Back to Index Back to Home Page

As printed in Michigan Health & Hospitals Magazine, Nov/Dec 1998

THE COMMUNITY BENEFITS COLUMN

Community Benefit Planning: The missing link in community health models

BY ROBERT M. SIGMOND

Recently, I attended an exciting meeting in Lansing, learning what it takes to sustain comprehensive community health models (CCHMs). Initiated in the mid-90s with generous start-up funding from the W.K. Kellogg Foundation, Kellogg partnered with three local foundations to form CCHMs. Now, the leaders of CCHM initiatives in Calhoun, St. Clair and Muskegon Counties are facing the harsh reality of relying on their own resources.

As reported by Bill Richardson, the foundation president, "CCHMs were established to allow communities to take charge of their own health care systems. "In each of the three counties, "community leaders have been committed to the hard work of changing mindsets and institutions, thinking in new ways, and learning to do business differently. Despite resistance from those satisfied with the status quo, a great deal has been accomplished, and the commitment to continue is strong." Now, these pioneer CCHMs are perfecting long-term strategies for going it alone.

How these pioneer communities solve this problem will be of interest to leaders in hundreds of community coalitions throughout the nation. Like the CCHM initiatives in Michigan, most of these were established within the past decade, with initial support from local foundations, hospital systems and other community entities, but with little long-term security for dedicated staffs.

The real issue in the CCHM communities, as elsewhere, is not lack of money. Almost all of these communities spend much more money per capita on health care than in any other nation in the world, including many nations with better health status indices. As these communities take charge of their own health systems on a collaborative basis, it should not be difficult to divert just one half of one percent of their health system expenditures to maintaining the vitality and value of CCHM initiatives. That's all it would take.

My own experience suggests that with involvement and support of all elements of the communities' health systems, an investment of half of one percent of health system

expenditures in CCHM initiatives to improve system effectiveness should pay for itself, and even earn a dividend. The key is to demonstrate value to the major elements of the community's health system, especially the hospitals, in helping solve their problems and accomplish their missions. If any element of a hospital's programs can be carried out more economically and effectively in collaboration with CCHMs, there is a strong incentive to change the status quo, and shift some expenditures to the CCHM collaborative. The most obvious candidate for hospital/CCHM collaborative planning and action that would be in the institution's interest and the community's interest is the hospital community benefits program.

This special opportunity involving community benefits was highlighted in Bill Richardson's remarks at an earlier gathering of the CCHM leadership in 1997. Here is part of what he said:

"... there's one area that hasn't received ... much attention [by CCHMs], and it's one I believe is worthy of expansion. I refer to the issue of hospitals and community benefits and how these can and should be applied.

"First, let me summarize the meaning and function of community benefits, because they're a little known facet of the health system. Basically, a nonprofit hospital system, as a condition of receiving tax-exempt status, is required by the federal government (and some states) to demonstrate a benefit to the communities they serve. In effect, the government says, 'We're giving you tax-exempt status, but in response, you must provide benefits to the community that help compensate for this forgone tax revenue.

"There are various legal viewpoints on what form these community benefits should take. Most typically, hospitals seek to provide community benefits by offering charity health care. The problem is, no clear standards exist as to how charity care should be calculated. And this absence of direction has led to debates over whether community benefits, as currently practiced, provide a fair compensation to communities.

"I regard community benefits as an undeveloped, almost unknown resource in community health care. I challenge you all to work with community members and trustees of your hospitals to change the status quo. Community benefits, in my view, are not fully meeting their intended purpose, and there's a great need to rethink and redirect this process."

In the three CCHM communities, as elsewhere throughout the United States, we find the startling but all too common paradox to which Bill Richardson called attention:

- The hospitals are enthusiastic supporters of and participants in CCHM-funded initiatives as clearly documented in the article by Mary Cohen in the September/October 1998 issue of Michigan Health & Hospitals magazine.

- CCHMs are not directly involved in the much larger community benefit expenditures of the hospitals and do not participate in the hospitals' community benefit plan development as suggested by the Kellogg Foundation (See box).

At the Lansing conference, it was suggested that the CCHM sustainability issue will be resolved when CCHM planning is in synch with hospital community benefit planning, demonstrating economic value to the hospitals in fulfilling their valid community benefit goals. These goals necessarily involve not only charity care but in the longer run, an improved health care system for the entire community as well.

Suppose that in close collaboration with the hospitals, CCHMs directed explicit attention to the problem that currently absorbs almost all of the money that hospitals spend on their community benefit commitments: unreimbursed patient care. In my judgment, a collaborative approach to this problem, involving widespread community participation, would cost the hospitals and the community much less money and would free up significant community benefit funds for support of other initiatives.

In my next column, I will outline practical ways that a community and its hospitals can take charge of unreimbursed care, greatly reduce that burden, and enable hospital community benefits expenditures to provide measurable benefits to the communities beyond the benefits to the patients served.

ROBERT M. SIGMOND IS A SCHOLAR-IN-RESIDFNCE AT THE DEPARTMENT OF HEALTH ADMINISTRATION AT TEMPLE UNIVERSITY, PHILADELPHIA, AND SPECIAL ADVISOR TO THE HEALTH RESEARCH AND EDUCATIONAL TRUST AT THE AMERICAN HOSPITAL ASSOCIATION.

07/06/2000