Flex Program Logic Model – Quality

Inputs *Resources needed to do the work*	**Activities** *Strategic processes or actions*	**Outputs** *Direct products, tools, and/or services*	**Outcomes** *Improvements that will drive impact*	**Impact** *End goals*
• Flex Funds • State Flex Coordinator Staff Time • TA providers (RQITA and TASC) • State partnerships, contractors, hospital quality staff time • MQBIP Quarterly Reports and CAHMPAS data • FMT Briefs	• 1.1 Report and improve Core Patient Safety/Inpatient Measures, including developing antibiotic stewardship programs (required) • 1.2 Report and improve Core Patient Engagement Measures (required) • 1.3 Report and improve Core Care Transitions Measures (required) • 1.4 Report and improve Core Outpatient Measures (required) • 1.5 Report and improve Additional Patient Safety Measures • 1.6 Report and improve Additional Patient Engagement Measures • 1.7 Report and improve Additional Care Transitions Measures • 1.8 Report and improve Additional Outpatient Measures	• Number and percent of hospitals that receive MBQIP quality measure reports to reference for QI purposes • Number and percent of hospitals that report data • Number and percent of states that meet MBQIP eligibility requirements • Using CAHMPAS data to inform Flex QI activities • Flex QI Projects • Using Flex TA products and trainings to inform state Flex QI initiatives • Using FMT policy briefs to inform QI interventions	• State-specific outcomes reported in PIMS that align with Activity Areas 1.1-1.8 • Knowledge gains through the use of TA resources, the TASC website, and participation in webinars & trainings • Number and percent of CAHs in the state reporting data every quarter for all MBQIP core measures during the budget year • Number and percent of CAHs in the state achieving defined performance levels on one or more targeted MBQIP quality measures • Number and percent of CAHs reporting improvement in activity categories 1.1 – 1.8	**Improve the health of rural people and the quality of health services by supporting performance improvement in rural health systems of care.**

*Logic model components and descriptions adapted from Watson, D., Broemeling, A. M., Reid, R. J., & Black, C. (2004). A results-based logic model for primary health care: laying an evidence-based foundation to guide performance measurement, monitoring and evaluation. University of British Columbia, Centre for Health Services and Policy Research; and Watson, D. E., Broemeling, A. M., & Wong, S. T. (2009). A results-based logic model for primary healthcare: a conceptual foundation for population-based information systems. Healthcare Policy, 5(Spec No), 33.

Contextual factors influencing the program include social, cultural, political, policy, legislative/regulatory, economic and physical environments for each program area