Community Impact of Critical Access Hospitals

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Flex Monitoring Team
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For Further Information

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Purpose

- Present a conceptual framework for understanding the community impact and benefits of CAHs
- Provide a program, state, and national context for monitoring community impact performance
- Describe the findings from our site visits to 6 CAHs
- Describe our efforts to date on developing CAH community impact measures

Program Context

- Concerns about cost-based reimbursement for CAHs
- Maintaining support for Flex grant program as conversion activity winds down
- Documenting program impact and performance (GPRA/PART)

State Context

- Community benefit reporting initiatives
  - 17 with mandatory reporting regulations (CA, CT, GA, ID, IL, IN, MD, MN, NH, NY, PA, RI, TX, UT, VT, WA, WV)
  - 1 with voluntary reporting standards developed by Attorney General's Office (MA)
  - 7 with voluntary reporting process developed by state hospital association (IA, MI, MO, NE, OR, TN, WI)

- Intent is to quantify community benefits provided by hospitals to justify non-profit tax benefits

National Context

- Voluntary Hospital Association/Catholic Health Association of the United States benefit reporting initiatives and the Public Health Institute standards and measures of community benefits

- Senate Finance Committee interest (spearheaded by Sen. Grassley of IA) in hospital charitable activities, billing activities, and ventures with for-profit hospitals and companies

- IRS Compliance Check Questionnaire mailed to 600 tax-exempt hospitals in 2006

Community Benefit

- Programs or activities that provide treatment and/or promote health in response to an identified community need. Key criteria:
  - Generates a low or negative margin;
  - Responds to needs of special populations (e.g., persons living in poverty);
  - Supplies a service/program that would likely be discontinued if based on financial criteria;
  - Responds to public health needs; or
  - Involves education or research that improves overall community health.

Community Impact

- Describes programs or activities that have a positive result for the community (e.g., service expansion or the economic benefits of the hospital as an employer), is unsubsidized, has a source for reimbursement to the hospital, and/or attempts to be self-sustaining.

Conceptual Framework

- **Identifying Unmet Community Needs**
  - Identification of community needs through a process of information gathering and action planning around community or population health needs.
- **Addressing Unmet Community Needs:**
  - Development of services identified as (1) needed by the community and (2) critical to the hospital.
- **Prevention and Disease Management**
  - Strengthening primary prevention in the community.

Conceptual Framework

- **Building a Continuum of Care**
  - Development of “seamless continuum of care” through service and organizational linkages with local clinical and community health organizations.
- **Building Community Health System Capacity**
  - Development of community partnerships designed 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.

Site Visit Locations

- Kearny County Hospital, in Lakin, KS;
- Littleton Regional Hospital, in Littleton, NH;
- Nor-Lea General Hospital, in Lovington, NM;
- Regional Medical Center, in Manchester, IA;
- Teton Medical Center, in Choteau, MT; and
- Weiser Memorial Hospital, in Weiser, ID

Findings from Site Visits

- **Identifying unmet community needs**
  - Broad based collaboration is critical
  - Formal community needs assessments are a complex, time consuming processes requiring a strong commitment of leadership and resources
  - TA needs - data collection and interpretation, facilitating community involvement, developing priorities, and translating needs into action
  - Best viewed as a continuous process of monitoring community needs
  - Informal needs assessment are not a substitute for formal, systematic assessment processes

Findings from Site Visits

- **Addressing unmet community needs**
  - Strategies: 1) Service growth/expansion and 2) community benefit/subsidized activities
  - Despite operating in an environment of scarce resources, hospitals are engaged in and committing resources and leadership to a broad range of activities
  - Hospitals are important players in these efforts but must exercise their leadership carefully

Findings from Site Visits

- **Prevention and health improvement**
  - Important to distinguish marketing efforts from coordinated efforts tied into a continuum of services
- **Building a continuum of care and enhancing community health system capacity**
  - Sensitivity to hospital role is vital
  - Local and regional networks are useful tools
  - Little attention has been paid to “telling the story” of these initiatives locally or nationally.

Role of Flex

- **Cost based reimbursement/enhancements to financial stability improves ability of CAHs to undertake these activities**
  - Efforts to assess the impact of CBR should be broad enough to encompass the impact of CAHs in identifying and addressing unmet community needs and strengthening the rural health system
- **State Flex grant program role**
  - Activities related to conversions
  - Create expectations
  - Grant funds supporting community initiatives

CAH Performance Measures

- Flex Monitoring Team is charged with 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.

Development of Indicators

- **Draft Indicators from the Literature:**
  - Catholic Health Association of the United States, Voluntary Hospital Association, Public Health Institute, American Hospital Association Annual Survey, and Wisconsin Hospital Association among others.
- **Secondary Data Sources:**
  - Medicare Cost Reports and the American Hospital Association Annual Survey
- **Expert Committee Input:**
  - Committee members prioritized these indicators using four criteria: validity, significance, reliability, and feasibility.

Expert Committee

- Tim Size, Rural Wisconsin Health Cooperative
- J. David Seay, NAMI, New York State
- Christine Shannon, NH Office of Medicaid Business and Policy
- Paul A. Hattis, MD, JD, MPH, Tufts University School of Medicine
- Kevin Barnett, DrPH, MCP, Public Health Institute

Development of Indicators

- **Revised Indicators:**
  - We used the Committee's rankings to guide selection of a revised set of core indicators.
- **Development of Survey Questions:**
  - From these indicators, we developed survey questions that are currently under review by additional members of the Flex Monitoring Team.
- **Pilot Test:**
  - 10 CAHs will be asked to pilot test our survey instrument. We will review the results of this pilot test with the expert panel and revise the survey instrument.

Core Indicators

- **Charity Care**
  - presence of a written policy providing for free and discounted care
- **Government-Sponsored Health Care**
  - losses incurred from caring for patients covered by Medicaid, SCHIP, or other local/state health plan
- **Hospital Commitment to Community Benefit**
  - mission statement, provision of resources, strategic/long term plan that includes elements of community benefit

Core Indicators

- **Community Needs Assessment**
  - information collected on community needs used to plan community benefit activities
- **Community Health Services**
  - presence of community health education services, clinical services, support services, or other community health services
- **Community Engagement**
  - provision of financial, staffing, or other support to community health care providers; involvement in community activities; networking with other providers to develop new or expand existing services

Data Sources

- **CAH Annual Survey**
  - primary data collection on all core indicators, with the exception of government sponsored health care
- **American Hospital Association Annual Survey**
  - variables include mission statement, community needs assessment, use of health status indicators to design new or modify existing services
- **Medicare Cost Reports** –
  - variables include uncompensated care costs, amount of shortfall from serving patients covered by Medicaid, SCHIP and local/state health plan

Final Thoughts

- CAHs must learn to tell their community impact stories
- State Flex Programs can play a role in distributing tools and providing TA to assist them in doing so
- ORHP can develop and encourage the use of a standard community impact reporting tool for states and CAHs