Managing Community Benefits in Turbulent Times

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A Performance Monitoring Resource for Critical Access Hospitals, States, and Communities

Flex Monitoring Team

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Overview of Presentation

- Explore ways in which CAHs can strategically manage their community benefit to maximize services to vulnerable residents during turbulent times
- Understand community needs and the role of the needs assessment
- Manage charity care demands
- Target unmet community needs

OHRP's Vision for Flex

- Support the development of collaborative community-based rural health delivery systems with Critical Access Hospitals (CAHs) as the hubs of those systems of care and
- Encourage CAHs to undertake collaborative efforts to address unmet community health and health systems needs and/or improve the health status of their communities

Community Expectations

- Not-for-profit and public CAHs are accountable to their communities
- Pressure to respond to community needs
- Limited resources requires strategic thinking
- Economic downturn affects the needs of populations most at risk such as the working poor or the chronically ill
  - Lack of or reduced access to primary care, medications, preventive services and elective procedures
  - Greater demand on emergency rooms and hospitals due to reduced access

Community Benefit

- A planned and managed approach to meeting indentified community needs
- Catholic Health Association framework - de facto standard
- The definition implies collaboration with a “community” to “benefit” its residents with special emphasis on improving the health status of vulnerable, underserved populations

Community Benefit Activities

- Resulting from patient care activities
  - Charity care and government health care program shortfalls
- Community-focused activities
  - Community Health Improvement Services
  - Health Professions Education
  - Subsidized Health Services
  - Research
  - Financial and In-Kind Contributions
  - Community-Building Activities
  - Community Benefit Operations

Evidence Needed to Support Community Benefits

- Community need
- Improved access to services
- Enhanced population health
- Advancement of knowledge
- Charitable purposes

Identifying Community Need

- 48% CAHs conducted a formal community needs assessment in the last 3 years (2007 FMT Survey of CAHs)
- 66% have a formal planning process to address hospital and community needs
- **Key issues:**
  - It is not enough that staff and board reside in community and are familiar with local needs - must reach out to vulnerable populations and ask what their needs are
  - Needs and populations change – needs assessments should be done every 3 years or so

Benefits

- Provides valuable market and community data to build programs
- A window to unmet needs
- Guide to targeting limited resources and maximizing impact
- Vehicle for strengthening important community relationships

Community Needs Assessment Process

- Establish assessment infrastructure
- Define purpose and scope
- Collect and analyze data
- Select priorities
- Document and communicate results
- Plan for action and monitor progress

Available Tools

- Association for Community Health Improvement' Community Health Assessment Toolkit
  - www.assesstoolkit.org
  - Available to members of the AHA, Association for Community Health Improvement, and Society for Healthcare Strategy and Market Development
- National Association of County and City Health Officials' MAPP process
  - www.nacho.org/mapp
  - Used by many health departments in conjunction with hospitals

Examples

- Regional Medical Center
  - Organized around 10 core areas of Iowa's Health People 2010 criteria
  - Each committee had 6 to 9 community representatives
  - Hospital provided subtle leadership behind the scene
  - Increased trust and collaboration among community agencies
- Littleton Regional Hospital
  - Collaborative process between LRH, Ammonoosuc Community Health Services, and North Country Home Health and Hospice
  - Conducts a joint community needs assessment every two years
  - Prepared by North Country Health Consortium

Options for Controlling Costs

- Use one of the previously mentioned tool kits
- Collaborate and share costs across community providers
- Define data needs carefully, use secondary data whenever possible, minimize original data collection
- Identify college programs in community or public health as a resource – use students if possible
- Train and use local residents for some data collection tasks
- Identify and build of strengths of members of assessment team
- Use student interns to assist with project coordination and tasks

Charity Care Activities

- Charity and uncompensated care
  - 99% offer financial assistance to patients.
  - 87% offer both charity care and discounted charges
  - 1/3 base eligibility at 100-200% of Federal Poverty Levels. 1/4 use higher income eligibility levels
- **Key Issues:**
  - Having a policy is not enough – it must be promoted and implemented well to reduce barriers to access and serve those with the greatest needs
  - Many CAHs (and other hospitals) cannot adequately distinguish between charity/uncompensated care and bad debt – you can't manage what you can't quantify

Tracking Charity Care

- Hospitals vary in the extent to which they track charity care, other forms of uncompensated care, and bad debt separately
- What should be counted:
  - The costs of charity and discounted care provided to individuals who qualify under the hospital's charity care policy
  - Costs of care provided to enrollees in Medicaid and other means-tested government programs not covered by revenues
- The IRS is collecting data on Medicare shortfalls and bad debt and asking hospitals to explain why some portion might be considered a community benefit
- Contractual adjustments for commercial insurances should not be counted

Bad Debt

- Hospitals report that significant portions of their bad debt is really charity care that has not been verified
- This is likely true for most hospitals for a number of reasons
- Sometimes patients do not complete charity care forms or submit necessary documentations
- More often, the system does not collect the information needed to make the determination at the time of service
- Administrative resources are consumed trying to collect money that cannot be paid and ill will is created in the community

Charity Care and Billing Policies

- Evaluate charity care policies
- Recommendations
  - Simplify charity care qualification procedures and promote them widely
  - Align charges to the uninsured to Medicare or managed care rates
  - Make information on charity care available at the start of care
  - Ensure that all staff are knowledgeable about charity care policies
  - Manage the charity care process
  - Comply with national standards on billing
    - AHA's Statement of Principles and Guidelines on Hospital Billing and Collection Practices or HFMA' Patient Friendly Billing Project
    - HFMA's P&PB Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers

Managing Charity Care

- Revised policies – loosen eligibility process
- Enrollment – support/assist patients to enroll in public programs
- Humane collection effort
- Understand demand – who is using charity/free care and amounts provided
- Reduce inappropriate classification of charity care as bad debt
- Approach philanthropic organizations to support charity care
- Promote patient accountability
- Implement well-designed demonstration

Example

- Weiser Memorial Hospital's Washington/Adams County Health Action Team
- Provides primary care to uninsured individuals over 18 with incomes of less than 150% of FPL
- 18 participating community organizations in three towns
- Rationalizes delivery of charity/discounted care
- Removes burden from individual providers
- Maintains patient dignity
- Minimizes unnecessary collection activity

Community Activities

- Prevention and health improvement
  - Nearly all offer some combination of health education, preventive screenings, clinical preventive services, and support services
- Enhancing community health system capacity
  - CAHs provide financial and other support to community health care providers including primary care providers (46%), FQHCs (29%), LTC (40%), mental health (31%), EMS (34%)
- **Key issues:**
  - Many are marketing or legacy activities
  - May not be connected to current needs

Target Priority Issues

- Base activities on a current needs assessment
- Review utilization data and base initiatives around the data
- Focus on expanding access to care and vulnerable populations
- Engage board, staff, docs, clinicians, and community
- Establish leadership and accountability
- Work collaboratively to identify priorities and solutions
- Plan, manage, and measure
- Establish business case for program where possible
  - Value to the community
  - Reduction in local health care delivery costs

Examples

- Regional Medical Center
- Established an extensive array of mental and behavioral health services serving multiple counties through the Backbone Area Counseling Center including:
  - Outpatient psychotherapy and counseling
  - Evaluation services
  - Emergency and crisis care
  - Supported community living
  - Intensive outpatient services, and child day treatment
  - Psychiatric services
  - psychological testing

Examples

- Springfield Hospital
- Based on 2004 needs assessment identified following priorities: Decrease obesity, substance abuse rates, mental illness and depression
- Expanded chronic disease initiative
- Increased resources for child psychiatry and treatment
- Improved integration of primary care and mental health
- Sought grant funding to develop chronic care services
- Maintains psychiatric DPU

Summary

- Increasing attention will be paid to community activities of hospitals
- Movement to establish standards for charity care and community benefit activities
- Many CAHs are already addressing community needs but not necessarily in a strategic systematic fashion
- Focus on evidence-based strategies
- Promote “best and promising practices” of CAHs as they address community needs

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