North Shore-Long Island Jewish Health System, Inc.	ADMINISTRATIVE POLICY AND PROCEDURE		
POLICY TITLE: COMMUNITY BENEFIT	**POLICY # 300.21**	**DEPARTMENT: FINANCE**	
Prepared by: Office of Community Health / Finance	**Effective Date**: 8/07	**Last revised:**	**Page 1 of 4**

POLICY

To fulfill its mission and meet its charitable purpose, North Shore-LIJ Health System, Inc ("Health System") and its Hospitals ("Hospital") offers community benefit programs and activities that provide access to treatment, enhance health as a response to identified community needs and promote the common good. The Health System integrates community benefit into the ongoing strategic and operational planning processes for the Health System. The purpose of this policy is to describe the processes that the Health System and its Hospitals use to ensure a strategic approach to community benefit planning, implementation and evaluation.

SCOPE

This policy applies to all members of the Health System workforce including but not limited to employees, business associates, medical staff, volunteers, students, physician office staff, and other persons performing work for or at the Health System.

Definitions [1]

Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They are not provided for marketing purposes. A community benefit must meet at least one of the following criteria:

- Generates a low or negative margin
- Responds to needs of special populations, such as persons living in poverty and other disenfranchised persons
- Supplies, services or programs that would likely be discontinued – or would need to be provided by another not-for-profit or government provider – if the decision was made on a purely financial basis.
- Responds to public health needs
- Involves education or research that improves overall community health.

The Health System defines **community** to include the counties of Nassau, Suffolk, Queens and Staten Island.

PROCEDURE

[1] Adopted from *"A Guide For Planning and Reporting Community Benefit"*, Catholic Health Association of the United States, 2006.

A. Organizational Infrastructure

The **Board of Trustees** ensures the development of community benefit initiatives to promote the broader health of the community. In fulfilling these responsibilities, the Board has charged the Health System Community Health Committee with establishing priorities based on community needs and assets, developing the hospital's community benefit plan and monitoring progress toward identified goals.

The Board of Trustees requires an annual report of community benefit from the CEO. Such report will contain an inventory of current services and practices; monies expended; and, as applicable, collaborations with other community agencies within its service area.

The **CEO** appoints a Community Benefit Officer to be responsible for the development, oversight and implementation of community benefits as it relates to the Health System's strategic plan, budget and programmatic design.

The **Executive Director** of each Health System facility ensures that their hospital or facility allocates adequate resources to develop and implement community benefit initiatives.

B. Community Health Assessment

In collaboration with community partners, the Health System participates in regular community health assessments, including current and projected population-related data and health services utilization trends for specific service areas and the region. Trends in health status, types of services received and patient origin studies provide information on the adequacy of the current continuum of care. In turn the evaluations also highlight areas in which additional resources should be committed.

C. Community-Based Partnerships

The Health System seeks to enhance existing programs and develop new ones by strategically allocating financial resources, materials, expertise and advocacy to build on what is already in place in our community. This enhances the effectiveness and viability of community-based organizations, reduces duplication of effort and provides a basis for shared advocacy and joint action. Collaborators include, but are not limited to the public health agency, the school system, community and faith based organizations, local employers and other nonprofit health and social service agencies.

D. Resource Allocation and Program Development

The Health System budget includes adequate financial resources to hire competent and effective staff to assess, plan, develop, implement, manage and report on community benefit initiatives. The planning, finance and community health departments collaborate to ensure successful outcomes of community benefit programs.

E. Performance Measurement

To measure the effectiveness of each community benefit activity, performance measures are assessed on a regular basis, including, when applicable, both outputs and outcomes. Measures of program outputs include: number of persons served, number of classes taught, and number of encounters. Many community benefit programs also include outcome measures such as: changed behavior, increased knowledge or skill, and health improvement.

F. Uniform Reporting

The Health System conforms to a uniform method of accounting for community benefit expenses. The following guidelines are used in the reporting of community benefit expenses:

1) Community benefit expenses are routinely reported and maintained in a dedicated database.
2) The total and net expense for providing community benefit programs are reported.
3) Community benefits are reported at cost.
4) Both direct and indirect or overhead costs are reported.
5) Direct offsetting revenue is reported.
6) The Health System utilizes the categories of community benefit expense defined in the Catholic Health Association publication, "A Guide for Planning and Reporting Community Benefit", 2006. A summary of each category:
    a) Uncompensated Care - uncompensated care is defined as including both charity care and bad debt. For purposes of community benefit reporting, both charity care and bad debt will be reported until such time as the Health System receives clarification from our external accountants regarding the classification of accounts into either charity care or bad debt categories. All uncompensated care will be reported at cost. Uncompensated care expenses will be net of bad debt and charity care funding received from federal and state governmental bodies.
    b) Unpaid cost of public programs – shortfalls related to Medicaid, State Children's Health Insurance Program (SCHIP), Public and/or indigent care programs for low-income or medically indigent patients, local and state government programs that reimburse health care providers for persons not eligible for Medicaid. Medicare shortfalls are not counted as community benefit.
    c) Community Health Services – the net cost of community health education programs, community-based clinical services and health care support services such as enrollment assistance and transportation assistance.
    d) Health Professions Education – the un-reimbursed costs associated with physician and medical student education, nurse and nursing student education, and educating students in other health professions
    e) Subsidized Health Services – the net costs (not including charity care or public program shortfalls) of subsidized services such as: emergency services, outpatient services, burn unit, women and children's services, hospice and palliative care services and behavioral health services.
    f) Un-sponsored Research - the costs of clinical research, community health research and research on innovative health care delivery, net of any direct or indirect grant funding or fundraising support.
    g) Financial Contributions – financial or in-kind donations to support community benefit activities provided by other organizations.
    h) Community Building Activities – the cost of area economic development, housing programs, disaster readiness activities (over and above regulatory requirements), environmental improvements and coalition building.

i) Community Benefit Operations – the cost of dedicated staff and the cost of preparing community health assessments.

G. Dissemination of Community Benefit Reporting

An annual community benefit report is developed for each non-profit Health System hospital. Community benefit reports are widely distributed to community stakeholders and also posted on the Health System public website. Community benefit summaries are also included with the IRS Form 990 for each Health System hospital.