Community Benefit: What It Is and Isn't

A CHA/VHA Inc. Group Offers Guidelines for Documenting Community Benefit Activities

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Catholic and other not-for-profit health care organizations have a rich tradition of providing benefit to their communities. These organizations were established out of need, not economic opportunity, and community members were aware of their good works. Today, however, people and groups who serve in, sponsor, and govern health care organizations want reassurance that their organizations are still providing community benefit. At the same time, governments and consumer advocacy groups want to know whether those organizations deserve tax exemption.

Many resources are available to help not-for-profit, tax-exempt health care organizations carry out a strategy for planning, implementing, evaluating, and reporting community benefit services (see the resources from the CHA, VHA Inc., and Lyon Software listed in this article's bibliography). These resources provide standards and guidelines to help lay the foundation for benchmarking and comparison in the future. However, users of these resources have asked for a more standardized approach, one that allows organizations to compare performance from year to year and among health care organizations. In answering these requests, a group of CHA and VHA Inc. members worked to create common community benefit definitions, categories, and reporting guidelines for organizations across the United States. Here we intend to present an overview of the group's results. The complete reporting guidelines are available at CHA's website, www.chausa.org/sab/sab.asp, or can be ordered from CHA.

DEFINING "COMMUNITY BENEFITS"

The CHA/VHA Inc. group defined "community benefits" as activities that respond to an identified

community need and meet at least one of three criteria. Such activities:

- Generate a low or negative margin
- Respond to needs of special populations, such as minorities, frail elderly, poor people with disabilities, the chronically mentally ill, and persons with AIDS
- Supply a service or programs that would likely be discontinued if the decision to offer it were made on a purely financial basis

To determine whether a program or cost is a community benefit, as opposed to a routine service or a marketing initiative, the group recommends that health care organizations answer the following questions:

- Does the activity address an identified community need?
- Does the activity support an organization's community-based mission?
- Is the activity designed to improve health in the community?
- Does the activity produce a measurable community benefit?
- Does the activity survive the "laugh" test (that is, is it unquestionably a service)?
- Does the activity require subsidization (that is, does it result in a net financial loss after applying grants and other supplemental revenue)?

Some organizations separate services provided for the economically poor from those provided to the broader community. These programs fall into the following categories:

- Most program users are economically poor.
- Most program users cannot afford to pay for needed health care services.
- Most program users are beneficiaries of Medicaid or state or local programs for the medically indigent.

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- The program is designed to reduce morbidity and mortality rates (e.g., low birth weight) caused by poverty.
- The program is located in an area that has a poverty rate higher than that of the state as a whole and is designated a "medically underserved area" or a "health manpower shortage area."

WHAT TO COUNT AS A COMMUNITY BENEFIT

Health care organizations typically report community benefits both *quantitatively,* counting in an inventory, and *qualitatively* in a narrative report. An inventory of counted community benefits should include services that:

- Result in a financial loss to the organization, requiring subsidization of some sort
- Are best quantified in terms of dollars spent or numbers of persons served
- Clearly meet a need
- Have an explicit budget

Some community benefit services, because they are not easily quantified, are best reported through a narrative summary. Such services:

- Provide significant community benefit but break even or involve minimal cost
- Are most accurately described in terms of benefit provided, rather than dollars spent; involve staff members who donate their own

SUMMARY

"Community benefit" is the measurable contribution made by Catholic and other tax-exempt organizations to support the health needs of disadvantaged persons and to improve the overall health and well-being of local communities.

Community benefit activities include outreach to low-income and other vulnerable persons; charity care for people unable to afford services; health education and illness prevention; special health care initiatives for at-risk school children; free or low-cost clinics; and efforts to improve and revitalize communities. These activities are often provided in collaboration with community members and other community organizations to improve local health and quality of life for everyone.

Since 1989, the Catholic health ministry has utilized a systematic approach to plan, monitor, report, and evaluate the community benefit activities and services it provides to its communities. This approach, first described in *CHA's Social Accountability Budget,* was updated in the recent *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability.* By using credible and consistent information, health care organizations can improve their strategic response to demands for information that demonstrates their worth.

time; or are provided entirely by volunteers

- May raise questions about whether the services represent a true community benefit, or are more of a public-relations or marketing activity than a community benefit (e.g., a health fair held in an affluent area).

These criteria will be revised as a result of ongoing discussion and experience. Readers may contact either of the authors of this article to suggest additions or changes.

Community Benefit Categories and Reporting Guidelines

The group identified seven standard reporting categories:

- Community health services
- Health professions education
- Subsidized health services
- Research
- Financial contributions
- Community-building activities
- Community benefit operations

Do Not Count These Categories

We recommend that Catholic health care organizations not count the following among their community benefit activities:

Activities specifically geared to increase market share

Facility anniversary celebrations

Grand-opening events, dedications, and related activities for new services and facilities

Nurse call lines paid for by insurers or physicians

The provision of copies of medical records and X rays

Continuing medical education, orientation, and in-service education

Discharge planning

Salaries and expenses paid to employees deployed for military services or jury duty (these expenses are considered employee benefit)

Promotional and marketing information about health care organization services and programs

Social services for patients

Problem resolution and referral of issues related to health system services

Cardiac rehabilitation services

Tokens of sympathy to staff or patients at times of crisis or bereavement (for example, flowers, cards, and meals)

Free or discounted immunizations and other health services to staff (employee benefit)

Information concerning the health system's services at a health fair or mall presentation

Holiday decorations

Free or discounted meals for volunteers or employees

Free parking for clergy or volunteers

A medical library unless the library focuses on consumer health

Staff donations to assist other staff

Pharmacy discounts for employees and volunteers

Reimbursed home health care services

Staff volunteer time, unless volunteering is done on work time

Volunteer time by community volunteers for either in-house or community efforts

Professional education such as in-services and cost for professional training

Employee contributions to organizations such as United Way or Adopt a Family

Physician referral if it is largely a marketing effort (but the service can be included if it makes referrals to many community organizations or to physicians from across an area, without regard to admitting practices)

Hospital tours

Amenities for visitors, such as coffee in the waiting rooms

Costs incurred for inpatient health education

Costs associated with provision of day care services for employees

Costs incurred by employees who participate on boards or in community activities when the employees are contributing their time to fulfill their own personal or civic interests

Staff presentations to professional organizations

Tuition reimbursement costs provided as an employee benefit

Costs associated with the teaching of classes or the delivery of papers at professional meetings by nurses

The group recommends that the following services be counted as community benefits in these categories. (Visit www.chausa.org/sab/sab.asp for complete information and recommendations.)

Community Health Services Community health services extend beyond patient care activities and are usually subsidized by the health care organization. They do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding-scale fee. (Any inpatient and outpatient care bills not charged to low-income persons should be reported separately as charity care.)

A subcategory of community health services is *community health education,* which includes lectures, presentations, and other programs and activities that are provided to *groups* and do not involve clinical or diagnostic services. Community benefit in this area can include staff time, travel, materials, and indirect costs. Activities that can be counted as community health education include:

- Training for home caregivers
- Education on specific disease conditions (e.g., diabetes)
- Health promotion and wellness programs
- Pastoral outreach education programs
- Parish congregational programs
- Prenatal classes serving at-risk populations

The following programs are activities that should *not* be counted:

- Health education classes designed to increase market share (e.g., prenatal programs for private patients)
- In-house pastoral education programs
- Volunteer time for parish- and congregation-based or other services

The costs of running support groups may be counted, as may those for wellness and health promotion programs.

Another subcategory of community health services is *community-based clinical services.* The services in this subcategory (e.g., free clinics, screenings, and one-time events) are provided to the community. One-time or occasionally held clinics (e.g., dental or immunization clinics) should be counted. However, if a fee is charged and the services make a profit, they should *not* be counted. Permanent ongoing programs should be counted in the subsidized health services category.

Clinics may be counted if they provide free or low-cost health care to the medically uninsured and involve the use of volunteers and health care professionals who donate their time. The costs to be included are hospital subsidies, such as grants and costs for staff time, equipment, overhead, laboratory, and medication. But volunteers' time and the contributions of other community partners should *not* be counted.

> Community benefit services do not generate inpatient or outpatient bills, although there may be a nominal fee.

Vans and other mobile units used to deliver primary care services (e.g., mammography or radiology) may be counted as long as the services are not an extension of the organization's outpatient department.

Another subcategory of community health services is *health care support services.* Support services that assist individual community members may be counted. These include, for example, helping people enroll in public programs, referring them to community services, and transporting them. Examples of costs that should not be counted are those for discharge planning or for physician referral if the referral service is primarily an internal marketing effort.

Health Professions Education The costs, for physicians and medical students, of providing a clinical setting for undergraduate and/or vocational training, internships, clerkships, and residencies, and for residency education may be counted. Costs that should not be included are those for continuing medical education, in-service training, and orientation programs.

Scholarships for community members may be counted, but tuition reimbursement provided as an employee benefit should *not* be counted.

On-site training for nurses, nursing students, and technicians that is subsidized by the organization may be counted. Many costs related to professional education for such other health care professionals as dietitians, physical therapists, and pharmacists may also be included. Costs for required staff education and standard in-service training should *not* be counted.

Examples of other types of education that may be counted are internships for pastoral education and social service, training for medical translators,

and specialty in-service programs for professionals in the community.

Subsidized Health Services The organization provides these services because the community needs them and other providers are unwilling to offer them, or because the services would otherwise not be available to meet patient demand. Among them are clinical patient care services that are provided despite a negative margin—for example, neonatal intensive care, some hospital outpatient services, burn unit, women's and children's services, renal dialysis, hospice, home care, adult day care, and inpatient and outpatient behavioral health.

It is important to separate these services from charity care, bad debt, and Medicaid and Medicare shortfalls. If, for example, a hospital emergency department operates at an annual loss of $200,000, and Medicare and Medicaid shortfalls and charity care account for half the total loss, only half ($100,000) of the emergency department loss would be counted as subsidized health services.

Research Research includes unreimbursed studies on therapeutic protocols, health issues for vulnerable persons, community health, innovative health care delivery models, and innovative treatments. The difference between operating costs and external subsidies such as grants (that is, negative margin) should be counted.

Financial Contributions Financial contributions comprise cash donations, grants, and in-kind services donated by staff to the community during working hours; expenses of donating space to not-for-profit community groups for meetings; donations of food, equipment, and supplies; and fund-raising costs for community programs.

Community-Building Activities Community-building activities include cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships. Specific activities include housing, participation in an economic development council, child care, advocacy, disaster readiness, and many more.

Community Benefit Operations

This new category covers operational costs for:

- Dedicated staff to manage community benefit activities
- Community health needs assessments
- Activities such as fund-raising, developing a community benefit plan, conducting community forums, and reporting a community benefit plan.

Value of Consistent Reports

If organizations use these or similar categories and criteria when reporting benefits, the reports will enable them to share information that is commonly understood and comparable. By using credible and consistent information, health care organizations can improve their strategic response to demands for information that demonstrates their worth. ■

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