COMMUNITY BENEFIT

"Honoring the Trust" through Community Benefit

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St. Joseph Health System (SJHS), Orange, CA, and Catholic Healthcare West (CHW), San Francisco, have been engaged in a national community benefit demonstration project called "Advancing the State of Art in Community Benefit" (ASACB). We who are involved in the project hope to open up a broad dialogue with other Catholic health providers on ways that the entire Catholic health care community can deepen the realization of Catholic social teaching through improved community benefit planning in hospitals around the country.

How can we together move our Catholic health systems to a point of distinction? How can we foster a transforming environment that achieves measurable change in community health outcomes? How can we best honor the covenant we have with our communities to help improve the quality of life? These are some of the questions we hope can be explored.

At the very core of Catholic social teaching is a belief in the sacredness of life and the dignity of the human person. In Catholic teachings, we are called to pay special attention to those who are most vulnerable and poor in our society. Our sponsors' vision of the future calls us to translate the teachings of the church into the real-life activities of our ministries; and one of our greatest opportunities to do this is through our community benefit planning and programming.

The ASACB Model

Our hospitals, like many across the nation, are not-for-profit. We have been granted tax exemption by our local, state, and national governments in part for promoting the common good, work for which Catholic healing ministries are uniquely suited—and were in fact performing long before tax exemption became an issue. As Sr. Carol Keehan, DC, president and chief executive officer, Catholic Health Association (CHA), said recently to the U.S. Senate Finance Committee, "We do *not provide community benefit in order to prove* we deserve tax exemption; we do so because of who we are."

We do feel called to return optimal value to our communities in exchange for our tax-exempt status. Unfortunately, when people talk about "community benefit," they tend to focus narrowly on the charity care provided by hospitals or on the costs they may incur as the result of state or federal programs that do not fully reimburse the hospitals for the care provided. We who serve the Catholic health ministry mean something different by "community benefit," however. When we use the term, we mean the strategically planned work we do to both address the unmet health-related needs of the community and to raise the level of health in the community.

In contrast to much health care marketing today, our Catholic tradition teaches us to put the needs of the poor and vulnerable first, to encourage broad participation in the health care system, and to seek the common good. The ASACB model contains a comprehensive yet focused set of core principles for community activity that aligns with the church's social teachings:

Principle 1: Emphasis on Disproportionate Unmet Health-Related Needs Focus programs on vulnerable populations who, because of financial, language/culture, legal or transportation barriers, or physical or mental disabilities, may lack access to health care service.

Principle 2: Emphasis on Primary Prevention Increase program activities that address the underlying causes of persistent health problems with a goal of improving health status and quality of life.

Principle 3: Build a Seamless Continuum of Care Develop evidence-based links between community health improvement activities and clinical service delivery.

Principle 4: Build Community Capacity Work in partner-

ship with the community to ensure that charitable resources are utilized to mobilize and build the capacity of existing community assets.

Principle 5: Emphasis on Collaborative Governance Engage diverse community stakeholders in the selection, design, implementation, and evaluation of programs, thereby fostering better coordination of activities, sharing of resources and skills, and sharing of risks.[1]

In the early stages of our ASACB demonstration project, we collaborated with CHA in clarifying, first, what does and does not qualify as a community benefit, and, second, how expenses should be calculated for accurate and consistent financial reporting of community benefit.

During the second phase of the ASACB project, we designed tools to help facilitate review of existing programs and to develop enhancement strategies to bring the programs into alignment with the core principles. The tools were then field tested and refined and are now available for broad use in hospitals across the nation (see the ASACB website at www.asacb.org. For an example of a completed program enhancement template, see **Box,** p. 8, on a program intended to combat diabetes in a vulnerable population.)

In the field testing we appraised the demonstration project as a model for community benefit programming that increases program effectiveness, ensures access for diverse communities, facilitates institution-wide alignment and accountability, and deepens the engagement of the hospital in local communities. We believe that these quality improvements will also help reduce health disparities.

Seventy hospitals—including the SJHS and CHW facilities in California, Texas, Arizona, and Nevada—are currently participating in the project, which will, we hope, implement a national model for community benefit programming. Under the leadership of Kevin Barnett, DrPH, and the Public Health Institute (www.phi.org), the participating hospitals are implementing the institutional and programmatic measures that the ASACB collaborative developed. Now in its third and final phase, the ASACB demonstration project has been a proving ground for the application of greater discipline in the practice of community benefit.

We believe that key to the project's success has been its participants' commitment to transformation, a commitment that started with the collaborating organizations' leaders. We are all dedicated to the stewardship of these hospital resources and to returning optimal value for them to the communities we serve.

An Invitation

Catholic social teaching proclaims that we are one human family. Those of us who have been involved in the demonstration project invite you, our sisters and brothers in the Catholic healing ministry, to review the work we have tested. We ask you to consider the ways in which the project we have developed may help meet your community's needs. Consider also how your own unique talents and gifts might further advance the art and science of community benefit. Toward that end, we offer the questions below and we stand ready to work with you in this effort.

- Is a broad range of community stakeholders engaged in your hospital's community health assessment and identification of priorities? How are these stakeholders chosen?
- How are community benefit priorities integrated into your hospital's strategic planning and budgeting processes?
- Does your hospital have a process in place for the development of a three-year community benefit plan, or do you simply prepare an annual report?
- How does your hospital's community benefit plan incorporate the core principles (see p. 8)?
- Does your hospital seek first and foremost to support communities with a high rate of unmet health-related needs and/or high-risk populations?
- Does your hospital endeavor to identify and remedy the underlying causes of persistent health problems?
- Does your hospital establish operational connections between clinical programs and community health improvement activities, in an effort to ensure that the right level of service is accessible at the right time and in the right place?
- Does your hospital work in partnership with the community to ensure that charitable resources are utilized to mobilize and build the capacity of existing community assets?
- Does your hospital engage diverse community stakeholders in the selection, design, implementation, and evaluation of programs to foster better design and mutual accountability?
- What percentage of your hospital's community benefit expense is devoted to *proactive health promotion* as opposed to traditional charity care and shortfalls from government-sponsored programs? Is that percentage increasing each year?
- Does your hospital establish institutional frameworks to support community benefit work,

An Example of an Application of the ASACB Model

"Make the Right Choices" is a community-based diabetes program that offers diabetes education, including healthy eating and physical fitness. Clients with diabetes are provided with free glucometers and blood glucose testing strips as well as testing services. Those who are found to have diabetes are case-managed and connected with a regular source of care. The program is intended to improve the health of diabetic patients enrolled in the program. Outcomes are measured by 1) reductions in the incidence of diabetes; and 2) increases in glycemic control in individual patients.

such as a board committee, job descriptions for community health with established core competencies, and community benefit policies?

- Are there specific social and/or physical conditions in your community that need focused community benefit and advocacy efforts—for example, air quality, nutrition in schools, or affordable housing?
- Does your board receive ongoing verbal and written reports concerning progress in outcomes? Is there an opportunity for dialogue? ■

NOTE

1. Kevin Barnett, *Advancing the State of the Art in Community Benefit: Core Principles,* Public Health Institute, Oakland, CA, available at www.asacb.org.

BASELINE

Core Principle #1	Core Principle #2	Core Principle #3	Core Principle #4	Core Principle #5
Emphasis on DUHN*	**Primary Prevention**	**Seamless Continuum of Care**	**Capacity Building**	**Collaborative Governance**
This hospital-based diabetes prevention and management program is currently available to the community at large.	Through the provision of screenings, health education, monitoring of blood glucose, and referrals to local clinics for follow-up care, "Make the Right Choices" provides health-promotion and disease-prevention services.	Data from 2004 and 2005 show that the diabetic patient experiences more complications when hospitalized, resulting in increased length and greater costs.	Some community partners are involved in "Make the Right Choices," including a clinic, physician, and the local chapter of the American Diabetes Association. Assessment shows duplication of services.	There is little community input into the program.

ENHANCEMENT STRATEGIES

Core Principle #1	Core Principle #2	Core Principle #3	Core Principle #4	Core Principle #5
Emphasis on DUHN	**Primary Prevention**	**Seamless Continuum of Care**	**Capacity Building**	**Collaborative Governance**
Identify geographic/population-based unmet needs in the community. Refocus the program. Develop staff skills and knowledge about prevention and management of diabetes in the local underserved high-risk community. Plan and implement a strategy to reach out to and serve the DUHN.	Establish measurements for health-related outcomes (e.g., HA1c), including changes in behavior, weight loss, and knowledge gained. Link with community resources to develop and add primary prevention components.	Document links between the diabetes-prevention program participation and subsequent hospital utilization.	Build more formal relationships with key commmunity partners to avoid current duplication and expand integration in the community beyond the medical community, (e.g., school nurses, churches).	Engage community partners and program recipients in collaborative decision making. Key stakeholders will review the program biannually.

* DUHN = Disproportionate Unmet Health Needs

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