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Executive Summary

A Review of State Flex Program Plans 2004-2005

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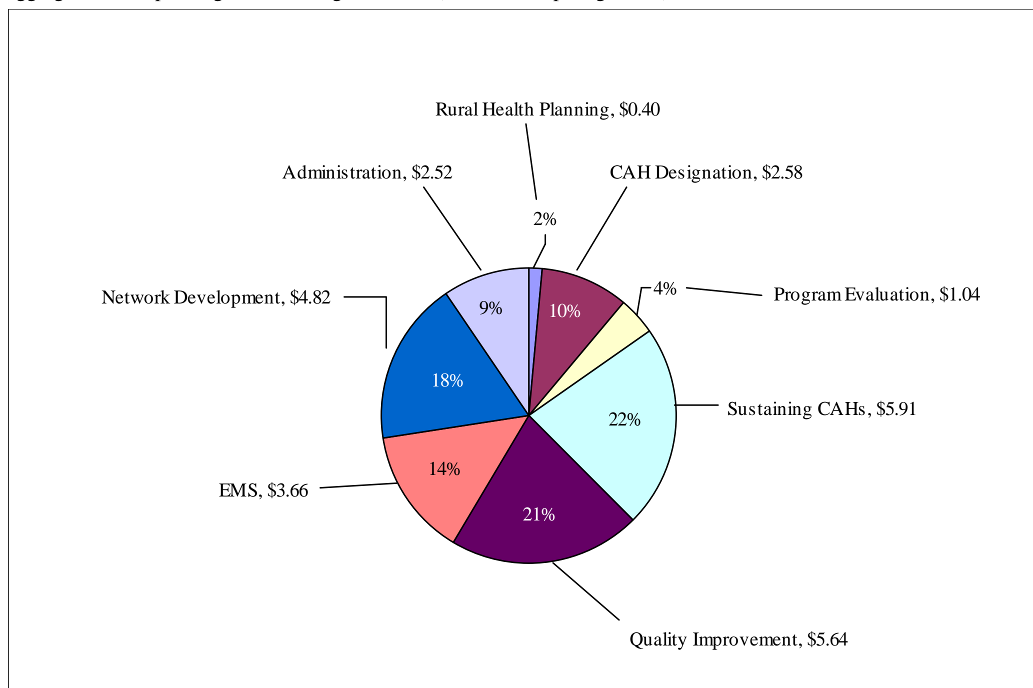
The full report may be viewed or downloaded from the Flex Monitoring Team web site at: http://flexmonitoring.org/documents/BriefingPaper10_StateFlexGrantReview.pdf

This briefing paper examines the project activities proposed by states in their Fiscal Year 2004 Flex Program grant applications (September 2004-August 2005) and highlights recent trends in State Flex Program planning, development, and implementation.

Methods
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. note 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.

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



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

Findings:
State funding requests were greatest for activities related to network development, quality improvement, and supporting existing CAHs. 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.

Conclusions

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.