

## CAH/FLEX

National  
Tracking  
Project

## FINDINGS FROM THE FIELD

Volume 2, Number 7  
September 30, 2002

## Consortium Members

Project HOPE Walsh  
Center for Rural Health  
Analysis

Rural Policy  
Research Institute

University of Minnesota  
Rural Health  
Research Center

University of  
North Carolina  
Rural Health Research  
and Policy Analysis  
Program

University of  
Southern Maine  
Rural Health  
Research Center

WWAMI Rural  
Health Research Center

## State Flex Programs<sup>1</sup> – Perspectives of the Flex Coordinators

The Medicare Rural Hospital Flexibility Grant Program (Flex Program) was enacted by Congress in 1997, and currently 47 states participate. In addition to promoting the conversion of qualifying small rural hospitals to Critical Access Hospital (CAH) status, the aims of the Flex Program are to strengthen state rural health planning capacity, develop rural health networks, enhance quality of care, and strengthen rural emergency medical services (EMS) systems. This *Findings* reports the perspectives of Flex Coordinators about foci of the Flex Program, excluding CAH conversions, which are discussed in detail in *Findings From the Field* Volume 2, Number 6.<sup>2</sup>

### Major Findings

#### ***State Rural Health Plans***

State rural health plans, which are required for participation in the Flex Program, have been useful to the Flex Coordinators. More than 80% of them reported that these plans have enabled them to raise awareness and increase engagement among policymakers, legislators, community members, and others about rural health issues. Nearly 90% believed that new relationships have been formed with organizations such as the state's Medicaid and EMS offices, the Indian Health Service, and the state hospital association as a result of implementing the Flex Program in their states. Flex Coordinators commented on the new relationships. One Flex Coordinator said, "The biggest thing that came out of [the rural health plan] was a steering committee to provide some guidance. [The steering committee has many types of members.] Because of the steering committee and because Medicaid was at the table, Medicaid decided to reimburse on a cost-basis right way."<sup>3</sup> Another pointed out, "I think the Flex Program brought new stakeholders to the table. It brought their understanding of 'rural' to a higher level." Only five states felt that additional collaborations had not occurred, mainly because a strong rural health infrastructure was already in place prior to the Flex Program.

***Flex Coordinators reported that the Flex Program has offered rural America more options and opportunities in providing health care, particularly in aiding hospitals to remain viable through CAH conversion.***

#### ***Networks and CAHS***

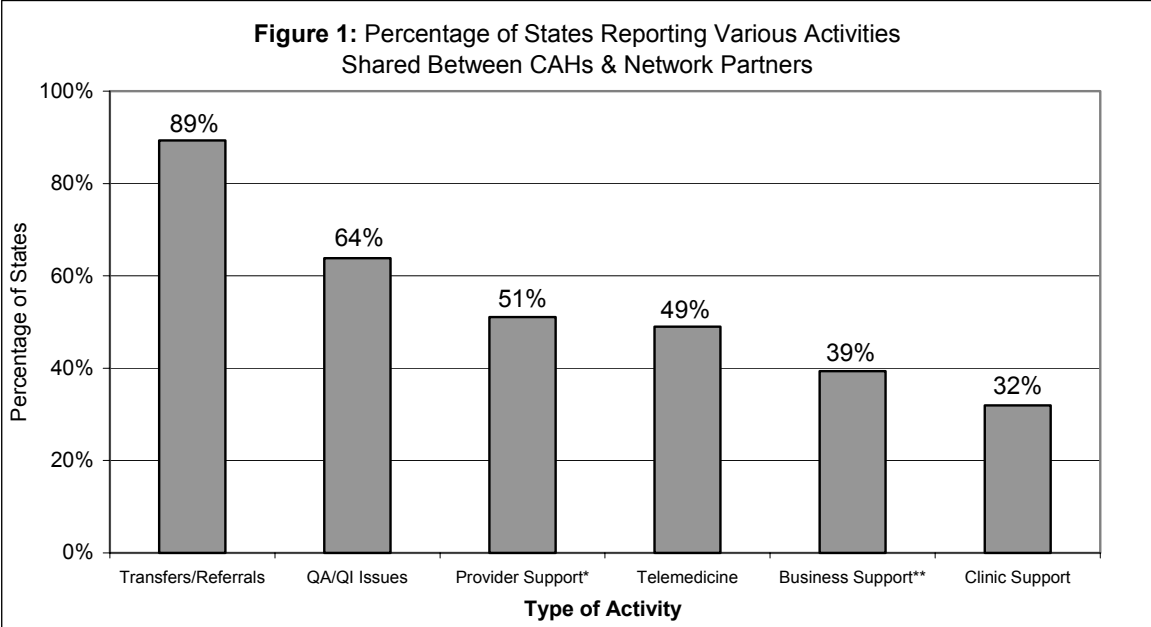
Networking between organizations can help to increase participants' abilities to deliver a broader range of services and improve patient access to care. The states implementing the Flex Program appreciate the advantages of networking. This is evident by the extended network requirements that many states have imposed upon facilities seeking certification as CAHs. Although the federal statutory requirement calls for at least one transfer and referral agreement per state between a CAH and another organization, many states have additionally required *all* of their CAHs to have their own transfer and referral agreement with a larger acute care facility. One Flex Coordinator pointed out, "The CAHs recognize that it is to their disadvantage [to be] without these networks."

<sup>1</sup>Medicare Rural Hospital Flexibility Grant Program (Flex Program)

<sup>2</sup>For a current update on Critical Access Hospital conversions, please see Findings from the Field Volume 2, Number 6: *A Critical Access Hospital Update, September 2002*. <http://www.rupri.org/rhfp-track/>.

<sup>3</sup>Medicaid agencies in several states have agreed to pay cost-based reimbursement or some other enhanced payment arrangement to CAHs.

Flex Coordinators reported that in addition to general transfer and referral agreements, many CAHs have formed both formal (a well-documented agreement) and informal relationships with various types of providers and for different types of services and capabilities. Examples of providers that network with CAHs include rural health clinics, public health departments, and private practitioners. **Figure 1** shows the types of CAH networking activities reported by Flex Coordinators.

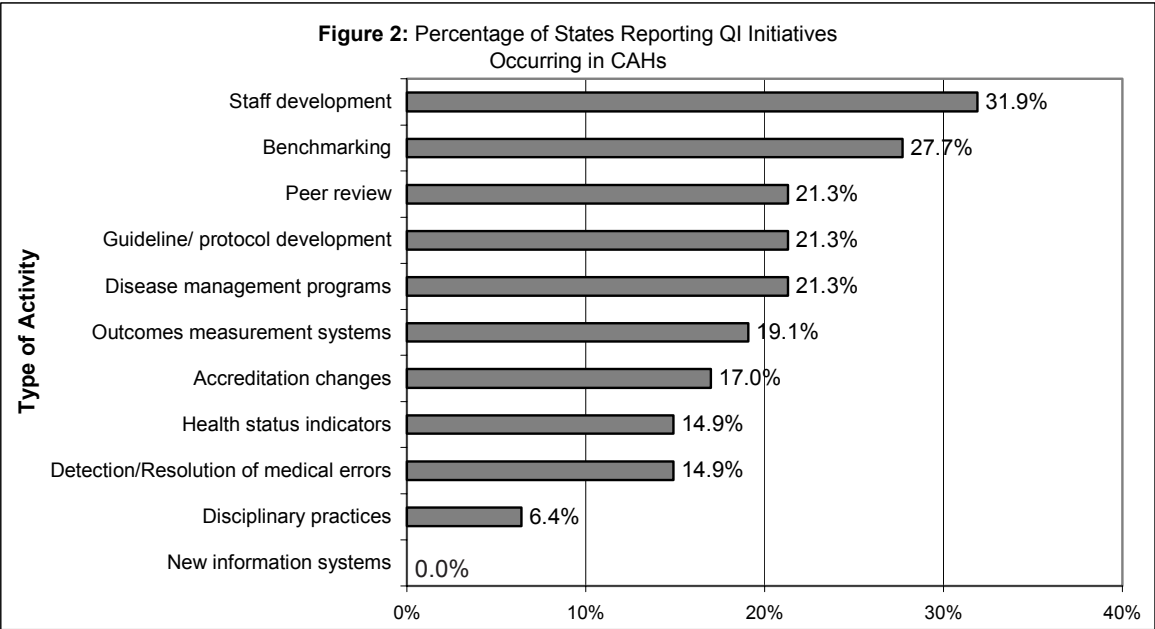


\*Provider support includes the following activities: credentialing, recruitment and retention, and continuing education.

\*\*Business support includes the following activities: administrative support, financial support, group purchasing, and marketing/public relations support.

**Quality Improvement Initiatives**

Flex Coordinators were queried about quality improvement activities that their states' CAHs were undertaking; their responses are shown in **Figure 2**.



## **Rural EMS**

Flex Coordinators commonly reported that rural EMS providers face difficulties such as lack of resources, inadequate staff numbers, and out-dated equipment. In addition, in some states, the already difficult provision of emergency care is complicated by geographic, climatic, and governance barriers. For example, one Flex Coordinator reported that only 1% of the state's roads are open year-round: "Our topography is treacherous."

Nearly 50% (N=22 states) of Flex Coordinators reported that recruitment and retention was the top issue facing their state's rural EMS system. Interestingly, one Flex Coordinator pointed out that the changing demographics in his state affects EMS, since the aging of the population has caused a decline in the pool of potential EMS volunteers, with few young people moving in to replace them.

The grant money provided by the Flex Program has, in many states, been distributed to local, regional, and statewide EMS divisions to support activities related to training, EMS needs assessments, database development, equipment improvements, billing, and developing treatment and transfer protocols. However, at the time of the telephone interviews, few Flex Coordinators were able to report the extent to which the Flex Program has benefited rural EMS. Only 13% of the Flex Coordinators reported that their state was in the process of completing or had already completed an evaluation of the effects of the Flex Program on rural EMS systems.

## **Successes and Challenges of the Flex Program**

The Flex Program has been accepted and implemented with much support and success. In general, the Flex Coordinators reported that the Flex Program has offered rural America more options and opportunities in providing health care, particularly in aiding hospitals to remain viable through CAH conversion. One Flex Coordinator noted, "[The Flex Program] is keeping hospital services available to rural residents."

***"The Flex Program has been the driving force for rural health."*** ---Flex Coordinator

Another individual pointed out, "The Flex Program has been the driving force for rural health." Furthermore, many Flex Coordinators applauded the Flex Program for increasing networking among small rural hospitals and other organizations. According to a Flex Coordinator, "The Flex Program has forced people to look at network development, forcing them to work together rather than against one another." Finally, another Flex Coordinator summarized the benefits of the Flex Program in her state: "[The Flex Program] has ensured the sustainability of the hospitals. It has improved communications across [the state] on rural health issues. It has raised awareness in the General Assembly of the program itself and of rural health issues."

Lastly, Flex Coordinators reported their greatest challenges with implementing the Flex Program. These varied across Flex Coordinators, but some themes were heard repeatedly.

- Several Flex Coordinators discussed the challenge they face in raising public awareness of and support for the Flex Program in rural communities, especially in places where CAH conversion or EMS system improvement is not readily visible.
- Some Flex Coordinators described their difficulties in keeping a long-range focus with the Flex Program. Specifically, since they were so anxious to implement the Flex Program, their initial instinct was to do everything at once.
- Another challenge expressed by some Flex Coordinators was the difficulty in finding their niche, since their pool of eligible CAHs was very small. These Flex Coordinators were able to recognize the benefits of the Flex Program by focusing on other facets such as EMS development and improvement rather than hospital conversion.

## **Methodology**

Since 1998, the Flex Program Tracking Team has conducted an annual telephone survey of Flex Coordinators who oversee the daily operations of their state's Flex Program. This year's survey (2001-2002) used a structured interview protocol that covered the major foci of the Flex Program. Forty-seven interviews, representing all of the participating states, were conducted between October 2001 and January 2002. Each interview typically lasted between 45 and 60 minutes, with one respondent per state (7 states had 2 interview participants).

### ***Where Can I Get More Information?***

About this report: Melissa A. Fruhbeis, MSPH, North Carolina Rural Health Research & Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina-Chapel Hill, (919) 966-9985 or melissa\_fruhbeis@unc.edu

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

### ***Previous Findings From The Field and Tracking Project Reports***

Report: Rural Hospital Flexibility Program Tracking Project Year Three

Vol. 2, No. 6: A Critical Access Hospital Update, September 2002

Vol. 2, No. 5: Reauthorizing the Medicare Rural Hospital Flexibility Grant Program: Lessons from the Field

Vol. 2, No. 4: Critical Access Hospitals and Community Development

Vol. 2, No. 3: Administration in Critical Access Hospitals

Vol. 2, No. 2: Regionalization of Emergency Medical Services: The Experience of Michigan's Upper Peninsula

Vol. 2, No. 1: Impact of the Rural Hospital Flexibility Program on Rural Emergency Medical Services: Evidence From the First Two Years

This Issue:  
FINDINGS FROM THE FIELD  
Volume 2, Number 7  
September 30, 2002

RUPRI Center  
for Rural Health Policy Analysis  
University of Nebraska Medical Center  
984350 Nebraska Medical Center  
Omaha, NE 68198-4350

PRSR STD  
AUTO  
U.S. POSTAGE PAID  
OMAHA, NE  
PERMIT NO. 454