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The Community Impact of Critical Access Hospitals

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Introduction

The impact of Critical Access Hospitals on community health and health systems is one of the four areas of performance that the Flex Monitoring Team is examining in its assessment of the impact of the Medicare Rural Hospital Flexibility Program (Flex Program). The Flex Program contains explicit expectations and financial incentives to encourage Critical Access Hospitals (CAHs) to engage with their communities to assess community health and health system needs and develop collaborative delivery systems. There is growing interest among stakeholders and policymakers in the impact that CAHs are having in their communities. This interest is also fueled by the growing adoption of voluntary or mandatory state community benefits reporting laws that require hospitals to document the benefits they provide to the community

This Issue Brief discusses the findings of a project to understand the community involvement and impact of CAHs and the Flex Program. Using a framework for identifying and assessing different dimensions of community impact, the Flex Monitoring Team conducted hospital and community site visits in six rural communities. These hospitals and communities were selected from a long list of potential sites that the Team identified through a national survey of CAHs as being engaged in significant community and health system development initiatives. This Brief discusses the findings and implications of our site visits.

- **CAHs are expanding services that positively impact their communities**
- **Strategies to meet community need include:**
  - *Growth/expansion strategies for services that contribute to CAH's long-term viability.*
  - *Services that address specific unmet community needs and are subsidized by the hospital*
- **CAHs are not consistently reporting on the ways in which they benefit and impact their communities.**
- **More formal performance measures capturing CAH community impact are needed.**

How Should We Assess Community Impact?

Based on our previous work, a review of the literature, and input from our National Advisory Committee, the core components of the Flex Monitoring Team's framework for assessing community impact include hospital involvement and/or leadership in:

- **Identifying Unmet Community Needs** through a process of information gathering and action planning.
- **Addressing Unmet Community Needs** by developing services needed by the community and critical to the hospital.
- **Prevention and Health Promotion** activities to provide preemptive health care.
- **Building a Continuum of Care** by developing service and organizational links with local clinical and community health organizations.
- **Building Community Health System Capacity** through partnerships to develop a local or regional service mix that avoids unnecessary duplication and meeting the needs of the community and its vulnerable populations.

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How Are CAHs in Responding to Community Needs?

Each hospital in this study is involved in initiatives that illustrate the impact of CAHs in their communities. We summarized the experiences and impact of these six hospitals and provide one or two brief examples from each framework component.

Identifying Unmet Community Needs

Hospitals were routinely involved in conducting community needs assessments by engaging local residents in an assessment of health needs and/or an assessment of the hospital's plans to address these needs. Several CAHs performed assessments as part of their on-going hospital planning and community outreach strategy. Some adopted a more informal process that relied on the involvement of hospital staff in the community to identify local needs while others assumed a formal process, analyzing primary and secondary data and involving a range of community stakeholders.

Manchester, Iowa: Regional Medical Center (RMC)

With a long-history of identifying community needs, RMC conducted its most recent assessment in 2004 to address state and county requirements as well as to examine community needs and to develop a long-term strategy for addressing those needs. RMC organized its assessment around *Iowa Healthy People 2010* criteria. Four priority areas emerged: mental health/psychiatry, substance abuse, prenatal care, and chronic disease management. RMC staff provided guidance and support to develop detailed action plans with immediate and longer-term action items, specific responsibilities for key staff from RMC and community partners, and timelines for accomplishing strategic goals.

Addressing Unmet Community Needs

All six hospitals were addressing needs identified through their community needs assessments. They undertook a wide range of activities to confront unmet needs including the development of specialty services, preventive care, chronic care and disease management, and community health improvement services and programs.

Littleton, New Hampshire: Littleton Regional Hospital (LRH)

LRH pursued a two-pronged strategy to address community needs. Using a business development strategy, LRH has sought to become a regional referral center through recruitment of internal medicine and specialty physicians. LRH's medical staff now includes 70 physicians representing 24 specialties. The financial stability provided by this strategy allows LRH to respond to service needs that require hospital subsidization. For example, LRH maintains a paramedic intercept team that responds to calls that cannot be fully met by local teams. Also, LRH is an active participant in a collaboration of health and human service providers that sponsors low cost dental care to children.

Lovington, New Mexico: Nor-Lea General Hospital (NLGH)

Prompted by community focus groups and its hospital chaplains, NLGH created the Heritage Program for Senior Adults in 2003. The Heritage Program provides outpatient mental health services to seniors and is staffed by a psychiatrist, therapists, a registered nurse, and mental health technicians. Patients receive an initial assessment of their cognitive ability and home environment leading to the development of a master treatment plan. Services include individual, family, and group therapy. A van transports clients from their home to the hospital for therapy. Services provided by the Heritage Program are reimbursed by Medicaid and Medicare and could not have been offered without the improved Medicare reimbursement NLGH receives as a CAH.

Prevention and Health Promotion

CAH designation has led many hospitals to transition their service mix from a focus on inpatient care to outpatient and emergency services. Our six hospitals have focused on expanding preventive, health promotion, disease management, and other community outreach services and programs. Because funding for many of these activities is limited to state or local grants, hospitals developing such programs do so largely as a community service activity.

Choteau, Montana: Teton Medical Center (TMC)

TMC has expanded wellness services through a collaborative venture with the high school, Teton Community Development Cooperative, County Extension Office, Great Falls Clinic, and others. Community members contributed a favorable bank loan, construction labor, and fundraising efforts to purchase building materials. Services include exercise programs, nutrition, health education, diabetes, stroke, and heart rehabilitation. While the program serves the general community, it has a special focus on health and fitness for high school students, firefighters, and persons with chronic illness.

Building a Continuum of Care

All six hospitals play an important leadership role in improving the continuum of care across community health services. Building a continuum of care focuses on ease and timely movement of patients between different levels of care. Our site visits revealed examples of CAHs undertaking important service expansions in behavioral health, primary, and long term care.

Lakin, Kansas: Kearny County Hospital (KCH)

To build its primary care capacity, KCH recruited and subsidized the practice of three young physicians to combat instability in physician coverage. The three physicians perform deliveries, including cesarean sections, and other general surgeries. KCH subsidizes the Deerfield Clinic in providing primary care to Medicaid and uninsured patients among a largely Hispanic population. To build its long term care capacity, KCH has developed and expanded home health, residential care, and physical therapy services and operates a nursing facility located on the hospital campus.

Building Community Health System Capacity

As the largest providers in their communities, these hospitals assumed a leadership role in addressing community or regional issues affecting access, quality, workforce, and cost. Several hospitals we visited were addressing health system capacity targeting underserved populations and involving significant inter-organizational collaboration within and across communities.

Weiser, Idaho: Weiser Memorial Hospital (WMH)

The Washington/Adams County Health Action Team (WACHAT) provides quasi-insurance coverage of primary care services for low-income, uninsured adults at area clinics. As a key partner in WACHAT, WMH processes program applications and provides free lab and X-ray services. While these services are provided at a financial loss, one of WMH's ER physicians believes the program reduces unnecessary ER utilization. Creating and sustaining this program has brought nearly 20 diverse agencies and organizations together and has heightened awareness of resources and needs in the community. WACHAT is seeking a Medicaid waiver to expand its services.

Conclusions

Hospitals' efforts to meet community needs fall into two broad categories. The first is a *service growth / expansion strategy* involving the development or expansion of services that are self-sustaining and contribute to the hospital's long term viability. The second involves the development of *services addressing specific unmet needs that may be subsidized* by the hospital. Maintaining core services that support the hospital is critical to developing and offering services in the second category, which are often only partially supported through local tax subsidies, grant funding, or other revenue streams.

We found little evidence of public reporting of community initiatives by these hospitals. Telling the story of these activities would assist in describing the impact of the Flex Program for local communities, stakeholders, and policymakers. Beyond anecdotal stories, it is critical that more formal performance measures be developed and deployed among CAHs and Flex Programs to provide a broader, national view of the Flex Program in this important performance domain. Based on the results of this study, the Flex Monitoring Team is developing a set of national indicators and measures for assessing the impact of CAHs and the Flex Program on rural communities.

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