

# Evaluation Minnesota Flex Program Grants Review

March 2006

Two hundred ninety-six grants totaling \$3,251,725 were reviewed and included as part of Minnesota's Medicare Rural Hospital Flexibility (Flex) Program 2006 evaluation. The grants were reviewed to determine who has received grant funding and how grant funding has been directed over the past seven years as well as what grant outcomes resulted during the 2004 and 2005 Flex Program grant years. In addition, interviews were conducted with 12 grantees to obtain supplemental information related to grant outcomes and the grants administration process. The Minnesota Department of Health-Office of Rural Health and Primary Care administers the Flex Program in Minnesota and sponsored this evaluation.

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## A. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

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The Medicare Rural Hospital Flexibility Program (Flex Program) was established through the Balanced Budget Act of 1997. It is a national program, including Minnesota and 44 other states. The Flex Program comprises two components—grants to assist states in implementing state specific program activities and an operating program, which provides cost-based Medicare reimbursement to hospitals that convert to CAH status. The federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (DHHS) administers the grant program. The operating component of the program is administered by the Centers for Medicare and Medicaid Services (CMS), also located DHHS.

Six priority areas have been established for states implementing the Flex Program:

- Creating and implementing a state Rural Health Plan
- Supporting facilities as CAHs
- Fostering and developing rural health networks
- Enhancing Emergency Medical Services (EMS)
- Improving the quality of health care
- Evaluating Flex Program activities and related outcomes.

All states participating in the Flex Program are required at a minimum to support activities rural health quality improvement, supporting CAHs, and evaluating their Flex Program.

There are 80<sup>1</sup> Critical Access Hospitals (CAHs) in Minnesota, third highest of all states (the national average is 28 per state).<sup>2</sup> Minnesota's Flex Program has been funded an average of \$695,019 per year by the federal Office of Rural Health Policy to support its program. This is the highest level of funding of all states. Although this report focuses on Minnesota Flex Program activities related to grants made to support Flex Program priority areas, Minnesota's Flex Program has also supported: the staff that provide technical assistance and training sessions to CAHs and other program partners;

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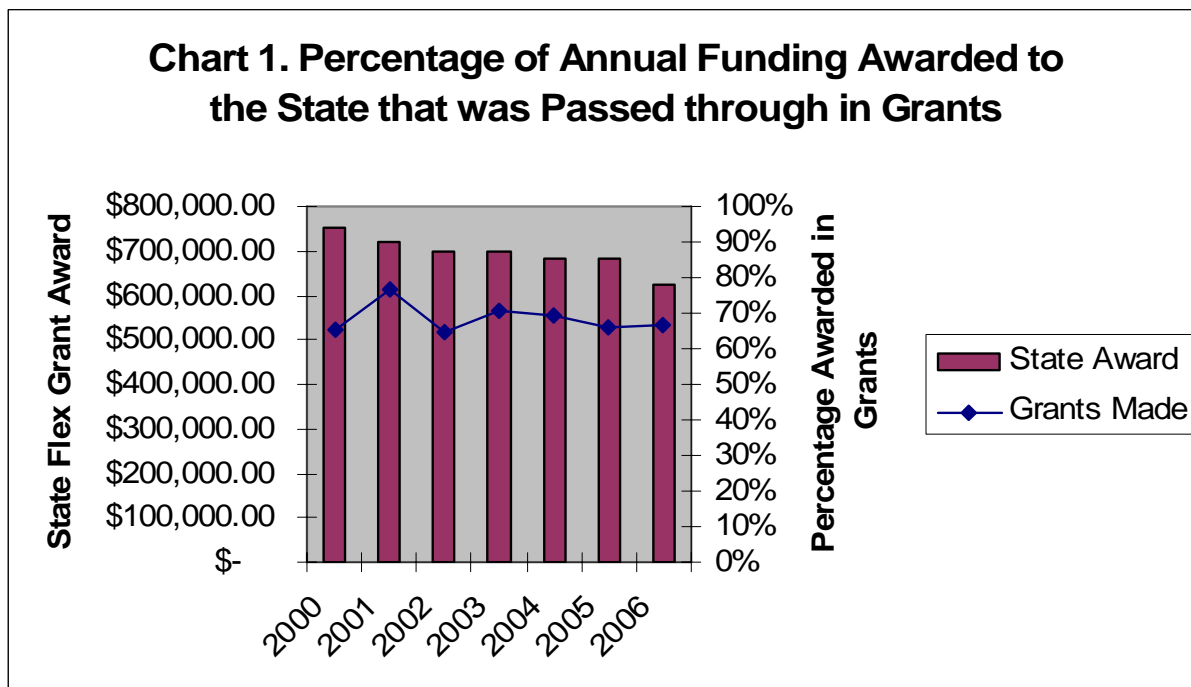
<sup>1</sup> Two CAHs have closed in the state: Zumbrota Health Center, Zumbrota, MN and Minnewaska Hospital District, Starbuck, MN.

<sup>2</sup> Flex Program Monitoring Team, <http://www.flexmonitoring.org> January 31, 2006.

the state Flex Program Advisory Committee; EMS, health workforce, and senior health services planning and research; the development and revision of the state rural health plan; annual Flex Program evaluation activities; and other activities. In addition, each year, the Minnesota Department of Health, Office of Rural Health and Primary Care provides an average of \$1.3 million in state-funded grants to small rural hospitals that directly compliment the goals of the Flex Program.

## B. GRANTS OVERVIEW

Over the past seven years, a total of 301 grants have been funded through the Flex Program totaling \$3,335,721 or 69% of the state’s Flex Program funding.<sup>3</sup> As shown in Chart 1, the percentage of federal funding awarded to the state that has been directed to Flex Program stakeholders through grants, has varied somewhat over the seven program years. Grants have ranged from 77% of funding in 2001 to 65% of funding in 2000.



Minnesota has used a variety of grant programs to advance national Flex Program goals in the state. Grants have been made available as part of *competitive grants*: Planning and Conversion Grants, Flex Grants, EMS Communications Systems Grants, CAH Performance Improvement Grants, and Rural Health Works Grants and *non-competitive grants*: Quality Improvement Collaborative Grants and Project/Partnership Grants. All of the competitive grants included a formal grant application and review process and in 2004, a formal grant reporting process was added to all grants.<sup>4</sup> The average competitive grants application score for grants awarded in 2004 and 2005 was 84.5 on a scale of 1 – 100 while the average score of those applicants that were not funded was 61.8.

<sup>3</sup> This includes five additional grants that were not reviewed as part of the grants review process but are planned for the 2005-2006 grant year.

<sup>4</sup> Competitive grants include a formal grant application process, a grants review by an independent team(s) of grant reviewers who make recommendations on applications to be funded and level of funding, and a final review and decision by the Commissioner of Health.

**Grant Name and Use/Intent:**

**Competitive Grants**

**Planning and Conversion Grants:** Assist small rural hospitals with CAH conversion related activities. Eligible applicants included: rural hospitals with less than 50 acute care beds.

**Flex Grants:** Assist rural health care providers and rural communities to respond in a comprehensive, collaborative, and therefore more effective fashion to the major changes affecting the rural health care system and rural communities. Applicants included: CAHs and other small rural hospitals, local and regional EMS, networks, local public health, and community and regional health collaboratives.

**EMS Communications Systems Grants:** Address the equipment needs and improve the level of communication between CAHs and EMS. Eligible applicants included: CAHs.

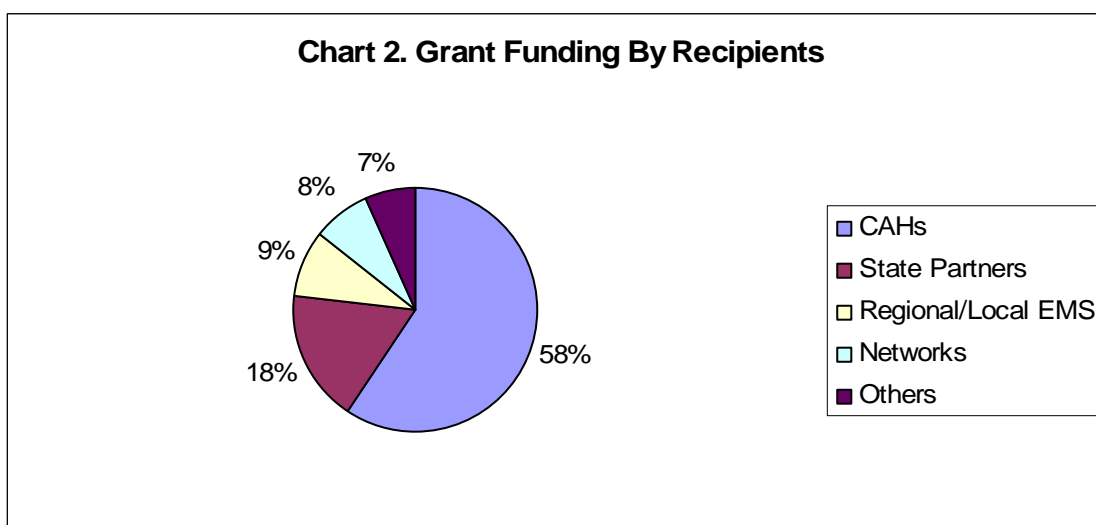
**Performance Improvement Grants:** Support CAHs to understand, plan and implement operational, financial and quality performance improvements. Eligible applicants included: CAHs.

**Non-Competitive Grants**

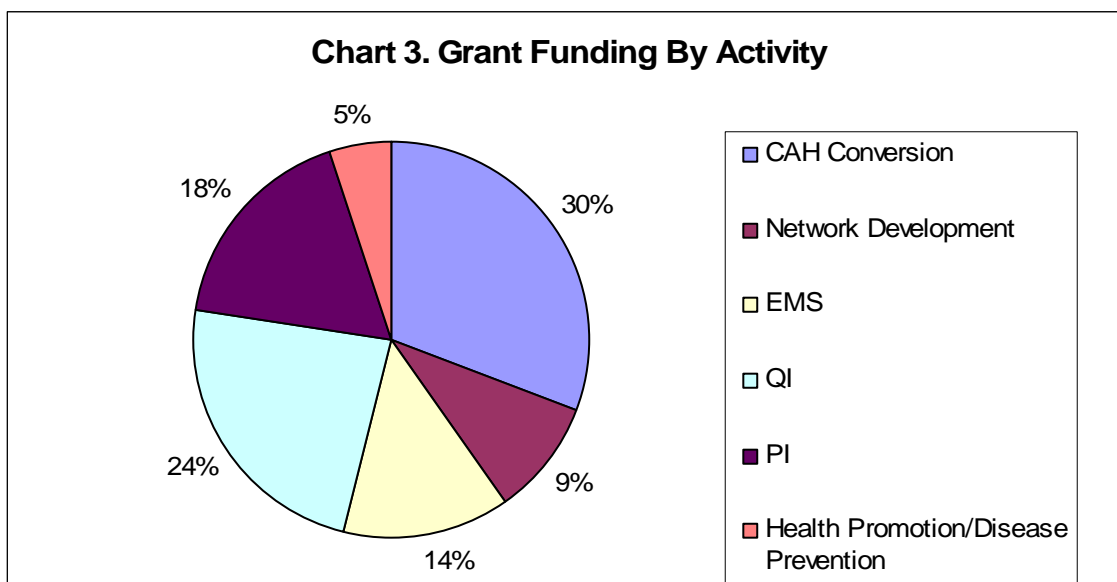
**Quality Improvement Collaborative Grants:** Support CAHs participation in the Quality Improvement Collaborative conducted by Stratis Health, the state Quality Improvement Organization. Eligible applicants included: CAHs.

**Project/Partnership Grants:** Support regional or statewide rural health projects or local pilot projects/initiatives that build rural health capacity to advance Flex Program goals. They also have the potential to address statewide or regional rural health care access issues. Those funded included: Stratis Health (state Quality Improvement Organization), Comprehensive Advanced Life Support (CALs) training program, Minnesota Hospital Association (MHA), University of Minnesota, Critical Illness and Trauma (CIT) Foundation, Rural Health Resource Center, CAHs, Emergency Medical Service Regulatory Board (EMSRB), and others.

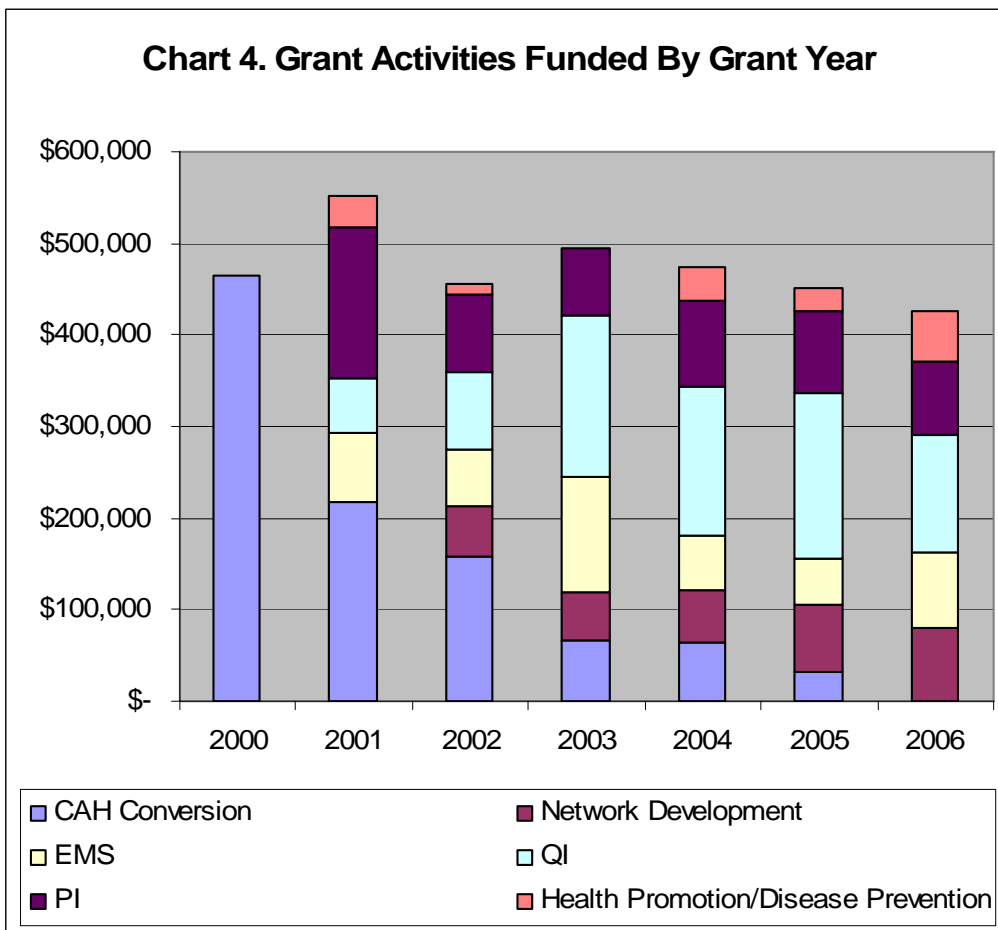
As displayed in Chart 2, the majority of Flex Program grants funding (58%) has been directed to CAHs in the state. Grants to CAHs addressed all Flex Program components and often included other partner organizations. Grants have also been made to state partners (e.g. Minnesota Hospital Association and Emergency Medical Services Regulatory Board) through Project/Partnership grants (18%), regional/local EMS through Flex Program grants and Project/Partnership grants (9%), networks through Flex Program grants (8%), and others (e.g. local public health, regional development commissions) through Flex Program grants (7%).



Grant funding has supported projects that address each of the national Flex Program priority areas including: CAH conversion, CAH support/performance improvement (PI), fostering and supporting network development, enhancing EMS, and quality improvement (QI). Grants have also supported activities related to health promotion and disease prevention, an area that is encouraged as part of the national Flex Program. While all grant projects had goals and objectives directly related to a Flex Program priority area, several addressed more than one priority area. Chart 3 below shows grant funding according to the grants' primary purpose based on Flex Program priority areas.



During the initial years of the Flex Program, grants were primarily directed to small rural hospitals for CAH conversion related activities. As the Flex Program developed, CAH conversion activities were standardized and best practices evolved, costs for some consulting services decreased significantly (e.g. financial feasibility studies conducted by accounting firms), hospitals relied more on operating CAHs for CAH conversion assistance instead of purchasing those services, hospitals knowledge of the Flex Program increased, and more hospitals were operating CAHs and had post-CAH conversion needs. As a result, grant funding was shifted from CAH conversion to other Flex Program priority areas. This shift in grant funding is displayed in Chart 4.



### C. GRANTS TO CAHS

Seventy-eight of the state's 80 CAHs have received \$1,981,708 in funding through the Flex Program. The two hospitals that have not received funding converted to CAH status in December 2005. The average grant funding awarded over the past seven years has been \$24,167 per CAH. Funding per CAH ranged from \$138,800, the highest level of funding to any one CAH to \$5,000, the lowest level of funding. Small rural hospitals that converted to CAH status during the first two Flex Program years averaged \$53,233 per CAH in grant funding while those that converted in years three and four averaged \$22,865 per CAH, and those that converted in years five and six averaged \$15,033 per CAH. Differences in funding can be attributed to increased competition for grant funding as more hospitals converted to CAH status; sharing of tools, resources, and expertise by those that converted to CAH status during the initial program years; and a decrease in consultant fees for standard CAH conversion related services (e.g. financial feasibility studies).

Although CAHs may have received a particular grant, grants to CAHs have addressed all Flex Program components and frequently included other partner organizations, including other CAHs.

Regardless of CAH conversion date, hospitals that applied for more funding have received it: the three top CAH grantees in the state (all receiving over \$125,000 each in grant funding) have applied for a total of 31 grants while the lowest three grantees (all receiving \$5,000 each) have applied for a total of four grants. In addition, four of the five top CAH grantees have a part-time grants writer/coordinator on staff.

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## **D. CAH CONVERSION**

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The Flex Program granted \$1,006,600 (30% of program funding) or an average of \$12,583 per small rural hospital for CAH conversion related activities.<sup>5</sup> Funding was made available through CAH Planning and Conversion Grants to small rural hospitals and Flex Program Partnership Grants to the Minnesota Hospital Association.

All but two hospitals that converted to CAH status received at least one CAH Conversion and Planning Grant. Grant funding ranged from \$31,000 (the greatest funded hospital) to \$3,000 (the least funded hospital). Grant applications revealed that the primary factors that attributed to these differences in funding included: significantly higher rates for accounting services during the initial program years; the lack of policies and procedures, networking, and other templates that had to be developed by hospitals during the initial program years and were then shared amongst hospitals that converted later; and federal program and reimbursement changes that either improved reimbursement for some services or eliminated the need for most hospitals to consider some initial program requirements (e.g. 96 hour limit, 15 bed limit).

CAH Conversion and Planning Grants were most commonly used for conducting financial feasibility studies, staff and community education regarding the CAH model, preparing the application for CAH conversion, updating hospital policies and procedures, developing network agreements, and preparing for survey and licensure. While most hospitals received one grant for all its CAH conversion activities, 37 hospitals received more than one grant. Hospitals that received multiple grants either used a phased approach to conversion that occurred over a period of few years or they conducted financial feasibility studies during the initial program years and decided not to convert until a later date, at which time they needed financial support for the CAH conversion process. Many of these hospitals that decided to convert later, did so because of program regulatory changes that were made as part of the Medicare Modernization Act of 2003, in particular the change that allowed CAHs to have up to 25 inpatient acute care beds. Of the 83 small rural hospitals that received Flex Program funding for CAH conversion related activities, one did not convert to CAH status.

In addition to CAH Conversion and Planning Grants, hospitals also received support from the Minnesota Hospital Association (MHA) through Flex Program Partnership Grants made in 2000 (\$26,667) and 2001 (\$20,000). The Minnesota Hospital Association provided preliminary financial feasibility studies to small rural hospitals, facilitated a small rural hospital planning and program implementation group, and shared national program, best practices, and regulatory information with all state and local Flex Program stakeholders.

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## **E. NETWORK DEVELOPMENT**

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Although none of the state's grant programs were designated purely for network development purposes, most grants had a network development component. Eleven grants were made directly to regional networks in the state totaling \$208,330; however, \$267,110 in grant funding was directed to activities where the primary activities of the grant were network related and an additional \$96,400 where it was the secondary activity of the grant. Therefore, 8% of all grant funding was directed to network development related activities. Table 1 includes a sample of network development grants that were made in 2004 and 2005.

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<sup>5</sup> This includes funding for the 2 CAHs that closed and the one hospital that decided not to convert to CAH status.

**Table 1: Sample Network Development Grants 2004/2005**

Grant/Grantee	Grant Award	Grant Activities	Outcome
Flex Grant/Hendricks Community Hospital	\$10,000	Assess the viability of teleradiology in Lincoln County, identify a hub for end-site users, and provide recommendations for implementing software by hiring a consultant to conduct a needs assessment, analyze information, and create a teleradiology plan.	Determined that a teleradiology network was not in the best interest of the three CAHs. Instead, they changed their focus and created a teleconferencing network that is being used for psychology and dermatology consultations, joint staff educational training, state meetings, and patient care conferences. This has decreased and/or eliminated travel times and costs for staff and patients and improved the collaborative relations between the three CAHs. The hospitals are now discussing plans to merge their EMS into a county-wide EMS system.
Flex Grant/North Valley Health Center	\$15,000	Improve connectivity of 10 health care providers through completion of a telecommunication system.	The network expanded from 10 members to 23 including 10 CAHs in Minnesota and 9 in North Dakota and 4 clinics. The connectivity has either eliminated or decreased travel times for network members, has allowed more hospital and clinic staff to attend meetings, and has allowed for joint educational programming. The grant also laid the foundation for adding teleradiology capacity for network members.
Partnership Grant/Tracy Area Medical Services	\$19,380	Contract with a consulting firm to conduct a feasibility study to determine need, scope of services, and sustainability of a system of transportation services provided by the Shetek member hospitals: Tracy, Westbrook, and Slayton.	A transportation feasibility study was conducted and network members met with regional transportation services and learned about the transportation system in place. They determined that a new transportation system is not needed rather that transportation and health care providers need to better collaborate to use the system already in place. Hospitals are now developing community/patient marketing materials and internal procedures to make local transportation services available to patients when they schedule appointments. This evolved into an on-going project for network members.
Flex Grant/Community Health Information Collaborative (CHIC)	\$10,000	Establish a pilot, web-enabled immunization registry system in 5 nursing homes and evaluate the program's benefits.	Trained nursing home staff on using the immunization registry both for patients and staff immunization records. Participating nursing homes found that using the immunization registry both decreased the number of repeat immunizations on their patients and that tracking employee health immunizations decreased administrative staff time and improved compliance with requirements.

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**F. EMS**

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Addressing issues related to EMS improvement and integration is a priority of the Flex Program. To address this goal, Minnesota’s Flex Program granted \$434,588 in funding for EMS related activities. Grants were either made through the annual Flex Grants, the EMS Communications Systems Grants to CAHs, or Flex Program Project/Partnership Grants to the Emergency Medical Services Regulatory Board (EMSRB) and Greater Northwest EMS, Inc. Sixteen grants were made directly to regional and/or local EMS in the state totaling \$215,558; however, \$434,588 in grant funding was directed to activities where the primary activities of the grant were EMS related and an additional \$146,220 where it was the secondary activity of the grant. Considering primary and secondary activities, 18% of all grant funding was directed to Flex Program activities that had an EMS component. Table 2 includes examples of EMS related grants from 2004 and 2005.

**Table 2: Sample EMS Grants 2004/2005**

Grantee	Grant Award	Grant Activities	Outcome
Flex Grant/Riverwood Healthcare Center	\$15,000	Recruitment and training of EMTs, including hosting training courses at the hospital, training staff on the 12-lead EKG equipment, and providing local CPR training.	49 EMTs and first responders around the county completed refresher courses locally and were retained on staff and 10 first responders were recruited and trained. Relations between the CAH, ambulance services, and fire departments in the County were improved significantly, primarily because of spending time together during training sessions. 60 high school staff are better able to respond to emergency situations that would require CPR or AED use.
Partnership Grant/Greater Northwest EMS	\$25,000	Provide a series of training workshops on recruitment and retention and Grantwriting, around the state; produce single subject video modules from workshops and other EMS management topics; and assist communities with EMS planning.	Training materials were created for use throughout the state, including an on-demand Web-based program. Two training sessions occurred and three additional are planned. 152 EMS and first responder personnel obtained recruitment and retention and grant writing training.

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**G. QUALITY IMPROVEMENT**

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Addressing issues related to rural health care quality improvement (QI) is a requirement of the national Flex Program. Therefore, Minnesota had several grant programs to address this goal, including: Flex Grants, QI grants, QI Collaborative Grants, and Project/Partnership Grants. Fifty-five QI related grants totaling \$383,028 were made directly to CAHs, networks, regional and/or local EMS, local public health, and others in the state where the primary activities of the grant were QI. An additional 31 grants, totaling \$406,612 were made as part of the Partnership Grants to Stratis Health, CALS, and the Minnesota Hospital Association to implement statewide QI initiatives. Adding to this, 20 QI related grants totaling \$322,770 were also made where QI was the secondary activity of the grant. As a result, 34% of all grant funding was directed to Flex Program activities that had a QI component. Table 3 includes examples of QI related grants that were made in 2004 and 2005.

**Table 3: Sample QI Grants 2004/2005**

Grantee	Grant Award	Grant Activities	Outcome
Mahnomen Health Center	\$24,000	Work with Perham Memorial Hospital to purchase and train medical staff with 12-lead EKG equipment to assist with cardiac care.	140 paramedics, ER nurses, and EMTs were trained in EKG interpretation; staff reported an increased comfort level in using the EKG equipment and providing care to patients; EKGs are now sent via modem from the ambulance directly to the ER allowing decreased patient treatment times and support for paramedics in the field. This project is being pilot tested for expansion purposes by Mayo Health System and MeritCare Hospital in hospitals with larger patient volumes.
St. Elizabeth's Medical Center	\$20,000	Develop a comprehensive dementia education and assessment program including information, education, workshops, and additional resources to medical staff, caregivers and the community.	A dementia team was formed and 147 staff completed dementia training modules on The Learning Network; a group of nursing home staff received special training to work as the community's dementia experts and who can be called upon by hospital staff as needed; a five-part series community workshop was hosted one time per month for five months training 30-50 community members per session; a "Brain Aerobics" program was hosted and targeted at those ages 40-60 with 120 community members participating; and dementia information materials were created that can be distributed to patients as needed.
CALS	\$50,000	Make CALS training more accessible to CAH health care providers by subsidizing course costs and encouraging providers to complete the Benchmark Skills Lab portion of the course.	235 CAH health care providers representing 38 CAHs in Minnesota were trained in CALS. Of those trained, 31% participated in the Benchmark Skills Lab portion of the course. Participant course fees were subsidized an average of \$187 per participant.
Avera Marshall Regional Medical Center	\$24,840	Create a clinical nursing specialty project to train RNs to improve and maintain skills in a variety of acute care settings.	All nurses are now trained and working in specialty areas (e.g. ER, ICU); physicians report increased satisfaction with the skills and training of nurses and physicians are now staffing the emergency room 24/7; and patient volume in the emergency ICU has increased.
Riverwood Healthcare Center	\$22,550	Create the Aitkin County Pressure Ulcer Quality Improvement Collaborative Project to create a seamless continuity of care between all agencies for prevention and treatment of ulcers.	A pressure ulcer community collaborative was created that includes the CAH, home care, and two nursing homes; policies, procedures, documentation, patient education, and training materials for staff were standardized across providers; 100% compliance across all agencies in using established policies and procedures was achieved; and 80% of nursing home staff, 30% of providers, 60% of home care staff, 20% of x-ray staff, and 10% of physical therapy and occupational therapy staff were trained and passed competency tests; and training to 18 community members was provided. This is an on-going project.

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## H. PERFORMANCE IMPROVEMENT

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Supporting and sustaining CAHs is another requirement of the Flex Program. To accomplish this, Flex Program grant funding has been used to address issues related to CAH performance improvement as part of the Flex Grants, Project/Partnership Grants, and QI Grants. Thirty-six grants totaling \$563,620 were made directly to CAHs, networks, regional and/or local EMS, local public health, and others in the in the state where the primary activities of the grant were performance improvement. An additional 52 performance improvement related grants were made where performance improvement was the secondary activity of the grant. These grants totaled \$651,288. As

a result, 37% of all grant funding was directed to Flex Program activities that had a performance improvement component. Table 4 reports examples of performance improvement grants and their outcomes that were part of the 2004 and 2005 Flex Program grant years.

**Table 4: Sample Performance Improvement Grants 2004/2005**

Grantee	Grant Award	Grant Activities	Outcome
Flex Grant/Riverwood Healthcare Center	\$3,000	Implement the Balanced Score Card (BSC)	All hospital managers were trained in the BSC; 13 hospital goals or 2-3 per department were established; and during the first five months using the BSC the days in A/R decreased by 14 days and they exceeded the CAH's new patient goal by 92% and the clinic's new patient goal by 53%.
Flex Grant/Tracy Area Medical Services	\$20,000	Recruitment of a urologist to provide services at Tracy Area Medical Services (TAMS)	The hospital was unable to recruit a urologist. Therefore, with assistance from TAMS' network hospital Sioux Valley, Sioux Valley hired and negotiated on behalf of CAHs to hire a retiring urologist to serve part-time in 8 CAHs. This has allowed on-going access to on-site urology services across the region.
Flex Grant/Mahnomen Health Center	\$25,000	Integrate software program that will post lab results into electronic patient record	Established the framework to connect the CAH lab with its network and lab results can now be auto faxed to any provider which has decreased lab times and the number of lab errors.

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## I. SUMMARY

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A Minnesota Flex Program grants review was conducted to determine who has received grant funding and how grant funding has been directed over the past seven years as well as what grant outcomes resulted during the 2004 and 2005 Flex Program grant years. This was accomplished by reviewing grants documentation from the past seven Flex Program years as well as conducting interviews with 12 grantees.

Using this process, the evaluators determined that the Minnesota Flex Program has made 296 grants totaling \$3,251,725 to advance the goals of the national Flex Program in the state. Grants have been made to CAHs and other small rural hospitals, local and regional EMS, networks, and other local, regional, and state partners. In reviewing the documentation of grants made and interviewing grantee staff, the following key findings were identified:

- 1) Sixty-seven percent of Flex Program funding has been directed to local, regional, and state rural health stakeholders in the form of grants to further the goals of the Flex Program.
- 2) Flex Program funding, directed in the form of grants, is aligned with the overall goals of the Flex Program which sets as its highest priorities, converting hospitals to CAH status (30% of grant funding), supporting and sustaining CAHs (37%), and QI (34%).
- 3) All but two CAHs have received Flex Program funding through grants. These hospitals converted to CAH status in December 2005.
- 4) Flex Program funded grants have predominantly been made to CAHs (58%) over the past seven years. Although CAHs may have been the recipient of a particular grant, grants to CAHs have addressed all Flex Program components and frequently included other partner organizations, including other CAHs.
- 5) CAH staff, as a part of the grants review process, reported the following: the grants have been key to their success, grants have allowed them to plan and implement innovative programs, grant guidelines are clear, and the grants administration process is efficient and consistent across all grant programs.

- 6) Some CAH staff reported that they continue to be unaware of the grants that are available and believe they have had few opportunities to learn about projects that have been funded.
- 7) The grants administration process has changed over the past seven years and grantees are now more clearly required to report project outcomes as part of the grants process. This includes submitting both mid-term and final project reports using a structured format. In the early program years, grantee reporting, although required, was less formal and structured. Grants outcomes reporting has increased since the more formal reporting process has been in place.
- 8) For competitive grants awarded, the average grant application score in 2004 and 2005 was 84.5 on a scale of 1 – 100, while the average grant application score of those that were not funded averaged 61.8, indicating a competitive grant process.
- 9) The grants review process only informally considers the grant applicants' past success in meeting project goals, objectives, and outcomes.

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## **J. RECOMMENDATIONS**

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In reviewing the documentation of grants made as part of the Flex Program and interviewing grantee staff, grants administration recommendations were identified. The recommendations pertained to two primary areas: communications and grants administration. The recommendations made by the evaluator are as follows:

### ***Communications -***

- 1) Although grants announcements and reminders are made to CAH administrators, additional communications are needed to assure the grants information is being reviewed by the appropriate staff within each CAH. CAHs that infrequently apply for Flex Program funding should be targeted to assure that they are receiving the grants announcement information. This additional assistance will be particularly helpful for those hospitals that have staff turnover, no dedicated grant writers/coordinators, and/or limited staff to track grants and the grant application process.
- 2) In addition to the program's required written reporting, grants administration staff should consider conducting a verbal check-in with each of the grantees mid-way through the project cycle. This will allow grantees to ask and/or clarify any questions that they have and better assure that projects are on track.
- 3) Although the Minnesota Flex Program has attempted to be responsive and informal in negotiating grant work plan changes with grantees, some grantees are seeking a more structured or formal process to seek work plan revisions. Therefore, the Flex Program should formalize and better communicate its process for grantee work plan changes and assure that the information is included as part of the grants administration process. Having a clear process in place will provide direction to the grantee and allow for documentation/tracking of project changes that are occurring.

### ***Grants Administration-***

- 4) The Flex Program should consider targeting some Flex Program funding to projects that have already proven successful as part of its grants programs. In particular, projects related to health promotion and disease prevention, staff training, and workforce development should be given greater prominence.
- 5) Grants administration staff should formally include grantees' past success in meeting project goals, objectives, and outcomes as part of the grants review process.

For additional information about the Flex Program, contact Pamela Hayes, Flex Program Coordinator, Minnesota Department of Health, Office of Rural Health and Primary Care at (651) 282-6304 or e-mail at [pamela.hayes@health.state.mn.us](mailto:pamela.hayes@health.state.mn.us) and online at [www.health.state.mn.us/divs/chs/grants.htm#flex](http://www.health.state.mn.us/divs/chs/grants.htm#flex).

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