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Community Involvement of Critical Access Hospitals: Results of the 2004 National CAH Survey

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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.

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Executive Summary

This report describes the ways in which Critical Access Hospitals (CAHs) are engaged with their communities, through analysis of data from a national telephone survey of CAH administrators conducted in 2004. Survey respondents were asked about community involvement activities, including: community needs assessment, outreach and formal health promotion programs, relationships with other community organizations, free or reduced cost health care, and hospital activities in support on special populations.

The majority of survey respondents (81%) reported that they have conducted a Community Needs Assessment (CNA). Forty-nine percent were conducted in the year of or prior to conversion. The decision to convert to a CAH was the most important operational change to result from the CNA in 31 CAHs.

Almost all CAHs are engaged in health promotion activities, including staffing health information booths, sponsoring health promotion programs, offering health education seminars, or sponsoring or participating in immunization drives. Many administrators (35%) obtained external funding for activities such as chronic care management, immunization programs, wellness programs, smoking cessation, prescription drug assistance, and various programs for women and children. Just over one-third of these community outreach and prevention programs involved investment by state governments, and nearly one in five programs were supported by federal funds.

Free care or medication are particularly important to the low income residents of CAH communities, but only one-fourth of CAHs have free clinics and just under one-third distribute free or reduced cost medications. The most commonly reported free or reduced-cost service was health screenings.

Hospital administrators were asked whether their CAH provided a health information resource center or library, a clinician-staffed health information line, a health promotion center, or non-emergency transportation service. Just over one-half (51.5%) had at least one of these four resources. The most commonly offered service was a health promotion center such as a fitness program, swimming pool, or exercise classes.

Three-quarters of the sampled CAHs reported use of interpreters in their facilities, a remarkably high percentage. In addition, nearly two-thirds of the facilities offer translated printed materials. Other services targeted at special needs populations included TTY/TDD machines, use of the AT&T language interpreter line and bilingual staff.

Administrators report relationships with a variety of community organizations, most commonly hospices, public health departments and schools. Although most CAHs do not share staff with community organizations to which they are linked, sharing facilities and/or equipment appears to be a relatively common practice.

Most CAHs are engaged in activities that offer benefit to their community beyond hospital-based acute care services. Administrators recognize the importance of being responsive to community needs and seek the financial support necessary to maintain outreach activities. The outreach programs reported by CAH administrators resembled typical community activities for a health care facility, with a particular emphasis on health promotion and management of chronic conditions. The data reported here provide a starting point for understanding CAH community involvement. As CAHs gain increased financial security, it is possible that administrators who have not already done so will turn their attention to this important issue.

Community Involvement of Critical Access Hospitals

INTRODUCTION

The Medicare Rural Hospital Flexibility Program (Flex program) was authorized by Congress to support small rural hospitals that are critical to the communities they serve. In addition to specific provisions for these hospitals to be designated as Critical Access Hospitals (CAH), with the benefit of Medicare cost-based reimbursement, the Flex program's intent is to strengthen and improve the rural healthcare infrastructure. As detailed in the Medicare Rural Hospital Flexibility Program Strategic Planning Outline (Office of Rural Health Policy), community orientation, responsiveness, and engagement are explicit expectations of the program. The Program vision statement calls for "the development and support of community-based collaborative rural delivery systems," and the Program mission statement includes that "the Flex program will 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."

The Strategic Planning Outline specifically identifies objectives related to community engagement and impact with related measures, including that the program "facilitate development of all types of effective formal networks and informal collaborations including local "vertical" community-based networks across the continuum of care (and) encourage community engagement/outreach as an integral program function to help support utilization and financial viability of CAHs and eligible facilities." In recognition of the Flex program goals, many state Offices of Rural Health are using their

Flex program grant dollars to encourage and support CAH involvement with local communities (Hagopian and Hart, 2001).

There are a number of ways for CAH to become involved in their communities. Hospital staff may form relationships with other community providers, engage in outreach activities and formal community health programs, provide hospital-based non-acute care resources and services, provide free or reduced cost care programs, and focus on special populations. CAHs may be engaging rural communities in healthcare decision-making and system development, thereby insuring that services meet identified needs, through both community needs assessments and ongoing efforts to incorporate community input.

Community involvement by CAHs may be facilitated by the return to cost-based reimbursement, which has improved the financial status of many small rural hospitals (Stensland, et al. 2004). In addition to assuring survival, financial stability can foster the expansion of community services by the hospital; CAHs may have the resources to be involved in community health promotion activities and provision of other health care services that might not otherwise be available to residents of small rural communities. Availability of enhanced services for community residents strengthens the ties between hospital and community, as it increases the community's support and use of the facility (which is related to perceptions of facility quality, hospital responsiveness to community needs etc). The increased community support in turn helps maintain CAH financial stability.

This report describes the ways in which Critical Access Hospitals (CAHs) are engaged with their communities. The community involvement of CAHs may include a variety of activities that promote community health. Hospitals may connect with local

residents by providing staff for community events such as health fairs, sponsoring health promotion programs, conducting immunization drives, or developing resource centers that are open to the public. Additionally, small rural hospitals may employ a majority of the community's health care providers and offer support for other local health care facilities. Other community benefit may accrue from the provision of free well care or acute care and/or free or reduced-cost medication. These activities collectively have an impact on a community that is difficult to quantify but which represents the building blocks of a strong health care system that enjoys community support.

METHODS

Data for this report were collected through a national telephone survey of CAH administrators conducted between January and April of 2004. The survey was developed by the Flex Monitoring Team and fielded by the Survey Research Center in the Division of Health Services Research and Policy at the University of Minnesota. This comprehensive survey included questions that addressed changes in the scope of services provided by the CAH, organizational linkages, quality improvement activities, and patient safety activities in addition to a detailed section on community involvement that is described here.

A random sample of 500 CAHs was selected for the survey, stratified into two groups: 1) CAHs that were certified by the Centers for Medicare and Medicaid (CMS) as of May 1, 2001 and that had responded to a previous survey of CAHs conducted in 2001; and 2) CAHs that were certified after May 1, 2001 but no later than December 1, 2002. All of the hospitals in the sample had at least one year of operational experience before they were surveyed; some had up to four years of experience as a CAH. One CAH closed

prior to being surveyed and two others were removed from the sample because their CEO reported being certified after December 1, 2002, reducing the sample to 497. A total of 474 CAHs responded to the survey, yielding a response rate of 95%.

In the area of community impact, survey respondents were asked about the following aspects of community involvement: community needs assessment; community outreach activities including funding to support such activities; provision of health information, health promotion and other services to the community; the structure and extent of relationships between the hospital and other community organizations; the provision of free or reduced cost health care programs; and hospital activities in support of special populations.

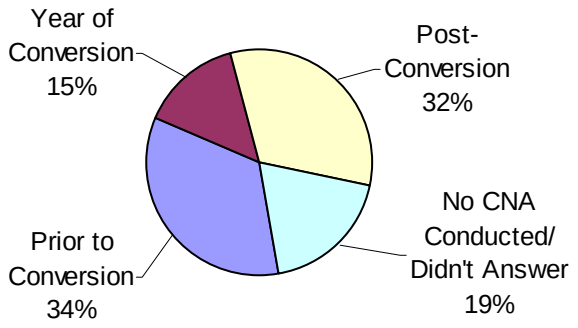
RESULTS

Community Needs Assessment

A community needs assessment (CNA) can be an effective technique for hospital administrators and others in small geographic areas to identify community needs by examination of community-specific data, when available, and exploration of the community's most pressing health care needs as identified by community members. Although a CNA is not a federal requirement, in 29 states such an assessment is required as part of the conversion process. The majority of survey respondents (81%) reported that they have conducted a CNA. Information obtained from site visits to CAHs (conducted independently of the survey reported here), indicates that some hospitals have used the findings from CNAs in their decision process when considering conversion to CAH status, thus engaging the community, albeit indirectly, in the conversion process. This survey

found that 34% of the hospitals conducted a needs assessment in the year prior to conversion, providing some indication of whether CAH status would meet the needs of the community (Figure 1). A CNA was conducted the same year as conversion in an additional 15% of surveyed facilities, although data do not allow identifying whether the assessment was conducted prior to or after the conversion date.

Figure 1. Community Needs Assessments
N=474



Respondents from 31 hospitals regarded the decision to convert to a CAH as the most important operational change to result from the CNA. A variety of other operational changes, such as service expansion, marketing, recruitment, and operational planning, were reported to have resulted from the assessment. Of interest to this report, however, is the finding that respondents from 38 facilities (8%) reported the establishment of health promotion or prevention programs and those from 11 CAHs (2%) reported the development of programs for their community's needy populations as a result of their CNAs.

Outreach Activities and Formal Health Promotion Programs

Activities that provide free care or medication are particularly important to the low income residents of CAH communities. Community outreach in the form of free or reduced-cost services is most likely to be limited to health screenings (Table 1). Fewer hospitals are involved in outreach activities that require substantial financial resources. Only one-fourth of CAHs have free clinics and just under one-third distribute free or reduced cost medications.

Table 1. CAH Community Outreach Activities by Region

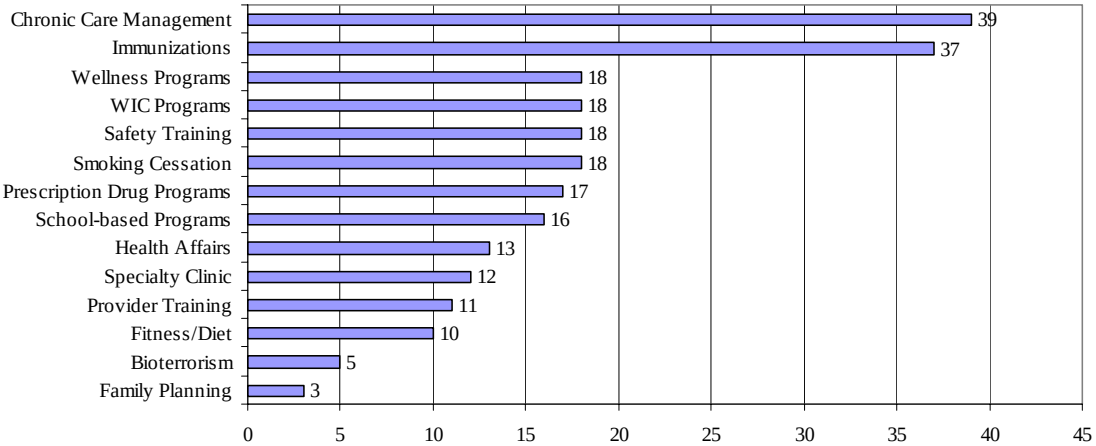
	All Regions	Northeast	Midwest	South	West
	(N=474)	(N=23)	(N=241)	(N=110)	(N=100)
Free Care					
Free clinics	24.7%	39.1%	24.9%	21.8%	24.0%
Free or reduced cost health screenings	82.9%	87.0%	80.9%	82.7%	87.0%
Free or reduced cost medications	31.2%	26.1%	30.7%	38.2%	26.0%
Health Promotion Activities					
Staffing health information booths	80.8%	73.9%	79.3%	85.5%	81.0%
Sponsorship of community and/or worksite health promotion programs	80.2%	82.6%	81.3%	75.5%	82.0%
Immunization drives	65.2%	87.0%	62.7%	61.8%	70.0%
Health education seminars	79.1%	91.3%	82.2%	74.6%	74.0%

The majority of hospitals are engaged in health promotion activities, including provision of staff for health information booths, sponsoring health promotion programs, offering health education seminars, or sponsoring or participating in immunization drives (Table 1). It should be noted, however, that while the impetus for conducting these activities may be responsiveness to community needs, it may also be from marketing strategies. When asked about the operation of seven specific outreach activities identified in Table 1, 98% of respondents reported participating in at least one of the activities with

9% of CAHs participating in all seven. Only small differences are seen across region in the types of community outreach activities offered.

Some administrators reported that they obtained external funding for community outreach, prevention, and health promotion programs. When asked to identify up to three externally funded programs, 166 CAH administrators (35%) described a total of 308 different programs. Respondents' descriptions of their externally funded program varied in detail and included descriptions that could be characterized by activity, population targeted, or health problem. Respondents were most likely to describe their programs by the type of activity supported (235 programs). The most commonly mentioned specific program activities included chronic care management, immunization programs, wellness programs, smoking cessation, prescription drug assistance, and various programs for women and children (Figure 2).

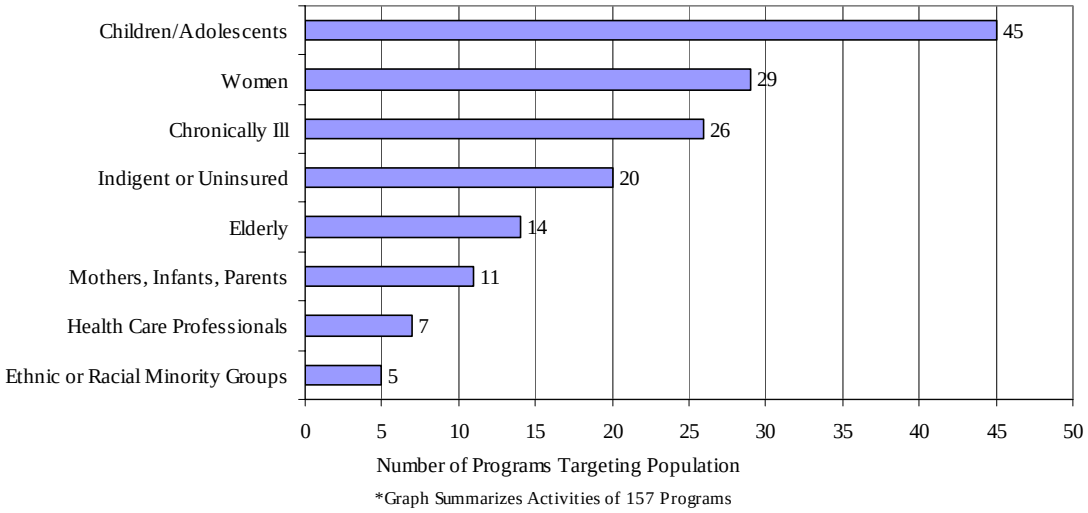
Figure 2. Types of Outreach Activities Among CAHs That Report Formal, Externally Funded Programs



*Graph Summarizes Activities of 235 programs

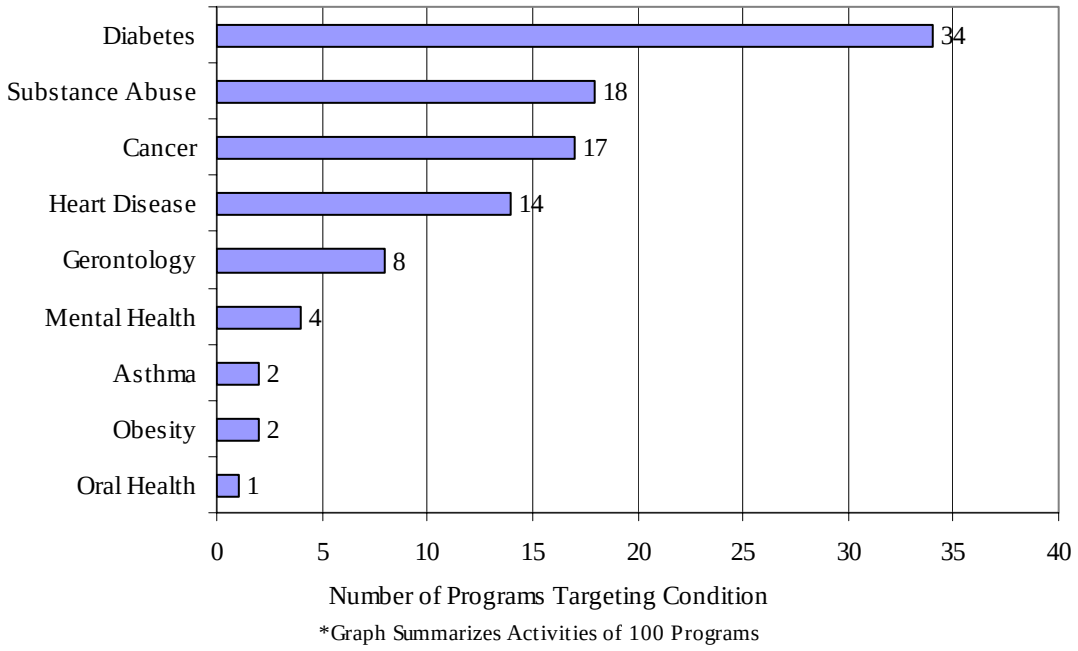
Among those respondents whose description included the population targeted (157 programs), programs were most frequently designed for children or adolescents, women, and the chronically ill (Figure 3). Finally, a much smaller number of program descriptions (100 programs) included the specific conditions on which they focused (Figure 4). Most frequently mentioned were diabetes, substance abuse, cancer, and heart disease, though a variety of other health issues were identified.

Figure 3. Types of Populations Targeted Through Formal, Externally Funded Programs in CAHs



*Graph Summarizes Activities of 157 Programs

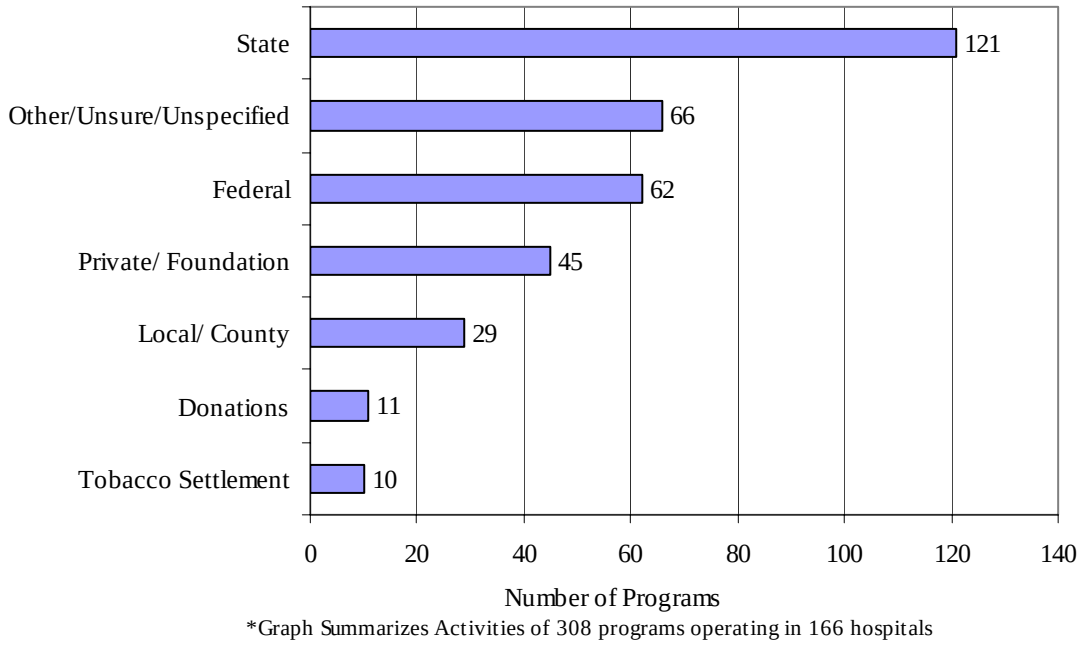
Figure 4. Types of Conditions Targeted Through Formal, Externally Funded Programs in CAHs



*Graph Summarizes Activities of 100 Programs

Respondents were asked to identify the source of external funding for these 308 community health outreach and prevention programs. At least 14% of hospitals obtained funding from multiple sources. Just over one-third of these community outreach and prevention programs involved investment by state governments, and nearly one in five programs were supported by federal funds (Figure 5). Administrators reported limited private foundation grant support, and very little of the funding for hospitals' formal community outreach programs was obtained through donations, tobacco grants, or local and county sources.

Figure 5. Funding Source of Formal, Externally Funded Outreach Programs Among CAHs



*Graph Summarizes Activities of 308 programs operating in 166 hospitals

Administrators were also asked specifically whether their institution received supplemental funding to support the provision of free or reduced care, and just under half (47.7%) reported receiving such funding. Less than one-third of CAHs receive state disproportionate share funds and one-quarter receive local, municipal, or county support (Table 2). Less than one-fifth (17.9%) of hospitals have multiple sources of supplemental funding.

Table 2. Supplemental Funding to Support Free or Reduced Cost Care, by Region

	All Regions (N=474)	Northeast (N=23)	Midwest (N=241)	South (N=110)	West (N=100)
DSH payments	29.3%	21.7%	13.3%	51.8%	45.0%
Local/Municipal support	25.5%	4.4%	21.6%	24.6%	41.0%
Private funding and grants	11.2%	17.4%	11.2%	11.8%	9.0%
Federal or State grants	6.3%	17.4%	5.4%	7.2%	5.0%
CHC or Migrant Clinic grants	0.6%	0.0%	0.8%	0.0%	1.0%

There was notable variation in the sources of supplemental funding across regions. CAHs located in the Northeast were more likely to receive funds from grants. In the South, state DSH payments were the most common source of external support. CAHs located in the West were more likely than those in other regions of the country to receive local support for the provision of free or reduced cost care.

Non-clinical Resources

Hospital administrators were asked whether their CAH provided specific resources to the community such as a health information resource center or library, a clinician-staffed health information line, a health promotion center, or non-emergency transportation service. As a measure of the degree of institutional commitment among those CAHs providing such resources, respondents were asked to report the percentage FTE devoted to the activity. Just over one-half (51.5%) of all CAHs had at least one of these four resources, and 17% offered more than one. The most commonly offered service was a health promotion center such as a fitness program, swimming pool, or exercise classes (Table 3). About 17% of hospitals offered non-emergency transportation services and a similar percentage offered hospital-based health information centers or libraries. Hospitals were most likely to provide personnel support for health promotion/fitness center activities and for transportation services. Fewer hospitals, but still more than two-thirds, reported providing staff for health information centers or health information lines. Notable regional differences included the observation that CAHs in the Midwest are much more likely to have a fitness center, while non-emergency transportation services are more commonly offered by CAHs in the West.

Table 3. Provision of Hospital-based Community Resources and Services

	All Regions	Northeast	Midwest	South	West
CAHs with:	N=474				
Health promotion/fitness center	**31.30%**	**26.1%**	**43.6%**	**16.4%**	**19.0%**
Among these:					
Percent reporting FTE devoted to activity	*90.5*				
Average Number of FTEs dedicated	*1.55*	*1.35*	*1.36*	*1.96*	*0.95*
Hospital-based health information center/library	**17.10%**	**34.8%**	**15.8%**	**12.7%**	**21.0%**
Among these:					
Percent reporting FTE devoted to activity	*71.6*				
Average Number of FTEs dedicated	*0.51*	*0.40*	*0.50*	*0.80*	*0.44*
Non-emergency transportation services	**16.90%**	**17.4%**	**17.0%**	**8.2%**	**26.0%**
Among these:					
Percent reporting FTE devoted to activity	*88.8*				
Average Number of FTEs dedicated	*0.88*	*1.33*	*0.81*	*0.85*	*0.97*
Clinician-staffed health information line	**6.60%**	**13.0%**	**5.8%**	**6.4%**	**7.0%**
Among these:					
Percent reporting FTE devoted to activity	*67.7*				
Average Number of FTEs dedicated	*0.87*	*0.40*	*1.34*	*0.60*	*0.30*

Despite the availability of these services in more than half of the sampled CAHs, not all hospitals had staff devoted to those activities. Among the 214 hospitals that reported *some* staff time for these activities, the number of FTEs dedicated specifically to these community services ranged from 0.1 to 9 with an average of 1.5 FTEs. Among the four services, health promotion centers tended to require the greatest staff commitment, with an average of 1.6 FTEs in the facilities that offered them.

Accommodations for Special Populations

In the health care setting, many organizations find it challenging to accommodate patients with special needs such as Low English Proficiency (LEP), illiteracy or a disability. This may be especially true in rural communities where resources are limited and the subpopulation of people with special needs is so small that health care providers

have limited experience with clients with special needs. While hospitals are legally required to provide access to those with language barriers by Title VI of the Civil Rights Act, interpretation of this law is subject to qualifications based on size of the population and other factors that might give small hospitals grounds for exceptions.

Our study inquired about specific efforts to accommodate the needs of some special populations. Three-quarters of the respondents in our sample reported use of interpreters in their facilities, a remarkably high percentage given that many of these hospitals may have grounds for exception from the Title VI requirements. In addition, translated printed materials were offered in nearly two-thirds of the facilities (Table 4). Other services targeted at special needs populations included TTY/TDD machines, use of the AT&T language interpreter line and bilingual staff. Provision of interpreters and printed materials in languages other than English by the majority of CAHs implies that their market area includes individuals from other cultures. Very few hospitals, however, offer training in cultural or language competency.

Table 4. Percentage of Hospitals Offering Services for Special Needs Populations

	All Regions	Northeast	Midwest	South	West
Language interpreters	75.1%	73.9%	74.7%	72.7%	79.0%
Translated printed materials	63.1%	56.5%	59.8%	65.5%	70.0%
Cultural/language competency training	17.9%	8.7%	18.7%	15.5%	21.0%
Other (e.g., sign language, TTY/TDD, AT&T phone interpreter line, bilingual staff)	17.9%	39.1%	14.9%	14.6%	24.0%

Relationships with Other Community Organizations

To assess the extent to which CAHs are meeting the Flex program vision of developing "community-based collaborative rural delivery systems," a series of questions

in the survey captures the nature and extent of relationships between CAHs and other community organizations. Relationships with three categories of organizations are assessed: Those that provide health care services that are supportive of the inpatient care (whether before, during, or after hospitalization), those that provide community health care services, and those whose focus is not primarily health care. Among providers of supportive health care services, Hospices are the most commonly reported programs with which CAHs have relationships (Table 5). Linkages with other community health care providers, both private and public, were also reported, although to a slightly lesser degree. Of note, almost 60% of CAHs have some sort of linkage with the public health department, which is a key indication of linkage to the population. Few administrators reported linkages with community organizations whose focus is not primarily health care, with the exception those (64.2%) who have formal or informal agreements with schools and 37.6% who report agreements with social service agencies.

Linkages with local organizations can take the form of formal contracts, written agreements, and informal agreements. To further assess the extent of the linkage and the degree of integration between organizations, administrators were asked whether they shared staff or equipment with local organizations, and, if so, whether a financial commitment was involved. The formality of the link seems to have little relationship to the extent of the commitment—administrators report that staff and equipment were both shared with other organizations and paid for by the CAH under all three types of agreements (data not shown).

Table 5. CAH Relationships with Other Community Organizations

	CAHs with Formal Contract	CAHs with Written Agreement	CAHs with Informal Agreement	CAHs Not Linked	N/A*
Supportive Health Care Services					
Hospice	47.7%	9.5%	6.5%	20.9%	14.8%
Private practice physicians	34.4%	6.3%	5.7%	47.3%	5.7%
Rehabilitation services	32.5%	3.4%	0.6%	23.4%	39.5%
EMS	19.8%	12.5%	24.9%	21.9%	20.3%
Home health agency	13.7%	5.3%	11.4%	34.6%	34.4%
Other Community Health Care Services					
Dentists	24.9%	10.1%	9.7%	50.8%	3.8%
Health Department	22.2%	6.5%	31.4%	36.3%	3.0%
Mental health agency	21.1%	9.3%	19.6%	46.2%	3.4%
FQHC, CHC, or RHC	7.0%	2.5%	5.7%	41.6%	42.4%
Other					
School	20.5%	11.2%	32.5%	35.4%	0.0%
Social services agency	12.7%	5.7%	19.2%	57.6%	4.4%
Legal services	3.6%	1.9%	4.2%	88.2%	1.5%
Head Start	3.4%	2.1%	5.1%	81.0%	8.0%
United Way	0.8%	1.1%	9.3%	79.5%	8.9%

* Entity is either owned by the CAH, or does not exist in local area

Most CAHs do not share staff with local community organizations to which they are linked (Table 6). Among organizations that provide supportive health care services, CAH are most likely to share staff with private physician practices (19.7%, and 17.1% cover all or part of salaries) and EMS (16.8%, and 15.3% contribute to salaries). Among other local health care providers, CAHs are most likely to share staff with public health departments (13.1%). Of interest, the one type of organization with which CAHs are most likely to share staff is schools (26.4%), and almost a quarter of CAHs (23.9%) pay all or part of the salaries for staff that they share.

Table 6. Staff Sharing with Organizations External to CAH

	Share Staff					
	Total	*CAH pays all of salary*	*CAH pays part of salary*	*N/A*	Linked But Don't Share Staff	Not Linked or N/A*
Supportive Health Care Services						
Hospice	14.2%	*7.8%*	*4.9%*	*1.5%*	49.6%	36.3%
Private practice physicians	19.7%	*12.6%*	*4.5%*	*2.6%*	26.4%	54.0%
Rehabilitation services	13.1%	*9.1%*	*3.6%*	*0.4%*	23.4%	63.5%
EMS	16.8%	*8.7%*	*6.6%*	*1.5%*	40.4%	42.9%
Home health agency	5.3%	*2.3%*	*1.7%*	*1.3%*	24.9%	69.8%
Other Community Services						
Dentists	3.1%	*2.1%*	*0.4%*	*0.6%*	41.6%	55.3%
Health Department	13.1%	*7.4%*	*3.8%*	*1.9%*	47.0%	39.9%
Mental health agency	4.8%	*1.7%*	*2.3%*	*0.8%*	45.1%	50.0%
FQHC, CHC, or RHC	4.2%	*1.9%*	*1.7%*	*0.6%*	11.0%	84.8%
Other						
School	26.4%	*18.6%*	*5.3%*	*2.5%*	37.8%	35.9%
Social services agency	7.3%	*4.2%*	*2.5%*	*0.6%*	30.2%	62.4%
Legal services	0%	*0.0%*	*0.0%*	*0.0%*	9.7%	90.3%
Head Start	3.5%	*2.1%*	*0.8%*	*0.6%*	7.0%	89.5%
United Way	2.3%	*1.7%*	*0.0%*	*0.6%*	8.7%	89.0%

* Entity is either owned by the CAH, or does not exist in local area

Sharing facilities and/or equipment with local organizations appears to be a more common practice than sharing staff (Table 7). Administrators are more likely to report these facility/equipment-sharing relationships with organizations that provide health care services likely to be used by the hospital's patients before, during, or after hospitalization, with almost a third of CAHs sharing equipment with hospice, rehabilitation services, and EMS.

Table 7. Equipment or Facility Sharing with Organizations External to CAH

	Equipment/Facility Share				Not Linked or N/A*	Linked But Don't Share Equipment or Facility
	Total	*CAH pays total cost*	*CAH pays part of cost*	*N/A*		
Supportive Health Care Services						
Hospice	29.3%	*12.3%*	*7.2%*	*9.8%*	36.5%	34.2%
Private practice physicians	26.4%	*10.1%*	*7.6%*	*8.7%*	53.7%	19.9%
Rehabilitation services	28.5%	*12.3%*	*9.6%*	*6.6%*	63.9%	7.6%
EMS	30.6%	*19.7%*	*8.1%*	*2.8%*	43.1%	26.3%
Home health agency	10.7%	*3.4%*	*4.6%*	*2.7%*	69.6%	19.6%
Other Community Services						
Dentists	8.4%	*7.4%*	*2.1%*	*3.0%*	55.3%	32.3%
Health Department	18.6%	*10.8%*	*5.1%*	*2.7%*	39.9%	41.6%
Mental health agency	16.5%	*11.2%*	*1.5%*	*3.8%*	50.2%	33.3%
FQHC, CHC, or RHC	6.9%	*2.5%*	*1.9%*	*2.5%*	84.8%	8.2%
Other						
School	19.1%	*14.8%*	*3.0%*	*1.3%*	35.9%	45.0%
Social services agency	10.4%	*7.6%*	*1.5%*	*1.3%*	62.4%	27.2%
Legal services	0.2%	*0.2%*	*0.0%*	*0.0%*	90.3%	9.5%
Head Start	2.1%	*1.5%*	*0.6%*	*0.0%*	89.5%	8.4%
United Way	2.5%	*2.3%*	*0.2%*	*0.0%*	88.8%	8.6%

* Entity is either owned by the CAH, or does not exist in local area

DISCUSSION AND CONCLUSION

Results from our survey demonstrate that most Critical Access Hospitals are engaged in activities that offer some benefit to their community beyond hospital-based acute care services. Administrators seem to recognize the importance of soliciting and being responsive to community needs and seek the financial support necessary to maintain outreach activities. The outreach programs reported by CAH administrators resembled typical community activities for a health care facility, with a particular emphasis on health promotion and management of chronic conditions. There was, however, a lack of FTE

support by CAHs for the community activities in which they are engaged. Given the average total FTE complement of CAHs, it is not surprising that very few FTEs are dedicated to outreach activities. This is an area where, as finances improve, CAH administrators might be able to direct resources.

Regional differences were noted in the operation of outreach activities by CAHs and in the presence of linkages with other community providers. To some extent, these regional differences may reflect variation in the populations in need of outreach activities or the availability of resources to initiate and maintain community outreach. Also, it is important to note that involvement in outreach activities or lack thereof may depend on the presence of other local resources. For example, the mission and scope of services provided by local health departments varies widely across regions. Thus, although the results in this paper describe the involvement of CAHs in community-level health promotion, education, and disease management activities, the survey does not provide a complete picture of whether or not community needs are being met.

The data reported here provide a starting point for understanding the community involvement of Critical Access Hospitals. It may well be the case that levels of involvement will increase over time, as the Flex program matures and CAHs gain increased financial security. The vision of the Flex program that CAHs should be community oriented, responsive, and engaged was arguably difficult to achieve in early program years when institutions were focused on financial survival. Now that the program has matured, it is possible that administrators who have not already done so will turn their attention to this important issue.

It was beyond the scope of this analysis to determine the extent to which CAHs with strong community involvement are located in states where Flex program dollars were targeted towards this goal. It will be important for future work to assess the extent to which state programs can facilitate CAHs' ability to engage with the communities they serve.

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