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THE COMMUNITY BENEFITS COLUMN

Making a Real Difference: Beyond community service to community benefit

BY ROBERT M. SIGMOND

Community benefits or community benefit? Plural or singular? In general, the "pluralists" come from a health insurance perspective and think about community benefits as elements, like benefits in health insurance contracts. The "singularists" come from a broader perspective, and think about community benefit like community service, as a broad direction and commitment related to mission. But there are important exceptions to this rule, of which the Michigan Health & Hospital Association is an outstanding example. That organization clearly belongs in the camp of the singularists, but is currently with the pluralists, perhaps reflecting their strong commitment to a pluralistic health system!

Speculation about singular or plural may set you to wondering where the term community benefit comes from and what it really means. In the sixties, community benefit started to show up in the literature as a result of a monumental misjudgment of the future of health insurance by some brilliant staffers at the Internal Revenue Service (IRS) in Washington, DC. They foresaw that the new Medicare and Medicaid entitlement legislation for the aged and poor would quickly lead to entitlement for everyone else and the end of traditional charity care. This was important to the IRS since hospitals qualify for tax exemption under the Internal Revenue Code only as charitable institutions; providing health services is not enough. To preserve hospital eligibility for tax exemption, the IRS decided to broaden the notion of charity from a contribution to deserving patients to a contribution to the entire community. More than that, they looked ahead to outcome management and decided to reward institutions for contributions to the community that really made a difference: beyond community service to community benefit.

In short, community benefit is community service with a modern outcome orientation. It's just that simple. The problem is that managing community service so as to achieve measurable outcomes is not at all simple. For outcome management, the communities to be benefited have to be defined with some precision.

Many hospitals view their service area as their community, the geographic area from which their charity patients come, or the beneficiaries of services that are not reimbursed. For some, community means any group of people or organizations with a common special interest, such as the physician community, the African-American community or even the hospital community.

Many of these notions have little in common with the idea of community benefit. Recently, the National Coalition of Healthy Cities and Communities adopted a definition of community consistent with the community benefit concept: all persons and organizations within a reasonably circumscribed geographic area, in which there is a sense of interdependence and belonging.

Using this operational definition, most hospitals target a number of different communities within their service area: inner city, various suburban and ethnic neighborhoods, downtown, rural enclaves, and more. This enables the hospital team to collaborate with different coalitions of community organizations in different geographic subsections of their service area, as well as in larger geographic communities, such as cities or regions.

National studies have revealed two almost universal characteristics of hospitals and health service organizations that are trying to make the difficult transition from community service to community benefit.

First, all health service organizations engage in many more community service activities than the typical CEO - and especially the CFO - know about. Many employees, professional and non-professional, for whom service is a way of life rather than a management objective, typically don't bother to keep top management informed of their community commitments. Hospital staffs especially have always been expert in carrying out activities that are not in the budget or strategic plan. Studies in many hospitals demonstrate that these activities are extremely widespread, though they only scratch the surface of the communities' problems. Committed to community service beyond what they believe top management would support, these members of the hospital staff are usually highly respected and trusted by community groups who share their skepticism about top management. Until a hospital makes a commitment to involve the staff and the community in managing a results-oriented community benefit program, similar to its managed programs to benefit patients and enrolled populations, institutional credibility in the communities served is typically quite low.

Second, most health service organizations do not have skilled staff with experience or expertise in converting community service activities into credible community benefit programs that work. Those most involved in community service generally do not start out with initial enthusiasm for having their activities under the control of the management team. This is especially the case when top management decides to engage in a professional community needs assessment without a companion community asset assessment of what is really going on, and of who is involved in attacking perceived problems. A shared vision of community service designed to achieve measurable results is a prerequisite for a successful community benefit program.

Hospitals that have organized credible community benefit programs have usually proceeded along four fronts at the same time: total quality governance and management, specific projects, outreach, and universal involvement.

Governance and management – The community benefit program has the same characteristics as any other program within the organization: mandate from and accountability to a governing board, assignment of explicit managerial accountability that cuts across the hierarchical structure, a work plan and budgeted resources focused on targeted geographic communities, an information system, and all the other elements for total quality management.

Projects – Projects fall into three categories in terms of objectives: improve community health status, narrow the gaps between the health status of the more and less advantaged, and reduce the costs of the communities' health systems. Al l projects should have measurable goals (either structure, process or outcome) and a timetable for accomplishment.

Outreach – Outreach may be in the form of involving other community organizations in the hospital's projects, involving the hospital in the projects of other organizations, and in its most sophisticated form, involvement in projects under multiple sponsorship, such as alliances or coalitions.

Involvement – All elements of the organization are encouraged to participate: trustees, top management and department heads, medical staff and other professionals, all employees, and volunteers. Of special importance is the involvement of hospital staff who focus sharply on managed patient care, because those who live and work in the community look to the hospital for patient care more than anything else. The hospital never wants to turn an individual away who has come for care, telling him or her to come back tomorrow; today we are concentrating on caring for the community!

Today, hospital and health system leaders are beginning to recognize that development of community care networks, integrated delivery systems and other major reform initiatives involve more than continuous improvement in quality patient care and capitated managed care programs. They also see the importance of developing and tying into a well-managed community benefit program that can improve the health of people and reduce the demand for and supply of redundant services.

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