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How Critical Access Hospitals Are Addressing the Social Needs of Rural Populations

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KEY FINDINGS

- Partnerships in rural communities are an essential feature of these social needs initiatives, and were highlighted as critical to address among the barriers, facilitators, and advice for future similar initiatives.
- CAHs identified the three most important components to establish a CAH-based social needs initiative as support of hospital leadership, ample funding, and dedicated staff to engage the community.
- Based on the above findings, increased focus on the Population Health Program Area of the Flex Program could help State Flex Programs work with CAHs interested in creating or maintaining projects related to social needs.

PURPOSE

The purpose of this policy brief is to summarize characteristics of Critical Access Hospital (CAH) initiatives addressing the social needs of individuals in their communities. While previous studies have looked broadly at population health activities in CAHs,[1] few have examined the programs providing social needs services in CAHs. Given that CAHs often operate under resource constraints, a better understanding of the factors that contribute to success and the barriers to developing and sustaining these programs will inform future efforts for CAHs as well as other rural hospitals.

BACKGROUND

Social needs such as access to education, food security, stable housing and employment, and interpersonal violence are estimated to contribute to more than 50% of U.S. health outcomes,[2] and interventions targeting these social needs have been shown to lower health care costs and alleviate inequities.[3,4] Despite the well-documented evidence supporting the influence of social conditions on population health, hospitals in the U.S. have only started to address the immediate social and economic needs of their patients in the past decade. This attention to social needs may have increased in part due to requirements from the Affordable Care Act, which requires all nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years.[5,6] However, only $2.5 billion of the estimated $60 billion hospitals spend annually on community benefit activities is dedicated to social determinants of health and social needs initiatives.[7]

Addressing social needs is especially relevant for hospitals in rural areas where patients are, on average, more

likely to live in poverty,[8] less likely to be employed,[9] and more likely to face greater transportation barriers[10–12] compared to patients in urban areas. These factors can limit access to health-promoting resources such as food, housing, social support, and violence prevention. According to an analysis of 2018 American Hospital Association Annual Survey data,[13] a smaller proportion of CAHs provided social needs services (transportation to health services, employment support services, violence prevention programs, and supportive housing services) compared to non-CAH facilities.

Compared to hospitals in urban areas, rural hospitals may also face greater challenges to investing in social needs services. Financial constraints are the biggest barrier, with recent data suggesting that one in five rural hospitals face a risk of closure due to their financial status.[14] Engagement in short-term initiatives focusing on social needs in rural communities is important for hospitals to prioritize, particularly to align with the mission of rural hospitals.

APPROACH

This policy brief includes primary data collected from CAHs about programs that focus on social needs in their communities. To identify CAH participants for this study, all 45 State Flex Coordinators were contacted for a list of CAHs in their state that were currently operating a program addressing social needs in their communities. The CAHs identified were invited to complete an online survey regarding their social needs programs. CAHs were asked to participate in a follow-up phone interview if the results of their online survey indicated that their program was focused on social needs, had a formal organizational structure, and was currently in operation at the time of the survey. Results of the survey were summarized and evaluated for commonalities. Qualitative data from the phone interviews were coded by two members of the research team using inductive content analysis to identify key themes.

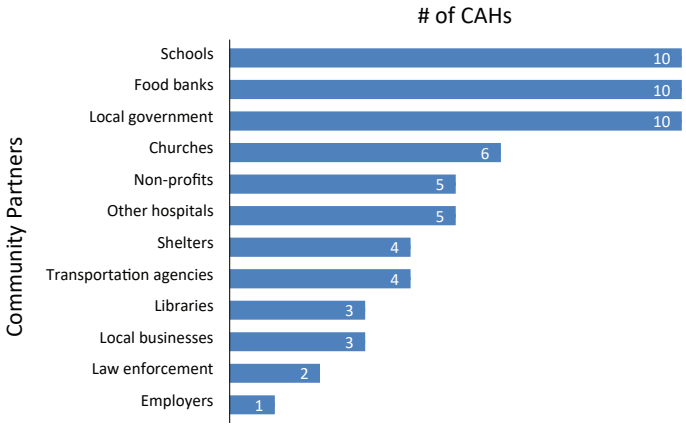
RESULTS

CAH Programs Addressing Social Needs

Twenty-one State Flex Coordinators responded to the request for information and identified 112 CAHs with programs addressing social needs. The online survey was completed by 28 of 112 CAHs (25%) in 14 states. Of the 28 survey responses, 15 CAHs (in Illinois, Kansas, Maine, Massachusetts, Michigan, Minnesota [6], Montana, Vermont, and Washington [2]) met the inclusion criteria to be interviewed.

CAHs identified the specific needs addressed in their programs, and many selected more than one. Of these programs, food insecurity was the most common social need addressed (nine CAHs), followed by health literacy (five CAHs), education (four CAHs), and transportation (four CAHs). Figure 1 displays the partners CAHs engaged with in their projects, indicating that the majority of programs worked with schools, food banks, and local governments. Respondents could select multiple answers for questions related to which partners they engaged with and which social needs their programs addressed.

FIGURE 1: Community Partners for Social Needs Programs (n=15 CAHs)



Source: Key informant interviews with Critical Access Hospital staff

For these CAHs, program start years ranged from 2009 to 2019, with a median start year of 2018. The median number of CAH staff involved in the social need programs was five staff members, while the median number of individuals outside of the hospital involved was nearly 23. The programs had a variety of target populations, including individuals with disabilities, opioid addiction, and chronic conditions (e.g., diabetes), as well as marginalized populations, students, senior citizens, uninsured individuals, as well as all residents of the hospital's service area.

Integral Components of Social Needs Programs

Fourteen of the 15 CAHs participated in the interviews and are referenced below by region: Midwest (Illinois, Kansas, Michigan, Minnesota [6]); Northeast (Maine, Massachusetts, Vermont); and West (Montana, Washington [one of the two CAHs opted out of participation]). The initiatives led by these CAHs were mainly concentrated into two categories: 1) those addressing overall wellness in their communities including issues related to overall health, physical fitness, mental health, healthy eating, and behavioral health (six CAHs), and 2) those addressing food access for their communities (six CAHs).

During phone interviews, CAH staff were asked about the impetus and funding for their program, as well as barriers and facilitators to making their program successful. Most often, CAH staff pointed to an "employee vision" as the motivating factor for originating these initiatives (six CAHs). One staff member at a Midwest CAH noted, "I wanted to make sure that the community was looking at us as kind of a resource for them to stay healthy, rather than just come to us when they're sick." Another Midwest respondent pointed to leadership as a facilitator for success, describing the new hospital CEO as someone who "really has wellness as a strategic priority and allowed us to refocus some of our programming and efforts on community wellness."

Respondents cited strong hospital leadership support and strong partnerships (both with eight CAHs) most often as the facilitators essential to the success of programs. One staff member at a Midwest CAH responded, "I am so blessed to have the executive administration that I have and the board that understands health happens outside our clinical walls."

Strong partnerships were also critical to achieving goals in communities. One Midwest respondent noted that "there was a strong understanding that we couldn't do this work alone…those collaborative arrangements were going to be vital for us to be impacting and even having the ability to procure and operate within this space." Community support, forged both internally with hospital leadership and externally with partners, was the most important component of success throughout the CAH projects.

The most common barrier cited by respondents was developing and maintaining partnerships in their communities (eight CAHs). One Midwest CAH mentioned that "there's (sic) always challenges working in partnerships and collaboration," while another from the West mentioned that "the rest of our community partners don't have the capacity to get in [the community]," highlighting the need for collaboration to accomplish these projects.

Two other significant barriers for CAHs were maintaining funding and engaging participants (five CAHs for each). All of the CAH respondents noted that their hospital (and/or hospital systems or foundations) provided funding, but many also depended on private grants (eight CAHs) or donations (six CAHs). Two of the CAHs reported that they received Flex Program funding for their initiatives.

In addition to facilitators and barriers for establishing these programs, CAH respondents offered advice for other CAHs looking to do similar work in their communities. The most common advice was to ensure ample staffing of programs (seven CAHs). At one Midwest CAH, staff members learned that having "a dedicated staff person is extremely helpful, and if you can't, having someone who at least has that responsibility of pulling a group together to create a workplan of 'what could we accomplish in the community.'" An-

other Midwest respondent mentioned that it was important to "look at your entire organizational resources and how they can help support the initiatives" in order to strengthen projects despite limited resources.

Again, the importance of engaging community partners was stressed by respondents (five CAHs). One Western respondent believed that it was essential to "find a strong partner in the community…hospitals can't do everything and especially these small hospitals are limited in their bandwidth." This recurrent theme, seen through facilitators, barriers, and advice for CAHs, highlights that community partners are critical to the success of these types of projects.

Overall, the CAH respondents emphasized ideas similar to a statement by a Western CAH staff member that "it's been a sigh of relief in this community that the hospital is taking this on in an evidence-based way and a comprehensive way," and that "if it's a priority in your community, then you've got to step up." CAHs taking on a leadership role to improve social needs in their communities was a recurring theme in the interviews.

DISCUSSION

The work being done in rural areas to address the social needs of their residents is critically important. Despite the work that has started to emerge in some CAHs across the country, there is a general lack of availability of social needs programs and a demand for more work in rural communities to address these needs.

Within their communities, hospitals are often seen as anchor institutions, drivers of the economy, and as leaders in supporting local populations in many other ways.[15] Rural hospitals are well-suited to provide leadership on local initiatives due to their location in small, close-knit communities, and are often keenly aware of the needs of their population through Community Health Needs Assessments, or through informal observation of needs in their patient population. However, identifying population needs and having the capacity to respond to those needs do not always align. Historically, nearly all of the funds CAHs have spent on community benefit activities have focused on direct patient care activities instead of community-focused activities.[16] While Medicare and some state Medicaid programs have started to reimburse for limited extra-clinical care in specific instances,[17,18] the lack of consistent reimbursement for initiatives addressing social needs makes these programs more challenging to initiate and fund.

Through this research, components were identified that are essential for CAHs to successfully establish programs that address social needs in rural communities. First, leadership support from hospital CEOs, board members, etc., who make organization-wide policy and financial decisions was critical for creating and sustaining programs run by the hospital.

Second, funding is an essential component to any effective community initiative. Funding for these types of programs can range from small in-kind donations or the allocation of employee time to substantial investments of hundreds of thousands of dollars each year. Additional money through state and federal initiatives or reimbursement would create opportunities for small hospitals, like CAHs, to increase the work they do to improve health outside of their walls. While current private grant funding exists,[19] it may not always be accessible for smaller hospitals to obtain (due to challenges applying for resources), or sustainable for long-term projects.

Finally, dedicated staff to engage and maintain relationships with community partners are crucial to addressing social needs. This may be difficult, particularly in small CAHs where staff members often already take on multiple roles, but creating the formalized opportunity for CAH staff to engage with the local population to create lasting partnerships can serve communities and CAHs better in the long term.

In the interest of creating and implementing social needs projects in CAHs, there should be an increased focus on the Population Health Improvement Program Area of the Flex Program. State Flex Programs

should assess the needs of CAHs in their state and aim to provide additional support and encouragement for addressing social needs initiatives to improve population health in their communities. While Population Health is an optional focus within the Flex Program, State Flex Programs can work with CAHs interested in creating or maintaining projects related to social needs to see if they are able to include initiatives like this in future work plans. Additional detail about two exemplary CAH social needs initiatives can be found in our previously published case series, Rural Initiatives Addressing Community Social Needs.

LIMITATIONS

The CAHs included in this survey were selected based on recommendations from State Flex Program Coordinators. Of those recommended, only a subset responded to the initial survey. These CAHs are not meant to be representative of all CAHs, but instead they provide examples of best practices from several CAHs and information on how they are working to improve social needs in their communities.

CONCLUSIONS

It is essential to address the social needs of individuals in rural communities to improve overall population health. These responsibilities will often be shared between hospitals and other community institutions and organizations throughout a single community. The efforts of CAHs to address social needs have highlighted key components for CAHs to establish relevant initiatives in their rural areas. CAHs and rural hospitals can evaluate their capacity and capitalize on partnerships within their community and state to improve their ability to address critical social needs in their communities.

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