

Health Care Reform

through Community Benefit Leadership

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Nonprofit hospitals are experiencing significant public scrutiny at the national, state, and local levels over their provision of community benefits and how it measures up to the value of their institutional tax exemptions.

Some nonprofit nursing homes are facing similar examination by their local governments, and some nonprofit health plans are under the watch of state governments.

Such scrutiny can be expected to continue, and may well intensify, irrespective of the outcomes of federal health care reform legislative efforts.

So what is community benefit about? How important is it, and will it be, to nonprofit health care organizations and the communities they serve with or without major federal health care reform legislation? Is community benefit part of health care reform or is it something else? What is the appropriate role of the board and CEO in a nonprofit health care organization's community benefit efforts? What are some critical success factors or best practices?

These are among the issues explored in the following discussion, another in *Inquiry's* ongoing Dialogue series, co-sponsored by the Alliance for Advancing Nonprofit Health Care to provide a variety of voices on important nonprofit health care issues.

The panelists for this discussion, held on October 5, 2009, were: **Joseph (Joe) Damore**, president and CEO of the Mission Health System in Asheville, N.C.; **Thomas (Tom) Royer, M.D.**, president and CEO of the Christus Health System in Dallas, Tex.; **Thomas (Tom) Strauss**, president and CEO of the Summa Health System in Akron, Ohio; and **Keith Volkmar**, senior vice president of Excellus BlueCross BlueShield in Rochester, N.Y. **Bruce McPherson**, president and CEO of the Alliance for Advancing Nonprofit Health Care, moderated the discussion.

Bruce McPherson: *To make sure we're all talking the same language, how do you each define community benefit, in a broad rather than technical sense?*

Tom Royer: Since Christus Health System was formed over 10 years ago—along what we call “a journey to excellence” we have had four directions, one of which is community value. We ask ourselves continuously in all the communities that we serve both in the United States and Mexico: Would the community be upset if we left? Would they really miss us? If we were to go away, would there be a real hole in that community—for patients and families, and for others who live there?

Keith Volkmar: I agree with Tom. At Excellus BlueCross BlueShield, where the majority of our business is health insurance, community benefit entails the work that we do to benefit people regardless of whether or not they are our members.

Tom Strauss: I would agree also. At Summa Health System, we see ourselves as an integrated delivery system, having not only the hospitals but also community health centers, physician practices and our own health plan. Our mission is to improve the health of the community, not just to treat the sick. In fact, we are now working with a group to design a prototype accountable-care organization that could enhance our value to the community.

Joe Damore: Mission Health is a community-owned organization, and our core mission is to improve the health of our community, which geographically encompasses a fairly large region.

McPherson: *Do quality and efficiency fit into your respective definitions of community benefit, or do you feel that they are separate and distinct dimensions of performance?*

Strauss: We at Summa feel that they are part of the community benefit equation. Through our health plan, which works with many employers in our region, we are able to provide greater value to the community.

As an example, we have awarded grants totaling about \$2.1 million to both employed and independent physicians to help them implement electronic health records in order to improve quality in and across patient care settings.

Damore: We believe that quality is an essential part of what we do for the community. We have a tremendous investment in, and responsibility for, improving our quality continuously. For example, we're investing significant time and money right now in benchmarking our quality processes, outcomes, and structures in a project with the Institute for Healthcare Improvement to further benefit our community.

We are in an interesting situation, however. Because we received a state antitrust exemption a number of years ago to merge our two community hospitals, we must regularly demonstrate to the state—and we have done so—that our costs are significantly below those of state and national comparison groups. In addition, we have been a top performer for five years in Medicare's quality demonstration program. Yet we lose \$30 million per year under the Medicare program, due to imperfections in certain payment adjustments. So in a very real sense, we have two community benefits at work here—subsidizing Medicare while still providing high-quality, low-cost care to the rest of the community.

Volkmar: We do not count our price negotiation efforts and results as being part of our community benefit. They lower premiums for our customers, but they do not necessarily lower health care costs for the broader community. On the other hand, we consider as community benefit any financial losses we incur from participation in under-funded government programs, such as Medicare, Medicaid, and special programs for those who don't qualify for Medicaid and can't afford a full premium.

Royer: For Christus Health to survive in the future—and thus to continue to be able to benefit our communities—we know that we will need to prove that we are providing high-quality, low-cost care. So, in that sense, quality, efficiency, and community benefit are inextricably related. That is why we have three other pillars of excellence beyond community benefit—clinical quality, service quality, and business literacy. We have a balanced scorecard that ensures we are addressing all four simultaneously.

McPherson: *Where does community benefit currently rank in terms of your organization's current priorities, and why do you give it that ranking?*

Damore: Community benefit ranks at the top for Mission Health. We are the safety-net hospital for our local community and the broader region. We are committed to serving the poor and uninsured, and we provide many services that are not self-sustaining, such as pediatrics, subspecialties, and mental health. We would never consider *not* providing those services, because there would be no one else to provide them.

Strauss: We are the largest employer in our five counties, as well as the largest safety-net health care provider. We've made a distinct, purposeful, strategic shift from community relations as a marketing tool to community benefit as a leadership responsibility and accountability. In fact, our new three-year strategic plan has a system initiative called the "Community Transformational Agenda," carried out in significant part by the president of the Summa Foundation and our vice president of community benefit and diversity. This initiative involves working with community partners to create a health and economic legacy for the region. Examples include partnering with our federally qualified community health clinic, Akron Community Health Resources, and our free clinics, as well as greater investments in community development across our region.

Royer: For a faith-based system like ours, community benefit has to be number one. Caring for those who are vulnerable and less fortunate is critical to our mission. We must be strong in quality, service, and business literacy, but they aren't enough to justify our existence.

For each of the last 11 years we have explicitly set aside 10 percent of our resources in community benefit activities and programs.

Volkmar: The board of Excellus BlueCross BlueShield has two long-standing goals for the organization: growth in membership with a slight positive operating margin, and caring for our communities.

McPherson: *How is CEO accountability for community benefit achieved in your organizations?*

Volkmar: The annual performance appraisal of our CEO, David Klein, is based on accomplishment of both of the goals I just mentioned, as is his incentive compensation. These goals are also incorporated into the performance appraisal and incentive compensation systems for senior leaders and others throughout the organization, so that community benefit is woven into the basic fabric of the company.

Royer: The pay-for-performance portion of compensation at Christus also involves not only meeting our budget, but also our community benefit goals.

Damore: We have a portion of incentive compensation tied to explicit strategic initiatives, one of which includes community benefit.

Strauss: As president and CEO, I am responsible for laying the foundation for our commitment to community benefit. It is a responsibility that I take very seriously. It is one of the six components of our strategic plan, and its execution is absolutely critical. Recently, we launched our board Community Benefit Committee, which will be responsible for assuring that this responsibility is clearly defined in my job description and in my performance appraisal.

McPherson: *How important is it that your board be involved in community benefit, and what is its role?*

Damore: Board involvement is critical. We have a board-level Community Benefit Committee that includes both board members, non-board members from the community, and myself. The board sets aside about \$2 million each year from our bottom line to fund community programs to help the uninsured or otherwise under-served, and one of the Community Benefit Committee's major roles is to rank proposals for that purpose from nonprofit organizations in the community. Some of the grants we provide are to the local public health department, one of which involves the preparation of a comprehensive community health assessment every five years. Our strategic planning staff provides support in this assessment. Our Community Benefit Committee also oversees our measurement, evaluation, and reporting on community benefit.

Strauss: We have always had a very active board, and it is becoming even more involved in the community as a result of the new strategic plan I mentioned earlier. We have a new board committee composed of board members and leaders of other stakeholders in the community to oversee our community benefit efforts, and we help fund community health assessments in collaboration with some other organizations in the area.

In addition, recently members of our board convened a meeting with area leaders to discuss health care job training in northeast Ohio.

Volkmar: In addition to incorporating community benefit in our CEO's performance appraisal and incentive compensation, our board reviews and discusses on an annual basis the impacts of our community benefit initiatives.

Royer: One of our six committees of the Christus board is the Mission Committee. Among its functions is to set annual community benefit goals—including a target expenditure level of about 10 percent—that are incorporated in our senior management performance appraisal and incentive compensation system throughout the region. Thus, the metrics we use in our balanced scorecard related to community benefit come through this committee.

Like our other board committees and the full board, the Mission Committee meets quarterly. It receives updates on our charity care, on projects in the community that we fund through our foundation, on our community health clinics, on our wellness efforts, and so forth. In addition, the Mission Committee and several others review the annual Form 990 report before it is filed with the IRS (Internal Revenue Service).

McPherson: *Does your board or community benefit-related committee establish and use any explicit criteria or weights for setting priorities for community benefit investments?*

Royer: At Christus we look at three things: preventable hospitalizations, preventable emergency room visits, and wellness.

Damore: We do have a criteria system based on relative needs as identified in the community health assessment I mentioned earlier, relative return to the community on funds invested, and opportunities for collaboration with others.

Strauss: Our criteria are based on identified need, outcomes, and value/return on investment.

Volkmar: Our criteria are based on the needs of each community we serve, which can vary. As I mentioned earlier, we are now looking much more closely at the outcomes of our initiatives.

McPherson: *Do you view what your organization is doing in community benefit to be part of, a substitute for, or separate from, needed health care reform?*

Volkmar: In a lot of the public rhetoric over health care reform, private health insurers have become the poster child for what is wrong with the health care system. I'm convinced that if all health insurers acted in community benefit-oriented ways, as Excellus BlueCross BlueShield has striven to do during all of the 29 years I've been associated with it, the private insurance sector wouldn't be the current public scapegoat. I dream about a system that provides incentives for healthy behaviors and taking greater personal responsibility, as well as for achieving positive medical outcomes—rather than simply paying for inpatient stays, tests, and so forth.

Royer: I think that community benefit and health reform are critically connected. The challenges we face are not only that overall health care costs are increasing at a high rate, but also that a higher portion of those costs are uncompensated with the growing number of uninsured, with uneven sharing of the uncompensated care burden. Our competitors, physician-owned in part or fully in some of our communities, often have small emergency departments designed to care only for people with minor injuries, generating limited charity care.

Health care reform could alleviate our uncompensated care burdens, and hopefully help to ensure that people get the right care in the right place at the right time, thereby helping to reduce the overall rate of increase in costs.

Strauss: As a private nonprofit health system and the largest safety-net provider in our region, we do not get any help from our county to support the \$52 million of charity care we provide each year. Providing charity care is part of our mission, and that will never go away. But just imagine that, as a result of health care reform, our system could shift those millions of dollars now devoted to charity care to greater investments in primary care clinics, preventive services, and wellness programs. We call ourselves a health care system, but it's truly a sick care system. Payment reform will help move us toward a real focus on prevention and wellness—making us accountable for improving the health of the community rather than just treating those who are already ill and filling our emergency departments and inpatient beds.

McPherson: *How have your organization's community benefit efforts helped your community and, in turn, your organization?*

Strauss: We're excited about the implementation of our Community Transformational Agenda. We and the other hospitals are now collaborating to support the only federally qualified health center in the Akron area, which since January has experienced a 22 percent increase in patient visits, a 41 percent increase in uninsured patients, and a 65 percent increase in the number of uninsured dental patients. It's exciting to see the hospitals coming together and our employees volunteering more than triple the time they did in 2008, now touching more than half a million lives in their volunteer efforts.

We and the other hospitals have also expanded a 10-year-old program, "Access to Care," which now links more than 2,600 low-income residents with primary care physicians and the resources of other providers, including Summa's personnel, facilities, equipment, pharmaceuticals, and other supplies.

We're also excited about the Austin BioInnovation Institute in Akron, a new and unique collaborative of complementary research, education, and health institutions that will expand upon the area's rich legacy in industrial and materials science to pioneer the next generation of life-enhancing and life-saving innovation for the 21st century. One of the centers in the institute is Clinical Outreach to the Medically Underserved, which will coordinate and deliver health care to the growing medically underserved populations, going beyond treatment to include the holistic integration of access, prevention, wellness, and disease management.

Volkmar: As a regional health insurer located in upstate New York, we view our community benefit activities as one of our sustainable competitive advantages over the national for-profit insurance companies. If you look at our relative sizes and capabilities, the one sustainable advantage we have is how we interact with our local communities. Some wise person once said that all health care is local, and we believe that our community benefit programs, in our local communities, provide us with a critical advantage in our market.

Royer: There are more wonderful community benefit programs going on than I could begin to summarize here. They are the core of who we are, reflect our culture, and aren't dependent on government support. Community benefit is part of our brand.

Community benefit has also been great for staff recruitment and retention. Many come to Christus and stay with us because of our mission—caring for the poor and disadvantaged. They see us engaged in improving the health of our communities, expanding our outreach clinics, joint-venturing with physicians who share the same mission, and so forth. All of these efforts get employees engaged, the board engaged, and our physicians engaged. There is tremendous cultural pride.

Community benefit programs have also been critical to the success of our fund-raising efforts, and to our growth. We now serve new communities in New Mexico, which embraced us over other hospitals and networks offering significantly more financial support. Our mission and brand are what carried the day.

Damore: When I arrived at Mission Health five years ago, there was some tension between the business community and our system. This tension has been reduced as we have refined our focus on community benefit, and in particular on health status improvement. We have developed numerous programs to improve the health of people under our “Know Your Numbers” initiative. Our “Lighten Up for Life” program, targeted at businesses, resulted in the participation of over 5,000 people and over 100 businesses. It received the American Hospital Association’s Nova Award this year, has dramatically improved our image with the business community and the general public, and has improved our fund-raising despite these tough economic times. We did the program to improve health status, and we’ve seen some positive results in that regard, but we’ve also received these other side benefits that were never anticipated.

McPherson: *How have you gained as professionals from your organizations’ community benefit efforts?*

Volkmar: A nonprofit, community-benefit orientation has been with me and our CEO all of our careers. It’s in our DNA. The fundamental function of health insurance as far as we are concerned is pooling risk at the lowest possible average cost so that people have access to affordable health care and are protected financially in doing so. You shouldn’t have to be focused on paying shareholders.

Strauss: I spent six years in the for-profit world of American Hospital Supply and the Baxter Health Care Corporation. It was a great learning experience and I enjoyed it, but I missed that nonprofit mission orientation—the culture and commitment to do noble work. Profitability is still important to our organization, but it’s a means to the end rather than the end.

Damore: I’ve spent my entire career in the nonprofit health sector—by choice. I had the opportunity to go into the for-profit sector, but personally I felt that health care is more of a community good. I entered this field because I believe we are here to serve people, and I feel blessed to have spent the last 33 years doing so. As Tom (Strauss) just said, good financial performance is the means to the end, not the end in itself, which is serving people.

Royer: I feel the same way. Before coming to Christus, I had the opportunity to work in three good nonprofit systems: Geisinger, Johns Hopkins, and Henry Ford. It’s attitude, really. You’re earning money in order to reinvest it in the system and to create programs to keep people healthy and to provide care to the underserved. We have to make some profit to sustain ourselves, as the other panelists have said. It’s what you do with the profit that spells the difference.

I’ve found something very special here at Christus, a Catholic organization, even though most of the people it serves are not Catholic, and neither am I. The faith-based orientation has added another dimension for me.

McPherson: *If universal or near-universal health care benefit coverage is achieved, do you see that changing either the ranking of community benefit as a priority for your organizations, or changing the mix or thrust of your programs and activities?*

Royer: We just had a board meeting where this very question was discussed. What would we do were we to be paid the millions of dollars that we currently lose in caring for the uninsured? Part of the answer is that not everyone will ever be covered, and there will continue to be significant differences in the degree of coverage. So perhaps we may receive 7 cents on the dollar rather than 0 to 3 cents. Consequently, the rest of the answer is that the improved payment would enable us to provide community benefit in other ways, such as more support to federally qualified health clinics or working in community health education.

Volkmar: The latest phase of community benefit evolution in our organization is the shift in our board's focus, from where and how much the plan invested to what were the outcomes in relation to the amounts invested. As an example, working with our partner hospitals, the rate of hospital-acquired infections has dropped. We are also working on improving the use of generic prescription drugs in our communities.

Strauss: I agree with both of you. In addition, and again within my broad definition of community benefit, we must fundamentally change the way we deliver care. If we just insure more people, the entire system will be bankrupted. We plan to create an accountable care organization—bringing together our Medicare Advantage plan, hospitals, ambulatory care network, physicians, health IT capabilities, medical home concepts, and other pieces—to enable Summa to operate more effectively and efficiently serve Medicare and other population groups under “bundled rates” or other new incentive payment approaches.

Wouldn't it be great to see nonprofit accountable care organizations blossoming all around the country, rather than some public health plan option that is being pushed by some in Washington?

Damore: Mission Health is also investing in areas to position us to be part of accountable community care organizations and to better integrate care. We're currently funding 50 percent of an operational regional health information exchange. We're also trying to advance the medical home concept for all our patients—private-pay, government-sponsored patients, and the uninsured. In addition, we're trying to integrate care across the continuum for Medicaid and uninsured patients. It's unfortunate that none of these are being counted as part of our community benefit, because they really are part of it. Community benefit is evolving, and its definition needs to reflect that evolution. Hopefully, government at all levels will begin to see it the way we do.

McPherson: *Some of you mentioned earlier illness prevention and health promotion. Do you see greater community benefit investments in those areas in the future, if and when universal or near-universal coverage is achieved?*

Strauss: It has been well documented that about 85 percent of all health care costs are driven by just 15 percent of the population with one or more of four chronic conditions—asthma, diabetes, heart disease, and high blood pressure. As the largest employer in our area (10,000 employees), we are investing in initiatives to change lifestyles affecting these conditions. As an example, we're partnering with the YMCA to build a new fitness center right on our flagship hospital's campus, with incentives to our employees to work out there, including a decrease in their health plan premium contribution. Thus, we are trying to align incentives.

We are also partnering with barber shops in our footprint to screen African-American adult males for high blood pressure, as well as partnering with domestic violence units and centers for senior health in the community to address other serious issues. It's these types of programs that underscore our commitment to keeping people well.

Volkmar: Our flagship insurance product, which is called HealthyBlue, actually rewards people who live a healthy lifestyle. Families can earn back up to \$1,000 each year by eating healthier, exercising regularly, and getting routine checkups. As Tom Strauss mentioned, this is our contribution to moving from a system of “sick” care to one of “health” care.

Royer: We're helping to subsidize low-cost housing and school-based health clinics—of which we have about 40 now within our system—because we believe that good housing, good food, and good education are essential foundations for good health.

It has been discouraging at times, however, for our system, and for me as a physician, in trying to motivate people, even in some life-threatening situations, to change their unhealthy lifestyle behaviors. Their health care benefit coverage should provide incentives for healthy habits so that they become aligned with the incentives that the rest of us are or will be operating under.

McPherson: *How important is collaboration in your organizations' community benefit efforts, now or in the future—in particular, collaboration among nonprofit hospitals and health plans in the communities you serve?*

Damore: Mission has the only two hospitals in our area, achieved through a merger that received a state antitrust exemption, so there aren't any further collaborative opportunities in that regard.

In recent meetings with the leadership of our major nonprofit health plan, BlueCross BlueShield of North Carolina, we discussed common issues and the fact that many of our community benefit investments benefit the plan and its members. I am more hopeful than I have been in a long time that they will reciprocate by making community benefit investments in our area.

Royer: Based on my 40-plus years of experience in health care, I don't believe that an economic competitive model is compatible with a service sector operating 24/7 dealing with people's health and lives. It results in unnecessary duplication of facilities and equipment, uneven charity care burdens, and, in some cases, fraud and abuse. One of the rainbows in the global economic crisis, however, is that even strong competitors are starting to falter and are beginning to come to the table to discuss collaboration. We are also finding more opportunities to collaborate with health insurers on value-based payment arrangements.

Strauss: We see competition breaking down around community benefit issues. As I mentioned earlier, hospitals in our area are truly working together on an access-to-care program, to which each has committed about \$4 million over five years. We have all supported the federally qualified community health clinic and opened up new dental clinics.

Our for-profit health plans, however, have not been as collaborative. Summa was one of the original 260 hospitals in Premier, Inc., participating in the Medicare value-based purchasing demonstration project. My concern is whether these plans will be willing to share cost savings generated through improvements in health care delivery and outcomes.

Volkmar: Excellus BlueCross BlueShield has been involved in community collaboration efforts throughout its history, and in today's environment, with so many unmet needs and shrinking resources, I can't imagine any way to effectively cope that doesn't involve heavy collaboration among all the key stakeholders in the community.