

*Flex Monitoring Team Briefing Paper No. 1*

# **A Synthesis of State Flex Program Plans 2003-2004**

**May 2004**



**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.

The authors of this report are Rochelle Schultz Spinarski, MPA, consultant to the University of Minnesota Rural Health Research Center (UMRHRC) and Walter Gregg, MA, MPH, Senior Research Fellow at UMRHRC.

**Flex Monitoring Team**  
<http://www.flexmonitoring.org>

**University of Minnesota**  
Division of Health Services Research & Policy  
420 Delaware Street, SE, Mayo Mail Code 729  
Minneapolis, MN 55455-0392  
612.624.8618

**University of North Carolina at Chapel Hill**  
Cecil B. Sheps Center for Health Services Research  
725 Airport Road, CB #7590  
Chapel Hill, NC 27599-7590  
919.966.5541

**University of Southern Maine**  
Muskie School of Public Service  
PO Box 9300  
Portland, ME 04104-9300  
207.780.4435

# **A Synthesis of State Flex Program Plans 2003-2004**

## **SUMMARY**

In FY03, states received just over \$22 million from the State Flex Grant Program for a state average of approximately \$490,000. Many states have shifted the focus of their efforts from conversion and designation to activities that strengthen and stabilize those areas of rural infrastructure that are important for the continued success of CAHs in meeting local health care needs (e.g., CAH performance improvement and EMS integration and systems development).

States are pursuing these activities using a variety of strategies including ad hoc state-to-state collaborations, formal multi-state initiatives, and key state stakeholder groups to maximize available financial and human capital and economies of scale related to program development and implementation.

## **INTRODUCTION**

This Flex Program Monitoring Team Briefing Paper highlights recent trends in the development and implementation of State Flex Programs. Data for the Briefing Paper were collected from state FY03 Flex Program grant applications and records of budget revisions, and directly from a number of state Offices of Rural Health. The national level funding information reflects data from all 45 states participating in the Flex Program; while the programmatic information reflects data from 40 states (budget revisions were not available for five states).

## **FLEX PROGRAM OVERVIEW**

The Balanced Budget Act of 1997 (BBA) established the Medicare Rural Hospital Flexibility Program (Flex Program). The Flex Program consists of two separate but complementary components: a Medicare reimbursement program that provides approved cost-based reimbursement for certified Critical Access Hospitals (CAHs) and a state grant program administered by the federal Office of Rural Health Policy (ORHP) to support the development of community-based rural organized systems of care in the participating states. As of March 4, 2004, 887<sup>1</sup> Critical Access Hospitals (CAHs) were operating in 45 U.S. states (a 15% increase over the eight months since submission of the FY03 applications).

This Brief focuses on the state grant program, which is authorized under the same legislation as the reimbursement component, but requires Congressional appropriations to continue each year. The goal of the state grant program is to strengthen the rural healthcare infrastructure using Critical Access Hospitals as the hub of organized, local systems of care. The overarching program goal is to foster the growth of collaborative rural delivery systems across the continuum of care at the community level with appropriate external relationships for referral and support.

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<sup>1</sup> The current CAH listing is available on the Flex Monitoring Team website: <http://www.flexmonitoring.org>

The statutory and regulatory provisions of the national program require states to engage in rural health planning through the development and maintenance of a State Rural Health Plan, to designate and support the conversions of CAHs, promote EMS integration initiatives by linking local EMS with CAHs and their network partners, develop rural health networks to assist and support CAHs, develop and support quality improvement initiatives, and evaluate their programs within the framework of national program goals.

The federal Office of Rural Health Policy (ORHP) within the Health Resources and Services Administration of the Department of Health and Human Services manages the grant program nationally, making funding available to state Flex Programs and providing program oversight. ORHP contracts with the Technical Assistance Service Center (TASC) at the National Rural Health Resource Center in Duluth, Minnesota to provide technical assistance to states, and has a cooperative agreement with the Flex Program Monitoring Team, a consortium of the Rural Health Research Centers at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine, to monitor program implementation, performance and changes over time. TASC is responsible for responding to program implementation issues in states, developing and sharing tools, supporting a Flex Program Website, and hosting on-going regional and national Flex Program meetings. The Monitoring Team is assessing the impact of the Flex Program on participating rural hospitals, their communities, and the states in which they operate.

There have been three revisions to the BBA since 1997. Most recently, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) made several key changes in the Flex Program, including: 1) increasing the reimbursement for CAHs to 101% of reasonable costs for inpatient, outpatient, and covered swing bed skilled nursing services; 2) raising the cap on acute care beds from 15 to 25 acute care beds (effective January 1, 2004); 3) allowing CAHs to establish a distinct part unit such as psychiatric and substance abuse units; and 4) eliminating states' authority to designate CAHs as necessary providers and waive distance limitations (as of January 1, 2006).<sup>2</sup> These changes are expected to affect the participation of rural hospitals in a number of states, particularly those where hospitals have been operating near the original 15-bed limit and where small rural hospitals have distinct part service units.

## **STATE FUNDING**

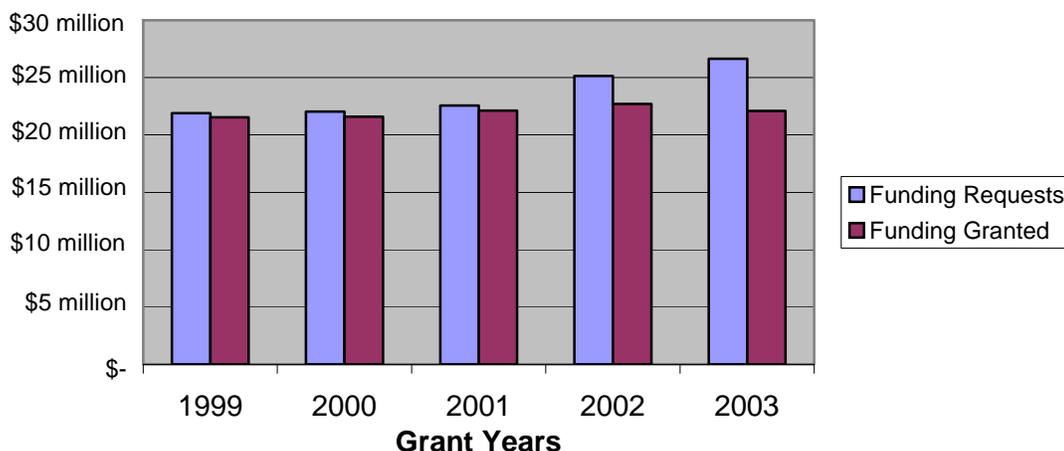
States received approximately \$22 million in state Flex grant funds in FY03, for an average state award of just under \$500,000 (Figure 1). During the first three years of the Flex Program (FY99 through FY01), state grant requests closely paralleled the available funding. However, funding requests exceeded available funding by \$2.42 million in FY02 and by \$4.54 million in FY03. Table 1 shows the funding levels by state.

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<sup>2</sup> RUPRI. (2004, January). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: A Summary of Provisions Important to Rural Health Care Delivery. (P2004-1). <http://www.rupri.org/healthpolicy>

**Figure 1**

**National Flex Program Funding**



**Table 1**

**FY03 Funding and Number of CAHs Operating by State, May 2003**

State	# CAHs	Funding	State	# CAHs	Funding	State	# CAHs	Funding
MA	3	\$223,340	SC	1	\$452,560	KY	15	\$583,800
NM	5	\$231,580	IA	51	\$465,000	WA	26	\$585,000
VT	3	\$234,250	ID	21	\$474,890	GA	28	\$585,000
CA	13	\$326,200	AK	1	\$480,000	OH	18	\$600,000
VA	3	\$352,000	WV	13	\$485,700	OK	20	\$614,000
PA	6	\$357,390	MI	16	\$513,600	TX	38	\$615,000
NH	5	\$365,500	TN	6	\$517,000	KS	54	\$620,000
UT	2	\$371,000	IN	17	\$526,000	NE	58	\$630,000
WY	4	\$379,300	CO	18	\$529,200	WI	28	\$651,145
LA	11	\$385,000	HI	6	\$543,000	OR	12	\$653,850
MS	11	\$395,000	AK	5	\$544,000	ND	28	\$655,000
MO	15	\$407,750	FL	8	\$550,000	SD	28	\$660,000
AZ	11	\$421,000	AR	17	\$573,000	MT	34	\$660,000
NY	7	\$421,250	NC	14	\$574,000	IL	26	\$668,000
ME	8	\$435,000	NV	6	\$578,000	MN	46	\$685,000

## STATE OPERATIONS

In 32 states, the state Flex Program is managed by a State Office of Rural Health (SORH) housed in state government, usually as part of a Department of Health. In 10 states, university-based state Offices of Rural Health run the Flex Program. In 3 states the Flex Program is managed by private non-profit organizations. A total of 80.5 FTEs are dedicated to working on state Flex Programs based in SORHs, universities, and private entities for an average of 1.8 FTEs per state. State applications suggest that a large number of additional personnel are linked with the state programs through private contracts with consultants and most notably with State Healthcare and Hospital Associations. Six states (California, Kansas, Kentucky, Mississippi, Montana, and Tennessee) work with their State Hospital Associations in a co-manager role, sharing program responsibilities for CAH conversion, financial feasibility studies, quality improvement activities and other functions.

Over the past year, 40% of the participating states experienced turnover of key Flex Program staff for a variety of reasons. Five states lost their only Flex staff person and another five lost one of the two staff that had been available to the program. Many states were further challenged as they faced state hiring and wage freezes. Delays in filling positions as well as getting replacements knowledgeable about program goals and objectives resulted in project delays and cancellations for approximately one-third of the states. Since rural health planning and EMS development are frequently staffed internally, the impact of the staffing challenges was especially felt in these areas.

The majority of states have used mini-grants and other funding vehicles to target their Flex Program funding to local hospitals and programs. Eighty percent of the participating states allocated between 30 and 70% of their FY03 budget for these purposes. As Flex Program activities have evolved to support CAH capital improvement, planning, recruitment and retention of health professionals, quality improvement, tele-health and tele-communications in CAHs, local and regional planning, and staff training (e.g. billing, licensing and certification survey readiness), state program staff have played a critical role in providing technical assistance and supporting communications and shared learning among CAHs and other program participants.

## STATE ACTIVITIES

State Flex Programs must address at least one objective in each of the following areas: quality improvement, program evaluation, and supporting/sustaining existing CAHs. In addition, they are required to include objectives addressing at least two out of the five core areas (e.g., State Rural Health Plan, Designation of CAHs, Rural Health Networks, EMS, and Quality of Care). The following section provides an overview of state activities and spending as well as information on national spending for core program areas (Figure 2). Information provided in this section reflects available data from the 40 states that provided revised Flex Program budgets.

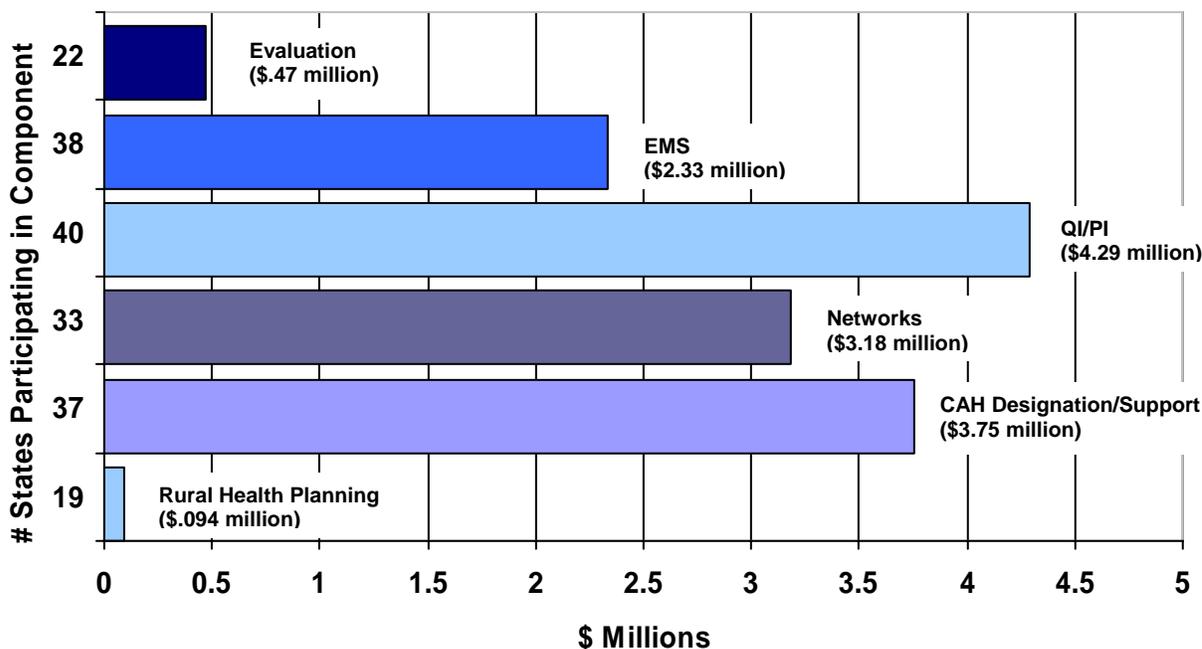
**Rural Health Planning.** Two-thirds of the participating states are engaged in rural health planning and the use of statewide planning groups to guide these efforts. Five states have formed planning committees specifically for addressing CAH issues while the rest have formed broader Flex Program Planning Committees that address a wide spectrum of rural infrastructure policy issues important for CAH operations and success. State program staff are responsible for

most rural health planning activities. A total of \$93,000 was targeted for contractual services to support state planning efforts in FY03 (e.g., data collection and analyses for State Health Plans, and facilitators to help state planning committees successfully implement measurable data based strategies). This figure does not accurately reflect the scope of planning activities, however, because most states are using project staff in addition to, or in place of, contractors for planning activities (i.e. these costs are part of the states' overall administrative costs). Specific planning activities have included ambulance and EMS service area needs assessments, bio-terrorism preparedness planning, refining EMS components of State Rural Health Plans, Rural Health Works initiatives, and statewide rural health data collection and reporting.

EMS systems development has been a growing focus of state planning efforts, particularly enhanced linkages for collaborating with CAHs and their network partners to coordinate pre-hospital services.

**FIGURE 2**

**National Spending For Flex Program Components**



**CAH Designation/Support.** Decreasing rates of CAH conversion coupled with the increasing state capacity for CAH designation and conversion have allowed states to shift the emphasis of their Flex Programs toward more long-term and complex infrastructure issues important for the ongoing operations of CAHs. States that continue to develop capacity for designation and conversion are requesting grant funds to provide internal staff support or to underwrite subcontracts (often with the state's Hospital Association) for technical assistance activities to help CAHs and eligible hospitals meet conversion and program requirements. Therefore, much of the program funding for providing technical assistance to CAHs and possible converters is included in the state's costs. In addition, \$1.5 million is supporting financial feasibility studies and technical assistance, typically using consultants, and another \$2.2 million is supporting other

designation and support activities such as community readiness studies and the development of key inter-organizational agreements for supporting CAH operations. The majority of the funding requests related to CAHs now target activities that can contribute to the ongoing operational success of existing CAHs (e.g., improving network relations, integrating EMS with CAH operational strategies, enhancing quality and performance improvement efforts).

**Networking.** Approximately three-quarters of participating states are actively addressing CAH network development activities through their state Flex Program. In FY03, states earmarked approximately \$2 million for networking related mini-grants and another \$1.2 million for other networking activities.<sup>3</sup> Much of the work involves local area planning and implementation through mini-grants to CAHs and other community partners. States commonly frame the priorities of local funding and mini-grant initiatives within national program goals, develop and issue a Request for Proposal (RFP) embodying the national program guidelines and requirements, conduct an external review, and subcontract with CAHs or their network partners to implement specific networking plans.

Networks of CAHs are most common, but states are also supporting networks among CAHs and other local and regional healthcare providers. Most examples of network activity center on the provision of a specific set of services and activities to members and the communities they serve. Many states are also supporting CAH network development to increase the integration of services and resources in a given area. Examples of key state networking activities include:

- **Illinois** – over a dozen CAHs have incorporated under a network corporation that the state expects to become self-sufficient in the near future. It has provided mutual assistance to its membership through the development of a mini-cost report program for financial benchmarking, group health insurance for CAH employees, clinical and patient safety benchmarks, a physician/state Quality Improvement Organization (QIO) peer review program, joint recruitment efforts, and in conjunction with the Western Illinois AHEC, a leadership development program (currently piloted with four CAHs).
- **Wisconsin** – has assisted 3 CAH networks to work on a variety of issues important for the on-going survival of CAH operations. A 5-CAH network has developed an Incident Reporting Pilot to provide a means for tracking and addressing patient safety issues specific to CAHs. A network of 6 CAHs has identified public relations and marketing issues important for strengthening CAH market share and stabilizing operations and focuses on community engagement strategies using quality “report cards” to demonstrate the value-added qualities of the CAH for the surrounding community. Another network of 6 CAHs is using information on the size of medical staff and best practice models of recruitment and retention to develop a mutual strategy for meeting the personnel needs of its members.

Many states have been strengthening the health information technology (HIT) capacity of CAHs and their network partners to achieve operational economies and better meet the health care needs of the communities they serve. For example,

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<sup>3</sup> Mini-grant funding is allocated based on the funding category identified in the grant applications. In many instances, mini-grants are used across Flex Program components, including EMS, networking and QI/PI.

- **New York** – has worked with its CAHs to establish electronic connections with their support hospital for laboratory results, order entry, pharmacy, and radiology. One CAH was able to implement an internet based laboratory reporting system between itself, the support hospital, physician offices, and area primary care clinics to improve continuity and quality of care for the service area.
- **Pennsylvania** – has a model telemedicine network with the Susquehanna Valley Rural Health Partnership (SVRHP), a rural health network consisting of three CAHs and a larger referral hospital considered one of the most wired hospitals in the nation. The network has incorporated as a not-for-profit 501(c)(3) and is currently working on a number of HIT projects including teleradiology linkages and a shared pharmacy information system. Another developing CAH network in Pennsylvania has a pilot project between a CAH, its support hospital and its physician web-portal. The project will ultimately allow a sharing of clinical information between CAHs and other rural hospitals in the network and primary care physicians, and an urban referral center along with its specialists.

A number of states have integrated their pre-existing networking or rural health infrastructure development initiatives with their State Flex Program and achieved some economies of scale. North Carolina, New York and Florida have successfully incorporated their Flex Program into existing network development initiatives and have been able to achieve increases in service capacity and have tapped into complementary resources from state networking funds.

- **Florida** – Each of Florida’s eight CAHs is now a member of one of the State’s pre-existing state certified rural health networks and thus in a stronger position to link with non-hospital providers (e.g. county health departments, primary care providers, and EMS squads) as well as hospital providers to meet local needs.
- **New York** – has incorporated its CAHs into existing networks supported under its rural health network development program. Network membership provides CAHs with additional access to statewide technical assistance that complements the Flex Program support (e.g., expertise targeting performance improvement issues).

**Emergency Medical Services.** The number and scope of state projects focusing on Flex-related EMS issues have increased in FY03. A little over \$2 million has been targeted for activities such as recruitment, retention, and training; state planning and assessment activities; mini-grants (e.g., for EMS quality improvement, networking, and purchasing equipment); statewide data collection and reporting; and rural trauma system development. States have dedicated almost \$1 million in FY03 to support EMS related mini-grant projects. Flex Program efforts targeting trauma system linkages with CAHs and their network partners increased in FY03, with eight states working to link aspects of their State Flex Program with statewide trauma activities. Much of the activity focuses on trauma system planning to link rural communities with an existing state-wide system; however, some states are also developing data collection and reporting capacities and HIT development linking medical direction with pre-hospital delivery providers and receiving hospitals. Examples of key state activities and achievements in EMS include:

- **Pennsylvania** – developed rural EMS high-risk transfer and triage protocols and is now in the process of adopting them and conducting training programs.

- **Illinois and Nevada** – are using current HIT strategies for linking CAHs with ambulance services in their area and with other state partners in the program (e.g., trauma registry, laboratory reports, and pre-hospital delivery system data on palm pilots). The palm pilot project in Nevada has reduced the collection and aggregation of pre-hospital data from approximately eighteen months to 48 hours.
- **Georgia** – has created mini-EMS networks using three existing collaboratives that through the sharing of equipment and staff resources have reduced operating costs and include areas of the state that previously had minimal or no access to EMS providers.
- **Nebraska** – has created a model state level capacity for strengthening EMS capacity in CAH communities at key points in the pre-hospital delivery system. Recent accomplishments have included the development of a quality assessment tool to monitor and improve the quality of transfers from CAHs to their support hospitals, an EMS squad assessment for strengthening their managerial and operational efficiencies, and the provision of specific technical assistance through a contracted physician to work directly with medical directors in resolving critical coordination and service delivery issues.
- **Michigan** –Michigan’s successful four county EMS project in the Eastern Upper Peninsula involved three CAHs and a Rural Referral Center in standardizing EMS patient protocols, training EMS volunteers, placing Advanced Life Support (ALS) personnel across the region, collecting and analyzing pre-hospital data, and developing a region-wide billing capacity. This project is being replicated in the Saginaw Bay West Shoreline area and the Thumb Area. A third project is in the planning stages for the Western Upper Peninsula.
- **Hawaii** – with the help of its state EMS system, the U.S. Coast Guard, CAHs and their physicians, has created a communications capacity for consultation and referral of trauma patients to significantly reduce transport times from the five rural islands to specialized medical centers in Honolulu (e.g., prompter treatment and increased flexibility of Coast Guard flights for Homeland Security activities).
- **Mississippi** – has created an EMT-Paramedic Training Scholarship Program (paramedics who agree to practice in a designated rural area upon graduation – one year of practice for each year of scholarship for up to two years credit). CAHs have also been provided with computers and software to participate in the state trauma registry making them eligible for uncompensated trauma care reimbursement.
- **California** – has facilitated linkages between emergency medical services networks and CAHs to integrate them into a statewide trauma care system expansion that covers counties that previously did not have access to the formal trauma system. The system development initiative not only provides standardization of trauma care in hospital settings but also the service support provided through pre-hospital care delivery.

**Quality Improvement (QI) and Performance Improvement (PI).** Most states are now engaged in quality and/or performance improvement activities with CAHs. In FY03, performance improvement and quality improvement led all other program development areas in

funding requests (Figure 2). Approximately one third of all participating states have created QI committees including CAH representatives, network hospitals, other network partners and/or statewide and regional QI stakeholders. Some states have also developed local CAH QI networks to identify, plan, develop and implement QI strategies appropriate for small hospitals such as CAHs. The bulk of the work continues to be carried out through subcontracts with \$4.3 million targeted for FY03. In the past, the creation of QI committees composed of CAHs, network hospitals, and other statewide QI stakeholders (e.g., QIOs and State Hospital Associations) supported both individual CAH and network efforts to develop greater QI capacity. These efforts have continued in FY03 for at least a third of the participating states. State mini-grants have also been a major component of state QI activities, with 19 states targeting approximately \$1.3 million in FY03 to build and enhance local QI capacity. State Hospital Associations and QIOs remain important partners for SORHs to collaborate with in the development of CAH and CAH network QI capacities.

Most states disseminate performance improvement (PI) best practices, provide technical assistance, and train state program staff and rural providers in PI strategies. Technical assistance and capital funding to facilitate data collection, monitoring and reporting activities may include paying for the software and hardware used in CAHs, making data collection available on the Web, and/or supporting Flex Program staff/contractors to analyze data and report results.

The use of the Balanced Scorecard Approach (BSC) for PI for CAHs has grown dramatically over the past year.<sup>4</sup> In FY03, fourteen states are using the BSC strategy to address CAH PI issues and requested approximately \$675,000 for their PI efforts. Maine, Massachusetts, New Hampshire and Vermont are collaborating to implement a BSC program for their CAHs based on a regional plan.

Examples of key state activities in QI/PI include:

- **Kentucky** – has combined Flex Program grant dollars with those of the Kentucky Hospital Association to establish a statewide rural hospital quality improvement program. Kentucky CAHs and their participating community health partners now have the data to benchmark themselves against other rural Kentucky providers to improve and support performance.
- **Idaho** – A partnership with the state QIO, CAHs, Flex Program Staff, and a regional hospital created a list of QI indicators for CAHs and developed the software for CAHs to report and retrieve data related to five selected indicators. Each of the four regional networks in the state provide PI and QI related assistance and coordination to their members.
- **Washington** – through its state QIO (with Flex Program support) has been able to telecast their training sessions allowing more CAH staff to participate and providing numerous opportunities for CAH staff to network with each other, share best practices and gain additional information on what works and what doesn't work.

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<sup>4</sup>The BSC is a conceptual framework for translating an organization's strategic objectives into a set of performance indicators focusing on finances, customers, internal business processes, and learning and growth. Through the BSC, organizations monitor both current performance (finance, customer satisfaction, and business process results) and efforts to improve processes, motivate and educate employees, and enhance information systems.

- **Texas** – through its work with Texas Tech has developed a capacity to provide satellite QI learning opportunities for all state CAHs and expanded opportunities for involvement and informal networking among staff on PI and QI issues.
- **Mississippi** – through a partnership with its State Hospital Association, has worked on PI development by providing technical assistance in the areas of coding, medical records, charge master, survey readiness, compliance, and operational efficiencies. It recently has begun moving into QI through a Balanced Score Card pilot project with three of the state’s CAHs.
- **Wisconsin** – currently has 22 CAHs under agreement to participate in the Rural Wisconsin Health Care Quality Indicators Program (RWHCQIP). The RWHCQIP is the standardized reporting package for the state’s larger effort to standardize quality measures for all WI hospitals. The project includes the Wisconsin Hospital Association and Meta Star (the state QIO) among others.
- **California** – is building on last year’s training and data collection efforts on program adherence to evidence based treatment guidelines for CHF and Community-Acquired Pneumonia (CAP) through the efforts of the SORH and the State Hospital Association. One-on-one training for physicians and professional staff is provided in quality improvement in CHF and CAP and in implementing the quality measures and reporting procedures for strengthening hospital quality improvement efforts.
- **Kansas** – has several CAH QI networks ranging in member size from five to seventeen hospitals, that have been working on QI and CQI initiatives, EMS data collection and quality measurement, network-wide credentialing and peer review programs, and network benchmarking initiatives. The state is considering either a statewide or a multi-state benchmarking and/or balanced score card project and has begun talks with other states on possible options.

Other states are working to develop and adapt best practice models of QI and PI for their state programs. Among the more popular models for adaptation are the quality models developed in Montana and Minnesota.

- **Minnesota** – Minnesota’s collaborative model includes CAHs, Stratis Health (the state QIO), and the state Office of Rural Health and Primary Care (ORHPC). The project began in 2001 to develop and implement a collaborative for the first 10 CAHs on heart failure and atrial fibrillation. Stratis Health adapted the Institute for Healthcare Improvement’s (IHI) Breakthrough Collaborative Series model to focus on rural health issues. Using this model, they provided QI measurement technical assistance, QI training and consultation, and facility level support while the ORHPC coordinated the project and provided all of the logistical arrangements and stipends for the participant CAHs. This collaborative is in its second phase, this time focusing on heart failure and inpatient immunization in 22 other CAHs.
- **Montana** – Montana’s CAH QI network includes all 34 CAHs in the state. The network began its work by focusing on Medicare regulatory compliance in hospitals and now

works on hospital performance issues, including credentialing and peer review programs; a benchmarking project related to hospital volume, financial status, and quality; and a clinical administrative policy and procedure review process.

**State Program Evaluation.** All states are required to evaluate their state Flex Programs. In FY03 states spent a total of \$474,300, or an average of just under \$12,000 per state, on evaluation. The most common focus of state program evaluation efforts has been on the financial impact of CAH conversion. Seven states are engaged in full state Flex Program evaluations. A few states indicate they have evaluation reports identifying outcomes related to their Flex Program. Of the states working on evaluation related activities, 14 states do this work internally with related costs included in their administrative costs.

**Inter-State and Regional Activities.** State-to-state and regional collaborative approaches have been gaining popularity among Flex states as a means for sharing resources, labor, tools, and leveraging technical expertise and securing a greater degree of legitimacy among various state agencies and stakeholders. Examples include:

- **Nebraska and Kansas** are working together on revising and implementing an EMS QI strategy in their states.
- **Alaska** has multiple state-to-state arrangements in place, including a networking initiative with Washington State on QI issues that may expand to other Northwestern states, and a collaboration with Arizona to support small tribally administered hospitals under a QI initiative.
- Working together to implement the Balanced Scorecard in their CAHs, **Maine, Massachusetts, New Hampshire, and Vermont** realized economies of scale when they shifted from state to regional plan development because of an increase in bargaining power with contractors. They were able to solicit a collective bid that could then be subdivided into its constituent state specific parts. Each state had an independent contract (as required by state statute and regulation) but was able to obtain significantly lower costs.
- Savings have also been realized through another multi-state regional model that convenes regional Flex Program Conferences for **Alaska, Arizona, Nevada, New Mexico, Oklahoma, and Utah**. The conference host rotates each year and conference costs are shared among the six states. Economies were achieved not only from the ability to share the costs of providing the conference over the six states but also from the numerous opportunities created for sharing information with each other. The increased size of the conference has attracted a large number of national experts to the event to provide technical assistance on common issues at a reduced price.

**Health Information Technology Activities.** States are beginning to take advantage of the health information technology opportunities and developments that have recently taken place. For example, Illinois, Nevada, and North Dakota are working to establish HIT connections between their CAHs, local ambulance services and other significant state partners (e.g. for laboratory reports, trauma care standardization, eliminating dead zones for medical direction and control, and linking with state trauma system registries). The benefits reported in applications

included increased stakeholder buy in and investment, reduction in operational costs, more efficient data collection, reductions in reporting times, and an increase in educational and training opportunities for key players in meeting local EMS needs.

## CURRENT ISSUES

Three key program issues that warrant attention were identified among the majority of State Flex Grant Program applications and their subsequent budgetary revisions.

- **State Program staff turnover** has been dramatic over the past year, with 40% of the participating states experiencing turnover of key Flex Program staff. State hiring and wage freezes complicated replacement of staff in many states. Salaries for Flex Program Coordinators vary considerably by state and the workloads in agencies with few Flex Program staff can be very high.
- **Mini-grants** represent a significant strategy for participating states to maximize local buy-in and promote innovative strategies for meeting rural health community needs. However, many states have not developed an effective and thorough means for documenting the outcomes of these local projects. Comprehensive information on activities and outcomes is needed to determine what efforts should be encouraged and disseminated to other localities and what efforts should not receive additional support.
- **Timelines** are becoming more important given the complexity of many of the new state projects. This is especially the case for EMS and QI due to the level of stakeholder involvement required to complete such activities. States should plan activities based on realistic estimates of the time and resources available to accomplish the tasks at hand.

## CONCLUSIONS

With funding from the Flex Program, states are engaged in a variety of strategies to assist CAHs and their partnering healthcare organizations to strengthen their local and regional health care delivery systems. Using local, state-to-state, regional and national collaboratives, states and CAHs are sharing and advancing knowledge on such critical issues as performance and quality improvement, health information technology development, and capital planning and acquisition. As states have streamlined the CAH designation and conversion process, they have directed their efforts to providing direct assistance to support and improve CAH operations. They are also supporting programs to strengthen rural EMS systems, and promote and support the development of a quality improvement and performance improvement capacity in CAHs and other small rural hospitals. The recent changes in the MMA, such as increasing the acute care bed capacity of CAHs to 25 beds and the inclusion of distinct part units, may increase CAH conversion rates in some states. The emphasis on infrastructure supports for continued CAH operations is likely to continue for years to come as states continue to build their capacity to strengthen their rural health infrastructure. As resources become tighter, participating states will likely find that the value of effective and empirically-based rural health planning and program design will grow as

will the need to have a parallel and robust mechanism for monitoring the outcomes of those efforts.

## **RESOURCES AND ADDITIONAL INFORMATION**

Additional information about successful State Flex Program activities and tools covering CAH designation, community development, EMS integration, network development, quality improvement, and evaluation can be accessed on the Tools and Resources page of the TASC Website at <http://tasc.ruralhealth.hrsa.gov>