Why Nonprofit Home Care & Hospice Leaders Need a Community Benefit Strategy…
AND 10 KEY STEPS TO GET YOU THERE

Written by Bruce McPherson
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Kinnser thanks Bruce McPherson, president and CEO, The Alliance for Advancing Nonprofit Health Care, for authoring this guide.

As President of the Alliance, and throughout his career, McPherson has worked to influence public policies at the national and local levels to improve health care access, quality, efficiency and people’s health status, especially through collaborative payment and other relationships among nonprofit health care organizations and other key stakeholders.

Prior to joining the Alliance, McPherson held executive and senior positions with National Rehabilitation Hospital in Washington, DC, the American Hospital Association in Chicago, IL, the Blue Cross Association in Chicago, IL, and the Greater Detroit Area Hospital Council.

McPherson received his Bachelor of Business and Master of Hospital Administration degrees from the University of Michigan, where he developed a passion for community-based nonprofit health care and local collaboration.
Your organization—along with other nonprofits—plays a prominent role in the U.S. health care system. The most recent analysis of federal data by the Alliance for Nonprofit Health Care (Alliance) in Washington, D.C. reports the following:

- **Close to 20% of the 12,000 Medicare-certified home health agencies are nonprofit, with concentrations ranging between 40% and 92% in sixteen states**
- **About 33% of the 3,600 Medicare-certified hospices are nonprofit, with concentrations ranging between 40% and 91% in twenty-seven states.**

Your organization also plays a unique role in our health care system, providing special community benefit. This community benefit can take the form of a wide variety of subsidized programs, services and activities intended to increase access to care, improve people's health, educate health professionals and/or conduct research.

It is because of your organization's community-benefit role that society has granted it exemption from federal, state and local taxes. In addition, you enjoy unique opportunities for gifts that are tax-deductible for private donors, government grants, and tax-exempt bond financing. These tax-related benefits enhance your organization's financial capabilities to provide special community benefit as well as to meet regular capital and operating needs.

Unfortunately, there are a number of forces in the environment that threaten your organization's ability to play its unique community-benefit role and retain its related tax benefits:

- **The Economy and Government Budget Deficits**
  One cannot overstate the importance and dire implications of the currently weak U.S. economic recovery in combination with the massive government budget deficits that policymakers face at the federal, state and local levels. Policymakers will be forced to deal with these deficits—likely sooner rather than later—as the interest expenses associated with those deficits are mounting rapidly.

- **Tax Reform**
  Congressional leaders in Washington are starting to look at federal tax reform as a means of stimulating the economy, creating jobs, and eliminating inequities created over many decades of special interest lobbying. Signs are emerging that this reassessment will include tax policies related to both the for-profit and nonprofit sectors.

- **Public Criticism**
  No other component of the nonprofit sector received as much public criticism as nonprofit health care—regarding mission, community benefits, tax exemption, profits and executive compensation. Nonprofit hospitals and systems have received most of the criticism thus far, but policymakers, the media and the general public will be tempted to tar everyone in the nonprofit health sector with the same brush.
Third Party Payment

As a result of the Affordable Care Act, nonprofit organizations like yours are facing rate reductions from government programs and tougher rate negotiations from private health plans.

These forces are likely to combined and create a “perfect storm” wherein your organization will be hard-pressed to maintain its current level of community-benefit investments while being challenged by government at all levels to demonstrate why it should continue to receive its current tax benefits. Your need for philanthropic giving will likely increase at a time when donors will be more discriminating, wanting to know what makes your organization unique and therefore worthy of support. Moreover, with pressures mounting on the total amount of community benefit investments your organization can afford, you and your Board need to know that you are getting the “best bang” out of the resources you are able to devote to those investments.

Why You Need a Community Benefit Strategy

To respond to challenges like those described above, you must have an effective and lasting community benefit strategy. History has shown that failure to read and deal with danger signs like these is fraught with peril. That is precisely how not-for-profit Blue Cross Blue Shield plans lost their federal income-tax exemptions in 1986. Those plans—almost without exemption—had no community benefit strategies and thus were unable to demonstrate how they were different from for-profit health plans.

The time for nonprofit home care and hospice leaders to prepare for these threats is now, not down the road when the storm has unleashed its fury.

This guidance is primarily directed to leaders of freestanding nonprofit home care and hospice providers. Most other providers are typically components of nonprofit hospitals or systems that already must meet the special tax exemption requirements for hospital organizations and have access to a variety of resources through their national, state and/or metropolitan hospital associations.
10 KEY STEPS TO ESTABLISHING A COMMUNITY BENEFIT STRATEGY

As you will see below, freestanding nonprofit home care and hospice providers can learn a great deal from the experiences of nonprofit hospitals and systems. The first five steps are essentially about building an organizational “infrastructure,” which is vital if there is to be an enduring strategy. The remaining four steps are ongoing—updated and refined as necessary and appropriate from year to year.

THE 10 KEY STEPS ARE:

1. Review with your Board the organization’s mission statement in relation to its nonprofit role
2. Develop and adopt with your Board an organization policy on community benefits
3. Incorporate community benefit responsibilities into your job description, along with a performance review and incentive pay arrangement (where applicable)
4. Designate an individual responsible for coordinating all community benefit efforts, with appropriate placement on the organization chart
5. Establish a standing committee on community benefits
6. Define categories of community benefit programs and activities, and decide on methods for estimating their costs
7. Develop a plan and budget for community benefits
8. Establish an internal system to monitor progress and evaluate the results of your community benefit efforts
9. Develop a plan for “telling your organization’s community-benefit story” to both internal and external audiences
10. Ensure that your national and state membership organizations are proactive in helping to preserve your special tax benefits
Step 1: Review with your Board the organization’s mission statement in relation to its nonprofit role

As discussed earlier, your organization’s nonprofit role is what makes it inherently unique. It only stands to reason then, that your organization’s mission statement must somehow incorporate that uniqueness, if the mission statement is to have any real meaning at all. And mission does matter, as evidenced in the mission focus of the Malcolm Baldrige National Quality Award1.

You should review your mission statement with your Board at least once every three years.

Two examples of mission statements that highlight nonprofit status

1. Dignity Health (formerly Catholic Healthcare West), one of the national leaders in nonprofit hospital community benefit practices, includes the following in its mission statement:

   Service to the poor and disenfranchised, and to advocate on their behalf.

2. Visiting Nursing Services of New York (VNSNY) includes the following in its mission statement: “To continue our tradition of charitable and compassionate care, within the resources available.” VNSNY’s vision statement is this:

   VNSNY will become the most significant, best-in-class, not-for-profit, community-based integrated delivery system providing superior care coordination and care management services to vulnerable populations across a broad regional footprint.

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1 This award was established by the U.S. Congress in 1987 to raise awareness of quality management and recognize U.S. companies that have implemented successful quality management systems. Awards can be given annually in six categories: manufacturing, service, small business, education, healthcare and nonprofit. The award is named after the late Secretary of Commerce Malcolm Baldrige, a proponent of quality management. The U.S. Commerce Department’s National Institute of Standards and Technology manages the award, and ASQ administers it.
Step 2: Develop and adopt with your Board an organization policy on community benefits.

 Provision of community benefits must be more than “random acts of kindness” by the organization and its individual staff members. Community benefit investments should be well thought-through, well organized and lasting.

 To that end, you should ask your Board to adopt (and periodically reassess) a policy statement committing itself and management to be accountable for the establishment and maintenance of an organized, lasting program of community benefits. At a minimum, the policy statement should spell out the specific responsibilities of the Board itself for community benefits (e.g., reviewing and approving an annual community benefits plan and budget; receiving and discussing quarterly reports on progress and results).

 Some nonprofit hospital organizations have extensive Board-approved policies which encompass most or all of the steps discussed in this section.

 Appendix A provides an example of such a policy statement, and includes procedures. Additional examples can be found under “Community Benefits” within the Resources section of The Alliance for Advancing Nonprofit Health Care’s website.
Step 3: Incorporate community benefit responsibilities into your job description, along with a performance review and incentive pay arrangement (where applicable)

To help clarify your role and responsibilities pertaining to community benefits, incorporate them into your job description. For those steps that you are implementing for the first time, include them in your annual performance goals, annual performance review, and any incentive pay arrangement you may have with the Board.

Once you have plans and budgets for specific community benefit programs or activities, incorporate their objectives (quantifiable to the extent possible) into your annual performance goals, annual performance review, and any incentive pay arrangement you may have with the Board, as well.

Finally, think about specific ways (e.g., presentations, committee involvement) in which you can be a role model and champion for community benefits, both internally and externally.

Examples of community benefits incorporated into job descriptions and incentive pay can also be found on the website of The Alliance for Advancing Nonprofit Health Care.
Step 4: Designate an individual responsible for coordinating all community benefit efforts, with appropriate placement on the organization chart

You need to designate someone in your organization to make community benefits happen—to coordinate the planning, budgeting, implementation, monitoring and evaluation of specific community benefit programs both internally and, where appropriate, externally. Ideally this individual should report to you or to one of your direct reports so community benefit gets the attention and recognition it deserves. See the website of The Alliance for Advancing Nonprofit Health Care for sample job descriptions of this role.

Nonprofit hospitals typically assign someone full-time (or at least half-time) to this set of responsibilities, often along with some full-time or part-time support staff. Your organization will not need that level of support, as you will be able to take advantage of the community health needs assessments already conducted by one or more nonprofit hospitals in your area, as well as the community benefit-related programs and activities that they and other organizations in the area are currently carrying out.
Step 5: Establish a standing committee on community benefits

Designating an individual to coordinate community benefits goes hand-in-hand with establishing a standing committee for that same purpose. The right people are needed on this committee to jointly assess and prioritize community health needs, plan programs and budgets, oversee plan implementation, monitor progress and report results. The committee should meet quarterly or more frequently as needed.

Initially, the members of this committee may be all or mostly internal staff, representing key departments or functions in the organization, such as clinical services, finance, advocacy, community relations, communications. Your membership on this committee will provide a clear signal to both the Board and staff that you are a “champion of community benefits.” Inclusion of one or two Board members, at least one member of the medical staff, and perhaps one or more individuals from the community who can speak to the needs of vulnerable populations will provide additional benefits.

Appendix B provides an example of a committee charter. Additional examples can also be found on the Alliance’s web site.
Step 6: Define categories of community benefit programs and activities, and decide on methods for estimating their costs

Over the past ten years, the Catholic Health Association (CHA) has been the national leader in developing and disseminating guidance to nonprofit health care institutions about defining and measuring community benefits—i.e., what categories of programs and activities should count as community benefits and how their costs should be estimated. This guidance is available at no cost on CHA’s website.

Your organization should take advantage of this excellent guidance if it hasn’t already.

In brief, CHA defines community benefits as programs or activities that provide treatment and/or promote health as a response to identified community needs. In addition, they should meet at least one of the following criteria:

- Improves access to health care services
- Enhances health of the community
- Advances medical or health knowledge
- Relieves or reduces the burden of government or other community efforts

Programs or activities should not be counted if they are:

- Provided for marketing purposes
- Restricted to the organization’s employees and physicians only
- Required of all health care providers by rules or standards
- Questionable as to whether they should be considered community benefits
- Unrelated to health or the mission of the organization

Based on the criteria above, CHA has established the following categories of community-benefit programs and activities:

- Financial Assistance
- Government-sponsored means-tested programs — unpaid costs of public programs
  - Medicaid
  - State Children’s Health Insurance Programs (SCHIP)
  - Medically indigent programs
Other Community Benefit Services
» Community Health Improvement Services
» Community Health Education
» Health Care Support Services
» Social and Environmental Improvement Activities
» Health Profession Education
» Subsidized Health Services
» Research
» Cash Donations and In-Kind Contributions
» Community Building Activities (Includes Advocacy)
» Community Benefit Operations

Appended to this article is a list of the types of community benefits questions to which CHA has responded. This list is shown on CHA’s website at the URL listed above. By clicking on a particular category you can find CHA’s responses to the field on questions related to that category. If you have a question that hasn’t already been addressed, you can click on the What Counts Email Hotline to receive an answer.

It is important to note that CHA’s guidance differs in two key respects from that being provided by the American Hospital Association (AHA) to its members:

» CHA does not include Medicare losses (Medicare payment shortfalls) as a community benefit, as does the AHA. CHA believes that serving Medicare patients is not a differentiating feature of tax-exempt healthcare organizations, because for-profits typically rely just as heavily on Medicare financing. This is not necessarily the case with Medicaid, a means-tested state program where payment shortfalls are driven by the individual state’s ability to pay.

» CHA does not include bad debt (as distinguished from charity care) as a community benefit, whereas the AHA does. CHA believes that bad debt is due to the failure of patients to pay whom the nonprofit health care provider decided did not qualify for financial assistance.
Step 7: Develop a plan and budget for community benefits

The Catholic Health Association has also produced A Guide for Planning and Reporting Community Benefit. The 2012 edition of this Guide provides a comprehensive framework for planning, implementing and reporting on community benefits. It can be purchased in both hard copy and PDF download formats for $75.00. (Note: This Guide also provides very detailed instructions on defining community benefit programs and activities and on measuring their costs.)

Inventory Current Programs and Activities and Costs
At the outset of planning and budgeting, if you haven’t already done so, an organization-wide survey should be developed and disseminated under the guidance of the standing committee to inventory what community benefit programs and activities are currently being pursued by the organization—along with their estimated costs. This inventory provides a critical baseline of information. As many nonprofit hospitals have found through this process, there are likely to be some programs and activities underway that are not well known and that in fact appear to be “random acts of kindness” spurred by the particular interests and passions of individuals in the organization.

The simple fact of announcing, conducting, and reporting the results of this survey will underscore to your staff the special mission of your organization and the high priority being placed on community benefits.

Define Your Community & Assess Its Needs and Current Resources
Any good planning process will then proceed with:

✔ A definition of your community (both geographically and otherwise)
✔ An assessment of its health needs
✔ An inventory of what others in your community are already doing to meet those needs
✔ A rank ordering of the “gaps” which your organization wishes to address

In these regards, you will be able to take advantage of the research and analyses already conducted by one or more nonprofit hospitals or systems in your service area. This is because all tax-exempt hospitals are required under the Affordable Care Act to report this information to the IRS. Many of these hospitals can also be expected to share their community benefit plans and results with the general public on their websites.
Collaborate
The nonprofit hospital or hospitals you approach are likely to welcome your questions and be interested in sharing ideas and exploring avenues for collaboration.

You may want to supplement the information you receive with input you glean from patient focus groups or other sources. Ultimately, however, you will need to set your own priorities regarding the gaps to be pursued, determine available resources, and select the specific programs and activities that you believe will best address the gaps.

If you are very fortunate, there may exist in your community a multi-stakeholder planning group—whether formal or informal—that seeks to jointly perform such planning, both to avoid unnecessary duplication of effort and to maximize results. Whether you are planning on your own or in concert with others, focus only on one or a very few community needs and programs at a time, rather than spreading resources thinly across a variety of areas.

Determine Available Resources
To determine the total amount of resources to be devoted to community benefits, you might want to consider alternatives such as a percentage of net income, a percentage of net revenues, or the estimated dollar value of your tax exemptions.

Prioritize
The CHA Guide noted above provides some excellent advice in terms of appropriate criteria to consider in both prioritizing community health needs (e.g., importance of the problem, scope of the problem) and in selecting programs and activities (e.g., costs and expertise required, likeliness of success, potential barriers).

For assessing and prioritizing community health needs, as well as for evaluating the results of community benefit programs, you may also wish to access the county health rankings and roadmaps provided by the Population Health Institute at the University of Wisconsin.

For selecting and implementing evidence-informed policies, programs, and system changes to improve the variety of factors affecting health, you may also wish to use of another Institute database. The Institute asserts that social and economic factors account for about 40% of an individual’s health status.

Again… whether you are planning on your own or in concert with others, it makes practical sense to focus on only one or a very few community needs and programs at a time, rather than spreading resources thinly across a variety of areas.

Finally, you will find many examples of community benefit plans (including health needs assessments) and annual reports on the website of The Alliance for Advancing Nonprofit Health Care.
Step 8: Establish an internal system to monitor progress and evaluate the results of your community benefit efforts

It is critical for every community benefit program to have specific objectives and a mechanism for evaluating its progress and results. As part of the evaluation, the program should be assessed not only in terms of attaining objectives, but also the adequacy of the resources committed, any unintended consequences or results, and relationships with other organizations.

Objectives and results may be expressed in such terms of the number of people served, number of classes held, number of volunteers, number of encounters, improved conditions, changed attitudes or behaviors, and/or increased knowledge or skills, improvement in certain health indicators.

Here again, CHA has developed and disseminated some useful advice, Evaluating Community Benefit Programs, which discusses key concepts and building blocks for conducting effective evaluations of community benefit programs and describes basic steps and tools for such evaluations. It applies the knowledge and experience of public health program evaluation to community benefit programs. It provides a comprehensive overview of program evaluation, including easy to use tools, expert advice, links to helpful resources and examples from the field. It discusses key concepts critical to conducting effective evaluations including the purpose of program evaluation, how evaluation differs from research, why and how evaluation scope and design will vary, the differences between prospective and retrospective evaluations, and the two types of program evaluations – impact and implementation.
Step 9: Develop a plan for “telling your organization’s community-benefit story” to both internal and external audiences

One aspect of community benefit practices where it appears that many nonprofit hospitals and other nonprofit health care providers have fallen short is in effectively telling a variety of audiences about their nonprofit role and mission, their assessment of community health needs, their specific community-benefit programs and activities, and their results.

You need to decide up-front the overall story or message you want to convey and what you want that message to accomplish. For instance, this may be a good place with at least some audiences to talk about the importance of your special benefits and why you deserve them.

Internal groups you should consider in telling your story include your Board, staff members, medical staff and vendors (who may be asked to participate in some way. External audiences can include such groups as program partners, current or potential donors, legislators and other government officials, public health department staff, local reporters, social and human service organizations, private health insurers, other nonprofit health care providers, church leaders, and school principals.

Vehicles for communicating your story include a published community benefit report, newspaper ads, verbal presentations, newsletters, orientation materials, brochures, and prominent placement on your web site.

You can download a free guide developed by the AHA—Telling the Hospital Story. Advisors in developing this guide were representatives of nonprofit hospitals that were past recipients of the Baxter Foundation award Hospital Excellence in Community Service. In this guide you will find useful checklists and other advice, along with specific examples of reports.

You can also find numerous examples of community benefit reports on the Alliance’s web site.
Step 10: Ensure that your national and state membership organizations are proactive in helping to preserve your special tax benefits

If you aren’t already aware of what your national or state associations are doing in regard to your tax exemptions, query them. For instance:

✔ Are they aware of any political developments or news stories that might have a bearing? If so, how are they responding?

✔ Do they see serious threats down the road for your special benefits? If so, do they have plans to address those threats? If they don’t have plans to address the threats, why don’t they?

✔ Do they have a communications plan that includes information about the special role and mission of nonprofit home care and/or hospice providers? Do they include specific examples of your or other organizations’ community benefit programs?
CONCLUSION

To carry out your fundamental responsibilities as a nonprofit health care provider, to attract private donors, and to preserve your tax exemptions, you must have a well-organized, lasting community benefit strategy. In the current economic and political environment this is more imperative than ever before.

I hope this paper will provide you with the framework and advice you need for developing and implementing such a strategy.

About the author

Bruce McPherson has served as President and CEO of the Alliance for Advancing Nonprofit Health Care, based in Washington, DC, since March 2004. As President of the Alliance, and throughout his career, McPherson has worked to influence public policies at the national and local levels to improve health care access, quality, efficiency and people’s health status, especially through collaborative payment and other relationships among nonprofit health care organizations and other key stakeholders.

Prior to joining the Alliance, McPherson held executive and senior positions with National Rehabilitation Hospital in Washington, DC, the American Hospital Association in Chicago, IL, the Blue Cross Association in Chicago, IL, and the Greater Detroit Area Hospital Council.

McPherson received his Bachelor of Business and Master of Hospital Administration degrees from the University of Michigan, where he developed a passion for community-based nonprofit health care and local collaboration.
APPENDIX A

NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM INC.
COMMUNITY BENEFIT POLICY AND PROCEDURE

Effective August 2007

POLICY
To fulfill its mission and meet its charitable purpose, North Shore-LIJ Health System, Inc (“Health System”) and its Hospitals (“Hospital”) offer 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
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
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.
APPENDIX B

PRESBYTERIAN INTERCOMMUNITY HOSPITAL
COMMUNITY BENEFIT OVERSIGHT COMMITTEE (CBOC)

PURPOSE
To increase transparency with respect to The PIH Organization’s charitable activities and to foster a culture of social accountability in keeping with PIH’s mission and strategic plan.

POLICY
It is the policy of The PIH Organization to establish and integrate into its strategic direction a Community Benefits Oversight Committee (CBOC).

PROCEDURE
The CBOC shall function as a committee that reports up to the Board of Directors and will act under a charter defining its role and responsibilities.

CHARTER OF THE COMMUNITY BENEFITS OVERSIGHT COMMITTEE CBOC
The CBOC, acting under authority from The Board of Directors, will oversee the implementation and enhancement of programs aimed at improving community health and will ensure that programs and activities claimed as community benefits meet at least one or more of the core principles of community benefits adopted by The PIH Organization. Specifically, any program or activity claimed as community benefit must address needs of populations with a disproportionate unmet health need.

Commitment:
Each CBOC member is committed to supporting the strategic direction of community benefits within The PIH Organization. Essential to the provision of community benefits as an expression of The PIH Organization’s charitable mission, each CBOC member is specifically committed to ensuring that all activities claimed by The PIH Organization as community benefit meet at least one or more of the adopted core principles and, at a minimum, address needs of constituents with a disproportionate unmet health need.

Committee Composition
The CBOC will be comprised of members who represent diverse sectors of the community and bring specific competencies essential to the provision of community benefit. Specifically, the committee will be comprised of:
• Five (5) or more Community Members—which may include representatives from local public health agencies, local school districts, other agencies and physicians;
• The CEO / President, Vice President and Director responsible for community benefits as well as PIH Foundation and Clinic Operations;
• And, at least one member of the PIH Board of Directors—who will serve as a liaison between the Board of Directors and CBOC.

Community representation should outweigh staff representation by at least two (2) members. Ad Hoc members from other PIH departments, such as Business Services and Marketing & Planning, may report to meetings an as-needed basis.

Sub-Committees
The CBOC will form and maintain a membership sub-committee to specifically address issues of membership. The CBOC may, at its discretion, form additional sub-committees to address specific areas of interest (i.e., community needs assessment, community benefit planning, policy review, community capacity building, etc.).

Term Limits
CBOC members will be asked to serve a two-year term with one-year renewal option(s) at the discretion of the membership sub-committee with total term not-to-exceed eight (8) years. It will be the goal of the membership subcommittee to add at least one new community member per term.

Meeting Frequency
The CBOC will meet at least quarterly. A CBOC meeting will be canceled in the event that a quorum is not established (i.e., minimum 60% of membership). No meetings will be held during the months of July, August or December.

Full Disclosure
To ensure a transparent decision making process, all members are requested to fully disclose affiliations (financial or otherwise) with organizations that might create a conflict of interest. In certain circumstances, members with a conflict of interest will be required to abstain from serving on subcommittees or voting.

Confidentiality
Members agree to respect the confidentiality of the CBOC and The PIH Organization such that everything said within the group stays within the group.

Responsibilities
Community Needs Assessments and Community Benefit Reports/Plans are the responsibility of the Community Benefits Department. CBOC members may be asked to participate or provide expertise specific to data compilation or other such activities to ensure that community needs are accurately assessed.

CBOC members will be provided with copies of all needs assessments and reports/plans. Members are expected to review the findings in an effort to maintain a clear understanding.
of challenges facing PIH and the communities served—especially the underserved. Most importantly, members are expected to ensure that all programs reported and claimed by The PIH Organization as community benefits meet, at a minimum, Core Principle # 1—address needs of populations with a disproportionate unmet health need.

Proposed programs and enhancements, along with proposed budgets, may originate from various sources such as hospital departments, senior leadership, the Board of Directors or the CBOC itself. After initial vetting by the Community Benefits Department, proposed programs and enhancements will be submitted to the CBOC for evaluation and detailed discussion. All programs and activities to be counted as community benefit require approval of the CBOC. While programs not approved by CBOC may continue, they must be reclassified and not counted as community benefits. CBOC may also review programs not previously counted as community benefit to determine if, with further enhancement, they may qualify under the guidelines.

Key criteria to be considered in evaluating new or existing programs include:
• Geographic/population (number of people affected per 1,000...)
• Gravity of problem (health impact at individual, family, community level)
• Economic feasibility (program cost, internal/external resources needed)
• Available expertise (can we make an important contribution?)
• Time Commitment (overall planning, implementations, evaluation)
• External salience (evidence of important to community stakeholders).

The Community Benefit Department staff is responsible for monitoring the progress being made with community benefit programs and activities. Specifically, the staff is responsible for examining progress as it relates to implementation and achievement of measurable program goals and objectives and for presenting periodic updates to the CBOC.

The securing of internal and external funding for community benefit programs is the responsibility of the CEO / President and PIH Foundation with support from the Community Benefits Department. CBOC members may recommend sources for external funding and may also provide letters of support or assistance with external donors when appropriate.

Decision Making Process by Consensus
Decision will be reached by consensus in an effort to take advantage of all members’ ideas and yield the highest quality decision and respecting that all participants are equal; rank, status and other external considerations aside.

Staff Support
The CBOC is to be staffed by the Community Benefits Department which shall be responsible for such activities as scheduling meetings, preparing agendas, maintaining and distributing meeting minutes, preparation and presentation of program and service descriptions for review and approval by the CBOC, submission of names of prospective new members and preparing reports as needed for CBOC review.
APPENDIX C

Types of Questions That the Catholic Health Association Has Responded to Regarding Its Categories of Community Benefit Programs and Activities

A. Community Health Improvement Services

Community-Based Clinical Services
Topic: Employee Health Promotion (2007)
Topic: Employer Screenings (November 2008)
Topic: Fast Track Clinic Expenses (August 2009)
Topic: Health Promotion for Long-Term Care Residents (April 2009)
Topic: Immunizations for Patients (August 2009)

Community Health Education
Topic: Addressing Hospital Industry Hazards and Injuries (August 2009)
Topic: Advanced Directives (October 2008)
Topic: Community Awareness/Education (June 2012)
Topic: Community Health Resource Center (February 2011)
Topic: Competition to Increase Awareness of Mental Illness (August 2009)
Topic: Health Fairs/Screenings (2007)
Topic: Hospital Website Provides Public Health Information (August 2009)
Topic: Is it Marketing? (April 2009)
Topic: Media Outreach Programs (Updated June 2012)
Topic: Prenatal Classes (May 2010)

Health Care Support Services
Topic: Applying for Guardianship (September 2012)
Topic: Baby Supplies for New Mothers (January 2011)
Topic: Bereavement Support Remembrance Services (June 2012)
Topic: Care Management (Updated November 2013)
Topic: Catholic Mass Open to Community (January 2009)
Topic: Enrollment Assistance (Updated November 2013)
Topic: Interpreter Services (May 2011)
Topic: Lifeline Services (January 2009)
Topic: Nurse Navigator Program (November 2013)
Topic: Pastoral Care Programs (August 2009)
Topic: Post-Hospital Services for Individual Patients (Updated September 2013)
Topic: Residential Facilities for Patients and Families (July 2013)
Social and Environmental Improvement Activities
Topic: Community-wide Quality Improvement/Care Coordination Efforts (March 2013)
Topic: Educating Hospitals About Successful Environmental Practices (August 2009)
Topic: Food Policy/Leadership Councils (August 2013)
Topic: Physician Recruitment (March 2013)
Topic: Sustainable Farming (March 2013)

B. Health Professional Education
Topic: Clinical Pastoral Education (January 2011)
Topic: Housing Costs (March 2013)
Topic: Libraries (February 2011)
Topic: Long-Term Care Administrator Internships (February 2011)
Topic: Master’s Degree in Public Health or Health Administration (February 2011)
Topic: Nurses Time Mentoring Students (February 2011)
Topic: Nursing Schools (February 2011)
Topic: Physician Education/CME programs (February 2011)
Topic: Physician Residents/Student Time (February 2011)
Topic: Physician Time in Health Profession Education (June 2012)
Topic: Scholarships (2007)
Topic: Tuition Assistance (February 2011)

C. Subsidized Health Services
Topic: Emergency Services (February 2010)
Topic: Hospice (February 2008)
Topic: Hospital Departments (February 2010)
Topic: Hospital Losing Money (April 2009)
Topic: Mammograms (February 2010)
Topic: Medical Practices (February 2010)
Topic: Organ Harvesting (May 2009)
Topic: Palliative Care (January 2008)
Topic: Paying Physicians to be On-Call (Updated June 2012)
Topic: Paying Physicians to Serve Low Income/Uninsured (Updated June 2012)
Topic: Services for Veterans (February 2010)
Topic: Specialty Hospital Services (April 2009)
Topic: Telehealth Services (2007)
Topic: Telemonitoring (May 2008)
D. Research
- Topic: Government Funded Research (August 2011)
- Topic: Institutional Review Boards (February 2011)
- Topic: Physician Research Presentations (February 2011)
- Topic: Quality Assurance or Research (February 2011)
- Topic: Registries (February 2011)

E. Cash Donations and In-Kind Contributions
- Topic: After Prom Donations (January 2009)
- Topic: Ambulance Service (February 2010)
- Topic: Attending Meetings (April 2009)
- Topic: Community Benefit or Community Building Donations (April 2009)
- Topic: Contribution For Fireworks Display (May 2010)
- Topic: Contributions to Statewide Nonprofit Insurance Organization (November 2013)
- Topic: Donated Equipment/Supplies — Locally & Globally (2009)
- Topic: Donated Food (2007)
- Topic: Donated Hospital Services — Lab, Radiology, Pharmacy (2007)
- Topic: Donated Space (2007)
- Topic: Donation to Endowment Fund for School for the Deaf (May 2010)
- Topic: Donations to Employees (February 2008)
- Topic: Employee Participation in Professional Organizations (May 2012)
- Topic: Employee Time and Fund-Raising Costs (April 2009)
- Topic: Entertainment/Sporting Fundraising Events (October 2008; revised November 2008; revised January 2011; revised February 2014)
- Topic: Foreign Poverty Tours/Medical Missions (September 2012)
- Topic: Free Telemedicine Services to Community Hospitals (January 2011)
- Topic: Funds and Services Donated by One Organization to Another (2007)
- Topic: Funds Raised by Hospital Auxiliary Groups (2007)
- Topic: Hospital Volunteers’ Time (2007)
- Topic: Medical Respite Program (August 2009)
- Topic: Parking (2011)
- Topic: Paying for Care in Outside Facility (October 2008)
- Topic: Providing Access to Post-Acute Care for Homeless and Uninsured August 2009
- Topic: Scholarships for Health Professions Education (August 2013)
- Topic: Scholarships for Pediatric Cancer Survivors (April 2011)
- Topic: School and Team Sports (December 2009)
- Topic: Voter Registration Education (June 2012)
F. Community Building Activities
   Topic: Advocacy (February 2010)
   Topic: Chamber of Commerce (May 2009)
   Topic: Child Day Care (2007)
   Topic: Disaster Preparedness (Updated November 2013)
   Topic: Green Purchasing (October 2008)
   Topic: Hiring and Training Handicapped Workers (April 2011)
   Topic: Income Tax Assistance Program (May 2010)
   Topic: Literacy Program (August 2010)
   Topic: PACE Housing Costs (February 2008)
   Topic: Physician Recruitment (Updated March 2013)
   Topic: Recruiting for Clinical Laboratory Personnel (April 2009)
   Topic: Socially Responsible Investing (October 2008)

G. Community Benefit Operations
   Topic: Attending Workshops (January 2008)
   Topic: Community Benefit Report (May 2010)
   Topic: Community Health Needs Assessment (Updated November 2013)
   Topic: Grant Applications (October 2008)
   Topic: IT Initiatives Supporting Community Benefit (January 2009)
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