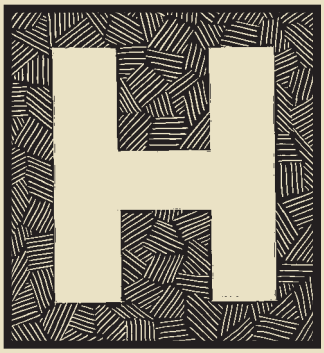
Counting the ways

By N. Carr Robertson, M.P.H.



SUZANNE DEJOHN

The basic idea behind community benefits is simple: Hospitals have a moral duty to promote health in their service areas. Their community benefits activities, some argue, justify their tax exemptions. But there are powerful voices in politics suggesting that some nonprofits are rolling in dough and that they all must prove they deserve tax exemptions.

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At last count, 31 states had passed laws that require or encourage hospitals to plan, track, and report on their community benefit activities. Noncompliance can result in the loss of state tax exemptions. The U.S. government also recently considered whether large hospitals can justify their federal tax exemptions. The Internal Revenue Service surveyed more than 550 hospitals in 2006 (including DHMC) about community benefit activities and executive compensation. The results are still being analyzed.

While community benefit laws differ from state to state, there are some common themes. To be counted as a community benefit, an activity must be related to health, must go above and beyond the normal business of a hospital, must include the poor and other needy groups, and must be provided at a loss.

Needs: In New Hampshire, the community benefit law applies to nonprofit clinics and health agencies as well as hospitals. So there's an incentive for organizations to work together to improve community health. Every five years, Dartmouth-Hitchcock Medical Center, the United Way, and other local hospitals and agencies collaborate on a needs assessment to analyze "health indicators" in our region. It's like giving the entire population a physical. We look at precursors for serious illness, such as rates of substance abuse; at the percentage of people without health insurance; and at other factors, such as the aging of the population. We set and address priorities together. We develop some interventions together and pursue others separately.

Substance abuse was one of the priorities identified in the last needs assessment, which was conducted in 2003-04. We realized several things about the problem: Alcohol is the most commonly abused drug—it is abused even more than tobacco. Rates of abuse and addiction are higher in New Hampshire and Vermont than in most other states. Per-capita spending on treatment services is extremely low in New Hampshire compared to other states. And, we found, there were fewer treatment resources available in the Upper Valley than in other parts of New Hampshire and Vermont.

The situation looks a lot different today. There are at least five new treatment programs in our region. One is the DHMC Addiction Treatment Program, which offers intensive outpatient therapy—including with buprenorphine, a medication used as a treatment for heroin addiction—for people with substance-use disorders. This approach has been incredibly successful. Another such effort is Youth Empowerment Services, a collaboration between DHMC and two local agencies to provide a short-term outpatient program for adolescents who are in the early stages of addiction. New Hampshire's community benefit law deserves some of the credit for these initiatives.

Mission: Before "community benefit" was a legal term, it was used by Catholic hospitals to describe their mission to care for the poor, the homeless, the uninsured, and others in distress. The concept has now been adopted by other nonprofit hospitals—including Dartmouth-Hitchcock Medical Center—that are members of the Voluntary Hospital Association (VHA). Together, the Catholic Hospital Association (CHA) and VHA help determine what to count as a community benefit. The organizations publish guidelines and field questions. Some common questions are:

- Does it count if a staff member teaches Sunday school? No. It's not health related, and it's not job related either.
- Does serving as the team physician for a school sports team count? Not unless it is part of a job assignment and also represents a loss to the hospital.
- Do free clinics for vaccinations or screenings count? Yes!
- Do patient-education programs, such as birthing classes, count? No. They are part of normal patient care.
- Hospitals often subsidize the cost of government health insurance programs. Do those subsidies count? Yes and no. Medicaid subsidies count, but Medicare subsidies do not. Medicare payments are intended to cover costs. So any Medicare losses may reflect operations problems rather than true subsidies.
- Does financial assistance to patients count? Yes, if the assistance represents a financial loss.
- Does bad debt count? Not under CHA-VHA guidelines, because it is considered a normal cost of doing business. The American Hospital Association, however, is arguing on a national level that bad debt should count.

Report: Community benefit laws clearly lay out expectations that health-care organizations will participate in health promotion, disease prevention, and early intervention; will assess health needs in their region; and will report on their progress in addressing those needs. Health-care institutions are becoming partners—with patients, as well as with community organizations—in promoting health, not just providing health-care services. And everyone benefits. ■

The Grand Rounds essay covers a topic of interest to the Dartmouth medical faculty. Carr Robertson is an adjunct research associate in the Department of Community and Family Medicine at Dartmouth Medical School and the director of community health improvement and benefits at DHMC. She also cochairs the Catholic Hospital Association-Voluntary Hospital Association's national What Counts Task Force.