2022 Flex Program Fundamentals

An Introduction to the Medicare Rural Hospital Flexibility Program

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National Rural Health Resource Center

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Executive Summary

The Medicare Rural Hospital Flexibility Program, or Flex Program, was established by the Balanced Budget Act (BBA) of 1997. With eligible rural hospitals and a state rural health plan, states could establish a Flex Program and apply for federal funding. Forty-five states participate in the Flex Program. The Flex Program also created critical access hospitals (CAHs) as a Medicare provider type. CAH designation allows the hospital to be reimbursed on a reasonable cost basis for inpatient and outpatient services, including lab and qualifying ambulance services that are provided to Medicare patients and, in some states, Medicaid patients.

The Flex Program cooperative agreement provides funding to state governments or other designated entities to support CAHs and provider-based rural health clinics (RHCs) in quality improvement, quality reporting, performance improvements and benchmarking, designating facilities as CAHs, population health, innovative model development, and the provision of rural emergency medical services (EMS). Only states with CAHs or hospitals eligible to convert to CAH status and a state rural health plan can participate in the Flex Program.

Flex funding encourages the development of cooperative systems of care in rural areas, joining together CAHs, providers of EMS services, clinics, and health practitioners to increase efficiencies and quality of care. The Flex Program requires states to assess statewide needs and funds their efforts to implement community-level outreach and technical assistance to advance the following goals:

- Increase the number of CAHs consistently reporting quality data
- Improve the quality of care in CAHs
- Maintain and improve the financial viability of CAHs
- Build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities
- Improve the organizational capacity of rural EMS
- Improve the quality of rural EMS

- Increase knowledge and evidence base supporting new models of rural health care delivery
- Assist rural hospitals in seeking or maintaining appropriate Medicare participation status to meet community needs

The Flex grant is organized into six program areas with goals, objectives, and related activities, some of which are required:

1. CAH Quality Improvement (required)
2. CAH Operational and Financial Improvement (required)
3. CAH Population Health Improvement (optional)
4. Rural EMS Improvement (optional)
5. Innovative Model Development (optional)
6. CAH Designation (required if rural hospitals request assistance)

The Flex Program is administered through the Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). The Flex funding to states is administered as a cooperative agreement in both competitive and non-competitive grant cycles. The fiscal year (FY) 2022 (September 1, 2022 – August 31, 2023) is the fourth year of a 5-year cooperative agreement cycle. A summary of the Flex cooperative agreement guidance goals, objectives, and activities can be found in Section 1 of this manual. Flex cooperative agreement guidance for each year of the funding cycle can be accessed on the Flex Cooperative Agreement Guidance page of the Technical Assistance and Services Center (TASC) website.

Federal Office of Rural Health Policy

FORHP coordinates activities related to rural health care within the U.S. HHS. Part of HRSA, FORHP has department-wide responsibility for analyzing the possible effects of policy on residents of rural communities. Created by Section 711 of the Social Security Act, FORHP advises the Secretary of HHS on health issues within these communities, including the effects of Medicare and Medicaid on rural citizens' access to care, the viability of rural hospitals, and the availability of physicians and other health professionals.

FORHP administers grant programs designed to build health care capacity at both the local and state levels. These grants provide funds to 50 State Offices of Rural Health (SORHs) to support ongoing improvements in care and rural hospitals through Flex and SHIP grants in 45 states. Through its Community Based Division, FORHP provides support to community organizations to improve health service delivery, strengthen rural health networks, and encourage collaboration among rural health care providers.

Learn more about FORHP in Section 2 of this guide.

Technical Assistance and Services Center

TASC was created in 1999 by the National Rural Health Resource Center (The Center) through funding from FORHP to provide technical assistance and resources to the grantees of the Flex Program. This Flex Program Fundamentals guide was developed as part of TASC's services and is updated annually. The TASC section of the guide includes information on the tools and resources found on the TASC website, Flex Program Workshops, communication tools, technical assistance, and contact information for TASC staff. State Flex Program contact information can also be found within the State Flex Profiles on the TASC website.

TASC's services are essential as the job duties of a Flex Coordinator are broad, far-reaching, and without step-by-step instructions. Because of the varying tasks associated with the Flex Coordinator position, it is essential to remember the following tips:

- The role of the Flex Coordinator is to be the convener and liaison between local, state, and national rural health groups, all the while maintaining a neutral position
- Partnerships are keys to success
- Understanding the CAH environment and how to promote financial and operational improvement are vitally important
- For quality improvement, look at what exists and think creatively about how to improve
- CAHs need to play a part in a comprehensive system of care
- Be aware of the resources available to help you be successful

TASC provides tools and resources on topics applicable to the Flex Program, including CAH surveys. CAHs must comply with Medicare Conditions of Participation (CoP) to receive Medicare/Medicaid payment. A CAH survey is used to determine whether a CAH complies with the CoP set forth at 42 Code of Federal Regulations (CFR) Part 485 Subpart F. Certification of CAH compliance with the CoP is accomplished through observations, interviews, and document/record reviews. The survey focuses on a CAH's performance of organizational and patient-focused functions and processes while assessing compliance with federal health, safety, and quality standards that will assure that the beneficiary receives safe, quality care, and services.

TASC maintains relationships with state, national, and federal organizations, and health information technology (HIT) organizations. One organization that TASC works closely with is the Flex Monitoring Team (FMT). The FMT is a consortium of the Rural Health Research Centers located at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. FMT monitors and evaluates the Flex Program by developing relevant quality, financial, and community-benefit performance measures, and reporting systems to help state and federal policymakers and rural health care providers understand the impact of the Flex Program. The FMT's research assesses the impact of the Flex Program on CAHs and communities. It examines the ability of the Flex grantee to achieve overall Flex Program objectives.

Medicare Beneficiary Quality Improvement Project

FORHP created the Medicare Beneficiary Quality Improvement Project (MBQIP) as a Flex Program activity within the core area of quality improvement. The primary goal of this project is for CAHs to implement quality improvement initiatives to improve their patient care and operations. MBQIP uses Flex funding to support CAHs with technical assistance and national benchmarks to improve health care outcomes. Participating CAHs report a specific set of annual and quarterly measures determined by FORHP and engage in quality improvement projects to benefit patient care.

Benefits of participating in MBQIP include:

- Engagement in quality improvement initiatives
- Improved patient care across a broad population
- Improved hospital services, administration, and operations
- Creation of clear benchmarking and the identification of CAH best practices
- Receiving technical assistance regarding cutting edge quality improvement tools and models
- Preparing CAHs for the future when they will likely have to report national standardized measures
- Fulfilling the quality improvement portion of the Flex grant

To support the technical assistance needs of state Flex Programs and participating CAHs, FORHP established the Rural Quality Improvement Technical Assistance (RQITA) cooperative agreement. RQITA works closely with TASC, FMT, and FORHP to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of FORHP quality initiatives, including MBQIP and the Small Health Care Provider Quality Improvement (SHCPQI) grantees. To support SHCPQI, RQITA works closely with the Georgia Health Policy Center.

Performance Improvement & Measurement System and Program Evaluation

The Performance Improvement & Measurement System (PIMS) module is a data collection tool integrated with HRSA's Electronic Handbooks system (EHBs), a grant support and performance management application that unifies HRSA grant management processes and enables electronic data submission. PIMS allows FORHP to gather standardized performance data from recipients. With PIMS data, FORHP will track activities with common measures that focus on CAH performance improvement.

Another part of a successful and effective Flex Program is program assessment which includes documenting outcomes and showing continuous program management and improvement. Assessments can also examine results with short and long-term outcomes. Assessment of the

state Flex Programs is critical to the program's success, sustainability, and continued funding. It is essential to assess impact to demonstrate value. TASC is available to assist in sorting through the various tools and resources available to state Flex Programs to find an evaluation model that will work for them. We highly recommend taking the time to review the Flex Program Performance Management/Program Evaluation Guide on the TASC website that was created in October 2019 and either establishing or reviewing your current evaluation model at least annually.

Introduction to the Medicare Rural Hospital Flexibility Program

- History of the Medicare Rural Hospital Flexibility Program
- Program areas of the Flex Program
- Flex Cooperative Agreement Resources
- Core Competencies for State Flex Program Excellence
- Flex Program Frequently Asked Questions

History of the Medicare Rural Hospital Flexibility Program

The Flex Program was established by the BBA of 1997. Any state with rural hospitals and a state rural health plan may establish a Flex Program and apply for federal funding that provides for the creation of rural health networks, promotes regionalization of rural health services, and improves access to hospitals and other services for rural residents.

The BBA also created CAHs as a Medicare provider type. CAH designation allows a hospital to be reimbursed on a reasonable cost basis for inpatient and outpatient services provided to Medicare patients (including lab and qualifying ambulance services) and, in some states, Medicaid patients.

The design of the CAH designation was based on the experiences of the Medical Assistance Facility (MAF) Demonstration Project and the Rural Primary Care Hospital (RPCH) Project. MAFs were initially developed through a demonstration project of the Montana Health Research and Education Foundation (MHREF) in 1987 and received Medicare waivers in 1990. CAH designation was designed, in part, to decrease rural hospital closures, strengthen local health care delivery, and improve rural health care access.

The legislation has undergone many changes and updates such as the Balanced Budget Refinement Act (BBRA) of 1999, the Benefits Improvement Protection Act (BIPA) of 2000, the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the Medicare Improvements to Patients and Providers Act (MIPA) of 2008, the American Recovery and Reinvestment Act (ARRA) of 2009, and the Patient Protection and Affordable Care Act (PPACA) of 2015.

In 1999, TASC was created by The Center through funding from FORHP to provide technical assistance and resources to the grantees of the Flex Program. TASC provides a resource network

for answers and information regarding the program including best practices, peer learning, and tools. TASC has been so successful that many other HRSA programs have used this model to develop technical assistance centers for their programs.

TASC recognized a growing need for a knowledge base in HIT for rural health grantees and providers. Currently, HIT requirements in quality, safety, Health Insurance Portability and Accountability Act (HIPAA), telemedicine, reimbursement, pharmacy, and meeting the three stages of Promoting Interoperability (formerly known as Meaningful Use) as set forth by the Centers for Medicare and Medicaid Services (CMS) are overwhelming many rural health care providers. In the past, TASC provided HIT informational resources, education, and technical assistance. As of late, an increased emphasis is placed on telehealth to support quality of care, access to care, collaboration and information sharing among care providers, patient satisfaction, and safety during the COVID-19 pandemic and beyond.

Up through FY 2021, TASC coordinated the National Rural HIT Coalition, an informal network of rural and HIT leaders from organizations at every level, working together to drive knowledge and information about rural HIT throughout the country. The purpose of the group was to educate key rural health stakeholders about rural HIT issues and resources, provide a forum for discussion of issues relevant to CAHs, RHCs, and other rural health providers and communities, and convene federal, national, and state organizations and agencies to share rural successes, opportunities, and perspectives. Webinar playbacks on relevant HIT topics are available on the TASC website.

As the U.S. transitions to a health care system that pays for value, there are new programs and projects in the areas of accountable care organizations (ACOs); bundled payments, telehealth, and patient-centered medical homes (PCMH); Medicare and Medicaid payment changes and demonstration projects including global budgeting; workforce; long-term care; and public health. Changes are occurring in the health care marketplace, and CMS has focused its priorities on better care, smarter spending, and healthier people and communities. In 2015, the Medicare

Access & CHIP Reauthorization Act (MACRA) was passed, introducing the Quality Payment Program (QPP), which has two tracks: Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS). In short, APMs provide an incentive payment based on a specific clinical condition, care episode, or population where providers assume some of the risk related to patient outcomes. MIPS provides a payment adjustment to health care providers built on evidence-based and practice-specific quality data demonstrating high quality and efficient care supported by technology such as the electronic health record.

Additional models have been introduced, including the Community Health Access and Rural Transformation (CHART) Model which is currently being piloted by CMS, and the recently finalized Rural Emergency Hospital (REH) designation. According to the Rural Health Information Hub's (RHIhub) topic guide, the REH designation is designed to maintain access to critical outpatient hospital services in communities that may not be able to support or sustain a CAH or small rural hospital. REHs are required to provide 24-hour emergency and observation services and can elect to furnish other outpatient services. Facilities designated as an REH will receive enhanced Medicare payments for certain outpatient services and additional monthly payments. Changes in Medicare and Medicaid payment and delivery systems are anticipated to have the following impact:

- Increased pressure on operating margins caused by payment reductions, both federal and state
- Physician integration will be necessary to support ACOs and other shared savings models
- Capital will be required to implement physician alignment strategies
- Quality will drive reimbursement levels and will be a market differentiator
- Quality reporting will require a more sophisticated infrastructure
- Collaboration and effective alignment with the physician-provider community will be imperative as health care moves from a volume-based system to a value-based system

As CAHs seek to understand their future value, they need to look at their economic value in a new world consisting of transitioned payments.

Challenges faced by rural hospitals are not insurmountable. To meet them head-on will require a strong commitment to the communities served and the desire to problem solve and work collaboratively. This commitment and desire, and collaboration are the qualities that define rural hospitals and rural leaders. Because they are the lifelines for the residents they call neighbors, rural hospitals can lead the way in transforming the American health care system. They are smaller, less complex, and, therefore, able to change quicker than their urban counterparts. Rural hospitals are also more closely connected to their local communities.

Nationally, there is an important movement toward increased quality of care and patient health care experiences. FORHP created MBQIP, a Flex Program activity within the program area of quality improvement. The primary goal of this project is for CAHs to implement quality improvement initiatives to improve patient care and operations. Flex Programs focus their work in the required Quality Improvement Program Area, specifically on MBQIP. This work provides support to CAHs with technical assistance and national benchmarks to improve health care outcomes.

Increased usage of and understanding of publicly available quality and patient satisfaction data from Care Compare and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys has contributed to increased knowledge and understanding of hospital quality improvement. In the environment of MACRA, pay for performance, bundled payments and ACOs, and use of data to improve care, CAHs may soon be compared with their urban counterparts to ensure public confidence in their quality of health services. The MBQIP initiative takes a proactive and visionary approach to ensure that CAHs are well-equipped and prepared to meet future quality legislation. Additionally, MBQIP fulfills the Flex grant quality improvement objectives regarding Care Compare reporting for hospitals and supporting participation in various multi-hospital quality improvement initiatives. The main emphasis of this project is putting patients first by focusing on improving health care services, processes, and administration. More information can be found on the MBQIP webpage of the TASC website.

Starting in FY 2015, FORHP required participation in MBQIP as a condition for CAHs to participate in Flex-funded activities. CAHs have the opportunity to work with their State Flex Program to meet the MBQIP reporting requirements and participate in Flex-funded activities. FORHP suspended eligibility requirements for FY 2020 (September 1, 2020 – August 31, 2021) and FY 2021 (September 1, 2021 – August 31, 2022) due to the COVID-19 pandemic. As hospitals prioritized their COVID-19 response, FORHP allowed all CAHs to participate in Flex-funded activities during this period. Information about MBQIP eligibility requirements is available on the Flex Eligibility Criteria for MBQIP Participation page of the TASC website. CAHs that have the ability to report are highly encouraged to continue reporting on as many measures as possible.

As of January 2023, there were 1,358 hospitals in the nation designated as CAHs. Most CAH designations in the country are now complete due to support provided by state Flex Programs. CAH designation is only one part of the Flex Program. The prevention of CAH closure or assisting them to identify other viable models to serve the health care needs of their rural communities is a vital role for state Flex Programs to play in this shifting health care environment. State Flex Programs also use their cooperative agreement dollars to improve networks, improve population health, and improve and integrate EMS; work on performance improvement, operational and financial improvement, address quality improvement issues; explore innovative models of care, all to enhance and ensure health care access to rural Americans.

Program Areas of the Flex Program

In FY 2019 (September 1, 2019 – August 31, 2020), the Flex Program began a new project period focused on providing training and technical assistance to build capacity, support innovation, and promote sustainable improvement in rural health care systems.

The Flex Program, a five-year project period, is designed to allow state Flex cooperative agreement partners to develop, implement, and measure impact and improvement within the program areas of the cooperative agreement:

1. CAH Quality Improvement (required)
2. CAH Operational and Financial Improvement (required)
3. CAH Population Health Improvement (optional)
4. Rural Emergency Medical Services (EMS) Improvement (optional)
5. Innovative Model Development (optional)
6. CAH Designation (required if rural hospitals request assistance)

The overall goal of the Flex Program is to ensure that high-quality health care is available in rural communities and aligned with community needs. The goals of each of the six program areas are as follows:

- CAH Quality Improvement (required)
    - Increase the number of CAHs consistently reporting quality data
    - Improve the quality of care in CAHs
- CAH Operational and Financial Improvement (required)
    - Maintain and improve the financial viability of CAHs
- CAH Population Health Improvement (optional)
    - Build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities
- Rural EMS Improvement (optional)
    - Improve the organizational capacity of rural EMS
    - Improve the quality of rural EMS
- Innovative Model Development (optional)
    - Increase knowledge and evidence base supporting new models of rural health care delivery
- CAH Designation (required if assistance is requested by rural hospitals)
    - Assist rural hospitals in seeking or maintaining appropriate Medicare participation status to meet community needs

I. CAH Quality Improvement

This program area, referred to as MBQIP, focuses on improving the quality of health care provided by CAHs and other rural health care providers. Other types of health care providers can and should benefit from this work, but most activities must target CAHs.

MBQIP activities are grouped in four quality domains:

- Patient Safety/Inpatient,
- Patient Engagement
- Care Transitions
- Outpatient

FORHP expects all grantees to select Activity Categories 1.1- 1.4 (required) which covers the four quality domains of MBQIP.

Building and maintaining the participation of all CAHs in MBQIP through quality measurement and reporting activities are required. In year one of the cooperative agreement cycle, it is acceptable to work towards building the capacity for CAHs to participate in these activities and report data if they are not already doing so. For CAHs already engaged in quality reporting, the focus should be quality improvement.

Every year, FORHP evaluates the MBQIP participation requirements for CAHs to be eligible to participate in the Flex Program and Flex-related activities. FORHP understands that certain circumstances hinder CAHs from reporting. Therefore, Flex Programs have the opportunity to request waivers for MBQIP participation requirements for the current fiscal year on behalf of CAHs initially deemed ineligible due to non-participation. The Flex Program must submit a waiver as part of their non-competing continuation (NCC) progress report as an attachment. Detailed participation criteria are currently available from FORHP concerning participation through FY 2020. Due to the COVID-19 pandemic, MBQIP Eligibility requirements were suspended temporarily.

Along with the required set of quality improvement activities, there are additional activity categories that grantees are encouraged to select based on the needs of the CAHs in their state (Activity Categories 1.5 – 1.8). These activity categories do not require participation by all CAHs. Instead, they should include a cohort(s) of CAHs in the state prepared to focus quality improvement efforts on the identified area. It is acceptable to work with an individual hospital, but the need must be clearly justified. While some of the additional activity categories have existing measures, some do not have a standardized measure set or reporting mechanism. These activity categories were included to give states an option to work on these national quality priority areas.

Potential resources related to quality improvement include:

- MBQIP website
- Emergency Department Transfer Communication (EDTC)
- Flex Monitoring Team (FMT)

For specific information on Program Area 1: CAH Quality Improvement goals, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

II. CAH Operational and Financial Improvement

FORHP requires all grantees to select Activity Category 2.1. Activity Categories 2.2 – 2.5 are not individually required. Still, FORHP requires state Flex Programs to support one or more improvement projects in this program area as determined by the state's needs assessment (Activity Category 2.1) and program capacity. FORHP encourages states to identify new or existing successful financial and operational improvement programs and leverage those to meet the collective needs of CAHs in each state to maximize the impact of limited Flex funds. States should minimize consultant expenditures toward individual CAHs for improvement activities, instead focusing on cohorts unless adequately justified. Work within this program area must

focus on CAHs; however, state Flex Programs may assist CAHs that operate provider-based RHCs or other off-campus health care sites.

For specific information on the Program Area 2: CAH Operational and Financial Improvement goal, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

III. CAH Population Health Improvement

This optional program area focuses on helping to build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities.

Activity categories for this program area focus on:

- Understanding health improvement needs
- Developing strategies
- Engaging with community stakeholders to address specific health needs

Flex funds cannot be used to pay for the completion of community health needs assessments (CHNAs).

For specific information on the Program Area 3: CAH Population Health Improvement goal, activity categories, requirement, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

IV. Rural EMS Improvement

This optional program area focuses on work to improve rural EMS as it is a vital link to emergency health care for rural residents. The Flex Program supports establishing and expanding programs that support the provision of rural EMS. Goals of this program area include improving organizational capacity of EMS providers and improving the quality of rural EMS. Projects within

this program area are to focus primarily on out-of-hospital emergency medical services. Projects including both EMS and CAH emergency departments (ED) are encouraged, but projects that focus solely on the CAH ED should be part of Program Area 2: Operational and Financial Improvement.

If Rural EMS Improvement program area is chosen, the required areas are:

- Completion of a statewide rural EMS Needs Assessment and Action Plan (Activity Category 4.1)
- And/or completion of a community-level rural EMS system assessment and action planning

It is expected that states working in this program area will complete at least one of these two types of assessments during the five-year program cycle.

For specific information on the Program Area 4: Rural EMS Improvement goal, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

Flex Program EMS Supplement

With declining numbers of volunteers to staff ambulances, declining financial support from local governments, and increased educational standards for emergency medical technicians and paramedics, access to emergency care is at risk in many rural communities. Flex Program stakeholders have identified addressing the needs of struggling ambulance agencies as a key issue to maintaining access to emergency care in rural communities. Stakeholders have also identified EMS quality improvement as a key challenge for both EMS sustainability and EMS participation in value-based care.

The Flex Program provides a platform and resources for states to strengthen rural health care by supporting improvement initiatives with CAHs and rural EMS agencies. State Flex Programs have

supported EMS improvement activities in the past but have faced challenges with limited capacity to address EMS needs given other rural health care priorities. In FY 2022, FORHP issued a competitive funding opportunity available only to state Flex Programs for supplemental EMS projects.

The goal of this supplemental funding is to expand upon the current Flex program by encouraging rural EMS agencies to educate staff and leadership on the importance of accurate reporting, and how it drives quality improvement efforts at the agency level. Improving and/or adding quality improvement activities allows EMS agencies to enhance clinical care and find efficiencies which has the potential to both expand their ability to care for patients and allow them to expand needed services. Additionally, these supplements will serve as examples to other EMS agencies interested in this topic.

The full Flex EMS Supplement NOFO can be viewed on the Flex Program Funding Guidance page on the TASC website.

State Flex Programs awarded the Flex EMS Supplement funding up to $300,000 per year for two years for FY 2022 – FY 2023 are:

- Arizona
- Michigan
- North Dakota
- New Mexico
- Utah
- Washington

TASC provides technical assistance and support to these additional six Flex EMS Supplement projects.

V. Innovative Model Development

If a state Flex Program is interested in developing innovative rural health care models to improve quality, finances, operations, population health, and/or system delivery, they may choose to do activities in this program area. The goal of this program area is to increase knowledge and the evidence base supporting new models of rural health care delivery. Projects in this program area can be for one to five years. Evidence must be provided by the state Flex Program that they can meet the majority of Program Area 1 and Program Area 2 needs in the state before opting to do work in Program Area 5. They also must demonstrate organizational capacity to manage projects in this program area. State Flex Programs were also required to submit a logic model with their application to work in this program area.

For specific information on Program Area 5: Innovative Model Development goal, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

VI. CAH Designation

In accordance with program authorizing authority, state Flex Programs must facilitate, when requested, appropriate conversion of small rural hospitals to CAH status. Flex Programs must assist hospitals in evaluating the effects of conversion to CAH status.

This may include assisting with financial feasibility studies for hospitals considering conversion to CAH status, as well as feasibility studies for reopening closed rural hospitals or converting CAHs to other types of facilities.

For specific information on the Program Area 6: CAH Designation, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2019 – FY 2023.

Flex Cooperative Agreement Guidance Resources

The Flex Program is administered through FORHP, an office within HRSA, an agency of HHS. The Flex funding to states is administered as a cooperative agreement in both competitive and non-competitive grant cycles. Fiscal year 2022 (September 1, 2022 – August 31, 2023) is the fourth year of a 5-year cooperative agreement cycle. Flex cooperative agreement guidance for each year of the funding cycle can be accessed on the Flex Cooperative Agreement Guidance page of the TASC website.

The competitive application for the Flex cooperative agreement occurs electronically through the grants.gov website. Each program year is September 1 – August 31.

The Core Competencies for State Flex Program Excellence Guide includes a section dedicated to Managing the Flex Program, with tips and resources for managing the cooperative agreement and resources for grant writing.

For an easy-to-use manual on writing Federal grant applications, with tips on grant management, please review the Federal Grant Writing Manual.

A Federal Grant Writing Manual Workshop was held in September 2014. Resources from this Workshop, including many examples related to the Flex Program, are available online.

For more information on applying for a federal grant, please visit the HRSA Apply for a Grant webpage. For Federal Funding Accountability and Transparency Act (FFATA) implementation requirements, please visit the HRSA website. For technical assistance resources from HRSA's Grants Management, please visit the Manage Your Grant Workshop webpage. Consider becoming a HRSA grant reviewer. For more information, please visit the HRSA Grant Reviewers webpage.

Core Competencies for State Flex Program Excellence

One role of the state Flex Program is to be a convener and liaison between local, state, and national rural health groups while supporting and promoting improvements in CAHs, population health, and the integration of health services through training and technical assistance.

The responsibilities of state Flex Programs are broad and far-reaching, with no step-by-step instructions for the work. The advantage and difficulty of managing the Flex Program is the flexibility of the assignment. Each state Flex Program needs to identify the strengths and challenges faced by their state's rural health care providers and set goals to build state and local capacity. However, the methods used will vary by state and region.

In the spring of 2015, a group of experienced state office of rural health (SORH) directors, Flex Program coordinators, and staff from FORHP, FMT, and TASC gathered for a Flex Program Leadership Summit to develop a framework of Flex Program core competencies and recommendations to achieve excellence in state Flex Programs. As a result of that meeting, the Core Competencies for State Program Excellence Guide was developed. The Guide provides:

- a framework for assessing state Flex Program strengths and weakness
- suggestions for developing or strengthening performance in each of the competency areas
- links to supporting resources organized by competency.

Below are summaries of each of the core competencies. For more information, please review the Core Competencies for State Flex Program Excellence Guide.

A self-assessment of the Core Competencies is available to assist users in identifying and prioritizing opportunities for enhancing competency within their state Flex Program at the organization-level, not the individual-level. Based on assessment results, resources can be identified for those areas in which the program self-identifies a gap or opportunity for

improvement. FORHP strongly suggests that state Flex Programs complete this assessment at least annually. Results of the assessment will not be used by FORHP to determine future funding levels. Users are encouraged to complete the assessment annually, and with personnel changes to monitor progress on their continuous journey towards Flex Program excellence. Assessment results can be used to establish a baseline, create benchmarks, and aid in strategic planning and evaluation.

Developing Leadership and Workforce

The Flex program and CAHs rely on leadership and skilled workforce to advance program goals and deliver high-quality, high-value care for patients. High turnover challenges many state Flex programs and CAHs. However, with strong leadership, planning, data collection, analysis, and a focus on workforce development, program goals can be set, advanced, and achieved.

Leaders set direction by building and communicating a common and inspiring vision. Leadership has the strongest impact on organizational outcomes and value, including for state Flex programs and CAHs. State Flex programs are funded to serve as leaders in addressing CAH needs related to quality improvement, financial and operational improvement, population health, and emergency medical services. To learn more about this competency and the proficiencies related to Developing Leadership and Workforce please see the Core Competencies for State Flex Program Excellence.

Managing the Flex Program

Managing the Flex cooperative agreement is one of the primary responsibilities of the state Flex programs and includes: budgeting, cooperative agreement application writing and submission, maintaining a relationship with the FORHP Project Officer (PO), working with partners, information management, and reporting. State Flex Programs should be aware of the

cooperative agreement requirements, goals and timelines as stated in the Flex Program Funding Guidance.

TASC, as well as other Flex Program partners, facilitate different learning opportunities with information related to managing the Flex Program. These include TASC 90 webinars, TASC Virtual Knowledge Groups (VKGs), learning collaboratives, and small group meetings. As with many of the core competencies, maintaining a relationship with your federal PO is important to managing a Flex Program. To learn more about this competency and the proficiencies related to Managing the Flex Program please see the Core Competencies for State Flex Program Excellence.

Planning Strategically

Planning ought to be purposeful, active, and relevant, with input from key stakeholders such as internal staff, rural provider leaders and staff, the state hospital association, quality improvement partners, and the state rural health and clinic organizations. Flex Program strategic planning should be completed to align with the new competitive funding opportunity application that occurs every three to five years and ought to include a vision, mission, and values as well as goals and objectives. Plans should be reviewed quarterly, and adjustments made with each application. To learn more about this competency and the proficiencies related to Planning Strategically please see the Core Competencies for State Flex Program Excellence.

Managing Information and Evaluation

State Flex programs are required to submit an annual report, PIMS, and program outcomes within the workplan to FORHP through the EHBs. To do this, your program needs to have a system in place to collect primary data about your program and often access secondary data to supplement these data to report outcomes. Data collection should be ongoing, reflected in the strategic plan and workplan, and tied to each program goal, objective, measure, and intended

outcome as described in your state Flex Program funding application, as well as PIMS. To learn more about this competency and the proficiencies related to Managing Information and Evaluation please see the Core Competencies for State Flex Program Excellence.

Building and Sustaining Partnerships

Strong partnerships lead to more informed and engaged stakeholders and ultimately increased program impact and outcomes. State Flex Programs remain vital because of the web of relationships developed and maintained within communities, providers, networks, states, regions, and nationally. As the health care system changes and staff turnover occurs, it is imperative that state Flex Programs have the skills, capacity, and commitment to build and sustain partnerships, new and old, to support rural providers and rural stakeholders. To learn more about this competency and the proficiencies related to Building and Sustaining Partnerships please see the Core Competencies for State Flex Program Excellence.

Understanding Policies and Regulations

Health policy, rules, and regulations have a profound impact on programs, services, reimbursement, and systems. State Flex Programs need to have an in-depth understanding of the policies and regulations governing the Flex Program, as well as a basic understanding of the policy making process and other policies and regulations affecting rural providers. While state Flex Programs do not need to be experts in all aspects of the rural health landscape, having a basic understanding of key components will: 1) allow state Flex Programs to better understand rural provider challenges and opportunities and develop strategies to address them, 2) communicate more effectively with program partners, 3) access resources and expertise when need, 4) educate others about rural communities and rural providers, and 5)anticipate and prepare for health system changes. To learn more about this competency and the proficiencies related to Understanding Policies and Regulations please see the Core Competencies for State Flex Program Excellence.

Strengthening Quality Reporting and Improvement

A core component and goal of the Flex Program is to support CAHs with quality improvement (QI). HRSA defines QI as "systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups". To accomplish this, state Flex Programs must understand QI principles, resources, and trends to support CAHs in advancing QI. This includes administering MBQIP and supporting other rural providers, such as EMS, with QI. To learn more about this competency and the proficiencies related to Strengthening Quality Reporting and Improvement please see the Core Competencies for State Flex Program Excellence.

Improving Financial Sustainability

Sustainable financial performance of rural providers is essential for both the day-to-day-operation as well as for needed investments in technology, infrastructure, and staff. The Flex Program and CAH designation was established and remains in place because of the financial vulnerability of small rural hospitals. CAH financial and operational improvement is one of the required program areas on the Flex Program.

Common financial and operational improvement concepts and terminology that state Flex Programs should be familiar with are cost-based reimbursement, revenue cycle management, and CAH financial indicators. There are acknowledged financial improvement strategies that can support improvement in these areas. All of these concepts, and more, are described in the Small Rural Hospital and Clinic Finance 101 Guide which is strongly suggested reading for all state Flex Program Coordinators. To learn more about this competency and the proficiencies related to Improving Financial Sustainability please see the Core Competencies for State Flex Program Excellence.

Understanding the Current and Future Health Care Environment

Given the goals and role of the Flex program, the role and services provided by CAHs, RHCs, and EMS, and the population health needs of rural communities, it is imperative that the state Flex Programs have an understanding of the health care system. This includes having basic knowledge of 1) the various roles and classification models of the types of hospitals, clinics, EMS, and long-term care (LTC) facilities prevalent in rural America, and 2) the rapidly evolving health care payment models, as payors increasingly pay for value and outcomes rather than for procedures. This understanding enables state Flex Programs to participate in discussions and planning to serve as a rural "voice" to ensure rural needs are met. To learn more about this competency and the proficiencies related to Understanding the Current and Future Health Care Environment please see the Core Competencies for State Flex Program Excellence.,

Addressing Community Needs

The World Health Organization defines social determinants of health (SDOH) as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agenda, social norms, social policies, and political systems." SDOH are being recognized as key factors contributing to health inequities. Addressing SDOH is fundamental to increasing quality and access to health services and decreasing costs.

State Flex Programs should be familiar with SDOH, the role that SDOH play in population health and value-based health care, and how health and community programs and services are changing to include and address SDOH. State Flex Programs should use and convey this knowledge to prepare CAHs to participate in current and future state, regional, and local health system planning. To learn more about this competency and the proficiencies related to addressing community needs please see the Core Competencies for State Flex Program Excellence.

Flex Program Frequently Asked Questions

Flex Program Operations

What is the Medicare Rural Hospital Flexibility (Flex) Program?

The Flex Program was created by the BBA in 1997. Revisions occurred through the BBRA; the Medicare, Medicaid, and State Children's Hospital Insurance Program (SCHIP) Benefits Improvement and BIPA; the MMA; and MIPA. The Flex Program is intended to preserve access to primary and emergency health care services, improve the quality of rural health services, provide services that meet community needs, and foster a health delivery system that is both efficient and effective. In addition, the Flex Program supports designation of a type of rural hospital: critical access hospital (CAH).

To accomplish the intent of the Flex Program, federal resources have been made available to:

- SORHs (those who implement state Flex Programs)
- TASC, a program of The Center, and RQITA, a technical assistance provider to support MBQIP data reporting and quality improvement
- Rural Health Research Centers and the FMT (those who are monitoring the Flex Program nationally)

States administer the Flex Program and can apply to HRSA's, FORHP for federal Flex Program funding.

For more policy/legislative information, please visit the Understanding Policies and Regulations section of the Core Competencies for State Flex Program Excellence Guide.

What are the primary components of the Flex Program? (See Section 1 for a description of each program area)

- Program Area 1: CAH Quality Improvement (required)
- Program Area 2: CAH Operational and Financial Improvement (required)

- Program Area 3: CAH Population Health Improvement (optional)
- Program Area 4: Rural Emergency Medical Services (EMS) Improvement (optional)
- Program Area 5: Rural Innovative Model Development (optional)
- Program Area 6: CAH Designation (required if requested)
- Other key areas of the Flex Program include the following
    - Network Development
    - State Rural Health Plan*
    - State Flex Program Evaluation

*Note: Each state participating in the Flex Program was required to develop a state rural health plan. This rural health plan was submitted to CMS for approval. Reporting outcomes of the Flex Program is becoming increasingly important to quantify the benefits of the program. Through continuous assessment, states must have a way to gather data and review the successes of their program and incorporate any needed improvements.

How are states made aware of the Flex Program and CAH changes?

Flex Program Coordinators and other applicable Flex Program personnel receive emails regarding Flex Program and CAH changes as information is made available. Information also comes directly from TASC, FORHP, RQITA, FMT, and state hospital associations and is reported in the Federal Register. Additionally, changes are posted on the TASC website or are reported through links to other websites. To join the TASC listservs, reach out to tasc@ruralcenter.org.

Can I expect other updates and information from TASC and others?

Yes. TASC and its partners stay abreast of rural health policy and program changes. Updates are provided via the Flex Program email lists, regularly scheduled events such as conference calls, and webinars such as TASC 90 and VKG webinars. Information is also shared via the Flex Program Forum (login required), TASC, and FMT websites, other stakeholder websites, conferences, and workshops throughout the year.

How do I apply for federal Flex Program funding?

Each state interested in acquiring federal Flex Program funding must submit an annual progress report or competitive application to FORHP. The state designated entity, appointed by the governor, is solely allowed to apply for the funding. The approximate timeline* for applications and awards is below:

- January/February: FORHP sends application guidelines to states
- March - May: Application submission
- August: Notice of Award announcements
- September 1: The federal program year begins

*Note: This schedule may change; contact FORHP for current year schedule.

Who should I contact if I have questions regarding the Flex Program?

TASC is available to answer your questions, see Section 3.

There are several other excellent resources, a sample of those to consider include:

- CAH Licensing and Certifications (including accrediting bodies) – contact your state hospital licensing bureau, your CMS regional office, or TASC.
- Federal Flex Program – contact the Flex Project Officer at FORHP (FORHP Flex Program Project Officers in Section 2).
- CAH CoP (State Operations Manual, Appendix W – Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals and Swing-Beds)
- Changes in federal laws and rules governing the Flex Program – contact your state hospital association, CMS or visit the Federal Register website and the Rural Policy Research Institute (RUPRI) website.
- Rural Health Value operates as the Rural Health System Analysis and Technical Assistance (RHSATA) cooperative agreement between FORHP, the RUPRI Center, and Stratis Health. The Rural Health Value Team analyzes rural implications of changes in the organization, finance, and delivery of health care services and assists rural communities and providers transition to a high-performance rural health system.

- The American Hospital Association (AHA) Rural Health Services — The AHA ensures the unique needs of this segment of its membership are a national priority. Working side by side with state and regional associations and with advice from its member council, the section tracks, develops policies, and identifies solutions to their most pressing problems.
- Annual Flex Program Reverse Site Visit – contact TASC for more information

If I want information from other states, e.g., asking questions or determining whether they are working on similar issues, how do I access this information?

There are several ways to access state Flex Program information, including:

- Contact information (email addresses, phone numbers and, websites) are available through the State Flex Profiles on the TASC website.
- The Flex Program Forum is a secure web-based message forum for use by the state Flex Programs. Forum content focuses on the Flex Program and rural health care. State Flex personnel can share messages, pose questions, post documents, web links, and comment on each other's posts. The Forum is a method for state Flex Programs to continue to connect and share information, ideas, lessons learned, and best practices.
- TASC hosts regularly scheduled TASC 90 webinars. These webinars address issues and topics of interest to state Flex Program Coordinators and CAHs. TASC 90 recordings are made publicly available on the TASC website. TASC hosts Flex VKG webinars, which are peer discussions for state Flex Coordinators to share best practices and lessons learned. VKG recordings are only shared on the Flex Program Forum.

Where can I find ideas that may assist me in building my state Flex Program?

There are several resources designed for state Flex Program development, including:

- Staff at The Center working on the TASC program, TASC 90 webinars, other topical webinars, VKG webinars, Flex Program Reverse Site Visit, TASC website, Flex Program Forum, and the *Rural Route* e-newsletter (all coordinated by TASC)
- Other state Flex Programs and their websites, which can be found within the State Flex Profiles
- Publications and the FMT website
- Health Resources and Services Administration (HRSA) FORHP
- National Rural Health Association (NRHA) Annual Conference and Annual CAH Conference

- National Organization of State Offices of Rural Health (NOSORH) Annual Meeting
- The Core Competencies for State Flex Program Excellence, which identifies nine Flex Program competencies and provides a guide to state Flex Programs for improving capacity in each of the nine areas.
- The Rural Health Information Hub (RHIhub) provides access to current and reliable resources to learn about rural health needs and work to address them, including toolkits, resources, and evidence-based best practices.

Critical Access Hospitals

What is a CAH?

A CAH is a small rural hospital that has 25 beds (inpatient and/or swing beds) or fewer. CAHs have unique operating requirements and receive cost-based plus one percent reimbursement (101% of allowable costs) for providing inpatient and outpatient services and certain other services to Medicare* beneficiaries.

*Note - some states also provide cost-based reimbursement for inpatient and/or outpatient services for Medicaid services. This varies by state.

Which hospitals are eligible for a CAH designation? **

A Medicare-participating hospital can become certified and remain certified as a CAH by meeting the following regulatory requirements (this list is not all-inclusive but indicates some of the basic criteria):

- Located in a state that has established a Medicare Rural Hospital Flexibility Program by submitting a State Plan to the Regional Administrator of the CMS Regional Office responsible for oversight of Medicare and Medicaid in the state. As of 2018, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island have not established Medicare Rural Hospital Flexibility Programs (State Plans).
- Designated by the state as a CAH.

- Located in a rural area or an area treated as rural under a special provision that allows treating qualified hospital providers in urban areas a rural (refer to 42 CFR 412.103 regulations).
- Furnishes 24-hour emergency services, 7 days a week, using either on-site or on-call staff, with specific on-site, on call staff response times.
- Does not exceed 25 inpatient beds also used for swing bed services. It may operate a distinct part rehabilitation and/or psychiatric unit, each up to 10 beds.
- Maintain an annual average acute care inpatient length of stay (LOS) of 96 hours or less (excluding swing bed services and distinct part unit (DPU) beds). Medicare does not assess this requirement on initial certification, and it only applies after CAH certification.
- A CAH that has not been designated as a necessary provider (a state designation that sunsetted December 31, 2005) must be located more than a 35-mile drive (or in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from any other CAH or hospital.

Can a CAH convert back from CAH designation to Prospective Payment System (PPS)?

Yes, a CAH can convert back to be a PPS hospital. Contact TASC for examples of hospitals that have converted back to PPS status.

Can a CAH have DPUs (e.g., psych units)?

Yes. As part of the MMA (2003), a CAH may operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds (e.g., one psychiatric DPU up to 10 beds and one rehabilitation DPU up to 10 beds).

What does "make available 24-hour emergency medical services" mean?

A CAH that does not have inpatients may close (e.g., be unstaffed) provided there is an emergency medical response system in place to address the needs of patients that present at the hospital. This emergency medical response system must ensure that a practitioner with training and experience in emergency care (Doctor of Medicine or Osteopathy, Physician Assistant, or Nurse Practitioner) is on-call and available by telephone or radio 24 hours a day and available on-site at the CAH within 30 minutes.

Are CAH licensure surveys announced or unannounced?

CAH licensure surveys are unannounced. CAHs have an initial survey and then a follow-up survey approximately one year later. Subsequent survey schedules vary by state.

Examples of mock surveys from state offices of rural health (SORH) can be requested from TASC.

Will the CAH be given a new provider number upon conversion to CAH?

Yes, a new provider number will be assigned.

What bed count will be used to determine whether a hospital qualifies as a CAH?

A CAH can have up to 25 Medicare certified beds, including swing beds. Some states allow CAHs to have a larger number (above 25) of state licensed beds; however, they cannot be staffed by the hospital as it will place them over the 25-bed count.

Are observation beds or recovery lounges counted towards the 25 acute care bed limit?

Beds used solely for patients receiving observation services are not included in the 25 acute care bed limit. There are some observation services that are not appropriate and can be referenced in Appendix W. Recovery lounges used in surgery do not count if the patient in the bed meets the criteria for use in the CMS Interpretive Guidelines. Remember, it does not matter the kind of bed (gurney, lounger, etc.), it is the status of the patient in the bed.

What happens if emergency situations require greater in-patient capacity than 25 beds?

CAHs can exceed the 25 acute care bed limit in emergency situations, e.g., a disease epidemic, but must document the circumstances to the satisfaction of federal and state officials.

Can a CAH build a new hospital and still be a CAH?

Yes, but certain requirements must be maintained or met anew. For hospitals that require a state necessary provider waiver to be a CAH, refer to the Medicare Conditions of Participation for CAHs, section §485.610(d) Standard: Relocation of CAHs With a Necessary Provider Designation Interpretive Guidelines §485.610(d).

For CAHs that are not designated as necessary providers, please see the Medicare Conditions of Participation for CAHs, section §485.610(c) Standard: Location Relative to Other Facilities or Necessary Provider Certification Interpretive Guidelines.

Are CAHs issues the same across all states?

No. All states have unique rules and regulations that may affect CAH operations in the state. Therefore, in many instances, states must refer to state licensing and other regulatory experts for information and guidance.

Federal Office of Rural Health Policy

- Overview and Funding
- FORHP Flex Program Project Officers
- Performance Improvement and Measurement System
- HHS Organization Chart
- FORHP Organization Chart

Overview and Funding

The Federal Office of Rural Health Policy (FORHP) was created in 1987 to advise the Secretary of the U.S. Department of Health and Human Services on health care issues impacting rural communities, including:

- Access to quality health care and health professionals
- Viability of rural hospitals
- Effect of the Department's proposed rules and regulations, including Medicare and Medicaid, on access to and financing of health care in rural areas

In line with the mission of HRSA, FORHP helps increase access to care for underserved populations and build health care capacity through several programs:

Community Based Division (CBD)

Provides support to community organizations to improve health care service delivery and strengthen health networks and encourages collaboration among rural health care providers.

Hospital State Division (HSD)

Supports on-going improvements in care to 50 SORHs and to rural hospitals through the Flex Program. HSD also supports technical assistance for small rural hospitals, including CAHs

Policy Research Division (PRD)

Coordinates the review of proposed regulations to assess the potential impact on rural health care delivery and financing. The division supports nine Rural Health Research Centers, information dissemination and policy programs, Rural Residency Planning and Development, and RHC technical assistance.

Rural Strategic Initiatives Division (RSID)

Coordinates the Rural Communities Opioid Response Program (RCORP) and other new initiatives that emerge as a result of Agency, Department, or Administration priorities.

Additional Resources

FORHP staffs the National Advisory Committee on Rural Health & Human Services.

For information on locations eligible to receive Rural Health Grants, please refer to the HRSA Eligibility Analyzer.

For more information on rural health grant opportunities, please refer to the Rural Health Find Grant Funding webpage.

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Minnesota	West Virginia	Illinois	South Carolina
New Hampshire	Wisconsin	Indiana	Tennessee
New York		Kentucky	

FORHP Project Officers for Rural Hospital Programs Regional Map

Performance Improvement and Measurement System

The Performance Improvement & Measurement System (PIMS) module is a data collection tool that is integrated with the HRSA EHBs, a grant support and performance management application that unifies the HRSA grant management processes and enables electronic data submission. PIMS allows FORHP to gather standardized data from recipients for each of the six Flex Program areas: CAH Quality Improvement (required); CAH Operational and Financial Improvement (required); CAH Population Health Improvement (Optional); Rural Emergency Medical Services (EMS) Improvement (Optional); Rural Innovative Model Development (Optional); and CAH Designation (required if requested). Award recipients annually complete PIMS reports which are due in October.

Using PIMS, state Flex recipients report:

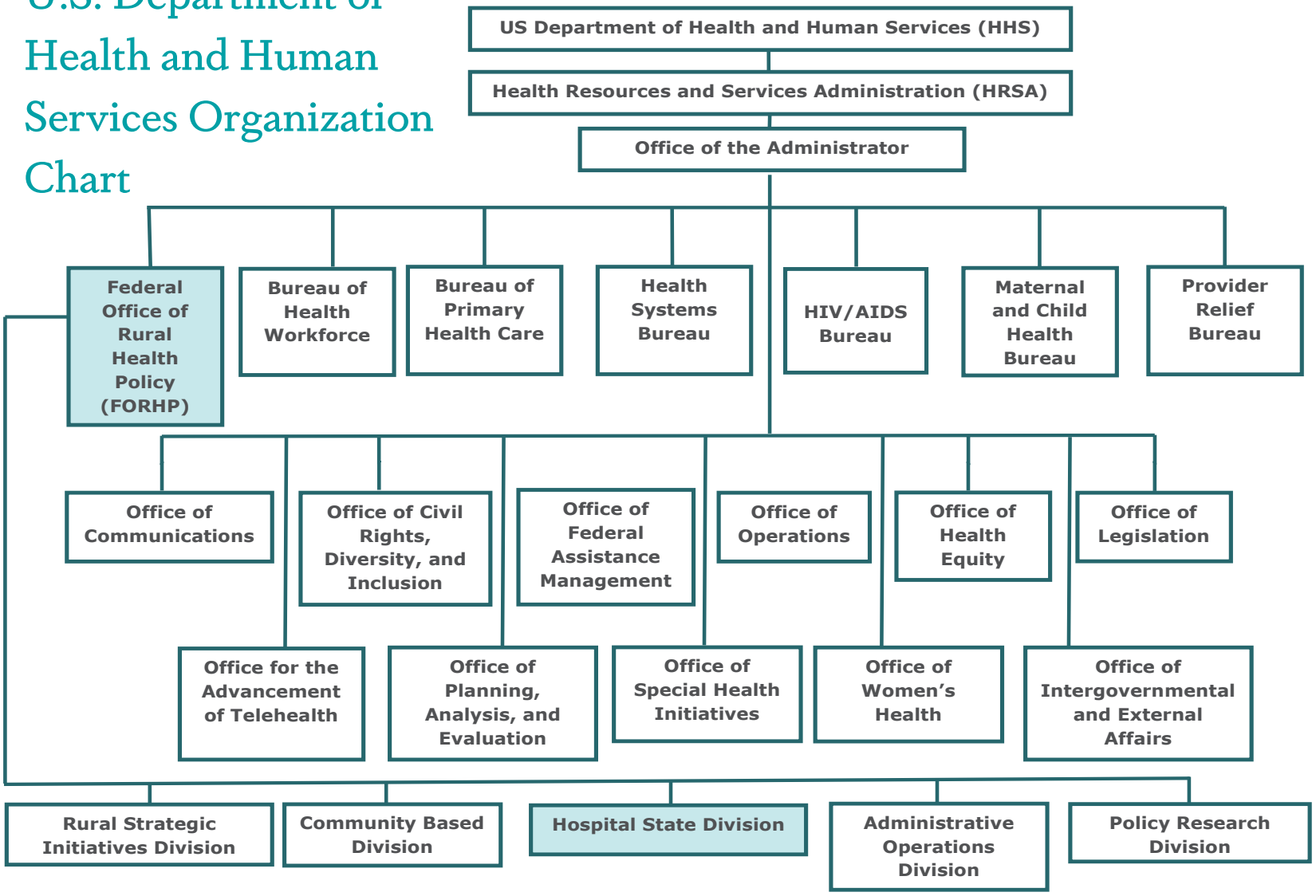
- CAHs that participated in Flex-funded improvement activities
- CAHs that improved on the measure or outcome that was the target of the activity
- EMS agencies that participated in Flex-funded improvement activities.
- Funds spent in each category of Flex activities
- Hospitals requesting and receiving help with CAH conversion

These reports document the important training, technical assistance, consultations, and other improvement projects provided to CAHs and rural health care organizations through the state Flex Programs. PIMS data improve program-wide measurement and evaluation and are used to calculate the Flex Program performance measures for the annual HRSA Budget Justification.

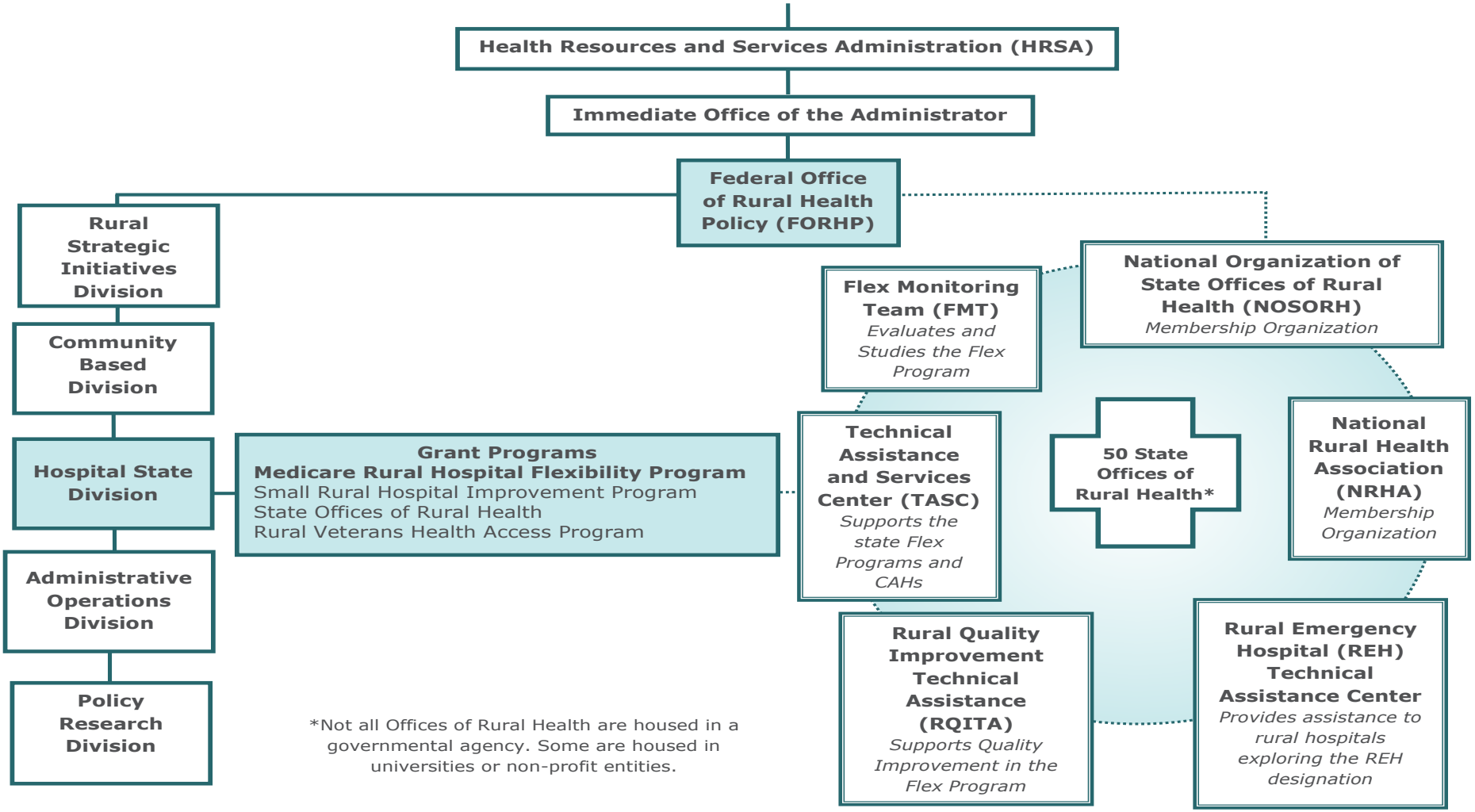
TASC and FORHP worked together to develop the PIMS Data Collection Tool to facilitate data collections and enable easy and accurate reporting by state Flex Programs. A webinar is recorded each year to explain the tool and updated PIMS reporting instructions for the fiscal year.

For questions on Flex PIMS data collection, please contact:
Laura Seifert, FORHP | lseifert@hrsa.gov | (301) 443-3343

U.S. Department of Health and Human Services Organization Chart



FORHP Organization Chart



Introduction to the Technical Assistance and Services Center

- TASC Staff
- TASC Communication Tools and Technical Assistance
- TASC Website
- FORHP Flex Program Workshop

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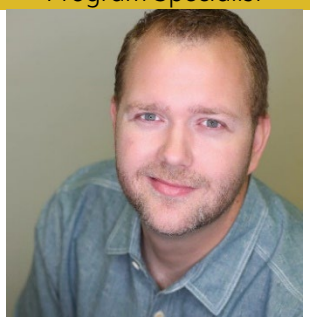

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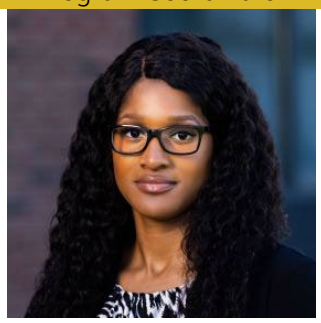

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TASC Communication Tools and Technical Assistance

The goal of TASC is to provide direct and timely information, education, tools, and resources that are easy for Flex Programs to use. TASC offers a variety of communication tools and technical assistance services.

Communication Tools

- TASC website
- TASC e-mail listservs
- TASC 90, Virtual Knowledge Groups (VKGs), and other educational webinars
- Podcasts
    - Apple iTunes
    - Google Podcasts
- Flex Program Forum
- Monthly electronic newsletter, *Rural Route*
- Social media
    - LinkedIn
    - Facebook
    - Twitter

For assistance getting signed up for the email listservs, webinars, Flex Program Forum, and Rural Route, please reach out to tasc@ruralcenter.org.

Technical Assistance

- Ad hoc TA via email and phone

    - E-mail: tasc@ruralcenter.org
    - Telephone: (218) 727-9390 or (877) 321-9393
- Educational presentations (onsite or virtual)
- Online resource library
- Consultant and subject matter expert speaker referrals
- Educational guides, manuals, and toolkits
- Learning collaboratives on specific topics to improve state Flex Program performance
- Semi-annual Flex Program Workshop for new state Flex Program personnel
- Annual Flex Program Reverse Site Visit (conference) for all state Flex Program personnel

TASC Website

The TASC website contains a wide variety of useful information, tools, and resources to support all program areas of the Flex cooperative agreement, including:

- Electronic version of the Flex Program Fundamentals Guide
- Flex cooperative agreement and Flex EMS supplement grant guidance and supporting documents
- Core Competencies for State Flex Program Excellence Guide and Self-Assessment
- Critical Access Hospital Recognition, and Hospital and Network Spotlights
- Flex Program Forum (login access required)
- Flex Program Reverse Site Visit information and materials
- Resources to support the Medicare Beneficiary Quality Improvement Project (MBQIP), including the MBQIP Monthly e-newsletter and Reporting Reminders
- Population Health Toolkit, data scenarios, resources, and population health readiness assessment

- Rural Community Ambulance Agency Transformation Toolkit, including self-assessment and resource collections
- State Flex profiles including current descriptions of Flex Program activities by program area, and state Flex Program staff contact information
- Upcoming and archived educational events, including TASC 90 webinars, Virtual Knowledge Group webinars, and Learning Collaborative recordings and supporting materials
- Health information technology (HIT) resources
- Leadership video series to educate CAH mid-level and board leaders in the transition to value-based care and payment

FORHP Flex Program Workshop

The FORHP Flex Program Workshop aims to provide new or existing state Flex Program staff an orientation to the Flex Program. Sessions are presented by TASC, FORHP, FMT, RQITA, and additional subject matter experts. Upon workshop completion, participants will better understand the Flex Program's goals and services available to support Flex Program excellence.

Attendance and Participation Requirements

As a condition of the state Flex Program cooperative agreement, state programs with new Flex Coordinators or Flex Program Directors are expected to attend the Flex Workshop within one year of their hire date. There is no fee to participate in the Flex Workshop. However, there are a few expectations for participating attendees:

- Complete the Core Competencies for State Flex Program Excellence self-assessment.
- Upon completing the workshop, participants will choose an activity to implement based on knowledge gained from the workshop related to the Core Competency self-assessment results. Participants receive individualized coaching and resources from TASC to support

the implementation of their chosen activity.

Workshop topics commonly include:

- History and direction of the Flex Program
- Program areas of the Flex Program
- Understanding the value-based health care system and resources to support rural value-based care and payment
- CAH finance and the top 10 financial indicators for CAHs
- CAH leadership perspectives panel discussion
- National quality initiatives and MBQIP
- Core Competencies for State Flex Program Excellence
- Rural emergency medical services (EMS) challenges and opportunities
- Community and population health
- Flex Program evaluation
- Best practices and tips for Flex Coordinators

The FORHP Flex Program Workshop is held twice a year, generally in April and October. While there is no charge to attend the workshop, state Flex Programs are required to pay for their travel to and from Duluth, MN, where the in-person events are held. Travel and lodging expenses are allowable as part of the Flex grant.

During the public health emergency (PHE), Flex Workshops were held virtually, but have recently resumed in-person. We will continue to make decisions on in-person versus virtual workshops for the foreseeable future in response to the PHE and pandemic. TASC and FORHP will make timely announcements about the location and logistics of future workshops.

For more information about the FORHP Flex Program Workshop, please contact TASC at tasc@ruralcenter.org or (877) 321-9393.

Flex Monitoring Team

- FMT Staff
- About the FMT
- How the FMT Can Help You
- Ongoing Projects
- New Projects 2021-2022
- Research Publications
- Contact the FMT

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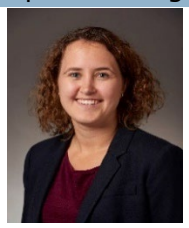

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Flex Program Fundamentals

About the Flex Monitoring Team

INTRODUCTION

The Flex Monitoring Team (FMT) is a consortium of researchers from the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. With a five-year (2018–23) cooperative agreement award (PHS Grant No. U27RH01080) from the Federal Office of Rural Health Policy (FORHP), the FMT monitors and evaluates the Flex Program by developing relevant quality, financial, and community-benefit performance measures and reporting systems. FMT research assesses the impact of the Flex Program on Critical Access Hospitals (CAHs) and rural communities. The team also examines the ability of the State Offices of Rural Health to achieve overall Flex Program objectives: improving access to quality health care services, improving the financial and operational performance of CAHs, and engaging rural communities in healthcare system development.

HOW THE FLEX MONITORING TEAM CAN HELP YOU

The FMT's researchers have years of experience examining topics that are directly relevant to CAHs and the Flex Program. Ongoing and annual research projects typically result in publications that state Flex Coordinators can use to gain a better understanding of CAH financial and operational performance, quality performance, and community impact to support your work (presentations and meetings, grant applications, publications, etc.) with CAH-relevant evidence. The FMT website provides access to all FMT publications, presentation slides, data reports, project descriptions, and more.

The Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS) is an online data query system that allows state Flex Coordinators to explore the financial, quality, and community-benefit performance of CAHs. The financial data portal requires an authorized login and password made available to state Flex Coordinators, State Office of Rural Health directors, and CAH CEOs and CFOs. Financial data for CAHs in your state are identified by name; however, data for CAHs in other states are shown but not identified. New developments to the financial portal include data visualizations showing predicted risk of CAH financial distress and showing state-level CAH reporting and performance on select financial indicators as compared to national benchmarks. Quality and community data are aggregated to the state level and publicly available without a login on the CAHMPAS site. For quality performance, users can create customized tables and

graphs with Medicare Beneficiary Quality Improvement Project (MBQIP) data, make comparisons between states, and create tables and graphs for individual or pre-defined sets of measures. Community data also allow users to create customized reports with measures related to community socioeconomic characteristics, health outcomes, health risks and behaviors, and more. Visit the CAHMPAS website for more information and, for financial CAHMPAS login credentials, contact the FMT at monitoring@flexmonitoring.org.

The FMT uses an email listserv to disseminate reports and publications. As a state Flex Coordinator, you are automatically subscribed to this list as a requirement of your grant award. Other Flex Program/CAH staff in your state can easily subscribe by contacting the FMT or submitting information via the FMT's homepage.

ONGOING PROJECTS

Analyzing Financial, Quality, and Community Impact Performance of CAHs
Purpose: to improve financial, quality, and community impact performance of CAHs through data analysis and dissemination in the three domains. The project will produce numerous data products on financial, quality, and community impact, using a variety of data sources, including the American Hospital Association Annual Survey, the Hospital Compare database, and the Medicare Beneficiary Quality Improvement Project (MBQIP).

CAHMPAS Query System Maintenance, Enhancement, and Development
Purpose: to prepare and upload updated data for CAHMPAS, develop new and maintain existing features on the website, and provide technical assistance to registered users. In the coming year, this project will refine the financial dashboard and enhance user functions for the financial, quality, and community data to provide

information in the most useable format for CAHs and state Flex Coordinators.
Maintaining and Updating the National CAH Database
Purpose: to continue tracking CAH conversions and closures. A CAH dataset housed at the University of North Carolina will be updated with information on conversions supplied by the Centers for Medicare and Medicaid Services (CMS). These data are

also used to update products on the FMT website, including a spreadsheet that lists all certified CAHs and a map of current CAHs. The site also includes a table that contains state-level totals of the number of CAHs, the number of CAHs with rehabilitation distinct part units (DPU), and the number of CAHs with psychiatric DPUs.

NEW PROJECTS, 2022–2023

Final Evaluation of the Flex QI Project
This project will build upon previous FMT work to collect data from SFPs after the completion of the Flex QI Project and Quality Innovation Labs (QILs), initiatives launched in September 2021 by the Federal Office of Rural Health Policy (FORHP). The objectives are to: collect and analyze data from SFPs; collect data from participating CAHs; and provide a final report evaluating the QI project overall.

Identifying Outcome Measures: Population Health Improvement and Rural EMS Improvement
Population Health Improvement and Program Area 4: Rural Emergency Medical Services (EMS) Improvement are ongoing, optional areas of SFP activity and remain challenging areas for SFPs to develop appropriate initiatives and to monitor outcomes. As a result, the purpose of this project will explore and identify short, intermediate, and long-term outcome measures for common initiatives under these program areas.

Financial Impact of COVID-19 on CAHs
The COVID-19 pandemic has disrupted the operations of hospitals nationally. However, little is known about the overall impact of COVID-19 on the financial performance and condition of CAHs. Through an examination of financial indicators

of CAHs in the five years before (2015-19) and during (2020-21) the COVID-19 pandemic, this research will provide SFPs with some context to help them interpret financial data in the years affected by the pandemic as compared to pre-pandemic years.

Advanced Electronic Health Record Use and Quality Measure Performance
Though the proportion of CAHs using at least a basic EHR is comparable to non-CAHs, CAHs are less likely to have advanced EHR functions as well as report using advanced clinical data analytics in their EHR than non-CAHs. The objectives are to assess the relationship between EHR use and quality measure reporting and performance in CAHs; evaluate how CAHs may differ from non-CAHs in their EHR capabilities; and provide an overview of how CAHs use EHRs for quality reporting.

Enhancement of Antibiotic Stewardship Programs in CAHs
Given the high level of performance achieved by CAH antibiotic stewardship programs (ASPs), it is valuable to supplement the existing measures with additional data to continue to inform program development. The FMT will investigate opportunities for further growth in the antibiotic stewardship measure for CAHs, including the potential use of antibiotic use (AU) data, the new "advanced" criteria for meeting CDC Antibiotic Stewardship Program requirements, and a further qualitative assessment of the activities CAHs engage in within each core element.

CAH Emergency Preparedness Planning
Building on the FMT's extensive body of work related to the role of CAHs in supporting the health of their communities, this project will examine challenges faced by CAHs in complying with federal regulations on emergency preparedness planning. Furthermore, this study aims to identify technical assistance and other resources to support development and implementation of the emergency response plans of CAHs.

Rural Hospital Transformation Programs
This study will examine rural hospital transformation programs designed to improve the performance of CAHs and other rural hospitals. These transformation programs are designed to help CAHs and other rural hospitals better serve the needs of their communities by enhancing their sustainability and financial viability, improving the health of their patients, managing chronic conditions, and maintaining their ability to provide necessary healthcare services.

RESEARCH PUBLICATIONS

The Flex Monitoring Team publishes research findings in the form of briefing papers (detailed, comprehensive reports), policy briefs (shorter overviews paired with key findings), data summary reports (comprehensive collections of data), topic-specific toolkits, and state-specific reports.

All publications are searchable on the website by topic, date, or keyword and are freely available for download. The Flex Monitoring Team's most recent publications include:

- Rates of Limited English Proficiency in Counties with Critical Access Hospitals
- Interpretation Services for Patients with Limited English Proficiency in Critical Access Hospitals
- MBQIP Quality Measures National Annual Report – 2021
- Financial Characteristics of Critical Access Hospitals Participating in Accountable Care Organizations
- Delivery of Cancer Screening and Treatment in Critical Access Hospitals
- Community Impact and Benefit Activities of Critical Access, Other Rural, and Urban Hospitals, 2020
- Supporting Critical Access Hospital Staff during COVID-19
- 2020 CAH Financial Indicators Report: Summary of Indicator Medians by State
- Year Two Evaluation of the Flex EMS Supplemental Funding Projects: Building an Evidence Base through Outcome Measurement
- Evaluating State Flex Program Population Health Activities
- An Inventory of State Flex Program Population Health Initiatives for Fiscal Years 2019-2023
- Outcome Measures for State Flex Program Financial and Operational Improvement Interventions
- Critical Access Hospitals' Initial Response to COVID-19 by System Affiliation

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Rural Quality Improvement Technical Assistance

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- MBQIP Technical Assistance Requests
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Rural Quality Improvement Technical Assistance (RQITA)

About RQITA

Demonstrating value through reporting and improving quality measures has become increasingly important for small rural hospitals and clinics. But understanding quality reporting systems and using data for improvement can be particularly challenging for rural health care organizations with limited resources.

Through the RQITA cooperative agreement with the Federal Office of Rural Health Policy (FORHP), Stratis Health aims to fill these gaps, focusing on improving quality and health outcomes in rural communities across the country by providing technical assistance to beneficiaries of quality initiatives, including:

- Small Health Care Provider Quality Improvement Grantees (Rural Quality Program)
- Medicare Rural Hospital Flexibility (Flex) Program, including the Medicare Beneficiary Quality Improvement Project (MBQIP)

- For more information about the RQITA project, visit the Stratis Health RQITA webpage.
- Learn more about the team by reviewing the RQITA Team Biographies.

About Stratis Health

Stratis Health is an independent nonprofit with more than 50 years of furthering the organizational mission to collaborate and innovate to improve health. For more information about Stratis Health, visit the Stratis Health website.

- Nationally recognized experts in rural health quality; longstanding trusted relationships with rural providers, critical access hospitals (CAHs), state offices of rural health, and FORHP.
- Other federal roles include serving as a Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) and as a partner in the FORHP funded Rural Health Value team.

- Through RQITA, Stratis Health works to implement technical assistance to support quality reporting and improvement, collaborating with FORHP and other partners, including:
    - Technical Assistance and Services Center (TASC)
    - Flex Monitoring Team (FMT)
    - State Flex Programs
    - Georgia Health Policy Center (Rural Quality Program technical assistance provider)

MBQIP Tools and Resources

MBQIP tools and resources are posted on the TASC MBQIP webpage. Some key resources include:

- **MBQIP Fundamentals Guide for State Flex Programs:** Intended to help state Flex Program personnel and relevant subcontractors understand the basics of MBQIP, including current state and history of the program, as well as key resources available to support them in their work.
- **MBQIP Monthly:** Monthly e-newsletter that provides CAHs with information and support for quality reporting and improvement.
- **MBQIP Quality Reporting Guide:** Helps Flex coordinators, CAH staff, and others involved with MBQIP understand the measure reporting process. For each reporting channel, information is included on how to register for the submission site, which measures are reported to the site, and how to submit those measures to the site.
- **Quality Improvement Basics Course**: A series of recordings and related resources designed to equip professionals (state Flex programs, CAHs, emergency medical service personnel, etc.) with the knowledge and tools to start quality improvement projects at their organizations. The course may be completed in sequence or individual modules and tools may be used for stand-alone training and review.
- **Quality Improvement Implementation Guide and Toolkit for CAHs:** Offers strategies and resources to help CAH staff organize and support efforts to implement best practices for quality improvement.
- **MBQIP Data Reporting Reminders:** Reminders of upcoming data submission deadlines for MBQIP measures, posted monthly for Flex staff to cut and paste into their state CAH communications as appropriate.
- **MBQIP Measure Fact Sheets:** One-page summaries of all MBQIP required measures.

Additional support

- **MBQIP Individualized Technical Assistance and Consultations:** RQITA team members are available for one-on-one discussions with Flex staff and/or MBQIP subcontractors to help support state level implementation (email RQITA staff directly or reach out to tasc@ruralcenter.org to get connected).
- **MBQIP Orientation Sessions:** RQITA offers orientation sessions for new state Flex staff, which are typically facilitated in follow up to orientation with the TASC team. These orientation sessions are also available for state Flex staff and MBQIP subcontractors upon request. Email tasc@ruralcenter.org to get connected.
- **MBQIP Virtual Knowledge Groups (VKGs):** A facilitated forum for state Flex Program personnel and subcontractors to share quality reporting and improvement successes, discuss challenges, and brainstorm strategies to assist hospitals toward reporting, improving, and excelling in quality. Recordings of past VKG webinars are made available in the Flex Program Forum.
- **Quality Training and Presentations:** RQITA team members are available to present at webinars and/or in-person training events and workshops.

MBQIP Technical Assistance Requests

Process for MBQIP technical assistance requests/questions:

- CAHs are encouraged to contact their state Flex Program as the first line of MBQIP support.
- Flex Coordinators should direct MBQIP questions to TASC, tasc@ruralcenter.org. TASC serves in a triage role to respond and resolve or forward to RQITA or FORHP as appropriate.
- TASC and RQITA have processes to connect with state Flex Coordinators when contacted directly by CAH.

Rural Quality Advisory Council

RQITA facilitates a quarterly Rural Quality Advisory Council on behalf of FORHP. The Council is comprised of leaders in rural health quality, representing diverse perspectives from across the country. The purpose of the Council is to:

- Provide feedback, guidance, and insight on the development, implementation, and evaluation of the RQITA technical assistance strategies for the MBQIP and SCHPQI programs.
- Offer advice and counsel on development of rural-relevant quality improvement goals and metrics, and their integration more broadly into new and existing FORHP funded programs.

Need more information?

Contact Sarah Brinkman, sbrinkman@stratishealth.org or 952-853-8552.

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Flex Coordinator Reference

- Useful Organizations
- Acronyms 101
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Useful Organizations

National Rural Health Resource Center

The Center is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

TASC, a program of The Center, provides information, tools, and education to CAHs and to individual state Flex Programs.

Federal Office of Rural Health Policy

FORHP was created in 1987 to advise the Secretary of HHS on health care issues impacting rural communities, including:

- Access to quality health care and health professionals
- Viability of rural hospitals
- Effect of the Department's proposed rules and regulations, including Medicare and Medicaid, on access to and financing of health care in rural areas

In line with the mission of HRSA, FORHP helps increase access to care for underserved populations and builds health care capacity through several programs:

Rural Community Programs - Provides support to community organizations to improve health care service delivery and strengthen health networks and encourages collaboration among rural health care providers.

State and Rural Hospital Programs - Supports on-going improvements in care to 50 SORHs and to rural hospitals through the Flex Program. State and Rural Hospital Programs also supports technical assistance for small rural hospitals, including CAHs.

Rural Health Research and Policy Programs - Coordinates the review of proposed regulations to assess the potential impact on rural health care delivery and financing, the division also supports eight Rural Health Research Centers across the country and staffs the National Advisory Committee on Rural Health & Human Services.

Rural Strategic Initiatives Division (RSID) - Coordinates the Rural Communities Opioid Response Program (RCORP) and other new initiatives such as the COVID-19 Tribal program.

Flex Monitoring Team

The Flex Monitoring Team (FMT) is a consortium of researchers from the Universities of Minnesota, North Carolina-Chapel Hill, and Southern Maine. They are funded by the FORHP to evaluate the impact of the Flex Program. The FMT also operates and maintains CAHMPAS for easy access to financial, quality, and community benefit measures.

All of their efforts aim to improve the accessibility, viability, and quality of health care for rural residents and communities. They provide state Flex Programs and CAHs with ways to optimize their performance based on evidence and/or best practices. FMT conducts analyses, collects and tracks

state-level CAH data, maintains a national database of CAHs, consults with their expert workgroup for feedback and input, collaborates with TASC and other organizations to provide project services, and shares findings at meetings, webinars, and conferences. The FMT's work focuses on three main topic areas: quality, finance, and community engagement.

Rural Quality Improvement Technical Assistance

The goal of the Rural Quality Improvement Technical Assistance (RQITA) is to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of FORHP quality initiatives, which are focused on quality measure reporting and improvement: Small Health Care Provider Quality Improvement (SHCPQI) and MBQIP. RQITA is intended to add expertise related to quality reporting and improvement by working closely with FORHP and technical assistance partners. RQITA is a program of Stratis Health, an independent nonprofit organization that leads collaboration and innovation in health care quality and patient safety.

Resources to support MBQIP can be found on the MBQIP webpage.

Agency for Healthcare Research and Quality

The Agency for Healthcare Research and Quality's (AHRQ) mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within HHS and with other partners to ensure the evidence is understood and used. AHRQ's broad programs of research bring practical, science-based information to medical practitioners and to consumers and other health care purchasers.

The American Health Quality Association

The American Health Quality Association (AHQA) is an educational, not-for-profit, national membership association dedicated to promoting and facilitating fundamental change that improves the quality of health care in America. AHQA represents Quality Improvement Organizations (QIOs) and professionals working to improve health care quality and patient safety.

American Hospital Association

The American Hospital Association (AHA) is a national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. Through representation and advocacy activities, AHA ensures that members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters. AHA provides education for health care leaders and is a source of information on health care issues and trends.

Bureau of Labor Statistics

The Bureau of Labor Statistics (BLS) of the U.S. Department of Labor is the principal federal agency responsible for measuring labor market activity, working conditions, price changes, and productivity in the economy. BLS is an independent national statistical agency that collects, analyzes, and disseminates essential economic information to support public and private decision-making.

Center for Connected Health Policy

The Center for Connected Health Policy (CCHP) is a nonprofit, nonpartisan organization working to maximize telehealth's ability to improve health outcomes, care delivery, and cost effectiveness. Established in 2008, CCHP acts as a catalyst for change by providing nonpartisan, unbiased, and

research-based analyses, reports, and telehealth resources to policy makers, the private health care sector, health plans, academic researchers, and consumer health advocates. CCHP's mission is to advance state and national telehealth policies that promote better systems of care, improved health outcomes, and provide more equitable access to quality, affordable health care and services.

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) is a federal agency within HHS tasked with strengthening and modernizing America's health care system while providing quality care at lower costs. More than 100 million people are covered through the CMS managed programs of Medicare, Medicaid, the Health Insurance Marketplace, and the Children's Health Insurance Program (CHIP). CMS is comprised of 10 regional offices with staff who work collaboratively with state and local representatives to provide oversight and foster innovation.

The Commonwealth Fund

The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

Georgia Health Policy Center

The Georgia Health Policy Center (GHPC) provides evidence-based research, program development and policy guidance to improve health status at the community level. The center conducts, analyzes and disseminates qualitative and quantitative findings to connect decision makers with the objective

research and guidance needed to make informed decisions about health policy and programs. The center provides technical assistance under contract with FORHP to rural health networks.

Health Resources and Services Administration

The mission of the Health Resources and Services Administration (HRSA), an agency of HHS, is to improve health outcomes and achieve health equity through access to quality services, a skilled health workforce and innovative high-value programs. HRSA's programs, including those overseen by the FORHP, provide health care to people who are geographically isolated, economically, or medically vulnerable.

Institute for Healthcare Improvement

The Institute for Healthcare Improvement (IHI), an independent, not-for-profit organization, is a recognized innovator, convener, leader, trustworthy partner, and driver of results in health and health care improvement worldwide. IHI's strategy to improve health and health care worldwide has four key areas: improve the health of populations, build the capacity to improve, and innovate and spark action. IHI works with a wide range of entities to seek and achieve science-based improvements in health and health care.

The Joint Commission

An independent, not-for-profit organization, the Joint Commission accredits and certifies nearly 22,000 health care organizations and programs in the US. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

MedlinePlus

MedlinePlus is the National Institutes of Health's (NIH) website for patients and their families and friends. Produced by the National Library of Medicine, MedlinePlus is the world's largest medical library, providing free, reliable, up-to-date information about diseases, conditions, and wellness issues. Resources include directories, a medical encyclopedia, a medical dictionary, health information in Spanish, extensive information on prescription and nonprescription drugs, health information from the media, and links to thousands of clinical trials.

National Center for Health Statistics

The National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention (CDC) is the nation's principal health statistics agency. NCHS compiles statistical information to guide actions and policies to improve health. NCHS is a unique public resource for health information.

National Consortium of Telehealth Resource Centers

The National Consortium of Telehealth Resource Centers (TRCs) provides assistance, education, and information to those individuals and organizations that are providing or are interested in providing health care via telehealth. With funding through the HRSA Office for the Advancement of Telehealth (OAT), the consortium of 12 regional and two national TRCs assist to expand the availability of health care to rural and underserved populations.

National Cooperative of Health Networks Association

The National Cooperative of Health Networks Association (NCHN) is a national, professional membership organization comprised exclusively of health networks, alliances, and/or consortiums dedicated to supporting the success of health networks.

National Library of Medicine

The National Library of Medicine (NLM) has been a center of information innovation since its founding in 1836. The world's largest biomedical library, NLM maintains and makes available a vast print collection and produces electronic information resources on a wide range of topics. NLM also supports and conducts research, development, and training in biomedical informatics and health information technology.

National Organization of State Offices of Rural Health

The National Organization of State Offices of Rural Health (NOSORH) was established in 1995 to assist State Offices of Rural Health (SORHs) in their efforts to improve access to, and the quality of, health care for America's 57 million rural citizens. NOSORH enhances the capacity of SORHs to do this by supporting the development of state and community rural health leaders; creating and facilitating state, regional and national partnerships that foster information sharing and spur rural health-related programming; and enhancing access to quality health care services in rural communities.

National Rural Health Association

The National Rural Health Association (NRHA) is a national, nonprofit membership of more than 21,000 members, whose mission is to provide leadership on rural health issues through advocacy, communications, education, and research. NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

National Rural Recruitment & Retention Network

The National Rural Recruitment & Retention Network (3RNet) is a nonprofit, membership organization who works to improve rural and underserved communities' access to quality health care through recruitment of physicians and other health care professionals, development of community-based recruitment and retention activities, and national advocacy relative to rural and underserved health care workforce issues. The 3RNet is the national leader for community-based health professional recruitment and retention, using interactive technologies and communication.

National EMS Quality Alliance

The National EMS Quality Alliance (NEMSQA) develops and endorses evidence-based quality measures for EMS and healthcare partners that improve the experience and outcomes of patients and care providers with a vision of improving patient outcomes through the collaborative development of quality measures for EMS and health systems of care.

Nursing Home Resource Center

CMS launched the Nursing Home Resource Center to serve as a centralized hub bringing together the latest information, guidance, clarification, instructions, and recent COVID-related policies and data on nursing homes that is important to facilities, frontline providers, residents, and their families.

Office for the Advancement of Telehealth

The Office for the Advancement of Telehealth (OAT) promotes telehealth as a way to deliver health care and supports the efforts of HHS to expand access and improvement health outcomes. OAT provides telehealth grant programs to promote and advance telehealth services in rural areas.

Rural Health Information Hub

The Rural Health Information Hub (RHIhub is funded by FORHP to be a national clearinghouse on rural health issues. RHIhub is committed to supporting health care and population health in rural communities. RHIhub provides access to current and reliable resources and tools to learn about rural health needs and work to address them.

Rural Health Innovations

Rural Health Innovations (RHI), LLC is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation's leading technical assistance and knowledge centers in rural health. In partnership with The Center, RHI enhances the health of rural communities by providing products and services with a focus on excellence and innovation.

Rural Health Redesign Center

The Rural Health Redesign Center a nonprofit committed to addressing the challenges facing rural hospitals and communities across the nation. RHRC is a FORHP funded technical assistance to rural hospitals exploring the Rural Emergency Hospital (REH) designation.

Rural Health Value

Rural Health Value is a cooperative agreement between the FORHP, the RUPRI Center for Rural Health Policy Analysis (RUPRI Center), and Stratis Health. The Rural Health Value Team will analyze rural implications of changes in the organization, finance, and delivery of health care services and will assist rural communities and providers transition to a high- performance rural health system. The RUPRI Center brings experience in a variety of research strategies including survey design, qualitative analysis, simulation development, and national database query and report design.

Rural Policy Research Institute

The Rural Policy Research Institute (RUPRI) undertakes unbiased research and analysis on the challenges, needs, and opportunities facing rural America. RUPRI's reach is national and international and is recognized as a trusted source of research-grounded expertise regarding the rural differential in public policies. RUPRI's activities encompass research, policy analysis and engagement, dissemination and outreach, and decision support tools. Through their work, RUPRI aims to foster public dialogue and help policymakers understand the impacts of public policies and programs on rural people and places.

Texas A&M Health Science Center for Optimizing Rural Health

The Center for Optimizing Rural Health is a program of the Texas A&M Health Science Center (TAMHSC) Rural and Community Health Institute (ARCHI). This FORHP funded technical assistance center supports the Targeted Technical Assistance for Rural Hospitals Program (TTAP), previously the Vulnerable Rural Hospital Assistance Program. This program provides targeted in-depth assistance to vulnerable rural hospitals within communities that are struggling to maintain health care services.

U.S. Department of Health and Human Services

The mission of the U.S. Department of Health and Human Services (HHS) is to enhance the health and well-being of all Americans. This is achieved by providing for effective health and human services and by fostering sound, sustained advances in medicine, public health, and social services. The department is comprised of 11 operating divisions, including HRSA, which oversee a wide spectrum of activities. The FORHP is located within HRSA and is charged with informing and advising HHS on matters affecting rural hospitals and health care, coordinating activities within the department that relate to rural health care and maintaining a national information clearinghouse.

Acronyms 101

3RNet .....National Rural Recruitment and Retention Network

AAA .....American Ambulance Association

AAFP.....American Academy of Family Physicians

ACA .....Affordable Care Act or Patient Protection and Affordable Care Act

ACHE .....American College of Healthcare Executives

ACLS.....Advanced Cardiac Life Support

ACO.....Accountable Care Organization

ACS.....American College of Surgeons

ADC .....Average Daily Census

ADE.....Adverse Drug Event

AED.....Automated External Defibrillator

AFIB.....Atrial Fibrillation

AFS.....Ambulance Fee Schedule

AHA .....American Hospital Association

AHC .....Accountable Health Communities Model or Academic Health Center

AHIMA.....American Health Information Management Association

AHQA .....American Health Quality Association

AHRQ .....Agency for Healthcare Research and Quality

AIM.....ACO Investment Model

AIMS .....Access Increases in Mental Health and Substance Abuse Services

AIR.....All Inclusive Rate

ALOS .....Average Length of Stay

ALS.....Advanced Life Support

AMA.....American Medical Association or Against Medical Advice

AMC.....Academic Medical Center

AMI.....Acute Myocardial Infarction

AMIA.....American Medical Informatics Association

ANA .....American Nurses Association

APC.....Ambulatory Payment Classification

APM .....Alternative Payment Model or Advanced Alternative Payment Model

AR .....Accounts Receivable

ARP .....American Rescue Plan

ARRA .....American Recovery and Reinvestment Act of 2009

ASC.....Ambulatory Surgical Center

ASP.....Antibiotic Stewardship Program

ATLS .....Advanced Trauma Life Support

BBA .....Balanced Budget Act of 1997

BBRA.....Balanced Budget Refinement Act of 1999

BCBS .....Blue Cross Blue Shield

BCHS.....Bureau of Community Health Services

BFCC.....Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)

BHP .....Bureau of Health Professions

BHW.....Bureau of Health Workforce

BHRD .....Bureau of Health Resources Development

BIA.....Bureau of Indian Affairs

BIPA.....Benefits Improvement and Protection Act of 2000

BLS .....Bureau of Labor Statistics or Basic Life Support

BPHC.....Bureau of Primary Health Care

BSC .....Balanced Scorecard

BTLS.....Basic Trauma Life Support

CAC .....Children's Asthma Care

CAH .....Critical Access Hospital

CAHFIR.....Critical Access Hospital Financial Indicator Report (FIR)

CAHMPAS.....Critical Access Hospital Measurement and Performance Assessment System

CALS.....Comprehensive Advanced Life Support

CAP.....Community Access Program

CARES Act.....Coronavirus Aid, Relief, and Economic Security Act

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

CAUTI.....Catheter-Associated Urinary Tract Infection

CBO .....Congressional Budget Office

CBSA.....Core Based Statistical Area

CC.....Care Coordination

CCHIT.....Certification Commission for Healthcare Information Technology

CCM.....Coordinated Care Model or Chronic Care Management

CCN .....CMS Certification Number

CCO.....Coordinated Care Organization or Community Care Organization

CDC .....Centers for Disease Control and Prevention

CDE.....Clinical Data Exchange

CDI .....*Clostridioides difficile* (*C. diff.*) Infection

CDS.....Clinical Decision Support

CEO .....Chief Executive Officer

CEHRT .....Certified Electronic Health Record Technology

CEU.....Continuing Education Unit

CFO.....Chief Financial Officer

CFR .....Code of Federal Regulations

CHC .....Community Health Center

CHART..... Community Health Access and Rural Transformation Model

CHIP.....Children's Health Insurance Program

CHNA .....Community Health Needs Assessment

CHW .....Community Health Worker

CIHQ.....Center for Improvement in Healthcare Quality

CIT .....Critical Illness and Trauma Foundation

CLABSI.....Central Line-Associated Bloodstream Infection

CLIA .....Clinical Laboratory Improvement Act of 1967 or Clinical Laboratory Improvement Amendments of 1988

CME .....Continuing Medical Education

CMHC.....Community Mental Health Center

CMMI .....Center for Medicare and Medicaid Innovation

CMO .....Chief Medical Officer

CMS .....Centers for Medicare and Medicaid Services

CON.....Certificate of Need

CoP.....Conditions of Participation

COPD.....Chronic Obstructive Pulmonary Disease

COVID-19..... Coronavirus Disease 2019

CP.....Community Paramedic or Community Paramedicine

CPC/CPC+.....Comprehensive Primary Care Initiative/Comprehensive Primary Care Plus Initiative

CPHQ.....Certified Professional in Healthcare Quality

CP-MIH .....Community Paramedicine-Mobile Integrated Health

CPOE .....Computerized Provider Order Entry

CPT .....Current Procedural Terminology

CQI.....Continuous Quality Improvement

CQM .....Clinical Quality Measure

CRNA.....Certified Registered Nurse

CY .....Calendar Year

DACA.....Data Accuracy and Completeness Acknowledgement

DEI.....Diversity, Equity, and Inclusion

DGME .....Direct Graduate Medical Education

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

DME .....Durable Medical Equipment

DNV .....Det Norske Veritas Healthcare (accrediting agency)

DPU.....Distinct Part Unit

DON.....Director of Nursing

DOQ-IT.....Doctor's Office Quality – Information Technology

DRG .....Diagnosis Related Group

DSA .....Disproportionate Share Adjustment

DSH.....Disproportionate Share Hospital

DUNS.....Dun and Bradstreet Universal Numbering System

DVT.....Deep Vein Thrombosis

EACH .....Essential Access Community Hospital

ECG.....Electrocardiogram

eCQM .....Electronic Clinical Quality Measure

ED.....Emergency Department

EHDI.....Early Hearing Detection and Intervention

EDIE .....Emergency Department Information Exchange

EDTC .....Emergency Department Transfer Communication

eHI.....e-Health Initiative

EHB .....Electronic Handbook

EHR .....Electronic Health Record

EMR.....Electronic Medical Record, Emergency Medical Responder

EMS.....Emergency Medical Services

EMT.....Emergency Medical Technician

EMTALA .....Emergency Medical Treatment and Labor Act

ESRD .....End Stage Renal Disease

FACHE .....Fellow of the American College of Healthcare Executives

FCC .....Federal Communications Commission

FCHIP.....Frontier Community Health Integration Project

FEC.....Freestanding Emergency Center

FEMA .....Federal Emergency Management Association

FESC.....Frontier Extended Stay Clinic

FFR .....Federal Financial Report

FFS .....Fee-for-Service

FFR .....Federal Financial Report

FHSR .....Foundation for Health Services Research

FI.....Fiscal Intermediary

FIR .....Financial Indicators Report

Flex .....Medicare Rural Hospital Flexibility Program

FMT.....Flex Monitoring Team

FOA.....Funding Opportunity Announcement

FOIA.....Freedom of Information Act

FORHP.....Federal Office of Rural Health Policy

FQHC.....Federally Qualified Health Center

FTE .....Full-Time Equivalent

FY .....Fiscal Year

GAO.....Government Accountability Office

GEMT.....Ground Emergency Medical Transport

GI.....Gastrointestinal

GME .....Graduate Medical Education

GMS.....Grants Management Specialist

GPRA .....Government Performance and Results Act

HAC .....Hospital Acquired Condition

HACRP.....Hospital Acquired Conditions Reduction Program

HAI .....Health Care-Associated Infection

HCAHPS .....Hospital Consumer Assessment of Healthcare Providers and Systems

HCPCS.....Healthcare Common Procedure Coding System

HCP.....Health Care Personnel

HCRIS.....Healthcare Cost Report Information System

Health IT .....Health Information Technology

HEN.....Hospital Engagement Network (see HIIN)

HFAP.....Healthcare Facilities Accreditation Program

HHA .....Home Health Agency

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

HIE.....Health Information Exchange

HIIN .....Hospital Improvement Innovation Network (formerly HEN)

HIMSS .....Healthcare Information and Management Systems Society

HIPAA .....Health Information Portability and Accountability Act

HIQR .....Hospital Inpatient Quality Reporting Program

HISPC.....Health Information Security and Privacy Collaboration

HIT .....Health Information Technology

HITECH.....Health Information Technology for Economic and Clinical Health Act

HITEQ .....Health Information Technology Evaluation, and Quality Center

HITSP .....Health Information Technology Standards Panel

HOQR.....Hospital Outpatient Quality Reporting Program

HPC.....Health Policy Commission

HPSA.....Health Professional Shortage Area

HRET.....Health Research & Education Trust (affiliate of AHA)

HRSA .....Health Resources and Services Administration

HSA.....Health Savings Account; or Health Systems Agency

HTN.....Hypertension

HUD.....Housing and Urban Development

IAFC .....International Association of Fire Chiefs

IAFF.....International Association of Fire Fighters

IBH.....Integrated Behavioral Health

ICT .....Information and Communication Technology

ICD-10 .....International Classification of Diseases – 10th Edition

ICU .....Intensive Care Unit

IHI.....Institute for Healthcare Improvement

IHS.....Indian Health Services

IOM .....Institute of Medicine

IP .....Inpatient

IPAB.....Independent Payment Advisory Board

IPPS .....Inpatient Prospective Payment System

IRF .....Inpatient Rehabilitation Facility

IRS .....Internal Revenue Service

IQR .....Inpatient Quality Reporting Program

IT .....Information Technology

JCAHO .....Joint Commission on Accreditation of Healthcare Organizations (the Joint Commission)

JCREC.....Joint Committee on Rural Emergency Care

LAN .....Learning Action Network

LOS .....Length of Stay

LPN.....Licensed Practical Nurse

LTC .....Long Term Care

LTCF .....Long Term Care Facility

MAC.....Medicare Administration Contractor

MACRA.....Medicare Access and CHIP Reauthorization Act of 2015

MAF .....Medical Assistance Facility

MAT .....Medication-Assisted Therapy

MBQIP.....Medicare Beneficiary Quality Improvement Project

MCO .....Managed Care Organization

MDH .....Medicare Dependent Hospital

MedPAC .....Medicare Payment and Advisory Commission

MIH .....Mobile Integrated Health

MIPPA .....Medicare Improvements for Patients and Providers Act of 2008

MIPS.....Merit-based Incentive Payment System

MMA .....Medicare Prescription Drug, Improvement and Modernization Act of 2003

MOA .....Memorandum of Agreement

MOU.....Memorandum of Understanding

MPI .....Master Patient Index

MRSA.....Methicilllin-resistent *Staphylococcus aureus*

MSA .....Metropolitan Statistical Area

MSSP.....Medicare Shared Savings Program

MU .....Meaningful Use (now known as Promoting Interoperability)

MUA .....Medically Underserved Area

MUP .....Medically Underserved Population

NACHC.....National Association of Community Health Centers

NACRHHS .....National Advisory Committee on Rural Health and Human Services

NAEMT .....National Association of Emergency Medical Technicians

NARHC .....National Association of Rural Health Clinics

NASEMSO .....National Association of State Emergency Medical Services Officials

NCC .....Non-Competing Continuation

NCQA .....National Committee for Quality Assurance

NCHN .....National Cooperative of Health Networks

NGA .....Notice of Grant Award

NHIN .....National Health Information Network

NHSN .....National Healthcare Safety Network

NHTSA.....National Highway Traffic Safety Administration

NIH .....National Institute for Health

NLM .....National Library of Medicine

NOA.....Notice of Award

NOFO .....Notice of Funding Opportunity

NoP.....Notice of Participation

NOSORH.....National Organization of State Offices of Rural Health

NP.....Nurse Practitioner

NPI.....National Provider Identifier

NPRM.....Notice of Proposed Rulemaking

NRHA.....National Rural Health Association

NTIA.....National Telecommunications and Information Administration

NQF.....National Quality Forum

OAT .....Office for the Advancement of Telehealth

OHITQ.....Office of Health Information Technology and Quality

OIG .....Office of Inspector General

OMB.....Office of Management and Budget

OMH .....Office of Minority Health

ONC.....Office of the National Coordinator for Health Information

Technology

OP .....Outpatient

OPPS.....Outpatient Prospective Payment System

OQR.....Outpatient Quality Reporting Program

OTP.....Opioid Treatment Program

P4P/PfP.....Pay for Performance or Partnership for Patients

PAC.....Post-Acute Care

PACS.....Picture Archiving and Communications System

PALS.....Pediatric Advanced Life Support

PB .....Provider-Based

PBPM.....Per Beneficiary Per Month

PCA.....Primary Care Association

PCC.....Primary Care Clinicians

PCMH .....Patient-Centered Medical Home

PCO .....Primary Care Office

PCP .....Primary Care Provider

PE .....Pulmonary Embolism

PFS .....Physician Fee Schedule

PHE .....Public Health Emergency

PHR .....Personal Health Record

PI .....Performance Improvement or Promoting Interoperability

PIMS.....Performance Improvement & Measurement System

PIN.....Policy Information Notice from HRSA

PMPM .....Per Member Per Month

PO .....Project Officer

POND.....Practice Operations National Database

POS .....Point of Service

PPACA .....Patient Protection and Affordable Care Act of 2010

PPO .....Preferred Provider Organization

PPP .....Paycheck Protection Program

PPS .....Prospective Payment System

PQRS.....Physician Quality Reporting System

PRF .....Provider Relief Fund

PRO.....Peer Review Organization

PSA.....Physician Scarcity Area

PSI .....Patient Safety Indicators

PTN .....Practice Transformation Network

QHI.....Quality Health Indicators

QHP .....Qualified Health Plan

QI .....Quality Improvement

QIL .....Quality Innovation Lab

QIN.....Quality Innovation Network

QIO .....Quality Improvement Organization

QNet .....QualityNet

QPP.....Quality Payment Program

RAC.....Recovery Audit Contractor

REH .....Rural Emergency Hospital

RFI .....Request for Information

RFP.....Request for Proposals

RHC.....Rural Health Clinic

RHIhub .....Rural Health Information Hub

RHIO .....Regional Health Information Organization

RHPI .....Rural Hospital Performance Improvement Project

RHRC .....Rural Health Research Center

RHSATA .....Rural Health System Analysis and Technical Assistance Program

RHV.....Rural Health Value

ROI.....Return on Investment

ROCI .....Return on Community Investment

RPCH .....Rural Primary Care Hospital

RQITA.....Rural Quality Improvement Technical Assistance

RRC.....Rural Referral Center

RSV .....Reverse Site Visit

RTTD.....Rural Trauma Team Development

RUPRI.....Rural Policy Research Institute

RUS.....Rural Utilities Service

RVU .....Relative Value Unit

SAM .....System for Award Management

SAN.....Support and Alignment Network

SAMHSA.....Substance Abuse and Mental Health Services Administration

SCH.....Sole Community Hospital

SCHIP.....State Children's Health Insurance Program

SDOH .....Social Determinants of Health

SRHA .....State Rural Health Association

SSIs.....Surgical Site Infections Colon or Hysterectomy

SHIP.....Small Rural Hospital Improvement Grant Program

SME.....Subject Matter Expert

SNF.....Skilled Nursing Facility

TTAP..... Targeted Technical Assistance for Rural Hospitals Program

VKG .....Virtual Knowledge Group

U.S. Time Zone Map