Flex Monitoring Team Briefing Paper No. 19

The Community Benefit and Impact of Critical Access Hospitals: The Results of the 2007 CAH Survey

March 2008

The Flex Monitoring Team is a consortium of the Rural Health Research Centers at the Universities of Minnesota, North Carolina, and Southern Maine. With funding from 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 (CAHs); and engaging rural communities in health care system development.

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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

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EXECUTIVE SUMMARY

The Medicare Rural Hospital Flexibility Program (Flex Program) contains explicit expectations and financial incentives 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 CAHs. The engagement and impact of the Flex Program and Critical Access Hospitals in supporting and building the local infrastructure of rural health services is one of three major components of the Flex Monitoring Team's assessment of the Flex Program.[*] In 2007, the Flex Monitoring Team conducted a national telephone survey of 381 critical access hospital administrators covering a wide variety of questions concerning hospitals' community benefit and impact activities. This Briefing Paper reports on the community benefit and impact findings of this survey.

The results of the 2007 survey indicate that critical access hospitals are active in monitoring the health and health system needs of their communities, are engaged with other community organizations and stakeholders to address those needs, and provide services (often free) for patients and other provider organizations in the community that enhance access to care and help build the local rural health system.

- **Nearly all CAHs offer financial assistance to patients in the form of both charity care and discounted charges.**

Eligibility for charity care and discounted charges is typically set below 200% of the federal poverty level. Nearly 90% of CAHs have formal processes to inform patients of their eligibility for charity care, discounted charges, and/or free care, although hospitals vary in how aggressive and transparent they are in communicating these policies to patients and in training their staff on the policies.

- **In addition to free and discounted care provided to patients, CAHs are engaged in community needs assessments, gap-filling service development and other activities that demonstrate their attention and responsiveness to community and rural health system needs.**

Nearly half of the CAHs surveyed had conducted a formal community needs assessment in the past three years and two-thirds have a formal planning process for addressing new service or other hospital and community needs. Moreover, a large majority of these hospitals actively involve the community in planning committees, meetings, and other components of the planning process, including local government, health care providers, consumers, local businesses and other community organizations. Nearly all of the CAHs surveyed offer services to address gaps in the community, including community health education, preventive screenings, free or reduced cost clinic services, clinical preventive service, and support services (e.g. Medicaid enrollment assistance). Moreover, these services are typically subsidized or offered at a final loss.

[*] The others are: state and institutional performance, including financial and quality performance.

- **Over three-quarters of CAHs have relationships with other CAHs and non-CAH hospitals, EMS, schools, and public health agencies. CAHs are also supporting many of these community organizations, especially schools, primary care, and EMS.**

The development of networks among CAHs and other health care providers in the community and or region is a core strategy in the Flex Program for helping to expand or develop local services. The support CAHs provide to other community health organizations varies by organization but is most often in the form of financial support and help with recruitment and retention of personnel. Other health system development and community building activities include active recruitment of providers, job creation and training programs, and workforce education. Relatively few CAHs are involved in the development of Rural Health Clinics or Federally Qualified Health Centers.

In the absence of an understanding of trends over time and whether CAHs differ from other hospitals with regard to these activities, it is impossible to assess the comparative performance of CAHs without more precise quantification of the value of many of these community benefits activities. The Flex Monitoring Team's Community Benefit and Impact Performance Reporting module, which will be piloted and finalized in 2008, will allow for quantification of the dollar value of some of the community benefit and impact activities of CAHs. If implemented nationally, it would also allow for comparisons of trends over time. In addition, the projected implementation in 2009 of the Internal Revenue Service's revised rules regarding the reporting of community benefit through Form 990 and Schedule H[1] would provide national data for assessing the performance of all CAHs over time and in relation to other hospitals.

INTRODUCTION

The Medicare Rural Hospital Flexibility Program (Flex Program) contains explicit expectations and financial incentives 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 CAHs. This interest is fueled in part by the adoption of either voluntary or mandatory federal and state community benefits reporting laws that require hospitals to document the benefits they provide to the community in return for their non-profit status. Additionally, the Internal Revenue Service has recently finalized reporting requirements for non-profit hospitals that will take effect over the next two years, intended to quantify their community benefit activities.[1] The projected implementation in 2009 of the Internal Revenue Service's revised rules regarding the reporting of community benefit through Form 990 and Schedule H[1] would provide national data for assessing the performance of all CAHs over time and in relation to other hospitals.

The engagement and impact of the Flex Program and Critical Access Hospitals in supporting and building the local infrastructure of rural health services is one of three major components of the Flex Monitoring Team's assessment of the Flex Program.[*] The Flex Monitoring Team has developed a Community Benefit and Impact Performance Reporting module designed to address the need for local, state and national monitoring of the community impact of CAHs and the Flex Program. This module has been developed through a series of steps including: (1) the development of a conceptual framework and preliminary set of community benefit and impact indicators and measures using a national, expert work group,[2](2) case studies of six CAHs and communities throughout the country,[3] and (3) a telephone survey in 2007 of 381 CAHs. This survey was the fourth in a series of national surveys of CAHs conducted by the Monitoring Team and focused on three special topics, including the community benefit and impact activities of CAHs. In addition to providing national data on the community benefit and impact activities of a nationally representative sample of CAHs, the survey allowed the team to test the feasibility of collecting information on key indicators and measures not available through other secondary data sources. In the final step in the development of the Community Benefit and Impact Performance Reporting module, the Monitoring Team is working with 25 hospitals in five states to pilot test the final module of indicators.

This Briefing Paper reports on the community benefit and impact findings of the 2007 survey.

[*] The others are: state and institutional performance, including financial and quality performance.

COMMUNITY BENEFITS AND IMPACT

The Monitoring Team has adopted a framework for assessing community benefit and impact that builds on the concept of "community benefit" and the work of many organizations and individuals who have examined the role of hospitals in community health.[4,5,6,7,8] The framework categorizes 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 Catholic Health Association of the United States (CHA) defines *community benefit* as a program or activity that provides treatment and / or promotes health in response to an identified need. A community benefit must meet one or more of the following criteria: 1) generates a low or negative margin; 2) responds to needs of special populations (e.g., persons living in poverty), 3) supplies a service/program that would likely be discontinued if based on financial criteria; 4) responds to public health needs; 5) involves education or research that improves overall community health.[6] Several organizations have developed materials to assist hospitals in defining, monitoring, and reporting their community benefit activities. We considered, in particular, the work of the CHA, VHA, Inc., the Public Health Institute, and the Wisconsin Hospital Association, among others. The CHA and VHA have developed comprehensive guidelines that are widely recognized as the "gold standard" for community benefit accounting.[9]

To this community benefit framework we have added measures that capture the impact of hospital activities on communities and the rural health system without the restrictions of community benefit reporting guidelines that limit reporting to activities that must be subsidized by the hospital. For example, health network building activities, a key goal of the Flex Program, may not meet the test of a subsidized activity in a community benefits accounting framework but are very important to understanding the role and impact of CAHs in rural health systems development.

The Monitoring Team's resulting framework for identifying and measuring community benefits and impact has eight major dimensions: (1) activities related to identifying and meeting community needs, (2) hospital community planning activities, (3) the provision of community health, public health, and other services in the community, (4) networking activities to expand or develop local services, (5) the provision of services or programs targeted to vulnerable populations or that meet a vital community need, (6) health and non-health community-building activities, (7) support provided by the hospital to local or community providers, and (8) the provision of charity, free, or discounted care.

[†] For more information on the Monitoring Team's framework for defining and measuring community benefit and impact, see Briefing Paper 14: http://www.flexmonitoring.org/documents/BriefingPaper14_CommunityImpact.pdf

SURVEY METHODS

Monitoring Team members from the Universities of Southern Maine and Minnesota designed a structured telephone interview survey using the framework described above. The survey was fielded by the University of Southern Maine's, Survey Research Center. A random sample of 450 CAHs was chosen for the survey. The 450 CAHs in the sample represented approximately 35% of all CAHs that were certified as of December, 2005. All of the hospitals in the sample had at least one year and up to 10 years of CAH operational experience before they were surveyed. A total of 381 CAHs responded to the survey, yielding a response rate of 85%.

Survey respondents were located in 45 states; 27 of those states had five or more CAH survey respondents (see Appendix A). The distribution of respondent hospitals reflects the national distribution of CAHs during the time periods used for identifying the sample. All but 27 respondents were Chief Operating Officers or Administrators of the hospital. For the 27 other respondents, the most common were Chief Financial Officers, Directors of Quality, and Vice Presidents.

SURVEY RESULTS

Financial Assistance for Patients

Interviewers asked respondents if they offered any financial assistance to low income or uninsured residents and patients. All CAHs that provided this assistance were asked to specify what type of assistance they offered (Charity Care, Discounted Charges, Both), how they determined eligibility, and whether they determined eligibility prior to providing care. The interviewers also inquired whether their financial assistance programs excluded certain services. CAHs were asked whether they provided special training to their staff about these programs and who received this training. Lastly, the interviewers requested information about the CAH's use of outside collection agencies.

Results:

- Nearly all hospitals (99%) reported providing some form of financial assistance to patients with 87% providing both charity and discounted care (Figure 1).

- Approximately one-third of CAHs offering charity care had an eligibility level at 100-199% of the Federal Poverty Level (FPL). Nearly one-quarter had more liberal eligibility levels ranging from 200-400% FPL. (Figures 2 and 3).

- Half of hospitals determined eligibility prior to providing care. Over 90% stated that their policies applied to all hospital services. Almost all reported that their policies covered self-pay or private accounts, 78% applied to co-pays or deductibles and 76% to denied charges.

- Approximately 88% had a formal process for informing patients or the public of their policies. The majority of these approaches involved informing patients who had already

arrived or been cared for in the hospital. Approximately half notified social service agencies and local health care providers, while 34% distributed brochures in the community and 26% provided public service announcements or ads (Table 1).

- Nearly 80% offered special training to their staff on the hospital's financial assistance programs. Admissions/Patient Registration and Financial Staff were the most likely to receive this training. Nearly three quarters of patient support and support staff were trained, while only 46% of direct care staff received training (Table 1).

Figure 1. Type of Financial Assistance Offered to Patients (N=368)

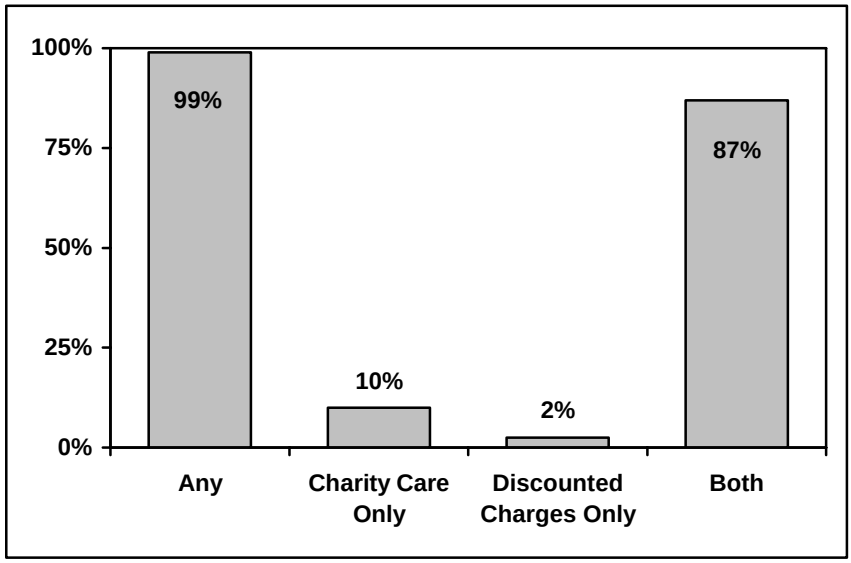


Figure 2. Eligibility Level for Charity Care (N=329)

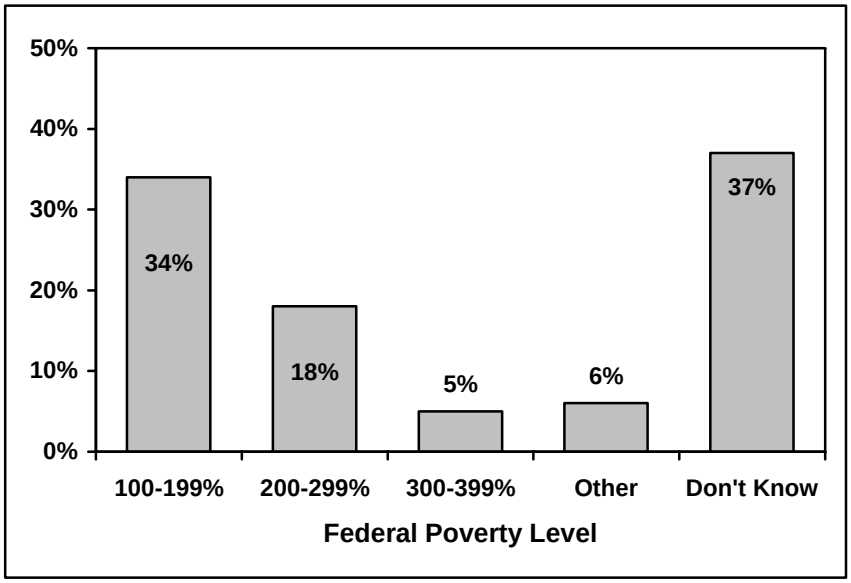


Figure 3. Eligibility Level for Discounted Charges (N=273)

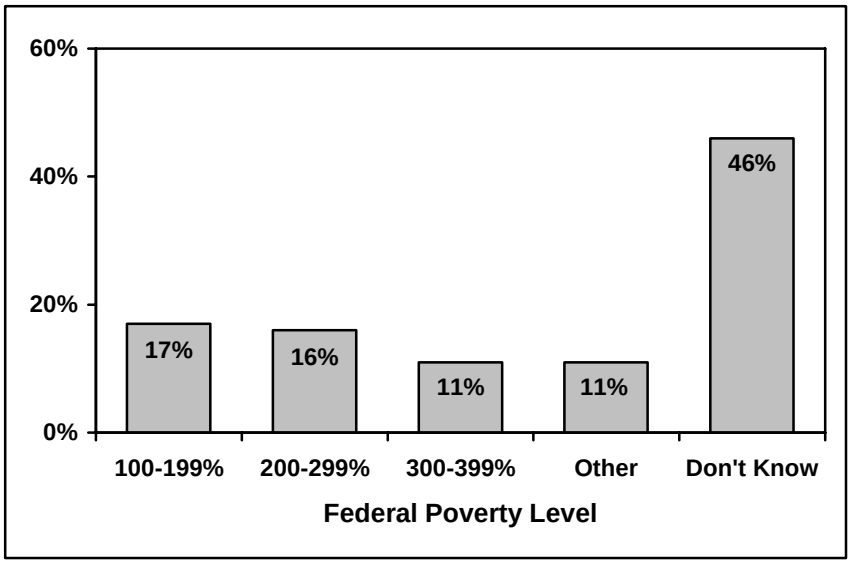


Table 1. Informing Patients of Financial Assistance Programs

	Number	Percent
Determine Eligibility Prior to Providing Care	189	51.4%
Formal Process to Inform Patients or Public	322	87.5%
Approaches to Informing Patients or Public		
Upon Request	235	73.0%
Written Materials at Registration	190	59.0%
Notices Posted in Public Areas of Hospital	261	81.1%
At Admissions	217	67.4%
By Billing or Collection Staff	256	79.5%
In Billing Statements	95	29.5%
Notify Social Service Agencies and Local Healthcare Providers	176	54.7%
Public Service Announcements or Ads	82	25.5%
Brochures Distributed in the Community	109	33.9%
Other Strategy	70	21.7%
Written Materials in Multiple Languages		
Yes	142	44.1%
No	65	20.2%
Not Enough Non-English Speakers	100	31.1%
Don’t Know/Not Applicable	15	4.7%
Offer Special Training	292	79.4%
Type of Staff Offered Training		
Admissions and Patient Registration	270	92.5%
Financial Staff	283	96.9%
Patient Support	216	74.0%
Direct Care Staff	134	45.9%
Administrative Staff	221	75.7%
Reception Staff	194	66.4%

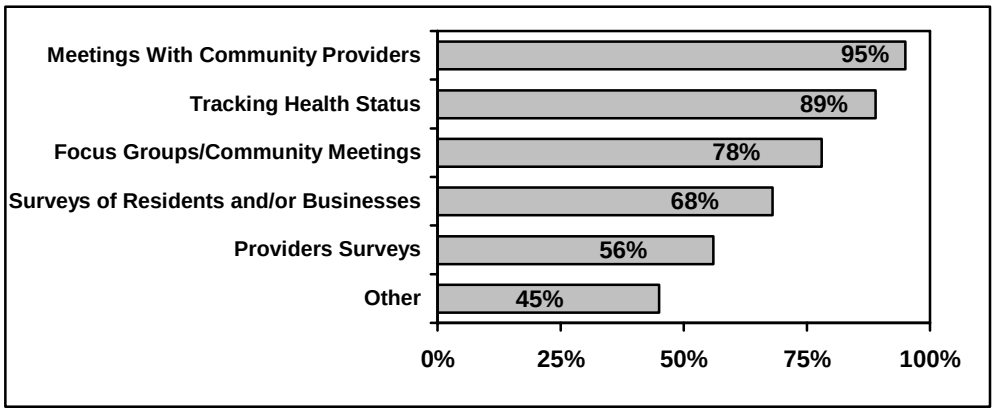
Community Needs Assessments and Formal Planning Processes

CAH CEOs were asked whether their hospitals had conducted a formal community needs assessment in the last three years. Hospitals that had conducted an assessment were asked what sources of information they used to identify community needs. Interviewers also requested that they briefly describe two community needs that they had addressed over the last two years. In addition, CEOs were asked whether their hospitals had formal planning processes for service development and enhancement, caring for vulnerable populations, and engaging in public or population health activities. Lastly, interviewers inquired of CAHs what types of providers were included in the planning process and what role they played.

Results:

- Approximately 48% of CAHs had performed a community needs assessment within the last three years. They used a wide variety of sources of information, including community meetings, health status tracking, and community provider meetings. Over half of CAHs still report that they have not conducted an assessment in the last three years. (Figure 4).

Figure 4. Sources of Information Used by CAHs that Conducted Needs Assessments (N=184)



- The majority of the community needs that hospitals addressed focused on adding or expanding services, public health activities (e.g., screenings, fairs), recruitment and retention of providers, chronic illness prevention and education, and capital improvements.

- Nearly 80% of CAHs reported having a formal planning process for service development and enhancement, caring for vulnerable populations, public or population health, or some other area. Over 300 reported having a formal planning process for service development and enhancement. Another 188 hospitals planned for caring for vulnerable populations.

Formal planning processes most commonly involved health care providers and consumers in the planning process (Figure 5 and Table 2).

Figure 5. Formal Planning Processes by Type of Activity

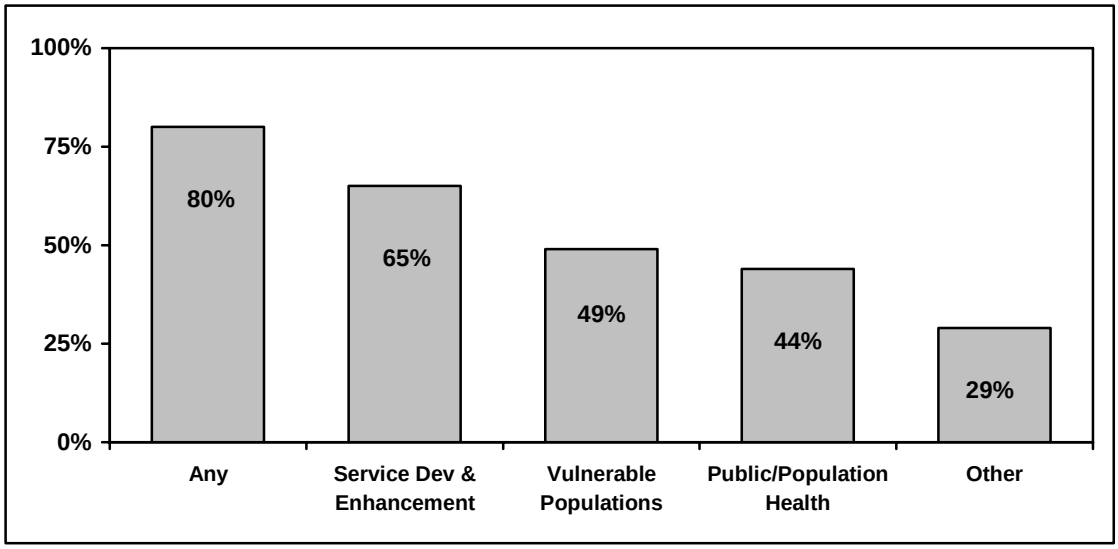


Table 2. Groups Included in Formal Planning Process and Their Role(s)

	Type of Group					
	Health Care Providers (N=293)	**Local Government Reps (N=207)**	**Human Service Agencies (N=139)**	**Consumers (N=224)**	**Local Employers/ Businesses (N=158)**	**Local/Regional Economic Dev Orgs (N=131)**
Role						
Planning Committees	91.4	71.0	74.1	75.5	72.0	64.1
Community/Provider Meetings	89.4	81.6	87.8	87.1	86.0	83.2
Input into Plan Development	98.6	90.3	89.2	92.4	93.0	90.8
Review and Comment on Plan	94.9	84.5	79.1	79.0	77.7	77.1

Community Health and Other Services Offered

Interviewers asked respondents what types of community-based services they offered. They specifically inquired about community health education, free or reduced cost care, community-based clinical services, and health care support services. Respondents offering a service were

then asked whether they subsidized the service or offered it at a financial loss. Subsidized services refer to those services offered despite a financial loss because they are needed in the community and would otherwise not be available or accessible. They include services that are partially or solely supported by hospital operating costs.

Table 3. Types of Community Services Offered by CAHs

	Offer Service N (%)	Subsidize/Offer at Financial Loss N (%)
Type of Service Offered		
Any Community Health Education Services	**366 (95.8%)**	**NA**
Health Information/Classes/Publications	349 (95.4%)	325 (93.1%)
Self-Help Groups	238 (65.0%)	209 (87.8%)
Community/Worksite Wellness Programs	251 (68.6%)	212 (84.5%)
Other Health Promotion Service	286 (78.1%)	259 (90.6%)
Other Education Service	169 (46.2%)	(95.9%)
Free or Reduced Cost Clinics	180 (47.2%)	NA
Free or Reduced Cost Medications	121 (31.7%)	NA
Primary Care Clinics for Low Income/Uninsured	215 (56.3%)	197 (91.6%)
Other Free/Reduced Cost Care	332 (86.9%)	NA
Community-Based Clinical Services		
Health Screenings	306 (92.2%)	279 (91.2%)
Immunization Programs	254 (76.5%)	201 (79.1%)
Chronic Care or Disease Management Programs	195 (58.7%)	168 (86.2%)
Other Community-based Clinical Services	104 (31.3%)	90 (85.7%)
Any Healthcare Support Services	**320 (83.8%)**	**NA**
Medicaid/Insurance Enrollment Assistance	275 (85.9%)	247 (89.8%)
Health Services Information or Referral	257 (80.3%)	223 (86.8%)
Interpretation Services	244 (76.3%)	218 (89.3%)
Transportation Services	110 (34.4%)	95 (86.4%)
Other Healthcare Support Services	43 (13.4%)	37 (86.1%)
Any Mental Health Services	**139 (36.4%)**	**NA**
Inpatient Services	30 (21.6%)	23 (76.7%)
Outpatient Services	106 (76.3%)	68 (64.2%)
Depression Screens for Schools	11 (7.9%)	9 (81.9%)
Depression Screens for the Elderly	59 (42.5%)	51 (86.4%)
Other Mental Health Service	55 (39.6%)	41 (74.5%)
Any Substance Abuse Services	**42 (11.0%)**	**NA**
Inpatient Services	11 (26.2%)	10 (90.9%)
Outpatient Services	29 (69.1%)	24 (82.8%)
Other Substance Abuse Service	15 (35.7%)	15 (100%)
Public Health Services	93 (24.4%)	75 (80.7%)
EMS or Ambulance Services	123 (32.2%)	99 (80.5%)

Results: (see Table 3 above)

- CAHs most commonly offered community health education services, health screenings, some form of free or reduced cost care, and Medicaid or insurance enrollment assistance.

- Approximately three-quarters of CAHs offer language interpreter services.
- Over half of CAHs (59%) offered chronic care or disease management services.
- One-third offered transportation services.
- 36% of CAH respondents offered mental health services. Of these hospitals, outpatient services were most often offered (76%).
- 11% of CAHs offered some type of substance abuse services. Of these hospitals, nearly 70% offered outpatient services.
- If CAHs offered a service, most (over 60%) subsidized the service or offered it at a financial loss.

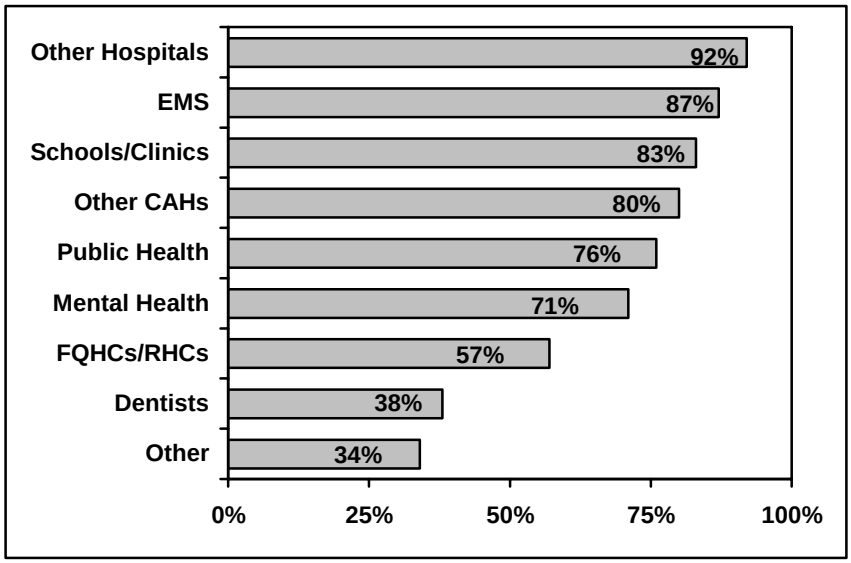
Networking With and Supporting Community Providers

Respondents were asked whether their hospitals had worked with various providers to develop or expand local services in the last three years. They were also asked if they had provided financial, material, in-kind, or other support to non-hospital community providers. If they had offered support, they were queried about what type of support was offered to the providers.

Results:

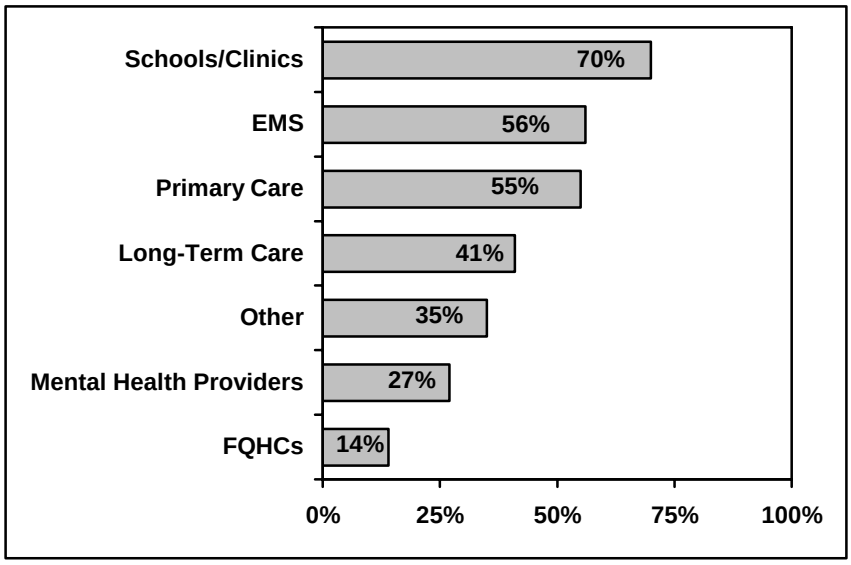
- At least three-quarters of CAHs reported working with other hospitals, emergency medical services (EMS), schools or school clinics, other CAHs, or public health to expand or develop local services. Relatively few CAHs worked with dentists (Figure 6).

Figure 6. Percent of CAHs Networking to Expand or Develop Local Services, By Type of Provider (N=329)



- CAHs most frequently offered support to schools or school clinics (70%), EMS (56%), and primary care providers (55%). Only 14% of CAHs offered support to Federally Qualified Health Centers (FQHCs) (Figure 7).

Figure 7. Percent of Hospitals Offering Support to Non-Hospital Providers



- Schools were most commonly supported through technical assistance and consultation (34%) and financial support (18%) (Table 4).
- CAHs supported primary care providers through recruitment and retention assistance (52%) and financial support (46%) (Table 4).
- Nearly 70% of CAHs report they provide some support to EMS providers with the most frequent type of support being financial assistance (38%) and technical assistance and consultation (32%) (Table 4).

Table 4. Types of Support Provided by CAHs

	Financial	Recruitment/ Retention	Management	TA/ Consultation	Office Space	Other
Provider Type						
Primary Care Providers (N=224)	46.0%	52.2%	21.9%	34.4%	41.1%	40.0%
Federally Qualified Health Centers (N=52)	28.9%	15.4%	7.7%	34.6%	23.1%	40.3%
Emergency Medical Services (N=219)	34.7%	12.8%	15.5%	31.5%	21.5%	77.2%
Long-term Care (N=157)	40.1%	20.0%	33.8%	37.0%	26.1%	64.3%
Mental Health (N=101)	31.7%	16.8%	8.9%	14.9%	54.5%	33.7%
Schools (N=265)	18.1%	3.0%	4.5%	33.6%	3.0%	81.5%

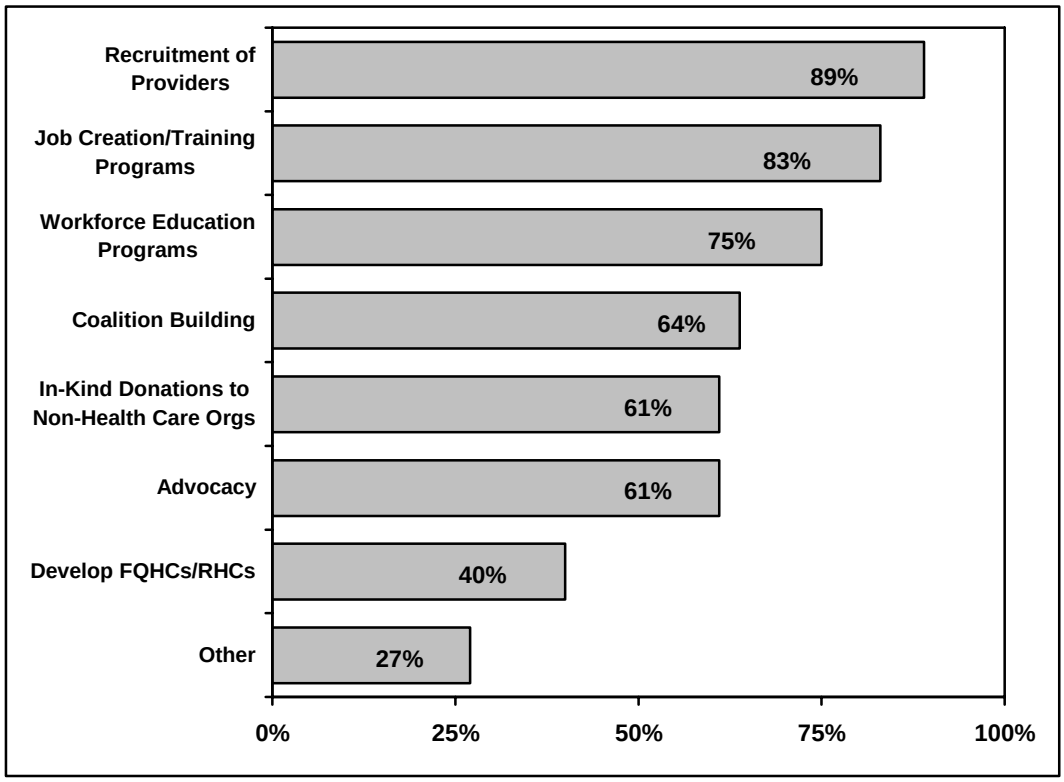
Community Building Activities

Respondents were asked whether they had participated in community building activities over the last three years, including involvement in community coalition building, advocacy, clinic development (e.g. Rural Health Clinics (RHC) or Federally Qualified Health Centers/Sites), and providing support to healthcare and non-healthcare organizations.

Results:

- Recruitment of providers, job creation or training programs, and workforce education programs were the most common community building activities among CAHs (Figure 8).
- 40% of CAHs had worked to develop FQHCs or RHCs in their communities (Figure 8).

Figure 8. Percent of CAHs Participating in Community Building Activities



Impact of Conversion on the Community

Each CAH was asked how their community would have been affected if they had not converted to Critical Access Hospital status. CEOs were also asked whether they had discontinued any services to avoid overhead expenses that might reduce Medicare payments and if so, what services were discontinued.

Results:

- 60% of respondents (229 CAHs) stated that they might have or would have closed if they had not converted to CAH status. One-third (N=126) of the hospitals stated that they would have had to decrease services or access to services significantly. Other hospitals stated that the community would be impacted significantly through job loss, increased taxes, or higher service fees. Ten hospitals stated that their conversion had little impact on their hospital.

- 12% of CAHs had discontinued a service due to overhead costs. The most commonly discontinued services were meals on wheels, post-acute or long-term care services (especially, home health), obstetrics, and surgery. Some of these services, like meals on wheels, were continued through another community-based organization.

SUMMARY AND CONCLUSIONS

The results of the 2007 survey indicate that Critical Access Hospitals are active in monitoring the health and health system needs of their communities, are engaged with other community organizations and stakeholders to address those needs, and provide services (often free) for patients and other provider organizations in the community that enhance access to care and help build the local rural health system.

- **Nearly all CAHs offer financial assistance to patients in the form of both charity care and discounted charges.**

Eligibility for charity care and discounted charges is typically set below 200% of the Federal Poverty Level. Nearly 90% of CAHs have formal processes to inform patients of their eligibility for charity care, discounted charges, and/or free care, although hospitals vary in how aggressive and transparent they are in communicating these policies to patients and in their training of staff on the policies.

Although we did not request that respondents quantify the dollar value of these and other activities that meet the guidelines and reporting requirements of the Catholic Health Association and other community benefit reporting systems, it is likely that the community benefit value associated with these activities and services (defined in terms of unreimbursed costs) is considerable. The non-financial, human and health system impact of these activities (defined, for instance, in terms of patient access to services, community level health improvement, and rural health systems development) are also likely to be significant.

- **In addition to free and discounted care provided to patients, CAHs are engaged in community needs assessments, gap-filling service development and other activities that demonstrate their attention and responsiveness to community and rural health system needs.**

Nearly half of the CAHs surveyed had conducted a formal community needs assessment in the past three years and two-thirds have a formal planning process for addressing new service or other hospital and community needs. Moreover, a large majority of these hospitals actively involve the community in planning committees, meetings, and other components of the planning process, including local government, health care providers, consumers, local businesses and other community organizations.

Community needs assessments are a core component of most community benefit guidelines. The fact that half of CAHs have not recently conducted a community needs assessment suggests this is an area where CAHs have a significant opportunity for performance improvement. This is also an area where state Flex Programs might be helpful by providing technical and/or financial assistance to encourage and support a more consistent approach to community needs assessment among CAHs.

Nearly all of the CAHs surveyed offer services to address gaps in the community, including community health education, preventive screenings, free or reduced cost clinic services, clinical preventive service, and support services (e.g. Medicaid enrollment assistance). Moreover, these services are typically subsidized or offered at a final loss. Comparatively few CAHs offer mental

health (36%) or substance abuse services (10%). This is not surprising given the financial risks associated with these services. This is confirmed by the fact that the majority of CAHs that offer these services do so by subsidizing them and/or offering them at a financial loss.

- **Over three-quarters of CAHs have relationships with other CAHs and non-CAH hospitals, EMS, schools, and public health agencies. CAHs are also supporting many of these community organizations, especially schools, primary care, and EMS.**

The development of networks among CAHs and other health care providers in the community and or region is a core strategy in the Flex Program for helping to expand or develop local services. The support CAHs provide to other community health organizations varies by organization but is most often in the form of financial support and help with recruitment and retention of personnel. Other health system development and community building activities include active recruitment of providers, job creation and training programs, and workforce education. Relatively few CAHs are involved in the development of Rural Health Clinics or Federally Qualified Health Centers.

It is currently impossible to assess the comparative performance of CAHs without more precise quantification of the value of many of these community benefits activities and in the absence of an understanding of trends over time and whether CAHs differ from other hospitals with regard to these activities. The Flex Monitoring Team's Community Benefit and Impact Performance Reporting module which will be piloted and finalized in 2008 will allow for quantification of the dollar value of some of the community benefit and impact activities of CAHs. If implemented nationally, it would also allow for comparisons of trends over time. In addition, the projected implementation in 2009 of the Internal Revenue Service's revised rules regarding the reporting of community benefit through Form 990 and Schedule H[1] would provide national data for assessing the performance of all CAHs over time and in relation to other hospitals.

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APPENDIX A: CAH SURVEY RESPONDENTS BY STATE

State	Number of CAHs	Percent	State	Number of CAHs	Percent
SC	1	.3%	AR	8	2.1%
AL	2	.5%	KY	8	2.1%
CO	2	.5%	NC	8	2.1%
FL	2	.5%	SD	8	2.1%
MA	2	.5%	IN	9	2.4%
NM	2	.5%	ID	10	2.6%
UT	2	.5%	LA	10	2.6%
VA	2	.5%	MI	10	2.6%
CA	3	.8%	OH	10	2.6%
NV	3	.8%	GA	11	2.9%
VT	3	.8%	MS	12	3.1%
AK	4	1.0%	MO	14	3.7%
AZ	4	1.0%	MT	14	3.7%
HI	4	1.0%	WA	14	3.7%
ME	4	1.0%	ND	15	3.9%
PA	4	1.0%	IL	16	4.2%
TN	4	1.0%	TX	18	4.7%
WV	4	1.0%	WI	18	4.7%
NH	5	1.3%	IA	19	5.0%
NY	5	1.3%	KS	20	5.3%
WY	5	1.3%	NE	23	6.0%
OK	6	1.6%	MN	26	6.8%
OR	7	1.8%			
			TOTAL	**381**	**99.4%**

Note: Total does not equal 100% due to rounding.

APPENDIX B: LIST OF ABBREVIATIONS AND ACRONYMS

CAH	Critical Access Hospital
CEO	Chief Executive Officer
CHA	Catholic Health Association of the United States
EMS	Emergency Medical Services
Flex Program	Medicare Rural Hospital Flexibility Program
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
RHC	Rural Health Clinic
VHA	VHA, Inc.