Oct 6, 2021
Copyright © 2021 Lilypad, LLC. All rights reserved. info@lilypad207.com

Lilypad

Example: Medicare PB-RHC Visit

Out-of-Pocket Expenses

$200	$400	$20	$40	$80
Cost	Charge	Commercial	20% Cost	20% Charge

The fully-allocated cost for a single visit according to the hospital Medicare cost report

The "retail price" of the visit according to the hospital's Chargemaster

A typical co-payment for a primary care visit under a commercial policy

Medicare beneficiary out-of-pocket obligation based on a "percent of charges" methodology for provider-based RHCs

An inflated CAH chargemaster passes on cost to your Medicare patients

Lilypad®

Next Steps

What's Next?

Let's be North Carolina RHC leaders:

1. View the Online Tutorial
2. Enroll your RHC(s)
3. Enter data
4. Generate reports
5. Spread findings

POND Summary Report

Site Audit

Cost Report Scorecard

Lilypad Award Rankings

Lilypad®

Lilypad is a Maine-based analytics firm that provides mobile and web-based applications for rural primary care practices. We adhere to a core business principle that accountable physicians/clinical leaders and administrators require sound data and simple, innovative tools to be successful in their roles within the emerging value-based care delivery environment.

Gregory Wolf, President
gwolf@lilypad207.com

Data Sources and Management

This report utilizes the CMS **December 2020 Medicare Cost Report** data release for FY 2019 performance analysis and the CMS **December 2020 Provider of Services** data release for RHC characteristics and enrollment summaries

Medicare Cost Report Data Files
Provider of Services Data Files

Lilypad warehouses Medicare Cost Reports for every Rural Health Clinic (RHC) in the United States and analyzes both provider- based and independent clinic reports.

As part of the data management process, we evaluate the integrity of each Cost Report to determine if the data furnished by CMS are complete and accurate. Cost Reports that violate our 29 proprietary integrity checks are handled separately to prevent erroneous data from corrupting the final analyses. As a result, each organization's Cost Report data are evaluated on a field- by- field basis and data sourcing for our analyses are selected only if our integrity analysis confirms that the data are valid and reliable.

Cost Reports with omissions or errors for integral data elements are considered "Incomplete" and may not be included in certain analyses. Some selected data from these incomplete Cost Reports may be used in our analyses, or depending upon our assessment, they may be excluded entirely.

Data Considerations

Source Data Integrity. Both the CMS Provider of Services (POS) and Medicare Cost Report data files contain raw data that are made publicly available for the purpose of research and analysis. These data files reflect the source data submitted to CMS by hospitals and clinics, and are subject to data errors, omissions and inconsistencies. In all instances Lilypad has made efforts to identify, resolve, eliminate and document material errors. **This may result in some RHCs being excluded from this report's analyses**.

Timing and Synchronicity. RHCs operate with a range of fiscal year start dates. Designations and re-designations occur continuously. To harmonize these phenomena, Lilypad uses the fiscal year date on the Medicare Cost report as the time frame basis; in the case of this analysis, we used FY 2019 for every RHC. As indicated, Lilypad aggregates multiple cost reports for RHCs representing more than one parent organization. **This may result in certain summary values differing from other publicly-available findings**.

Cost Report Preparation and Compliance. The quality and completeness of Medicare cost report preparation is highly variable across different organizations. To address this variation, Lilypad implements 29 data integrity checks on every electronic cost report. Material data integrity check errors may result in some RHC cost reports being excluded from certain analyses. In addition, organizations may elect to consolidate multiple RHCs yet fail to report the identities of each RHC. Lilypad attempts to establish RHC relationships between the POS and Medicare cost report data files. **This may result in non-material variances in RHC counts and aggregated reimbursement values across different analyses in this report**.

SOUTH CAROLINA OFFICE OF

RURAL HEALTH

Investment. Opportunity. Health.

COVID Programs for Rural Health Clinics

Shannon Chambers

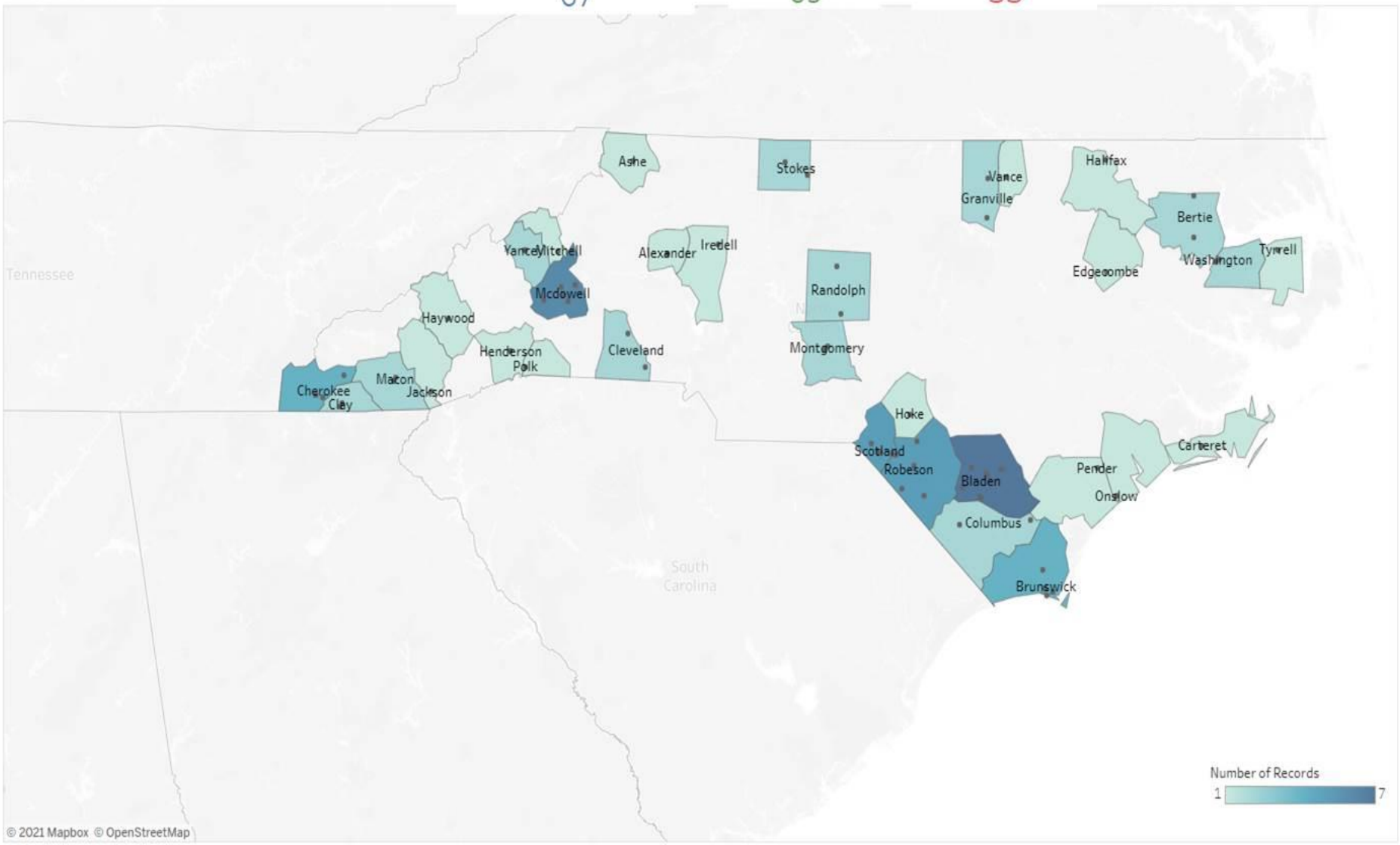
The Current State

- Almost 70 Rural Health Clinics in North Carolina
- Still under a PHE until January 2022. PHE renews every 90 days if needed. Last renewed October 18th, 2021.
- Can still serve as the Distant site for telehealth since we are under the PHE.
- Several Telehealth bills that will permanently change the RHC telehealth model.

North Carolina Safety Net Map

Select county or site to filter, reselect to undo filter
Hold down 'Ctrl' to select multiple units

Total Organizations	Total Sites	Total Counties
67	69	33



RHC COVID 19 Testing Funds

RHC COVID Testing Funds

- Eligible RHCs received $49,461.42
- Those funds must be spent out by **December 31st, 2021**
- You must continue to submit the total number of monthly tests performed and the total number of positive tests results.

www.rhccovidreporting.com

RHC COVID 19 Testing and Mitigation Funds

RHC CTM

- Eligible RHCs received $100,000
- The funds must be used by **December 31st, 2022**
- Must continue to report total number of monthly tests and total number of positives until January 31st, 2023
- New mitigation question coming in the portal
- These funds include expenses for mitigation as well as testing
  - There are 4 eligible categories for these expenses- COVID19 Testing Expenses, COVID 19 Mitigation Expenses, COVID 19 Testing-Related Expenses, and COVID 19 Mitigation-Related Expenses

Allowable Expenses | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov)

Allowable Expenses

- Hand Sanitizing Stations
- Replacing carpet
- Replacing cloth chairs
- Adding to your waiting room to allow for Social Distancing
- Ensuring Water systems are safe
- Ensuring Heating and Air systems are safe
- Retention payments to staff
- Hiring Bonuses for new employees for COVID testing
- PPE
- Digital Technologies

RHC Vaccine Confidence and Hesitancy Grant

RHC Vax Confidence

- NOSORH is the TA provider and will meet with Rural Health Clinics directly to discuss workplans, budget review, and answer any questions.
- Works with the HRSA team on any outstanding issues.
- Period of performance is **July 1st, 2021 to June 30th, 2022**
- Dedicated email address: rhcvaxconfidenceinfo@nosorh.org
- 17 South Carolina RHCs applied for and received grant

Rural Health Clinic Vaccine Confidence (RHCVC) Program | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov)

Fighting Vaccine Hesitancy

- Have a provider champion for those patients that might need additional conversations about the vaccine and myths.
- Pull the top myths and then debunk them!
- Create a social media campaign!
  - I got my vaccine for my mother
  - Hashtags

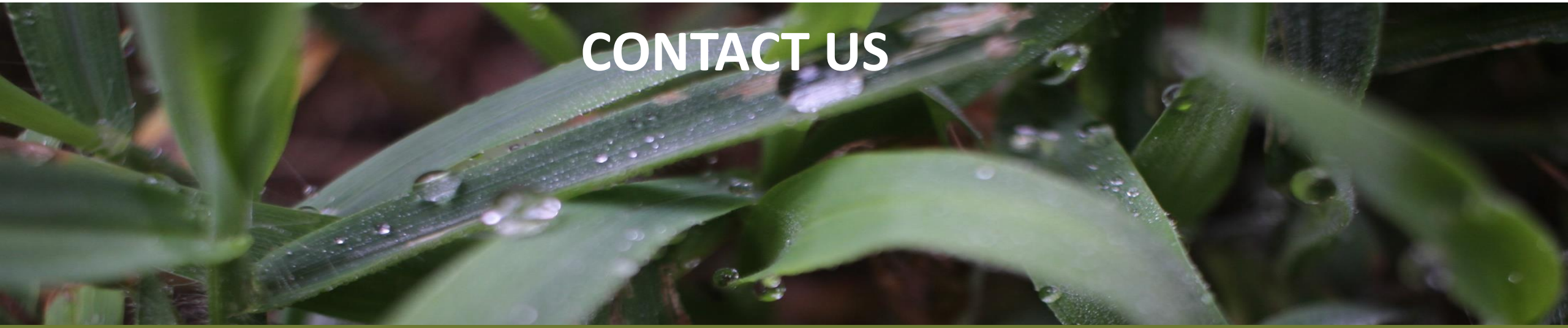
Vaccine Distribution

Vaccine Distribution

- This wonderful opportunity allows RHCs to receive direct shipments to their clinics!
- You can request all 3 vaccines
- Ordering is simple!
- Order this week and receive next week after registration is completed.

Rural Health Clinic COVID-19 Vaccine Distribution (RHCVD) Program | Official web site of the U.S. Health Resources & Services Administration (hrsa.gov)

SOUTH CAROLINA OFFICE OF
RURAL HEALTH
Investment. Opportunity. Health.



CONTACT US

Shannon Chambers
Director of Provider Solutions
chambers@scorh.net

Social:

@SCORH
@scruralhealth
@scruralhealth

Website:
scorh.net

Address:
107 Saluda Pointe Drive Lexington, SC 29072

Phone:
803-454-3850

Text SCRURALHEALTH to 66866 to subscribe to our "Rural Focus" newsletter!

Foundation for Health Leadership & Innovation

NC RURAL HEALTH LEADERSHIP ALLIANCE

Engaging Rural Health Stakeholders: CDC Health Equity Focus

Carla Obiol, VP of Community Voice & Advocacy
Foundation for Health Leadership & Innovation

North Carolina Rural Health Leadership Alliance (NCRHLA)

- NCRHLA is a program of the Foundation for Health Leadership and Innovation (FHLI) and is a coordinated network of leaders and practitioners representing more than 25 organizations with a rural health interest.

- NCRHLA serves as a hub, a single organizer whose role it is to **convene**, **foster**, **share**, **advocate** and **offer a unified voice** that promotes better rural health for our state.

- The NCRHLA emphasizes three activities: engagement, collaboration, and education.

A partnership to promote an equitable response to the pandemic and recovery

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Rural Health

Foundation for Health Leadership & Innovation

NC RURAL HEALTH LEADERSHIP ALLIANCE

NCRHLA's work includes the NC Rural Coalition Fighting COVID-19 (NCRCFC) and other FHLI programs.

The NCRCFC includes leaders from rural-focused organizations, including the FHLI, NC Rural Center, Hometown Strong, and AHEC. This coalition partners with the NC DHHS Office of Rural Health to extend the ORH's reach in disseminating vital resources and messaging to rural communities

NC Rural Coalition Fighting COVID-19 convenes regularly to:

- Host subject matter experts.
- Host regular conversations between rural organizations, county officials, elected officials, care providers, community leaders, and the public.
- Collect real-time feedback about what's working and what's not working.
- Provide and share tools and resources.
- Facilitate connections!

Our Objective:

As part of the CDC Health Equity grant, the NC Rural Health Leadership Alliance (NCRHLA) will partner with the Office of Rural Health to *build community infrastructures that both address disparities in the current COVID-19 pandemic and set the foundation to address health equity in NC communities and among historically marginalized populations for years to come*.

Our Goals:

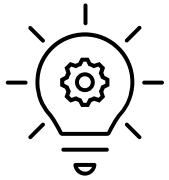
- Increase vaccine uptake in rural communities and among vulnerable populations in counties with low vaccination rates.
- Connect communities, local leaders, providers, public health, and organizations around response ideas and share those ideas to help communities respond faster.
- Build a foundation for equitable future recovery efforts among vulnerable populations and rural communities.

NCRHLA's Approach to Achieve Success

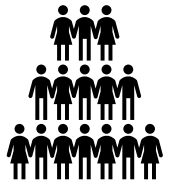
- Start with **TRUST.**
- All work must be **community-led** and will vary in different regions of the state and among different populations.
- A **multi-pronged approach is necessary**, including enrolling a wide range of groups, organizations and leaders (i.e., CHWs, health department workers, county officials, church members and civic leaders).
- Leveraging and following the data **is essential.**
- **Augmenting DHHS rural approach, communications, and work of the Community Health Workers Program and Healthier Together.**

How we'll do it:

Strategy One:
Assess and Map



Strategy Two:
Convene, Collaborate, and Educate



Strategy Three:
Mobilize and Activate

Strategy One: Assess and Map

- Develop a mapping matrix based on assessment of existing data sets, including:
  - Counties with low vaccine rates
  - Zip codes within counties with low vaccine rates (social vulnerabilities database)
  - Layer counties with highest rates of chronic conditions
  - Identification of cultural nuances based on populations in mapped areas
- Pair this with a local trust assessment: Who is trusted in the community (individuals and groups)? What are the messages that will resonate and how should these message be delivered?
- Output: Defined locations and populations for launching and targeting efforts

Strategy Two: Convene, Collaborate, and Educate

- Convene and facilitate a coalition of multi-sector rural health stakeholders that include members of underserved communities and organizations that serve the community. The workgroup will collect input on gaps in access and delivery of rural health services and identify strategies for bridging the identified gaps.

- Lead a leadership-level health equity workgroup that will provide advice, guidance, and recommendations that will address COVID-19 response and advance health equity in underserved, high-risk communities.

- Leverage the data gathered during the local trust assessment to enroll leaders and key organizations that will support and serve as conduits for the local, on-the-ground work.

Strategy Three: Mobilize and Activate

- Absorb the convening and facilitation of meetings of North Carolina Rural Coalition Fighting COVID-19 to highlight, discuss, and provide rural-oriented tools, training, guidance, and messaging to community leaders who are visible and trusted in their communities.
- Enhance existing website landing page to serve as the digital space for this work.
- Launch content that supports all outreach and programming efforts.
- NCRHLA Director of Community Voice leads the work of the CDC Grant

NCRHLA - CDC Work Groups

Health Equity

Chair: Bridgett Luckey MHA, Manager of Uninsured Programs, Vidant Health
First meeting: December 1, 2021, 9:00am-10:30am
Registration link: https://bit.ly/healthequitydec21

NC Rural Coalition Fighting COVID-19

Chair: Donald Hughes, MPA, Director of Community Voice, FHLI
First meeting: December 8, 2021, 9:00am-10:00am
Registration link: https://bit.ly/ncrcfcdec21

Next Steps for NCRHLA

- CDC Health Equity Focus
- NC Rural Coalition Fighting COVID-19
- Rural Health Snapshot Report
- Membership Drive for 2022
- Rural Health Issues Legislative Agenda
- Advocacy Expansion

Invitation to Join NCRHLA

- NCRHLA convenes diverse stakeholders, leads action-oriented workgroups, organizes educational events, and fosters collaborative rural health solutions through best practices and strategies.

- We need your expertise to help improve the health of our rural communities in North Carolina!

- If you have questions or are interested in joining the NCRHLA or any of these workgroups, please email Donald Hughes, FHLI Director of Community Voice at donald.hughes@foundationhli.org.





To be rather than to seem

Victor Armstrong, MSW
Chief Health Equity Director

November 18, 2021

NC's motto

Closing Remarks

- **Resiliency**
- You will find a unique endurance quality in those who choose rural health as their career path.
- **Resolve**
- Although resources are often constrained, you'll find rural health professionals are masterfully skilled at securing solutions.
- **Relationships**
- Behind the story of rural health heroes are extraordinary people collaborating to make rural life better.
- **Readiness**
- The work of those committed to rural vitality is never-ending. The challenges they encounter are met with determination.

Thank You For Attending!

Today's recording & exit survey will be emailed to you