

# Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023

This document contains Flex program area details, resources, and suggestions for activities and interventions. State Flex programs can use this document to gain ideas for Flex program activities. Flex project officers will use this document to when reviewing state Flex program work plans and answering questions about activities that are allowable within Flex.

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## Key Flex Program Terms

**Program Area:** Expansive grouping of Flex program work with one or two overarching goals for each area. For example CAH Operational and Financial Improvement is a program area with the overarching goal of maintaining CAH financial stability to maintain access to services.

**Activity Category:** Specific category of interventions and activities within each program area. We organize activities and interventions into categories to identify similar projects, define allowable activities, and structure PIMS reporting. For example, Activity Category 2.2 includes projects conducting in-depth assessments and action planning at individual CAHs.

**Goals:** High-level statements that outline the ultimate purpose of a program. This is the end toward which program efforts are directed. In this document we use

goals to refer to high-level aspirational statements which must be operationalized through specific objectives and measures.

**Objectives:** Concrete statements describing what a program's activities must achieve in order to reach the program's ultimate goals. Clearly described objectives create specific, time-bound targets for both output and outcome measures and allow you to assess progress toward meeting your targets.

**Activities:** Action(s) that will result in achievement of the objective, activities may include training, technical assistance, workshops, consultations, meetings, improvement projects, etc.

**Measures:** Clearly defined quantitative or qualitative indicators that relate to a program's stated goals, objectives, and activities. A measure description should include the concept to be measured, the applicable population, the process for calculating numerator and denominator, and the data source. A well-specified measure facilitates assessment of changes over time.

## Description of Program Area 1: CAH Quality Improvement (MBQIP)

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. The purpose of MBQIP is to improve the quality of care provided in CAHs by increasing quality data reporting by CAHs and then driving quality improvement activities 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. The National Quality Forum Rural Health Committee recommends that rural providers participate in quality reporting and quality improvement activities<sup>1</sup> and MBQIP supports CAH participation in those efforts.

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

**Program Area 1 Goals:** 1) Increase the number of CAHs consistently reporting quality data, and 2) Improve the quality of care in CAHs

**Activity Categories:**

- 1.1 Report and improve Core Patient Safety/Inpatient Measures, including develop antibiotic stewardship programs (required annually)

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<sup>1</sup> Performance Measurement for Rural Low-Volume Providers, FINAL REPORT by the NQF Rural Health Committee, September 14, 2015;  
[https://www.qualityforum.org/Publications/2015/09/Rural\\_Health\\_Final\\_Report.aspx](https://www.qualityforum.org/Publications/2015/09/Rural_Health_Final_Report.aspx)

- 1.2 Report and improve Core Patient Engagement Measures (required annually)
- 1.3 Report and improve Core Care Transitions Measures (required annually)
- 1.4 Report and improve Core Outpatient Measures (required annually)
- 1.5 Report and improve Additional Patient Safety Measures (optional)
- 1.6 Report and improve Additional Patient Engagement Measures (optional)
- 1.7 Report and improve Additional Care Transitions Measures (optional)
- 1.8 Report and improve Additional Outpatient Measures (optional)

**Suggested participation (output) measure:**

- Number and percent of CAHs in the state participating in Flex-funded quality reporting and quality improvement activities each year. Set a target in the future work plan and report the actual number in PIMS (1.1-1.8).
- Other output measures as applicable for specific activity categories.

**Suggested outcome measures:**

- Consistent reporting: Number and percent of CAHs in the state reporting data every quarter for all MBQIP core measures during the budget year.
- High-quality performance: Number and percent of CAHs in the state achieving defined performance levels on one or more targeted MBQIP quality measures. Explain the reasons for selecting the chosen measure for a statewide target and the reasons for the benchmark chosen for defining high-quality performance on that measure.
- Other outcome measures as applicable for Quality Improvement and MBQIP.

MBQIP activities are grouped in four different quality domains: Patient Safety/Inpatient, Patient Engagement, Care Transitions, and Outpatient. The four domains have core measures which are required and monitored for MBQIP participation and additional measures which are optional and may be added by states addressing additional quality improvement needs. For a full list of the current measures in each quality domain see the latest [MBQIP Measures list](#). Flex quality improvement activity categories align with the MBQIP measure domains. FORHP expects all recipients to work in, at minimum, Activity Categories 1.1 – 1.4 which cover core measures in the four quality domains of MBQIP. Activity Categories 1.5 – 1.8 reflect the additional measures in each MBQIP domain and are optional categories depending on state needs and capacity.

Many of these quality measures have existing quality improvement best practices and resources available for recipients to implement when working with CAHs to improve quality of care. We encourage you to identify and use existing resources and best practices for quality improvement interventions. We also recognize that there may also be additional innovative projects that you can implement. All projects in this program area should be linked to measures to show improved

quality of care in the CAHs. Resources for quality improvement activities include the [MBQIP website](#) maintained by TASC and RQITA and the [quality studies and reports produced by FMT](#) (filter publications using the topics Quality and MBQIP). Please see the [MBQIP website](#) for suggested activities to improve quality measures in the required and optional activity categories.

CAHs already participating in other quality reporting programs outside of the MBQIP program (whether required or optional) should continue with those efforts.

### Core MBQIP Measures

As part of quality improvement activities in each activity category, recipients should work with CAHs to maintain and improve reporting on the MBQIP core measures, including publicly reporting applicable measures to CMS Hospital Compare. 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 in order to measure and evaluate the outcomes of quality improvement activities.

Building and maintaining the participation of all CAHs in MBQIP quality measurement and reporting of MBQIP core measures is required. This 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. Individual CAHs that do not participate in MBQIP reporting or work towards capacity building, if needed, in core MBQIP measures will not be eligible to benefit from Flex funds in future years. Criteria for minimum levels of MBQIP participation will be revisited and updated annually. See the [MBQIP Fundamentals Guide](#) for details on measure changes and data reporting processes.

In 2018 FORHP added Antibiotic Stewardship to the MBQIP core measures in the Patient Safety/Inpatient domain. We measure antibiotic stewardship via the Centers for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey. CAHs will be required to meet all of the seven core elements of an antibiotic stewardship program by August 31, 2022. For FY 2022 and future years, CAHs will have to report that they are meeting all seven elements in order to meet MBQIP participation requirements and maintain eligibility to benefit from Flex funds in future years.

## Additional MBQIP Measures

Along with the required quality improvement activity categories that correspond to the MBQIP core measures; there are activity categories for the additional measures that recipients are encouraged to select based on the needs of the CAHs in their state (Activity Categories 1.5 – 1.8). These categories do not require participation by all CAHs, but instead could include an identified group of CAHs in the state that needs 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 activities have existing additional MBQIP measures, some do not yet have a standardized measure sets or reporting mechanisms. These activities are included to give states an option to work on these national quality priority areas. Recipients must propose appropriate outcome measures and processes for activities focused on quality measures that do not have a national reporting mechanism in place for reporting standardized measures and work with FORHP for final approval.

## Description of Program Area 2: CAH Operational and Financial Improvement

This required program area focuses on work to improve CAH efficiency, operations, and financial stability. All state Flex programs must assess the financial status of CAHs in the state, identify CAHs with greater needs, and plan interventions to address those needs. The results of this assessment should be described in the Needs Assessment section of the project narrative. Activity Categories 2.2, 2.3, 2.4, and 2.5 are not individually required; however state Flex programs are required to support one or more improvement projects in this program area, specific projects and approaches determined by the state's needs assessment and program capacity.

**Program Area 2:** CAH Operational and Financial Improvement (required)

**Program Area 2 Goal:** Maintain and improve the financial viability of CAHs

**Activity Categories:**

- 2.1 Statewide operational and financial needs assessments (required annually)
- 2.2 Individual CAH-specific needs assessment and action planning (optional)
- 2.3 Financial improvement (optional)
- 2.4 Operational improvement (optional)
- 2.5 Value-based payment projects (optional)

**Suggested participation (output) measure:**

- Number and percent of CAHs in the state participating in Flex-funded operational and financial improvement projects each year. Set a target in the future work plan and report the actual number in PIMS (2.2-2.5).
- Other output measures as applicable for specific activity categories.

**Suggested outcome measures:**

- Number and percent of CAHs in the state meeting the benchmark for a measure identified in the [Small Rural Hospital and Clinic Finance 101 Manual](#). Explain the reasons for selecting the chosen measure or measures for statewide tracking and the reason for the benchmark chosen for that measure.
- *Example of a widely-applicable measure from the manual:* Number and percent of CAHs in the state with operating margins above 0.9 percent each year. Objective could be for all CAHs in the state to meet this threshold by year 4. In this example, threshold set slightly below the national median due to state-specific conditions that reduce average margins. Improving operating margins over time will contribute to the goal of improving financial viability of CAHs.
- *Example of a high-level, long-term measure:* Number and percent of CAHs in the state rated high or mid-high in the Financial Distress Index (FDI) calculated by UNC each year (data and historical trend available in CAHMPAS). The objective could be to decrease the number of CAHs to no more than X CAHs in the state rated high or mid-high in the FDI by year 4. Note that some states have few or no CAHs rated high or mid-high so the measure would not apply.
- Other outcome measures as applicable for operational and financial improvement.

In the upcoming performance period, FORHP will work with state Flex programs and technical assistance partners to continue to develop regular reports and resources to improve analysis and monitoring of CAH financial data for actionable insights.

In addition to the suggested activities identified in the activity categories below, TASC has collected [financial and operational improvement resources](#) that identify consultant-recommended best practices and strategies for improving financial performance and increasing operational efficiencies.

Flex investments in this area must focus on CAHs. However, Flex programs may assist CAHs that operate provider-based RHCs or other off-campus health care sites to improve the operations of those sites along with the main campus because that also helps improve the overall financial picture for the CAH. As appropriate to the specific interventions and supported by the needs assessment, provider-based

RHCs and other on- or off-campus CAH-owned health care sites may be included in any improvement projects in this program area.

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. FORHP also encourages group activities and cohorts to maximize the impact of limited Flex funds. We recognize that improvements to CAH operations may also improve patient satisfaction and quality of care and such secondary outcomes will also benefit CAHs.

#### Activity Category 2.1, Statewide operational and financial needs assessments

This required category includes statewide assessment and monitoring activities to identify operational and financial needs of CAHs. Work in this category will often vary in intensity and level of effort from year to year. It can 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.

This category is required annually and the application should describe your plans to monitor changing needs every year throughout the five-year period of performance. On an appropriate schedule conduct a systematic, in-depth statewide needs assessment to determine CAH needs and opportunities for Flex interventions. State Flex programs should conduct an in-depth assessment at least once during the period of performance but it may be more frequent if needed to ensure that programs can respond to environmental changes and meet evolving CAH needs.

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,<sup>2</sup> with [peer group](#)<sup>3</sup>, state, and national comparative data, as well as quality and community data. FMT has published [resources for using CAHMPAS](#) and

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<sup>2</sup> Total Margin, Cash Flow Margin, Return on Equity, Operating Margin, Current Ratio, Days Cash on Hand, Days in Net Accounts Receivable, Days in Gross Accounts Receivable, Equity Financing, Debt Service Coverage, Long-Term Debt to Capitalization, Outpatient Revenues to Total Revenues, Patient Deductions, Medicare Inpatient Payer Mix, Medicare Outpatient Payer Mix, Medicare Outpatient Cost to Charge, Medicare Acute Inpatient Cost per Day, Salaries to Net Patient Revenue, Average Age of Plan, FTEs per Adjusted Occupied Bed, Average Salary per FTE, Average Daily Census Swing-SNF Beds, Average Daily Census Acute Beds

<sup>3</sup> Net patient revenue categories, government ownership, provision of long-term care, and operation of a rural health clinic

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.

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.

#### Activity Category 2.2, Individual CAH-specific needs assessment and action planning

This optional category includes activities to identify specific needs for individual CAHs and cohorts of CAHs and develop action plans to address those needs. The outcomes of projects in this category will often be action plans for future implementation.

##### Suggested Activities:

- Facilitate in-depth assessments of CAHs identified as higher need in the statewide assessment.
- Work with CAHs to develop action plans.
- Evaluate adoption and implementation progress of action plans through the Recommendation Adoption Process (RAP) Model<sup>4</sup>.

#### Activity Category 2.3, Financial Improvement Projects

This optional category includes activities to improve CAH financial stability and revenue cycle management processes.

##### Suggested Activities:

- Comprehensive chargemaster review to assess appropriateness of charges and to create a more efficient and compliant pricing mechanism.

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<sup>4</sup> See <https://www.ruralcenter.org/events/program-evaluation-workshops> for an example of assessing behavior change using the RAP model.

- Billing and coding education to improve the understanding of CMS policies, National Correct Coding Initiative, and Current Procedural Terminology (CPT) instructions for reporting and reimbursing services. Education can also improve coding accuracy and compliance; identify strategies to capture missed revenue; and increase productivity.
- Training and technical assistance on implementation of an effective revenue control process.
- Use of financial improvement networks to share best practices and improve revenue cycle efficiency.
- Education and training for hospital personnel and boards to improve revenue management and processes.
- Training on [revenue cycle process improvements](#).

#### Activity Category 2.4, Operational Improvement Projects

This optional category includes activities to improve CAH operations which may include hospital-wide, department, or service line interventions. These projects should improve efficiency, lower cost, increase patients served, or otherwise positively impact CAH operations.

#### Suggested Activities:

- Technical assistance on the development and use of productivity benchmarks to improve departmental efficiency.
- Technical assistance to improve hospital processes such as supply management systems, integration of materials management, billing, purchasing, and patient information systems, work environment, workflow improvement, and pharmacist review of medication orders.
- Training and technical assistance on improvement methodologies and management tools such as Lean, Six Sigma, or a [Performance Excellence Framework](#).
- Education and technical assistance to assist CAHs to implement [best practice operational strategies](#) and leverage quality performance to increase market share.
- Education and technical assistance to help CAHs understand and comply with Medicare Conditions of Participation, state Medicaid requirements, state licensing requirements, or other applicable regulatory requirements.
- Training and technical assistance to implement new services lines and expand access to services, e.g. develop telehealth services or expand service offerings by participating in technology-enabled collaborative learning and capacity-building models such as [Project ECHO](#).

### Activity Category 2.5, Value-based Payment Projects

This optional category includes activities to help CAHs transition to value-based payment.

#### Suggested Activities:

- Support CAHs to implement strategies in the [Rural Hospital Toolkit for Transitioning to Value-based Systems](#).
- Support CAHs to implement models and strategies identified by [Rural Health Value](#) including use of the [Value-Based Care Assessment Tool](#).
- Facilitate use of the [Self-assessment for Transition Planning](#) by CAHs and sharing of results to inform future state Flex program work.
- Educate CAH leaders and boards about state and national value-based payment programs.
- Educate rural providers and CAH leaders on risk adjustment models including the CMS hierarchical condition categories (HCC) that impact value-based payment. A [July 2018 research brief](#) identified concerns with HCC scores and rural providers.

## Description of Program Area 3: CAH Population Health Improvement

The goal of this optional Flex program area is to build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities. Population health is commonly defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. Flex funds can support certain activities that contribute to community health outcomes, 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 along a continuum 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. 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)

**Program Area 3 Goal:** Build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities

#### **Activity Categories:**

- 3.1 Support CAHs identifying community and resource needs (optional)

- 3.2 Assist CAHs to build strategies to prioritize and address unmet needs of the community (optional)
- 3.3 Assist CAHs to engage with community stakeholders and public health experts and address specific health needs (optional)

**Suggested participation (output) measure:**

- Number and percent of CAHs in the state participating in Flex-funded population health improvement projects each year. Set a target in the future work plan and report the actual number in PIMS (3.2-3.3).
- Other output measures as applicable for specific activity categories.

**Suggested outcome measures:**

- Determine outcome measure appropriate to the population health interventions planned.

Through these optional activity categories, CAHs will build capacity to implement population health initiatives reflective of the completed Community Health Needs Assessment (CHNAs), as well as other types of assessments. As in previous years, Flex funds cannot be used to pay for the completion of CHNAs which are a fundamental part of health care operations.

The following FMT papers include examples of CAH population health projects and population health measures at the hospital and county level:

- [“Critical Access Hospitals’ Community Health Needs Assessments and Implementation Plans: How Do They Align?”](#) Flex Monitoring Team Briefing Paper #39, October 2018.
- [“Population Health Strategies of Critical Access Hospitals,”](#) Monitoring Team Briefing Paper #36, August 2016.
- [“Critical Access Hospital-Relevant Measures for Health System Development and Population Health,”](#) Flex Monitoring Team Policy Paper #42, December 2015.

TASC has also developed a collection of resources for state Flex programs about [addressing community health needs](#).

Activity Category 3.1, CAHs identifying community and resource needs

This optional category includes planning and assessment activities to support CAH population health initiatives and plan targeted interventions for Activity Categories 3.2 and 3.3. Flex Programs can aid in local, regional or state coalition building or sharing of information to prepare CAHs for these projects. The purpose of this activity category 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](#) through TASC's [Population Health Portal](#). This assessment utilizes a systems-based framework to ensure a holistic approach to population health. The Population Health Portal has eleven 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.

#### Suggested Activities:

- CAHs complete Population Health Readiness assessment and share results.
- State Flex programs offer CHNA training.
- State Flex programs track CHNA completion and information for population health cohort planning. The IRS requires not-for-profit hospitals [including not-for-profit CAHs] to complete triennial CHNAs, CAHs not required to report CHNAs for tax purposes are encouraged to use CHNAs or similar processes to identify their community's needs.

Activity Category 3.2, Assist CAHs to build strategies to prioritize and address unmet needs of the community

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 implementation strategies to prioritize and address the unmet health needs identified from CHNAs, all CAHs including publicly-owned and for-profit facilities should consider ways to incorporate input from these key stakeholders in developing their population health strategies. All CAHs should also engage community members in implementing and evaluating the impact of these strategies.

The growing recognition that acute health care is only one contributing factor to the health of a community has encouraged CAHs and other hospitals to embrace population health strategies. These strategies can address the needs of vulnerable populations in their communities, re-focus community benefit activities to improve the overall health of their communities, demonstrate accountability to local stakeholders, and move toward value-based models of health care delivery and financing. This focus on population health is pushing CAHs to think outside of their walls and consider programs to address the health inequities and social determinants affecting the health of the communities they serve.

With the focus on engaging patients, partners, and communities, CAHs may integrate a population health action-plan into their system-wide implementation

strategy or be involved in other activities to prioritize the needs of their communities. The [Performance Excellence Framework](#), a tool that can be used to reach organization excellence by adopting a systems approach, is a proven example for how health care organizations can manage the many complexities in a changing health care environment as they work towards achieving excellence in quality and safety. State Flex coordinators can play a major role to facilitate strategic planning, community engagement discussions, workshops, and linking relevant technical assistance to specific CAHs or cohorts of CAHs.

Suggested activities:

- Share resources and tools to inform community health action planning for a cohort of CAHs.
- Facilitate the process for CAHs to create action plans that prioritize and address population health needs through workshops, conferences, CAH network meetings, etc.
- Identify and partner with stakeholders in the development of community health programs and activities.
- Facilitate ongoing collaboration between CAHs and other community stakeholders such as schools, public health departments, civic groups, social service organizations, and other stakeholders.
- Evaluate adoption/progress of action plan through the Recommendation Adoption Process (RAP) Model.<sup>5</sup>
- Provide funding for subject matter experts to aid in topic-specific adoption of strategies such as care coordination, telehealth implementation, identifying social determinants of health, accessing behavioral health, and chronic care management.

Activity Category 3.3: Assist CAHs to engage with community stakeholders and public health experts and address specific health needs

With the assistance of FORHP’s technical assistance partners and support of state Flex programs, CAHs will begin to implement specific activities that respond to the population health needs of their communities. This activity category aims to put into action information gleaned from the identification of community needs and integrate activities related to population health. State Flex coordinators may work with subject matter experts to create CAH networks and address common CAH action plan items, while collecting and sharing outcomes and best practices. For example, State Flex programs may work to encourage the implementation of sustainable programs and care management tools such as the implementation of

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<sup>5</sup> See <https://www.ruralcenter.org/events/program-evaluation-workshops> for an example of assessing behavior change using the RAP model.

diabetes education programs or chronic care management programs that could be reimbursed by Medicare, Medicaid, and potentially other third party payers using the chronic care management or behavioral health integration codes.

Suggested activities:

- Chronic Care Management
- Substance and Opioid Use Prevention Treatment, and Recovery
- Behavioral Health
- Public Health, Wellness, and Social Determinants of Health

The following is a sample of population health strategies and activities relevant to CAHs and their communities, as well as the role of state Flex coordinators. Some of the examples are drawn from recent population health publications and Flex-related presentations. Others are evidence-based strategies that have been implemented in rural communities. For a more details on the projects cited below and a longer list of potential projects for CAHS, please visit the Models and Innovations section of the [Rural Health Information Hub \(RHI Hub\)](#).

### **Examples of Chronic Care Management Activities**

Support CAHs to develop chronic care management services to meet the needs of their local communities by identifying and engaging with a subject matter expert on culturally appropriate health education. Many of these services can provide a revenue stream for the care management services provided by the hospital and its staff through the use of chronic care management or behavioral health integration codes as well as health and behavior assessment and intervention codes to identify and address the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.

Develop and/or facilitate rural health networks and associated clinical partners to implement evidence-based diabetes programs in rural counties and incorporate trainings/use of community health workers (e.g. *Heartland Rural Health Network in Florida*). Support the outreach of comprehensive, culturally competent diabetes education program serving US/Mexico border communities (e.g. *The Vivir Mejor! (Live Better!) System of Diabetes Prevention and Care*)

Facilitate collaboration and training so CAHs may partner with community volunteers and health coaches to mentor discharged patients with certain chronic conditions, to help them transition from home health care to self-care. (*Community Health Coaches for Successful Care Transitions*). Connect CAHs to case management programs targeting individuals at risk for stroke and heart disease in the rural counties (*Healthy People: Healthy Communities*). Convene workshops so

CAHs can learn strategies to use community-oriented, outcome- and team-based care to address rural community members' high rates of hypertension (*Roane County Hypertension Control*) or to provide diabetes outreach screening and education sessions in rural communities (*Meadows Diabetes Education Program*).

### **Examples of Substance Use Prevention and Treatment Activities**

Support CAHs to develop local capacity to identify and treat opioid and other substance use disorders. Because rural residents are often required to travel outside of the community to obtain services, CAHs can explore opportunities to expand access to evidence-based treatment programs. Hospital and community providers can be encouraged to regularly screen for substance use issues using evidence-based screening tools such as SBIRT (Screening, Brief Intervention, and Referral to Treatment), the NIDA Drug Use Screening Tool, CRAFFT, the Alcohol Use Disorders Identification Test-C, the Opioid Risk Tool, AUDIT, CAGE-AID, Drug Abuse Screen Test (DAST-10), and DAST-20: Adolescent version. Resources and tools to implement these screening tools are available from multiple sources.

The following papers include examples of strategies to engage rural health care organizations to improve care for substance use disorders:

- Gale, JA, Hansen, AY, Williamson ME. [Rural Opioid Prevention and Treatment Strategies: The Experience in Four States](#). University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center; April 2017. PB 63-2. (6 pages)
- Gale, JA, Hansen, AY, Williamson ME. [Rural Opioid Prevention and Treatment Strategies: The Experience in Four States](#). University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center; April 2017. Working Paper #62. (43 pages)
- The [Fiscal Year 2017 Flex Supplemental Funding Instructions](#) included an extensive list of additional resources related to substance use disorders.

CAHs can also explore options to expand access to treatment services either directly or in collaboration with specialty mental health providers. Examples include the use of buprenorphine to manage opioid use issues by primary care providers and the development of hub and spoke models to engage specialty treatment providers to support local systems of care. CAHs can also explore the development of pain management programs to provide an alternative to the use of opioids for chronic pain patients.

An additional role of state Flex coordinators may be to coordinate, organize, and facilitate the training needs of the CAHs as it relates to:

- *Community strategies focused on substance use prevention:* Facilitate CAH adoption of resources and tools related to community organizing and prevention initiatives and/or evidence-based organizing frameworks focused on reducing the burden of opioid use, both prescription opioids and heroin, in rural communities (*Project Lazarus, SAMHSA’s Communities that Care curriculum and Strategic Prevention Framework*).
- *The use of evidence-based prescribing guidelines for opioids, benzodiazepines, and other prescription medications:* Opioids and benzodiazepines are two categories of prescription medications with significant abuse potential that are frequently prescribed by rural providers. The Centers for Disease Control and Prevention have published evidence-based opioid prescribing guidelines as have a number of states and professional associations. The Maine Benzodiazepine Study Group has published a set of recommended guidelines of the use of benzodiazepines in office practice in the state of Maine along with evidence supporting the group’s recommendations. CAHs can implement these guidelines in their own settings as well as encourage other local providers to do the same.
- *Implementation of harm reduction and prevention strategies for opioids:* CAHs can support the adoption of local harm reduction strategies including needle exchanges or the expanded availability of naloxone to reduce opioid overdose deaths as well as programs to collect and dispose of unused prescription medications. Note that Flex funds may be used to support training and collaboration activities, but cannot pay for needle exchanges, medications, or other direct patient care activities.

### **Examples of Behavioral Health Activities**

Provide technical support to CAH interested in developing an integrated behavioral health program to reduce the use of emergency department by behavioral health patients and to provide care locally. The service may be developed in collaboration with area behavioral health providers and community task groups and based on the health needs identified in CHNAs (*Essentia Health St. Mary’s Hospital-Superior in Wisconsin, the [Minnesota Integrative Behavioral Health \(IBH\) Program](#)*).

Support the use of technology to address the needs of behavioral health patients presenting at the participants’ emergency departments. The goal of these programs are to reduce the burden of mental health patients on local emergency department staff by using standardized protocols/algorithms to assess and engage patients. The program will also make use of Telehealth consultations by the specialty mental health staff (*Wabash Valley Telehealth Network in Indiana*).

## **Examples of Public Health, Wellness, and Social Determinants of Health Activities**

A CAH has the unique opportunity to provide leadership, staffing, and resource support for rural community initiatives. Examples include coalitions of community agencies and providers that facilitate strategic planning, ongoing communication, and local oversight in promoting the health of the community. Another example would be the establishment of a hospital employee wellness program. State Flex coordinators can serve as central point to connect CAHs with these community organizations and provide tools and resources to the hospital to initiate action. They may also assess impact of outreach efforts and monitor change in behaviors or health outcomes.

Hospital leaders stress the importance of providing leadership and resources while sharing the credit with community providers and agencies. A specific example of this collaboration is seen with *Redington-Fairview General Hospital* and Somerset Public Health in Maine. Redington-Fairview supports a broad portfolio of community health improvement initiatives through Somerset Public Health (SPH), a local public health partnership organization based in and funded by the hospital with additional support from federal, state, and foundation funding sources. Through close collaboration with local providers and organizations, SPH has secured funding for numerous community health initiatives, including the *Move More Kids* program, which provides support for nutrition and physical activity policy and environmental changes in schools; the *Micro Wellness Project for Small Businesses*, which offers worksite support to small businesses of 20 employees or less on substance abuse prevention, healthy nutrition and physical activity along with health screenings, weight management, oral health, and tobacco cessation services throughout Somerset County; and the regional *Partnerships to Improve Community Health* in which SPH collaborates with other hospitals and providers to support its evidence-based chronic disease prevention programs.

## **Description of Program Area 4: Rural EMS Improvement**

This optional program area focuses on work to improve rural Emergency Medical Services (EMS). EMS serves as a vital link to emergency health care for rural residents. 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.” The [Rural and Frontier Emergency Medical Services Agenda for the Future](#), first published in 2004, describes national challenges and opportunities for rural EMS and lists some important barriers to the provision of EMS in rural communities: 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.

In response to these issues, the Flex program will focus on two primary areas of concern: improving the organizational capacity of rural EMS services and improving the quality of those services. The focus on organizational capacity encourages the creation of interventions that address financial and operational problems in vulnerable rural EMS agencies in order to maintain and improve the availability of EMS services to every rural resident. The focus on quality of care encourages the development of interventions that improve the management of time-sensitive diagnoses as well as providing technical assistance for data reporting. We include assessment activities to help states understand the needs of their EMS agencies and facilitate the development of relevant Flex activities.

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

**Program Area 4 Goals:** 1) Improve the organizational capacity of rural EMS, and 2) Improve the quality of rural EMS

**Activity Categories:**

- 4.1 Statewide rural EMS needs assessment and action planning (optional)
- 4.2 Community-level rural EMS assessments and action planning (optional)
- 4.3 EMS operational improvement (optional)
- 4.4 EMS quality improvement (optional)

**Suggested participation (output) measure:**

- Number and percent of rural EMS agencies in the state participating in Flex-funded improvement projects each year. Set a target in the future work plan and report the actual number in PIMS (4.2-3.4).
- Other output measures as applicable for specific activity categories.

**Suggested outcome measures:**

- Number and percent of rural EMS agencies participating in Flex activities that report quality data through a state-level data collection tool or through the National EMS Information System (NEMSIS).
- Number and percent of rural EMS agencies in the state that are financially stable, financial indicators may include operating margins, total margins, or days cash on hand meeting benchmarks.
- Other outcome measures as applicable for EMS improvement.

For the FY19-FY23 performance period, we encourage states to consider EMS projects after allocating appropriate resources to required Flex program activities. In order to focus on the issues unique to out-of-hospital emergency medical services, projects implemented in Program Area 4 should primarily focus on out-of-hospital emergency medical services. We encourage projects which involve 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, Operational and Financial Improvement. EMS leadership training, with appropriate baseline data and outcome measures to identify behavior change from the training, may be implemented under Activity Category 4.3.

State Flex programs working in the optional rural EMS improvement program area must include Activity Category 4.1 and/or 4.2 to inform priorities for EMS work. We expect states working in the EMS program area to complete at least one statewide or community-level assessment activity during the five-year program cycle. Activities in the EMS Operational or EMS Quality Improvement categories should be supported by the results of the assessment(s). Projects can be for one to five years. Recipients may undertake assessment work during the first year of the award cycle with development and implementation of targeted activities taking place during following years. Recipients may also choose to complete needs assessments in the last year of the period of performance to prepare for the next competitive cycle. Recipients may choose a statewide strategy or may choose to work with individual agencies or communities. Recipients should select the type of needs assessment that best reflects the state's priorities and capacity. Assessment recommendations should include suggestions for future Flex projects.

#### Activity Category 4.1, Statewide Rural EMS Needs Assessment and Action Planning

The purpose of this activity category is to facilitate statewide needs assessment projects designed to inform the design of state Flex program EMS activities. Assessment activities should be completed either in year one or before the start of year one and the results used to select activities for subsequent years. Work in this category may include participation in a statewide assessment conducted by another organization in the state, an assessment of EMS systems in the area around the CAHs in the state, or some other assessment that targets multiple rural EMS agencies in order to determine areas of need. These assessments should provide a broad picture of EMS statewide, or across multiple agencies.

An example of an assessment tool is the [Attributes of a Successful Rural Ambulance Service](#) developed by the Wisconsin Office of Rural Health. The FMT policy brief [EMS Assessment Activities of State Flex Programs](#) reviews successes and challenges of statewide EMS assessments including delays caused by extended development time for new tools. We encourage recipients to use existing tools to enable timely completion of assessments. Tools and resources for completing these assessments are available on [TASC's website](#). These tools are designed for use at the EMS agency level, but the results may be aggregated to provide an overview of EMS in the state.

Regardless of the tool you choose, 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

#### Activity Category 4.2, Community-level Rural EMS System Assessment and Action Planning

The purpose of the assessments is to identify areas of need in individual agencies or all agencies in a particular community and recommend improvement activities. This activity should focus on individual agencies and provide insight on the specific needs of individual agencies to provide targeted technical assistance in future years. 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.

An example of an assessment tool is the [Attributes of a Successful Rural Ambulance Service](#) developed by the Wisconsin Office of Rural Health. The FMT policy brief [EMS Assessment Activities of State Flex Programs](#) reviews successes and challenges of statewide EMS assessments including delays caused by extended development time for new tools. We encourage recipients to use existing tools to enable timely completion of assessments. Tools and resources for completing these assessments are available on [TASC's website](#).

Regardless of the tool you choose, 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

**Possible outcome measure:**

- Number and percent of communities implementing recommendations that address priority needs identified in the assessment.

### Activity Category 4.3, Rural EMS Operational Improvement

EMS Operational Improvement activities are intended to address one of the most discussed needs for rural EMS: the need for organizational transformation. This optional activity category provides an opportunity for states to dedicate resources to activities that benefit vulnerable agencies that need significant changes to continue operations. Such activities might target EMS decision-makers, leaders responsible for agency or system management, day-to-day managers, and/or agency staff. Objectives of the projects may include changing management, financial, or operational practices or changing the structure of EMS in a community. Activities should contain substantive, well-designed elements that will result in improvements to EMS agency operations. The specific content of the activities should be selected based on the results of a needs assessment and reflect state and community priorities.

Suggested interventions include training and technical assistance targeted at needs identified in the assessment, subject matter expert consultation on restructuring an agency or local EMS system, or technical assistance and consultation for implementing Community Paramedicine.

#### Suggested Activities:

- Technical assistance to make organizational changes.
- EMS agency personnel training and development.
- Training on personnel management.
- Training and technical assistance with electronic health records.
- Billing and coding education to improve the understanding of CMS policies, National Correct Coding Initiative, and Current Procedural Terminology (CPT) instructions for reporting and reimbursing services.
- Training and technical assistance on implementation of effective financial controls and a revenue control process.
- Use of financial improvement networks to share best practices and improve revenue cycle efficiency.
- Education and training for EMS personnel and leadership to improve revenue management and processes.
- Revenue cycle process improvements.

#### **Possible outcome measures:**

- Number and percent of rural EMS agencies able to bill third party payers and patients for services rendered.
- Number and percent of rural EMS agencies able to access and analyze patient billing and agency financial data for performance improvement.

### Activity Category 4.4, Rural EMS Quality Improvement

This optional activity category relates directly to the second goal of improving the quality of care provided by rural EMS agencies. The EMS Quality Improvement activities are intended to address two needs:

- 1) The need to introduce quality improvement activities and measures to better integrate EMS with the wider health care delivery systems, and
- 2) The need to support rural agencies with training and tools to improve the quality of patient care.

In the FY15-FY18 Flex project period, Activity 3.05, “Improve Time Critical Diagnoses EMS System Capacity,” was narrowly focused on interventions to improve patient care. For this period of performance, the Rural EMS Quality Improvement category incorporates this activity, but also encompasses technical assistance around data reporting, a necessary component of long-term efforts to improve patient care. Data reporting is particularly problematic for rural agencies already struggling with staffing and finance issues. This activity category includes interventions to provide training and technical assistance for quality improvement and reporting.

The specific content of the activities should be selected based on the results of a needs assessment and reflect state and community priorities. Activities in this category should focus on building EMS capacity for quality reporting and/or focus on training and process improvements that enhance the management of time critical diagnoses. For example activities, please visit [TASC's website](#).

#### Suggested Activities:

- Training to improve the management of STEMI, stroke or trauma.
- Developing protocols in cooperation with local hospitals to establish criteria to determine the most appropriate hospital for each patient.
- Improving processes for transferring patients and prehospital activation.
- Technical assistance for data reporting to NEMSIS and state-level quality reporting systems.
- Training and technical assistance to support activities that improve performance on one or more of the NEMSIS or state-level measures.
- Encourage CAHs and rural EMS agencies to participate in collaborative review/debriefings of TCD events.
- Facilitate and develop EMS quality improvement networks.

**Possible outcome measures:**

- Number and percent of rural EMS agencies with formal quality improvement protocols/continuous quality improvement (CQI) processes.
- Number of CAHs/EMS systems of care that engage in local quality review and improvement committees.
- Number and percent of rural EMS agencies that use quality data for performance improvement.
- Number and percent of rural EMS agencies using the Centers for Disease Control and Prevention’s Guidelines for the Field Triage of Injured Patients (trauma) of all ages.
- Number and percent of rural EMS agencies using the American Heart Association’s Mission (AHA): Lifeline Guidelines (STEMI).
- Number and percent of rural EMS agencies using protocols that meet current American Stroke Association/AHA guidelines for stroke care.
- Number and percent of rural EMS agencies with emergency dispatch protocols.
- Number and percent of rural EMS staff with training on recognition of STEMI and stroke.
- Number and percent of rural EMS staff with training on trauma/field triage protocols for all ages.

**Description of Program Area 5: Innovative Model Development**

This optional program area focuses on developing innovative rural health care models that improve quality, finances, operations, population health, and/or system delivery in rural communities. Ideally, successful models will improve care in rural areas and serve as best practices or strategies for other states. Projects can be for one to five years.

When proposing a project in this program area, applicants must include evidence that the state Flex program has been able to meet the majority of quality, operational, and financial improvement needs of CAHs within the state and has additional organizational capacity to take on an innovative project that is not captured in the other program areas.

Projects proposed must include clear methodology and clear and measurable outcomes. Projects in this program area must include a logic model for the innovative model activity as part of the project description.

**Program Area 5: Innovative Model Development (optional)**

**Program Area 5 Goal:** Increase knowledge and evidence base supporting new models of rural health care delivery

**Activity Categories:**

- 5.1 Develop and test innovative models and publish report or documentation of the innovation
- 5.2 Develop and test CAH outpatient clinic (including CAH-owned rural health clinics) quality reporting and publish report or documentation

**Suggested participation (output) measure:**

- Number and percent of CAHs in the state participating in Flex-funded innovative model projects each year. Set a target in the future work plan and report the actual number in PIMS (5.1-5.2).
- Other output measures as applicable for specific activity categories.

**Suggested outcome measure:**

- Increased rural evidence base as shown by a published report on positive and negative results of each model including health outcomes and replicability assessment (one report reflecting the multi-year project, not expected annually).
- Other outcome measures appropriate to the innovative model planned.

## Description of Program Area 6: CAH Designation

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.

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.

**Program Area 6: CAH Designation (required if requested)**

**Program Area 6 Goal:** Assist rural hospitals to seek or maintain appropriate Medicare participation status to meet community needs

**Activity Categories:**

- 6.1 CAH conversions (required if assistance is requested by rural hospitals)
- 6.2 CAH transitions (required if assistance is requested by CAHs)

**Suggested participation (output) measures:**

- Number of rural hospitals requesting conversion assistance. Set a target in the future work plan and report the actual number in PIMS (6.1).

- Number of CAHs requesting transition assistance. Set a target in the future work plan and report the actual number in PIMS (6.2).

**Suggested outcome measure:**

- Number of new CAHs receiving CMS certification in the year.

Suggested Activities:

- Support financial feasibility studies for CAHs or rural hospitals assessing their status
- Assist rural hospitals exploring or pursuing conversion to CAH status (6.1)
- Assist CAHs with a planned transition to other types of health care services when an inpatient hospital is not viable or doesn't meet community needs (6.2)

## Frequently-used Acronyms

CAH: Critical Access Hospital

CART: Centers for Medicare and Medicaid Services Abstraction and Reporting Tool

CDC: Centers for Disease Control and Prevention

CHNA: Community Health Needs Assessment

CHW: Community Health Worker

CMS: Centers for Medicare and Medicaid Services

CoP: Conditions of Participation

CQI: Continuous Quality Improvement

CQMs: Clinical Quality Measures

CY: Calendar Year

DHHS: Department of Health and Human Services (or HHS)

ED: Emergency Department

EMS: Emergency Medical Services

Flex: The Medicare Rural Hospital Flexibility Program

FMT: Flex Monitoring Team

FORHP: Federal Office of Rural Health Policy

FY: Fiscal Year

HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems

HIIN: Hospital Improvement Innovation Network (formerly HEN)

HRSA: Health Resources and Services Administration

IRS: Internal Revenue Service

MBQIP: Medicare Beneficiary Quality Improvement Project

NoP: Notice of Participation

PIMS: Performance Improvement & Measurement System

PO: Project Officer

RHC: Rural Health Clinic

RHIhub: Rural Health Information Hub

RQITA: Rural Quality Improvement Technical Assistance

TA: Technical assistance

TASC: Technical Assistance and Services Center

TCD: Time Critical Diagnoses

## Description of Flex Program Measurement Framework

The purpose of program measurement is to show the changes resulting from Flex work—the outcomes. This measure framework provides additional examples about the different types of outcomes measures we can track to show such changes.

Flex program work plans must include annual outputs (process measures) for each activity category and a timeline for activities with key milestones to track progress. Some output measures, e.g. number of CAHs participating in improvement projects, are reported on a yearly basis in PIMS. Work plans must also include outcome measures at the program area level; we recommend selecting one to three clearly defined outcome measures for each program area. In addition to identifying the measures, work plans must include a clear, time-based target for each outcome measure. We also encourage interim targets to easily monitor progress.

Outcome measures fall into four general categories: learning, behavior, conditions, and impact. These different types of outcome measures are hierarchical and require different spans of time in order to show changes. Since these are shorter-term measures, states will generally choose learning, behavior, and conditions outcome measures that can realistically demonstrate changes in one to five years, but you may also select impact outcome measures if appropriate and timely data are available. You will report annual updates on your outcome measures every year in the progress report. At the end of the five-year period of performance you will have five years of data for each outcome measure and be positioned to discuss changes over time, analyze trends, and evaluate progress compared to the objectives and targets set in the application.

Available data (or lack of data) can cause problems for outcome measurement. When selecting medium and long-term outcome measures you should carefully consider the availability and timing of data to ensure that you can report new data each year. Collecting data directly, and with the help of contractors and collaborators, is one way to ensure you have timely data.

**Outcome measure hierarchy:** Learning enables people and organizations to change behavior, which leads to changes in the conditions created by those behaviors. Changes in conditions, e.g. health care practices, leads to changes in health status for the people served by the organization—the ultimate impact of the work. Consider outcome measures at different levels of this hierarchy to reflect the range of outcomes of a program.

Table comparing and contrasting output and outcome measures

<b>Type of measure</b>	<b>What to measure</b>	<b>When to measure</b>	<b>How to measure</b>	<b>When to expect change</b>
Short Term Process: <b>Output</b>	Measures <b>number of products</b> . How many planned events were completed? How many people participated?	As soon as activities and products are completed	Track number of actual participants, events, documents, etc. and compare to expected number	<i>Does not measure change</i>  Example: monitor number of participants or events for internal program management.
Short Term Outcome: <b>Learning</b>	Measures <b>knowledge change from the activity</b> . Did the activity have an immediate effect on the participants' knowledge?	Before and after an activity	A pre-test and a post-test or another method to measure knowledge gain	Immediately after the activity is completed  Example: workshop participants increased knowledge of how to report quality measures.
Medium Term Outcome: <b>Behavior</b>	Measures <b>changes in policy, processes, or staff behavior</b> . Did hospital or EMS agency policy, processes, or staff behavior change after the intervention?	Measured a few weeks or months after the activity ends	Follow-up interviews or monitor behavior	Within one year  Example: workshop participants increased reporting rates for quality measures in the six months following the training.
Long Term Outcome: <b>Conditions</b>	Measures <b>changes in quality of care or financial stability</b> . Did quality or financial metrics change after the intervention?	Regularly collected and reported, monitor over time to track trends	Standard data sets such as MBQIP and CAHMPAS, custom metrics collected regularly over time	In one to five years  Example: participating CAHs reported higher operating margins two years after the consultation.
Longer Term Outcome: <b>Impact</b>	Measure <b>changes health and wellness</b> in a population. Did the change in conditions influence patient outcomes over the long term?	Usually only measureable over long time frames (not required of individual state Flex programs)	Data sets that measure health status such as claims data or patient registries	In more than five years  Example: stroke patients transported by EMS in the region with the intervention have increased survival rates, lower readmissions, and improved functional status.