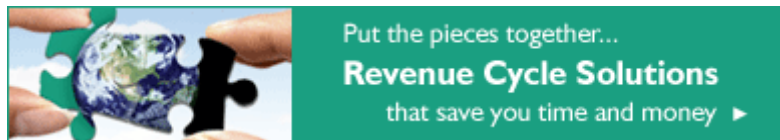




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Community Benefit Strategies for a Changing Economy

Jeni Williams

In today's economic climate, meeting the healthcare needs of vulnerable populations through community benefit programs is becoming more important than ever. Three health systems discuss unique programs that are helping those at risk.

At a Glance

Community benefit leaders offer these suggestions for meeting the healthcare needs of those most at risk:

- Review utilization data to assess the greatest areas of need in your community.
- Engage physicians and clinicians in determining how best to meet community health needs.
- Establish the business case for the program, both in terms of the value for the community and the reduction in healthcare delivery costs, where possible.
- Collaborate with other organizations.

Changes in the economy will affect the types of community benefit programs most needed by populations at risk, such as those who are chronically ill and the working poor, one community benefit expert says.

“We are seeing an increasing number of community benefit programs addressing access to care inequalities for vulnerable populations as well as tackling significant public health issues that impact overall healthcare delivery and costs,” says Patsy Matheny, a community benefit consultant who was a contributing author for *A Guide for Planning and Reporting Community Benefit*, released in 2006 and revised by the Catholic Health Association (CHA) and VHA, Inc., in 2008, and who staffs the CHA’s community benefit hotline, “What Counts.”

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Starting with tax year 2009, Schedule H of the revised Form 990 requires that hospitals collect and analyze additional data regarding their community benefit activities and the charity care they provide, and determine the value of both according to standards adopted by the IRS. As hospitals prepare to meet federal demands for greater accountability and transparency regarding community benefit, now is a good time for them to evaluate the impact of their community health programs and determine whether changes are needed in light of today's economy to more fully meet the needs of their communities.

"Community benefit programs are developed and implemented in response to community needs. As the economic climate changes, the community's needs will also," Matheny says. "Taking the time to evaluate the impact of community benefit programs in light of changes in the economy will help to ensure that the programs provided demonstrate good stewardship of the organization's resources. It's also an important step toward reinforcing community benefit as a core strategy for the organization."

Here, three health systems share unique community benefit programs that are making a difference in their communities by helping those most at risk—and reducing the costs of healthcare delivery as well.

Catholic Healthcare West

At Catholic Healthcare West's Marian Medical Center in Santa Maria, Calif., a program designed to help patients with congestive heart failure (CHF) avoid inpatient and emergency department (ED) care has significantly reduced ED visits and inpatient readmissions among program participants and reduced healthcare costs for patients, payers, and the medical center itself.

CHF is the most common diagnosis for Medicare patients and one of the top two admitting diagnoses for Marian Medical Center. It is an illness that has no cure. More than 550,000 Americans are diagnosed with this chronic illness each year, according to the American Heart Association, which estimated the direct and indirect cost of heart failure in the United States at more than \$33 billion in 2007. Nationally, 18 percent of CHF patients who receive inpatient treatment are readmitted within 30 days, and 50 percent are readmitted within three to six months.

In 2002, Marian Medical Center hired a registered nurse to serve as a case manager for patients with CHF, meeting with patients while they are in the hospital and enrolling them in a free outpatient case management program. Every two weeks, the case manager calls these patients and monitors their health status through a series of questions regarding their health, answering any questions they might have about their treatment. When responses to questions about their health indicate the need for a patient to meet with a physician, the case manager assists in scheduling an appointment with the physician. The program also provides "real-time" clinical updates to physicians and other providers via fax and/or the Internet. Early intervention has enabled patients to receive treatment before their ailments become serious enough to require hospital care, enhancing patients' quality of life while reducing healthcare costs for patients, payers, and the medical center itself.

"The reduction in readmissions has been outstanding," says Eileen Barsi,



director of community benefit for Catholic Healthcare West. “Fewer than 1 percent of inpatients with CHF are readmitted within 30 days after discharge, and fewer than 5 percent are readmitted within three to six months, compared with 50 percent of patients with CHF nationally [see exhibit] . Prior to the implementation of this program, Marian Medical Center’s readmission rate for patients with CHF averaged about 20 percent. More than 800 patients have been helped through this program so far, and we estimate a cost savings of \$1,800 per case.”

The cost to support the program is minimal: the salary for a caseworker plus technology to support the program. Patients are enrolled in the program for one year, and are linked with community resources that provide medication assistance, nutritional services, and senior home repairs, when applicable.

Catholic Healthcare West, which is based in San Francisco, also sponsors a free chronic disease self-management program at 10 of its hospitals. Patients with chronic diseases are invited to attend a series of six two-and-a-half-hour workshops, held at local community centers or churches rather than at hospitals, that teach patients how to better manage their symptoms, improve interactions with their physicians, manage their medication plans, reduce stress, and become more empowered to care for their conditions. “We piloted the program at our California Hospital Medical Center in the heart of Los Angeles, where, based on the socioeconomic status of the residents, we have large numbers of high-risk patients,” Barsi says. “We’ve seen a 50 percent decrease in inpatient admissions and an 80 percent decrease in ED visits among participants in this program” (see exhibit).

Barsi observes that programs such as this are a change in practice from traditional community benefit efforts. “They require increased engagement of clinical staff in resource planning and budgeting, an increase in technology to track outcomes, and increased collaboration among caregivers, such as primary and specialty care physicians,” she says.

Today, Catholic Healthcare West is partnering with the California Department of Aging and other health systems to expand the chronic disease self-management program across the state. “It is a goal of the California Department of Aging to offer this program throughout our state,” Barsi says. Each quarter, the hospitals taking part in the program share best practices with each other to continue to enhance the quality of life for people in their communities.

“As the Medicare population advances in age and grows in number, the demand for disease management services will also grow. We’ve got to make an investment to proactively address this growing need,” Barsi says.

CHRISTUS Health

Located in eight states in the southwest United States and areas of Mexico, the hospitals of Irving, Texas-based CHRISTUS Health’s hospitals serve communities that rank among the highest in the nation in percentage of uninsured residents. In one community alone, 40 percent of the population is uninsured, according to Donna Meyer, senior system director, community health for CHRISTUS Health, Houston.

“We’ve got an extraordinary challenge in meeting the healthcare needs of the uninsured,” Meyer says. “We ask ourselves, ‘What can we do to offer care for the uninsured that helps them maintain their health status in a more effective way, but also lowers healthcare costs—not at the expense of health, but while improving health status?’”

CHRISTUS Health trains community health workers in Texas and Louisiana to help patients in need better manage their health. “We identify those patients who come to our hospitals on a frequent basis and ask if they would be willing to enter our community care management program,” Meyer says. “We match clients with community health workers who are culturally similar to the clients, and who help clients better manage not only their health condition—making sure clients get their medications, are able to pay for them, know how to take the medications correctly, and follow the medical team’s orders—but also help them with their social situation as well. For example, if a client doesn’t have good housing or is unemployed and looking for work, we try to help the client address these issues as well.”

CHRISTUS Health developed a curriculum for training community health workers, who often meet with patients in the patients’ homes. The health system tries to identify patients who could benefit from this program at the point of service. “We have the best luck if the case manager in the ED or the inpatient case manager asks a patient, ‘Wouldn’t you like to have someone help you manage your health situation?’, and gets the patient to sign a consent form right then. In those instances, community health workers are sometimes able to meet with the patients while they’re in the hospital,” Meyer says. In the case of patients who frequently use ED services, if a referral is not made at the point of service, “We try to call them afterward and say, ‘We’d be glad to help you with managing your care and finding the right kinds of service, at no cost to you,’” Meyer says.

Today, 300 clients are managed through CHRISTUS Health’s community health program; 140 clients have been part of the program for more than a year. The health system estimates that for every dollar spent on the program, the health system avoids \$2.50 in healthcare delivery costs that might otherwise result from frequent ED utilization or inpatient admissions.

The initiative is already attracting positive attention from the Centers for Medicare & Medicaid Services (CMS) and the Congressional Budget Office, which are reviewing the data from the program. “We’re hoping this is a model that could be rolled out across the country,” Meyer says. “Certainly the data we have support further investigation, but we need a bigger population to make sure the data are statistically significant. We also need to make sure that the data become evidence based, and that we identify the very best practices through this program.”

Kaiser Permanente

In 2006 and 2007, Kaiser Permanente, a multistate health system based in Oakland, Calif., partnered with the National Council on Aging (NCOA) to help provide assistance to its members who are eligible for the Medicare limited-income subsidy (LIS) program.

The LIS program was created by CMS and the Social Security Agency to provide financial support to low-income Medicare beneficiaries with drug costs related to their Medicare prescription drug coverage. Beneficiaries who qualify for LIS pay no or low copayments, deductibles, and premiums and do not have a coverage gap for their Medicare prescription drug coverage. Medicare recipients whose incomes are above the income guidelines for Medicaid are required to apply for the LIS benefit.

Kaiser Permanente was concerned that some of its low-income members would fall through the cracks. “We knew that if we didn’t provide low-income members of our health plan with supplemental assistance such as this, there was a good chance that at least some of them would be unable to afford the costs of their prescription drugs. Assisting them with the screening and application process for LIS was a critical linkage we could provide,” says Maureen Hanrahan, national director of Medicaid and subsidy programs for Kaiser Permanente.

But identifying those who qualified for assistance was a challenge for the health system. Kaiser Permanente initiated a communications campaign to let its members know about the program through newsletters, e-mails, and posters at Kaiser Permanente facilities; these efforts were in addition to the communications provided by CMS. The health system also worked with the NCOA to mount a call center dedicated to helping members complete and electronically submit applications for LIS assistance and customized a program called “KP CheckUp” that could provide eligibility screening for LIS and other public programs.

More than 700 Kaiser Permanente staff members were trained to use a web-based tool to determine whether clients might be eligible for the LIS program and submit applications on behalf of the members as well screen for other types of assistance, such as food stamps, energy assistance, Supplemental Security Income (SSI), or Medicaid. Referrals to the screening program were made through Kaiser Permanente’s customer care line, medical offices, and the organization’s pharmacy department.

“Even before the current economic crisis, 40 percent of seniors who were eligible for Medicaid (3.5 million) and 47 percent of seniors who were eligible for Supplemental Security Income (1 million) were not receiving those benefits. This amounts to billions of dollars a year in lost benefits,” says Jay Greenberg, executive vice president, long-term services and support, NCOA.

Today, more than 10,000 members of Kaiser Permanente’s health plan have received assistance through the LIS outreach program. The health system estimates that the projected lifetime value of the supplementary prescription drug assistance provided to those who qualify will exceed \$40 million.

“To me, the value is not just the LIS campaign itself, but the ability of our staff to use this web-based program to screen people for other assistance programs as well,” Hanrahan says. “Given these economic times, outreach programs such as this provide strong value for our members. They enable our members to access benefits that help meet their healthcare needs.”

The program also has been enthusiastically received by Kaiser Permanente staff. “Initially, we weren’t sure whether Kaiser staff would welcome bringing

the tool in-house—whether they would view it as just more work,” Greenberg says. “But the staff seem genuinely pleased and excited to have a tool such as this to use in working with members. They really feel it’s helping them to make a difference for those in need.”

Lessons Learned

Community benefit leaders offer these suggestions for meeting the healthcare needs of those most at risk through community benefit initiatives.

Review utilization data to assess some of the greatest areas of unmet need in your community, and base major community benefit initiatives around these data. “A review of utilization, particularly around ambulatory-care-sensitive conditions, will open your eyes to real needs that are present right in front of you,” says Barsi of Catholic Healthcare West. She recommends reviewing one year’s worth of data to most accurately identify the types of patients who frequently rely on the organization for conditions that might more appropriately be treated in a community setting.

In 2005, Catholic Healthcare West developed its Community Need Index, a tool for assessing the health risks of their communities based on socioeconomic barriers. The organization’s research found that residents in the highest-need neighborhoods were hospitalized twice as often for ambulatory care conditions than those living in lower-need communities. These data were then used to formulate strategies for partnering with the community to meet these unmet health-related needs, with the goal of reducing readmissions for ambulatory care-sensitive conditions among participants in the hospital’s intervention programs by 2010.

Engage physicians and clinicians in collaborative efforts to best meet the health needs of the community. For example, in addressing the areas of greatest unmet health-related need in your community, share the utilization data and community needs with physicians and nurses—and plan collaborative approaches to address the care needs of the patients you serve in common, Barsi says.

Establish the business case for the program, both in terms of the value for the community and the reduction in healthcare delivery costs, where possible. “We as healthcare providers need to be part of the solution in terms of managing care in a way that both manages cost and produces better health status outcomes,” says Meyer of CHRISTUS Health. “I think the whole concept is something that everyone who is engaged in health care—especially those who are involved with not-for-profits—really need to focus on.”

Collaborate with community organizations, businesses, and other health systems in strengthening community benefit programs. For example, sharing best practices with other health systems that offer similar programs can help strengthen the programs’ impact on the communities your organization serves. “I think health systems have to join hands with each other to improve the value of the community benefit programs we offer for the dollars we spend,” Meyer says.

Greenberg of the NCOA points to the Kaiser Permanente’s LIS program, which would not have been as successful if either of the organizations had

chosen to pursue it independently.

“As we go forward as a country and determine how to provide health care more efficiently and effectively, partnerships such as this are incredibly valuable,” he says. “This is a good example of how two organizations can do a lot of good for their communities if they partner together in a serious way.”

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