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

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Introduction

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. Community benefit activities are programs and services that provide treatment and/or promote health in response to identified community needs. In order to monitor 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 2010 to examine the community benefit profiles of CAHs. We linked the AHA Survey data with the Flex Monitoring Team's list of CAHs (as of June 30, 2012) 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 2010 AHA database contains self-reported data on 1,319 CAHs, 1,129 non-metro hospitals, 3,820 metro, and 66 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 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. While CAHs reported substantial community benefit activity in 2010, 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 (79%, 85%, and 84% respectively), having a specific budget for community benefit activities (59%, 71% , and 74% respectively), working with other local providers, public agencies, or community representatives to conduct a health status assessment of the community (76%, 78%, 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%, 69%, and 69% respectively).

Services offered by hospitals. We compared CAH involvement in the provision of important health care services to the performance of other hospitals. CAHs were less likely than non-metro and metro hospitals to provide substance abuse (4%, 12%, and 25% respectively), dental (8%, 21%, and 29% respectively), hemodialysis (4%, 21%, and 43% respectively), obstetrical (OB) (38%, 72%, and 56% respectively), psychiatric (22%, 46%, and 56% respectively), palliative care (14%, 23%, and 41% respectively), or inpatient palliative care (4%, 7%, and 12% respectively) services. CAHs were slightly less likely than non-metro and slightly more likely than metro hospitals to be certified as trauma centers (34%, 35%, and 32% respectively), and were more likely than both non-metro and metro hospitals to offer adult day care (6%, 4%, and 5% respectively), ambulance (25%, 17%, and 12% respectively), and long-term care services (49%, 32%, and 27% respectively). For specific long-term care services, CAHs were more likely than both non-metro and metro hospitals to provide skilled nursing (43%, 26%, and 16% respectively), intermediate (16%, 8%, and 5% respectively), and other long-term care services (9%, 5%, and 3% respectively). However, CAHs were just slightly more likely than non-metro and less likely than metro hospitals to offer acute long-term care services (3.6%, 3.5%, and 9% respectively).

Services offered by hospital systems, networks, and joint ventures. Hospital involvement in systems, networks, or joint ventures can greatly expand the availability of services within communities. Generally speaking, 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. For example, the availability of any long-term care services rose by 17% for metro hospitals, compared to 7% for non-metro hospitals, and just 4% for CAHs. Availability of certified trauma centers and ambulance services followed a similar pattern (certified trauma centers increased by 10% for metro hospitals, 3% for non-metro hospitals, and 2% for CAHs; ambulance services increased by 32% for metro hospitals, 19% for non-metro hospitals, and 21% for CAHs). While participation in systems, networks, and joint ventures had a greater impact on the availability of services in metro hospitals, CAHs were more likely than non-metro and metro hospitals to offer ambulance services (46%, 36%, and 45% respectively), hospice programs (59%, 52%, and 56% respectively), and any long-term care services (53%, 39%, and 44% 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 supplemental indicators are measures of hospital community benefit engagement. The percentage of CAHs with a mission statement that includes a focus on community benefits (93%) was roughly equal to all other hospitals. While CAHs and non-metro hospitals were equally likely to partner with school systems to offer health or wellness programs to help the community (74%), metro hospitals were less likely to do so (69%). For the seven other indicators, CAHs lagged behind other hospital types by between 4% for community building activities in non-metro hospitals, and 20% for dedicated staff to manage community benefit activities in metro hospitals.

Community benefit activities of hospitals: The remaining eight supplemental indicators measure the provision of specific types of community benefit activities by CAHs and other hospitals. CAHs were more likely than non-metro and metro hospitals to offer health screenings (78%, 75%, and 71% respectively) and equally likely to offer community health education (70%). CAHs were less likely than non-metro but more likely than metro hospitals to conduct health fairs (76%, 78%, and 68% respectively), and were more likely than non-metro but less likely than metro hospitals to offer immunization programs (36%, 30%, and 38% respectively). The percentage of CAHs engaging in community outreach, providing enrollment assistance, participating in health research, and operating indigent care clinics lagged behind other hospitals by between 1% for indigent care clinics in non-metro hospitals and 32% for health research in metropolitan hospitals. The widest differential was in health research where just 2% of CAHs and 7% of non-metro hospitals were engaged in these activities compared to 34% of metro hospitals. However, this finding was not unexpected given that CAHs and other small hospitals typically lack the patient volume required 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. In general, availability improved more in metro communities (between 5% and 16%) than in non-metro communities (between 2% and 6% for CAHs and between 3% and 9% for non-metro hospitals).

Conclusions

CAHs were less likely than non-metro and metro hospitals to provide many of the core and supplemental community benefit indicators we examined. This may be attributable to their limited size and relatively vulnerable financial situations. Indicators on which CAHs outperform other hospitals may indicate areas where CAHs fill critical gaps in the local safety net. Participation in systems, networks, or joint ventures may provide opportunities to develop and offer services that hospitals could not otherwise offer on their own. Further research is needed to understand the factors driving community benefit activity by CAHs and what resources and incentives are needed to help CAHs refine and better target their community benefit activity. This report suggests that CAHs can contribute more to the health of their communities by better targeting and managing their community benefit efforts.

COMMUNITY BENEFIT PERFORMANCE: ALL STATES

Core Indicators

Indicator	Hospital provides service (%)			Service provided by hospital and/or system, network, or joint venture (%)		
	CAH	Other Non-Metro	Metro	CAH	Other Non-Metro	Metro
Has long-term plan for improving health of the community	78.8	84.8	83.9	--	--	--
Has specific budget for community benefit activities	58.7	71.3	73.5	--	--	--
Works with external stakeholders to conduct a community health status assessment	76.1	78.0	77.0	--	--	--
Works with external stakeholders to develop written assessment of the appropriate capacity for health services in the community	63.3	68.7	68.9	--	--	--
Adult day care	6.3	3.9	4.7	9.0	7.5	13.9
Any substance abuse services	4.2	12.3	24.5	12.3	19.0	41.0
Alcohol/drug abuse or dependency inpatient care	2.2	7.6	13.2	6.2	11.2	26.7
Alcohol/drug abuse or dependency outpatient care	2.7	8.7	21.4	9.9	15.2	37.4
Ambulance services	24.7	16.8	12.1	46.1	35.8	44.5
Certified trauma center[1]	33.7	35.0	31.8	35.8	37.6	41.4
Dental services	7.6	20.7	28.5	24.7	28.9	42.1
Hemodialysis	4.2	21.4	42.9	14.1	40.3	73.4
Home health services	31.4	40.5	22.7	53.0	57.9	53.1
Hospice program	19.7	22.5	20.7	58.5	52.3	56.3
Obstetrics care	38.0	71.8	55.6	42.7	74.9	64.8
Any psychiatric services	22.0	45.9	55.8	38.1	54.6	69.8
Psychiatric inpatient care	6.6	33.3	43.9	12.1	37.8	58.1
Psychiatric outpatient care	18.5	36.1	50.1	34.6	44.6	64.8
Palliative care program	13.8	22.8	40.9	23.5	31.4	54.4
Inpatient palliative care unit	3.9	6.5	12.2	7.1	9.7	22.1
Any long-term care	49.0	32.0	27.1	52.5	38.6	44.4
Skilled nursing care	42.7	25.8	16.4	45.6	31.5	30.9
Intermediate nursing care	16.4	7.5	4.6	18.8	11.6	15.2
Acute long-term care	3.6	3.5	9.4	6.5	7.4	22.5
Other long-term care	8.9	4.5	3.4	11.8	9.0	13.0

Source: 2010 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 (%)		
	CAH	Other Non-Metro	Metro	CAH	Other Non-Metro	Metro
Mission statement includes a focus on community benefit	92.5	93.8	90.4	--	--	--
Has dedicated staff to manage community benefits	48.0	62.6	68.4	--	--	--
Provides support for community building activities	48.3	51.9	53.3	--	--	--
Makes financial contributions, provides in-kind support, or participates in fundraising for non-hospital affiliated community programs	76.2	83.1	81.2	--	--	--
Partners with schools to offer health or wellness programs	73.8	73.4	68.6	--	--	--
Uses health status indicators to design and/or modify services	70.2	79.9	82.1	--	--	--
Uses health status assessments to identify unmet needs, excess capacity, or duplicative services in community	66.9	72.6	73.3	--	--	--
Works with other providers to collect, track, and communicate clinical and health information across cooperating organizations	73.8	79.7	82.7	--	--	--
Disseminates reports on quality and costs of health services	66.4	72.4	72.5	--	--	--
Community outreach	58.2	64.6	68.1	61.7	67.8	73.8
Enrollment assistance services	32.7	42.7	54.7	37.3	49.8	64.0
Health fair	75.5	77.5	68.1	79.6	80.1	74.8
Community health education	69.8	69.7	69.7	73.3	72.8	76.4
Health screenings	77.7	74.9	70.6	80.0	78.0	75.8
Health research	1.6	6.8	34.3	4.8	11.0	45.6
Immunization program	35.7	30.1	38.0	41.6	34.5	47.8
Indigent care clinic	7.4	8.2	20.7	12.5	16.8	36.8

Source: 2010 American Hospital Association Annual Survey

Critical Access Hospitals Responding to Survey: 1,319
Non-Critical Access Non-Metropolitan Hospitals Responding to Survey: 1,129
Metropolitan Hospitals Responding to Survey: 3,820