

CAH/FLEX

National Tracking Project

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Impact of the Rural Hospital Flexibility Program on Rural Emergency Medical Services: Evidence from the First Two Years

Why Examine Emergency Medical Services Issues Under the Rural Hospital Flexibility Program?

The Rural Hospital Flexibility Program (Flex Program) authorizes use of grant funds to improve rural emergency medical services (EMS) systems and support hospital conversions to Critical Access Hospital (CAH) status. Accordingly, the Federal Office of Rural Health Policy made rural EMS improvements one of five areas states must address in their annual grant applications. In addition, changes in day-to-day operations occurring when a hospital becomes a CAH may, in turn, change the community's EMS system or the facility's provision of emergency services. For these reasons, the Flex Program Tracking Team has been monitoring changes in rural EMS systems associated with the Flex Program grants and CAH conversions.

While sweeping fundamental improvements to rural EMS systems will take more time, states' successes during the coming year in implementing well-chosen EMS projects may be important for informing the grant reauthorization debate.

Data Sources

- Telephone survey of 217 CAH administrators that included a section on EMS issues.
- Review of Year 2 Flex Program grant applications from 20 states.
- Follow-up phone interviews with all sites visited by the Tracking Team in Spring 2000.¹
- Site visits to nine additional states in Spring 2001 by the Tracking Team.²

Effect of CAH Conversions on Rural EMS Systems

Almost none of the CAH administrators surveyed reported a change in whether they provide ambulance services or in the way EMS medical direction is provided in their communities. Likewise, only a small number of CAHs reported a change in emergency room patient volume, patient transfers, or their use of hospital RNs to accompany critically ill patients during transfers. The site visits confirmed that few CAHs made significant changes in day-to-day operations and, therefore, few CAH communities saw significant changes in their EMS systems simply as a result of the CAH conversions.

Challenges Facing Rural EMS Systems

Approximately three-fourths of the CAH administrators reported that the local EMS system was working well. They did, however, frequently cite problems with recruitment and retention of EMS personnel, inadequate funding/reimbursement, and lack of training opportunities. These same problems were echoed during virtually all site visits.

State and local initiatives to address problems with recruitment and retention of EMS personnel, EMS financial shortfalls, and EMS training issues would respond to significant identified needs and would, thus, seem to be particularly appropriate uses of Flex Program funds.

States' EMS Activities Under the Flex Program in Year 2

An increasing number of states are now moving into the “second generation” of the Flex Program, giving heightened attention to broader system goals beyond state plan development and hospital conversions.

Many states have completed EMS needs assessments begun in Year 1 and are now developing and implementing specific projects to address identified needs. According to estimates made by the Federal Office of Rural Health Policy, states planned to spend between \$3 and \$4 million of the Year 2 grant funds on EMS projects. Many states used mini-grants to distribute their Flex Program funds designated for EMS improvements. Most often these grants were made directly to CAHs. While some states required the CAH to involve local EMS providers or other stakeholders in grant activities, this requirement was not widespread. A few states structured their EMS mini-grants so that the money was distributed directly to EMS systems or other non-hospital entities. Examples include grants to collaborative partnerships between EMS providers and CAHs or tribal organizations, as well as grants made directly to EMS providers or EMS trauma system organizations.

Training initiatives. Clinical training in all aspects of emergency care for EMS personnel, hospital personnel, and medical directors, as well as training in management, billing, and data entry, were by far the most popular EMS activities carried out by the states. Many of the states planned to conduct this training in rural communities, sometimes in cooperation with the local CAH, or to employ distance-learning techniques that make it easier for students to obtain training without leaving their community. Some states were also using Flex Program funds for scholarships for EMS training.

EMS needs assessments. Needs assessments continued to be a popular activity in Year 2. In general, these assessments measured EMS system performance, identified problem areas, and developed strategies to respond to these problems. States varied in the degree of central control they maintained over the assessment process (e.g., a single contractor versus independent assessments) and in the degree to which decisions about subsequent activities were made by the state or left to the discretion of communities. Some states used the grant funds as a “carrot” to encourage local collaboration by requiring that relevant parties cooperate on common projects in order to receive funds. This collaboration was sometimes viewed as a precursor to building more extensive, regionally coordinated systems of emergency care.

Other activities:

- ❑ A large number of states proposed establishing pre-hospital data collection systems and purchasing computer hardware and software to support these data systems. The computer equipment could also support distance-learning initiatives and EMS billing.
- ❑ Several states used Flex Program funds to help implement EMS billing systems. Improved billing capability may increase the financial resources of EMS providers and facilitate movement toward partially or fully paid squads, perhaps alleviating recruitment and retention problems and reducing reliance on volunteers.
- ❑ A few states used Flex Program funds to help develop regional EMS systems or to encourage integration of the local ambulance service and the CAH, including CAH ownership of the ambulance service.

Conclusions

The second year of the Flex Program has brought increased attention to rural EMS initiatives and, in many states, is fostering stronger working relationships between the state offices of EMS and other state bureaus. In some states, new working relationships have also been forged between local EMS stakeholders, hospitals, and others, further strengthening the local health care infrastructure.

The Flex Program's adaptability is well suited for allowing states and individual communities to define their priorities and develop creative approaches to address their specific local needs. Efforts to involve all key players from the early stages, and to build consensus for common goals, appear to be important to the successful design and implementation of EMS initiatives.

Fundamental change will take more time. Some of the most successful initiatives the Flex Program Tracking Team observed are in areas where change has been underway for many years—even pre-dating the Flex Program. A few states are attempting to maximize the effectiveness of limited Flex Program funds by focusing their efforts in such areas, where the probability of success seems to be greatest.

The coming year will bring debate about reauthorization of the Flex Program, possibly including discussion of whether the support for rural EMS improvements should be expanded. While it is not realistic to expect sweeping EMS system improvements in time to inform this reauthorization decision, the next year will be critical as states continue to implement substantial EMS improvement projects and document their early successes.

This brief summarizes information presented in Chapter 4 of the Flex Program Tracking Project's Year 2 Report. The complete report is posted on the project website, <http://www.rupri.org/rhfp-track/>.

¹Year 1 site-visit states were: Arkansas, Georgia, Idaho, Kansas, Maine, Minnesota, Missouri, Montana, North Carolina, Oklahoma, Texas, and Wisconsin.

²Year 2 site-visit states were: Iowa, Michigan, Nebraska, New Mexico, North Dakota, Oregon, South Dakota, Tennessee, and West Virginia. South Dakota was visited solely to learn about EMS activities.

Where Can I Get More Information?

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About this project: Check our website: <http://www.rupri.org/rhfp-track/>

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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