CAH/FLEX

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Lessons from Maine, Minnesota, Texas, and Wisconsin:

The Continuum of Work Groups in the Rural Hospital Flexibility Program

Background

States that participate in the Rural Hospital Flexibility Program (Flex Program) must develop a State Rural Health Plan with input from their State Hospital Associations, State Offices of Rural Health, and rural hospitals. States are also strongly encouraged to seek participation from additional stakeholders such as emergency medical services, public health offices, and primary care providers. The intent of seeking broad participation is to foster, among the stakeholders, the development of collaborative relationships that are essential to the successful implementation of the Flex Program.

In keeping with this intent, many states have formed work groups to assist in developing a rural health plan and implementing the state Flex Program. These work groups assume varying levels of responsibility related to the Flex Program in their states. The specific tasks and responsibilities depend on a variety of factors including: 1) the state's experience with rural health and hospital issues, 2) the state's goals for the Flex Program, and 3) the evolution of the relationship between the state and the members of the work group. These work groups reflect a continuum of responsibilities and activities that provides a useful framework for understanding the role of work groups in the Flex Program and for tracking their evolution over time.

Work Groups Reflect a Continuum of Responsibilities and Activities

At one end of the continuum are ***planning groups***, which provide comment and feedback on a state-developed plan, with few additional responsibilities.

In the middle are ***steering/advisory committees***, which provide ongoing input about the development, implementation, and operation of the state Rural Health Plan and state Flex Program and disseminate information from the state to committee members and rural hospitals.

At the other end are ***coalitions***–public/private partnerships–which provide ongoing input into policy decisions affecting the state Flex Program, Program priorities, and the distribution of Flex Program grant funds. Coalitions also fill a technology transfer role by providing forums for the exchange of information among their members, the rural hospital community, and the state.

The Continuum of Work Group Activities

Planning Group Model

Maine's Core Committee is typical of those states whose work groups have assumed a planning group role. The Core Committee is a relatively small group composed of individuals from state government, including the State Office of Rural Health, and rural hospitals. Although the Core Committee was formed to develop Maine's Flex Program, the state, on behalf of the Core Committee, hired a consultant to write the rural health plan. The Core Committee, which continues to meet, provides ongoing input into the state's Flex Program planning efforts.

Advisory/Steering Committee Model

Minnesota and Texas are examples of states with work groups that have assumed an advisory or steering committee role. Minnesota has established a 27-member Flex Advisory Committee with representatives from a broad range of stakeholders including third-party payers, emergency medical services, regulatory agencies, the State Hospital Association, the fiscal intermediary, the peer review organization, state legislators, various trade organizations, and rural providers. The Flex Advisory Committee has been charged with program planning, development, and evaluation responsibilities. The Office of Rural Health views the Flex Advisory Committee as an important vehicle for sharing Flex Program information with interested parties and hopes that eventually it will enable Critical Access Hospitals (CAHs) to share their experiences with hospitals that are considering conversion. The Texas CAH Advisory Committee was established under the leadership of the Center for Rural Health Initiatives and brought together all of the main regulatory and agency players necessary for the implementation of the Flex Program. The level of collaboration made possible by this group is widely credited with the rapid and successful implementation of the Texas Flex Program and the relatively painless conversion of seven hospitals by May 2000.

Coalition Model

The Wisconsin CAH Coalition is made up of organizations that have a direct interest in the operation and success of the state's Flex Program. The distinguishing feature of the Wisconsin CAH Coalition is that it is the state's partner in developing and managing the Flex Program and shares responsibility for the success of the Program rather than serving solely as an advocate for the interests of its constituents. It fills a technology transfer role by sharing information between coalition members, the rural hospital community, and the state. The Wisconsin CAH Coalition provides technical assistance and offers a forum in which providers can share their conversion experiences with one another and with hospitals considering conversion. It also provides a continuing venue for rural hospitals to address future operational challenges. As the state's partner in the Flex Program, the Wisconsin CAH Coalition participates in decisions regarding the development of Flex Program priorities and the use and distribution of Flex Program grant funds. The Wisconsin CAH Coalition also provides a rural focus not found in Wisconsin's policy or regulatory infrastructure.

The Benefits of Work Group Participation in the Flex Program

The classification of work groups on the continuum is not meant to infer that one approach is superior (or inferior) to another. Rather, it is designed to provide a context for understanding the roles that these work groups play in an individual state's Flex Program and the ways in which work groups can grow and evolve to support the state's efforts.

Work groups can offer a number of benefits to states in the development of the Flex Program, including:

- the opportunity for valuable provider-level input into the Flex Program development process;
- the cultivation of provider support for the Flex Program;
- the development of improved working relationships among key stakeholders;
- the sharing of knowledge between rural hospitals;
- the improvement of communications between key stakeholders (including the state);
- a medium for ongoing feedback into the operation of the Flex Program; and
- the development of a vehicle that can be used to tackle future rural health policy issues.

The Development of Flex Program Work Groups

Obvious stakeholders for the Rural Hospital Flexibility Program include, but are not limited to, State Offices of Rural Health, State Hospital Associations, rural hospitals, rural communities, medical associations, state Medicaid offices, peer review organizations, emergency medical service agencies, state health planning agencies, and other professional organizations. Developing a functional work group, however, is not as easy as pulling together key representatives from these stakeholder organizations. States must honestly assess the status of their relationships with these key stakeholders as they develop their work groups. They must evaluate their own willingness to share responsibility for the Flex Program with these stakeholders and evaluate the ability of these stakeholders to move beyond their own self-interest in order to advance the goals of the Flex Program. States must also balance issues of inclusiveness (e.g., whether to include all possible stakeholders or only those with a direct interest) against the need to maintain a manageable group size. They must decide how much responsibility to delegate to these work groups. Finally, states must communicate honestly and openly with the work group once it is established.

Work groups will likely grow and evolve as they gain experience with the Flex Program and each other. States should look for opportunities for their work groups to assume expanded roles appropriate to the group's level of organizational maturity. As the trust between state agencies and the work group develops, the work group can take on progressively more important and collaborative roles regarding the Flex Program which will decrease demands on the state infrastructure, increase "buy-in" among the provider community, and provide a framework for addressing future rural health policy issues. A work group can be a vehicle for communicating about the Flex Program, developing collaborative problem-solving mechanisms, encouraging strong policy coordination, and sharing lessons learned among hospitals that have converted and those that are thinking about it.

Where Can I Get More Information?

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BACKGROUND

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

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