

Far From the City: Community Orientation and Responsiveness of Rural Hospitals

Key Findings

- Community orientation includes assessing and prioritizing local health care needs, and marshalling resources to address those needs. Community orientation is greater in rural hospitals that are larger, not-for-profit, affiliated with a system and/or network, and Joint Commission accredited. It is also greater in rural hospitals that contract with health maintenance organizations (HMOs), operate in competitive markets, and are located in states with community benefit laws.
- Community responsiveness focuses on the collaborative use of local resources to develop and implement activities to address identified health needs. It is greater in rural hospitals that are larger and that are affiliated with a system.
- Critical Access Hospitals (CAHs) engage in a greater number of community orientation and responsiveness efforts than rural non-CAHs.
- Measures of community orientation and responsiveness differ between urban and rural hospitals. Therefore, the application of prior research findings, which were based largely on urban hospital information, could mislead federal and state efforts to develop a community benefit standard applicable to rural hospitals.

Background and Purpose of the Study

Rural non-profit hospitals are a key dimension of strategies to implement the Institute of Medicine's (IOM's) six quality aims in rural communities (IOM, 2005). Their success in the IOM rural quality strategy hinges on their ability to collaborate with community organizations, assess and prioritize local health care needs, and develop/implement health programs to address community needs (Moscovice et al., 1995; Bazzoli et al., 1997; Gurewich et al., 2003). The provision of charity care and providing access for disadvantaged groups are also important indicators of the provision of community benefits, which is a key criterion for hospital tax-exempt status under federal law.

Tax exemption under current federal tax law is based on the assumption that hospitals will use the resulting tax savings to support charitable activities that would otherwise fall to the government to provide as well as services to promote the health of the general population (IRS, 1969; CBO, 2006). Examples of these activities include medical education and training, medical research, and community programs such as immunization, community health screening and education, community needs assessments, and efforts that improve access to care for disadvantaged groups and promote population health (IRS, 2007). In principle, tax-exempt status is a government subsidy to encourage provision of services and activities that provide a public good. High profile scandals over executive and board member perks, for-profit ventures, and the billing and collection practices for indigent patients have raised concerns about the ability of some hospitals to meet their charitable obligations under the federal tax law (Committee on Ways and Means 2005; U.S. Senate Committee on Finance, 2005). Congressional hearings and federal agency investigations have been joined by state class action suits and legislation to define and monitor hospital community benefit efforts. Hospital associations are also working to identify ways to measure the provision of community benefits (CHA, 2006). Some of their proposals are being considered for inclusion in revisions of the current tax law.

In addition to these ongoing efforts, a considerable body of research has been devoted to 1) the definition and measurement of hospital community and population health activities (Proenca, 2000; 2003; Lee et. al., 2004); 2) the application of research findings to community benefits, and 3) the influence of state community benefit laws (Ginn and Moseley, 2004; 2006). While this research has significantly contributed to the understanding of factors associated with hospital community benefits, it has contributed little to the understanding of their meaning and value in a rural context. Most studies of community benefit have used pooled urban and rural hospital data in their analysis. This approach

assumes that the measurement of community benefit activities and the context in which they occur are equivalent. The lack of attention to the potential influence of the rural context makes the development and application of community benefit policy problematic.

This gap in policy relevant information is addressed by focusing on variation in hospital community orientation and responsiveness across differing rural contexts (see definition of rural areas in the box below). Additionally, earlier research models are extended by incorporating measures associated with the provision of community benefits in the literature such as financial contributions, uncompensated care, Medicaid costs, and cost-to-charge ratios (Nicholson et al, 2000).

Rural areas were defined using the USDA Urban Influence Codes. A micropolitan area is a non-metropolitan central county with at least 10,000 persons; outlying counties are included if commuting to the central county is 25% or higher, or if 25% of the employment in the outlying county is made up of commuters from the central county. Noncore counties are the remaining non-metropolitan counties that have no urban cluster of 10,000 or more residents. The UICs categorize micropolitan and non-core counties based on their adjacency to larger communities and population size.

Results

Study findings indicate that the community orientation of rural hospitals is greater in facilities that are larger, not-for-profit, affiliated with a system or network, Joint Commission accredited, contract with HMOs, operate in competitive markets, in states with community benefit laws, and are CAHs. Community responsiveness is greater in rural hospitals that are not-for-profit, CAHs, and affiliated with a system.

Compared to urban hospitals, rural hospitals report higher Medicaid costs and hospitals in non-core rural areas report higher cost-to-charge ratios. These effects are largest for hospitals in non-core areas that are not adjacent to a metropolitan area. Compared to hospitals in micropolitan communities, non-core hospitals have lower community responsiveness. The higher Medicaid costs and cost-to-charge ratios for non-core areas may suggest that services to the poor and uninsured increase as distances from higher population areas increase.

Compared to for-profit rural hospitals, not-for-profit rural hospitals report engaging in a greater number of community-oriented activities, are more dependent on local contributions, and have higher uncompensated care

expenses and higher cost-to-charge ratios. Rural hospitals located in states with community benefit laws engage in a greater number of orientation activities than hospitals in states without such laws. CAHs have greater community orientation, responsiveness, local contributions, and cost-to-charge ratios than non-CAHs.

Policy Implications

Study findings suggest that measures of community orientation and responsiveness differ between urban and rural hospitals. Consequently, applying the findings of prior studies of orientation and responsiveness, which focused on urban hospitals, could mislead federal and state efforts to develop a community benefit standard applicable for rural hospitals. Further research is needed to develop an improved, context specific, model for community benefits. Higher levels of orientation and responsiveness for hospitals located in larger rural (micropolitan) areas compared to those located in smaller rural (non-core) areas may be indicative of the differences in provider supply and resource availability.

Higher levels of orientation and responsiveness for rural hospitals serving larger micropolitan areas compared to non-core areas and differences in Medicaid costs, uncompensated care, and cost-to-charge ratios suggest that the smaller, more remote facilities are hard pressed to meet basic health needs. They may not have the resources to provide population health services that are available to larger facilities serving more densely populated areas. The availability of providers in smaller, more remote communities can be quite limited placing a stronger reliance on hospitals for care, including uncompensated care. The higher orientation and responsiveness for CAHs suggests that participation in the Medicare Rural Hospital Flexibility Program has made it possible for them to address community health needs as well as basic safety net needs in ways that rural non-CAHs are not able to match.

Both orientation and responsiveness are context dependent. Just as the mix of provider organizations and organizational interests can be expected to vary by community, so will those differences influence the role of hospitals in meeting local needs. As state budgets are challenged and numbers of uninsured continue to grow, concern over the balance of tax relief and public good will likely increase. This trend will make it even more important to ensure that the measures used are appropriate for rural and urban facilities and environments.

The issue of community benefits extends beyond the issue of being eligible for tax exemption. Identifying ways to improve population health requires looking beyond hospital focused activities and embracing a broader systems perspective. Approaching these issues from a systems development perspective can help identify strategies to improve primary prevention efforts, promote a

seamless continuum of care, build community capacity to meet current and emerging needs, and encourage collaborative governance models to support the availability of community-based, population health services. This orientation and commitment helps to realize the IOM report recommendations as well as make tax exempt policy sensitive to variations in community context.

About the Study

The study population includes for-profit, non-profit, and governmental short stay non-federal, general medical-surgical hospitals operating in rural areas in the United States from 1997 to 2004. The study is a retrospective multivariate analysis of archival data on hospital characteristics from American Hospital Association (AHA) surveys, hospital financial measures from the Center for Medicare and Medicaid Services' Healthcare Cost Report Information System (HCRIS), and community measures from the Area Resource File. Hospital and community data were organized by micropolitan and non-core location using the USDA Urban Influence Codes.

We examine the relationships between each of the six response variables and hospital and community characteristics, controlling for community, state and time differences. Financial contributions (as a percentage of revenues) are used as an indicator of non-fee based revenue available for operational support and a proxy for community support. Uncompensated care (as a percentage of operating expenses) is the unpaid dollar amount for services (excluding Medicare bad debt) and is a common element in community benefit legislation and definitions of a hospital provision of public goods. Medicaid costs (as a percentage of operating expenses) is used as a measure for providing care to Medicaid enrollees (publicly insured compared to privately insured) and a proxy for the safety net role of hospitals. Cost-to-charge ratios compare the amount a hospital bills for services to the funds received and is a proxy for the safety net role of hospitals.

References

- Bazzoli, G., Stein, R., Alexander, J., Conrad, D., Sofaer, S., and Shortell, S. "Public private collaboration in health and human service delivery: evidence from community partnerships." *Milbank Quarterly* 75:533-561, 1997.
- Catholic Health Association. "Association updates senate finance committee chairman Charles Grassley on Catholic health ministry community benefit initiative." In News Release of the CHA of the United States, 2006. Available at: <http://www.chausa.org/Pub/MainNav/Newsroom/NewsReleases/2006/R060913a.htm>.

- Committee on Ways and Means. "The tax-exempt hospital sector." Washington, DC: U.S. House of Representatives, 2005.
- Congressional Budget Office (CBO). Nonprofit Hospitals and the Provision of Community Benefits. The Congress of the United States, Congressional Budget Office, Publication No. 2707 (December) 2006.
- Ginn, G. and Moseley, C. "The impact of state community benefit laws on the community health orientation and health promotion services of hospitals." *Journal of Health Politics Policy and Law* 31:321-344, 2006.
- Institute of Medicine, Committee on the Future of Rural Health Care. *Quality Through Collaboration: The Future of Rural Health*. Washington, DC: National Academies Press, 2005.
- Internal Revenue Service (IRS). Revenue Ruling 69-545, 1969-2 C.B. 117, Examples Illustrating Whether A Non-Profit Hospital Claiming Exemption Under Code Section 501(c)(3) Is Operating To Serve A Public Rather Than A Private Interest. Available at: <http://www.irs.gov/charities/charitable/article/0,,id=96099,00.html>. Accessed July, 2007.
- Lee, S., Chen, W., and Weiner, B. "Communities and hospitals: social capital, community accountability, and service provision in U.S. community hospitals." *Health Services Research* 39:1487-1508, 2004.
- Moscovice, I., Christianson, J., Johnson, J., Kralewski, J., and Manning, W. *Building Rural Hospital Networks*. Ann Arbor, MI: Health Administration Press, 1995.
- Nicholson, S., Pauly, M., Burns, L., Baumritter, A., and Asch, D. "Measuring community benefits provided by for-profit and nonprofit hospitals." *Health Affairs* 19:168-77, 2000.
- Proenca, E., Rosko, M., and Zinn, J. "Community orientation in hospitals: an institutional and resource dependence perspective." *Health Services Research* 35:1011-1035, 2000.
- Proenca, E., Rosko, M., and Zinn, J. "Correlates of hospital provision of prevention and health promotion services." *Medical Care Research and Review* 60:58-78; discussion 79-84, 2003.
- U.S. Senate Committee on Finance. "Grassley asks non-profit hospitals to account for activities related to their tax-exempt status." Washington, DC: United States Senate, 2005.

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