Health Resources and Services Administration
Office of Rural Health Policy

MEDICARE RURAL HOSPITAL FLEXIBILITY GRANT PROGRAM

Instructions for Completing the FY2013 Non-Competing Continuation (NCC) Progress Report

Funding Announcement Number: HRSA-5-H54-13-001
Available: March 4, 2013
Due: May 2, 2013
Funding Start Date: September 1, 2013

This is the Health Resources and Services Administration (HRSA) streamlined process to renew your budget period and release the continuation funding for your ongoing award. Submission and HRSA approval of your progress report will trigger the budget period renewal and the release of funds.

HRSA's expectations are that grantees will pursue all years of their grant projects as originally proposed and recommended for approval in competitive review, in terms of scope of work and budget line items. If significant changes in scope or budgeting of your project are believed necessary, you must request prior approval from the Grants Management Officer, as endorsed by your HRSA Office of Rural Health Policy Project Officer and as specified in your Notice of Award (NoA). **This continuation funding process is not intended as the vehicle for grantees to request prior approval for such changes. Grantees should request prior approval for changes of scope and rebudgeting separately through the EHBs**

Funding beyond the first year (budget period renewal) is dependent on the availability of appropriated funds, recipient satisfactory performance, and a decision that continued funding is in the best interest of the Federal government. Failure to submit **timely**, accurate, and complete reports will delay processing of budget period renewals and ongoing funding and may result in a lapse in funding.

NCC Progress Report Required Sections

The NCC progress report should not exceed 80 pages (including attachments). Progress reports that exceed the specified page limits may be deemed non-compliant. Please refer to the NCC Progress Report User Guide for detailed instructions on how to submit this report in EHB. The 80 page limit applies to any document uploaded into EHB, to include the Current Work Plan, Future Work Plan, both Matrices, and the Evaluation Plan. EHB web-based forms (i.e. SF-PPR, SF-PPR 2) will not count towards the 80 page limit.
The following sections are required to submit the NCC Progress Report in HRSA EHBs:

- Basic Information
    1. SF-PPR (EHB)
        a. This form is an EHB web-based form and therefore will not count towards the 80-page limit.
        b. Please refer to pages 13-21 of the NCC Progress Report User Guide for Grantees.
    2. SF-PPR – 2 (cover page continuation) (EHB)
        a. This form is an EHB web-based form and therefore will not count towards the 80-page limit.
        b. Please refer to pages 21-28 of the NCC Progress Report User Guide for Grantees.
    3. Performance Narrative (Defined as Current Year Work Plan Narrative, EHB attachment; no more than 20 pages)
        a. The Performance Narrative will be uploaded in EHB as an attachment and therefore will count towards the 80-page limit.
        b. Please refer to pages 28-30 of the NCC Progress Report User Guide for Grantees.
        c. The Performance Narrative should be typed single-spaced in 12-point Times New Roman font with 1-inch margins.
    4. Appendices
        a. Please refer to page 36-38 of the NCC Progress Report User Guide for Grantees.
        b. Each attachment must contain the Grant Number, Project Title, Organization Name, and Primary Contact Name.
        c. Grantees are allowed to attach only the appendices listed below with the NCC Progress Report submission and ensure that each attachment is correctly labeled and attached in the “Appendices” section as follows.

Reminder: ***Per the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, HRSA funds may not be used to pay the salary of an individual at a rate in excess of $179,700 (the Executive Level II salary of the Federal Executive Pay Scale). This amount reflects an individual’s base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. Reasonableness and allowability regulations continue to remain in effect.***

Reminder: Specific requirements for the Flex Grant Program, such as the FTE position of a Flex Coordinator, travel and attendance at meetings, are still in effect. Additionally, if new personnel are hired, they are *required* to attend the Flex Workshop within the covered budget year.

Appendices

Grantees are allowed to include only the attachments listed below with the NCC Progress Report submission. Each attachment must contain the Grant Number, Project Title, Organization Name, and Primary Contact Name. Grantees must ensure that each attachment is correctly labeled and attached in the "Appendices" section as follows:

- **Attachment 1:** Position Descriptions for all new positions for which grant support is requested.
- **Attachment 2:** Curriculum vitae for any staff hired since submission of the most recent application.
- **Attachment 3:** Future Work Plan Matrix (**spreadsheet**) for the Sept. 1, 2013-Aug. 31, 2014 period.
- **Attachment 4:** Future Work Plan Narrative
- **Attachment 5:** Current Work Plan Matrix (**spreadsheet**) for the Sept. 1, 2012-Aug. 31, 2013 period.
- **Attachment 6:** Evaluation Plan

General Federal Reporting Requirements

1. Prior budget period Federal Financial Report (FFR) submitted through HRSA EHBs
FFRs must be submitted **no later than January 30, 2014**, and must be submitted electronically through the HRSA EHBs. While it is an expectation that all funds are used within the year they are awarded, if you anticipate that there will be an unobligated balance (UOB) of funds at the completion of the current budget period and that these funds will be needed to complete the activities of the project objectives, you must request prior approval to use the UOB as carryover for your project in the new budget period. You may do so by submitting a prior approval request through the HRSA EHBs within 30 days of the electronic FFR submission. The request to use the UOB shall include an explanation of why the funds were not spent and why the carryover is needed, a detailed budget justification and SF424A. The prior approval is subject to review by grants management and the program office for appropriate modification of the UOB and the grantee is reminded only activities listed in the FY 2012 work plan are eligible for carryover into FY 2013 budget period.

2. The Office of Rural Health Policy has created specific performance measures that grantees will be required to report within the **Performance Improvement System (PIMS) located in HRSA's Electronic Handbook (EHB)**. Within 60 days of the end of the budget period (August 31, 2014) for this non-competing continuation application (no later than October 30, 2014), grantees will be required to update the FY 2013 program specific performance measures in the HRSA Electronic Handbooks (EHBs).

Program Specific Instructions for the Performance Narrative and Appendices

Performance Narrative

The Performance Narrative section in EHB includes discussion of the Current Work Plan. It should provide a comprehensive discussion of project activities and accomplishments since submission of your FY 2012 (September 1, 2012 - August 31, 2013) grant application, including progress to date, and planned activities for the remainder of the current year.

In the Performance Narrative, describe the following: (1) progress on all activities since submission of the last (FY2012) application; (2) a discussion of activities to be conducted for the remainder of the current budget period (ending August 31, 2013), (3) discussion of any challenges faced or anticipated in the remainder of the year; and (4) any lessons learned. Progress must relate to the goals and objectives stated in your FY2012 application. The information presented must clearly demonstrate the progress of the goals, objectives, activities, measures (output, process, and outcome) and impact for each of the core areas listed below. Lastly, please provide a brief explanation of the activity you learned about at the July 2012 National Flex Meeting and chose to implement within your Flex Program, and describe what progress you've made.

Core Areas:

(1) Support for Quality Improvement (QI)
(2) Support for Operational and Financial Improvement
(3) Support for Health System Development and Community Engagement
(4) Facilitate Conversion of Small Rural Hospitals to Critical Access Hospital (CAH) status (as applicable)

Instructions for the Appendices

- **Attachment 1:** Position Descriptions for all new positions for which grant support is requested.

- **Attachment 2:** Curriculum vitae for any staff hired since submission of the most recent application.

- **Attachment 3:** Future Work Plan Matrix (**spreadsheet**) for the Sept. 1, 2013-Aug. 31, 2014 period. The Future Work Plan should be presented in an operationalized format, defined as translating program inputs, outputs, objectives, and goals into specific measurable variables. Include ongoing activities that will continue from the current budget period, and any new activities. Projects designed for a single budget year should fully develop their measurement strategy and present it clearly. Projects designed for more than one year will need to define the measurement strategy and set intermittent targets reflective of the activities to be executed in addressing the Objectives. The measurement strategy is defined as the development of the translation of inputs, outputs, objectives, and goals into specific measurable variables. Flex grantees should prioritize funding evidence-based projects (practices that are developed from scientific evidence and/or have been found to be effective based on results of rigorous evaluations) and report the results and lessons learned from the projects. If a needs assessment has not been performed recently, the assessment should be executed and the results should support the proposed activities. Objectives are required in the following core areas (see the Flex Program Core Areas Section of this document specific details):

    - Support for Quality Improvement
    - Support for Operational and Financial Improvement

- Support for Health System Development and Community Engagement
- CAH Conversion (*if applicable*)

As requested last year, ORHP expects ***all*** grantees to participate in the Flex National Meeting with the understanding they ***must*** identify one activity they can implement and measure to be reported in the FY 2014 Progress Report.

- **Attachment 4:** Future Work Plan Narrative (To be submitted separately from the Future Work Plan Matrix.) Provide a narrative explanation of the Future Work Plan strategy, addressing each activity. Provide an explanation of any ongoing activities and of current progress, to include ongoing or expected challenges, intended outcomes, and expected impact. Continuation of ongoing activities and any new activities should include an explanation of how the activity meets the need previously identified in the needs assessment. Multi-year activities initiated in the new budget year should be noted and an update of progress must be reported as part of the next progress report. Strategic thinking regarding potential risk in completing any future projects is encouraged and your narrative should reflect how you will mitigate risk through risk management planning. (Limit 20 pages). Applicants must certify that the activities they undertake using Flex resources do not duplicate activities funded with Small Rural Hospital Improvement (SHIP) Grants.

- **Attachment 5:** Current Work Plan Matrix (**spreadsheet**). Submission of the measurement strategies executed in FY 2012. The Matrix should reflect the quantitative outputs associated with the activities. Additionally if a new activity has been introduced through a change in scope or any terminated activities must be noted and identified clearly. The Current Work Plan Matrix is a snapshot of what will be captured in the Performance Narrative (Uploaded into EHB). ORHP expects the Objectives, linked Activities, and Outcomes to be outlined in a spreadsheet format ***without*** narrative.

- **Attachment 6:** Evaluation Plan. Grantees are expected to provide an update of the previously submitted and approved evaluation plans indicating current progress and challenges as appropriate. This is a document describing the overall approach or design that will be used to guide an evaluation. It includes what will be done, how it will be done, who will do it, when it will be done, why the evaluation is being conducted, and why the specific evaluation type was chosen. The plan describes how program performance will be measured and includes performance indicators.

Flex Program Core Areas

i. Support for Quality Improvement (QI)

Flex Programs are required to support efforts to improve and sustain the quality of care provided by CAHs to ensure that rural citizens receive high-quality, appropriate care in their communities. Activities in this area include supporting CAHs with quality measurement, reporting, and benchmarking as well as supporting CAHs in building quality and patient safety improvement systems and capacity. Efforts should focus on QI programs that sustain efforts over time. Participation in the Flex Medicare Beneficiary Quality Improvement Project (MBQIP) is strongly encouraged. Objective #1 below is MBQIP-specific. Because this is currently a voluntary project, there may be CAHs who are not participating in MBQIP. For those CAHs not currently participating in MBQIP, and for CAHs who are reporting above and beyond the Hospital Compare measures captured in MBQIP, there is a separate Objective #2 for public reporting to Hospital Compare outside of MBQIP participation. Going forward, ORHP expects that MBQIP will become a much more integral quality improvement activity in the Flex Program and Hospital Compare participation will likely not be measured separately from MBQIP participation. Applicants are also encouraged to engage Quality Improvement Organizations (QIOs) in their programs.

a. Quality Improvement Objectives and Interventions:

All Objectives should be linked to affecting improved quality of care for rural stakeholders. The linkage of activities to objectives should reflect the overarching goal of attaining improved health care.

Objectives

The work plan must include at least one of the following QI objectives:

1. Sign up and actively report Phase 1 and Phase 2 measures of the Flex Medicare Beneficiary Quality Improvement Project (MBQIP). Begin planning and implementing Quality Improvement interventions for CAHs that address the needs identified through analysis of the outcomes of Phase 1 and Phase 2 measures. Begin planning for and/or implementing Phase 3 measures.

2. Encourage CAHs in your state to publicly report data to Hospital Compare on relevant process of care quality measures for inpatient and outpatient care, and HCAHPS patient experience of care survey results. Participation in Hospital Compare is defined using the Flex Monitoring Team's definition as submitting data on at least one inpatient measure.

- Reporting to Hospital Compare should include as many inpatient and outpatient measures applicable (to include MBQIP defined measures) at the time of data submission.
- Assist CAHs with submitting quality data.
    a. The CMS Abstraction and Reporting Tool (CART) is one free method for data submission to CMS. Alternative submission methods are allowable.
    b. Trainings are currently available at https://www.qualitynet.org to assist in hospital and health system data submissions.
- In partnership with QIOs, use Flex funds to extend QIO projects to CAHs. Flex funds should not supplant current activities outlined in the 10th Scope of Work, including chart abstraction, assisting rural providers with reporting on inpatient and/or outpatient measures to Hospital Compare, and Hospital Acquired Conditions (HAC) reduction initiatives. For example, if a QIO is putting on a training

related to the reporting of outpatient measures in Hospital Compare, the Flex funds cannot be used to support the work shop. However, if the Flex program uses funds to assist in covering travel expenses for CAH personnel attending, that would be considered an acceptable expense. Collaboration between QIOs and the Flex program is encouraged, however, please discuss if there have been any challenges in developing the collaboration.

3. Support participation of CAHs in your state in a multi-hospital QI project. This project should address a priority QI need identified using quality data from CAHs in your state.
- Encourage CAHs to implement evidence-based protocols for common diagnoses (e.g., pneumonia, chest pain, heart failure, diabetes).
- Support CAHs in implementing activities to reduce unnecessary hospital readmissions (e.g., efforts to improve care coordination and transitions from the hospital to home, skilled nursing care, or home health care).
- Encourage CAHs in developing internal peer review programs.
- Supporting the reduction of HACs and establishing benchmarks for trending.

4. Support CAH participation in quality reporting and benchmarking initiatives other than Hospital Compare (e.g., state and multi-state CAH quality networks).
- Support CAH participation in national QI training or capacity building programs (e.g., Institute for Healthcare Improvement programs).
- Provide CAHs with technical assistance on national and/or state survey processes and requirements (e.g., arrange mock surveys to assist in identifying structural requirements for Joint Commission certification.)

5. Support CAHs in implementing a multi-hospital quality/patient safety project focused on leadership and organizational culture. Support should be provided in follow-up to areas identified during the project.
- Support TeamSTEPPS
  - Use of the TeamSTEPPS Teamwork Perception Questionnaire and the TeamSTEPPS Teamwork Attitudes Questionnaire to determine pre and post measures.
- Support Agency for Healthcare Research and Quality (AHRQ) Patient Safety Culture Surveys
  - Benchmarks should be established for trending analysis
- Support CAH participation in infection control programs (e.g., Centers for Disease Control and Prevention (CDC.)
  - Determining pre and post measures for infection control programs.

The work plan may also include the following *optional* QI Objective:

Support QI education/training programs for managers, staff and/or board members of CAHs. Please note that all of optional QI objective activities will be reviewed by the project officer and if too many resources are dedicated to the objective a change will be requested.

Interventions

Additionally, ORHP expects all grantees to select one intervention, either a continuation from FY 2012 or a new selection for FY 2013 from the following menu set (the same menu set as in FY2012). You can use the same intervention as last year but must report on all measures associated with the intervention. The menu set for quality improvement consists of:

- **Encourage CAHs in state to publicly report Hospital Compare on relevant inpatient and outpatient measures and HCAHPS patient assessment of care survey measures.**
    - This intervention's outcome is to encourage public Quality reporting.
- **Encourage CAHs in state to participate in MBQIP**
    - Encouragement of robust participation in MBQIP to use the identified measures to target specific interventions within the Flex Program.
- **AHRQ Culture of Patient Safety/Team STEPPS**
    - Actively working towards raising staff awareness about patient safety; examining trends in patient safety culture; identification of areas of strength and possible improvement.
- **Support for Quality Network/Work Group Quality Benchmarking and Quality Improvement Activities**
    - Using networks/Work Groups to identify specific quality benchmarking and quality improvement activities.
- **Support for Evidence-Based Protocol Implementation**
    - Using evidenced-based practices to implement protocols for serious medical conditions
- **Care Transitions/Readmissions**
    - Making it clear how the Flex Program activities differ from CMS/QIO activities on care transitions/readmissions

b. Evaluative measures for QI Objective activities and interventions:

The NCC progress report is expected to include evaluation measures capable of being used on a wider scale to include state, regional, and national comparisons. Flex grantees are highly encouraged to adopt the evaluative measures outlined below, as these will be incorporated into the Flex Performance Improvement Measurement System (PIMS). By using uniform evaluative measures the impact of quality improvement initiatives will be identified and used by the grantees to support progress or the need for improvement. Though we are providing a number of uniform measures, Flex grantees are encouraged to develop complementary measures, both process and outcome, to assist in executing program activities and for evaluative purposes.

Additionally, this NCC outlines two types of data collections, the first is the required PIMS submission, and the second is data collection to be incorporated into the work plans. The work plan data collection will create the back story for the PIMS reportable and will be used to identify the steps to the PIMS submission. In some cases, work plan data collection may not be necessary; the grantee is encouraged to review the corresponding Objective and to determine if additional data collection is warranted.

For all evaluative measures in Core Area I, Flex programs are expected to identify a baseline benchmark and these benchmarks should be provided in the work plan. States are to define the benchmarks to show associative change within the State but may also use any relevant national benchmarks. Associated with each Objective within the Core Area, there are activities and Interventions to be executed in completing the Objective. For each Objective and Intervention, there are measures that must be captured in PIMS. When reporting on the measures, grantees will need to provide the numerators and denominators for each measure. If change is being measured then the benchmark numerator and denominator and the change numerator and denominator must be provided. The provision of the raw numbers will allow roll-up across states for similar activities. ORHP is aware we are asking for a significant increase in data and Flex may not

be fully responsible for any changes that occur, but we are trying to measure the overall impact of the program. Change, positive or negative, will help ORHP and you, the Flex Coordinator, direct Flex dollars to the right interventions.

Objectives

1. For QI Objective #1 (MBQIP) and #2 (Hospital Compare), the number of CAHs in each state participating in Hospital Compare is a national Flex Program Performance measure that will be calculated annually by the Flex Monitoring Team (FMT). As part of MBQIP, FMT will also be conducting additional analysis on the outcomes of the MBQIP measures. State Flex Programs should report the number and type of activities that they have undertaken within the grant budget year to encourage CAH participation in public reporting, and to improve outcomes based on the needs identified from the MBQIP measures. State Flex Programs should also provide an explanation of the strategies used to enhance reporting participation and if the strategies were effective. If the strategies were ineffective, provide an explanation of the barriers. With the initial data capture for MBQIP Phase I, some changes have occurred regarding the inpatient measure data capture. Starting with the first Quarter of 2012, CMS has retired a number of the pneumonia measures. The expectations of the MBQIP project remain the same, with the reporting requirements aligning with the CMS reportable measures. Any measure deemed no longer reportable by CMS is not expected to be reported as part of MBQIP after the retirement date of the measure. Any measures associated with MBQIP Phase 3 are solely to establish a baseline for future comparative analysis.

PIMS Measures: **(required reporting)**

- Number of CAHs participating in the MBQIP this budget year
  - o Total number of CAHs in the state
  - o Number of new CAHs participating in MBQIP
  - o Number of CAHs continuing participation in MBQIP from the prior year
  - o Number of CAHs no longer participating in MBQIP this year
  - o Number of CAHs that reported improvement in one or more MBQIP clinical measure
- Number of total CAHs participating in Hospital Compare
  - o Number of new CAHs participating in Hospital Compare this grant budget year.
  - o Change in number of CAHs participating in Hospital Compare based on total number of CAHs within the State.

2. For QI Objective #3 (Multi-state QI projects) and #4 (CAH Quality Reporting), the State Flex Program should report the number of CAHs actively participating in a multi-hospital QI project, the amount and type of assistance provided to the CAHs, and, depending on the type of project undertaken, any relevant measures of the impact of the project on the quality of care provided by the CAHs involved (e.g., increases in the percent of CAHs providing recommended care for patients with heart failure). Flex grantees are should establish baseline benchmarks for comparative review. If the project includes "other rural providers," (any health care entity responsible for any part of the continuum of care (i.e. RHCs, Rural PPS, and EMS)) those entities must be able to provide corresponding measures. **Please note: While the Flex program allows "other rural providers" to benefit from QI activities, this core area is intended to primarily assist CAHs.**

PIMS Measures: **(required reporting)**

- Number of CAHS actively participating in a Flex-funded multi-hospital QI initiative

- Number of CAHs with an improvement in one or more measure based on active participation in a QI project.
- Number of other rural providers actively participating in a Flex-funded multi-hospital QI initiative
    - o Number of other rural providers with a change in one or more measure based on active participation in a QI project.

Work Plan Data Collection

- Number of measures reported by CAHs
- What measures were reported?
- Type of other rural providers?
- Number of measures reported by other rural providers
- What measures were reported?

3. For QI Objective # 5 (multi-organizational PI/QI leadership Project) and the optional objective (education and training), the State Flex Program will be expected to report: a) the number of CAHs participating in the project and b) the amount and type of assistance provided to the CAHs. For objectives involving training initiatives, the number of clinicians and staff who participated in training should be reported. The staff type should be parsed out to determine the job categories taking advantage of the opportunities. Depending on the type of QI project undertaken, the State Flex Program should also report any relevant measures of the impact of the project on the quality of care provided by the CAHs involved. The training provided by Flex grantees to the CAHs in their respective states varies depending on the individual needs of the state. What is consistent across all Flex programs is the need for the training provided to be effective in conveying important information to CAH staff. Therefore, the evaluative measures for any training activity conducted by Flex grantees will include an assessment of the effectiveness of the training.

To assist in supporting the collection of the effectiveness of educational/training programs, ORHP has identified a uniform methodology for the collection of retention data. This methodology only applies to retention and any cultural/behavioral monitoring programs in place are encouraged to continue. Additionally, this specific methodology does not apply to webinars or brown bag sessions. Any training in excess of three hours will need to design and implement post-test retention evaluation. Grantees will design a 10-question, multiple-choice, post-training learning assessment that addresses the key points of the training. This assessment will be administered to all attendees immediately following the training. To measure long-term changes in knowledge the same assessment will be administered to the attendees four months post-training. Flex grantees will report the percentage of attendees who achieved a score of 90% or better on the learning assessment at the zero- and four-month mark.

PIMS Measures: **(required reporting)**

- Number of CAHs actively participating in the project
- Total hours dedicated to the project
- Number of Total Participants in the project
- QI education/training programs for managers, staff and/or board members of CAHs: ***These are only required if you have workshops or trainings 3 hours or longer in duration.***
    - o Percent of total CAHs participating in training
    - o Total number of CAH staff participating
    - o Percent of CAH staff who attended training achieving a score of 90% or better on post-training learning assessment

- Percent of CAH staff who attended training achieving a score of 90% or better on post-training learning assessment four months post-training
- Total Number of CAH staff contacted to fill out survey
- Total Number of CAH staff that completed the survey
- Percent of total other rural providers participating in training
- Total number of other rural providers participating
- Percent of other rural providers who attended training achieving a score of 90% or better on post-training learning assessment
- Percent of other rural providers who attended training achieving a score of 90% or better on post-training learning assessment four months post-training
- Total Number of other rural providers contacted to fill out survey
- Total Number of other rural providers that completed the survey

Work Plan Data Collection:

- Total hours dedicated to the project
- Number of Staff (to include part-time, governing board, & contract personnel) participating in the project)
- Type of staff (provide all role categories) and staff counts
- Number of clinicians participating in project
- Clinical staff breakdown (provide all categories available) and staff counts

Interventions

Flex requires one intervention to be chosen from the Quality Improvement menu set. The menu set has not changed from the previous submission and allows for a continuation of activities previously initiated. For every intervention chosen, grantees are required to submit all measures associated with the intervention. If the measure is null, then a report of zero or not applicable will be acceptable. The interventions have been provided to assist in identifying the measures necessary to capture. These measures are divided into PIMS and Work Plan Measures and should be reported in the appropriate resource. Remember, you are only responsible for the measures that correspond with the intervention you select, not all of the interventions.

1. **Encourage CAHs in state to publicly report Hospital Compare on relevant inpatient and outpatient measures and HCAHPS patient assessment of care survey measures.**

PIMS Measures (if intervention chosen, required)

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

2. **Encourage CAHs in state to participate in MBQIP**

- **Phase 1 PIMS Measures: (if intervention chosen, required)**

- Number and percent of CAHs in state implementing a quality improvement project based on MBQIP pneumonia data
- Number and percent of CAHs in state implementing a quality improvement project based on MBQIP heart failure data

Work Plan Data Collection

- Number and percent of CAHs that submitted an MOU that are actively submitting data for MBQIP measures
- Number and percent of CAHs in state reporting data on all pneumonia measures to MBQIP
- Number and percent of CAHs in state reporting all heart failure measures to MBQIP

- **Phase 2 PIMS Measures**: **(if intervention chosen, required)**
  - Number and percent of CAHs in state reporting all outpatient quality measures
  - Number and percent of CAHs in state implementing a quality improvement project based on HCAHPS data
  - Number and percent of CAHs in state implementing a quality improvement project based on outpatient quality data

  Work Plan Data Collection
  - Number and percent change in state reporting of at least one outpatient measure by CAHs
  - Describe and detail the circumstances of any CAH that is reporting all of the outpatient measures
  - Number and percent of CAHs in state reporting HCAHPS data

- **Phase 3 PIMS Measures**: (Benchmark data) **(if intervention chosen, required)**
  - Number and percent of CAHs in the process of implementing ED Transfer Measures
  - Number and percent of CAHs that have implemented and are reporting on ED Transfer Measures
  - Number and percent of CAHs that have provided education for ED staff on the use of the ED Transfer Measures
  - Number and percent of CAHs that have electronic medication order entry
  - Number and percent of CAHs conducting medication order review within 24 hours

3. Support for Quality Network/ Work Group Quality Benchmarking and Quality Improvement Activities

PIMS Measures (if intervention chosen, required)

- Number and percent of CAHs in state actively participating in quality benchmarking activities (separate from MBQIP)

Work Plan Data Collection

- What quality improvement activities are occurring?

4. **Support for Evidence-Based Protocol Implementation** (Practices that are developed from scientific evidence and/or have been found to be effective based on results of rigorous evaluations)

   PIMS Measures (if intervention chosen, required)
   - o Total number of hospitals implementing evidence-based practices for quality improvement this budget year
   - o Total number of EMS units implementing evidence-based practices to improve rural response times this budget year
   - o Number and percent of CAHs in state implementing evidence-based protocols for a serious medical condition (e.g., stroke)
   - **o** Number and actual change in CAH based on evidence-based practice implementation to affect each condition. For all conditions identified provide total numerators and denominators as they related to each condition.
   - **o** Of the evidence-based practices implemented, how many of the participating facilities are still actively utilizing the practices?

   Work Plan Data Collection
   - **o** What serious conditions had evidence-based practices implemented?

5. **Support Care Transitions and/or reduction of Hospital Readmissions**

   PIMS Measures (if intervention chosen, required)
   - **o** Number of hospitals participating in a care transitions project
   - **o** Number of hospitals participating in a readmission reduction project
   - **o** Number and percent change in readmissions for each CAH associative of the project

6. **AHRQ Patient Safety Survey/Team STEPPS**

   PIMS Measures (if intervention chosen, required)
   - o Number and percent of CAHs in state implementing pre and post patient safety culture surveys
   - o Number of survey responses
   - o Number CAHs continuing to use patient safety surveys at six(6) months
   - o Number and percent of CAHs actively participating in Team STEPPS training

ii. Support for Operational and Financial Improvement

Flex Programs are required to support efforts to improve CAH financial and operational performance improvement. Activities in this area may include: assisting CAHs in identifying potential areas of needed financial and operational improvement; supporting CAHs in planning and implementing evidence-based strategies for improving financial performance; and supporting CAHs in planning and implementing strategies for improving operational performance. To the extent possible, programs should use strategies that are evidence-based (have been shown to be effective). Programs are encouraged to refer to the FMT, TASC, and other resources to identify need and effective strategies to address the needs. If the assistance includes "other rural providers," (any health care entity responsible for any part of the continuum of care, (i.e. RHCs, Rural PPS, and EMS)) those entities must be able to provide corresponding measures. **Please note: While the Flex program allows "other rural providers" to benefit from financial/operational activities, this core area is intended to primarily assist CAHs.**

a. Financial and Operational Performance Objectives and Interventions:

Objectives

The grantee is highly encouraged to include Objective #1 in the work plan and is also encouraged to include at least one of the other Financial and Operational Performance objectives. All Objectives should be linked to affecting improved financial and operational sustainability for health care providers serving rural stakeholders. The linkage of activities to objectives should reflect the overarching goal of attaining improved health care through better access.

The use of Objective #1 will establish a baseline for need, and the remaining Objectives can and should be used to target activities to address any needs the assessments yield. TASC released Critical Access Hospital Finance 101 to assist Flex Coordinators in identifying activities to support the Objective listed below.

1. Assist CAHs in identifying potential areas of financial and operational performance improvement.

    - Financial and Operational Condition Assessments, both hospital-wide analysis and/or hospital departmental level assessments for financial and/or operational systems.
    - Use of FMT reports to identify struggling CAHs within the state to determine where to provide targeted TA to assist in improved financial and operational performance.

2. Support CAHs in planning and implementing interventions for improving financial performance. Support may include technical assistance, educational programs/seminars, user group meetings, and consultation, facilitated or funded by the State Flex Program. These interventions relate to technical assistance applied through direct consultation.
    - Foster financial integrity reviews of charge master billing, charity care, and bad debt policies.
    - Provide support for revenue cycle improvement, cost report evaluations, increased charge capture, and maximization of Medicaid reimbursement.
    - Foster group purchasing/provision/contracting of goods and services such as pharmaceuticals, information technology, and physician recruitment.
    - Coordination of network and user group meetings for CFOs and managers to discuss operational and financial issues
    - Provide or arrange for direct technical assistance to individual CAHs, including scope of services assessment, physician-hospital alignment, managed care contracting, charge master update, and/or market analysis.
    - Sponsor workshops and other educational programs to improve financial performance.

3. Support CAHs in planning and implementing interventions for improving operational performance. Support may include technical assistance, educational programs/seminars, user group meetings, and consultation provided, facilitated or funded by the State Flex Program.
    - Support the development of productivity benchmarks, departmental efficiency improvement, and centralization of ancillary services.

- Sponsor workshops and other educational programs to improve operational performance of individual CAHs, including staff productivity management, Lean management techniques, enhancement of board leadership, balanced scorecard implementation, departmental efficiency improvement, supply management systems, integration of materials management billing, purchasing, and patient information systems, work environment and workflow improvement, and/or revenue cycle review.

4. Develop and provide the infrastructure for multi-hospital/multi-organizational collaboratives that support CAHs and other rural providers in planning and implementing evidence-based strategies for improving operational and financial performance. The collaboratives may be based on general improvement strategies, such as sharing of best practices and benchmarking, or specific improvement strategies such as revenue cycle management and departmental efficiency. The intent of the collaborative is to reduce the costs of the network members and is done by measuring profitability, liquidity, capital structure, and operational ratios. Support may include technical assistance, educational programs/seminars, user group meetings, and consultation, facilitated or funded by the State Flex Program.

   - Encourage collaborative learning across CAHs in the state, including development of productivity benchmarks and sharing of evidence-based practices developed in local CAHs.

Interventions

Additionally, ORHP expects all grantees to select one intervention, either a continuation from FY 2012 or a new selection for FY 2013 from the following menu set (the same menu set as in FY2012). You can use the same intervention as last year but must report on all measures associated with the intervention. For financial and operational improvement, the following interventions represent the menu set:

- **Financial/Operational Assessments**
  - Assisting CAHs in identifying potential areas of financial and operational improvement through the development of internal and external financial and operational targets and benchmarks. The assessments should identify strengths and weaknesses of Flex-supported entity to assist in developing business strategies to provide needed services in the area.
- **Revenue Cycle Management**
  - This intervention is intended to increase a CAH staff's ability to better manage their revenue cycles; to foster financial integrity of pricing, charity care and bad debt policies; to increase hospital revenue and cash flow; to better server patients and customers by informing them upfront of financial obligations; to improve hospital business and operational processes; and to build department manager accountability for CAH financial performance.
- **Charge Master Review**
  - This intervention maximizes CAH net patient revenue; creates an efficient and compliant charging mechanism; and produces patient-friendly billing process.
- **Emergency Department Operational Improvement**
  - To provide services and opportunities for networking and sharing best practices around CAH emergency department operations; to improve appropriate patient triage, transfer and treatment in the CAH emergency department; to help CAHs

benchmark ED performance data; and to promote ownership and participation by ED medical directors.

- **Lean Training and Implementation**
  - To support the continued spread of "Lean Transformation" techniques to CAHs; to decrease readmission rates, unplanned readmissions and defective hand-offs; to increase patient and customer satisfaction; to save CAHs both money and time; to improve the quality of clinical, business and operational processes in CAHs; and to assist hospitals in making improvements in their CMS and MBQIP quality scores.
- **Billing and Coding Education**
  - To improve CAH staff understanding of CMS, NCCI, and CPT instructions as they apply to reporting and reimbursing these services; timprove coding accuracy and compliance, to capture missed revenue and to increase productivity; and to help CAHs prepare for ICD-10 conversion.
- **Board Education and Leadership Development**
  - To improve and sustain the skill and knowledge of the CAH board of directors, including legal and fiduciary responsibilities and roles; to help to educate CAH boards as to cost-based reimbursement, as well as alternative financial strategies to ensure sustainable revenue sources; to educate CAH boards and leadership about health care reform models and how their hospitals can play a role in these models; and to provide leadership and management education, support and/or mentoring for CAH leaders designed to improve overall CAH financial and quality performance.
- **Financial Improvement Collaborative**
  - To bring shared rural-specific financial expertise to CAHs at lower costs; to facilitate discussion and analysis of common financial issues shared by CAHs, and to create synergistic problem solving; to develop a shared CAH financial knowledge base, among the CAHs including best practices, tools and information; to develop peer to peer learning both informally, and through formal education; to reduce the cost of education and support for CAH leaders; and to provide the infrastructure for a multi-hospital collaborative that supports CAHs in planning and implementing evidence-based practices.

b. Evaluative measures for Financial and Operational Performance (FO) activities and interventions:

Not all of the following measures may apply to every State Flex Program. State Flex Programs should use the key benchmark measures identified by the Flex Monitoring Team to show support for financial and operational improvement of CAHs. Additionally, with the release of the CAH Finance 101 manual, a list of 10 financial indicators has been identified as a means of monitoring CAH fiscal health. ORHP expects State Flex Programs to utilize this resource in conjunction with the FMT reports, or other comprehensive financial assessments, to identify appropriate, planned assistance. ORHP intends to use the information provided to show the status of CAH performance through a trend analysis and encourages Flex Programs to use the information to identify direct technical assistance requirements.

In the current year budget, Grantees should have identified key benchmarks for assistance provided to their CAHs; these benchmarks are a continuation of those efforts to improve fiscal health. Additionally, Grantees should use the common metrics for financial and operational interventions identified in Evaluation Measure #2. ORHP is aware we are asking for a significant increase in data and Flex may not be fully responsible for any changes that occur, but we are trying to measure the overall impact of the program. Any change, positive or negative, will help ORHP and you, the Flex Coordinator, direct Flex dollars to the right interventions and adjust activities as necessary.

Objectives

1. In completing Evaluation Objective #1 (Financial/Operational Assessment), the initial performance measurement will be the development of the baseline benchmark and Flex Programs are encouraged to use this baseline in the planning of their work plans for the remainder and potential new project periods. For FO Objective #1, State Flex Programs providing Financial and Operational Performance Assessments, programs will report on the number of financial and operational assessments conducted and the outcomes and recommended follow up from those assessments. ORHP expects Flex grantees to have access to any Flex-funded financial/operational assessment to allow for a tracking of change based on the initial analysis and the subsequent completion of activities that show change from the baseline data capture.

PIMS measures (required reporting)

- The number of CAHs undergoing financial and operational performance assessments.
- The number of CAHs who implemented changes to process based on the recommendations
- Does your state have an established network to look at financial and operational improvement? Y/n, if yes:
  - Number of Networks
  - Number of critical access hospitals participating
  - Total number of other rural providers.
- The number of CAH staff (including part-time, contractors, and governing board) attending network or user group meetings related to financial and operational performance assessment.
- Number of improvement activities based on meetings
- The number of CAHs with identified outcomes derived from the meetings.

For any Flex program providing Financial and Operational Performance Assessments, a post evaluation directly related to the assistance should occur at the conclusion of the intervention, with a follow-up behavioral acceptance evaluation occurring at some point following the assistance. Flex Programs are encouraged to work with CAHs within their States to improve their financial and operational indicators through measurement of change in the performance of the State's CAHs.

- The number of CAHs demonstrating behavioral change based on the assessment.
- The number of other rural providers demonstrating behavioral change based on the assessment.
- Number of total CAHs still using the new processes 90 days after implementation?
- Number of other rural providers still using the new processes 90 days after implementation?

- Percent of the recommendations made during the assessment that were implemented by the CAH in the post assessment period (could be 6, 9 or 12 months)
- Number of new, needed services developed

Work Plan Data Collection

- The number of network and user group meetings related to financial and operational performance assessment.
- What activities were identified?
- What outcomes were identified?
- If new, needed services were developed:
  - Type of service and financial impact?
- Financial performance of the CAH as measured by:
  - Average Days in Net Account Receivable
  - Average Days in Gross Accounts Receivable
  - Average Days Cash on Hand
  - Average Total Margin
  - Average Operating Margin
  - Average Debt Service Coverage Ratio
  - Average Salaries to Net Patient Revenue
  - Average Payor Mix Percentage
  - Average Age of Plant
  - Average Long Term Debt to Capitalization

2. For FO Objective #2 (Financial Performance) and #3 (Operational Performance), State Flex Programs providing ***Direct Consultations,*** defined as providing in-depth consultations to a CAH or a small group of CAHs should describe the need and associated outcomes related to each consultation.

PIMS Measures (required reporting)

- Number of CAHs receiving Flex-funded financial consultations;
- Number of CAHs receiving Flex-funded operational consultations.

For FO Objectives #1-#3 State Flex programs are strongly encouraged to use Objective #1 financial and operational assessment to establish baseline data for interventions and measure outcomes following Flex interventions.

When executing FO Objectives #1-#3 activities and interventions, ORHP has identified an initial activity and measure to be included in the work plans. Because there is a known relationship between Days in Account Receivable and profitability, we have chosen it as the overall measure for the improvement activities. State Flex Program Coordinators are encouraged to perform an environmental scan of all of their CAHs to identify hospital candidates for technical assistance. ORHP has specifically identified updating the chargemaster as an activity that impacts the total revenue, which in turn affects profitability. For the Chargemaster review, Flex Coordinators are expected to provide benchmarks and change documentation. All activities and measures should be reflected in the workplan, as well as any related explanations.

PIMS Measures (required reporting)

For each CAH:

- Number of CAHs who reported improvement in Days in AR based on Flex-Funded activity
    - Number of CAHs that performed a Business Office Assessment
    - Number of CAHS that implemented a revenue cycle management program
    - Number of CAHs providing education for staff and department heads on documenting charity care
    - Number of staff and department heads showing 90% information retention four months after education on documenting charity care
  - Number of CAHs that used Flex funding for updating their chargemaster this year
    - Revenue prior to chargemaster update?
    - Revenue after chargemaster update?
    - Number of claims denied prior to chargemaster update?
    - Number of claims denied after chargemaster update?

3. For FO Objective #2 and #3, State Flex Programs providing Educational Programs and Seminars should describe the type and topic of the programs and seminars and demonstrate the impact of the trainings.
   PIMS Measures (required reporting)
   - Number of seminars & workshops sponsored;
   - The number of CAHs attending each seminar &/or workshop.
   - The number of total participants in each seminar &/or workshop
   - Total cost of seminars & workshops
   - Average cost per seminar
   - Average cost per workshop

Interventions

Flex requires one intervention to be chosen from the Financial/Operational Improvement menu set. The menu set has not changed from the previous submission and allows for a continuation of activities previously initiated. For every intervention chosen, grantees are required to submit all measures associated with the intervention. If the measure is null, then a report of zero or not applicable will be acceptable. The interventions have been provided to assist in identifying the measures necessary to capture. These measures are divided into PIMS and Work Plan Measures and should be reported in the appropriate resource. Remember, you are only responsible for the measures that correspond with the intervention you select, not all of the interventions.

1. Financial Assessments

The financial assessment is inherently linked to FO Objective #1and will not be counted as your intervention when associated with it. The financial assessment should identify baseline numbers to determine where key targeted activities can be applied to effect change. The financial assessment should measure the ten (10) metrics listed be below for each CAH receiving an assessment. ORHP intends for follow-up to occur with any assessment that leads to a corrective action activity.

PIMS Measures (if intervention chosen, required)

- Financial performance of the CAH as measured by change in:
    - Average Days in Net Account Receivable
    - Average Days in Gross Accounts Receivable
    - Average Days Cash on Hand
    - Average Total Margin
    - Average Operating Margin

- Average Debt Service Coverage Ratio
- Average Salaries to Net Patient Revenue
- Average Payor Mix Percentage
- Average Age of Plant
- Average Long Term Debt to Capitalization

2. Revenue Cycle Management

PIMS Measures (if intervention chosen, required)

- Percent improvement in bad debt as a per cent of gross charges and/or net patient revenue
- Number and percent of CAHs completing analyses
- Improvement in point of service collections as a percent of total revenue
- Percent reduction in claims review and denial rates
- Percent improvement in days in AR, based on gross revenue
    - Percent change in gross revenue captured
    - Percent change in number of clean claims
    - Percent change in the reduction of denials

3. Charge Master Review

PIMS Measures (if intervention chosen, required)

- Number and percent of line items with CPT/HCPCS code changes added, deleted or revised
    - Number and percent of CDM items deleted
    - Number and percent of CDM items added
    - Number and percent of CDM items revised
    - Number and percent of CDM CPT codes deleted
    - Number and percent of CDM CPT codes added
    - Number and percent of CDM CPT codes revised
- Number of line items with revenue code changes recommended, and implemented
    - # and % of CDM revenue codes revised
- Percent reduction in CDM errors
- Percent reduction in cost-report errors

4. Emergency Department Operational Improvement

PIMS Measures (if intervention chosen, required)

- Number of participating CAHs
- Reduction in percent of total ED waiting time
- Reduction in percent of time from the ED to medical screening exam
- ED education outcome and satisfaction scores

Work Plan Data Collection

- Increase patient satisfaction scores by X%

5. Lean Training and Implementation

PIMS Measures (if intervention chosen, required)

- Number of hospitals completing the Lean readiness assessments
- Number of hospitals participating in a Lean collaborative
- Total revenue at start of Lean Project in targeted area
- Total number of dollars saved by Lean implementation
    - Percent change in operations cost based on Lean implementation
- Total amount of staff required for operations prior to Lean
- Total amount of staff time saved by Lean implementation
    - Percent change in staff time after Lean Implementation
- Percent reduction in the average amount of patient waiting time
- Number of Lean initiatives and events that took place in each hospital
    - Percent change in operations based on Lean initiatives and/or events
- CMA and MBQIP quality scores

6. Billing and Coding Education

PIMS Measures (if intervention chosen, required)

- Percent change in the reduction of coding errors
- Percent change in the reduction of denial rates
- Percent increase in gross AR days
- Percent of total CAHs participating in training
- Total number of CAH staff participating
- Change in participant pre and post knowledge assessments
    - Decreased denials by X% within 1 year
    - Coding Denials Goal: <2.0% per month
    - Billing Denials Goal: <2.0% per month

7. Board Education and Leadership Development

PIMS Measures (if intervention chosen, required)

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

8. Financial Improvement Collaborative

PIMS Measures (if intervention chosen, required)

- Number and percent of CAHs participating in the financial collaborative
- Number of contact hours (meeting hours times number of people attending)

- Percent change in Education outcome survey scores
  - Average survey scores
- Percent change in Education satisfaction scores
  - Average satisfaction scores

Participants should be administered an evaluation at the conclusion of the educational opportunity, followed by a behavioral evaluation to determine retention/impact at a later point in time. A post assessment of similar design to the quality improvement post-test should be applied to all seminars and webinars. Retention and implementation of the lessons and principles demonstrated must be captured.

Grantees will design a 10-question, multiple-choice, post-training learning assessment that addresses the key points of the training. This assessment will be administered to all attendees immediately following the training. To measure long-term changes in knowledge the same assessment will be administered to the attendees four months post-training. Flex grantees will report the percentage of attendees who achieved a score of 90% or better on the learning assessment at the zero- and four-month mark.

PIMS Measure (if intervention chosen, required)

- Number of participants in seminars and/or workshops still using lessons learned
- Percent of total CAHs participating in training
- Total number of CAH staff participating
- Percent of CAH staff who attended training achieving a score of 90% or better on post-training learning assessment
- Percent of CAH staff who attended training achieving a score of 90% or better on post-training learning assessment four months post-training
- Total Number of CAH staff contacted to fill out survey
- Total Number of CAH staff that completed the survey
- Percent of total other rural providers participating in training
- Total number of other rural providers participating
- Percent of other rural providers who attended training achieving a score of 90% or better on post-training learning assessment
- Percent of other rural providers who attended training achieving a score of 90% or better on post-training learning assessment four months post-training
- Total Number of other rural providers contacted to fill out survey
- Total Number of other rural providers that completed the survey

iii. Support for Health System Development and Community Engagement

Flex Programs are required to support efforts to assist CAHs in developing collaborative regional or local systems of care, addressing community needs, and integrating EMS in those regional and local systems of care. CAHs can only be viable by meeting the needs of their communities. The Flex Program must foster the growth of collaborative rural delivery systems across the continuum of care at the community level with appropriate external relationships for referral and support, thus maintaining access to high quality care for rural Medicare beneficiaries. EMS services are an important component of collaborative regional and local delivery systems and serve a pivotal role in regional and state trauma systems.

Grantees are limited to budgeting, at most, one third of their award in this core area.

a. Health System Development and Community Engagement Objectives:

The work plan must include at least one of the following system development and community engagement objectives:

1. Support CAHs, communities, rural and urban hospitals, EMS, and other community providers in developing local and/or regional health systems of care.

2. Support the inclusion of EMS services into local and/or regional systems of care and/or regional and state trauma systems.

3. Support CAHs and communities in conducting or collaborating on assessments to identify unmet community health and health service needs.

4. Support CAHs and communities in developing collaborative projects/initiatives to address unmet health and health service needs.

The following objective may also be included:

5. Support for the sustainability and viability of EMS within the community.

b. Evaluative measures for health system development (HSD) and community engagement activities:

The following measures are intended to create a baseline of short, medium, and long-term measures to determine the impact of activities that lead to the development of appropriate interventions. ORHP encourages State Flex Programs to utilize one of identified activities and their subsequent measures to assist ORHP in the creation of a comparative data set capable of showing change. ORHP is aware we are asking for a significant increase in data and Flex may not be fully responsible for any changes that occur, but we are trying to measure the overall impact of the program. Change, positive or negative, will help ORHP and you, the Flex Coordinator direct Flex dollars to the right interventions. Lastly, we will continue to collect the EMS measures collected previously and we will be adding the measures linked to the Objectives outlined below.

PIMS Measures (required reporting)

- Number of Trained or recruited EMS medical directors
- Number of EMS recruitment/retention projects initiated
- Number of EMS (Ambulance) budget model courses conducted
- Number of Managers trained in EMS (Ambulance) budget model courses
- Number of EMS (Ambulance) services supported to join a network
- Number of Services supported for group billing
- Number of EMS assessments and strategic planning sessions conducted
- Number of EMS leadership courses conducted
- Number of Managers trained in EMS leadership courses
- Number and variety of EMS-based Community Healthcare Models projects initiated
- Number of Rural Trauma Team Development or Comprehensive Advanced Life Support (CALS) courses taught
    - Number of personnel trained

- Number of communities affected
- Number of facilitated BIS assessments conducted
- Number of quality improvement activities implemented. A reassessment of BIS scores compared to the baseline score for that system
- Number of Trauma System Consultations performed
- Number of quality improvement activities directly linked to Trauma System Consultation report recommendations

1. In completing Evaluation Objective #1 (Regional systems), the initial performance measurement will be the development of the baseline benchmark and Flex Programs are encouraged to use this baseline in the planning of their work plans for the remainder and potential new project periods. For HSD Objective #1 and #2 (EMS Regional), State Flex Programs providing support for CAH/EMS involvement in regional systems of care the following measures can be used to show short term processes that result in medium to long term outcomes.

PIMS Measures (required reporting)

- Number of CAHs engaged in STEMI.
  - Number of STEMI patients in total
  - Number of STEMI patients receiving aspirin within 24-hours in total
  - Number of STEMI patients not receiving aspirin within 24 hours in total
  - Number of STEMI patients with a STEMI Referral Hospital door-to-balloon (first device used) time within 90 minutes upon transfer
- Number of CAHs engaged in regional and/or national stroke programs.
- Number of CAHs obtaining trauma designation this budget year.
  - Number of CAHs rated Trauma Level III? Level IV? Level V?
  - Number of CAHs that enhanced their trauma designation
  - Number of CAHs that reduced their Trauma designation

Work Plan Data Collection

- If a CAH reduced their Trauma designation, what was the reasoning?

2. For HSD Objective #1 and the optional Objective (EMS Sustainability), State Flex Programs providing support to improve EMS financial and operational performance should report the following measures to show short term processes that result in moderate to long term outcomes.

PIMS Measures (required reporting)

- Number of EMS units or providers participating in Flex-funded activities to improve EMS financial/operational performance (process measure that includes all activities listed below)
  - Number of EMS units engaged in group purchasing arrangements
  - Number of EMS personnel participating in billing/coding programs
  - Number of EMS personnel reporting that participation in the activities was valuable
  - Number of EMS units that changed procedures based on activities
- Number of EMS units reporting a positive change in revenue
  - Number of EMS personnel participating leadership training
  - Number of EMS units participating in recruitment and retention programs

3. For HSD Objective #3 (Needs Assessments) and #4 (Collaborative development), State Flex Programs providing support to hospitals in conducting and implementing community health needs assessments should report the following measures to show short term processes that result in medium to long term outcomes.

PIMS Measures (required reporting)

- Number of CAHs receiving support and/or TA to support them in conducting community health needs assessments
- Number of CAHs that have completed a community needs assessment (including the development of strategies to address identified needs)
- Number of interventions implemented as a result of needs identified by CAHs conducting community needs assessments
    - o Number of interventions implemented to address new and ongoing community needs
- Number of CAHs that report improvements in conditions addressed by their community health needs interventions at subsequent needs assessments
- Number of community paramedicine programs identified as a potential intervention based on the community needs assessment
    - o Number of communities that have begun piloting community paramedicine programs

iv. Facilitate Conversion of Small Rural Hospitals to CAH status

In accordance with current statute, State Flex Programs are expected to facilitate appropriate conversion of small rural hospitals to critical access status. Flex programs must assist hospitals in evaluating the effects of conversion to critical access status.

PIMS Measures (required reporting)

- Number of new CAHs
    - o Number of hospitals eligible for CAH conversion.
    - o Number of hospitals requested assistance in conversion to CAH status.
    - o Number of hospitals helped in conversion to CAH status
    - o Number of hospitals unsuccessful in their attempt to convert to CAH status
- Number of CAHs de-designating.
- Number of CAHs closed

Work Plan Data Collection

- What was the reason for de-designation?
- What were the circumstances surrounding the closure of the CAH?

HRSA Contacts

Grantees are encouraged to request assistance, if needed, when submitting their NCC Progress Report. Please contact the Flex Program Coordinator or your ORHP project officer to obtain additional information regarding overall program issues:

Michael McNeely
Flex Program Coordinator
Office of Rural Health Policy
5600 Fishers Lane, 5A-35
Rockville, MD 20857
(301) 443-5812
(301) 443-2803 (Fax)
mmcneely@hrsa.gov

Grantees may obtain additional information regarding business, administrative, or fiscal issues related to this NCC Progress Report by contacting:

Carolyn Cobb, Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 11A-02
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-0829
Fax: (301) 594-4073

Email: ccobb2@hrsa.gov

Grantees may need assistance when working online to submit their information electronically through HRSA's Electronic Handbooks. For assistance with submitting information in HRSA's EHBs (i.e. technical system issues), contact the HRSA Call Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Call Center
Phone: (877) 464-4772
TTY: (877) 897-9910
Fax: (301) 998-7377
E-mail: CallCenter@HRSA.GOV

HRSA reserves the right to request subsequent information as necessary.