EACH Program
Evaluation: State
Site Visit Reports on
Early Implementation

July 27, 1992

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I. CALIFORNIA
A. STATE RURAL HEALTH POLICY CONTEXT

California has a history of involvement in rural health policy development that dates back to 1978. In that year the legislature established criteria to identify small, rural hospitals for the purposes of planning. The criteria were modified by the legislature in 1982 and again in 1987, resulting in the identification of 65 rural hospitals both within and outside of metropolitan statistical areas (MSA). In 1988 the legislature passed Assembly Bill No. 2148, which directed the Office of Statewide Health Planning and Development (OSHPD) (1) to review acute care operating and building code regulations, (2) to assume responsibility for granting waivers or exceptions to regulations that were deemed excessively burdensome to rural hospitals, and (3) to research existing alternative rural hospital models and to design and develop a new model for California.

OSHPD appointed a technical advisory committee (TAC) to advise it on the development of the model and on the implementation and administration of other aspects of the legislative mandate. The TAC included representation from OSHPD, the Department of Health (Licensing and Certification Division and Rural and Community Health Division), the Association of California Hospital Districts, the California Association of Hospitals and Health Systems, the California Medical Association, the California Nurses Association, and five rural hospital administrators. OSHPD contracted with the National Rural Health Association (who subcontracted with Rosenberg Associates) to define and develop the new alternative model. The TAC and the consultants met monthly during the design and development of the model.

In late 1989 after a year of study, the TAC established an entity called the Alternative Rural Hospital Model (ARHM). The ARHM is a limited service rural hospital. Unlike the Montana Medical Assistance Facility (MAF), the ARHM was designed such that it would not require a waiver of certain Medicare conditions of participation for hospitals in order to be implemented. California hospital licensure and certification laws and regulations are more stringent than the Medicare conditions of participation, and they require a hospital to satisfy criteria beyond the conditions before
it can be licensed. Among these criteria are that hospitals must provide surgical and anesthesia services. The study concluded that the financial stability of small, rural hospitals could improve if they were granted regulatory relief from the requirement to provide these services. Accordingly, the ARHM is based on a modular approach in which facilities are required to offer a "core" module (standby emergency medical services, basic acute care for "medical holding and stabilization," basic ambulatory care, basic laboratory services, and basic radiology services) and may offer additional services modules (surgical services, alternative birthing services, and expanded radiological and laboratory services). Other service limitations, such as a time limit on length of stay, were evaluated and rejected.

Ten hospitals are designated ARHMs and two additional hospitals are being evaluated for certification. OSHPD's authority to experiment with intrastate waivers of hospital licensure and certification criteria sunsets on January 1, 1994. OSHPD considers its participation in the EACH program a direct outgrowth of its work with ARHMs. All of the designated PCHs are also designated ARHMs.

The OSHPD budget provides approximately one-third of a million dollars for rural health activities related to AB2148. In addition, OSHPD administers a number of other related programs including training and placement of rural practitioners, Cal Mortgage administration, building code "waiver" assessment, and uniform data set collection and research, and capital needs assessment. With funding support from the Sierra Foundation, OSHPD will soon sponsor a cycle of conferences throughout the state, the outcome of which will be a revised and updated State Rural Health Plan that focuses on the comprehensive health care delivery needs of California.

B. PROGRAM DESCRIPTION

1. Organization and Administration

Assembly Bill No. 2811, signed by the governor on September 11, 1990, directed OSHPD, "in consultation with the Small and Rural Hospital Advisory Committee" (the TAC), to develop and
submit to the federal government an application on behalf of the state of California to seek designation and grant funding under the EACH program. The law also provided that after receiving designation and grant funding, OSHPD would be responsible for implementing the program. OSHPD is an independent department under the organizational umbrella of the California Health and Welfare Agency. It is responsible for the planning, development, and analysis of health programs. The Department of Health Services is responsible for health service delivery and financing. The Division of Licensing and Certification is part of the Department of Health Services. Within OSHPD, the development of the program was assigned to the Division of Health Projects and Analysis. The deputy director of OSHPD, Peg Gerould, is also the chief of the Division of Health Projects and Analysis and is responsible for providing administrative oversight to the program. The health planning specialist who provided the primary staff support to the TAC in the development of the ARHM, Ernesto Iglesias, is the EACH project director. He is supported by two health planning analysts and the ten-member technical support staff of the division. The TAC will continue to advise OSHPD on the development and implementation of the EACH program in California. OSHPD is assessing TAC membership and may expand it to include constituencies that are not currently represented such as emergency medical services. Because the Division of Licensing and Certification is a member of TAC, EACH program implementation can be coordinated with the division’s activities.

2. Program Goals

The primary goal of the EACH program in California is to establish "comprehensive health networks," which serve as models of cooperation for future PCHs and other rural hospitals and providers. It is believed that networks will reduce duplication of services, improve the use of personnel, produce greater efficiency in the health care system areas, strengthen the capabilities of existing providers, improve continuity of services, foster greater community education of health service delivery, and permit local services to be integrated. Comprehensive health networks will encourage greater community involvement in health planning and will therefore be a more accurate reflection
of community demand for services. One person interviewed suggested that the rural health network of the program provided a model to help "others with the politics of change." Another commented that should PCH participants drop out of the EACH program because of a strict interpretation of the statute, the networks would remain the legacy of the program.

Specific program objectives are (1) to inform rural hospitals of the EACH program, designation procedures, and OSHPD technical assistance availability, (2) to identify communities that might benefit from rural health networks, (3) to provide technical assistance to communities interested in developing rural health networks, (4) to evaluate the impact of the EACH program. The EACH program is viewed as a continuation of the efforts that began with the design of the ARHM. The two primary goals of the ARHM project were to provide regulatory relief and financial stability to very small rural hospitals. People involved in the design of the ARHM admit that the greatest deficiency of the model is that it does not require network linkages.

3. EACH Program

OSHPD and the TAC were already at work on designing the EACH program in California when the legislature passed Assembly Bill 2811. The state application for designation and funding was prepared by a consultant to OSHPD from California State University, Northridge. Network applicants were provided with technical assistance by OSHPD to complete their applications.

OSHPD is the state health data authority. It collects, processes, and analyzes hospital discharge abstracts containing some 17 data elements for every inpatient treated at a California hospital. Using these abstracts as an information source, OSHPD and the TAC analyzed data from all rural hospitals. Bed size, and acute and skilled nursing (SNF) average daily census were evaluated; referral patterns were studied. Based on the analysis, the TAC tentatively matched potential PCHs with potential EACHs. OSHPD sent a letter to all rural hospitals informing them of the EACH program. The hospital associations also informed their members about the opportunities offered by the program. When invited, OSHPD visited communities to discuss the concept and implications of networking.
OSHPD presented three workshops in different areas of the state to explain the program. Approximately 30 persons attended each workshop. When grant/designation applications were available for distribution, 40 potential applicants contacted OSHPD requesting applications. A majority of the requests were made by potential EACHs that were "shopping" for network partners. OSHPD received six applications (three networks). The applications were reviewed by the TAC, which did not establish review criteria because it wanted participation to be "inclusive rather than exclusive."

OSHPD currently provides technical assistance to the networks in the area of planning. OSHPD staff visit the sites and meet with administrators and Boards to talk about networking issues. Program staff is modifying its approach to targeted technical assistance. Originally, OSPHD had planned to develop and promulgate a list of qualified consultants to perform targeted technical assistance. Instead, OSHPD now plans to identify a list of technical assistance needs and to provide support through workshops rather than individual consultations. Program staff are also developing a state evaluation plan. Based upon the TAC's analysis of rural hospital data and its identification of communities that might benefit from program participation, OSHPD staff contacted facilities to inquire if they were interested in participating in the second round of designation/grants. The office has the authority to experiment with the use of "multicompetency" health personnel. It is evaluating whether to develop a dual licensure (for example, laboratory technician and radiology technician) pilot project and to extend it to the PCH. The program director is also engaged in such administrative duties as evaluating and making recommendations on the composition of the TAC (he is considering enlarging it to include EMS, primary care clinic, and payer representation), serving as liaison to HCFA, and meeting and sharing ideas with the other designated program states.

4. Use of Grant

Grant funds are used mainly for staff salaries and benefits, travel, and consultation. Two half-time positions (program director and associate planning analyst) are financed by the grant. However,
they will be available to the program on a full-time basis. All other time is donated by the state. Grant funds also are budgeted for travel to rural health networks and potential rural health networks as well as out-of-state travel to "HCFA and/or to present and disseminate information about the California program at other rural health meetings." As mentioned, the funds allocated for technical assistance (feasibility, agreements, procedures, architectural assessment) will not be spent on individual consultation but on rural health network workshops.

C. PROGRAM DEVELOPMENT

1. Overview and Strategy

California's participation in the EACH program is considered a seamless extension of its previous work in rural health policy. Since 1988, the legislature, the administration (and all of its relevant agencies), and various private constituencies (represented by trade and professional associations as well as individuals) have cooperatively planned policies aimed at preserving and improving access to health care services in sparsely populated, remote areas of California. All participants in the planning process believe that the EACH program introduced an element to the policy mix that was previously absent: networking and local integration of services. The fact that all of the designated PCHs are ARHMs (30 percent of the total) indicates that the ARHM may be considered a necessary incremental step in the downsizing process. OSHPD believes that the addition of the EACH program provides small, rural hospitals with a range of licensure options designed to fit the needs of a community and the resources available to it. The program activities of OSHPD and the TAC have focused on the creation of networks.

The rural health planning process, based on input from the TAC, is characterized as a "bottom up" approach. Various constituencies are represented on the TAC. However, OSHPD is aware of certain deficiencies in TAC membership. For example, EMS and primary care are not currently represented. Because California is both large and socioeconomically diverse, its health care providers (even within provider types) are far from homogeneous. For example, there are at least 8 different
hospital associations, 3 hospital councils, and various hospital conferences that represent hospitals politically or provide training and education programs. There are 11 different clinic associations, 8 of which deal with rural issues. EMS management is divided into administrative regions, each of which establishes its own criteria for equipment, personnel, and procedures. The problem experienced by OSHPD in basing participation on broad public involvement is not so much in deciding which constituency to invite to the table, but in deciding which group would best represent the constituency.

2. First Steps

OSHPD and the TAC first heard about the EACH program from their NRHA consultant while they were designing the ARHM. The EACH program was not yet law. OSHPD staff discussed the program with staff of the federal Health Research and Services Administration Office of Rural Health Policy. OSHPD staff followed the fate of the EACH program through Congress and when the program was signed into law, began to evaluate its potential for use in California.

As described above, the TAC’s first steps in the program were to analyze rural hospital data and to match potential PCHs with potential EACHs. This was an internal exercise to evaluate the utility of the program. PCHs and EACHs were not proposed as such against their will, and PCHs were not approached by OSHPD with the suggestion that they convert. The Division of Licensing and Certification and the TAC evaluated EACH legislation and California licensure law, and it concluded that the EACH program could be implemented without significant changes to California law or administrative rules.

OSHPD sent a letter to all rural hospitals explaining the program, and the California Association of Hospitals and Health Systems and the Association of California Hospital Districts explained the program in member publications. OSHPD staff visited communities at the invitation of hospital administrators to explain the program, and OSHPD sponsored three informational workshops at different locations throughout the state, which were attended by approximately 90 persons. The
office received requests for and sent out approximately 40 EACH program grant applications. OSHPD staff provided applicants with technical assistance on grant preparation. Six completed applications, representing three rural health networks, were received. Two of the three rural health networks had a history of cooperation. One network (Southern Humbolt) had been working for five years to establish linkages between the hospitals and other providers. The other (InterMountain) had used an earlier Rural Health Transition Grant to begin to establish its network. The six applications were reviewed and approved by the TAC.

3. Application Development

The state EACH grant application was written by a consultant to OSHPD from California State University at Northridge. He based the application on the notes of the TAC, internal OSHPD documents, and oral directions from OSHPD staff. Drafts of the application were reviewed by OSHPD staff and the TAC. Because of the broad TAC representation and the belief that the EACH program was a natural extension of the previous rural policy efforts in the state, drafts of the application were not more widely circulated. It was believed that all of the relevant constituencies were either represented on the TAC or served as staff to it.

4. Involvement of Hospital Association and Other Provider Representatives

Approximately 15 percent of all hospitals in California are classified by OSHPD as rural. (OSHPD's definition of rural is somewhat broader than OMB's definition of rural as non-MSA.) Approximately 46 percent of all rural hospitals are district hospitals. The California Association of Hospitals and Health Systems (CAHHS) represents all hospitals in the state; the Association of California Hospital Districts (ACHD) represents district hospitals. Both CAHHS and ACHD were members of the TAC from its formation. They participated in the design of the ARHM and the evaluation of the EACH program. ACHD was responsible for drafting and sponsoring Assembly Bill No. 2811, which directed OSHPD to apply for EACH program designation and funding. A staff
member of the Division of Licensing and Certification characterized the hospital associations as having "done much of the work of promulgating the idea [of networks]." A vice president of CAHHS accompanies OSHPD staff on site visits to networks and is available to provide networks with technical assistance from the office.

The California Medical Association and the California Nurses Association also participated in the deliberations of the TAC since its inception. They agreed with all of the decisions of the TAC.

D. STATE PROGRESS TO DATE

1. Summary

California has designated first-round PCHs and EACHs and is providing technical assistance to the networks. At the time of our visit, it was attempting to generate interest in second-round applications from facilities. It was also designing an evaluation of the effects of the program on services and expenses. OSHPD is implementing all aspects of the program outlined in the grant application. Despite this activity, OSHPD is cautious about the degree to which it should commit itself to the program until final program rules are published and evaluated. The office believes that participation in the program may be hampered by strict operating rules, a view shared by CAHHS. OSHPD is reluctant to "sell" the EACH program (but not the networking concepts) to small rural hospitals until the final operating rules are known.

In its evaluation of the utilization and financial status of small rural hospitals, OSHPD and CAHHS have concluded that participation of small hospitals in the distinct part-skilled nursing facility (DP-SNF) program of Medicare and Medicaid (MediCal) is a more dominant factor in their continued viability than is PCH certification. ARHMs are licensed as hospitals. If the inpatient component of the PCH is restricted below the state definition of a hospital, OSHPD and CAHHS are fearful that PCHs may lose their hospital designation. This loss would mean that the hospital would forego participation in the DP-SNF Program. The MediCal DP-SNF Program reimburses hospitals at reasonable cost to a maximum per diem cost of $210 per day. Free-standing SNF
reimbursement is capped at about $65 per day. Small hospitals use the DP-SNF Program as a way of shifting hospital overhead and of providing stand-by professional staffing. Networking ARHMs and sustaining participation in the DP-SNF Program may be more beneficial for small hospitals than participation in the EACH program. All agree that the facilities currently participating in rural health networks will continue to maintain those linkages whether or not they continue to participate in the EACH program.

OSHPD identified the lack of rules as the primary barrier to program expansion. The office stated its (and facilities') reluctance to proceed under uncertainty. OSHPD expressed its desire that HCFA broadly interpret the legislation that created the EACH program so that more facilities would be willing to participate. Neither OSHPD nor the Division of Licensing and Certification have the expertise to deal with EACH program reimbursement issues and rely upon CAHHS for assistance. CAHHS has not evaluated the proposed reimbursement mechanism for PCHs.

CAHHS suggests that the largest barriers, aside from the rules, concern physicians. CAHHS staff believe that physicians will be reluctant to participate in networks both because of a loss of earning power and because they are apprehensive about peer review from EACH physicians. CAHHS also expressed concern about the California statute regulating the corporate practice of medicine, an issue OSHPD believes is not a concern.

2. Factors Affecting Program Implementation

Passing of federal limited service rural hospital legislation when the state had just finished designing its own limited service rural hospital model favorably disposed OSHPD and the TAC to investigate the EACH program more fully. While designing the ARHM, OSHPD routinely observed other state experiments with limited service hospitals. The TAC was accustomed to OSHPD staff presenting features of other models to it for discussion. OSHPD and the TAC were immediately attracted to the networking element of the EACH model. In addition to bringing the networking concept to California's previous work with alternative hospital models, OSHPD and the TAC believed
that the facility grants were sufficient inducement to draw ARHMs (and perhaps other rural hospitals) into the program. These grant-financed networks would serve as models for other network development in the state. These factors, the ability to continue to improve on alternative model policy, and to finance that policy development with federal funds are the main determinants of California’s participation in the EACH program, and they have framed OSHPD’s implementation activities to date.

The absence of final program rules and concern for their content has had something of a chilling effect on implementation. While the absence of rules has not entirely frozen activity, it has considerably slowed implementation as the state and the facilities attempt to cope with the resulting uncertainty. OSHPD and CAHHS are somewhat pessimistic about the future of the EACH program should the rules be less flexible than they hope. On the other hand, one of the Division of Licensing and Certification representatives on the TAC believes that the intent of the legislation was clear from the beginning, and although the definition of an PCH is narrower than that of a hospital, some ARHMs will want to avail themselves of the designation regardless of the rules.

In the absence of rules, PCHs continue to operate as hospitals, making no provisions to eliminate routine inpatient services. OSHPD was reluctant to aggressively market the second round of EACH program grants because it did not believe a strict interpretation is in the best interest of the state.

3. Importance of the Grant

The ARHM was developed exclusively with state funds. The ongoing rural projects of OSHPD's Division of Health Projects and Analysis are funded at a level of approximately $330,000 per year. OSHPD is seeking supplemental funding from the Sierra Foundation for an expanded rural health planning effort. Notwithstanding the state’s commitment to rural health, California is experiencing a severe budget crisis. Although the state grant was not a necessary precondition for California’s participation in the EACH program, the grant funding was a welcomed addition, and the facility grants were considered a key inducement to participate in the program.
E. STATE GRANTEE EVALUATION OF LAWS/REGULATIONS

Because of previous amendments to California law and administrative rules made necessary by the ARHM, OSHPD and the Division of Licensing and Certification do not believe additional amendments are needed to implement the EACH program. The program can be implemented within OSHPD’s statutory "waiver" authority.

OSHPD and CAHHS, following their meeting with HCFA staff, came to believe that a strict interpretation of the 72-hour maximum length of stay rule and the "immediate and temporary" clause violates their understanding of the role of an PCH. They believe that an PCH is a downsized, limited service, rural hospital, capable of treating low-intensity, short-term patients. Their understanding of HCFA’s interpretation is that PCHs will not play a role in providing routine inpatient services within the rural health care delivery system, but will only hold patients for longer than 24 hours when it is necessary to stabilize them before transfer; in no case will patients be held longer than 72 hours. OSHPD and CAHHS are concerned with this interpretation for three reasons. First, they perceive that PCHs and ARHMs and other hospitals that might become PCHs will not participate in the program if they are required to discontinue all inpatient services. Second, they believe that continuing inpatient services will mean that an PCH is neither a hospital nor able to participate in the DP-SNF Program of MediCal. Third, OSHPD believes that strictly interpreted rules will be difficult to implement and may hamper its primary goal of building comprehensive rural health care networks. "We must do what is best for California," said the Deputy Director of OSHPD.

The Division of Licensing and Certification has fewer problems with the proposed rules and strict interpretation of the law, although the division representative admitted that voluntary downsizing to the strictly interpreted PCH level would make implementation difficult. She said, "When I first read the law, what I saw was a rural health clinic with holding beds." She believes that to be an appropriate model of care delivery in some communities, but estimated that in the state of California there were "probably only two hospitals that would fit that model."
The Division of Licensing and Certification assisted OSHPD with its review of the proposed program rules and concurred with OSHPD’s comments. The division believes that the following amendments should be made to the rules: (1) eliminate the need for both a physician and a mid-level practitioner on the medical staff of an PCH, (2) provide an exceptions process for the 72 hours (so it does not interfere with payment for patients that are kept in PCHs beyond the control of the facility), and (3) allow PCHs to link with EACHs in urban areas.

F. UNIQUE FEATURES OF THE PROGRAM AND APPROACH

California is alone among the seven designated states to have previously experimented with limited services rural hospitals. (Colorado’s alternative model experience did not involve hospital downsizing.) Although the service limitations of ARHMs are not as great as those for medical assistance facilities (MAF), California, by designating ARHMs a few months before Montana licensed MAFs, has the longest experience of any state in administering an alternative model program. California was able to draw upon this experience and that of the TAC in implementing the EACH program. The TAC is not only broadly representative, but by the time it turned its attention to the EACH program, it had already accumulated a wealth of information and understanding about alternative models. In terms of familiarity with the subject, California policymakers had an advantage over the other states.

Perhaps because the pre-existing ARHM lacked a networking component, networking has been the main program focus. As a result, the EMS policy for PCHs has not yet been developed at the state level. Instead, implementing the EMS requirements of the program has been left to the facilities. OSHPD likely will expand the TAC to include an EMS representative, but unlike the other states, California’s program goals are silent about EMS.

California has participated with the other designated states in group meetings and conference calls, and it views these sessions as useful for information sharing. OSHPD believes that the EACH program is important. It views the program as a "partnership" between the federal government and
states, their counties, and communities. Networks are seen as "a real opportunity to stabilize rural health care." However, OSHPD believes that if the rules are not changed, "HCFA will lose this tremendous opportunity" (Iglesias).
II. COLORADO
A. STATE RURAL HEALTH POLICY CONTEXT

Colorado represents an interesting case in which rural health policy has evolved with three distinctive characteristics: (1) a long tradition of little active government involvement, (2) a reputation for innovation in rural health care delivery, and (3) a pattern of recent changes, largely in response to the EACH program and other federal initiatives. These three characteristics have exercised an important influence on the EACH program in Colorado.

1. Tradition of Limited State Role

More than any of the other EACH states, Colorado has traditionally not had a strongly organized or highly visible rural health program. The Colorado Department of Health has limited authority and resources. Persons we interviewed estimated that only 17 percent of the department’s budget was drawn from state revenue; the rest was supported by various federal grants. The proportion of state money for the Division of Family and Community Health Services, which houses the EACH program, is even smaller—less than five percent of expenditures for the fiscal year 1991. In addition, Colorado eliminated CON requirements in 1987.

Even though Colorado is a very rural state with a high proportion of "frontier" counties, there has been no point of focus for rural health concerns until recently. Some respondents thought that the Department of Health traditionally had a "Denver bias." There has never been a state rural health plan, and there are no plans for creating one. In general, the state has limited authority to dictate to counties. The Office of Emergency Services has no general authority to mandate specific emergency services, and can only require local EMS planning as a condition of new grant money.

The lack of a strong state rural health program does not mean that the counties have played a notably active role in health care. Reportedly, only 24 of the 63 counties are covered by a full local department of public health, most of which are in metropolitan areas. There are actually 14 local health departments, some of which serve more than one county. A strong tradition of local autonomy has meant not only a limited role for state government, but also highly idiosyncratic local structures.
For example, some counties have two publicly controlled hospitals—one owned and supported by the countywide government, the other by a subcounty hospital district with its own taxing authority.

2. **Reputation for Innovation**

Despite the lack of a strong state role in rural health policy, Colorado has developed innovative answers to the problems of frontier communities and health facilities. Specifically, three initiatives have preceded and, indeed, have helped shape the EACH-PCH program. First, in 1986 a new licensure category was developed—the Community Clinic Emergency Center (CCEC) emphasized integrating ambulatory primary care with a limited inpatient capacity. In some respects the model for the PCH legislation, CCECs have been basically infirmaries with a maximum of six beds in which patients could stay for up to 72 hours. However, of the 28 CCECs, most are prison or educational infirmaries, or they are located in tourist sites. A few, including CHCs funded under Section 330, were developed for isolated rural communities. This model has been widely publicized (for example, Roscnberg, 1989), but CCECs have never been Medicare certified, and since they are not licensed as hospitals, PCH designation is not possible. Department of Health officials noted that after the publicity and resulting inquiries into CCECs, they realized that the licensure standards for CCECs were not what they should be. At the time of the site visit, they had only begun the process of reworking regulatory standards.

Another innovation was the Silverheels Health Center in Fairplay, Park County. This clinic, which opened up after a nine-bed county hospital closed, became the nonphysician staffing model that also received considerable publicity (for example, Alpha Center, 1991). Formally tied to a Denver hospital, the Fairplay clinic was the work of energetic local leaders, not the result of Department of Health intervention.

Finally, and perhaps most important for the EACH program, The Colorado Trust, a foundation established in 1985 to enhance the health and well-being of the state’s citizens, supported a five-year Rural Healthcare Initiative. The initiative’s grants to clusters of rural health facilities supported the
organization and development of local regional health care systems. Although the trust's project officer felt that the grants had not been notably successful in regionalizing health care (a formal evaluation has yet to be completed), some of the hospitals and areas that have led the development of Colorado's EACH program were grantee recipients and had previously developed the concept of local planning and inter-hospital networks.

3. Recent Changes

The advent of the EACH program has coincided with recent significant changes, which are generating a distinct locus for rural health policy in the Department of Health. The department set up a Section (not a formal division) for Rural and Primary Health Policy and Planning in December of 1990. The section's director had no staff. The EACH program grant enabled the director to hire one professional to administer the program starting in February 1992. In January, the section's director was also able to hire an experienced administrator for a new Office of Rural Health, using a grant from the PHS Office of Rural Health Policy. Prior to the actual establishment of this office, the Department of Health helped establish a Consortium for Rural Health made up of 15 organizations representing mostly providers.

Other significant changes have occurred in the organization of emergency services in rural areas. The Department of Health's Emergency Medical Services Division had little budget since the elimination of federal funding in the early 1980s. By 1989, the lack of equipment and training, which became a subject of newspaper exposes, was coupled with a financial crisis--local jurisdictions had no funds to upgrade the aging equipment of a largely volunteer EMS system. New designated taxes have given the EMS Division grant resources, which for the first time required counties to develop an EMS plan by October 1991. Despite these important steps forward, the impact of these initiatives is limited by resources. For instance, the EMS Division has only a staff of six with which to monitor and certify all emergency services and technicians in the state.
B. PROGRAM DESCRIPTION

As a Type B state, Colorado's program has been oriented to developing a version of the EACH-PCH initiative that could be implemented by local regulatory authorities and to fostering the development of networks. To date, the program has closely followed the five major activities outlined in Colorado's application:

- Develop licensure criteria and standards for EACHs and PCHs
- Establish a structure and parameters for rural health networks
- Develop and recognize at least five health networks
- Evaluate the impact of the networks on access to care
- Replicate the networks in other areas of the state

The project has sought to coordinate the activities of three divisions of the Department of Health and has focused on a task force that has had two separate functions: (1) develop plans and parameters for PCHs, EACHs, and networks and (2) recruit and interest local hospitals in the program by involving them in the planning process. Unlike the Type A grant states, Colorado has had time to work with local potential networks before they submit an application for EACH program grants.

1. Organization and Administration

The overall direction of Colorado's EACH Program is provided by Lindy Nelson, director of the Section for Rural and Primary Health Policy and Planning of the Colorado Health Department. Other senior staff represent two other key Department of Health agencies: Susan Dorman, director of operations, Emergency Medical Services Division, and Susan Rehak, deputy director of Health Facilities Division--the largely regulatory agency, which is in charge of facility licensure and standards.

To actually carry out the program, the Department of Health hired an EACH program administrator. The responsibilities of the position are to conduct the day-to-day operations, work
closely with the potential hospitals in networks, and staff the coordinating task force. This position was first filled in February 1992 after procedural delays, but unfortunately, the person hired lasted only a few months, and the position is currently open.

The Colorado Hospital Association has been very supportive, participating in the first EACH Type B grant application and sending a representative to many of the meetings of the task force. However, most of the leadership and resources for the project are coming from the three key persons in the Department of Health.

2. Goals of the Program in the State Context

Respondents viewed Colorado as a "natural" for the EACH program, since it has so many frontier counties with hospitals that are often quite isolated and struggling to remain viable. In addition to having performed the five activities previously outlined, the program is viewed as a potentially important tool for persuading local communities and health providers to work together. The grants program of The Colorado Trust had previously identified the lack of such coordination and integration as a key problem, one which the grants themselves had only limited success in addressing. The EACH program offered not only grant conversion support but eligibility for Medicare reimbursement.

In addition, Colorado is only just beginning a process of consistently planning for EMS systems on a county level. The network model is seen as one means of addressing the lack of coordination between community EMS systems, particularly in hospital-based EMS units.

3. Use of the Grant

Grant funding is being used to pay for some of the time of the three senior Department of Health administrators as well as a full-time EACH program administrator and a researcher. It also has covered the cost of the task forces and consultants working with potential networks.
C. PROGRAM DEVELOPMENT

1. Overview of Strategy

To date, the principal focus of the Colorado project has been to develop an EACH-PCH model using a task force that has met periodically since 1991. The task force members have represented diverse interests and perspectives, but the dominant voices have been representatives of hospitals interested in applying for a grant, seriously considering the PCH option, and willing to explore creating networks. In facilitating the work of the task force, the project has also required coordinating the efforts of three rather distinct agencies within the Department of Health—the Section for Rural and Primary Health Policy and Planning, the Health Facilities Division, and the EMS Division. All three have had representatives on the task force.

The first outcome of the project has not been a complete elaboration of the EACH-PCH regulatory structure to be implemented in Colorado. Rather, it has been the development of six networks each submitting a detailed application for Type A grants. To foster this development, Colorado has made local consultants available to work with each network in local planning and in developing applications.

2. Initiating the Program Development Effort

Colorado’s interest in the program developed after Director of the Section for Rural and Primary Health Policy and Planning Lindy Nelson heard about the EACH program at a national meeting. Ms. Nelson contacted the rural health program officer of The Colorado Trust and key people in the Department of Health. The director of the Colorado Hospital Association put a notice in the association’s newsletter and was reportedly surprised by the level of interest and attendance of hospital representatives at an informational meeting. Following this first meeting in October 1990, four or five additional such state-wide meetings were held in conjunction with developing an application. The Colorado Hospital Association supported this effort with a small grant, and an experienced local consultant was retained to help staff the meetings and write the proposal.
These statewide meetings evolved into an ongoing task force—one that represented different interests but was basically a self-selected group of people interested in the program's potential. Since neighboring Kansas was ahead in program development, Colorado obtained copies of the Kansas EACH plan and distributed them to all rural hospitals. Beyond disseminating information, however, there was not an intensive recruiting effort. One respondent characterized the startup of the program as a *Field of Dreams* strategy: "If you build it, they will come."

A key early decision was that Colorado did not simply want to adopt the Kansas plan. Applying for a Type B grant was dictated by an absence of prior active policy debate in state government and the desire to create a program with the active participation of hospitals.

3. Application and Program Development Before Grant Award

None of the respondents interviewed drew sharp distinctions between activities before and after the award. Although the initial meetings were supported with only limited external financing and were undertaken specifically in response to the grant solicitation, the application process set off a planning and implementation mechanism that remains in force. The initial application identified five potential networks. With some modifications, four of these five have gone on to submit Type A applications. The issues identified in the early meetings remained the principal agenda of the task force.

4. Involvement of the Hospital Association and Other Provider Representatives

Unlike some of the advisory groups in other EACH states, the Colorado task force is not highly structured. Meetings are held on an "as needed" basis, and membership is drawn from interested parties. From the beginning, the Colorado Hospital Association has sent either its president or a representative to most task force meetings, but it has not played a leading role in the program and is not a recipient of EACH grant funds. Other provider groups, particularly the Colorado Medical Society, have sent representatives to some meetings. Unlike it has in some other states, the EACH
implementation process uncovered few competitive relationships between providers. However, two respondents noted that, in fact, there has been very little clinical representation on the task force. Indeed, most of the attendees are administrators, and few are directly involved with patient care.

D. STATE PROGRESS TO DATE

1. Achievements and Activities

The core of the program to date has been developing draft recommendations on standards for EACHs, PCHs, and networks. The key to this effort was the task force, which was designed to help small hospitals buy into the program by giving them a voice in developing the criteria under which they would be licensed. At the time of the site visits, the task force had met approximately ten times. It used subcommittees, one for EACHs and the other for PCHs, to develop draft criteria. There are, of course, still important issues to be addressed. At the time of the site visit, commercial insurers and the PRO had yet to be brought into the process.

At the same time, the program has worked to identify networks that would apply for Type A EACH grants. In some cases, this effort has required flexibility, since specific hospitals lost interest, proved ineligible, closed, or chose to collaborate with another facility. Department of Health staff traveled to all potential sites. They developed a list of potential consultants who would be available to work with networks to develop Type A proposals. The initial Type B grant paid for a limited number of days (12) for consultants to assist each of the potential networks with planning and grant applications. As a form of peer review, network proposals were to be read by the task force for comment. The outreach to local communities to be served by networks has only recently begun. There is a need to distribute educational materials in communities. Beyond the Type A application stage, work has not yet begun on developing risk management or quality assurance plans for the potential PCHs.

A major accomplishment since the fall of 1990 has been a change in the working relationship between hospitals and the Colorado Department of Health. Whereas the latter was basically viewed
by the hospitals as an adversary in a regulatory role, the cooperative venture is reported to have substantially improved the relationship.

2. Problems and Difficulties

To date, there have been remarkably few difficulties in the process of planning the EACH program for Colorado. The program has been hampered operationally by delays in staffing the project coordinator position. Initially, filling the position was stalled by a stringent hiring freeze, and approval had to be personally granted by the governor, who is now aware of the program. Unfortunately, the new hire did not work out, and the position is open.

The actual planning process has operated with a minimum of conflict. Some respondents felt, however, that the task force had avoided certain difficult issues, and that the hardest part was still to come. In the development of state criteria for EACHs and PCHs, the single most contentious issue was emergency services. Since the EMS Division has been trying to raise the qualifications of and provide equipment for rural EMS personnel, there was a reluctance to allow less stringent qualifications for PCHs. They felt that, otherwise, trained ambulance personnel would be in the position of transferring patients down to a lower standard of care. Small rural hospital administrators felt that the cost of equipment and training would be prohibitive. The medical director of the EMS Division felt strongly enough about the issue to submit a highly detailed letter and critique to HCFA during the comment period for the proposed federal EACH regulations. There was a difference of opinion among respondents on the degree to which the issue was actually resolved.

On a broader level, the task force draft criteria for licensure of EACHs and PCHs are being submitted to the Health Facilities Division of the Department of Health. This largely regulatory agency sets standards, issues licenses, and inspects facilities. The agency did not feel that a new licensure category needed to be developed for PCHs. Rather, PCHs could be authorized as a category under existing hospital licensure standards. At the time of the site visit, however, the agency was concerned that difficult issues of quality assurance, fit with federal standards, and conformity with
existing hospital regulations had not been adequately addressed by the task force, and that the division would wind up as the "bad guy" in reconciling task force recommendations with actual regulations.

2. **State Factors Affecting Program Implementation**

Three key factors have shaped the evolution of planning for the EACH program in Colorado--factors closely related to the terrain and traditions of the state.

First, Colorado has many sparsely populated frontier counties with significant transportation difficulties. Even hospitals with a relatively strong financial base are willing to consider a PCH model out of concern for the effects of low volumes and a perceived need for stronger ties to larger facilities. There is a strong potential interest in the PCH model.

Second, Colorado is a western mountain state steeped in a tradition of local independence from government. Compared to many other states, health care is less regulated. As a result, a state-level focus for rural health policy has only recently begun to develop. The EACH program therefore could not rely on any existing health plans or planning structure, but has had to create everything from scratch and/or borrow from other states. This was one reason that Colorado opted for a Type B grant. Moreover, the state government did not institute a highly structured, top-down program planning process. The task force met on an as needed basis and used volunteers for key tasks. The task force was also not composed of a carefully drawn membership that represented all key "players." Instead, it rather informally drew in as members largely people who were interested in, or were to some extent committed to, the program.

Third, program development has been influenced by the lack of resources and personnel from within the state government. As a result, the state opted to use consultants to work with potential networks. This and the strong hospital representation in the task force has focused the program on maximizing hospital participation and elaborating hospital plans for using funds and network development.
3. Importance of EACH Program Grants

All respondents thought that the planning grant money was critical to Colorado's ability to participate in the program. Not only does the Department of Health have very limited resources, but the severe lingering recession has created a budget crisis. Without the federal funding, there would be no resources to support the task force or the consultants working with the local networks. Indeed, respondents commented that the state grants were far more critical than future possible grants to facilities. That is, as much as small hospitals would want funds for new equipment, grants for help with local planning and conversion are not enough to significantly influence hospital decision making. For the state-wide planning and implementation effort, however, the grant funding was considered crucial.

E. STATE GRANTEE EVALUATION OF LAWS/REGULATIONS

As in other states, many respondents cited the need for greater flexibility in the EACH regulations. In addition to perceived problems with the 72-hour, six-bed and temporary/immediate admission status requirements, Colorado personnel pointed out two specific areas that were already hampering the program:

- The prohibition against EACH location in metropolitan areas. Even some rather remote rural hospitals have their primary natural referral relationships with urban hospitals. The state has found itself creating rather artificial networks with a reduced probability of success, to work around this restriction.

- The requirement that PCHs have been a Medicare-certified hospital within the past 12 months. This knocked out a recently closed but "ideal" candidate. It also means that the PCH concept cannot be extended to Colorado's unique Community Clinic/Emergency Centers (CCECs) which are already designed to operate like PCHs, but whose limited inpatient beds are not covered by Medicare.

It should be noted, however, that some respondents thought that the federal regulations regarding emergency services in PCHs were too lax and needed to be tightened to ensure adequate EMS care.
F. UNIQUE FEATURES OF THE PROGRAM AND APPROACH

Colorado is unlike other states in its early emphasis on getting small hospitals to buy into the PCH model. The task force approach was, in large measure, designed to give input and voice to those small facilities that would eventually have to decide to convert to a limited service model. The use of individual local consultants to work with each network in defining their needs and applications for Type A grants is another facet of this focus. Although the task force structure resembles that used in other states, its composition and orientation are different.
III: KANSAS
A. STATE RURAL HEALTH POLICY

The state government has devoted few bureaucratic resources specifically to rural health care. In the past decade, however, it has become increasingly involved in rural health, due primarily to the highly visible problems of its rural hospitals. After Texas, Kansas has more rural community hospitals than any state in the union (117 in 1991). As in Colorado, Kansas combines a modest official rural health program with several well-known innovations in rural care delivery—sparked primarily by private-sector initiative.

In the past, the Kansas Department of Health and Environment did not maintain a specific organizational entity for rural health policy. To some degree, the absence of a unique organizational identity may not have been as critical as in other states, since the highly rural character of Kansas pervades much of government thinking. In 1989, the department created an Office of Local and Rural Health Systems, but the office has few staff, and it has focused primarily on the EACH program. Beyond creating a service-contingent scholarship program for medical students, the department has not been active in establishing specific rural policies or comprehensive rural health plans. As in other states, emergency care has been directed by a separate Board of Emergency Medical Services. Thus, EMS concerns have traditionally been somewhat separate from health policymaking.

The increasingly severe problems faced by rural communities and hospitals in Kansas have prompted a series of essentially private-sector experiments. In 1982 the Kansas Hospital Association became part of the Robert Wood Johnson (RWJ) Swing-Bed Demonstration Project. The success of the concept led to its adoption as a national Medicare program. Prior to the EACH program, two small rural hospitals developed their own models, which have received national attention (see The Alpha Center, 1991). One, the Jane Phillips Community Health Center in Caney Kansas, emerged from the closure of Caney Municipal Hospital in 1989. Affiliated with a hospital in Bartlesville,
Oklahoma, it provides comprehensive outpatient services with inpatient beds that are limited to a subacute-care nursing unit ineligible for Medicare reimbursement.

The other model, St. Johns Primary Care Hospital, was developed with foundation support but was never implemented. The design called for providing comprehensive primary care (but without an emergency room) along with 3 observation beds and 14 SNF beds. St. Johns subsequently sought to join the EACH program as a PCH grantee, but closed in early 1992. It should be noted that none of the respondents indicated that these initial experiments with alternative model hospitals had any particular influence on the development of Kansas' EACH program. Indeed, may hospitals viewed the Caney model negatively because it meant the loss of hospital status and inpatient care.

Private foundations have played a particularly influential role in rural health policy. In 1985, the Robert Wood Johnson Foundation (RWJF) awarded a grant to the Kansas Hospital Association to explore the potential for providing nontraditional health and human services in small rural hospitals. The local Wesley Foundation has funded a special Primary Care Bridging Program that supports residency training in rural communities. Most important for the EACH program, the Wesley Foundation provided joint funded the Kansas Hospital Association, the Department of Health and Environment, and the EMS Board in 1990 to explore the potential for EACH-PCH networks in Kansas and to prepare an application for a HCFA grant. Its findings were critical to structuring the state's participation in the EACH program.

B. PROGRAM DESCRIPTION

As a Type A state, Kansas had already undertaken considerable planning activities to develop an EACH program adapted specifically for the state. In its application for HCFA funding, Kansas proposed the following core activities:

- Develop the Kansas EACH-PCH model further on the basis of reviews of federal program regulation, ensuring that state rules are in compliance.
• Develop rural health networks by creating training programs, statistics, analytical tools, and consultant directories available to local networks. The networks were to encourage the integration of local health services.

• Improve communication systems by studying barriers and technologies for transmitting administrative and clinical data to and from rural hospitals.

• Integrate EMS transportation systems with rural health networks, with an emphasis on developing model agreements and protocols.

• Support the development of financially viable health networks with information and technical assistance in obtaining both Medicare Parts A and B revenues.

The EACH program in Kansas has focused on continuing the work of the technical advisory group (TAG), which had originally been funded by the Wesley Foundation to help prepare the EACH program proposal. There is a strong sense that the state agencies that are working with the predominately private-sector TAG are setting out not simply to implement a national initiative but to create a program tailored to Kansas. This basic orientation is well illustrated by the very first sentence of the Kansas development plan for the EACH program: "What follows is a 'plan for creating options.' It is the first step in suggesting options for redesigning the health care delivery system." Far from seeking a way simply to implement a federal EACH program, the planning process in Kansas has sought to develop its own criteria for EACHs and PCHs and to expand the concept of rural health networks. All respondents commented extensively on the energy and level of commitment that TAG members brought to this enterprise.

1. Organization and Administration

Formally, the EACH program and grant are being administered by the Office of Local and Rural Health Systems of the Kansas Department of Health and Environment. The position of office director was vacant at the time of the site visit. (The former director still works occasionally with the project as a consultant.) Project direction is being provided temporarily by Mr. Richard Morrissey, the deputy director of the Division of Health. According to respondents, the project is operated by three co-grantees: the Department and of Health and Environment, the Board of Emergency
Medical Services (directed by Steve McDowell), and the Kansas Hospital Association (represented by its vice president, Melissa Hungerford).

This "troika" structure is an outgrowth of the Wesley Foundation grant that was made to all three agencies to plan an EACH program. Indeed, the current program is funded jointly with in-kind contributions, Wesley Foundation funds (the foundation is paying for key staff time and the direct costs of the TAG), and the HCFA grant, which is covering primarily external consultants, the expansion of TAG membership, and required computer equipment. More so than in any of the other EACH grantee states, the Kansas program is a joint venture of the public and private sectors.

3. Goals of the Program in the State Context

Respondents indicated that the EACH program was instituted at about the same time that concern about the future of rural hospitals in the state was becoming acute. In their view, "with all its current flaws, the EACH program is the only game in town." Considerable energy and local resources have been invested in the program because it was deemed to be the only vehicle on the horizon for ensuring some future for many local health facilities. All parties expressed much hope that draft federal regulations for the program could be modified in order to accommodate local goals.

In addition to creating an alternative hospital model, the initial EACH planning financed by the Wesley Foundation grant also introduced a second goal for the program—to integrate a fractured health delivery system at both the state and local levels. The TAG brought "unusual players to the same table" and began a process of integrating diverse viewpoints and interests. Respondents indicated that this cooperative effort had never occurred before, and compared the process to the "passive" planning under the old certificate of need program. That is, rather than having to wait for applications, which would be compared with a set of existing plans or standards, the TAG process facilitated setting an agenda, pursuing conflicting viewpoints, and recruiting hospitals or interest groups whose input was thought desirable. The hope was that the same process could be repeated at the local level in building EACH-PCH networks.
Other states, particularly Colorado (which modeled its approach after Kansas), have stated the same informal objective for their EACH programs—to provide the structure and motivation for addressing a fractured health care system.

3. **Use of Grant**

The HCFA EACH program grant is *not* funding the time of core staff or the per-diem costs of existing TAG members. Instead, it is augmenting core foundation support in the following areas:

- Funds for the Kansas Hospital Association to administer monthly TAG meetings and expand the number of participating organizations
- External consultants for such operational tasks as developing model protocols for hospitals participating in networks, plans to update EMS communications, inter-hospital electronic linkages, and data collection software
- External consultants on statewide network development, including needs assessments, the identification of obstacles, and plans for community network education
- The travel of program staff to participating hospitals and to Washington, DC
- Computer equipment and other direct costs of the Board of Emergency Medical Services

The grant does not cover the costs of consultants to work directly with hospitals and/or networks. Although work on the Kansas project will entail developing a list of external experts and resources for local communities, any costs are the responsibility of network hospitals.

C. **PROGRAM DEVELOPMENT**

1. **Overview of Strategy**

To date, the Kansas project has focused primarily on completing the work of the TAG to develop a fully elaborated model of the EACH-PCH program that covers the full range of implementation areas, including the conditions for participation, licensure, quality assurance, and personnel standards. Great stress has been placed on the process and on including as many diverse
stake holders as are willing to participate. The emphasis has been on the state level with representatives from statewide organizations. Over 10 different consultants have participated in a variety of tasks, including financial modeling, agenda setting, and developing profiles of small hospital utilization. At the time of the site visit, program activities had not yet emphasized fostering local networks and providing technical assistance at the local level.

2. Initiating the Program Development Effort

In Kansas, the EACH program was announced at the time that key organizations were becoming increasingly aware that new initiatives were necessary. The Department of Health and Environment had established the Office of Local and Rural Health Care Systems, but it had neither a formal budget nor assigned staff. The director, Steve McDowell, was actually "borrowed" from elsewhere in the department, but his energy and an informal style were appreciated by local communities and providers. An RWJF grant to the Kansas Hospital Association on alternatives for rural hospitals had pointed out the lack of coordination of providers in rural communities. The Board of Emergency Medical Services was aware that rural EMS was often poorly integrated into health delivery and that the Board needed more state-wide involvement with health care.

When funding for state EACH programs was announced by HCFA, Melissa Hungerford of the Kansas Hospital Association discussed the possibility of a proposal with Steve McDowell, who called up Robert McDaneld, director of the EMS board. The idea was then brought to the Wesley Foundation, which in June 1990 provided the Kansas Hospital Association with a two-year grant of approximately $264,000 to develop the EACH concept.

The first meeting of the TAG was held in August 1990, and its members were provided with texts of the major alternative models for limited-service hospitals, based on materials presented at a Washington conference on alternative models sponsored by the PHS Office of Rural Health Policy. The TAG met virtually every month thereafter.
3. Application and Program Development Prior to the Grant Award

Local foundation support allowed the state to undertake a ten-month intensive program development effort prior to actually applying for a Type A EACH program grant. In addition to monthly TAG meetings, the process was supported extensively by external consultants, who undertook legal analyses, created models of financial viability based on actual hospital discharge data, studied quality assurance issues and mechanisms, and discussed options and policy issues to be addressed. A key activity was defining what came to be known as "a priori assumptions"--the key issues to be addressed by any new program. External consultants wrote much of the materials to support these assumptions.

By the time it sent its application to HCFA, the "troika" team working with the TAG had developed a 150-page publication, the *Kansas Rural Health Network Development Plan: Preserving and Enhancing Access Through Cooperation* (spring 1991). This document briefly described the background to rural health care in Kansas and developed detailed discussions of:

- Applicable licensure rules and other relevant regulatory issues
- The process and criteria for designating networks
- Network operations--particularly in relation to quality assurance and communications
- Emergency services
- The financial viability of the PCH model
- The future role of state policy and evaluation

In addition to this plan, which was incorporated into its proposal to HCFA, the Kansas project endeavored to identify networks. After sending out information and holding a statewide information meeting, TAG received and reviewed 11 applications for networks. Eight met the state's criteria and were incorporated into the proposal. (With 17 PCHs, Kansas is by far the largest of the seven state
EACH programs.) It should be noted that, consistent with the state’s broad approach, not all these networks were eligible for federal designation. Also ineligible were several supporting "member" hospitals that were interested in, and designated as, belonging to a network. It should also be noted that, in applying as networks, participant hospitals had to sign a model Network Agreement that had been developed by an external consultant. In principle, PCHs were to choose EACHs, but in practice, some networks are led by EACHs.

Finally, due in part to the continued support of the Wesley Foundation, the EACH implementation process did not consist merely of pre- and post-HCFA-application stages. The pace of TAG meetings did not change after Kansas submitted its application. As with Colorado, respondents described the Kansas program as a continuous process punctuated by deadlines imposed by the HCFA grant applications.

4. The Involvement of the Hospital Association and Other Provider Representatives

As described earlier, the Kansas Hospital Association plays an integral role in the EACH program. While the State Office of Rural Health is the stated recipient of HCFA’s EACH grant, the Kansas Hospital Association is the grantee of the companion funding from the Wesley Foundation. All respondents used the phrase "troika" to describe the joint leadership of the three agencies in carrying out the project. The TAG has significant and consistent representation from a wide variety of provider groups. In sum, Kansas has a greater degree of private-sector involvement and leadership than any of the other EACH states.

D. STATE PROGRESS TO DATE

1. Achievements and Activities

The Kansas project has moved a long way toward creating an EACH program that is institutionalized, ready for implementation, and capable of expansion. Among its accomplishments, it has:
• Created an ongoing TAG and institutional structure with procedures for designating networks

• Developed model protocols, agreements, and procedures to be used by local networks

• Performed a detailed review of licensure and other relevant regulations and developed draft legislation for implementing the EACH program

• Drafted a Rural Health Network EMS plan for implementation at the local level

• Drafted a detailed Rural Health Network Development Plan and a brief summary for wide distribution to communities

• Created a Physician Education Task Force and conducted a study of physician and community attitudes toward the PCH concept

• Supported open and extensive debate over critical design issues at the state level and built a consensus model for facilities and networks

• Identified a comparatively large number of networks and participating hospitals

• Created a position of leadership among EACH states

The extensive involvement of the TAG is noteworthy. Meetings are usually held monthly in an airport hotel at either Wichita or Topeka. Staff work extensively to support each meeting by developing and mailing out a detailed agenda and briefing books with tabbed exhibits, data, and reports before each meeting. The initial membership included three individuals from each of the following categories--nurses, hospital administrators, physicians, and EMS providers. In addition to the consultants and the "troika" TAG staff, single representatives were sent by a consumer group, the Office of the Governor, the Department of Health and Environment, and the Kansas University School of Medicine. Membership has remained quite stable, and the group has been expanded to include representatives from Blue Cross/Blue Shield, home health agencies, public health departments, nursing homes, and the PRO.

The TAG has tried to operate on a consensus basis by revisiting issues and offering new data until agreement is reached. Among the more difficult issues addressed were the draft EACH program regulations for the state, which had reportedly been "torn apart" initially. More difficult
were the rules for staffing emergency rooms, which some described as an issue of "turf protection."
With respect to mid-levels, physician representatives could not reach consensus on the degree of
supervision or the degree to which mid-levels should practice independently. By far the most difficult
issue was whether PCHs should be allowed to perform surgical procedures. Some advocates of small
hospitals felt such a restriction would lead to an unacceptable loss of patients and physicians.

Although the Kansas model does not yet include the strict 6-bed, 72-hour, and temporary-
admission regulations of the national program, it does impose its own additional conditions—in
particular, a maximum of 75 miles between EACH and PCH and a prohibition on inpatient surgery.

2. Problems or Difficulties Encountered

People we interviewed during site visit were very positive about accomplishments and felt that
they had been remarkably successful in engendering the cooperation of a highly diverse group of
representatives in developing a coherent program. Two problems were evident—a feeling of "burn
out" by some TAG members, and difficulties in replicating the statewide planning process at the local
level.

The burn-out problem refers to the frustration of some TAG members that all of their hard,
creative work must now confront national regulations. Most felt that the draft EACH regulations
from HCFA were highly restrictive and would undo much of their efforts. Since the key to the
process has been the sense that the group was providing answers to the problems facing small rural
hospitals in Kansas, it is not clear how their frustration about federal specifications for structure and
flexibility will affect the progress of the program.

The views of hospital administrators and others on the TAG clearly suggest that implementing
the EACH program successfully requires not only a state-level debate, but also a parallel effort at
the local level. Too, at the time of the site visit, the number of hospitals that were readily willing to
convert to a PCH was uncertain given participation criteria that approximated the draft HCFA
regulations. A few hospitals turned down their HCFA grant funds and withdrew from the program.
Cooperative working relationships with local communities have not yet been a high priority. The state staff or consultants made available to local communities and facilities in some other states have not been a key aspect of the Kansas program. A key issue for the EACH program nationwide is whether planning resources are best devoted to state or the local-level activities. Both appear to be necessary, but the proper allocation is unclear.

3. **State Factors Affecting Program Implementation**

The role of private-sector initiatives in the state has been critical to developing the Kansas program. The Kansas Hospital Association has a history of innovation, including experience in the swing bed demonstration program. The new Wesley Foundation played a key role in financing a high-intensity planning effort. Without these assets, respondents thought it unlikely that the Kansas program would have reached its current stage of development. An important feature is the smooth relationship among the Department of Health and Environment, the Hospital Association, and the EMS Board, which has facilitated the EACH planning process. There is a striking degree of trust among the principal leaders, including the chairman of the TAG, who reportedly has the gift of making everyone feel that they are being heard. Finally, the marked depopulation and large number of very small, poorly used facilities creates a demographic and health environment in Kansas that supports testing the willingness of a significant number of local communities to accept a new PCH model outside of "frontier" locales.

4. **Importance of EACH Program Grants**

All respondents felt that grants to the states were more critical than grants to facilities, since facilities' decisions concerning PCH conversions would not be materially influenced by a moderate-size grant. Since the Kansas project has been supported by funding from a local foundation in addition to the HCFA grant, the role of federal money has perhaps not been so critical as it has been in other states, all of which face very tight fiscal conditions.
E. STATE GRANTEE EVALUATION OF LAW/REGULATIONS

Kansas has been a leading voice in a joint seven-state critique of the draft HCFA regulations. Respondents strongly stressed that the lack of flexibility on key provisions in the federal EACH law regulations would seriously undercut the program in their state. The case of Caney, whose existing alternative facility is disqualified from participation because it is affiliated with a network EACH in another state, was cited as an example of counter-productive rigidity. Citizen members of the TAG expressed the opinion that the program "in Washington" was designed to cut capacity and save money rather than help ensure access.

F. UNIQUE FEATURES OF THE PROGRAM AND APPROACH

Four features of the Kansas EACH program differentiate it from the approach used in other states. First, it has potentially the largest number of participating hospitals and networks. Although many of these hospitals are very small and need to assume a new role, few are as isolated as those in Colorado, South Dakota, or in the Montana MAF Demonstration. Second, private-sector funds and organizations are substantially involved in the Kansas program. The Hospital Association, in particular, works in close partnership with the state government.

A third distinguishing characteristic is that, as much as in any other state, its program to date has been built around a representative task force. Many resources and much effort have been devoted to creating and working with this planning body, which has assumed significant authority in the program. In particular, both the Department of Health and Environment and the Board of Emergency Medical Services have apparently been willing to cede real decision-making power, and not simply an advisory status, to this body.

Finally, the Kansas program has developed ahead of the other states in many important respects. It published a detailed plan more than a year ago. It has developed community dissemination materials and model agreements and had legal analyses conducted to identify necessary changes in
legislation. Some of the Kansas materials could be useful to other states, and in fact, are already being used.
IV. NEW YORK STATE
A. STATE RURAL HEALTH POLICY CONTEXT

New York State has been extensively involved in rural health policy since 1988, when it created the Rural Health Council to oversee the implementation of recommendations made by the state's Task Force on Rural Health Strategies.¹ Prior to the EACH program, the council had been involved in developing hospital/nursing home projects, implementing swing beds, and increasing reimbursement for rural hospitals,² as well as producing reports on primary care, long-term care, and rural hospitals. At the time the EACH program was announced, a top priority for the council was encouraging integration of services--networking.

Two state network development efforts are relevant for the program. The New York State Rural Health Network Demonstration Program, now run by the state's Office of Rural Health, has provided 14 areas with network planning grants (up to $50,000 per year for three years) since 1987. These networks often did not include hospitals or emergency care; for example, some initiatives focused exclusively on long-term care or maternal and child health care. In response to the EACH program announcement, the state solicited grant applications for a second related effort. This effort required that applicants consider the EACH-PCH concept, and that their networks include acute care, emergency care, and primary care. Awards were for up to $50,000 per year for 3 years. Of 19 initial responses, 7 areas were selected for site visits, and 4 were funded at the maximum funding level. Three of the 4 areas include potential EACH-PCH sites (depending on the exact shape of the program next year), while the other 2 do not contain eligible sites.

Other state efforts that may overlap with EACH-PCH areas are workforce productivity demonstrations and other demonstrations, including an all-payer payment demonstration. Workforce productivity demonstrations include, for example, experiments in cross-training hospital technical personnel.

¹The Task Force on Rural Health Strategies had been created out of concern that particular rural hospitals were being targeted by the state for closure.

²For example, there is a special reimbursement provision for financially distressed hospitals.
New York has a relatively new Office of Rural Health, established in 1991 with grant funds from the federal Office of Rural Health Policy. Prior to the EACH program, the office had no full-time personnel. However, the current office director had previously been managing the state's Rural Health Network Demonstration Program from the Division of Planning, Policy, and Resource Development, where the office now resides.

The relationship between the state and hospitals has historically been strained, and before the EACH program was implemented, the New York State Department of Health and the Hospital Association of New York State had never worked cooperatively on such a major rural health initiative.

B. PROGRAM DESCRIPTION

New York's Type B Program consists of five major efforts: (1) developing network goals and requirements that incorporate a range of service and facility integration and complexity; (2) developing criteria for EACHs and PCIIs; (3) selecting three to four rural health network sites and helping them develop and complete operational plans for start-up by the end of the grant year; (4) integrating rural health networks, EACHs, and PCHs into the regulatory structure of the New York State Department of Health; and (5) identifying permanent financing mechanisms for rural health networks, EACHs, and PCHs. The program is located in the state Department of Health's Office of Rural Health, a position that carries high visibility. Program staff were hired under the grant, although state- and hospital association-funded personnel have also been key players in the program's development. The program is believed to have limited potential for expansion (involving perhaps a dozen PCHs) but to be important for maintaining access to care in some areas and strengthening primary care and emergency care through service integration.
1. **Organization and Administration**

   Overall direction of New York’s EACH program is provided by Paul FitzPatrick, director of the Office of Rural Health, a subunit of the Division of Planning, Policy, and Resource Development. The director of the division reports directly to the state’s commissioner of health. Given the large size of the state’s health department, this position gives the Office of Rural Health and the program a high level of access to the state’s top health policymakers.

   The director of the Division of Planning, Policy, and Resource Development, the director of the Office of Rural Health, and a hospital association representative have been substantially involved in developing the EACH program, although their time is not funded by the grant. The day-to-day project coordinator is Walter Gregg, who was hired in December under the grant. He has completed Ph.D. coursework at the University of Michigan in organizational behavior, and is completing his dissertation on the entry of rural hospitals into long-term care markets.

   The office has also hired a senior health planner and a health systems analyst for the program. The senior health planner is the liaison for four sites and performs contract management functions on the network development grants for those sites. The health system analyst is located in the Department’s Division of Health Care Financing of the Office of Health Systems Management. She was hired in February to focus on network financing issues.

   The Rural Health Council is considered the "driving force" behind the EACH-PCH program; the hospital association and the state Office of Rural Health function in an informal partnership to implement the program.

2. **The Goals of the Program in the State Context**

   The ultimate goal of New York’s program is to ensure that rural residents of the state have access to financially viable, high-quality health care services by creating a range of integrated service networks.
Two themes emerged in discussions among respondents about the goals of the program for the state. First, the respondents expressed hope that the PCH model will be a successful transitional model for the following reasons. With the high technological and procedural emphasis on acute care, the numerous small rural hospitals that never provided such care are no longer required in their traditional form. But because physicians demand a place to admit their patients, the communities with financially distressed hospitals risk losing a health care presence without a viable alternative model.

The second theme is that the EACH program will be used to further the state's goal of strengthening primary care and improving the quality of emergency care through networking. The goal of the networks is to create efficiencies from sharing local health services and, through the combined services, the economic power necessary to leverage additional resources to maintain and strengthen the network. Networks are also felt to be important for assisting many areas that badly need not only better access to services, but better emergency services. For example, the volunteer ambulance services that are prevalent in rural areas often do not have adequate communications systems.

3. Use of the Grant

Grant funding is being used primarily to fund several staff positions for the project: a project coordinator, two senior health planners, and a senior secretary. Travel costs for technical assistance to potential EACH-PCH sites was also included.

C. PROGRAM DEVELOPMENT

1. Overview of Strategy

Initial program development efforts have focused on establishing program requirements and network guidelines at the state level. State program staff, a hospital association representative, and state Rural Health Council members have worked collaboratively on this effort, providing broad-based
thinking on and planning for rural health networks and limited licensure models, rather than a narrower focus on the federal EACH-PCH model alone. This focus appears to be consistent with the state’s application. Many state-level issues on program requirements and reimbursement and regulatory incentives must still be resolved.

In selecting demonstration sites for a state network development grant program, the state emphasized potential EACH-PCH sites, and several potential EACH-PCH sites have been identified from the program’s grantees. The demonstration sites will be expected to consider the EACH-PCH criteria as they develop operational plans during the last four months of the first project year.

2. Initiating the Program Development Effort

State staff became interested in participating in the EACH program as they reviewed the program in the context of increased emphasis on networking in rural areas. To assess preliminary interest, the hospital association sent a brief survey form to the state’s 70 rural hospitals to ask their opinion about the state’s participation after the federal program announcement was issued. The 25 responses indicated that they should go forward with an application—very few of the 25 were negative.

3. Application Development and Program Development Prior to Grant Award

The application development process took place within tight time constraints once the Division of Planning, Policy, and Resource Development decided to go forward with the application. The application was drafted by division staff, including the current project director, and reviewed and endorsed by the Rural Health Council and the hospital association. The hospital association met with the involved state health department personnel with comments, and requested and received assurances that the program would be a voluntary program.

Subsequently, the state used Rural Health Network Demonstration Program funds to award grants for more structured network development in areas that would consider the EACH-PCH model. The effort was to go forward regardless of the outcome of the state’s application to HCFA. The
hospital association communicated with member hospitals to encourage them to apply, and to take an active role in becoming the focal point for a network in their area. As noted, four networks were selected in fall 1991 to begin implementing their projects (planning and network formation activities) in January 1992, including four possible PCHs located in three of the networks.

4. Involvement of Hospital Association and Other Provider Representatives

The hospital association has participated fully with the state in developing the EACH program—the first time that the two entities have worked cooperatively on a rural health initiative of this magnitude. The hospital association's involvement in the project from the beginning was considered to be critical to its success because of the difficult relationship between providers and the state in the past.

Other entities have expressed concern that the state was required to work with the hospital association, but not with other groups. For example, the state nursing association lodged a formal protest with the state because it was not allowed to speak at the Rural Health Council table, but the hospital association could. The Rural Health Council is structured to provide input from persons with varied backgrounds. It includes several physicians, as well as nurses, nurse practitioners, emergency medical technicians, hospital, nursing-home and ambulatory-care administrators, and migrant health and Native American health interests, among others, but does not include representatives of professional organizations. Due to the requirements of the EACH-PCH program, however, representatives of the hospital association and the Hospital Trustees of New York State were added to the two subcommittees formed by the council.

The four potential PCH sites have participated in developing the program to the extent that they reviewed and signed off on draft network guidelines prior to their issuance for public comment.
D. STATE PROGRESS TO DATE

1. Achievements and Activities to Date

The major effort to date has entailed developing draft network guidelines and requirements, which were issued for public comment in late March. Both members of the Rural Health Council and staff at the funded network sites provided detailed comments on the draft, which was revised extensively. Two major issues that were discussed and resolved through this process were the types of potential network models being encouraged, and the required organizational structure of the networks.

The guidelines provide for three types of networks. One includes a full-service hospital, comprehensive primary care providers, and an upgraded emergency medical service delivery system. The second consists of the same three elements, except that the primary care providers can also deliver enhanced emergency services. The third includes an EACH, a PCH, and other providers of comprehensive care, as well as support for an upgraded emergency medical service delivery system. These three network types will be defined further over the next few months.

The governing body of the networks must include representatives of the participating organizations’ boards of trustees, administrative staff, practitioners, and representatives of the community, including consumers of services. All health entities in the area must be allowed to join. After consulting with a state attorney, state program staff believe this open organizational structure of the network will help protect the program from anti-trust issues.

Several topics must still be addressed, including the requirements to be added by the state to federal requirements for PCHs. At a recent meeting of the Rural Health Council's Network Guidelines Committee, attended by the MPR site visitor, the members discussed the type of limited licensure hospitals that should be allowed or required in the networks. The discussion was broad and not limited to the types of facilities that meet federal PCH requirements. For example, there was
discussion of allowing primary care clinics and nursing homes to upgrade to provide limited inpatient services.

State staff we interviewed believed that the program has:

- Significantly boosted the state's network development. The state would have encouraged networks regardless of program participation, but would not have made comparable progress.

- Prompted much-needed discussions about EMS.

- Facilitated communications with the other program states, allowing the exchange of ideas (for example, California's ARHM is of interest as they consider a limited licensure hospital model for the state).

- Increased the state's focus on rural health ('to about 10 times the prior level').

- Demonstrated that the hospital association and the state can work together, and that hospitals can support a state effort.

- Allowed the Office of Rural Health to have full-time staff, which has enhanced its functioning.

2. Problems or Difficulties Encountered

No major problems have been encountered thus far in the process of developing or implementing New York State's program. However, three difficulties are noteworthy: adhering to the project schedule, the effort to involve regulatory and finance personnel from the Department of Health in the process, and allaying hospitals' fears that the program would be mandatory for them. The difficulty of involving regulatory and finance personnel is the only one of the three that could have a significant adverse effect on implementation, but it is too soon to tell.

The state has found it difficult to adhere to the schedule set forth in its application because it asked for and received so much feedback on the proposed network guidelines. Staff believed that the wide internal circulation of the guidelines before issuing them for public comment created a more effective document, but the production and review process was time-consuming and labor-intensive.
The effort cut down on the time that could be devoted to working with new potential sites to assess the potential applicability of EACH-PCH or another network type.³

State Office of Rural Health staff have had to spend more time and effort than anticipated to work through program issues with the Department’s regulatory and finance staff. To better facilitate implementation, two internal workgroups have now been formed—standards development and finance. Program staff noted that it would have been optimal to organize these groups at the start of the program. The implementation role and policy positions of the regulatory and finance groups are still evolving.

At first, hospitals were concerned that they would be forced into the program. It was difficult initially for the state to allay their fears since providers had come to blame the state for historically having added to federal requirements. As noted earlier, the hospital association’s partnership was key to overcoming this difficulty.

3. State Factors Affecting Program Implementation

Respondents identified four major factors at the state level that affect or are likely to affect program implementation: (1) the state’s ability and willingness to use powerful reimbursement and regulatory incentives beyond federal requirements; (2) the state’s difficult fiscal situation, since it affects the attractiveness of the program for communities relative to alternatives; (3) the placement of the program near the commissioner level and the fact that the position of commissioner of health is currently vacant, and (4) the priority placed by the Rural Health Council on quality of care issues. In addition, prescriptive authority for nurse practitioners, effective March 1992, could increase the involvement of this group in implementing the program at the local level.

A major factor that affects the shape and potential success of program implementation is the New York Prospective Hospital Reimbursement Methodology (NYPHRM), New York’s system for

³However, despite relatively little emphasis on developing sites beyond the four already receiving state grants, five new sites became interested in the program and were included in the state’s second-year EACH grant application.
controlling hospital reimbursement for all payers except Medicare. The state has promised to improve reimbursement under NYPHRM for network members, with the higher rewards going to networks with greater structural integration. Reimbursement incentives, together with the state's authority to waive regulatory requirements for demonstrations, enable the state to encourage participation in networks substantially beyond the incentives provided by the federal EACH program. The state plans to use these tools to encourage participation (and, as noted earlier, may also add requirements governing the formation of networks that go significantly beyond those of the federal EACH program).

The state's difficult fiscal situation may have a positive effect on program implementation; as more cost control efforts are implemented, the options offered by the EACH program and state network development grants and incentives become more attractive. The only potential negative effect of state budget reductions thus far is a change in the scheduling of Rural Health Council meetings from bimonthly to quarterly; however, respondents felt that this factor has not significantly affected implementation at this time.

When the Department of Health obtains a new commissioner, it may have a positive effect on the program. Dr. Axelrod, the former commissioner, had supported the program; the attention of a new commissioner will give the program greater priority and may facilitate and hasten the development of regulatory and reimbursement mechanisms for networks--especially because the program will be run in an office that interacts regularly with the commissioner. Convincing the key regulatory and reimbursement players to support the program is currently an important and difficult challenge for the program as was noted earlier.

The Rural Health Council was initially concerned that the PCH aspect of the federal EACH-PCH model would lead to a second-class standard of care for rural areas. However, the council decided that it would go forward with the program in the interest of preserving access and fostering networks, and would ensure, with additional requirements if necessary, that the PCHs provide quality
care. A current issue is what the State will require or allow in terms of emergency services. The fact that the EACH program will allow emergency care to be maintained in these communities is considered a critical feature by some Rural Health Council members, who argue that urgent care is not enough. Other council members believe that locally based emergency care is not essential if urgent care is offered, arguing instead that urgent care is the appropriate level of care to be provided by a limited licensure hospital to maintain the quality of emergency care.

In March 1992, prescriptive authority for nurse practitioners became effective; this may positively affect program implementation since it allows greater practice independence for this group. Nurse practitioners, to the extent that they can practice with some independence, offer an important option for potential PCHs with shortages of primary care practitioners.

4. Importance of the Grant

The state would probably not have participated in the EACH program had it not included a grant. Although network issues would probably eventually have been addressed given the state's pre-existing interest in them, the process of developing and encouraging a state network model would have taken much longer. Conversely, accepting federal dollars requires committing to timeframes; thus, more progress has been made.

E. STATE GRANTEE EVALUATION OF LAWS/REGULATIONS

State, hospital association, and Rural Health Council staff we interviewed were all hoped that modifications would be made and flexibility added to the program requirements either by HCFA or the Congress. The major specific concerns of the state were incorporated into the letter sent by the seven-state program group to HCFA just prior to the site visit. Particular concerns discussed with the MPR site visitor included the following:

• The requirement that PCH patients need temporary and immediate care requires a great deal of risk-taking by providers to decide whether or not a patient falls into that category.
• In some areas such as Ticonderoga, an isolated resort area, it would make more sense to allow the PCH to handle an influenza epidemic and seasonal fluctuations without restricting the facility to 6 beds and 72 hour limits at all times.

• Urban hospitals should be allowed to participate as EACHs, even if they cannot receive a grant. If an urban hospital in Glens Falls were eligible, there is an isolated hospital that would be interested in being its PCH, and there are no reasonable alternative EACHs for that hospital.

• The 12-month limitation on allowing closed hospitals to enter the program is a concern, particularly for one hospital that is interested in the program but will miss the 12-month time limit. If New York had been a Type A state, this hospital would appear to have been eligible to participate.

• The hospital association believes that the survival of rural hospitals is a critical component of rural health systems, and is concerned that the regulations imply the PCH would be a rural health clinic with very little else. They would like the PCH to be a type of facility that does not now exist, rather than mimicking a rural health clinic so closely.

F. UNIQUE FEATURES OF THE PROGRAM AND APPROACH

New York is unique because it has considered what it wants to require and expect from networks, EACHs, and PCHs from the beginning, rather than working with a particular state model or the EACH-PCH requirements.\(^4\) Moreover, the nature of the existing Rural Health Council, which plays an important role, is unique in that it is led by a consumer representative, pulls together persons of diverse professional backgrounds from different parts of the state, and does not include professional association representatives.\(^5\)

\(^4\)However staff had obtained some information on other models and had begun to familiarize themselves with them at the time of the site visit.

\(^5\)As noted earlier, a hospital association representative is included in the two subcommittees of the Rural Health Council.
V. NORTH CAROLINA
A. STATE RURAL HEALTH POLICY CONTEXT

The state of North Carolina, through its Office of Rural Health and Resources Development (ORHRD), has been extremely active in initiatives to improve health services for the state's rural residents. Created in 1973, ORHRD has long focused on improving access to primary care by developing Rural Health Centers. In 1985, the state’s rural hospitals began to show signs of weakness, drawing the attention of the state legislature to their problems. The legislature responded by mandating that ORHRD provide technical assistance to the hospitals—a solution considered less expensive and more appropriate than a policy based primarily on financial support.

To carry out the technical assistance mandate, ORHRD began developing strategic plans with hospitals. When a hospital’s strategic plan was agreed upon, ORHRD had the resources to help the hospital implement it. ORHRD staff include eight field staff, who devote much or most of their time to providing on-site technical assistance to rural health facilities. Office staff have varied backgrounds and specialties, including architecture, graphics, laboratories, primary care, reimbursement, and data analysis. One of the tools available to support hospital decision-making is a computer program that determines the most advantageous configuration of services among Rural Health Clinics and Federally Qualified Health Centers (FQHCs).

ORHRD has also been using Robert Wood Johnson Foundation (RWJF) funds to develop regional alliances in the state. Three alliances have been created, each including four to six hospitals. Three of the PCH grantees and two EACH grantees are participating in these alliances. According to office staff, their experience in working with those hospitals through the RWJF project promoted their interest in the EACH-PCH concept. The office's other programs include a project in which primary care physicians are paid to act as medical gatekeepers, a capital improvements grant program, a quality assurance/risk management program that support quality-of-care improvements by 38 participating health centers (this effort includes patient chart review by ORHRD consultants), and a major recruitment program for obtaining providers.
The philosophy of ORHRD is to promote community ownership and involvement. The staff see themselves as consultants who provide assistance when necessary. The office's goals are to continue strengthening and developing the rural health infrastructure in underserved areas and facilitating and encouraging hospitals and other entities to work together to increase the regionalization/coordination of services.

Two local-area ORHRD efforts are particularly relevant models for the state's EACH-PCH program. One is the assistance given to Our Community Hospital, in Scotland Neck, North Carolina. ORHRD has assisted the failing 20-bed hospital, a PCH grantee, in planning for and beginning its conversion to a new, 100-bed medical facility, primarily for the elderly. The project, costing approximately $4.2 million, will include a long-term care complex with varied levels of services, a 24-hour emergency room, public health and social services, and an expanded primary health care center.\(^1\) The state considers this hospital's conversion to be the classic PCH model.

The second relevant local-area effort is ORHRD's assistance to Warren County Hospital. This hospital had been in such desperate condition that ORHRD actually managed it for a time, and then closed it with a plan for renovation. The hospital has been reopened as a coordinated community health/public health center, and three young physicians have been recruited to the town.

B. PROGRAM DESCRIPTION

1. Organization and Administration

James Bernstein, the Director of ORHRD since its inception nearly 20 years ago, is the project director of the state's EACH-PCH program. Mr. Bernstein was heavily involved in developing the EACH-PCH concept during 1989-90 with Congressional staff. Nan Rideout and Serge Dihoff are the key field staff in the office who have been and are working with the facilities to implement their networks and conversions (they are well known to the facilities, especially those that are also in the

\(^1\)The hospital's story is documented in Kushner (1991). The hospital benefited from the support of several foundations and the community itself, in addition to ORHRD.
Robert Wood Johnson-sponsored alliances). The project also involves two data specialists who will use computers bought with the grant funds to monitor network utilization. As implementation progresses, other important persons will include a staff member from the EMS agency of the state and from the mountain Area Health Education Center (AHEC), as well as members of implementation working groups when they are formed. William Bradley, of the state's Division of Facility Services (Licensure), coordinates staff for the committee that is revising the state's hospital licensure laws.

2. Program Goals

The program was viewed as using state-federal coordination to facilitate regionalizing health services, given the current fragmentation of care at the local level. The state believes that the PCH concept is to provide incentives for small rural hospitals to provide low-tech medicine, and to change the federal regulations to allow them to do so. State staff also expressed hope that the program would help build a primary care infrastructure in medically underserved areas. More concretely, a successful program would create (1) financially viable PCHs, (2) a stronger primary care base (such as an increase in primary care practitioners in the participating areas), and (3) network service planning efforts, thus improving services especially for the aged and for children.

3. Program

The state's program largely focuses on providing technical assistance to the EACH and PCH grantees to support their conversion efforts and strengthen their networks. Other key components include a contract to the state's Office of Emergency Medical Services to plan expanded communications and transportation systems, and a contract to the state's AHEC program (in particular, the mountain branch of the program) to use their (proprietary) instrument to assess the quality of hospital management (including department heads), and then provide training to improve
it. To eliminate state regulatory barriers to implementation, the state formed a committee to review hospital licensure requirements and recommend changes.

The state will also form implementation working groups, consisting of representatives of involved state agencies, the hospital association, and hospital administrators. These groups will meet to analyze problem policy issues (in such areas as finance, provider recruitment/retention, and practice management) and propose recommendations to further the EACH-PCH program. Hospital meetings will also be held among the EACH and PCH grantees, to provide an opportunity for the facilities to share experiences and innovations, and for ORHRD staff to offer advice/information.

4. Use of the Grant

The grant will be used primarily to (1) hire/support staff to provide technical assistance to the facilities in implementing their conversions and networks, (2) allow outside contracts for EMS improvements in the EACH-PCH areas, assessment and training by an AHEC for hospital management, and consultants, (3) buy computer equipment to support the evaluation/monitoring of network utilization, and (4) pay expenses to convene hospital participant meetings and implementation working group meetings.

C. PROGRAM DEVELOPMENT

1. Overview of Strategy

The North Carolina approach to EACH-PCH participation is based on the belief that communities must decide for themselves what option they should pursue when their hospital is no longer viable in its present form, but that information and technical and financial assistance can help such communities choose and implement changes most appropriate to the area. The community-based strategy, however, does not mean that the state is reactive rather than proactive. The state initiated one-on-one contact with several potential PCHs to explain the program (in addition to providing general information to a broad hospital group), and devoted considerable staff time and
resources (including computer time and travel expenses) to providing in-depth, on-site, tailored information to interested hospitals. At the request of the prospective PCH, the state made the first contact with several of the potential EACHs about participating in a specific network.

The state ultimately wants to include nonhospital providers in the EACH-PCH networks, but believes that the historical autonomy of and past disputes between EACHs and PCHs require a slow approach that focuses first on implementing linkages between the EACH and PCH. Historical barriers to cooperation are extensive both among hospitals and between single hospitals and the other providers (such as health departments and clinics) in their areas.

2. Initial Steps in Program Development

Mr. Bernstein led the program’s development from the beginning; the state had a two-pronged strategy for generating facility interest in participating. After talking with the hospital association and agreeing on some facilities that would make good PCH participants, Office staff contacted their administrators to discuss the program as an option. Four of the six eventual PCH participants were contacted as part of this effort.

The other two PCH grantees became interested after a meeting sponsored by the hospital association, at which Mr. Bernstein explained the program and offered ORHRD staff to meet with the administrators and boards of interested hospitals at their request to discuss the issues further. Many calls were received and followed up by staff, who explained the program further in person, and left the relevant written materials for the facility to review. (The written materials included both the law that established the program and data on trends in the utilization of the facility.) This meeting and the time spent with the many interested hospitals assured the facilities that the program would not be a targeted effort.

Multiple meetings and discussions took place between Office staff and the hospital administrators and sometimes the boards and medical staffs of the hospitals that finally applied for the program. All of the follow-up assistance was at the request of the PCH administrator. Two hospitals that were
initially interested decided eventually not to apply because their Administrators could not convince their Board that doing so was a good idea. At the same time, the office did not request designation for all of the facilities that were interested because the project director believed that the first group should include those that would be easier to work with; the others may be included in the next round of applications.

The PCH administrators took the lead in deciding which potential EACH they wanted to work with. The chosen EACH was not always the most logical facility to serve that role according to statistical data, but the choice reflected the political realities of the area. In many cases, the preferred EACH was obvious to the PCH but, in at least one case, the PCH wrote to several EACHs and received several responses, and then selected the one they wanted to work with.

In some cases, office staff rather than the PCH administrator first approached the EACH with the idea of participating in a specific network. This strategy allowed open discussion of the benefits for the EACH, and staff believed that it helped the networks get off to a better start in the absence of past cooperation between the two hospitals.

3. Application Development

The two field staff who had worked with potential facility applicants on their decision to apply (Nan Rideout and Serge Diboff) wrote the application, with two data specialists contributing the data summaries on the prospective EACHs and PCHs.

4. Involvement of the Hospital Association and Other Provider Representatives

Groups external to ORHRD did not play a major role in program development, although the hospital association has played a supporting role. For example, it sponsored the initial meeting for its members at which information was presented, and a representative talked with Mr. Bernstein during the development period to discuss the facilities that would make good EACHs and PCHs. In addition, every other month, a group of representatives of various agencies, including ORHRD, the
hospital association, the medical society, the state health department, and the two big foundations in the state (Kate B. Reynolds and the Duke Endowment) meets to discuss current health policy issues. The EACH-PCH program was discussed at at least two of their meetings. Everyone supported applying for it, although some were more and less skeptical about whether implementation would proceed as smoothly as hoped.

F. STATE PROGRESS TO DATE

1. Summary

Some parts of the state’s program have begun to be implemented, some will be implemented over the next few months, and others have been delayed pending more certainty about the final program regulations:

- **Already Underway.** A committee was formed in October and has been meeting monthly to completely revise North Carolina’s hospital licensure laws, eliminating any barriers to EACH-PCH networks in the process. Computers for monitoring and evaluating the state’s six EACH-PCH networks have been specified and ordered. ORHRD staff have worked to maintain the interest of current grantees in the program in the hope that Congress will adopt provisions to make the program more flexible. The ORHRD field staff are providing ongoing technical assistance with network planning. At the time of the site visit, a meeting of all participants had been scheduled for May 1.

- **Will Begin Implementation Over the Next Few Months.** The state will assess the EMS needs of each participating network area and develop a contract with the state’s EMS office to fund improvements.

- **Delayed Pending More Regulatory Certainty.** Implementation working groups will be formed to address issues that arise during network implementation, but they are viewed as potentially counterproductive until the program’s requirements are more final.

a. Activities and Achievements

Grant funds had been available to the state only for about a month prior to the site visit; however, some implementation had begun. The main area of program effort to date has been to revise state regulatory requirements that affect EACHs and PCHs. This effort is part of a broad-
based effort to re-think the state's requirements for all types of hospitals, rather than a targeted effort to examine a few areas. According to Mr. Bernstein, the process of initiating the EACH-PCH program prompted the state to form a committee to revise the state's hospital licensure laws; the committee has been meeting once each month since October 1991. The effort is necessary because nearly all of North Carolina law is antiquated and irrelevant to today's facilities. One person we interviewed cited the rule that visitors may not sit on a patient's bed, and others cited much language that states that hospitals "could" or "should" do things.

The committee comprises 15 members of varied groups, including different-size rural and urban hospitals, Blue Cross, the state's Medicare/Medicaid, Licensure, and Construction agencies or sub-units, the Duke Endowment, and a physician. At an early session, Mr. Bernstein explained the EACH-PCH program. The committee is first addressing the minimum requirements to be a hospital, will proceed to long-term care, and then to specialty rules. The regulations for Pennsylvania are being reviewed extensively as a model, since a review of state requirements found that those in Pennsylvania were the most comprehensive without being overburdensome. No new rules will take effect until the entire two- to three-year process is complete.

The hospital association is working to exempt PCHs from certificate of need (CON) requirements to facilitate their conversion. Hospitals now need CON approval to add long-term care beds and other special care beds, as well as home health agencies, but not to implement swing beds.

In addition, the computers necessary for tracking the utilization of participating facilities have been ordered.

The field staff (Ms. Rideout and Mr. Dihoff) have increased their assistance to the grantees since the grants were awarded, although their time thus far has not been funded by the grant. For example, Mr. Dihoff has been working with the Anson County Memorial/Richmond Memorial network to shift all obstetrics services to Richmond Memorial (the EACH grantee) and to develop patient transfer protocols--two components of the network under the EACH-PCH program. The
facilities had not yet begun to use their grant funds to implement their projects, but Mr. Bernstein believed that the availability of funds would soon enable them to do so. All grantees, including the two that would be unlikely or less likely to convert to PCHs when proposed regulations are finalized, are being advised they can begin implementing their grant projects because conversion is not a condition of the grant, and the final PCH operational requirements are unknown.

Initiating the program has prompted discussion in the participating communities about linkage issues and the role of the prospective PCH in the area's health care system. According to the ORHRD respondents, the linkages will likely go forward regardless of whether the grantees ultimately convert to PCHs and EACHs.

b. Problems Encountered, Delays, or Activities More Difficult Than Anticipated

The uncertainty of the content of final program requirements has delayed those aspects of the program that depend on them. In particular, implementation working groups have not been formed as originally planned because the project director believes that they would be unproductive at best in the absence of greater certainty about the program's requirements. In addition, planning is very difficult in the face of uncertain final regulations. Mr. Bernstein and the field staff have devoted a substantial amount of time to keeping the current grantees and their communities positive and interested in the program, rather than risk losing them before the final regulations are issued.

The data specialists who will use the computer equipment ordered under the grant stated that the state's required purchasing process for the equipment was much more time-consuming than they had anticipated. They noted, however, that the process forced them to consider in detail what they required from the equipment.

2. Factors Affecting Program Implementation

The people we interviewed believed that the community-oriented approach to program development—with the state acting primarily as an information source—was a critical factor in
generating interest in the program by facilities and communities. Alternative approaches in which the state would target areas for involvement would not have worked because the communities dislike government regulation and mandates. Moreover, those interviewed felt that pushing a particular PCH to join with a particular EACH would not have worked, because of the strong influence of politics and historical relationships and conflicts among localities.

The fact that both the field staff and ORHRD are well known to and trusted by the facilities also helped generate interest in the program. The staff believed that their experience with the Robert Wood Johnson Foundation alliances has prepared them to help the facilities break down inter-organizational barriers to form the networks.

The ORHRD data specialists believed that producing a standardized statistical handout for potential PCHs that inquired about the program helped foster discussion of the facility's circumstances and options for possible EACHs. The data specialists devoted time to explain to the ORHRD field staff how the handout should be interpreted; the field staff then used it in their discussions with the hospitals about participating in the program. (The handouts for the PCH grant applicants were included in the state's application.)

3. Importance of the Grant

North Carolina would have participated in an EACH-PCH Program even if the program did not carry a grant. However, the existence of the grant made the program a higher priority in terms of Mr. Bernstein's and the staff's time than it would have been otherwise.

G. STATE GRANTEE EVALUATION OF LAW/REGULATIONS

The persons we interviewed did not believe that the PCH model was workable as proposed. Given the proposed model, they believed that it would be more advantageous to allow some hospitals to close and convert to a FQHC or a Rural Health Clinic, both of which have long-term, cost-based reimbursement, rather than convert to a PCH, which would be subject to an unknown prospective
payment system after initial implementation. They suggested that physicians did not want to have to certify that a patient needs temporary and immediate care at the PCH, which they interpret as meaning the patient could not get to another hospital. In addition, the hospitals in North Carolina want to retain their swing beds and to convert many of their acute care beds to swing beds. They noted that a 98.4 percent occupancy rate for long-term care beds pointed to the need for swing beds, which also make sense given the fairly large structure of some of the potential PCHs (two of the PCH grantees have approximately 50 beds).

The stipulation that the lower of costs or charges be used for reimbursement was also considered to be problematic, as was the 72-hour length-of-stay limit unless provisions are made for exceptions. In reviewing the implications of the 72-hour length-of-stay limit for the state, the data specialists computed the average length of stay by DRG by type of hospital. They found that because most had an average length of stay of longer than 72 hours, the low-intensity types of services normally provided by small rural hospitals would no longer be provided in many cases. A few DRGs had an average length of stay of shorter than 72 hours, but they were types of cases that required services not provided by small rural hospitals. The state staff noted that North Carolina hospitals tend to have longer average lengths of stay than other states, but that the potential PCHs do not have much longer lengths of stay than do other hospitals in the state.

If the PCH requirements are finalized as proposed, it is likely that four of the current six PCH grantees will convert to a PCH (Bertie, Sealevel, Scotland Neck, and Burnsville).

ORHRD field staff we interviewed believed that the isolation of two of the PCH grantees in particular indicated a strong need for a viable PCH in those communities. Ambulances from the Sealevel area (a PCH grantee site) must travel over a drawbridge. If up, the bridge seriously delays the ambulance; a typical 45-minute drive could take 1-1/2 hours. In addition, one of the two EACH-PCH networks located in the mountains (the Burnsville/Spruce Pine network) is quite isolated.
Although the drive is only 15 miles, the roads are such that in the winter travel can be very slow, and portions of the road are sometimes closed, requiring detours.

H. UNIQUE FEATURES OF THE PROGRAM AND APPROACH

The unique features of North Carolina’s program and approach thus far can be summarized as follows:

- The program context created by the trust and familiarity that have developed between the state and local providers over two decades of close state assistance with rural health service delivery problems

- The high degree of interest by Mr. Bernstein in developing the program, together with his credibility with local providers and state policymakers, facilitated using existing staff and expertise to develop the program, with outside groups playing a supportive role

- The experience of ORHRD staff in helping hospitals undertake the strategic planning and implement change (including two hospital conversions), and in working with providers to form networks through a Robert Wood Johnson Foundation project

- The state’s plans to address management weaknesses at the sites by using a management assessment tool followed by tailored training
VI. SOUTH DAKOTA
A. STATE RURAL HEALTH POLICY CONTEXT

For several years, the South Dakota Department of Health has had a cooperative agreement with the American Hospital Association (AHA) to collect and share financial and utilization information from hospitals within the state. The Department supplemented the data elements of the AHA survey. The Department continued to employ a number of health care planners when it phased out its certificate-of-need program in 1986. In the early 1980s, the Department's health planners, using data from the expanded AHA survey began to prepare "medical facility plans." These plans analyzed the utilization, finances, market share, patient origin, and service needs of hospitals and long-term care facilities. Based on a set of rural medical facility plans, the Department concluded that many rural hospitals were in frail condition. Nine rural hospitals had closed since the early 1980s, 2 had closed more recently (1989), and the Department estimated that as many as 10 to 15 more might close in the next several years.

Partially in response to the rural hospital findings of the Department, the Governor formally established the Office of Rural Health (ORH) in March 1989. ORH is a joint project of the Department of Health and the University of South Dakota School of Medicine. ORH has two offices—one in Sioux Falls, staffed by the director of ORH, Loren Amundson, M.D., and a branch manager (Scot Graff), and one in Pierre, staffed by the other branch manager, Bernard Osberg. Dr. Amundson is designated as the EACH project director, and Mr. Osberg is designated as the project supervisor. Mr. Osberg will provide day-to-day supervision of the project. ORH reports to the secretary of health, who is appointed by the Governor and the Dean of the University of South Dakota School of Medicine.

The primary mission of ORH in its formative stage has been the recruitment and retention of health care professionals. That mission is being expanded as ORH identifies new problems and proposes new solutions. In addition to the EACH program, ORH, in cooperation with the South Dakota Hospital Association (SDHA), is mounting a broad rural health initiative. The effort began
in June 1990 at the Governor's Rural Health Strategy Meeting, an invitational conference of providers and rural community citizens. The participants identified and prioritized 11 issues of importance to rural South Dakota. The top five were:

1. Rural hospitals
2. Underserved populations and financial barriers to access
3. Emergency medical services
4. The supply of primary care physicians
5. Nurse practitioners and physician assistants

The State Rural Health Plan, which was also a product of this meeting, identified the following services as essential health care services: acute care, primary care, long-term care, and emergency medical services. The enumerated priorities of ORH and its definition of essential services seemed to mesh nicely with goals and programmatic elements of the EACH Program. Thus, ORH attempted to assess the level of interest in the program among providers and began the steps necessary to obtain designation and implement the program. Those activities are explained below in Section C.

Although the EACH program is an important component of ORH activity, it is only one aspect of the total effort. In fall 1990, ORH wrote a rural health legislative agenda that was embraced by the Governor. All but one of the legislative initiatives passed. ORH and the Division of Licensure and Certification are drafting rules to implement a new combined hospital license that will become effective on July 1. Under the new rules, each facility will have one license and one licensure inspection, regardless of the number of health care facilities that are allocated. Following his conference in 1990, the governor formed a Special Committee on Rural Hospitals, which is staffed by ORH. The Special Committee established several work groups that are examining such topics as access to capital and regulatory flexibility. The Special Committee has also established criteria for certifying hospitals as "at risk of closure" and "access critical." A hospital may be designated as one
or the other or both. One of the first applications of this designation will be to target Community Development Block Grants (CDBG) to health care facilities. Facilities that are "at risk" and "access critical" will receive assistance from ORH to improve their CDBG applications. Through its Health Care Assessment Program, ORH is also providing direct technical assistance to communities in the areas of strategic planning and community development. Finally, the Rural Health Plan directs ORH to pursue EACH program designation and to perform a "comprehensive review of state licensure laws and regulations to permit development of alternative models."

South Dakota has made a substantial investment in rural health, and the EACH program has been woven into the fabric of several complementary ongoing and proposed ORH programs.

B. PROGRAM DESCRIPTION

1. Organization and Administration

The governor of South Dakota designated ORH to administer the EACH program. ORH and its parent organizations, the Department of Health and School of Medicine, are assisted in EACH program policy formation by an advisory board, the State Rural Health Network Board. The Board meets quarterly; it has met twice since being established in November 1991. Its membership includes the secretary of health (Chair), the Director of ORH, the president of SDHA, the Dean of the School of Medicine, two EACH administrators, two PCH administrators, and two primary care physicians from EACH communities.

As mentioned earlier, the ORH Director and the Pierre branch manager serve as the EACH project director and project supervisor, respectively. ORH also has a full-time rural health network coordinator, who provides technical assistance, staff support, and coordination to the network grantees. The EACH program is also supported by a full-time secretary. The efforts of ORH are also supported by staff from the Emergency Medical Services (EMS) Program. The Division of Licensing and Certification does not provide direct services to the EACH program, but assisted ORH in EACH program planning and reviewed and commented on the proposed EACH program rules.
The division will also play a role in the implementation of the networks (that is, in the initial and subsequent licensing of facilities) once the rules are finalized. ORH, EMS, and Licensing and Certification all report to the secretary of health.

2. Program Goals

The South Dakota EACH program has three goals: (1) to preserve and improve access to essential services in PCH communities, (2) to establish rural health networks, and (3) to improve the EMS system in rural health networks. ORH decided to pursue EACH designation because it believed that the program supported the preservation of the services that it had defined as essential health care services: acute care, primary care, long-term care, and emergency medical services. Just as the essential health care services are interrelated, so too are the program goals. ORH believes that local networking (or integrating services) and formal rural health networks between PCHs and EACHs will help preserve and improve essential health services. Networking is not an end in itself, but a means to an end. Similarly, improving the EMS system is not an end in itself but a way to transfer the patient safely and quickly from the site of illness or injury to the most appropriate provider. The EMS system serves the network, and the network helps ensure that essential health care services are provided.

According to ORH, the essential element of the EACH model is the PCH. The PCH is a new kind of provider; it is not simply a downsized rural hospital. According to Dr. Amundson, the goal of PCHs is to provide "reasonable access to quality primary care services." PCHs should be primary care centers that focus their efforts on integrating services at the local level in order to reduce duplication and to match resources with health care needs. Persons we interviewed believed that as fewer health professionals are locating in isolated rural areas, increased collaboration among communities will be necessary to ensure continued access to services.
3. EACH Program

ORH began its involvement with the EACH program by providing information to prospective PCHs about the program. Potential PCHs have been the focus of all information sharing about the program because ORH wanted hospitals interested in participating in the program as PCHs to select their EACHs. ORH did not want hospitals that were interested in becoming EACHs to "sell" the PCH concept to other, smaller hospitals. Once interested hospitals and potential networks were identified, ORH provided further information on applying for grant funding and designation. Upon receiving the applications, ORH reviewed and scored them, and the secretary of health designated facilities as EACHs, PCHs, and rural health networks. The process of designation is explained in greater detail in Section C.

Following the notification of grant awards, ORH began providing technical assistance to the designated facilities. A rural health network coordinator was appointed in ORH, with responsibility for helping the PCH communities assess the local health care delivery system (to facilitate integrating services) and develop agreements to support network development. ORH reviewed the proposed EACH program regulations and prepared and submitted written comments to the Health Care Financing Administration. ORH and the Division of Licensure and Certification reviewed South Dakota law and regulations for the changes that it deemed necessary to implement the EACH program. Based on that assessment, ORH and the Division believe that only the administrative rules of the state need be changed, and that those changes can be made in a timely fashion and without opposition. The EMS Division will design a data collection system, assess the EMS training needs of rural health networks, provide the necessary EMS training, update the EMS training equipment that can be located in the networks (mannikins and audio-visual learning aids), and attempt to establish an EACH physician as the medical director of the PCH community EMS service. ORH is also establishing an electronic mail system that allows facilities and ORH to communicate with each
other, sharing policy and procedure drafts, treatment protocols, and other information. An attempt will be made to integrate the EMS Division into the EACH program electronic mail system.

ORH is also identifying potential applicants for the second round of grant funding/designation and providing applicants with technical assistance.

4. Use of the Grant

Approximately 40 percent of grant funding is being used to pay salaries and benefits for ORH staff participating in the project to develop the EACH program including two full-time positions—a rural health coordinator and a secretary. Grant funds will be used to support technical assistance in the field by both ORH and EMS Division staff. Grant monies will be used to pay for travel, educational materials, and contractual EMS instructors. The costs of attending quarterly State Rural Health Network Board meetings will be reimbursed from grant funds. The software and a limited amount of hardware to implement the electronic mail system were purchased with grant funds. Peripheral computer hardware and software and design consultation will be necessary to implement the EMS data collection system (a scannable trip report). A limited amount of grant money is being spent on administrative and office expenses, and 17.1 percent of direct expenses are considered to be the indirect expenses of the EACH program. The state is contributing a match of $22,173, or roughly 14 percent of the total cost of the project.

C. PROGRAM DEVELOPMENT

1. Overview of Strategy

Interest in the EACH concept is a direct result of a previous planning effort of ORH in which it identified access to rural hospitals as the chief priority of rural health policy in the state and identified essential services as acute care, primary care, long-term care, and emergency medical services. This initial planning effort was broad-based and accessible to the public. State employees, a variety of providers, and the public participated in sketching the outlines of the State Rural Health
Plan. In contrast, the EACH program planning process was not as open. A multidisciplinary technical advisory group was not used in the formative stages of program development. Rather, ORH and SDHA were responsible for calling the potential of the program to the attention of small, isolated hospitals. ORH and SDHA expanded the planning group to include the EMS and Licensure and Certification Divisions. The planning group was expanded once again to include potential applicants. However, the group meetings were largely informational: potential applicants were informed about decisions regarding goals and policies, and they received technical assistance. No groups outside of the circle of the Department of Health, SDHA, and the applicants participated in program planning or reviewed the state EACH Program Grant application.

Two possible explanations for the lack of broad participation are (1) the belief that EACH program is merely an implementation step of a plan (the State Rural Health Plan) that was formally agreed upon by a broad-based and publicly visible group, and (2) the belief that the role of ORH is to implement a program created by the federal government. Unlike some other states, South Dakota did not believe that it had the latitude to design an EACH program tailored local needs. ORH interpreted its role more as the implementer of federal policy, rather than as the creator of state/federal policy.

ORH characterized its role in the program as a "bottom up approach," meaning that the state did not designate PCHs and EACHs without the hospitals' first applying for designation. ORH did not want to be perceived as "selling" the program to communities (even though ORH believed that it knew which communities would benefit most by the transition). ORH wanted to inform the hospitals about the opportunity of program participation, and once the hospitals decided to proceed, ORH wanted to work as partners with the communities to implement the program.

2. Initial Steps in Program Development

In summer 1989, SDHA and ORH cosponsored a conference to consider several different alternative models, such as the Montana Medical Assistance Facility. Those who attended the
meeting did not express interest in pursuing the idea of developing an alternative model in South Dakota. In November 1990, ORH sponsored a one-day conference to introduce the EACH concept to hospital providers. Many of those who attended the conference were familiar with the concept because SDHA had reported on the EACH program in its member newsletter (all but one hospital in the state is a member of SDHA). The conference was suggested and funded by the Northwest Area Foundation and presented by the National Rural Health Association through its contractor Rosenberg Associates, represented by George McNeely. At the conclusion of the conference, five hospitals (all of which were potential PCHs) expressed interest in pursuing the program further. Between summer 1989 (the first conference on alternative models) and fall 1990 (the EACH conference), two rural hospitals had closed.

Three of the five facilities decided to pursue PCH designation. Each of the three PCHs then selected a hospital with which it would have a logical EACH relationship. ORH and SDHA held a series of three meetings with the applicant facilities to discuss the program and the grant-making process. Through an informal network of grant writers, ORH was able to provide technical assistance to facilities that were unable to complete the grant application themselves. When invited, ORH and SDHA made site visits to applicant facilities to meet with hospital boards and staffs. Communities expressed some reservations about the program, but expressed greater concern about that lack of published regulations for the program. The facility applications were due to ORH one month before they were due to HCFA. A three-member panel consisting of the executive assistant to the secretary of health, the Pierre branch manager of ORH, and a vice president of SDHA developed application scoring criteria and reviewed and ranked all applications. The panel suggested some revisions in the applications. The secretary of health designated all facilities that applied. Three networks were proposed, comprising three PCHs and three EACHs. HCFA disallowed one of the networks because the proposed EACH was in North Dakota.
Both networks have a series of agreements and written protocols which formally tie the EACHs and PCHs together. One of the EACHs had extensive experience in outreach services. Its existing contracts were modified and used as network agreement models. ORH reviewed and approved the agreements.

3. Application Development

The state grant application was written by ORH with input from the EMS Division. The person who wrote the grant started on the project on February 20, 1991. Grant applications were due to HCFA on May 1, 1992. In preparation for writing the grant, the person charged with the responsibility reviewed the written products from the Northwest Area Foundation EACH Project and discussed the project with the Pierre branch manager of ORH, the administrators of EACHs and PCHs, and the EMS Division. Drafts of the application were shared with the director of ORH (who served as a liaison to the South Dakota Academy of Family Physicians), SDHA, and the EMS Division. Comments and suggestions for changing the application were incorporated into the final document. The completed state application was submitted with the facility applications.

4. The Involvement of Hospital Association and other Provider Representatives

The South Dakota Hospital Association played a role secondary only to ORH in developing the EACH program in the state. It shares the credit with ORH for introducing the concept to hospitals. It participated in planning the program with the state and in providing technical assistance to facilities. It sat on a panel to review EACH/PCH grant/designation applications. It reviewed and commented on the state grant application. And, finally, it sponsored the program that is the state’s vehicle for identifying potential grantees for the second round of the program. SDHA has been involved at each stage of program development, although its involvement seems to have been relatively nominal. SDHA credits ORH as "the spark plug" of the program, staffing the functions, coordinating activities, and writing the grant. SDHA’s involvement was limited by the amount of
resources that it could dedicate to the program. ORH is willing to share responsibility for program development with SDHA; a SDHA vice president said, "We are just limited by our time."

No provider groups (other than the applicants themselves) were formally involved in planning the policy for the EACH program. ORH staff believe that the office director is a bridge to the South Dakota Academy of Family Physicians, but there is no evidence of formal or informal involvement by that or any other group of providers.

D. STATE PROGRESS TO DATE

1. Summary

ORH is making good progress at implementing the EACH program in South Dakota. It is adhering strictly to the goals, objectives, and work plan proposed in the state grant application. The rural health network coordinator routinely reviews the work plan and assesses progress. To date, significant portions of the work plan have been completed. ORH has designated EACHs, PCHs, and rural health networks. The office is ensuring that all of the agreements necessary to establish a formal linkage between the EACHs and PCHs are in place. After several false starts, the interim rural health network coordinator was replaced with a permanent one, within the last month. Because of difficulty in recruiting a qualified coordinator, an existing Department of Health employee was reassigned to the position. The interim coordinator will remain in ORH and is training and supporting the permanent coordinator. The coordinator has assessed the training needs of networks and has begun providing specific, targeted technical assistance. The coordinator is also overseeing the facility grant work plans to ensure that project milestones are met in a timely manner. The coordinator and the project supervisor staff State Rural Health Network Board meetings (it has met twice) and EACH/PCH Coordinators meetings (it has met once). ORH is currently conducting a survey to help assess the feasibility of a rural health professional resource pool. It has completed its review and assessment of the proposed HCFA rules for the EACH program and has prepared written comments on the proposed rules. It has completed its review of state laws and regulations necessary
to implement the EACH program. It is within weeks of implementing the electronic mail system. Finally, ORH prepared an application kit, spoke at the SDHA Spring Institute EACH Forum, and invited eligible PCHs to apply for second round grant funding. ORH is also providing technical assistance in application preparation.

The EMS aspects of the EACH program have not yet been implemented. The EMS Division plans to begin training after the beginning of May 1992. It is assessing the automated trip reporting systems of other states and is modifying those systems to be adapted to South Dakota. No effort has been made to have EACH physicians accept responsibility for the medical direction of PCH community EMS services.

No significant problems have been encountered to date. It was suggested that it may be difficult to integrate services given the resistance of communities and providers to consolidation. Similarly, reluctance on part of hospitals to networking may impede implementing the concept further.

2. Factors Affecting Program Implementation

Between the first alternative models conference in 1989 and the EACH program conference in 1990, two hospitals closed. It was suggested that the two closures, plus the deteriorating conditions of some rural hospitals, were sufficient to cause some hospitals to reevaluate their opinions of limited-service rural hospitals. Other major factors were the passage of the EACH legislation itself and heightened awareness about rural hospital issues at the state level. The timeliness of the Northwest Area Foundation Program (the EACH conference) also played a role in beginning the process of implementation. A key factor was not that the conference was held, but how it was structured by SDHA and ORH—ensuring that rural communities would have ample information and time to "make up their minds" about whether to submit an application. Once several facilities expressed interest in the program, ORH and SDHA played an important role in providing the hospitals with technical and emotional support. Neither ORH nor SDHA wanted to be perceived as marketing the concept to hospitals, yet both seem convinced that the PCH model is a reasonable and, in many cases, desirable
option for small rural hospitals. The presence of SDHA at the EACH conference and at community visits helped reinforce the notion among hospitals that the PCH model was a legitimate option and to dispel residual doubt about the program’s desirability. The hospitals that are participating in the program are doing so in the belief that the PCH is a down-sized rural hospital.

3. Importance of the Grant

Although the grant is financing the development of the EACH program, ORH would likely have supported program development from internal funds had the grant not been available. South Dakota has a sizeable investment in rural health policy development and services. It is committed to finding solutions that preserve access to essential services. It would likely have participated in the program, albeit in a more limited way, without grant funds. The facilities rely more heavily on grant funds than does the state. One person interviewed expressed confidence that the state would have funded the EACH planning effort or future efforts that are an outgrowth of the EACH program. Another noted that providers in the state had been successful at obtaining federal grants (such as Rural Health Transition Grants and Rural Outreach Grants), but somewhat less successful at obtaining private grants.

E. STATE GRANTEE EVALUATION OF LAWS/REGULATIONS

ORH’s evaluation of the South Dakota’s laws and regulations suggests that the EACH program can be implemented with only minor changes to the state’s administrative rules. However, within the state no clear consensus has emerged about the eventual effect of the final rules or the interpretation of the final rules on program development. Some people we interviewed expressed concern that the PCH may be considered a primary care clinic with holding beds, rather than a limited-service rural hospital. Others found no problem with that interpretation of the model. The latter group agreed that while the limited PCH model may make sense as a pure type, it may be more difficult than the
more expansive model to implement. Hospitals willing to downsize to a limited-service model may not be willing to downsize to a clinic with holding beds.

Licensure and Certification staff expressed concern that existing long-term care regulations may conflict with EACH rules whereby a skilled nursing-bed shortage would exist in PCH communities. Since the demise of CON in South Dakota, a moratorium has been imposed on long-term care beds. A limit has also been imposed on swing beds. Only 50 percent of the number of acute care beds in a facility can be "swung." Strictly interpreted, the six-bed limit of the proposed rules would mean that a facility in South Dakota could have a maximum of only three swing beds. Current plans are to allow six beds to be dedicated for "swing bed" use only, and there is some debate about whether a PCH should be allowed to swing 10 of its total 12-bed complement. In many potential PCH communities, the hospital swing beds are the only Medicare-certified SNF beds in the community. Only state regulations need be changed to allow more swing beds. An attempt to relax the swing-bed requirements would invite opposition from the two organized nursing-home associations in the state.

Because policymakers in South Dakota (including the hospital association) view their role as implementing federal policy, they are sanguine about the prospects of implementing the program, regardless of the shape of the final rules. The persons we interviewed, even those who expressed reservations about the rules, repeatedly confirmed that they will do what is necessary to make the program work.

F. UNIQUE FEATURES OF THE PROGRAM AND APPROACH

Among the seven states implementing the EACH program, South Dakota is less interested than the others in placing its unique stamp on the program. This approach to the program may be due to two factors--isolation and administrative philosophy. South Dakota has not been able to participate in as many of the meetings of the seven states. It has not been able to share ideas and learn the approaches adopted by the other states. ORH even senses a feeling of isolation from
HCFA in developing its program. The project supervisor had hoped that HCFA would have provided more direction, and that planning would have been more of a partnership effort with the federal government. Second, as mentioned earlier, ORH believes that the role of the executive branch of government is to faithfully implement the laws passed by the legislature. This philosophy of government extends to the EACH program. To ORH, the EACH program is what HCFA says it is.

A unique feature of the South Dakota Program is the State Rural Health Network Board. No other state has a body that routinely reviews the activities of a program in which such high-level persons from the state administration and university system participate. Another unique feature of the program is the grantee electronic mail system. This innovation, which uses existing technology, will be especially useful as the number of networks grows. A similar network among grantees in all states would help to rapidly disseminate information and technical assistance.
VIII: WEST VIRGINIA
A. STATE RURAL HEALTH POLICY CONTEXT

The state of West Virginia has had virtually no involvement in rural hospital issues prior to the EACH-PCH program, except in such regulatory functions as Medicare certification and certificate of need. However, state has actively addressed other rural health issues: since the early 1980s, the state has been heavily involved in developing primary care centers and recruiting physicians for both the centers and hospitals. The position of director of the state’s new Office of Rural Health Policy (ORHP) is currently vacant. However, the office’s one staff person (who is also the EACH program director) continues to be guided by the recently promoted former office director.

B. PROGRAM DESCRIPTION

1. Organization and Administration

Mary Huntley has led the state’s EACH program efforts from the beginning. She was recently promoted from director of the ORHP to the director of the Office of Community and Rural Health Services (OCRHS), which contains ORHP in addition to EMS, primary care, and local health subunits. However, she retains a strong interest in assuring the program’s progress, and will remain involved as the chairman of the state’s EACH-PCH Advisory Council. Sandra Pope was hired in March as the director of the EACH program in the ORHP. She had previously directed the federally funded Black Lung Clinics Program. At the time of the site visit, her role was evolving and not clearly defined.

Two main mechanisms have promoted progress on the state’s program thus far. One is an informal partnership between Mary Huntley with the state and Robert Whitley with the West Virginia State Hospital Association; they communicate about the program frequently. The other is the state’s EACH-PCH Advisory Council, which has been the program planning mechanism since 1990 and continues to shape program implementation and policy. It assumes a formal role in the designation process, reviewing facility applications for designation. During the program planning period, the Advisory Council was an informal working group that functioned by consensus. Since the grant was
awarded, the need for a more formal group with wider representation has become apparent, and this transition is taking place.

2. **Goals of Program Participation in the State Context**

   As in the other states we visited, West Virginia's health services are fragmented, weakening the areas' service delivery systems, as well as creating needless duplication of services. The state's project director believes the EACH program has the potential for integrating services beyond the hospital, thereby benefiting both patients and facilities. The legislative representative whom we interviewed believes that the program will strengthen primary care in the PCH areas, and encourage hospitals to work together. She noted that the feeling before the EACH-PCH program was that rural hospital issues should be addressed, but no one could agree on how to do so. This program resolved that dilemma.

3. **Program**

   West Virginia's program requires a two-stage process for network designation. Potential networks receive provisional designation in order to apply for federal grant funds, but must then conduct a community needs assessment according to state criteria, conduct a financial feasibility study, and submit to the state a revised budget before applying for final designation. The state supports this process by holding periodic meetings of the grantees to give them advice and clarify the state requirements, and to allow them to share their experiences and ideas with each other. Before the commissioner of public health makes a final network designation, a public hearing is held in the network's area. In addition to developing and implementing the designation process, the state ORHP will:

   - Provide about a third of the grant funds to the state EMS unit to conduct training and purchase steel for a communications tower
   - Hire a coordinator for the project, who will serve as a liaison with the participating sites
• Develop an evaluation plan and evaluate the state program through a contract with a private consulting firm

• Develop materials (through a contract with a local university) to keep the program visible and expanding

• Expand and formalize the advisory committee and continue its bi-monthly meetings to address implementation issues

Because the EMS component is a separate and distinct major state program effort, it merits further explanation. A major planned purchase under the EMS program component is steel for a microwave communications tower. The tower is considered essential for maintaining the quality of care under the PCH model, because it permits direct communication between ambulance personnel and the regional emergency medical command center. This linkage allows the emergency medical command to direct an emergency case to an appropriate source of care, bypassing the PCH where appropriate. When the ambulance stops at the PCH for a case that requires a higher level of care, the PCH is responsible for transporting the patient to that care. According to the leader of the state's EMS component, this arrangement could potentially deplete the PCH of the only medical staff at the hospital, and/or could delay appropriate treatment.

Without a microwave tower, the only potential communications link from the ambulance is to the local hospital. West Virginia now has microwave towers that cover 40 percent of the state's population, but they exist in the more densely populated areas. The mountainous terrain of the state makes extending this technology more expensive—it requires more towers spaced more closely together than does a flat terrain.

The state's EMS unit also considers advanced EMS capability (including paramedics) at all PCH sites to be essential for maintaining the quality of care under the EACH program because of the relaxed PCH emergency room staffing requirements. This attitude prompted the development of training plans at the PCH sites to provide advanced lifesaving care.
4. Use of the Grant

As noted earlier, one-third of the grant will be allocated to improving EMS through a contract with the state EMS unit for training and equipment purchase. The grant will also be used to fund the program director’s position, to obtain technical assistance for the state from Rosenberg Associates and Marshall University, and to pay grantee expenses for technical assistance meetings. It should be noted that facilities must use their own grant funds or other funds to obtain the technical assistance they might require to meet the state’s requirements for a community needs assessment and financial impact study.

C. PROGRAM DEVELOPMENT

1. Overview of Strategy

West Virginia began exploring the EACH-PCH program in Spring 1990, long before the federal program announcement was issued. An informal advisory council organized to explore the program, together with the hospital association’s partnership with the state, were key to the early progress of the state in reaching consensus on major program issues. To develop potential network sites, the state combined a broad, informational approach with more focused efforts (including informational site visits initiated by the state) directed at hospitals identified by the state as good PCH candidates. Within the Bureau of Public Health, the state hired a full-time, day-to-day coordinator for the program, and the state’s EMS unit is preparing to implement the program component to develop training and communications at the PCH sites. The state has relied extensively on contracted assistance from two organizations to develop and implement its program. West Virginia’s extensively defined process for EACH, PCH, and network designation is a central feature of its program.

2. Pre-Award Program Development

Ms. Huntley’s initial interest in the EACH-PCH concept sprang from her attendance at the National Rural Health Association’s annual conference in 1990, a year when rural hospital issues were
a political priority for the state. Speakers included David Abernethy, Steve Rosenberg, and Dena Puskin, discussing the EACH-PCH concept. As a result of the discussion, Ms. Huntley (who was then in the state's planning agency) formed an advisory council to explore options for rural hospitals. The persons chosen for the committee were those whom she believed could find common areas of agreement on rural hospitals, even though cooperative efforts among the groups they represented were not the usual order of state business. The council included persons from the Hospital Association, the state's Health Care Cost Review Authority, the state's licensure bureau, and the Professional Review Organization (PRO). It met informally almost each month from May 1990 until the state's application was forwarded to HCFA.

According to the director of OCRHS, the informal and cooperative nature of the council enhanced its efficiency at addressing many issues and approving a state rural health plan, center around the EACH program, that was included with the state's application. For example, the group reached a consensus on the following program issues prior to the grant award:

- The EACH must agree to support the medical staff credentialing, peer review, quality assurance, and risk management programs of the PCH, and the PCH must agree to develop such programs cooperatively with the EACH and other network providers.

- On-line medical control (on-scene and transport medical advice via radio communication) from the Regional Medical Command Center would be made available to pre-hospital care providers, as well as to the PCH, to ensure proper triage decisions. (This requirement necessitates the substantial EMS communications improvements discussed earlier.)

- Only surgical procedures that require local anesthesia may be performed at the PCH; a PCH may not offer full anesthesiology services. (This requirement affected one current grantee's plans.)

- Obstetrical care at the PCH is limited to routine prenatal and postpartum care and low-risk births, except in emergency situations. (Mary Huntley explained that this requirement codified the council's position that PCHs should not provide obstetrical services unless a low-risk arrangement, such as a birthing center were closely linked to the EACH.)
The council approached program development by reviewing California's ARHM demonstration, and found this strategy helpful. However, the group wrestled extensively with several issues. For example, the council had decided that networks should have a formal, incorporated structure that included representatives from each member, but the potential network sites refused to accept that requirement, and so it was withdrawn. The 6-bed and 72-hour requirements were discussed at great length. The 72-hour requirement was especially troublesome for the Webster County Memorial Hospital; because of its isolation, allowing it to continue treating all low-intensity cases of which it was capable was considered especially important. The council's solution, worked out with the PRO representative, was to request in its application that the PRO be allowed to make exceptions to the 72-hour limit on a case-by-case basis.

To develop EACH program network sites, West Virginia pursued a combined strategy of disseminating information on the program to a wide audience and making concurrent, more focused efforts to identify and encourage potential PCHs to apply. The concurrent nature of these two efforts was deemed important to prevent hospitals from believing that they were targeted by the program. The information that was disseminated consisted of (1) an informational letter to all of the state's hospitals following the federal program announcement, with more detailed program information distributed to those that responded to the letter (29 hospitals), and (2) a presentation at a hospital association meeting to explain the program. State staff were surprised at the sizeable response to the informational letter. Two hospitals that had not been identified under the more focused effort (described below) applied for PCH grants after these broader efforts and follow-up contacts.

The more focused site development effort proceeded as follows. The state first identified 15 likely PCH candidates based on utilization and financial data, and the Advisory Council then reviewed the group more closely based on the hospital association representative's knowledge of the areas, and on a further exploration of financial trends and payor mix at those hospitals. The closer
review narrowed the field to six hospitals, which were contacted about the program by the hospital association representative. Informational site visits were then made to each hospital by a consultant to the state and a hospital association representative.

Although the sites were somewhat skeptical about the program because it was sponsored by the federal government and lacked implementing regulations, three of the sites that were visited applied and became PCH grantees. Of those that did not apply, one’s potential EACH was across the state line in Virginia.

We were told that the hospitals knew they were in financial jeopardy at the time of the first site visits, but had not yet faced the reality of the situation. For example, one administrator initially objected to the idea of reducing unused inpatient beds because he believed that the beds would be needed when the coal mining industry resumed growth, although there was no evidence of a change in the long-term decline of this industry at this location.

Multiple contacts were made with the hospitals that were initially interested in the program before they decided to apply. The state consultant who often communicated with potential applicants at this stage remembered that two to three telephone conversations were held with each site, as well as one or two in-person meetings with each potential site’s administrator after the initial site visit. Often, the in-person meetings took place at other functions, such as state hospital association meetings.

It should be noted that a contract with an external consultant was a major factor in facilitating pre-award program development in West Virginia. Prior to the state’s application, a Marshall University consultant (Timothy Crofton) under Mary Huntley’s oversight produced two reports on the potential applicability of the EACH program to the state, and also facilitated the Advisory Council meetings.
3. Application Development

West Virginia's application was written by a local writer and health planner, Katina Cummins, who worked under contract. Timothy Crofton, Mary Huntley, Robert Whitley, and others reviewed and assisted with it. The Advisory Council reviewed all of the networks' applications, and it will continue to play this role as new facilities apply for provisional or final designation.

4. The Involvement of the Hospital Association and Other Provider Representatives

The state and hospital association have worked together in an informal partnership from the beginning—no other external group has exerted an influence nearly as strong. The initial working group that developed the program included a representative of the West Virginia Association of Community Health Centers, but was intended to be informal rather than fully representative, and thus did not include a physician or nurse representative or an EMS representative. A physician's perspective was obtained from a council member physician who was a key representative of the PRO. The state now believes that it is important to include greater participation by primary care, EMS, nurse, and physician representatives, and it is endeavoring to expand the council's membership.

D. STATE PROGRESS TO DATE

1. Activities and Achievements

State activities and achievements since receiving the EACH grant award may be grouped into four major types of activities: (1) providing technical assistance to grantees, (2) addressing or reviewing state regulatory barriers, (3) defining network requirements further, and (4) preparing for EMS training and equipment purchase activities. In addition, the state has hired a program director.

To date, West Virginia has provided technical assistance at four meetings of the hospital grantees. The meetings have thus far focused primarily on communicating state program decisions to the sites and explaining how the state requirements can be met. For example, one session focused on the state's requirements for a community needs assessment. The protocol for conducting this
assessment is fairly specific, which requires developing a community advisory council, reviewing data (including data on acute care and primary care utilization, EMS patterns, and health status), administering a series of key informant interviews with 20 to 25 community leaders, and developing a local health services delivery plan. Other topics have included the requirement for a financial feasibility study, and how a qualified consultant can be selected.

The major state regulatory issue addressed pertained to the state's certificate of need (CON) requirements. Legislation known as the "bed-banking law" (Senate Bill 88) was developed and passed to address the hesitancy of hospitals to participate in the EACH program without some escape mechanism that would prevent them from being required to obtain a new CON to increase their acute care beds should the program prove disadvantageous (discussed further below). The state was unable to identify any other regulatory issues that needed to be addressed. For example, the licensing unit representative whom we interviewed had been involved with program planning from the beginning and did not believe that any licensure issues required resolution. Although survey procedures for PCHs would need to be changed, the licensing unit works cooperatively with the HCFA regional office and would work with them to understand the appropriate survey approach when the time came. The state does not add requirements to Medicare's conditions of participation—it simply implements Medicare requirements and will continue to do so with the PCHs.

Network requirements have been defined further in ongoing meetings of the Advisory Council (the council meets bimonthly) and through the state's contract with Rosenberg Associates. Anthony Wellever of Rosenberg Associates developed a protocol for the community needs assessment that must be completed before final designation of a network in the state. (It was subsequently approved by the Advisory Council.) A key feature of the protocol is the creation of a community advisory council for each network that must include local or regional representatives of the county health department, primary care centers, emergency medical services, and behavioral health centers.
Guidance for sites in choosing a consultant capable of assisting both in the required needs assessment activities and the financial feasibility assessment was also developed under this contract. A list of minimally qualified consultants (including 13 firms or individuals) was subsequently developed by the state and provided to the grantees at a grantee technical assistance meeting.

The state’s EMS office has been preparing for EMS training and equipment purchase activities. (Before implementing its portion of the grant, the EMS office had to change existing contracts between the Bureau of Public Health and the local area EMS agencies.) The initial focus has been on one PCH area—Webster Springs—with the others to follow over the next year. At the time of the site visit, an off-site paramedic training program, CPR training, and advanced life support training were under development, and technical considerations were being explored prior to the purchase of communications equipment.

2. Difficulties Encountered

The one difficulty with the development process as implemented was that the physicians at the hospitals were not always involved in the discussions about the program. At those sites where the site visit meetings excluded the physicians, the process was less effective and efficient we were told, because the hospital administrator and the physicians often disagreed. (However, it should be noted that a site visit strategy that included physicians and hospital administrators would not necessarily prevent disagreement in the presence of a long-standing, ongoing conflict.)

Two of the potential PCHs (one a grantee and one a more recently interested potential PCH) encountered difficulties in developing plans for service expansion as they convert to PCHs, but at both sites the problems appear to have been resolved. Because West Virginia has a moratorium on long-term care beds, Broaddus Hospital (the interested facility that is not a grantee) successfully requested special legislation to allow it to convert some acute beds to skilled nursing beds provided that they obtain PCH designation and a certificate of need for a new service. The other facility, Grafton Hospital, faced strong objections from the primary care center in its area regarding its plans
to expand primary care services. The hospital and the primary care center were historically divided, but the two are now communicating about the program and possibilities for the hospital.

3. **Factors Affecting Program Implementation**

Several factors have affected and will continue to affect the program's implementation in West Virginia:

- The hospital association's partnership role has been critical to convincing providers that the program is legitimate.

- The informal and cooperative nature of the Advisory Council that developed the program made the group very productive in talking through program issues. (Example areas of consensus were provided earlier.)

- At the local level, the hospital association representative believed that consultants will be important for helping hospitals shift from an institutional to a community needs service focus.

- Also at the local level, economic factors will likely affect implementation at two PCH sites. One area (Pocahontas) will be assisted by a new resort tax (valued at $100,000 annually) passed to support building a new facility to house the PCH, and the other (Grafton) may be affected by population growth when the FBI center located nearby opens.

- The state's ability and willingness to offer additional incentives for participation will likely affect implementation (and program impact).

- Other programs that overlap with the EACH-PCH sites will affect implementation at those sites.

The last two factors require more discussion. To date, the state's major success in offering additional incentives for participation has been the passage of "bed-banking" legislation in February 1992. This law allows hospitals to implement the PCH conversion for up to two years while retaining the option of re-opening up to the number of beds previously available. It also loosens some of the state's CON provisions to reduce the potential bureaucratic problems of a facility's planning for several service changes simultaneously. In addition, the EMS Regional Emergency Medical Service Units covering PCH grantee areas are receiving priority consideration for paramedic training.
programs. One avenue still being considered is the state's working with the Public Employees Insurance Association (the insurer for 17 percent of the state's population) to persuade them to alter their payment to participating facilities.

Other potential incentives for participation were considered, but on closer examination were discarded. For example, the state considered whether incentives could be offered through Medicaid, but found no reasonable option because hospitals already receive cost-based reimbursement throughout the state. Similarly, hospital licensure laws were reviewed to determine whether reduced licensure requirements would serve as an incentive; this option was rejected because of the already "wide open" nature of the laws--where there are no barriers, relief is not an incentive.

Two other state laws or initiatives--the Primary Care Support Act and the Rural Health Initiative--will affect local program implementation because they overlap with the EACH-PCH sites. The Primary Care Support Act will provide $1 million in grants to support new primary care services in the state; some of this funding may go to PCH grantees or their communities. The Rural Health Initiative, an effort to establish primary care physician training sites in rural areas, will provide $2 million for six rural sites to participate with the state's three medical schools. Two of the network areas have applied (Grafton/United and Guyan/Logan).

4. The Importance of the Grant

West Virginia would not have participated in the EACH program in the absence of the grant. The grant led the state to explore the related issues of networking and service integration, which had not previously been subject to discussion. According to the OCRHS Directory, these discussions likely will lead to other efforts by the state to focus on primary care.

E. STATE GRANTEE EVALUATION OF LAWS/REGULATIONS

Changing the program rules and regulations, and, if not, the legislative language of the program was a major objective of state program staff at the time of our visit. The 72-hour limit was
considered to be the most problematic for the grantees thus far, but at the time of our visit personnel at the local level had not yet realized the implications of the requirement that the only patients to be admitted are those who need immediate and temporary care. According to the interviewees, the local residents, especially the physicians, want to retain some sort of hospital—if the PCH is a low-intensity hospital, they will support it; if it is used for inpatients only on a temporary basis for emergencies, they probably will not support it.

We were informed that local communities have adjusted gradually to the PCH concept over time. At first, they objected strongly to the program, but they now recognize realities; the local hospital boards have been willing to give up some of what they had hoped for as time has passed. The legislative representative whom we interviewed reported that not having a finalized financing mechanism was a major problem for the hospitals in considering whether to participate in the program. The hospitals' dilemma prompted the legislature to pass the bed-banking legislation (noted earlier) as a safety net measure.

The hospital association's first priority with the regulations was the idea that the PCH should treat only the types of patients who need to be admitted on a temporary basis. The representative also strongly believed that the 6-bed and 72-hour limits were unnecessarily restrictive.

Finally, we were told that travel times in West Virginia are considerably longer than elsewhere because of the mountainous terrain. If the 35-mile distance requirements for EACHs were instead 45-minute travel time requirements, more hospitals would be eligible for the program.

F. UNIQUE FEATURES OF THE PROGRAM AND APPROACH

Probably the two most notable unique features of West Virginia's program are its process for designating networks, and the bed-banking legislation passed to encourage hospitals to try the PCH model. No other state at this point requires such an extensively defined process to become designated. The concept of requiring that community residents and all health entities in the area be included in developing the plans for PCH conversion (and the public hearing prior to final
designation) is also unique. Finally, designation by the state's top health official is another unique feature.