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Community Benefit Activities of Critical Access Hospitals, Non-Metropolitan Hospitals and Metropolitan Hospitals

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Introduction

Beginning in tax year 2009 (for returns filed in 2010), nonprofit hospitals, including Critical Access Hospitals (CAHs), are required to report their community benefit activities to the Internal Revenue Service using Form 990, Schedule H. Although standards of community benefit performance for nonprofit hospitals have not been established, rural stakeholders and hospital advocates have expressed interest in understanding how CAHs compare to other hospitals in terms of community benefit performance. In order to learn more about the community benefit activities of CAHs and understand whether and how their community benefit profiles differ from the profiles of other hospitals, we compared CAHs to non-metropolitan non-CAHs (non-metro hospitals) and metropolitan (metro) hospitals using a set of community benefit indicators developed by the Flex Monitoring Team (FMT).

Methods

We used the American Hospital Association (AHA) Annual Survey Database for Fiscal Year 2007 as our data source for examining the community benefit profiles of CAHs. We linked the AHA Survey database with the Flex Monitoring Team's list of CAHs (as of December 17, 2007) to identify CAHs in the dataset and with the 2003 Rural Urban Continuum Codes (RUCCs) to classify the remaining non-CAH acute care hospitals as either non-metropolitan (RUCCs 4 through 9) or metropolitan (RUCCs 1 through 3). The AHA database contains self-reported data on 1,245 CAHs, 1,191 non-metro hospitals, 3,782 metro, and 95 hospitals for which metro/non-metro/CAH status could not be determined.

We constructed community benefit profiles using a set of core and supplemental indicators developed by the FMT. The core indicators include four measures of the extent to which hospitals are engaged in improving the health of the community, have a budget for community benefit activities and work with other local providers, public agencies, or community representatives to conduct a health status assessment of the of the community and/or prepare a written assessment of the appropriate capacity for health services in the community. The core set also includes indicators for the provision of important health services by hospitals either directly or through participation in a system, network, or joint venture. The supplemental set includes nine additional measures of the community benefit engagement activities of hospitals and eight measures describing their provision of specific community benefit services either directly or through participation in a system, network, or joint venture. Data for these indicators were drawn from sections E ("Community Benefit") and C ("Facilities and Services") of the AHA survey. The AHA survey only collects data on the impact of system, network, or joint-venture participation on the delivery of services in Section C (Facilities and Services).

Core Indicators for All U.S. Hospitals

Community benefit engagement activities of hospitals. Although many CAHs responded positively, they lagged behind non-metro and metro hospitals on all four core measures of community benefit engagement: having a long-term plan for improving the health of the community (77%, 85%, and 84% respectively), having a specific budget for community benefit activities (55%, 68% , and 72% respectively), working with other local providers, public agencies, or community representatives to conduct a health status assessment of the community (75%, 80%, and 77% respectively), and working with other local providers, public agencies, or community representatives to develop a written assessment of appropriate health service capacity in the community (63%, 67%, and 70% respectively).

Services offered by hospitals. We examined CAH involvement in providing important health care services and compared that performance to other hospitals. CAHs were less likely than non-metro and metro hospitals to provide substance abuse (6.2%, 15%, and 26% respectively), dental (8%, 22%, and 29% respectively), hemodialysis (4%, 18%, and 41% respectively), obstetrical (OB) (43%, 72%, and 58% respectively), psychiatric (20%, 45%, and 56% respectively), palliative care program (14%, 22%, and 37% respectively), or inpatient palliative care (4%, 5%, and 11% respectively) services. CAHs were slightly less likely than non-metro and metro hospitals to be certified as trauma centers (29%, 34%, and 31% respectively). On the other hand, CAHs were more likely than non-metro and metro hospitals to offer adult day care (9%, 4%, and 6% respectively), ambulance (24%, 18%, and 12% respectively), and long-term care services (52%, 37%, and 33% respectively). For specific long-term care services, CAHs are more likely than non-metro and metro hospitals to provide skilled nursing (45%, 31%, and 22% respectively), intermediate (18%, 9%, and 7% respectively), and other long-term care services (11%, 7%, and 5% respectively), but less likely to offer acute long-term care (4%, 5%, and 11% respectively).

Services offered by hospital systems, networks, and joint ventures. The involvement of hospitals in hospital systems, networks, or joint ventures can expand the availability of services within communities. For some services, the involvement of hospitals in systems, networks, and joint ventures expanded the overall level of services available in metro communities more than in non-metro communities. The availability of any long-term care, for instance, rose by 16% for metro hospitals, compared to 5% for non-metro hospitals, and just 3% for CAHs. Availability of certified trauma centers and ambulance services followed a similar pattern (certified trauma centers increased by 10% for metro hospitals, 2% for non-metro hospitals, and 3% for CAHs; ambulance services increased by 30% for metro hospitals, 17% for non-metro hospitals, and 20% for CAHs). Although participation in systems, networks, and joint ventures had a greater impact on the availability of some services in metro hospitals, CAHs are more likely than non-metro and metro hospitals to offer ambulance services (44%, 35%, and 40% respectively), hospice programs (60%, 54%, and 57% respectively), and any long-term care (55%, 42%, and 49% respectively) in their communities through involvement in systems, networks, and joint ventures.

Supplemental Indicators for All U.S. Hospitals

Community benefit engagement activities of hospitals. The first nine indicators are measures of hospital community benefit engagement. The percentage of CAHs (93%) with a mission statement that includes a focus on community benefits or partner with school systems to offer health or wellness programs to help the community (66%) are roughly equal to all other hospitals. For the seven other indicators of community benefit engagement, CAHs tend to lag behind other hospital types by between 5% for community building activities and 21% for dedicated staff to manage community benefit activities.

Community benefit activities of hospitals: The remaining eight indicators measure the provision of specific types of community benefit activities by CAHs and other hospitals. The percentages of CAHs offering health fairs, health screenings, and immunization programs are similar to the percentages for the other types of hospitals. The percentages of CAHs engaging in community outreach, providing enrollment assistance, offering community health education, participating in health research, and operating indigent care clinics lag behind other hospitals by between 1% for indigent care clinics and 27% for health research in metropolitan hospitals. The widest gap is in health research where only 2% of CAHs and 6% of non-metro hospitals are engaged in these activities compared to 19% of metro hospitals. This difference should not be surprising as CAHs and other small hospitals do not have adequate patient volume to participate in medical research activities.

Services offered by hospital systems, networks, and joint ventures. Overall, hospital participation in systems, networks, and joint ventures improved the availability of community benefit services within communities. In general, availability improved more in metro communities (between 5% and 14%) than in non-metro communities (between 2% and 5% for CAHs and between 2% and 6% for non-metro hospitals).

Conclusions

CAHs are less likely than non-metro non-CAHs and metro hospitals to respond affirmatively to many of the core and supplemental community benefit indicators we examined. This may be a function of their size and relatively vulnerable financial situations. Indicators on which CAHs outperform other hospitals, such as ambulance services and long-term care, may indicate areas where CAHs are playing a critical safety net role in their communities. Participation in systems, networks, or joint ventures may provide hospitals with an opportunity to develop and offer services that they could not offer on their own. These areas warrant further study. Further study is also needed to understand the factors driving community benefit activity by CAHs and the resources and/or incentives needed to encourage more community benefit activity. This report suggests that CAHs, by focusing on expanding their community benefit efforts, can contribute more to the health of their communities.

COMMUNITY BENEFIT PERFORMANCE: ALL STATES

Core Indicators

Indicator	Hospital provides service (%)			Service provided by hospital and/or system, network, or joint venture of which hospital is a part (%)		
	CAH	Non-Metro Non-CAH	Metro	CAH	Non-Metro Non-CAH	Metro
Has a long-term plan for improving the health of the community	77.1	85.0	83.8	--	--	--
Has a specific budget for its community benefit activities	55.0	68.2	71.6	--	--	--
Works with other providers, public agencies, or community representatives to conduct a health status assessment of the community	75.3	79.9	77.3	--	--	--
Works with local providers, public agencies, or community representatives to develop a written assessment of the appropriate capacity for health services in the community	63.2	67.4	70.4	--	--	--
Adult day care	8.7	4.0	6.2	11.3	7.9	16.5
Any substance abuse services	6.2	14.6	26.4	13.9	22.2	42.3
Alcohol/drug abuse or dependency inpatient care	3.4	8.6	14.3	7.7	13.3	27.4
Alcohol/drug abuse or dependency outpatient services	3.5	10.5	22.6	10.1	17.0	38.3
Ambulance services	23.9	17.8	12.3	44.3	35.0	42.5
Certified trauma center ¹	29.4	33.5	30.7	32.1	35.6	40.3
Dental services	7.5	21.7	28.8	24.3	29.0	41.7
Hemodialysis	3.9	18.2	40.9	13.5	35.4	70.8
Home health services	37.9	45.5	26.6	58.2	62.0	55.1
Hospice program	23.0	25.9	22.9	60.0	54.2	57.3
Obstetrics care	43.0	71.5	57.9	47.2	74.0	66.8
Any psychiatric services	19.9	44.7	55.5	35.6	52.3	70.2
Psychiatric inpatient care	7.3	33.2	45.4	12.5	36.8	58.8
Psychiatric outpatient services	15.6	35.1	49.7	31.4	42.8	65.3
Palliative care program	13.6	22.0	37.2	21.9	29.6	49.9
Inpatient palliative care unit	3.7	4.6	11.2	6.4	7.6	18.6
Any long-term care	52.2	37.1	32.9	54.8	42.3	49.0
Skilled nursing care	44.5	30.8	21.9	47.3	35.5	35.8
Intermediate nursing care	18.2	9.0	7.0	20.7	12.5	17.3
Acute long-term care	3.8	5.2	11.0	5.8	8.4	22.6
Other long-term care	11.0	6.5	4.9	13.5	9.8	15.2

Source: 2007 American Hospital Association Annual Survey

¹ Because of the nature and wording of the AHA survey, hospital responses may not align with state and/or American College of Surgeons (ACS) lists of certified trauma centers.

Supplemental Indicators

Indicator	Hospital provides service (%)			Service provided by hospital and/or system, network, or joint venture of which hospital is a part (%)		
	CAH	Non-Metro Non-CAH	Metro	CAH	Non-Metro Non-CAH	Metro
Mission statement includes a focus on community benefit	93.4	93.6	92.6	--	--	--
Has dedicated staff to manage community benefits	41.6	57.1	63.0	--	--	--
Provides support for community building activities	41.3	46.2	46.0	--	--	--
Makes financial contributions , provides in-kind support, or participates in fundraising for community programs not directly affiliated with the hospital	68.9	76.6	76.3	--	--	--
Partners with the school system to offer health or wellness programs to help the community	66.1	68.6	64.6	--	--	--
Uses health status indicators to design new services or modify existing services	67.8	79.3	83.6	--	--	--
For hospitals that conduct health status assessments, those that use the assessment to identify unmet needs, excess capacity, or duplicative services in the community	66.1	71.7	75.1	--	--	--
Works with other providers to collect, track, and communicate clinical and health information across cooperating organizations	73.5	80.7	83.7	--	--	--
Disseminates reports to the community on the quality and costs of health care services	60.1	70.1	71.8	--	--	--
Community outreach	56.4	63.7	69.4	60.3	66.0	74.9
Enrollment assistance services	27.6	37.2	51.8	31.1	42.9	59.6
Health fair	72.7	75.8	69.2	77.5	78.2	75.3
Community health education	51.7	58.1	63.1	55.4	61.2	70.6
Health screenings	74.6	74.2	71.5	76.8	76.7	76.9
Health research	1.8	6.2	28.9	3.6	9.5	38.2
Immunization program	28.4	27.9	32.7	33.8	32.0	40.1
Indigent care clinic	7.2	8.3	19.1	10.6	14.7	32.7

Source: 2007 American Hospital Association Annual Survey

Critical Access Hospitals Responding to Survey: 1,245

Non-Critical Access Non-Metropolitan Hospitals Responding to Survey: 1,191

Metropolitan Hospitals Responding to Survey: 3,782