SPECIAL SECTION

CATHOLIC HOSPITALS AND COMMUNITY BENEFIT ACTIVITIES

A Comparative Inventory of Policies and Programs Reveals a Wide Range of Services

BY SR. SUSAN M. SANDERS, RSM, PhD

What contributions do Catholic hospitals make to their local communities? At one time, hospital administrators might have answered by rattling off a list of free or below-cost programs or services their facilities provided that presumably improved local residents' welfare. However, with recent challenges to the tax-exempt status of not-for-profit hospitals, it is imperative that administrators account with precision for community benefit programs. To help these administrators inventory such community benefit activities, the Catholic Health Association developed the *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint* (St. Louis, 1989).

Once administrators have inventoried their community benefit activities, they may use this information not only for in-house evaluation but also for comparison with the programs of other Catholic healthcare providers, especially in terms of protecting their not-for-profit, tax-exempt status. Moreover, many administrators are interested in adopting community benefit programs that have been effective in other Catholic healthcare facilities.

Using the results of my 1990 survey of U.S. Catholic hospitals, this article:

- Identifies and describes the most and least common community benefit activities
- Proposes ways that Catholic healthcare providers can become more involved in their local communities

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DEFINING COMMUNITY BENEFIT ACTIVITIES

A community benefit activity occurs when a hospital receives little or no compensation for sponsoring or engaging in activities that improve the health status of persons within its local community. (For a more detailed definition of community benefit, see my article in the July-August 1992 *Health Progress*, "Defining the Value of Community Benefits," pp. 33-37.)

Summary Results from a 1990 survey of 595 acute care, short-term, U.S. Catholic hospitals help identify and describe the most and least common community benefit activities and propose ways Catholic healthcare providers can become more involved in their local communities. The response rate for this mailed, self-administered questionnaire was 72 percent (n = 429).

The survey data indicated that Catholic hospitals engaged in a variety of healthcare efforts in their local communities. These efforts ranged from occasional activities (e.g., delivering food baskets to the needy at Christmastime) to sponsoring long-term programs (e.g., continuing case management).

To expand involvement throughout the community, hospitals can do the following relatively low-cost tasks:

- Have volunteers visit area residents in their homes and report their findings.
- Sponsor focus groups (facilitated by graduate students from area colleges and universities) that include the various community members.
- Assess the human needs of the communities that surround the hospital. Graduate students may conduct preliminary studies to identify the scope and variety of community healthcare needs.

Community benefit activities fall into several broad categories, including:

• The educational contributions and scientific research that generate new knowledge which helps many more people than those who produce and pay for it.

• The non–revenue-producing, or in-kind, services or programs designed to promote the health of community members who use the services at no or reduced cost.

• Special programs and initiatives on behalf of the poor. These initiatives, in some cases, overlap with non–revenue-producing services. The distinction here is that the hospital *targets* the poor or the medically indigent. Moreover, such initiatives reflect the hospital's direct and consistent outreach to the poor, as well as its involvement with other healthcare providers and agencies. The purpose of these activities is to develop programs that address the social conditions which exacerbate healthcare problems of the poor.

• Public advocacy efforts to secure resources that address housing, nutrition, and education.

• The various formal and informal interactions of the hospital with the local community. These interactions include those with persons having formal political or social power and with average residents, working for and through neighborhood-based civic, religious, social, and political organizations and agencies.

SURVEY RESULTS

A survey of the chief executive officers (CEOs) of 595 acute care, short-term Catholic hospitals generated the study data (see my dissertation, "The Measurement of Charity Care and Community Benefit in Catholic Nonprofit Hospitals: Implications for Tax-exemption Policy," University of Chicago, 1991). The sample excluded specialty hospitals. The response rate for this mailed, self-administered questionnaire was 72 percent (n = 429).

The survey data indicated that Catholic hospitals engaged in a variety of healthcare efforts in their local communities. These efforts ranged from occasional activities (e.g., delivering food baskets to the needy at Christmastime) to sponsoring long-term programs (e.g., continuing case management). See the **Table** (pp. 46-47) for survey results.

Educational and Scientific Activities Survey data indicated that at least 80 percent of responding hospitals sponsored training programs, such as those for persons aspiring to be registered nurses or allied health professionals. This statistic is somewhat surprising, since only 9 percent of the facilities are certified as teaching hospitals.

Sample hospitals were engaged both in the education and training of healthcare practitioners, as well as in original scientific research. For example, 25 percent of the facilities reported that their associates or employees conducted clinical research, while slightly more (29 percent) reported that their associates or employees wrote papers that were published or presented at professional meetings.

More than 80 percent of responding hospitals sponsored a variety of educational programs free to the community. These programs included general lectures; cardiopulmonary resuscitation training at schools, churches, and community group meeting places; community health promotion; and patient education on healthy behavior and life-style.

Non–revenue-producing Services More than 90 percent of responding CEOs indicated that they often made meeting rooms available free to

health-related groups, such as Alcoholics Anonymous and Al-Anon. They also offered space to local civic or religious organizations.

Special Initiatives for the Poor Most impressive among the initiatives for the poor was that 55 percent of facilities sponsored a clinic for the poor. However, apart from any Hill-Burton obligation to publicize the availability of free or below-cost services for the poor, only 51 percent of hospitals publicized the availability of financial assistance throughout the hospital. Even fewer (34 percent) publicized the availability of financial assistance to the community, although almost every respondent indicated that a majority of its employees, patients, and volunteers came from the local community.

Public Advocacy Efforts A majority (65 percent) of responding CEOs reported that their hospital personnel annually sought monies or grants from foundations or from the government to fund healthcare programs for the poor or for the local community; 77 percent indicated that, between

COMMUNITY BENEFIT ACTIVITIES IN CATHOLIC HOSPITALS (n = 429)

Activity	%
EDUCATIONAL ACTIVITIES	
Hospital sponsors off-campus educational programs free to community.	97%
Hospital sponsors training programs (nursing and allied health disciplines).	≥83%
Hospital sponsors stop-smoking clinic.	77%
Hospital offers worksite health promotion services.	65%
Hospital sponsors weight-reduction programs.	62%
Hospital provides community-based, high school work experience programs in health sciences.	62%
Hospital participates in American Medical Association residency training programs.	53%
Hospital sponsors psychiatric education programs.	50%
Hospital trains or supervises pastoral care givers.	34%
Hospital offers medical school clerkship.	33%
Hospital is certified as teaching hospital.	9%
SCIENTIFIC ACTIVITIES	
Hospital's associates or employees publish papers or present at professional meetings.	29%
Hospital's associates or employees conduct basic clinical research.	25%
Hospital assumes the unreimbursed costs of maintaining laboratory or research space.	22%
NON-REVENUE-PRODUCING SERVICES	
Hospital often makes meeting rooms available to health-related groups at no or below cost.	90%
Hospital provides free or reduced-rate housing in facility or related facilities.	66%
Hospital provides below-cost physicals to schoolchildren.	34%
Hospital provides below-cost hearing examinations to schoolchildren.	26%
Hospital provides below-cost immunizations to schoolchildren.	23%
Hospital provides below-cost laundry services to homeless persons.	3%
SPECIAL INITIATIVES FOR THE POOR	
Hospital sponsors an adopt-a-family food or clothing program.	85%
Hospital donates equipment to other area healthcare clinics and social service agencies.	80%
Hospital donates food to community groups.	73%
Hospital sponsors clinic for the poor.	55%
Hospital publicizes the availability of financial assistance throughout facility (apart from Hill-Burton requirements).	51%
Hospital sponsors recreational or social activities to raise money for the poor or the local community.	45%
Hospital publicizes availability of financial assistance to the community (apart from Hill-Burton requirements).	34%
Hospital holds annual fund-raiser to offset the healthcare costs of the poor.	29%
PUBLIC ADVOCACY EFFORTS	
Hospital pressured city or state for additional resources (between 1988 and 1990).	77%
Hospital works with government and/or nongovernment agencies to address healthcare problems of the poor or the local community.	76%
Hospital administrators encourage personnel to write letters on the health of the poor.	67%
Hospital personnel annually seek monies or grants from foundations or from government to fund healthcare programs for the poor or for the local community.	65%
Hospital is involved with nongovernment groups to expand services such as housing, transportation, and education.	64%
Hospital representative recently testified before policymaking bodies.	59%
Hospital is involved with government groups to expand services.	51%

1988 and 1990, they had pressured the city or state for additional resources. In so doing, 77 percent of the respondents indicated that they worked with both government and nongovernment agencies to address the healthcare problems of the poor or the local community. Some of the nongovernment groups represented other area healthcare providers (e.g., local public health departments), whereas other group efforts indirectly affected community healthcare status (e.g., housing, education, nutrition, and the environment).

A majority of CEOs (67 percent) engaged in other types of advocacy by encouraging all persons associated with their hospitals either to write letters or to prepare memos and legislative briefs for elected officials and policymakers on issues that affected the health status of the poor or of the local community.

Linkages to the Community Responding CEOs indicated that Catholic hospitals linked with their communities in a variety of ways. Some of these linkages (96 percent) were interpersonal (e.g.,

Linkages to the Community

Hospital staff coordinate community support programs to take effect once patients are discharged.	98%
Hospital board members serve on boards of other community organizations.	96%
Hospital has 24-hour emergency room.	96%
Hospital introduces or expands services or programs to address unmet community needs specifically because of community's input.	79%
Hospital has home care program.	79%
Hospital's interactions with community result in implementation of new or expansion of existing community-oriented programs.	79%
Hospital has patient relations program.	72%
Hospital staff follows up with patients for whom community services had been arranged at discharge.	63%
Hospital has patient representative.	60%
Hospital formally includes local community representatives (other than board members) in healthcare planning processes.	55%
Hospital formally invites community representatives (other than board members) to give input into planning processes.	55%
Hospital includes community's healthcare needs in new employee orientation program.	48%
Hospital is designated as trauma center.	42%
Hospital provides formal opportunities for community members to directly express needs and concerns to a hospital's governing board, administrators, or medical staff.	30%
Hospital offers continuing care case management.	28%
Hospital sponsors community forum where community members discuss their healthcare needs and suggest how hospital could better address those needs.	16%
Hospital governing board occasionally holds public meetings.	8%
Hospital makes an annual formal payment in lieu of taxes or pays a user fee to fund local taxing district's public services.	4%

Medical Staff Involvement

Hospital's medical staff live in the local community.	87%
Hospital administrators report to medical staff members on services to the poor or the local community.	58%
Hospital involves medical staff in the planning or budgeting of services for the poor or for the local community.	42%
Hospital recruits physicians committed to serving the poor.	40%

Linkages to Other Healthcare Providers

Hospital collaborates with other local hospitals to design, sponsor, or implement programs to meet healthcare problems of the local community.	66%
Hospital contributes financial resources to help support other health-related, not-for-profit organizations in the area.	66%
Hospital collaborates with other local hospitals to purchase expensive, high-technology equipment.	48%
Hospital collaborates with other local hospitals to eliminate duplication of programs and services.	46%

Mission and Public Policy Commitments

Hospital has made a policy commitment to offer care to acutely ill persons regardless of ability to pay.	97%
Hospital admits emergency room patients as inpatients without assurance they can pay for services provided.	90%
Hospital provides same services and amenities to indigent or public aid patients as to paying patients.	87%
Hospital has made specific commitment to improve cost-effectiveness of its healthcare services.	84%
Hospital sometimes bases rates on patients' ability to pay.	64%

when hospital administrators sat on the boards of local community organizations or participated in community committees). According to 79 percent of responding CEOs, these types of interactions typically resulted in the implementation of new or the expansion of existing community-oriented programs. Respondents noted that, between 1988 and 1990, their staffs had in some way worked with the community to plan the community's future.

Although these linkages were fairly common in the sample hospitals, community members were not usually engaged in formal hospital planning processes. For example, only 30 percent of respondents provided opportunities for community members to directly express their needs and concerns to the governing board, administrators, or medical staff.

Overall, these linkages did generate some change in hospital operations and programing. For example, 28 percent of respondents said that their hospitals had either introduced or expanded services or programs to address unmet community needs specifically because of community input. Moreover, 48 percent instructed new employees about community needs as part of their orientation programs.

The hospitals also attempted to link with their communities at service or programmatic levels. For example, 96 percent of the hosptials surveyed had a 24-hour emergency room, and 79 percent had a home care program.

Almost every hospital (98 percent) indicated that staff members coordinated community support programs to take effect once patients had been discharged. Furthermore, a majority (63 percent) indicated that they had followed up with patients for whom community services had been arranged at discharge. However, only 28 percent of hospitals offered continuing care case management.

Interesting by virtue of its rarity—especially with the growing number of challenges to the not-for-profit, tax-exempt status—survey data indicated that only 4 percent of the sample made an annual formal payment in lieu of taxes (PILOTs) or paid a user fee to fund the local taxing district's public services. Not-for-profit organizations sometimes pay PILOTs to offset the costs of the safety and sanitation services a city provides.

Medical Staff Involvement Most respondents (58 percent) indicated that administrators had reported to medical staff members on the scope of services to the poor or local community. Often physicians were absent from the hospital planning process. For example, most hospitals did not seem to involve physicians in their ongoing efforts to update medical staff about community's changing healthcare needs. Nonetheless, a majority of physicians did have some exposure to the local community because many either lived in or had an office in the area.

> Although linkages to the community were fairly common, community members were not usually engaged in formal hospital planning processes.

Linkages to Other Healthcare Providers In addition to myriad links to community members and physicians, hospitals also collaborated with other healthcare providers. However, collaboration requiring joint financing was less typical than that which simply coordinated service delivery among facilities. For example, although 66 percent of responding CEOs indicated that their facilities collaborated with other local hospitals to design, sponsor, or implement programs to meet the particular healthcare problems of the community, only 48 percent indicated that they had collaborated to purchase expensive, high-technology equipment.

Public Policy Commitments Although a policy commitment to serve the local community does not necessarily mean that implementation will follow, such a mission or policy statement can indicate a commitment of resources. Ninety-seven percent of the sample had made at least a policy commitment to offer care to acutely ill persons regardless of ability to pay. The responses of more than 80 percent of the CEOs confirmed that their hospitals had made a specific commitment to improve the cost-effectiveness of their healthcare services.

Creative Community Initiatives

What are some of the creative things hospitals can do to expand this involvement throughout the community? Although implementation of any community initiative is not without cost, I suggest the following relatively low-cost ideas:

- Recruit "precinct captains" for each block that surrounds the hospital. Hospital volunteers could do this, suggested one speaker at the May 1993 Estes Park Health Care Conference. Volunteers visit area residents in their homes and report their findings. These efforts produce goodwill, make the hospital more approachable, and generate up-to-date information about community healthcare needs. Such a program could be effective even if it focused on a small geographic area.

- Sponsor focus groups that include the various community members. Under the supervision of professors and hospital personnel, graduate students from area colleges and universities could facilitate focus groups of 8 to 15 people. The groups could meet at the hospital—a good way to introduce people to the hospital. Or the groups could meet at local churches, senior citizen centers, schools, and park districts. This is a relatively inexpensive way to get information from average area residents. To facilitate the focus groups, a hospital might consider using students in public service,

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policy, or administration; health administration; nursing; sociology; social work; or business.

- Assess the human needs of the communities that surround the hospital. Graduate students may conduct preliminary studies to identify the scope and variety of community healthcare needs. For example, reviewing materials developed by Mercy Health Services and Mercy Hospital and Medical Center, Chicago, graduate students from DePaul University's Public Services Graduate Program are in the early stages of this type of collaborative project (see *Community Assessment of Human Needs [CAHN]*, a project of Mercy Health Services Special Initiative for the Poor, Mercy Health Services, Farmington Hills, MI, 1987).

A STARTING POINT

This research indicates that many Catholic hospitals are already responding creatively to the needs of their local communities. Specifically, it indicates that Catholic hospitals are extensively linked to their local communities through their educational activities; the special initiatives they undertake on behalf of the poor; and the activities and interactions with their administrators, board members, employees, and medical staffs. However, the results also show that the community—apart from its formal leaders—has relatively little input into hospital planning processes. Moreover, hospitals seldom involve physicians directly in planning with the local community.

These results may give hospital administrators and board members a perspective from which to evaluate their response to community needs. The survey results could serve as an impetus for hospital board members and administrators to be even more creative and responsive to community needs, particularly as healthcare reform demands even more creativity and responsibility from community healthcare institutions. □

LONG-TERM BENEFITS

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administrators in training, business interns, gerontology specialists, and social workers.

COMMUNITY CONNECTIONS

Senior Network About five years ago St. Leonard and St. Elizabeth collaborated to open Senior Network, a resource center for seniors providing a variety of services. Functioning as a referral base for St. Elizabeth, Senior Network's programs complemented those already in place (e.g., adult education, various health screenings, assistance in filling out Medicare forms) at St. Leonard and thus further extended the retirement community's mission. About 25,000 members are currently enrolled.

The network's most popular program, outside the health screenings it offers, has been its Gadget Shop, which sells a variety of assistive devices for persons with various physical difficulties. The devices include such items as telephones with large numbers, grippers for reaching packages on high shelves, and snap-on additions to door handles to make them easier to grasp. The network also has a library, which offers videotapes, audiotapes, books, and magazines.

Community Center St. Leonard has a well-established reputation as a community center. Until recently, it hosted wedding receptions and conferences. Although it has discontinued these services for the most part, it still hosts the weekly luncheon for the local Rotary Club. In addition, in 1991 a Knights of Columbus Council was officially installed at the center. The council has significantly helped St. Leonard's fundraising efforts.

A modest concert series spotlighting local talent was started a few years ago for residents and proved so popular that nonresidents began attending. Today the series is linked with the St. Leonard Senior Network and the Wright State University visiting artist series. The free concerts, which are underwritten in part by small businesses, draw people from throughout the area.

Children's Education As the center began to expand its services and facilities for seniors, it also continued to broaden its outreach efforts. St. Leonard has developed three educational programs for children: one for the severely and multiply disabled, one for the developmentally disabled, and one for preschool children. The programs help transform the center from an age-segregated "ghetto" into a community with a variety of relationships vital to area residents.

Adult Day Care A recent initiative has been the opening of an adult day care center. Although no local retirement community had ever succeeded in such a project, St. Leonard planners decided to offer the service after a survey of the local community indicated that it was needed. Planners also studied factors that may have prevented success in earlier ventures. In its first nine months the program, called DayAway, has attracted 40 active participants and achieved a financial breakeven point. St. Leonard's latest project, a respite care program, began operation late last year.

MUTUAL BENEFIT

Charitableness does not have to be a one-way street. All the activities described above demonstrate the commitment to the community of the Franciscan Sisters of the Poor and, as such, provide the foundation of St. Leonard Center's tax-exempt status. At the same time, all the activities directly benefit the center in some form, whether it be revenues from rental payments for use of the facility, surplus revenues from rehabilitation or home care services, service and money contributions from local residents and organizations, or referrals through the Senior Network or the Senior Citizen's Center. Without our community outreach programs, we would never be able to attract the funds and volunteers we need to carry out our mission of ensuring that high-quality services are available to the poor and the underserved. □