SPECIAL SECTION

RETOOLING FOR COMMUNITY BENEFIT

Healthcare Reform Must Include Incentives For Improving Public Health

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Summary Healthcare providers today must have a mission of service both to the individual and to the community. In 1990 the Hospital Community Benefit Standards Program (HCBSP) was launched as a demonstration project to begin the process of defining the elements that constitute community benefit.

The HCBSP standards are that a hospital (1) evince a significant organizational and operational commitment to a community benefit process, (2) plan and implement projects and activities that address specific community public health needs, (3) cultivate and maintain relationships with other organizations to foster community benefit, and (4) foster an internal environment that encourages everyone in the organization to participate in community benefit programs.

The following elements are important to an effective community benefit program:

- Governing board involvement
- CEO understanding and commitment
- A key senior manager to coordinate
- An explicit commitment of human and financial resources
- An epidemiologic data base describing a defined community or population
- A mechanism for bringing together people in the organization interested in community benefit
- A mechanism for facilitating dialogue between hospital leaders and representatives from the community
- A method of linking community benefit processes to outcomes

Most of us who work in the healthcare field are wondering what medical care reform is really all about. We remain hopeful that Congress and President Clinton will take at least some concrete steps to craft a medical care system that addresses the issues of access, cost, and quality of medical care services. If medical care reform can successfully accomplish this, our nation will be much better off.

However, even successful medical care reform will have only a limited impact on the overall health status of the population. In fact, it has been estimated that such reform will just marginally reduce premature deaths in this country.[1] This is because medical care services do not address most of the causes of morbidity and mortality. For example, recent studies have suggested that providing health insurance to low-income women will not by itself improve either maternal or neonatal outcomes.[2]

Limits of Medical Care Reform

Because of these limitations, I have been careful to use the term "medical care reform" rather than "healthcare reform." Clinton and Congress are dealing with the portion of healthcare services related to caring for *individual* patients. Almost completely missing from their discussions is talk about *community* care, which addresses problems of community health from an epidemiologic perspective. Most people view this latter portion of healthcare services as part of the public health sector.

The distinction is important to understand—especially for those of us who work in hospitals or

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other acute care settings. We tend to point to our disease prevention or health promotion services as evidence of our commitment to improve the public's health. But too often our screenings, health fairs, and the like are designed to benefit individual patients rather than to improve the health status of communities.

Many people do not think the distinction is important. After all, much needs fixing in the current system, and medical care reform will likely address aspects of preventive care. For example, it is expected that the administration's proposal will provide coverage for clinical preventive services such as Pap smears, mammograms, and hypertension screenings in its basic package of services for everyone. These are important steps toward a system that emphasizes keeping people well rather than treating only those who are already sick.

In addition, many would argue that caring for whole communities or populations is what people in public health—not hospitals—are supposed to do. Although the public health sector has been greatly underfunded, the optimists among us can point out that successful medical care reform should help relieve some of the sector's fiscal problems. Monies that health departments have been spending on individual patient care services can now be reallocated to address the problems that need a community care approach.

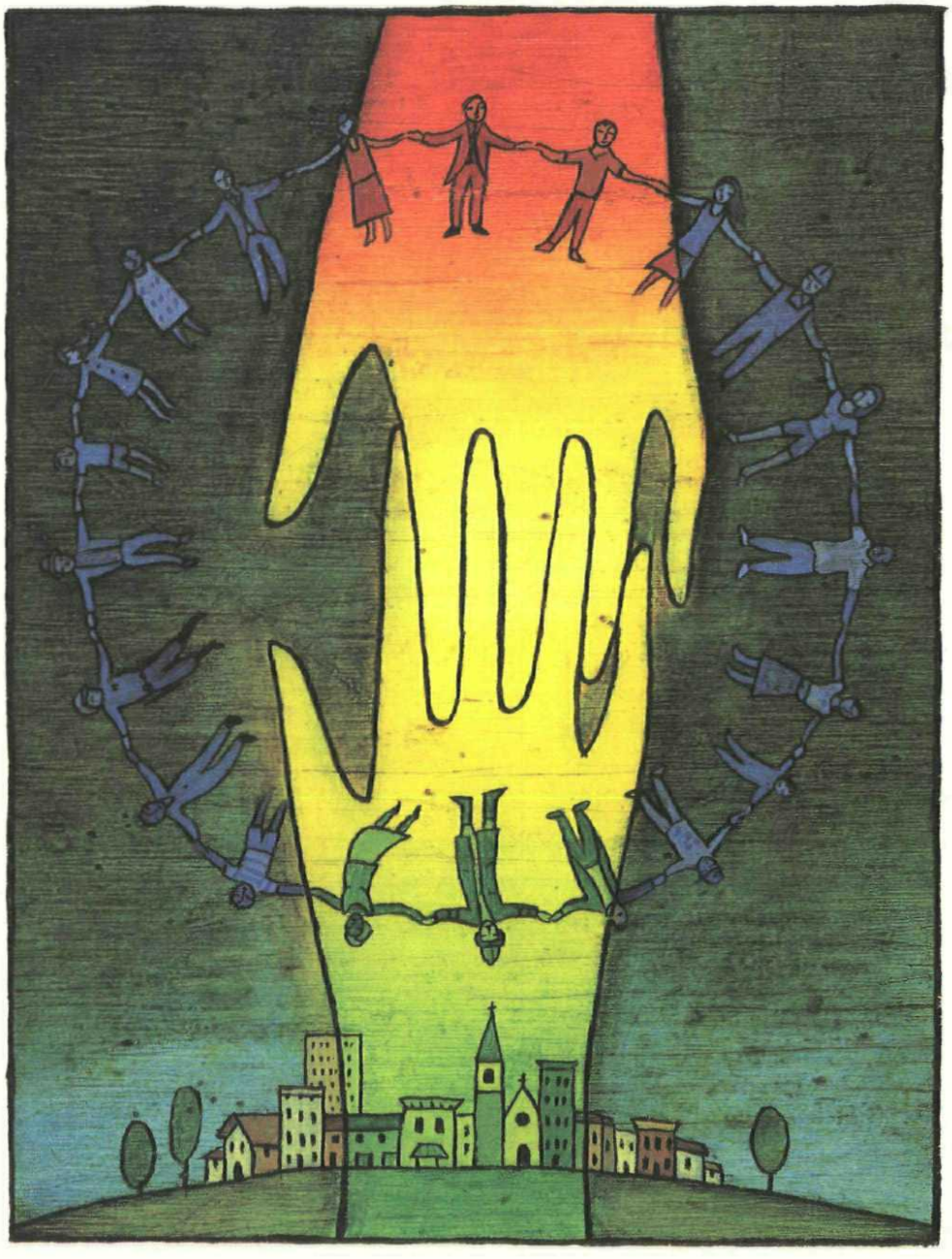
A "Community Benefit" Approach

Those of us who in some way live in the worlds of both clinical care and public health realize that all healthcare providers must pursue both missions. For example, hospitals must have a public health mission in addition to offering teaching, research, and patient care services. In today's vernacular, this role is often referred to as the "community benefit" mission of hospitals.

The United Hospital Fund, Catholic Health Association, American Hospital Association, and others have articulated this concept in their vision of healthcare reform. Each of these organizations has emphasized the need for integrated networks of providers whose responsibilities include improving the health status of the communities they serve. Implicit in these organizations' vision of reform are definitions of community benefit and need that call on providers to work with others to improve the health status of the entire community, not just of those who happen to make it inside their doors.

Principled Framework for Community Benefit

Such an approach to defining "community benefit" roles for hospitals comes out of the work of



Stefano Vitale

the Hospital Community Benefit Standards Program (HCBSP), a demonstration project at the Wagner School at New York University funded by the W. K. Kellogg Foundation.[3] According to the HCBSP, "community benefit" is defined as a hospital's *organized* approach to improving the health status of a community (or population) in an economically efficient manner. The HCBSP standards are listed in the **Box**.

Although the demonstration project was conceived and developed for hospitals, its underlying principles are as valid—actually more so—for the organization and delivery of medical care through the community care, or integrated delivery, network—an integrated network of providers such as hospitals, physicians, and home health agencies that offers the full spectrum of medical services.

Show Commitment The HCBSP's first standard—that a hospital evince a commitment to community benefit—challenges facilities' governing bodies, managers, and clinical staff to demonstrate that community benefit is a top organizational and operational priority for their institution. Appropriate mission statements, written community benefit plans, reports to the community, and governing board involvement and oversight are just a few of the signs of this commitment.

Evidence of financial commitment is also important. Hospitals must understand that this is measured less by the facility's level of uncompensated care than by its investment in people and programs that support community care activities.

Many hospitals are already taking steps to demonstrate such a commitment. For example, in 1989 the Daughters of Charity National Health System, St. Louis, in its policy statement on "Care of the Poor and Community Benefit," issued guidelines for member hospitals specifying a number of elements of a community benefit program. These include a needs assessment, mission statements, community benefit plans, and reports to the community.

Stimulating a hospital-wide effort will nurture a culture of caring within the organization.

COMMUNITY BENEFIT STANDARDS

Standard 1 There is evidence of the hospital's formal commitment to a community benefit program for a designated community.

Standard 2 The scope of the program includes hospital-sponsored projects for the designated community in each of the following areas:

- improving health status,
- addressing the health problems of minorities, the poor and other medically underserved populations,
- containing the growth of community health-care costs.

Standard 3 The hospital's program includes activities designated to stimulate other organizations and individuals to join in carrying out a broad health agenda in the designated community.

Standard 4 The hospital fosters an internal environment that encourages hospital-wide involvement in the program.

From Anthony Kovner and Paul Hattis, "Benefitting Communities," *Health Management Quarterly*, 4th Quarter, 1990, pp. 6-10.

Target Services The second HCBSP standard requires that hospitals plan and implement projects that address specific community public health needs. Such activities should improve the health status of the overall community, as well as specifically address the access and other needs of disadvantaged groups and the medically needy.

Often hospitals have defined as community benefit programs disease prevention and health promotion services they already offer. The challenge is to reframe these projects incorporating an epidemiologic approach. For example, objective and subjective community health status measures can help a provider plan a hypertension screening program that targets those at greatest risk of hypertension and its complications. By specifying who needs the service, providers can mold a simple, often unfocused health screening activity into a community care project.

Stimulate Other Organizations' Involvement The third standard requires hospitals to cultivate and maintain relationships to foster community benefit. Hospitals often play leading roles in their community. The purpose of partnership and the resulting dialogue with others—including members of grassroots community groups—is twofold. First, working with other organizations will enable a hospital to make its own projects and activities more relevant and responsive to community needs. Second, through its communication efforts, the hospital will stimulate others to identify community problems and participate in their solutions.

Foster a Supportive Internal Environment The final standard is that hospitals foster an internal environment that encourages everyone to participate in the program. Stimulating a hospital-wide effort, with many departments actively contributing to a community benefit mission, will nurture a culture of caring within the organization. As in the process of continuous quality improvement (CQI), all persons in the organization need to be part of the community benefit process.

Training hospital staff, especially clinicians, in a number of public health and community-responsive care skills is essential. One important example of such training is taking place at the Carney Hospital in Boston.[4] In the Community-oriented Primary Care Program, we are educating health professionals so they can participate in any community benefit process. Physicians, nurses, and others in this formal training program learn the public health, preventive care, and community

skills necessary for them to become agents and catalysts for the improvement of community health status. They receive training in such areas as community needs assessment, epidemiologic data analysis, community organizing, cultural competency development, and teamwork facilitation.

Getting Started

Many questions remain related to how best to put principles such as those proposed by HCBSP into operation. The specific place to start will depend on the situation of the institution and the communities it serves. Nevertheless, I do have a few "generic" thoughts on what implementing a community benefit program will require:

- *Governing board involvement in the concept and process of community benefit sends the right message about the organization's goals and directions.* Hospital boards define and defend the organization's mission. If community benefit is part of that mission, the board members need to understand and participate in the process.
- *Chief executive officer (CEO) understanding and commitment to the concept and process of community benefit is critical.* People take cues from the person at the top. If CEOs do not understand and believe in the community benefit process and fail to encourage behavior that makes it happen at their institutions, it probably will fail.
- *At least one key senior manager (or the CEO) should manage the community benefit process.* Someone with managerial stature and authority needs to worry about the day-to-day operational aspects of the process.
- *An explicit commitment of human and financial resources to the community benefit process is essential.* Carrying out an effective community benefit program is just like carrying out a CQI initiative. It takes time, people, and a financial commitment.
- *The development of an epidemiologic data base that describes the health status and healthcare resource use of a defined community or population will focus community benefit activity.* Looking at health data from a community perspective rather than from an institutional marketing perspective should be a welcome change for hospital administrators. A fair amount of public health and hospital discharge data, organized by ZIP code or census tract, is available for constructing such a community data base.
- *A mechanism for bringing together people in the organization interested in community benefit will facilitate the community benefit process.* Such a group can discuss, plan, and implement the hospital's part of a systematic approach to community benefit. Program people, clinicians, and administrators all need to be part of this process.

> Clinicians and administrators need to learn how to remold existing, often unfocused projects so that they truly respond to community needs.

- *Creation of a mechanism that facilitates dialogue between hospital leaders and representatives from the community is also important.* An effective partnership for addressing public health needs requires broad involvement, including participation of community representatives and organizational leaders. By bringing in a broad array of participants to discuss, plan, and implement services, hospitals assure people that their commitment to community benefit is genuine.
- *Educating and training healthcare professionals in what community benefit is and how problems can be understood and attacked from a community perspective gives direction to the community benefit process.* Clinicians and administrators need to learn how to remold existing, often unfocused projects so that they truly respond to community needs. This requires a commitment to learning and incorporating a range of public health and community care skills.
- *The creation of a method of linking processes to outcomes enables a hospital to evaluate its performance and adopt a systematic approach to community benefit.* It is not enough to simply implement a community health project. Defined, measurable goals and objectives are necessary to ensure accountability and evaluate success or failure.

A New Paradigm for Reform

A shift from the medical care reform paradigm to a healthcare reform paradigm must occur if our healthcare system is to get on track. For those willing to make the leap in both concept and practice, it will be well worth it. The task will be challenging but by no means impossible. But from a community health status perspective, true healthcare reform depends on it. □

NOTES

1. Remarks of J. Michael McGinnis, deputy assistant secretary for health and director, Office of Disease Prevention and Health Promotion, U.S. Public Health Service, at "Prevention 93," St. Louis, April 19, 1993; see also David Hamburg, Glen Elliott, and Delores Parron, eds., *Health and Behavior: Frontiers of Research in the Bio-Behavioral Sciences*, Institute of Medicine, 1982.
2. Jennifer S. Haas, Steven Udvarhelyi, and Arnold M. Epstein, "The Effect of Health Coverage for Uninsured Pregnant Women on Maternal Health and the Use of Cesarean Section," *JAMA*, July 7, 1993, pp. 61-64; Jennifer S. Haas et al., "The Effect of Providing Health Coverage to Poor Uninsured Pregnant Women in Massachusetts," *JAMA*, January 6, 1993, pp. 87-91.
3. Anthony Kovner and Paul Hattis "Benefitting Communities," *Health Management Quarterly*, 4th Quarter, 1990, pp. 6-10.
4. Hugh Fulmer et al., "Bridging the Gap between Medicine, Public Health, and the Community: PATCH and the Carney Hospital Experience," *Journal of Health Education*, vol. 23, 1992, pp. 167-170.