

Flex Monitoring Team Briefing Paper No. 14

**EXPLORING THE COMMUNITY
IMPACT
OF CRITICAL ACCESS HOSPITALS**

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The Flex Monitoring Team is a consortium of the Rural Health Research Centers located at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. Under contract with the federal Office of Rural Health Policy (PHS Grant No. U27RH01080), the Flex Monitoring Team is cooperatively conducting a performance monitoring project for the Medicare Rural Hospital Flexibility Program (Flex Program). The monitoring project is assessing the impact of the Flex Program on rural hospitals and communities and the role of states in achieving overall program objectives, including improving access to and the quality of health care services; improving the financial performance of Critical Access Hospitals; and engaging rural communities in health care system development.

This report was prepared by John Gale and Andrew Coburn of the Maine Rural Health Research Center at the University of Southern Maine; Walt Gregg of the University of Minnesota Rural Health Research Center; and Rebecca Slifkin and Victoria Freeman of the University of North Carolina Rural Health Research and Policy Analysis Center. Michelle Casey and Ira Moscovice of the University of Minnesota Rural Health Research Center provided input into the development of the interview protocols, selection of the site visit communities, and reviewed drafts of the paper.

Questions regarding the report should be addressed to: John Gale 207-228-8246
jgale@usm.maine.edu.

Flex Monitoring Team
<http://www.flexmonitoring.org>

University of Minnesota
Division of Health Services Research & Policy
420 Delaware Street, SE, Mayo Mail Code 729
Minneapolis, MN 55455-0392
612.624.8618

University of North Carolina at Chapel Hill
Cecil B. Sheps Center for Health Services Research
725 Martin Luther King Jr. Boulevard, CB #7590
Chapel Hill, NC 27599-7590
919.966.5541

University of Southern Maine
Muskie School of Public Service
PO Box 9300
Portland, ME 04104-9300
207.780.4435

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The Medicare Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program (Flex Program), created by Congress in 1997, allows small hospitals to be licensed as Critical Access Hospitals (CAHs) and offers grants to States to help implement initiatives to strengthen the rural health care infrastructure. To participate in the Flex Grant Program, States are required to develop a rural health care plan that provides for the creation of one or more rural health networks; promotes regionalization of rural health services in the State; and improves the quality of and access to hospital and other health services for rural residents of the State. Consistent with their rural health care plans, states may designate eligible rural hospitals as CAHs.

CAHs must be located in a rural area or an area treated as rural; be more than 35 miles (or 15 miles in areas with mountainous terrain or only secondary roads available) from another hospital or be certified before January 1, 2006 by the State as being a necessary provider of health care services. CAHs are required to make available 24-hour emergency care services that a State determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e., for the reasonable costs of providing inpatient, outpatient and swing bed services).

The legislative authority for the Flex Program and cost-based reimbursement for CAHs are described in the Social Security Act, Title XVIII, Sections 1814 and 1820, available at http://www.ssa.gov/OP_Home/ssact/title18/1800.htm

EXECUTIVE SUMMARY

The Medicare Rural Hospital Flexibility (Flex) Program contains explicit expectations and financial incentives at the federal and state levels to encourage Critical Access Hospitals (CAHs) to engage with their communities, develop collaborative delivery systems in their communities with CAHs as the hub of those systems of care, and undertake collaborative efforts to address unmet community health and health system needs. Given these expectations and incentives, there is growing interest in understanding the community impact and benefits of the activities of CAHs. This interest is fueled in part by the growing adoption of either voluntary or mandatory state community benefits reporting laws that require hospitals to document the benefits they provide to the community.

The Flex Monitoring Team undertook this project in order to understand the community involvement and impact of CAHs and the Flex Program and to support our efforts to develop financial, quality, and community impact performance measures for CAHs. To guide our efforts, we developed a framework identifying the ways in which CAHs monitor the health and health system needs of their communities and engage with other community organizations and stakeholders to address those needs. The core components of this framework include: 1) Identifying Unmet Community Needs; 2) Addressing Unmet Community Needs; 3) Prevention and Health Improvement; 4) Building a Continuum of Care; and 5) Building Community Health System Capacity.

Using this framework, we drew on the experiences of six hospitals and communities to illustrate the roles that CAHs play in each dimension. There are both broad and specific conclusions to be drawn from a comparative, cross-site analysis of the six sites. Most broadly, these six hospitals and communities illustrate that CAHs are engaged in a wide range of formal initiatives and activities to identify and respond to community health and health system needs. Some of these initiatives are targeted and limited, as in the case of health screening programs; others represent more complex and sustained interventions that address critical gaps in the community's service and health system capacity.

More specifically, the six hospitals are engaged in formal and informal efforts to engage with their communities to systematically identify community health and health system needs. These examples illustrate the importance of broad-based collaborative efforts between the hospital, other community agencies and organizations, and citizens. The complexity of these undertakings often requires a strong commitment of leadership and resources by the hospital and outside technical assistance. These efforts are best viewed as a continuous process of monitoring community needs, not one time activities.

These case studies reveal that hospitals' efforts to meet community needs fall into two broad categories. The first is a *service growth/expansion strategy* which involves the development and/or expansion of services that are self-sustaining and contribute to the long term viability of the hospital. The second involves the *development of services that meet specific unmet community needs* or are *subsidized* by the hospital. Maintaining core services that support the hospital is critical to being able to develop and offer services in the second category, which are often sustained through local tax subsidies, grant funding, or other revenue streams.

The case studies reveal important examples of efforts by CAHs to fill service gaps which contribute to building a stronger continuum of care in the hospital and among other service providers in the community. They also point out the need for sensitivity on the part of hospitals as to how their role appears to other participants in the community and to developing collaborative linkages and relationships with other community agencies and providers. Finally, they highlight the importance of “telling the story” of these initiatives and their contribution to the community’s health system, both locally and nationally.

The Flex Program has had an effect on the community activities of CAHs in two ways. The first is through the provision of Medicare cost-based reimbursement, which has improved the core finances of most CAHs. According to most respondents, the stabilization of hospital finances has enabled them to redirect internal resources to address community health care needs. Consistent with the intent of the Flex Program, efforts to assess the impact of cost-based reimbursement should employ a framework that is broad enough to encompass the impact of CAHs in identifying and addressing community needs and strengthening the rural health system.

The second is through the Flex Grant Program. The role and impact of state Flex grant programs appears to have been more indirect than direct. Some state Flex Programs have created expectations about the role of CAHs in supporting the community health infrastructure and have provided grant funds to support CAHs’ efforts to engage with their communities through community needs assessments and/or other activities. Moving forward, Flex funds could be used to develop tools, resources, and technical assistance for CAHs to undertake community needs assessments, support the development of community collaboratives, and support the community infrastructure in primary care, EMS, and other areas addressing community needs.

Finally, we found comparatively little public reporting of the community-related initiatives and activities undertaken in the six sites we visited. To address policymakers’ questions about the impact of the Flex Program, it will be important to measure CAHs’ efforts to expand access to essential health services and build local health system capacity. With funding from the Federal Office of Rural Health Policy (ORHP), the Flex Monitoring Team is developing a process to provide this information by identifying CAH appropriate indicators of community impact and available sources of secondary and primary data, including its survey of CAHs, to measure them. ORHP could further support this effort by using the indicators developed by the Flex Monitoring Team as the basis for a standard “community impact” reporting tool for states and Critical Access Hospitals in much the same way that the Centers for Medicare and Medicaid Services has developed a standard reporting tool for quality measurement and by encouraging all states and CAHs to collect and report community impact data using this tool.

PART I: Community Involvement and the Impact of Critical Access Hospitals

Introduction

The Medicare Rural Hospital Flexibility (Flex) Program was established to sustain access to essential, quality health care services for rural Americans. The program aims to strengthen the rural healthcare infrastructure through the development of State Rural Health Plans, the conversion of hospitals to Critical Access Hospital (CAH) status with cost-plus reimbursement under Medicare, collaborative quality improvement initiatives, integration of emergency medical services (EMS) with CAH-based delivery systems, and the formation of rural health networks. Participating states are encouraged to apply for funding under the Medicare Rural Hospital Flexibility Grant program to implement these and other strategies to fulfill national program goals.

Grant awards are made on an annual basis under the auspices of the federal Office of Rural Health Policy (ORHP). According to the ORHP Medicare Rural Hospital Flexibility Strategic Planning Outline (2003), the purpose of the program is to “help sustain the rural healthcare infrastructure by strengthening CAHs and eligible facilities and helping them operate as the hub of a collaborative delivery system in those communities where they exist. By applying the components of Flex [State Rural Health Plan (SRHP), CAHs, networks, Quality Improvement and EMS integration initiatives], the Program can foster the growth of rural collaborative healthcare systems across the continuum of care at the community level with appropriate external relationships for referral and support” (Office of Rural Health Policy, 2003). Applicants are assessed along a number of performance and outcome domains including their potential for improving access to care, safety and quality of care, economic performance and viability of rural hospitals and rural healthcare delivery systems, community engagement in health systems improvement, and community health status. The orientation and responsiveness of CAHs to their communities and regions are explicit expectations of the Flex program because of their importance in realizing core program goals.

The Flex Program establishes requirements for small rural hospitals converting to CAH status to respond to identified local healthcare and related needs. For many small rural hospitals, the exigencies of financial survival have limited their community focus to traditional inpatient and outpatient missions. With conversion to CAH status and the financial support of cost-based reimbursement and the Flex Grant Program, however, CAHs have access to new resources and expertise with which to undertake initiatives that improve the economic and financial viability of the hospitals and enable them to work on strengthening the healthcare delivery system in the communities they serve.

In addition to the expectations established by Federal Office of Rural Health Policy, state Flex Program policies and regulations have an impact on the community impact and benefit activities of CAHs. According to a 2001 Flex Program Tracking Team survey of State Office of Rural Health staff, almost half of the thirty State Offices of Rural Health responding to the survey required CAHs to engage in community development activities as a condition of participation in

the Flex Program or CAH conversion (Hagopian, 2001). Eighty three percent of participating states were using a portion of their Flex Program grant funds to “conduct, facilitate, or promote community development and engagement activities”. Two-thirds required hospitals undergoing conversion to conduct a community needs assessment as part of the conversion process. Frequently, these needs assessments were funded with Flex grant dollars.

The adoption of either voluntary or mandatory state community benefits reporting laws requiring hospitals to quantify and document the benefits they provide to the community has also contributed to interest in understanding the community impact and benefit activities of CAHs. (Coalition for Nonprofit Health Care, 1999 & Community Catalyst, Inc, 2003).¹ Finally, the growing attention paid to the tax benefits provided to non-profit organizations by local, state, and federal policymakers has fueled this interest.²

Under a five year cooperative agreement with the Federal Office of Rural Health Policy, the Flex Monitoring Team has undertaken a performance monitoring initiative to assess the impact of the Flex Program on rural hospitals and communities and the role of states in achieving overall program objectives, including: 1) improving access to and the quality of health care services; 2) improving the financial performance of Critical Access Hospitals; and 3) engaging rural communities in health care system development. As part of this effort, the Monitoring Team is developing a national set of performance indicators measuring the community benefits and impact of Critical Access Hospitals and accompanying data collection strategies. This will be done with input and guidance from an expert panel of hospital industry representatives, CAH administrators, state officials involved with the community benefit reporting/compliance programs, and Flex Program Coordinators/State Office of Rural Health representatives.

The process of developing these measures involves the development of a conceptual framework to guide our efforts, community level-site visits to validate our framework, a thorough review and analysis of existing community impact and benefits measurement tools in use by hospitals and hospital systems and the states, the identification of secondary and primary data needed to

¹ As of July 2006, 17 states have adopted such legislation (Coalition for Nonprofit Health Care, 1999; Community Catalyst, Inc, 2003; Illinois Hospital Association, 2005; Access Washington, 1994; & State of Vermont, 2006). In addition, state hospital associations in Iowa, Michigan, Missouri, Nebraska, Oregon, Tennessee, and Wisconsin have developed voluntary hospital community benefits reporting programs as has the Attorney General’s Office in Massachusetts (Iowa Hospital Association, 2006; Massachusetts Attorney General’s Office, 2006; Michigan Health and Hospital Association, 2006; Nebraska Hospital Association, 2005; Hospital Alliance of Tennessee, 2004; & Wisconsin Hospital Association, 2006). National organizations such as the Voluntary Hospital Association, the Catholic Hospital Association of the United States, and the Public Health Institute have initiatives underway to develop specific standards and measures for community benefits monitoring and reporting (Catholic Health Association of the United States, et al, 2004; Catholic Health Association of the United States, 2006, & Public Health Institute, 2004).

² Federal lawmakers have also become interested in the tax-exempt status of hospitals. In May, 2006, Senator Grassley of Iowa sent a letter to ten of the nation’s largest hospitals and hospital systems requesting information about their charitable activities, patient billing, and ventures with for-profit companies and hospitals (U.S. Senate Committee on Finance, 2005, May 25). In response to investigations by the Senate Finance Committee and the House Ways and Means Committee, the Internal Revenue Service sent a “Compliance Check Questionnaire” to 600 tax-exempt hospitals across the country in 2006 to obtain information on uncompensated care policies, community care programs, compensation practices, and board organization. (Snowbeck, 2006 & Wisconsin Hospital Association, 2006).

create the indicators, the identification and testing of a proposed set of core measures, and the development of a national community benefits and impact reporting system based on these measures. This paper reports on the Flex Monitoring Team's qualitative study of the impact of CAHs at the local community level.

This report is based on a series of site visits conducted during the summer and fall of 2005. The site visits targeted six diverse rural communities and CAHs to assess the experiences and impact of these hospitals in responding to their community's health infrastructure needs. The semi-structured interview protocols were designed to allow the research team to gain an "on the ground" understanding of the roles that CAHs play in their communities and their impact on the local and regional rural health system. At each site, team members interviewed 20 or more respondents including: hospital staff and board members; community providers (including primary care, specialty care, long term care, and EMS providers); staff from community agencies and public health agencies; business and municipal leaders; and representatives from other organizations with which the hospitals collaborate.

A Framework for Assessing Community Impact

The goal of this phase of the overall initiative is to develop and test a conceptual framework to explore the extent to which CAHs are responding to the needs of their communities and the impact of their efforts. During the second phase of this initiative, we will use this framework to identify, develop, and implement a set of community impact indicators and measures for CAHs.

The importance of small rural hospitals to their communities cannot be underestimated. Small rural hospitals are often the first or second largest employers in their communities and are critical elements in the infrastructures of small rural communities (AHA Board of Trustees, 1999; Berry and Seavey, 1994). These hospitals are viewed by many as an important source of charity care as well as emergency, public health, and other services that are not necessarily self-supporting (Berry & Seavey, 1994, Proenca, 1998). Driven by the importance of local hospitals to their communities and the tax benefits provided to non-profit hospitals, the 1990s saw an increasing interest in understanding the extent to which hospitals are accountable to their communities, patients, and to society in general for the services they provide and the benefits they receive (Gamm, 1996, AHA Board of Trustees, 1999). This call for accountability has been a driving force in the growing adoption of community benefit reporting standards (Coalition for Nonprofit Health Care, 1999 & Community Catalyst, Inc, 2003) and patient safety and quality improvement and reporting systems such as the Center for Medicare and Medicaid Services Hospital Compare program (Institute of Medicine, 2001; Institute of Medicine, 2000; Casey and Moscovice, 2006).

Addressing community health and other social needs is one of four dimensions of accountability for non-profit hospitals and health systems described by Gamm (1996). The other dimensions include political accountability related to the retention of tax-exempt status; commercial accountability in terms of the hospital's role in selling low cost and high value health care; and patient/clinical accountability in terms of improving access and quality outcomes. These dimensions of accountability are consistent with the Flex Monitoring Team's work on

performance measurement of the financial performance, community impact and quality activities of CAHs.

The expectation that hospitals serve as the hubs of collaborative systems of care and address the needs of their communities in a collaborative, coordinated fashion has its roots in 1932 report *Medical Care for the American People*, developed by the Committee on the Costs of Medical Care (CCMC) (Committee on the Costs of Medical Care, 1932, Time, 1932, California and Western Medicine, 1932, Ross, 2002). The report recommended that health services should be provided by organized, preferably hospital-related, groups of professionals; that hospitals should function as comprehensive community medical centers, networked within regions; that public health services be greatly expanded and defined to include the community-focused activities of both governmental and nongovernmental agencies; and that health services should be coordinated at the community and state levels (Sigmond, 1995). Although interest in the CCMC's community-focused reform proposals were supplanted during the 1980s by a focus on competition and other marketplace incentives, various elements of their recommendations, particularly those focusing on community involvement, public health, and identification of community need, have found their way into many initiatives, including the Flex Program.

In developing our framework, we sought to move beyond the reporting of the simple dollar benefits provided by hospitals to their communities, as is the case with many community benefit reporting systems. We focused instead on measuring the broader impact of hospital activities on communities to recognize that the accountability implied by a performance measurement system is more than simple charity and requires a specific connection between activities and outcomes (Beckham, 1997). While identifying hospital spending on health promotion activities is important, it is also important to know how these activities match patients to needed care or serve to expand access to services. At the same time, our performance measurement framework will provide a vehicle through which CAHs can communicate their "accountabilities" to key stakeholders and community members.

In formulating our framework, we considered the principles underlying community health initiatives such as Community Care Networks, Healthy Community Coalitions, the Turning Point program, the Community Health Models of Michigan and the Community Voices project (Health Research and Educational Trust, 2000; Conrad, et al, 2003; Bazzoli, et al, 1997; Shortell, et al, 2002; Barnett & Williams-Torres, 2001; VHA Health Foundation and the Health Research and Educational Trust, 2000; Wolff, 2003; Baxter, 2001; Turning Point, 2007; W.K. Kellogg, 2001; Meyer, Silow-Carroll, & Waldman, 2004; Community Voices, 2007; Adams, 1995). These initiatives share a number of common elements and are grounded in a focus on community health.

Central to each initiative is a focus on engaging a broad range of stakeholders in a collaborative partnership to identify and address community level health care needs. Each initiative is built on a collaborative model that called for the engagement of key community health and social service providers, community leaders, consumers, and other appropriate stakeholders in a formal, ongoing process to identify and prioritize community needs, develop and implement community-level interventions based on the identified needs and priorities, and to track the implementation and success of these initiatives.

The importance of local networking strategies in relation to the Flex Program and CAHs was first discussed by members of the Rural Hospital Flexibility Tracking Team as an important element in the efforts of CAHs to connect with their communities (Gale, 2001). Based on a survey of CAHs conducted in the winter of 2000, the majority of CAH networking initiatives focused on interactions between the CAHs and their affiliate hospitals with relatively little formal networking taking place between CAHs and local providers. When local networking did occur, it generally focused on public health or social support activities and on efforts to identify the health care needs of the community (39% of CAHs). While 83% of State Flex Programs used some Flex grant funds to support hospitals in conducting, facilitating, or promoting community development and engagement activities, only half required these activities as a condition of participation in the Flex Program or CAH conversion (Hagopian, 2001).

Another key element identified by these community health initiatives was the need to engage these collaborative partnerships in an assessment process to identify and prioritize community needs. In the Flex Monitoring Team's 2004 survey, 81% of responding CAHs reported that they had conducted a community needs assessment with 34% of these needs assessments conducted in the year prior to conversion, 15% during the year of conversion, and 32% post-conversion (Poley and Slifkin, 2005). However, the extent to which these needs assessments focus on the health status of the whole community in general rather than hospital patients is not clear.

These initiatives also emphasized the importance of developing targeted interventions to meet specific community needs. Participants in these initiatives were encouraged to move beyond the traditional medical model (e.g., inpatient, outpatient, and ambulatory services) to include activities related to public health, health improvement and primary prevention, and chronic care/disease management (MacStravic, 2006; Bilton and Barnett, 2006; Public Health Institute, 2004; Bilton, 2005). MacStravic (2006), in particular, argues that rural hospitals may actually enjoy an advantage over urban hospitals in their ability to undertake proactive health management activities as they may be the only providers in their markets large enough to employ the mix of health personnel necessary to deliver these services efficiently and effectively.³ Evidence from the Flex Monitoring and Flex Tracking Teams suggests that CAHs have been moving in this direction (Pole & Slifkin, 2005; Gale, 2002). Based on surveys of CAHs conducted in 2001/2002 and 2004, a substantial number of CAHs provide a range of safety net services (such as free clinics, charity and discounted care, and free and reduced-cost medications) as well as a growing range of public health and outreach activities including chronic care management (39%), immunizations (37%), wellness programs (18%), WIC programs (18%), safety training (18%), smoking cessation (18%), school based programs (16%), fitness and diet services (10%) and family planning (3%).

These community-based initiatives recognize that no one organization may address the full health needs of their communities alone, particularly in the current environment of scarce resources. In order to manage within available resources, collaboratives were encouraged to streamline their local delivery systems by coordinating service delivery across providers and to ensure patients receive timely care in the most appropriate setting. To do so, collaboratives reduced duplication

³ Proactive health management activities include interventions related to: 1) health, wellness, and fitness promotion; 2) risk behavior management; 3) risk condition management; and 4) disease management.

of services, expanded access to care, simplified the referral process, and reduced unnecessary competition. In the Flex Tracking Team's 2000 survey of CAHs, 39% of responding hospitals indicated that they networked with local providers to address community health needs. In the Flex Monitoring Team's 2004 survey of CAHs, nearly two-thirds of CAHs reported having a formal or informal relationship with local provider organizations.

Finally, participants in community-based initiatives were encouraged to focus on community building and enhancing community capacity (Barnett and Williams-Torres, 2001; Kretzmann, 2002; Sigmond, 1998). Local efforts, particularly those from the Community Care Network Demonstration, often used the tools of "asset-based community development" as promoted by McKnight and Kretzmann at Northwestern University (Barnett and Williams-Torres, 2001). These tools encouraged collaboratives to identify and use the unique and diverse combinations of strengths and resources inherent in their local communities as building blocks to address local needs (Kretzmann, 2002). As part of this process, hospitals and partners are encouraged to engage community members and other providers as partners; identify existing assets and services that serve as entry points for efforts to address health related problems; make strategic investments in existing community assets to increase their effectiveness, efficiency, and sustainability; emphasize community rather than individual problem solving; and make long term investments in community quality of life (Barnett and Williams, 2001).

In developing our framework, we identified key elements from these community-oriented initiatives. These included the development of: collaborative partnerships involving a broad range of local providers, community leaders, and consumers of services; formal processes to identify unmet community needs; interventions to address community needs; prevention and health improvement activities to supplement traditional hospital services and to focus on community health improvement; systems to build a seamless continuum of care; and activities to enhance community health system capacity. Although we recognize that there is overlap between each element of our framework, we felt that each was important enough to merit individual discussion and consideration. We also did not identify the development of collaborative partnerships as an individual element as this activity underlies each of the five elements of our framework.

Defining Community Roles and Impact of Hospitals

The goal of our site visits was to understand the community involvement and impact of CAHs and the Flex Program as the initial step in our plan to develop measures and indicators to capture the community impact of these facilities. To guide our efforts, we developed a framework for hospital community involvement and impact based on our previous work, the literature, and input from members of the Flex Monitoring Team's National Advisory Committee. The purpose of this framework is to identify and categorize the ways in which CAHs monitor the health and health system needs of their communities and engage with other community organizations and stakeholders to address those needs. This information will support our subsequent work to develop and test appropriate measures and indicators. The core components of the framework are the following:

- **Identifying Unmet Community Needs:** Hospital involvement in the identification of community needs through a process of information gathering and action planning around community or population health needs.
- **Addressing Unmet Community Needs:** Hospital involvement/leadership in the development of services identified as (1) needed by the community and (2) critical to the hospital, including specialty services, preventive care, chronic care/disease management, and/or community health improvement services and programs.
- **Prevention and Health Improvement:** Hospital leadership and the investment of resources to strengthen prevention and health improvement activities in the community, including health promotion, disease prevention, and health protection.
- **Building a Continuum of Care:** Hospital leadership in the development of a “seamless continuum of care” through service and organizational linkages with local clinical and community health organizations, including EMS, physicians, primary care practices such as Rural Health Clinics and Federally Qualified Health Centers, public health agencies, home health, and nursing facilities.
- **Building Community Health System Capacity:** Hospital involvement and leadership in development of community partnerships to address community health needs and develop a community level or regional service mix that avoids unnecessary duplication/redundancy and best meets the needs of the community and its vulnerable populations.

Using this framework, we draw on the experiences of six hospitals and communities to illustrate the roles that CAHs play in each of the five dimensions of the framework. The hospitals were chosen because they have all been engaged in significant community and health system development initiatives. They were identified using a variety of information sources. First, we used the findings of a national 2004 telephone survey of 488 CAH administrators to identify hospitals that were actively involved in assessing community needs, had undertaken significant service expansions, and/or were involved in community or regional partnerships designed to expand access or improve services. This analysis yielded 18 hospitals in 16 states. We then spoke with representatives of the State Offices of Rural Health in these states to learn more about what each of these hospitals was actually doing in order to understand the state and regional context within which these hospitals were operating. Next, we spoke with the administrator in each hospital to gain first hand information to inform our selection process and to ascertain his/her interest in participating in this project. Members of the project team reached consensus on a final list of six hospitals using all the information collected to compare the hospitals along a number of organizational, financial, and operational characteristics. The final six locations were selected because they gave us geographic diversity and allowed us to visit hospitals and communities that were involved in different types of initiatives and that faced different financial or community circumstances. Hospitals visited included Kearny County Hospital, in Lakin, Kansas; Littleton Regional Hospital, in Littleton, New Hampshire; Nor-Lea General Hospital, in Lovington, New Mexico; Regional Medical Center, in Manchester, Iowa; Teton Medical Center, in Choteau, Montana; and Weiser Memorial Hospital, in Weiser, Idaho.

We wish to caution the reader that this phase of our project is not meant to be a comprehensive study representative of the community impact activities of all CAHs, but, rather, a qualitative

study of six hospitals designed to validate and refine our framework. The information obtained and the resulting refinements to our framework will support our efforts to develop appropriate community impact indicators and measures in the subsequent phase of this project.

Profiles of Study Hospitals

Kearny County Hospital (KCH): KCH is a non-profit, county-owned, 25-bed CAH located in Lakin, Kansas, approximately 35 miles west of Garden City, Kansas. KCH participated in the earlier Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) demonstration as an RPCH.

Lakin (population 2,316) is the largest town in Kearny County (population 4,156) which is located in western Kansas near the Colorado border. The county has a growing Hispanic population (27.2% of the county population), many of whom have settled in the town of Deerfield, located halfway between Lakin and Garden City. The county's racial composition is predominantly white (97%). The county's economy has traditionally been predominately agricultural, though this is changing as Lakin is increasingly becoming a bedroom community for Garden City.

KCH is the county's largest employer, employing 170 people. The hospital was built in the 1950s as part of the Lutheran Association of Hospitals and was taken over by the county in 1975. Due to the old facility's extensive building code problems, the county undertook a 1976 bond issue for a new building which was completed in 1978. In response to a need for nursing home beds, the County completed construction of a new nursing home in 1983. The hospital and the nursing home operate under one administrative structure and governing board.

The High Plains Retirement Community is located on the hospital campus. High Plains includes the nursing home, a home health agency, and independent living apartments. The hospital is in the process of adding assisted living apartments to its continuum of long-term care services. The local, independently-owned pharmacy is also located in the hospital.

KCH has an informal affiliation for support services with St. Catherine's Hospital in Garden City, a Mercy Health System hospital. Other nearby hospitals include Hamilton County Hospital (a CAH) in Syracuse, 30 miles to the west; Bob Wilson Memorial Hospital in Ulysses, 30 miles to the south; and Wichita County Hospital (a CAH) in Leoti, 42 miles to the north. Western Plains Regional Hospital in Dodge City, located 80 miles southeast of Lakin, is the nearest medical center and is the referral hospital of choice for many of the physicians in Lakin. Wichita is also a large referral destination for complex patients from the area.

KCH offers inpatient and outpatient care, including obstetrical, limited surgical, and physical therapy services. The hospital's medical staff includes three family practice physicians who are salaried employees of the hospital. An additional physician, an otolaryngologist (ear, nose and throat doctor) who grew up in the area, has recently located her practice in Lakin. KCH has a PA-staffed clinic in Deerfield that serves mostly low income and indigent Hispanic patients. The

county's Emergency Medical Services are located adjacent to the hospital but are separately administered.

Littleton Regional Hospital (LRH): LRH is a non-profit, 25-bed CAH located in Littleton, New Hampshire. Its primary service area includes the town of Littleton (population 5,845) and numerous, small surrounding towns. Its secondary service area extends north to the Canadian border; south to Haverill, NH; west to Danville/Lyndon Center, VT; and east to Gorham/Berlin, NH. Located in Grafton County, Littleton is the business, shopping, and cultural hub of the region. It is also a four season recreational destination. LRH, given its mix of services and specialties, serves as the area's regional referral center.

Littleton has minimal racial and ethnic diversity with a population that is 96.5% white and less than 1.5% Hispanic. Within Littleton, 11.4% of the population and 8.6% of families live below the poverty line. LRH is a major area employer, with over 400 full and part time employees and an annual payroll of \$23 million. Littleton received a Great American Main Street Award in 2003 from the National Trust for Historic Preservation for the revitalization of its downtown area.

Opened in 1907, LRH has undergone numerous renovations and expansions. Due to growing maintenance and renovation costs for the aging landlocked building, hospital trustees undertook the construction of a new hospital and adjoining medical office building, which opened in January 2001. The hospital converted to CAH status in 2001 and is managed by Quorum Health Resources. LRH estimated that it provided \$3 million in community benefits last year (as calculated under New Hampshire's mandatory community benefit reporting regulations). It also estimated that it will provide \$2 million in charity care this year. It further participates in the "Littleton Cares" indigent care program.

Compared with other CAHs, LRH offers an extensive array of services and medical specialties, including ambulatory and inpatient surgery, OB/GYN services, cardiac rehabilitation, emergency services, lab, radiology, hospice care, intensive care, occupational health, oncology, palliative care, pharmacy services, rehabilitation, and respiratory therapy. The active and associate medical staff consists of 42 physicians with the following specialties: anesthesiology, cardiology, emergency medicine, family practice, gastroenterology, general surgery, internal medicine, neurology, obstetrics/gynecology, occupational health, oncology, ophthalmology, orthopedics, otolaryngology, pathology, pediatrics, physiatry, radiology, and urology. Nine nurse practitioners and physician assistants work with the medical staff. LRH operates the on-site Veteran's Clinic, a community-based outpatient clinic, under a contract with the White River Junction Veterans Administration Hospital.

Within its extended service area are four CAHs located in Berlin, Colebrook, Lancaster, and Woodsville. Dartmouth-Hitchcock Medical Center in Hanover is a major referral center for patients from Littleton. Additional local health services in Littleton include Littleton Orthopaedics, Ammonoosuc Community Health Center (an FQHC), a private practice gastroenterologist, North Country Otolaryngology, Summit Medical Group, and White Mountain Mental Health and Development Services (a community mental health agency).

LRH participates in the North Country Health Consortium, a not-for-profit consortium of providers serving northern New Hampshire and whose members include two federally qualified health centers, two home health and hospice agencies, five CAHs, a family planning agency, four mental health agencies, and a Community Action Program. The Consortium sponsors a wide array of projects addressing community needs, including a mobile dental van, transportation services, substance abuse services, elderly and disability services, and public health services.

Nor-Lea General Hospital (NLGH): NLGH is a non-profit 25-bed CAH located in Lovington, New Mexico, in Lea County in southeast New Mexico. The hospital serves the northern part of the county including the towns of Lovington (population 9,471), which is the county seat, Tatum (population 683), and Hobbs (population 28,657), located 20 miles to the south. Located near the Texas border, NLGH is managed by Covenant Health Systems, which is headquartered 100 miles away in Lubbock, TX.

In 2000, the population of Lea County was 67.1% white and 39.6% Hispanic. Just over 21% of its population had incomes below the federal poverty level. Major industries in the area include oil and gas, ranching and dairy. The economy of the county has improved in recent years after a period of decline. The hospital is the second largest employer in Lovington with 213 employees.

NLGH is one of two hospitals in the county. The hospital was previously owned by the county and was closed in 1974. Local support for the hospital was very strong and town residents raised funds and successfully lobbied the state for the creation of a health care district. Nor-Lea Hospital District was created in 1980 and the hospital reopened. The Hospital District has since been supported, in part, by a tax levy that has been approved by taxpayers in each subsequent election. The hospital became a CAH in August 2002.

Using revenue bonds and cash reserves, Nor-Lea Hospital District secured the resources to construct and equip a new inpatient facility that opened in 2005. The new facility includes a six-bed emergency department suite, two operating rooms with a six-bed recovery area, a 25-bed inpatient care wing, a six-room imaging suite and a new registration area and lobby. Technology upgrades in the new facility include a Point of Care electronic charting system, a PACS imaging system, and a spiral CT scanner.

NLGH provides a wide range of inpatient and outpatient services. The hospital operates an on-site Rural Health Clinic (RHC) and two additional RHCs in Tatum and Hobbs. Outpatient care is provided by five physicians, one physician's assistant and four nurse practitioners. The hospital's outpatient surgery service has expanded in recent years and includes a general surgeon, two gastrointestinal surgeons, two ob-gyn surgeons, and a urologist. Specialty services are offered at NLGH through 16 specialty clinics. The hospital recently opened an outpatient chemotherapy clinic and has a cardiopulmonary rehabilitation program under development. The hospital also provides home health services and has recently opened a mental health program for the elderly.

NLGH works collaboratively with other private and public agencies to improve health and health care for county residents. Along with Lea County Health Department, it administers the Lea County Diabetes Program, providing clinical services and education for program participants. Community outreach activities include monthly informational luncheons for senior citizens at the

hospital and an annual health fair held at the hospital during National Hospital Week. Through a 14-year partnership with the Lea County Electric Cooperative, the hospital provides similar health promotion activities annually for the employees of the Coop and their spouses. Service expansion has been a major focus of NLGH in recent years based on community need assessed by means of both formal and informal processes.

Regional Medical Center (RMC): RMC is a 25-bed, non-profit, county-owned facility located in Manchester, Iowa (population 5,247), which is the county seat of Delaware County (population 18,400). RMC began operation in August 1950 as the Delaware County Memorial Hospital.

Since the 1960s, Manchester's tax base has shifted from agriculture to the professional, manufacturing, and service sectors. The transition has been driven by local public/private collaborations that have maintained the area's livestock industry, encouraged rural tourism, fostered micro enterprise development, revitalized downtown Manchester, and facilitated expansion of the local manufacturing sector. The proportion of Delaware County families at or below the federal poverty level stands at 8%.

Since its opening, RMC has undergone a variety of improvements including the addition of a new acute care wing in 1957 and construction of a replacement building in 1977. The original hospital building was used to house non-acute care services. By the early 1990s, the hospital had dramatically expanded outpatient services, assumed responsibility for the county's public health services, and developed behavioral health services. RMC's growing satellite clinic network has expanded access to primary care and preventive services in neighboring counties.

RMC's service area has grown to cover all of Delaware County and parts of Clayton, Buchanan, and Fayette Counties, and encompasses a population of more than 60,000 persons. In recognition of its growing role in the region's healthcare system, the hospital changed its name to the Regional Medical Center of Northeast Iowa and Delaware County in 1999. Three years later, RMC was designated as a CAH.

RMC is managed by St. Luke's Hospital in Cedar Rapids under an ongoing management contract. St. Luke's also serves as its support hospital and network affiliate. Post conversion, RMC has expanded its outpatient psychiatric services, home health services, rural health clinics, and specialty clinics. As of June 2005, the hospital employed 239 people.

Access to secondary and tertiary care is available 45 miles to the east in Dubuque (two hospitals with 263 beds and 158 beds), and 49 miles to the west in Waterloo (three hospitals with 200 beds, 366 beds, and 100 beds). St. Luke's (560 beds) and Mercy Medical Center (372 beds) are located 43 miles to the south in Cedar Rapids. Many of the clinical specialists practicing in RMC's outpatient clinics come from these facilities. Three other CAHs are located within 20 to 30 miles of Manchester.

Medical services in Manchester are provided by Manchester Family Medical Associates and Strawberry Point Medical Center as well as two independent physicians. In addition to its Manchester facility, Manchester Family Medical operates clinics in Manchester, Colesburg, and

Edgewood. Strawberry Point Medical operates clinics in Manchester and Strawberry Point. Also located in Manchester are a 120-bed nursing home, several dentists, health promotion and wellness programs, and a branch of a substance abuse service center based in Dubuque.

In addition to acute inpatient and swing bed services, RMC offers outpatient services including behavioral health, ambulatory surgery, rehabilitation, and massage therapy. It also offers health promotion, wellness, and community and industry outreach services. The hospital operates Delaware County Community Health and Hospice of Comfort which delivers home health, inpatient and outpatient hospice, and public health services. It owns two ambulances and a non-emergent transport service for its behavioral health clients. RMC operates a fitness center and provides on-site dialysis services through a contract with Tri-State Dialysis from Dubuque.

Teton Medical Center (TMC): TMC is a non-profit, county-owned 10-bed CAH and 36-bed extended care facility in Choteau, Montana (population 1,781). Choteau is located 20 miles east of the Rocky Mountains and is the county seat for Teton County (population 6,371). Since opening in the 1930s, TMC has undergone many changes to stay viable and meet local needs. TMC converted to a four-bed Medical Assistance Facility in 1995 and transitioned to a ten-bed CAH in 1999. Over time, the hospital has reduced its inpatient acute care capacity and expanded its ambulatory care and long-term care services. TMC is leased to Benefis Healthcare, an affiliate of the Deaconess System in Billings, Montana. TMC's network affiliate is Benefis Healthcare in Great Falls.

Choteau is a four season recreation destination for a large number of visitors who participate in such activities as skiing, hiking, climbing, fishing, hunting, and trail riding. Recreation and tourism contribute heavily to the local economy and complement the grain and livestock industries that form the traditional backbone of the economy. Choteau is a growing retirement destination for individuals attracted to its natural beauty and access to recreational activities.

Other local services include a chiropractic clinic, two dental clinics, an optometrist, the Teton Nursing Home, Skyline Lodge senior housing, Beehive assisted living, two medical clinics, and several home care options. Benefis Healthcare in Great Falls is the closest tertiary care hospital (52 miles from Choteau). Physician services are provided by the Moore Medical Clinic and the Great Falls Clinic. Moore Medical is associated with the Pondera Medical Center; a CAH located 30 miles to the northeast in Conrad, and is staffed primarily by a nurse practitioner. In addition, a surgeon and a family practice physician from Pondera provide coverage at the clinic. The Great Falls Clinic, a Rural Health Clinic staffed by a physician and three physician assistants, is part of a multi-specialty group practice based in Great Falls and draws on the resources of the group to offer family medicine, pediatrics, perinatal care, gynecology, ENT, psychology, internal medicine, minor surgery, orthopedics, emergency medicine, and geriatric services.

Since 2001, TMC has implemented a number of service and operational improvements. Service improvements have included a major updating of laboratory capacity, bone densitometry services through a monthly mobile service, a twice monthly foot clinic, and the implementation of on-site pharmacy services (through its collaboration with a local home health agency) on a two hours per day, four days per week basis. Two recent areas of service expansion involve the provision of

wellness/spa services and the development of services for Choteau's growing elderly population. Operationally, TMC has reduced days in accounts receivable, increased operating revenue, and increased staffing in just four years.

TMC's major networking relationships include Benefis Healthcare and the Northcentral Montana Healthcare Alliance, a 33-hospital regional healthcare network. Both relationships have contributed to TMC's expanded scope of services. TMC's service mix includes inpatient, outpatient, swing bed, long term care/extended living (with six Alzheimer beds), home health, and preventive care services. It offers a full service laboratory, a radiology department linked through tele-radiology to specialists across the region, a complete range of rehabilitative services, and mobile mammography and bone densitometry.

Working closely with the area High School and the Teton Community Development Coop, the hospital has expanded its developing rehabilitation and community wellness capacity beyond a small space on the hospital campus to a large facility located on the High School campus. Co-locating the facility on school property permitted it to be used not only for physical rehabilitation and public wellness activities but for school sports training as well. The development of aging services has been a goal of the current Chief Executive Officer (CEO) and has involved working with the Teton Nursing Home, Teton County Commissioners, and various area-aging facilities.

Weiser Memorial Hospital (WMH): Weiser Memorial Hospital is a non-profit 25-bed CAH located in Weiser, Idaho, 73 miles northwest of Boise. The hospital serves its immediate community (population 8,365) as well as other residents of Washington County (population 10,090), the neighboring county of Adams, and other surrounding communities. Weiser is the county seat for Washington County.

Washington is one of the poorest counties in the state. Primarily an agricultural and ranching area, the most prevalent crops are onions and sugar beets. In addition to family farms and ranches, major employers include food processing plants, Champion Homes, and the school system. The population is 85% white. Hispanic residents make up 16.2% of the population (2000 Census). Economically, 12.5% reported incomes below the federal poverty level. Although a quiet town, the population swells every June during the National Old Time Fiddlers' Contest, which brings thousands of visitors to Weiser for a week.

In addition to WMH, local health providers in the Weiser area include three primary care practices (Two River Medical Clinic, an RHC; the Family Medical Center, a private family practice; and the Physicians Primary Care Center, a clinic staffed by physician assistants). Specialty care is provided by the Medical Specialty Clinic, located in the hospital, which is staffed on a rotating schedule by specialists from Boise and Nampa, Idaho and Ontario, Oregon. Services offered include podiatry, cardiology, surgery, asthma and allergy care, urology, OB/GYN, hearing & balance services, and diabetic counseling. Skilled nursing services are available from a private facility near the hospital. Pharmacy services are provided at a local grocery store and an independent pharmacy. On weekends, the nearest open pharmacy is thirteen miles away, so the hospital dispenses short packs of medications to get patients through until the pharmacies open. Two dentists provide services in Weiser. Mental health services are limited with only one local counselor practicing in the area at the local counseling service.

Opened in 1950, WMH is owned and operated by Weiser Valley Memorial Hospital Taxing District, a county taxing district. It is the only hospital in the county. Taxes for WMH are collected through a municipal assessment on property. The total collected on behalf of the hospital represents a small percentage of its budget. Although WMH has gone through difficult financial times in the past, the hospital's financial situation has been improving since its conversion to CAH status in 2000. Admissions are on the rise, and the hospital's image in the community has improved substantially.

Although WMH is not part of a hospital system, it participates in several rural health networks. WMH is one of eight rural hospitals participating in Rural Connections, a rural health network that focuses on the development of consistent standards of care across the participating hospitals for conditions such as myocardial infarction and pneumonia. By doing so, it hopes to ensure that a patient in one of the participating facilities receives the same standard of care as they would in a tertiary care center. WMH is also the lead agency on an Agency for Healthcare Research and Quality funded health information technology project and participates in a group purchasing organization.

Services offered at WMH include inpatient and outpatient acute care, ambulatory and inpatient general surgery (including OB/GYN), emergency care, lab, radiology (CT scan, ultrasound and mobile MRI), obstetrics, respiratory therapy, home health, and swing beds. Specialty care is provided by the Medical Specialty Clinic located in the hospital as described above.

PART II: CAHs and Responding to Community Needs: A Profile of Six Communities

Introduction

Each of the six hospitals in this study is involved in different initiatives that illustrate the roles that CAHs are playing in their communities and regions. In our site visits, we met with hospital and community leaders to learn from their varying perspectives about the impact of the CAH in the community. Our interviews with hospital and community leaders were guided by semi-structured interview protocols that allowed us to collect the breadth and depth of information we needed and to discover the diversity of views that the multiple stakeholders might have concerning the role and impact of the hospital.⁴

The site visits and interviews yielded a rich source of information on key hospital initiatives, their origins, and their impact over time. In the narrative that follows, we have synthesized the experiences and impact of these six hospitals and communities with regard to each of the five key dimensions of the framework. In order to keep our report to a reasonable length, for each dimension only a few hospitals are highlighted as examples of activities that are occurring. We observed many more interesting and important community-focused activities than could be reported here. The fact that a given CAH is not mentioned under a dimension does not necessarily mean that the CAH is not involved in those types of activities.

Identifying Unmet Community Needs

Hospitals are routinely involved in conducting community needs assessments. The strategies and methods of community needs analysis typically involve engaging residents in providing their assessment of the health and healthcare needs of the community and/or assessment of the hospital's and other health care providers' plans to address these needs. These assessments may be undertaken to meet legal or regulatory requirements (as part of a Certificate of Need application process or to meet state community benefit reporting requirements), as part of CAH conversion, to fulfill state grant funding requirements, or to inform strategic planning.

Hospital-led community needs assessments are a strategy for gaining community input on new services or initiatives that the hospital seeks to pursue. They are also used more generally as part of a hospital's outreach and marketing strategy with the community. Hospitals that have taken on public health or community health functions may use community needs assessments to identify community health improvement needs or to evaluate the impact of their community health programs. Distinguishing among the many reasons that motivate hospitals to undertake community needs assessments is a challenge. While these initiatives are undoubtedly undertaken with an eye toward "selling" the hospital to the community, hospital boards and leaders also

⁴ A sample copy of the interview protocol for the hospital chief executive officer/administrator is included as Appendix B. We developed and used similar protocols for each of the types of interviewees we met with (e.g. Board members, clinical quality managers).

understand the value of obtaining an honest and objective view of concerns about the community's health and the hospital. Moreover, it has become increasingly important for hospitals to not only document community needs, but also demonstrate how they are addressing those needs. This is especially true in states that have expanded their community benefit reporting requirements (Ginn and Moseley, 2006, Coalition for Nonprofit Health Care, 1999, & Community Catalyst, Inc, 2003).

As mentioned earlier, almost two-thirds of the state Medicare Rural Hospital Flexibility Programs (29 out of 45 participating states) require that hospitals choosing to convert to CAH status conduct an assessment of community needs and submit the results with their CAH application to the Flex Program Coordinator in their states. Often these hospitals received federal grant funding from the Flex Program to undertake these assessments. Although this is generally a one-time requirement, and for many CAHs occurred a number of years ago, many hospitals continue to conduct periodic community needs assessments. Our 2004 Survey of CAHs indicated that 34% had conducted a community needs assessment in the year prior to conversion, 15% had conducted one during the year of conversion, and 32% had conducted a community needs assessment post conversion (Poley and Slifkin, 2005).

All of the CAHs we visited had completed community needs assessments as part of or coincidental to their conversion process. Several have continued to do assessments as part of their on-going hospital planning and community outreach strategy. We have chosen to feature four examples. The first describes a formal community needs assessment process that the Regional Medical Center has recently undertaken with substantial community participation. The second example, from Nor-Lea General Hospital, illustrates a continuous approach to community needs analysis. The third example, from Littleton Regional Hospital, describes a collaborative, ongoing process conducted on behalf of three key community providers. The final example, from Weiser Memorial Hospital, describes the role of staff in identifying community needs.

The types of needs assessments conducted, the information used as part of the process, and the variety of stakeholders involved in the process varied from hospital to hospital. As described below, some hospitals adopted a more informal process that relied on the involvement of hospital staff in the community to identify local needs. Others used a more formal process using both secondary and primary data in the process and involving a range of stakeholders including local residents, providers, community leaders, and hospital employees. These examples are not intended to be an exhaustive description of every aspect of the needs assessments conducted by these hospitals but, rather, an attempt to provide an overview of the general the process they used to identify community needs.

Conducting Community Needs Assessments: Regional Medical Center (RMC)

RMC has a long history of using community assessment efforts to identify and respond to local community needs. RMC conducted its most recent needs assessment in 2004 to remain eligible for state public health funding and as part of its responsibilities as the public health agency for Delaware County. Hospital leadership also used this opportunity to take a hard look at the

broader needs of the communities and populations served by the hospital and to develop a long-term strategy for addressing those needs.

In compliance with Iowa's public health funding criteria, RMC organized its community needs assessment effort around the core features of the State Health Department's *Iowa Healthy People 2010* criteria. Planning began in the spring of 2004 with the formation of 10 community-wide subcommittees to address each of the 10 core areas (e.g., births, chronic disease, and safety). Each subcommittee had six to nine members representing local schools, health care providers and organizations, community and county health and human services organizations, local business leaders, other community leaders, and community and county residents. RMC limited the involvement of hospital staff during this stage of the process, which maximized community input and allowed for the introduction of new and innovative interpretations of local needs and priorities.

Each subcommittee reviewed local and regional assets and needs and generated a report that prioritized three to five community health needs and identified barriers preventing local collaborations from addressing those needs. RMC's leadership took another departure from standard community needs assessment efforts by actively encouraging the subcommittees to look beyond RMC to identify potential partners from public health, education, social services, and long-term care to work with the hospital in addressing identified needs.

The preliminary reports were reviewed by a second group of stakeholders, including representatives from RMC, which was charged with validating the findings in each report. Four priority areas emerged from this process: mental health/psychiatry, substance abuse, prenatal care, and chronic disease.

RMC staff, including its Director of Community Health, provided guidance and support to help this second group develop detailed action plans with immediate and longer-term action items, specific responsibilities for key staff from RMC and community partners, and timelines for accomplishing strategic goals. For example, the action plan for prenatal care involved convening a community roundtable of obstetrical providers and staff, personnel from the local Special Supplemental Nutrition Program for Women, Infants, and Children, and immunization program staff to complete a detailed assessment of current services and programs and develop a strategy for improving prenatal services in the county. A community "interagency committee" was formed to keep track of existing assets and monitor challenges requiring the attention of the hospital and its community partners.

The 2004 community needs assessment generated a number of important outcomes, not the least of which was an increase in trust and collaboration among community organizations and local citizens. Although the leadership of RMC recognized that it had the potential to assume responsibility for the county's healthcare needs, it also recognized that such an approach would not be in the best interests of the community at-large. Instead, RMC used its leadership and resources to guide the assessment process in a way that encouraged the involvement of local providers and organizations. Fostering a greater degree of community collaboration and partnerships has made it possible, according to participants, to more effectively focus efforts and resources to enhance the service capacity of the local delivery system.

RMC's experience suggests that conducting a comprehensive community needs assessments can be challenging. To organize and support a community and/or countywide process takes leadership skills, time, funding, and a bit of risk taking on the part of a hospital to encourage collaboration among local stakeholders (e.g., relinquishing assessment and planning autonomy to foster ownership and responsibility). Engaging citizens in the assessment process is also a challenge, as many community residents and leaders find it difficult to attend meetings due to work, family, and community commitments. RMC overcame this problem by scheduling meetings over lunch (provided by the hospital) instead of in the evening when many are committed to other activities.

When asked if they would have undertaken the community needs assessment without the state requirement to do so, RMC representatives stated emphatically that they would. They felt that the process and its results have been valuable for the hospital's strategic planning and management and has produced important community-level initiatives and changes that justify the investment.

Continuous Community Assessment Models: Nor-Lea General Hospital (NLGH)

Not all community needs assessments are formal community-wide data gathering and analysis exercises. NLGH is community oriented in both formal and informal ways, and identified community needs at both a global and an individual level. Immediately prior to conversion, NLGH conducted focus groups to gauge the need for services, but not to aid in the conversion decision. Focus groups were held with women, Hispanic community members, seniors, government officials, and small business owners. The hospital's service expansion in the intervening period has been largely a result of needs identified through the focus groups. NLGH is systematically working through the list of needs identified by the focus group participants. The hospital plans to do another community needs assessment during their 2006 Health Fair. Community needs are also identified by staff at NLGH who have responsibility for outreach to the community, including a full-time Community Services Advocate.

NLGH also stays connected to the community in an informal way by the involvement of their CEO and other hospital staff in the community. The hospital CEO is president of the Chamber of Commerce and Vice President of the Economic Development Council. He is a deacon at his church and an active Sunday school teacher. He also serves on the County Indigent Care Review Board. His numerous community service activities allow him to stay in touch with the needs of the community.

Hospital leadership is receptive to input from others through informal processes. The hospital chaplains identified a need for mental health services for the elderly, and a program was implemented to meet those needs. Outreach to the community is not limited to health care. There had been no new housing construction in Lovington in 20 years and the housing shortage limited the hospital's ability to recruit employees. The hospital CEO brought together potential contractors, buyers, appraisers, lenders, and others to address this need. As a result, twenty houses are slated for construction over the next few years. He would also like to stimulate

support for building an apartment complex to provide affordable housing for hospital employees and others.

Collaborative Community Needs Assessment Models: Littleton Regional Hospital (LRH)

In an effort to identify and respond to community needs, LRH, Ammonoosuc Community Health Services, an FQHC in Littleton, and North Country Home Health and Hospice conduct a joint community needs assessment every two years. The results of the last community needs assessment were released in 2004 and serve as a map for the collaborative efforts of the participants. At the time of our visit (August 2005), data collection efforts were underway for the current needs assessment. The North Country Health Consortium (NCHC) coordinates the community needs assessment process on behalf of the three organizations. NCHC develops the survey instrument and trains the surveyors on how to field it. Support for the effort comes from a public health networking initiative funded by Centers for Disease Control bio-terrorism funding, which also requires a community needs assessment.

Informal Information Gathering, the Role of Staff in Identifying Community Needs: Weiser Memorial Hospital (WMH)

Although it has been a number of years since WMH conducted a formal needs assessment, the process of informal identification of community needs is ongoing. The hospital offers home health services, and staff continually solicit feedback and input from community members while conducting blood pressure and foot clinics and having lunch at the senior center. The CEO of WMH maintains a high visibility in the community. She is president of the local Chamber of Commerce, attends educational activities and participates on task forces. Through all these activities, the CEO brings information about community needs back to the hospital's senior management team for discussion. Many community respondents noted that WMH works to meet identified community needs, and is doing its best to serve patients while remaining financially viable. The hospital has developed a number of new programs that target community issues and are open to the public. The hospital is described as having "a good sense of the pulse of the community." For example, the hospital has brought in mobile MRI and added surgeons because people said they wanted to be able to have surgery in Weiser.

Addressing Unmet Community Needs

The benefit and impact of community needs analyses come in the development and implementation of a plan of action to respond to unmet community health and health service needs identified in the assessment process. Translating needs into actions, services, and programs is not a trivial exercise, as it usually requires a commitment to develop new resources and funding or to re-allocate existing resources and the development of collaborative partnerships between the hospitals and local providers and agencies. Ultimately, the goal of each of these initiatives is to improve the health of residents of the community as well as to decrease morbidity and mortality. The six hospitals undertook a wide range of activities to address unmet community needs including the development of specialty services, preventive care, chronic care/disease management, and/or community health improvement services and programs.

Under this element of our framework, we focus on the development and refinement of more traditional programs and services designed to improve the health of community members and reduce morbidity and mortality. Although there is some overlap between this element of our framework and the next, *Prevention and Health Promotion*; we have chosen to separate these two categories of activities. We did so to give added emphasis to each aspect of the process as well as to recognize the broader range of less traditional services that are encompassed in the category of *Prevention and Health Promotion*.

All of the hospitals we visited that had undertaken formal or informal community needs had developed and were implementing action plans to address the identified service needs in the community. The following are examples from Nor-Lea General Hospital in New Mexico and Littleton Regional Hospital in New Hampshire.

Expanding Services, Increasing Patient Access: Nor-Lea General Hospital (NLGH)

The expansion of health care services has been a major focus for NLGH and includes improving access to primary care, specialty care, and mental health services. Findings of focus groups and other input helped create a master list for needed service expansion, and NLGH is working to address the listed needs. New services, some of which were made possible by conversion to CAH status, are highlighted here.

In 2005, the Family Health Center in Hobbs became the hospital's third Rural Health Clinic. Originally owned by St. Mary's Hospital, the clinic was the only outpatient provider for the indigent population in southern Lea County before its closure in 2001. The Guidance Center, a mental health provider in Hobbs, recognized the unmet need for indigent care in the area and reopened the clinic with funding from the State. NLGH helped with credentialing of the clinic and ran the facility under a contract with the Guidance Center until October 2005. At that time, NLGH purchased the clinic and incorporated it into its "family" of Rural Health Clinics. Although the acquisition of this third RHC, which is outside the hospital district, was viewed with some concern by the Hospital Board, the purchase is now considered a success. Opening this clinic has improved access to care for a large portion of the county's underserved population whose only option previously was travel to Lovington. Hobbs residents traveling to the hospital or using NLGH services based in Hobbs contribute almost half of the hospital's operating revenue. To support this clinic and also as a service to other hospital clients from Hobbs, NLGH opened a blood drawing station in Hobbs that is served by courier to the hospital twice a day.

Under a State program that has allocated funds for the development of school-based clinics, NLGH is working with Lovington Public Schools to develop a clinic that would be located near three schools. Initially the clinic will provide primary care for students during the school year. They will partner with the Guidance Center to provide mental health services. The long-term goal is to keep the clinic open year-round as a fourth RHC and provide services to the families of students and other community members.

The need for local chemotherapy services was another need identified at the focus groups held to assess community need. NLGH will open an outpatient chemotherapy clinic when its new

pharmacy has been inspected and a pharmacist has been hired. The clinic will be staffed by oncologists from the Joe Arrington Cancer Center in Lubbock, thereby saving area residents the 100-mile drive for cancer treatment. NLGH will charge minimal rent to the physicians and will provide related lab and radiology services. At the time of our site visit, the chemotherapy unit was complete and being used for NLGH's outpatient Remicade clinic.

Cardiopulmonary rehabilitation was another need identified through the focus groups, as there is a high rate of chronic obstructive pulmonary disease in the community. Implementation of this service is in process and construction will start this year. Hospital officials cite this new program as another example of services made possible by their becoming a CAH. With no local services available, cardiac patients currently must return to Lubbock for rehabilitation and cannot always complete the program due to travel barriers. The state legislature has supported implementation of these services by providing \$100,000 for equipment and \$250,000 for a sprinkler system. A smoking cessation program is being developed, also with funds received from the state. The program will be piloted with hospital employees and then incorporated into the pulmonary rehabilitation program.

Outpatient surgery has been expanded both in the types and numbers of procedures. Two gastrointestinal surgeons, a general surgeon, two obstetrical/ gynecological surgeons, and a urologist currently serve patients at NLGH.

The Heritage Program for Senior Adults was added in 2003. The addition of this outpatient mental health program was prompted by a need identified through the community focus groups and by hospital chaplains. The program serves persons 65 years of age or older and is staffed by a psychiatrist, master's-level therapists, an RN, and mental health technicians. The program manager is a Heritage employee; all others are employees of NLGH. Services include an initial assessment including measures of cognitive ability, assessment of the home environment and other assessments all of which contribute to the development of a master treatment plan. Services for program participants can include individual and/or family therapy and group therapy, both focus and process. A van is available to transport clients to the hospital for services. Services provided by the Heritage program are reimbursed by Medicaid and Medicare, and could not have been offered without the improved Medicare reimbursement received as a CAH.

Other service changes include the expansion of laboratory services. Radiology has also grown. There is an MRI on site, owned by a management group and CT has moved into the building from a mobile unit. Other services include mobile echocardiology coordinated with their cardiologist visits. Technicians are available three days per week and they can now send tracings via the internet to the cardiology group to be read. And finally, hospice services have been added in response to a perceived need in the community.

A Multi-Pronged Approach to Expanding Services and Meeting Community Needs: Littleton Regional Hospital (LRH)

LRH has a two-pronged strategy for the development of services and programs to meet community needs. The first is a very clear high growth business development strategy that supports the hospital's goal of becoming a regional referral center for the North Country area of

New Hampshire. To do so, LRH is developing of a broad mix of specialties and services that makes it unique among CAHs. LRH's active, associate, consulting, and courtesy medical staff consists of 70 physicians representing 24 specialties. LRH continues to recruit physicians and develop specialty services in support of this goal. At the time of our site visit, the hospital was actively working with an oral/maxillofacial surgeon who was relocating to the area and establishing a practice in the old hospital building. The hospital is also expanding its primary care capacity through the recruitment of internal medicine rather than family practice physicians to support the hospital's growing role as a referral facility.

The CEO describes the hospital's growth strategy as fueled by a "circle of energy". By this he means that the expansion of hospital services makes it easier to recruit additional high quality physicians and clinical staff. The additional clinicians support the expansion of the hospital's laboratory and diagnostic services, which allows LRH to further expand its service offerings. The expanded service mix enhances the hospital's ability to recruit additional specialists and so on. The key to this strategy is the development of financially viable, high quality services that will not only meet the needs of local residents but also draw patients from the surrounding region.

The financial stability provided by this growth strategy and the benefits of CAH conversion (e.g., cost-based reimbursement) allows the hospital to respond to community needs that may provide less financial benefit to the hospital. An example of this type of service is the Paramedic Intercept Program established by LRH, developed to address the shortage of paramedic-level services in the North Country. Funded in part by the hospital and using equipment purchased through grants, LRH maintains a team of paramedics that responds to calls from local ambulance services. LRH's paramedics will meet a local ambulance on-site or en-route and "climb in the back of the vehicle" to provide care that cannot be rendered by the local ambulance crew. Patients served by the Paramedic Intercept Service do not necessarily end up at LRH. As the Paramedic Intercept Program's service overlaps the service areas of a number of hospitals, the choice of receiving hospital is driven by the patient's medical condition, the patient's choice, and/or the location of the patient's primary care physician. Demand for this service is such that it has grown from a staff of 3 providing 12 hour per day coverage to 11 full- and part-time staff providing services around the clock.

Another example includes the hospital's response to a request from a local business to address an access problem experienced by its employees. The employees covered by this business's health plan were having trouble finding primary care physicians that would accept the plan's payment rates (which were low in comparison to other health plans). The employer approached the hospital for assistance. LRH was able to recruit and support a family practice physician to resolve this access barrier.

LRH is also an active participant in collaborative partnerships to address community needs. The primary vehicle for its collaborative partnerships is the North County Health Consortium (NCHC), a 501(c)3 organization created in 1997 as a vehicle for addressing common issues through collaboration among health and human service providers serving northern New Hampshire. An important service developed by NCHC is the Molar Express, a mobile dental van serving residents of Coos and northern Grafton Counties who are under 21 years of age. The

service accepts clients covered by New Hampshire and Vermont Medicaid, NH Healthy Kids (NH's State Children's Health Insurance Program), and commercial dental insurance. It also offers discounted services based on a sliding fee scale and allows clients and their families to develop payment arrangements. The program is supported by patient revenues and grants from the NH Medicaid program, the Endowment for Health (NH's Blue Cross/Blue Shield conversion foundation), the Delta Dental Foundation, the Cogswell Benevolent Trust, and the hospitals in the North Country.

Prevention and Health Promotion

In addition to the financial benefits provided by CAH conversion, many state Flex Programs have supported hospitals through the provision of grant funding and/or technical assistance as they have sought to re-engineer their service mix and develop new services and programs. While many have focused primarily on expanding primary care and specialty services, others have sought to expand preventive, health promotion, disease management, and other community outreach services and programs in their communities. Our 2004 survey of Critical Access Hospitals identified that 98% of facilities were involved in one or more of seven specific community outreach/health promotion activities (Poley and Slifkin, 2005).⁵ When asked to identify up to three externally funded community outreach, prevention, and health promotion programs conducted by their hospitals, 35% described a total of 308 different programs. Among the most commonly mentioned activities were chronic care management, immunization programs, wellness programs, smoking cessation, prescription drug assistance, and programs for women and children such as school-based programs, family planning, and WIC.

Because funding for many preventive services and programs is limited to grants from state or local public health agencies, hospitals that develop such programs do so largely as a community service activity. Increasingly, however, hospitals are being encouraged to take on a broader role in community health (Institute of Medicine, 2005; Size, et al, 2006; Zigmond, 2006). In some states, this role is explicitly identified in the state's community benefits reporting requirements (Community Catalyst, Inc., 2003).

Each of the hospitals we visited is engaged in community health improvement activities and initiatives. We have chosen to profile two hospitals. Our description of the health promotion activities at Kearny County Hospital's annual health fair is typical of prevention-related outreach activities conducted by many CAHs. More unique is the case of Teton Medical Center's collaborative development of a comprehensive wellness center on the local high school campus offering wellness and fitness programs and services targeting the general public, school age athletes, firefighters, and individuals with chronic illnesses.

Community Health Promotion: Kearny County Hospital (KCH)

⁵ The services included free clinics, free or reduced cost health screenings, free or reduced cost medications, sponsorship of community and/or worksite health promotion programs, immunization drives, health education seminars, and staffing health information booths.

KCH conducts an annual health fair every August that serves as an important component of its health promotion and prevention strategy. The fair rotates between Lakin and Deerfield, and a children's health fair is held every other year. The 2005 health fair attracted over 1,100 participants, representing approximately one-fourth of the county's total population. Last year, over 1,000 blood samples were drawn for testing by KCH staff. The health fair is promoted by word of mouth and through the local newspaper. As an annual event, it is well known in the community and attended by a broad spectrum of individuals.

Although sponsored by the hospital, a number of community providers and health related services staff booths at the health fair. Last year, more than 40 professionals from a variety of health care organizations and health services were represented. In addition to KCH, the American Cancer Society, the American Heart Association, a local chiropractor, the Mexican American Ministries, the Senior Center, the Area Agency on Aging, the American Association of Retired Persons, and an eye surgeon were among the organizations present at the health fair. Services available to the participants included blood testing, bone density checks, and back strength testing, as well as a variety of information about health issues. KCH's staff drew blood samples, which were processed through its lab. Its Certified Diabetic Educator staffed a booth and provided information on diabetes.

The hospital makes an effort to cultivate senior participation by allowing seniors to arrive early to have their blood drawn. Last year, the hospital drew blood for 200 seniors participating in the health fair. KCH also encourages the participation of programs targeting seniors. The Director of the Senior Center noted that her clientele is very excited about the fair and views it as a social event.

The hospital also cultivates the participation of local business in the health fair. It offers follow-up services to local companies who participate in the health fair through the hospital's home health service. The companies pay a fee for these additional services.

Based on feedback from a wide variety of community respondents, the health fair is well received in the community and is viewed as more than just a marketing vehicle for the hospital. The health fair serves as an outreach activity to individuals who might not otherwise visit a doctor during the year and is treated by many of these individuals as an opportunity to have basic diagnostic testing done. The hospital sends the results of this testing to each participant's family physician, if they have one. For individuals with abnormal results and without a family physician, the hospital works to connect these individuals with a local physician in their communities.

Wellness Promotion: Teton Medical Center (TMC)

TMC has embarked on a collaborative venture with the high school, the Teton Community Development Cooperative (TCDC), and others to expand wellness services for the community. Historically, the hospital provided limited wellness activities along with physical rehabilitation services for its patients and the community using exercise equipment located in its old operating suites. Called the "Spa Program," members of the community paid \$25 for a fitness evaluation

and could then use the facility for \$25 per month. The hospital-based program attracted older community members who often combined Spa visits with visits to elderly friends in the hospital's nursing home unit.

The idea for a larger Wellness Center took shape in the thinking of different county organizations. The Teton Community Development Cooperative, during community forum discussions over renovations to the community's aging swimming pool, considered the addition of other wellness services. TMC had begun to expand its wellness activities to younger community residents, e.g., school athletes, and was seeking to expand its capacity to provide these services to the community. The County Extension Office offered nutrition information as part of a popular meal preparation demonstration. The Great Falls Clinic came on board, provided some seed money, and brought in specialists and other staff for providing health education, diabetes, stroke, and heart rehabilitation. The development and construction of the Wellness Center on the high school campus was the result of this broad coalition of community stakeholders. The bank provided the loan for the project and did not seek payment guarantees. The community donated construction labor. Funds for building materials (approximately \$90K) were raised by TCDC from the community. At the time of the site visit, half of the facility was already in use by the high school sports department and the other half, while still being developed, already housed yoga classes and other exercise programs. TMC has conducted a pilot fitness program with the firefighters and plans to offer the same to the community. The original "Spa" in the hospital's operating room space will be used for other wellness activities.

Building a Continuum of Care

Community hospitals often play an important leadership role in identifying and addressing the needs in a community for an improved continuum of care across the health services. A hallmark goal of the Flex Program has been to build a stronger, better integrated primary care, emergency care, inpatient capacity, and service system in small rural communities. These efforts may take the form of the development of new collaborative systems of care or an improved coordination of efforts between existing programs or services. In many ways, this element of our framework focuses on developing and/or coordinating a system of care designed to ease the movement of patients from one level of care to another and to ensure that patients receive the appropriate level of care in a timely fashion.

Prior research has identified many instances in which CAHs have undertaken important service expansions or collaborative program developments to better connect and integrate other community health services such as emergency medical services, long-term care, behavioral health, and women's health. Our first example profiles the development of behavioral health services by Regional Medical Center. Our second example describes the efforts of Kearny County Hospital to develop its primary care and long term care service capacity.

Development of Behavioral Health Services: Regional Medical Center (RMC)

RMC has undertaken a major initiative in the development of behavioral health services for Delaware and surrounding counties. This service accounted for virtually all of RMC's new hires

during fiscal year 2005 (32 staff). Hospital leadership expects continued growth for this service and plans to work with one or more of the three social work schools in the state to develop an internship program that will expose students to rural practice opportunities.

RMC's initial foray into behavioral health began in the 1990s following a state de-institutionalization initiative that included the downsizing of a major institution in Independence and the related increase in demand for community-based behavioral health services. RMC's first effort to expand behavioral health services involved the development of contracts with outside agencies for the delivery of services in Manchester.

Over time, RMC's leadership decided that it needed to take a more central role in the delivery of community and behavioral health care. To do so, it established a separate department known as the Department of Community and Behavioral Health with its own advisory board. The Department is made of six units, including Community Health (overseeing community health and hospice services), Public Health (overseeing county mandated services), Bio-Emergency (addressing Centers for Disease Control and Health Resources and Services Administration priorities), the Backbone Area Counseling Center (BACC) (providing behavioral health programs), Behavioral Health Support (supporting hospital-based and BACC services), and Psychiatry (providing consultative and psychiatric support).

BACC has lead responsibility for developing community-based behavioral health services and was established in 1992 as a Community Mental Health Center licensed by the State of Iowa. County Block Grants funded one third of the Center's start-up costs (\$42,000 from each of three counties). Private pay payments and a tax levy covered the remaining costs. At the time of our site visit, BACC held contracts with Delaware and Buchanan Counties to provide mental health services, including 24 hour emergency coverage. Services are also provided to residents of neighboring counties. The main office is housed at RMC. BACC also maintains a satellite office in Independence. In fiscal year 2004, the agency had an unduplicated census of more than 1080 individuals, ranging from three to eighty years of age.

BACC provides a range of accredited services, including outpatient psychotherapy and counseling, evaluation services, emergency and crisis care, supported community living, intensive outpatient services, and child day treatment. BACC also provides psychiatric services, psychological testing, a drop in center, an alternative school, psychiatric nursing, and a "Parents as Teachers" Program. BACC's major source of revenue is Medicaid. BACC is also supported through private payments, donations, and block grant funds. BACC reported a \$600,000 loss in 2004, largely due to contractual disallowances.

Psychotherapy services are provided on a full-time basis in the Manchester and Independence clinics, and on a part-time basis at the Strawberry Point (three days a week) and Colesburg (one day a week) clinics. BACC plans to expand services at Strawberry Point to full-time and open a new, full-time clinic in Oelwein to serve Fayette County. Psychotherapy services are provided by eight masters-level social workers, six of whom are Licensed Independent Social Workers (LISWs) and two of whom are in the process of obtaining licensure. The program provides care for clients with co-occurring disorders (e.g., those with both substance abuse and mental health

disorders). BACC does not provide services to clients needing only substance abuse treatment. These individuals are referred to the Dubuque-based Substance Abuse Services Center.

Collaborative arrangements have been established with four LISWs to provide screening, diagnosis, and assessment of individual and family functioning and to determine status and functioning in the activities of daily living. The LISWs also provide emergency services for assessment and stabilization of acute symptoms of mental illness or emotional distress.

Supported Community Living services are provided to help with daily living skills for individuals with mental illness, mental retardation, or developmental disability. A collaborative arrangement is in place with the Cedar Centre Psychiatric Group in Cedar Rapids for monthly adult psychiatric services (seven days in Manchester and three days in Independence) and with the Poweshiek County Mental Health Center in Grinnell (100 miles to the southwest) for children's services (three days in Manchester and one day in Independence). BACC also provides a range of community-oriented services including employee assistance programs, educational programs, school-based programs, health education presentations, and pipeline activities to promote careers in behavioral healthcare services.

Building Primary Care and Long-term Care Capacity: Kearny County Hospital (KCH)

Physician recruitment and retention and long term care (LTC) are KCH's service expansion goals and initiatives. After more than a decade of instability in physician coverage, the hospital has successfully recruited two young; locally (Kansas) trained family physicians to form the core of the Family Health Center. One was funded by the hospital to attend medical school under an agreement that he would return to the community upon completing his training. Recognizing the importance of women's health, the hospital recruited a female osteopathic physician who was completing her residency in Wichita. All three physicians perform deliveries, including cesarean sections (after having completed specialized training). In addition, the two male physicians perform some common general surgeries such as routine hip fracture repairs and gall bladder surgeries. The physicians are advocating with the hospital that a fourth physician is needed to handle after hours calls and what they believe will be a growing patient population in the area. The hospital subsidizes the physician practices as part of its strategy to maintain stable physician coverage.

KCH has not sought to import additional specialty services from other communities, preferring instead to establish referral relationships with physicians in Dodge City or Garden City. It had previously worked with physicians from Garden City to offer on-site specialty clinics but discontinued this approach, as coverage was unreliable (the physicians gave first priority to their existing busy practices in Garden City). KCH also tried to maintain general surgery services by importing a general surgeon from Dodge City but also found this approach to be unsuccessful.

The development of the Deerfield Clinic is also part of the hospital's primary care expansion strategy and an effort to provide access to vulnerable individuals residing in Deerfield, many of whom are Hispanic with high rates of Medicaid coverage or no insurance coverage at all. Without the Deerfield Clinic, these individuals would have difficulty obtaining access to services

as the medical practices in Garden City reportedly do not accept Medicaid or uninsured patients. Although the clinic loses money, KCH maintains it as it the only source of care for the community of Deerfield. The county's tax support of KCH is vital to maintaining this facility and service.

The development and expansion of LTC services is another core focus of KCH's expansion strategy. Developed in response to an identified community need in the early 1980s, LTC services, including retired and assisted living facilities and home health services, have been critical to building the hospital's reputation and support in the community. Increasingly, the hospital views these services as central to the continuity of care in Lakin and Kearny County. In particular, the home health service has been used flexibly to help patients transition from hospital to independent living, to assisted living, or to home with minimal disruption.

The development of physical therapy (PT) services has also been a priority for the hospital. Staffed by a full-time physical therapist, rehab aide, and PT assistant, this service is an integral part of KCH's inpatient and LTC programs. It has also been a regional resource to schools and other community agencies in the area that contract with KCH for physical therapy services.

The hospital is beginning to address other local public health needs. KCH provides diabetes education through a Certified Diabetes Educator, but the staff would like to be able to do more in the community. It is exploring the implementation of a community "tough talk" campaign focused on trauma prevention. KCH has also participated in a community survey of chronic health care needs funded by the Sunflower Foundation. It provides support to local school nurses when needed and is involved with the state and county bioterrorism and trauma networks through its participation in the Southwest Kansas Network. KCH has organized the local response team and does "table top" drills. It has also purchased some of the equipment needed for the bioterrorism and trauma response teams.

Building Community Health System Capacity

As CAHs are typically the largest providers of health services in their communities, they often assume a leadership role in addressing broad-based community or regional health systems problems that affect health care access, quality, adequacy of the workforce, and/or cost. For example, CAHs and other rural hospitals have developed local and regional strategies for addressing the problems of insurance coverage, uncompensated care, and the needs of low income, uninsured residents. These initiatives may take the form of specific programs targeting vulnerable populations; efforts to support local providers through recruitment and retention efforts, provision of management or billing support, joint purchasing, or shared space; and/or undertaking fundraising or grant writing efforts on behalf of the community to expand local capacity.

Several of the hospitals that we visited are engaged in these types of activities. An effort spearheaded by the CEO of Weiser Memorial Hospital focuses on the uninsured, Teton Medical Center is working to improve care for the elderly, and Littleton Regional Hospital is a member of a consortium undertaking a wide array of activities to support the local health care safety net.

Although the problems addressed and strategies used vary, the key characteristic of these initiatives tends to be that they involve significant inter-organizational collaboration within and across communities.

Weiser Memorial Hospital (WMH): The Washington/Adams County Health Action Team (WACHAT) is a program that provides primary care for uninsured individuals over age 18 with incomes of less than 150% of the Federal Poverty Level. The program is a collaboration between 18 community organizations, social service agencies, and providers in the towns of Weiser, Council, and Cambridge. Qualifying individuals are given a laminated identification card, which can be used to obtain primary care services at the Two Rivers Rural Health Clinic in Weiser as well as at practices in Council and Cambridge. It can also be used to obtain basic lab and x-ray services at the hospital. Enrollees are expected to pay a co-payment of between \$5 and \$15, depending on income, with the remainder of program services donated by the providers. If an enrollee needs services beyond primary care, he or she can apply for indigent care funds through the county, apply for Medicaid coverage, or develop long term payment arrangements with the appropriate providers.

Washington is the second poorest county in Idaho, with a large number of uninsured working poor. The Chief Executive Officer of WMH was the driving force behind the development of WACHAT. Her interest in the program has been described by others as driven by a “genuine concern for patients.” A planning committee was formed to decide how to improve access to primary care for the uninsured. The intent was to remove barriers to care so that these individuals would seek treatment for problems when they arose, rather than to wait until their conditions worsened. Over a 12 to 18 month period, committee members visited different uninsured and indigent care programs and used their observations to develop a model that best suited the needs of local residents and providers. Local health care providers wanted a strategy that would provide continuity of care, especially for those with chronic diseases. The planning group was not interested in opening a free clinic, feeling that it created an underclass of patients and did not foster long term provider-patient relationships. By creating a program in which enrollees are part of the existing system, it was felt that WACHAT would provide continuity of care for individuals, particularly those who later obtain health insurance by enabling them to receive care from the same provider. The program rationalizes the delivery of free and reduced cost care by creating a process to qualify individuals in advance for free and reduced cost care and by removing that burden from individual providers. It also provides patients with a sense of dignity by streamlining the process of qualifying for participation and enabling them to obtain primary care services while contributing what they can to the cost of their care. It also minimizes unnecessary collection activity by clearly identifying those who are unable to pay when they enter the health care system.

WMH processes all applications to the WACHAT program and provides free lab and X-ray services to WACHAT enrollees. No formal study has been conducted of the impact of participation on the hospital. While the hospital experiences a financial loss on the donated lab and X-ray services, a physician who staffs the emergency room believes that WACHAT reduces unnecessary ER utilization. Several individuals in the community felt that participation has had a positive impact on the image of the hospital, as it provides evidence of its compassion and willingness to respond to community need. In contrast, others feel that WMH does not get a great

deal of “goodwill” from its support for and commitment to the program, because not enough people are aware of the program and the hospital’s role in it.

The WACHAT program reflects the commitment of WMH to serve all residents of the community, regardless of their ability to pay, as well as the community-oriented philosophy of the Two Rivers Rural Health Clinic. When talking to members of the community, it became apparent that WACHAT has had a greater impact on the community than just the insurance function it provides, by providing a venue in which community providers work together for the common good. The director of a local domestic violence agency described the WACHAT program as a “life saver” and “door opener.” The process of creating and sustaining this program has brought a number of diverse agencies and organizations together and has heightened awareness of resources and needs in the community. WACHAT also provides a vehicle for agencies to deal with community level concerns, and it provides a venue for communication among providers. A different agency is highlighted at each WACHAT meeting and tells the rest of the group who they are and what they do. They “all pass business cards,” as many of the participating organizations deal with the same concerns.

To date, WACHAT has not been able to address the need for prescription medications and specialty care among participants in the program. WACHAT is in the process of seeking a Medicaid waiver to expand services available through the program under the premise that participation in WACHAT is already based on the Medicaid eligibility assessment process. The Waiver would cover a pilot program in which participants who receive indigent funds would be included as Medicaid enrollees, thereby allowing the county to draw down the federal match. A waiver application has been submitted to the Centers for Medicare and Medicaid Services to pilot this program in Washington and Adams Counties.

Addressing Elder Care Needs: Teton Medical Center (TMC)

Choteau and surrounding communities are undergoing demographic shifts that are driving the hospital’s development plans for future services. These shifts include the aging of the existing population and the desirability of Choteau and Teton County as a retirement destination. As early as 1995, TMC noticed the beginning of these trends and responded by increasing the number of skilled nursing and nursing facility beds and related outpatient services. The continued development of a comprehensive senior services strategy received strong support during the June 2005 Board retreat. This concept fits well within the strategic goals of the hospital and the collaborative vision of the Chief Executive Officer (CEO).

In recognition of the fact that TMC cannot develop a comprehensive continuum of senior services on its own, its CEO works to bring community stakeholders and providers together. Rather than assuming a leadership role, he focuses on being a “supporter and proponent of collaboration among community stakeholders.” One respondent described his vision as that of a “medical chamber of commerce.” It was noted that he was more “more interested in finding ways to expand the pie than increasing TMC’s slice of that pie.” Although this vision seems to be shared by most key providers in the area, a tense relationship between TMC and the county nursing homes remains a barrier to forward progress in the development of a long term care plan

of action. This tension stems from efforts by past hospital administrators and County Commissioners to have the hospital assume control of the county nursing home.

TMC's CEO has worked to overcome turf issues by engaging in collaborative projects with local providers. For example, TMC has worked with Spectrum Medical, a local Medicare certified home health agency, to expand the hospital's home health and pharmacy services. TMC has also worked closely with the Teton Community Development Cooperative and the local school district to develop a physical rehabilitation and community wellness facility on the high school campus. In collaboration with the Area Council on the Aging, the hospital developed the "Home Helper" Program, a personal care initiative which provides home and personal care services for a nominal fee. The Area Council contributes \$10,000 annually to cover residents unable to pay for the service.

TMC's CEO has described his initial senior care meetings as "starting the process of building trust." The development of senior services provides a common ground among established community providers to address the needs of the area's growing elderly population. The hospital has nurtured stronger ties with the Great Falls Clinic in recent years and hopes to build similar linkages with elderly service agencies and providers (e.g., assisted living, senior ombudsman services, adult protective services, and regional aging services among others). Given the growing need, the availability of existing resources, and the growing collective will to develop a coordinated senior care service capacity, this may well be the opportunity to realize the CEO's vision of a community-based system of care.

Community Collaboration to Strengthen the Primary Care Safety Net: Littleton Regional Hospital (LRH)

New Hampshire's Flex Program requires each hospital applying for CAH conversion to develop an Access Improvement Plan (AIP) as part of its conversion application. The AIP must describe the hospital's plans to increase local collaboration and enhance community efforts to strengthen the primary care safety net, deliver primary care services, enhance access to primary care providers, and strengthen local emergency medical services. Following conversion, the hospital is expected to maintain and update that plan and periodically report its progress in achieving its goals to the Flex Program. In developing its AIP, LRH built upon its long-standing relationship with Ammonoosuc Community Health Services (Ammonoosuc), a Federally Qualified Health Center with locations in Littleton, Woodsville, Warren, Whitefield, and Franconia.

In addition to providing direct financial support to Ammonoosuc, the hospital has collaborated with and supported Ammonoosuc in a variety of ways including an agreement to provide services to its patients using a sliding fee scale of up to 200% of the federal poverty level. The hospital also provides Ammonoosuc with subsidized clinic space at its (LRH's) Whitefield satellite and has forgiven a portion of the billing balances incurred by its patients for lab and diagnostic services provided by the hospital. The hospital supports the recruitment of physicians for Ammonoosuc and recently entered into a memorandum of understanding to provide a practice assessment of Ammonoosuc's operations with the goal of developing recommendations to improve its operational efficiency and enhance its long term financial viability. As mentioned

earlier, LRH, Ammonoosuc, and North Country Home Health and Hospice jointly conduct a community needs assessment every two years.

The hospital is an active participant in the North Country Health Consortium (NCHC), an organization which focuses the collaborative efforts of its members on addressing the health needs of Grafton, Carroll, and Coos Counties in northern New Hampshire. Its members include five CAHs (LRH, Androscoggin Valley Hospital, Cottage Hospital, Weeks Medical Center, and Upper Connecticut Valley Hospital), two FQHCs (Ammonoosuc and Coos County Family Health Services), two home health agencies (Androscoggin Valley Home Care and North Country Home Health and Hospice), the four offices of White Mountain Mental Health and Developmental Services (Conway, Littleton, Berlin, and Colebrook), and Tri-County Community Action Program.

NCHC is engaged in the development of a wide array of programs and services including: the Molar Express (a mobile dental van) and related dental health initiatives; the North Country Health Information Network which provides internet and intranet access to members; community substance abuse prevention activities; rural transportation initiatives; the development of a community/public coalition; and the development of a care coordination model for low income and indigent residents of the North Country.

In addition to their work with NCHC, staff from LRH are represented on a wide range of community coalitions and task forces as part of their daily professional responsibilities. Examples of these coalitions and task forces include the Northern New Hampshire EMS Council, the New Hampshire Medical Reserve Corps, the Littleton Area Public Health Coalition, the Grafton Dental Task Force, and the Littleton Human Services Council. In support of its efforts to strengthen access to health care in Littleton, LRH has developed a Department of Community Health Access and designated one of its employees as the Director. The goals of the Department of Community Health Access are to improve patient access to care, strengthen LRH's relationship with the communities it serves, strengthen its relationships with other local providers and agencies, and strengthen its response to community health and health prevention needs.

PART III: Discussion and Policy Lessons

Introduction

The aim of this study was to understand how Critical Access Hospitals identify and respond to the health and health systems needs of their communities and the impact they have had. With the help of the Monitoring Team's National Advisory Committee, we developed a framework for hospital community involvement and impact that could help us systematically identify and categorize the ways in which CAHs monitor the health and health system needs of their communities and engage with other community organizations and stakeholders to address those needs. The core components of the framework include: (1) Identifying Unmet Community Needs, (2) Addressing Unmet Community Needs, (3) Prevention and Health Improvement, (4) Building a Continuum of Care, (5) Building Community Health System Capacity. The six hospital-community site visits were invaluable in illustrating the what, how, and whys of hospitals' activities in each of these areas. Although we cannot generalize from only six case studies, there are important conclusions and potential policy lessons that can help inform the field as we continue to examine the impact of the Flex program.

Discussion

There are both broad and specific conclusions to be drawn from a comparative, cross-site analysis of these six hospitals and communities. Most broadly, these six hospitals and communities illustrate the engagement of Critical Access Hospitals in a wide range of formal programs, initiatives and activities that identify and respond to community and regional health and health system needs. Some of these initiatives are targeted and limited, as in the case of health screening programs; others represent more complex and sustained interventions that are addressing critical gaps in the community's service and health system capacity. The following represent some of the important, specific observations and conclusions from these six communities:

- 1. Identifying Unmet Community Needs:** hospitals are engaged in formal and informal efforts to engage with their communities by systematically identifying community health and health system needs.
 - The examples of these communities reveal that broad-based collaboration between the hospital, other community agencies and organizations, and citizens (including representatives from underserved, vulnerable populations) is critical to understanding the full range of community needs and to implementing interventions designed to address them.
 - Formal community needs assessments are complex, time-consuming processes that require a strong commitment of leadership and resources by the hospital. Communities and hospitals may need assistance in conducting a needs assessment in terms of

collecting and interpreting data, facilitating community involvement, developing priorities, and translating needs into action.

- Effective community needs assessments are not one-time activities but are best viewed as a continuous process of monitoring community needs. They are most useful if updated on a regular basis.
- The “informal” needs assessment process described by hospital staff, board members, and administrators is an important aspect of understanding community needs and typically part of their role as representatives of a key community organization. These informal processes are not a substitute for a formal assessment process that is more inclusive of the broader community and more systematic in the identification and prioritization of community needs.

2. Addressing Unmet Community Needs: These case studies reveal that hospitals’ efforts to meet community needs fall into two broad categories. The first is a *service growth/expansion strategy* which involves the development/expansion of services that are self-sustaining (in terms of revenue generation) and contribute to the long term viability of the hospital through expansion of its patient base/market share. The second involves *the development of services that meet specific unmet community needs or are subsidized by the hospital*. Maintaining core services that support the hospital is critical to being able to develop and offer services in the second category, which are often sustained through local tax subsidies, grant funding, or other revenue streams.

- All of the CAHs we visited operate in environments of scarce resources, yet all are involved in important efforts to address health and health service gaps in their community. Commitment and leadership of the hospital administrator and Board have been critical in each instance to these efforts.
- Hospitals do not always have to take the lead in efforts to address community needs. In many cases, collaboration with other agencies and organizations has proven critical in addressing unmet needs. Hospitals can play an important role in supporting/leading collaborative activities by providing technical assistance, grant writing support, meeting space, and other resources to support these initiatives.

3. Prevention and Health Improvement: The hospitals we visited were undertaking a range of prevention and/or health promotion activities. Some of these activities appear to be marketing and promotional activities. Others are more formal programs targeting specific populations and needs. These are more likely to rise above the level of marketing or promotional activities if they are undertaken as part of a coordinated strategy that is tied into the continuum of services in the community.

4. Building a Continuum of Care and Building Community Health System Capacity: These six hospitals and communities reveal important examples of efforts by CAHs to fill service gaps that contribute to building a stronger continuum of care in the hospital and among other service providers in the community. Whether in the areas of assuring access to

care for indigent residents, EMS, long-term care, or mental health, these efforts illustrate most directly the impact CAHs are having.

- Although the hospital is an important force in collaborative efforts to identify and address community needs, successful initiatives depend on hospital administrators being sensitive to how that role appears to other participants in the community and to developing collaborative linkages and relationships with other community agencies and providers.
- Building system capacity can sometimes be enhanced through collaborations that extend beyond the community to other hospitals and agencies in the region that face similar service gaps. Formal networking arrangements can be a useful vehicle for effecting such collaborations.
- Despite the important contributions that these hospitals are making to their communities' health system, little attention has been paid to "telling the story" of these initiatives locally or nationally.

Policy Lessons

- 1. The Role and Impact of Cost-Based Reimbursement under the Medicare Rural Hospital Flexibility Program:** As other analyses from the Flex Monitoring Team have shown, access to cost-based payments has improved the core finances of most Critical Access Hospitals (Holmes, Pink, & Slifkin, 2006). According to administrators, hospital board members, and others we interviewed in this study, conversion to CAH status and the stabilization of hospital finances have enabled them to develop and implement service development and expansion strategies and undertake the development of programs and services that fill an important need but are not self-supporting without subsidization by the hospital. Efforts to assess the impact of cost-based reimbursement should employ a framework that is broad enough to encompass the impact of CAHs in identifying and addressing unmet community needs and strengthening the rural health system.
- 2. The Role and Impact of the Flex Grant Program:** The role and impact of the states' Flex grant program has been more indirect than direct. As illustrated by states such as New Hampshire, some state Flex Programs have created expectations about the role of CAHs in supporting the development of community health infrastructure. In addition, Flex Grant funds targeted to CAHs and to specific initiatives (e.g. networking assistance and grants) have contributed to the efforts of some CAHs to engage with their communities through community needs assessments and/or other activities. Nevertheless, the link between the Flex Grant Program and the role and activities of CAHs in identifying and responding to community needs is not as explicit as it could be. The grant program has not specifically targeted resources or technical assistance to CAHs to help them to identify and respond to problems and gaps in the local community health system. Moving forward, Flex funds could be used to develop tools, resources, and technical assistance for CAHs in undertaking ongoing community needs assessments, supporting the development of community collaboratives, activities to support the community infrastructure in primary care, EMS, and

other areas addressing community needs. At the same time, state Flex Programs can create incentives, through the use of their grant funds, to encourage CAHs to undertake measurable community focused activities and to track and report the results of those efforts through their evaluation efforts and through the collection and dissemination of “community impact stories”.

- 3. The Challenge of Measuring Community Impact:** A major challenge related to the development of community impact measures and indicators is the range of diversity among rural communities and hospitals. Given this diversity, it is not surprising that hospitals and communities undertake varied activities to meet their unique needs. This is a strength of the program in that hospitals and communities have the flexibility to address their individual needs. It is also a challenge, as the lack of uniformity makes it difficult to measure and compare community impact across hospitals. This will be our major task as we move into phase 2 of this project, to create a set of process and impact measures that will appropriately capture and reflect the diversity of community impact activities across varied rural settings and quantify these activities to enable comparison across hospitals and communities.
- 4. Monitoring the Impact of the Flex Program:** A growing number of state hospital associations and states have developed community benefit reporting initiatives. These initiatives are encouraging hospitals to expand their community focused activities and provide a vehicle for reporting on these activities. As noted above, we found little or no public reporting of the community-related initiatives and activities undertaken in the six sites we visited. To address policymakers’ questions about the impact of the Flex Program, it will be important to measure CAHs’ efforts to expand access to essential health services and build local health systems capacity. With funding from the Federal Office of Rural Health Policy (ORHP), the Flex Monitoring Team is developing a process to provide this information by identifying CAH appropriate measures of community impact and available sources of secondary and primary data, including its survey of CAHs, to construct them. The indicators can serve as the basis for a standard “community impact” reporting tool for states and Critical Access Hospitals in much the same way that the Centers for Medicare and Medicaid Services has developed a standard reporting tool for quality measurement.

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APPENDIX A: List of Acronyms

AIP	Access Improvement Plan
BACC	Backbone Area Counseling Center
CAH	Critical Access Hospital
CCCM	Committee on the Costs of Medical Care
DCBH	Department of Community and Behavioral Health
EACH	Essential Access Community Hospital
EMS	Emergency Medical Services
Flex	Medicare Rural Hospital Flexibility Program
FQHC	Federally Qualified Health Center
GFC	Great Falls Clinic
KCH	Kearny County Hospital
LISW	Licensed Independent Social Worker
LRH	Littleton Regional Hospital
LTC	Long Term Care
NCHC	North Country Health Consortium
NLGH	Nor-Lea General Hospital
ORHP	Federal Office of Rural Health Policy
PT	Physical Therapy
RHC	Rural Health Clinic
RMC	Regional Medical Center
RPCH	Rural Primary Care Hospital
SRHP	State Rural Health Plan
TCDC	Teton Community Development Cooperative
TMC	Teton Medical Center
WACHAT	Washington/Adams County Health Action Team
WMH	Weiser Memorial Hospital

APPENDIX B: Critical Access Hospital – CEO Protocol

Thank you for agreeing to meet with us. We appreciate your time and effort in helping arrange this visit. The purpose of our visit is to understand better:

- How CAHs identify and address community needs and
- The role that CAH conversion and the Flex Program may have played.

Your responses to our questions will remain confidential. The information collected through this interview and all other interviews will remain confidential and be reported only in summary form in the reports and publications generated from this study. If the research team feels that it is necessary to identify a particular institution or individual in order to better illustrate our key findings, we will obtain permission from the appropriate individuals before doing so.

We will cover six topics in this interview:

- Your community
- Local and state issues programs and mandates that influence your activities in and for the community
- Hospital strategic planning
- Connecting with the community
- Service expansion, coordination, and links with area health care providers and others

We have structured this interview so that we can collect the same information from all 6 hospitals. We will have time at the end to talk about anything we might not have covered regarding your hospital's impact on and involvement with the community.

I. A Brief Description of Your Community

1. Major health and social service providers?
2. Environment of the health community in terms of competition vs. collaboration.
3. Major employers?
4. Does local municipal/country government have a role health care?

II. Local and/or state planning/development initiatives that influence hospital interaction with and services to the community over the last few years.

1. Community level planning and development activities (e.g., health, economic, education) (Probes: Was the hospital involved? If no, why not? If yes, how were it involved?)
2. State-level initiatives, regulations, mandates (e.g., community benefit legislation, Flex program requirements or initiatives, public health or health planning initiatives) How did they influence hospital activities?

III. Hospital strategic planning – When was the last strategic plan done?

1. Focus of recent strategic planning (e.g., operations, services, community outreach, networks)
2. Does the plan include specific strategies to meet community need or address community issues? If yes, what?
3. Community involvement/input into strategic planning process

IV. Community needs assessment

1. Have you done one or participated in community needs assessment, separate from strategic planning? If yes,
 - When was most recent needs assessment done?
 - What was the relationship to conversion?
 - Were other organizations involved? If yes, please identify.
 - What process was followed? (e.g., data, focus groups, town hall meeting, committee meetings)
 - What were the major findings?
 - What activities resulted from the effort?

V. Meeting Community Needs

Hospital Resources

1. Is there a dedicated staff for community outreach? (who, tasks, level of support, how long in place)
2. Do other staff have community outreach activities/responsibilities? (describe)
3. What is the structure and composition of hospital board (e.g., community representation, examples of board input)?

Expansion of Hospital Services

1. You reported in your survey and during our recent phone interviews that you have added, improved or dropped hospital-based services in recent years. List and confirm services. For each service, please describe:
 - Why did you decide to make this change?
 - Was conversion or state Flex support part of the decision?
 - What was the impact on the community? (e.g., filled gaps, convenience, access for vulnerable populations)
 - What was the impact on the hospital? (e.g., finances, staffing, reputation, market expansion)

Collaboration with other agencies (health care and other)

1. You also reported in your survey and particularly during our recent phone interviews that you work/collaborate with the following local health care providers or other agencies (review list). For each:
 - Describe the program or initiative (e.g., the goal and problem it addresses);
 - Role of CAH and other collaborators;
 - Role of conversion or state Flex program;
 - Resources needed to support collaboration;
 - Barriers to implementation and how they were how addressed; and
 - The impact of these collaborations. What were/are the results and who benefits from the collaboration?

2. Are there other ways you work with other providers/agencies to provide services OR improve the health care infrastructure, e.g., through local health planning initiatives and/or by improving coordination between providers' services to reduce redundancy, improve the continuum of care, enhance service capacity, reduce response time, etc.? For each:
 - Describe the program or initiative (e.g., the goal and problem it addresses);
 - Role of CAH and other collaborators;
 - Role of conversion or state Flex program;
 - Resources needed to support collaboration;
 - Barriers to implementation and how they were how addressed; and
 - The impact of these collaborations. What were/are the results and who benefits from the collaboration?

Emergency Medical Services

1. Please describe the EMS system that serves your community and hospital.
 - Number of ambulances services/companies and ownership structure
 - The level of service provided (e.g., ALS v BLS)?
 - Does the service include non-emergent transportation?
 - Does it meet community need? Hospital need?

2. How would you describe your working relationship with non-hospital based EMS?

3. Role of conversion or state Flex program vis-à-vis your role in EMA activities or relationship with EMS services?

4. Is there anything else that we should know about the relationship between conversion and state Flex activities and your hospital's efforts to meet community health care needs and/or its impact on the community that we have not already covered?