

## Chapter 6

# State-Based Evaluations

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### Introduction and Summary

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In this chapter, we examine the progress of the states in performing evaluations of their Flex Programs. Each year when the states apply for funding from the Federal Office of Rural Health Policy (FORHP) under the Flex Program, they submit plans for evaluating their progress in attaining several goals of the Flex Program, as well as any other goals that they may have set specific to their states. Because this program has been well underway for almost three years, we expected that the 47 participating states have made progress with evaluation activities.

Specifically, we are interested in the following questions about the states' progress with their evaluations:

- What progress have the states made on their evaluations?
- What methods were used?
- What are the findings?
- What is planned for evaluation in the coming year?

To date, only modest progress has been made by the states on their evaluations. Some states have had thoughtful and thorough evaluation processes in place since the beginning of the Flex Program. These states have used a variety of methodologies including mail surveys, site visits, and focus groups. However, many states have done very little evaluation. These states cite several reasons for not making progress: too little experience with the program to be able to track changes, lack of knowledge of how to do evaluations or what the FORHP expects for evaluations, and competing needs for resources for other aspects of the program that could have been devoted to an evaluation.

Regardless of the progress being made on evaluations, there is a universal sense on the part of the states that the program is succeeding, particularly in terms of its benefit to hospitals that have converted to critical access hospital (CAH) status. While CAH status does not solve all of the financial problems faced by America's smallest hospitals, it does improve their financial viability. Furthermore, the states have also reported that they have received praise from the hospitals for the work that the states are doing in implementing the Flex Program in terms of facilitating the CAH conversion process. However, the states indicate that there has been less progress in efforts related to improving rural emergency medical services (EMS), network development, and quality improvement.

We recommend that the Federal Office of Rural Health Policy require the states to submit written results of in-state evaluations by the end of calendar year 2002. Evaluations have always been a requirement of the program, and there has now been sufficient time under the Flex Program for each of the state grantees to report their progress with implementation. Besides offering the opportunity for summative findings, evaluations more importantly provide formative information that will help the states improve their Flex Programs. This chapter, in addition to the Technical Assistance Services Center (TASC) Web site (<http://www.ruralresource.org/eval.shtml>), offers ideas and resources to guide the states in completing their contractual obligation to prepare and complete program evaluations.

## Methods

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We looked at what each state submitted concerning a program evaluation in its grant application, and we attempted to contact (by telephone) each state that has a Flex grant to interview them about their progress on evaluation activities. We succeeded in reaching by telephone 38 of the 47 states with Flex grants. (See Appendix 1 for the outline of the telephone interviews.) As available, we reviewed evaluation materials sent to us by the states that had made some progress. We also reviewed information from the e-mail and telephone surveys of Flex Coordinators that is managed by the University of North Carolina's Cecil G. Sheps Center for Health Services Research.<sup>1</sup> When we talked with the states by telephone, we told them that we would be contacting them again at the end of 2002 and in early 2003 to request written evaluation reports.

## Findings

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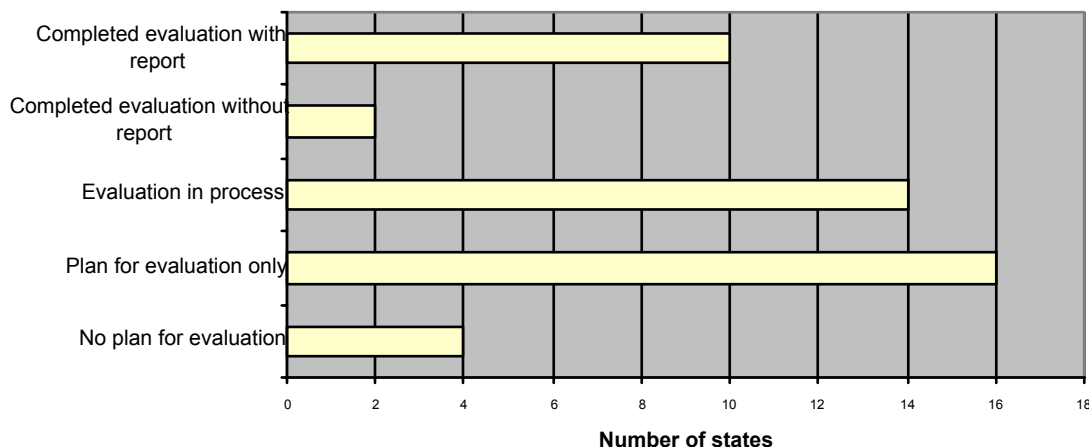
### ***Limited Progress with State Evaluations***

As we near the end of the third year of the Flex Program, there has been little progress made by the states on performing evaluations of their Flex Programs (see Table 1). While each of the states follows the progress of its programs under Flex, only ten have progressed to the point where they were able to share a written report with us. Another two states have completed evaluations but have not yet produced written reports. Fourteen states have evaluation activities in process and thereby have some information to share on the progress of the Flex Program in their states. Sixteen states have plans for an evaluation, while four states do not. Such scant progress on state-based evaluations is a problem for a program that depends on continued legislative support.

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<sup>1</sup> The e-mail survey is a monthly survey of Flex Coordinators that requests them to answer several questions related to CAH conversions, Medicaid reimbursement, rural health plan development, and program evaluation. The telephone survey is an annual survey of these same individuals in which more detailed questions are asked encompassing multiple aspects and objectives of the Flex Program.

**Table 1  
Progress on State-Based Evaluations**



The states cited the newness of the program as the most common reason for not making headway on their evaluations. The abiding interest of most observers of the Flex Program is the financial impact on the converted hospitals. Many states argue that their converted hospitals have not been operating under cost-based reimbursement long enough to have audited cost reports, and as such, they cannot determine the influence of the Flex Program on their financial health.

States also reported that they have been devoting their energies to implementing the program and have not had the resources to conduct formal evaluations. They have been working to convert hospitals to CAH status, making mini-grants available, and working with other state agencies on improving their rural EMS systems. Some state Flex Programs are operated by very small agencies and, given all of their responsibilities, program evaluation often gets overlooked. Several states also admitted a lack of knowledge on how to perform program evaluation.

The states that have made little progress expressed interest in learning what the expectations are from the FORHP. In the remainder of this chapter, we supply examples of evaluations from several states. Additionally, we refer states to the TASC Web site to get more ideas and guidance about evaluations. Finally, we suggest elements of and approaches to evaluation activities.

***Approaches to Flex Program Evaluation***

The states have employed a variety of approaches to evaluation. They are examining both satisfaction with their own activities (e.g., advice on conversion, financial feasibility studies, mini-grants, help with licensure, etc.) as well as the program’s effects on the converted hospitals (e.g., financial health, progress with network development, improvements to EMS, and quality).

Table 2 shows the various entities employed by the states to participate in evaluation efforts. Note that most states have involved several groups in work on the evaluations. The most common approach is the “do-it-yourself” model, with the staff from the Flex grantee (most typically the state office of rural health) conducting the evaluation. Several states have used academicians to lead the evaluation, while others have employed private consultants, hospital associations, other state agencies, and the state peer review organization (PRO). Some states used a Request for Proposal (RFP) approach to find consultants to conduct the evaluations, while others contracted directly with other external organizations.

**Table 2  
Who Has a Role in the State-Based Evaluations?**

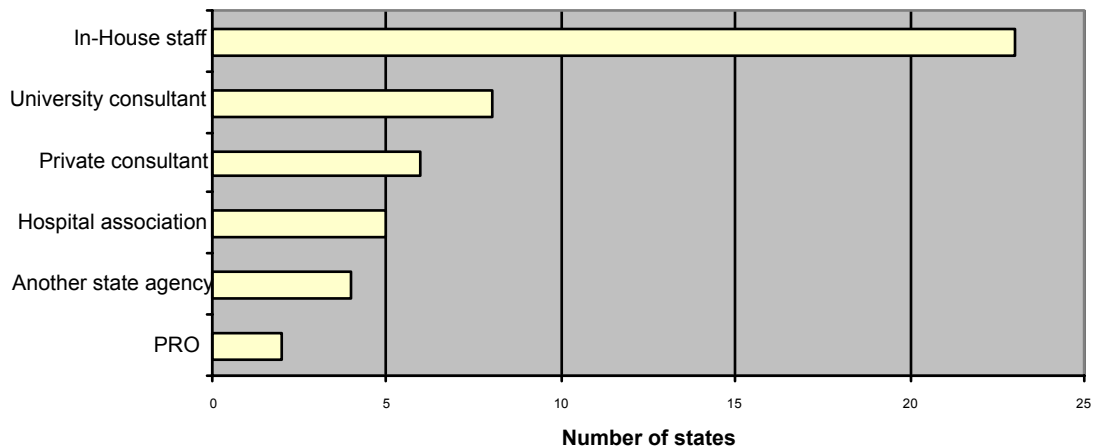
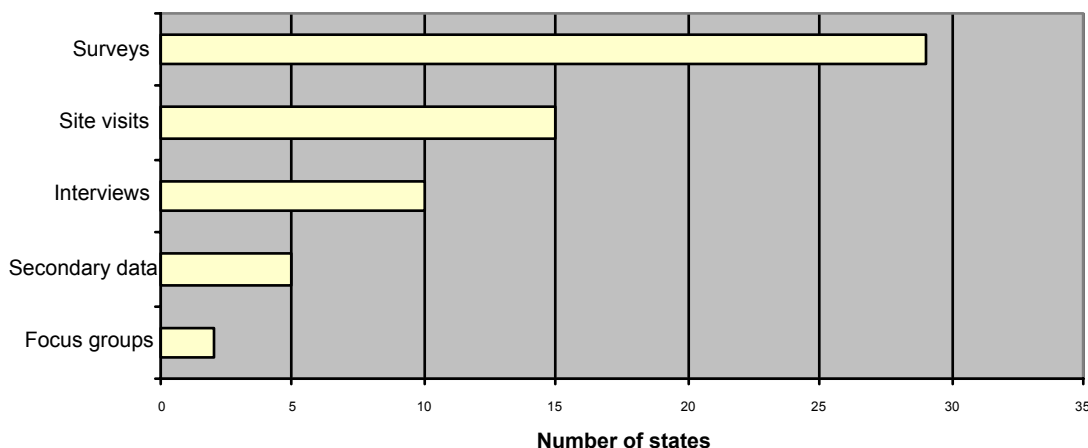


Table 3 shows the methods employed by state-based evaluators. Most commonly, the states and consultants have used surveys of CAH-eligible hospitals to assess the impacts of the Flex Program on hospitals, and to ascertain the levels of satisfaction with the services and activities of the Flex grantees. Other techniques include site visits, telephone interviews, analyses of secondary data, and, in a few cases, focus groups. In addition, many states sponsor meetings of their CAHs and take this opportunity to obtain feedback on the strengths and weaknesses of the program.

**Table 3  
Evaluation Methods Used by the States**



**Results from the States’ Evaluations**

A sampling of results from the states that shared evaluation reports with us is provided below. While there may be other hospitals that have completed written evaluations, these are the ones that were available at the time this chapter was prepared.

**Idaho** (Andrea Fletcher, Office of Rural Health, 208-332-7212):

*Methods:* Idaho contracted with a private consultant to prepare its evaluation. The evaluator made site visits to the first eight CAHs in the state. The site visits included a tour of the facilities and structured interviews with key administrative personnel. The evaluator reviewed financial records and policies and procedures.

*Findings:* The CAHs in the first cohort of converters were experiencing financial losses prior to conversion. After conversion, cost-based reimbursement brought them all close to break-even positions. Early converters in Idaho experienced difficulty in working with the Centers for Medicare and Medicaid Services (CMS) on the changeover to cost-based reimbursement. Conversion has not affected the case mix at the hospitals. The CAHs reported no new networks being developed as a result of conversion, although several reported the formalization of existing networks. While there appears to have been little effect on the EMS systems, four of the CAHs reported improvements to their quality assurance systems due to CAH conversion.

**Indiana** (John Braeckel, Policy Division of the State Health Department, 317-233-7365):

*Methods:* The Indiana Peer Review Organization (Health Care Excel) was contracted to conduct the evaluation. The evaluator used a survey tool for on-site reviews of the CAHs,

evaluated the CAHs' quality improvement activities, telephoned eligible hospitals that did not convert, and interviewed players key to the implementation of Flex at the state level. The evaluation focused on a determination of whether the goals of the Indiana Flex Program had been met.

*Findings:* The evaluation report describes the situation in each hospital that was contacted by the evaluator. The report also contains a useful matrix that summarizes the progress of the CAHs on the key features of the Flex Program. Most CAHs experienced substantial financial benefits from conversion. Network development included broad-based groups (clinicians, other hospitals, and other non-provider facilities). While the level of activities under each network related to the CAHs was variable, most surveyed hospitals credited their participation in the Indiana Flex Program with enhancing the usefulness of networks and improving some aspect of patient care. The Indiana State Department of Health got high ratings for its efforts in implementing the Flex Program.

**Kentucky** (Larry Allen, University of Kentucky Center for Rural Health, 606-439-3557):

*Methods:* Kentucky prepared its own evaluation and administered a survey that was mailed to each CAH-eligible hospital. Seventeen of the 34 eligible hospitals responded overall, and 7 of the 13 CAHs replied to the survey. The survey covered a wide range of topics including conversion decisions, EMS, community involvement, network development, scope of services, access to capital, quality assurance, performance improvement, and information systems. Hospitals were not queried about the performance of the Center for Rural Health in implementing the program.

*Findings:* The survey gives insights into the activities of the hospitals and only tangentially touches on the Flex Program and the effects of its implementation in Kentucky. As such, the survey takes "vital signs" of the hospitals and will provide a baseline of information for future surveys as the Flex Program develops in Kentucky. The survey showed only a modest effect of the Flex Program on EMS systems. Network development benefited as a result of the Flex Program.

**Michigan** (Angela Dietlein, Michigan Center for Rural Health, 517-432-1066):

*Methods:* The Center for Rural Health (CRH) partners with another office at Michigan State University to visit each of the CAHs annually. The site visits use a structured interview to examine both the services of the CRH and the effects of the Flex Program on the converted hospitals. The three key foci of the site visits are networks, outcomes (both financial and health care), and linkages to promote information sharing. The CRH has prepared reports on the progress of the program in Michigan and includes summary statements from the evaluation.

*Findings:* The hospitals give very high ratings to the CRH concerning its role in implementing the program. The Flex Program has substantially improved the financial health of all of the converters, with some hospitals reporting dramatic financial turnarounds.

Delays in the implementation of cost-based reimbursement did, however, strain the converters in the short run. According to the CAHs, a prime benefit of the program has been its effect on network developments; the CAHs have formed both horizontal and vertical networks. While physician input was important during the conversion process, community involvement during conversion was variable.

**Minnesota** (Linda Grohoski, Office of Rural Health and Primary Care, 651-282-3819):

*Methods:* Minnesota contracted with an outside firm for the first-year evaluation but now does it in-house. The evaluation is based on a very detailed evaluation plan, and the evaluation is being carried out in phases. Two reports have been published to date. Site visits are made to each CAH community to conduct structured interviews with key hospital personnel and focus groups with community members. In addition, the progress of the hospitals is tracked by reviewing financial data and information from surveys. Minnesota plans to perform an in-depth analysis of financial effects in the coming year when more data are available from CMS.

*Findings:* The surveys have shown that the state's CAH-affiliated physicians believe that there has been a positive impact on their practices. There is little evidence, however, that the communities themselves have even noticed conversions. The evaluation demonstrates positive effects on financial stability, networking, quality assurance, scope of services and workforce recruitment.

**Montana** (Pamela Sourbeer, Department of Public Health and Human Services, 406-444-9519):

*Methods:* The Montana Health Research and Education Foundation (MHREF) administers the Flex Program via a contract with the state. MHREF contracts with the Quality Assurance Division to track and evaluate the progress of the Flex Program in Montana. The evaluator has chronicled the activities of Flex Program in Montana and has written brief summaries about program implementation in each converted hospital. Tools used in the evaluation include a survey of the CAHs, e-mails and telephone calls to CAH administrators, and observations at Flex-related activities in the Montana and the region. Montana produces a very well documented report each year of Flex Program activities and accomplishments.

*Findings:* The Flex Program has succeeded in Montana in stabilizing the finances of the converted hospitals, many of which were formerly Medical Assistance Facilities (a state-based pilot program prior to the implementation of the Flex Program.) The hospitals appreciate the technical assistance that they get from MHREF. The state plan calls for substantial work on improving the EMS system and the state continues to make progress in the program focus areas. Data collections systems were improved this year and 12 grants were given for automated external defibrillators. The Flex Program has provided funds for a statewide quality improvement network that is moving toward implementation. CAHs have the option to participate in this network.

**Nebraska** (Li-Wu Chen, Nebraska Center for Rural Health Research, 402-559-7113):

*Methods:* Nebraska contracted with the Nebraska Center for Rural Health Research to prepare an evaluation. The evaluators used a case study approach and visited seven CAHs where they conducted structured interviews. They examined reasons to convert, preparation for conversion, and results of conversion. The findings are available in a written report.

*Findings:* Most Nebraska CAHs have experienced financial benefits from conversion. Some hospitals have become more efficient since conversion, an important finding given that CAHs are reimbursed for costs. Networks developed under the Flex Program have had a beneficial effect on the health care delivery system in Nebraska.

**North Dakota** (Brad Gibbens, Center for Rural Health, University of North Dakota, 701-777-3848):

*Methods:* The Center for Rural Health (CRH) examined a variety of secondary data to develop a first-pass evaluation of the goals (“themes”) of the North Dakota Flex Program. This portion of the evaluation is available in a written report. This year, the CRH will conduct a survey of CAH administrators to assess their perspectives on stakeholder development, grant programs, assistance from hospital associations, and community development. A third phase of the evaluation will involve acquiring data from a quality assurance organization (PRO) looking at the impacts of conversion.

*Findings:* All North Dakota CAHs have formed network agreements with tertiary hospitals. North Dakota invested substantial funds in the improvement of the state’s EMS systems. The Flex Program distributed mini-grants and collaborated with several statewide groups on EMS. Several CAHs have used Flex mini-grants to work on quality improvements at their facilities. The PRO has offered assistance in this area. The state’s CAHs have a sustaining effect on the local communities that they serve. An aggregate of the state’s CAHs has a direct payroll of \$57.9 million per year. The Flex Program has implemented 12 community assessments, and Flex staff have facilitated several strategic planning processes at CAHs.

**Oklahoma** (Gerald Doeksen, Oklahoma State University, 405-744-6081):

*Methods:* The Oklahoma Office of Rural Health contracted with Oklahoma State University to prepare an evaluation of the Flex Program. The evaluator prepared case studies of each CAH. The evaluator also performed a telephone survey with each CAH to develop a quantitative database on the CAHs. The surveys gathered financial performance data (predominantly unaudited) to obtain a preliminary assessment of the financial health of the CAHs. This evaluation approach was presented at the Flex Conference in Washington, DC in April 2002. A written report on the evaluation is available.

*Findings:* Oklahoma’s CAHs have thrived under the Flex Program. The financial health of the CAHs has been stabilized and improved, thereby allowing the hospitals to add services.

The Oklahoma CAHs are an important part of the local economies in the towns that they serve.

**Washington** (Beverly Court, Washington State Department of Health, 360-45-6439):

*Methods:* Washington contracted with the University of Washington to prepare an evaluation. The evaluators completed a telephone survey with 17 of the 31 CAH-eligible hospitals (including those that had converted) and convened a focus group meeting of CAH and CAH-eligible hospital administrators at a statewide meeting sponsored by the state hospital association. The interviews and focus groups addressed both the performance of the state in implementing the Flex Program as well as the effects (including financial performance) on converted hospitals. In addition, the evaluators contacted individuals in other states to gain an understanding of how other states were implementing the Flex Program. The evaluators prepared a written report that was shared with interested persons via teleconference. The evaluators also conducted a follow-up set of telephone interviews with the first six Washington CAH converters to ascertain estimates of the financial impact of conversion.

*Findings:* The Office of Rural Health (the Flex grantee) received very high ratings for the work that it did in supporting the hospitals considering and going through the conversion process. In addition, the state licensure department was praised for its work in surveying and re-licensing CAHs. One problem was that the early financial feasibility studies were inconsistent from hospital to hospital. The follow-up interviews showed that each of the original CAHs benefited financially from conversion: while all are still in loss positions, their losses have dropped, on average, about \$300,000 per year.

## Discussion and Recommendations

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Overall, the progress of the states undertaking program evaluations is disappointing. Given that the preparation of an evaluation is a requirement of the Flex grants and that each grantee has submitted plans for an evaluation, we expected to see more progress on evaluations at this point in the program. We note, however, that several states (some of which are featured above) have made substantial progress on their evaluations and their efforts can serve as models (or even templates) for states still struggling with completion of evaluation reports. State evaluations are often limited by their subjectivity, lack of standardization, internal nature (self-evaluations), and limited funding.

The FORHP should require, via explicit communication, that each Flex grantee complete a written evaluation report for its state's activities under the Flex Program. Each state has committed to evaluating its activities, and, as we approach the end of current funding for the program, we need to have strong and supportive information regarding this program. It will be useful to the funders and other states to share each state's experience with the program's implementation in a thoughtful and thorough manner.

The FORHP can direct grantees to this chapter for guidance on what to include in an evaluation report. Sections above outline the evaluation activities of states that have completed evaluation reports. States just getting started on evaluations can consult the persons listed in each state summary and can request reports from those states. States can also consult with the TASC Web site at <http://www.ruralresource.org/eval.shtml> for tools for evaluations.

Evaluations should focus on assessing the progress that the states have made in implementing their Flex Program goals and objectives as submitted in their Flex grant applications. The activities and accomplishments should first be summarized. Next, there should be an examination of the performance of the Flex grantee in implementing the program in that state. This would include asking all CAH-eligible hospitals (whether or not converted) to assess the strengths and weaknesses of the state's program. Written or telephone surveys work well in this arena and examples are readily available as indicated in the sections above. In addition, an evaluation should assess the effects on converted hospitals and their communities in the areas of financial impact, quality assurance systems, EMS systems, and network development. Site visits and/or telephone interviews work well in completing this component of the evaluation. Finally, the best evaluations include suggestions from the evaluator for program improvements.

## Appendix 1 – Telephone Interview Format

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Flex/CAH Tracking Project  
Evaluations Section of Year Three Report

Interviews with state Flex/CAH contractors (e.g., State Offices of Rural Health)  
**(Revised April 23, 2002)**

Date:

Name of interviewee:

**Preamble:** I am calling about the implementation of your state's Medicare Rural Hospital Flexibility/Critical Access Hospital Program. I am part of a national team of researchers that are tracking the progress of the FLEX Flex/CAH Program. As such, we make contacts with the states from time-to-time to get reports on the progress they are making.

My focus at this time is on evaluation. I am interested in both your plans to evaluate what you are doing, as well as any evidence that you can provide concerning how well the program is going in your state.

Questions:

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1. Are you the person in your state that would know about evaluations of the Flex/CAH Program? If not, whom should I call?
2. Describe your agency (that is responsible for implementing /the Flex/CAH Program in your state.)  
Is it (Office of Rural Health, state agency, hospital association, etc.)  
How big is it? How many staffers? etc.
3. Is your state conducting an evaluation of its Flex/CAH grant-funded activities?  
If YES, who is responsible for that part of your the Flex/CAH Program?  
Describe the activities of the evaluation?  
Who is doing the evaluation (consultants, staff, others)?  
What methods are being used (will be used)?  
How much progress has been made to date?
4. Do you have an evaluation report on your Flex/CAH Program activities?  
*If yes, would you send us a copy?*
5. Give us the results of your evaluation activities to date.