WHAT ARE TRUE COMMUNITY BENEFITS?

"We've added full-time Medicaid intake staff to our emergency room."

"Many in our dietary department spend days off working in a homeless shelter."

"Our marketing staff operates a booth at the county fair."

"We have a fully staffed pastoral care department and never charge for this service."

"Our chief executive is on the board of a community drug abuse prevention program and the symphony."

Not-for-Profits Must Distinguish True Benefits From Basic Services

BY JULIE TROCCHIO

These statements all reflect worthwhile activities for a healthcare organization to undertake—but are they true "community benefit services"?

In recent years, not-for-profit healthcare organizations have increasingly recognized the need to document their community benefit services. The push to identify and report these services has come from several sources: state-imposed community benefit requirements, challenges by for-profit organizations regarding levels of community benefit, and requests by governing bodies and religious sponsors to demonstrate the organization's mission. Advancing the trend to document community benefits has been the availability of tools for tracking community services (see **Box**).

But not all healthcare services should be included in a community benefits report to demonstrate fulfillment of an organization's community benefit purpose. Which services meet the higher community accountability standard set for voluntary, not-for-profit healthcare organizations? How do these services differ from the reg-

Ms. Trocchio is a government liaison, Catholic Health Association, Washington, DC. This article is based on a policy developed jointly by CHA and VHA Inc. for the users' manual of the Community Benefit Inventory for Social Accountability, *a Lyon Software program for tracking community benefits.*

Summary Not-for-profit healthcare organizations have increasingly recognized the need to document their community benefit services, but not all healthcare services should be included in a community benefits report. Some services are reasonably expected of any high-quality healthcare organization, regardless of its tax status. Others are provided as part of a commitment to the community, but they cannot or should not be quantified. A third group of services, however, can be counted and reported in an inventory of benefits.

To qualify as a true community benefit, an activity must respond to a particular health problem in the community, especially one involving special populations. In addition, it must be financed through philanthropic contributions, volunteer efforts, or an endowment; generate a low or negative margin; or be a service that would be discontinued if the decision were made on a purely financial basis.

Once an organization has determined that an activity is a community benefit and not a basic service or promotional program, organizational leaders must decide whether to include the service in a quantitative inventory or in a more general narrative, without assignment of specific financial benefit. The commmunity benefit services might be further broken down according to the intended recipient, whether it is the poor or the broader community.

ular activities performed by all healthcare organizations?

To identify community benefit activities provided by voluntary, tax-exempt healthcare organizations, it is helpful to categorize services into the following groups:

- The first group comprises those services and activities which are reasonably expected of, or performed by, high-quality healthcare organizations, regardless of their ownership or tax status.
- The second category contains services and programs provided by the voluntary, not-for-profit healthcare organization that reflect its mission and commitment to the community. These services can be described generally but cannot or should not be quantified or included in a cumulative community benefit inventory.
- The third group consists of those services and activities which are properly counted and reported in an inventory of benefits. This group (and the second) may be divided further into services for the poor and services for the broader community.

Basic Service or Community Benefit?

As the examples at the beginning of this article illustrate, it is sometimes difficult to distinguish basic services and standard or promotional activities, performed by all healthcare organizations, from the community benefits expected of voluntary, tax-exempt organizations. The following guidelines may help clarify the differences.

A community benefit should respond to a particular health problem in the community. For example, it could be designed to meet the needs of special populations, such as minorities, frail elderly, poor persons with disabilities, the chronically mentally ill, or persons with AIDS. In addition, the community benefit should meet at least one of the following criteria. It should:

- Be financed through philanthropic contributions, volunteer efforts, or an endowment
- Generate a low or negative margin
- Be a service or program that would be discontinued if the decision were made on a purely financial basis

Categorizing Services

Once an organization has determined that an activity is a community benefit and not a basic service or promotional program, organizational leaders must decide how to report on the activity to trustees, staff, patients, government officials, and the general public. Should the service be included in a cumulative, quantitative inventory or presented in a more general narrative, without the assignment of a specific financial benefit?

Services to be included in a quantified inventory are those which:

- Result in a financial loss to the organization, thereby requiring subsidization of some sort
- Can be quantified most easily in terms of dollars spent (rather than hours spent or numbers of participants served)
- Are not of a questionable nature, so as to jeopardize the credibility of the inventory (e.g., cholesterol screening in an upper-income neighborhood)

Items better reported in a narrative summary include those which:

- Are of significant community benefit but break even or involve minimal cost
- Are better appreciated by a reader when described in terms of benefit provided or numbers served rather than dollars spent
- Are provided entirely by volunteers or by staff who donate their time to the program
- Are somewhat controversial or require qualification regarding the community benefit they provide

The **Table** on pp. 36-37 distinguishes basic healthcare services, general community benefits, and specific community benefits.

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A community benefit should respond to a particular health problem in the community.

CHA'S COMMUNITY BENEFIT RESOURCES

Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint
A workbook for planning, budgeting, and reporting community services, including services for the poor.

Social Accountability Program: Continuing the Community Benefit Tradition of Not-for-Profit Homes and Services for the Aging
A blueprint for planning, providing, and reporting community services and activities. Published jointly with the American Association of Homes and Services for the Aging.

Community Benefit Inventory for Social Accountability
Software providing a systematic way to recognize, describe, and quantify community benefit activities. A joint effort of CHA, VHA Inc., and Lyon Software.

A Workbook on Community Accountability in Integrated Delivery
A solid rationale and operational guidelines for fostering a community focus in integrated delivery networks.

Preserving a Tradition of Service: Reflections on the Tax-exempt Status of Not-for-Profit Healthcare Institutions
An examination of the issues involved in the tax-exempt debate, including views of noted health policy experts.

For more information or to order any of these resources, call CHA's Order Processing Department at 314-253-3458.

DEFINING COMMUNITY BENEFITS

Basic Services (Expected of all healthcare organizations) *Do Not Report*	**General Community Benefits** (Characteristic of a community benefit organization but pose quantification problems) *Include in Narrative Report*	**Specific Community Benefits** (Help define the organization's contribution to the community) *Include in Community Benefit Inventory*
Public Information		
Promotional/marketing information about organizational services and programs *Example: Brochures describing high-quality health services offered by facility*	Promotional efforts to publicize unprofitable outreach programs to vulnerable groups *Example: Visits to low-income housing units to enroll pregnant women in maternity clinic*	Promotional efforts to vulnerable groups, requiring budgeted funds *Example: Development of public service announcements about free immunization clinics*
Prevention activities designed to promote community goodwill toward organization *Example: Blood pressure screening or distribution of disease-prevention literature at an upscale mall or a county fair*		Prevention activities designed to meet an identified community need *Example: Comprehensive effort to educate Spanish-speaking community about diabetes following assessment of increase in preventable complications in this group*
Health promotion services designed to increase market share *Examples: Fitness programs for cardiac patients; prenatal classes for private patients*		Health promotion activities designed to meet an identified community need or targeted to a vulnerable group *Examples: Smoking-cessation classes; prenatal classes for low-income or non-English-speaking persons*
Social Services		
Social service staff for basic social services considered necessary for comprehensive patient care *Example: Discharge planning*	Expanded social service capacity because of increased community need *Example: Doubling size of social service staff following influx of new immigrant population*	Specific social service programs for vulnerable persons, generating identifiable costs *Examples: Emergency fund account for discharged patients in distress; donation of social work staff to free clinic or parish nurse program*
Emergency Services		
Emergency room open to general public	Emergency or urgent care services designed to reduce healthcare costs *Examples: Placement of medical intake staff in emergency rooms; 24-hour urgent care; primary care for low-income persons designed to reduce unnecessary ER visits*	Critical emergency services provided at a financial loss *Examples: Trauma center; emergency care to uninsured persons*
Outpatient Services		
Ambulatory services for broad community *Examples: Same-day surgery; outpatient radiology services*	Reimbursed ambulatory services developed because of identified community need or targeted to vulnerable or needy persons *Example: Fully reinsured prenatal and child health clinics*	Unreimbursed ambulatory services developed because of identified community need or targeted to poor and needy *Examples: Mobile services for homeless persons; free immunization services for migrant families*

DEFINING COMMUNITY BENEFITS—CONT'D

Basic Services (Expected of all healthcare organizations) *Do Not Report*	**General Community Benefits** (Characteristic of a community benefit organization but pose quantification problems) *Include in Narrative Report*	**Specific Community Benefits** (Help define the organization's contribution to the community) *Include in Community Benefit Inventory*
Home Health		
Profitable home health services	Reimbursed home health services developed because of identified community need or targeted to vulnerable group *Examples: Home health services for frail elderly to avoid preventable hospital admissions; staff contributions to holiday baskets for poor families*	Unreimbursed home health services developed because of community need or targeted to vulnerable groups *Examples: Unreimbursed homemaker or chose services that help elderly stay in own home; arrangements for free equipment for children with cystic fibrosis in uninsured or underinsured families*
Pastoral Care		
Standard pastoral care program *Examples: Pastoral care visits to inpatients; coordination with local clergy*	*Pastoral care services that respond to community need beyond inpatient services* *Example: Bereavement and other support groups open to nonpatients*	*Budgeted pastoral care–sponsored activities and services that respond to specific community need* *Examples: Free parking and/or meals for clergy; work with local churches and religious congregations for parish-based health services; consultations to schools, police, others*
Volunteer Efforts		
Staff volunteering time for nonhealth-related community service *Examples: Teaching Sunday school; coaching soccer; participation on library board*	Staff volunteering their own time to health-related community services *Examples: Staff and physicians volunteering in free clinics, homeless shelters, disease prevention programs*	Staff using organizational funds or working hours to provide community service *Examples: ER nurse speaking to high school students about drunk driving as part of work responsibilities; organization offering start-up funds for a meals program a staff member wants to start; any formal program allowing time off for community service*
Administrative expenses associated with volunteer programs *Examples: Volunteer coordinator staff; volunteer recognition items*		
Professional Education		
Education required for staff *Examples: Orientation program; standard in-service program; nurse aide training*	Community benefit education programs for which there is no clear or identifiable cost *Examples: Vocational training for which the facility is paid; free center for excellence; in-service programs open to professionals in other facilities; staff presentation of papers or lectures before professional groups*	Professional education programs where there is an identifiable cost *Examples: Clinical training programs in medicine, nursing, pastoral care*

COMMUNITY BENEFITS

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Some organizations separate benefits for the poor from those for other groups.

Defining Benefit Services to the Poor

The community benefit services identified in the **Table** might be further broken down according to the intended recipient. Some not-for-profit healthcare organizations, including religiously sponsored facilities and programs established to serve the poor, separate community benefit services for the poor from services for the broader community. It is not always possible or appropriate to formally means test each service recipient (i.e., to ask for participant income and asset data). Instead, the following criteria can be used to identify services for the poor:

- Most program users are poor (i.e., at 150 percent or less of the federally defined poverty level).
- Most program users are beneficiaries of Medicaid or of state and/or local programs for the medically indigent.
- The program is directed at reducing high morbidity or mortality rates (e.g., low birthweight) caused by poverty.
- The program is physically located in and apparently draws most of its users from a site shown to be populated by low-income or medically underserved residents, as demonstrated by:

—Demographic data (e.g., from the census) demonstrating a higher poverty rate than the average for the state as a whole

—Designation as a "medically underserved area" or a "health manpower shortage area"

Applying the Criteria

To apply the benefits categorization criteria, consider the examples presented earlier. Do these services qualify as community benefits?

- Medicaid workers in emergency room. This is definitely a community benefit because it helps uninsured persons access more appropriate primary care. However, this would probably not appear in a quantified, cumulative community benefit inventory because it is likely a cost-saving, and not a cost-generating, activity.
- Dietary staff volunteering their time. This is a wonderful community service, one for which both the organization that encouraged the service and the individuals involved deserve recognition. However, it should not appear in a cumulative report because it does not involve budgeted funds.
- Marketing at the county fair. This is a nice thing to do, but the for-profit in town was probably in the booth next door. It is not a community benefit.
- Pastoral care. Because pastoral care is integral to overall good care, the staffing and basic services should not be regarded as community benefits; however, all outreach services sponsored by pastoral care may be considered community services.
- CEO leadership. Executive and staff collaboration with community service organizations should always be counted as community benefits, at least in the narrative report. CEO membership on the symphony board, an example of nonhealth-related civic participation, does not qualify for inclusion in the community benefit inventory. □

For more information, call Julie Trocchio at 202-296-3993.

DRUG USE

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and babysitting. They provide bus passes to women who are able to use them. In other cases, care managers drive women to their appointments in vans leased by the hospitals, accompanying their clients during the visit to assist with other children.

The Program's Success

In the second fiscal year of operation (1994-95), 4 care managers worked with 91 clients. In 1995-96 MAP served 102 women (excluding 12 who either did not meet the admission criteria or were referred but refused services). The majority of clients are residents of Harrisburg. Twenty-one women were evaluated at the Dauphin County Prison and referred for treatment before their babies were born. This represents a 100 percent increase in this service area compared with the previous year. Of the 55 babies born to MAP clients, 20 were healthy and drug free; 10 were healthy but tested positive for drug exposure.

During 1995-96, seven clients successfully completed involvement with MAP and received certificates acknowledging this accomplishment.

Comments received in surveys conducted by telephone and in person with mothers who have been helped by the program indicate that MAP is achieving its goals. The vast majority reported home visits, transportation, and referrals to be the most helpful services, along with education and moral support. For example, one mother stated, "I was tired of running from justice, and prison life was hard. Thank God it's over. I'm proud I made the decision to contact MAP. I've gained a lot." Another client commented, "MAP made me think of life in a different way—the right way." □

For more information, call Joyce Zandieh at 717-763-2575.