**What Counts Task Force Report from November 2014 Meeting**

**PACE**

Q: We are in the development phase of a PACE program and will not open until spring, 2015. Even though most PACE programs break even once fully operational, can we count expenses incurred during the long ramp-up period prior to breaking even? The PACE program is part of our needs assessment priority areas and implementation strategies. Visit this link to learn about PACE programs - [http://www.npaonline.org/website/article.asp?id=12&title=Who,_What_and_Where_Is_PACE](http://www.npaonline.org/website/article.asp?id=12&title=Who,_What_and_Where_Is_PACE).

Final Recommendation: *We recommend reporting start-up costs for establishing a PACE program as a Subsidized Service as long as there is an identified community health need for the program. For example, some organizations have been asked by legislators or government agencies to start a program. Unmet needs of persons dually eligible for Medicare and Medicaid being identified in the CHNA would be another indication of need. Once the program is operational, unreimbursed costs or shortfalls may also be reported as community benefit under the Subsidized Services category.*

**Enrollment**

Clarification was requested as to what enrollment assistance costs can be reported as community benefit. Existing guidance was revised to reflect the task force’s recommendations.

**Revised guidance:**

*In regard to assisting a patient to enroll in public programs and facility financial assistance, we recommend:*

- **Do not count as community benefit the routine business office assessment or financial counseling, such as discussion of discounts, payment plans, or assessment for the facility’s financial assistance program. That is, do not report the cost of all admissions/business office in-take staff members.**
- **Count as community benefit the costs related to counseling and assessment for public program/insurance exchange eligibility for uninsured and underinsured persons when the activity goes beyond routine business office procedures. This can be reported whether or not the patient is found eligible for assistance as long as there was a likelihood of eligibility. How an organization chooses to count these costs can vary, some only count the assistance costs for persons who get enrolled while others have processes in place that allow them to determine costs associated with assisting all patients who they believe are eligible but who may not end up getting enrolled.**
• Be careful not to double count. Make sure the cost is not being included in the cost of charity care or public program shortfalls (December 2014).

Preceptors/Mentors

Q: Is there a recommended percentage of staff time spent mentoring students that can be reported as community benefit?

Final Recommendation: We recommend that, if possible, the organization should study what percentage of time staff spends away from their duties when mentoring students and use the findings to set a percentage. We recommend this approach because the percentage can vary based on type of hospital, hospital floor (surgical floor vs. medical floor), and whether the student is clinical or non-clinical.

In any case, we do not recommend reporting more than 25 percent of a staff person’s time if they are mentoring a student. If an organization reports 100 percent of a staff person’s time then they should justify this cost. Situations where 100 percent of staff time might be reported might include activities, such as classroom training, that take staff away from regularly scheduled activities.

Disaster Preparedness

The task force’s discussion around Ebola planning led to two decisions, one around how to report Ebola planning, the other around how to incorporate changes to the TY2014 IRS Form 990, Schedule H related to reporting activities that strengthen community health resilience into CHA guidance.

• Ebola planning

Q: Can costs to prepare for Ebola be reported as community benefit?
Final recommendation: We recommend retaining the current guidance on disaster preparedness. If costs to prepare for Ebola response meet these criteria (see below) they may be reported as community benefit/building.

Current guidance:

Recommendation: Disaster readiness costs over and above accreditation, licensure requirements and standard practice may be reported as community benefit. Be careful not to double-count with in-kind donations and be certain that these expenses are not already captured in indirect costs.

Report costs associated with:

• Participation in community-wide assessments of community (not facility) disaster preparedness and resilience.
- Report under Category G. Community Benefit Operations when done as part of the organization's broader community health needs assessment.
- Report under F3. Community Support when done as a separate assessment for community disaster preparedness.

- Participation in planning for preparing the community for disaster preparedness.
  - Report under G. Community Benefit Operations when done as part of the organization's implementation strategy.
  - Report under F3. Community Support when done as a separate plan for community disaster preparedness.

- Participation in implementing plans associated with preparing the community for disaster preparedness (such as mental health resource costs associated with training, community partnerships, and outreach planning).

- Assisting other hospitals and health care facilities not having the resources, capacity or expertise to meet their own preparedness needs. Examples of assistance include stockpiling medical, surgical, and pharmaceutical supplies for other health care organizations or providing staff and community member training and drills.
  - Report in category F3. Community Support. If contributions are financial, be sure to retain documentation from receiving organization that funds will be used to support a community benefit activity.

- Other costs for activities over and above accreditation, licensure requirements and standard practice.

- **Community Health Resilience**

CHA will amend its guidance related to A. Community Health Improvement, A4. Social and Environmental Improvement Activities as follows—changes in red text below—to reflect changes in the instructions for TY2014 Schedule H that allow reporting of activities that strengthen community health resilience under the category of Community Health Improvement.

**Revised Guidance:**

**A4. Social and Environmental Improvement Activities**

These are programs and activities that improve the health of persons in the community by addressing the determinants of health, which includes the social, economic and physical environment. They may be related to activities in Category F: Community-Building (physical improvements and housing, economic development, community support, environmental improvements, leadership development, coalition building, community health improvement advocacy and workforce development). These activities can be reported as community health improvement under A4 when they meet the criteria for community benefit described in Chapter 2, Guideline 1 and are not reported in Category F.

**Count:**

- Removal of harmful materials (such as asbestos, lead) in public housing.
- Improving availability of fresh fruits and vegetables in areas known as “food deserts.”
- Violence prevention.
- Coalitions involved in task-specific projects and initiatives that address community health needs.
- Efforts to improve the ability of a community to withstand and recover from public health emergencies such as activities to ensure continuity of healthcare and related social services, providing accurate information about health threats, involving community members in planning and decision making on issues related to response and recovery, encouraging personal and community preparedness and developing strong partnerships within and between government and other community organizations. (New language noted in red.)