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THE COMMUNITY BENEFITS COLUMN

The Community Benefits and the Bottom Line

BY ROBERT M. SIGMOND

Currently, hospital and health system executives are focusing sharply on the bottom line. Reduced payments from governmental programs like Medicare, pressures of the competitive marketplace, and delayed and lower returns from third party payers are producing negative bottom lines and concern about survival.

In this situation, activities without potential to increase income or reduce expenses are at risk - even projects that reduce expenses if they also reduce income correspondingly. As a result, community benefit programs that do not focus on increased net income are easy targets. At a time when these programs should be expanding, many are facing cutbacks.

Few community benefit programs have demonstrated capacity to contribute to short-term institutional financial stability. In fact, many community champions believe that activities in the community like fitness centers, for example, that are marketed to produce net income, cannot be classified as community benefits. In this view, community benefits necessarily involve spending scarce hospital resources on nonmarketplace activities. These activities do not produce any income, let alone net revenue.

To the best of my knowledge, there is no ethical or legal foundation for this position. Community benefits reflect a charitable concept of institutional contribution to the entire community, not simply to beneficiaries of unreimbursed services, important as they are. Despite aberrant legislative and court actions in Utah, Texas, Florida and Pennsylvania, there is much more to community service than free care. The idea that marketplace and community goals are incompatible disregards the proud history of American hospitals, beginning with Benjamin Franklin's Pennsylvania Hospital.

This limited perspective of community service is the major obstacle in the evolution of community benefit programs. There is no reason for excluding any community initiative simply because it is designed to generate revenue or, as they say, stand on its own bottom. The basic question is whether the initiative includes an explicit goal of benefiting one or more targeted communities.

Most simply, any community service that is designed, organized and managed, among other goals, to improve a target community's health status or the effectiveness of its health services should be included as an essential element of the organization's community benefit program. Income or lack of income is not a basic criterion, so long as the activity does not discriminate in

any way against those in the community with inadequate financial or other resources.

Some elements of virtually every department of a health service organization can be organized for community benefit, from the emergency department to the surgical suites to the information system to the collection department. This means that the activity is designed not only to support the organization's patient care initiatives in the service area, but also more explicitly in terms of quantitative goals to benefit one or more targeted communities.

Working with health services organizations throughout the country, I am calling attention to the many exciting opportunities to restructure a wide range of activities to simultaneously increase income, decrease expenses, and bolster the bottom line through collaborative activities targeted to benefit specific communities. In most cases, these initiatives also contribute to improved quality and increased access.

In the current complex environment, these opportunities tend to be overlooked when the community benefit program is not seen as an integral element of every department's strategic planning. But this requires that those responsible for the community benefit program devote at least as much time to collaborating with elements within the organization as they do to community collaboration.

One simple example of a project that reduces expenses is found in some nurseries in which an organized community group of grandmothers take turns holding and nurturing premature babies whose mothers have been discharged. The result is well-documented reduction in length-of-stay and related expense, and also healthier discharged babies. Like so many other projects, this involves the community as a resource as well as a target. Whether income is affected depends, of course, on the payment methodology. With capitation, the reduction in expenditures will not be offset by reduction in income.

As an example involving both income and expense, in three recent columns, I sketched out a community approach to managing the uncompensated care problem, designed to make a major contribution to a healthy institutional bottom line and also to benefit disadvantaged residents of targeted communities.

Future columns will outline many other such opportunities. In almost all instances, such initiatives call for collaboration with other community organizations, including competing provider organizations. Of greatest importance is partnership with the public health department and other governmental agencies. Their active involvement is the major protection from anti-trust legal actions that may attack collaborative community benefit initiatives. Today, the greatest obstacle to true community partnerships among provider organizations is not anti-trust, but lack of trust.

Experience with any one community benefit program that also strengthens institutional bottom lines can help overcome this lack of trust. Each success will lead to the discovery of other exciting opportunities for collaborative community programs to simultaneously benefit target communities and the bottom line.

If any readers of this column have explicit examples of community benefit projects that also contribute to the institution's bottom line, please share them with me for use in future columns, with or without identification of the name of the organization.

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