

Appendix B

Content of State Applications

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Introduction

This Appendix provides a review of the grant proposals submitted by state grantees in the Rural Hospital Flexibility Program (Flex Program). The proposals reviewed for this chapter report on activities completed in Year 2, and activities proposed for Year 3. *Year 2* refers to the federal fiscal year that began in the fall of 2000 and *Year 3* refers to the federal fiscal year that began in the fall of 2001. A spreadsheet is attached at the end of this Appendix that provides a summary of budget activity related to the five program objectives for the participating states established by the Federal Office of Rural Health Policy (FORHP).¹

The goals of the Flex Program are to assist rural hospitals improve access to health services in rural communities, and strengthen the overall rural health infrastructure. Specifically, states are to use grant funds to achieve the following program objectives:

- Develop and implement a state rural health plan with broad collaboration among stakeholders.
- Assist rural hospitals and their communities to become aware of the opportunity to convert, and then assess and convert (if applicable), to critical access hospital (CAH) status.
- Support CAHs, providers and communities as they develop and implement rural health networks.
- Support the establishment or expansion of programs to improve and integrate rural emergency medical services (EMS) into rural health networks
- Encourage CAHs in their quality assurance/quality improvement efforts.

Grant funds were made available to any state:

¹Note: The reader should be cautious in interpreting Year 3 figures because we are reporting *proposed* expenditures, not actual expenditures.

1. With at least one hospital located in a non-metropolitan statistical area (non-MSA) county (New Jersey and Rhode Island are not eligible for this program because of their metropolitan status).
2. That chooses to implement a Flex Program and provides the Centers for Medicaid and Medicare Services (CMS) with the necessary assurances as described in CMS guideline materials and has CMS approval for its state rural health plan.

Forty-seven states have received funds from CMS since 1999 to participate in the Flex Program.

Methods

For the purposes of this report, 47 state non-competing grant proposals were reviewed and summarized by the objective subheadings found in the FORHP’s FY2001 Non-Competing Grant Application (September 1, 2001-August 31, 2002):

- Develop State Rural Health Plan
- Designation of CAHs in the State
- Development and Implementation of Rural Health Networks
- Improvement of EMS Services
- Quality of Care
- Evaluation of Program Effectiveness

A spreadsheet was created summarizing each state’s accomplishments, strategies, and expenditures by goal. Table 1 lists the states included in this review.

Alabama	Indiana	Montana	South Carolina
Alaska	Iowa	Nebraska	South Dakota
Arizona	Kansas	Nevada	Tennessee
Arkansas	Kentucky	New Hampshire	Texas
California	Louisiana	New Mexico	Utah
Colorado	Maine	New York	Vermont
Connecticut	Maryland	North Carolina	Virginia
Florida	Massachusetts	North Dakota	Washington
Georgia	Michigan	Ohio	West Virginia
Hawaii	Minnesota	Oklahoma	Wisconsin
Idaho	Mississippi	Oregon	Wyoming
Illinois	Missouri	Pennsylvania	

The Grant Applications

At this time, all of the states have received approval of their rural health plans from CMS and most states are in the process of revising their plan or had just recently submitted a plan to reflect changes due to the Benefits Improvement and Protection Act (BIPA), 2000.

The entity applying for federal funding was either the state's office of rural health, a university, or another agency-based center for rural health, or department of health. Any one of these entities will be referred to as "grantee" throughout the remainder of this appendix. Thirty-seven applicants were offices of rural health housed in a state department of health. Another five applicants were departments of health that did not include the state Offices of Rural Health. Finally, five applicants were university-based Offices of Rural Health.

Information presented in this report is a summary of the applications, which provided information on the progress, accomplishments, and future plans related to the objectives stated in the previous section. In general, the content of the applications is similar to last year's applications—some states followed the FY2001 non-competing grant application format explicitly. On the other hand, other states' application content was ambiguous. However, the level of detail has improved over last year and it appears that as the Flex Program matures and as more CAHs are designated, the majority of states are shifting their focus to other components of the Flex Program. Specifically, in Year 1 and much of Year 2, the primary focus was creating the state rural health plan to submit to CMS for approval. In Year 2, the primary focus was on CAH designation. Now, in Year 3, states are developing the other components of the program. However, the component of the program with the least emphasis is the evaluation of program effectiveness in each state.

In addition to the state application summaries, this report also includes a summary of total state expenditures—year-to-date and projected. In most cases, it was not possible to distinguish the amount or allocation of state contributions and/or other funding sources from the reviewed applications.

Grant awards ranged from \$110,000 to \$700,000 for the Year 3 cycle. The largest grants in Year 3 (grants over \$650,000) went to Kansas, Kentucky, Minnesota, Montana, North Dakota, Nebraska, Oklahoma, Tennessee, and Wisconsin. The smallest grants (under \$300,000) went to Connecticut, Louisiana, Maryland, Mississippi, New Mexico, and Virginia. The states that received the biggest increases (over \$50,000) between Year 2 and Year 3 were Florida, Georgia, Indiana, Kentucky, Missouri, New Hampshire, Nevada, Ohio, and Washington. See the spreadsheet at the end of this appendix for state-specific year-to-year grant awards. Compared to last year's summary, Kentucky was the only state added to the group of largest recipients, those grantees receiving \$650,000 or more. Kentucky's net increase from Year 2 to 3 totaled \$62,000.

It is hard to identify commonalities and/or trends across the states based on the applications' content. No two applications look alike. This reviewer would recommend an application structure that provides some congruency and consistency of the applications' content, but still

allows for descriptive text. A consistent format proscribed in the grant application packet would allow similarities and trends to be more easily recognized.

The primary challenges in reviewing the grant applications include:

- It is hard to determine what portion of funds is state, federal, in-kind, and/or other support. There are a few states that provide this breakdown.
- Few states identify the breakdown of fund allocation to specific activities within each part of the application. Most applicants provide a financial description of what is being spent for the entire Flex Program in the Budget Justification section, however, a detailed description of fund expenditures by the various components of the program is not delineated. As a result, determining why a substantial amount of funding is projected for network development, for example, is difficult since little programmatic activity is detailed.
- Applications provide states the opportunity to describe, in detail, what is happening in that state. Since there is no consistency among the state applications, however, it is difficult to determine the themes, patterns, and trends across the states.

Opportunities exist to improve the grant process of the Flex Program. The grant proposals could be more informative about progress on and plans to meet the federal goals. State matching funds could be more clearly spelled out. Partnerships and projects could be more clearly described. Applying a template for grant applications would allow those writing the document to replace subjective text with progress reports and evaluations from year to year. Based on the current application writing process, it is not apparent on what basis grants are awarded.

Develop State Rural Health Plan

The state rural health plan provides states the opportunity to assess and identify their own state's rural health needs and to develop a vision around improving rural health in the state. The degree to which these needs were addressed varies by state.

In this section of the application, grant applicants were asked to discuss the vision for rural health in their state and the strategy (-ies) for achieving the described vision. In addition, applicants were asked to describe how they were using their state rural health plan to further Flex Program goals.

Unlike last year, all 47 participating states have completed and received approval for their state rural health plan. Most states focused on fine-tuning their plans to address state-specific issues or revising their plans to address federal changes. Some states, such as Alaska, are using their plan to achieve the state's vision by bringing together local, state, federal, and private partners to develop state policy and make recommendations for improving the rural environment.

Like last year, few states discussed community involvement in their rural health plans, which makes it difficult to determine if there is any such participation. Of the states that did mention it, some briefly stated that the community was involved while others noted ways in which their communities are involved.

Compared to last year's applications, when a majority of applicants were in the formulating, assessing and/or identifying stage of vision development, most applicants included the state's vision. The majority of states' rural health visions focused on creating and/or strengthening networks and improving access to health care services for rural residents. However, very few described the goals and objectives needed to attain the vision.

Unlike last year, there was a heightened focus on how the state rural health plan acted as an impetus for legislative and policy changes. For example:

- **Illinois'** Center for Rural Health, with the Illinois Institute for Rural Affairs and the Governor's Rural Affairs Council, produced a report, *Rural Illinois: Charting a Course for the New Millennium*. The information in this report is the compilation of a series of public hearings in six rural communities where the challenges and opportunities of rural business were presented.
- **Kansas** contracted with the Kansas Health Institute to develop a rural health policy agenda and conducted an assessment of the appropriate role of the Flex Program as a consideration for the state's rural health efforts.
- **North Carolina** was successful in its efforts to get more than 196,000 Medicaid recipients covered by managed health care systems.
- **Oregon's** state rural health plan is updated frequently and is an integral document for communicating with policymakers.

In other states, it is unclear how or if the plan is used. **Mississippi** expressed concern that its state rural health plan may need to be overhauled since four hospitals have closed in the past three years. Interestingly, despite this anticipated re-structuring of its plan, zero dollars went towards re-developing its rural health plan and only \$1,113 is projected to be spent on this component in Year 3. Rather than revising its state rural health plan because of changing rural health needs, **Arkansas'** revisions are reactive to federal changes, such as BIPA 2000.

Budget Activity

	Amount spent through 4/30/01	Amount estimated for the full Fiscal Year 2 (9/1/00-8/31/01)	Projected amount proposed to be spent in Year 3 (9/1/01-8/31/02)
Number of states	45	45	45
Total	\$857,279	\$1,115,644	\$992,577
Per state mean	\$19,051	\$24,792	\$22,057
Median	\$7,750	\$8,326	\$10,000

Note: Not all states included budget details with dollar amounts. States excluded from all columns are ID and NM. Fund figures include federal, state, in-kind, and other resources utilized for the project.

States with expenditures greater than \$100,000 in Year 2 were:

- Alabama \$115,125
- Florida \$123,000
- Kentucky \$288,880

Alabama revised its rural health plan to reflect Balanced Budget Act changes. **Florida** has linked the development of its rural health plan to the development of a rural economic plan. A rural health summit was planned to bring together leaders from across the state to discuss how to expand the state rural health plan. **Kentucky's** state rural health plan activity expenditures are significantly more than any other state, however a detailed explanation of how the funds were spent was not provided.

States with expenditures between \$50,000 and \$100,000 in Year 2 were:

- Connecticut \$86,850
- Massachusetts \$57,181
- Missouri \$50,000
- Oregon \$65,538

Connecticut is using funds to collect data and hold focus groups to assess needs, barriers, and gaps in the state's health care delivery system. **Massachusetts** has begun developing an enhanced state rural health plan so it can be used as a policy tool. **Missouri** is focusing on refining analytical tools and network development processes. **Oregon** had an extensive list of accomplishments that included the development of information tools, creating and updating databases, and building and developing community partnerships.

Other examples of the changes that states have made include:

- **Georgia** revised its plan to reflect current state health data and the new federal regulations. The new federal regulations increased the number of eligible hospitals from 38 to 68.

- **Louisiana** put on hold its development of the five-year health plan that addressed community and network development. Instead, it is focusing on its “7 Point Plan for improving health care in Louisiana,” the objective of which seems to be to improve access to primary care.
- **Minnesota** established a Flex Committee for program planning, development, implementation, consultation, problem solving, and evaluation development. The Flex Committee has collected data and reported on services, providers, and reimbursement mechanism serving rural seniors.
- **New Mexico** is using mapping to delineate differences in health status and health services measures within the state.
- **Oklahoma** developed and implemented a new trauma care designation system.

Common goals among states for Budget Year 3 were:

- To continue to work with stakeholders to review, revise and develop (as needed) the state rural health plan.
- To continue rural health plan education efforts with rural hospitals, health providers, and rural residents.
- To gather, compare, and analyze rural health services information for CAH communities and integrate this information into the state rural health plan.

The majority of the states will make revisions to the plan as needed. However, more time, money, and energy are now being shifted to further the development of the other components of the program.

Designation of CAHs in the State

This portion of the application asks applicants to explain eligibility criteria for CAH designation in their state and identify the total number of designated and eligible hospitals. States were also asked to identify hospitals that had expressed interest in converting to CAH status, to detail their plans for enlisting new communities in the conversion process and to explain the extent of stakeholder and community involvement in these activities.

All applicants stated how many hospitals were eligible for CAH status in their state as well as how many had converted at the time of grant application submission. The level of detail regarding eligibility criteria and conversion difficulties varies by state.

As of June 1, 2002, 620 hospitals in 43 states had converted to CAH status and 1,431 were eligible for CAH status.^{2,3} Over half of the 620 CAHs (319) were located in ten states: **Georgia, Iowa, Kansas, Minnesota, Montana, North Dakota, Nebraska, South Dakota, Texas, and Wisconsin.**

All states are continuing to provide some level of technical assistance to eligible and converted hospitals. Technical assistance provided to CAHs and their supporting facilities typically includes financial feasibility studies, educational workshops, communication “toolkits”, computer support, community needs assessments, policy and procedure development and similar activities. This type of support varied widely among states. Educational workshops/conferences and informational materials were the primary tools used in enlisting communities.

The focus given to this section has significantly decreased over the last year. Most states have identified the hospitals eligible for conversion but are beginning to shift focus and funding to issues of networking, EMS, and quality in Year 3. However, some states such as **Alabama** have made very little progress in the conversion area. **California** CAH growth is small given the amount expected.

Total funds have significantly increased over last year (see Table 3). This is largely due to a shift in establishing conversion criteria, to funding feasibility studies technical assistance grants to assist in the conversion process.

Budget Activity

	Amount spent through 4/30/01	Amount estimated for the full Fiscal Year 2 (9/1/00-8/31/01)	Projected amount proposed to be spent in Year 3 (9/1/01-8/31/02)
Number of states	45	45	45
Total	\$4,780,001	\$4,815,444	\$5,242,413
Per state mean	\$106,222	\$107,010	\$119,146
Median	\$80,305	\$84,000	\$107,500

Note: Not all states included budget details with dollar amounts. States excluded from columns one and two are AR and NM. States excluded from column three are AR, ID, and NM. Fund figures include federal, state, in-kind, and other resources utilized for the project.

² The total number of CAHs changes continuously. As of June 1, 2002, there were 620 CAHs. The most current information is available at <http://www.rupri.org/rhfp-track/mrhfggrid.html>.

³ The definition of *eligible* hospitals includes the number of hospitals that have already converted, those that have declined conversion at this point in time, those that are awaiting CAH certification, and those that have not yet applied for conversion.

States with expenditures greater than \$200,000 in Year 2 were:

- Alabama \$250,720
- Alaska \$209,250
- Colorado \$215,000
- Georgia \$240,000
- Idaho \$203,973
- Maine \$242,400
- Minnesota \$325,000
- Montana \$204,015
- Pennsylvania \$268,600
- Tennessee \$275,500
- Washington \$208,680

States with expenditures between \$100,000 and \$200,000 in Year 2 were:

- Florida \$100,000
- Maryland \$113,381
- Mississippi \$102,000
- Missouri \$132,500
- New Hampshire \$139,040
- Oklahoma \$143,778
- Oregon \$104,180
- South Dakota \$135,500
- Virginia \$153,806

Common goals among states for Budget Year 3 were to provide:

- Technical assistance to potential CAHs.
- Education efforts to enlist communities to convert their hospitals to CAHs.
- Contact with CAHs to facilitate designation.
- Education efforts about the Flex Program and CAH conversion process.
- Continue to fund feasibility studies.

In addition to converting facilities to CAH designation, some states have exceeded their responsibilities. For example, **Alaska** has created a Small Hospital Work Group to continue to infuse life into the Flex Program as well as to ensure it is relevant to the hospitals' and communities' changing needs. **Florida** has developed a process that coordinates certification along the continuum of decision-makers.

Very few states are broadening the community needs assessment beyond the federal requirement.

Development and Implementation of Rural Health Networks

In this section of the grant application, it was requested that applicants describe their state networks and current and intended membership as well as the extent of stakeholder and community involvement in this activity. It was stated that the focus of this component should be on the activities relating to the development of rural health networks rather than the “definition” of networks since the CMS grant application guidelines previously defined *network*. According to the guidelines, “a network is a formal agreement between one CAH and one acute care hospital with agreements regarding patient referral, transfer, communications and transportation.”

This portion of the application has visibly improved compared to last year in terms of the level of detail and description surrounding network development initiatives in the states. Nevertheless, the definition of *network* remains elusive. Like last year, the interpretation of a *network* varied across states. Again, this year, however, it is clear that most states exceed the minimal federal requirement for network development. Additionally, network development is receiving increased attention as CAH conversions begin to slow. The majority of states described hospital networks and plans to improve patient referral, transfer agreements and communications, However, some applicants were unclear as to the type of networks they intended to create as well as whether or not their CAHs were participating in a pre-existing network(s). Finally, community involvement was rarely mentioned in this section.

State requirements for network development varied. Some states required all CAHs to belong to extensive networks. For example, Massachusetts requires more extensive networking agreements than does the federal definition. Specifically, it developed the MA Rural Health Network as a collaborative approach to network arrangements that involves communities, universities, and government agencies. Additionally, **Michigan** also expanded federal government requirements to include not only other health care providers, but community members, local businesses, local government, intermediate school districts, and other interested organizations. **Ohio**, a state that had no network development activity last year, is implementing a statewide Rural Health Network Development Grant Program. **Georgia** is using funds to develop a Central Billing Office pilot project to centralize billing for 10 CAHs. Interestingly, despite these vignettes of what specific states have been doing, the level of detail in descriptions of how the states supported networks was minimal even though all of the applicants stated that they did support networks.

Like last year, the states with the formal networks in place were the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) states. All of the EACH/RPCH states (**California, Colorado, Kansas, Nebraska, New York, South Dakota, and West Virginia**) had a history of network development, so transitioning to follow the CAH network requirements was easy and beneficial to these states. Three CAHs, all former RPCHs, in **Colorado** stated that their network activities with the most return on their efforts were facilitated meetings, needs assessments, strategic planning, community development, and public relations. The Office of Rural Health in **Kansas** views networks as fundamental to the Flex/CAH Program and believes

networks cannot and should not be separated from other aspects of the program. **South Dakota** is focusing on electronic networks and is piloting a project for accessing health providers via videoconferencing. Some states are struggling with network development due to mistrust of networks. For example, **Alabama** stated that networks worked to the detriment of the community. This has resulted in concerns about networking by many rural hospitals. In **Wyoming**, network development has been very slow because of the distrust that exists between large and small facilities.

Budget Activity

Table 4: Networks — Total Funds			
	Amount spent through 4/30/01	Amount estimated for the full Fiscal Year 2 (9/1/00-8/31/01)	Projected amount proposed to be spent in Year 3 (9/1/01-8/31/02)
Number of states	46	46	46
Total	\$2,531,814	\$4,329,697	\$6,573,721
Per state mean	\$55,040	\$94,124	\$146,083
Median	\$39,240	\$60,919	\$129,059

Note: Not all states included budget details with dollar amounts. The state excluded from all columns is NM. ID and NM are excluded from Year 3. Fund figures include federal, state, in-kind, and other resources utilized for the project.

States with expenditures greater than \$100,000 in Year 2 are:

- Alabama
- Colorado
- Florida
- Idaho
- Kentucky
- Maine
- Massachusetts
- Nebraska
- New York
- North Carolina
- Minnesota
- Oklahoma
- Texas
- South Dakota
- Vermont
- Wisconsin
- Wyoming

States with expenditures between \$50,000 and \$100,000 in Year 2 are:

- Alaska
- Arkansas
- Maryland
- Michigan
- Oregon
- South Carolina
- Washington
- West Virginia

The common objectives for Year 3 are to continue to support networks by encouraging CAHs to pursue network development, and to establish more formalized networks. Other Year 3 objectives are:

- To offer workshops for CAH facilities to discuss advantages of network development.
- To work to develop and implement a formal mechanism to identify existing network relationships with every eligible CAH.
- To provide technical assistance in the areas of coalition building, survey design and data analysis, community needs assessment, asset mapping and strategic planning.

Improvement of EMS Systems

Improving EMS systems was the next section of the application in which applicants were asked to discuss what activities they plan to establish or expand to improve and integrate rural EMS, especially where CAH designations will occur. Applicants were also asked to identify the CAH service areas in which EMS systems will be integrated as part of the network development efforts. In addition, applicants were asked to discuss activities associated with supporting the establishment or expansion of programs to improve and integrate rural EMS into rural communities, especially where CAH designation will occur.

Almost all of the states encouraged and provided support to enhance and develop the EMS systems serving CAH networks. In addition, almost all applicants described challenges and barriers to EMS development, but very few offered solutions. **Alaska** is one exception. It has a strong application which states the problem followed by a proposed solution. Some applicants' EMS efforts do not differ from those stated in last year's application. A significant amount of effort was placed on recruitment and retention activities. **Florida** has funded seven scholarships to increase retention rates among rural EMS providers. **Nebraska** has distributed a recruitment and retention manual to all of the CAH communities. Last year, Nebraska conducted three studies. The first identified key factors that have caused adult test anxiety that decreases the number of certified EMS volunteers. The second study looked at the key factors affecting recruitment and retention of EMS volunteers, and the last study focused on the quality assurance and quality improvement plans and policies that rural hospitals and local ambulance services currently have in place. Unfortunately, the findings of these studies were not discussed, however their inclusion would have been an excellent resource for others. Finally, **Minnesota** is conducting a pilot project to cross-train paramedics to perform certain nurse duties within the hospital and offer emergency medical technician (EMT) training to college students.

Common challenges listed by the states included EMS boundary and turf battles, lack of training and adequate funding, and recruitment and retention of qualified personnel. Many states have difficulty in training and upgrading the existing skill levels of current or potential employees to meet local needs. Recruitment and retention of EMTs continue to plague most states due to low

wages, low ambulance run volume, and the lack of advancement opportunities. In addition, states face the challenges of providing appropriate continuing education to their paramedics, EMT-basics, and EMT-first responders.

Many states reported their plans for developing an integrated EMS agency that would work as a central authority with the intentions of streamlining communications while avoiding unnecessary ambulance re-routing. Some of the other states were focusing on creating and improving trauma programs. For example, **Mississippi** created a Trauma Task Force responsible for the development of a trauma plan. **New Hampshire** developed the Trauma Triage Pathways Program even though New Hampshire has no plans to integrate rural EMS into rural health networks.

The majority of states were focusing on at least one, if not several, of these activities:

- Development/modification of referral and transfer protocols.
- Training of emergency medical personnel.
- Upgrading EMS equipment and providing computers to small ambulance services.
- Recruitment and retention of EMS personnel.
- Improving communication between the hospital and EMS providers.
- Developing assessment tools to determine EMS needs in CAH service areas.
- Developing EMS information system to collect and analyze data on EMS response time.

Budget Activity

	Amount spent through 4/30/01	Amount estimated for the full Fiscal Year 2 (9/1/00-8/31/01)	Projected amount proposed to be spent in Year 3 (9/1/01-8/31/02)
Number of states	46	46	46
Total	\$2,173,600	\$2,717,891	\$3,954,350
Per state mean	\$47,252	\$59,085	\$87,874
Median	\$31,500	\$48,422	\$75,000

Note: Not all states included budget details with dollar amounts. The state excluded from all columns is NM. ID and NM are excluded from Year 3. Fund figures include federal, state, in-kind, and other resources utilized for the project.

States with expenditures greater than \$100,000 in Year 2 are:

- Alabama \$104,622
- Tennessee \$107,500
- Wisconsin \$114,112
- Minnesota \$115,000
- Wyoming \$129,000
- New York \$140,000
- Kentucky \$160,000

- Ohio \$168,627
- Iowa \$206,772

States with expenditures between \$50,000 and \$100,000 in Year 2 are:

- Vermont \$50,000
- Oklahoma \$57,468
- West Virginia \$59,000
- Colorado \$61,628
- Oregon \$63,297
- Connecticut \$67,300
- Montana \$67,890
- Maryland \$71,900
- Texas \$75,000
- Alaska \$77,399
- South Dakota \$81,250
- Washington \$82,348

Common goals among states for Budget Year 3 were:

- To provide grants for recruitment and retention efforts.
- To provide funding for equipment purchase.
- To provide funding to develop centralized purchasing, billing, and inventory control systems.

Quality of Care

In the fifth section of the application, applicants were asked to describe activities associated with ensuring quality of care delivered in critical access hospitals and activities related to the implementation of these activities. In addition, applicants were asked to describe what certification or accreditation procedures were being implemented as well as the type and amount of stakeholder and community participation.

Despite improvements in the amount and type of information provided in this component of the application compared to last year, overall quality improvement and quality assurance efforts are still difficult to determine. Like last year, most of the applications provided the least amount of information compared to the discussion of the other objectives. The majority of applicants chose to focus on credentialing, certifications and standards that are currently in place. In most states, CAHs are either Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited or are strongly urged to seek accreditation. However, most states provided minimal detail about the accreditation process and agreements. If there was additional information regarding accreditation, it was merely an outline of the JCAHO or PRO agreements. All states appeared to be using outside assistance to help with this portion of the Flex Program.

Minnesota had a strong application in this area, which included quality monitoring and a CAH evaluation process. **Georgia, Florida, South Dakota,** and **Mississippi** did not conduct any quality activities during Year 2. In fact, **South Dakota** does not see the need for CAHs to be actively involved in quality improvement and assurance activities. **Massachusetts** spent zero dollars in Year 2 and has not requested any funding in this area for Year 3.

Budget Activity

	Amount spent through 4/30/01	Amount estimated for the full Fiscal Year 2 (9/1/00-8/31/01)	Projected amount proposed to be spent in Year 3 (9/1/01-8/31/02)
Number of states	46	46	46
Total	\$1,035,420	\$2,004,072	\$2,949,874
Per state mean	\$25,966	\$50,102	\$71,948
Median	\$9,102	\$28,900	\$52,500

Note: Not all states included budget details with dollar amounts. States excluded from all three columns are CA, GA, HI, ID, NM, and VA. Funds include all resources utilized for the project, including those other than the requested Federal grant funds.

States with expenditures greater than \$100,000 in Year 2 are:

- Kentucky \$129,500
- Oklahoma \$274,855
- Wisconsin \$280,605
- Oregon \$104,100
- New York \$120,000

States with expenditures between \$50,000 and \$100,000 in Year 2 are:

- Vermont \$50,000
- Colorado \$52,000
- Maryland \$54,585
- Iowa \$66,144
- Alabama \$68,000
- Washington \$75,343
- Minnesota \$76,000
- Arkansas \$78,827
- Texas \$85,000
- West Virginia \$90,000
- Montana \$98,300

Wisconsin CAHs have signed an agreement to participate in the Robert Wood Johnson Quality Indicators Program for two years to monitor and improve the quality of patient care. They also have developed a plan to address the nursing education needs among CAHs. In **Oklahoma**, the

state legislature and Department of Health have developed an approach to monitoring and tracking quality of care. A detailed list of criteria is included in the application.

States that spent zero dollars on quality improvement in Year 2 yet were requesting grant funding for Year 3 were:

Louisiana: Louisiana requested money for Year 2, but did not spend any. It has requested \$5,000 for Year 3. In Year 3, the plan is to implement a quality assurance survey tool and agreements for credentialing and quality assurance. In addition, two monitoring surveys will be conducted.

Indiana: Plans to extend the use of its patient satisfaction instrument are in place, however Indiana has only requested \$1,000 for printing supplies.

Mississippi: Money was requested for Year 2 and zero was spent. This was largely due to having only one CAH. In Year 3, the plan is to work with a PRO to design an education program for CAH utilization review. Medical staff are also slated to address necessary changes to ensure facility compliance with federal regulations of maintaining the average length of stay of 96 hours.

Missouri: In Year 3, Missouri plans to implement the Health Care Quality Improvement Program to improve the health of Medicare beneficiaries.

New Hampshire: New Hampshire provided limited information as to where CAHs were in terms of quality issues. In Year 3, the plan is to evaluate progress and outcomes of each CAH.

South Dakota: There were no activities in Year 2. In Year 3, the plan is to enhance the quality of care within CAHs by using information technology and distance learning applications to improve management and delivery of clinical services.

Evaluation

In this final section of the grant application, applicants were asked to describe the methods used to evaluate the impact of the Flex Program. In addition, applicants were asked to describe progress in relation to the performance measurement and outcome systems, indicators, and data collection mechanism identified in the original proposal as well as the evaluation design and findings to date.

This component of the Flex Program varies widely by state. The differences in program evaluation are the result of a few factors. First, some Flex Programs are newer than others. Connecticut, for example, only recently received approval for its rural health plan while a state like Nebraska has been participating since the program's inception. Next, several grantee programs are very small offices (e.g. 1 person only); therefore, the amount of time needed for a

complete and effective evaluation is much greater for a smaller office staff, particularly for those grantees who are in the midst of hospital conversions and program implementation. As a result, the states are at different places in terms of evaluating their own program. A few states have completed evaluations based on their Years 1 and 2 activities, but the majority of programs are not there yet. Furthermore, there appears to be a discrepancy as to what a comprehensive evaluation should include. States such as **Minnesota, Michigan, Oregon, and Arkansas** could serve as potential models.

States that spent zero dollars in Year 2 and did not request Year 3 funding are **Florida, Kentucky, New Mexico, New York, North Carolina, and Vermont**.

Budget Activity

	Amount spent through 4/30/01	Amount estimated for the full Fiscal Year 2 (9/1/00-8/31/01)	Projected amount proposed to be spent in Year 3 (9/1/01-8/31/02)
Number of states	46	46	46
Total	\$403,299	\$692,866	\$1,000,518
Per state mean	\$10,613	\$18,233	\$25,013
Median	\$4,835	\$8,690	\$23,852

Note: Not all states included budget details with dollar amounts. The states excluded from all columns are FL, KY, NC, NM, NY, and VT. ID, KY, NM, NY, NC, and VT are excluded from Year 3. Fund figures include federal, state, in-kind, and other resources utilized for the project.

States with expenditures greater than \$100,000 in Year 2 are:

- **Oregon** \$104,000

States with expenditures between \$50,000 and \$100,000 in Year 2 are:

- **Indiana** \$50,000
- **California** \$50,330
- **Colorado** \$54,000
- **Texas** \$60,000
- **West Virginia** \$60,000

There were very few commonalities across the states for Year 3 evaluation objectives. Plans for Year 3 varied from collecting data to continuing Year 2 activities to participating in a national evaluation.

States that have made the most progress are:

Colorado: An evaluation framework has been developed along with evaluation indicators.

Kansas: It is the model for Nebraska. It has detailed evaluation results from Years 1 and 2. The plan is to look at the financial impact and effect on access to services in CAH communities.

Massachusetts: This state has contracted with BDMP/Westport Group to develop the Evaluation Plan Matrix. This matrix is a framework for collecting and presenting data for evaluation purposes. The plan is to use the data to make informed program planning decisions and to aid in policy development.

Michigan: Qualitative and quantitative data are being collected. Short and long-term goals as well as evaluation strategies and methods have been identified.

Minnesota: Minnesota has completed a first year finding report. The plan for Year 3 is to have completed an evaluation finding report for all 10 CAHs and comparison hospitals.

Oregon: Oregon, which expended the most dollars in this section, has a long list of accomplishments. The Office of Rural Health contracted with the Oregon Association of Hospitals and Health Systems to develop a financial tool to assist in monitoring the Flex Program's progress. In addition, the health status of CAH communities is being tracked and monitored through a Community Profile database.

Table 8: Budget Activity Summary for Six Goals of the Medicare Rural Hospital Flexibility Grant			
	Per State		
	Total	Mean	Median
1. RURAL HEALTH PLANS			
Amount spent so far in Year 2, as of 4/30/01	\$857,279	\$19,051	\$7,750
Amount expected to be spent for the full fiscal Yr 2	\$1,115,644	\$24,792	\$8,326
Projected amount proposed to be spent in Yr 3	\$992,577	\$22,057	\$10,000
2. CAH DESIGNATION			
Amount spent so far in Year 2, as of 4/30/01	\$4,780,001	\$106,222	\$80,305
Amount expected to be spent for the full fiscal Yr 2	\$4,815,444	\$107,010	\$84,000
Projected amount proposed to be spent in Yr 3	\$5,242,413	\$119,146	\$107,500
3. NETWORKS			
Amount spent so far in Year 2, as of 4/30/01	\$2,531,817	\$55,040	\$39,240
Amount expected to be spent for the full fiscal Yr 2	\$4,329,697	\$94,124	\$60,919
Projected amount proposed to be spent in Yr 3	\$6,573,721	\$146,083	\$129,059
4. EMS			
Amount spent so far in Year 2, as of 4/30/01	\$2,173,600	\$47,252	\$31,500
Amount expected to be spent for the full fiscal Yr 2	\$2,717,891	\$59,085	\$48,422
Projected amount proposed to be spent in Yr 3	\$3,954,350	\$87,874	\$75,000
5. QUALITY ASSURANCE			
Amount spent so far in Year 2, as of 4/30/01	\$1,035,420	\$25,866	\$9,102
Amount expected to be spent for the full fiscal Yr 2	\$2,004,072	\$50,102	\$28,900
Projected amount proposed to be spent in Yr 3	\$2,949,874	\$71,948	\$52,500
6. EVALUATION			
Amount spent so far in Year 2, as of 4/30/01	\$403,299	\$10,613	\$4,835
Amount expected to be spent for the full fiscal Yr 2	\$692,866	\$18,233	\$8,690
Projected amount proposed to be spent in Yr 3	\$1,000,518	\$25,013	\$23,852

Note: Not all states included budget details with dollar amounts. Funds include all resources utilized for the project including those other than the requested Federal grant funds

	Year 1	Year 2	Year 3
State	FY 99	FY 00	FY 01
AK	\$382,705	\$620,000	\$620,000
AL	\$162,650	\$450,800	\$450,000
AR	\$478,381	\$470,000	\$455,000
AZ	\$124,379	\$525,000	\$525,000
CA	\$220,055	\$450,000	\$400,000
CO	\$382,705	\$546,000	\$545,848
CT	---	\$100,000	\$100,000
FL	\$191,352	\$548,000	\$600,000
GA	\$411,408	\$520,000	\$588,000
HI	\$162,650	\$392,000	\$390,000
IA	\$231,378	\$415,000	\$410,000
ID	\$334,867	\$549,000	\$545,000
IL	\$478,381	\$490,000	\$470,000
IN	\$287,029	\$215,000	\$410,000
KS	\$550,138	\$705,600	\$700,000
KY	\$191,352	\$625,000	\$687,991
LA	\$220,055	\$275,600	\$290,954
MA	\$81,325	\$343,000	\$310,000
MD	\$83,717	\$100,000	\$120,000
ME	\$124,379	\$375,000	\$355,000
MI	\$224,839	\$510,000	\$537,544
MN	\$550,138	\$720,000	\$700,000
MO	\$81,325	\$310,000	\$415,000
MS	\$171,403	\$215,000	\$219,985
MT	\$574,057	\$730,000	\$700,000
NC	\$287,029	\$539,000	\$539,000
ND	\$541,712	\$712,000	\$680,000
NE	\$550,138	\$720,000	\$700,000
NH	\$95,676	\$138,000	\$335,861
NM	\$153,082	\$170,000	\$170,000
NV	\$220,055	\$490,000	\$561,000
NY	\$550,138	\$475,000	\$460,000
OH	\$95,676	\$390,000	\$513,644
OK	\$478,381	\$712,000	\$700,000
OR	---	\$640,000	\$640,356
PA	---	\$350,000	\$355,000
SC	\$263,110	\$558,000	\$515,000
SD	\$287,029	\$637,000	\$605,000
TN	\$399,448	\$712,000	\$700,000
TX	\$478,381	\$624,000	\$555,000
UT	---	\$390,000	\$370,000
VA	\$167,433	\$245,000	\$254,238
VT	\$167,433	\$370,000	\$355,000
WA	\$550,138	\$455,000	\$550,000
WI	\$550,138	\$716,000	\$699,837
WV	\$358,786	\$600,000	\$600,000
WY	\$220,055	\$395,000	\$390,000
TOTAL	\$12,731,801	\$21,618,000	\$22,794,258