DEMONSTRATING VALUE

Healthcare Organizations Can Document Positive Outcomes from Their Community-Benefit Services

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Catholic and other not-for-profit hospitals have long been challenged to justify their tax exemptions by showing how much they contribute to the community. In response, those facilities would usually tally up the cost of charity care, free programs, and unprofitable services, and report such sums as their investments in the community. But critics of tax-exempt healthcare say these responses are insufficient. Increasingly, not-for-profit hospitals are being asked not only for the amounts they invest in their communities but for descriptions of the *outcomes* of those investments as well.

Unfortunately, showing outcomes is much more difficult for hospitals than simply adding up community contributions. Although there are many *measures* that can be used to track and report outcomes, their value is not always clear. Moreover, the tabulation of outcomes must be accompanied by some foundation for *attribution*, which enables the hospital to argue that any positive outcomes found were due to its contributions, not to extraneous factors. And, finally, the hospital must be able to show that these outcomes do in fact have significant *value* for the community.

The measures for gauging outcomes fall into seven basic categories: participation, mind states, behavior, health status, sickness care utilization, sickness care expenditures, and community value. Each category offers a basis for determining and reporting the specific positive results of the hospital's contribution to the community. Each involves a mix of measures that can be used to gauge an initiative's impact and thus serve as a basis for attribution.

PARTICIPATION

This category includes measures of the community's initial response to the hospital's initiatives, with particular measures geared to particular initiatives. For a health education effort, for example, the pertinent measure might be the number of people attending a seminar, completing a course, or attending a health fair. For an immunization program, it would be the number of people immunized. For a health education program, measures could include the number of phone calls from people seeking triage, counseling, or general information; the number of "visits" to a website; or the number of people com-

Summary When challenged to demonstrate their contributions to the community, Catholic and other not-for-profit hospitals have traditionally reported the sum of their charity care, free programs, and unprofitable services. But critics of tax-exempt healthcare now say this is insufficient and ask such hospitals for descriptions of the outcomes of their contributions.

There are seven basic measures for gauging outcomes: participation, mind states, behavior, health status, sickness care utilization, sickness care expenditures, and community value.

Some of these measures will, when used singly, fail to produce clear and convincing results. Moreover, all of them must be accompanied by a foundation for attribution. Finally, the hospital must be able to show that the outcomes have significant value for the community.

But documenting the complete set of effects is worth the effort spent on it. Hospitals that carefully weigh the results of their contributions increase the likelihood that their community will truly benefit from them, and will themselves benefit from their ability to show that this is so.

ing to a health library.

If a hospital sponsored a self-care or disease self-management program, the measure for it might be the number of people either attending the program or requesting that a self-care manual be mailed to them. Similar measures include the attendance figures for sessions on prenatal and child care training, meetings of support groups for patients with chronic and life-threatening illnesses, or discussions of alternative therapy.

Many measures can be used to track outcomes, but their value is not always clear.

Participation measures are relatively easy to track and can often give the healthcare organization an early indication of its initiative's impact on the community. Moreover, since the hospital can usually determine which publicity methods have been most effective in attracting participants, it will have little trouble with attribution. The basic problem with participation measures is that they are indicators of process, not of the process's outcome, and therefore say little about its value.

Mind States

These measures—which reveal changes in awareness, knowledge, beliefs, attitudes, and intentions—do indicate outcomes, not just process. Because employing them requires interviews, surveys, or other devices, mind-state measures are more difficult to obtain than participation measures, which require only simple record keeping. A hospital can get general information concerning local mind-state changes by sampling the community's response to its media and social advocacy efforts. On a more focused level, the hospital might measure mind-state changes brought about through education (for example) by using course evaluations.

Studies have shown that mind-state changes do not always ensure changes in health or lifestyle. However, some mind-state changes—for example, those occurring when a patient gains confidence in his or her ability to use self-care techniques—can, by reinforcing that ability, improve the patients health, reduce the use of emergency services, and cut sickness healthcare expenditures.

In most cases where such changes have been the hospital's goal, and where they can be shown to be the result of its initiative (an education program, for example), the hospital is justified in attributing the changes to that initiative. The trouble with mind-state measures is that unless they clearly produce behavior changes, reduce utilization, or cut expenditures, they are ill-suited as bases for assigning value to a contribution. Like participation measures, mind-state measures are often early and easily attributed indicators of an initiative's impact, but they are weak indicators of its value.

Behavior

Although behavior changes do not necessarily result from participation changes and mind-state changes, they do begin to suggest value. Positive changes in lifestyle—giving up smoking, drugs, alcohol, and unsafe sexual practices, for example—have been clearly and consistently linked to improved health and reduced healthcare costs.

These changes are not always easy to measure, however. Most efforts to track them rely on self-reporting by people with risky health behaviors—that is, people who may report what they *should* be doing, rather than what they *are* doing. Such changes can be accurately tracked only through constant monitoring, which would be prohibitively expensive.

But the problem of attribution remains even when behavior measures are trustworthy. Given the sheer amount of information available—via newspaper stories, magazine articles, TV programs, conversation with friends, and other media—how can a hospital claim that behavior changes in its community are the result of *its* efforts? But if a hospital can show that positive behavior changes occurred to a greater degree among its program's participants than in the population at large—and especially if the behavior changes occurred among participants who had had immediately preceding mind-state changes—then the hospital can claim its initiative made the difference.

Improvement in behavior is stronger evidence of an initiative's value than participation changes and mind-state changes. Today most people know that, because risky health behavior has been

linked to a higher incidence of illness, improved behavior can be expected to reduce morbidity, utilization, and costs. Less illness, moreover, means a better quality of life, more worker productivity, and lower social costs. So added value can also be predicted.

The problem is that there is sometimes a lengthy period of time between improvement in behavior and the benefits produced by it. Since not everyone who smokes gets lung cancer, heart disease, or another tobacco-linked illness, not everyone who *quits* smoking (or is persuaded not to start) makes a significant contribution to community health. Positive changes involving diet or exercise may take years to show up as a reduced incidence of heart disease or osteoporosis. Hospitals can assert value in the behavior changes they attribute to their efforts, but it may be some time before the community is able to see that value for itself.

Health Status

Improvements in health status that are the results of an organization's initiatives may come quickly or slowly. They may be tracked via the self-reporting of single measures (e.g., weight loss or gain, ability to perform activities of daily living) or through multiple measures (e.g., health status questionnaires such as the short form SF-36 and SF-12 surveys). More often, clinical measures are needed (e.g., of blood pressure, blood sugar, cholesterol); for these, the people tracked must obtain professional healthcare services, thereby incurring or generating costs.

Attributing changes in health status may be problematic, given the variety of factors that can affect such measures. If, for example, a patient's elevated blood pressure goes down, that might be the result of a stress management program, of the patient's own efforts in diet and exercise, or of a physician's prescription of a particular drug. Even if positive mind-state and behavior changes appear to be the results of a particular initiative, the evidence for this may be inconclusive. The hospital may want to conduct further studies (e.g., comparisons of experimental and control groups) to rule out other factors.

But health status improvements are almost always clear indicators of value. Better health invariably means improved quality of life, for both patient and caregivers. And improved health status adds value because it is accompanied by less absenteeism, more productivity, and reduced social burden. So long as such improvements can be reliably measured and attributed, the organization responsible for them can be proud of its work.

Sickness Care Utilization

Reduced sickness care use is another positive indication. It should not be confused with such initiatives as immunizations, health screenings, or prenatal care visits, in which *increased* use is the goal (these initiatives should be measured under the participation category).

Improved health status is one obvious cause of reduced sickness care use. Another is education: When people learn to practice self-care and disease self-management, they lessen their reliance on healthcare professionals. And healthcare organizations can also reduce use by counseling patients about, for example, the pros and cons of alternative treatments.

Tracking changes in sickness care use can be extremely complicated. For example, a healthcare organization can, by launching an initiative aimed at the early detection of health problems, increase the number of people seeking care, improve the outcomes of care in most cases—and reduce the total amount of care used. And, through counseling patients, the hospital may reduce the use of some dubious forms of treatment, even if it does not cut the overall demand for treatment or its costs. In such cases, the quality of sickness care may be affected more than the quantity.

A hospital will probably find it easier to attribute positive changes in sickness care utilization to its efforts than to attribute similar changes in behavior and health status. Most programs that try to reduce utilization through self-care, disease self-management, or counseling maintain records of participants' progress. The connection between triage counseling and patient response, for example, can usually be tracked directly: Did callers use the suggested forms of care? Did participants in a disease self-management program have fewer crises requiring emergency room visits or inpatient admissions? (To get a complete picture, the hospital may need to supplement such records with surveys of callers and health insurance claims.)

The benefits of reducing utilization are obvious: The community is less burdened. Consumers save money and time, experience less stress, and are less at risk for iatrogenic and nosocomial illness. And physicians save time and energy.

In fact, sickness care reduction is good for everyone except those healthcare providers who, still practicing fee-for-service medicine, depend on increased sickness care volume for revenue.

Expenditures

Expenditures for sickness care generally fall as a result of a hospital's effort to improve community health. In fact, since such efforts typically res-

onate throughout the community, expenditures are likely to fall in all local hospitals, not just in the one sponsoring the effort.

Because of this, the sponsoring hospital will probably find that its own records are insufficient for tracking changes in sickness care expenditures. To obtain a complete picture, it will also need consumer surveys and records from insurance companies, public health agencies, physicians, home health agencies, nursing homes, community clinics, and other relevant sources. To provide a basis for attribution, moreover, the hospital will need to track individual consumers' patterns of sickness care utilization.

Expenditure reductions, expressed in dollars, are clear measures of value.

Expenditure reductions are clear measures of value because they are expressed in dollars. It is only when savings can be thus measured—and attributed to the hospital's efforts—that return-on-investment amounts and ratios can be calculated. Although the other six set-of-effects measures have value, they cannot be directly translated into dollars. With expenditure measures, no such problem exists.

Because most hospitals track their investments (of both dollars and staff time) in community health, they are in a good position to track and report returns on investment in terms of expenses saved on sickness care. This is true even for hospitals that lose fee-for-service revenue through such efforts. By forgoing revenue as well as investing dollars and staff time, they strengthen their claim to have contributed to the community.

Community Value

Community value logically includes any savings in sickness care expenditures, minus the costs of the hospital initiatives that produced the savings. However, community value goes well beyond direct dollar savings.

Consumers From self-care and disease self-management initiatives, consumers can gain—along with better health—an improved quality of life, a greater sense of control, and more independence. By learning to take care of themselves, they avoid many of the hassles involved in obtaining professional care, calculating insurance deductibles and copays, and paying out-of-pocket costs.

Employers Hospitals have shown that, as a result of their initiatives, employees become healthier and more productive and have improved morale.

In addition, employers who cooperate with local hospitals on such issues as fitness, work site safety, and the prevention and early detection of illness usually get both reduced employee turnover and a healthier pool from which to recruit new workers. And reduced sickness care utilization among employees (and among dependents and retired workers) brings employers lower health insurance rates and fewer workers compensation and disability claims.

Government Agencies and Health Plans By cutting sickness care expenditures, government agencies find it easier to balance their budgets. Health plans, typically plagued by high annual turnover rates, enjoy increased member retention.

Healthcare Organizations A hospital that can demonstrate it has improved its patients' health and quality of life can expect patient loyalty and even financial contributions, political support, and volunteer work. Among other things, loyal patients can advise the hospital on ways it might build volume through patient recommendations and referrals. In ideal circumstances, a hospital could make up from this new business the fee-for-service revenue it loses through community health initiatives.

Difficult but Rewarding Work

It is not easy to measure, correctly attribute, and accurately weigh the value of a hospitals contribution to its community. Indeed, some hospitals will choose simply to assert its contribution's value, rather than take the trouble to establish it as fact.

But documenting the complete set of effects of contributions to the community is worth the effort spent on it. Hospitals that painstakingly measure, attribute, and weigh the results of their contributions increase the likelihood that their communities will truly benefit from them. And those hospitals will themselves benefit from their ability to show that this is so. □

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