



# Planning for Community Benefit: The Past Is Prologue

Imagine traveling back in time to 1194 AD, to the construction site of one of the world's most renowned cathedrals, Notre Dame de Chartres in France. Eventually completed in 1260, Chartres Cathedral is widely recognized today as one of the architectural masterpieces of the Middle Ages. Of penetrating beauty are the rose and lancet windows, famous for their gorgeous shades of blue. People of every rank helped build the church, either with their labor or with lavish benefactions. If we could interview three laborers on the first day of construction, what would we be able to learn from them?

In an imaginary interview, we will ask each the same question, "What are you doing here?"

The stone cutter looks up from the work and answers, "I will work from sunup to sundown for so little money, barely enough to support my family."

A mason's apprentice replies, "I am simply carting these stones to the site of the foundation."

A carpenter puts down his tool, looks up to the clouds, and answers simply, "I am building a cathedral."

Thus it is that, while the stonemason and the mason focus on their respective jobs, they do so without reference to a vision of how their disparate efforts are connected to a larger whole. The third worker, the carpenter, holds the vision of the cathedral.



**BY LEWIS C. RUDOLPH**

*Mr. Rudolph is grants manager, Sisters of Providence Health System, Springfield, MA.*

## COMMUNITY BENEFIT IN HOLYOKE

Something similar is true of the story of community benefit. And today, when community benefit is becoming a frequent topic of conversation and even debate, it's important not to lose sight of the whole—or, in this case, the mission.

The idea or spirit behind community benefit is not new to Catholic hospitals. It is imbedded deeply in the history and mission of Christianity and ties back to the healing ministry of Jesus Christ. Community benefit today is defined as programs that respond to identified needs in a community, and meet at least one of the following criteria:

- Generate a low or negative margin
- Respond to those who are uninsured or underinsured, and to needs of special populations, such as minorities, single women, immigrants, frail elderly, the chronically mentally ill, and persons with AIDS
- Supply services or programs that would likely be discontinued or need to be provided by another organization or government provider if the decision were made on a purely financial basis
- Respond to public health needs
- Involve education or research that improves overall community health<sup>1</sup>

In New England, the idea of ministering to the health needs of the poor took root in places like Holyoke, MA, in the late 19th century. Towns such as Holyoke were the birthplaces of the industrial revolution in this country. When engineers harnessed the power of the Connecticut River with a dam in 1849, Holyoke was transformed from a quaint New England town into a burgeoning city. Thousands of men from area farms moved to Holyoke to build the canals. Immigrants from Canada and Europe journeyed there to work in its paper, cotton, and woolen mills.

If the industrial revolution advanced our notions

of human progress, it also produced its share of dreaded consequences. Holyoke's infrastructure was ill-equipped to support the sudden and massive influx of people. Overcrowded housing and inadequate sanitation set the stage for a public health catastrophe. Following a typhoid epidemic and a severe outbreak of smallpox in 1872, the death rates for Holyoke were the highest in Massachusetts, except for the town of Fall River.<sup>2</sup>

Enter the Sisters of Providence from Kingston, Ontario—women of extraordinary faith who found themselves in the midst of an unfolding series of unmet needs, most of which stemmed from the unplanned consequences of the industrial revolution. The sisters witnessed first-hand the needs of the families of canal builders and mill workers, most of whom were immigrants from Ireland and Scotland. There was no formal needs assessment or planning process. The sisters identified and responded to these needs immediately, tacitly, and experientially as acts of profound faith.

As Mother Mary of Providence explained, "The field for the exercise of charity had no narrow limits. . . . Trust in Divine Providence was deep and all were ready to press forward and meet the emergencies that might be present."<sup>3</sup> The sisters took in orphaned children, set up schools, and cared for the sick. In 1873, they established Providence House, the first Catholic hospital in western Massachusetts. Much of what remains today, as the Sisters of Providence Health System, is their legacy.

### **LESSONS LEARNED FROM THE PAST**

But what lessons from this early history can we apply to the planning of community benefits today? Some of the original impetus or true spirit behind community benefits may get muddled or even lost in today's complicated business model of health care, and in the contentious political climates in Washington and many state capitals.

Much has changed from the early days. Many hospitals have spawned health systems. Health systems have begotten specialty treatment facilities and entities equipped with sophisticated diagnostic instruments. A complex matrix of payer mix and reimbursement systems, combined with layers of bureaucratic requirements, make modern health care one of the most challenging businesses ever conceived.

Responding to the immediate needs of patients with well-trained and caring physicians and nurses is the "front end" of the business. In the "back-

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room," administrators, accountants, and planners sort out mazes of complex regulations, reimbursement schedules, cash-flow projections, and guidelines that demand strict adherence and timely compliance. Today this "backroom" is the place where administrators plan and track various community benefits, tally their numbers, and tout them in reports.

In contrast to the early days, community benefit planning today is much more analytical and databased. The process is fairly complex, and generally boils down to:

- Forming an assessment and planning work-group
- Defining "community" and the scope of assessment
- Reviewing and analyzing secondary data, such as demographics, health status, chronic disease, and emergency department discharges
- Collecting primary data from surveys, interviews and focus groups
- Assessing community assets that the organization can build upon
- Setting priorities
- Developing and detailing the plan.<sup>4\*</sup>

Two forces push and pull on community benefit to shape planning and program delivery. In Catholic hospitals, the first and foremost force is a devotion to do God's work by ministering to the health needs of the most vulnerable and poor in the community. This is the mission. It is not negotiable. Second, there is the obligation to ensure government officials that the hospital serves disadvantaged populations and is worthy of maintaining its not-for-profit tax status. This is a business and legal requirement.

The two forces are not necessarily incompatible, yet they spring from different sources. The

\*More will be written about planning in future columns.

mission to provide community benefit is a moral imperative that resides in the human heart of compassion. It is a commandment from God. The business and legal requirements of community benefit constitutes a civic obligation, grounded in sound social policy and fiscal accountability. One could argue that the two forces, though different, are fairly complementary. Without its not-for-profit status, a hospital or health system would not be eligible for many grants and tax-deductible gifts, which, in turn, fund many community benefit programs. It is just that one demand—to provide community benefit—is imbedded in our mission. The other demand implores us to respond to secular authorities and policies for social justice and not-for-profit status.

### AN IMAGINARY INTERVIEW IN THE 21ST CENTURY

Now imagine visiting a local shelter for families and children, one of the 46 sites operated by Mercy Medical Center of Springfield, MA, as part of its Health Care for the Homeless program. The waiting room is full; many nationalities and racial groups are represented. Many in the room are new immigrants.

Children are scurrying about, mostly unattended by their parents, who are visibly distracted and obviously in crisis. One parent is speaking to a

staff member in Spanish about a referral to an alcohol treatment facility. If we could interview three medical staff members, what would we learn from them? We will, in our imaginations, ask each of them the same question we asked the workers on the cathedral at Chartres: "What are you doing here?"

The first staff member, busy locking the medication cabinet, answers, "I am providing primary health care to homeless families."

The second, who is completing a service report on a laptop, replies, "I'm recording the number of people I saw this past month for a community benefit report."

The third, soothing a two-year-old who is crying from an immunization shot, wipes the child's tears away, looks over the crowded waiting room and says proudly, "I am continuing a great legacy." ■

### NOTES

1. Catholic Health Association, *A Guide for Planning and Reporting Community Benefit*, St. Louis, 2006, p. 28.
2. Dolores Liptak and Grace Bennett, eds., *Seeds of Hope: The History of the Sisters of Providence*, Holyoke, MA, Sisters of Providence, Holyoke, MA, 1990.
3. Liptak and Bennett, p. 36.
4. Catholic Health Association, pp. 13-20.