Medicare Rural Hospital Flexibility Program Structure for FY 2024 – FY 2028

This document contains information regarding the purpose and allowable activities within each Flex program area, as well as suggested outcome measures for each program area. This document may be used in the following ways:

- State Flex Programs may use this information to design their work plans, evaluation plans, and see what activities are allowable with the Flex funding.
- Flex Project Officers will use this document when reviewing State Flex Program work plans and when answering questions regarding allowable activities within Flex.
- State Flex Programs and Flex Program Partners may use this document to assist in determining useful outcome measures for Flex work.

One key change in this program cycle compared to previous cycles is our focus on evaluation and the language we are using, specifically the difference between an activity and a project and which types of projects will have outcomes. Please see the next page for these definitions and keep these in mind as you are reading the rest of the document.

The Flex Program has 5 distinct program areas:

- Program Area 1: CAH Quality Improvement (MBQIP)
- Program Area 2: CAH Financial & Operational Improvement
- Program Area 3: CAH Population Health Improvement
- Program Area 4: Rural EMS Improvement
- Program Area 5: CAH Designation

FORHP encourages State Flex Programs to examine Innovative Models for rural healthcare and if capacity allows, to include those projects in one of the above program areas, depending on what is being measured.

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Key Flex Program Terms for Evaluating Your Program

The purpose of program measurement is to show the changes resulting from Flex funding—the outcomes as well as the outputs. This information can be used by State Flex Programs to inform future work and is also used by FORHP to inform Congress of the far-reaching impacts the program has.

Work plans should include a minimum of one project with a defined and measurable outcome per program area. All Flex Program work plans must include annual outputs for each activity, a timeline for activities with key milestones to track progress, as well as outcomes for each project. Below you will see the difference between activities and projects, and suggested measures for each.

Below you will find a few of the key definitions we will use throughout this document to explain the Flex Program work. Please see our full list of definitions for common evaluation terms for further information.

- **Program Area**: Expansive grouping of Flex Program work with one or two overarching goals for each area.
    - **Example**: CAH Financial & Operational Improvement is a program area with the overarching goal of maintaining CAH financial stability to maintain access to services.
- **Activity**: A specific action taken to produce a result, but that may not always be able to measure an outcome, such as networking meetings, information sharing, or one-time webinars.
    - **Example:** Sharing MBQIP reports to all CAHs in your state.
- **Project:** A series of activities that leads to one or more outcomes.
    - **Example:** A cohort of CAHs participating in a learning collaborative to improve HCAHPS scores. They meet monthly, receive resources, analyze current reporting scores, and implement best practices shared by their peers.
- **Output:** Measures that an activity occurred, stepping stones used to move forward.
    - **Example:** number of meetings, education programs, webinars provided.
- **Outcome:** Measurable change resulting from an activity or series of activities. Outcomes can be short-term, intermediate, and long-term.
    - **Example:** Revenue Cycle Management project
        - **Short-term Outcome:** Effects that occur more immediately, typically during the first year.
            - Reduced registration errors as a percent of total registrations
            - Increased percentage of point-of-sale collections
        - **Intermediate Outcome:** Effects that may occur in the first 1-2 years.
            - Reduced percentage of claims denied
            - Increased percentage of denied claims re-billed
            - Improved clean claims rate
        - **Long-term Outcome:** Effects that may occur after 3 years.
            - Improved days' net revenue in accounts receivable (CAHMPAS)
            - Greater days cash on hand (CAHMPAS)
            - Improved current ratio (CAHMPAS)
- **Impact:** The result or effect that is attributed to a project or program. Impact is often used to refer to higher level effects of a program that occur in the medium or long term and can be intended or unintended, positive or negative.
    - **Example:** Improved financial stability of CAHs, reducing risk of closing or losing service lines.

Program Area 1: CAH Quality Improvement (MBQIP) (required)

This required program area focuses on work to improve the quality of care delivered by CAHs and other rural health care providers. The Medicare Beneficiary Quality Improvement Project (MBQIP) is the organizing structure for Flex quality improvement activities. Work completed under MBQIP aims to increase quality data reporting by CAHs and then drive quality improvement projects based on the data.

Other types of health care providers can and should benefit from this work, such as provider-based rural health clinics or other small rural hospitals, but the majority of activities must target CAHs. Hospitals demonstrating their quality outcomes and capacity to engage in quality improvement strategies is a key part of many CMS and third-party insurer programs and MBQIP supports these aims.

Core MBQIP Measures

In 2023, FORHP released a new core measure set for MBQIP, along with reporting expectations for State Flex Programs. The roll out includes expectations for continuing with the current core Measure Set and identifies the new MBQIP 2025 core measure set (with reporting officially beginning in the 2025 calendar year).

States should work with CAHs to maintain and improve reporting on the MBQIP core measures. States should identify CAHs in need of reporting assistance as part of the needs assessment process. State Flex Programs may engage partners to provide the necessary technical assistance around quality reporting with a focus on enhancing CAH capacity (at an organizational level, not only individual staff level) to report quality measures. FORHP expects CAHs to collect and report quality data as a fundamental part of health care operations and use quality data to make decisions. Periodic retraining and assistance on quality reporting is allowable when challenges are identified during the project. Quality data must be reported to measure and evaluate the outcomes of quality improvement projects.

The table below shows the Core MBQIP measures grouped into five domains: Global Measures, Patient Safety, Patient Experience, Care Coordination, and Emergency Department. For more information regarding the current measures in each domain see the latest MBQIP Measures list. Building and maintaining the participation of all CAHs in MBQIP quality measurement and reporting of MBQIP core measures is expected. Participation may start with capacity building for new CAHs and new MBQIP measures. For CAHs already engaged in quality reporting, the focus should be on quality improvement as well as consistent reporting. State Flex Programs are expected to track individual CAH reporting of all MBQIP core measures. They are also expected to track CAHs that are not reporting, including the reasons why, and report that information to FORHP on an annual basis. We encourage you to identify and use existing resources and best practices for quality improvement interventions when working with CAHs to improve quality of care.

Measures in gold denote **new measures added for MBQIP reporting** within the Flex Program and are to be added to reporting data by calendar year 2025. Measures in blue are **existing measures within the MBQIP Flex Program**.

MBQIP Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
CAH Quality Infrastructure *(annual submission)*	**HCP/IMM-3:** Influenza Vaccination Coverage Among Healthcare Personnel (HCP) *(annual submission)* **Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey *(annual submission)* **Safe Use of Opioids (eCQM)** *(annual submission)*	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *(quarterly submission)*	**Hybrid Hospital-Wide Readmission** *(annual submission)*	**Emergency Department Transfer Communication (EDTC)** *(quarterly submission)* **OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients *(quarterly submission)* **OP-22:** Patient Left Without Being Seen *(annual submission)*

FORHP expects all State Flex Programs to include a focus on improvement in the Core MBQIP measures, not just reporting. It is expected that a minimum of one improvement project, with a measurable outcome, is included in each year's work plan. A list of allowable projects and example outcomes is provided below.

- Projects should have short, intermediate, and long-term outcomes listed.
- FORHP does not expect that all hospitals in your state participate in every project. You should analyze which hospitals are most in need of the targeted interventions to efficiently use Flex resources.
- It is possible that the intervention of the project may only take place over one year, but it is expected that State Flex Programs review data for the participating hospitals in future years, to determine if the long-term outcomes are met after the project has been completed.

Additional MBQIP Measures

FORHP recognizes there may be additional innovative projects that you choose to implement, based on the needs of CAHs in your state. All projects in this program area should be linked to measures to show improved quality of care in CAHs. FORHP does not expect all CAHs to report these suggested additional measures or participate in these projects. Instead, states may identify a group of CAHs that need to focus quality improvement efforts in the identified area. While some of the additional MBQIP measures may be very common across State Flex Programs, some do not yet have standardized measure sets or reporting mechanisms. These projects are included to give states an option to work on these national quality priority areas. State Flex Programs should propose appropriate outcomes for these projects and work with FORHP for final approval. CAHs already participating in other quality reporting programs outside of MBQIP (whether required or optional) should continue with those efforts. Please reach out to TASC, FMT, or RQITA for additional resources.

Suggested Additional Quality Measures for Flex Improvement Activities

Global Measures	Patient Safety	Patient Experience	Care Coordination	Emergency Department

Quality Improvement Basics
 	
Quality Related Certification
	• **Antibiotic Use (AU)**
	• **COVID Vaccination**
	• **Healthcare-Associated Infections (HAI)**
	• **Perinatal Care**
	  ○ Birthing-Friendly Hospital Designation
	  ○ PC-01: Elective Delivery
	  ○ PC-05: Exclusive Breast Milk Feeding (eCQM)
	• **Falls**
	  ○ Falls with Injury
	  ○ Patient Fall Rate
	  ○ Screening for Future Fall Risk
	• **Adverse Drug Events (ADE)**
	  ○ Opioids
	  ○ Glycemic Control
	  ○ Anticoagulant Therapy
	• **Patient Safety Culture Survey**
	• **Inpatient Influenza Immunization**
	• **eCQMs**
	  ○ VTE-1: Venous Thromboembolism Prophylaxis
	  ○ ED-2: Median Admit Decision Time to ED Departure Time for Admitted Patients
		Emergency Department Patient Experience
		
		Swing Bed Patient Experience
		
		Clinic Group CAHPS
			Discharge Planning
			
			Medication Reconciliation
			
			Swing Bed Care
			
			Claims-Based Measures: The following Measures are automatically calculated for hospitals using Medicare Administrative Claims Data
			• Complications
			• Hospital Return Days
			
			Global Malnutrition Composite Score (eCQM)
				OP-40: ST-Segment Elevation Myocardial Infarction (eCQM)
				
				Chest Pain/Acute Myocardial Infarction
				
				ED Throughput
				• Door to Diagnostic Evaluation by a Qualified Medical Professional
				
				American Heart Association Get with the Guidelines (Stroke, Heart Failure, AMI)

Program Area 1: CAH Quality Improvement (required)

Goals:

1. Increase the number of CAHs consistently reporting quality data, and
2. Improve the quality of care in CAHs.

Program area structure, project types, and example output and outcome measures:
This structure matches the work plan template. Please see the new FY24 Work Plan Template for detailed instructions and additional examples.

For each program area, the first section of the work plan will contain your activities. FORHP does not expect these activities to have an associated outcome. Please see below for some examples of what may be included. This list is not exhaustive, there may be other things you wish to add.

Work Plan Category	Example Allowable Activities	Outputs
Needs Assessment	• Statewide needs assessment to determine which MBQIP measures CAHs are struggling with • Reviewing results of the CAH Quality Infrastructure Assessment to determine common characteristics or challenges	• Number of CAHs with needs identified and action plans created
Education, Information Sharing, Meetings	• Distributing MBQIP reports to the CAHs • Hosting networking meetings for quality directors • Holding an annual webinar	• Number of meetings, educational programs, or events held. • Number of CAHs and number of staff participating in meetings and events. • Number of CAHs sharing best practices. • Percentage of CAHs that report having implemented changes in their policies and/or operations following participation in meetings or programs.

We included a section of the workplan specifically for quality measure reporting support. We understand that with the introduction of new MBQIP measures, your work will involve engaging your hospitals in reporting the new measures. You may list your work in this area in just this one section of the work plan, you don't need to list the support you are providing for each individual measure.

Work Plan Category	Example Allowable Activities	Short-term Outcome
Reporting Support	• TA for new quality staff in the CAHs on MBQIP measures and how to report them • Working to have more CAHs complete the CAH Quality Assessment • Tracking which CAHs are not reporting core MBQIP measures and why	• Increased number of CAHs reporting all MBQIP Core Measures

The second section of the work plan contains your projects. As defined above, a project is a series of activities that has a measurable outcome. A project may consist of a cohort of hospitals meeting quarterly to share best practices and implement changes, a learning collaborative or learning action network, or a cohort of hospitals who are implementing a PDSA-style project. The table below shows the project topics that are in a drop-down list in the work plan template. You may choose from the list below or choose "other" if your topic is not seen here.

Project Type	**Outcomes** (Note: For quality improvement, these outcomes can be short- term, intermediate, or long-term depending on your intervention. It is acceptable to list the same outcome for multiple years)
CAH Quality Infrastructure	• Increase in number of core elements/criteria for elements of CAH quality infrastructure met
Healthcare Personnel Influenza Immunization	• Increase in rate of healthcare personnel influenza immunization (HCP/IMM-3)
Antibiotic Stewardship	• Increase in number of core elements/criteria for elements of antibiotic stewardship met
Safe Use of Opioids	• Reduction in rate of inpatient adults prescribed two or more opioids or an opioid and benzodiazepine concurrently on discharge
HCAHPS	• Improvement in rate of performance for Communication with Nurses • Improvement in rate of performance for Communication with Doctors • Improvement in rate of performance for Restfulness of Hospital Environment • Improvement in rate of performance for Care Coordination • Improvement in rate of performance for Responsiveness of Hospital Staff • Improvement in rate of performance for Communication about Medicines • Improvement in rate of performance for Discharge Information • Improvement in rate of performance for Cleanliness of Hospital Environment • Improvement in rate of performance for Information About Systems • Improvement in rate of performance for Hospital Rating • Improvement in rate of performance for Willingness to Recommend the Hospital
Readmissions	• Reduction in rate of all-cause readmissions • Reduction in rate of swing bed readmissions • Reduction in rate of AMI readmissions • Reduction in rate of pneumonia readmissions
EDTC	• Improvement in rate of performance for all EDTC components (EDTC-ALL) • Improvement in rate of performance for Home Medications • Improvement in rate of performance for Allergies and/or Reactions • Improvement in rate of performance for Medications Administered in ED • Improvement in rate of performance for ED Provider Note • Improvement in rate of performance for Mental Status/Orientation Assessment • Improvement in rate of performance for Reason for Transfer and/or Plan of Care • Improvement in rate of performance for Tests and/or Procedures Performed • Improvement in rate of performance for Tests and/or Procedures Results

ED Throughput	• Reduction in median of Admit Decision Time to ED Departure Time for Discharged Patients (OP-18) • Reduction in rate of Patients Left Without Being Seen (OP-22) • Reduction in median of Admit Decision Time to ED Departure Time for Admitted Patients (ED-2) • Reduction in median of ED Arrival Time to Diagnostic Evaluation by • Qualified Medical Professional
Healthcare-Associated Infections	• Reduction in CAUTI rates • Reduction in MRSA rates • Reduction in CLABSI rates • Reduction in CDI rates • Reduction in SSI rates
Perinatal Care	• Improvement in rate of exclusive breast milk feeding (PC-05) • Reduction in rate of elective delivery (PC-01)
Other Patient Safety (Falls, Adverse Drug Events)	• Reduction in patient falls rate • Reduction in rate of falls with injury • Increase in screening for future fall risk • Reduction in opioid-related adverse drug events • Reduction in glycemic control adverse drug events
ED CAHPS	• Improvement in rate of performance for timeliness of care • Improvement in rate of performance for nurse and doctor communication • Improvement in rate of performance for medication communication • Improvement in rate of performance for follow-up care communication • Improvement in rate of performance for overall rating of ED • Improvement in rate of performance for willingness to recommend ED
Swing Beds	• Improvement in rate of swing bed patient satisfaction • Improvement in rate of discharge disposition • Improvement in rate of 30-day follow-up status • Improvement in swing bed patient self-care • Improvement in swing bed patient mobility
Rural Health Clinics	• NQF 0038: Increase in children receiving recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday. • NQF 0018: Patients 18 - 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period, or any time prior. Increase in patients whose blood pressure at the most recent visit is adequately controlled during the measurement period. • NQF 0059: Decrease in percent of patients ages 18-75 with a diagnosis of diabetes who had a Hemoglobin A1c>9percent within 12 months. • NQF 0419: Increase in percent of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications on the date of the encounter.

Program Area 2: CAH Financial & Operational Improvement (required)

This required program area focuses on improving CAH financial stability, operations, and efficiency. All State Flex Programs must assess the financial status of CAHs in the state, identify CAHs with greater needs, and implement interventions to address those needs. Work on the statewide needs assessment may range from intensive data collection and analysis for a systematic, in-depth statewide needs assessment to plan a new period of performance to a brief annual review of new data in the context of an existing assessment to ensure that planned activities are responsive to current CAH needs. Assessment activities may include reviewing and analyzing data from the Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS) and other sources, and collecting input from state stakeholders through surveys, meetings, committees, or other approaches.

State Flex Coordinators can access data for all CAHs in their state from CAHMPAS (requires username and password). CAHMPAS includes data for 23 financial indicators, with peer group, state, and national comparative data, as well as quality and community data. FMT has published resources for using CAHMPAS and additional studies of national CAH financial indicators. The University of North Carolina Rural Health Research Program developed a rural hospital Financial Distress Index which predicts risk of financial distress for rural hospitals; data from the index is available to state Flex coordinators in CAHMPAS. The Small Rural Hospital and Clinic Finance 101 Manual has information on understanding financial indicators and improving rural hospital financial performance. The 2018 Rural Hospital and Clinic Financial Summit Report recommends other leading indicators of operational and financial performance that can also inform Flex strategies and interventions. TASC has also created a financial and operational improvement toolkit with resources that identify consultant-recommended best practices and strategies for improving financial performance and increasing operational efficiencies.

State Flex programs that have equally robust but more recent data than that available in CAHMPAS and FMT reports may use these newer data in the needs assessment. Programs should identify any supplemental or replacement data sources and justify for their use by explaining how these data sources improve on the nationally comparable and standardized data in CAHMPAS.

Flex investments in this area must focus on CAHs. However, as appropriate to the specific interventions and supported by the needs assessment, Flex programs may assist CAHs that operate provider-based RHCs to improve their operations along with the main campus as it also helps improve the overall financial picture for the CAH. To increase efficiency and maximize the impact of limited Flex funds, FORHP encourages states to identify new or existing successful financial and operational improvement programs and encourage CAH engagement or otherwise leverage those programs to meet the collective needs of CAHs. We recognize that improvements to CAH operations may also improve patient satisfaction and quality of care and such secondary outcomes will also benefit CAHs.

It is expected that a minimum of one improvement project, with a measurable outcome, is included in each year's work plan. A list of allowable projects and example outcomes is provided below. More information regarding these outcomes can be found on the FMT website.

- Projects should have short, intermediate, and long-term outcomes listed.
- FORHP does not expect that all hospitals in your state participate in every project. You should analyze which hospitals are most in need of the targeted interventions to efficiently use Flex resources.
- It is possible that the intervention of the project may only take place over one year, but it is expected that State Flex Programs review data for the participating hospitals in future years, to determine if the long-term outcomes are met after the project has been completed.

Program Area 2: CAH Operational and Financial Improvement (required)
Goal: Maintain and improve the financial viability of CAHs

Program area structure, project types, and example output and outcome measures:
This structure matches the work plan template. Please see the new FY24 Work Plan Template for detailed instructions and additional examples.

For each program area, the first section of the work plan will contain your activities. FORHP does not expect these activities to have an associated outcome. Please see below for some examples of what may be included. This list is not exhaustive, there may be other things you wish to add.

Work Plan Category	Example Allowable Activities	Outputs
Needs Assessment	• Statewide needs assessment to determine financial status of CAHs in the state • Individual CAH-level needs assessment	• Number of CAHs with needs identified and action plans created
Education, Information Sharing, Meetings	• Distributing CAHMPAS financial data reports • CFO Networking Meetings • Hosting a one-time webinar	• Number of meetings, educational programs, and events held. • Number of CAHs and number of staff participating in meetings and events. • Number of CAHs sharing best practices. • Percentage of CAHs that report having implemented changes in policies and/or operations following participation in meetings or programs.

The second section of the work plan will contain your projects. As defined above, a project is a series of activities that has a measurable outcome. A project may consist of a cohort of hospitals meeting quarterly to share best practices and implement changes, a learning collaborative or learning action network, or a cohort of hospitals who are implementing a PDSA-style project. The table below shows the project topics that are in a drop-down list in the work plan template. You may choose from the list below or choose "other" if your topic is not seen here.

There are two areas of work under financial and operational improvement where FORHP is still working with the Flex Program partners to determine outcomes: Value-based care projects and work involving Rural Health Clinics. Below are examples of outputs you may choose to complete. We encourage State Flex Programs to work in these topics and work with your Project Officer to describe what you are working to improve.

Value-Based Payment Projects	• Number of CAHs implementing models and strategies identified in the Road to Value: Financial Strategies to Transition to a Value-Based System Guide, developed by TASC. • Number of CAHs completing the Value Based Care Assessment Tool, developed by Rural Health Value. • Number of CAH board members receiving education about state and national value-based payment programs
Rural Health Clinics (FMT does not have nationally standardized financial metrics for RHCs. You may focus on operational metrics or choose to determine if the financial metrics that apply to the CAHs in your state also apply to the RHCs)	• Number of RHCs attending webinars or trainings • Number of RHCs participating in benchmarking data collection through the State Flex Program

Project Type	**Short-term Outcome Measures (within 1 year)**	**Intermediate Outcome Measures (2-3 years)**	**Long-term Outcome Measures (over 3 years)**
Service Line Assessment	• Improved average daily census by service line • Improved outpatient utilization by service line	• Improved inpatient payer mix • Higher acute care average daily census • Higher swing bed average daily census • Improved outpatient revenue to total revenue	• Higher contribution margin (contribution to profitability) by service line • Improved operating margin (CAHMPAS)
Chargemaster Review	• Changes to coding and billing systems identified through chargemaster reviews are implemented • Reduced percentage of claims denied • Improved clean claims rate	• Improved net revenue per adjusted admission	• Improved cash on hand (CAHMPAS) • Improved operating margin
Revenue Cycle Management	• Reduced registration errors as a percent of total registrations • Increased percent of point-of sale collections	• Reduced percentage of claims denied • Increase percentage of denied claims re-billed • Improved clean claims rate	• Improved days' net revenue in accounts receivable (CAHMPAS) • Greater days cash on hand (CAHMPAS) • Improved current ratio (CAHMPAS)

Market Share/ Outmigration	• Improvement in patient satisfaction (HCAHPS) • Improvement in perception of quality (community survey) • Improvement in community knowledge of available services (community survey)	• Improved inpatient market share (by service line) • Increase in utilization by individuals living in the community compared to local population growth (by zip code)	• Improved total and/or operating margin (CAHMPAS) • Greater days cash on hand (CAHMPAS) • Improved return on equity • Improved current ratio (CAHMPAS)
Billing and Coding Education	• Changes to coding and billing systems identified	• Reduced percentage of claims denied • Increased percentage of denied claims re-billed • Improved clean claims rate	• Improved days' net revenue in accounts receivable (CAHMPAS)
Workforce and/or Operations	• Number of CAHs implementing policy change • Percentage improvement in scheduling efficiencies • Percentage reduction in patient registration errors	• Percentage reduction in provider response time • Percentage increase in provider availability • Improvement in recruitment policies • Reduction in the number of temporary personnel being used for staffing	• Maintaining/retaining appropriate staffing levels • Improvement in patient flow throughout the hospital

**An important note regarding workforce, specifically supporting any certifications for hospital employees. Flex funding can support certification, with certain limitations. It cannot support any certifications or training classes that involve clinical rotations or patient care hours. The certification must also fit into the larger picture goals of your Flex work plan.

Program Area 3: CAH Population Health Improvement (optional)

This optional Flex program area focuses on building capacity of CAHs to achieve measurable improvements in the health outcomes of their communities, with consideration of determinants of health, such as medical care systems and social and physical environments. CAHs are engaged in a broad variety of population health initiatives ranging from enhanced clinical care management tied to accountable care organization (ACO) and other value-based purchasing initiatives to community-based interventions to improve health and address the social and community factors that influence health status. As in previous years, Flex funds cannot be used to pay for the development and completion of Community Health Needs Assessments (CHNAs), as they are a requirement through the IRS and are a fundamental part of health care operations. Flex funding can be used to support CAHs in implementing population health initiatives to address findings from the completed CHNAs, as well as other types of assessments.

Flex Programs can aid in local, regional, or state coalition building or sharing of information to prepare CAHs for these projects. The purpose is to connect facilities and organizations with tools and resources to identify their unique strengths and needs as they consider population health initiatives. CAHs should be encouraged to complete the Population Health Readiness Assessment though TASC's Population Health Toolkit. This assessment utilizes a systems-based framework to ensure a holistic approach to population health. The Population Health Portal has data scenarios that are specific to the state and county, as well as the CAH, that can be used in population health planning and addressing CHNA findings. CAHMPAS also includes community indicators related to market characteristics, socioeconomic factors, clinical care and access to care, charity care and bad debt, health behaviors, and health outcomes.

Based on the results of the Population Health Readiness Assessment and CHNA, CAHs will design an action plan to address the needs of the community. While only 501(c)3 tax-exempt CAHs are required by the IRS to include input from community members and public health experts to develop action plans, all CAHs including publicly-owned and for-profit facilities should incorporate input from these key stakeholders in developing their population health strategies.

It is expected that a minimum of one improvement project, with a measurable outcome, is included in each year's work plan.

- Projects should have short, intermediate, and long-term outcomes listed.
- FORHP does not expect that all hospitals in your state participate in every project. You should analyze which hospitals are most in need of the targeted interventions to efficiently use Flex resources.
- It is possible that the intervention of the project may only take place over one year, but it is expected that State Flex Programs review data for the participating hospitals in future years, to determine if the long-term outcomes are met after the project has been completed.

A list of allowable projects and example outcomes is provided below. This list is only meant to serve as an example, you may have other projects you wish to add. FORHP recognizes that the scope of population health work for each state and each CAH is different.

Program Area 3: CAH Population Health Improvement (optional)
Goal: Build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities.

Program area structure, project types, and example output/outcome measures:
This structure matches the work plan template. Please see the new FY24 Work Plan Template for detailed instructions and additional examples.

For each program area, the first section of the work plan will contain your activities. FORHP does not expect these activities to have an associated outcome. Please see below for some examples of what may be included. This list is not exhaustive, there may be other things you wish to add.

Work Plan Category	Example Allowable Activities	Outputs
Needs Assessment	• Statewide review of completed CHNAs to determine common needs or challenges	• Number of CAHs identified with common community needs that are willing to engage in a Flex-funded cohort project to address concerns
Education, Information Sharing, Meetings	• Facilitating community engagement discussions or workshops • Building partnerships with community organizations or public health departments	• Number of CAHs building relationships with local public health departments • Number of meetings, educational programs, and events held. • Number of CAHs and number of staff participating in meetings and events. • Number of CAHs sharing best practices. • Percentage of CAHs that report having implemented changes in policies and/or operations following participation in meetings or programs.

The second section of the work plan will contain your projects. As defined above, a project is a series of activities that has a measurable outcome. A project may consist of a cohort of hospitals meeting quarterly to share best practices and implement changes, a learning collaborative or learning action network, or a cohort of hospitals who are implementing a PDSA-style project. The table below shows the project topics that are in a drop-down list in the work plan template. You may choose from the list below or choose "other" if your topic is not seen here.

Project Type	**Short-term Outcome Measures (within 1 year)**	**Intermediate Outcome Measures (2-3 years)**	**Long-term Outcome Measures (over 3 years)**
Primary Care	• Number and percent of diabetic patients registered in CCM program • Number and percent of pre-diabetic patients registered in prevention programs • Number and percent of patients receiving diabetic education • Number and percent of patients participating in diabetes interventions (e.g., blood glucose logs, exercise and weight loss goals) • Number and percent of patient interactions including coordination of care	• Number and percent of patients receiving regular HbA1c testing, eye exams, and medical attention for complications • Reduction in number and percent of prediabetic patients developing Type 2 diabetes • Reduction in number and percent of patients with poor control of daily blood glucose level • Reduction in number and percent of patients with a BMI>25 kg/m2 • Reduction in number and percent of patients with poor control of hemoglobin A1C levels	• Reduction in rate of unnecessary hospital admissions due to complications of diabetes (for participating patients) • Reduction in emergency department use due to complications from diabetes (for participating patients) • Reduction in rate of participating patients with diabetic complications (e.g., cataracts, glaucoma, or blindness; nerve damage, amputations, etc.)
Behavioral Health Integration	Increase in number and percent of CAH-based RHCs developing an action plan to implement integrated behavioral health services • Increase in number and percent of CAH-based RHCs participating in learning collaboratives on the development of integrated behavioral health services	• Increase in number and percent of RHCs operating integrated behavioral health Services • Increase in number and percent of patients served by CAH-based RHC integrated units • Increase in number and percent of RHC patients reporting satisfaction with integrated behavioral health services	• Increase in number and percent of CAH-based RHCs that have sustained and/or expanded integrated behavioral health services • Reduction in rate of unnecessary ED use by participating patients • Reduction in rate of unnecessary hospital admissions by participating patients

		• Increase in number and percent of participating patients reporting greater quality of life • Increase in number and percent of providers reporting satisfaction with integrated behavioral health services • Increase in number and percent of participating patients reporting improved mental health wellness in the last 14 days • Increase in number and percent of participating patients with improvement in depression or anxiety based on a validated screening tool	• Improvement in number and percent of patients reporting fewer days of poor mental health in the last 30 days
Chronic Care Management	• Number and percent of patients with 2 or more chronic conditions registered in CCM program • Number and percent of patients receiving self-management education and support specific to their condition • Number and percent of patients participating in CCM interventions (e.g., keeping blood pressure logs, setting exercise and/or weight loss goals, adhering to dietary/salt restrictions for hypertension) • Number and percent of patient interactions including coordination of care	• Increase in number and percent of patients receiving monthly check-ins, regular lab testing, and early medical attention for complications • Reduction in Number and percent of low patient satisfaction survey scores • Reduction in number and percent of patients non-compliant with treatment regimen • Reduction in number and percent of patients with poor control of key biometrics (specific to diseases)	• Reduction in the rate of readmission after discharge from the hospital for all cause readmissions for participating patients

Substance Use Disorder	Prevention: • Increase in number and percent of CAHs participating in community prevention partnerships, programming, and education • Increase in number and percent of CAHs implementing prescribing guidelines • Increase in number of provider referrals to alternative pain management methodologies Treatment: • Increase in number and percent of CAHs screening for SUDs in primary care and ED settings • Increase in number and percent of CAH providers qualified and offering MAT • Increase in number and percent of CAHs developing SUD treatment programs • Increase in number and percent of CAHs participating in community efforts to address SUDs	Prevention: • Reduction in percent of underage alcohol, marijuana, and prescription use/ misuse in the community • Increase in number and percent of patients in primary care and ED screened for SUDs • Increase in number and percent of patients receiving brief interventions after screening for SUDs • Increase in number and percent of providers complying with prescribing guidelines • Reduction in number and percent of patients receiving prescriptions for commonly abused prescription drugs Treatment: • Increase in number and percent of patients receiving MAT and wrap-around treatment such as counseling • Increase in number and percent of patients referred for specialty SUD treatment	• Reduction in rates of SUDs in the patient population or the community • Reduction in rates of substance misuse-related ED visits • Reduction in rates of hospitalization for SUD or overdose • Reduction in opioid or other substance-related overdoses • Reduction in substance misuse related mortality
Community Engagement	• Increase in number of participating organizations partnering with CAHs to create action plans	• Increase in number and percent of collaborative partnerships implementing action plans to address one or more community needs	

Program Area 4: Rural EMS Improvement (optional)

This optional program area focuses on work to improve rural Emergency Medical Services (EMS). The authorizing legislation for the Flex program states that the purpose of funding for EMS activities is "for the establishment or expansion of a program for the provision of rural emergency medical services." Rural EMS agencies face many important barriers to providing services, including long distances, challenging geography, low call volumes, higher cost per call to maintain the system, fewer monetary and other resources, and a dependence on volunteerism.

We expect states working in the EMS program area to complete at least one needs assessment during the five-year program cycle, and it may be statewide or with individual agencies or communities. Recipients should select the type of needs assessment that best reflects the state's priorities and capacity, and recommendations should include suggestions for future Flex projects. Assessment activities should be completed prior to any EMS specific interventions are implemented. For these assessments, we suggest that local community leaders and other health care providers be involved to gain a more complete understanding of the gaps in the local emergency health care system.

We recommend that the assessment include the following for each participating EMS agency:

- Ownership: CAH-based, public, non-profit, for profit, etc.
- Compensation: volunteer, paid, mixed, full time, part time
- Call volume per year
- Patient transport volume per year
- Do they bill insurance/Medicare/Medicaid?
- Do they receive public funding?
- Other information as needed to inform EMS improvement activities

Interventions in this program area should be supported by the results of the assessment(s). In the section below, you will see several different suggested project topics focusing on improving quality of services and organizational capacity as well as addressing financial concerns. This list is not exhaustive, you can find additional measures on the NEMSQA website. Work improving quality of care may encompass technical assistance around data reporting, training to improve the management of time-sensitive diagnoses (STEMI, stroke, or trauma), improving processes for transferring patients and prehospital activation, or technical assistance for data reporting and performance improvement to state-level reporting systems. Programs may also focus work on improving finances or organizational capacity, addressing personnel management or retention, technical assistance with Patient Care Records (PCRs), billing and coding education, improving revenue cycle efficiency, leadership education, or implementing Community Paramedicine.

It is expected that a minimum of one improvement project, with a measurable outcome, is included in each year's work plan.

- Projects should have short, intermediate, and long-term outcomes listed.
- FORHP does not expect that all EMS agencies in your state participate in every project. You should analyze which EMS agencies are most in need of the targeted interventions to efficiently use Flex resources.
- It is possible that the intervention of the project may only take place over one year, but it is expected that State Flex Programs review data for the participating EMS agencies in future years, to determine if the long-term outcomes are met after the project has been completed.
- We encourage projects involving both EMS and CAH emergency departments, however projects that exclusively address CAH emergency department operations are out of scope for Program Area 4. Such activities may be completed in Program Area 2, Financial & Operational Improvement.

Program Area 4: Rural EMS Improvement (optional)
Goals:

1. Improve the organizational capacity of rural EMS, and
2. Improve the quality of rural EMS

Program area structure, project types, and example output/outcome measures:
This structure matches the work plan template. Please see the new FY24 Work Plan Template for detailed instructions and additional examples.

For each program area, the first section of the work plan will contain your activities. FORHP does not expect these activities to have an associated outcome. Please see below for some examples of what may be included. This list is not exhaustive, there may be other things you wish to add.

Work Plan Category	Example Allowable Activities	Outputs
Needs Assessment	• Statewide needs assessment to determine financial status of EMS agencies in your state • Individual EMS agency needs assessment to determine agency-level needs	• Number of EMS agencies participating in statewide needs assessment efforts • Number of EMS agencies completing individual needs assessments • Number of action plans developed after completing the needs assessment
Education, Information Sharing, Meetings	• Leadership education • Staff education	• Number of meetings, educational programs, and events held. • Number of EMS agencies and number of staff participating in meetings and events. • Number of EMS agencies sharing best practices. • Percentage of EMS agencies that report having implemented changes in policies and/or operations following participation in meetings or programs.

The second section of the work plan will contain your projects. As defined above, a project is a series of activities that has a measurable outcome. A project may consist of a cohort of EMS agencies meeting quarterly to share best practices and implement changes, a learning collaborative or learning action network, or a cohort of EMS agencies who are implementing a PDSA-style project. The table below shows the project topics that are in a drop-down list in the work plan template. You may choose from the list below or choose "other" if your topic is not seen here.

Project Type	Short-term Outcome Measures (within 1 year)	Intermediate Outcome Measures (2-3 years)	Long-term Outcome Measures (over 3 years)
Quality Improvement (Clinical)	• Increase in number and percent of EMS agencies equipped to acquire 12-lead EKGs and identify or recognize STEMIs • Increase in number and percent of staff with training on recognition of STEMI and stroke • Increase in number and percent of staff with training on trauma/field triage protocols for all ages • Increase in number and percent of EMS agencies using the American Heart Association's Mission (AHA): Lifeline Guidelines (STEMI)	•Increase in number and percent adaptation of regional protocols to improve early notification times	• Increase in number and percent of EMS agencies functioning as part of an integrated system of emergency care • Reduction in number and percent of inpatient mortality rate of patients treated for TCD by agency
Quality Improvement (Data Reporting)	• Increase in number and percent of EMS agency providers, medical directors, and administrators trained on state-level run reporting system. • Reduction in number of errors in submitted run data • Increase in number of data sharing arrangements between EMS providers and CAHs, rural hospitals, and their Emergency Departments • Increase in number of data bridges established between EMS data systems and state or national initiatives (e.g., health information exchanges or the National EMS Information System)	• Increase in number and percent of rural EMS agencies submitting accurate run reports and data for 100percent of required transports and encounters • Increase in number and percent of state EMS authorities submitting run report data consistently to NEMSIS • Increase in number and percent of EMS agencies utilizing EMS data for quality and performance improvement	• Increase in number and percent of rural EMS agencies exhibiting improved quality performance based on agreed upon quality metrics
Financial Improvement	• Increase in number and percent of agencies with appropriate billing and collection capacity • Increase in number and percent of agencies able to bill third party payers and	•Percent reduction in time of processing claims •Reduction in number and percent of denied claims •Reduction in number and percent in days to collection	• Increase in number and percent of EMS agencies with improved financial stability based on key financial indicators • Improvement in the

	patients for services rendered • Increase in percent of runs for which all appropriate billing, demographic, and insurance information was collected • Reduced percent of errors in financial and billing data collected for each run	• Increased percent of clean claims rate • Reduction in number and percent of registration errors	percent of expenses covered by patient/transport revenues • Reduction in the percent of expenses covered by other revenue sources (e.g., local tax revenues, grants, revenues)
Recruitment/Retention	• Increase the number of paid EMS providers (not including advanced level providers) • Increase the number of volunteer EMS providers (not including advanced level providers) • Increase the number of advanced level EMS providers (such as paramedic or AEMT)		• Turnover rate – Reduction in percentage of new employees that resign within a certain time frame
Collaborative Activities	• Increase in number and percent of EMS agencies meeting regularly with partners to create action plans • Increase in number and percent of EMS agencies implementing a community paramedicine practice	• Increase in number and percent of partnerships implementing action plans to address one or more community needs • Decrease in number and percent of hospital readmissions	• Number of community paramedicine programs that can continue to run sustainably.

Program Area 5: CAH Designation (required if requested)

As required by the program authorizing legislation, State Flex Programs must assist with appropriate conversion of small rural hospitals to CAH status when requested. Flex programs must assist hospitals in evaluating the effects of conversion to CAH status.

There are no outcomes to report for this program area, only outputs.

Program Area 6: CAH Designation (required if requested)
Goal: Assist rural hospitals to seek or maintain appropriate Medicare participation status to meet community needs

Work Plan Category	**Example Allowable Activities**	**Outputs**
CAH Conversions or CAH Transitions	• Individual TA support to educate hospitals on facility designations • Financial feasibility studies to determine financial status of facility designation.	• Number of hospitals requesting assistance • Number of PPS hospitals converting to CAH status • Number of feasibility studies conducted • Number of closed hospitals that have re-opened • Number of CAHs that have transitioned to another facility type