

CAH/FLEX National Tracking Project

FINDINGS FROM THE FIELD

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Critical Access Hospitals and Community Development

While the Federal Office of Rural Health Policy has not made “community development” one of its five specific goals* for the Rural Hospital Flexibility Program (Flex Program), it has certainly encouraged states to support such activity in rural communities, and it has funded efforts at local, state, and national levels to promote it.



Hospital support group
in Algona, Iowa

Community development can include everything from “health fairs” to “needs assessments” to “community-based strategic planning.” We argue that programs that actively engage community members (stakeholders) in *decision making* related to health care can be characterized as meaningful community development.

These decision-making activities usually bring together members of a community to engage in strengthening and expanding their health care systems. Typically, citizens are engaged in assessing the strengths and weaknesses of their health care system, and then work together to make improvements. Implementation of plans generally involves all parts of the health system, from public health and mental health to traditional and alternative providers to social support organizations.

The most obvious motivation for hospitals to engage in community development activities is that it builds market share.¹ By involving community members in identifying community needs, planning, solving problems, fund raising, improving the hospital’s reputation, marketing, recruiting a workforce, and expanding services, hospitals gain visibility and credibility, typically resulting in increased utilization. Building support from community leaders also provides opportunities for hospitals to gain support for tax support through ongoing levies or capital bonds as well as increased private fund-raising capacity through gifts, endowments, and capital campaigns. In addition, all of these types of activities help to ensure that the hospital produces quality care, is in touch with its community and meeting its needs, and is perceived as (and is) fiscally efficient.

The National Rural Health Association (NRHA) published a report in 1995² summarizing a variety of approaches and techniques for community rural health development that were developed around the country over the previous decade by universities, state offices of rural health (SORHs), Area Health Education Centers, private consultants and other rural health advocates. That publication notes:

Reimbursement policies, provider shortages, and economic and population trends were blamed for the health system failures of the last decade, but new research shows that the level of community awareness of, confidence in, and support for the local health care delivery mechanisms play critical roles in sustaining community services.

*The five goals include state rural health plan creation, hospital conversion, quality of care improvements, emergency medical services improvements, and networking.

As hospitals consider Critical Access Hospital (CAH) status, many view conversion as an opportunity to engage the community's health care providers and consumers in a discussion about the health care system as a whole.

Thirty SORHs responded to a Flex Program Tracking Team e-mail survey regarding how communities are engaging in health system development coincident with CAH conversion. Eighty-three percent of these SORH respondents indicated they were using some of their Flex Program grant dollars to conduct, facilitate, or promote community development activities in CAH locales.

Two-thirds of these SORHs reported that "many" communities were taking advantage of conversion as an opportunity to engage in development, and 86% of the SORHs were convinced these activities were valuable. Fewer than half of the SORH respondents, however, said they were *requiring* community development as a condition of participation in the Flex Program or CAH conversion.

One community development trainer told an audience at the 2000 NRHA conference in New Orleans that the most important requirement for a community developer is the possession of a valid driver's license. We believe the staff in SORHs who have developed active and meaningful relationships with their hospitals, and who make frequent trips to visit those facilities, are making the most effective use of their Flex Program funding.



Patient focus group in Mississippi

Survey of CAH Administrators

In the fall of 2000, the University of Minnesota conducted a telephone survey of all hospital administrators whose facilities had converted to CAH status by September 1, 2000. We inquired about community support for the hospital, the frequency of meetings among all the community's health care providers, and local tax support for hospitals (as an expression of local support). Our survey found the following associations (which may not be causal):

1. Community support of hospitals (both general and financial support in tax dollars) was positively associated with a more frequent number of meetings among the community's various health care providers.
2. Communities that support their hospitals with tax dollars experienced lower turnover in their hospital administration.
3. Hospitals with lower turnover tended to be in communities rated more supportive by the administrators.
4. About 57% of administrators, overall, reported the community's level of support for the hospital was "high," 32% said "medium," and 12% said "low."

Only 35% of hospital administrators said they met monthly or more frequently with "representatives of local public health, mental health, emergency medical services, and/or other similar community-based health care providers who were not formally affiliated with the hospital." Of the administrators who responded that they met with local providers at least monthly, 70% characterized their communities as "highly supportive" of the hospitals. Only half of the administrators who met less frequently reported that their communities were highly supportive (significance: $p < 0.01$).

Site Visits

A few, but not many, of the CAH conversion communities visited by the Tracking Team are spending considerable effort on creating collaborative relationships between and among health care providers within the same town. The efforts of four of the hospitals that we visited provide interesting examples of intra-community networking. Their preliminary efforts suggest the benefits that may accrue to hospitals and communities that engage in this exercise.

Providers from one New Mexico CAH routinely meet with other community providers as part of a local perinatal providers' group and a maternal and child health coalition. These committees serve as an informal case management service for low-income women in their community.

A northern Michigan CAH has worked with the local county health department and local American Indian tribes to expand women's services including diagnostic testing. Representatives from the same hospital also serve on the local human services collaborative board with a wider variety of community agencies including public health, mental health, and domestic violence agencies. The board is charged with analyzing and addressing local coordination and service issues.

A North Carolina CAH has close relationships to the local health department and supports part of the director's salary. In addition to expanding programs (e.g., a diabetic program) to underserved populations, the hospital has been in a position to maintain public health services in its community in the face of state budget cuts.

A CAH in central West Virginia has partnered with the local school department to open a clinic at the school. The clinic is available to students and staff as well as their families on a sliding fee scale. No patient is turned away because of an inability to pay. The hospital is planning an additional school-based clinic in a nearby community. This clinic will be the only source of primary care in that town.

These hospital-based programs have not only expanded services to vulnerable populations in the communities where they are located, but they have also helped to identify the hospital as an essential community provider. As a result, the administrators report greater community support, which has translated into tax support in one community and expanded private fund-raising capacity in another. Three of the administrators specifically noted increased utilization of ambulatory and outpatient services resulting from their local networking efforts.

Summary

While not the highest Flex Program priority, it does appear that a substantial amount of community development activity is associated with the Flex Program and that this activity varies by state. SORHs are involved to varying degrees with facilitating community development work in CAH conversion and non-conversion communities. There are complex interrelationships between community development, hospital success, administrator turnover, and the CAH conversion process. While not all of the community development activities we enumerate were a direct consequence of the Flex Program, we believe the Flex Program is directly responsible for some of them and has acted as a catalyst for many of the rest. Furthermore, we believe these types of activities are essential to the development of long-term viability of CAHS.

References

¹Amundson, B., Hughes, R. (June 1989). Are dollars really the issue for the survival of rural health services? (Working Paper #3). Seattle, WA: WWAMI Rural Health Research Center.

²Mayfield, J., for the National Rural Health Association. Community development applied to health care. Available from NRHA Publications Department, 1 W. Armour Blvd., Suite 301, Kansas City MO 64111. Contact NRHA at 816-756-3140, or email mail@NRHArural.org, or see the website at <http://www.NRHArural.org>

Where Can I Get More Information?

About this report: Amy Hagopian, M.H.A., and L. Gary Hart, Ph.D., WWAMI Rural Health Research Center, University of Washington (206) 616-4989 or hagopian@u.washington.edu

About this project: Check our website: <http://www.rupri.org/rhfp-track/>

Other contacts: The Mountain States Group has published several high-quality “how to guides” on various aspects of community and governing board development. Contact them at (208) 336-5533. See their website at <http://www.mtnstatesgroup.org/>

Background

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

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