ConnectedHealthInitiative

CHI Recommended Measures for States' Rural Health Transformation Program Grants

RHTP Priority Area	CHI Recommended Measures	CMS RHTP Requirements
PRIORITY 1 **Prevention**	• Primary prevention: incidence of new diabetes, hypertension, dyslipidemia, and tobacco-related disease in served populations. • Secondary prevention: completion rates for breast, cervical, colorectal, lung, and AAA screening; teleretinal screening for diabetic retinopathy; stage-at-diagnosis distribution for cancer. • Tertiary prevention: ambulatory-care-sensitive (ACS) hospitalization rates; HF/COPD exacerbation rates; sepsis early-warning catches; medication errors prevented by AI reconciliation. • Adult and childhood immunization rates (flu, pneumococcal, shingles, COVID-19, RSV, HPV, HEDIS CIS/IMA). • Maternal prevention: timely prenatal care initiation; postpartum hypertension RPM enrollment in counties without obstetric services. • Wearable and PGHD-driven AI tool adoption and outcome impact, reported as headline measures. • Prevention savings: comparison cohort method (preferred) — propensity-matched digital-health-enrolled vs. non-enrolled patients × cost-of-care PMPY delta. Actuarial-value method as sanity check. Sensitivity range and methodology disclosed alongside every figure.	• RHTP Strategic Goal: "support rural health innovations and new access points to promote preventative health and address root causes of diseases." • Allowable use: prevention, chronic disease management, lifestyle and nutrition initiatives, community-based outreach.
PRIORITY 2 **Chronic Disease Management and Outcomes**	• Adopt ACCESS Model Outcome-Aligned Payment (OAP) Measure specifications directly for all RHTP-funded chronic care programs targeting ACCESS conditions; use the dual-target (Control or Minimum Improvement) structure rather than HEDIS thresholds alone. • Hypertension (ACCESS-aligned): Final systolic BP <130 mm Hg OR 15 mm Hg systolic reduction. • Diabetes (ACCESS-aligned): Final HbA1c <7.5% OR 1 percentage point reduction. Prediabetes: Final HbA1c <6.5%. • Dyslipidemia / ASCVD (ACCESS-aligned): Final LDL-C <100 mg/dL (dyslipidemia) or <70 mg/dL (ASCVD), OR 30 mg/dL reduction. • Weight management (ACCESS-aligned): Final BMI <30 kg/m^2 AND no more than 5% weight gain, OR 5% weight reduction. • CKD (ACCESS-aligned): baseline eGFR and quantitative uACR for all patients with diabetes or CKD. • Behavioral health (ACCESS-aligned): PHQ-9 <10 or 5-point reduction; GAD-7 <10 or 4-point reduction; PGIC end-of-period. • Chronic MSK pain (ACCESS-aligned): site-appropriate PROM (ODI, NDI, QuickDASH, KOOS/HOOS JR, PROMIS PI/PF) with quantitative improvement targets; pain intensity (NRS); PGIC. • Outcome Attainment Rate (OAR): share of attributed beneficiaries meeting all required OAP targets over 12-month Care Period; 50% as default success benchmark. • Medication adherence (PDC ≥80%) for diabetes medications, RAS antagonists, and statins. • Wearable and PGHD use among chronic disease patients; share of patients with AI-driven personalized alert thresholds vs. static thresholds.	• RHTP Strategic Goal: "evidence-based, outcomes-driven interventions to improve disease prevention, chronic disease management, behavioral health, and prenatal care." • Allowable use: consumer-facing technology for prevention and management of chronic diseases. • Technical Score Factors B.3 and B.4 reward chronic disease initiatives; specific measure definitions are left to state plans.

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PRIORITY 3 **Access to Care**	• Third Next Available Appointment (IHI) for primary care and the top 10 specialties by rural demand; median and 90th percentile. • Share of primary care and specialty consults delivered via telehealth (synchronous video, audio-only, store-and-forward, eConsult). • Care-delivered-locally rate: share of episodes initiated and completed without out-of-county travel. • RPM and RTM enrollment and active-use rate (≥16 days of readings per 30-day period) among eligible rural patients. • eConsult turnaround: median time from PCP referral to specialist response; resolution-without-referral rate. • Number of unique specialties available via telehealth in each rural county (capacity, not just utilization). • Tele-behavioral encounters per 1,000 rural patients; MAT initiation and 6-month retention. • Tele-stroke door-to-needle time at participating rural EDs. • No-show rate, comparing in-person vs. telehealth modalities. • Telehealth utilization that would have been restricted under Social Security Act §1834(m) absent waiver — supports CHI's position that legacy Medicare telehealth restrictions should not apply to RHTP deployments. • Telehealth encounter reliability: share of encounters completed with sufficient clinical interaction time, as determined by the treating clinician. • Patient-reported access experience: validated patient experience measures (CAHPS-Telehealth or equivalent); share of patients reporting they were able to access care they would not otherwise have received; trust score for digitally delivered care.	• RHTP Strategic Goal: "utilize technology, especially telehealth capabilities, to improve health access for rural communities." • Allowable uses: remote monitoring, robotics, AI, telehealth, and other advanced technologies. • Technical Score Factor [B.X] rewards investments in consumer-facing health apps and telehealth-enabled care.

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PRIORITY 4 **Reduced Acute Utilization**	• All-cause hospitalization rate per 1,000 rural-attributed patients per year, overall and restricted to digital-health-enrolled cohort. • AHRQ Prevention Quality Indicators (PQI 90 overall, PQI 92 chronic) per 100,000 rural population. • 30-day all-cause readmission rate, risk-adjusted, all-payer; report for AMI, HF, COPD, pneumonia. • ED visits for non-emergent conditions per 1,000 rural patients (NYU ED algorithm or CMS "Avoidable ED" definition). • ED visits for ambulatory-care-sensitive conditions per 100,000 rural population. • Avoidable inter-facility transfers from Critical Access Hospitals (CAHs), enabled by tele-consultation (tele-stroke, tele-ICU, tele-behavioral, tele-cardiology). • Average inpatient length of stay, risk-adjusted, for top 5 DRGs by rural volume. • Frequent-utilizer reduction: count of patients with 4+ ED visits in a rolling 12 months.	• RHTP Strategic Goal: "alleviate overload on hospitals by strategically shifting patient care to other settings or reducing length of stay, both to control cost and to preserve capacity for patients who need emergency or hospital-based care." • Allowable use: remote monitoring, telehealth-enabled care coordination, hospital-at-home models, and other advanced technologies that reduce avoidable acute care utilization. • Annual Progress Report submission against state-defined milestones in the approved Transformation Plan. • Technical Score Factors B.4 (chronic disease prevention/management) and B.6 (innovative care models) rely on hospitalization and utilization measures. • Workload-funding recalculation each fiscal year is based on state-reported metrics under NOFO Appendix C/D.

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PRIORITY 5 **Workforce Sustainability**	• EHR time per visit and after-hours EHR work per provider per week, from Epic Signal, Cerner Lights On, or vendor analytics. • Documentation minutes per encounter, pre/post ambient AI scribe deployment. • Inbox message turnaround time; volume of patient portal messages handled per provider per week. • Patients seen per provider per day, reported separately for in-person and telehealth. • Clinician burnout score (Mini-Z 2.0 or Maslach single-item burnout question), baseline and annual. • Clinical FTE vacancy rate, by role (MD/DO, NP/PA, RN, behavioral health, pharmacy). • Annual clinician turnover rate, reported separately for primary care, specialty, behavioral health, and nursing. • Self-reported net minutes saved per shift attributable to digital tools. • Prior authorization turnaround time and denial rate, pre/post AI-assisted PA workflows. • Share of clinical workflows running on cloud-based tools; IT FTE time saved through cloud vs. on-premises infrastructure.	• RHTP Strategic Goal: "attract and retain a high-skilled health care workforce." • Allowable use: workforce recruitment and retention. • 5% cap on EHR replacement steers states toward documentation-burden tools rather than wholesale system overhauls. • CMS has not prescribed workforce or burden measures.
PRIORITY 6 **Financial Sustainability of Rural Providers**	• Operating margin and days cash on hand for participating CAHs, RHCs, FQHCs (Medicare Cost Reports / HCRIS). • Cost per encounter, reported separately for in-person and telehealth modalities. • Cost per attributed patient per year (PMPY), stratified by digital health engagement. • Clean claims rate and initial denial rate; days in accounts receivable (and A/R >90 days); net collections rate. • Share of digital health investments sustainable post-RHTP without ongoing federal subsidy (self-attested with methodology). • Documented dollar savings attributable to specific digital tools (RPM-avoided admissions × CMS Hospital Compare unit costs; AI-coding-prevented denials × average denial cost). • Cloud-driven cost savings: capital costs avoided, IT FTEs saved, infrastructure refresh costs deferred through cloud adoption vs. on-premises equivalents. • ACCESS Model revenue: total Outcome-Aligned Payment revenue for grantees who become ACCESS Participants; PCP co-management payments; revenue from outcome-aligned arrangements with non-Medicare payers using ACCESS infrastructure (Medicaid, MA, commercial). • Substitute Spend ratio: total Medicare spending on the ACCESS-defined substitute service list by other providers during the attributed Care Period.	• RHTP Strategic Goal: "help rural providers become long-term access points." • Allowable use: provider payments (≤15% of total award per budget period). • Budget caps: 10% admin; 20% infrastructure; 5% EHR replacement; 10% (or $20M) Rural Tech Catalyst per period. • CMS may reduce, withhold, or recover funds for misuse — sustainability evidence is leverage.

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PRIORITY 7 **Rural Population Reach**	• Stratify every Priority 1–6 headline measure by: (a) HRSA-designated HPSAs, (b) frontier counties (USDA/HRSA definition), (c) non-HPSA rural counties. • Stratify by payer: Medicare FFS, Medicare Advantage, Medicaid, dual-eligible, commercial, and uninsured/self-pay. • Stratify by age band: 0–17, 18–64, 65–74, 75+. • FCC Connect2Health priority counties: identify rural counties with the highest health need and lowest broadband connectivity using the FCC Mapping Broadband Health in America platform; target RHTP investment and report outcomes for these counties as a discrete cut. • Travel miles avoided per quarter at county level. • Broadband-related access barriers: share of telehealth encounters downgraded from video to audio-only; share of RPM patients with cellular- vs. broadband-dependent devices. • Patient portal activation and quarterly active-use rate among rural-attributed patients. • Tele-behavioral health reach per 1,000 rural Medicaid enrollees. • Maternal health in counties without obstetric services: prenatal care initiation, postpartum visits via telehealth, postpartum hypertension RPM. • School-based telehealth utilization where deployed.	• RHTP Strategic Goal: “extend digital health access to the rural communities with the greatest unmet need.” • Allowable use: investments that target Health Professional Shortage Areas (HPSAs), Critical Access Hospital service areas, frontier counties, and other high-need rural populations. • Rural facility and population score factors set in Year 1 from NOFO Appendix A (rural population, frontier metrics, HPSA-relevant indicators). • Technical Score Factors reward initiatives that reach HPSAs, CAH-served communities, and frontier counties.

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PRIORITY 8 **Safe and Responsible Technology Deployment**	• State-maintained inventory of AI/ML tools deployed under RHTP at the use-case or category level used for clinical decision support, diagnosis, treatment recommendation, triage, risk stratification, or direct patient interaction (intended use, FDA status, deployment date, sites), with appropriate protection of confidential commercial information. • Share of eligible clinicians actively using each AI tool; user satisfaction; workflow integration (in-EHR vs. separate application). • AI recommendation acceptance rate and false-positive/false-negative rates tracked through periodic chart audit at the use-case or category level. • Time-to-action vs. pre-AI baseline; documented cost savings with methodology disclosed. • Human-in-the-loop escalation rate, with documented clinician training on the specific tool, formal override authority, and protected time and workflow capacity to exercise meaningful oversight. • Documented post-deployment AI monitoring and drift detection; patient and clinician transparency attestations. • Share of digital health infrastructure running on enterprise cloud platforms vs. on-premises. • Cybersecurity outcomes: reportable cyber incidents (frequency, severity, downtime, ransom payments), stratified by cloud vs. on-premises where attributable. • Interoperability: share of digital tools that exchange data via FHIR-based APIs with the local EHR and the state HIE; adherence to ONC information blocking rules. • Use of FHIR-based API submission (ACCESS-aligned specifications) so RHTP grantee data flows into ACCESS infrastructure without rework.	• RHTP Strategic Goal: "transparency, human oversight, auditing, and information sharing for safe and responsible technology development and use." • Allowable uses: AI, robotics, remote monitoring, and other advanced technologies. • Technical Score Factors reward AI-enabled tools and consumer-facing apps. • CMS has not prescribed AI governance, cybersecurity, or interoperability measures for RHTP. • Information blocking rules and the CMS Health Tech Ecosystem Initiative apply as baseline federal requirements.

Harmonization note. CHI-recommended measures above align with established federal measure sets and data sources, including the CMS Universal Foundation, NCQA HEDIS, AHRQ Quality Indicators, CMS eCQMs and MIPS, Million Hearts, HRSA UDS, CMS Hospital Compare, the CMMI ACCESS Model, FCC Connect2Health, and the ONC Trusted Exchange Framework — so rural providers do not maintain parallel reporting systems. See the companion CHI framework document for measure-by-measure source mapping.