Community Impact of Critical Access Hospitals

John A. Gale, MS

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Flex Monitoring Team
University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

For Further Information

John A. Gale, M.S., Research Associate

Maine Rural health Research Center

Muskie School of Public Service

96 Falmouth St.

Portland, ME 04104

jgale@usm.maine.edu

207-228-8246

Purpose

- Present a conceptual framework for understanding the community impact 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 findings from our 2006/2007 survey of CAHs
- Discuss plans for the development of a community impact performance indicators for CAHs

National Context

- VHA/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

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

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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)

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., uninsured);
  - 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

- Includes the activities described under the definition of community benefits as well as programs or activities that have:
  - Positive results for the community (e.g., service expansion or the economic benefits of the hospital as an employer);
  - Are unsubsidized, have a source for reimbursement to the hospital, and/or are expected 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
- Weiser Memorial Hospital, in Weiser, ID

Findings from Site Visits

- **Identifying unmet community needs**
  - Broad based collaboration is critical
  - Formal CNAs are complex, time consuming processes requiring 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.

Survey of CAHs

- Conducted during the winter of 2006/Spring 2007
- Random sample of 450 CAHs
- Response rate 85% (383 respondents)
- Questions focused on community impact activities, quality and performance improvement, and access to capital

Charity Care

- Provides assistance/relief to low income patients 97%
  - Charity care only (100% write off of charges) 11%
  - Discounted care only (partial write offs) 3%
  - Both charity and discounted care 87%
- Use Federal Poverty Guidelines for charity care 79%
- Use Federal Poverty Guidelines for discounted care 78%
- Determination in advance of care being provided 51%
- Policies apply to all services 91%

Charity Care

- Hospital provides special training to employees and staff about the availability of charity/discounted care? 80%
  - Admissions/patient registration 71%
  - Financial staff 75%
  - Patient support 57%
  - Direct care staff 35%
  - Administrative staff 58%
  - Reception staff 50%

Community Needs Assessments

- Conducted a systematic CNA in the last 3 years 49%
- Sources of information for CAN
  - Focus groups/community meetings 78%
  - Tracking health statistics 89%
  - Meetings with community providers 94%
  - Community surveys (residents and/or businesses) 69%
  - Provider surveys 55%

Hospital Planning Process

- Formal planning process for any of the following community-focused activities?
  - Service development and enhancement 66%
  - Caring for vulnerable populations 49%
  - Public health/Population health 43%

Hospital Planning Process

- Organizations involved in the planning process:
  - Health care providers 77%
  - Local government representatives 55%
  - Human service agencies 36%
  - Consumers 58%
  - Local employers/businesses 40%
  - Local/regional economic development organizations 36%

Community Services

- Health information/education classes or publications 96%
- Self-help groups 65%
- Community or worksite wellness programs 68%
- Health promotion services or facilities 77%
- Free or reduced cost clinics? 48%
- Free or reduced cost medications? 32%
- Health care support services 84%

Services to Meet Vital Community Needs

- Mental health services 37%
  - Inpatient MH services 20%
  - Outpatient MH services 76%
- Substance abuse services 11%
  - Inpatient SA services 24%
  - Outpatient SA services 68%
- Public health services 24%
- EMS or ambulance services? 32%
- Primary care services for low income patients 57%

Networking to Develop Community Services

- Networked with other providers or organizations to expand/develop local services in the last three years 87%
  - RHCs/FQHCs 56%
  - Other Critical Access Hospitals 80%
  - Other hospitals 92%
  - Public health 75%
  - EMS 87%
  - Mental health providers 71%
  - Schools/school clinics 83%

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Support to Community Providers

- Involved in providing financial, material, in-kind, or other support to community providers in the last 3 years
  - Primary care providers 59%
  - FQHCs 14%
  - EMS/ambulance 57%
  - Nursing home/long-term care 41%
  - Mental health providers 27%
  - Schools/school clinics 71%

Community Building Activities

- Involved in the following community-building activities within the last three years
  - Advocacy to improve public health, transportation, access to health care by uninsured persons, etc. 61%
  - Development of RHCs or FQHCs 40%
  - In-kind donations to non-health organizations/programs 60%
  - Job creation/training for health and non-health careers 84%
  - Workforce education for health/non-health employees 75%
  - Recruitment of physicians/other providers (to support local organizations, serve underserved populations/areas) 89%

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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 quality of health care services:
  - improving financial performance of CAH; and
  - engaging rural communities in health system development.

Development of Indicators

- **Draft Indicators from the Literature:**
  - Catholic Health Association of the United States, VHA, Public Health Institute, American Hospital Association Annual Survey, and Wisconsin Hospital Association
- **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 formed the basis of our survey of CAHs
- **Pilot Test:**
  - CAHs will be asked to pilot test indicators. We will revise the indicators based on the pilot test with the expert panel

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 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

Policy Lessons

- **Cost based reimbursement/enhanced financial stability improves ability of CAHs to undertake CI 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

Policy Lessons

- **Challenge of monitoring community impact**
  - Diversity of CAHs and rural communities
  - Creating process and impact measures to capture community impact activities and quantify these activities to enable comparison across rural hospitals and communities
  - Minimize the need for original data collection
- **Monitoring impact of the Flex Program**
  - Document role of Flex Program in encouraging and supporting development of community impact initiatives
  - Develop standardized community impact reporting tools for states and CAHs

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
- Encourage CAHs to submit community benefit information through IRS Form 990