POLICY BRIEF #56 MARCH 2021

CAH Partnerships during the COVID-19 Pandemic

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KEY FINDINGS

- In a survey of Critical Access Hospital (CAH) CEOs in eight states, 90% of respondents replied that they partnered with local public health agencies for their COVID-19 response, and described a wide variety of partnership activities.
- Activities with local public health departments included communication (e.g. weekly or daily calls, public facing communications), community partnerships outside of local public health (with long term care facilities, county staff, and others), and COVID-19 testing.
- Thirty-nine percent of respondents reported receiving support from their State Flex Program, with financial support as the most commonly mentioned type.

PURPOSE

During the novel coronavirus of 2019 (COVID-19) pandemic hospitals around the United States (U.S.), including Critical Access Hospitals (CAHs), experienced significant challenges.[1,2] Some early reports indicated that hospital partnerships can mitigate financial burden in COVID-19 hot spots,[3,4] but detailed information on the use and impact of CAH partnerships with state and local agencies is currently lacking. Understanding local partnerships is critical for supporting CAH responses to the ongoing COVID-19 crisis and preparing for future public health emergencies. This policy brief presents findings from a survey of CAHs in eight states and describes ways in which CAHs partnered with their communities and public health agencies to respond to the multitude of difficulties they faced relating to the COVID-19 pandemic.

BACKGROUND

During the pandemic, CAHs have faced, and continue to face, challenges such as surges of COVID-19 cases,[5] shortages of personal protective equipment (PPE),[6,7,8] and a heightened risk of closure in the midst of the COVID-19 pandemic.,[1,9,10] In response to this public health crisis, partnerships beyond traditional inter-hospital relationships have emerged to buoy rural hospitals. Local public health departments have helped coordinate hospital supplies[11] and COVID-19 testing,[12] and community partnerships have helped supply PPE through donations.[11] These partnerships with local and state-level organizations may help alleviate the burden for some rural hospitals, but there is limited information on how many CAHs utilize these partnerships or the focus of the partnerships' activities.

APPROACH

This analysis uses data from a survey of 158 CAH CEOs across eight states. The survey was fielded between September 8, 2020 and October 30, 2020, and participants answered questions about their hospital's capacity to respond to the COVID-19 pandemic from February to August 2020.

To select the study states, the prevalence of COVID-19 cases in July 2020 in rural (non-metropolitan micropolitan and non-core) counties[13] was assessed for each state with at least 10 CAHs using data from USA Facts.[14] The two states with highest rural prevalence in each of the four U.S. Census regions were selected. The study states included Arizona, Florida, Indiana, Iowa, Louisiana, New York, Pennsylvania, and Utah, and all CAHs in these states were surveyed.

Survey questions were developed based on a literature review and expert panel, and included questions on several topics: finance, federal policies, capacity for treatment, workforce, and partnerships. Feedback from an initial pilot test with five CAHs from three states was integrated before finalizing the survey. To field the survey, CAH CEOs were emailed a link to the online survey, and follow up was conducted via email and phone. CAH CEOs could also designate another staff member to respond to the survey on their behalf. Out of a total of 216 CAHs contacted, a response rate of 73% was achieved, with 58 CAHs that did not respond to the survey.

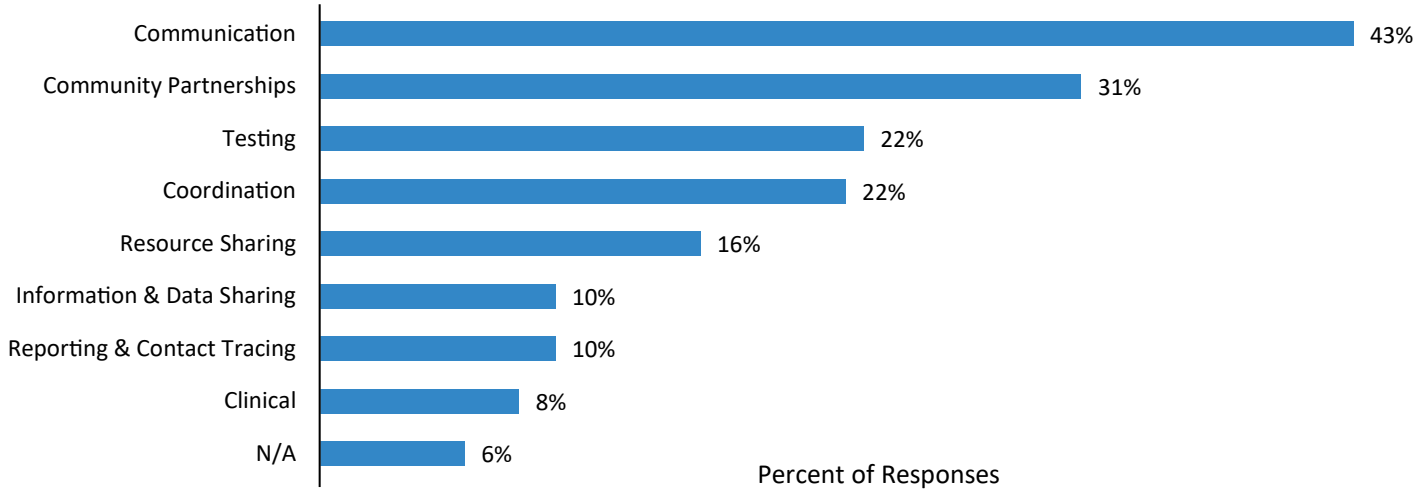
Qualitative data from the survey's open-ended prompts for this analysis included responses to 1) how their hospital worked with local public health agencies for their COVID-19 response; and 2) what type of support they received from their State Flex Program (SFP). Responses were coded by two members of the research team using conventional inductive content analysis to identify key themes. Additional data on response rates and frequencies were calculated using STATA software.

RESULTS

Local Public Health Partnerships

Respondents were asked if they partnered with local public health agencies in response to the COVID-19 pandemic. Of the 155 respondents who answered this question, 90% replied affirmatively and 134 participants provided a specific example of collaborative activities. Responses were categorized into eight themes: 1) Communication; 2) Community Partnerships; 3) Testing; 4) Coordination; 5) Resource Sharing; 6) Information and Data Sharing; 7) Reporting and Contact Tracing; and 8) Clinical (see Figure 1).

FIGURE 1. Types of CAH Collaboration with Local Public Health Agencies during COVID-19 Response (February to August 2020)



Note: Respondents could provide more than one answer for types of collaboration

The most common theme was communication, with the overwhelming majority of responses mentioning regular (daily or weekly) calls with local public health, but also included activities such as collaborating on external public messaging and generally having open communication.

Broader community partnerships were mentioned in almost one-third of responses, including additional partnerships with long-term care facilities, county staff, and tribal health departments. These partners were involved in the COVID-19 response through regular phone calls, emergency planning, collaborating on testing efforts, and sharing supplies.

Other common themes included working with local public health on COVID-19 testing efforts, including using the CAH as a testing site, and coordination efforts with emergency management and/or incident command.

Additional themes included resource sharing with responses including PPE, testing supplies, and medications, and information and data sharing such as reporting COVID-19 cases, information about testing, and CDC guideline updates. Remaining themes included partnering for case reporting and contact tracing (e.g. mandatory reporting of cases to local public health or expanding community surveillance and contact tracing) and clinical activities (e.g. working together for a flu clinic or sharing clinical expertise from CAH physicians).

Quotes from respondents illustrating various ways CAHs partnered with local public health are described in Table 1.

TABLE 1. CAH Partnerships with Local Public Health Agencies (February to August 2020)

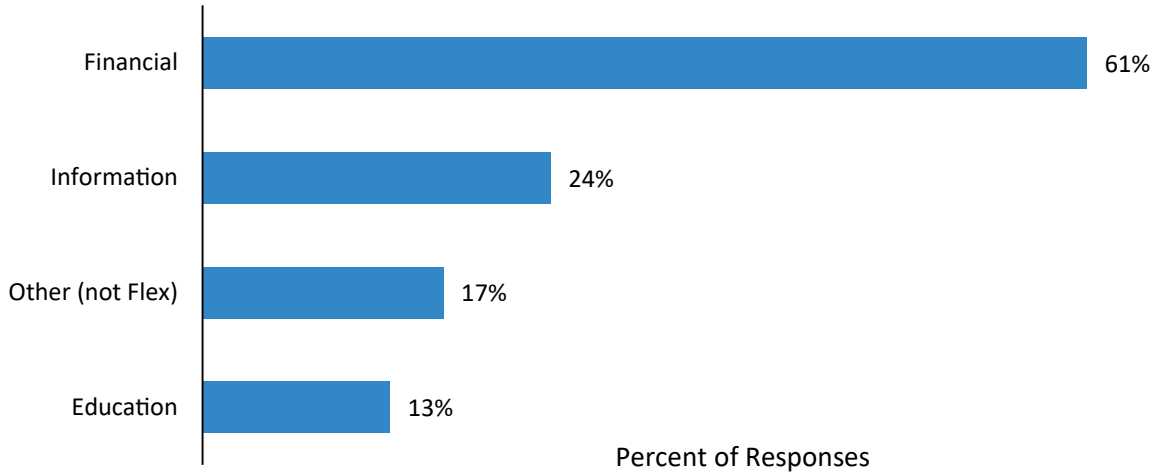
Theme	Quotes
Communication	"We met with local public health multiple times a week and learned what the needs were and worked together to try to problem solve." – Indiana CAH
Community Partnerships	"We met daily with all our community partners to ensure the response across the community was integrated and well planned out." – Iowa CAH
Testing	"We also worked with the PHD [Public Health Department] to develop an asymptomatic testing program for people in our community at a high risk for exposure." – Utah CAH
Coordination	"The county established an Emergency Response Coalition to address needs throughout the county." – Pennsylvania CAH "Public health became part of the hospital on 7/1/19 and was part [of] our ongoing incident command meetings. It was critical to our response." – Iowa CAH
Resource Sharing	"We worked with them to address shortages of PPE, they were helpful in providing some. We also did group purchasing with them because they were able to buy in a larger quantity." – New York CAH "They supplied us with a testing media and then later provided us with a rapid COVID test instrument." – Louisiana CAH
Information and Data Sharing	"[We] shared data back and forth and asked for their help early on in getting test results until that process improved." – Utah CAH
Reporting and Contact Tracing	"We coordinated with local public health to provide testing and contact tracing as well as sharing interpreters." – Iowa CAH
Clinical	"Our county health department doesn't have a physician so I liased [sic] and functioned as the physician advisor." – Arizona CAH "[Local public health] joined us in staffing 50% of one of our COVID clinics." – New York CAH

Flex Program Partnerships

Almost 40% of respondents reported they received support from their SFP in response to the COVID-19 pandemic. Twenty-five percent of respondents reported they did not receive support from their SFP, and the remaining 36% either replied "don't know" or did not answer this question.

Of the participants who indicated that they received support from their SFP, 89% gave an example of the support they received. These examples were categorized into four main themes: 1) Financial; 2) Information; 3) Education; and 4) Other (not Flex) (see Figure 2).

FIGURE 2. Types of Support CAHs received from State Flex Programs (February to August 2020)



Note: Respondents could provide more than one answer for types of State Flex Program support

The most common theme was financial, with many respondents reporting receipt of a grant (e.g. for PPE or supplies). Participants also frequently mentioned receiving information from their SFP, including situation updates and communication, daily briefings, or technical support.

Responses in the "other" category mainly mentioned Small Rural Hospital Improvement Program (SHIP) grants, which may in some states be administered through the same office as Flex Programs. The final theme, education, was mentioned by a small number of respondents with one example including educational resources such as webinars about how to understand and access funding.

DISCUSSION

This analysis describes the value of partnerships for CAHs during a public health emergency such as the COVID-19 pandemic. The vast majority of our respondents (90%) reported some type of partnership with their local public health agencies. The most common partnership activities with local public health were in communication, activities involving partnerships with other organizations, testing, and coordination. Responses also revealed that these partnerships were bidirectional. For example, in some instances local public health helped secure testing supplies for CAHs while in other instances, CAHs were instrumental in helping local public health with mass testing events. Some responses indicated that CAHs were focused on forming or

strengthening their partnership with local public health, whereas others may have had a more robust existing partnership and described activities or changes that happened as a result of that partnership.

In terms of support from SFPs, less than half of respondents reported receiving some type of support. However, 35% of respondents said they "didn't know" if they had received assistance from their SFP, and some participants mentioned SHIP grants and other types of government support that were not through the Flex Program. Data from a previous survey of State Flex Coordinators indicated that all of the 45 SFPs reported providing some sort of support during the COVID-19 crisis.[15] The most common type of support was education and information dissemination,[15] although many State Flex Coordinators mentioned that they worked with a variety of other partnerships and thus may not have been visible as the primary source of this assistance. Our findings combined with this previous study may indicate the need for additional outreach and/or education from SFPs on what the Flex Program is, what it does, and what resources it can provide related to COVID-19 and other CAH-related issues.

LIMITATIONS

The study has some limitations. First, there may be some nonresponse bias where CAHs may not have responded to the survey due to time constraints related to their COVID-19 response or caseload. Also, despite our efforts to standardize the phone survey, there may have been some differences in how the surveys were administered that impacted the responses.

CONCLUSIONS

Results from a survey of CAH CEOs in eight states provided insight into partnerships with local public health departments and SFPs. An overwhelming majority of respondents reported partnering with their local public health department, most commonly in communication, activities with other community organizations, and COVID-19 testing. This demonstrates the importance for CAHs to develop or maintain relationships with local public health agencies. Prioritizing these relationships may help CAHs during the ongoing COVID-19 crisis and future public health emergencies. Only 39% of respondents reported receiving support from their SFP, and financial support was the most commonly reported type. This finding indicates a need for ongoing efforts from SFPs to better understand how they can connect directly with CAHs to provide support and create awareness about the resources available to CAHs through the Flex Program.

For more information on this study, please contact Madeleine Pick at pickx016@umn.edu.

This study was conducted by the Flex Monitoring Team with funding from the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS), under PHS Grant No. U27RH01080. The information, conclusions, and opinions expressed in this document are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.

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