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Developing Indicators to Document the Community Impact of Critical Access Hospitals

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Project Summary

The Flex Monitoring Team, led by the University of Southern Maine, has developed a set of community impact and benefit indicators for Critical Access Hospitals (CAHs). The goal has been to develop a set of rural-relevant community impact indicators for CAHs to quantify the ways in which they impact and benefit their communities to:

- Document the community impact activities underway in CAHs;
- Monitor the progress of CAHs in addressing community needs;
- Provide the Federal Office of Rural Health Policy (ORHP) with community performance indicators to document the Medicare Rural Hospital Flexibility Program's (Flex Program) performance for its Government Performance and Results Act of 1993 (GPRA) and Office of Management and Budget's Program Assessment Rating Tool (PART) reporting requirements; and
- Provide tools for CAHs to strategically manage, monitor, and report their community impact activities.

Background

Hospitals, including CAHs, operate in an environment of growing public scrutiny of the ways in which they serve and improve the health of their communities. The Balanced Budget Act of 1997, the legislation establishing the Flex Program, anticipated the community role of CAHs by requiring eligible hospitals to engage their communities as part of the conversion process. In addition, ORHP has created clear expectations and incentives for CAHs to: engage with their communities; develop collaborative delivery systems in their communities with CAHs as the hub of those systems of care; and undertake collaborative efforts to address unmet community health and health system needs.

Coinciding with the Flex Program's community focus has been the emerging interest in the "community benefits" provided by not-for-profit hospitals. The development of community benefit reporting standards has been led by the Catholic Health Association of the United States (CHAUSA), VHA, Inc., and the Public Health Institute. Twenty-six states have implemented mandatory or voluntary community benefit reporting requirements. The goal of these reporting initiatives is to quantify the community benefits provided by not-for-profit hospitals to justify their tax benefits.

Nationally, the IRS has revised its Form 990, *Return of Organization Exempt from Income Tax,* to collect community benefit data from not-for-profit hospitals. The revisions to Form 990, which are consistent with the CHAUSA's community benefit standards, will be fully implemented in tax year 2009 (for returns filed in 2010). At that time, not-for-profit hospitals will be required to submit comprehensive data on their community benefit activities.

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Defining Community Impact

We developed a three-tiered definition of community impact that identifies the full range of hospital activities and programs that positively impact the health and well-being of communities including those that:

1. Expand access to health care services and programs for members of the community including those services and programs that are unsubsidized, have a source for reimbursement to the CAH, and/or are expected to be self-sustaining;

2. Document the economic benefits of the CAH as an employer and consumer of services and goods in the community; and

3. Fall into the more tightly defined category of community benefit activities as developed by CHAUSA and adopted by the IRS and state community benefit reporting initiatives.

Methods

In developing our community impact indicators, we began by focusing on community benefit indicators (category 3 above) as the timing of the IRS revisions to Form 990 made this work a priority. We identified an initial set of community benefit indicators based on previous work by the Flex Monitoring Team (see Table 1) and the work of the CHAUSA, VHA, Inc., the Public Health Institute, state community benefit reporting initiatives, and voluntary hospital association community benefit reporting programs. The indicators are grouped into the following categories:

- Charity (free) and discounted care;
- Government-sponsored health care;
- Hospital commitment;
- Identifying and meeting community needs;
- Community health services;
- Services for vulnerable population or that fill vital community needs; and
- Community engagement.

A five-member expert panel, including experts in community benefit activities, hospital tax exemption issues, rural health policy, and hospital operations, was assembled to evaluate and prioritize the preliminary indicators in terms of validity, significance, reliability, and feasibility and assess data collection strategies to create the indicators. Based on their work, we finalized a set of CAH-specific community impact indicators (Table 2).

These indicators are currently being pilot tested with approximately 25 CAHs in six states. The final indicator set will be revised based on the results of the pilot test. They will also be revised to reflect the IRS's final instructions for Form 990 as well as relevant state reporting systems to minimize the reporting burden for CAHs.

Upon completion of this phase of the project and the development of the community benefit indicators for CAHs, we will finalize a set of indicators for the service activities of CAHs and their economic benefits (Categories 1 and 2 above). We will use secondary data from the AHA Annual Survey of Hospitals to provide data for the service expansion indicators. We will explore the use of economic data from the National Center for Rural Health Works at Oklahoma State University to develop a set of economic impact measures.

Conclusions

The Flex Monitoring Team's community impact indicators differ from the more commonly discussed community benefit standards in that they build on and go beyond the community benefit reporting standards developed by CHAUSA and others to provide a comprehensive framework to measure the full impact of CAHs on their communities. In addition to contributing to the assessment of the Flex Program by documenting the role of CAHs in health care system improvement and addressing community health needs, the development of CAH-specific community impact indicators will enable CAHs to strategically manage their impact on their communities using a consistent, comprehensive, and validated framework.

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Table 1. Previous Flex Monitoring and Tracking Project work in Community Impact and Benefit

Gale, J., Coburn, A.F., Gregg, W., Slifkin, R., & Freeman, V. (2007). *Exploring the community impact of Critical Access Hospitals.* (Briefing Paper No. 14). Portland, ME: Flex Monitoring Team.

Poley, S., & Slifkin, R. (2005). *Community involvement of Critical Access Hospitals.* (Briefing Paper No. 6). Chapel Hill, NC: Flex Monitoring Team.

Gale, J.A. (2001). Local networking strategies used by Critical Access Hospitals. In *Rural Hospital Flexibility Program Tracking Project. Year 02 report (covering fiscal year 2000-2001)*. (pp. 3D1-14). Washington, DC: Federal Office of Rural Health Policy.

Gale, J.A. (2001). Safety net activities of Critical Access Hospitals. In *Rural Hospital Flexibility Program Tracking Project. Year 02 report (covering fiscal year 2000-2001)*.(pp. 3F1-18). Washington, DC: Federal Office of Rural Health Policy.

Hagopian, A., & Hart, L.G. (2001). *Critical Access Hospitals and community development.* (Findings from the Field, Vol. 2, no.4, November 19). Seattle, WA: National Tracking Project Consortium Coordinating Center.

Gale, J.A. (2000). *From Wisconsin: Strategies for hospital communication with the community.* (Findings from the Field, Vol. 1, no. 6, October 2). Seattle, WA: National Tracking Project Consortium Coordinating Center.

Hartley, D. (2000). *From Oklahoma and Wisconsin: "Right sizing"--Matching the scope of services to the population.* (Findings from the Field, Vol. 1, n.4, August 11). Seattle, WA: National Tracking Project Consortium Coordinating Center.

Table 2. Preliminary Community Impact Indicators by Category

Charity (Free) and Discounted Care – The costs and delivery of free and reduced care provided to people who cannot afford to pay for services and who meet criteria for financial assistance
% of CAHs providing charity/discounted care to low income and uninsured patients
Mean ratio of: • uncompensated care costs to total hospital costs • uncompensated care costs to total (and/or net) hospital margin
Mean % of Federal Poverty Level used by CAHs to qualify individuals for: • Charity care • Discounted care
% of CAHs using: • Federal poverty guidelines to determine eligibility for charity and discounted care • Other methods to qualify individuals from charity and discounted care
% of CAHs separately identifying charity care and bad debt within their accounting systems
% of CAHs using any of the following strategies to notify the general public and patients of the availability of charity/discounted care: • Upon request • Written materials provided to all patients upon registration • Notices posted in public areas of the hospital and hospital facilities • Admissions staff informs patients of availability of charity/discounted care at intake • Billing/collection staff informs patients of availability of charity/discounted care • Billing statements contain notice of availability of charity/discounted care • Notifies social service agencies and/or local health care providers • Public service announcements and/or advertisements in local media • Brochures distributed in community
Government Sponsored Health Care – The costs (in excess of revenues) of providing care to beneficiaries enrolled in these programs
Ratio of: • Medicaid shortfall costs to total hospital costs • SCHIP shortfall costs to total hospital costs • Local and/or state indigent care shortfall costs to total hospital costs
Hospital Commitment – Evidence of hospital commitment to the provision of community benefits through its mission statement and commitment of resources to community benefit activities
% of CAHs: • With a mission statement that includes a focus on community benefit • That have committed resources for community benefit activities

Identifying and Meeting Community Needs – Through the systematic collection of data on community needs to inform hospital decision making in the development of services and programs

% of CAHs with a planning process for one or more of the following community-focused activities:

- Service development and enhancement
- Caring from vulnerable populations
- Public/population health
- Other

% of CAHs involving any of the following in these planning process:

- Health care providers
- local government representatives
- Human service agencies
- Consumers (not employed by or a board member of the hospital)
- Local employers/businesses (not a board member of the hospital)
- Local/regional economic development organizations
- Other organizations

% of CAHs that conducted a formal or systematic community needs assessment in the past three years

% of CAHs identifying community needs using one or more of the following sources of information:

- Focus groups/community meetings
- Tracking health statistics
- Meetings with community providers
- Community surveys
- Provider surveys
- Other methods

Community Health Services – Hospital-funded activities to improve community health

% of CAHs offering:

- Community health education services
- Community based clinical services
- Free clinics
- Free/reduced cost medications
- Health care support services
- Other community health services

Services That Fill Vital Community Needs or Serve Vulnerable Populations – Includes all services offered by the hospital including, but not limited to, subsidized services

% of CAHs offering one or more of the following services:

- Mental health services
- Substance abuse services
- Public health services
- EMS or ambulance services
- Primary care services for low income and/or uninsured patients

Community Engagement – The hospital's role within the community, its provision of support to stabilize other providers, community-building activities, and coalition building and networking to augment local services
% of CAHs providing support to stabilize another provider
% of CAHs providing support to stabilize one or more of the following types of providers (CAH Survey): • Primary care providers • Federally Qualified Health Centers • EMS and/or ambulance services • Nursing home/long-term care providers • Mental health providers • Other type of providers
% of CAHs hospital engaged in one or more of the following community building activities • Coalition building • Advocacy to improve public health, transportation, access to care for the uninsured, etc. • Development of RHCs or FQHCs • In-kind donations to non-health care organizations or programs • Job creation and training programs for health and non-health careers • Workforce education programs for health and non-health employees • Recruitment of physicians and other providers (to support community providers, serve underserved populations/areas) • Other community building activities
% of CAHs engaged in networking with other providers to enhance local services
% of CAHs networking with one or more of the following providers to enhance local services: • RHCs or FQHCs • Other CAHs • Other hospitals • Public health • EMS • Dentists • Mental health providers • Other providers