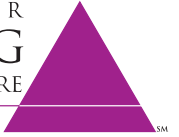


Community Benefit: Overcoming Organizational Barriers and Laying the Foundation for Success

REPRINT OF *INQUIRY* ARTICLE 47, SUMMER 2010

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This Dialogue features five community benefit leaders who work “in the trenches” of nonprofit health care systems and hospitals. In this conversation, they share their views on how to overcome organizational barriers to community benefit and describe the basic infrastructure that any type of nonprofit health care organization, whether health care provider or insurer, should have in place to achieve both successful and sustainable community benefit performance.

This exchange is another installment in *Inquiry's* ongoing Dialogue series, cosponsored by the Alliance for Advancing Nonprofit Health Care to provide a variety of voices on important nonprofit health care issues. In the Winter 2009/2010 Dialogue, “Health Care Reform through Community Benefit Leadership,” four nonprofit health care executives provided their perspectives on the meaning of community benefit, its fit with health care reform initiatives, critical success factors, and the roles of the board and chief executive officer (CEO) in community benefit.

The panelists for this discussion, held on Feb. 11, 2010, were: **Eileen Barsi**, director, community benefit, at Catholic Healthcare West in San Francisco, Calif.; **Diane Jones**, vice president, healthy communities, at Catholic Health Initiatives, in Denver, Colo.; **DawnMarie Kotsonis**, executive director of community benefit

and of Presbyterian Intercommunity Hospital Foundation in Whittier, Calif.; **Monica Lowell**, vice president, community relations, at UMass Memorial Health Care in Worcester, Mass.; and **Carol Paret**, chief community benefit officer at Memorial Hermann Healthcare System in Houston, Tex. **Bruce McPherson**, president and CEO of the Alliance for Advancing Nonprofit Health Care, in Washington, D.C., moderated this discussion.

Bruce McPherson: *By all reports, your organizations have made tremendous strides in your community benefit practices and programs in recent years. What has been the impetus for your advances? Was there some particular development or event, internal or external, that might have affected the timing or extent of your organizations' improvements?*

Monica Lowell: Our hospital system, UMass Memorial Health Care, has been planning, budgeting for, and reporting on community benefit for many years. There have been two recent developments, however, that are elevating our focus on this area. First, last year our state attorney general issued a new set of guidelines on community benefit practices and reporting for nonprofit hospitals and health plans. Those guidelines have stimulated our system to reassess what we are doing and how we are doing it. While we have not significantly altered our approach, we needed to ensure that it was consistent with the guidelines. Secondly, coincidental with the Internal Revenue Service's reform of its Form 990 for reporting by tax-exempt charitable organizations, we established a governance committee to review all of those changes, including the new Schedule H requiring community benefit-related information. That review heightened the board's interest in community benefit and has further stimulated a self-assessment of reporting and other practices related to community benefit.

Diane Jones: For Catholic Health Initiatives (CHI), providing community benefit and building healthy communities have been part of the legacy of care of our local ministries since their inception, and have been a core focus of our system since its formation 14 years ago. We have a Mission and Ministry Fund, established in 1996, which has awarded 241 grants totaling over \$29 million to our facilities for the promotion of healthy communities in addition to direct services provided by our local ministries. Our present infrastructure for community benefit has evolved over the

past several years, driven by our commitments to building healthy communities and meeting changing community needs, our advocacy priorities, as well as regulatory developments.

Like many others, we are focusing at the moment on understanding the new Form 990 Schedule H. We have a close working relationship with our financial and tax teams, and we are working together to help all of our facilities provide and report on community benefit.

Eileen Barsi: While our system, Catholic Healthcare West (CHW), has been in existence over 20 years, many of our hospitals have been serving their communities for more than 100 years, with a particular focus on the poor and the underserved. As our health system began to grow, the need became apparent in our headquarters to standardize reporting and other program practices related to community benefit throughout our system. We engaged the Public Health Institute in Oakland to help us in that regard, and that partnership evolved into a three-year demonstration project, "Advancing the State of the Art of Community Benefit (ASACB)," involving several health care systems and independent hospitals. Thus, we have been very focused in our community benefit efforts over the past eight years.

DawnMarie Kotsonis: While our hospital has been planning, budgeting for, and reporting on community benefit for many years, Presbyterian Intercommunity Hospital (PIH) was poised to take community benefit to new heights when we learned about the ASACB demonstration project that Eileen just spoke about. Like many nonprofit hospitals at that time, we were looking at the changing landscape, with skyrocketing costs colliding with increasing unmet needs, struggling to figure out how we could better carry out our charitable mission and make a difference. We started looking around for best practices and discovered ASACB. Since then, community benefit at PIH has taken off like a rocket ship.

As an independent, free standing hospital we have been able to try out a lot of different community benefit approaches in a relatively short amount of time, which may be harder to do in a large multihospital system.

Carol Paret: Memorial Hermann may be a bit unique as a multihospital system, in that all 11 of our hospitals are located in one metropolitan area, the Greater Houston area. We first began formalized community benefits efforts in 1995, which have evolved gradually since then through trial and error.

McPherson: *How important has top-level commitment and involvement been to your organization's community benefit efforts, and how has that commitment come about?*

Barsi: We have always had the commitment of our CEO, Lloyd Dean. Our board's role in community benefit is spelled out in our corporate bylaws, and our board has adopted policies and procedures that codify our structure and administrative roles and responsibilities for community benefit. However, it wasn't until we were able to get the real attention and backing of the finance and operations executives in our individual facilities that we were able to achieve real support for community benefit.

We got the backing from finance and operations executives by building the business case for community benefit. We provided them with facility-specific data on ambulatory care-sensitive conditions being treated in emergency rooms and inpatient units, and how much uncompensated care and Medicaid payment shortfalls could be reduced if those patients were treated in a timely manner in primary care settings. That data opened their eyes, and got us all working together for the good of both the community and our organization in ways that had never happened before. The importance of effective case management and discharge planning for our vulnerable hospitalized patients, to prevent unnecessary readmissions, has also become an important aspect of our business case.

We got the suggestion to look at this data from the ASACB demonstration project, but in 2003 we had also developed with our partner, Solucient, now part of Thompson-Reuters, our own assessment tool called the Community Need Index, which analyzes socioeconomic barriers in the communities we serve to identify health service utilization risks, particularly for ambulatory care sensitive conditions.

Lowell: Even though Massachusetts is ahead of the curve in terms of health care coverage, UMass Memorial is still serving many uninsured people, so the business case for community benefit is still there. Like Eileen's system, we are addressing socioeconomic risk factors and those social determinants that impact the health of the community through collaborative efforts with key stakeholders. In addition, we are working to reinforce the infrastructure of local community health centers.

Kotsonis: Getting the finance and operations buy-in, as well as board support, was also critical for us at PIH, and we were able to piggyback on hospital-wide initiatives and successes in improving quality. Meeting community needs had always been a part of our mission and culture, but we were able to take community benefit to a new level when our finance and operations people saw that providing the right care at the right time in the right place for all of our patients, including the uninsured, both improved patient outcomes and saved money. Community benefit was no longer a hard sell—not just seen as the “warm and fuzzy” work of “tree huggers.”

Paret: In a market like the Greater Houston area, with 30 percent of the population uninsured, getting top-level commitment hasn't been an issue. The business case stares us in the face every day, because as a matter of sheer survival, we have been compelled to look beyond our institutions to the entire community health care infrastructure and try to figure out, working with large community coalitions, what are the most efficient and effective ways to meet the needs of our uninsured. One example of the results of these efforts is that the percentage of the uninsured with access to primary care has grown over the past five years from less than 50 percent to over 75 percent. Even with that success, however, studies continue to show that 50 percent of the ER visits in every Houston-area hospital are for conditions that were treatable in primary care settings. So clearly, we have a long way to go in educating people on how to best use the health care system.

Jones: Our challenge early on was to create a standardized approach to community benefit across our system, which includes a wide variety of different types of health ministries, including small critical-access hospitals, large and midsize hospitals serving diverse urban and rural communities, as well as long-term care and residential centers spread across 18 states. To help meet that challenge, our national Board of Stewardship Trustees endorsed a three-year strategy to develop comprehensive community benefit plan practices within each facility according to system-wide standards. We also established a national multidisciplinary team to guide and assist in the implementation. This helped us move more quickly to create a common community benefit infrastructure throughout the system.

McPherson: *That's a great lead-in to my next question. Would each of you please describe the various ways in which your board is responsible for and involved in community benefit?*

Jones: Beyond the three-year strategy I just mentioned, our system's Board of Stewardship Trustees has established a community benefit policy that is reviewed every three years. The board's Mission and Ministry Fund Advisory Committee oversees the grants provided to our facilities for the promotion of healthy communities. Our system board meetings also feature a presentation by a local ministry CEO highlighting local community benefit activities. In addition, our local ministry boards have adopted community benefit policies and procedures, approve annual community benefit plans, and participate in local community benefit advisory committees. Community benefit is also integrated into regular planning and budgeting processes extending to the individual department level.

Paret: We've taken a different approach at Memorial Hermann. Two years ago, we created a separate corporation dedicated solely to our system's community benefit effort, with its own 13-member board. Based on \$5 million of funding provided each year by our hospital system, which is augmented by grants from a variety of external sources, the board of our community benefit corporation sets priorities, allocates the funds, and assesses outcomes and future directions. Knowing that there is going to be the same committed block of money each year from the system has motivated this separate board to be thoroughly engaged in carrying out its responsibilities and has enabled it to support programs that it might not otherwise have without the assurance of that sustained commitment from the system. In fact, the thorough engagement of this board would make it near impossible for a system to ever walk away from its commitment.

Lowell: UMass Memorial has a system-level board committee meeting quarterly to oversee our community benefit efforts. While it is currently composed of members of our system board, senior managers and some physicians, we are in the process of expanding it to include community representatives. In addition, each of our hospitals has its own community advisory board with whom we work to assess and prioritize needs and community benefit programs.

Also, one of the goals that our system board has set as part of our strategic plan is to build a vibrant and healthy community, and employees assess whether and how they contribute to that goal in their own jobs.

Barsi: The CHW board sets a variety of performance objectives for the system, some annual and some applicable over a three-year period. When we first realized that we needed to standardize some approaches throughout our system, the board adopted a community benefit policy and then linked achievement over time of certain community benefit practices to each hospital's executive compensation, such as assessment and improvement of the current competencies of community benefit staff and evaluation of the effectiveness of their community benefit programs. The full board, as well as its audit and compliance committee and its strategy committee, are actively engaged in monitoring progress in achieving these objectives as well as updating and refining them as needed. We also ask the board of each of our 41 hospitals to be actively engaged in the assessment and prioritization of community needs, program planning, and monitoring progress and results.

Kotsonis: PIH has a community benefit oversight committee that operates as a subcommittee of our hospital's board. The committee consists of: one or two members of our board; leaders from several key stakeholder organizations in the community, such as the director of the public health department, the superintendent of schools; and several key internal operations managers, such as the vice president of our community clinics.

At the same time, however, budgeting for community benefit programs is decentralized in order to instill better ownership of the programs. Centralized versus decentralized budgeting for community benefit is a nagging question, however, as is linking compensation to community benefit performance, which we don't do currently.

McPherson: *What has been the specific role and involvement of your CEO in community benefit?*

Paret: Memorial Hermann's CEO, Dan Wolterman, has been very visible around our community benefits internally. The tack that he has taken that's really driven a lot of change is to

be extremely visible around these issues externally, such as chairing the Greater Houston Partnership, which is our Chamber of Commerce, and serving on its health committee. Given the magnitude and complexities of the health care issues we are facing, we need to reach out to others in health care, the business community, and the political arena to work with us in making the kinds of changes that will truly make the Houston area a healthy community. We are doing so through Dan's leadership.

Jones: I couldn't agree more. As much as we need our leaders to be strong voices and advocates for community benefit within our organizations, we also need them to be active at the regional, state, and national levels to gain support for what we are trying to accomplish with our communities. Our CEO, Kevin Lofton, through his past leadership at the American Hospital Association, multiple national advocacy efforts, and direct participation in local activities, has been a strong champion for community benefit.

Kotsonis: Our CEO, Jim West, has also been a real champion of community benefit, along with our vice president of continuing care, Pat Bray, who brought up the whole idea of organizing community benefit efforts. Our CEO has carried the banner for community benefit as passionately and consistently as he has for our quality initiatives, and he expects nothing less from everyone else in the organization.

Barsi: We at CHW have been blessed with the same degree of leadership in community benefit from our CEO, Lloyd Dean, as well as from many committed board members. In fact, our current board chair, Jarrett Anderson, an attorney from Southern California, even served as a member of the national steering committee for the ASACB demonstration project we were talking about earlier.

I should also note that CHW recently changed the titles and job descriptions of our hospital leaders. They are now service area leaders, rather than presidents, to emphasize their roles in understanding the disproportionate unmet health-related needs of their communities and directing community benefit strategies to meet those needs, taking into account socioeconomic and other factors impacting those needs. This change speaks volumes about the commitment at the CHW executive and board levels to community benefit.

Lowell: If your CEO is rolling up his sleeves—internally working with staff to identify and address community needs, as well as working with others out in the community in the same fashion—he or she becomes an indispensable role model for community benefit. That passion and commitment will spread throughout the organization and beyond. Luckily for us at UMass Memorial, we have that role model in our CEO, John O'Brien. He co-chairs several community-based initiatives that are having an impact in the community and has achieved numerous awards for his efforts.

McPherson: *While your CEOs clearly have the ultimate managerial responsibility for community benefit, what kind of operational infrastructure does your organization have in place to coordinate and support community benefit efforts? And where do you personally fit into that infrastructure?*

Kotsonis: I am executive director of PIH's Foundation and Community Benefit, and report directly to our CEO. In addition to the 33 percent to 50 percent of my time devoted to community benefit, I have two full-time staff in our community benefit department, which I personally had the pleasure of starting several years ago.

As a result of our most recent community health assessment, we are currently focusing our community benefit efforts on three priorities, and several other senior managers are actively working on subcommittees of our community benefit oversight committee on a daily or weekly basis to address those priorities.

Barsi: I'm the director of community benefit within the Mission Integration Department in CHW's corporate office, reporting to the vice president of community health.

Each hospital has an individual responsible operationally for community benefit, and we recommend that that individual report directly to the CEO or to an individual who directly reports to the CEO. The total number of staff full-time equivalents (FTEs) dedicated to community benefit varies by hospital, but can range from one-half as a minimum to as many as 12. In addition, we have increased the engagement of our clinical staff in community benefit efforts.

Jones: At the system level of Catholic Health Initiatives, as vice president for healthy communities within the National Mission Group, I have responsibility for our healthy community strategies, our Mission and Ministry Fund, and our global ministries. Recently my responsibilities have been expanded to include community benefit. I report to the senior vice president of mission.

At the local level, each of our facilities has a multidisciplinary community benefit advisory committee, on which we recommend representation from mission, finance, communications, clinical services, strategic planning, information technology, administration, and other areas. Directing that committee is a community benefit leader who reports directly to the CEO on community benefit activities. The community benefit leader may wear multiple hats and have multiple reporting relationships, which they often do in small facilities. I work closely with the senior vice presidents of mission and advocacy, as well as the facility community benefit leaders on strategies and structure. We are assessing this year how to best integrate finance, clinical care, quality improvement, and community benefit efforts.

Lowell: As vice president of community relations at UMass Memorial, I have the day-to-day operational responsibility for community benefit. I report to the senior vice president for the clinical system, but also meet regularly with our CEO on community benefit matters. My staff and I spend most of our time conducting community outreach, collaborating with others in the community in identifying and meeting needs, and helping to bring to bear other resources in our system where appropriate and feasible.

McPherson: *Before we conclude, are there any additional “lessons learned” or other final points you would like to make on laying the foundation for community benefit in your organizations?*

Kotsonis: Achieving excellence in community benefit is not a race that will be won in a sprint. It requires a long-term commitment and perseverance to see lasting change, particularly in an environment that is as challenging as we all currently face. Having the basic infrastructure in place is critical—the board policies, the board and CEO involvement, the dedicated resources, and the other pieces we have been discussing here.

Paret: To really achieve meaningful community benefit, you have to be focused and you have to be able to measure outcomes—not the number of people served, but rather the change in their health status. Also, while building the business case in your organization for community benefit can be important, I think that passion for it within the organization is the key sustaining ingredient, and it is the job of people like us to create and maintain that passion if and when it’s absent.

Jones: Another key element we haven’t talked about is telling the community benefit story. We get so engaged in doing the work that we often forget to take the time to tell our successes to all key internal and external stakeholders. And telling the story is often about the heart—examples of individuals who have benefited—rather than about the numbers.

Lowell: Speaking of numbers, my final point is a plea to both the IRS and state officials to come to an agreement on one set of community benefit reporting requirements, so that we are able to spend less time on gathering and filing such information and more on actually improving access to health care.

Barsi: You are so right. The numbers game is so frustrating, and it gets even worse when policymakers want to impose a minimum charity care requirement. We have to keep educating them that we are proactively trying to reduce the need for charity care while improving health status for the uninsured through community health centers and other community outreach programs.

The last point I would like to stress is how invaluable it has been for me over the years to network with community benefit colleagues across the country through the Catholic Health Association (CHA) and the Association for Community Health Improvement (ACHI). I also am very grateful to the St. Louis University School of Public Health, whose faculty has been working with CHA to develop a curriculum for a certificate in community benefit. That online program will be launched later this year and will be available to anyone who wants to enroll. I think the greatest legacy that we who have been in this field for some time can leave to the next generation of community benefit leaders is enhanced education through a structured program and curriculum (see <http://publichealth.slu.edu/certificatecommunitybenefit.htm>).