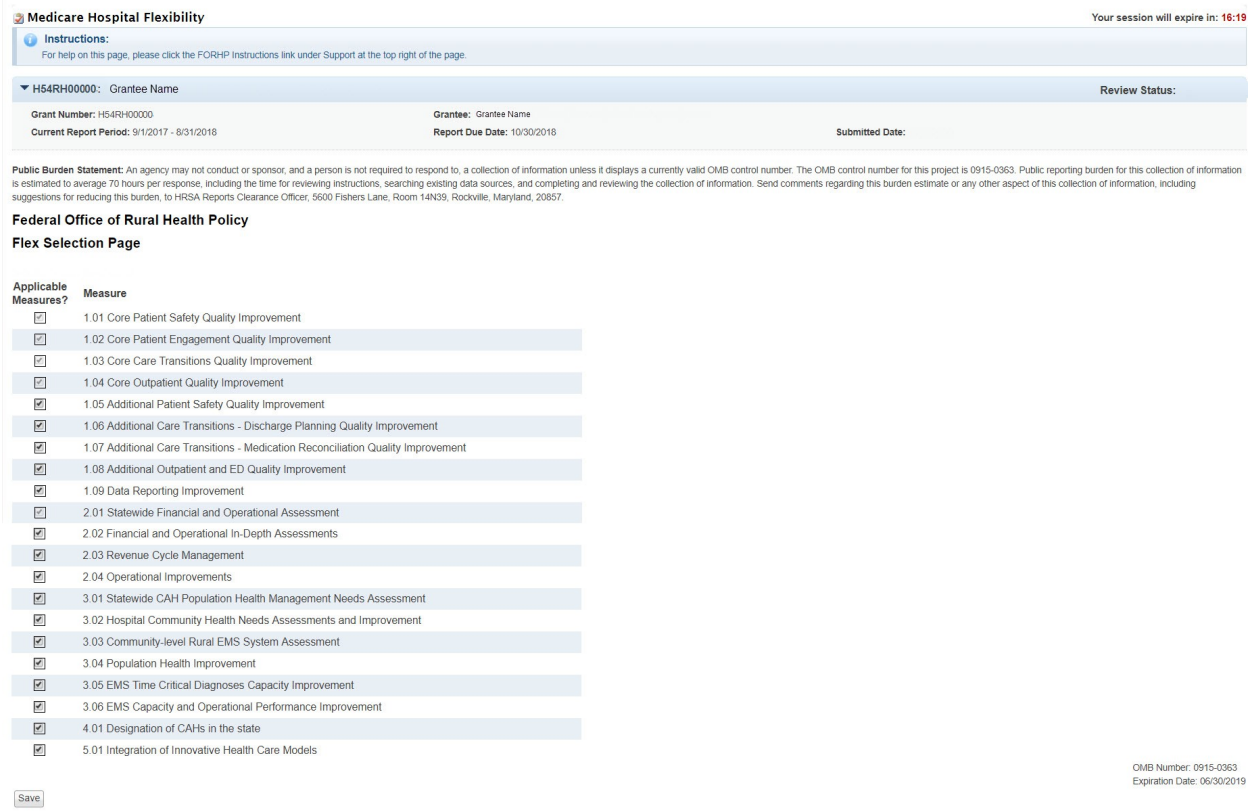
Flex PIMS Screenshots of electronic data submission forms

March 20, 2019

These screenshots show all of the information collected in this secure online system. Respondents use the Selection Page to unselect categories that don’t apply to their specific project so respondents only see and report a smaller subset of applicable measures when completing their annual PIMS report.

These screenshots are blinded examples of the reporting system without identifying information. In production the online reporting system reduces burden for respondents by providing a pre-populated list of critical access hospitals for each state.

Form 1, Selection Page



Medicare Hospital Flexibility

Your session will expire in: 16:19

Instructions:
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H54RH00000: Grantee Name — **Review Status:**

Grant Number: H54RH00000 **Grantee:** Grantee Name
Current Report Period: 9/1/2017 - 8/31/2018 **Report Due Date:** 10/30/2018 **Submitted Date:**

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0363. Public reporting burden for this collection of information is estimated to average 70 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857.

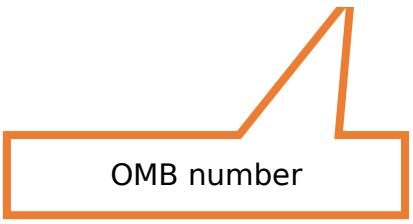
Federal Office of Rural Health Policy

Flex Selection Page

Applicable Measures?	Measure
☑	1.01 Core Patient Safety Quality Improvement
☑	1.02 Core Patient Engagement Quality Improvement
☑	1.03 Core Care Transitions Quality Improvement
☑	1.04 Core Outpatient Quality Improvement
☑	1.05 Additional Patient Safety Quality Improvement
☑	1.06 Additional Care Transitions - Discharge Planning Quality Improvement
☑	1.07 Additional Care Transitions - Medication Reconciliation Quality Improvement
☑	1.08 Additional Outpatient and ED Quality Improvement
☑	1.09 Data Reporting Improvement
☑	2.01 Statewide Financial and Operational Assessment
☑	2.02 Financial and Operational In-Depth Assessments
☑	2.03 Revenue Cycle Management
☑	2.04 Operational Improvements
☑	3.01 Statewide CAH Population Health Management Needs Assessment
☑	3.02 Hospital Community Health Needs Assessments and Improvement
☑	3.03 Community-level Rural EMS System Assessment
☑	3.04 Population Health Improvement
☑	3.05 EMS Time Critical Diagnoses Capacity Improvement
☑	3.06 EMS Capacity and Operational Performance Improvement
☑	4.01 Designation of CAHs in the state
☑	5.01 Integration of Innovative Health Care Models

OMB Number: 0915-0363
Expiration Date: 06/30/2019

Save



Form 2: Quality Improvement

Medicare Hospital Flexibility Your session will expire in: 12:36

Instructions:
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H54RH00000: Grantee Name — Review Status:

Grant Number: H54RH00000 **Grantee:** Grantee Name
Current Report Period: 9/1/2017 - 8/31/2018 **Report Due Date:** 10/30/2018 **Submitted Date:**

Quality Improvement

Core MBQIP Metrics | Additional MBQIP Metrics

Core MBQIP Metrics

Please indicate which CAHs participated and improved in each MBQIP activity category during the budget period. Select all that apply.

1.01 Core Patient Safety Quality Improvement: OP-27

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☑	☐	☐
000002 - Hospital B	☑	☐	☐
000003 - Hospital C	☑	☐	☐
Total:	3	0	0

1.01 Core Patient Safety Quality Improvement: IMM-2

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☑	☐	☐
000002 - Hospital B	☑	☐	☐
000003 - Hospital C	☑	☐	☐
Total:	3	0	0

1.02 Core Patient Engagement Quality Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☑	☐	☐
000002 - Hospital B	☑	☐	☐
000003 - Hospital C	☑	☐	☐
Total:	3	0	0

1.03 Core Care Transitions Quality Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☑	☐	☐
000002 - Hospital B	☑	☐	☐
000003 - Hospital C	☑	☐	☐
Total:	3	0	0

1.04 Core Outpatient Quality Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☑	☐	☐
000002 - Hospital B	☑	☐	☐
000003 - Hospital C	☐	☐	☐
Total:	2	0	0

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Additional MBQIP Metrics

Please indicate which CAHs participated and improved in each MBQIP activity category during the budget period. Select all that apply.

1.05 Additional Patient Safety Quality Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☑	☐	☐
000002 - Hospital B	☑	☐	☐
000003 - Hospital C	☑	☐	☐
Total:	3	0	0

1.06 Additional Care Transitions - Discharge Planning Quality Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☐	☐	☐
000002 - Hospital B	☐	☐	☐
000003 - Hospital C	☐	☐	☐
Total:	0	0	0

1.07 Additional Care Transitions - Medication Reconciliation Quality Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☐	☐	☐
000002 - Hospital B	☐	☐	☐
000003 - Hospital C	☐	☐	☐
Total:	0	0	0

1.08 Additional Outpatient and ED Quality Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☐	☐	☐
000002 - Hospital B	☐	☐	☐
000003 - Hospital C	☐	☐	☐
Total:	0	0	0

Return to Top (Index)

Any Comments About this Form or the Data You Entered

Is this Form Complete?

If selected "No", you're not required to fill in all fields before you save.
○ No ◉ Yes

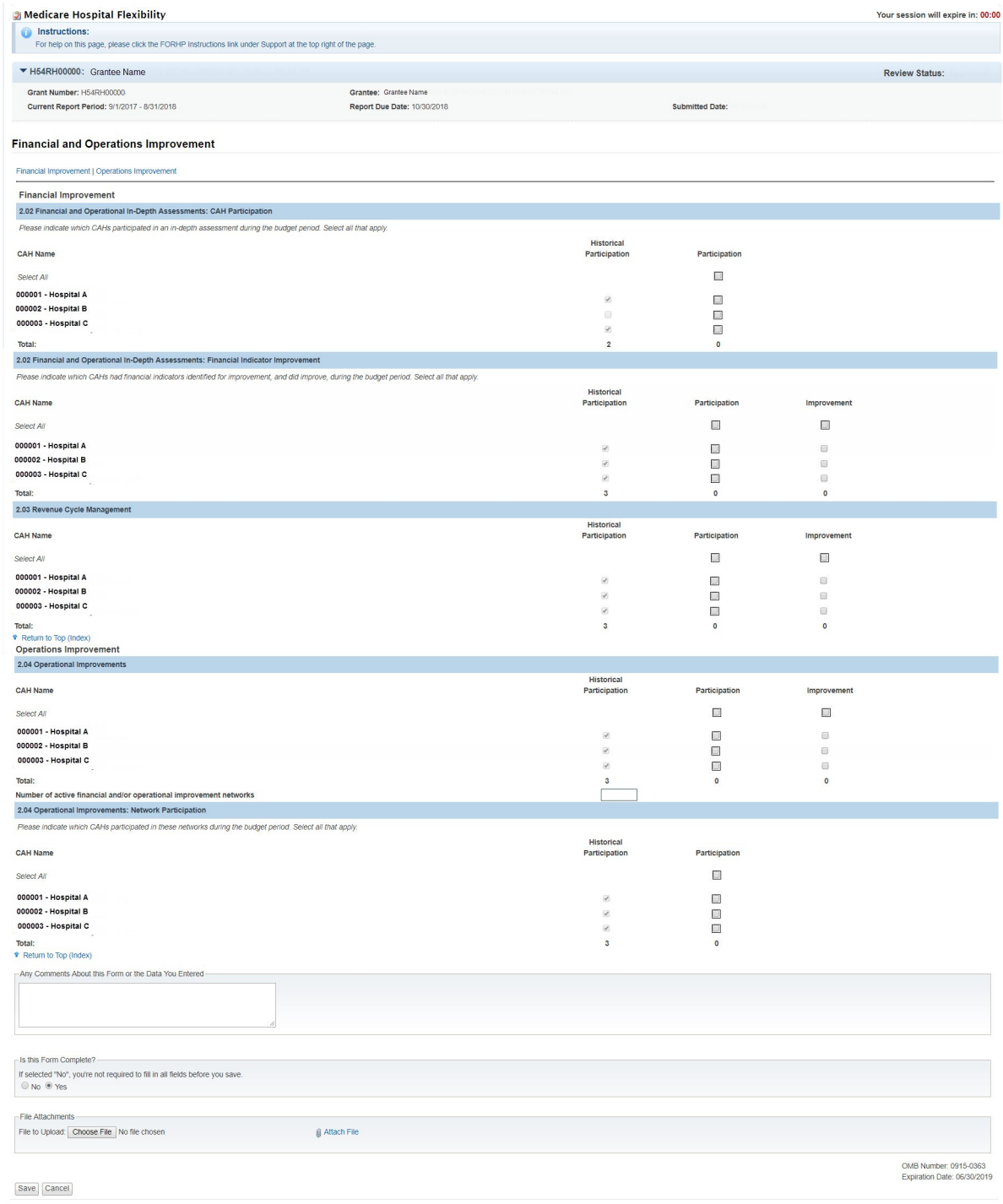
File Attachments

File to Upload: Choose File No file chosen Attach File

OMB Number: 0915-0363
Expiration Date: 06/30/2019

Save Cancel

Form 3: Financial and Operations Improvement



Medicare Hospital Flexibility

Your session will expire in: 00:00

Instructions:
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H54RH00000: Grantee Name — Review Status:

Grant Number: H54RH00000 **Grantee:** Grantee Name
Current Report Period: 9/1/2017 - 8/31/2018 **Report Due Date:** 10/30/2018 **Submitted Date:**

Financial and Operations Improvement

Financial Improvement | Operations Improvement

Financial Improvement

2.02 Financial and Operational In-Depth Assessments: CAH Participation

Please indicate which CAHs participated in an in-depth assessment during the budget period. Select all that apply.

CAH Name	Historical Participation	Participation
Select All		☐
000001 - Hospital A	☑	☐
000002 - Hospital B	☐	☐
000003 - Hospital C	☑	☐
Total:	2	0

2.02 Financial and Operational In-Depth Assessments: Financial Indicator Improvement

Please indicate which CAHs had financial indicators identified for improvement, and did improve, during the budget period. Select all that apply.

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☑	☐	☐
000002 - Hospital B	☑	☐	☐
000003 - Hospital C	☑	☐	☐
Total:	3	0	0

2.03 Revenue Cycle Management

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☑	☐	☐
000002 - Hospital B	☑	☐	☐
000003 - Hospital C	☑	☐	☐
Total:	3	0	0

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Operations Improvement

2.04 Operational Improvements

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☑	☐	☐
000002 - Hospital B	☑	☐	☐
000003 - Hospital C	☑	☐	☐
Total:	3	0	0
Number of active financial and/or operational improvement networks			

2.04 Operational Improvements: Network Participation

Please indicate which CAHs participated in these networks during the budget period. Select all that apply.

CAH Name	Historical Participation	Participation
Select All		☐
000001 - Hospital A	☑	☐
000002 - Hospital B	☑	☐
000003 - Hospital C	☑	☐
Total:	3	0

Return to Top (Index)

Any Comments About this Form or the Data You Entered

Is this Form Complete?

If selected "No", you're not required to fill in all fields before you save.

○ No ◉ Yes

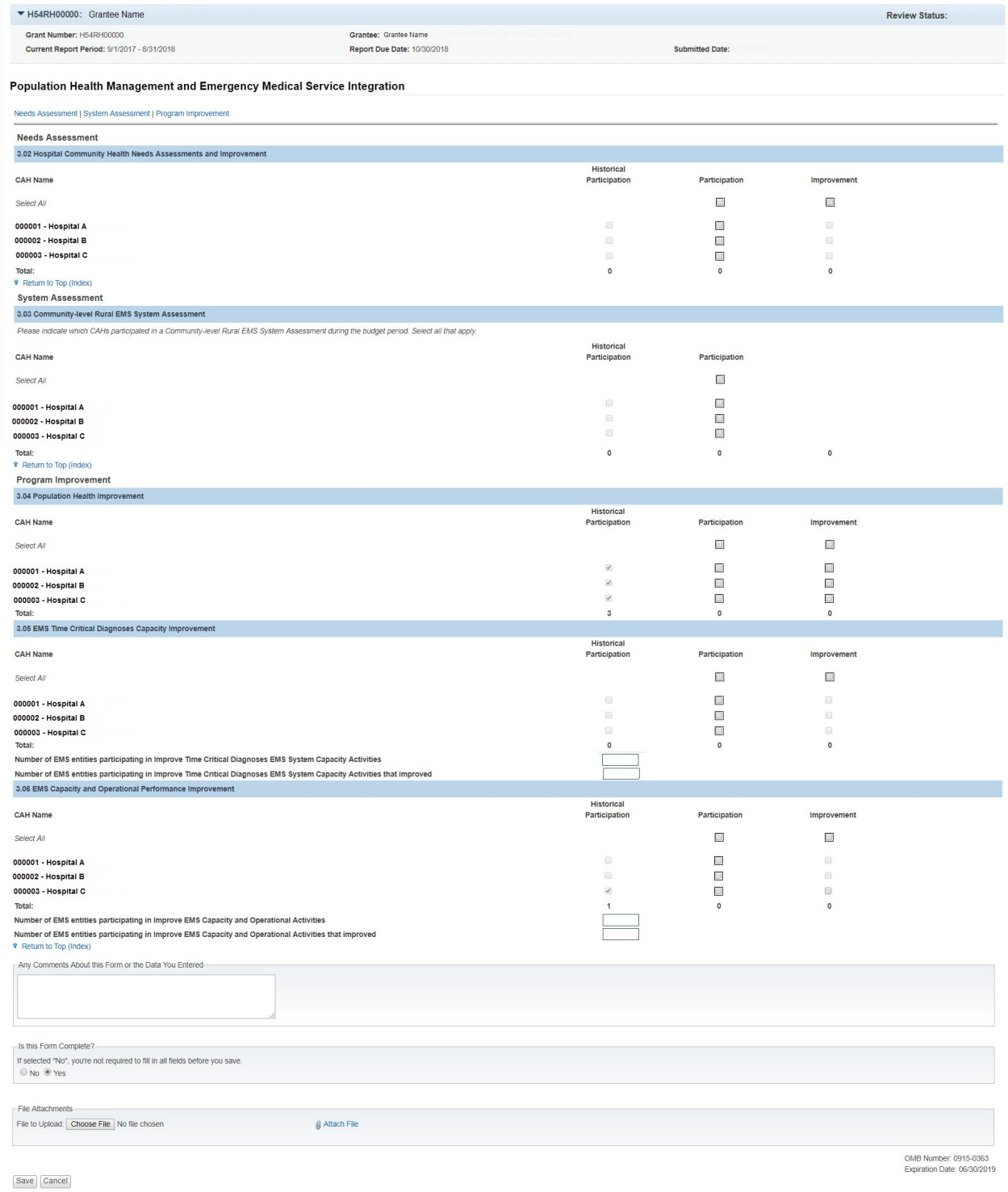
File Attachments

File to Upload: Choose File No file chosen Attach File

OMB Number: 0915-0363
Expiration Date: 06/30/2019

Save Cancel

Form 4: Population Health and Emergency Medical Services Integration



▼ H54RH00000: Grantee Name — Review Status:

Grant Number: H54RH00000 **Grantee:** Grantee Name
Current Report Period: 9/1/2017 - 8/31/2018 **Report Due Date:** 10/30/2018 **Submitted Date:**

Population Health Management and Emergency Medical Service Integration

Needs Assessment | System Assessment | Program Improvement

Needs Assessment

3.02 Hospital Community Health Needs Assessments and Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☐	☐	☐
000002 - Hospital B	☐	☐	☐
000003 - Hospital C	☐	☐	☐
Total:	0	0	0

Return to Top (Index)

System Assessment

3.03 Community-level Rural EMS System Assessment

Please indicate which CAHs participated in a Community-level Rural EMS System Assessment during the budget period. Select all that apply.

CAH Name	Historical Participation	Participation
Select All		☐
000001 - Hospital A	☐	☐
000002 - Hospital B	☐	☐
000003 - Hospital C	☐	☐
Total:	0	0

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Program Improvement

3.04 Population Health Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☑	☐	☐
000002 - Hospital B	☑	☐	☐
000003 - Hospital C	☑	☐	☐
Total:	3	0	0

3.05 EMS Time Critical Diagnoses Capacity Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☐	☐	☐
000002 - Hospital B	☐	☐	☐
000003 - Hospital C	☐	☐	☐
Total:	0	0	0
Number of EMS entities participating in Improve Time Critical Diagnoses EMS System Capacity Activities			
Number of EMS entities participating in Improve Time Critical Diagnoses EMS System Capacity Activities that improved			

3.06 EMS Capacity and Operational Performance Improvement

CAH Name	Historical Participation	Participation	Improvement
Select All		☐	☐
000001 - Hospital A	☐	☐	☐
000002 - Hospital B	☐	☐	☐
000003 - Hospital C	☑	☐	☐
Total:	1	0	0
Number of EMS entities participating in Improve EMS Capacity and Operational Activities			
Number of EMS entities participating in Improve EMS Capacity and Operational Activities that improved			

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Any Comments About this Form or the Data You Entered

Is this Form Complete?

If selected "No", you're not required to fill in all fields before you save.
○ No ◉ Yes

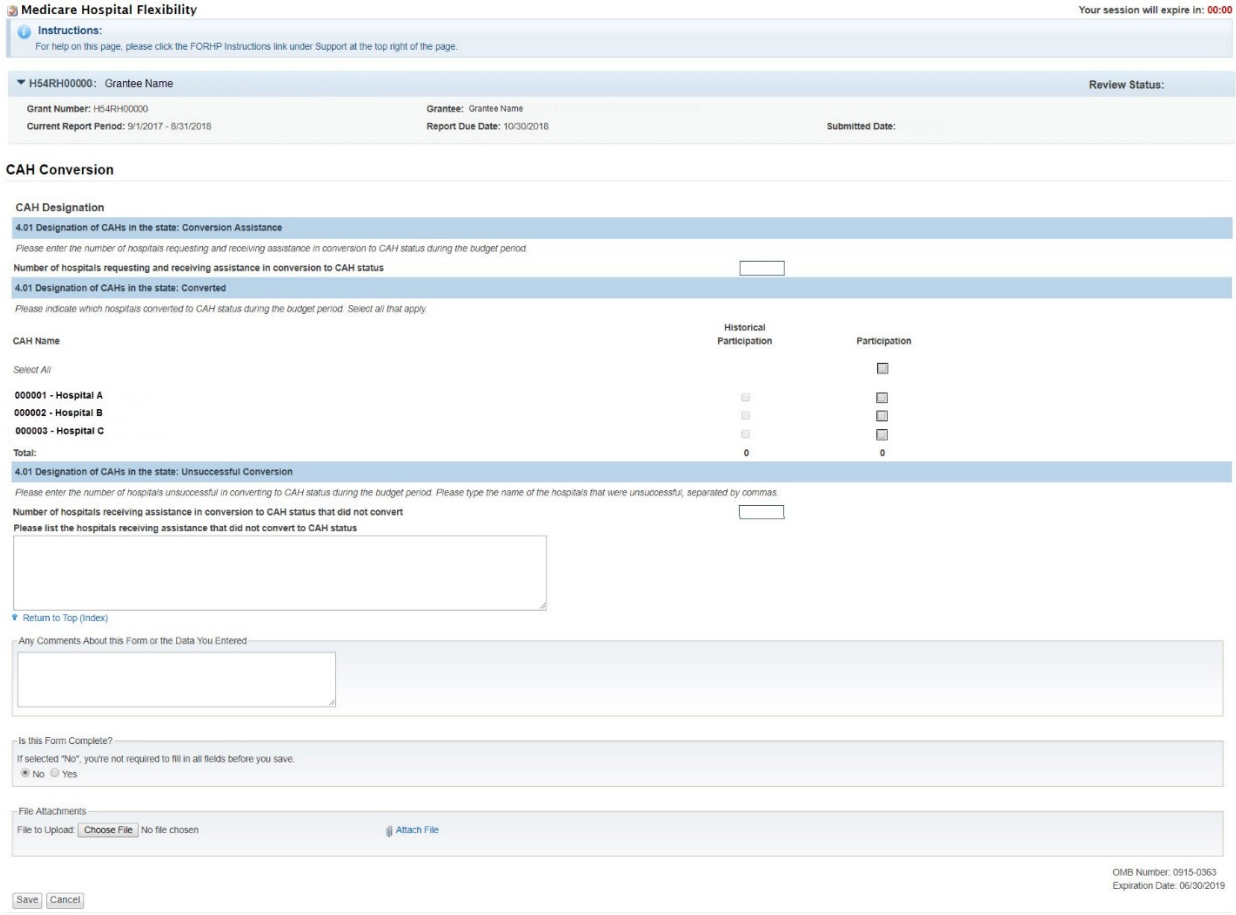
File Attachments

File to Upload: Choose File No file chosen Attach File

OMB Number: 0915-0363
Expiration Date: 06/30/2019

Save Cancel

Form 5: CAH Conversion



Medicare Hospital Flexibility

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Instructions:
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H54RH00000: Grantee Name — Review Status:

Grant Number: H54RH00000 — Grantee: Grantee Name
Current Report Period: 9/1/2017 - 8/31/2018 — Report Due Date: 10/30/2018 — Submitted Date:

CAH Conversion

CAH Designation

4.01 Designation of CAHs in the state: Conversion Assistance

Please enter the number of hospitals requesting and receiving assistance in conversion to CAH status during the budget period.

Number of hospitals requesting and receiving assistance in conversion to CAH status

4.01 Designation of CAHs in the state: Converted

Please indicate which hospitals converted to CAH status during the budget period. Select all that apply.

CAH Name	Historical Participation	Participation
Select All		☐
000001 - Hospital A	☐	☐
000002 - Hospital B	☐	☐
000003 - Hospital C	☐	☐
Total:	**0**	**0**

4.01 Designation of CAHs in the state: Unsuccessful Conversion

Please enter the number of hospitals unsuccessful in converting to CAH status during the budget period. Please type the name of the hospitals that were unsuccessful, separated by commas.

Number of hospitals receiving assistance in conversion to CAH status that did not convert

Please list the hospitals receiving assistance that did not convert to CAH status

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Any Comments About this Form or the Data You Entered

Is this Form Complete?

If selected "No", you're not required to fill in all fields before you save.
No Yes

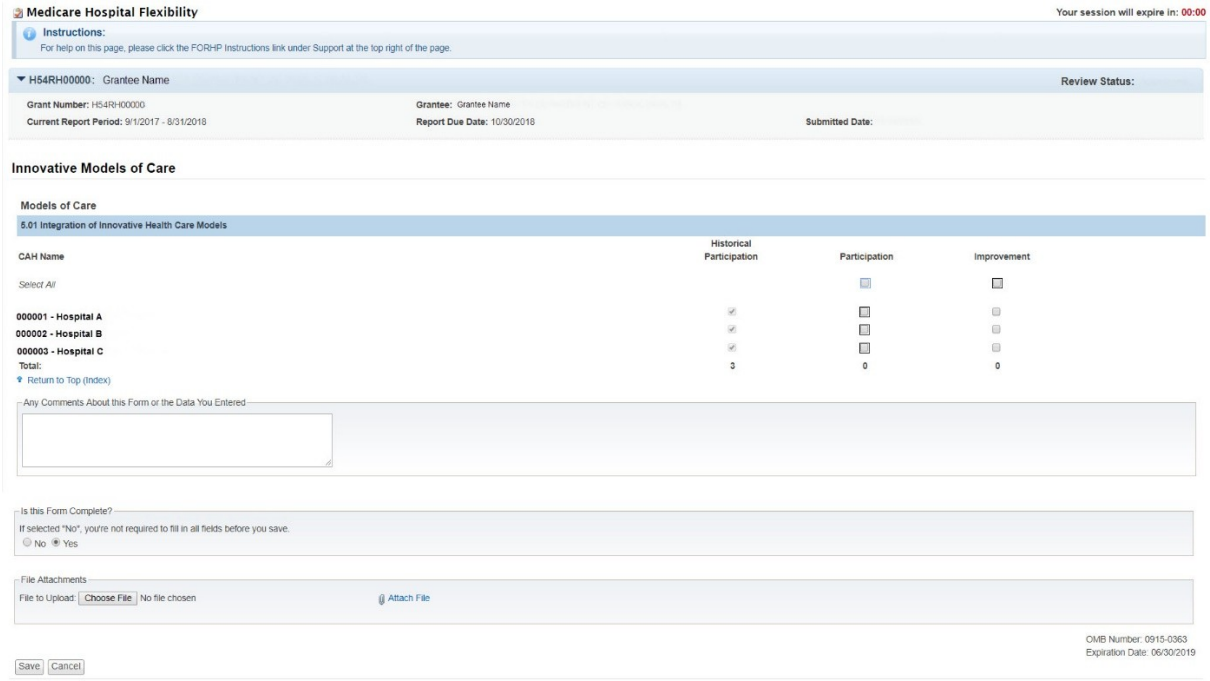
File Attachments

File to Upload: Choose File No file chosen — Attach File

OMB Number: 0915-0363
Expiration Date: 06/30/2019

Save Cancel

Form 6: Innovative Models of Care



Medicare Hospital Flexibility

Your session will expire in: 00:00

Instructions:
For help on this page, please click the FORHP Instructions link under Support at the top right of the page.

H54RH00000: Grantee Name — Review Status:

Grant Number: H54RH00000 — Grantee: Grantee Name
Current Report Period: 9/1/2017 - 8/31/2018 — Report Due Date: 10/30/2018 — Submitted Date:

Innovative Models of Care

Models of Care

5.01 Integration of Innovative Health Care Models

CAH Name	Historical Participation	Participation	Improvement
Select All			
000001 - Hospital A			
000002 - Hospital B			
000003 - Hospital C			
Total:	3	0	0

Return to Top (Index)

Any Comments About this Form or the Data You Entered

Is this Form Complete?

If selected "No", you're not required to fill in all fields before you save.
No Yes

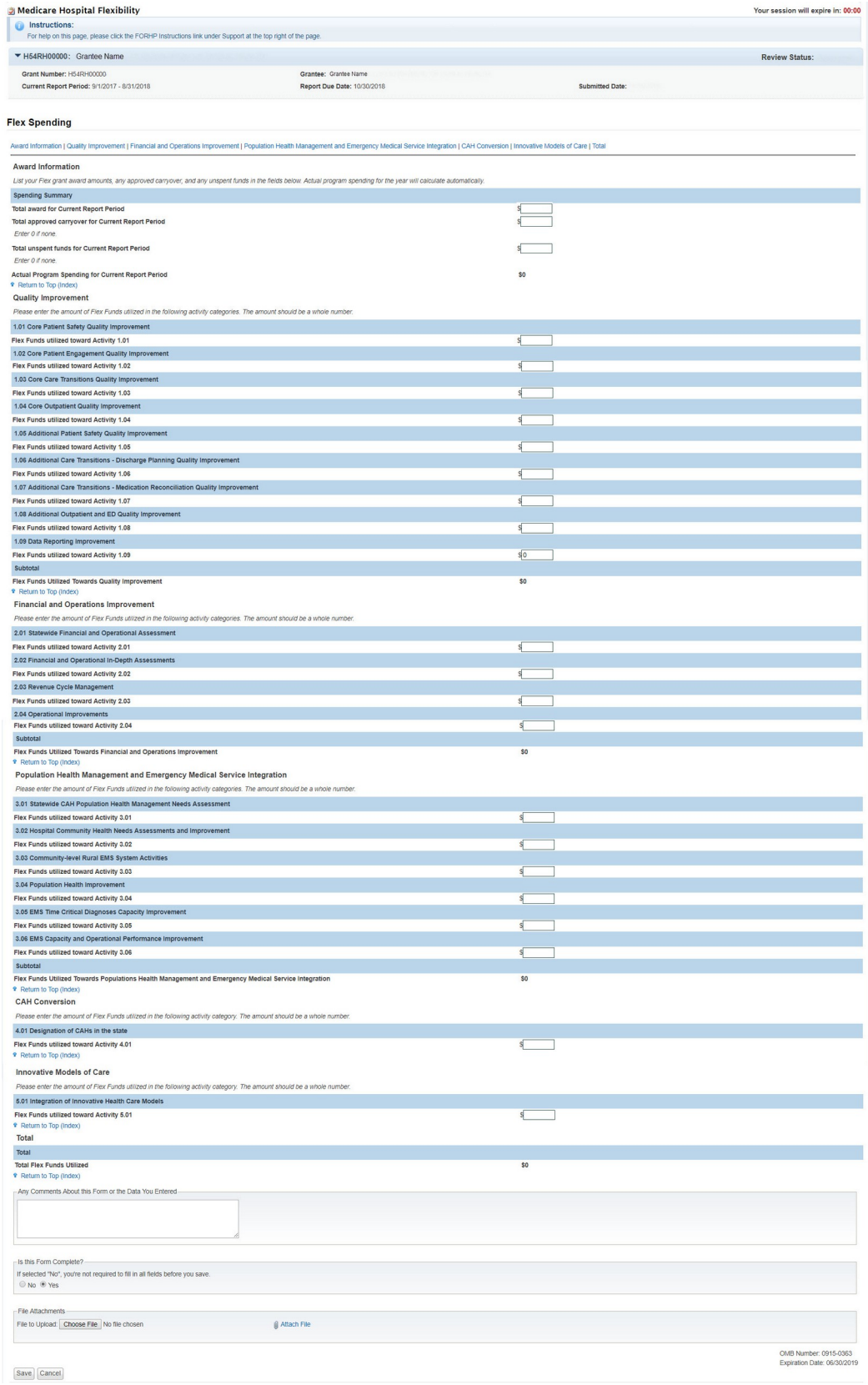
File Attachments

File to Upload: Choose File No file chosen — Attach File

OMB Number: 0915-0363
Expiration Date: 06/30/2019

Save Cancel

Form 7: Flex Spending



Medicare Hospital Flexibility

Your session will expire in: 00:00

Instructions:
For help on this page, please click the FORHP Instructions link under Support at the top right of the page.

H54RH00000: Grantee Name — Review Status:

Grant Number: H54RH00000 — Grantee: Grantee Name
Current Report Period: 9/1/2017 - 8/31/2018 — Report Due Date: 10/30/2018 — Submitted Date:

Flex Spending

Award Information | Quality Improvement | Financial and Operations Improvement | Population Health Management and Emergency Medical Service Integration | CAH Conversion | Innovative Models of Care | Total

Award Information

List your Flex grant award amounts, any approved carryover, and any unspent funds in the fields below. Actual program spending for the year will calculate automatically.

Spending Summary	
Total award for Current Report Period	$
Total approved carryover for Current Report Period	$
Enter 0 if none.	
Total unspent funds for Current Report Period	$
Enter 0 if none.	
Actual Program Spending for Current Report Period	$0

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Quality Improvement

Please enter the amount of Flex Funds utilized in the following activity categories. The amount should be a whole number.

1.01 Core Patient Safety Quality Improvement	
Flex Funds utilized toward Activity 1.01	$
1.02 Core Patient Engagement Quality Improvement	
Flex Funds utilized toward Activity 1.02	$
1.03 Core Care Transitions Quality Improvement	
Flex Funds utilized toward Activity 1.03	$
1.04 Core Outpatient Quality Improvement	
Flex Funds utilized toward Activity 1.04	$
1.05 Additional Patient Safety Quality Improvement	
Flex Funds utilized toward Activity 1.05	$
1.06 Additional Care Transitions - Discharge Planning Quality Improvement	
Flex Funds utilized toward Activity 1.06	$
1.07 Additional Care Transitions - Medication Reconciliation Quality Improvement	
Flex Funds utilized toward Activity 1.07	$
1.08 Additional Outpatient and ED Quality Improvement	
Flex Funds utilized toward Activity 1.08	$
1.09 Data Reporting Improvement	
Flex Funds utilized toward Activity 1.09	$ 0
Subtotal	
Flex Funds Utilized Towards Quality Improvement	$0

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Financial and Operations Improvement

Please enter the amount of Flex Funds utilized in the following activity categories. The amount should be a whole number.

2.01 Statewide Financial and Operational Assessment	
Flex Funds utilized toward Activity 2.01	$
2.02 Financial and Operational In-Depth Assessments	
Flex Funds utilized toward Activity 2.02	$
2.03 Revenue Cycle Management	
Flex Funds utilized toward Activity 2.03	$
2.04 Operational Improvements	
Flex Funds utilized toward Activity 2.04	$
Subtotal	
Flex Funds Utilized Towards Financial and Operations Improvement	$0

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Population Health Management and Emergency Medical Service Integration

Please enter the amount of Flex Funds utilized in the following activity categories. The amount should be a whole number.

3.01 Statewide CAH Population Health Management Needs Assessment	
Flex Funds utilized toward Activity 3.01	$
3.02 Hospital Community Health Needs Assessments and Improvement	
Flex Funds utilized toward Activity 3.02	$
3.03 Community-level Rural EMS System Activities	
Flex Funds utilized toward Activity 3.03	$
3.04 Population Health Improvement	
Flex Funds utilized toward Activity 3.04	$
3.05 EMS Time Critical Diagnoses Capacity Improvement	
Flex Funds utilized toward Activity 3.05	$
3.06 EMS Capacity and Operational Performance Improvement	
Flex Funds utilized toward Activity 3.06	$
Subtotal	
Flex Funds Utilized Towards Populations Health Management and Emergency Medical Service Integration	$0

Return to Top (Index)

CAH Conversion

Please enter the amount of Flex Funds utilized in the following activity category. The amount should be a whole number.

4.01 Designation of CAHs in the state	
Flex Funds utilized toward Activity 4.01	$

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Innovative Models of Care

Please enter the amount of Flex Funds utilized in the following activity category. The amount should be a whole number.

5.01 Integration of Innovative Health Care Models	
Flex Funds utilized toward Activity 5.01	$

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Total

Total	
Total Flex Funds Utilized	$0

Return to Top (Index)

Any Comments About this Form or the Data You Entered

Is this Form Complete?

If selected "No", you're not required to fill in all fields before you save.

No Yes

File Attachments

File to Upload: Choose File No file chosen — Attach File

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Expiration Date: 06/30/2019

Save Cancel