An Interim Evaluation Report of the Innovative Projects Portfolio of the Medicare Flex Grant Program

Flex Monitoring Team
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HIGHLIGHTS

- Sixteen states applied for Innovative Projects funding in FY2015 or FY2016. Proposed activities covered a wide range of innovations, including telehealth, health and delivery system redesign, care coordination, and quality improvement.

- The participating states are implementing Innovative Projects specific to the needs of their CAHs and rural delivery systems.

- All of the projects align with the intended goal of helping support the financial and operational transition of CAHs to value based models and health care transformation models.

- Many of the states are using Flex Program funding to leverage other funding and support for their projects.

- As reflected in these projects, innovation in the Flex Program context means the adoption of proven interventions to support CAHs and rural communities in new ways.

INTRODUCTION

The Medicare Rural Hospital Flexibility Program (Flex Program) is designed to strengthen rural health care delivery systems by supporting Critical Access Hospitals (CAHs) and encouraging the development of local and regional systems of care with CAHs as the hubs. States' participation in the Flex Program creates a vehicle for helping CAHs improve quality, strengthen their financial and operational performance, and assist with population health initiatives and the integration of Emergency Medical Services (EMS) into those systems of care. Flex Program funding provides important support for vulnerable rural hospitals in a challenging health care environment, and helps ensure that rural populations have access to essential health services.

In the most recent competitive grant cycle (FY2015-17), the Flex Program included an optional new program area focused on rural health system innovations—Program Area 5: Integration of Innovative Health Care Models (Innovative Projects)—to address needs not covered by the other core areas of the grant program. The Flex Monitoring Team (FMT) has undertaken an evaluation of the states participating in this new program area, with a particular focus on activities involving the transition to value-based care, telehealth, care coordination, quality improvement, and system delivery in rural communities. This report provides background on the Flex Program and the Innovative Projects program area. With a focus on the projects and implementation experiences of seven states participating in the Flex Monitoring Team evaluation, we describe the states' projects and desired outcomes, and discuss initial evaluation observations.

BACKGROUND

The Flex Program historically targeted four priority areas for supporting CAHs, EMS, and the rural communities they serve: quality improvement; financial and operational improvement; population health management and EMS integration; and conversion of eligible hospitals to CAH status. Program Areas One and Two are mandatory, Program Area Three is optional, and Program Area Four is required only if a hospital requests designation as a CAH. Program Area Five: Integration of Innovative Healthcare Models was added in the Fiscal Year 2015 Flex Competitive Guidance, and was described as follows:

This optional program area focuses on developing and integrating innovative health care models around the areas of quality, financial/operations, population health and/or system delivery in rural communities. Ideally, successful models will improve care in rural areas and serve as best practices or strategies for other states.

The guidance established the following goal for this program area:

To support the financial and operational transition to value based models and health care transformation models in the health care system.

As such, innovative health care models proposed for this area of Flex Program activity are expected to have a "positive transformational impact on rural health." The intent was to "allow states to think creatively about transforming rural care across their state given gaps identified through the application development process, initial needs assessment collection and other relevant data." The guidance stated that specific areas of focus for projects proposed in Program Area Five may include: clinically integrated networks, population health management, addressing frequent/high cost users of health care or emergency department services, and care coordination. There was no cap set on how much a state could spend on the Innovative Projects program area.

Sixteen states applied for Innovative Projects funding in the initial application or in the second year of the funding cycle. Proposed activities covered a wide range of innovations, including telehealth, health and delivery system redesign, care coordination, and quality improvement. Some states chose to use Flex Program funds to create wholly new projects, while others added Flex Program dollars to existing initiatives, created new components to those existing projects, or funded new staff positions.

In 2017, FMT members at the University of Southern Maine began a fifteen-month evaluation of the Innovative Projects to monitor and assess their implementation and impact. Based on an initial screening process via interviews and review of the applications, seven states—clustered in three areas of innovation—were identified for a more in-depth evaluation:

- Telehealth: Hawaii and Nevada (Project ECHO), and Oregon (telehealth needs assessments);
- Care Coordination: Colorado (Improving Communications and Readmissions (iCARE) program) and Illinois (Illinois Rural Community Care Organization (IRCCO)), and
- Quality Improvement: Michigan (RHC Quality Improvement Network) and Tennessee (Upper Middle Tennessee Rural Health Network).

The selection of these states was based on their projects being far enough along to be suitable for evaluation, as well as selecting a diverse set of projects within the three thematic categories. Relevance to Flex Program goals and the potential for the project to be replicated by other state Flex Programs were also considerations.

For each of these projects, we provide a brief description of the innovative activities undertaken by these seven states and an assessment of: (1) each state's approach to the design and implementation of their Innovative Projects, (2) each project's intended short- and intermediate-term goals and outcomes, and (3) an overview of their implementation progress. Descriptions of the Innovative Projects that are not part of the FMT evaluation can be found in the Appendix.

Telehealth

Hawaii: Hawaii's Innovative Project uses technology to support clinicians in rural and underserved communities and to improve access to specialty care for rural residents through support for development of a new Project ECHO hub in the state. Project ECHO is a technology-based videoconferencing program that offers peer to peer learning sessions ("clinics") for clinicians practicing in rural and underserved communities. These clinics are provided by appropriate specialists in academic medical centers or tertiary care centers linked to the Project ECHO hub on topics such as endocrinology, behavioral health, medication assisted treatment for opioid use, or geriatric medicine. Project ECHO clinics provide virtual learning opportunities to enable participating rural clinicians to improve their skills in treating complex conditions without the burden of out-of-community travel. The goal of this training is to enable clinicians to treat patients with more complex conditions within their practices rather than having to refer them to specialty care services in urban settings. Project ECHO also facilitates the development of peer and mentoring relationships between participants, thereby reducing professional isolation reported by rural clinicians. The benefits of Project ECHO are particularly important in Hawaii where the costs and burdens of off-island travel are significant for both clinicians and patients.

Hawaii's Project ECHO program focuses on improving the skills of rural providers on the islands in treating complex conditions and reducing the number of referrals to specialty care services in Honolulu, which typically involve air travel for patients. Ideally, this should improve timely access to specialty care, improve patient outcomes, and create savings for patients in terms of both cost and time. In developing its Project ECHO hub, the Hawaii Flex Program is focused on developing new topic modules based on the needs identified by rural providers, engaging CAHs as local sites, and encouraging the participation of rural clinicians in appropriate ECHO clinics by demonstrating the value to providers, their hospitals, and their patients. Hawaii is working to develop partnerships in and out of state to strengthen the program and to find sources of funding to sustain it. Flex officials hope to generate data on cost savings associated with Project ECHO to leverage support for the program from the state legislature and local insurers.

Project activities include developing and implementing ECHO clinics, recruiting providers to participate in the clinics, engaging CAHs in Project ECHO, and creating partnerships with other agencies. Anticipated short- and intermediate-term outcomes for this project include increasing the number of providers participating in and presenting cases at ECHO clinics,

increasing awareness of ECHO in the state, improving the capacity of rural clinicians to treat more complex patients, reducing unnecessary off-island referrals for specialty care, decreasing rural provider burnout and isolation, and developing stable funding. Long-term goals include improved care delivery and community health outcomes in rural areas, enhanced CAH quality and patient satisfaction, and greater cost savings to payers and patients.

Hawaii's Project ECHO hub has already developed and conducted four clinics and has requests for the development of new topics contingent on funding. The program is collecting data through surveys of participants to demonstrate program effectiveness. Program officials have received positive feedback from participants about the value of the clinics and providers report that they are better able to care for their patients with complex conditions. Program officials report that interest in the program is growing and efforts are underway to obtain Hawaii Med-QUEST (Medicaid) funding. Additional funding from small grants programs are supplementing Flex Program funding. Program officials also report that clinicians from islands in the Pacific Rim have participated in in Project ECHO clinics and that the program is interested in developing ECHO clinics with content targeted specifically at these providers.

Nevada: Nevada is also supporting a Project ECHO program as the primary strategy for its Innovative Project. The Project ECHO hub is operated by the University of Nevada, Reno School of Medicine. Flex funding for this initiative allowed the School of Medicine to underwrite a full-time Project ECHO coordinator to manage the program, which was established in 2012. The School of Medicine currently has 14 ECHO clinics in rotation which are open to rural clinicians. The current schedule of clinics includes antibiotic stewardship, behavioral health in primary care, cardiology, diabetes and general endocrinology, gastroenterology, geriatrics, medication-assisted treatment, pain management, pediatric endocrinology, public health, rural mental health professional development group, school based mental health, sports medicine, and a special series of topics. Clinicians from the School of Medicine provide the content for the ECHO clinics. Nevada's Project ECHO seeks to improve access to care in rural areas by increasing the skills and comfort of primary care providers in delivering specialty care as well as reducing provider burnout by forging connections between urban and rural providers. The Nevada program, through its infectious disease staff, also offers modules to support CAHs in complying with federal antibiotic stewardship requirements. Nevada hopes to develop additional funding to support provider participation in Project ECHO clinics and allow them to provide technical assistance to other SORHs seeking to create their own ECHO hubs.

Nevada's project activities revolve around implementing and growing the Project ECHO program, developing clinics, engaging CAHs as participants in Project ECHO, creating and nurturing partnerships with other agencies, and outreach to CAHs encouraging them to utilize Project ECHO Infectious Disease staff. Short- and medium-term outcomes focus on increasing the number of providers using ECHO and the frequency of their participation in clinics; a greater awareness of ECHO among providers, a greater proportion of patients receiving care locally from Project ECHO participants (along with a decrease in referrals outside the community); and improvements in the number of CAHs in compliance with antibiotic stewardship requirements. Nevada hopes these outcomes lead to their longer-term goals of

improved patient outcomes and satisfaction, increased quality of care provided by CAHs, and better integration of telehealth into the health care system.

Nevada's project staff report that the overall number of clinic participants and repeat attendees are increasing. The creation of the coordinator position, funded by the Flex Program, allows for greater coordination between Project ECHO and state Flex Program activities.

Oregon: Oregon's primary strategy for its Innovative Project involves conducting targeted assessments of the telehealth and technology needs of CAHs in rural Oregon. Oregon's initial strategy was to work in conjunction with a project funded by a CMS State Innovation Model (SIM) grant to establish a Project ECHO hub focused on addiction and psychiatry services for CAHs in rural and frontier areas. As the state SIM project did not move forward with the development of the Echo hub, the Flex Program revised its project to fund a full time telehealth coordinator to work directly with CAHs to determine their telehealth needs and their current capacity, identify the telehealth options and Project ECHO hubs that are right for them, and match them with relevant services. Data for the assessment are being collected through an online survey of hospital leadership and providers, and through site visits by the telehealth coordinator. The telehealth coordinator will also help implement telehealth activities at the CAHs.

Oregon's project activities include encouraging CAHs to participate in the assessment process, conducting the telehealth/technology assessments, preparing written assessment reports, and providing technical assistance to participating CAHs to expand their use of telehealth. Anticipated short- and intermediate-outcomes include an increase in the number of Oregon CAHs participating in Project ECHO hubs and implementing telehealth programs; improved CAH provider satisfaction; increased access to specialty care due to service line expansion by ECHO participants; and greater use of telehealth as a means of attracting providers and resources to CAHs. These outcomes will support the long-term goals of increased integration of telehealth into the health care system, and improved quality, patient outcomes, and patient satisfaction for participating CAHs. Oregon also anticipates a reduction in costs at CAHs due to fewer outside referrals and improved population health outcomes.

Oregon's Innovative Project was delayed by the need to retool its initial project following changes to the scope of activities under the SIM grant. Oregon has successfully hired a telehealth coordinator and began piloting the assessment tool during the spring and summer of 2017. The coordinator is currently working with Oregon's CAHs to recruit participants for the assessment process.

Care Coordination

Colorado: Colorado's Innovative Project strategy builds on its longstanding iCare initiative that works with 22 CAHs and 34 Rural Health Clinics (RHCs) to reduce avoidable readmissions, facilitate communications between facilities, and improve transitions of care from one facility to another. The project team has identified issues related to the timely and appropriate exchange of patient information and discharge instructions during care transitions between Colorado's CAHs and other care settings. Colorado's initiative engages CAHs with other health care facilities in

their communities to improve care transitions, readmissions, and care coordination for people with chronic conditions.

Colorado's activities include convening regular electronic health record (EHR) user group calls to address communication issues between users of disparate EHRs; assessing communication between CAHs, provider-based clinics, and other facilities; holding quality improvement webinars on topics such as information transfer protocols between care settings, data transfer, patient communication, and follow-up processes, training participants in process mapping, better coordinating care; and improving patient outcomes. Colorado is also working to create profiles of CAH communities, based on available quality data, and looking to improve clinical processes at CAHs and RHCs. Short- and intermediate-term goals include improving workflow at hospitals and clinics, improving data capacity at CAHs, and increasing the number of data performance reports developed and shared by CAHs/clinics. In the long-term, Colorado plans to establish communication and coordination pathways between various provider types; increase the use of data in CAH and RHC decision making; and reduce avoidable admissions at CAHs. Colorado also believes that that iCare will lead to the adoption of management and clinical practices that support participation in value-based care.

Project staff report that its biggest challenges involve hospital staff turnover and issues with functionality and communication of the EHRs used by participating CAHs and RHCs. Staff also report that there is considerable interest in the EHR vendor user group calls.

Illinois: The primary strategies implemented by Illinois involve two components of its Illinois Rural Community Care Organization (IRCCO) accountable care initiative. The first project is designed to improve communication and care coordination during transfers between CAHs and nursing homes to reduce ED visits and inpatient readmissions by nursing home patients. The second is designed to implement evidence-based protocols for congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) in CAH emergency departments to improve patient outcomes. Both programs address frequent/high cost users of care, as well as deficiencies within the current health care system that hinder effective communication between health care facilities.

Project activities related to care transitions between CAHs and nursing homes focus on increasing the number of transfer tools developed and disseminated by IRCCO to participating CAHs; the number of provider workgroup sessions held, and the number of individual hospital support and technical assistance contacts. CHF/COPD activities focus on increasing the number of care coordination tools refined/developed and disseminated by IRCCO, the number of education materials developed and disseminated by IRCCO, and the number of regional care manager/ED staff meetings held. Anticipated short- and medium-term outcomes for both projects include improvements in relevant Clinician/Group and Hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, changes to participants' EHRs to improve care management and information exchange, and development of CAH/clinic structural and clinical changes to improve care coordination. Long-term goals include the adoption of management and clinical practices to support participation in value based care, decreases in unnecessary healthcare spending, and improvements in patient outcomes.

Illinois' project team report challenges with getting hospitals to submit timely data reports and the need to improve communication between hospitals and nursing homes. As with Colorado, EHR-related issues are a concern. Illinois notes that the greatest impact has centered on transitions in care outcomes, both in transfers from hospitals to nursing homes and in discharge techniques designed to improve the patient's understanding of self-care.

Quality Improvement

Michigan: Michigan's project strategy focuses on improving the quality of care provided by Rural Health Clinics (RHCs), particularly those affiliated with CAHs. These are an important source of primary care in rural communities. The project has three primary goals: 1) support the development of an RHC quality improvement network for provider-based RHCs operated by CAHs; 2) encourage participating RHCs to collect and report data on three common primary care issues (i.e., body mass/obesity, blood pressure, and tobacco use); and 3) assist participants with implementation of evidence-based protocols to improve performance on addressing these issues. Participating RHCs report quality metrics addressing these issues through a data portal developed by Quality Health Indicators (QHi), a subsidiary of the Kansas Hospital Education and Research Foundation. The portal allows participating clinics to benchmark their performance on the three core measures against other clinics participating in the network. RHCs are expected to enter monthly data into the portal, present at quarterly meetings, and participate in peer education cohorts.

Key process targets include increasing the number of RHCs participating in the network and reporting quality data, the number of quarterly project meetings held and peer education cohorts developed, and the number of core measures-related best practices developed and implemented. Short- and intermediate-outcomes include increasing the consistency and frequency of RHC quality reporting; improving the quality of care delivered by participating RHCs; and increasing QI support for the RHCs from their associated hospitals. Michigan's long term-goal is for this project to better prepare rural providers for value-based purchasing reforms, demonstrate improved quality of care in rural communities, and enhance the financial performance of CAHs, RHCs, and other rural providers.

Michigan's RHC quality improvement network is in the process of becoming a formal organization, separate from the SORH, with members expected to participate in the QI project. There have been ongoing issues with the consistency of RHC data collection and entry (often due to changes in staff and competing obligations), although Michigan has found that offering to enter the data into QHi on behalf of the RHC generated some uptake. Ongoing education and re-education about QHi and the core metrics has also been helpful.

Tennessee: Tennessee's project strategy involves support for the primary care infrastructure in rural communities. Through a collaboration with the Upper Middle Tennessee Rural Health Network (UMTRHN), the Flex Program is exploring the use of Patient Center Medical Home programs (PCMH) and other primary care-based models to help CAHs and rural systems of care to prepare for value-based purchasing arrangements and support the development of a rural Clinically Integrated Network (CIN) model offering enhanced care coordination between members. A chronic care management pilot program with one rural provider practice is currently

underway. UMTRHN is providing technical expertise and other resources to support PCMH recognition.

To monitor project implementation, the project is tracking the number of participating physicians and number of patients covered. It is also tracking measures related to the development of the CIN (such as the protocols that define and enforce standards of care and coordinate patient care between members) as well as the status of efforts to gain PCMH recognition for participating practices.

Short and intermediate outcomes focus on one or more practices implementing the PCMH model and receiving official recognition as a PCMH. An additional expectation is that one or more practices will participate in the CIN. To monitor project implementation and outcomes, the project will track the number of clinics reporting quality metrics, the number of patients being managed for chronic care, and the number of quality improvement initiatives undertaken. Longer-term goals include preparing rural providers to participate in value based purchasing, improving the quality of care delivered by providers in rural communities, and improving the financial performance of CAHs, RHCs, and other rural providers.

Tennessee is currently working with one Federally Qualified Health Center (FQHC) to implement the project and enroll patients in the chronic care management program.

EVALUATION APPROACH

As a process evaluation, the FMT's approach has been to describe the strategies states are employing in their Innovative Projects, to monitor the states' progress and experience in implementing their projects, and to document the early results of the states' projects. To describe each project and set a framework for the evaluation, we worked directly with the states' Flex coordinators to develop a logic model of their proposed project. The logic models helped clarify the underlying strategy supporting their projects, describe key project activities, establish a timeline for project implementation, identify relevant process and output measures to monitor project implementation, and identify appropriate short-, intermediate-, and long-term outcomes to monitor project impact and achievement of overall project goals. The project team developed a draft logic model for each of the seven projects based on the states' FY2015 Flex Program grant applications and work plans which laid out their scope of project activities and intended deliverables. Through an iterative process, we worked with the Flex coordinators to refine the logic models to clarify underlying project strategies and select a realistic set of process and outcome measures for the duration of the three-year funding cycle. We also worked with the Flex coordinators to select measures that could be rolled up to demonstrate progress toward achieving desired long-term project goals.

A key component of the FMT evaluation is to provide data to the states and the Federal Office of Rural Health Policy (FORHP) on the states' progress in implementing their projects. Once the logic models were complete, we created tracking tools for the states to report data on their process and outcome measures as well as implementation progress. The tracking tool consists of a

two-page spreadsheet with a common set of implementation questions for all seven states and a table of the specific quantitative measures identified for each project. This process encouraged the states to think clearly about their projects, set realistic short- and intermediate-term measures that were aligned with long-term project goals, and identify sources of data to support the measures. The implementation questions were designed to capture qualitative information about project successes, challenges, and lessons learned. They also allowed the states to update the FMT on project status and to discuss how Flex Program funding has been used to advance their projects.

In addition to the logic models and tracking tools, the FMT evaluation team conducted informal calls and semi-structured key informant interviews with each of the participating states, through which it has gained a more detailed understanding of the states' projects, their progress toward implementation, and the challenges and successes they have encountered.

OBSERVATIONS

While the FMT's monitoring and evaluation activities are on-going, the qualitative data submitted as part of the tracking tools, together with key informant interviews with the states offer observations about project implementation.

The participating states are implementing innovative models specific to the needs of their CAHs and rural delivery systems.

For example, Nevada and Hawaii seek to help CAHs and their affiliated providers improve local access to specialty care through the telehealth-based Project ECHO training model designed to improve the capacity of local providers to handle more complex cases. Their desired goals are to reduce out-of-community referrals for specialty care that could be provided locally, improve patients' experience, and reduce the travel costs and time delays associated with out-of-community referrals. Due to the costs of off-island travel necessary to access specialty care, Hawaii has a major goal of reducing the burden of travel costs for patients living on the smaller islands. Nevada's project is primarily focused on assisting CAHs in complying with federal antibiotic stewardship regulations and expanding the comfort of local providers in treating patients with more complex needs. Oregon is working directly with CAHs to determine their telehealth needs, assess their current telehealth infrastructure, and help them develop a telehealth strategy and funding plan. Both Michigan and Tennessee are working with primary care providers, in RHCs or in FQHCs, to improve primary care quality in rural areas through increased quality reporting and participation in new patient-centered primary care models. Illinois is addressing unnecessary hospital readmissions by focusing on care coordination and communication problems between nursing homes and hospitals and implementing evidence-based protocols for patients with chronic conditions treated in the ED. Finally, Colorado is working to reduce readmissions at CAHs by improving communications related to transfers, particularly around discharge instructions and other clinical processes as well as developing EHR user groups to improve the transfer of information encounter by CAHs working with disparate EHR systems.

Many of the states are using Flex Program funding to leverage other funding and support for their projects.

A number of the states, including Nevada, Colorado, and Illinois, are using Flex Program funding to augment other resources devoted to their projects. In other states, like Hawaii, Flex Program funds have enabled the state to launch their project with the hopes of securing other federal, state, or foundation funding to continue or expand the project.

All of the projects align with the intended goal of helping support the financial and operational transition of CAHs to value based models and health care transformation models.

All of the Innovative Projects align with the defined objective of having a positive transformational impact on rural health care. For example, Tennessee's project focuses on helping rural practices transition to value-based case. Colorado and Illinois are focusing on care coordination, which improves outcomes and reduces costs. Michigan is working to improve quality at RHCs by encouraging them to track key quality metrics. Oregon is addressing access to care and CAH telehealth infrastructure in rural communities by focusing on CAH capacity and needs, while Nevada and Hawaii are attempting to keep patients in their communities by supporting rural primary care providers through Project ECHO.

As reflected in these projects, innovation in the Flex Program context means the adoption of proven interventions to support CAHs and rural communities in new ways.

The Flex Program guidance defined innovation quite broadly, directing states to focus on transformational activities in areas including quality, financial, or operational improvement, population health, and/or system delivery in rural communities. Demonstrating this breadth, states proposed a diverse array of projects, which reflect state priorities and capacities and the application of strategies which have largely been used in non-rural contexts. Under the aegis of the Flex Program, the projects represent innovative application of strategies for helping CAHs adapt in the current rural health care environment. For example, Michigan's work to benchmark core quality improvement metrics is innovative because RHCs do not often report such data, not because the metrics themselves are innovative.

NEXT STEPS

In addition to monitoring the progress and outcomes of the states' Innovative Projects, the FMT evaluation will continue to track the states' implementation experiences to determine whether and how these projects might serve as examples for other states. The evaluation team will continue to review and report on the states' quarterly tracking data with another round of interviews with the states in the spring of 2018. The evaluation will be completed in the late summer 2018 with a final report summarizing the evaluation results.

In response to the participating states' requests, the evaluation team hosted two webinars in November and December 2017 in which participating states presented their projects and discussed their implementation experiences. These peer-to-peer learning sessions were recorded and will be reported on in a subsequent report for this evaluation.

APPENDIX: ADDITIONAL INNOVATIVE PROJECTS

Alaska: Alaska's strategy for its Innovative Project is to assess the readiness of its CAHs to transition to value-based models of care and to assist them in preparing for the transition. Alaska's scope of work includes a readiness assessment using a modified version of the Technical Assistance and Services Center's (TASC) Performance Excellence Framework, ongoing education and peer networking through a small hospital network to prepare hospitals to survive in the changing health care environment, and the development of a multi-stakeholder effort with one or more CAHs to explore options for new models to deliver care in rural communities. As part of its work, Alaska has created a task force on sustainability and transformation to explore new models of care. This work is being conducted in collaboration with the Alaska State Hospital and Nursing Home Association as its Flex Program contractor.

Idaho: Idaho's primary Innovative Project strategy involves development of an annual competitive funding opportunity to support CAHs in participating in value-based and healthcare transformation models. In its first year, Idaho awarded money to a single CAH to support the launch a telepsychiatry program in its emergency department and pediatric programs. In its second year, Idaho funded three hospitals. Two hospitals are starting a clinically integrated network and the third is working to improve financing and operations. In addition, Idaho's Flex Program staff is working with CAHs and other rural providers to participate in a state-wide Center for Medicare and Medicaid Innovation (CMMI) grant involving the development of telehealth, community health workers, and community paramedicine.

Illinois/North Dakota: Illinois and North Dakota are pursuing a joint strategy to develop and implement an emergency department Consumer Assessment of Healthcare Providers and Systems (ED CAHPS) project in eight CAHs (four in each state). The ED-CAHPS surveys are conducted by the Illinois Critical Access Hospital Network under a contract with both Flex Programs. A unique aspect of this project is the collaboration between states and the modification of the ED CAHPS survey to tailor it to the needs of CAHs and to improve response rates. Although not mandatory for CAHs, an ED CAHPS survey targets a critical area of CAH services and provides a model for other CAHs to follow.

Massachusetts: Massachusetts' Innovative Project strategy supports the development of a Statewide Rural Telemedicine Group to overcome the barriers to telehealth implementation in Massachusetts. The state has completed needs assessments and surveys to identify barriers to telehealth use such as reimbursement challenges and a lack of clarity and consistency regarding the inclusion of telemedicine coverage in health plans. The Massachusetts Hospital Association and rural hospitals are supporting proposed legislation to establish telemedicine parity across payers in Massachusetts. The SORH is also working directly with rural hospitals to implement and expand telehealth usage.

Montana: Montana's project strategy builds on the Montana Medical Association's leadership model (Leadership Montana) to create a program for health care teams to address the challenge of moving towards population health management and value-based care. The intent of the leadership program is to engage board members, providers, and community partners to work

collaboratively towards these outcomes. The goal is to improve hospital performance and stability and advance population health. While the project's goal focused on the leadership necessary to transition to value-based care, the original Leadership Montana program was more heavily oriented towards patient centered medical homes than hospital-focused value-based systems of care. The program is revising the leadership program to better address the needs of hospital-based providers.

New Mexico: During the second year of the Flex funding cycle, New Mexico proposed an Innovative Project with a strategy that encouraged the partnership of a black lung program from Miners Colfax Medical Center (a CAH) and a HRSA-funded mobile clinic to address diabetes among a population of active and retired miners. The black lung program has identified diabetes as a significant health problem among this population and will use the resources of the mobile clinic to address this need.

Pennsylvania: Pennsylvania's Innovative Project strategy is to work with the Center for Health Organization Transformation on a data visualization project using Healthy Communities Institute population health data for the communities served by the state's CAHs, and to support the development of hospital global budgets. Flex funding will supplement funding from a statewide CMMI grant to develop a global budget for hospitals similar to the global budget initiative undertaken by the state of Maryland. Two CAHs are exploring participation in the first cohort of hospitals to participate in the global budget initiative.

South Carolina: South Carolina's primary project strategy supports the involvement of CAHs in the statewide Healthy Outcomes Plan (HOP) initiative, a Medicaid population health home program that is mandatory for all hospitals. HOP concentrates on a high risk, vulnerable population of Medicaid enrollees that are heavy users of emergency department services. Hospitals serve as medical homes for a defined population of these high risk patients. The goal of hospital-level HOPs are to reduce inappropriate utilization and improve management of chronic diseases such as behavioral health, COPD, and diabetes. The hospitals receive a per-member, per-month payment to serve their identified population and provide required care coordination services. The Flex Program supports CAHs by representing the needs of small rural providers on numerous statewide committees and planning initiatives. Other Innovative Project work involves participation in the statewide Population Health Summit and ongoing assistance to the Abbeville County EMS Community Paramedic program

Washington: Washington's project strategy focuses on the exploration of alternative models of care, new facility types, and payment design to support vulnerable, at-risk CAHs in the state. This project builds on the work of the Washington Rural Health Access Preservation work group and the state CMS Innovation plan. Plans include: development of new reimbursement models for vulnerable CAHs; a noncompetitive request for proposals for an innovative integrative healthcare model that will have an impact on rural health; and two workshops to expand knowledge on funding sources, training, telemedicine, and other innovation rural health improvements.

For more information on this study,
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