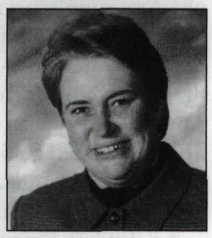
COMMUNITY BENEFIT

Community Benefit is No One's Job (It's *Everyone's* Job)



BY JULIE TROCCHIO & JOAN LINDENSTEIN

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We have come almost full circle. Twenty years ago, it was rare to find a health care staff member assigned to community benefit. Instead, efforts to reach out to people who were living in poverty or uninsured and to improve community health were spread throughout the organization.

For example: Social workers often maintained emergency funds for discharged patients who were homeless; mission leaders would make special arrangements with attending physicians and anesthesiologists for uninsured persons who needed surgery; staff members volunteered to serve in free clinics; emergency department staff were guest speakers at high schools, talking about the dangers of alcohol poisoning and drunk driving; nursery nurses sent extra packets of formula home with low-income parents; nursing home pharmacists held brown-bag lunches to which older persons in the community would bring their medicines for the pharmacists to check for counter indications.

In a manner of speaking, community benefit was no one's job—but it was *everyone's* job. Staff members in mission-driven Catholic health care facilities were inspired by the tradition of the sisters who had founded those ministries. Like the founding sisters, they were spontaneous in their charity toward and compassion for those in need and vigilant about ways to make their communities healthier.

The trouble was, such activities were rarely planned, budgeted for, or reported. They took place under the radar screen of planners, finance officers, communications staff, and even the CEO. In fact, when CHA was first developing its *Social Accountability Budget,*[1] the task force that did the original work debated about how to distinguish community benefit from marketing. "I've got it!" said someone. "If you have to keep it a secret from the CFO, it's a community benefit."

This may have been true, but it meant that those wonderful programs lacked permanent funding and were never reported. If asked what a hospital did for its community, a CEO or CFO would likely say, "We provide charity care but that's about it." Oh, what they didn't know!

As community benefit programs matured, staff were hired or assigned to run "social accountability departments." Typically, this was an administrator-in-training, mission leader, or intern asked to implement the original *Social Accountability Budget.*

These pioneers, usually working alone and often on a part-time basis, had the responsibility of coordinating and reporting existing programs and adding new ones. They were often stymied in trying to uncover "covert" community benefits that staff members wanted to provide but did not want others to know about. They worked with community members to uncover needs and plan joint initiatives, but often found themselves spread thin.

Community Benefit Today

Today's successful community benefit programs still have staff, but they no longer work alone. The community benefit position is usually at least a full-time job intended for a staff professionally trained and experienced in public health and community organizing.

In 2006 a community benefit leader is no stranger to the CEO—to whom he or she often reports directly—or to the CFO, who oversees the allocation of financial resources to community benefit programs. Just as important, successful community benefit programs are now integrated across the health care organization through:

- *Planning* Strategic and operational plans take into account community needs assessments and give special recognition to community benefit goals and programs. Operations plans are

interrelated with, not apart from, community benefit plans.

■ *Communications* Professional communications staff are involved in all aspects of community benefit programs, helping to collect data on community needs and resources; working with community groups to gauge how the organization is perceived; and reporting community benefits—not just in an annual report but on an ongoing basis as well.

■ *Physicians* Staff and community physicians are especially important in making sure that uninsured persons get the care and follow-up they need before their conditions reach emergency status. They are the key to community coalitions dedicated to finding "medical homes" for chronically ill working poor who lack health insurance.

■ *Clinical Programs* Gone are the days when community benefit programs are isolated from the main work of the health care institution. For example, at Holy Cross Hospital in Silver Spring, MD, the maternity program has been expanded and modernized to serve both insured and uninsured families. As the facility became a center of excellence in cancer care, it increased its outreach in cancer screening and prevention in ethnic populations.

■ *Human Resources (HR)* Aware that a professional workforce is essential for a community's future health care and aware too that youth in the community need career assistance, HR departments and community benefit programs are working together with local schools to provide hands-on health career experience, job training for developmentally disabled students, and health professional scholarships for community members.

■ *Emergency Departments* An important goal of most community benefit programs today is preventing admissions for "ambulatory sensitive conditions," conditions which probably could have been forestalled or treated early without hospitalization if proper primary care had been available. Emergency department and community benefit programs now work together to identify preventable problems and the neighborhoods where patients with such problems live. They then provide those patients with the follow-up care that makes repeat admissions unnecessary.

Systematic and Integrated

So we are back to community benefit being no one's job but everyone's job. These days, however, the entire organization is involved with its communities in a systematic assessment of what is needed to improve access and improve community health. In an organized and integrated way, community benefit and other key staff integrate and coordinate their activities to better serve their communities. ■

NOTE

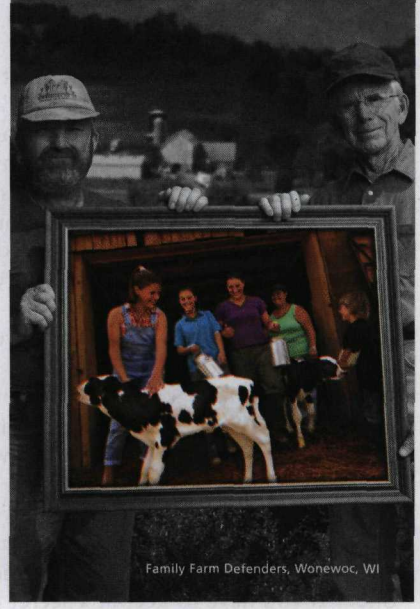
1. Catholic Health Association, *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint,* St. Louis, 1989.

Picture this: In the green farmland of Wisconsin, hope is growing. Family dairy farmers, who work long, hard hours every day, have started their own cooperative so they can pool their production and get better prices for their milk. Earning a little more helps to ease the strain on families struggling to pay their bills and keep their farms. Even more important, these farmers have found a new confidence and optimism for the future. Today, 37 million Americans live in poverty. But a fresh idea can change the landscape. For easy ways you can help, visit www.povertyusa.org.

POVERTY IN AMERICA WE CAN END IT

Catholic Campaign for Human Development

One in ten families lives in poverty. These farmers opened the door to hope.



Family Farm Defenders, Wonewoc, WI