Flex Program Fundamentals

An Introduction to the Medicare Rural Hospital Flexibility Program

Fiscal Year 2021

Updated December 2021

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This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, $1,560,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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A list of state Office of Rural Health Directors/Flex Program contacts is available within the State Flex Profiles on the TASC website.

Executive Summary

The Medicare Rural Hospital Flexibility Program, or Flex Program, was established by the Balanced Budget Act (BBA) of 1997. With eligible rural hospitals and a state rural health plan, states could establish a Flex Program and apply for federal funding. Forty-five states participate in the Flex Program. The Flex Program also created critical access hospitals (CAHs) as a Medicare provider type. CAH designation allows the hospital to be reimbursed on a reasonable cost basis for inpatient and outpatient services, including lab and qualifying ambulance services that are provided to Medicare patients and, in some states, Medicaid patients.

The Flex Program cooperative agreement provides funding to state governments or other designated entities to support CAHs and provider-based rural health clinics (RHCs) in quality improvement, quality reporting, performance improvements and benchmarking, designating facilities as CAHs, population health, innovative model development, and the provision of rural emergency medical services (EMS). Only states with CAHs or hospitals eligible to convert to CAH status and a state rural health plan can participate in the Flex Program.

Flex funding encourages the development of cooperative systems of care in rural areas, joining together CAHs, providers of EMS services, clinics, and health practitioners to increase efficiencies and quality of care. The Flex Program requires states to assess statewide needs and funds their efforts to implement community-level outreach and technical assistance to advance the following goals:

- Increase the number of CAHs consistently reporting quality data
- Improve the quality of care in CAHs
- Maintain and improve the financial viability of CAHs
- Build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities
- Improve the organizational capacity of rural EMS
- Improve the quality of rural EMS
- Increase knowledge and evidence base supporting new models of rural health care delivery
- Assist rural hospitals in seeking or maintaining appropriate Medicare participation status to meet community needs

The Flex grant is organized into six program areas with goals, objectives, and related activities, some of which are required:

1. CAH Quality Improvement (required)
2. CAH Operational and Financial Improvement (required)
3. CAH Population Health Improvement (optional)
4. Rural EMS Improvement (optional)
5. Innovative Model Development (optional)
6. CAH Designation (required if rural hospitals request assistance)

The Flex Program is administered through the Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). The Flex funding to states is administered as a cooperative agreement in both competitive and non-competitive grant cycles. The fiscal year (FY) 2021 (September 1, 2021 – August 31, 2022) is the third year of a 5-year cooperative agreement cycle. A summary of the Flex cooperative agreement guidance goals, objectives, and activities can be found in Section 1 of this manual. Flex cooperative agreement guidance for each year of the funding cycle can be accessed on the Flex Cooperative Agreement Guidance page of the Technical Assistance and Services Center (TASC) website.

Federal Office of Rural Health Policy

FORHP coordinates activities related to rural health care within the US HHS. Part of HRSA, FORHP has department-wide responsibility for analyzing the possible effects of policy on residents of rural communities. Created by Section 711 of the Social Security Act, FORHP advises the Secretary of HHS on health issues within these communities, including the effects of Medicare and Medicaid on rural citizens' access to care, the viability of rural hospitals, and the availability of physicians and other health professionals.

FORHP administers grant programs designed to build health care capacity at both the local and state levels. These grants provide funds to 50 State Offices of Rural Health (SORHs) to support ongoing improvements in care and rural hospitals through Flex and SHIP grants in 45 states. Through its Community Based Division, FORHP provides support to community organizations to improve health service delivery, strengthen rural health networks, and encourage collaboration among rural health care providers.

Learn more about FORHP in Section 2 of this guide.

Technical Assistance and Services Center

The Technical Assistance and Services Center (TASC) was created in 1999 by the National Rural Health Resource Center (The Center) through funding from FORHP to provide technical assistance and resources to the grantees of the Flex Program. This Flex Program Fundamentals guide was developed as part of TASC's services and is updated annually. The TASC section of the guide includes information on the tools and resources found on the TASC website, Flex Program Workshops, communication tools, technical assistance, and contact information for TASC staff. State Flex Program contact information can also be found within the State Flex Profiles on the TASC website.

TASC's services are essential as the job duties of a Flex Coordinator are broad, far-reaching, and without step-by-step instructions. Because of the varying tasks associated with the Flex Coordinator position, it is essential to remember the following tips:

- The role of the Flex Coordinator is to be the convener and liaison between local, state, and national rural health groups, all the while maintaining a neutral position
- Partnerships are keys to success
- Understanding the CAH environment and how to promote financial and operational improvement are vitally important
- For quality improvement, look at what exists and think creatively about how to improve
- CAHs need to play a part in a comprehensive system of care
- Be aware of the resources available to help you be successful

TASC provides tools and resources on topics applicable to the Flex Program, including CAH surveys. CAHs must comply with Medicare Conditions of Participation (CoP) to receive Medicare/Medicaid payment. A CAH survey is used to determine whether a CAH complies with the CoP set forth at 42 Code of Federal Regulations (CFR) Part 485 Subpart F. Certification of CAH compliance with the CoP is accomplished through observations, interviews, and document/record reviews. The survey focuses on a CAH's performance of organizational and patient-focused functions and processes while assessing compliance with federal health, safety, and quality standards that will assure that the beneficiary receives safe, quality care, and services.

TASC maintains relationships with state, national, and federal organizations, and health information technology (HIT) organizations. One organization that TASC works closely with is the Flex Monitoring Team (FMT). FMT is a

consortium of the Rural Health Research Centers located at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. FMT monitors and evaluates the Flex Program by developing relevant quality, financial, and community-benefit performance measures and reporting systems to help state and federal policymakers and rural health care providers understand the impact of the Flex Program. The FMT's research assesses the impact of the Flex Program on critical access hospitals (CAHs) and communities. It examines the ability of the Flex grantee to achieve overall Flex Program objectives.

Medicare Beneficiary Quality Improvement Project

FORHP created the Medicare Beneficiary Quality Improvement Project (MBQIP) as a Flex Program activity within the core area of quality improvement. The primary goal of this project is for CAHs to implement quality improvement initiatives to improve their patient care and operations. MBQIP uses Flex funding to support CAHs with technical assistance and national benchmarks to improve health care outcomes. Participating CAHs report a specific set of annual and quarterly measures determined by FORHP and engage in quality improvement projects to benefit patient care.

- Benefits of participating in MBQIP include:
- Engagement in quality improvement initiatives
- Improved patient care across a broad population
- Improved hospital services, administration, and operations
- Creation of clear benchmarking and the identification of CAH best practices
- Receiving technical assistance regarding cutting edge quality improvement tools and models
- Preparing CAHs for the future when they will likely have to report national standardized measures
- Fulfilling the quality improvement portion of the Flex grant

To support the technical assistance needs of state Flex Programs and participating CAHs, FORHP established the Rural Quality Improvement Technical Assistance (RQITA) cooperative agreement. RQITA works closely with TASC, FMT, and FORHP to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of FORHP quality initiatives, including MBQIP and the Small Health Care Provider Quality

Improvement (SHCPQI) grantees. To support SHCPQI, RQITA works closely with the Georgia Health Policy Center.

Performance Improvement & Measurement System and Program Evaluation

The Performance Improvement & Measurement System (PIMS) module is a data collection tool integrated with HRSA's Electronic Handbooks system (EHBs), a grant support and performance management application that unifies HRSA grant management processes and enables electronic data submission. PIMS allows FORHP to gather standardized performance data from recipients. With PIMS data, FORHP will track activities with common measures that focus on CAH performance improvement.

Another part of a successful and effective Flex Program is program assessment which includes documenting outcomes and showing continuous program management and improvement. Assessments can also examine results with short and long-term outcomes. Assessment of the state Flex Programs is critical to the program's success, sustainability, and continued funding. It is essential to assess impact to demonstrate value. TASC is available to assist in sorting through the various tools and resources available to state Flex Programs to find an evaluation model that will work for them. We highly recommend taking the time to review the Flex Program Performance Management/Program Evaluation Guide on the TASC website that was created in October 2019 and either establishing or reviewing your current evaluation model at least annually.

Section 1 - Introduction to the Medicare Rural Hospital Flexibility Program

History of the Medicare Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program, or Flex Program, was established by the Balanced Budget Act (BBA) of 1997. Any state with rural hospitals and a state rural health plan may establish a Flex Program and apply for federal funding that provides for the creation of rural health networks, promotes regionalization of rural health services, and improves access to hospitals and other services for rural residents.

The BBA also created critical access hospitals (CAHs) as a Medicare provider type. CAH designation allows a hospital to be reimbursed on a reasonable cost basis for inpatient and outpatient services provided to Medicare patients (including lab and qualifying ambulance services) and, in some states, Medicaid patients.

The design of the CAH designation was based on the experiences of the Medical Assistance Facility (MAF) Demonstration Project and the Rural Primary Care Hospital (RPCH) Project. MAFs were initially developed through a demonstration project of the Montana Health Research and Education Foundation (MHREF) in 1987 and received Medicare waivers in 1990. CAH designation was designed, in part, to decrease rural hospital closures, strengthen local health care delivery, and improve rural health care access.

The legislation has undergone many changes and updates such as the Balanced Budget Refinement Act (BBRA) of 1999, the Benefits Improvement Protection Act (BIPA) of 2000, the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the Medicare Improvements to Patients and Providers Act (MIPA) of 2008, the American Recovery and Reinvestment Act of 2009, and the Patient Protection and Affordable Care Act of 2015.

In 1999, the Technical Assistance and Services Center (TASC) was created by the National Rural Health Resource Center (The Center) through funding from the Federal Office of Rural Health Policy (FORHP) to provide technical assistance and resources to the grantees of the Flex Program. TASC provides a resource network for answers and information regarding the program including best practices, peer learning, and tools. TASC has been so successful that many other Health Resources and Services Administration (HRSA) programs have used this model to develop technical assistance centers for their programs.

TASC recognized a growing need for a knowledge base in health information technology (HIT) for rural health grantees and providers. Currently,

HIT requirements in quality, safety, Health Insurance Portability and Accountability Act (HIPAA), telemedicine, reimbursement, pharmacy, and meeting the three stages of Promoting Interoperability (formerly known as Meaningful Use) as set forth by the Centers for Medicare and Medicaid Services (CMS) are overwhelming many rural health care providers. TASC has been providing HIT informational resources, education, and technical assistance since 2006. As of late, an increased emphasis is placed on telehealth to support quality of care, access to care, collaboration and information sharing among care providers, patient satisfaction, and safety during the COVID-19 pandemic and beyond. As such, TASC works in collaboration with HRSA's Office for the Advancement of Telehealth (OAT) to support telehealth related education.

TASC coordinates the National Rural HIT Coalition, an informal network of rural and HIT leaders from organizations at every level, working together to drive knowledge and information about rural HIT throughout the country. The purpose of the group is to educate key rural health stakeholders about rural HIT issues and resources, provide a forum for discussion of issues relevant to CAHs, rural health clinics, and other rural health providers and communities, and convene federal, national, and state organizations and agencies to share rural successes, opportunities, and perspectives. State Flex Programs and state offices of rural health are encouraged to participate in National Rural HIT Coalition events.

As the U.S. transitions to a health care system that pays for value, there are new programs and projects in the areas of accountable care organizations (ACOs); bundled payments, telehealth, and patient-centered medical homes; Medicare and Medicaid payment changes and demonstration projects including global budgeting; workforce; long-term care; and public health. Changes are occurring in the health care marketplace, and CMS has focused its priorities on better care, smarter spending, and healthier people and communities. In 2015, the Medicare Access & CHIP Reauthorization Act (MACRA) was passed, introducing the Quality Payment Program (QPP), which has two tracks: Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS). In short, APMs provide an incentive payment based on a specific clinical condition, care episode, or population where providers assume some of the risk related to patient outcomes. MIPS provides a payment adjustment to health care providers built on evidence-based and practice-specific quality data demonstrating high quality and efficient care supported by technology such as the electronic health record. Additional models have been introduced, with the most recent introduction of the Community Health Access and Rural Transformation (CHART) Model in September 2020.

Changes in Medicare and Medicaid payment and delivery systems are anticipated to have the following impact:

- Increased pressure on operating margins caused by payment reductions, both federal and state
- Physician integration will be necessary to support ACOs and other shared savings models
- Capital will be required to implement physician alignment strategies
- Quality will drive reimbursement levels and will be a market differentiator
- Quality reporting will require a more sophisticated infrastructure
- Collaboration and effective alignment with the physician-provider community will be imperative as health care moves from a volume-based system to a value-based system

As CAHs seek to understand their future value, they need to look at their economic value in a new world consisting of transitioned payments.

Challenges faced by rural hospitals are not insurmountable. To meet them head-on will require a strong commitment to the communities served and the desire to problem solve and work collaboratively. This commitment and desire, and collaboration are the qualities that define rural hospitals and rural leaders. Because they are the lifelines for the residents they call neighbors, rural hospitals can lead the way in transforming the American health care system. They are smaller, less complex, and, therefore, able to change quicker than their urban counterparts. Rural hospitals are also more closely connected to their local communities.

Nationally, there is an important movement toward increased quality of care and patient health care experiences. FORHP created the Medicare Beneficiary Quality Improvement Project (MBQIP) a Flex Program activity within the program area of quality improvement. The primary goal of this project is for CAHs to implement quality improvement initiatives to improve patient care and operations. Flex Programs focus their work in the required Quality Improvement Program Area, specifically on MBQIP. This work provides support to CAHs with technical assistance and national benchmarks to improve health care outcomes. Currently the Flex Programs are supporting a one-year quality improvement project with participating CAHs in their state. This quality improvement project is conducted via cohorts of states, or Quality Innovation Labs, which are grouped by similar project topics. The quality improvement project has four aims:

1. Information national priorities for rural quality measurement and

quality improvement, based on implementation of state projects and dissemination of lessons learned

2. Implement a collaborative model to integrate technical assistance efforts and resources, in order to enhance support for Flex Program grantees and program sustainability
3. Identify gaps in state Flex Program quality improvement capacity, knowledge, services, and/or resource needs to meaningfully engage CAHs in quality measurement and improvement activities; and assess how quality measurement and quality improvement innovations at the state-level can influence hospital-level improvements in care
4. Identify feasible, rural-relevant approaches for assessing hospital quality of care, and innovations in quality improvement that may mitigate data reporting challenges and reduce reporting burden for CAHs. This will help FORHM inform strategic plans for Flex and MBQIP

Increased usage of and understanding of publicly available quality and patient satisfaction data from Hospital Compare and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys has contributed to increased knowledge and understanding of hospital quality improvement. In the environment of MACRA, pay for performance, bundled payments and Accountable Care Organizations (ACOs), and use of data to improve care, CAHs may soon be compared with their urban counterparts to ensure public confidence in their quality of health services. The MBQIP initiative takes a proactive and visionary approach to ensure that CAHs are well-equipped and prepared to meet future quality legislation. Additionally, MBQIP fulfills the Flex grant quality improvement objectives regarding Care Compare reporting for hospitals and supporting participation in various multi-hospital quality improvement initiatives. The main emphasis of this project is putting patients first by focusing on improving health care services, processes, and administration. More information can be found on the MBQIP webpage of the TASC website.

Starting in Fiscal Year (FY) 2015, FORHP required participation in MBQIP as a condition for CAHs to participate in Flex-funded activities. CAHs have the opportunity to work with their State Flex Program to meet the MBQIP reporting requirements and participate in Flex-funded activities. However, as our nation grapples with the COVID-19 pandemic, FORHP has decided to suspend eligibility requirements for FY 2020 (September 1, 2020 – August 31, 2021) and FY 2021 (September 1, 2021 – August 31, 2022). In order to support all hospitals in prioritizing their COVID-19 response, FORHP will also allow all CAHs to participate in Flex-funded activities during this period.

Per FORHP policy, CAHs must meet two criteria to be eligible for FY 2020 Flex-funded activities:

1. A signed MOU to submit and share MBQIP data
2. Reported data on at least one MBQIP Core measure, for at least two quarters, in at least three of the four quality domains, within the FY 2020 reporting period. For this policy exception, Flex grantees will not need to submit an MBQIP waiver for FY 2020 and will not be penalized for not meeting minimum reporting requirements for MBQIP.

CAHs that have the ability to report are highly encouraged to continue reporting on as many measures as possible.

As of October 2021, there were 1,353 hospitals in the nation designated as CAHs. The majority of CAH designations in the country are now complete due to support provided by state Flex Programs. CAH designation is only one part of the Flex Program. The prevention of CAH closure or assisting them to identify other viable models to serve the health care needs of their rural communities is a vital role for state Flex Programs to play in this shifting health care environment. State Flex Programs also use their cooperative agreement dollars to improve networks, improve population health, and improve and integrate emergency medical services (EMS); work on performance improvement, operational and financial improvement, address quality improvement issues; explore innovative models of care, all to enhance and ensure health care access to rural Americans.

Program Areas of the Flex Program

In fiscal year (FY) 2019 (September 1, 2019 – August 31, 2020), the Flex Program began a new project period focused on providing training and technical assistance to build capacity, support innovation, and promote sustainable improvement in rural health care systems.

The Flex Program, a five-year project period, is designed to allow state Flex cooperative agreement partners to develop, implement, and measure impact and improvement within the program areas of the cooperative agreement:

1. CAH Quality Improvement (required)
2. CAH Operational and Financial Improvement (required)
3. CAH Population Health Improvement (optional)
4. Rural Emergency Medical Services (EMS) Improvement (optional)
5. Innovative Model Development (optional)
6. CAH Designation (required if rural hospitals request assistance)

The overall goal of the Flex Program is to ensure that high-quality health care is available in rural communities and aligned with community needs. The goals of each of the six program areas are as follows:

- CAH Quality Improvement (required)
    - Increase the number of CAHs consistently reporting quality data
    - Improve the quality of care in CAHs
- CAH Operational and Financial Improvement (required)
    - Maintain and improve the financial viability of CAHs
- CAH Population Health Improvement (optional)
    - Build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities
- Rural EMS Improvement (optional)
    - Improve the organizational capacity of rural EMS
    - Improve the quality of rural EMS
- Innovative Model Development (optional)

    - Increase knowledge and evidence base supporting new models of rural health care delivery
- CAH Designation (required if assistance is requested by rural hospitals)
    - Assist rural hospitals in seeking or maintaining appropriate Medicare participation status to meet community needs

I. CAH Quality Improvement

This program area, referred to as the Medicare Beneficiary Quality Improvement Project (MBQIP), focuses on improving the quality of health care provided by CAHs and other rural health care providers. Other types of health care providers can and should benefit from this work, but most activities must target CAHs.

MBQIP activities are grouped in four quality domains:

- Patient Safety/Inpatient,
- Patient Engagement
- Care Transitions
- Outpatient

FORHP expects all grantees to select Activity Categories 1.1- 1.4 (required) which covers the four quality domains of MBQIP.

Building and maintaining the participation of all CAHs in MBQIP through quality measurement and reporting activities are required. In year one of the cooperative agreement cycle, it is acceptable to work towards building the capacity for CAHs to participate in these activities and report data if they are not already doing so. For CAHs already engaged in quality reporting, the focus should be quality improvement.

Every year, FORHP evaluates the MBQIP participation requirements for CAHs to be eligible to participate in the Flex Program and Flex-related activities. FORHP understands that certain circumstances hinder CAHs from reporting. Therefore, Flex Programs have the opportunity to request waivers for MBQIP participation requirements for the current fiscal year on behalf of CAHs initially deemed ineligible due to non-participation. The Flex Program must submit a waiver as part of their non-competing continuation (NCC) progress report as an attachment. Detailed participation criteria are currently available from FORHP concerning participation through FY 2021.

Along with the required set of quality improvement activities, there are additional activity categories that grantees are encouraged to select based on the needs of the CAHs in their state (Activity Categories 1.5 – 1.8). These activity categories do not require participation by all CAHs. Instead, they should include a cohort(s) of CAHs in the state prepared to focus quality improvement efforts on the identified area. It is acceptable to work with an individual hospital, but the need must be clearly justified. While some of the additional activity categories have existing measures, some do not have a standardized measure set or reporting mechanism. These activity categories were included to give states an option to work on these national quality priority areas.

Potential resources related to quality improvement include:

- MBQIP website
- Flex Monitoring Team (FMT)
- Emergency Department Transfer Communication

For specific information on Program Area 1: CAH Quality Improvement goals, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

II. CAH Operational and Financial Improvement

FORHP requires all grantees to select Activity Category 2.1. Activity Categories 2.2 – 2.5 are not individually required. Still, FORHP requires state Flex Programs to support one or more improvement projects in this program area as determined by the state's needs assessment (Activity Category 2.1) and program capacity. FORHP encourages states to identify new or existing successful financial and operational improvement programs and leverage those to meet the collective needs of CAHs in each state to maximize the impact of limited Flex funds. States should minimize consultant expenditures toward individual CAHs for improvement activities, instead focusing on cohorts unless adequately justified. Work within this program area must focus on CAHs; however, state Flex Programs may assist CAHs that operate provider-based rural health clinics (RHCs) or other off-campus health care sites.

For specific information on the Program Area 2: CAH Operational and Financial Improvement goal, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

III. CAH Population Health Improvement

This optional program area focuses on helping to build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities.

Activity categories for this program area focus on:

- Understanding health improvement needs
- Developing strategies
- Engaging with community stakeholders to address specific health needs
- Flex funds cannot be used to pay for the completion of community health needs assessments (CHNAs).

For specific information on the Program Area 3: CAH Population Health Improvement goal, activity categories, requirement, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

IV. Rural EMS Improvement

This optional program area focuses on work to improve rural EMS as it is a vital link to emergency health care for rural residents. The Flex Program supports establishing and expanding programs that support the provision of rural EMS. Goals of this program area include improving organizational capacity of EMS providers and improving the quality of rural EMS. Projects within this program area are to focus primarily on out-of-hospital emergency medical services. Projects including both EMS and CAH emergency departments (ED) are encouraged, but projects that focus solely on the CAH ED should be part of Program Area 2: Operational and Financial Improvement.

If Rural EMS Improvement program area is chosen, the required areas are:

- Completion of a statewide rural EMS Needs Assessment and Action Plan (Activity Category 4.1)
- And/or completion of a community-level rural EMS system assessment and action planning

It is expected that states working in this program area will complete at least one of these two types of assessments during the five-year program cycle.

For specific information on the Program Area 4: Rural EMS Improvement goal, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

Flex Program EMS Supplement

With declining numbers of volunteers to staff ambulances, declining financial support from local governments, and increased educational standards for emergency medical technicians and paramedics, access to emergency care is at risk in many rural communities. Flex Program stakeholders have identified addressing the needs of struggling ambulance agencies as a key issue to maintaining access to emergency care in rural communities. Stakeholders have also identified EMS quality improvement as a key challenge for both EMS sustainability and EMS participation in value-based care.

The Flex Program provides a platform and resources for states to strengthen rural health care by supporting improvement initiatives with critical access hospitals and rural EMS agencies. State Flex Programs have supported EMS improvement activities in the past but have faced challenges with limited capacity to address EMS needs given other rural health care priorities. In the Fiscal Year 2019 (FY19) Flex Program funding cycle, the Federal Office of Rural Health Policy (FORHP) issued a Notice of Funding Opportunity (NOFO) for supplemental EMS projects. The goal of the supplemental funding is to improve access to quality emergency care in rural communities. The projects will develop an evidence base for Flex Program EMS activities by funding four multi-year projects in each of the following two focus areas:

- Focus Area 1: To implement demonstration projects on sustainable models of rural EMS care. Projects will facilitate the development and implementation of promising solutions for the problems faced by vulnerable EMS agencies and contribute to an evidence base for appropriate interventions.
- Focus Area 2: To implement demonstration projects on data collection and reporting for a set of rural-relevant EMS quality measures. Projects will facilitate the development of a core set of validated, rural-relevant EMS quality measures.

The Flex EMS Supplement's performance period is September 1, 2019, through August 31, 2022 (three years). The supplement is now in its final year. Funding beyond the first year is subject to the availability of federally appropriated funds for the Flex Program in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government. The full Flex

EMS Supplement NOFO can be viewed here: https://www.ruralcenter.org/resource-library/flex-program-fiscal-year-2019-ems-supplement-funding-guidance-and-supporting

State Flex Programs awarded the Flex EMS Supplement funding up to $250,000 per year for three years for FY 2019 – FY 2021 are:

- Focus Area 1: Sustainable models of rural EMS care
  - Arizona
  - Ohio
  - South Carolina
  - Washington
- Focus Area 2: Data collection and reporting
  - Florida
  - Kentucky
  - New Mexico
  - North Dakota

The Technical Assistance and Services Center (TASC) provides technical assistance and support to the eight Flex EMS Supplement projects.

V. Innovative Model Development

If a state Flex Program is interested in developing innovative rural health care models to improve quality, finances, operations, population health, and/or system delivery, they may choose to do activities in this program area. The goal of this program area is to increase knowledge and the evidence base supporting new models of rural health care delivery. Projects in this program area can be for one to five years. Evidence must be provided by the state Flex Program that they can meet the majority of Program Area 1 and Program Area 2 needs in the state before opting to do work in Program Area 5. They also must demonstrate organizational capacity to manage projects in this program area. State Flex Programs were also required to submit a logic model with their application to work in this program area.

For specific information on Program Area 5: Innovative Model Development goal, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

VI. CAH Designation

In accordance with program authorizing authority, state Flex Programs must facilitate, when requested, appropriate conversion of small rural hospitals to CAH status. Flex Programs must assist hospitals in evaluating the effects of conversion to CAH status.

This may include assisting with financial feasibility studies for hospitals considering conversion to CAH status, as well as feasibility studies for reopening closed rural hospitals or converting CAHs to other types of facilities.

For specific information on the Program Area 6: CAH Designation, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

Flex Cooperative Agreement Guidance Resources

The Flex Program is administered through the Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). The Flex funding to states is administered as a cooperative agreement in both competitive and non-competitive grant cycles. The fiscal year (FY) 2021 (September 1, 2021 – August 31, 2022) is the third year of a 5-year cooperative agreement cycle. Flex cooperative agreement guidance for each year of the funding cycle can be accessed on the Flex Cooperative Agreement Guidance page of the Technical Assistance and Services Center (TASC) website.

The competitive application for the Flex cooperative agreement occurs electronically through the grants.gov website. Each program year is September 1 – August 31.

The Core Competencies for State Flex Program Excellence Guide includes a section dedicated to managing the Flex Program, with tips and resources for managing the cooperative agreement and resources for grant writing.

For an easy-to-use manual on writing Federal grant applications, with tips on grant management, please review the Federal Grant Writing Manual.

A Federal Grant Writing Manual Workshop was held in September 2014. Resources from this Workshop, including many examples related to the Flex Program, are available online.

For more information on applying for a federal grant, please visit the grants.gov Apply for a Grant webpage. For Federal Funding Accountability and Transparency Act (FFATA) implementation requirements, please visit the HRSA website. For technical assistance resources from HRSA's Grants Management, please visit the Manage Your Grant Workshop webpage. Consider becoming a HRSA grant reviewer. For more information, please visit the HRSA Grant Reviewers webpage.

Core Competencies for State Flex Program Excellence

One role of the state Flex Program is to be a convener and liaison between local, state, and national rural health groups while supporting and promoting improvements in critical access hospitals (CAHs), population health, and the integration of health services through training and technical assistance.

The responsibilities of state Flex Programs are broad and far-reaching, with no step-by-step instructions for the work. The advantage and difficulty of managing the Flex Program is the flexibility of the assignment. Each state Flex Program needs to identify the strengths and challenges faced by their state's rural health care providers and set goals to build state and local capacity. However, the methods used will vary by state and region.

In the spring of 2015, a group of experienced state office of rural health (SORH) directors, Flex Program coordinators, and staff from the Federal Office of Rural Health Policy (FORHP), Flex Monitoring Team (FMT), and Technical Assistance and Services Center (TASC) gathered for a Flex Program Leadership Summit to develop a framework of Flex Program core competencies and recommendations to achieve excellence in state Flex Programs. As a result of that meeting, the Core Competencies for State Program Excellence Guide was developed. The Guide provides:

- A framework for assessing state Flex Program strengths and weakness
- Suggestions for developing or strengthening performance in each of the competency areas
- Links to supporting resources organized by competency.

Below are summaries of each of the nine core competencies. For more information, please review the Core Competencies for State Flex Program Excellence Guide.

A self-assessment of the Core Competencies is available to assist users in identifying and prioritizing opportunities for enhancing competency within their state Flex Program at the organization-level, not the individual-level. Based on assessment outcomes, resources can be identified for those areas in which the program self-identifies a gap or opportunity for improvement. FORHP strongly suggests that state Flex Programs complete this assessment at least annually. Results of the assessment will not be used by FORHP to determine future funding levels. Users are encouraged to complete the assessment annually and with personnel changes to monitor progress on

their continuous journey towards Flex Program excellence. Assessment results can be used to establish a baseline, create benchmarks, and aid in strategic planning and evaluation.

Managing the Flex Program

Future funding for the national Flex Program is dependent on strong program planning, operations, and demonstrable outcomes through reporting. This can only be accomplished through competent program management on the part of state Flex Program leadership.

Government programs are facing similar challenges to those of health care providers: improving quality and outcomes and decreasing costs. Therefore, as state Flex Programs support CAHs and other rural health organizations with collecting data, improving quality, and making process improvements, they should be applying these same concepts internally as part of their overall program management and operations.

Building and Sustaining Partnerships

Partnerships lead to more informed and involved stakeholders, and ultimately, increase program impact, outcomes, and support. The national Flex Program has been able to evolve because of the partnerships established and maintained within communities, networks, states, regions, and nationally. As the health care system changes, it is imperative that state Flex Programs have the skills, capacity, and commitment to build and sustain partnerships, new and old, to support CAHs and the national Flex Program.

Improving Processes and Efficiencies

Process improvement is one of the most valued concepts used in all industries, including health care and government. It is applied in operations, production, and customer service, and is key to quality, cost savings, and outcomes. Process improvement and creating efficiencies go hand in hand with change. Change is constant and spawns the adaptation of processes toward continued improvement. Therefore, it is necessary for those who engage in process improvement to support change. Any organizations or individuals not engaged and participating in process improvement are missing opportunities to meet or exceed the expectations of their patients, customers, coworkers, partners, or stakeholders.

As health care organizations increasingly participate in new delivery and reimbursement models with shifting market expectations for quality, cost and outcomes, the need for continuous process improvement is becoming more evident. State Flex Programs can be the drivers of process improvement in rural health services by understanding and sharing concepts with health care providers and building process improvements into activities.

Therefore, when thinking of process improvements and efficiencies, think of them both across external programs directed at CAHs and stakeholders as well as internal program operations.

Understanding Policies and Regulations

Health policy, rules, and regulations have a profound impact on programs, services, reimbursement, and systems. State Flex Programs need to have an in-depth understanding of the policies and regulations governing the Flex Program. Additionally, a basic understanding of the policy-making process, other policies and regulations affecting CAHs, and the rural health landscape as a whole are critical. This knowledge will allow state Flex Programs to communicate more effectively with program partners; educate others about CAHs, rural communities and rural health systems; and provide support on their behalf.

Promoting Quality Reporting and Improvement

Quality reporting and improvement are priorities of the Centers for Medicare & Medicaid Services (CMS) Quality Strategy and goals. The national Flex Program is in alignment with these goals and has identified quality improvement as one of its program areas.

In order to build program plans and support CAHs in their quality improvement (QI) efforts, Flex Programs need to be aware of the various quality reporting initiatives and requirements, in particular the Medicare Beneficiary Quality Improvement Project (MBQIP) and Care Compare. Through communications with CAHs and by using MBQIP and FMT data and reports, state Flex Programs can develop a thorough understanding of CAH QI performance, including needs and successes.

Supporting Hospital Financial Performance

CAH financial and operational improvement is one of the primary goals of the Flex Program. Sustainable financial performance of CAHs is essential for both the day-to-day operation of the facility as well as for needed investments in technology and infrastructure. Recent market forces and dramatic changes in payor reimbursement have resulted in financial challenges for many of the nation's smallest hospitals. This financial distress has led to the closure of dozens of rural hospitals throughout the country, and several hundred more classified as financially distressed.

Given the complexity of Medicare and Medicaid regulations, billing codes, and private payer contracts, rural hospital financial improvement is often dependent on access to financial expertise both within and outside the

facility. Hospitals need to follow the most effective financial and business processes and utilize an efficient revenue cycle management system.

Addressing Community Needs

Health care services, such as those furnished at CAHs, are intended to meet the needs of their communities. Health needs can be identified from a variety of sources including demographic data, social and economic status, physical environment, clinical care, health behaviors, and health outcomes. It is important for state Flex Programs to understand the community needs of their CAHs to develop or leverage program activities in support of health system development, community engagement, and population health improvement.

To gain understanding of community health needs, a formal, systematic process that identifies and analyzes needs and assets should be completed. For CAHs, this is a community health needs assessment (CHNA) that drives local planning, decision making, and programs. For state Flex Programs, this is a statewide assessment that includes reviewing all CAH CHNAs.

Understanding Systems of Care

The health care system in the U.S. is a market-based system that lacks universal access. A greater majority of rural residents are uninsured or underinsured with high deductible health plans compared to their urban counterparts. Lack of access is particularly evident in rural areas where chronic shortages of primary care providers and key specialists are common, such as emergency room physicians and behavioral health providers, as well as health information technology professionals. Moreover, while most urban area ambulance services are staffed by paid paramedics, rural ambulance services are more likely to be volunteer based with basic level emergency medical technicians (EMTs) with a more limited scope of practice. Although rural areas generally offer a limited set of health care services, technology and equipment upgrades are still needed. The same quality and value of care is expected and should be delivered in rural areas as in urban areas.

Systems thinking is crucial to understanding how various health and social service providers can work together in rural communities to improve the health of populations. Since health outcomes are the product of social, environment, personal behavior, genetic disposition, and available health services, achieving a desired outcome of excellent population health will require collaboration among those who influence the drivers and resisters to that outcome. Systems thinking is also required to understand how various critical success factors in rural hospital performance can be incorporated into a strategic plan and then managed to produce sustainable high-performance outcomes. Systems approaches are most effectively implemented with the use of systems frameworks, like those found in the Baldrige framework and

Small Rural Hospital Blueprint for Performance Excellence and Value, which include a broad range of quantifiable goals that measure and communicate progress.

Preparing for Future Models of Health Care

State Flex Programs can help CAHs make a successful transition into value-based reimbursement and population health models through education, network support, facilitation of new partnerships, and technical assistance. For example, leadership understanding of the new models and transition strategies will be crucial and will require a great deal of education. CAHs will also need to develop partnerships with other community service providers, as well as participate in either networks or larger health systems to coordinate and manage care. Public health concepts will be important in managing the health of populations, presenting good opportunities for hospital-public health collaboration. The movement to value will be more rapid in some states, but ultimately all CAHs will need to find a place in the emerging systems.

Flex Program Frequently Asked Questions

Flex Program Operations

What is the Medicare Rural Hospital Flexibility (Flex) Program?

The Flex Program was created by the Balanced Budget Act (BBA) in 1997. Revisions occurred through the Balanced Budget Refinement Act (BBRA); the Medicare, Medicaid, and State Children's Hospital Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA); the Medicare Prescription Drug, Improvement and Modernization Act (MMA); and the Medicare Improvements to Patients and Providers Act (MIPA). The Flex Program is intended to preserve access to primary and emergency health care services, improve the quality of rural health services, provide services that meet community needs, and foster a health delivery system that is both efficient and effective. In addition, the Flex Program supports designation of a type of rural hospital: critical access hospital (CAH).

To accomplish the intent of the Flex Program, federal resources have been made available to:

- State Offices of Rural Health (those who implement state Flex Programs)
- The Technical Assistance Service Center (TASC), a program of the National Rural Health Resource Center (The Center), and Rural Quality Improvement Technical Assistance (RQITA), a technical assistance provider to support Medicare Beneficiary Quality Improvement Project (MBQIP) data reporting and quality improvement
- Rural Health Research Centers and the Flex Monitoring Team (FMT) (those who are monitoring the Flex Program nationally)

States administer the Flex Program and can apply to the Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy (FORHP), for federal Flex Program funding.

For more policy/legislative information, please visit the Understanding Policies and Regulations section of the Core Competencies for State Flex Program Excellence Guide.

What are the primary components of the Flex Program? (See Section 1 for a description of each program area)

- Program Area 1: CAH Quality Improvement (required)
- Program Area 2: CAH Operational and Financial Improvement (required)
- Program Area 3: CAH Population Health Improvement (optional)
- Program Area 4: Rural Emergency Medical Services (EMS) Improvement (optional)
- Program Area 5: Rural Innovative Model Development (optional)
- Program Area 6: CAH Designation (required if requested)
- Other key areas of the Flex Program include the following
    - Network Development
    - State Rural Health Plan*
    - State Flex Program Evaluation

*Note: Each state participating in the Flex Program was required to develop a state rural health plan. This rural health plan was submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. Reporting outcomes of the Flex Program is becoming increasingly important in order to quantify the benefits of the program. Through continuous assessment, states must have a way to gather data and review the successes of their program and incorporate any needed improvements.

How are states made aware of the Flex Program and CAH changes?

Flex Program Coordinators and other applicable Flex Program personnel receive emails regarding Flex Program and CAH changes as information is made available. Information also comes directly from TASC, FORHP, RQITA, FMT, and state hospital associations and is reported in the Federal Register. Additionally, changes are posted on the TASC website or are reported through links to other websites. To join the TASC listservs, reach out to tasc@ruralcenter.org.

Can I expect other updates and information from TASC and others?

Yes. TASC and its partners stay abreast of rural health policy and program changes. Updates are provided via the Flex Program email lists, regularly scheduled events such as conference calls, and webinars such as TASC 90 and Virtual Knowledge Group (VKG) webinars. Information is also shared via the Flex Program Forum (login required), TASC and FMT websites, other stakeholder websites, conferences, and workshops throughout the year.

How do I apply for federal Flex Program funding?

Each state interested in acquiring federal Flex Program funding must submit an annual progress report or competitive application to FORHP. The state designated entity, appointed by the governor, is solely allowed to apply for the funding. The approximate timeline* for applications and awards is below:

- January/February: FORHP sends application guidelines to states
- March - May: Application submission
- August: Notice of Award announcements
- September 1: The federal program year begins

*Note: This schedule may change; contact FORHP for current year schedule.

Who should I contact if I have questions regarding the Flex Program?

TASC is available to answer your questions, see Section 3.

There are several other excellent resources, a sample of those to consider include:

- CAH Licensing and Certifications (including accrediting bodies) – contact your state hospital licensing bureau, your CMS regional office, or TASC.
- Federal Flex Program – contact the Flex Project Officer at FORHP (FORHP Flex Program Project Officers in Section 2).
- CAH Conditions of Participation (State Operations Manual, Appendix W – Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals and Swing-Beds)
- Changes in federal laws and rules governing the Flex Program – contact your state hospital association, CMS or visit the Federal Register website and the Rural Policy Research Institute (RUPRI) website.
- Rural Health Value operates as the Rural Health System Analysis and Technical Assistance (RHSATA) cooperative agreement between FORHP, the RUPRI Center, and Stratis Health. The Rural Health Value Team analyzes rural implications of changes in the organization, finance, and delivery of health care services and assists rural communities and providers transition to a high-performance rural health system.
- The American Hospital Association (AHA) Rural Health Services — The AHA ensures the unique needs of this segment of its membership are a national priority. Working side by side with state and regional associations and with advice from its member council, the section

tracks, develops policies, and identifies solutions to their most pressing problems.

- Annual Flex Program Reverse Site Visit – contact TASC

If I want information from other states, e.g., asking questions or determining whether they are working on similar issues, how do I access this information?

There are several ways to access state Flex Program information, including:

- Contact information (email addresses, phone numbers and, websites) are available through the State Flex Profiles on the TASC website.
- The Flex Program Forum is a secure web-based message forum for use by the state Flex Programs. Forum content focuses on the Flex Program and rural health care. State Flex personnel can share messages, pose questions, post documents, web links, and comment on each other's posts. The Forum is a method for state Flex Programs to continue to connect and share information, ideas, lessons learned, and best practices.
- TASC hosts regularly scheduled TASC 90 webinars. These webinars address issues and topics of interest to state Flex Program Coordinators and CAHs. TASC 90 recordings are made publicly available on the TASC website. TASC hosts Flex Virtual Knowledge Group (VKG) webinars, which are peer discussions for state Flex Coordinators to share best practices and lessons learned. VKG recordings are only shared on the Flex Program Forum.

Where can I find ideas that may assist me in building my state Flex Program?

There are several resources designed for state Flex Program development, including:

- Staff at The Center working on the TASC program, TASC 90 webinars, other topical webinars, VKG webinars, Flex Program Reverse Site Visit, TASC website, Flex Program Forum, and the *Rural Route* e-newsletter (all coordinated by TASC)
- Other state Flex Programs and their websites, which can be found within the State Flex Profiles.
- Publications and the FMT website
- Health Resources and Services Administration (HRSA) FORHP
- National Rural Health Association (NRHA) Annual Conference and Annual CAH Conference

- National Organization of State Offices of Rural Health (NOSORH) Annual Meeting
- The TASC Core Competencies for State Flex Program Excellence, which identifies nine Flex Program competencies and provides a guide to state Flex Programs for improving capacity in each of the nine areas.
- The Rural Health Information Hub (RHIhub) provides access to current and reliable resources to learn about rural health needs and work to address them, including toolkits, resources, and evidence-based best practices.

Critical Access Hospitals

What is a CAH?

A CAH is a small rural hospital that has 25 beds (inpatient and/or swing beds) or fewer. CAHs have unique operating requirements and receive cost-based plus one percent reimbursement (101% of allowable costs) for providing inpatient and outpatient services and certain other services to Medicare* beneficiaries.

*Note - some states also provide cost-based reimbursement for inpatient and/or outpatient services for Medicaid services. This varies by state.

Which hospitals are eligible for a CAH designation? **

A Medicare-participating hospital can become certified and remain certified as a CAH by meeting the following regulatory requirements (this list is not all-inclusive but indicates some of the basic criteria):

- Located in a state that established a rural health plan for Medicare Rural Hospital Flexibility Program (as of 2018, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island have not established Medicare Rural Hospital Flexibility Program (State Rural Plans).
- Located in a rural area or an area treated as rural under a special provision that allows treating qualified hospital providers in urban areas a rural (refer to 42 CFR 412.103 regulations).
- Furnishes 24-hour emergency services, 7 days a week, using either on-site or on-call staff, with specific on-site, on call staff response times.
- Does not exceed 25 inpatient beds also used for swing bed services. It may operate a distinct part rehabilitation and/or psychiatric unit, each up to 10 beds.

- Maintain an annual average acute care inpatient length of stay (LOS) of 96 hours or less (excluding swing bed services and DPU beds). Medicare does not assess this requirement on initial certification, and it only applies after CAH certification.
- A CAH that has not been designated as a necessary provider (a state designation that sunsetted December 31, 2005) must be located more than a 35-mile drive (or in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from any other CAH or hospital.

Can a CAH convert back from CAH designation to Prospective Payment System (PPS)?

Yes, a CAH can convert back to be a PPS hospital. Contact TASC for examples of hospitals that have converted back to PPS status.

Can a CAH have distinct-part units (DPUs) (e.g., psych units)?

Yes. As part of the MMA (2003), a CAH may operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds (e.g., one psychiatric DPU up to 10 beds and one rehabilitation DPU up to 10 beds).

What does "make available 24-hour emergency medical services" mean?

A CAH that does not have inpatients may close (e.g., be unstaffed) provided there is an emergency medical response system in place to address the needs of patients that present at the hospital. This emergency medical response system must ensure that a practitioner with training and experience in emergency care (Doctor of Medicine or Osteopathy, Physician Assistant, or Nurse Practitioner) is on-call and available by telephone or radio 24 hours a day and available on-site at the CAH within 30 minutes.

Are CAH licensure surveys announced or unannounced?

CAH licensure surveys are unannounced. CAHs have an initial survey and then a follow-up survey approximately one year later. Subsequent survey schedules vary by state.

Examples of mock surveys from state offices of rural health (SORH) can be found in the resources on the TASC website.

Will the CAH be given a new provider number upon conversion to CAH?

Yes, a new provider number will be assigned.

What bed count will be used to determine whether a hospital qualifies as a CAH?

A CAH can have up to 25 Medicare certified beds, including swing beds. Some states allow CAHs to have a larger number (above 25) of state licensed beds; however, they cannot be staffed by the hospital as it will place them over the 25-bed count.

Are observation beds or recovery lounges counted towards the 25 acute care bed limit?

Beds used solely for patients receiving observation services are not included in the 25 acute care bed limit. There are some observation services that are not appropriate and can be referenced in Appendix W. Recovery lounges used in surgery do not count if the patient in the bed meets the criteria for use in the CMS Interpretive Guidelines. Remember, it does not matter the kind of bed (gurney, lounger, etc.), it is the status of the patient in the bed.

What happens if emergency situations require greater in-patient capacity than 25 beds?

CAHs can exceed the 25 acute care bed limit in emergency situations, e.g., a disease epidemic, but must document the circumstances to the satisfaction of federal and state officials.

Can a CAH build a new hospital and still be a CAH?

Yes, but certain requirements must be maintained or met anew. For hospitals that require a state necessary provider waiver to be a CAH, refer to the Medicare Conditions of Participation for CAHs, section §485.610(d) Standard: Relocation of CAHs With a Necessary Provider Designation Interpretive Guidelines §485.610(d).

For CAHs that are not designated as necessary providers, please see the Medicare Conditions of Participation for CAHs, section §485.610(c) Standard: Location Relative to Other Facilities or Necessary Provider Certification Interpretive Guidelines.

Are CAHs issues the same across all states?

No. All states have unique rules and regulations that may affect CAH operations in the state. Therefore, in many instances, states must refer to state licensing and other regulatory experts for information and guidance.

Section 2 - Federal Office of Rural Health Policy

Overview and Funding

The Federal Office of Rural Health Policy (FORHP) was created in 1987 to advise the Secretary of the U.S. Department of Health and Human Services on health care issues impacting rural communities, including:

- Access to quality health care and health professionals
- Viability of rural hospitals
- Effect of the Department's proposed rules and regulations, including Medicare and Medicaid, on access to and financing of health care in rural areas

In line with the mission of the Health Resources and Services Administration (HRSA), FORHP helps increase access to care for underserved populations and build health care capacity through several programs:

Community Based Division (CBD)

Provides support to community organizations to improve health care service delivery and strengthen health networks and encourages collaboration among rural health care providers.

Hospital State Division (HSD)

Supports on-going improvements in care to 50 State Offices of Rural Health (SORH) and to rural hospitals through the Medicare Rural Hospital Flexibility (Flex) Program. HSD also supports technical assistance for small rural hospitals, including critical access hospitals.

Policy Research Division (PRD)

Coordinates the review of proposed regulations to assess the potential impact on rural health care delivery and financing, the division also supports eight Rural Health Research Centers across the country and staffs the National Advisory Committee on Rural Health & Human Services.

Rural Strategic Initiatives Division (RSID)

Coordinates the Rural Communities Opioid Response Program (RCORP) and other new initiatives such as the COVID-19 Tribal program.

For information on locations eligible to receive Rural Health Grants, please refer to the HRSA Eligibility Analyzer.

For more information on rural health grant opportunities, please refer to the Rural Health Funding Opportunities webpage.

Federal Office of Rural Health Policy Flex Program Project Officers

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FORHP Project Officers for Rural Hospital Programs Regional Map

Performance Improvement and Measurement System

The Performance Improvement & Measurement System (PIMS) module is a data collection tool that is integrated with the HRSA Electronic Handbooks system (EHBs), a grant support and performance management application that unifies the Health Resources and Services Administration (HRSA) grant management processes and enables electronic data submission. PIMS allows FORHP to gather standardized data from recipients for each of the six Flex Program areas: CAH Quality Improvement (required); CAH Operational and Financial Improvement (required); CAH Population Health Improvement (Optional); Rural Emergency Medical Services (EMS) Improvement (Optional); Rural Innovative Model Development (Optional); and CAH Designation (required if requested).

The Federal Office of Rural Health Policy (FORHP) completely revised PIMS in 2016 to collect data for the previous project period from September 1, 2015, to August 31, 2019. Award recipients annually complete PIMS reports which are due in October.

Using PIMS, state Flex recipients report:

- CAHs that participated in Flex-funded improvement activities
- CAHs that improved on the measure or outcome that was the target of the activity
- Funds spent in each category of Flex activities
- Hospitals requesting and receiving help with CAH conversion

These reports document the important training, technical assistance, consultations, and other improvement projects provided to CAHs and rural health care organizations through the state Flex Programs. PIMS data improve program-wide measurement and evaluation and are used to calculate the Flex Program performance measures for the annual HRSA Budget Justification.

For questions on Flex PIMS data collection, please contact:

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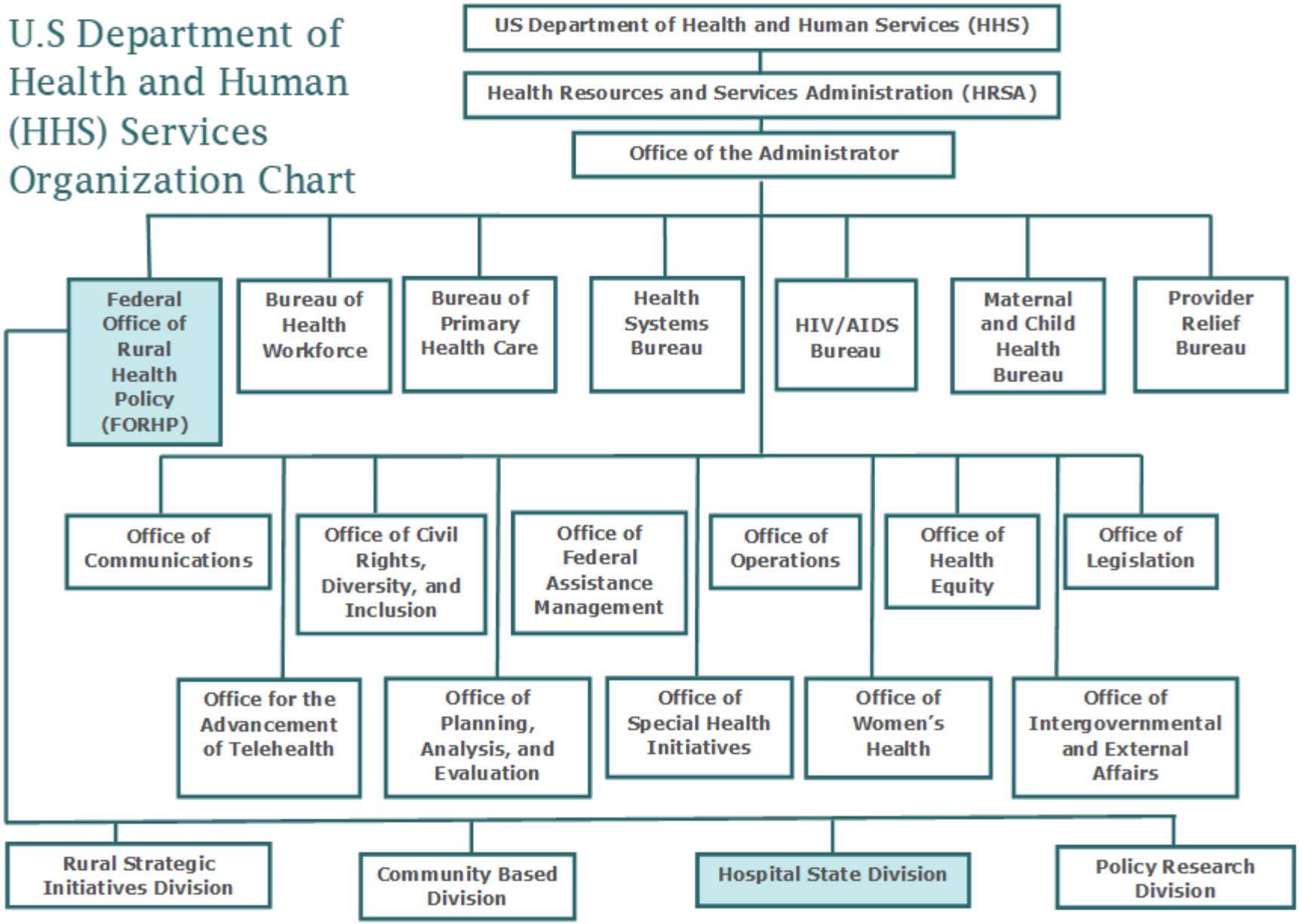
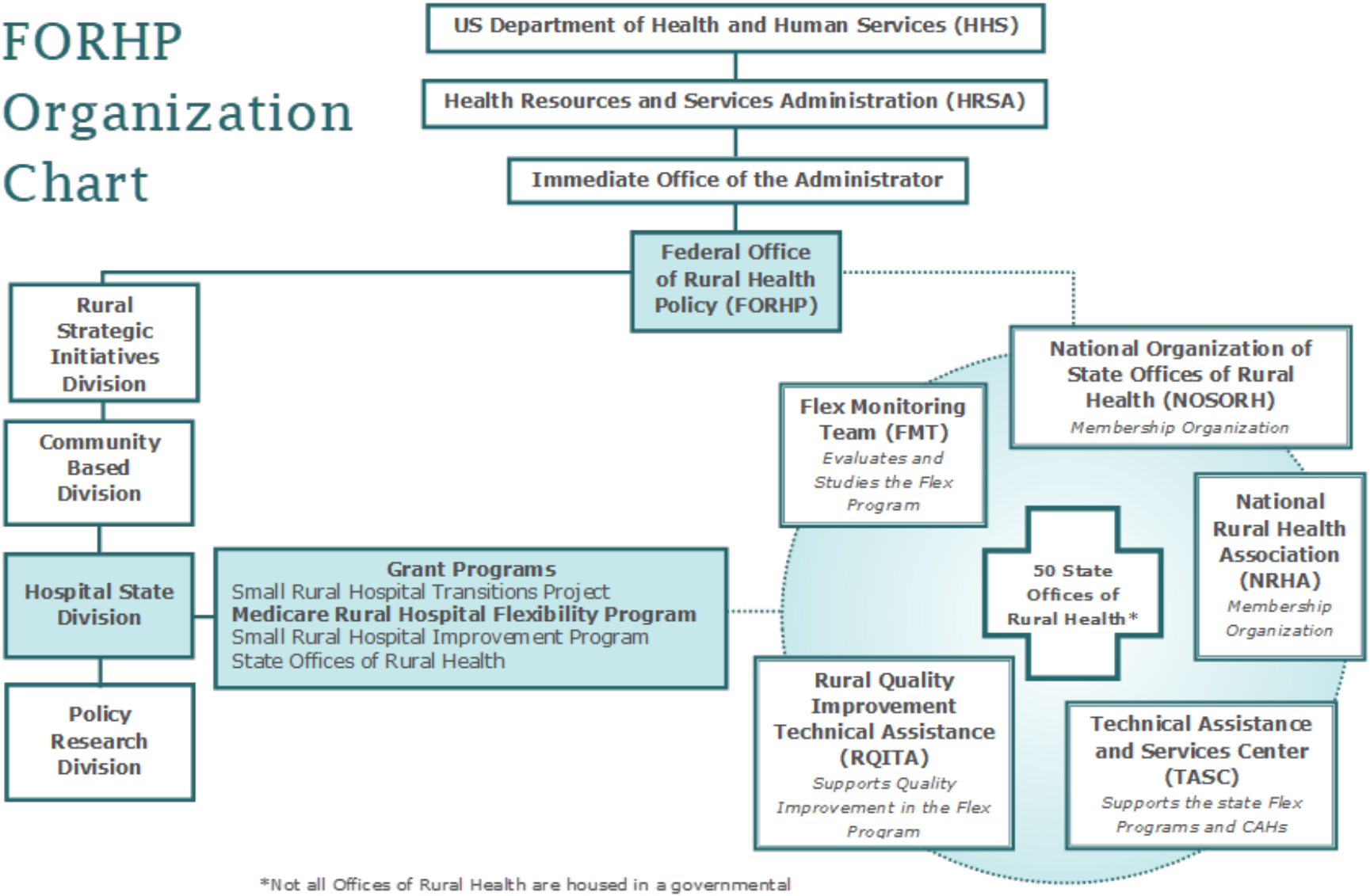
U.S Department of Health and Human (HHS) Services Organization Chart



FORHP Organization Chart



*Not all Offices of Rural Health are housed in a governmental agency. Some are housed in universities or non-profit entities.

Section 3 - Introduction to the Technical Assistance and Services Center

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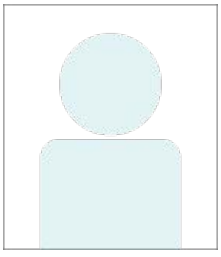

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Technical Assistance and Services Center Communication Tools and Technical Assistance

The goal of the Technical Assistance and Services Center (TASC) is to provide direct and timely information, education, tools, and resources that are easy for Flex Programs to use. TASC offers a variety of communication tools and technical assistance (TA) services.

Communication Tools

- TASC website
- TASC e-mail listservs
- TASC 90, Virtual Knowledge Groups (VKGs), and other educational webinars
- Podcasts
  - Also found on iTunes and Google Play
- Flex Program Forum
- Monthly electronic newsletter, *Rural Route*
- Social media
  - LinkedIn
  - Facebook
  - Twitter

For assistance getting signed up for the email listservs, webinars, Flex Program Forum, and Rural Route, please reach out to tasc@ruralcenter.org.

Technical Assistance

- Ad hoc TA via email and phone
  - E-mail: tasc@ruralcenter.org
  - Telephone: (218) 727-9390 or (877) 321-9393
- Educational presentations (onsite or virtual)
- Online resource library
- Consultant and subject matter expert speaker referrals

- Educational guides, manuals, and toolkits
- Learning collaboratives on specific topics to improve state Flex Program performance
- Semi-annual Flex Program Workshop for new state Flex Program personnel
- Annual Flex Program Reverse Site Visit (conference) for all state Flex Program personnel

Technical Assistance and Services Center Website

The Technical Assistance and Services Center (TASC) website contains a wide variety of useful information, tools, and resources to support all program areas of the Flex cooperative agreement:

- Electronic version of the Flex Program Fundamentals Guide
- Access to federal Flex Program and regulatory updates
- Flex cooperative agreement and Flex EMS supplement grant guidance and supporting documents
- Core Competencies for State Flex Program Excellence Guide and Self-Assessment
- Critical Access Hospital Recognition, and Hospital and Network Spotlights
- Flex Program Forum (login access required)
- Flex Program Reverse Site Visit information and materials
- Resources to support the Medicare Beneficiary Quality Improvement Project (MBQIP), including the MBQIP Monthly e-newsletter and Reporting Reminders
- Population Health Toolkit, data scenarios, resources, and population health readiness assessment
- Rural Community Ambulance Agency Transformation Toolkit, including self-assessment and resource collections
- State Flex profiles including current descriptions of Flex Program activities by program area, and state Flex Program staff contact information
- Upcoming and archived educational events, including TASC 90 webinars, Virtual Knowledge Group webinars, and Learning Collaborative recordings and supporting materials
- Health information technology (HIT) resources, and open invitation to state Flex Programs to participate in the National Rural HIT Coalition informational calls
- Leadership video series to critical access hospital mid-level and board leaders in the transition to value-based care and payment

Federal Office of Rural Health Policy Flex Program Workshop

The Federal Office of Rural Health Policy (FORHP) Flex Program Workshop aims to provide new or existing state Flex Program staff an orientation to the Medicare Rural Hospital Flexibility (Flex) Program. Sessions are presented by the National Rural Health Resource Center/Technical Assistance and Services Center (TASC), FORHP, Flex Monitoring Team, Rural Quality Improvement Technical Assistance (RQITA), and additional subject matter experts. Upon workshop completion, participants will better understand the Flex Program's goals and services available to support Flex Program excellence.

Attendance and Participation Requirements

As a condition of the state Flex Program cooperative agreement, state programs with new Flex Coordinators or Flex Program Directors are expected to attend the Flex Workshop within one year of their hire date. There is no fee to participate in the Flex Workshop. However, there are a few expectations for participating attendees:

- Participate in a pre-event webinar.
- Complete the Core Competencies for State Flex Program Excellence self-assessment.
- Upon completing the workshop, participants will choose an activity to implement based on knowledge gained from the workshop related to the Core Competency self-assessment results. Participants receive individualized coaching and resources from TASC to support the implementation of their chosen activity.

Workshop topics commonly include:

- History and direction of the Flex Program
- Program areas of the Flex Program
- Understanding the value-based health care system and resources to support rural value-based care and payment
- Critical access hospital (CAH) finance and the top 10 financial indicators for CAHs
- CAH leadership perspectives panel discussion
- Network collaboration and development

- National quality initiatives and the Medicare Beneficiary Quality Improvement Project (MBQIP)
- Core Competencies for State Flex Program Excellence
- Rural emergency medical services (EMS) challenges and opportunities
- Community and population health
- Flex Program evaluation
- Best practices and tips for Flex Coordinators

The FORHP Flex Program Workshop is held twice a year, generally in April and October. While there is no charge to attend the workshop, state Flex Programs are required to pay for their travel to and from Duluth, MN, where the in-person events are held. Travel and lodging expenses are allowable as part of the Flex grant.

The past few Workshops have been held virtually. We will continue to make decisions on in-person versus virtual workshops for the foreseeable future in response to the public health emergency and pandemic. TASC and FORHP will make timely announcements about the location and logistics of future workshops.

For more information about the FORHP Flex Program Workshop, please contact TASC at tasc@ruralcenter.org or (877) 321-9393.

Section 4 - Flex Monitoring Team

The Flex Monitoring Team Staff

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Kristin Reiter, PhD
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Flex Program Fundamentals

About the Flex Monitoring Team

INTRODUCTION

The Flex Monitoring Team (FMT) is a consortium of researchers from the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. With a five-year (2018–23) cooperative agreement award (PHS Grant No. U27RH01080) from the Federal Office of Rural Health Policy (FORHP), the FMT monitors and evaluates the Flex Program by developing relevant quality, financial, and community-benefit performance measures and reporting systems. FMT research assesses the impact of the Flex Program on Critical Access Hospitals (CAHs) and rural communities. The team also examines the ability of the State Offices of Rural Health to achieve overall Flex Program objectives: improving access to quality health care services, improving the financial and operational performance of CAHs, and engaging rural communities in healthcare system development.

HOW THE FLEX MONITORING TEAM CAN HELP YOU

The FMT's researchers have years of experience examining topics that are directly relevant to CAHs and the Flex Program. Ongoing and annual research projects typically result in publications that state Flex Coordinators can use to gain a better understanding of CAH financial and operational performance, quality performance, and community impact to support your work (presentations and meetings, grant applications, publications, etc.) with CAH-relevant evidence. The FMT website provides access to all FMT publications, presentation slides, data reports, project descriptions, and more.

The Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS) is an online data query system that allows state Flex Coordinators to explore the financial, quality, and community-benefit performance of CAHs. Data for CAHs in your state are identified by name; however, data for CAHs in other states are shown but not identified. The financial data portal requires an authorized login and password made available to state Flex Coordinators, State Office of Rural Health directors, and CAH CEOs and CFOs. New developments to the financial portal include data visualizations showing predicted risk of CAH financial distress and showing state-level CAH reporting and performance on select financial indicators as compared to national benchmarks. Quality and community data are now aggregated to the state level and are publicly available without a login on a new website, launched in early 2019. For quality performance, users can create customized tables and graphs with Hospital Compare data, make comparisons between states, and create tables and graphs for individual or pre-defined sets of measures. Community data also allow users to create customized reports with measures related to community socioeconomic characteristics, health outcomes, health risks and behaviors, and more. Visit the CAHMPAS website for more information and, for financial CAHMPAS login credentials, contact the FMT at monitoring@flexmonitoring.org.

The FMT uses an email listserv to disseminate reports and publications. As a state Flex Coordinator, you are automatically subscribed to this list as a requirement of your grant award. Other Flex Program/CAH staff in your state can easily subscribe by contacting the FMT or submitting information via the FMT's homepage.

ONGOING PROJECTS

Analyzing Financial, Quality, and Community Impact Performance of CAHs
Purpose: to improve financial, quality, and community impact performance of CAHs through data analysis and dissemination in the three domains. The project will produce numerous data products on financial, quality, and community impact, using a variety of data sources, including the American Hospital Association Annual Survey, the Hospital Compare database, and the Medicare Beneficiary Quality Improvement Project (MBQIP).

CAHMPAS Query System Maintenance, Enhancement, and Development
Purpose: to prepare and upload updated data for CAHMPAS, develop new and maintain existing features on the website, and provide technical assistance to registered users. In the coming year, this project will refine the financial dashboard and enhance user functions for the financial, quality, and community data to provide information in the most useable format for CAHs and state Flex Coordinators.

Maintaining and Updating the National CAH Database
Purpose: to continue tracking CAH conversions and closures. A CAH dataset housed at the University of North Carolina will be updated with information on conversions supplied by the Centers for Medicare and Medicaid Services (CMS). These data are also used to update products on the FMT website, including a spreadsheet that lists all certified CAHs and a map of current CAHs. The site also includes a table that contains state-level totals of the number of CAHs, the number of CAHs with rehabilitation distinct part units (DPU), and the number of CAHs with psychiatric DPUs.

NEW PROJECTS, 2021–2022

Supporting CAHs and CAH Staff During the COVID-19 Pandemic
This project will: A) assess the impact of system affiliation among CAHs and identify best practices for supporting independent CAHs during the COVID-19 crisis, and B) identify and highlight best practices for CAHs supporting their staff during the COVID-19 pandemic.

Evaluation of the Flex Program
This project will: A) collect and analyze data to evaluate FORHP's Quality Innovation Labs projects, and B) produce recommendations for the future of the Flex Program during the current funding cycle and the next funding cycle.

Evaluating the EMS Supplemental Funding Program and Identifying EMS Licensure Elements
This project concludes a multi-year evaluation of the eight Flex EMS Supplemental funding grantees, and also will identify a rural-relevant minimum data set of core EMS agency licensure elements for consideration by state EMS agencies.

Financial and Community Characteristics of CAHs Participating in Value-Based Care
This project will describe the participation of CAHs in value-based care (VBC) initiatives, and compare the financial and community characteristics of CAHs participating in VBC initiatives and CAHs not participation in VBC initiatives.

Examining CAH Engagement in Multi-Sector Community Networks
This project will examine the involvement of CAHs in multi-sector community health networks and identify strategies to assist CAHs in developing collaborative relationships with local health departments, other health care providers, and social service agencies to develop and improve local systems of care.

Use of Translation Services in CAHs
This project will identify and disseminate best practices for providing translation services in CAHs, particularly those in communities with larger populations who have limited English proficiency.

RESEARCH PUBLICATIONS

The Flex Monitoring Team publishes research findings in the form of briefing papers (detailed, comprehensive reports), policy briefs (shorter overviews paired with key findings), data summary reports (comprehensive collections of data), topic-specific toolkits, and state-specific reports.

All publications are searchable on the website by topic, date, or keyword and are freely available for download. The Flex Monitoring Team's most recent publications include:

- Outcome Measures for State Flex Program Financial and Operational Improvement Interventions (policy brief)
- Critical Access Hospitals' Initial Response to COVID-19 by System Affiliation (data report)
- MBQIP Quality Measures National Annual Report – 2020 (data report)
- Critical Access Hospitals' Initial Response to the COVID-19 Pandemic: Use of Federal Funding and Regulatory Flexibilities (policy brief)

- How Critical Access Hospitals Are Addressing the Social Needs of Rural Populations (policy brief)
- The Association Between System Affiliation and Financial Performance in Critical Access Hospitals (policy brief)
- Community Impact and Benefit Activities of CAHs, Other Rural, and Urban Hospitals, 2019 (data report)
- CAH Financial Indicators Report: Summary of 2019 Indicator Medians by State (data report)
- Promising Flex Program Initiatives to Support Critical Access Hospitals during the COVID-19 Pandemic (policy brief)
- Evaluation of the Use of CAH Cohorts for Quality Improvement Activities (policy brief)
- Innovations and Workforce Challenges for CAHs during COVID-19 (policy brief)
- CAH Partnerships during the COVID-19 Pandemic (policy brief)
- Monitoring State Flex Program Financial and Operational Improvement Activities (policy brief)
- Rural Initiatives Addressing Community Social Needs (case series)
- MBQIP Quality Measures Annual Report – 2019 (data report)

CONTACT THE FLEX MONITORING TEAM

Email: monitoring@flexmonitoring.org

FMT website: flexmonitoring.org

CAHMPAS website: cahmpas.flexmonitoring.org

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Section 5 - Rural Quality Improvement Technical Assistance

Rural Quality Improvement Technical Assistance Staff

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Rural Quality Improvement Technical Assistance (RQITA)

About RQITA

RQITA's goal is to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of Federal Office of Rural Health Policy (FORHP) quality initiatives, which are focused on quality measure reporting and improvement:

  - Small Health Care Provider Quality Improvement Grantees (Rural Quality Program)
  - Medicare Rural Hospital Flexibility (Flex) Program, including the Medicare Beneficiary Quality Improvement Project (MBQIP)

- Intended to add expertise related to quality reporting and improvement, not to replace technical assistance support already in place.
- Funded through a Health Resources and Services Administration (HRSA) FORHP cooperative agreement to Stratis Health, initially awarded 2015-2018, and awarded again for 2018-2023.
- For more information about the RQITA project, visit the Stratis Health RQITA webpage.
- Learn more about the team by reviewing the RQITA Team Biographies.

About Stratis Health

Stratis Health is an independent nonprofit with more than 50 years of furthering the organizational mission to collaborate and innovate to improve health. For more information about Stratis Health, visit the Stratis Health website.

- Nationally recognized experts in rural health quality; longstanding trusted relationships with rural providers, critical access hospitals (CAHs), state offices of rural health, and FORHP.
- Other federal roles include serving as a Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) and as a partner in the FORHP funded Rural Health Value team.
- Through RQITA, Stratis Health works to implement technical assistance to support quality reporting and improvement, collaborating with FORHP and other partners, including:
  - Technical Assistance and Services Center (TASC)
  - Flex Monitoring Team (FMT)
  - State Flex Programs
  - Georgia Health Policy Center (Rural Quality Program technical assistance provider)

MBQIP Tools and Resources

MBQIP tools and resources are posted on the TASC MBQIP webpage. Some key resources include:

- **MBQIP Fundamentals Guide for State Flex Programs:** Intended to help state Flex Program personnel and relevant subcontractors understand the basics of MBQIP, including current state and history of the program, as well as key resources available to support them in their work.
- **MBQIP Monthly:** Monthly e-newsletter that provides CAHs with information and support for quality reporting and improvement.
- **MBQIP Quality Reporting Guide:** Helps Flex coordinators, CAH staff, and others involved with MBQIP understand the measure reporting process. For each reporting channel, information is included on how to register for the submission site, which measures are reported to the site, and how to submit those measures to the site.
- **Quality Improvement Basics Course**: A series of recordings and related resources designed to equip professionals (state Flex programs, CAHs, emergency medical service personnel, etc.) with the knowledge and tools to start quality improvement projects at their organizations. The course may be completed in sequence or individual modules and tools may be used for stand-alone training and review.
- **Quality Time: Sharing PIE (performance improvement experience):** Recorded conversations in a podcast format featuring skilled CAH quality improvement staff from across the country sharing lessons and key themes that help drive quality improvement in their hospitals.
- **Quality Improvement Implementation Guide and Toolkit for CAHs:** Offers strategies and resources to help CAH staff organize and support efforts to implement best practices for quality improvement.
- **MBQIP Data Reporting Reminders:** Reminders of upcoming data submission deadlines for MBQIP measures, posted monthly for Flex staff to cut and paste into their state CAH communications as appropriate.
- **MBQIP Measure Fact Sheets:** One-page summaries of all MBQIP required measures.

Additional support

- **MBQIP Virtual Knowledge Groups:** A facilitated forum for state Flex Program personnel and subcontractors to share quality reporting and improvement successes, discuss challenges, and brainstorm strategies to assist hospitals toward reporting, improving, and excelling in quality.
- **MBQIP Individualized Technical Assistance and Consultations:** RQITA team members are available for one-on-one discussions with Flex staff and/or MBQIP subcontractors to help support state level implementation (email RQITA staff directly or reach out to tasc@ruralcenter.org to get connected).
- **MBQIP Orientation Sessions:** RQITA offers orientation sessions for new state Flex staff, which are typically facilitated in follow up to orientation with the TASC team. These orientation sessions are also available for state Flex staff and MBQIP subcontractors upon request. Email tasc@ruralcenter.org to get connected.

- **Quality Training and Presentations:** RQITA team members are available to present at webinars and/or in-person training events and workshops.

MBQIP Technical Assistance Requests

Process for MBQIP technical assistance requests/questions:

- CAHs are encouraged to contact their state Flex Program as first line of MBQIP support.
- Flex Coordinators should direct MBQIP questions to TASC, tasc@ruralcenter.org. TASC serves in "triage" role to respond and resolve or forward to RQITA or FORHP as appropriate.
- TASC and RQITA have processes to connect with state Flex coordinators when contacted directly by CAH.

Fiscal Year 2021 Quality Improvement Projects

RQITA is supporting state Flex programs with their fiscal year 2021 quality improvement projects through individualized technical assistance and convening of quality innovation labs (QILs) offering an opportunity for states working to learn from and with one another. For more information, contact Sarah Brinkman, sbrinkman@stratishealth.org.

Rural Quality Advisory Council

RQITA facilitates a quarterly Rural Quality Advisory Council on behalf of FORHP. The Council is comprised of leaders in rural health quality, representing diverse perspectives from across the country and its purpose is to:

- Provide feedback, guidance, and insight on the development, implementation, and evaluation of the RQITA technical assistance strategies for the MBQIP and SCHPQI programs.
- Offer advice and counsel on development of rural-relevant quality improvement goals and metrics, and their integration more broadly into new and existing FORHP funded programs.

Need more information?

Contact Sarah Brinkman, sbrinkman@stratishealth.org or 952-853-8552.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $740,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official view of, nor an endorsement, by HRSA, HHS or the U.S. Government. (November 2021).

Section 6 - Flex Coordinator Reference

A list of state Office of Rural Health Directors/Flex Program contacts is available within the State Flex Profiles on the TASC website.

Useful Organizations

National Rural Health Resource Center

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

The Technical Assistance and Services Center (TASC), a program of The Center, provides information, tools, and education to critical access hospitals (CAHs) and to individual state Medicare Rural Hospital Flexibility (Flex) Programs.

Federal Office of Rural Health Policy

The Federal Office of Rural Health Policy (FORHP) was created in 1987 to advise the Secretary of the US Department of Health and Human Services (HHS) on health care issues impacting rural communities, including:

- Access to quality health care and health professionals
- Viability of rural hospitals
- Effect of the Department's proposed rules and regulations, including Medicare and Medicaid, on access to and financing of health care in rural areas

In line with the mission of the Health Resources and Services Administration (HRSA), FORHP helps increase access to care for underserved populations and builds health care capacity through several programs:

Community Based Division (CBD) - Provides support to community organizations to improve health care service delivery and strengthen health networks and encourages collaboration among rural health care providers.

Hospital State Division (HSD) - Supports on-going improvements in care to 50 State Offices of Rural Health (SORH) and to rural hospitals through

the Flex Program. HSD also supports technical assistance for small rural hospitals, including CAHs.

Policy Research Division (PRD) - Coordinates the review of proposed regulations to assess the potential impact on rural health care delivery and financing, the division also supports eight Rural Health Research Centers across the country and staffs the National Advisory Committee on Rural Health & Human Services

Rural Strategic Initiatives Division (RSID) - Coordinates the Rural Communities Opioid Response Program (RCORP) and other new initiatives such as the COVID-19 Tribal program.

Flex Monitoring Team

The Flex Monitoring Team (FMT) is a consortium of researchers from the Universities of Minnesota, North Carolina-Chapel Hill, and Southern Maine. They are funded by the FORHP to evaluate the impact of the Flex Program. The FMT also operates and maintains the Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS) for easy access to financial, quality, and community benefit measures.

All of their efforts aim to improve the accessibility, viability, and quality of health care for rural residents and communities. They provide state Flex Programs and critical access hospitals (CAHs) with ways to optimize their performance based on evidence and/or best practices. FMT conducts analysis', collect and track state-level CAH data, maintains a national database of CAHs, consults with their expert workgroup for feedback and input, collaborates with TASC and other organizations to provide project services, and share findings at meetings, webinars, and conferences. The FMT's work focuses on three main topic areas: quality, finance, and community engagement.

Rural Quality Improvement Technical Assistance

The goal of the Rural Quality Improvement Technical Assistance (RQITA) is to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of FORHP quality initiatives, which are focused on quality measure reporting and improvement: Small Health Care Provider Quality Improvement (SHCPQI) and the Medicare Beneficiary Quality Improvement Project (MBQIP). RQITA is intended to add expertise related to quality reporting and improvement by working closely with FORHP and technical assistance partners. RQITA is a program of Stratis Health, an

independent nonprofit organization that leads collaboration and innovation in health care quality and patient safety.

Resources to support MBQIP can be found on the MBQIP webpage.

Agency for Healthcare Research and Quality

The Agency for Healthcare Research and Quality's (AHRQ) mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within HHS and with other partners to ensure the evidence is understood and used. AHRQ's broad programs of research bring practical, science-based information to medical practitioners and to consumers and other health care purchasers.

The American Health Quality Association

The American Health Quality Association (AHQA) is an educational, not-for-profit, national membership association dedicated to promoting and facilitating fundamental change that improves the quality of health care in America. AHQA represents Quality Improvement Organizations (QIOs) and professionals working to improve health care quality and patient safety.

American Hospital Association

The American Hospital Association (AHA) is a national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. Through representation and advocacy activities, AHA ensures that members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters. AHA provides education for health care leaders and is a source of information on health care issues and trends.

Bureau of Labor Statistics

The Bureau of Labor Statistics (BLS) of the U.S. Department of Labor is the principal federal agency responsible for measuring labor market activity, working conditions, price changes, and productivity in the economy. BLS is an independent national statistical agency that collects, analyzes, and disseminates essential economic information to support public and private decision-making.

Center for Connected Health Policy

The Center for Connected Health Policy (CCHP) is a nonprofit, nonpartisan

organization working to maximize telehealth's ability to improve health outcomes, care delivery, and cost effectiveness. Established in 2008, CCHP acts as a catalyst for change by providing nonpartisan, unbiased, and research-based analyses, reports, and telehealth resources to policy makers, the private health care sector, health plans, academic researchers, and consumer health advocates. CCHP's mission is to advance state and national telehealth policies that promote better systems of care, improved health outcomes, and provide more equitable access to quality, affordable health care and services.

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) is a federal agency within HHS tasked with strengthening and modernizing America's health care system while providing quality care at lower costs. More than 100 million people are covered through the CMS managed programs of Medicare, Medicaid, the Health Insurance Marketplace, and the Children's Health Insurance Program (CHIP). CMS is comprised of 10 regional offices with staff who work collaboratively with state and local representatives to provide oversight and foster innovation.

The Commonwealth Fund

The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

Georgia Health Policy Center

The Georgia Health Policy Center (GHPC) provides evidence-based research, program development and policy guidance to improve health status at the community level. The center conducts, analyzes and disseminates qualitative and quantitative findings to connect decision makers with the objective research and guidance needed to make informed decisions about health policy and programs. The center provides technical assistance under contract with FORHP to rural health networks.

Health Resources and Services Administration

The mission of the Health Resources and Services Administration (HRSA), an agency HHS, is to improve health outcomes and achieve health equity through access to quality services, a skilled health workforce and innovative high-value programs. HRSA's programs, including those overseen by the FORHP, provide health care to people who are geographically isolated, economically, or medically vulnerable.

Institute for Healthcare Improvement

The Institute for Healthcare Improvement (IHI), an independent, not-for-profit organization, is a recognized innovator, convener, leader, trustworthy partner, and driver of results in health and health care improvement worldwide. IHI's strategy to improve health and health care worldwide has four key areas: improve the health of populations, build the capacity to improve, and innovate and spark action. IHI works with a wide range of entities to seek and achieve science-based improvements in health and health care.

The Joint Commission

An independent, not-for-profit organization, the Joint Commission accredits and certifies nearly 22,000 health care organizations and programs in the US. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

MedlinePlus

MedlinePlus is the National Institutes of Health's (NIH) website for patients and their families and friends. Produced by the National Library of Medicine, MedlinePlus is the world's largest medical library, providing free, reliable, up-to-date information about diseases, conditions, and wellness issues. Resources include directories, a medical encyclopedia, a medical dictionary, health information in Spanish, extensive information on prescription and nonprescription drugs, health information from the media, and links to thousands of clinical trials.

National Center for Health Statistics

The National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention (CDC) is the nation's principal health statistics

agency. NCHS compiles statistical information to guide actions and policies to improve health. NCHS is a unique public resource for health information.

National Consortium of Telehealth Resource Centers

The National Consortium of Telehealth Resource Centers (TRCs) provides assistance, education, and information to those individuals and organizations that are providing or are interested in providing health care via telehealth. With funding through the HRSA Office for the Advancement of Telehealth (OAT), the consortium of 12 regional and two national TRCs assist to expand the availability of health care to rural and underserved populations.

National Cooperative of Health Networks Association

The National Cooperative of Health Networks Association (NCHN) is a national, professional membership organization comprised exclusively of health networks, alliances, and/or consortiums dedicated to supporting the success of health networks.

National Library of Medicine

The National Library of Medicine (NLM) has been a center of information innovation since its founding in 1836. The world's largest biomedical library, NLM maintains and makes available a vast print collection and produces electronic information resources on a wide range of topics. NLM also supports and conducts research, development, and training in biomedical informatics and health information technology.

National Organization of State Offices of Rural Health

The National Organization of State Offices of Rural Health (NOSORH) was established in 1995 to assist State Offices of Rural Health (SORHs) in their efforts to improve access to, and the quality of, health care for America's 57 million rural citizens. NOSORH enhances the capacity of SORHs to do this by supporting the development of state and community rural health leaders; creating and facilitating state, regional and national partnerships that foster information sharing and spur rural health-related programming; and enhancing access to quality health care services in rural communities.

National Rural Health Association

The National Rural Health Association (NRHA) is a national, nonprofit membership of more than 21,000 members, whose mission is to provide leadership on rural health issues through advocacy, communications, education, and research. NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

National Rural Recruitment & Retention Network

The National Rural Recruitment & Retention Network (3RNet) is a nonprofit, membership organization who works to improve rural and underserved communities' access to quality health care through recruitment of physicians and other health care professionals, development of community-based recruitment and retention activities, and national advocacy relative to rural and underserved health care workforce issues. The 3RNet is the national leader for community-based health professional recruitment and retention, using interactive technologies and communication.

Nursing Home Resource Center

CMS launched the Nursing Home Resource Center to serve as a centralized hub bringing together the latest information, guidance, clarification, instructions, and recent COVID-related policies and data on nursing homes that is important to facilities, frontline providers, residents, and their families.

Office for the Advancement of Telehealth

The Office for the Advancement of Telehealth (OAT) promotes telehealth as a way to deliver health care and supports the efforts of HHS to expand access and improvement health outcomes. OAT provides telehealth grant programs to promote and advance telehealth services in rural areas.

Rural Health Information Hub

The Rural Health Information Hub (RHIhub), formerly the Rural Assistance Center, is funded by FORHP to be a national clearinghouse on rural health issues. RHIhub is committed to supporting health care and population health in rural communities. RHIhub provides access to current and reliable resources and tools to learn about rural health needs and work to address them.

Rural Health Innovations

Rural Health Innovations (RHI), LLC is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation's leading technical assistance and knowledge centers in rural health. In partnership with The Center, RHI enhances the health of rural communities by providing products and services with a focus on excellence and innovation.

Rural Health Value

Rural Health Value is a cooperative agreement between the FORHP, the RUPRI Center for Rural Health Policy Analysis (RUPRI Center), and Stratis Health. The Rural Health Value Team will analyze rural implications of changes in the organization, finance, and delivery of health care services and will assist rural communities and providers transition to a high- performance rural health system. The RUPRI Center brings experience in a variety of research strategies including survey design, qualitative analysis, simulation development, and national database query and report design.

Rural Policy Research Institute

The Rural Policy Research Institute (RUPRI) undertakes unbiased research and analysis on the challenges, needs, and opportunities facing rural America. RUPRI's reach is national and international and is recognized as a trusted source of research-grounded expertise regarding the rural differential in public policies. RUPRI's activities encompass research, policy analysis and engagement, dissemination and outreach, and decision support tools. Through their work, RUPRI aims to foster public dialogue and help policymakers understand the impacts of public policies and programs on rural people and places.

Texas A&M Health Science Center for Optimizing Rural Health

The Center for Optimizing Rural Health is a program of the Texas A&M Health Science Center (TAMHSC) Rural and Community Health Institute (ARCHI). This FORHP funded technical assistance center supports the Vulnerable Rural Hospital Assistance Program. This program provides targeted in-depth assistance to vulnerable rural hospitals within communities that are struggling to maintain health care services.

U.S. Department of Health and Human Services

The mission of the U.S. Department of Health and Human Services (HHS) is to enhance the health and well-being of all Americans. This is achieved by providing for effective health and human services and by fostering sound, sustained advances in medicine, public health, and social services. The department is comprised of 11 operating divisions, including HRSA, which oversee a wide spectrum of activities. The FORHP is located within HRSA and is charged with informing and advising HHS on matters affecting rural hospitals and health care, coordinating activities within the department that relate to rural health care and maintaining a national information clearinghouse.

Acronyms 101

3RNet ..... National Rural Recruitment and Retention Network
AAA ..... American Ambulance Association
AAFP..... American Academy of Family Physicians
ACA ..... Affordable Care Act or Patient Protection and Affordable Care Act
ACHE ..... American College of Healthcare Executives
ACLS ..... Advanced Cardiac Life Support
ACO..... Accountable Care Organization
ACS ..... American College of Surgeons
ADC..... Average Daily Census
ADE..... Adverse Drug Event
AED..... Automated External Defibrillator
AFIB ..... Atrial Fibrillation
AFS ..... Ambulance Fee Schedule
AHA..... American Hospital Association
AHC..... Accountable Health Communities Model or Academic Health Center
AHIMA ..... American Health Information Management Association
AHQA..... American Health Quality Association
AHRQ..... Agency for Healthcare Research and Quality
AIM ..... ACO Investment Model
AIMS ..... Access Increases in Mental Health and Substance Abuse Services
AIR..... All Inclusive Rate
ALOS ..... Average Length of Stay
ALS ..... Advanced Life Support
AMA ..... American Medical Association or Against Medical Advice
AMC ..... Academic Medical Center
AMI ..... Acute Myocardial Infarction
AMIA ..... American Medical Informatics Association
ANA..... American Nurses Association
APC ..... Ambulatory Payment Classification
APM..... Alternative Payment Model or Advanced Alternative Payment Model
AR..... Accounts Receivable
ARP ..... American Rescue Plan
ARRA..... American Recovery and Reinvestment Act of 2009
ASC..... Ambulatory Surgical Center
ASP ..... Antibiotic Stewardship Program
ATLS..... Advanced Trauma Life Support
BBA..... Balanced Budget Act of 1997
BBRA..... Balanced Budget Refinement Act of 1999
BCBS..... Blue Cross Blue Shield
BCHS..... Bureau of Community Health Services
BFCC ..... Beneficiary and Family Centered Care Quality Improvement

BHP ..... Bureau of Health Professions
BHRD..... Bureau of Health Resources Development
BIA..... Bureau of Indian Affairs
BIPA ..... Benefits Improvement and Protection Act of 2000
BLS ..... Bureau of Labor Statistics or Basic Life Support
BPHC ..... Bureau of Primary Health Care
BSC..... Balanced Scorecard
BTLS..... Basic Trauma Life Support
CAC..... Children's Asthma Care
CAH..... Critical Access Hospital
CAHFIR ..... Critical Access Hospital Financial Indicator Report (FIR)
CAHMPAS .. Critical Access Hospital Measurement and Performance Assessment System
CALS ..... Comprehensive Advanced Life Support
CAP ..... Community Access Program
CARES Act. Coronavirus Aid, Relief, and Economic Security Act
CART ..... Centers for Medicare and Medicaid Services Abstraction and Reporting Tool
CAUTI ..... Catheter-Associated Urinary Tract Infection
CBO..... Congressional Budget Office
CBSA ..... Core Based Statistical Area
CC..... Care Coordination
CCHIT..... Certification Commission for Healthcare Information Technology
CCM ..... Coordinated Care Model or Chronic Care Management
CCN..... CMS Certification Number
CCO..... Coordinated Care Organization or Community Care Organization
CDC..... Centers for Disease Control and Prevention
CDE..... Clinical Data Exchange
CDI ..... Clostridioides difficile (C. diff.) Infection
CDS..... Clinical Decision Support
CEO..... Chief Executive Officer
CEHRT ..... Certified Electronic Health Record Technology
CEU ..... Continuing Education Unit
CFO ..... Chief Financial Officer
CFR ..... Code of Federal Regulations
CHC..... Community Health Center
CHIP..... Children's Health Insurance Program
CHNA..... Community Health Needs Assessment
CHW ..... Community Health Worker
CIT..... Critical Illness and Trauma Foundation
CLABSI ..... Central Line-Associated Bloodstream Infection
CLIA ..... Clinical Laboratory Improvement Act of 1967 or Clinical Laboratory Improvement Amendments of 1988
CME..... Continuing Medical Education
CMHC ..... Community Mental Health Center

CMMI ..... Center for Medicare and Medicaid Innovation
CMO ..... Chief Medical Officer
CMS ..... Centers for Medicare and Medicaid Services
CON ..... Certificate of Need
CoP ..... Conditions of Participation
COPD..... Chronic Obstructive Pulmonary Disease
COVID-19.. Coronavirus Disease 2019
CP ..... Community Paramedic or Community Paramedicine
CPC/CPC+ . Comprehensive Primary Care Initiative/Comprehensive
CPHQ..... Certified Professional in Healthcare Quality
CP-MIH ..... Community Paramedicine-Mobile Integrated Health
CPOE ..... Computerized Provider Order Entry
CPT ..... Current Procedural Terminology
CQI ..... Continuous Quality Improvement
CQM ..... Clinical Quality Measure
CRNA..... Certified Registered Nurse
CY ..... Calendar Year
DACA..... Data Accuracy and Completeness Acknowledgement
DEI..... Diversity, Equity, and Inclusion
DGME ..... Direct Graduate Medical Education
DHHS ..... Department of Health and Human Services (or HHS)
DME ..... Durable Medical Equipment
DPU..... Distinct Part Unit
DON ..... Director of Nursing
DOQ-IT ..... Doctor's Office Quality – Information Technology
DRG ..... Diagnosis Related Group
DSA ..... Disproportionate Share Adjustment
DSH ..... Disproportionate Share Hospital
DUNS ..... Dun and Bradstreet Universal Numbering System
DVT..... Deep Vein Thrombosis
EACH..... Essential Access Community Hospital
ECG..... Electrocardiogram
eCQM ..... Electronic Clinical Quality Measure
ED..... Emergency Department
EHDI ..... Early Hearing Detection and Intervention
EDIE..... Emergency Department Information Exchange
EDTC ..... Emergency Department Transfer Communication
eHI..... e-Health Initiative
EHBs ..... Electronic Handbooks System
EHR..... Electronic Health Record
EMR..... Electronic Medical Record, Emergency Medical Responder
EMS..... Emergency Medical Services
EMT..... Emergency Medical Technician
EMTALA..... Emergency Medical Treatment and Labor Act
ESRD..... End Stage Renal Disease

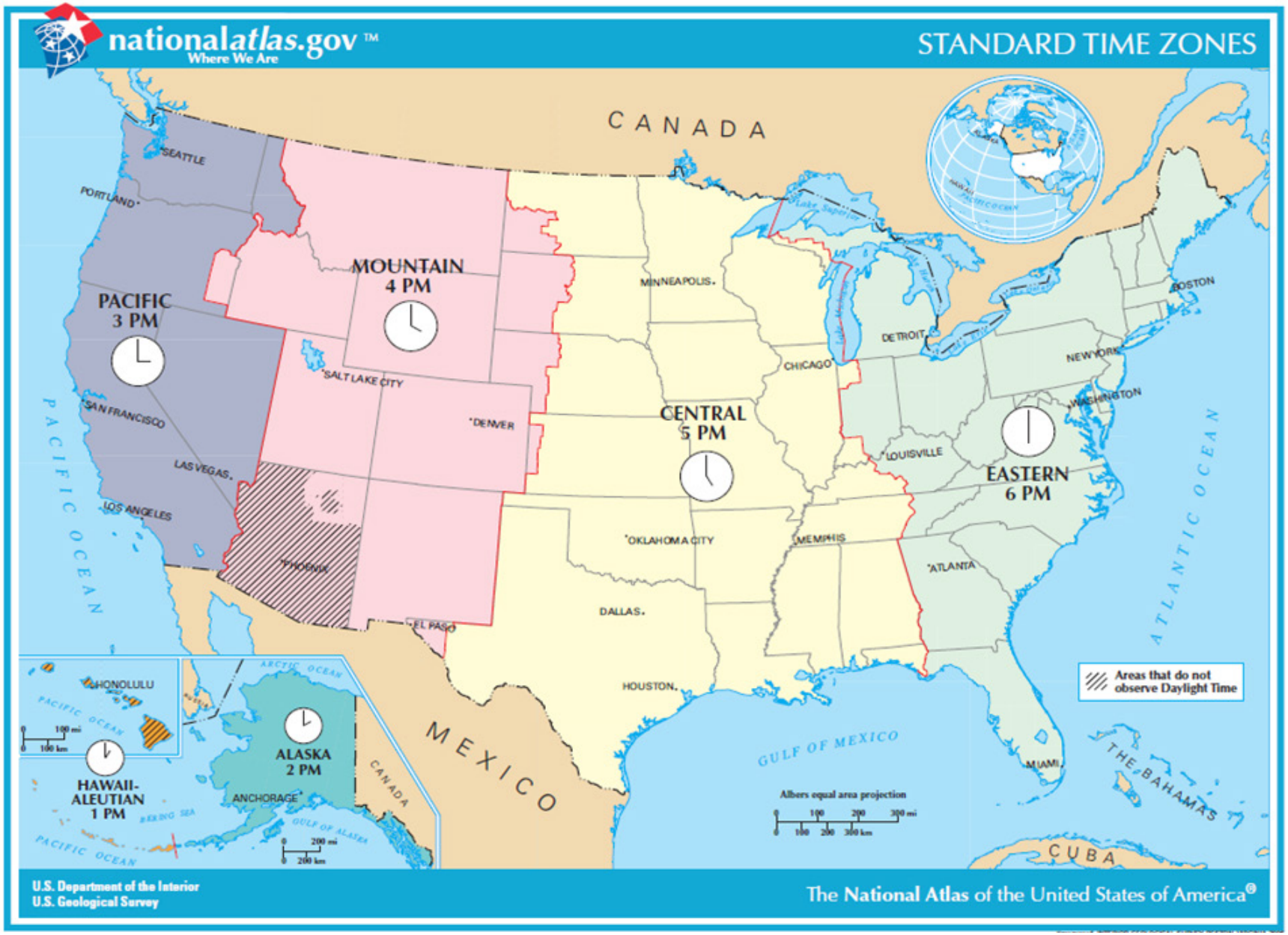
FACHE ..... Fellow of the American College of Healthcare Executives
FCC ..... Federal Communications Commission
FCHIP ..... Frontier Community Health Integration Project
FEC ..... Freestanding Emergency Center
FEMA ..... Federal Emergency Management Association
FESC ..... Frontier Extended Stay Clinic
FFR ..... Federal Financial Report
FFS ..... Fee-for-Service
FFR ..... Federal Financial Report
FHSR ..... Foundation for Health Services Research
FI ..... Fiscal Intermediary
FIR ..... Financial Indicators Report
Flex ..... Medicare Rural Hospital Flexibility Program
FMT ..... Flex Monitoring Team
FOA ..... Funding Opportunity Announcement
FOIA ..... Freedom of Information Act
FORHP ..... Federal Office of Rural Health Policy
FQHC ..... Federally Qualified Health Center
FTE ..... Full-Time Equivalent
FY ..... Fiscal Year
GAO ..... Government Accountability Office
GEMT ..... Ground Emergency Medical Transport
GI ..... Gastrointestinal
GME ..... Graduate Medical Education
GMS ..... Grants Management Specialist
GPRA ..... Government Performance and Results Act
HAC ..... Hospital Acquired Condition
HACRP ..... Hospital Acquired Conditions Reduction Program
HAI ..... Health Care-Associated Infection
HCAHPS .... Hospital Consumer Assessment of Healthcare Providers and Systems
HCPCS ..... Healthcare Common Procedure Coding System
HCP ..... Health Care Personnel
HCRIS ..... Healthcare Cost Report Information System
Health IT ... Health Information Technology
HEN ..... Hospital Engagement Network (see HIIN)
HHA ..... Home Health Agency
HHS ..... Department of Health and Human Services (or DHHS)
HIE ..... Health Information Exchange
HIIN ..... Hospital Improvement Innovation Network (formerly HEN)
HIMSS ..... Healthcare Information and Management Systems Society
HIPAA ..... Health Information Portability and Accountability Act
HIQR ..... Hospital Inpatient Quality Reporting Program
HISPC ..... Health Information Security and Privacy Collaboration
HIT ..... Health Information Technology

HITECH ..... Health Information Technology for Economic and Clinical
HITEQ ..... Health Information Technology Evaluation, and Quality Center
HITSP ..... Health Information Technology Standards Panel
HOQR ..... Hospital Outpatient Quality Reporting Program
HPC ..... Health Policy Commission
HPSA ..... Health Professional Shortage Area
HRET ..... Health Research & Education Trust (affiliate of AHA)
HRSA ..... Health Resources and Services Administration
HSA ..... Health Savings Account; or Health Systems Agency
HTN ..... Hypertension
HUD ..... Housing and Urban Development
IAFC ..... International Association of Fire Chiefs
IAFF ..... International Association of Fire Fighters
IBH ..... Integrated Behavioral Health
ICT ..... Information and Communication Technology
ICD-10 ..... International Classification of Diseases – 10th Edition
ICU ..... Intensive Care Unit
IHI ..... Institute for Healthcare Improvement
IHS ..... Indian Health Services
IOM ..... Institute of Medicine
IP ..... Inpatient
IPAB ..... Independent Payment Advisory Board
IPPS ..... Inpatient Prospective Payment System
IRF ..... Inpatient Rehabilitation Facility
IRS ..... Internal Revenue Service
IQR ..... Inpatient Quality Reporting Program
IT ..... Information Technology
JCAHO ..... Joint Commission on Accreditation of Healthcare Organizations
JCREC ..... Joint Committee on Rural Emergency Care
LAN ..... Learning Action Network
LOS ..... Length of Stay
LPN ..... Licensed Practical Nurse
LTC ..... Long Term Care
LTCF ..... Long Term Care Facility
MAC ..... Medicare Administration Contractor
MACRA ..... Medicare Access and CHIP Reauthorization Act of 2015
MAF ..... Medical Assistance Facility
MAT ..... Medication-Assisted Therapy
MBQIP ..... Medicare Beneficiary Quality Improvement Project
MCO ..... Managed Care Organization
MDH ..... Medicare Dependent Hospital
MedPAC .... Medicare Payment and Advisory Commission
MIH ..... Mobile Integrated Health
MIPPA ..... Medicare Improvements for Patients and Providers Act of 2008
MIPS ..... Merit-based Incentive Payment System

MMA ..... Medicare Prescription Drug, Improvement and Modernization Act of 2003
MOA ..... Memorandum of Agreement
MOU ..... Memorandum of Understanding
MPI ..... Master Patient Index
MRSA..... Methicilllin-resistent Staphylococcus aureus
MSA ..... Metropolitan Statistical Area
MSSP..... Medicare Shared Savings Program
MU ..... Meaningful Use (now known as Promoting Interoperability)
MUA ..... Medically Underserved Area
MUP..... Medically Underserved Population
NACHC..... National Association of Community Health Centers
NACRHHS.. National Advisory Committee on Rural Health and Human Services
NAEMT..... National Association of Emergency Medical Technicians
NARHC..... National Association of Rural Health Clinics
NASEMSO.. National Association of State Emergency Medical Services Officials
NCC Non-Competing Continuation
NCQA..... National Committee for Quality Assurance
NCHN ..... National Cooperative of Health Networks
NGA ..... Notice of Grant Award
NHIN ..... National Health Information Network
NHSN ..... National Healthcare Safety Network
NHTSA..... National Highway Traffic Safety Administration
NIH ..... National Institute for Health
NLM..... National Library of Medicine
NOA ..... Notice of Award
NOFO..... Notice of Funding Opportunity
NoP ..... Notice of Participation
NOSORH ... National Organization of State Offices of Rural Health
NP..... Nurse Practitioner
NPI..... National Provider Identifier
NPRM..... Notice of Proposed Rulemaking
NRHA..... National Rural Health Association
NTIA..... National Telecommunications and Information Administration
NQF..... National Quality Forum
OAT ..... Office for the Advancement of Telehealth
OHITQ ..... Office of Health Information Technology and Quality
OIG ..... Office of Inspector General
OMB ..... Office of Management and Budget
OMH ..... Office of Minority Health
ONC ..... Office of the National Coordinator for Health Information Technology
OP..... Outpatient

OPPS ..... Outpatient Prospective Payment System
OQR ..... Outpatient Quality Reporting Program
OTP ..... Opioid Treatment Program
P4P/PfP ..... Pay for Performance or Partnership for Patients
PAC ..... Post-Acute Care
PACS ..... Picture Archiving and Communications System
PALS..... Pediatric Advanced Life Support
PB ..... Provider-Based
PBPM ..... Per Beneficiary Per Month
PCA ..... Primary Care Association
PCC ..... Primary Care Clinicians
PCMH..... Patient-Centered Medical Home
PCO ..... Primary Care Office
PCP ..... Primary Care Provider
PE ..... Pulmonary Embolism
PFS ..... Physician Fee Schedule
PHE ..... Public Health Emergency
PHR ..... Personal Health Record
PI..... Performance Improvement or Promoting Interoperability
PIMS..... Performance Improvement & Measurement System
PIN..... Policy Information Notice from HRSA
PMPM..... Per Member Per Month
PO..... Project Officer
POND..... Practice Operations National Database
POS ..... Point of Service
PPACA..... Patient Protection and Affordable Care Act of 2010
PPO ..... Preferred Provider Organization
PPP..... Paycheck Protection Program
PPS ..... Prospective Payment System
PQRS ..... Physician Quality Reporting System
PRF ..... Provider Relief Fund
PRO ..... Peer Review Organization
PSA ..... Physician Scarcity Area
PSI..... Patient Safety Indicators
PTN ..... Practice Transformation Network
QHI ..... Quality Health Indicators
QHP..... Qualified Health Plan
QI ..... Quality Improvement
QIL..... Quality Innovation Lab
QIN ..... Quality Innovation Network
QIO ..... Quality Improvement Organization
QNet..... QualityNet
QPP ..... Quality Payment Program
RAC..... Recovery Audit Contractor
RFI..... Request for Information

RFP ..... Request for Proposals
RHC..... Rural Health Clinic
RHIhub ..... Rural Health Information Hub
RHIO ..... Regional Health Information Organization
RHPI..... Rural Hospital Performance Improvement Project
RHRC..... Rural Health Research Center
RHSATA..... Rural Health System Analysis and Technical Assistance Program
RHV..... Rural Health Value
ROI ..... Return on Investment
ROCI ..... Return on Community Investment
RPCH ..... Rural Primary Care Hospital
RQITA ..... Rural Quality Improvement Technical Assistance
RRC..... Rural Referral Center
RSV..... Reverse Site Visit
RTTD ..... Rural Trauma Team Development
RUPRI ..... Rural Policy Research Institute
RUS..... Rural Utilities Service
RVU..... Relative Value Unit
SAM ..... System for Award Management
SAN..... Support and Alignment Network
SAMHSA.... Substance Abuse and Mental Health Services Administration
SCH..... Sole Community Hospital
SCHIP..... State Children's Health Insurance Program
SDOH ..... Social Determinants of Health
SSIs ..... Surgical Site Infections Colon or Hysterectomy
SHIP..... Small Rural Hospital Improvement Grant Program
SME..... Subject Matter Expert
SNF ..... Skilled Nursing Facility
TRC ..... Telehealth Resource Center
VKG..... Virtual Knowledge Group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