

Flex Monitoring Team Briefing Paper No. 10

A Review of State Flex Program Plans 2004-2005

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Monitoring
Team** | University of Minnesota
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The Flex Monitoring Team is a consortium of the Rural Health Research Centers located at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. Under contract with the federal Office of Rural Health Policy (PHS Grant No. U27RH01080), the Flex Monitoring Team is cooperatively conducting a performance monitoring project for the Medicare Rural Hospital Flexibility Program (Flex Program). The monitoring project is assessing the impact of the Flex Program on rural hospitals and communities and the role of states in achieving overall program objectives, including improving access to and the quality of health care services; improving the financial performance of Critical Access Hospitals; and engaging rural communities in health care system development.

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The Medicare Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program (Flex Program), created by Congress in 1997, allows small hospitals to be licensed as Critical Access Hospitals (CAHs) and offers grants to States to help implement initiatives to strengthen the rural health care infrastructure. To participate in the Flex Grant Program, States are required to develop a rural health care plan that provides for the creation of one or more rural health networks; promotes regionalization of rural health services in the State; and improves the quality of and access to hospital and other health services for rural residents of the State. Consistent with their rural health care plans, states may designate eligible rural hospitals as CAHs.

CAHs must be located in a rural area (or an area treated as rural); be more than 35 miles (or 15 miles in areas with mountainous terrain or only secondary roads available) from another hospital or be certified before January 1, 2006 by the State as being a necessary provider of health care services. CAHs are required to make available 24-hour emergency care services that a State determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e., for the reasonable costs of providing inpatient, outpatient and swing bed services).

The legislative authority for the Flex Program and cost-based reimbursement for CAHs are described in the Social Security Act, Title XVIII, Sections 1814 and 1820, available at http://www.ssa.gov/OP_Home/ssact/title18/1800.htm

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) established the Medicare Rural Hospital Flexibility Program (Flex Program) which consists of two separate but complementary components: 1) a Medicare reimbursement component that provides approved cost-based reimbursement for certified Critical Access Hospitals (CAHs) and 2) a state grant component administered by the Federal Office of Rural Health Policy (ORHP) to strengthen the rural healthcare infrastructure using CAHs as the hubs of organized systems of care. This briefing paper focuses on the state grant component of the Flex Program, examining the objectives and project activities proposed by states in their Flex Program grant applications for Fiscal Year 2004 (September 2004-August 2005).

As directed by the Fiscal Year 2004 Program Guidance, states proposed a range of activities to best meet the needs of their rural hospitals, EMS services, and communities in the following areas: developing and maintaining a State Rural Health Plan; designating new CAHs; supporting existing CAHs; developing and implementing rural health networks; improving and integrating EMS services; improving quality of care; and program evaluation. To collect information on the activities undertaken in each program area, the Flex Monitoring Team reviewed grant applications and budget requests from the 45 states participating in the Program. Our analysis is based on the amount requested by each state rather than the amount awarded by ORHP as revised budgets detailing changes in spending by objective were unavailable for some states.

State funding requests were greatest for activities related to network development, quality improvement, and supporting existing CAHs at \$4.82, \$5.64, and \$5.91 million respectively. Support for existing CAHs can be provided in a number of ways and vary from state to state. Some states provided funding directly to CAHs under state administered mini-grant programs to support hospital specific activities while others chose to use funds to support more statewide and/or regional activities to address the needs of CAHs through conferences and meetings, training and education initiatives, technical assistance services, recruitment and retention initiatives, operational assessments, and community needs assessments among others.

Forty one state proposals focused on network development efforts at the community, regional, or multi-state level. Although efforts to support the development of horizontal networks among CAHs and/or other hospitals have been common, states increasingly described plans to develop vertical networks between CAHs and other rural health care providers. Many of these efforts focused on the development of networks between CAHs, Federally Qualified Health Centers, and/or Rural Health Clinics.

Nearly half of the states proposed to use the Balanced Scorecard Approach to track performance and quality improvement, while several states proposed to support hospital participation in statewide, multi-state, and/or national quality improvement initiatives. Other proposed state activities included: the creation of CAH quality improvement networks; the development of clinical and quality measures specific to CAHs; development of data collection and reporting strategies; the development of benchmarking initiatives; and the development of disease

management initiatives for pneumonia, congestive heart failure, diabetes, and other chronic conditions.

Forty-four states requested almost \$3.66 million to support activities to improve EMS services. One common strategy was the development of education initiatives for rural EMS providers through activities such as mini-grants and scholarships to attend training programs, the creation of an EMS education infrastructure, and conducting EMS leadership training programs. Another core activity involved initiatives to improve the quality of EMS and emergency care. A third common area included support for EMS needs assessments at the state and/or local level.

Forty states requested almost \$2.75 million to support activities related to the designation of CAHs. Proposed activities included the education of eligible hospitals about the conversion process (particularly for those newly eligible under the provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003), the provision of technical assistance related to conversion, and the funding of financial feasibility studies to support the conversion decision.

Forty one states requested approximately \$1.04 million to support evaluation activities during the current grant year. Twenty two states requested \$0.40 million to support rural health planning activities such as revising the state rural health plan, conducting statewide planning initiatives, or conducting special studies of specific illnesses or health care needs.

Due to expansion in the number of facilities eligible for CAH conversion under the Medicare Modernization Act of 2003, most states continued to request funding for activities to support conversion. However, states have shifted the focus to other program goals, such as quality improvement, networking, and strengthening the rural healthcare infrastructure. The Federal Office of Rural Health Policy (ORHP), the Flex Monitoring Team, and the Technical Assistance Service Center of the Rural Health Resource Center are currently working with states, CAHs, and others to develop national financial, quality, and other performance measures relevant to CAHs and the Flex program. Over time, these measures will be helpful in identifying performance barriers and problems and priorities for performance improvement.

INTRODUCTION

The Balanced Budget Act of 1997 (BBA) established the Medicare Rural Hospital Flexibility Program (Flex Program). The program consists of two separate but complementary components: 1) a Medicare reimbursement component that provides approved cost-based reimbursement for certified Critical Access Hospitals (CAHs) and 2) a state grant component administered by the Federal Office of Rural Health Policy (ORHP). This briefing paper focuses on the state grant component of the Flex Program.

The state grant program's overall goal is to strengthen the rural healthcare infrastructure using CAHs as the hubs of organized systems of care. To advance this goal of the state grant program and to ensure that rural Medicare beneficiaries have access to high quality care, states are expected to develop and implement project activities in the following program areas:

- Developing and maintaining a State Rural Health Plan;
- Designating new CAHs;
- Supporting existing CAHs;
- Developing and implementing rural health networks;
- Improving and integrating EMS services
- Improving quality of care; and
- Program evaluation.

The Fiscal Year 2004 (September 2004-August 2005) Program Guidance requires each applicant to describe at least five activities that they will focus on during the funding year. The application must address at least one activity in each of the three required areas: quality improvement; program evaluation; and supporting/sustaining existing CAHs. At least two other program areas (e.g., development of the state rural health plan, designation of CAHs, development of rural health networks, and EMS) must be addressed in the remaining two activities. States may also add up to five additional activities (up to a maximum of ten) that can be tailored to fit state priorities.

This briefing paper examines the project activities proposed by states in their Fiscal Year 2004 Flex Program grant applications and highlights recent trends in State Flex Program planning, development, and implementation. To collect information on these activities, the Flex Monitoring Team reviewed grant applications and budget requests from all 45 states participating in the Flex Program. Please note that this paper is based solely on the applications submitted by state Flex Programs for Fiscal Year 2004 and, as such, contains information only on the activities proposed, not on the actual awarded as revised post-award budgets detailing changes in spending were not available for some states.

PROGRAM FUNDING AND OPERATIONS

The forty-five states eligible for participation in the Flex Program requested a total of \$26,568,178 from the Federal Office of Rural Health Policy for Fiscal Year 2004. Table 1 shows the

amount requested and the number of CAHs certified by August 2004 for each state. For all states, the average request was \$590,404 (with a range of just over \$290,000 to the maximum limit per request of \$700,000).

Among the 45 state Flex Programs, 33 are managed by a state government agency, typically the State Office of Rural Health. The remaining 12 are overseen by university-based offices or non-profit organizations. Some states have opted to use a joint management approach, partnering with state health or hospital associations, or university-based organizations to administer the program.

Many state Flex Programs supplement their core staff through a variety of contractual and/or organizational linkages with other rural stakeholders organizations to carry out project activities. The most common of these working relationships are with state hospital associations (40 states), EMS agencies (28 states), and Quality Improvement Organizations (24 states). Other program participants include primary care associations, local universities, medical schools, state rural health associations, and Area Health Education Centers.

Table 1: FY04 Funding Requests and Number of CAHs Operating as August 31, 2004

State	Amount Requested	# of CAHs		Amount Requested	# of CAHs
AK	\$544,000	8	NC	\$586,869	18
AL	\$670,861	1	ND	\$700,000	30
AR	\$539,344	21	NE	\$700,000	60
AZ	\$571,733	10	NH	\$675,354	7
CA	\$442,000	14	NM	\$336,455	5
CO	\$673,687	24	NV	\$596,562	7
FL	\$650,052	9	NY	\$461,844	9
GA	\$621,346	32	OH	\$695,982	24
HI	\$540,000	6	OK	\$695,930	25
IA	\$700,000	59	OR	\$690,524	22
ID	\$536,724	24	PA	\$357,390	8
IL	\$698,000	39	SC	\$497,938	1
IN	\$567,937	23	SD	\$697,615	35
KS	\$700,000	73	TN	\$700,000	7
KY	\$690,617	22	TX	\$700,000	56
LA	\$469,579	14	UT	\$465,890	6
MA	\$290,247	3	VA	\$649,846	5
ME	\$403,110	8	VT	\$421,152	4
MI	\$572,295	20	WA	\$650,000	32
MN	\$700,000	55	WI	\$700,000	42
MO	\$457,305	18	WV	\$700,000	15
MS	\$699,858	16	WY	\$449,962	13
MT	\$700,000	39			

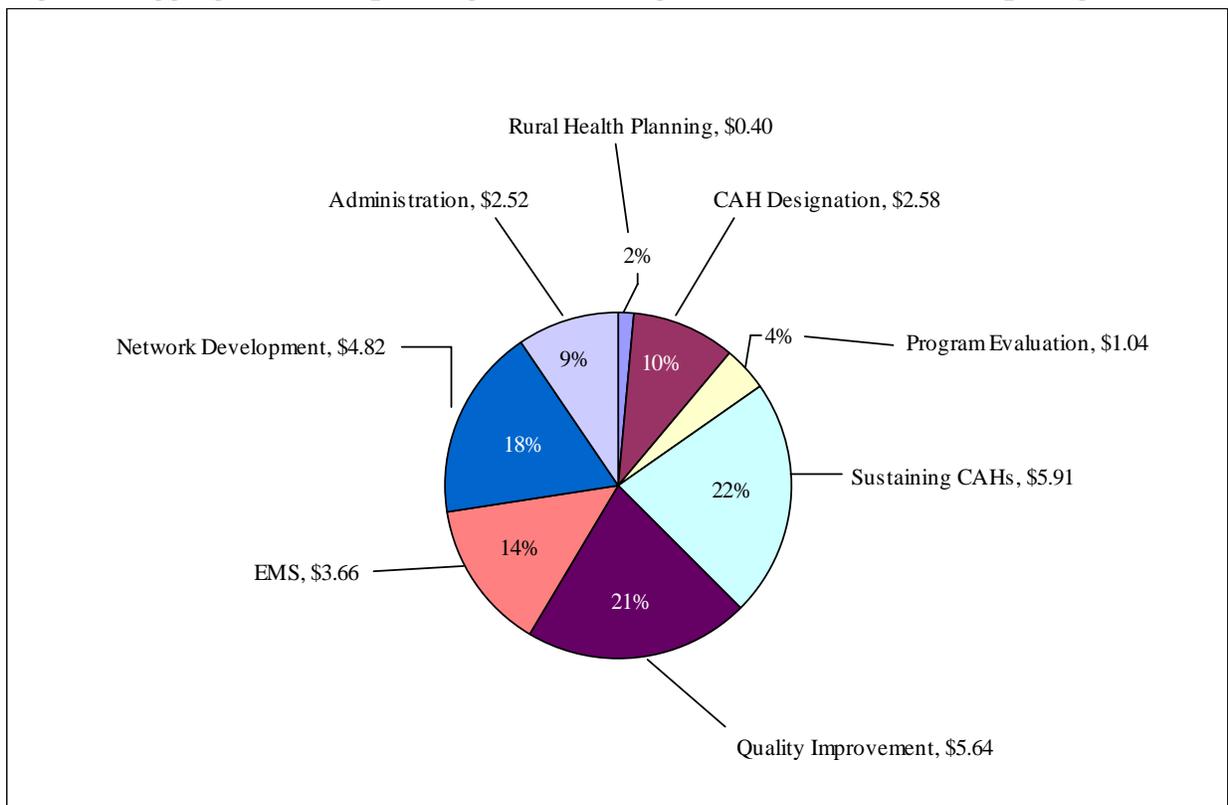
Source: Fiscal Year 2004 Flex Grant applications and Flex Monitoring Team website.

PROGRAM OBJECTIVES

As described above, the Fiscal Year 2004 Program Guidance requires applicants to include a minimum of five, but no more than ten objectives that they propose to address in the coming year. At least one objective must address each of the following areas: quality improvement, program evaluation, and supporting/sustaining existing CAHs although there is no requirement for the amount of funds that must be devoted to these efforts. The remaining objectives must target at least two of the additional core areas.

As shown in Figure 1, total funding requested for the seven program areas varied considerably.¹ The total funding requests were greatest for activities that directly impact hospitals and communities including those that support existing CAHs, develop and implement rural health networks, improve quality, support EMS, and designate CAHs. Comparatively less funding was requested for evaluation and rural health planning activities.

Figure 1 Aggregate State Spending for Flex Program Areas (N=45 Participating States)



Source: Fiscal Year 2004 Flex Grant Applications (\$ in millions)

In reviewing this paper, it is important to recognize that many activities proposed by state Flex Programs typically cross over multiple program objectives. For example, networking initiatives

¹ Our discussion is based on the amount requested by each state rather than the amount awarded by ORHP as revised budgets detailing changes in spending by objective were unavailable for some states.

can be undertaken to support quality improvement activities, EMS development, and/or supporting and sustaining existing CAHs. When categorizing these activities, we chose to use the goal statements developed by the states for these objectives to assist us in assigning them to the appropriate categories of activities.

State Rural Health Planning Activities

Twenty two of the states included rural health planning activities in their proposals and focused their activities on revising the state rural health plan, comprehensive statewide planning efforts, and/or special studies of specific illnesses or health care needs. These states requested a total of approximately \$404,000 to conduct these activities. Sixteen states proposed to revise their state rural health plan by updating data on the health and service needs of rural residents or getting input from rural stakeholders, while four expected to participate in statewide planning initiatives. The following are examples of the types of state rural health planning activities undertaken by the states.

- **Alaska** planned to assist community organizations in collaborative planning and to participate in statewide planning for telemedicine.
- **Arizona** proposed to continue to refine its planning document entitled, *Arizona Rural EMS Agenda for the Future*, in conjunction with the priorities outlined in its state wide EMS document, *Arizona's EMS Agenda for the Future*.
- **Hawaii** proposed to collaborate with the Hawaii Performance Improvement Collaborative, the state Rural Health Association, and Department of Health to track and improve health status in local communities.
- **Massachusetts** planned to conduct special studies on cardiovascular disease, women's health needs, and diabetes in rural areas.
- **Vermont** planned to design an EMS planning process to focus on the needs of rural communities and integrate the planning process in the Vermont Health Resource Allocation Plan and State Health Plan. The EMS planning process will include developing strategies for quality improvement, including EMS accreditation for rural services, and models for rural EMS best practices and collective training needs. The process would be integrated into two current statewide health planning and resource initiatives.

Designation of CAHs

Thirty eight states requested a total of \$2.58 million to support CAH designation and conversion. Although conversion activity had slowed in recent grant years, changes enacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 have spurred renewed interest in conversion among hospitals that were previously undecided about or otherwise ineligible for

conversion.² Proposed activities included educating eligible hospitals about CAH conversion, providing technical assistance related to the conversion process, and funding financial feasibility studies to assess the benefits of conversion.

Program Evaluation

Forty one states proposed specific evaluation activities in their Fiscal Year 2004 applications. The amount requested to support these activities totaled \$1.04 million. Proposed evaluation activities fell into three major categories: 1) financial impact of conversion on the hospital and/or local communities (17 states); 2) evaluation of overall program activities (16 states); and 3) evaluation of select program activities (20 states) and were typically designed to meet specific state needs. Examples of the range of evaluation activities are described below.

- **Alaska** proposed to evaluate Federal Extended Stay Clinics as part of its evaluation activities in order to track the implementation of these clinics and better understand their impact on CAHs and the development of vertical rural health networks.
- **Hawaii** planned to hire an outside consultant who will not only conduct the evaluation, but also train and educate local residents and program staff in evaluation techniques to build the state's evaluation capacity.
- **Massachusetts** has developed an evaluation matrix that is updated annually to track the effectiveness of the program since its inception and make improvements or changes based on multiple years of data.
- **Nevada** proposed to develop a data collection instrument to identify and quantify the type and amount of technical assistance that the program provides to CAHs and CAH eligible hospitals.

Supporting/Sustaining Existing CAHs

Forty two states requested a combined total of \$5.91 million to fund activities to support and sustain existing CAHs. The type and scope of the proposed activities varied widely based on individual state needs. Some states opted to give funding directly to CAHs through mini-grants to support hospital specific activities related to training, equipment purchases, etc. The majority, however, chose to support CAHs through state-developed activities including CAH conferences

² The Medicare Prescription Drug, Improvement and Modernization Act of 2003 enacted the three changes to the program that served to broaden the number of hospitals eligible for CAH conversion and accelerate the pace of conversions. The Act increased the number of hospitals eligible for CAH conversion by raising the cap on acute care beds from 15 to 25 beds (effective January 1, 2004) and allowing CAHs to operate distinct part psychiatric and rehabilitation units (effective October 1, 2004). The pace of CAH conversions were accelerated by the elimination of the Necessary Provider exception (effective January 1, 2006) by encouraging hospitals that were previously undecided about CAH conversion and did not meet the federal mileage requirements to convert before the option was lost to them. Raising the cap on acute care beds has already had a significant impact in some states as over 111 hospitals with 16 or more acute beds converted to CAH status between January 2004 and August 2004. (Source: Flex Monitoring Team CAH Conversion Process Statistics Grid, Fourth Quarter Survey, August 2004).

and meetings, training and educational programs, technical assistance activities, hospital and/or community assessment activities, and recruitment and retention activities. Eight states proposed to hold CAH meetings and conferences or host listservs to keep CAHs informed about updates to state and federal policy changes. Another popular activity involved the development of training programs and workshops to educate CAH staff on topics related to financing and operations, service expansion, swing bed utilization, recruitment and retention, billing, etc. Examples of these activities are provided below.

- **Colorado** proposed ongoing training sessions to increase awareness and utilization of the swing bed program. As part of this program, the state developed a swing bed manual (which includes updated information on regulatory changes) and a swing bed informational brochure for patients and families. Colorado also proposed to develop a guide for capital funding for rural hospitals that includes all funding options available in the state.
- **Kansas** planned to work with the Kansas Hospital Association to develop a CAH Board leadership development program. This program is intended to increase the effectiveness and knowledge of hospital trustees, develop leaders who understand health care financing and management, and build a shared cooperative vision for the future. The educational program is intended to provide board members with information on legal requirements, financial oversight, quality processes, strategic planning, patient and employee satisfaction, CEO and board self-evaluation resources, and the workings of the health care system.
- **Idaho** proposed a training program on a digital medical library offered through Telehealth Idaho for health care providers to increase its usage. This comprehensive, internet-based medical library provides easily accessible, up-to-date medical information that will enhance quality of care and facilitate accurate decision making in rural settings.
- **Michigan** proposed to hire a “Community Grant Consultant” to assist CAH staff in identifying and applying for grants thereby improving the ability of CAHs to access outside funding. This consultant will assist hospital CEOs to identify staff or community members who can write grants and will develop a curriculum to train these individuals on grant writing.
- **Minnesota** proposed to assess the capacity of CAHs to deal with emergency mental health patients in order to respond to community needs.

Technical assistance is another important activity proposed by states to support CAHs. The types of technical assistance offered by states include assistance with strategic planning, re-certification, marketing, operations and financing, billing and reimbursement, and information technology. Again, since these activities vary so much from state to state, we have chosen to provide a few examples of these activities.

- **Colorado** planned to develop a comprehensive catalog of services and technical assistance for Rural Health Clinics (13 of Colorado’s CAHs own and operate Rural

Health Clinics). These services are expected to focus on cost reporting, billing and reimbursement assistance, human resources, community development, needs assessment, and funding opportunities.

- **Louisiana** proposed to work with the Louisiana Rural Hospital Coalition to hire a hospital practice manager who would provide ongoing operational support to CAHs. This practice manager will assist rural hospitals to assess the best reimbursement models for the delivery of primary care services in their communities.
- **Nevada** proposed to work with Nevada's Medicaid program to finalize formal agreements for cost-based reimbursement for outpatient services and the payment/reimbursement of telehealth consultations for Medicaid clients.
- **Oregon** planned to assist CAHs in assessing physical plant and telehealth needs. They will also work closely with the hospitals to formulate a strategic plan for meeting identified these needs.

Eleven states planned to support studies to assist CAHs in improving their service mix. Arkansas, Idaho, Kentucky, and South Dakota planned to conduct financial assessments and market share analyses to assist hospitals in improving their financial performance. Alaska and Oregon planned to assess information technology needs, while Arkansas proposed to assess capital improvement needs among its CAHs.

Several states proposed to address recruitment and retention issues as described in the following examples.

- **Alaska** proposed to develop a statewide rural network to explore a centralized, CAH based recruitment network.
- **Kansas** proposed a broad range of recruitment and retention activities including: continuing its support for Team Kansas (a collaborative approach stressing the creation of a positive work environment and team building skills); renewing its agreement with the Kansas Recruitment Center to recruit physicians, physician extenders, dentists, and other health professionals to rural communities; and participation in the Kansas Recruitment Network, a broad group of agencies that collaborate to enhance rural health professional recruitment efforts in the state.
- **Pennsylvania** proposed to work with the Department of Health Policy and Administration at Penn State to develop internships for students in CAHs to provide CAHs with additional workforce support and develop a pool of future administrators with rural health care experience.

Development and Support of Rural Health Networks

Forty one states requested a combined total of \$4.82 million to support network development initiatives in Fiscal Year 2004. Although most states initiatives in this area focus on the development of either in-state regional or statewide networks, there is a growing emphasis on

multi-state networks. While some states continued to work the development of new horizontal hospital networks (including CAHs, larger hospitals, and hospital systems), the majority of state activity has shifted to working with and supporting existing horizontal hospital networks. Activities include the provision of support for the coordination of network activities, financial support for network-based health and quality improvement projects, and ongoing technical assistance to sustain network activities, examples of which are described below.

- **Arizona, Alaska, and Nevada** proposed to work collaboratively to support an interstate Indian Health Service CAH network focused on improving performance.
- **Kansas** proposed to create a Technical Assistance and Education Center to provide rural health networks with technical assistance in areas such as network governance and operations, continuing education consortiums, network telemedicine development, grantmaking and other areas of interest.

In addition to developing and supporting horizontal networks, several states have focused on developing vertical networks between CAHs and other rural health care providers. The majority of these initiatives are focused on developing networks between CAHs, Federally Qualified Health Centers, Community Health Centers, Rural Health Clinics, and other community providers to expand access and improve coordination of care. Below we provide a more detailed description of proposed state activities to develop community oriented, vertical networks.

- **Alabama** proposed to award mini-grants to fund the development of vertical networks between CAHs and mental health programs in recognition of the fact that rural hospital emergency departments are increasingly being used for behavioral acute care services although they do not have appropriately trained staff to provide this service. Alabama also planned to award mini-grants for development of vertical networks to reduce the impact of chronic disease by administering population-based screening programs which identify residents at high risk for morbidities and mortalities associated with adverse health conditions.
- **California** planned to collaborate with the Center for Technology, eHealth, and Telemedicine, the University of California Telemedicine Center Davis, and the California Health Foundation Trust to expand its pilot telepharmacy network statewide to 10 CAHs. It also proposed to complete its evaluation of the CAH pharmacy service gaps, develop a pharmacy information system, and provide resources to CAHs to purchase pharmacy hardware and software products.
- **Minnesota** proposed to support the development and institutionalization of formal continuity of care networks in CAH communities. In addition, they will encourage and assist CAHs to establish formal vertical networks with FQHCs, RHCs, provider-based clinics, and physician hospital organizations.
- **Vermont** planned to support activities to enhance the effectiveness and efficiency of community health care networks including the development of patient information systems, integration of behavioral and primary care, and planning and coordinating

patient care between hospitals and FQHCs. The development of community health care networks is intended to lead to better coordination across the continuum of care.

- **Washington** proposed to support two types of vertical network development. First, they planned to conduct a CAH/FQHC demonstration project, which will provide a national example of collaboration between these types of organizations. Second, they planned to encourage the development of a vertical network between local health jurisdictions, tribal health organizations, FQHCs, schools and CAHs. These network members will work together to conduct community health assessment and planning activities.

Improvement and Integration of EMS

Forty four states requested funding to support the improvement and integration of EMS. Total funding requests to support approached \$3.66 million. One common strategy adopted by the states involved the development of education and training initiatives for rural EMS providers. Proposed activities included the provision of mini-grants and training scholarships to support attendance at training programs, the creation of an EMS education infrastructure through collaborations with community colleges, medical schools, and other educational organizations, the development of computer based training programs, and holding training and leadership development conferences for EMS providers. Another core area of activity involved the development of initiatives to improve the quality of EMS and emergency care including the development of clinical protocols to guide patient transfers and the delivery of trauma services and EMS specific performance and quality improvement programs. A third common area of activity included funding and support to conduct EMS needs assessments at the state and local level. Examples of the different state activities are provided below.

- **Arizona** planned to provide EMS services in each CAH region with an interactive training CD entitled “Critical Decisions in Pre-Hospital Management”.
- **Massachusetts** proposed to implement a stroke initiative to assess regional systems of stroke services, build regional systems for hospital and pre-hospital stroke care (point of entry plans), and to ensure that rural hospitals and EMS providers are well integrated to provide rural communities with access to a network of quality stroke services.
- **Minnesota** proposed to develop and provide tailored performance improvement tools to rural ambulance services including EMS leadership management institutes, a recruiting video, and/or a recruitment support package.
- **Nebraska** planned to develop a Comprehensive Advanced Life Support (CALS) program to meet a need for advanced EMS training. Initially, the program will support the attendance of five physicians and five nurses at a CALS program offered by the University of Minnesota Medical School (UMMS). These providers and the Flex Program will then work with the University of Nebraska Medical Center and the Creighton University Medical School to develop a joint CALS program. Technical assistance will be provided by representatives from UMMS.

- **Pennsylvania** planned to support the development and implementation of rural transfer and triage protocols and train the staff of the CAHs, referral hospitals, and local EMS units on the use of the protocols.
- **South Carolina** planned to develop and offer a “New EMS Leader” boot camp for EMS professionals to help combat burnout and unrealistic expectations among EMS providers and support their career progression by enhancing their supervisory, management and writing skills and by engaging them in discussions regarding educational opportunities and possible career ladders.
- **South Dakota** proposed to develop and implement an electronic ambulance run ticket data system. The data collected will facilitate statewide planning and resource allocation by providing information on the purpose for ambulance runs (e.g., trauma, transfer, illness, etc.)
- **Utah** planned to support and conduct a series of courses including: a Pre-Hospital trauma life support (PHTLS) course for rural EMS providers; Together Everyone Achieves More (TEAM) courses for rural EMS and hospital health care providers, a trauma education course for rural providers; and a medical director course for rural EMS medical directors. Coordination of the courses will be provided by BEMS staff at rural sites.

Quality Improvement

Forty four states requested \$5.64 million in funding to support quality and performance improvement activities. Nearly half expected to assist CAHs in the implementation of the Balanced Scorecard approach to support their performance and quality improvement efforts. Several states supported the development of and participation in state, regional, and national quality and performance improvement initiatives. Other states proposed to support the creation of quality and performance improvement networks to assist CAHs in identifying areas needing improvement and developing appropriate responses including the development of CAH specific protocols. Others have proposed to support networks focused on benchmarking initiatives that involve the development of CAH-specific quality measures as well as collecting and reporting data on those measures to enable CAHs to compare themselves to similar hospitals. Finally, other states proposed to encourage hospitals to participate in disease management initiatives for pneumonia, congestive heart failure, diabetes, and other chronic conditions. Below are several examples of quality improvement activities proposed by state Flex Programs.

- **Alabama** proposed to support the development of a Rural Hospital Performance Improvement Committee with the goal of developing a benchmarking program for small, rural hospitals. It also proposed to award mini-grants to 12 hospitals to participate in the Joint Commission on Accreditation’s Continuous Survey Readiness Program (or similar program) to encourage participation in an established and ongoing process to monitor the delivery of quality care.
- **Arkansas** proposed to work with the state QIO to address concurrent chart review and help improve CAHs’ scores on 10 core measures of quality improvement. Arkansas also planned to facilitate the identification of two to three additional protocol needs of CAHs.

Protocols being used in similar hospitals, in terms of size and geography, will be gathered for review by appropriate hospital staff. The top protocols will be distributed in a reference manual to each hospital.

- **California** planned to develop and implement a chronic disease management pilot project in two CAH communities, evaluate results, and prepare final reports with recommendations for each site. It also proposed to continue its collaboration with the California Institute for Health Systems Performance to provide resources and technical assistance to six additional CAHs to participate in Patients' Evaluation of Performance Program in California, a statewide voluntary survey of recently discharged patients regarding their perception of hospital care that is published in a patient consumer guide.
- **Florida** proposed to work with Florida Medical Quality Assurance, Inc. (the state's Quality Improvement Organization) to expand its quality improvement initiative to additional rural providers. The goals of this initiative are to develop a blameless culture of patient safety, reduce medication errors in CAHs, pursue private and public funding to purchase automated dispensing equipment for CAHs, and establish electronic informational linkages between community pharmacy providers.
- **Illinois** proposed to develop a cooperative partnership between the Center for Rural Health, the Illinois Health Education Consortium, the University of Illinois, Southern Illinois University, and Western Illinois University to develop a community health education template for chronic disease management that would be made available to CAHs and other rural providers.
- **Massachusetts** planned to provide leadership to improve and enhance the system of care for rural pregnant women and newborn infants by participating in the review and revision of the state's maternal newborn regulations and assisting rural hospitals and providers with developing better local and regional systems of care.
- **Utah** proposed to hire a clinical facilitator to establish a functional trauma committee in each CAH facility. The committee will deal with internal issues and facilitate communication between the CAHs and their response partners. Building upon past collaborative activities between EMS providers and CAHs, pre-hospital emergency care and transfer protocols for each facility will be established and implemented in communities to ensure appropriate continuity of care using established best practices, the provision of appropriate care, and the continued viability of the CAHs and EMS services within rural communities.
- **Vermont** proposed to have its CAHs participate in the Institute for Health Care Improvement IMPACT program to support a coordinated statewide initiative that generates measurable improvement in quality and patient safety. The hospitals will determine the best strategy for participating in the IMPACT network including setting specific improvement aims. The action and leadership teams will meet five times per year with other IMPACT members and work towards improvement between meetings.

- **Virginia** proposed to work with Virginia Commonwealth University to develop a patient safety fellowship program. The program will require fellows to study and develop a patient safety intervention for small rural hospitals.
- **Washington** planned to continue its support of the Rural Health Care Quality Network through the provision of support for an Executive Director and Medical Director; the development of policies, procedures, resources, and standards; and the ongoing development of the network infrastructure. The purpose of the network is to meet Medicare Conditions of Participation requirements for credentialing, peer review, and quality improvement oversight for CAHs in Washington.

Administrative Activities

The total amount requested for Flex Program administrative activities and support (\$2.52 million) represented 9% of the total funding requested by the states. These funds were requested to support staffing, travel, and other costs necessary to operate individual state Flex Programs.

CONCLUSIONS

Although some states continue to include CAH conversions as a major area of program activity, most have shifted the focus of their programs to supporting the ongoing viability of CAHs and core rural providers including EMS. Their efforts target the core objectives outlined in the Flex Grant Program Guidance including quality improvement, network development, and strengthening the rural healthcare infrastructure. These latter efforts include the provision of technical assistance to hospitals, EMS services and communities; the development of recruitment and retention programs; support for the expansion of telemedicine and health information technology capacity; and programs to assist with the expansion of services. The majority of the Flex funds requested by the states are being requested to support activities in these core areas. One growing area of Flex Program activity is that of quality and performance improvement. Some state quality improvement efforts have reached beyond their borders to engage in multi-state, regional and national quality improvement initiatives. The range of quality improvement initiatives proposed by the states include the development of statewide quality and performance improvement networks, CAH-specific clinical protocols and quality measures, systems to collect and report quality data, and benchmarking programs that allow the CAHs to compare themselves against similar hospitals. The Federal Office of Rural Health Policy (ORHP), the Flex Monitoring Team, and the Technical Assistance Service Center of the Rural Health Resource Center are currently working with states, CAHs, and others to develop national financial, quality, and other performance measures relevant to CAHs and the Flex program. Over time, these measures will be helpful in identifying performance barriers and problems and establishing priorities for performance improvement.

ACRONYMS USED IN THIS REPORT

BBA	Balanced Budget Act of 1997
BEMS	Bureau of Emergency Medical Services
CAH	Critical Access Hospital
CALS	Comprehensive Advanced Life Support
CEO	Chief Executive Officer
EMS	Emergency Medical Services
FLEX PROGRAM	Medicare Rural Hospital Flexibility Program
FQHC	Federally Qualified Health Center
ORHP	Federal Office of Rural Health Policy
PHTLS	Pre-hospital Trauma Life Support
QIO	Quality Improvement Organization
RHC	Rural Health Clinic
TEAM	Together Everyone Achieves More, a recruitment and retention project developed by the Kansas Flex Program
UMMS	University of Minnesota Medical School