

CAH/FLEX National Tracking Project

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Critical Access Hospitals: An Annotated Bibliography

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This annotated bibliography of research literature, trade journal articles, and federally funded projects was compiled to provide researchers and practitioners with a single resource to consult specific to the subject of Critical Access Hospitals (CAHs).

Organization

The entries are grouped into the following 10 categories, in alphabetical order by author:

1. *Models for Categorizing Hospitals and Designating CAHs*: Individual experiences, issues, and information relevant to obtaining CAH designation
2. *Use of Technology, Including Information Technology, by CAHs and Networks*: The impact of changing technology on CAHs and any disparity between rural vs. urban service provision as a function of available information technology
3. *Staffing in CAHs*: Customization of service delivery and staff skill acquisition specific to CAHs
4. *Financing Care in CAHs*: Maintaining adequate financial capacity challenges CAH viability
5. *Case Studies of CAHs*: Individual experiences of various CAHs
6. *Evaluation and Assessment of CAHs*: Studies utilizing scientific methodology
7. *CAH Networks and CAH Governance*: Findings From the Field
8. *Trends in the Rural Hospital Flexibility Program and CAHs*: Tracking development/evolution of CAHs and the Rural Hospital Flexibility Program
9. *Emergency Medical Services*: EMS and CAHs
10. *CAHs and the Rural Hospital Flexibility Program Interface with Quality Improvement/Patient Safety*: Rural challenges with quality care provision

Annotated Bibliography

1. Models for Categorizing Hospitals and Designating CAH's

Avery, S. (1999). A limited-service rural hospital model: The freestanding emergency department. *Journal of Rural Health, 15(2), 170-179.*

Avery proposes a rural hospital that has been downsized to a freestanding emergency department as a model that offers a possible solution to a community's need to have emergency-care services locally available. Results point to the need for a financial subsidy, and Avery notes regulatory and other barriers to implementation.

www.rupri.org/ruralhealth/jrh.avery.pdf

Christiansen, D. A. (2003). CAH designation earns deemed status. *Nursing Management, 34(4), 18.*

Earning JCAHO's Critical Access Hospital designation is challenging. Christiansen describes what it takes to receive it.

Christiansen, D. A. (2002). Follow the ins and outs of CAH designation. *Nursing Management*, 33(8), 18.

Christiansen focuses on the U.S. Joint Commission on Accreditation of Healthcare Organizations' CAH designation, including the requirements for CAH designation, where CAHs are located, and how the Joint Commission evaluates CAHs.

Coile, R. C. Jr. (2001). Rural health in the millennium. *Russ Coile's Health Trends*, 13(12), 1-4.

Coile discusses trends in rural health in the U.S. He considers rural population statistics, Critical Access programs for small rural hospitals, rural health insurance, and budget for rural health services.

Galloro, V. (2001). Peaches and cream. *Modern Healthcare*, (31)29, 20-21.

Galloro focuses on the Critical-Access program and the planned Medicare reform in 2000 in the United States. He presents background information on the program aimed at keeping small rural hospitals open, changes being considered for Medicare, and the stance of the National Rural Health Association.

Gearon, C. J. (2002). Dirty little secret. *Hospitals & Health Networks*, 76(7), 28-29.

Gearon reports on an increase in Medicare payment in the U.S. noting implications for rural hospitals. The report also includes comments from Alan Morgan (Vice President of Government Affairs for the National Rural Health Association) and a discussion of the provisions in the proposed rules that may render the increase negligible.

Greene, J. (2002). Saving the small rural hospital. *Trustee*, 55(7), 20-23.

Greene offers advice for trustees of rural community hospitals in the U.S. regarding the CAH program, which allows rural hospitals to get cost-based reimbursement for Medicare services in exchange for maintaining fewer beds, keeping patients an average of four days or less, and establishing a relationship with a larger hospital. Greene includes relevant information needed by the board before initiating the CAH process and discusses the role of the board in educating people about what Critical Access conversion means.

Hoeth, R. (2000). The Critical Access Hospital program: A service delivery model for selected rural hospitals. *Texas Journal of Rural Health*, 18(1), 12-18.

Hoeth asserts that rural hospitals must carefully consider the health care needs of the community and the financial viability of the organization when deciding whether to pursue CAH designation.

Parrish, W. M., Jr. (2001). Conversion to a Critical Access Hospital. *Texas Journal of Rural Health*, 19(1), 14-18.

Parrish discusses how and why cost-based reimbursement works, the characteristics of reimbursement, and what the Balanced Budget Refinement Act has done for CAHs.

Ricketts, T. C. (2000). The changing nature of rural health care. *Annual Review of Public Health*, 21, 639-657.

The rural health care system has changed dramatically over the past decade because of a general transformation of health care financing, the introduction of new technologies, and the clustering of health services into systems and networks. Despite these changes, resources for rural health systems remain relatively insufficient.

Shreffler, M. J., Capalbo, S. M., Flaherty, R. J., & Heggem, C. (1999). Community decision making about Critical Access Hospitals: Lessons learned from Montana's Medical Assistance Facility Program. *Journal of Rural Health*, 15(2), 180-188.

Limited-service hospitals have been used as a means of maintaining health care services in rural communities with full-service hospitals at risk of closure. This study examined rural community decision making regarding Medical Assistance Facility (MAF) conversion. www.rupri.org/ruralhealth/jrh/shreffler.pdf

Size, T. (2002). The way to pay for rural care. *Modern Healthcare*, 32(31), 23.

Size comments on the importance of cost-based payment to U.S. rural hospitals, the need to create a payment classification of rural community hospitals, the requirement that rural hospitals offer essential services to Medicare beneficiaries, and the significance of the Rural community Hospital Assistance Act to U.S. health services. <http://www.rwhc.com/papers/MHC.8.5.02.html>

Sloane, T. (2002). Congress should go country. *Modern Healthcare*, 32(16), 23.

Sloan comments on the case made by rural hospital advocates that rural hospitals deserve immediate financial help from the U.S. Congress. He presents details on the CAH program established by the U.S. Congress and includes some recommendations.

2. Use of Technology, Including Information Technology, by CAHs and Networks.

Bauer, J. C. (2002). Breaking down barriers. Information technology and rural health. *Michigan Health and Hospitals, 38(2)*, 16-17.

Bauer discusses how advances in technology since the 1960s have changed health care delivery and put rural hospitals at a disadvantage.

Cupito, M. C. (1997). Making the connection: Far from a central hospital, network access is critical. *Health Management Technology, 18(4)*, 14-17.

Cupito discusses the importance of network access to information for better health care delivery, the demand for network connections for caregivers, the application of integrated services digital network in connecting remote users to a central network, and alternatives to ISDN.

Memel, D. S., Scott, J. P., McMillan, D. R., Easton, S. M., Donelson, S. M., Campbell, G., Sheehan, M., & Ewing, T. N. (2001). Development and implementation of an information management and information technology strategy for improving healthcare services: A case study. *Journal of Healthcare Information Management, 15(3)*, 261-285.

In 1990, PeaceHealth (a multi-state, not-for-profit integrated delivery network that owns and operates five acute care hospitals, one CAH, and twenty-five outpatient clinics) developed a set of strategic priorities for delivering seamless care across the continuum. This case study discusses the drivers behind the development of this strategy; specific components of the information management and technology infrastructure; examples of the impact they have had on patients, caregivers, and the organization; and lessons learned.

http://www.himss.org/content/files/him15307_9612.pdf

3. Staffing in CAHs

Bushy, A. (2001) Critical Access Hospitals: Rural nursing issues. *Journal of Nursing Administration, 31(6)*, 301-310.

Noting the scarcity of information about nursing practice in CAHs, Bushy used survey techniques to examine nurses' perceptions about hospitals that converted to CAHs. Results are offered as information that nursing administrators/educators could use to prepare nurses to work in CAHs that are located in more remote areas of the U.S.

Cameron, A., & Zelman, B. (2001). From Arkansas, Georgia, North Carolina, and Texas: Physician recruitment and retention. *Findings From the Field, 1(10)*. Omaha, NE: CAH/Flex National Tracking Project.

The authors consider the strategies and state-level approaches that CAHs and states have taken to attract and retain physicians. <http://www.rupri.org/rhfp-track/results/vol1num10.pdf>

Capalbo, S. M., Heggem, C. N. (1999). Innovations in the delivery of health care services to rural communities: Telemedicine and limited-service hospitals. *Rural Development Perspectives, 14(3)*, 8-13.

Capalbo and Heggem present an overview of telemedicine technologies and CAHs. They discuss changes in rural population, hospital closures, and federal health care policy, providing anecdotal evidence on the impact of these changes in rural Montana, and they suggest that different health care solutions are needed for different situations.

<http://www.ers.usda.gov/publications/rdp/rdpoc99/rdpoc99b.pdf>

4. Financing Care in CAHs

CMS Makes Billing and Payment Changes for Critical Access Hospitals. (2003). *Healthcare Financial Management, 57(2)*, 11.

The journal reports on the Centers for Medicare & Medicaid Services' publication of a Program Memorandum describing changes regarding claims and payments for services furnished by CAHs, the need for the 'GF' modifier to be used for physician services rendered by nonphysicians, and the percentage of the 85 percent of the Physician Fee Schedule that CAHs will receive.

Dalton, K., Slifkin, R. T., & Howard, H. A. (2000). The role of Critical Access Hospital status in mitigating the effects of new prospective payment systems under Medicare. *Journal of Rural Health, 16(4)*, 357-70.

This article examines rural hospitals that potentially qualify as CAHs and identifies facilities at substantial financial risk as a result of Medicare's expansion of prospective payment systems to nonacute settings. The authors offer recommendations for making the Rural Hospital Flexibility Act more beneficial to rural hospitals.

www.rupri.org/ruralhealth/jrh/dalton.pdf

Poley, S. (2002). State Medicaid payment policies for Critical Access Hospitals. *Findings From the Field*, 2(8). Omaha, NE: CAH/Flex National Tracking Project.

Because Medicaid revenue is important to rural hospitals and Medicaid reimbursement policies are significant factors in deciding whether to convert to CAH status, the author reports on the methods states use to pay hospitals generally and CAHs in particular. <http://www.rupri.org/rhfp-track/results/vol2num8.pdf>

Sutton, J. P. (2001). Profitability of rural hospitals in Texas: Implications for access to charity care. *Texas Journal of Rural Health*, 19(1), 40-48.

Despite the relief that hospitals received from the Balanced Budget Refinement Act of 1999, the Balanced Budget Act of 1997 is expected to have a disproportionately negative impact on rural hospitals. Increased financial pressure on hospitals could lead to closures and effectively erode the health care safety net for the nearly 30% of rural Texans who are uninsured and rely on hospital charity care. This study analyzes the financial vulnerability of rural hospitals in Texas and attempts to measure the risk of losing charity care services if vulnerable hospitals were to close.

Tieman, Jeff. (2003). Rural aid. *Modern Healthcare*, 33(18), 12.

Tieman reports on a recent legislative proposal that would increase reimbursements to rural hospitals.

Zelman, B., & Cameron, A. (2001). From Arkansas, Georgia, North Carolina, and Texas: Revenue enhancement and cost containment strategies. *Findings From the Field*, 1(12). Omaha, NE: CAH/Flex National Tracking Project.

Following site visits, the authors report on CAH administrators who are pursuing a range of revenue enhancement and cost containment measures to enhance the CAH's financial condition.

<http://www.rupri.org/rhfp-track/results/vol1num12.pdf>

5. Case Studies of CAHs

Galloro, V. (2002). The little hospital that could. *Modern Healthcare*, (32)3, 17.

Galloro reports on the qualification of the Johnson County Health Center in Tennessee for Medicare's CAH program. He provides a brief background on the Johnson County Health Center, details of Medicare's Critical Access Hospital program, and Johnson County's eligibility for federal grants to buy hospital equipment.

Greene, J. (2002). Against the odds. *Hospitals & Health Networks*, 76(6), 18-19.

Greene reports on the financial success of Mayo Regional Hospital in Dower-Foxcroft, Maine, gives a brief history of the rural hospital, outlines the effort to improve both employee and patient satisfaction, and details the hospital's financial performance.

Greene, J. (2001). If you build it. *Hospitals & Health Networks*, 75(12), 30.

Greene presents information on the Bertie Memorial Hospital in Windsor, North Carolina, which was built to CAH specifications, and describes the hospital facility, benefits of the CAH program for rural hospitals providing services to emergency and short-stay patients, and services offered by the hospital.

Jaklevic, M. C. (2000). On the critical list: For small rural hospital, Critical-Access designation has been a financial lifesaver. *Modern Healthcare*, 30(28), 36-37.

Jaklevic discusses how the Critical Access designation program helped Atoka Memorial Hospital to recover from its financial losses. Jaklevic also provides an overview of the program, describes the results of the program in accomplishing the hospital's mission, and discusses how hospitals could qualify for the program.

Rees, T. (2002). North Carolina hospital redefines itself as Critical-Access facility. Bertie Memorial called a national model. *Profiles Healthcare Mark*, 18(1), 34-39.

Bertie Memorial Hospital, Windsor, North Carolina, is redefining itself in its new home as a national model for CAHs designated by the federal Office of Rural Health Policy. The hospital recently opened a new \$10 million, 48,000-square-foot, state-of-the-art facility.

Romano, M. (2001). An unlikely savior. *Modern Healthcare*, 31(3), 35-36.

Romano details the efforts made by Jim Burnette, a health care consultant who took over the Tattnall County Hospital in southeastern Georgia, to save the hospital. Romano describes hospital admissions for the first three months after reopening in October 2000, challenges faced by Burnette, plans for the hospital, number of employees of the hospital, and how the shutdown of the hospital affected the residents.

Schumock, G., Walton, S., Sarawate, C., & Crawford, S. Y. (2003). Pharmaceutical services in rural hospitals in Illinois—2001. *American Journal of Health-System Pharmacy*, 60(7), 666-674.

The authors investigate the characteristics of pharmaceutical services in rural hospitals in Illinois. They discuss clinical pharmacy services, unit dose services, patient education and counseling, and pharmacokinetic consultations.

Taylor, M. (2000). Critical Access revives rural hospitals. *Modern Healthcare*, 30(1), 48.

Taylor discusses the Critical Access status achieved by Southwest Georgia Regional Medical Center in Cuthbert, Georgia, and specifies reasons the hospital applied for Critical Access status, the number of rural hospitals in the U.S. designated as CAHs, and criteria to qualify for Critical Access status.

6. Evaluation and Assessment of CAHs

Angelelli, J., Fennell, M. L., Hyatt, R. R., & McKenney, J. (2003). Linkages in the rural continuum: The Balanced Budget Act and beyond. *Gerontologist*, 43(2), 151-157.

This study examined how rural hospitals altered their postacute and long-term care strategies after the Balanced Budget Act of 1997. A nationally representative sample of 540 rural hospital discharge planners were interviewed in 1997. In the year 2000, 513 of 540 discharge planners were reinterviewed. The study is a descriptive analysis of how rural hospitals formed new, and altered existing, organizational strategies during a time of turbulent changes in federal government reimbursement policy.

Cameron, A., & Zelman, B. (2001). From sixteen Critical Access Hospitals: Strategic planning and the balanced scorecard. *Findings From the Field*, 1(11). Omaha, NE: CAH/Flex National Tracking Project.

The authors use the Balanced Scorecard as an analytical framework to identify and catalog activities in the strategic management of CAHs. <http://www.rupri.org/rhfp-track/results/vol1num11.pdf>

Greene, J. (2002). Rural renewal. As momentum builds, Critical Access Hospital program shows signs of success. *Hospitals & Health Networks*, 76(4), 50-54.

Greene suggests that the CAH program looks like a success so far, keeping vulnerable rural facilities from closing and maintaining a continuum of care in communities where the next nearest hospital might be hours away. Greene reports that although conversions can be bumpy, one in four rural hospitals is now a CAH and that number is increasing.

Lawler, M. K, Doeksen, G. A, & Schott, V. (2003). Impact of conversion to Critical Access Hospital status for Oklahoma's rural hospitals. *Journal of Rural Health*, 19(2), 135-138.

This article describes the impact of conversion to CAH status for 15 small rural hospitals in Oklahoma. Objectives of the study were to identify how conversion to CAH affected hospital utilization and finances for the first year after conversion. www.rupri.org/ruralhealth/jrh/lawler.pdf

Mueller, C. *Alternatives to the 96-Hour Rule for Critical Access Hospitals: Sponsor: Health Care Financing Administration/Barents subcontractor*

Hospitals that obtain the CAH designation under the Rural Hospital Flexibility Program are required to limit inpatient stays to an average of 96 hours. The Walsh Center is examining whether any exceptions or alternatives to the 96-hour limit should be considered. The analysis includes examinations of length-of-stay by Diagnosis-Related Group.

Mueller, C. 8/31/2001. *National Rural Hospital Flexibility Program Tracking Project: Perceptions of Community Physicians.*

Mueller discusses why an understanding of the perceptions of physicians who have chosen to affiliate and not affiliate with CAHs is crucial in understanding how CAHs are functioning in their communities.

Raines-Eudy, R. (2002, November). *Defining Critical Access Hospital service areas and measuring patient outflow to other hospitals (Abstract #47879)*. Presentation at the annual meeting of the American Public Health Association, Philadelphia, PA.

Raines-Eudy describes development and implementation of a quantitative method for measuring CAH service areas in Arkansas. Raines-Eudy discusses understanding the CAH program and its connection to rural public health and the utilization of hospital discharge survey data to design methodology for quantitatively defining CAH service areas and understanding outflow of patients from rural CAH service areas.

http://apha.confex.com/apha/130am/techprogram/paper_47879.htm

Reif, S. S., & Ricketts, T. C. (1999). The Medicare Critical Access Hospital Program: The first year. *Journal of Rural Health, 15*(1), 61-66.

The authors describe their study, in which structured interviews were conducted in August and September 1998 with key people in state offices of rural health, state hospital associations, departments of health or departments of facility licensing in all 50 states to assess their progress in the development of the CAH program. They also discuss issues related to successful implementation of a CAH program development plan. www.rupri.org/ruralhealth/jrh/reif.pdf

7. CAH Networks and CAH Governance

Gale, J. A. (2001). Lessons from Maine, Minnesota, Texas, and Wisconsin: The continuum of work groups in the Rural Hospital Flexibility Program. *Findings From the Field, 1*(13). Omaha, NE: CAH/Flex National Tracking Project.

Gale discusses how work groups assist in developing state rural health plans and implementing the state Flex Program. He considers different types of work groups—from planning groups through coalitions—and the continuum of responsibilities and activities of each type. <http://www.rupri.org/rhfp-track/results/vol1num13.pdf>

Gale, J. A. (2001). From Wisconsin: The role of the stakeholder coalition model in the Rural Hospital Flexibility Program. *Findings From the Field, 1*(14). Omaha, NE: CAH/Flex National Tracking Project.

Gale describes the role that stakeholder coalitions play in the planning process, policy development, and implementation of the state Flex Program. He reports on Wisconsin's CAH Coalition as an example of how the model can work. <http://www.rupri.org/rhfp-track/results/vol1num14.pdf>

Hagopian, A., & Hart, L. G. (2001). Administration in Critical Access Hospitals. *Findings From the Field, 2*(3). Omaha, NE: CAH/Flex National Tracking Project.

Following a telephone survey of hospital administrators, the authors conclude that rural hospital administrators can do their jobs better and are more likely to stay in their jobs if they get support from the community, the state office of rural health, and each other through a hospital association. <http://www.rupri.org/rhfp-track/results/vol2num3.pdf>

Hagopian, A., & Hart, L. G. (2001). Critical Access Hospitals and community development. *Findings From the Field, 2*(4). Omaha, NE: CAH/Flex National Tracking Project.

The authors report on how CAHs approach community development. They conclude that the Flex Program is directly responsible for some community development activities and has been a catalyst for many others.

<http://www.rupri.org/rhfp-track/results/vol2num4.pdf>

8. Trends in the Rural Hospital Flexibility Program and CAHs

Fruhbeis, M. (2002). A Critical Access Hospital Update, September 2002. *Findings From the Field, 2*(6). Omaha, NE: CAH/Flex National Tracking Project.

Fruhbeis describes characteristics of CAHs as of August 2002. <http://www.rupri.org/rhfp-track/results/vol2num6.pdf>

Fruhbeis, M. (2002). State Flex Programs—Perspectives of the Flex coordinators. *Findings From the Field, 2*(7). Omaha, NE: CAH/Flex National Tracking Project.

Fruhbeis reports the perspectives of Flex Program coordinators about the foci of the Flex Program, excluding CAH conversions. <http://www.rupri.org/rhfp-track/results/vol2num7.pdf>

Greene, J. (2003). SHIPS Come In: Small hospitals get a welcome, if limited, grant to help meet privacy requirements. *Hospitals and Health Networks, 77*(1), 24.

Greene discusses the Small Rural Hospital Improvement Program's funding that rural hospitals can use for quality improvement or for meeting privacy and electronic transaction requirements of HIPAA.

Hagopian, A. (2003). The role of international medical graduates in America's small rural "Critical Access Hospitals." *Findings From the Field, 3*(1). Omaha, NE: CAH/Flex National Tracking Project.

Hagopian reports survey findings about the role of international medical graduates in CAHs.

<http://www.rupri.org/rhfp-track/results/vol3num1.pdf>

Medicare Rural Hospital Flexibility Program Tracking Team. (2002). Reauthorizing the Medicare Rural Hospital Flexibility Grant program: Lessons from the field. *Findings From the Field*, 2(5). Omaha, NE: CAH/Flex National Tracking Project.

Representatives from six rural health research and policy analysis centers (Tracking Team) collaborated to study the implementation and early impact of the Flex Program. In this *Finding*, the Tracking Team summarizes their key findings. <http://www.rupri.org/rhfp-track/results/vol2num5.pdf>

Poley, S. (2001). Participation in the Medicare Rural Hospital Flexibility Program: Documenting trends and changes. *Findings From the Field*, 1(15). Omaha, NE: CAH/Flex National Tracking Project.

Poley reports on what has been learned from the Monitoring Data Set—a catalog of trends and changes in Flex Program activities. <http://www.rupri.org/rhfp-track/results/vol1num15.pdf>

9. Emergency Medical Services

Schoenman, J. (2001). Regionalization of emergency medical services: The experience of Michigan's Upper Peninsula. *Findings From the Field*, 2(2). Omaha, NE: CAH/Flex National Tracking Project.

Schoenman reports on a project in Michigan that used Flex Program funds to support regionalization projects of emergency medical services. <http://www.rupri.org/rhfp-track/results/vol2num2.pdf>

Schoenman, J., Mohr, P., & Mueller, C. (2001). Impact of the Rural Hospital Flexibility Program on rural emergency medical services: Evidence from the first two years. *Findings From the Field*, 2(1). Omaha, NE: CAH/Flex National Tracking Project.

The authors report their findings from a study of changes in rural emergency medical services systems associated with the Flex Program grants and CAH conversions. <http://www.rupri.org/rhfp-track/results/vol2num1.pdf>

10. CAHs and the Rural Hospital Flexibility Program Interface With Quality Improvement/ Patient Safety

Moscovice, I., & Rosenblatt, R. (2000). Quality of care challenges for rural health. *Journal of Rural Health*, 16(2), 168-176.

The authors examine the issue of quality of care in rural America with the intent to help others examine this issue in a way that is consistent with the very real challenges faced by rural communities in ensuring the availability of adequate health services. www.rupri.org/ruralhealth/jrh/moscovice/pdf

Methodology

The entries in this annotated bibliography were obtained by searching various databases for the years 1997 through 2003 using explicit key words.

The following databases were searched: Gateway from NLM-PubMed for journals and health services research projects in progress; First Search, including World Cat, ArticleFirst, and ECO for business, economics and anthropology; CINAHL for nursing and allied health; and ERIC for educational material.

Key terms used in the search:

- Critical Access Hospitals
- CAH designation
- Rural hospitals
- Emergency medical services in rural areas
- Rural hospital networks
- Hospital financing
- Rural health care delivery systems
- Small rural hospitals

Key journals cited:

- American Journal of Health System Pharmacy
- Annual Review of Public Health
- Gerontologist
- Health care Financial Management
- Health Information Management
- Health Management Technology
- Hospital and Health Networks
- Journal of Nursing Administration
- Journal of Rural Health
- Michigan Health and Hospitals
- Modern Healthcare
- Nursing Management
- Profiles Health care Marketing
- Russ Coile's Health Trends
- Rural Development Perspectives
- Texas Journal of Rural Health
- Trustee

Background

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
 2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
 3. Encourages the development of rural-centric health networks.
 4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.
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