



Accountability for Community Benefit

Posted: May 28, 2008

By Eileen Barsi, Director of Community Benefit,
Catholic Healthcare West, San Francisco, California

Catholic Healthcare West applies a rigorous implementation and evaluation plan to its community benefit programs.

The applause stunned me. I simply hadn't expected the chief financial officers of our 41 hospitals to respond to a community benefit presentation with such affirmation. When I asked what had prompted their reaction, they told me that for the first time, they had heard the business case for community benefit programming. This was language they understood. It was a major turning point for me and for the community benefit program at Catholic Healthcare West (CHW).

Over the last five years, CHW has brought more rigor and effectiveness to community benefit programming by promoting greater accountability, which ensures a comprehensive and focused effort. We learned that bringing a strategy to action, an organizational structure to life and a vision to realization requires each of us to understand the goals clearly so that we reach a level of conviction. When we pivot from such a point, we are acting from an inner sense of what is right.

Our first step in reaching that level of conviction was to ensure that the roles, responsibilities and accountabilities of each community board member, hospital leader and staff charged with community benefit programming were codified and clearly understood. The individuals charged with the oversight and implementation of community benefit programming needed to understand what their part is and why their responsibility is so important. Hospital leaders and staff members had long thought of community benefit as what "they do out there" rather than what "we can do together." We needed to change that thinking to integrate work occurring inside hospital walls with intervention approaches outside.

Establishing Accountability

The CHW board implemented a community benefit governance policy that called for a uniform measurement and improvement of community benefit work. This work would preserve the flexibility of each facility to respond to the local needs of its unique community. The goals set forth in our community benefit policy and CHW's "Standards for Mission Integration" were included as part of each hospital president's performance metrics. The goal established for each president in the first year of this new approach was to achieve compliance in the following areas:

- Assess the competencies of current community benefit staff and determine their capacity for implementing CHW's community benefit policy. Plan and budget for any necessary adjustments.
- Establish a baseline by assessing the hospital's current community benefit programs to evaluate their effectiveness and their relatedness to the hospital's local health priorities.
- Develop a work plan that includes measurements of progress and a budget based on the findings from the above assessments.

In the second year of the initiative, facilities submitted two community benefit goals to be monitored for outcomes over the next two years. The CHW system



office provided guidance to staff at each facility to help them determine the baseline for performance improvement, set realistic goals, establish measurable outcomes and develop an effective intervention strategy for the health issue being addressed. Beyond reporting the number of people served, community benefit staff also described the health impact of the program. At the end of the third year of applying greater rigor to community benefit programming, more than 85 percent of our hospitals met or exceeded their stated goals.

In 2002, CHW engaged in a grant-funded national demonstration project, Advancing the State of the Art in Community Benefit (ASACB). The demonstration brought together a diverse group of 70 hospitals in California, Texas, Arizona and Nevada to develop and implement uniform standards that would align hospital governance, management and operations and would ensure that hospital community benefit resources were used to address unmet health-related needs. The Public Health Institute, a private, nonprofit research, technical assistance and training organization based in Oakland, Calif., administered the ASACB demonstration.

The creation and adoption of community benefit performance measures assessing both organizational policies and program operations was an important part of both the demonstration and CHW's evolution. A central objective in the demonstration was to use a more strategic approach to program planning and implementation, which is guided by a commitment to five ASACB core principles. CHW integrated these core principles into its administrative policy to ensure a strategic approach to program planning, implementation and evaluation. The principles are:

1. **Emphasis on disproportionate unmet health-related needs.** All services, activities and donations to be counted as community benefits will include outreach and design elements that ensure access for communities with disproportionate unmet health-related needs.
2. **Emphasis on primary prevention.** CHW hospitals will work with the community on program activities that address the underlying causes of persistent health problems as part of a comprehensive strategy to improve the health status and quality of life.

The term primary prevention refers to three types of activities: (1) health promotion—encouraging healthy lifestyles, (2) disease prevention—focusing on people identified as at risk for health problems and (3) health protection activities—creating a healthier environment that will support individual healthy behaviors.

3. **Building a seamless continuum of care.** CHW will develop operational linkages between clinical services and community health improvement activities. The intent is to ensure that the CHW hospital's investment in community health improvement activities will yield measurable impacts on health status and quality of life.

To build a seamless continuum of care, CHW facilities are committed to engaging more clinicians in the design and implementation of program activities.

4. **Building community capacity.** CHW will target charitable resources to mobilize and build existing local assets, such as community-based organizations, businesses, physical infrastructure, community groups and skills of individual families.

CHW hospitals will strategically allocate financial resources, materials, expertise and advocacy to build on what is already in place in the community. This will enhance the effectiveness and viability of community-based organizations, reduce duplication of effort, and provide a basis for shared advocacy and joint action.

5. **Emphasis on collaborative governance.** CHW is committed to collaborating with community members who have a direct stake in the success of a program. This provides a platform for shared action and advocacy to address systemic problems such as access to health care.

Following the ASACB demonstration, CHW leaders reviewed and revised the CHW governance policy, calling for greater accountability of community boards and hospital leaders. In collaboration with finance and community benefit staff, they developed operations guidance as well as standardized calculation and reporting guidelines. CHW leaders educated stakeholders, including hospital community boards, in these policies. At the conclusion of the demonstration in 2007, CHW had implemented the principles and practices throughout the organization.

Data for Strategic Decisions

Like similar organizations, CHW recognizes that accurate measurement of community needs is essential. In California, where the majority of our facilities are located, state law requires nonprofit hospitals to assess the needs of their communities every three years. CHW used to practice a variety of methods to do so—ranging from a comprehensive assessment by an outside agency to reliance on United Way data or survey results. Rather than rely solely on these methods, in 2004 Catholic Healthcare West developed, in partnership with Solucient LLC, the nation's first standardized and scientific approach: the community need index (CNI), which would later prove critical in helping us build a business case for this work.

Using a combination of research, literature and experiential evidence, CHW identified five prominent socioeconomic barriers that enable us to quantify health care access in the communities we serve. These barriers are income, culture/language, education, insurance and housing. The CNI accounts for the underlying social and economic barriers that affect overall health and identifies the severity of health disparity by ZIP code in our service areas.

Applying a disparity scale from 1 to 5 to assess risk, CHW found a 97 percent correlation with high-need communities and high use of hospital services. In fact, we found that patients in high-need communities were more than twice as likely to be hospitalized for conditions that could have been treated in an outpatient setting had the condition been identified earlier. We have used the CNI scores to map by ZIP code the health needs of every community we serve. Catholic Healthcare West and Solucient have agreed to share the methodology with other health systems and community benefit organizations to improve community needs analysis nationally.

An important next step was to compile and present the data to a variety of internal audiences. The facts created a clear and compelling picture of how the unmet health-related needs of the community directly affected utilization of hospital services. In fact, Carol Bayley, CHW vice president of ethics and social justice teaching, remarked, "*We have seen a face of the poor unlike any we have seen before.*"

When our internal workgroups viewed this data, they were able to fully comprehend and appreciate community benefit programming: targeting specific neighborhoods and the specific conditions that disproportionately affect members of the community served. For those in governance and leadership whose responsibility and accountability is to ensure the fulfillment of our mission imperatives and compliance with legal mandates, this new information resulted in a community benefit strategy for the organization.

For the first time, our colleagues in the finance department gained a clear understanding when presented with a business case that drew a direct line between the identified need of the community and its demand for health care services. Strategy and business development staff appreciated that benefiting the

community can increase preference and share of the market. It also helped these staff members identify the need for improved access to primary care services.

For our colleagues in hospital operations, it was important to relate how helping patients manage their chronic conditions in the community would help decrease complications for subsequent acute care admissions, result in fewer denied days, or perhaps even free up bed capacity for more appropriate inpatient admissions. Everyone now understands the work and the reasons for the renewed focus of our community benefit efforts.

With the full support and leadership of our president and CEO, Lloyd H. Dean, and the board of directors, Catholic Healthcare West has fully embraced this method of community benefit programming to allot our resources where there is demonstrable and greatest need. In fact, CHW is now applying the same level of scientific rigor expected in the provision of clinical services to our work in community benefit programming. The central goal of our efforts is to move away from the model in which we simply enumerate our activities and accomplishments to a more strategic and evidence-based approach that ensures our resources are used in the wisest and most effective manner.

With a primary focus on the identified unmet health-related needs of the communities we serve, we are striving to achieve measurable results from our intervention efforts—that is, fewer hospitalizations for manageable conditions. For those whose lives we are able to touch through our community benefit interventions, this may also translate to an improved quality of life, which is our ultimate goal.

Despite the magnitude of the task, we have eagerly begun. In the words of J.W. von Goethe, “*Knowing is not enough; we must apply. Willing is not enough; we must do.*”

This article was submitted in cooperation with H&HN Online, a publication of the American Hospital Association's Health Forum.

The views expressed in this article are the author's and do not necessarily reflect the positions or policies of the Association for Community Health Improvement or the Health Research & Educational Trust.