2014 State Flex Program Profiles

February, 2014

The information contained in this document was compiled from the 2014 Flex State Program Profiles available on the TASC web site at: http://www.ruralcenter.org/tasc/flexprofile/2011. In order for the state Flex programs to network together, TASC contacted the Flex programs and the State Offices of Rural Health to collect information on their staff members, major program areas, and successful activities. The information can be used to facilitate communication among other state Flex programs with similar interests.

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For questions, concerns, clarification, or technical assistance, please contact:

National Rural Health Resource Center
600 East Superior Street, Suite 404
Duluth, Minnesota 55802
Phone: 218-727-9390
Fax: 218-727-9392
www.ruralcenter.org

NATIONAL RURAL HEALTH RESOURCE CENTER

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Alabama

Best Practice
The Rural Quality Network is a favorite activity of the critical access hospitals (CAHs) and small, rural hospitals. Quality projects are determined by the group each year. At least three meetings are held, during which training, discussion, and networking occurs. Mileage and lodging are covered by the Flex grant, which is an encouragement for more hospitals to participate. The number has risen from 17 to 21 currently participating, of the 27 eligible hospitals.

The number of CAHs and other eligible hospitals participating; number of hospitals reporting improvement in 1+ measure. Positive aggregate trending of data. For the past two years, the hospital with the lowest core measure scores has received one-on-one mentoring by a consultant. Both hospitals have seen scores improve significantly following the mentoring exercises.

Core Area 1: Quality Improvements
Rural Quality Network: Providing funding and logistics for hospitals to network; receive training, information, and best practices; benchmarking core measure scores; and sharing best practices for the measures tracked. Quality projects are determined by the group, with this year's focus being on the continued benchmarking of the selected core measures, benchmarking and improving Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, and reducing readmission rates. Medicare Beneficiary Quality Improvement Program (MBQIP): Continuing support, as since its inception.

Core Area 2: Operational & Financial Development
Financial Improvement Network: Hospitals will not only receive training, but will benchmark and compare financial indicators, drawing best practices and lessons learned from participating hospitals.

Core Area 3: Health System Development & Community Engagement
Telehealth Support: Flex hospitals will be provided up-to-date information regarding telehealth funding opportunities, initiatives, and resources, as the Flex Co-directors partner with the Alabama Partnership for Telehealth. A compendium of telehealth activity is being compiled, which serves as a resource and coordination tool. Funding sources will continue to be sought for hospitals' telehealth initiatives.

Network Description
See above for the Rural Quality Network and the Financial Improvement Network details. Hospitals must be willing to share data and benchmarking scores in order to participate. The Grant Oversight Committee provides direction for the Flex Program, including these networks.

The Rural Quality Network captures core measure scores, readmission scores, and HCAHPS scores on participating hospitals. These scores are benchmarked and

trends are identified, which leads to improvement activities. Financial baseline benchmarks will be captured for participating hospitals, with tracking, trending, and training provided. Hospitals assessed, tracked, and implementing recommendations will be measured, as well as long term assessments of gains realized.

Collaborative
The Alabama Hospital Association is co-director of the Flex grant and works closely with the State Office of Rural Health. The Flex and Small Rural Hospital Improvement Program (SHIP) activities are shared, to avoid duplication and to target needs. The Quality Improvement Organization (QIO) is a partner, serving on the Grant Oversight Committee. The Alabama Partnership for Telehealth is a major partner in the telehealth arena, collaborating with the hospitals and writing grants to fund telehealth projects. Four hospitals are currently engaged in telehealth initiatives.

Telehealth activities and other Federal Office of Rural Health Policy (ORHP) grants in Alabama are tracked via TruServe, capturing the impact of technical assistance and other support. The hospital association provides aggregate measures for specific work plan activities.

Alaska

Best Practice
Development of the Hospital to Hospital Mentoring Program provides a venue for critical access hospital staff and management to be mentored by other similar professionals as to the best practices for their particular specialty or management position. The goal of this program is to support a mentoring process that provides both parties with greater awareness, sharper skills, and deeper knowledge. The program provides the opportunity for staff at critical access hospitals (CAHs) in Alaska to travel to partnering CAHs and other hospitals in Alaska for a mentored experience with similar staff in order to share best practices for their particular specialty or management position. Mentoring trips are generally three to five days. The program is a wonderful opportunity for selected staff to travel to other hospitals and feel more engaged in their profession by:

- Receiving peer support. Mentors provide support, help, enthusiasm and inspiration in a non-judgmental environment.
- Sharing experiences. Sharing skills and experience encourages the identification of best practices and leads to growth and sustained improvement.
- Establishing relationships with other organizations. Forming coalitions with other groups of similar interests and goals allows members to combine their resources and become more powerful than when acting alone.

This program has been well received and provides opportunities for professional growth in both the mentor and mentees.

Every individual who participates must complete a post-mentoring evaluation. The evaluation reflects on the objectives that were identified in the mentoring application process and whether these objectives were met or not. Prior to the mentoring experience, it is important for the participant to identify what they want to accomplish to improve the quality of the work/services provided to their customers/patients. The evaluation asks for participants to elaborate on how objectives were met and all disciplines who participated in mentoring the participant. The evaluation attempts to capture the positive as well as the negative attributes of the experience as well as capture the perceived competency obtained as a result of the mentoring experience. Last but not least, the evaluation attempts to collect information on how the mentoring program might be improved for future participants.

Core Area 1: Quality Improvements

- The Alaska Flex Program is working with the Quality Improvement Organization (QIO)to encourage increased participation in the Medicare Quality Improvement Project (MBQIP) and encourage public reporting
- Collaboration with the Alaska State Hospital and Nursing Home Association on Centers for Disease Control (CDC) National Healthcare Safety Network on reducing hospital acquired infections/conditions and falls prevention
- CAHs are participating in a quality collaborative which includes face-to-face meetings, webinars, and teleconferences to share best practices, set quality benchmarks and collect data to support quality improvement activities
- Actively working to raise staff awareness about patient safety and examining trends in patient safety cultureFacilitating education, training and links with resources for CAH staff and/or board members to improve quality performance

Core Area 2: Operational & Financial Development

- Provide or arrange for direct technical assistance to individual CAHs on charge master updates or other financial management tools
- Provide the infrastructure for a multi-hospital financial collaborative that supports CAHs in sharing best practices, benchmarks, resources and expertise
- Scholarships for joint meetings between CFOs and CNOs to improve coding and capturing services for cost report
- Provide training on improving revenue cycles to hospital leaders to increase their ability to better manage their revenue cycles
- Technical support for work environment and workflow improvement through Lean activities
- Recruitment/retention planning and hospital-physician integration strategy
- CFO education through Healthcare Financial Management Association meetings, monthly teleconferences

Core Area 3: Health System Development & Community Engagement

- Support CAHs and their communities in collaboration of assessments to identify unmet community health needs
- The Trauma System Review Team will work to identify eligible acute care hospitals interested in becoming Level II trauma centers
- Rural Trauma Training and Development courses will be provided to CAHs and rural acute care hospitals

Network Description

The small hospitals in Alaska are involved in three networks: 1) quality improvement involving the chief nursing officers as the leaders and the quality improvement personnel from the hospitals; 2) operational improvement involving the chief operating officer; and 3) financial improvement involving the chief financial officers. There is overlap in the area of operational improvement as quality leaders from nursing and the CEOs are involved in Lean training. Also there is overlap in financial improvement as nursing and the CFOs meet together to work on improving coding and capturing services for the cost reports.

We are looking at the number of activities that are provided to the networks in which participants have the opportunity to share best practices and lessons learned or interact with subject matter experts on identified problems. We are also tracking financial and quality indicators that hospitals report on either through MBQIP, activities supported by the hospital association as well as utilizing Flex Monitoring Team indicators.

Collaborative

The Flex program, the QIO and the hospital association are working together to support MBQIP reporting as well as public reporting. The hospital association and Flex program are encouraging hospitals to work on a number of hospital acquired infections as identified by the National Healthcare Safety Network. The hospital association and the Flex program are working together to provide multiple opportunities for hospital leadership to learn about improvements for revenue and operational improvement.

The Flex program is monitoring the MBQIP indicators and financial indicators while the hospital association is working on the ten hospital acquired conditions indicators. By monitoring the indicators, we can encourage consistent reporting, look for trends over time, and provide technical support to those hospitals who have missed opportunities identified or trends indicating problems.

Arizona

Best Practice

There are three Arizona-Flex success stories to share with other states that include: (1) Efforts to solicit and maintain Medicaid match funds to support Arizona critical access hospital (CAH) operations; (2) Efforts to establish a multi-hospital quality

network to increase patient satisfaction; and (3) Efforts to expand the number of Level IV Trauma Centers (currently eight designated).

The Arizona CAH (Medicaid Match) Pool was established in 2001 through Flex intervention and has continued to generate $1.7 million that is shared among the CAHs that are not designated as Indian health hospitals. AZ-Flex services have, during the past two years, provided technical assistance to help CAHs pursue additional Medicaid match funding through the Safety Net Care Pool (SNCP) and the Disproportionate Share Hospitl (DSH) Pool5 programs. For the Quality Network, AZ-Flex helped 6 hospitals to select Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) vendors and then provided technical support to help hospitals use their patient satisfaction metrics. For the Level IV Centers, AZ-Flex is now working with the State to develop a common performance improvement system and provide assistance during the re-certification process.

The AZ-Flex Evaluator tracks Medicaid match dollar distributions that are posted on the State Medicaid program website. The AZ-Flex Rural Services Coordinator recently completed a mid-point assessment of the Quality Network and we are collecting HCAHPS metrics to support an outcome evaluation to address the issue whether changes occurred associated with hospital interventions. AZ-Flex has not yet completed an assessment of Level IV designation although we do track participation, assess meeting satisfaction, and conduct the post test assessments.

Core Area 1: Quality Improvements

- Organize the AZ CAH Quality Network as a formal network comprised of fifteen critical access hospitals with the goal to promote peer-to-peer exchange and strengthen the quality improvement infrastructure at each hospital
- Provide technical assistance to 15 AZ CAHs in the use of Hospital Compare so that all AZ CAHs achieve Phase I Medicare Beneficiary Quality Improvement Project (MBQIP) standards (i.e. data entry for pneumonia, congestive heart failure, and readmissions)
- Work with 15 AZ CAHs to improve HCAHPS scores

Core Area 2: Operational & Financial Development

- Provide educational programs and technical services to develop AZ CAH capacity to improve financial and operational performance
- Develop a grant development infrastructure that enables AZ CAHs and emergency medical service (EMS) providers to identify and pursue local, state, federal, and private foundation funding

Core Area 3: Health System Development & Community Engagement

- Conduct a patient migration study and hospital service profile to identify patient migration trends, unmet community health needs, and health service gaps

- Provide educational opportunities, increasing Level IV Trauma Center (L4TC) designations, and assessing the impact that L4TCs have within the state's critical access hospital communities
- Provide technical support to hospitals regarding CAH designation

Network Description
Arizona's Flex Program supports four multi-hospital networks that track core program activities. The four networks include: Leadership (focus on policy and operational performance), Quality, HIT User Group, and Emergency Department (ED) Managers / Level IV Trauma. Each Network is convened at least once per year in face-to-face workshops intended to strengthen relationships.

In addition to the face-to-face workshops, each Network is also convened three or four times per year for webinars designed to address core topics. The Leadership Network is comprised of the CEO and CFO from each CAH. The Quality Network is comprised of directors of nursing and/or quality. The HIT User Group is comprised of hospital CIOs or information directors, and the ED Managers / Level IV Trauma Coordinator Network is comprised of ED Managers and/or Level IV Trauma coordinator.

The purpose of each Network is to encourage peer to peer exchange, enhance knowledge and develop skills. These four networks are core design features of the AZ-Flex program as Arizona's CAHs are dispersed across a wide territory spanning 400 miles (north-to-south) and 300 miles (east-to-west). These networks help structure communications and technical services.

Evaluation of the four AZ-Flex networks is organized through a series of process, output, and outcome measures. Participation in every network event is tracked by hospital and individual. Meetings are evaluated using a satisfaction tool that is delivered either remotely or on-site using a structured satisfaction survey. For network events lasting greater than three hours, AZ-Flex implements the post-test evaluation strategy. AZ-Flex is currently involved in evaluating outcomes of the Quality Network using HCAHPS reporting tools. The Quality Network has, since November 2011, focused on using HCAHPS to evaluate patient satisfaction and the AZ-Flex program is collecting specific HCAHPS questions and composites for each participating hospital with the goal to evaluate changes in patient satisfaction that can be associated with AZ-Flex supported hospital quality improvement interventions.

Collaborative
AZ-Flex sustains long-term working partnerships with the State's Quality Improvement Organization (QIO), Health Services Advisory Group (HSAG), the Arizona Hospital and Healthcare Association (AzHHA), and the Arizona Telemedicine Program (ATP) which is based at the University of Arizona. With HSAG, AZ-Flex schedules regular teleconferences to identify and troubleshoot problems that rural hospitals have with the Centers for Medicare and Medicaid Services (CMS) Abstraction and Reporting Tool (CART).

During previous years, HSAG provided technical support for the different AZ-Flex Quality Networks by providing faculty to guide the quality improvement collaborations. With AzHHA, AZ-Flex staff participates on the Small Rural Hospital Committee which meets quarterly to discuss hospital leadership and legislative policy issues. The ATP co-sponsors with AZ-Flex, educational classes in a quarterly schedule using the ATP webinar system and, as needed, it makes available video-conferencing facilities to support AZ-Flex Network activities.

Most recently, the AZ-Flex organized a six-hour workshop using the ATP video-conference bridge to connect eleven hospitals and faculty from four different cities to address use of Electronic Medical Records that support hospital quality improvement programs. The entire video-conference was recorded and is available online and the instruction materials are available through the AZ-Flex website.

Participation in every AZ-Flex partner event is tracked by organization and individual. Meetings are evaluated using a structured satisfaction survey that is delivered either remotely or on-site depending on the program's venue. For any educational event lasting greater than three hours, AZ-Flex implements a post-test. Collaborative arrangements with AzHHA, HSAG, and ATP are all intended to strengthen Flex-related program activities. AZ-Flex currently is a dues-paying member of the AzHHA. For the current fiscal year AZ-Flex does not have a contractual arrangement with HSAG due to overlapping Scopes of Work, however, in previous years AZ-Flex has provided sub-contract support for HSAG technical services provided to the Quality Network. AZ-Flex maintains a longstanding relationship with ATP as both programs are part of the Arizona Health Sciences Center at the University of Arizona.

Arkansas

Core Area 1: Quality Improvements
The Arkansas Flex Program conducts quality improvement activities through a collaborative relationship with the Arkansas Foundation for Medical Care (AFMC). The Arkansas Flex Program provides funding to the AFMC for training and education to Arkansas' critical access hospitals (CAHs) for Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS), and other quality and patient safety initiatives.The Arkansas Flex Program encourages hospitals to participate in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) by providing one time assistance of $1,000 to each CAH. This project will be evaluated at the end of the grant year to determine if assistance will be provided in the future.

Core Area 2: Operational & Financial Development

- Entered into an agreement with an outside vendor to provide access to market, quality, safety, patient satisfaction and financial performance data to

the 29 CAHs. The vendor has provided three webinars to review the methodology and results of the reports.
- Provide a 2-day workshop on revenue cycle management
- Provide updated maps of local market share and service area migration

Core Area 3: Health System Development & Community Engagement
Facilitate collaboration among the 29 CAHs to increase community awareness of local hometown health coalitions. Provide support to the Arkansas Ambulance Association in providing education to emergency medical services (EMS) Managers and EMS Medical Directors.

California

Best Practice
The strength of the relationships between all organizations and the direct interaction with California's critical access hospitals (CAHs) is considered an important best practice. The collaborative working relationship among California CAHs and the diverse organizations strengthens the hospitals' knowledge and skills through sharing resources, education, trainings and innovation. The California State Office of Rural Health (CalSORH) Flex Program has interaction with CAHs to support quality improvement through the Quality Health Indicators (QHi) multi-hospital benchmarking program, and quality improvement organization (QIO) coordination to assist with reporting on MBQIP measures. Support for operational and financial improvement through a continued collaborative partnership with California Hospital Association / Rural Healthcare Center (CHA/RHC), California Critical Access Hospital Network (CCAHN) and Western Healthcare Alliance (WHA) by providing education, financial webinars and financial assessments. Support for health system development and community engagement through the contractual relationship provided by Rural Health Services (RHS) and its strong partnership with the California Emergency Medical Services Agency and the Local Emergency Services Agency as it focuses on quality and performance improvement needs of rural emergency medical services (EMS) and the development of rural trauma systems to improve the health care delivery in rural communities.

During the last CCAHN General Meeting of the year, CAHs are asked to complete the CCAHN Priority List and vote on the desired services for the upcoming year. The services with the most votes are shared with the CalSORH Flex Program for consideration and inclusion into the Flex work plan. Additionally, CAHs CEOs provide direct input during the Flex meetings. Based on the needs of the CAHs services, vendors/consultants are selected.

Core Area 1: Quality Improvements
Participate in the Kansas-based QHi Benchmarking project. The CalSORH Flex Program continues to use the Kansas based QHi as a tool for CAH data collection and reporting of quality and performance improvement, multi-hospital

benchmarking, sharing of best practices, and networking. All QHi data are entered on a monthly basis. There are a total of 130 measures: 65 quality improvement and 65 performance/financial/operational improvement. The four core QHi quality improvement measures include: Healthcare Acquired Infections, Unassisted Patient Falls, Pneumococcal Immunizations for those 65 years and older, and Discharge Instructions provided to heart failure patients.

National QHi conference calls and meetings with other state Flex Programs. These meetings provide an opportunity to share QHi technical updates, Medicare Beneficiary Quality Improvement Project (MBQIP) information, Flex Monitoring Team (FMT) data and analysis, data on the highest performing CAHs, and best practices from and between CAHs and as reported by the FMT and other QI expert organizations e.g., Agency for Healthcare Research and Quality (AHRQ).

Activities one and two above are being measured by doing an annual QHi User Group satisfaction survey. Feedback is used to guide program changes throughout the year. This work will continue as part of FY 2013-2014 as it's a valuable component to program operations.Track CAH's Participation in the MBQIP and Hospital Compare (HC) Using QHi, HC and FMT Data.

The CalSORH Flex Program is actively supportive and engaged in the MBQIP project. This work will continue to be completed in coordination with the state's QIO, including quarterly meetings, regular data sharing, joint technical assistance to CAHs, reporting MBQIP program changes and findings to CAHs as part of the regular QHi User Group Meetings. CAHs participation in MBQIP will continue to be tracked using the QHi Project, Hospital Compare, FMT, QIO and Telligen data.

Core Area 2: Operational & Financial Development
Respond to CAH technical assistance services and information for 32 CAHs on Flex Program Areas. The CalSORH Flex Program will continue to assess the financial status of California's most vulnerable CAHs with data provided from QHi, and FMT. Each hospital has its own unique issues that impact their financial stability. The common denominators are: hospitals located in remote locations, administrative turnover, physician recruitment and retention, cost of implementation of quality improvement projects, low community engagement, uninsured patients and decreased state reimbursement.

Technical assistance is provided specifically to each hospital's financial and operational needs. A repository of technical assistance requests will also be maintained by the California Hospital Association, so that resolutions can be easily referenced should a similar request be made in the future.

- Conduct One Performance Assessments for Most Financially Challenged CAH. Complementing the work in QHi, the CalSORH Flex Program uses statewide data (along with QHi's hospital specific data) and FMT data to track and assess the financial status of California's most vulnerable CAHs. For FY 2013 the CalSORH Flex Program will be assisting with the performance assessment

of one CAH. The criteria for application to undergo the performance assessment process will be released late January, or early February 2014.

- Support Implementation of Recommendations Identified in CAH Performance Needs Assessment. Activity Three is the follow-up to Activity Two. Key performance improvement needs are identified as: Automating patients statements, restructuring departments, developing policies and procedures (e.g., financial assistance), establishing a work plan to address needed action steps, accessing staff training (e.g., customer service), addressing collections challenges, by consultation from the WHA. Project outcomes will be monitored using QHi, as well as reports directly from the CAH and WHA.

Core Area 3: Health System Development & Community Engagement

- Support rural emergency medical service (EMS) providers attendance at the State EMS Conference. Rural EMS quality and performance improvement continues to be a priority for the CalSORH Flex Program. The conference features national speakers and break-out sessions geared towards improving quality and performance, sharing best practices, and learning about new state and national EMS initiatives. A post conference evaluation is sent to all Flex Program funded participants. A follow-up survey is also conducted four months following the conference. Survey findings will continue to guide the CalSORH Flex Program development and support project reporting.
- Train CAH emergency department and paramedic staff in Rural Trauma Team Development Course (RTTDC). California's RTTDC was first established in 2011 and since that time, RHS has been working with Sutter Roseville Medical Center and the Trauma Nurse Managers Association of California to establish the course for implementation in California. Evaluation activities are built into RTTDC project plans and are a continuation of FY 2012 work. Additionally, pre and post tests for course participants and post course and 4-month post course training evaluations are conducted.
- Conduct CAH community case studies that include an EMS component. In FY2012 a case study was conducted in Lake Isabella, California, at Kern Valley Healthcare District Hospital. Case study methodology: Obtained local health services and community background information; Interviewed hospital staff, hospital board members, and local emergency medical services personnel; Conducted a survey of health care providers (e.g., physicians, physician assistants, and nurse practitioners) and a community focus group.Findings and follow-up technical assistance were provided to CAH leadership. The technical assistance included information, model, tools, and support related to: Establishing an oncology and/or dialysis program; establishing a chemotherapy program; designation of a trauma center; selecting a Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) vendor; performance based incentives for staff and staff participation in the QHi Program.

- This work will continue and is part of FY2013. Fairchild Medical Center in Yreka, California has been selected to participate in the FY 2013 CAH case study.

Network Description

The CCAHN formed in 2009 is a statewide organization with the purpose of creating collaborative working relationships among California CAHs to strengthen its members through sharing resources, education, and innovation by developing and maintaining: Quality of care initiatives, performance improvement measure; cost savings, revenue enhancement opportunities, and innovative health information technology applications. The Advisory Board is comprised of seven members and the Executive Director of the California Hospital Association, California Health Foundation and Trust (CHA/CHFT). The CCAHN Advisory Board is appointed by the CHA/CHFT Board through the ratification of nominations made by the CCAHN membership. The Advisory Board appoints a chair and vice-chair; Advisory Board members serve a two year term and may serve three consecutive terms. The CCAHN functions under the auspices of CHA/CHFT, and it is managed by the Western Healthcare Alliance. Additionally, the CalSORH Flex Program, the CHA/RHC and Rural Health Solutions are invited to attend and participate in the CCAHN Advisory Board and General Membership meetings. The CHA/RHC's vice president sits on the Advisory Board of the CCAHN and provides overlap between the CalSORH Flex Program activities and the CCAHN services.

The CalSORH Flex Program does not directly measure CCAHN activities. The CCAHN, through its WHA Executive Management team, submits a monthly Executive Director report to the members and to CHA/CHFT.

Collaborative

The CalSOHR Flex Program has a direct collaborative partnership with the California Hospital Association-Rural Health care Center (CHA-RHC). CHA-RHC in turn manages and coordinates the team of subcontractors and partners which includes: Rural Health Solutions, California Critical Access Hospital Network, California Hospital Engagement Network, Hospital Quality Institute, California Rural e Health Information Network, California Emergency Medical Services Authority, California State Rural Health Association, California Department of Public Health, California Health Information Partnership & Services Organization, United States Department of Agriculture, Health Services Advisory Group and the University of Southern California Viterbi School of Engineering.

Activities are being measured by CHA-RHC through their internal tool mechanism. The intent of this collaborative partnership is to provide technical support and expert services to CAHs, perform activities that support and strengthen the California Network, and implement Flex Program activities included in the work plan that support quality improvement projects, operational and financial improvment, emergency medical services technical assistance, facilitate CAH and CAH eligible stakeholder meetings, trainings, and educational opportunities.

Colorado

Best Practice
Colorado Rural Health Center (CRHC) felt the incorporation of a Gantt chart would benefit the Flex activities as it allows for a visual representation of the activities throughout our office to help reduce scheduling webinars or events on the same day or so close to one another that rural providers might not be able to attend due to their limited staff availability.

We are still identifying the most effective use of this resource and how it can most benefit our organization. But the intended benefit is mainly with the scheduling of our activities and ensuring there is no overlap.

Core Area 1: Quality Improvements
For our quality improvement activities, the CRHC has continued to build on previous work continuing efforts with our Quality Network, Quality Improvement (QI) Workshops, and our Improving Communications and Readmission(iCARE program) among other efforts. To measure the benefit of these projects we utilize Medicare Beneficiary Quality Improvement Project (MBQIP) data, Quality Health Indicators (QHi) reports, Flex Monitoring Team (FMT) reports, as well as additional data and information gathered from participants during activities.

- Critical Access Hospital (CAH) Quality Network
- Providing Quality Improvement (QI) Workshops
- Improving Communications and Readmission program (iCARE)
- Conducting monthly conference calls to share lessons learned, best practices, and barriers related to MBQIP and hospital compare measures.

Core Area 2: Operational & Financial Development
- Annually, CRHC updates our Swing Bed and Utilization Management manuals. As part of this process we host a two part swing bed webinar and one utilization management webinar to provide updates on any changes to regulations
- Continuing to provide QHi benchmarking tool for reporting financial measures as well as iVantage reports to assist hospitals in identifying areas of need in financial and operation performance
- Providing assistance and information to assist CAHs with compliance with federal and state regulations

To measure these activities we utilize information submitted to QHi, examine the Flex Monitoring Team reports and the iVantage reports as well as information provided during our CAH Financial Workgroup Network webinars and focused one-on-one calls with our Senior Financial Advisor. All of these activities build upon previous years' work.

Core Area 3: Health System Development & Community Engagement

- Provide education and resources on emergency medical services (EMS) recruitment and retention strategies
- Educate EMS agencies, CAHs and personnel on American Heart Association's (AHA) Mission
- Collaborate with the state to link providers to technical assistance to strengthen compliance and participation in state trauma system

These activities are measured through examining the amount of CAHs/EMS attending the trainings as well as examination of MBQIP data to evaluate the ST segment elevation myocardial infarction (STEMI) improvements. These efforts build upon previous years efforts.

Network Description

The iCARE project brings hospitals and their provider based clinics together to help improve communication and readmissions. Currently we have 16 CAHs participating in the project and 14 provider based clinics. CRHC hosts monthly webinars where data is examined and best practices discussed. The webinars are a great forum for peer learning and provides opportunity for facilities to hear from one another what they have been working on, what has been working well and where they may have encountered barriers.

CRHC holds Regional Quality Improvement Workshops each spring. They are repeated in three locations in an effort to mitigate the distance each facility has to travel. CRHC manages the CAH Peer Review Network in an effort to provide objective, rural providers chart reviewers from other CAHs who have an understanding of the unique working conditions of rural providers. CRHC also manages a Financial Workgroup where quarterly webinars with CAH CEOs and CFOs are able to discuss/learn the latest financial trends and any new regulations. CRHC, in partnership with the state QIO, hosts bi-monthly CAH Quality Network webinars.

Measurement for each of our networks is done in a combination of ways. CRHC utilizes MBQIP data to examine trends in hospital data,the QHi benchmarking tool, as well as the Flex Monitoring Team reports and iVantage data. The webinars and communication with participating facilities enables CRHC to maintain open lines of communication with network participants.

Collaborative

CRHC partners with our quality improvement organization (QIO), to provide bi-monthly CAH Quality Network Webinars.

Efforts are measured through analysis of MBQIP data as well as the QHi benchmarking tool as well as the data hospitals send through their participation in projects like iCARE.

Florida

Core Area 1: Quality Improvements
The Florida Flex Program has contracted with the Florida Quality Improvement Organization (QIO) to administer a Critical Access Hospital (CAH) Patient and Medication Safety Program for the past ten years to improve medication and patient safety. The program provides onsite reviews of CAHs by pharmacy consultants to identify unsafe practices and provide specific recommendations for improvement.

Core Area 2: Operational & Financial Development
The Florida Flex Program sponsors a Financial Improvement Collaborative with HomeTown Health, Georgia. The collaborative provides onsite visits, webinars and workshops with financial experts to all of Florida's CAHs and tracks improvement in specific financial benchmarks.

Core Area 3: Health System Development & Community Engagement
The Florida Flex Program provides funding to: CAHs for trauma training of emergency staff; rural County Health Departments for community health needs assessments using the Mobilizing for Action Through Planning and Partnership process; and Rural Health Networks with CAHs for various health projects that develop and strengthen rural health services. Examples includes: disease management services, credentialing verification services, and primary and dental care services to low income persons.

Network Description
Flex provides funding for both a quality improvement and financial improvement network. Each of Florida's CAHs participate in both networks. The quality network is administered by Florida's quality improvement organization (QIO), with subcontracted pharmacy consultants providing site visits to each hospital, along with extensive consultation. The financial network is administered by HomeTown Health GA, which includes access to and utilization of an extensive list of business partners providing various financial services.

Quality Network: The primary measurement of activities within the quality improvement network tracks each CAH's progress on numerous indicators from the Medication Safety Assessment Survey Tool, which is utilized on site visits. Financial Network: The financial network uses a combination of quantitative and qualitative measures to assess the degree to which goals and objectives are achieved with the hospitals. HomeTown Health staff regularly gather feedback (qualitative) and review data (quantitative) to measure the activities in this network.

Collaborative
Florida's Flex Program has both a quality and financial improvement collaborative. We are currently in year 12 of the Medication Safety Project with Florida's QIO. We are in year two of a financial collaborative with HomeTown Health, GA.

Georgia

Core Area 1: Quality Improvements
Georgia's Quality Improvement (QI) Program is structured on the requirements of Medicare Beneficiary Quality Improvement Project (MBQIP), Culture of Patient safety, technical assistance, education and training for CAHs. The Georgia Hospital Association Research and Education Foundation (GHAREF) serves as the sub-grantee for the Georgia Flex QI Program. GHAREF works directly with the hospitals that have chosen to participate in the MBQIP and with those hospitals that have elected to delay participation.

The objectives of the Georgia QI Program include public quality reporting, participation in MBQIP, raising staff awareness regarding patient safety, and examining trends in patient safety culture.

The overall program activities include:

- Provide education and training in the use of the Centers for Medicare and Medicaid Services (CMS) Abstraction and Reporting Tool (CART), core measures and MBQIP; encourage public reporting to Hospital Compare on relevant processes of care quality measures; inpatient, outpatient and Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS)
- Actively work towards staff awareness about safety; examining trends in patient safety culture and identifying areas of strength and possible improvement

Georgia provides a program with emphasis on quality improvement (QI) education and training for CEOs, Boards of Directors and QI professionals. Georgia CAHs experience a persistent high rate of turnover at both the CEO and QI professional levels. The education and training needs are two-fold, ongoing education for those who are veteran professionals and education and training for the new CEO, Board member and QI professional. All education and training must focus on the mechanics and requirements of QI but must never exclude the purpose and goal of the program which is to ensure patient safety and to deliver expected quality patient care outcomes. In-person group trainings are held in geographically convenient locations to promote optimum participation as well as through other venues such as onsite visits, webinars and conference calls.

The number of CAHs receiving notifications of training opportunities, the number of CAHs registered, the number participating in training opportunities, and receiving dashboards and Appropriate Care Measure (ACM) Composite Score Reports will be tracked. CART trainings will be held a minimum of twice annually. The HCAHPS and MBQIP training opportunities will be planned and tracked as well as the amount and type of QI technical assistance provided by the GHA Patient Care Specialists. Participant evaluations will be conducted of all training including if the participants strongly agree or agree that the training provided would significantly reduce barriers to CART usage as well as describe the effectiveness of other focused training. Data collection tools and definitions, CART manuals, transfer/discharge

checklists will be developed and provided to CAHs to assist in enhancing the QI program overall as well as to provide the QI professionals with tools that contribute to a more user friendly process.

A thorough education and training program integrated with ample, easily accessible, expert technical assistance will increase and assist in stabilizing core measure data submissions to Hospital Compare when minimum case thresholds are met.

The SORH and GHAREF will actively work to raise staff awareness about safety; examining trends in patient safety and the identification of areas of strength and opportunities for improvement. This will be accomplished through educational/training programs related to various topics, including:

- Patient and Family Centered Care
- Rounding
- Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS)
- Reliable Process Design
- Frontline Defect Analysis
- Plan-Do-Check-Act (PDCA) Process Improvement Principals

Electronic and hardcopy resources, onsite coaching and SWOT (strength, weakness, opportunities and threats) reports identifying program highs and lows, will be used to supplement the various education/training topics. Topics related to the cultures of safety will be incorporated into rural cohort calls, best practices as well as the Power Hour and Regional hospital meetings.

All sessions will be tracked and data collected that includes the number of CAHs receiving notification of education/training, number of hospital staff members registered, number attending; the number of CAHs participating in the Organizational Assessment Tool (OAT) training as well as the number of CAHs maintaining use of patient safety surveys at three-years (the revised Joint Commission Standard).

Improved staff awareness will be confirmed by a change in employees' knowledge of the culture of patient safety through the acknowledgement of strongly agree or agree that knowledge gained will be used to improve patient safety and the recognition of their role in ensuring a safe workplace. Additionally, the number of CAHs completing the Culture of Patient Safety and OAT training as well as the number of CAHs accessing coaching for specific culture of change or staff engagement will be tracked and reported to the SORH quarterly.

Increased staff awareness and ability to identify opportunities for improvement will be indicated by changes in staff behavior, improvement in patient safety, the number of opportunities for improvement identified and action plans developed by the by the CAHs to produce positive patient safety outcomes. Staff use of information and tools to enhance a culture of Patient Safety will be calculated by

the number of CAHs in the state implementing pre and post Patient Safety surveys at six months.

The overall impact of the program will be demonstrated by an improved Culture of Patient Safety in Georgia CAHs by an increase in the OAT and Culture of Patient Safety scores. Georgia will strive to improve the knowledge of CAH managers, staff and board members through education and training programs coordinated, with other partners engaged in QI, the Hospital Engagement Network (HEN) and the Georgia Quality Improvement Organization (QIO). All venues of education/training will be supplemented with electronic and hardcopy resources to improve knowledge of QI. Confirmation will be indicated by changes in knowledge as reflected in a perception-based evaluation; the number of participants who strongly agree or agree they will actively seek to be fully engaged in the QI process and the number who strongly agree or agree that the education provided will be used in their daily processes.

The increase in CAH staff, managers and Board members willingness to use QI processes will be supported by changes in CAHs' ability to use QI processes and tools and the decrease in technical assistance calls relating to QI. The sustainability of changes in staff, managers' and Board members' behavior long-term will be evidenced by their willingness to use QI processes as well as evidence of an increase in number of CAH Board member certifications. The Georgia QI partners actively compliment and support the QI programs of the Flex, Small Rural Hospital Improvement Program (SHIP), HEN and QIO without duplicating quality improvement activities.

Phase III of MBQIP, Pharmacist/Computerized Physician Order Entry (CPOE)/Verification of Medication Orders within 24 hours and Outpatient Emergency Department Transfer Communication has begun in Georgia with the development of a needs assessment survey that will be distributed to all CAHs to establish baselines. The focal point of planning consists of technical assistance around data collection, analysis and reporting.

Core Area 2: Operational & Financial Development

The Georgia Flex Financial and Operational Improvement Program is a three-year project to strengthen the financial and operational infrastructure of the state's CAHs. While 100 percent of the 32 CAHs in the state are eligible to join the project, participation is discretionary. Twenty-six CAHs are participating in the comprehensive project. In 2013, three of Georgia's 34 CAHs closed due to the myriad of factors that threaten CAH survival in the state. The remaining hospitals must recognize these threats and actively engage in all available opportunities to improve their organizations' ability to provide continuous rural health care services well into the future.

The Executive Summary of Critical Access Hospitals Fiscal Analyses, published by DCH, SORH in February 2012, summarized the findings of the CAH Fiscal Analyses. The summary revealed, "of the 32 hospitals who participated in the analyses only

ten had a positive Total Margin, while only five had a positive Operating Margin, and 69 percent (22/32) were operating with a negative Total Margin. Georgia's median Total Margin, minus 1.6 percent," was significantly below the national median of 2.4 percent. ☐

This data is also confirmed by the Flex Monitoring Team's CAH Financial Indicators Report which is provided annually to CAHs. The three-year Financial and Operational Performance Improvement Program is derived from previous Flex grant work that began in 2007 with the financial and operational analyses of 32 CAHs which revealed weaknesses in addition to those stated above. In the intervening years, the weaknesses identified by the analyses were addressed with two-years of education and training targeting these areas. In the current and remaining years of the Flex non-competing grant cycle, the participating 26 CAHs will receive a financial and operational re-evaluation with a focus on the revenue cycle from pre-admission through collections. Action plans/interventions will be provided to address identified weaknesses designed to strengthen the CAH financial and operational systems.

The overall program includes the following activities:

- CAH financial and operational assessments SWOT analyses
- Charge master revenue code and charge reviews
- Provider recruitment through utilization of eligible SORH and Primary Care Office Resources
- Analyses of the significant settlement items in the Medicare cost reports and implementation of tools to monitor factors that influence the cost report to prevent unexpected cost report settlements.
- Analyses of each step in the revenue cycle from pre-admission through collections

Within the objective of identifying potential areas of financial and operational improvements of the revenue cycle and increasing hospital revenue and cash flow; 26 CAH financial and operational assessments and SWOT analyses will be conducted with specific action plans/interventions developed to address all identified opportunities for improvement.

The hospitals will be provided technical assistance and the tools necessary to address the outcome of the SWOT analyses in both the financial and operational processes. The outcome measures developed to gauge process improvement will be used to monitor and report results to the SORH on a quarterly basis as well as to make adjustments in the process improvement indicators as may be necessary.

Conducting the CAH financial and operational assessment, developing associated financial indicators and providing interventions to addresses any weaknesses, opportunities or threats has the strong potential to increase the knowledge and skill sets necessary for CAH leadership and staff to successfully manage and financially stabilize their hospitals. Additionally, monitoring outcomes on a regularly scheduled

basis provides the flexibility to alter, as necessary, any action/intervention plans over the project period that may not be producing the desired results as well as to promote and ensure staff accountability. The provision of abundant technical assistance and support is crucial in a project of this size and scope.

Ongoing technical assistance will promote continued program momentum as well as the hospital staff's willingness to continually monitor and meet performance indicators, which is a critical component in producing the outcomes required to ensure CAH financial and operational stability.

While there are outcomes that can be improved in the short-term such as expanding staff knowledge and awareness of critical job functions and skills, and the development of strategies to address opportunities, threats and weaknesses; there are others that will be more difficult and take longer to demonstrate improved performance, these include:

- Increase in average days cash on hand
- Decreasing average net and gross days in accounts receivable
- Average operating margin
- Average debt service coverage ratio
- Average salaries to net patient revenue
- Average payor mix percentage
- Average age of plant
- Average long-term debt to capitalization

The goal, of course, is to strengthen the financial health of the CAH; however, many of the ratios that support good financial health are dependent upon factors beyond the CAHs' control such as the community demographic, poverty and unemployment. Improving these ratios will take longer to accomplish. The right payor mix, which is a derivative of the community demographic, as well as vigorous and appropriate utilization of services, has a powerful influence on the strength of the CAHs' financial and operational performance. Therefore, these factors will be considered in developing realistic, hospital achievement targets. Action plans/interventions and ongoing monitoring will be executed to address these key financial ratios; however, expectations for positive outcomes may not be achieved until well into or beyond the project period.

The charge master reviews are being conducted to evaluate compliance and to enhance net patient revenues where possible. If the hospitals do not have an actively functioning individual or revenue cycle review committee as well as approved policies in place to systematically maintain the charge master, a recommendation will be made to the applicable CAHs to establish the committee. Appropriate revenue code assignment in the charge master is imperative to ensure compliance, enhance patient revenues where possible and to produce accurate cost reports. Recommended corrections in the charge master as well as other related recommendations will be monitored over the project period to create and sustain a

culture of compliance, to assist in ensuring proper program payments and submissions of accurate cost reports.

Additionally, the amount of revenue and the number of claims denied prior to the review of the charge masters will be captured for each of the 28 hospitals. Ongoing monitoring of revenue and the number of claims denied following the charge master reviews will be conducted with the results reported quarterly to the SORH. The number of recommended revenue code changes will also be reported following completion of the charge master reviews. As stated by a CAH CEO, in the needs assessment conducted by the SORH, physician recruitment is the crown jewel in the CAH needs category. When identified and with CEO approval, all recruitment needs will be referred to the Georgia Office of Primary Care (PCO), which is located within the SORH. The Flex and PCO Programs enjoy a complimentary and effective relationship. Utilization of the programs available through the PCO; National Rural Recruitment and Retention Network (3RNet), National Health Service Corp and the J1-Visa Waiver Program has the potential to assist in relieving the physician shortage in rural areas thereby helping to meet the critical recruitment needs of CAH communities in Georgia.

We continue to strive to ensure the CAHs possess a strong financial and operational infrastructure, that they have a charge master that is current and correct, and that they have personnel who are skilled, well-trained and perform at the highest levels. While these elements are critically important, if there isn't a practitioner to see the patients, write the orders, and utilize the services; the future of the CAH to provide continued access to health care locally is at risk as proven by the recent closure of two CAHs in Georgia.

One of the key elements in securing a strong financial and operational infrastructure is the submission of an accurate cost report. One of the primary objectives of this portion of the program is to increase the staff's knowledge and understanding of Medicare cost reports and cost-based reimbursement which will assist in the annual submission of an accurate cost report.

An analysis of significant settlement items in the cost reports and cost-based reimbursement will be conducted in each hospital. Based on the results of the analyses, hospitals will be provided tools and an action plan/intervention designed to ensure correctly predicted receivable and payable cost settlements at year end. The action plan/interventions will be monitored throughout the project period to ensure they continue to provide year end protection against cost report surprises. In addition to avoiding end-of-the-year surprises, the cost report determines the reimbursement CAHs will receive the next year. It is critical that the CAH staff understands the need for correct statistical and other data that impact the outcome of the cost report. In five years, after participation in the Flex Financial and Operational Performance Improvement Program and with continued adherence to the implemented action plans/interventions, CAHs in the state of Georgia can decrease the likelihood of unexpected Medicare payables to zero percent. Building

revenue department managers' accountability and increasing the staffs' ability to better manage the revenue cycle as well as developing internal financial and operational targets and benchmarks will help CAHs to increase collections throughout the year.

An analysis of each step in the revenue cycle from pre-registration through collections will be conducted. Based on the results of the analyses, hospital-specific actions plan/interventions will be applied to address opportunities for improvements in net patient revenues, net operating margins and days cash on hand. The interventions chosen to address opportunities, weaknesses, and threats identified throughout the revenue cycle will include those that have the ability to enhance the staffs' knowledge and understanding of the complete process. It is imperative, for the financial sake of the hospital that all personnel who work with individual segments along the revenue cycle not only have a thorough understanding of their job and its impact on the revenue cycle, but they must also have knowledge of the complete cycle from the beginning to final collections.

This knowledge and understanding will strengthen the process resulting in maximum collections in minimal time. To further strengthen the revenue cycle, recommendations will be made to initiate and maintain a revenue cycle committee to address strengths, weaknesses, opportunities and threats to the revenue cycle process. Action plans/interventions will be monitored and adjusted as necessary throughout the project period to ensure maximum project outcomes. A strong revenue cycle has enormous potential to assist in the financial stability of the state's CAHs long-term. The impact of this project is a predicted five percent aggregate increase in CAH profitability as indicated by the Process Improvement Management System (PIMS). In collaboration with the CAH CEOs and managers, revenue cycle manager accountability plans will be developed and monitored to support maximum expected productivity and desired outcomes. Organizations have the best opportunity to succeed when managers and employees have a vested interest in the organization's goals and objectives. According to the Workplace Wrangler, “many organizations today reflect our society's tendency to blame other people, act like a victim, and generally not take responsibility for our own actions. This lack of accountability is a problem in the workplace because it is unproductive, it negatively impacts employee engagement and it leads to poor results. A productive workplace requires every employee to be held accountable for his or her actions. When a manager is not accountable, commitments slide, decisions don't get made, responsibilities are not fulfilled and, worst of all, results are not delivered. An accountability tool enables managers to deliver results.” Stephen R. Covey also states, “Accountability breeds response-ability.”

While it is vital that accountability is an integral part of the CAHs' business philosophy it is just as essential that the organization provides managers with the mechanisms necessary to, produce, track and report expected outcomes including recommendations concerning what the manager must do to meet previously established goals. Additionally, a manager accountability plan will be developed and

implemented in all participating hospitals. If CEOs choose, the accountability plan will provide measures that can be adopted into the revenue cycle department managers' annual performance evaluations.

Core Area 3: Health System Development & Community Engagement
ST Elevated Myocardial Infarction (STEMI) Program.

In the current grant cycle, Georgia began the development of a rural STEMI Program that will be implemented in 32 CAH communities over three years. In FY2012, the program included six CAHs and provider-based Emergency Medical Services. In the two subsequent years of the Flex Non-competing grant cycle, the program will be extended to the remaining 26 CAH communities. Lessons learned in FY2012 will be applied in FY2013; however, at this time the program will be conducted based on the FY2012 objectives, process measures and predicted outcomes. To properly initiate the program in each of the 32 CAHs communities a detailed medical record review will be conducted. CAH Emergency Department records and emergency medical services (EMS) Patient Care Reports (PCR) will be used to assemble local information. The data compiled will be used to establish a baseline for each hospital/service from the STEMI diagnosis to intervention.

CAH Emergency Departments (ED)/EMS will be provided with all results of data mining to increase their awareness of gaps in the STEMI systems of care. The short-term dimension of participants' knowledge of identified gaps will be measured through post testing with an aggregate score of above 90 percent. Intermediate and long-term outcomes will be measured by the number of CAH ED/EMS that have implemented STEMI protocol monitoring, number that retain and report protocol monitoring outcomes over three-years. The anticipated impact, improving data collection to modify local STEMI protocols as needed.

The implementation of STEMI protocols will be accomplished through education and training resources on the recognition of ST elevation, methods of improving Door-to-Balloon (D-2-B) time, basic or advanced 12 lead Electrocardiogram (EKG) interpretation, pharmacology as well as other topics identified through assessments and evaluations that will elevate services to meet the American College of Cardiology (ACC) and American Heart Association (AHA) Standards of Management.

The number of CAH ED/EMS engaged in STEMI education and training; the number of personnel trained per category; nurses, physicians, paramedics, emergency medical technicians (EMT) and dispatchers will be will be monitored and reported including number of education and training hours in which each participated. All are expected to participate in a minimum of 95 percent of education and training sessions provided. The effectiveness of the training will be measured by the participants improved knowledge of STEMI protocols, ST elevation recognition, improving D-2-B time, basic or advanced 12 lead EKG interpretation, pharmacology and attainment of ACC/AHA protocol Standards of Management.

Intermediate and long-term outcomes will be measured through the number of participants who score above 90 percent on retention and efficiency skills tests. Over the long-term, CAH ED/EMS will maintain compliance with ACC/AHA STEMI Standards of Management as indicated by the change in the number of correctly identified patients who did or did not receive a diagnosis of STEMI.

It is predicted that a decrease in time from identified STEMI to intervention can be accomplished through adopting protocols, protocol education and training and by tracking and evaluating STEMI outcomes. Early in program development the STEMI Receiving Centers (SRC)/Percutaneous Coronary Intervention (PCI) Centers will be accessed for inclusion into the program to provide guidance and assist in program development where appropriate. It is anticipated that through these efforts a formal STEMI Network/Partnership can be created to dramatically reduce the time from identified STEMI to intervention.

In year two, protocols and process measures will be re-evaluated and analyzed to identify strengths and weaknesses of post STEMI education and training. This will be calculated by the number of CAHs/EMS tracking previously established measures, the number of CAHs/EMS reporting protocol and process measures and the number of Drip and Ship agreements activated between the CAHs/EMS and the PCI Centers. Increase in CAH/EMS compliance with STEMI protocols will also be highlighted by the change in knowledge indicated by the number of randomized samples of monitoring reports that are compliant with aspirin administration and the increased use of STEMI protocols as well as the number of "Drip and Ship" agreements between the PCI Centers and the CAH. This will increase and solidify compliance with previously implemented protocols.

The needs assessment conducted by the State Office of EMS and Trauma and the SORH identified 12 lead EKG equipment as a need by several emergency medical services. Efforts will be made to assist in improving the capabilities to implement/maintain compliance with protocols through the identification of funding resources and potentially through agreements between CAHs and SRC/PCI Centers to obtain the 12 lead EKG equipment that is necessary for these services. It is anticipated the long-term outcome of the program will be CAHs/EMS effectively utilize protocols and possess the necessary equipment to properly identify and appropriately manage STEMI patients according established protocols decreasing the D-2-B time.

Over the three-year period this project will include STEMI protocol education and training, development of performance measures, and evaluating the outcomes of the continuum of care from the field identified/ walk-in STEMI at the CAH to intervention at the SRC/PCI Center. All activities and outcomes of the program will be reported quarterly to the SORH. The timely and accurate identification and intervention of the STEMI will result in reaching the ultimate goal of this program to reduce the number of cardiovascular deaths in rural Georgia which currently exceeds the national and Georgia urban mortality rates.

Hawaii

Core Area 1: Quality Improvements

- Maintain the Hawaii Performance Improvement Collaborative (HPIC), a performance improvement network made up of the nine critical access hospitals (CAHs) that meets regularly to identify and address areas for quality improvement
- Provide assistance where needed to keep CAHs involved with the Medicare Beneficiary Quality Improvement Project (MBQIP)
- Serve on the Hawaii Affinity Team for Partnership for Patients to promote appropriate measures for small hospitals and CAH involvement

Core Area 2: Operational & Financial Development

- Conduct revenue cycle assessments in designated CAHs
- Maintain quarterly meeting of CAH CEOs and CFOs to review financial and operational indicators and to share best practices

Core Area 3: Health System Development & Community Engagement

- Develop and maintain a distance education course for rural health care informatics
- Develop and support a community health model in rural communities
- Integrate CAHs with the state trauma network

Idaho

Best Practice

Creating the Idaho Medicare Beneficiary Quality Improvement Project (MBQIP) peer learning collaborative series to "Move the Needle" for Idaho CAHs with regard to core measure data. These events took place via webinar, one-day regional workshops, and a one-day interactive presentation at the State Office of Rural Health annual conference. The State Office of Rural Health contracted with a consultant to provide best practices for critical access hospitals (CAHs) with regard to inpatient, outpatient and HCAHPS data.

- The number of Idaho CAHs participating in each event
- The number of CAHs participating in MBQIP Inpatient core measure data (MBQIP state aggregate data) and Outpatient core measure data (MBQIP state aggregate data)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) reports (MBQIP)
- Difference in CAH quality improvement (QI) staff pre- and post-education knowledge levels
- The number of CAHs who report implementing a quality improvement project based on MBQIP data

Core Area 1: Quality Improvements
Recruit CAH QI staff to participate in the MBQIP peer learning collaborative focused on improving core measures and HCAHPS data.

Projected Outcomes:

- November 2013 full-day educational MBQIP peer learning event focused on improving HCAHPS scores and outpatient core measures
- February 2014 MBQIP peer learning webinar focused on benchmarking highest MBQIP measures from two Idaho CAHs and presenting their best practices; sharing effective strategies to improve core measures
- April 2014 full-day educational MBQIP peer learning event focused on outpatient core measures and pharmacy Phase 3 measures
- June 2014 MBQIP peer learning webinar focused on benchmarking highest MBQIP measures from two Idaho CAHs and presenting their best practices; sharing effective strategies to improve core measures
- Idaho CAH core measure and HCAHPS data compared to baseline data to capture improvement
- Learning assessments implemented immediately post full-day workshop and four months post-event to capture immediate and sustained knowledge change

Core Area 2: Operational & Financial Development
Use Flex Monitoring Team (FMT) reports to identify struggling CAHs within state to determine where to provide targeted technical assistance (TA) to assist in improved operational performance.

Projected Outcomes:

- Improvement in financial indicators related to revenue cycle analysis: average days in net account receivable, average days in gross accounts receivable, average days cash on hand, and operating margin
- Project will also be evaluated regarding staff participation in activities and the percent of recommendations made during the assessment which are implemented at 90 days and sustained at 12 months post assessment period
- Identifying two CAHs at risk based on FMT data is an on-going activity

Core Area 3: Health System Development & Community Engagement
Develop a plan to establish a community health emergency medical services (EMS) pilot program in partnership with a CAH. The plan will be similarly structured to rural community paramedicine initiatives but align with the scope of practice for advanced emergency medical technicians (EMTs).

Projected Outcomes:

- CAH, community EMS, and stakeholders will identify resources and develop a plan to implement a community health EMS project that meets community needs. Idaho currently has two community paramedicine projects, however,

most CAHs do not have paramedic level services. This effort will identify resources, strategies, and educational needs aligned with the Advanced EMT scope of practice that will decrease readmission rates, reduce unnecessary emergency department visits, and improve community health.
- Develop a plan to implement a project that meets the needs of Idaho CAHs that lack paramedic services

Network Description
There are three regional, independent, non-profit networks in Idaho that the State Office of Rural Health & Primary Care partners with. These networks are made up of CAH and prospective payment system (PPS) hospitals and receive some Flex funds to implement projects related to Core Area 2: Support for Operational and Financial Improvement. In the current Flex year, these networks will provide board education and leadership development for the CAH member hospitals. The education will improve the knowledge and skills for CAH boards of directors.

MBQIP peer learning collaborative was created in FY2012 by the State Office of Rural Health. This collaborative is made up of CAH quality improvement staff to support their efforts to report core measure and HCAHPS data for MBQIP. Please refer to the initiative described in Core Area 1: Support for Quality Improvement.

Board Education and Leadership Development measures:

- The number and percent of CAHs actively participating in CAH governance events
- The number of CAHs developing financial components in their board education programs
- Difference in CAH board members' and leaders' pre- and post-education knowledge levels
- The number of CAH leaders and managers participating in financial education workshops and collaboratives

MBQIP peer learning collaborative measures:

- See projected outcomes from Core Area 1 activities

Collaborative
Qualis Health (QIO), Idaho Hospital Association (IHA) and the State Office of Rural Health meet in-person for monthly meetings to determine how best to collaborate on quality improvement initiatives for Idaho.

Measures from the Qualis Health, IHA, and the State Office of Rural Health collaborative include the number of CAHs reporting to Hospital Compare and MBQIP and outcomes focus on improvement to quality core measure data in the state aggregate as reported on MBQIP.

Illinois

Best Practice
Last year, the Illinois Critical Access Hospital Network (ICAHN) implemented an Innovations Award program where CAHs can share their new programs and services. It was very well received and several CAHs added programs similar to the award winners. Award winners are announced at the annual CAH conference.

The use of nurse practitioners as hospitalists was the award winner last year. Since the Innovation Award was announced and members received information on this program, four new CAHs added midlevels as hospitalists. The innovative CAH has experienced a 20 percent inpatient increase (keeping patients locally), improved Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores and cost savings as opposed to physician coverage.

Core Area 1: Quality Improvements

- Governing Board Leadership Regional SummitMedication Safety Assessment Project
- Team Strategies and Tools to Enhance Performance and Patient Safety (STEPPS)
- Six Sigma Training Customer Service Training
- Quality Health Indicators (QHi) Benchmarking Program
- Quality Improvement Support Staff
- Rural Patient Safety Certification Program

Core Area 2: Operational & Financial Development

- Enhancement of rural health clinic mock survey program
- Executive Leadership Training Senior Level
- Clinical Education Series for Nursing
- Practice Management
- Evaluation of Hospitalist Services
- Projects funds to improve rehab and financial services
- HCAHPS support

Core Area 3: Health System Development & Community Engagement

- Support of new statewide rural emergency medical services (EMS) alliance
- Stroke Community Educational Program expansion
- Project funds for population health intervention strategies for hospitals
- Hospital Association Community Education Series

Network Description
ICAHN was established in 2003 and celebrated ten years in November 2013. ICAHN is comprised of the 51 (soon to be 52) critical access hospitals (CAHs) and provides education, shared services, group purchasing which includes health insurance, IT support, physician recruitment services, external peer review, and peer networking opportunities for 16 different hospital groups and services.

Collaborative
Illinois has a strong history of cooperation and partnerships among its rural providers and state organizations. State universities, quality improvement organization (QIO) and hospital association are recipients of grant subcontracts each year.

Participation levels and development of new services for rural communities.

Indiana

Best Practice
We utilized our evaluator from the beginning of the Flex activity period to help the Flex program create several documents that were referred to throughout the Flex grant year. Each contract met with the evaluator and Flex Coordinator in August to create a logic model and work plan (which included measures and outcomes). These were used throughout the year for reports and were the basis of determine success with each project. Having these meetings and creating the documents early on in the activity year allowed all persons involved to start off knowing what was expected and how they would be measured on their individual projects.

All contractors reported back to the Flex Coordinator on the measures determined from the August 2012 meetings throughout the year. At the next year's strategic planning sessions, the documents were discussed and tweaked as deemed appropriate by the parties involved.

Core Area 1: Quality Improvements

- Medicare Beneficiary Quality Improvement Project (MBQIP): aiding critical access hospitals (CAHs) in publicly reporting specific inpatient and outpatient measures to Hospital Compare, reporting on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient assessment of care survey measures, and reporting on Computerized Physician Order Entry and Outpatient Emergency Department Transfer Communication, allowing for improvements to health care service, processes, and administration.
- CAH Readmissions Project: reducing avoidable hospital readmissions for patients admitted with diagnoses of pneumonia or congestive heart failure to improve health care quality and reduce health care costs
- CAH Quality Education Programs: providing CAH programs focusing on quality improvement, leadership development, and health information technology

Core Area 2: Operational & Financial Development

- CAH Education Programs: providing CAH programs focusing on revenue cycle processes and procedure improvement
- CAH Charge Description Master (CDM) Review and Cost Reporting Services: support for the review of CAHs cost reports and preparation of a market

comparison of the CAHs procedure prices to available market data, assisting hospitals in financial and operational improvement

Core Area 3: Health System Development & Community Engagement

- CAH Lean Healthcare Training for Meaningful Use and Patient Engagement: leverage previous Flex funded Lean Healthcare training through CAHs by providing coaching and facilitation for Lean team projects for patient engagement while supporting the CAHs in meeting Stage 2 meaningful use requirements
- E-Learning Network: supporting CAH staff to attend meetings and webinars at their hospital or a nearby hospital, eliminating the need for travel to major cities for all conferences and meetings
- Community Health Needs Assessment (CHNA) Technical Assistance: assist CAHs by providing resources and technical assistance with their required CHNAs, including developing action and implementation plans

Collaborative

The Indiana Flex program staff holds quarterly meetings with other rural health key stakeholders in Indiana to discuss potential collaborations and provide each other updates on what each organization is doing.

The measurement of this activity is the number of phone calls/meetings being held and the collaboration of any projects from the meetings. The anticipated outcome is increase future collaboration among the Indiana rural health key stakeholders.

Iowa

Core Area 1: Quality Improvements

- Collaborated with Iowa Quality Improvement Initiative and critical access hospitals (CAHs) to increase the percentage of CAHs participating in Hospital Compare. Over 80 percent of Iowa's CAHs now participate.
- Provided more than $355,000 in sub-contracts to individual CAHs, network hospitals, and stakeholder organizations. Funds were used to conduct patient safety, health information technology (HIT), emergency medical services (EMS), and other quality related initiatives.

Core Area 2: Operational & Financial Development

Partnered with the Iowa quality improvement organization (QIO) to provide TeamSTEPPS train-the-trainer, and master trainer course to seven CAHs. Thirty-two staff members, including quality improvement coordinators, director of nurses, department heads, and physicians received the training.

Core Area 3: Health System Development & Community Engagement

- Collaborated with EMS bureau to advanced state-wide EMS system standards
- Provided support to Iowa EMS Bureau to aid in EMS leadership training for 120 EMS personnel

Kansas

Best Practice
Collection to Action Collation Project

Initiative is based on the Institute for Healthcare Improvement (IHI) collaborative model. Training is focused on accurate data abstraction/submission; development of provider common knowledge base for basic quality improvement, review and action planning.

We have an external entity provide evaluation support through the two-year initiative. At the end of year one, on-line surveys and phone interviews were conducted to provide formative evaluation/feedback to the project team. At the end of year two, follow-up surveys/interviews will be complete to measure knowledge and participant's experiences. Other outcome measures being collected by the Kansas Foundation for Medical Care (KFMC) include data reporting acurracy and reduction in failure rate.

Core Area 1: Quality Improvements

- Quality Health Indicators (QHi)

  A multi-state benchmarking project designed for small rural hospitals to compare selected measures with other similar hospitals. Kansas critical access hospitals (CAHs) can compare data and share best practices not only among themselves, but with CAHs in all participating states.

- Collection to Action Collation Project - Year 2

  Partnership with the Kansas Foundation for Medical Care to improve CAH participation in reporting data consistently to the Centers for Medicare and Medicaid Services (CMS) and CAHs' performance in the Medicare Beneficiary Quality Improvement Project (MBQIP) measures. Based on the IHI collaborative model, training focus on accurate data abstraction/submission; development of provider common knowledge base for basic quality improvement; review and action planning.

- Lean Performance Improvement (LEAN) (PI) Initiative

  Through a partnership with the Kansas Hospital Association, the Flex program implemented a pilot project designed as an interactive performance improvement training focus on Lean. Nine hospitals are currently participating in the initiative, which will be completed in December. Plans are underway to continue the Lean PI initiative in 2014, with some redesign based on the evaluation results of the pilot project.

Core Area 2: Operational & Financial Development

- QHi benchmarking of financial metrics

The QHi project is a multi-state benchmarking project designed for small rural hospitals to compare selected measures with other similar hospitals.

- Revenue Cycle Trainings

Based on results from the 2013 Revenue Cycle Assessment project, a series of trainings are being offered state-wide. These trainings are focusing on improving front-end patient processes (e.g, financial counseling and point of service collections) of the revenue cycle model, which was the greateast need identified in the assessment. Each training series includes in-person workshop along with a workbook and other web-based review courses and webinars.

- Financial Improvement Initiative

This initiative is in the development phase. Targeted technical consultation will be offered to participating CAHs to assess and provide actional recommendations in improving specific elements of the hospitals' finances or revenue cycle management process. This project will be designed based around the Rural Hospital Performance Improvement (RHPI) project, managed by the National Rural Health Resource Center.

Core Area 3: Health System Development & Community Engagement
The Kansas Flex Program developed a partnership with the State Trauma Program to:

- Support the training of rural health providers optimal trauma care including: Advanced Trauma Life Support Trauma, Trauma Nurse Core Course, and Pre-Hospital Trauma Life Support
- Provide support to each Regional Trauma Council to offset the cost of Rural Trauma Team Development Course (RTTDC) training sessions in all six regions
- Educate critical access hospitals (CAHs) about the state's new Level IV Trauma Center designation and providing technical assistance for interested CAHs

Chronic Disease Pilot Project

- The Kansas Flex Program has partnered with the Bureau of Health Promotion to implement the Virtual Life Management pilot in five rural and frontier clinics. The purpose of this initiative is to identify feasible ways to adapted evidence-based prevention strategies in rural and frontier areas. The goal is to create opportunites for providers to engage their patients and communiteis in effective population heath management activities.

Community S-C-O-R Card initiative

- The Kansas Flex program has partnered with Rural Health Education and Services to technical assistance to hospitals through the implementation of the Community S-C-O-R Card initiative that evaluates the hospital's as well

as the community's health professional workforce retention and recruitment strengths and challenges. The tool focuses on community demographics and amenities; organizational culture and aspects; and, community engagement aspects.

Network Description
Kansas state statutes require that all critical access hospitals are part of a rural health network, which is defined as "an alliance of members including at least one critical access hospital and at least one other hospital which has developed a comprehensive plan submitted to and approved by the secretary of health and environment units beregarding patient referral and transfer; the provision of emergency and nonemergency transportation among members; the development of a network-wide emergency services plan; and, the development of a plan for sharing patient information and services between hospital members concerning medical staff credentialing, risk management, quality assurance and peer review." As such, we have approximiately a dozen state-designated rural health networks across Kansas who provide various levels of service to our critical access hospitals. http://krhop.net/cahs_networks.php

Collaborative
We partner with various entities across all of our projects. Almost all of our Flex-supported initiatives involve at least one outside entity, including the following: Kansas Hospital Assoication; Kansas Foundation for Medical Care; and, Kansas Rural Health Education and Services.

Kentucky

Best Practice
Yearly hospital visits are not feasible for a lot of states but really make our program strong. A lot of our hospitals never speak out or ask for assistance even though we encourage them. So during these visits, we are able to visit with these hospitals one-on-one, and they seem to be more comfortable asking questions. We get a lot of great feedback for our office and the Flex program, and it is always great to provide technical assistance when it is really needed. We always make sure to ask for their input on activities they would like to see in the Flex grant and put those at the top of our list for writing the next grant. These visits are also a great time to connect them with peers. They may have a certain question about a program and want to know how it is working for others, so we can connect them with another hospital who is already doing that program.

We visit all 29 critical access hospitals (CAHs) and as many of our small rural hospitals as possible, given time and budget constraints. We have a standardized form used to record answers to questions, and and we open it up to them to talk about any questions or suggestions they have. This all helps us to formulate future grant activities, and hospitals receive timely information on rural relevant issues.

Core Area 1: Quality Improvements
Participation in Patient Safety Organization (The Kentucky Institute for Patient Safety and Quality [KIPSQ]): Hospitals receive an electronic patient safety event reporting system and participate in one "deep-dive" for small rural hospital quality improvement unintended events. Will provide best practice guidelines in areas identified in deep dive, and train hospitals on utilization of Patient Safety Organization (PSO) for peer review activities and review of patient safety and patient error data using Agency for Healthcare Research and Quality (AHRQ) common formats. This will be measured by the number of hospitals participating in KIPSQ, the number of hospitals participating in KIPSQ webinars, and the number of hospitals submitting data in a "deep dive". We will survey hospitals to determine implementation of education and best practice guidelines distributed by the PSO. We are hoping to have an increase in participation by two Kentucky CAHs and reach 90 percent participation in KIPSQ webinars.

Stroke Care Improvement: Use developed Stroke Care Improvement program in partnership with the American Heart Association/ Stroke Association for small rural and CAHs to provide a comprehensive training program and best practices guide through certified Primary Stroke Center. Three workshops will be held in the state. Three hospitals will be able to attend the first and two will attend the second. This session will have post-training assessments.

Quality Improvement Training and Resources to Improve Core Measure/MBQIP Scores on Heart Failure and Pneumonia. We will measure the number of hospitals attending the training and will have a post-training assessment. Our goal is to provide statewide small hospital support on best practices around heart failure and pneumonia process measures and reducing mortality rates. Participation in face-to-face training by 60 percent of eligible CAHs in collaborative (coaching and data benchmarking). Provide technical assistance on improvement work with seven identified hospitals.

Core Area 2: Operational & Financial Development
Financial Improvement Technical Assistance: Use the Flex Monitoring Team CAH Financial Indicator Report to identify CAHs that have poor financial performance in a number of indicators in at least the recent three years. KHREF/ KHA staff will work with a nationally recognized accounting firm specializing in rural issues or with another nationally recognized consultant to provide on-site analysis and technical assistance. We will review all 29 of the Kentucky CAH financial indicator reports and use these to identify CAHS needing assistance and provide on site technical assistance.

Continue to schedule and facilitate on-site visits to small rural hospitals to: a) consult with administrators and key staff, b) identify and prioritize individual hospital needs, c) share rural relevant information and updates on state and national agendas, and d) rank all visited hospital needs in order of significance to: determine the most appropriate utilization of grant funds; select topics/speakers for

regional meetings; and, share with all administrators and partners to create an arena for networking and strategic planning. These visits are done every year to really get a feel for where hospitals are and what they may have questions about or need assistance with.

Encourage the Western Kentucky Network (seven small rural hospitals) to utilize evidence-based tools for operational improvement through: a) on-site education and technical assistance, b) continue support for the network hospitals to participate in the Kentucky Telehealth Network (made available by US Department of Agriculture (USDA) grant to purchase equipment for the network hospitals), and c) continue to support development of network peer groups.

This group of seven small rural and CAHs has been very successful in the formation of peer groups. The network consists of a CEO group, human resources (HR) group, quality improvement group, and chief nursing officer group. The flex grant is able to provide someone to facilitate and coordinate these meetings. This network was recently awarded with a telehealth grant and continue to have great successes.

Core Area 3: Health System Development & Community Engagement
Organize/ facilitate meetings with staff from the Rural Hospital Performance Improvement Project, Murray State University and KRHW to identify a community project/ initiative for CAHs and small rural hospitals to: a) engage collaborative partners in planning and decision making, and b) implement system to address unmet needs. We are looking at the possibility of doing an emergency room "secret shopper" project for this group. We will measure the number of providers and communities participating and the number of education sessions provided. If we continue with the ER secret shopper we will be able to provide a report back to leadership with our findings.

Rural Health Improvement Plan: A rural health improvement plan will be drafted to reflect opportunities to improve health in rural Kentucky. We will measure the number of communities interviewed and providing input, the number of new stakeholders that represent rural health organizations and the number of strategic initiatives. Our goal is to identify the unmet needs of rural communities and work to address those needs within the community.

Grant Writing Workshop(s) focused on rural health opportunities. We will measure the number of people that attend and the number of agencies attending. We hope to assist rural providers in applying for and securing rural health related grants.

Network Description
As stated before, we have a group of seven small rural and CAHs that has been very successful in the formation of peer groups. The network consists of a CEO group, HR group, Quality Improvement group, and Chief Nursing Officer group. The Flex grant is able to provide someone to facilitate and coordinate these meetings. This network was recently awarded with a telehealth grant and continue to have great successes. We also have a recently revived hospital network in the South

Central Region of the state that consist of 6 small rural and CAH CEOs. Our office is able to facilitate and plan quarterly meetings for these hospitals. We are also going to open this group up to other hospital leadership and look at the possibility of forming peer groups similar to the Western Kentucky network.

We also work with a network in the northern part of the state that consists of rural hospitals, a local health department and a local federally qualified health center. They also meet quarterly to share best practices and see how they can work together to improve their communities health while avoiding duplication of services.

We keep track of everything that takes place during these meetings. That includes, minutes, grants they are working on, meeting information, etc. We also help encourage these groups to pick a project that they might want to work on together. Usually someone from our office is able to attend/assist with network meetings.

Collaborative
We work very closely with our hospital association and contract quite a bit of flex activities to them. They have some really great resources that we are able to utilize, and it allows us and Kentucky Hospital Association to really help rural hospitals and make them a priority.

Louisiana

Best Practice
The Louisiana Flex Program contracts for Medical Coding Certification Boot Camp courses and ICD-10 courses for CAH staff. As of March 30, 2013, two coding courses and two ICD-10 courses have been provided in the program year. A total of 34 critical access hospital (CAH) staff participated in the ICD-10 courses, representing 12 CAHs. A total of 42 CAH staff participated in the coding courses, representing thirteen CAHs.

This is being measured by the number of CAHs prepared for ICD-10 transition.

Core Area 1: Quality Improvements

- Host facilitated discussions and informative presentations at Louisiana CAH network meetings to: a) promote benefits of public data reporting; b) promote discussion of common challenges and solutions relevant to quality improvement (QI) & data reporting; and, c) educate CAHs on requested QI related topics
- Support CAH participation in a multi-hospital project focused on reducing unnecessary hospital readmissions

Core Area 2: Operational & Financial Development

- Support billing, coding and/or financial management trainings for CAHs
- Support individualized financial/operational assessments on focus areas selected by each participating CAH

Core Area 3: Health System Development & Community Engagement

- Support emergency medical services (EMS) training for hospital staff (i.e. Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), national conferences) and collaborate with Louisiana Emergency Response Network (LERN) and other partners to identify and implement strategies for incorporating CAHs into the statewide EMS/trauma system
- Support training/consultation for CAHs in conducting assessments to identify unmet community health needs

Network Description

During the current year, Louisiana CAHs will be involved in facilitated discussion meetings to explore networking options that will best serve the needs of their respective communities.

We expect to develop an action plan for implementation in the 2014-2015 grant year.

Collaborative

Twenty of the 27 Louisiana CAHs are participating in the Hospital Engagement Network (HEN) project aimed at improving health outcomes for their patients.

Each of the participating CAHs are measuring similar outcomes, including reduction of unnecessary hospital readmissions.

Maine

Best Practice

Collaboration within our region of New England through the New England Performance Improvement (NEPI) Network. This ongoing collaboration has allowed our critical access hospitals (CAHs) to benefit from our regional offerings (Institute for Healthcare Improvement (IHI) programming, for example) while simultaneously providing our Flex programs shared learning opportunities.

Number of and success of offerings we make available to our CAHs and successful collaboration and strategic planning as a regional group.

Core Area 1: Quality Improvements

Under support for quality improvement, Maine's Flex program brings together networks of CAH staff from all 16 CAHs in the state and measures activities through the Medicare Beneficiary Quality Improvement Project (MBQIP) and other publicly available quality data as well as through survey instruments. The Maine CAH CEO network provides overall strategic direction to the Flex program. The Maine CAH CNO network serves as a work group to share best practices and learning opportunities as well as provide strategic direction to the newest network of Maine CAH Nurse Managers. The Maine CAH Quality Improvement (QI) Directors Network meets quarterly, and all 16 hospitals participate in a benchmarking project to identify MBQIP measures, particularly Hospital Consumer Assessment of Healthcare

Providers and Systems (HCAHPS) scores, that network members agree to address at their individual facilities, work as a group to identify best practices to impact, and report back to the group on successes and challenges.

Through participation in NEPI Network, a collaboration of Flex programs in Maine, New Hampshire, Vermont and Massachusetts, Maine CAH staff have free access to various offerings from the IHI including IHI Open School and Expeditions. Also through NEPI, Maine CAH staff is able, on a limited basis, to pursue free certification programs to become either a Certified Professional in Patient Safety (CPPS) or Certified Professional in Healthcare Risk Management (CPHRM).

Core Area 2: Operational & Financial Development
The Maine CAH CFO network's objective is to bring together CFOs in order to identify financial indicators that the group can address as a whole and at their individual facilities, leading to improvement. Activity and progress towards goals are measured through use of iVantage's Hospital Strength Index Reports, the Flex Monitoring Team's Financial Indicators reports, and other more current data provided by the hospitals themselves. Healthcare consultants with broad expertise in areas such as revenue cycle management and charge master review attend CFO network meetings and provide guidance and education to the group on best practices to improve financial performance. This network was newly established in FY 2012 and progress has been slow to identify measures to address as the group works to provide more current data than what is publically available currently. To support operational performance at Maine CAHs, the newly established Maine CAH Nurse Manager network serves to bring together mid managers to share best practices, network and learn operational improvement techniques from one another as well as leading experts in this work in Maine and beyond.

Core Area 3: Health System Development & Community Engagement
The Maine Emergency Medical Service (EMS) Trauma System project provides guidance to CAHs and other rural emergency care providers with a statewide trauma system plan, technical assistance program, clinical consensus guidelines for patient care and transfer, and the development and implementation of trauma care performance measures. Maine Flex funds also support the development of a community paramedicine (CP) program with the goals of better integrating EMS and community health resources in rural areas to fill gaps in advanced and basic life support EMS coverage; and addressing other community health and medical gaps.

Network Description
The Maine Flex Program brings together various networks including a CEO network, CNO network, CFO network, Quality Director network and Nurse Manager network. All are comprised of CAH staff in specific functional roles (which determines the network they participate in) with the addition of Rural Health and Primary Care Program staff and a Maine Hospital Association staff member who participates in the CEO and CFO networks. These networks serve as unique arenas for Maine CAHs to come together as a group, discuss their challenges in the critical access hospital

realm, share best practices, network and identify projects to engage with as a group. The high level of sharing that happens in these networks (and the lack of competition between CAHs) gives purpose to the Flex program.

Through process measures and outcomes related to public reporting of the data for Maine hospitals, MBQIP reports, key informant interviews with CAH networks members.

Collaborative
NEPI is a collaborative described above. Maine is one of eight states participating in the Centers for Medicare and Medicaid Services-funded Quality Improvement Organization (QIO) Emergency Department (ED) Transfer Communication Measure pilot. Lastly, Maine was awarded a Rural Veterans Health Access Program (RVHAP) grant which, as a major focus of its work, will link the statewide health information exchange bidirectionally with the US Department of Veterans Affairs (VA) electronic medical records system.

- NEPI: Activities measured through process measures primarily with anticipated outcomes to include greater number of professionally certified staff at Maine CAHs as well as increased quality scores for CAHs
- QIO and RVHAP grant will measure activity per those particular grant requirements. Anticipated outcomes for the QIO project include improvement in ED Transfer Communication at participating hospitals and for RVHAP include improved care coordination for rural veterans regardless of where they get their care

Michigan

Best Practice
We have developed a Rural Health Clinic Quality Network (RHC QN) that meets quarterly. Measures have been developed, and Rural Health Clinics are submitting to Quality Health Indicators (QHi). The program began in June 2011. The measures are tobacco cessation, controlling high blood pressure, and BMI screening and follow-up. Twenty-seven rural health clinics (RHCs) are participating in collecting the measures, and over 65 RHCs are active in the RHC QN meetings.

RHC's collect and place their data into Quality Health Indicators (QHi).

Core Area 1: Quality Improvements
- Support Michigan Critical Access Hospital (MICAH) Quality Network activities
- Support member quarterly meetings, provide follow-up activities, support listserv
- Support data submission through Quantros web-based program

Core Area 2: Operational & Financial Development

- Continue recruitment of all CAHs to participate in the Financial Benchmark Group. Currently 19 of 36 CAHs are participating. Encourage CFO's efforts to submit financial benchmarks into QHi.
- Continue to support two face-to-face meetings per year
- Provide one Lean activity per year

Core Area 3: Health System Development & Community Engagement

- Sponsor two emergency medical service (EMS) Leadership Academy Workshops; one level I and one level II
- Sponsor continuing education webinars for rural EMS personnel
- Provide Comprehensive Life Support (CALS) training for six CAHs

Network Description

Michigan has the MICAH Quality Network (QN). All 36 CAHs in Michigan, including three prospective payment system (PPS) hospitals, belong to the MICAH QN. They are a 501(c)3 organization. Members attend quarterly quality meetings and communicate with each other via listserv. Composition of the Network includes: Directors of Nursing (DON), Quality Directors, Patient Safety Managers, Hospital Administrator, Managers, etc.

MICAH QN agrees on a set of core measures, collects data on a monthly basis and enters it on a monthly basis into the Quantros Regulatory Reporting Management tool. Also the QN enters MBQIP data into the Telligen Peer Review Organization tool.

Collaborative

The MICAH QN is involved in collaboratives with the Michigan Health and Hospital Association (MHA), and the Michigan Peer Review Organization (MPRO).

MHA has 100 percent participation from all 36 CAHs in Michigan. Reporting: heart attack, heart failure, pneumonia, Surgical Care Improvement Project (SCIP), Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), all cause re-admissions data report. MPRO supports MICAH with Centers for Medicare and Medicaid Services (CMS) issues. They attend every quarterly meeting, and assist hospitals with issues as needed. The outcome is that the MI CAHs will continually improve services. MI CAHs participate in the Governor's Quality Award.

Minnesota

Core Area 1: Quality Improvements

- Encourage and support crirtical access hospitals (CAHs) reporting to Hospital Compare, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and Minnesota inpatient and outpatient quality measures. Increase CAH measurement capability through the Medicare Beneficiary Quality Improvement Project (MBQIP) and MN State Quality

Reporting and Measurement System by increasing validity and reliability of measures submitted by CAHs
- Provide technical assistance to CAHs for the 2013 data submission requirement for the Emergency Department Transfer Communication measures
- Offer web or conference calls, tools and resources to address new topics in quality and safety with a focus on the applicability in CAHs
- With up to eight communities, use a community capacity development process to explore quality and health data across settings of care and identify and address community focused opportunities for care improvement
- Provide technical assistance (TA) or referral to the Regional Extension Assistance Center for Health Information Technology (REACH) to CAHs requiring assistance in achieving meaningful use and obtaining electronic health record (her) incentive payments
- Participate in MBQIP
- Manage CAH Talk, an interactive web group for CAH quality care coordinators to share quality improvement (QI) questions and answers, best practices, and documents
- Provide QI grants to eligible CAHs, emergency medical services (EMS) agencies and other community groups through a competitive grant process

Core Area 2: Operational & Financial Development
- Provide onsite TA to CAHs needing assistance based on Flex Monitoring Team indicators, benchmarking data, leadership interviews, etc., to assist CAHs in improving financial performance
- Continue to work with the Minnesota Hospital Association (MHA) to encourage CAH active membership in Quality Health Indicators (QHi)
- With MHA, assist CAHs in making wider use of hospital administrative data by developing a web-based platform to make market share, financial and quality reporting data more accessible for use in daily management
- Facilitate a quarterly roundtable CFOs of Minnesota CAHs. Engage high performing CAHs to serve as mentors to the lowest performing CAHs in the areas of financial and operational performance.
- Conduct Rural Health Works assessments
- Provide performance improvement (PI) and financial improvement (FI) grants to eligible CAHs through a competitive process

Core Area 3: Health System Development & Community Engagement
- Provide subsidies for Comprehensive Advanced Life Support (CALS) training of CAH staff
- Provide financial support for provision of Advanced Trauma Life Support (ATLS) courses at rural sites
- Conduct Rural Health Works assessments
- Support development of Rural Trauma Advisory Committees in eight regions of the statewide Trauma System

- Conduct assessment of community benefit activity in CAHs and provide onsite TA to CAHs requesting it
- Provide community development grants to eligible CAHs, EMS agencies, and other community groups through a competitive process
- With Stratis Health, develop a Community Capacity Development pilot (see quality improvement section)
- Host community forums to learn about local health care access issues

Mississippi

Core Area 1: Quality Improvements
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

Core Area 2: Operational & Financial Development
Cost report consultations.

Core Area 3: Health System Development & Community Engagement
Community health needs assessments.

Missouri

Best Practice
The Missouri Hospital Association has taken the Medicare Beneficiary Quality Improvement Project (MBQIP) data received and developed reports for their dashboard. These reports have given the hospitals the opportunity to compare their progress against the other critical access hospitals (CAHs) in the state.

Quality improvement projects and technical assistance (TA) questions around quality improvement have increased since these reports from the Missouri Hospital Association (MHA) have been produced. The hospitals seem to respond to these reports.

Core Area 1: Quality Improvements
In order to achieve the objectives in this area the Flex program has contracted with MHA to offer technical assistance. MHA offers technical assistance for the MBQIP utilizing webinars, conference calls, in person trainings, regional trainings and one statewide training annually. MHA is building a dashboard for CAHs that will promote MBQIP and utilize the data for quality improvement activities. Each hospital now has the ability to look at aggregate performance, most current average performance as a state, and most current average performance nationally on the dashboard. It also provides information about rates and how each hospital ranks by state for the most current quarter, last four and eight quarters. Lastly, the dashboard will provide charts for the rate of each measure against the rate of other hospitals in the state and nationally.

Core Area 2: Operational & Financial Development
The Flex program is in the middle of a three year contract with Wipfli, LLC to provide financial improvement services for CAHs. They have conducted a statewide financial assessment and obtained financial baselines and data comparisons. Wipfli has also developed an online portal just for Missouri CAHs that streams webinars, articles and other learning tools for financial improvement. They conduct a webinar once a month that targets an area on which the CAHs have said they need more technical assistance. The portal also provides a visual display of the each CAH's revenue cycle, protected by password, and ranks them against their peers.

Core Area 3: Health System Development & Community Engagement
The Flex program collaborates with the Missouri Department of Health and Senior Services Staff in the Bureau of Health Care Analysis and Data Dissemination (BHCADD) to conduct trainings on the Missouri Information for Community Assessment (MICA) tool. These trainings help hospitals to generate statistics and provides communication strategies and examples of how to clearly communicate health data through a variety of presentation formats. The Missouri State Office of Rural Health (SORH) hosts a Rural Health Conference every year. This conference has two tracks, one for hospitals and one for rural health clinics. The Flex program, along with all other programs in the Office of Primary Care and Rural Health, supports the Rural Health Innovation Service Awards annually as well. The object is to solicit proposals to assist rural communities develop, implement or leverage innovative or grassroots projects that address disease prevention, improve healthcare quality, increase access, decrease disparities, or other projects that improve health and well-being.

Montana

Best Practice
Our pilot regional trustee meeting was a great success with approximately 45 participants and 100 percent stating the meeting was worth their time and they would recommend this conference to others. We used a one-day format and meet on a Saturday per planning committee recommendation. There were four critical access hospital (CAH) trustees on the planning committee.

We measure this best practice by evaluation and pre- and post-test.

Core Area 1: Quality Improvements
- Medicare Beneficiary Quality Improvement Project (MBQIP) participation: Forty-seven out of 48 MT CAHs participate in MBQIP on a regular basis with all 47 CAHs publically reporting Hospital Compare data
- MT Flex has conducted quality initiatives on heart failure measures aspirin on arrival and time to EKG, outpatient measures four and five and the emergency department transfer measures using our clinical improvement study format

- We now have seven virtual peer groups that meet on a quarterly basis to review cases
- MT Flex is in the process of remodeling their 12-year old benchmarking program by network member request. We hope to reduce data reporting redundancy and streamline the data reporting process while shifting the focus to moving the performance improvement needle.
- We will host a rural quality summit next spring for CAH CEOs, Nursing Directors and Quality Coordinators and other interested personnel. In addition, we will host regional meetings for CAH Nursing Directors and Quality Coordinators and our nine-year old Champions for Quality series for CAH providers. We also provide new Quality Coordinator performance improvement education programming to assist in the implementation of quality improvement program at MT CAHs.

Core Area 2: Operational & Financial Development

- MT Flex is in the process of revising our popular survey assessment tool. We also summarize the Statement of Deficiencies (CMS-2567) reports and translate them into useful information that will be shared with all CAHs. We plan on conducting another round of the popular standards' calls which are simply conference calls that review the Medicare Conditions of Participation (CoPs) tag by tag in a round robin fashion checking in on how CAHs meet these tags, tools they may have developed which are shared with group, areas they struggle with which usually prompts the need for more intensive education via webinar.
- We are hosting some CAH finance education webinars, a networking meeting for CAH CEOs. We offer scholarships for CAH staff to attend their state professional organization meetings. Based on member request, we are also offering a 'utilization review' boot camp.
- We will continue our Lean internship program, a collaborative effort with Montana State Univerisity (MSU)-Bozeman. MT Department of Public Health & Human Services (DPHHS) is planning trauma registry coding workshops. Our annual coding workshops are scheduled for next spring and will most likely focus on ICD-10.
- We will host a regional trustee meeting next spring

Core Area 3: Health System Development & Community Engagement

- MT Flex will support the pursuit of trauma designation for MT CAHs and also Advanced Trauma Life Support (ATLS) training
- MT Flex is also supporting community health needs assessment for MT CAH through a collaborative effort with the MT State Office of Rural Health. We will reassess the community paramedicine and emergency medical services programming efforts in MT as well.

Network Description
MT has a very active, mature Performance Improvement Network that was formed to help MT CAHs meet the Medicare QA Conditions of Participation. All 48 MT CAHs are voluntary members and participate in varying degrees.

We measure our networking activities by participation counts and implemented interventions.

Collaborative
We collaborate with Mountain Pacific Quality Health on many levels, including Hospital Compare and MBQIP participation, new QI Coordinator education, utilization review boot camp, Champions for Quality and the new Rural Quality Summit. We could not function as well as we do in the quality area without the help of our quality improvement organization (QIO).

We measure these activities by participation, pre- and post-test scores and documented performance improvement on remeasurment data.

Nebraska

Best Practice
The Flex program continues to support Lean Management Projects. The Flex program contracts out to provide training and technical assistance. Thus far, a total of 20 critical access hospitals (CAHs) have received training and they have all completed at least one Lean project. In addition to greater efficiencies, the application of Lean principles has created better working relationships and enhanced the collaborative partnerships within the hospitals. One of the lessons learned is that there is a relatively steep learning curve and that with limited staff, it is difficult to expand training throughout the organization. In order to overcome this challenge, a three-and-one-half day Lean/Six Sigma Green Belt Certification Program has been developed and was offered in August of 2013 and the second one will be held in January of 2014. The purpose of the course is to expand the number of CAH staff that have the knowledge and skills to apply the Lean Management principles. With more people trained, there is greater potential to not only increase the number of Lean projects, but also generate greater cost savings and improve the quality of care.

In order to become certified as a Lean Six Sigma Green Belt, each participant has to pass an exam at the end of the three and one-half day course and complete a Lean Project. Flex staff and the consultant who provides technical assistance on the project evaluate each one to determine the cost savings, changes in patient or employee satisfaction, and/or significant improvements in treatment processes.

Core Area 1: Quality Improvements
The Nebraska Flex Program uses the Baldrige model as a framework for improving quality and the overall performance of CAHs. This model is used because it

emphasizes the importance of leadership in changing the culture of the organization and improving communication at all levels. There is also a strong focus on customer satisfaction, and measuring results. The key activities under quality improvement are:

- Support CAHs participating in the Medicare Beneficiary Quality Improvement Project (MBQIP) (currently all of the hospitals are in the program). In order to improve our scores, staff is working with the Nebraska Hospital Association, the quality improvement organization (QIO), and the CAH networks to identify best practices and share these practices in all of the CAHs.
- Continue to support the training and implementation of Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS). Thus far, 52 CAHs have implemented TeamSTEPPS.
- Continue to support the CAH Executive Fellowship Program which has trained over 30 CAH administrators and other leaders by providing them with the leadership competencies and tools that are necessary to build a culture of change
- Conduct mock surveys in 90 percent of the CAHs
- Support participation of CAHs in Quality Health indicators (QHi) multi-state benchmarking project with the Kansas Hospital Association

Core Area 2: Operational & Financial Development
Good financial performance is also based on the elements in the Baldrige model. For example, good leadership and open communication throughout the organization will enhance both operational and financial improvement. The key activities under this area are:

- Providing training and education to CAHs on Lean Management techniques. Once training has been completed, monitor and provide technical assistance on the implementation of Lean Projects. Thus far 14 CAHs are receiving or have completed the training and have implemented at least one Lean Project.
- Conducting a comprehensive financial and operational assessment for low or negative margin CAHs. Once the assessment has been completed, a tracking system has been developed to assess the progress and changes in meeting the recommendations contained in the report. Thus far ten assessments have been completed and at least four more will be done by the end of 2013.

Core Area 3: Health System Development & Community Engagement
There are two main areas of focus for health system development. The first major area is to enhance emergency medical services (EMS) capacity by expanding the number of trauma centers (46 so far), provide training and support to medical directors, conduct EMS needs assessments, and organize a leadership development program. The second major area is to develop strategies that will lead to a strong regional system of care for patients who need immediate treatment for a heart attack. These strategies involve developing more formal acceptance agreements

between CAHs and referral hospitals and increase the use of telemedicine to reduce the time for transfers.

Network Description

For MBQIP, we use seven CAH Networks which range in size from two to 22. The networks consist of CAHs and one large regional or urban hospital. Each network is required to establish a goal for one inpatient and one outpatient Hospital Compare measure as well as one Hospital Consumer Assessment of Healthcare and Provider Systems (HCAHPS) measure. All of the networks are expected to address the following HCAHPS measure: "Nurses always communicate well." Each network is in the process of identifying the factors that contribute to low or high scores on the inpatient and outpatient Hospital Compare measures and the HCAHPS measures. For example, the lack of pre-printed orders and concurrent reviews usually result in lower scores. Once all of these factors are determined, best practices will be developed and shared across the state.

Compare HCAHPS scores on a quarterly basis. If the scores are consistently low, technical assistance is provided by the CAH Network Coordinator, the QIO, the QI Director from the Nebraska Hospital Association, and Flex staff. Webinars are also scheduled to share best practices (e.g., hospital discharge instructions). Best practices are also discussed at the CAH Network meetings, which are usually held four times a year.

Collaborative

A learning collaborative has been established for the 12 CAHs that have experienced a financial and operational improvement assessment. The collaborative meets once a year face-to-face to discuss some of the key performance barriers (e.g., collection of bad debts, ineffective strategic plan, and high turnover of staff) and the steps they have taken to overcome some of these barriers (e.g., more effective revenue cycle management, updated chargemaster review, and the development of a new strategic plan). Both the Flex Coordinator and the contractee who conducted the assessments also share their observations. The collaborative has produced very open and honest discussions about both continued challenges and successes.

Based on the recommendations contained in the financial and operational assessment report, the Flex Coordinator contacts each CAH on a semi-annual basis to identify the recommendations that have been completed, those still in progress, and areas where limited or no progress has been made. For example, many CAHs have expanded their clinical service lines, reduced bad debt, created a new strategic plan, or recruited new primary care practitioners. For some CAHs, improving their financial performance has been challenging because of a low population base and a high percentage of patients with very high deductible plans.In addition to these semi-annual reports, Flex staff carefully monitor the annual financial data that is organized by the Flex Monitoring Team at the University of North Carolina. Although there is a lag in the data, over time it is

possible to observe the changes in key financial performance indicators such as total margin, days in accounts receivable, and days of cash on hand.

Nevada

Best Practice
The Nevada Flex Program has developed and refined a process for undertaking community health needs assessments and the utilization of those assessment findings for rural hospital strategic planning and broader community health planning.

This best practice was primarily measured by the number of Nevada critical access hospitals (CAHs) or rural communities that have designed and developed collaborative community health interventions and strategies to improve population health as a result of Flex-supported community health needs assessments and technical assistance.

Core Area 1: Quality Improvements
The Nevada Flex Program's support for rural hospital benchmarking represents a major set of multi-year activities initiated during previous fiscal periods with Flex funding and the pooled resources of the Nevada Small Rural Hospital Improvement Program (SHIP) Consortium.

The Nevada Flex Program and Nevada Rural Hospital Partners (NRHP) have established these measures and are currently developing the means to capture and report benchmarking data. The financial measures will mirror those adopted by the Healthcare Financial Management Association and the operating measures mirror those of the Larson Allen Gold Standard for CAHs. Quality measures include those captured through the Medicare Beneficiary Quality Improvement Project (MBQIP) and rural relevant measures developed and captured by the Nevada Rural Hospital Quality Improvement Network, a committee comprised of rural hospital risk management and quality improvement coordinators. The goal of the benchmarking initiative is utilization of financial, operational, and quality indicators and benchmarks in all requesting CAHs or CAH-eligible hospitals in Nevada.

Core Area 2: Operational & Financial Development
Recognizing the need to create more effective, long-term solutions, health care financial leaders developed a process known as revenue cycle management. Through the use of comprehensive measurement and reporting, all hospital processes and employees are monitored, measured, and altered for optimum performance. Consistent with revenue cycle management, new tools are implemented to drive work performance and to optimize the use of existing information technology.

To address revenue cycle problems faced by rural hospitals in Nevada, the Nevada Flex Program, through its Flex and SHIP subcontract with NRHP, will continue

implementation of the revenue cycle management activities initiated in previous budget periods. The program involves a complete review of the flow of patient financial information (PFI), the functions involved in the processing of PFI, and the identification of needed revisions. To assist in the monitoring of the effectiveness of the program, facility-specific reports and dashboards have been developed by NRHP to review the results of accounts receivable and to identify key trends assessing the effectiveness of rural hospital business offices. The goal of the revenue cycle initiative is to provide this service to any requesting CAH or CAH-eligible hospital in Nevada.

Core Area 3: Health System Development & Community Engagement
The Nevada Flex Program has pursued a variety of activities to support health system development and community engagement in rural areas. The centerpiece of these efforts has been a wide-range of applied health services research to any requesting CAH or CAH-eligible facility including: community-wide health care needs assessments for any requesting CAH or rural community; service delivery gap assessments for CAHs; county-level economic impact analyses of hospital and health care sectors in rural and frontier counties with health services for rural health care stakeholders; and, sub-county and facility specific economic assessments for requesting CAH or rural communities. During the current budget period, the Nevada Flex Program will coordinate comprehensive community health needs assessments in three CAH communities.

Network Description
The Nevada Flex Program continues to provide financial and technical support to the Nevada Rural Hospital Quality Improvement (QI) Network, a group of Nevada CAH and CAH-eligible QI and Risk Managers who meet on a quarterly basis to assess, develop, and implement rural hospital QI and patient safety activities.

Some of the process measures used to assess rural hospital QI network activities include:

- Number and percent of Nevada CAHs receiving quality reporting technical assistance from the Nevada Flex Program and/or program partners and subcontractors
- Number and percent of Nevada CAHs participating in the quarterly network meetings
- Number of Nevada CAH and CAH-eligible hospital QI/Risk Managers participating in quarterly network meetings

Outcome measures include:

- Number and percent of Nevada CAHs implementing a QI project based on participation in network meetings and/or education programs
- Number of QI and patient safety projects implemented by Nevada CAHs as a result of participation in network meetings and/or education programs

Collaborative
The Nevada Flex Program is currently involved with Project ECHO Nevada, which is an innovative health care delivery solution pioneered in New Mexico by Dr. Sanjeev Arora and replicated in Washington, urban Chicago, and now Nevada. ECHO is a simple telehealth linkage connecting University-based faculty specialists to primary care providers in rural and underserved areas to extend specialty care to patients with chronic, costly and complex medical illnesses.

The goal of Project ECHO Nevada is to meet the needs of primary care providers by offering an alternative to costly travel and long waits for rural patients in Nevada who need specialty care. By developing the knowledge base of primary care providers through the innovative telehealth consultations offered by Project ECHO, patients in rural and underserved areas benefit from the specialty care available without the cost and time of accessing specialists directly.

New Hampshire

Best Practice
Lean Process Improvement Project, Year 2 with activities focused on transitions with primary care. The project included: data analysis per hospital; phone interviews with quality improvement directors per hospital; hospital team and theme selection; training session customized preparation (based on interviews); introductory executive session; frontline training sessions #1-3, phone call/email mentoring between sessions #1-4; final training session with executive leaders; final report cards to hospitals; and peer review.

We utilized the following measures: number of hospitals participating in a Lean collaborative; number of Lean initiatives and events that took place in each hospital; percent change in operations based on Lean initiatives and/or events; and, number of participants in seminars and/or workshops still using lessons learned six months later.

Core Area 1: Quality Improvements
- Support all critical access hospitals (CAHs) to continue reporting Phase 1 Medicare Beneficiary Quality Improvement Project (MBQIP) and assist those who have not started reporting Phase 2
- Support for Partnership for Patients where needed, especially around patient safety, transitions in care, and hospital readmissions
- Support for quality improvement training through the Institute for Healthcare Improvement (IHI) Open School through the New England Performance Improvement network of the New England Rural Health Round Table

The Process Measures we will be using are as follows:

- Total number of CAHs reporting data on at least one inpatient measure

- Total number of CAHs in state reporting data on at least one outpatient measure
- Number and percent of change in state reporting by CAHs on at least one outpatient measure
- Number and percent of CAHs in state reporting Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data
- Number and percent of new CAHs reporting HCAHPS data this budget year
- Number and percent of CAHs in state implementing a quality improvement project based on Hospital Compare data

Core Area 2: Operational & Financial Development

- We will support CAHs in planning and implementing evidence-based strategies for improving financial performance through the Financial Improvement Network (FIN) (all 13 CAHs) in the Rural Health Coalition
- We will support FIN services to increase a CAH staff's ability to better manage their revenue cycles; to foster financial integrity of pricing, charity care and bad debt policies; to increase hospital revenue and cash flow; to better server patients and customers by informing them upfront of financial obligations; to improve hospital business and operational processes; and, to build department manager accountability for CAH financial performance
- Process Measures will be as follows:
    - Number of CAHs receiving Flex-funded financial consultations
    - Percent improvement in bad debt as a percent of gross charges and/or net patient revenue
    - Number and percent of CAHs completing analysesImprovement in point of service collections as a percent of total revenue
    - Percent reduction in claims review and denial rates
    - Percent improvement in days in Accounts Receiveable (AR), based on gross revenue
    - Percent change in gross revenue captured
    - Percent change in number of clean claims
    - Percent change in the reduction of denials

Core Area 3: Health System Development & Community Engagement

The Rural Health Manager will continue to be involved with ST segment elevation myocardial infarction (STEMI)/Stroke system development activities. Future project plans involve a stroke planning advisory group that includes rural hospitals to assist with developing a statewide stroke system. Flex funds will also be used to provide consultant staffing resources to organize the startup of the trauma registry, assist with training of trauma registrars at the smaller rural hospitals, and provide ongoing assistance with this process for at least the first year of startup.

We will also provide financial and technical assistance to one CAH and their Public Health Region to conduct a community needs assessment and/or implementing best practice activities identified by their community needs assessment.

Process measures include:

- Number of CAHs engaged in regional and/or national stroke programs
- Number of CAHs that receive technical assistance (TA)
- Number of CAHs using trauma registry
- Number of CAHs receiving support and/or TA to support them in conducting community health needs assessments
- Number of CAHs that have completed a community needs assessment (including the development of strategies to address identified needs)
- Number of interventions implemented as a result of needs identified by CAHs conducting community needs assessments
- Number of CAHs that report improvements in conditions addressed by their community health needs interventions at subsequent needs assessments

Network Description

We have several networks addressing various parts of the core areas. There is the Rural Health Coalition which meets monthly and is comprised of the CEOs from the 13 CAHs. This group monitors, guides, and collaborates across a wide range of issues affecting CAHs, including the Flex and Small Rural Hospital Performance Improvement (SHIP) programs. There is a Quality Improvement Network which meets regularly and is made up of quality improvement directors from the 13 CAHs. They are often funded in part by Flex dollars for specific pieces of work. Finally, there is the Financial Improvement Network that meets regularly and is comprised of the Chief Financial Officers from the 13 CAHs. This group has used Flex funds to support quality improvement around options in Core Area 2.

Anything that is developed with Flex funds has output and outcome measures that are reported at the end of the project. Output measures have been easier to quantify. There is great collaboration in developing these projects so that they reflect both the purposes of the grant and bring real value to the CAHs. In the past year we focused on Lean training and all participating hospitals had projects that they measured and reported at the end of the year. Lean culture has taken root in most of these hospitals as a result.

Collaborative

An important collaborative for us involves the New England Rural Health Round Table which brings the six New England states together and has been important for a number of years. Out of this collaborative was also developed the New England Performance Improvement (NEPI) Network, which focuses on things we can do together across the six states for quality improvement. This has included purchasing online education, special courses offered in each state, and other efforts to improve quality and performance.

Much of the work is measured in outputs with broader goal of having effects on outcomes from the education and training offered. These outcomes would include

New Mexico

Best Practice
The New Mexico Flex Program is working with community health councils within the state. These councils strengthen partnerships, bring new resources into their communities, improve collaboration among programs and services, and develop joint programs. Three of the nine communities where critical access hospitals (CAHs) are located have indicated access to care as a priority health improvement issue. The Office of Primary Care and Rural Health, together with the New Mexico Department of Health Office of Health Promotion and Community Health Improvement, will provide support to the health councils that have indicated access to care as a priority health improvement issue in developing and implementing a collaborative project designed to enhance the rural health delivery system.

This best practice will be measured by the number of CAH and Community health Councils conducting a collaborative community health needs assessment. After survey the community health councils the Flex coordinator was able to identify communities that are willing to collaborate with the local CAH.

Core Area 1: Quality Improvements
The New Mexico Flex Program intends to build upon the well-established accomplishments of prior years through expansion, enhancement, and community engagement. In support of quality improvement, the NM Flex Program will continue its partnership with HealthInsight New Mexico the state's only designated Medicare quality improvement organization (QIO), maintaining and expanding the statewide rural health care quality network of providers it has established in the current funding period. HealthInsight will conduct quality and performance improvement activities, including quarterly quality meetings, trainings, webinars, online tools, and on-site meetings and assessments. In addition, HealthInsight will serve as a consultant to the state of New Mexico in participation in the special multi-grantee project focused on Medicare beneficiary health status improvement.

Core Area 2: Operational & Financial Development
The NM Flex Program will support CAHs in planning and implementing evidence-based strategies for improving operational performance through partnership with NMMRA, as well as through the efforts of New Mexico Health Resources (NMHR). NMHR, a current contractor under the state Rural Primary Health Care Act, will sponsor educational programs/seminars to this end, as well as provide support for hospital administrators to attend out-of-state activities such as the National Rural Health Association (NRHA) Annual Conference. These educational programs and seminars provide opportunities for CAH staff to increase and enhance their financial and operational skills, as well as continue to build on the relationships established in the Quality Improvement Network.

Core Area 3: Health System Development & Community Engagement
The NM Flex Program will continue its partnership with the Emergency Medical Services (EMS) Bureau, located within the NM Department of Health's (NMDOH) Epidemiology and Response Division, to provide targeted EMS regions with training, communications, recruitment and retention of personnel, and the improvement of EMS medical direction. In addition, the NM Flex Program envisions much greater community engagement through a planned partnership with the Office of Health Promotion and Community Health Improvement, co-located with the Office of Primary Care and Rural Health (OPCRH) in the Health Systems Bureau. In this effort, over the next five years the program will provide support for the collaboration of CAHs and communities through county health councils to jointly develop and implement projects/initiatives to address unmet health and health service needs.

New York

Best Practice
Ellenville Regional Hospital, a critical access hospital (CAH), enrolled in the Health Resource and Service Administration (HRSA's) Patient Safety and Clinical Pharmacy Services Collaborative to help improve the health status and safety of our patients with multiple chronic conditions. One way to meet this objective was to create a seamless process of medication management as patients transition within and/or across organizations. With tools from HRSA, they established systems facilitating medication event reporting and identification, encourage adverse drug event and medication event reporting, and we routinely share results with staff and leadership. The hospital successfully developed and implemented a source of accurate patient medication information available to all persons involved in the health care of an individual.

Consumers have complete medication reconciliation on admission, transfer and discharge and a post discharge call-back to discuss concerns with medications. By the end of 2012, Ellenville estimated over $1.8 million savings to the health care system through significant reduction in medication misadventure by community members. Ellenville's participation in HRSA's Patient Safety and Clinical Pharmacy Services Collaborative has resulted in national recognition and four national awards for their performance.

Ellenville Regional Hospital provided our office monthly updates on their progress.

Core Area 1: Quality Improvements
New York has formed a network among their CAH quality improvement (QI) staff. The network has monthly conference calls/webinars and three yearly meetings. The network is reporting their Medicare Beneficiary Quality Improvement Program (MBQIP) data, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores and working on improving their scores.

Core Area 2: Operational & Financial Development
New York has formed a CEO/CFO Performance Improvement Network. Financial assessments have been conducted and plans developed based on the findings. Additionally, ten financial indicators are monitored on a monthly basis.

Core Area 3: Health System Development & Community Engagement
CAH community service plans are reviewed and shared with their rural health networks to determine collaborative activities to address needs.

Network Description
Please see core area information above.

We review data and performance on a monthly basis.

Collaborative
In New York, we collaborate with the quality improvement organization (QIO) and the Hospital Association on network activities.

North Carolina

Best Practice
Lean implementation in CAHs.

This best practice will be measured as follows:

- Number of rapid improvement events
- Number of active value streams
- Number of staff actively participating
- Return on investment (savings/investment)

Core Area 1: Quality Improvements
North Carolina has a long history of supporting quality improvement efforts in hospitals. The NC Office of Rural Health & Community Care has worked collaboratively with the North Carolina Hospital Association (NCHA) and the Carolinas Center for Medical Excellence (NC's quality improvement organization) to improve core measure and Hospital Compare reporting. This work will continue and expand in line with the Medicare Beneficiary Quality Improvement Project (MBQIP).

A new initiative for 2013-2014 will be to identify up to four NC critical access hospitals (CAHs) that require intensive on-site technical assistance with their core measure scores and/or HCAHPS scores. We will be contracting with a private consulting firm (NCHA was instrumental in identifying this firm) who will provide this technical assistance to the selected CAHs.

Core Area 2: Operational & Financial Development
Currently there are three active Carolina Lean Collaboratives with a total of 18 rural hospitals participating in three-year projects to transform the culture of their organizations. While this can be seen as a quality improvement tool, the reality of

Lean is that when it is done correctly, it changes the way the hospital operates as the culture of the organization embraces systematic, ongoing improvement. The most successful hospitals have seen multi-million dollar returns on these efforts and the entire staff is engaged in improvement like never before. The NC Office of Rural Health & Community Care believes that Lean Management requires a change in culture beyond the implementation of Lean tools and that it is the future of health care management. For 2013-2014, we will be providing funding to six hospitals so they can continue their Lean journey.

We have two new initiatives for 2013-14: 1) A contract with the University of North Carolina Sheps Center which will fund the development of a NC-specific financial indicator report for all 21 NC CAHs and also the establishment of a CAH CFO learning collaborative; and 2) A pilot project with Truven Health Analytics will be initiated (NCHA will hold the contract with Truven). Five or six CAHs will participate in a pilot project whereby the CAHs will gain access to the Truven Action Operational Improvement (OI) product for the purpose of improving financial performance especially as it relates to departmental staffing and productivity. One benefit of the Action OI product is that these CAHs will have comparably sized CAHs and small rural hospitals with which they can compare and create targets/benchmarks (by department).

Core Area 3: Health System Development & Community Engagement
A new initiative for 2013-2014 is a contract with East Carolina University Department of Psychiatric Medicine. This will fund the establishment and administration of a statewide tele-psychiatry program that allows referring CAHs to utilize consulting providers at a remote site to provide timely psychiatric assessment and rapid initiation of treatment for patients who are at the referring CAH's emergency department and are experiencing an acute mental health or substance abuse crisis.

North Dakota

Best Practice
Community Health Needs Assessments (CHNA) Facilitation and Support

The Center for Rural Health (The Center) in North Dakota uses an assessment process involving multiple visits to the community, centered on convening a broad-based Community Group that reviews data and information to identify health needs of the population, provides qualitative input, and makes recommendations to the health facility. Specifically, the Community Group reviews data collected from a community survey, health professional survey, focus groups, key informant interviews, and secondary data about health conditions and outcomes of area residents and then works to identify and prioritize the health needs of its community. In-depth reports for each assessment detailing its findings are provided.While the needs assessments are ongoing, results to date reveal that

although each community is unique and has needs specific to it, several broad categories of needs have emerged that are common to multiple communities throughout North Dakota.

The dominant concerns among assessed communities involve the following:

- health care workforce shortages
- obesity and physical inactivity
- addressing mental health and substance abuse issues
- chronic disease management

The Center has worked with nine critical access hospitals (CAHs) on strategic planning related to implementation strategies to address significant needs identified in CHNAs, including facilitation of strategic planning workshops and drafting plan reports.

These activities meet federal regulation requirements of the Patient Protection and Affordable Care Act for charitable hospitals. To help ensure compliance with regulations, the Center for Rural Health has developed a checklist to use when preparing a community health needs assessment written report and implementation strategy.

Core Area 1: Quality Improvements

- Encourage public quality reporting
- Encourage (maintain) CAH participation in the Medicare Beneficiary Quality Improvement Project (MBQIP)
- Use ND CAH Quality Network to identify specific quality benchmarking and quality improvement activities
- Collaborate with other quality improvement-related initiatives involving ND CAHs and emergency medical services (EMS)

Core Area 2: Operational & Financial Development

- CAH Finance training sessions assist CAHs in identifying potential areas of financial and operational improvement
- Support revenue cycle management analysis to increase hospital revenue and cash flow

Core Area 3: Health System Development & Community Engagement

- Support the inclusion of EMS into local and regional trauma systems of care
- Support CAHs and communities in conducting assessments to identify unmet community health and health service needs
- Support CAHs and communities in developing collaborative projects to address unmet health and health service needs
- Support for the sustainability and viability of EMS within the community

Network Description

The sustainability and success of the North Dakota CAH Quality Network has been a significant contribution to all of ND health care. The Network is supported by Flex

funding and other funding secured through the Network's efforts. All 36 of the state's CAHs are members, and over the past five years regional networking between CAHs and large referral centers has strengthened tremendously due in part to the efforts of the Network.

Projects over the past two years have included: development of a ND Uniform Initial Credentialing form; participating in statewide systems of care for ST segment elevation myocardial infarction (STEMI) and stroke; maintaining a standardized checklist for CAHs to use in managing their Centers for Medicare and Medicaid Services (CMS) Conditions of Participation; development of a highly utilized listserv; and other modes of communication including a website and newsletter.

The Network has developed a reputation as the go-to place for CAH quality questions. There is trust among the members, Network staff are highly regarded and a trusted resource, and CAHs are moving in a positive direction toward improving quality outcomes. This Network is successful because of its members and partners CAHs helping CAHs and remaining true to their mission.

The ND Flex program uses TruServe, a web-based tracking system that allows the CAH Quality Network to monitor and report progress that is tailored to our project needs. A focus will also be on the measurement of outcome measures (participant surveys, interviews with key decision makers, and other impact measurement techniques). The outcome measure will help to identify the so what effect and impact of the action. The CAH Quality Network will monitor process measures to show what was done and the outcome measure to identify the effect of what was done. Both the outcome and process measure tracking will help us to gain insights into the impact or benefit of our actions.

Collaborative

The ND Flex program's approach has included working collaboratively with key stakeholders through its CAH Quality Network's advisory committee, which includes representation from the ND Department of Health (division responsible for surveying and certifying CAHs), the ND Hospital Association, the state's quality improvement organization (QIO) ,ND Health Care Review, Inc.

Collaborative efforts have been on topics, for example, state stroke and STEMI systems of care; vendor rates for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); and, for MBQIP, the QIO and CAH Quality Network collaboratively host meetings with a focus on data collection issues, questions, and concerns related to hospital reporting measures. Relationships with stakeholders have grown over the past five years. The Network members feel strongly about its value within the state and strive to fully meet the vision to be the state's leader in rural health quality.

The ND Flex program uses TruServe, a web-based tracking system that allows the program to monitor progress by capturing the activities of staff, information later

used to provide detailed and accurate reports. Various Flex participant surveys are also utilized.

Ohio

Best Practice
What makes the Ohio Flex Program unique is our ability to customize services and activities to meet the diverse needs among the 34 Ohio critical access hospitals (CAHs). In addition, we are able to leverage Flex funding with other local resources to maximize support to Ohio CAHs. The Ohio Flex Program has aimed to provide assorted activities and services to encourage the participation of CAHs at whatever level is appropriate for their individual hospital. The Flex Program has successfully adapted to the changing healthcare landscape in terms of quality, financial, operational and community engagement and health systems development to keep the Ohio CAHs in line with national standards. Ohio CAHs have continued to produce excellent quality outcomes and are staples in their rural communities. Each Flex program initiative experienced continuous growth as we pay close attention to the needs of the hospitals and the recommendations of our vendors. Each vendor is asked to provide feedback and recommendations for next steps that will lead us closer to the goal of improved financial, quality and operational improvement. As we receive the recommendations, we adjust and plan our next steps.

All quality activities are measured and monitored with the use of our quality improvement tools that track measures, trends and benchmark in order of the Flex Program to effective analysis effective interventions.

Core Area 1: Quality Improvements

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Performance Improvement Plan (Target Setting Project)

  Eight Ohio CAHs are participating in the Performance Improvement Plan (PIP) for HCAHPS project, which is an opportunity for CAHs to concentrate on HCAHPS and develop a core group of peers to share best practices and their experience in implementing a quality improvement intervention. The Quality Improvement (QI) Network provided baseline data, benchmarks and trends for HCAHPS performance. HCAHPS benchmarks included all areas by state and the nation including both CAH and prospective payment system (PPS) hospital cohort analysis.

  Each of the participants has identified which HCAHPS measures they will focus on and what interventions they will implement. Ohio CAHs have selected interventions on an individual level which may or may not correspond with what other Ohio CAHs are doing.

- Patient Safety Consortium

Twenty Ohio CAHs are participating in the CAH Patient Safety Consortium, which is facilitated in collaboration with the Ohio Hospital Association (OHA). The CAH Patient Safety Consortium is in its second year and continues to engage additional CAHs. OHA provides technology for data collection, internal notification, investigation and analysis of patient safety performance based on the Preventable Harm Index model. CAHs are able to participate in benchmarking patient safety indicators. To supplement the technology and benchmarking of patient safety indicators hospitals are receiving training and education to improve patient safety performance based on their identified needs.

Core Area 2: Operational & Financial Development

Each year the Flex Program selects several hospitals depending on need to receive individual financial assessments. Participating hospital will receive one-on-one consultation to include site visits, cost report analysis, revenue recovery assessment, charge master analysis and coding education. These services are provided throughout an eight month period. The participating hospitals also report back to the QI Network about how the quality of the services they receive and how they have utilize the services provided by the financial consultant.

- Rural Operational Assessments

  Nine Ohio CAHs are participating in an operational improvement project. Each of the participating hospitals is provided with a Rural Operational Assessment (ROA) in order to provide baseline data and identify areas of concern. The ROA includes comprehensive analysis of hospital operations integrating functional cost excess, staffing and productivity excess and clinical cost excess with a focus on quality, outcomes, patient safety and patient satisfaction. Data and assessments are then analyzed and reviewed by the hospital with support for a consultant to develop a plan to address areas of concern. At this time, the Ohio CAHs are in the second year of the project and working to develop the plans to address identified concerns and will select interventions. As new hospitals participate in the workgroup hospitals will be at different levels of implementation. Each hospital will be provided with an updated ROA each year to monitor performance.

Core Area 3: Health System Development & Community Engagement

The Flex Program support emergency medical service (EMS) collaboration between CAHs and local EMS providers. In 2013 the Flex Program supported collaborative projects in two Ohio regions. Avita Health Systems established CAH-EMS Council in Crawford County and conducted the 2013 EMS Summit in Crawford County. The EMS Summit trained and educated over 140 EMS and rural health providers in Crawford County and surrounding areas. This supported the recruitment and retention of EMS providers in the Crawford County area especially those that are volunteer workers. Fayette County Memorial Hospital provided training and education to support EMS providers in their county affiliated with the critical access

hospital. Fayette County Memorial Hospital provided First Responder and Basic emergency medical technician training to eight individuals in efforts improve response call time and quality of care.

Network Description
Ohio has organized a CAH Quality, Financial and Operational Improvement Network that consists of 25 out of the 34 Ohio CAHs. Participants have access to quality management tools, technical assistance, benchmarking activities, and networking. CAHs even have direct access to their own data to conduct individual analysis instantly.The Flex Program is partnering with iVantage Health Analytics, Inc. to work with the QI Network. iVantage technologies both collect and report data for each participating Ohio CAH and to enable the aggregation of hospital specific indicators into an electronic benchmarking system. The iVantage quality improvement tools allow for comparing local performance in real time, to national and state data. The key components of the QI Network include process of care measures, financial, emergency department and operational benchmarks with an emphasis on the Medicare Beneficiary Quality Improvement Project (MBQIP).

Quality activities are measured in various ways through the structure of the Ohio CAH Quality, Financial and Operational (QI) Improvement Network analytical tools. iVantage Health Analytics is used to collect data, evaluate projects and provide reports to analyze quality, financial and operational performance. Reports and evaluations are customized to collect the appropriate information to determine what is working well, were improvements can be made and how participants view the project or activity. Tracking data trends and benchmarking pre and post interventions is the foundation of the QI Network project implementation plans.

Collaborative
The Flex Program is part of several different types of collaboratives both with formal and informal participation. The Flex Program collaborates with the Ohio quality improvement organization (QIO), Ohio KePro. In addition, the Flex Program collaborates with the Ohio Hospital Association and with the CAH Patient Safety Consortium. While CAHs and the Flex program provide a rural perspective with Coverdell Stroke Program's Transitions of Care Project, the Ohio Department of Health Heart Disease and Stroke Prevention Council, Ohio KePro Learning and Action Network: Transitions of Care and 30 Readmission Rates and the Ohio EMS Board formal activities have not been developed. In some cases the QI Network is working on developing formal activities that include identifying measures and a structure to collect data as well as provide education to the CAHs.

QIO activities are measured in various ways through the structure of the Ohio CAH Quality, Financial and Operational Improvement Network analytical tools. The intended outcome when working with the Ohio KePro is that The Patient Safety Consortium is measured through the use of tools provided in the preventable harm index web based reporting tool. The intended outcome is to improve patient safety measure performance and to share best practices.

Oklahoma

Core Area 1: Quality Improvements
Oklahoma is actively involved in a multi-state quality and performance improvement project as well as providing a subscription to Quality Health Indicators (QHi) for participting hospitals. The Flex Program also provides a number of webinars to the hospitals through our state's hospital association.

Core Area 2: Operational & Financial Development
The Oklahoma Flex Program will provide feasibility studies for hospitals on an as-requested basis. In the Fall of 2012, Oklahoma succesfully launched a collaborated conference with our rural health association and primary care association. In addition, hospitals are also able to participate on webinars hosted by our state's hospital association.

Core Area 3: Health System Development & Community Engagement
The Oklahoma Flex Program is well known throughout the state by our work on the community health needs assessment. We have worked in almost every community with a hospital in the state. We provide hospitals with access to the Comprehensive Advanced Life Support (CALS) training programs on a regional level in the state and have had great success.

Oregon

Best Practice
Oregon Flex has succeeded in the area of financial and operational improvements through our partnership with the Oregon Association of Hospitals and Health Systems (OAHHS). This partnership allows us to assist our critical access hospitals (CAHs) during the implementation of health care reform in Oregon by utilizing the resources of OAHHS and leveraging the available Flex dollars.

We have measured the success of this program through the participation of CAHs and their ability to respond to change.

Core Area 1: Quality Improvements
The Oregon Flex Program continues to conduct the majority of quality improvement activities through collaborative relationships and established CAH networks, such as the Oregon Rural Healthcare Quality Network (ORHQN). The ORHQN is a quality and performance improvement network of Oregon's CAHs. More than half of the CAHs in Oregon are participating in web-based benchmarking Quality Health Initiative (QHi).

We will continue to work with our partner organizations to assist CAHs in utilizing QHi to streamline required data reporting to organizations such as the state hospital association, quality improvement organization (QIO), Oregon Patient Safety Commission, and to the Centers for Medicare and Medicaid Services (CMS)

Hospital Compare website. ORHQN will assist CAHs with HCAHPS implementation and improving patient satisfaction results. ORH will work with OAHHS and ORHQN to determine benchmarking needs of Oregon's CAHs.

The Flex Program continues to support ORHQN's extensive training and assistance for CAHs in implementing TeamSTEPPS, an evidence-based teamwork system developed by the Agency for Healthcare Research and Quality (AHRQ) and the Defense Department. ORHQN will work with hospitals that have received training to encourage continued use of patient safety surveys.

A top priority for Oregon's CAHs and Flex Program is a continued focus on quality improvement activities relating to health information technology (HIT). We will continue to partner closely with the hospital association to support CAHs with implementing electronic medical records (EMRs) and creating community health information exchanges (HIEs). OAHHS will continue to convene stakeholders and conduct on-site visits of CAHs to help develop comprehensive HIT plans for their communities and train CAH clinicians and staff on meaningful use of EHRs and HIEs. The Flex Program, in partnership with the Oregon Emergency Medical Services (EMS) Office and Oregon Fire Fighters Association, offers a web-based database for EMS agencies throughout the state to identify and collect run data.

Core Area 2: Operational & Financial Development

The Oregon Flex Program will continue to work with our partners to encourage collaborative learning among Oregon CAHs by developing educational programs utilizing evidence-based improvement curricula, such as the principles of Lean/Six Sigma. We will establish user groups for hospitals to share learning and problem-solve as they implement operational improvement techniques to improve efficiency and reduce unnecessary costs. We plan to conduct financial and operational assessments of CAHs and to strengthen performance through collaboration with the state hospital association and established Rural Health Reform Initiative (RHRI). We will develop productivity benchmarks and share evidence-based practices by identifying successful hospitals.

ORH will partner with OAHHS to support the RHRI to help sustain and support Oregon's rural hospitals and health systems in this time of reform. RHRI has dedicated resources to studying health care data about cost, utilization, quality indicators and workforce. They have created a dashboard of four areas to assess all these indicators. ORH will work with all 25 CAHs to participate in the RHRI to develop ideas and solutions for long term sustainability. ORH will provide technical assistance to CAHs to better understand health utilization in their community and maximize market share for increased revenue.

Using the National Center for Health Statistics data to predict demand for inpatient services in a hospital service area, we will assist hospitals to identify services for which patients are seeking treatment outside of the service area. We also calculate actual market share and provide hospitals with a financial analysis of the impact of capturing low intensity diagnosis-related groups (DRGs). Flex funding has allowed

the ORH to create a rich and comprehensive Primary Care database that is continually updated. This data is used for all of our community assessments and to create standard community profiles for each CAH rural community.

Core Area 3: Health System Development & Community Engagement
We will continue to dedicate funding and technical assistance to conduct community needs assessments to assist CAHs with state and federal reporting requirements. These activities will assist CAHs to implement community accountability programs and consistent reporting of community benefit activities. The result of these community planning and assessment activities will enable CAHs to better meet the needs of the community, and as a result enhance the health of their community.

We will continue to employ the Community Health Improvement Partnership (CHIP), which is a community-based collaborative designed to facilitate health care system development by engaging community members and utilizing qualitative and quantitative health data. CHIP partners include the CAH, solo practitioners, rural health clinics, and federally qualified health centers (FQHCs) as well as community employers and civic leaders. ORH will continue to revisit previous CHIP sites to quantify the community and provider level impact that resulted from network activities. In addition, we will support the existing CHIP processes in six local CAH communities through a competitive application process. Communities will receive technical assistance to review progress and impacts of collaboration, partnerships and assistance in developing new goals.

The Oregon Flex Program remains committed to strengthening EMS services as an important component of collaborative delivery systems and will continue to engage in performance improvement activities with EMS agencies. ORH's overarching goal in the arena of EMS is quality improvement. Through leadership training, we will provide technical assistance to improve business practices and increase EMS personnel effectiveness. We will continue to provide monthly EMS and trauma based continuing education webinars to rural EMTs and trauma coordinators. Through our partnership with the Oregon Department of Transportation and the state EMS office, we will continue innovative low frequency/high intensity trauma simulations to further integrate EMS providers with CAHs throughout rural Oregon.

Network Description
Oregon Flex works closely with a number of networks. These networks work closely with the Flex program and in many cases, each other. Networks include ORHQN, RHRI, OAHHS and Rural Health Coordinating Counsel (RHCC). The ORHQN and the OAHHS both work on improving quality. The OAHHS/RHRI both work on financial and operational improvement and the OAHHS and RHCC work on community development.

We have created a Flex Program performance scorecard that allows us to measure whether and to what degree we met each objective listed in our annual work plan. Just as a program evaluation yields recommendations for improvement, the SRHP will contain recommendations to guide future Flex Program goals and activities. We

have historically alternated between internal and external evaluations of the Flex Program. The internal evaluations tend to be more qualitative in nature, while the external evaluations for which we have contracted with outside experts yield more quantitative data. This grant year we will contract for an external evaluation.

Collaborative
Oregon Flex Program works closely with OAHHS in quality and financial improvement for CAHs. Through our partnership, the RHRI is working to sustain CAHs and help them adapt with the implementation of health care reform. Additionally we have developed a robust Partnership for Patients program. We work closely with Accumentra, our QIO, to increase quality reporting and understanding of quality measures. Flex has with the Oregon Trauma and Health Systems Office to develop a system to collect data and increase rural training to better integrate rural EMS into the health care system. Flex also works with the Telehealth Alliance of Oregon on a learning series to help CAHs understand the fundamentals of HIT and telehealth utilization. With each collaborative project, the Flex program requires specific measurements to judge how the program is utilized and the outcomes of the program.

Each Scope of Work (SOW) agreement within the collaborative lays out a series of agreed upon outcomes. These outcomes are measured through the process measures that can include data on the number and types of participants, number of system changes, and measureable quality improvements. Process measures vary depending on the type of activity.

Pennsylvania

Best Practice
Two of the Pennsylvania critical access hospitals (CAHs) came together to participate through Penn State University Continuing Education in the Toyota Production System (TPS) for Healthcare Program. Each CAH had 8 staff (16 total) trained in Lean rinciples. Each hospital had two or three teams that selected a performance improvement project to implement using Lean Principles. Both CAHs are further implementing these Lean Principles in their facilities this year.

Each team measures the financial savings of their project. At the conclusion of the program there is a "Report Out,”and the team identifies the savings financially and if possible in hours saved as well.

Core Area 1: Quality Improvements
In coordination with our quality improvement organization (QIO), an evidenced-based protocol project will be initiated. A baseline measurement for the protocol will be established at the beginning of the project and a remeasurement will occur at the conclusion.In coordination with our QIO Part II of the Agency for Healthcare Research and Quality (AHRQ) Culture of Patient Safety survey will continue with a survey at the conclusion.

Core Area 2: Operational & Financial Development

- Rural Operational Assessment program: Using iVanatge's iBenchmark program clinical, general ledger and payroll data will be utilized to generate operational, financial and clinical benchmarks at the diagnosis-related group (DRG), cost center and physician levels.
- Pennsylvania CAHs receive cost-based reimbursement for Medicaid. Medicaid cost-reports are collected from all the CAHs and verified for accuracy before being submitted to the state Medicaid agency.
- The Toyota Production System for Healthcare Program will be offered to 16 CAH staff. Using Lean principles the staff participate in a Lean collaborative.

Core Area 3: Health System Development & Community Engagement

Assistance is being given to a select number of CAHs on their Community Health Needs Assessments (CHNA) by using the Healthy Communities Institute system. The CAHs will not only use the system to track their progress on their (CHNAs) but also collaborate on programs to improve health outcomes in rural Pennsylvania.

Working in collaboration with the Pennsylvania Trauma Systems Foundation, three CAHs are pursuing Level IV Trauma designation. Educational support and trauma system registry support is being provided.

Network Description

- The Pennsylvania CAHs have come together as the Pennsylvania Critical Access Hospital Consortium. The CAHs meet on a quarterly basis for education on the core areas of the Flex Program. The Pennsylvania Trauma Systems Foundation, Quality Insights of Pennsylvania and other state agencies are present at most of the meetings. The CAHs often present on specific initiatives for "shared learning."
- Six of the CAHs are also members of the Pennsylvania Mountains Health Alliance, which provides group purchasing and information technology support to the CAHs. The Pennsylvania CAHs use the Hospital Strength Index through iVantage Health Analytics to measure their progress on the core areas of the Flex Program.

Collaborative

Quality Insights of Pennsylvania (QIP) has been a strong partner over the years developing a number of quality improvement collaboratives.

The Pennsylvania Trauma Systems Foundation (PTSF) is working with the CAHs on Level IV development and the Rural Trauma Team Development Course.

The Hospital and Healthsytem Association of Pennsylvania works closely with Pennsylvania Office of Rural Health (PORH) on a number of initiatives to support rural hospitals. Last year, PORH, through Flex funds, helped support an educational program on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

PORH, being located at Penn State University, works closely with a number of the Colleges (HHS, Engineering, Nursing) to provide unique programs to the CAHs.

QIP typically conducts measurements at the beginning and at the conclusion of one of its Quality Improvement Collaboratives. PTSF is collecting trauma system data through its registry program. For programs such as Lean education the financial savings for each project is collected at the "report out."

South Carolina

Best Practice
The South Carolina Flex Program has been working for the past two years on the development of a Community Paramedicine (CP) pilot program in one of the critical access hospital (CAH) communities in the state. This community had five CPs trained through the Colorado Mountain College's national program in the spring of 2012 using Flex funds. During the last project year, to bolster the training of the CPs and to create necessary linkages for the State Emergency Medical Services (EMS) Office, the same CPs were afforded the opportunity to do local as well as national clinical rotations through Flex funding. The Flex Coordinator has developed a continuous working relationship with the local EMS Director and hospital CEO to develop a work plan for the program. This partnership resulted in the program receiving funding from the Duke Endowment in June 2013. The first CP patients were seen in September 2013 and the South Carolina Flex Program continues to be involved in supporting the overall evaluation of the program.

Measurement is in the form of trainings completed, program created and started and funds leveraged.

Core Area 1: Quality Improvements
Participate in Medicare Beneficiary Quality Improvement Project (MBQIP) to include quarterly CAH Quality Workgroup Meetings, staff trainings, and site assessments: measured by CAH participation in MBQIP and new projects established as a result of MBQIP.

Support and participate in South Carolina Hospital Association, Carolinas Center for Medical Excellence (quality improvement organization) and South Carolina Association for Healthcare Quality trainings with, and on behalf of, South Carolina CAHs: measured by increased knowledge, confidence, and satisfaction of CAH staff as well as new projects established as a result of trainings.

Support the development of quality programs for South Carolina CAH provider-based rural health clinics (RHCs): measured by RHC participation in quality programs and new projects established as a result of these programs.

Core Area 2: Operational & Financial Development
Provide revenue cycle management assessments and operational trainings for SC CAHs to include quarterly Financial Workgroup meetings, staff trainings and site

visits: measured by changes in CAHs' total margin, cash flow margin, operating margin, days cash on hand, days in net and gross accounts receivable, and Medicare revenue per day.

Support and participate in South Carolina Hospital Association trainings with, and on behalf of, South Caronlina CAHs: measured by increased knowledge, confidence, and satisfaction of CAH staff as well as new projects established as a result of trainings.

Support South Carolina CAH provider-based RHC participation in South Carolina Office of Rural Health (SCORH) financial technical assistance programs: measured by staff behavioral change and reduction in poor revenue cycle processes and financial outcomes in RHCs.

Core Area 3: Health System Development & Community Engagement
Support South Carolina CAHs and communities through Rural Health Networks (RHN) and other network development activities such as consultations, workgroup meetings, strategic planning, and staff trainings in order to support the development of collaborative projects to address unmet health needs: measured by changes in network member engagement, program development and knowledge, confidence, and satisfaction of RHN staff.

Support local and regional systems of care including ST segment elevation myocardial infarction (STEMI), Stroke, and Trauma networks: measured by active participation of South Carolina CAHs.

Support the sustainability and viability of rural EMS agencies through the development of South Carolina Community Paramedicine pilot programs, emergency medical technician (EMT) tuition assistance and annual leadership trainings: measured by changes in number of programs, number of EMTs, and knowledge, confidence, and satisfaction of EMS staff.

Network Description
There are two informal CAH workgroups that meet quarterly: one that is quality focused for chief nursing officers (CNOs) and Quality Directors and one that is finance focused for CEOs and CFOs. The two workgroups have one annual meeting each year to network, discuss their individual workgroup outputs, and to get Flex Program updates.There is also a South Carolina Small Rural Hospital Improvement Program (SHIP) Network which includes all five CAHs plus five other small rural hospitals. This network is focused on financial benchmarking and ICD-10 implementation, so there is overlap with the Flex Program Operational and Financial Improvement Core Area.

Activities are measured by CAH participation and new activities or projects undertaken by the hospitals as a result of participation in the workgroups as well as any realized quality or financial health improvements in the CAHs.

Collaborative
The South Carolina Flex Program works closely with the South Carolina Hospital Association and Carolinas Center for Medical Excellence on an informal basis. Many quality programs overlap for the hospitals so these entities meet on a semi-regular basis to check-in on hospital and/or project status(es).

South Carolina RHC quality programs are supported by national collaborations with the University of Southern Maine and state level collaborations with South Carolina Blue Cross Blue Shield, South Carolina Primary Health Care Association, and the South Carolina Medical Association.

Network activities are supported by another South Carolina Hospital Association collaboration, AccessHealth South Carolina. EMS activities are made possible by work with the South Carolina Department of Health and Environmental Control's Office of EMS & Trauma, four Regional EMS Offices, South Carolina EMS Association, and the Joint Committee on Rural Emergency Care (JCREC). SCORH also actively participates in the South Carolina Heart Care Alliance - bringing together STEMI, Stroke, Sudden Cardiac Arrest, and Heart Failure care under one umbrella group.

These activities are primarily measured through participation of the Flex Program staff and/or the CAHs. Intended outcomes include increased efficiencies and resources for rural providers.

South Dakota

Best Practice
During the FY2011 and FY2012 budget periods, Flex funds were used to designate all the state's rural hospitals (including the 38 critical access hospitals (CAHs)) as Trauma Facilities.

This best practice will be measured through two activities. First, we will ensure the hospitals maintain their Trauma Facility designations trough on-site recertifications every three years. Second, eight performance measures have to been developed that will be monitored through a state-wide trauma registry.

Core Area 1: Quality Improvements
- Will conduct the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture. This also includes supporting projects that improve patient safety in CAHs
- Will participate in the multi-state Medicare Beneficiary Quality Improvement Project (MBQIP)
- Will assist the state's QIO with their 10th Scope of Work to increase the number of CAHs reporting to CMS Hospital Compare. This also includes supporting projects that improve quality of care in CAHs.
- Will support Emergency Nursing Pediatric Course (ENPC) for 40 CAH nurses

Core Area 2: Operational & Financial Development

- Will complete the annual Access Critical Enhanced Reimbursement Study to determine which CAHs are eligible to receive enhanced Medicaid reimbursement
- Will work with the South Dakota Healthcare Financial Managers Association (HFMA) to host a CAH Coding/Billing Bootcamp
- Will work with the Healthcare Financial Management Association (HFMA) to host a CAH Financial/Operational Strategic Planning Workshop
- Will assist CAHs with 340B Drug Discount Program implementation
- Will support CAH financial and operational assessments

Core Area 3: Health System Development & Community Engagement

- Developing a trauma registry to track trauma outcomes
- Providing technical assistance for trauma facility recertification
- Supporting trauma coordinator and registrar education
- Supporting Trauma Nurse Core Courses (TNCC) for CAHs
- Assisting with rural community trauma team development
- Supporting Emergency Medical Services (EMS) Leadership Development

Network Description

We involve our partners in almost everything we do because most of our hospitals are part of health systems. We rely on them to help carry out everything we do. We always include our quality improvement organization (QIO) and hospital association too.

Collaborative

To accomplish activities in Core Area 1, the South Dakota Office of Rural Health convened a Quality Improvement Collaborative. Members of this collaborative include the state's rural hospitals, hospital association, QIO, and three hospital systems.

To accomplish activities in Core Area 2, the Flex Program partners with the South Dakota Healthcare Financial Management Association (SDHFMA). Membership in SDHFMA includes the state's CAHs, the hospital systems, and the state hospital association.

To accomplish activities in Core Area 3, a Trauma Council was convened. The State Trauma Council partners with the Departments of Health and Public Safety in the development and implementation of the Statewide Trauma System. Members of the State Trauma Council represent statewide stakeholders across the continuum of trauma services that include the state hospital association, the state's hospital systems, trauma surgeons, ambulance services, and community/patient representatives.

Tennessee

Best Practice
The Flex program provided assistance to critical access hospitals (CAHs) to improve clinical, financial, and operational performance. The Flex program used an innovative medical quality rating system designed to assist hospitals in improving the quality of inpatient care. Public and proprietary measures of performance were used to compare the quality of hospital care against national, State, and local standards. This was achieved by using a variety of outcome measures to assign a composite quality score and rating by hospital. The objective was to provide a comprehensive, multidimensional analysis of medical quality and clear focus on areas where clinical improvement is needed.

The program goals were to unify multiple dimensions of quality performance into a composite score as follows:

- To rate CAHs against national performance within, and across, dimensions of quality
- To facilitate discussion and focused learning around the assessment, communication and deployment of quality metrics across all stakeholders in community health care delivery
- To facilitate learning around the proper way to assemble and aggregate quality metrics in understanding performance
- To facilitate the use of percentiles, statistical significance and other statistical algorithms in performance improvement efforts
- To prepare hospitals for the emergence of pay for performance programs based on hospital performance
- To foster improvement to embrace the central tenets of recent policies around value based purchasing

Core Area 1: Quality Improvements
CAHs have had the opportunity to participate in a quality improvement project focusing on improving hospital clinical care to patients with heart attacks, heart failure, and pneumonia. Participation also allows CAHs to benchmark their performance against regional, state, and national averages in addition to peer group comparisons. The project includes abstraction of clinical data submitted electronically for data analysis and comparative benchmarking. Educational workshops and conference calls are also conducted throughout the year.

For CAHs that have been abstracting and submitting clinical measure data to the Quality Improvement Organization (QIO) Warehouse, the goal was to improve care on one clinical measure. Additional goals include: acting on the data with a common-measure quality improvement (QI) project; agreement to publicly report their data; collaborative sharing of the quality improvement journey; and sharing of best practices in engaging leadership, front line staff, and physicians.

Core Area 2: Operational & Financial Development
Implemented the Hospital Strength Index (HSI)Performance Initiative which provides a comprehensive program for comparing general acute care hospitals

across a continuum of financial, value-based and market-driven performance indicators based on publicly available data. Benchmarks are based on publicly available data sources, including Medicare Cost reports, Medicare claims data and Hospital Compare quality reporting.

The HSI is the first rating system to incorporate market position, competitive intensity, and accountable care demand, modeled on research-based financial ratios that are most determinant of long-term financial sustainability. The HSI is a broad scorecard designed to reflect the complexity of the healthcare industry. The HSI strives to provide a holistic evaluation of hospital performance in the ever-evolving landscape of health care reform, value-based purchasing, transparency and related industry trends. Hospitals can access new benchmarking and peer-to-peer comparative analytics, new interactive mapping platforms for market visualization, and new marketing and branding solutions.

We will also utilize the Clinical & Operational Benchmarks Web-based product ("iBenchmarks") to integrate claims-level clinical data with payroll and general ledger data supplied directly by hospitals to produce a complete set of analytical tools enabling hospital decision makers to understand cost drivers, performance variance, comparisons to other rural and community hospitals, and practice patterns for individual members of the medical staff.

The tool and analysis focuses on the cost side of the value equation, a critical management priority in the new health care. The clinical and operational benchmarks product maps the general ledger to operational cost centers; functional and clinical. It evaluates operations, clinical effectiveness, safety and quality offering insights of unmatched depth giving rural hospital and CAH executives the information they need to act quickly and confidently on the areas of greatest cost opportunity and highest need. The Assessment shows the hospital's cost and quality position, value potential, and unique pathway to success and sustainability.

Core Area 3: Health System Development & Community Engagement
The Flex Program uses an innovative medical quality rating system designed to assist CAHs in improving the quality of inpatient care. Relying on both public and proprietary measures of performance, we will compare the quality of hospital care to national, state, and local standards using a variety of process, outcome, and patient satisfaction measures to assign a composite quality score and rating. This provides a comprehensive, multidimensional analysis of medical quality.

Network Description
The Upper Middle Tennessee Rural Health Network (UMTRHN), a coalition of hospitals and clinics in a six county area of upper middle Tennessee, has developed a Rural Health Cooperative (RHC) clinically integrated network model to work with area physicians to implement the Patient-Centered Medical Home model in conjunction with a new pay for value program. The Flex program has been an integral partner in the development of the RHC.

Program goals include:

- Providing community based care transition services to discharged hospital patients to help reduce unnecessary hospital readmissions (for those with congestive heart failure, pulmonary disease (COPD), asthma, and pneumonia)
- Expanding and enhancing community based programs for diabetes management
- Expanding and enhancing community based programs for respiratory illnesses (pulmonary, COPD, and asthma)
- Working with Medicare, Tenncare (Medicaid), and other healthcare payers to implement new payment programs that reward value based health care in the region

Collaborative
The Flex Program, in partnership with QSource, Tennessee's quality improvement organization, supports clinical quality improvement activities for Tennessee's CAHs through two primary activities: development and dissemination of individual and comparative data reports and onsite visits to assess and share best practices in quality improvement. QSource works closely with CAHs to accomplish transfer of abstracted clinical quality measurement data for pneumonia and heart failure patients. Using data from each CAH, QSource develops hospital level and comparative data reports for each measure of interest.

Quality Improvement (QI) Support for Participant CAHs:

- Conducting onsite visits for CAHs, as needed or requested, to provide clinical and QI technical support
- Conducting onference calls or webinars on clinical and QI process topics, including the sharing of best practices and tools
- Encouraging and supporting participation in the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Culture Survey
- Participating in quality improvement conferences such as the Rural Health Association of Tennessee annual meeting, or regional CAH meetings held by Tennessee Hospital Association (THA) or other state or rural partners such as the Rural Hospital Performance Improvement (RHPI) Project
- Facilitating an "all teach, all learn" sharing environment within the collaborative
- Assisting with accurate pneumonia and heart failure data abstraction (including AMI and SCIP)
- Promoting concurrent data collection and care management of pneumonia and heart failure patient populations

Communications with Flex program regarding performance improvement, project outcomes and issues, obstacles encountered, assistance needed, etc. are conducted via onsite visits, e-mail and/or phone discussions primarily by Qsource.

Texas

Best Practice
It is important to involve stakeholder input from the beginning. Measurement is in the form of the number of stakeholder meetings held.

Core Area 1: Quality Improvements

- Needs assessment for Texas critical access hospitals (CAHs) including baseline assessment of CAH participation in Performance Improvement Measurement System (PIMS) relevant measures
- Strategic plan development for Flex program based on stakeholder summit and needs assessment
- Targeted technical assistance to increase number of reporting sites through assistance collecting and analyzing data
- Conduct site visits to CAHs to provide technical assistance related to quality, benchmarking, performance, and recruit to participate in Medicare Benefiary Quality Improvement Project (MBQIP)

Core Area 2: Operational & Financial Development

- CAH needs assessment, strategic planning process and utilization of Flex Monitoring Team reports to identify Texas CAHs in need of financial and operational improvements
- Identify specific CAHs in need of on-site intervention financial/operational condition assessment activity and provide on-site consultative and educational services
- Activities above must collect baseline data and post evaluation data, with a follow-up behavioral acceptance evaluation following the assistance.
- Financial performance improvement training needs will be identified through stakeholder summit and needs assessment processes and Objective 1 activities listed above and will result in at least one educational activity
- Identify specific CAHs in need of intervention for financial consultation activity that would provide on-site consultative and educational services
- Development of evaluation for training including required Office of Rural Health Preparedness methodology

Core Area 3: Health System Development & Community Engagement
Needs assessment will identify Texas CAH health system needs, strengths, and on-going issues that can be used as a tool for system improvement.

Utah

Best Practice
The value of networks has been established. The network of the nine rural independent hospitals in the state has been a success. As an extension of this

network of hospital CEOs, subgroups of nurse managers and CFOs have been established. The nurse manager group has been a resounding success, and although the CFO group is early in development, it has already shown much promise.

Activities and programs of the network and subgroups are continually monitored to assure goals and objectives are met and that the programs add real value to the hospitals. The measurements are not quick numerical indicators. The measurements will be shown over time in improved care, decreased untoward incidents, improved morbidity and mortality, and increased satisfaction of hospital administration, staff, patients, and community.

Core Area 1: Quality Improvements

1) Initiated and continue to support meetings of the nurse managers of the nine rural independent hospitals in the state. This group is meeting three times a year, taking turns meeting at their respective hospitals. The nurse managers are engaged and enthused about these meetings, which last two days and cover a myriad of topics. They have the opportunity to network and share best practices. Attendance is monitored, as well as projects that result from these meetings, such as group quality initiatives.

2) One quality improvement project that came out of the nurse manager meetings was to arrange for opportunities for rural nurses to receive hands-on training at the University of Utah Hospital, which is a teaching and tertiary care hospital. Nurses from the rural hospitals spend several days at the University hospital shadowing and obtaining hands-on training in Labor & Delivery, Surgical Services and Peripherally Inserted Central Catheter (PICC). Emergency Department training will be added soon. We monitor this program in conjunction with the University by asking each nurse participant to complete a fairly extensive questionnaire as to his or her training experience.

3) The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) vendor market was canvassed and narrowed to about six vendors. Service offerings and quotes, which included group discounts, were summarized and then presented to the independent rural hospital CEOs, from which they choose a common vendor. We then worked with this vendor to set up all hospitals for HCAHPS reporting, and just recently completed site visits to all the hospitals to illustrate HCAHPS reporting capabilities to hospital management and quality personnel. With a common vendor and web-based access to all the HCAHPS data, we can monitor HCAHPS reporting real-time and communicate findings with the hospitals. This will also allow us to focus in on common low performance areas for improvement.

Core Area 2: Operational & Financial Development

1) Have collaborated with a larger hospital system in the state to provide ongoing ICD-10 conversion training to the independent rural hospitals. This training includes three-day boot camps and ongoing monthly webinars and

newsletters. The hospital system is willing to provide these training opportunities at no cost to the rural hospitals except some direct costs like textbooks. We have monitored participation of the hospitals in all training opportunities (e.g. boot camps, webinars) as well as assessment of value of the training.

2) We initiated and continue to support meetings of the CFOs of all the rural independent hospitals. The first meeting was a face-to-face meeting, and the second was held over a state-wide telehealth conferencing system. The CFOs have very much appreciated the opportunity to get together to network and share best practices. Initial projects included staffing efficiency models in which the CFOs shared ideas and models in the first meeting. They subsequently reported back during the second meeting with implementation of the models and reports of reduced full time equivalent (FTE) employees. Attendance is monitored as well as projects that are implemented from the meetings.

3) Equipment maintenance and service vendors were canvassed and a list narrowed for consideration. Summaries of services offered and costs (with group discounts) were presented to the CEOs of the rural independent hospitals, from which they invited three for presentations and eventually choose one common vendor. This vendor is in the process of taking equipment inventories at each facility, and will move equipment to the new agreement as it comes off current service agreement or new equipment is purchased. Will monitor actual cost savings at each facility.

Core Area 3: Health System Development & Community Engagement

1) Previously organized a governing board training event to which all board members and hospital administration were invited. The event began with a nationally known keynote speaker, Mr. Jamie Orlikoff, and then each of the hospitals were assigned a separate room to discuss Mr. Orlikoff's presentation and conduct specific strategic planning for the hospital. All participants completed assessment surveys of the training, and because of positive feedback, a similar event is being planned for 2014.

2) We have worked and provided funding for community needs assessments for a number of CAHs in the state. The National Rural Health Resource Center and Rural Health Works have assisted with the assessments, including conducting community focus groups. Once the assessment is completed, the National Rural Health Resource Center and RHW have presented findings to the hospital boards, administration and community leaders. Specific action items were delineated in these meetings and assignments for completion & follow-up made. Two additional assessments are planned for 2014. All of these were assisted with Flex funding.

3) Currently we are working on a contract for Community Apgar Program evaluations with Boise State University.

Network Description

A formal network of the nine rural independent hospitals in the state was organized in 2013. The network has articles of incorporation and by-laws, with the board chair position filled by one of the hospital CEOs. The state Flex program and Flex Coordinator work closely with this group to help advance programs and projects that take advantage of economies of scale with nine hospitals as a group, versus each hospital alone. There have been many successful programs implemented to help this group of hospitals, mainly along the lines of financial and operational improvement. For example, the hospitals entered into an agreement with a law firm in the state to provide unlimited initial legal advice and assistance for a nominal monthly fee. Other programs such as a common insurance broker for property insurance have been implemented. We are currently also working with the network to find a solution to behavioral health access issues and are focusing on potential telehealth solutions in conjunction with hospital systems in the state.

All the network programs are monitored to assess if the goals are achieved. For example, for the program to retain a common broker for property insurance, actual savings on property insurance costs are monitored, comparison with the detail of coverage is monitored, along with extras that were offered to the network as part of the up-front negotiating process, such as risk management services. Activities are also measured through satisfaction surveys given to the participating hospital CEOs.

Collaborative

Our Flex program works closely with the state quality improvement organization (QIO) on quality reporting, including MBQIP, HCAHPS and Hospital Compare. Our Flex Coordinator is an employee of the Utah Hospital Association (UHA) with whom we contract for that position, which increases the communication and collaboration between the UHA and the Flex Program. The Flex Coordinator is a member of the Utah Telehealth Network board, and as such is able to monitor and collaborate with telehealth activities in the state. The Flex Coordinator worked with the director of the Center of Rural Health (local rural health association) to obtain a network planning grant that was used to initiate and organize the network of the nine rural independent hospitals in 2013. Our strongest collaborations are with our rural hospital administrators, the Hospital Association, Rural Health Association, QIO, PCA, University of Utah and our largest hospital systems.

In working closely with the state QIO, quality reporting is continually monitored and assessed. Site visits are made when needed to help correct problems and assist. Quality reporting data are presented during the nurse manager meetings and discussed. Two quality improvement projects have been initiated (median time to ECG and patient falls) from these quality discussions with the nurse managers, with baseline data on both established with plans for ongoing monitoring to assess improvement.

Virginia

Best Practice
Site visits continue to be a best practice for maintaining cohesion among Virginia CAHs. PIMS are the only measures.

Core Area 1: Quality Improvements

- Support CAHs in implementing a multi-hospital quality/patient safety project, focused on leadership and organizational culture and as follow-up to previous areas identified by Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) Teamwork Perception Questionnaire and the TeamSTEPPS Teamwork Attitudes Questionnaire to determine pre and post measures
- Agency for Healthcare Research and Quality (AHRQ) Patient Safety Culture Surveys, establishing benchmarks for trending analysis
- Centers for Disease Control (CDC) Infection Control Programs for determining pre- and post-measures for infection control programs
- Enhance development of the Virginia Medical Interpreters Collaborative and Database

Core Area 2: Operational & Financial Development

- Support operational and financial improvement of Virginia's small rural hospitals and rural health clinics
- Financial/Operational Assessments: Support CAHs in identifying potential areas of financial and operational improvement
- Revenue Cycle Management: Increase critical access hospital (CAH) staff ability to better manage revenue cycles; foster financial integrity of pricing, charity care and bad debt policies; increase hospital revenue and cash flow; serve patients and customers by informing them upfront of financial obligations; improve hospital business and operational processes; and build department manager accountability for CAH financial performance.
- Charge Master Review: Maximize CAH net patient revenue; create an efficient and compliant charging mechanism; and produce patient-friendly billing processes
- Emergency Department (ED) Operational Improvement: Provide services and opportunities for networking and sharing best practices around CAH ED operations; improve appropriate patient triage, transfer, and treatment in the CAH emergency department; help CAHs benchmark ED performance data; and promote ownership and participation by ED medical directors
- Lean Training and Implementation: Support the continued spread of Lean Transformation techniques to CAHs; decrease readmission rates, unplanned readmissions, and defective hand-offs; increase patient and customer satisfaction; save CAHs both money and time; improve the quality of clinical, business, and operational processes in CAHs; and assist hospitals in making

improvements in their Centers for Medicare and Medicaid Services (CMS) and Medicare Beneficiary Quality Improvement Project (MBQIP) quality scores.

- Billing and Coding Education: Improve CAH staff understanding of CMS, National Correct Coding Initiative (NCCI), and Current Procedural Terminology (CPT) instructions as they apply to reporting and reimbursing these services; improve coding accuracy and compliance, to capture missed revenue and to increase productivity; and help CAHs prepare for ICD-10 conversion
- Board Education and Leadership Development: Improve and sustain the skill and knowledge of the CAH board of directors, including legal and fiduciary responsibilities and roles; help to educate CAH boards as to cost-based reimbursement, as well as alternative financial strategies to ensure sustainable revenue sources; educate CAH boards and leadership about health care reform models and how their hospitals can play a role in these models; and provide leadership and management education, support, and/or mentoring for CAH leaders designed to improve overall CAH financial and quality performance
- Financial Improvement Collaborative: Bring shared rural-specific financial expertise to CAHs at lower costs; facilitate discussion and analysis of common financial issues shared by CAHs, and create synergistic problem solving; develop a shared CAH financial knowledge base among CAHs, including best practices, tools, and information; develop peer to peer learning both informally, and through formal education; reduce the cost of education and support for CAH leaders; and provide the infrastructure for a multi-hospital collaborative that supports CAHs in planning and implementing evidence-based practices
- Review Flex Monitoring Team (FMT) reports to identify struggling CAHs within the state to determine where to strategically provide technical assistance to facilitate improved financial and operational performance

Core Area 3: Health System Development & Community Engagement

- Support the implementation of the objectives of the Virginia State Rural Health Plan (VSRHP)
- Draw attention to the existence of health inequities and identify strategies for promoting health equity in rural communities in Virginia, and support a Virginia Rural Health Conference
- Improve patient interactions through community engagement and participatory processes
- Support development of local and/or regional health systems of care
- Support CAHs and communities in developing collaborative
- Projects/initiatives to address unmet health and health service needs
- Support the inclusion of EMS services into local and/or regional systems of care and/or regional and state trauma systems
- Support CAHs and communities in developing collaborative projects/initiatives to address unmet health and health service needs

Collaborative
Virginia Rural Health Association (VRHA): Consists of organizational and individual rural health stakeholders.

Virginia Community Heatlhcare Association (VACHA): Members include community health centers, migrant health centers, healthcare for the homeless, rural health clinics, National Health Service Corps Sites, and associate members.

Virginia Association of Free and Charitable Clinics (VAFCC): Network of 53 member free clinics serving over 114 cities and counties throughout Virginia.

Virginia Telehealth Network (VTN): Hospitals, corporations, foundations, community healthcare association, state and local government agencies, and individuals.

The lead agency for each collaborative is responsible for measuring outcomes.

Washington

Best Practice
The Critical Access Hospital Network (CAHN) which has several projects listed above has been hard at work for several years to improve care transitions between their rural facilities and providers and the tertiary physicians and facilities in Spokane. Rapid transport of chest pain patients to a cath lab and potential stroke patients to a tertiary neurologist have been addressed. Last year they worked on improved management of chronic disease patients with better information sharing and coordination between rural and tertiary settings. Nurse case managers have been employed for each rural facility and their medical staff. Some transfer protocols have been mutually developed. This work has been well received by both rural and urban providers.

Measures will include:

- Number & percent of critical access hospitals (CAHs) participating in a care transitions/readmissions project
- Number and percent of CAHs participating in quality benchmarking activities
- Number and percent of CAHs participating in specific quality improvement activities

This year we will be looking at more outcome-focused measures, such as readmissions and others to be determined.

Core Area 1: Quality Improvements
The statewide Rural Health Quality Network (RHQN) assists 37 of 39 CAHs with submitting the Medicare Beneficiary Quality Improvement Project (MBQIP) quality data via the Centers for Medicare and Medicaid Services (CMS) Abstraction and Reporting Tool (CART); provide technical assistance on quality improvement projects related to MBQIP data; inventory the quality improvement projects

implemented based on MBQIP pneumonia and heart failure data and share lessons learned with all CAHs through webinars, conference calls, etc.; and plan for implementation of Phase 3 measures.

Measures: basic outputs; descriptions of quality improvement (QI) projects implemented related to MBQIP measures and lessons learned shared; trend MBQIP data.

Contract with RHQN to assist with Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Hospital Survey on Patient Safety Culture (HSOPSC), and infection control.

CAHN supports care coordinators in five critical access hospitals to improve care transitions between healthcare settings (hospital to hospital, home/physician, nursing home, home health) and reduce readmissions.

Coordinators will use the previously Flex-funded disease registry and referral tracking system.

Measures: Percent change in readmissions and other indicators identified to evaluate the effectiveness of care coordinator services in the hospital and clinic setting.

The Emergency Cardiac and Stroke System, reported under Core Area 3, also supports quality improvement by requiring CAHs to provide cardiac and stroke care according to national guidelines, and to do internal and regional quality improvement.

Core Area 2: Operational & Financial Development
New financial network to improve critical access hospital financial and operational performance. An advisory committee of CFOs and the State Flex Coordinator will be formed to identify educational needs, areas where financial and operational improvements are needed, and identify vendors where appropriate. Benchmarking, revenue cycle management, using financial indicators, joint contracting and purchasing, ICD 10, and Lean will all be considered. Four to six educational events and a statewide CFO conference specific to CAH finance and operations will be provided. Measures: Basic output and learnings; standard financial indicators.

Network of 19 CAHs to identify and share best practices for negotiating contracts with health plans and negotiate language and rates among members. Includes workshops on value based contracting for public and private payers, and what organizations need to do to prepare. Measures: Basic output and learnings; attempt to quantify operational and monetary savings.

Regional CAH Conference: The States of Alaska, Idaho, Oregon and Washington have for several years sponsored a regional CAH conference in Spokane, Washington. Several sessions are on finance and operations. Evaluation will be done according to Flex grant requirements.

Core Area 3: Health System Development & Community Engagement
In partnership with the Washington State Hospital Association (WSHA), we will continue implementation of the Washington State Rural Strategic Plan. Priorities are regional systems, medical home, and payment reform. A workgroup staffed by Flex and State Office of Rural Health (SORH) is tasked with developing models for rural health care delivery to address changing community needs (e.g., less inpatient care) sustainability of rural hospitals and clinics, and healthcare reform. We are thinking big and out of the box, and looking at regulatory barriers and opportunities to ensure the services needed in rural communities are available and sustainable.

We have a small project with a CAH (a public hospital district) to work with their county health department to complete a community needs assessment and develop an action plan to address community health risks and issues.

Support for regional systems of care includes support for CAHs to participate in the statewide Emergency Cardiac and Stroke System. We review their capabilities and policies and procedures for heart attack, cardiac arrest, and stroke care, quality improvement, and regional coordination. This year, efforts will focus on obtaining data from Get With the Guidelines for Stroke, a quality improvement program that over 50 hospitals, including several CAHs, participate in, and from the Clinical Outcomes Assessment Program, which has a registry for STEMI system performance.

Network Description
RHQN: supports clinical quality in 37 of 39 CAHs. (CAHN): supports six hospitals and associated rural health clinics in quality, finance and operations, systems development, care coordination, staffing, health information exchange and more.

Western Washington Rural Health Care Collaborative (WWRHCC): 12 plus rural hospitals. Flex supports finance and operations primarily around contracting and purchasing. Similarto CAHN, WWRHCC works on quality, finance and operations, systems development, care coordination, staffing, health information exchange (HIE) and more.

West Virginia

Best Practice
The best practice would be for each state to work collaboratively with the State Critical Access Hosital (CAH) Network. If they do not have one, it is important to form one. This has been the greatest achievement and joint collaboration that the state Flex program has ever had.

Continued collaboration monthly meetings with the CAH Network Administrator and progress reports.

Core Area 1: Quality Improvements
The West Virginia Flex Program and West Virginia Hospital Association (WVHA) CAH Network will collaborate in the effort to encourage CAHs in West Virginia to publicly report data to Hospital Compare on relevant process of care quality measures for inpatient and outpatient care, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care survey results.

The WV Flex Program and WVHA CAH Network will collaborate in the following ways:

- Inthe Medicare Beneficiary Quality Improvement Project (MBQIP) in the effort to improve outcome scores for CAHs in West Virginia publicly report data to Hospital Compare
- In the support of CAH participation in quality reporting and benchmarking initiatives other than Hospital Compare
- In the support WV CAH participation in the Balanced Scorecard data collection and analysis on a quarterly basis
- In the support of quality improvement education/training programs for managers, staff and/or board members of West Virginia CAHs.
- To offer CEOs, CFOs, Patient Account Representatives, Directors of Nursing, Performance Improvement Personnel and Board Member Education Programs.
- To improve participation and provision of technical assistance for the WVHA CAH Network Executive Director and possible WV CAH staff representative for contract administration and to attend training and educational networking opportunities to discuss best practices
- To support development of multi-hospital medical peer review assistance and support.
- To continue the facilitation and coordination of the Peer Review Program and continue the upkeep of the Peer Review Program in places that use West Virginia CAH physicians as reviewers.

Core Area 2: Operational & Financial Development
The West Virginia Flex Program and WVHA CAH Network will collaborate to assist West Virginia CAHs in identifying potential areas of operational and financial performance improvement.

The West Virginia Flex Program and WVHA CAH Network will collaborate in the following ways:

- To provide the analysis and discussion of WVHA CAH Network members' financial, clinical and operational performance at quarterly WVHA CAH Network Meetings
- To support CAHs in planning and implementing evidence-based strategies for improving financial performance. Support may include technical assistance, educational programs/seminars, user group meetings, and consultation provided, facilitated or funded by the State Flex Program

- To provide technical assistance and quarterly meeting opportunities for CAH Chief Financial Officers and Patient Account Representatives. This includes a listserv service for these members
- To provide consultation and education related to cost reporting, physician contracting and Evaluation and Management Coding
- To conduct reviews and comparisons of labor statistics for improved clinical and operational areas in West Virginia CAHs.
- To develop and provide the infrastructure that support CAHs in planning and implementing evidence-based strategies for improving operational and financial performance. The collaborative is based on general improvement strategies, such as sharing of best practices and benchmarking, or specific improvement strategies such as revenue cycle management, ICD-10 transitional training and departmental efficiency. Support includes technical assistance, educational programs/seminars, user group meetings, and consultation provided, facilitated or funded by the West Virginia Flex Program
- To provide workshops and other educational programs to improve operational performance of individual West Virginia CAHs

Core Area 3: Health System Development & Community Engagement
In a collaborative effort, the Flex Program will work with the First Impression Teams at West Virginia University, which works as a partner with the Recruitable Community Program (RCP). The West Virginia SORH and West Virginia Flex Program's goal is to assist in the development of a partnership that will support rural communities' ability to identify factors that will improve community desirability when assisting with stability for health care delivery systems in rural areas. Participating communities will receive a First Impressions Team visit and undertake a community revitalization project. The Community Revitalization visits are done by a contract with land grant College/University or Community Revitalization Organization to bring groups of professionals to evaluate health care, community business and revitalization that will help attract and retain health care providers in small rural communities. This initiative will be supported by the West Virginia Flex Program in WV CAH communities and catchment areas.

In recognition of the invaluable role that local Emergency Medical Service (EMS) agencies play in rural communities, the West Virginia Flex Program will continue to support efforts to stabilize these entities. The West Virginia Office of Emergency Medical Service (OEMS) will work with the West Virginia Flex Program and WVHA CAH Network to complete this project. The West Virginia OEMS, Workforce Development Section and the West Virginia Flex Program will collaborate on this initiative.

This collaborative initiative will expand and secure the retention of rural emergency medical professionals through several viable projects identified through ongoing discussions with the West Virginia OEMS Workforce Section Chief, local EMS Squad Training Officers and the local, regional and state EMS Medical Directors.

These projects may include exhibit opportunities at career fairs, conferences, and retention-specific events that will promote collaboration between West Virginia CAHs and the West Virginia OEMS. Another proposed project will include a scholarship program for EMT-Paramedics in return for a service obligation in a rural West Virginia CAH community and catchment area.

Network Description
The West Virginia Flex Program and the WVHA CAH Network work very closely together on most or all Flex initiatives. We have a great working relationship. Due to this great partnership and collaboration, all 19 CAHs in West Virginia are reporting to MBQIP in many different areas.The West Virginia Flex Program and the WV CAH Network are working in a collaborative partnership with the State quality improvement organization, West Virginia Medical Institute, on a Phase 3 MBQIP project for the reduction of CAH emergency room readmissions.

All projects are measured with the process of progress report updates, monthly meetings and telephone/e-mail technical assistance.

Collaborative
The West Virginia Flex Program and the West Virginia CAH Network are working in a collaborative partnership with the state quality improvement organization (QIO) on a Phase 3 MBQIP project for the reduction of CAH emergency room readmissions.

The West Virginia Flex Program continues to collaborate with the West Virginia OEMS, Trauma Division and WVHA CAH Network to support trauma and EMS systems development.

For in-hospital emergency care, Level IV trauma designation under the West Virginia OEMS trauma system designation process has improved coordination of care in communities served by the West Virginia CAHs.

The West Virginia OEMS, Workforce Development Section and the West Virginia Flex Program have continued to collaborate on an initiative to increase the recruitment and retention of rural emergency medical professionals. Emergency Medical Technician (EMT) Paramedics in West Virginia currently do not have any active recruitment and retention activities focused on their profession. We will continue our work on the scholarship program for EMT-Paramedics in return for a service obligation in a rural West Virginia CAH catchment area. The service obligation will be for at least two years of service, with the possibility of additional service commitments for retention purposes.

All projects are measured with the process of progress report updates, monthly meetings and telephone/e-mail technical assistance.

Wisconsin

Best Practice
We worked with the Rural WI Health Cooperative to coordinate three Hospital Best Practice Events designed to showcase critical access hospitals (CAHs) that have mastered common process improvement challenges. Event topics included the following:

- Communicating Quality Peformance Indicators
- Performance and Competencies Evaluations
- Peer Review Processes

Measurement includes the folowing:

- Pre- and Post-Event Evaluation Scores
- Event Attendance

Core Area 1: Quality Improvements
- Rural Hospitals Stroke Improvement Program
- Web-based Event Reporting Project

Core Area 2: Operational & Financial Development
- Critical Access Hospital Finance Workshop
- Hospital Foundation Workshop in partnership with the Hospital Association

Core Area 3: Health System Development & Community Engagement
- We are piloting two "Frequent Flyer" inititives aimed at reducing overuse/innapropriate use of Emergency Departments and Emergency Medical Services
- Emergency Medical Services Leadership Academies

Collaborative
- We are working with our quality improvement organization (QIO), MetaStar, on the Centers for Medicare and Medicaid Services (CMS) Emergency Department Transfer Measures Pilot Project
- We serve on the Wisconsin Hospital Association's Rural Health Council
- We are a member of the Wisconsin Hospital Emergency Preparedness Program (WHEPP) Leadership Group, representing rural hospital, EMS and clinic interests, assuring that they are properly prepared to respond to emergency situations, such as mass casualty incidents
- Wisconsin Stroke Coalition

Wyoming

Best Practice
The Flex Program expanded the wyominghealthmatters.org website, which hosts health and demographic data, from 1 county to all 23 Wyoming counties.

This website was used as the comprehensive health needs assessment for 11 of Wyoming's 16 critical access hospitals (CAHs) per the Affordable Care Act requirement. The site itself also contains a variety of best and promising practices which those communities use to create their community health improvement plans.

Core Area 1: Quality Improvements
To accomplish activities in this core area, the Wyoming Office of Rural Health hosted an annual Flex Program Planning meeting with statewide stakeholders which included: CAHs, quality improvement organization (QIO), emergency medical services (EMS), Wyoming Hospital Association, Wyoming Critical Access Hospital Network, and Rural Health Solutions. Key activities for 2013 will be:

- Participate in Kansas-based Quality Health Indicators (QHi) benchmarking project and QHi Users Group
- Support CAH participation in QHi through project administration, technical assistance, data monitoring and reporting. Measurement: Number of CAHs participating in technical assistance (TA) calls; Number of CAHS actively entering data
- Provide technical assistance and support toward addressing issues related to falls: website, webinars, toolkits, best practices, and resources. Measurement: Number of CAHS participating; Number of falls and/or reduced injury related to falls
- Offer Leadership Development Courses for new managers in a CAH. Measurement: Evaluations and number of participants
- Implement peer review program for CAHs
- Reimburse CAH travel and conference costs to trainings, meetings, and workshops

Core Area 2: Operational & Financial Development
Key activities in this core area include:

- Assist with Studer collaborative for Wyoming CAHs. Implementation of leadership evaluation systems and processes at each participating CAH to hardwire objective accountability. Measurement: Development of a standardized collaborative performance dashboard to track common metrics across all organizations for benchmarking purposes.
- Chart audits and training to provide training to coding and billing staff in areas where errors are found. Measurement: reduce errors and increase revenue.
- Wyoming Critical Access Hospital Network will provide a financial workshop to CAH CEOs and CFOs.

Core Area 3: Health System Development & Community Engagement
Key activities in this core area include: Collaborate with the Wyoming Office of Emergency Services for the improvement and integration of EMS services into the local healthcare service delivery system to strengthen local health system

development, support quality, financial, and operational systems. The goals will be met by:

- Hosting an EMS physician medical directors and services directors summit
- Host Rural Trauma Team Development classes
- Provide emergency medical technician (EMT) Leadership Course which provides instruction for EMS administrators, directors, and chief officers in all aspects of managing the intricacies of a modern EMS agency

Network Description
In Wyoming, we have a Critical Access Hospital Network (WCAHN) which is comprised of a Director and the CAH CEOs. It is an unofficial arm of the Wyoming Hospital Association. This network works together to develop the activities in which to pursue with Flex grant funding which overlaps into core areas 1 and 2.

Each area has its own set of measures.

Collaborative
See core area 1 in regard to falls prevention education project. Also Wyoming was selected to be a participant in the Emergecy Department Transfer Communication Pilot Project. We have ten hospitals participating and working with the QIO. Measurement: Quality and quantity of information transferred to next facility in continuum of care. See Core are 1.

Measurement: number of CAHs and long-term care facilities participating in the initiative; reduction in falls and/or injury in the participating CAHs.