Elements of Governance®

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A Series by The Governance Institute

Community Benefit

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Elements of Governance®

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Background and Overview

Serving the community remains the cornerstone of the mission for today's hospitals. Some hospitals claim to fulfill this mission simply by keeping their doors open in service areas with an unfavorable payer mix (i.e., high concentrations of uninsured, underinsured, and Medicaid certified recipients). Some develop additional programs and services for the residents of underserved communities. An increasing number of these programs involve partnerships with community organizations. Still others explore more strategic approaches that emphasize building community capacity to improve health status and community quality of life.

The breadth and depth of "community benefit" activities undertaken by hospitals vary widely, but all hospitals devote substantial resources to fulfill their mission. That's good, because communities need their hospitals, and not just for the delivery of acute medical services. There are more people looking at what may be the optimal role of non-profit hospitals in addressing health needs in local communities.

Tax-exemption for non-profit hospitals comes with an expectation that they share responsibility for addressing the healthcare needs of their communities. Historically, this responsibility was defined as the provision of free and/or discounted medical services to the poor. In 1969, the Internal Revenue Service (IRS) expanded the interpretation of charity to include community benefit, defined as "the promotion of health for a class of beneficiaries sufficiently large enough to constitute benefit for the community as a whole" (IRS Rulings 60–545 (1969) and 85–157 (1983)). This became the crux of a hospital's charitable mission.

The impetus for this change, to a significant degree, was the passage of Medicare and Medicaid legislation, which contributed to what turned out to be false optimism that universal access was an emerging reality. The expansion of the IRS definition was intended, at least in part, to provide a means for hospitals to fulfill their charitable obligations in the relative absence of a need for free and discounted medical services.

While the IRS definition of community benefit appears at first glance to be vague and open to broad interpretation, closer examination provides insights into a more specific set of expectations. For example, the reference to "the community as a whole" suggests a population health orientation, in that one would need to identify specific parameters (e.g., a city, a county, a primary service area, a set of census tracts, a zip code). Such an orientation is further reinforced by the need to identify a "class of beneficiaries sufficiently large enough;" in essence, a numerator that when compared to the community parameter (i.e., the denominator), will be large enough to produce a measurable impact.

In the context of current demographic trends, the growing cost of healthcare, and a closer examination of public expectations associated with tax exemption for non-profit hospitals, one might summarize the intent of the IRS definition as having three dimensions:

- To encourage hospitals to play a role in efforts to *improve health status and quality of life* in local communities
- To move *beyond charity care as the exclusive means* to demonstrate commitment as a tax-exempt healthcare institution
- An expectation that community benefit programs and activities will have a substantial focus in *communities with disproportionate unmet health-related needs*

The Context for Today's Community Benefit Initiatives

States began moving towards the development of state requirements for non-profit hospitals in the late 1980s. An increasing number of state statutes emphasized the link between the clinical care delivery system and more strategic ways to address both the symptoms and underlying causes of health problems in local communities.

In recent years, work in the field has begun to move beyond a focus on programs, practices, and projects of hospitals within their communities and into the issue of governance. The inclusion of governance became apparent as hospital managers tried to implement innovative ways of delivering services to their community, but then reached roadblocks (sometimes, stone barriers) built over time and still surviving because of a reluctance to try something new—or because they were stymied by the enormity of the challenges they faced.

It has become clear that hospitals must not only address the programmatic side of community benefit, but they also must align the institution with its charitable mission to promote the health of the community. A number of state and federal lawmakers have taken up community benefit as a cause. The increased scrutiny has captured the attention of hospital senior leadership, and leaders are now guiding their hospitals through efforts to formalize both their community benefit activities and the methods by which those activities are reported to the various interested publics. Once again, all parties are participants in the dialogue.

It is important to note that a small percentage of hospitals have been engaged in the development and implementation of comprehensive community benefit activities for many years. These are the leaders—at the forefront—and many have placed board-level involvement at the heart of their efforts. We offer a list of those organizations in Appendix 2 (on page 12).

What is Community Benefit?

It is important to remember that community benefit should not just be measured in terms of dollars, or the services provided to individuals, but the measurable impacts that are achieved—both in clinical and community settings.

—Kevin Barnett, Dr. P.H., Senior Investigator, Public Health Institute

The general idea in the 1969 IRS Ruling was to create the flexibility for hospitals to move beyond charity care as the exclusive means to fulfill their tax-exempt responsibilities. Nevertheless, the shadow of charity care still looms—driven primarily by growing rates of uninsured and underinsured populations in our communities. In the context of growing costs and demographic trends that suggest fairly dramatic increases in the demand for treatment of chronic illness, the question becomes one of stewardship. How do we move beyond a simple compilation of charitable expenditures and begin to ask whether we are making optimal use of our limited resources? A key step in the process is the identification of communities with disproportionate unmet health-related needs, and the targeting of resources to reduce the demand for high cost medical services to treat preventable illnesses.

Communities with disproportionate unmet needs typically are those regions or sub-regions in a hospital's service area where there may be a higher prevalence or acuity for a particular health

issue and/or there are other proxy measures that clearly demonstrate that these populations experience health problems disproportionately. (Household income or unemployment rates are common proxy measures.)

Trends in Practice

There are many examples of outstanding programs in hospitals across the country, but market dynamics have tended to influence the interpretation of community benefit. Consider, for example, both the business/marketing imperatives and political orientation.

Business/marketing imperative: Many hospital-sponsored activities focus to a significant degree on *insured populations* and though they may be excellent ancillary services for these populations, the intent is to help to market the hospital to the general population. As such, these kinds of activities are considered part of doing business, and expenses associated with them cannot be considered a community benefit.

Political orientation: Many hospitals report a large number of relatively small-scale activities, few of which can be shown to have produced any measurable impact. The high number and small scale of these efforts suggests a political motive, rather than a commitment to achieve measurable and sustainable improvements in health status and quality of life. To be sure, this scenario is most often the result of an ongoing effort to be responsive to the wide array of requests for support that are presented to hospitals over the years. The net effect, however, is to give the impression of doing much in terms of inputs, when there is little of substance that can be reported in terms of outcomes.

Hospitals often promote facility-hosted education programs, such as asthma management, in newsletters that are mailed to residents at a specific income level, or on flyers that are posted in a hospital elevator or bulletin board. Without also considering those with income, insurance, transportation, and/or cultural barriers in the promotion of the educational offering, the potential community benefits are not optimized. It may be a wonderful set of services for the commercially insured patients who receive care in the hospital, but it is not by design a community benefit program.

If a hospital wants to have an impact on health status, it should focus its services and education on where they are needed most, including consideration for an alternative location for the educational offering (e.g., community center or local church).

Impetus for a New Approach

There is renewed commitment to develop a comprehensive solution to address the growing number of uninsured in the U.S.; there are some areas of the country that are moving forward with the implementation of universal coverage strategies. For hospitals with visionary leadership, this trend provides the impetus to engage in community-based prevention initiatives that address not only the symptoms, but also the underlying causes of persistent health problems in local communities. So the question becomes one of how hospitals build the capacity to improve health status and quality of life for their communities, and how do they do so in a manner that makes optimal use of their limited resources?

One strategic approach to allocation of community benefit resources involves focusing on preventable hospitalizations. A significant portion of charity care expenditures in non-profit hospitals currently result from emergency room (ER) and inpatient treatment of preventable illness/conditions—from asthma, to diabetes, to cardiac related conditions. This raises ques-

tions about stewardship of the institution's resources. If a hospital spent $5 million last year to provide emergency and inpatient care for 200 uninsured people, one could argue that is not an effective use/stewardship of that $5 million. Instead, the hospital should identify effective ways to reduce the demand for emergency and inpatient care among the 200 uninsured people through proactive investments in prevention, and reallocate the savings for other community benefit purposes. This approach is becoming an important strategic component for determining community benefit services and programs. For many hospitals there has been a shift towards programs addressing obesity, diabetes, asthma, and stroke. Some also have begun to evaluate data related to co-morbidity and readmission among Medicare patients, and have plans to design programs to deliver care to these patients in less costly (and more patient friendly) settings.

Hospitals can play an important role in helping recreate the public health infrastructure. Local public health agencies tend to be challenged by a lack of leadership; money is provided for one-by-one care, not on a population basis; little attention is given to finding ways to reduce demand for service and/or to achieving sustainable improvements in health status. Hospital leaders can assist with specific strategies and tactics, and also help build a framework for shared advocacy in the public policy arena.

(From the *National Steering Committee on Hospitals and Public Health*)

Advancing the State of the Art in Community Benefit

A multi-year, two-phase project begun in 2002, the Advancing the State of the Art in Community Benefit (ASACB) demonstration originally involved a group of hospitals in California, Texas, Arizona, and Nevada to develop and implement a series of uniform standards to align hospital governance, management, and operations, and to make optimal use of limited charitable resources to address unmet health-related needs in these hospitals' communities.[1] ASACB has become the standard bearer for development and implementation of community benefit programs in many U.S. hospitals.

ASACB has specific programmatic and institutional goals. Its *programmatic* goals are:

- To improve health status and reduce health disparities through targeted investment and program design
- To focus on strategic investment of charitable resources to reduce the demand for high cost treatment of preventable conditions

Its *institutional* goals are:

- To establish a community benefit governance structure for:
    - Increased accountability and oversight
    - Clarity of function—transparency
    - Breadth of competencies
- To increase competency and organizational support of community benefit management by:
    - Devoting attention to skills needed for quality
    - De-marginalizing the community benefit function

Many hospitals clearly demonstrate their charitable commitment *simply by keeping their doors open.* Some people in the public policy arena want hospitals to be required to meet a 'threshold' for charity care, without consideration of whether these expenditures represent the best use of limited resources to serve these populations. As has been demonstrated in states such as Texas, Pennsylvania, and Utah, this approach has not resulted in increased access; rather, it has become a 'numbers game' for chief financial officers. This approach to policymaking and community benefit oversight is fundamentally flawed.

—Kevin Barnett, Dr. P.H.

1 ASACB is a demonstration administered through the Public Health Institute. This description of ASACB is from the Public Health Institute Web site.

The ASACB demonstration, through the participation of hospital/health system leadership, seeks to shift the focus of the public debate about community benefit from a simple focus on the volume of inputs to one that focuses on quality, outcomes, and stewardship.

There is no question that lawmakers will continue to challenge the legitimacy of tax-exempt status for hospitals—and even if the clamor of activity comes and goes over time, there will be a resurgence of noise if/when universal access comes to pass and charity care is no longer the primary financial commitment of hospitals. If the issue of the uninsured is resolved, then the most logical repository of community benefit resources is and should be in the community-based prevention arena. Many hospitals are already there—as evidenced by those that participated in the ASACB demonstration. Their message should be delivered to the public, loudly and clearly.

ASACB Five Core Principles

There are five core principles that underlie the work in the ASACB demonstration, and many of these principles are now being applied in hospitals across the country. Each principle and its core components are listed below.

Core Principle #1: Emphasis in Communities with Disproportionate Unmet Health-Related Needs (DUHN)

- Identify communities with high prevalence for health issue of concern or high concentration of health-related risk factors.
- Develop outreach mechanisms to inform members of DUHN communities of available services and activities.
- Facilitate participation of members of DUHN communities through program location, timing, and/or transportation assistance.
- Ensure that program design and content is relevant and responsive to the particular needs and characteristics of members of DUHN.

Core Principle #2: Emphasis on Primary Prevention

- Health promotion: encourage/educate people to change their behavior.
- Disease prevention: reduce the demand for treatment through work with at-risk populations.
- Health protection: work with communities to address obstacles to changes in behavior.

Core Principle #3: Build Community Capacity

- Identify and mobilize community assets (e.g., community-based organizations, neighborhood associations, coalitions, informal networks, individual skills, physical space, facilities) to address health-related problems.
- Engage community stakeholders as full partners in comprehensive strategies to address both symptoms and underlying causes.
- Focus hospital resources (e.g., financial support, technical assistance, in-kind support, advocacy) on strategies to increase the effectiveness and sustainability of community-led efforts to address persistent health-related problems.

Core Principle #4: Build a Seamless Continuum of Care

- Identify links between community health improvement activities and medical care service utilization.
- Identify measures for community health improvement activities that validate progress towards improved health status and quality of life.
- Engage providers and develop expanded protocols that make optimal use of community resources to manage chronic disease and minimize future medical care service utilization.

Core Principle #5: Collaborative Governance

- Breadth of competencies and diversity are needed for informed decision making.
- Shared accountability with diverse community stakeholders for the design, implementation, and refinement of community health initiatives.
- Diverse community stakeholders have a role in identifying measurable objectives, data collection, and the interpretation of findings.

An additional, important component of the ASACB demonstration involved developing reporting standards based on uniform content categories. The standards help community benefit managers and executives to focus on both internal and external accountability, and provide consistency across programs for comparative analyses.

ASACB Institutional Policy Standards for Community Benefit—the Importance of Board Involvement

Making community benefit a viable, rich endeavor for the hospital involves adopting explicit standards including active board involvement.

Establish a board-level oversight committee: This committee should include one or two board members, senior leadership and staff, and community members with specific experience or skills.

Develop a formal committee charter: The board committee should have a formal charter that includes the specific responsibilities of the committee, its role and the roles of its members, criteria and process for recruitment to the committee, and criteria and process for community benefit priority setting.

The board-level oversight committee must have clear roles and responsibilities as they relate to program design, fundraising, and the development of a monitoring strategy. Committee members should understand "why they are there" and their role in moving the community benefit agenda. For ASACB demonstration hospitals/health systems, the quality of involvement by the board has dramatically improved, as has the overall quality of the community benefit efforts of these institutions.

Community Benefit Committee Responsibilities

- Safeguard the organization's attention to mission.
- Review and approve the organization's community benefit plan.
- Ensure the organization's community benefit plan is based on findings from a comprehensive community assessment.
- Establish and monitor criteria for community benefit program selection and oversight.
- Guide and monitor planning, development, and implementation of major programs to improve the health of the community.
- Establish criteria for scalability of community benefit programs to ensure expansion (or, if necessary, compression) needs are balanced with the organization's overall financial performance.
- Recommend financial assistance policies for approval by the board.
- Advise on communication plans and strategies about the organization's community benefit activities.

The Board Community Benefit Committee

This committee should have explicit criteria for committee *member recruitment*. Board members selected for participation on this committee should have an abiding interest in and commitment to community benefit. Representatives from hospital leadership can include senior executives (CEO, COO, CFO, for example) as well as senior program managers and medical staff representatives.

Committee members from the community should bring specific skills to the table. Defining those necessary skills will vary from organization to organization; in general, it is important to have someone with public health experience and someone with epidemiological training or experience. Also desirable is expertise in program evaluation and/or service utilization and related research. For other community representatives, the committee should look for people who have lived in "disproportionate unmet health-related needs" communities—they often bring a sense of what has worked or failed in their communities, as well as a bit of reality about future projects. Typically, hospital program staff can help identify potential community representatives for the committee.

This committee should use clear *criteria and processes for priority setting*. Committee members need a way to determine which new programs it will recommend, existing programs it wants to expand, and programs it wants to scale back or eliminate. Criteria also are good tools for evaluating ways to improve existing programs.

Community benefit managers and hospital leadership probably have used criteria in the past to determine community benefit programs; it is important for the committee to review those criteria and modify as necessary. Examples of *basic* items on the list of criteria include:

- Identifying the size and scope of the problem
- How much the problem is costing the organization
- Who else is working on the issue (i.e., in the community)
- Whether the issue is controversial
- What would be required to move forward
- Other programs that would suffer from an emphasis on this issue

With focused attention to community benefit, over time the organization will begin to see a reduction in the ***number of activities*** and an increase of the ***scale and comprehensiveness of activities***; essentially, moving towards a position where the organization can more effectively articulate what it's doing and the effects in its communities.

Most of the board community benefit committees set up at participating hospitals/health systems during the initial ASACB demonstration took a firm step to "say no" to proposals for new community benefit programs until they had the opportunity to assess current program offerings and to determine if/how to improve them.

Of course, community benefit staff people at these institutions were concerned that the board level committees would raise the standards and "give up all the things that used to count as community benefit"…but that did not happen. What actually did happen was that the committees from these organizations began to work with community benefit staff to strengthen existing programs through a better alignment with the ASACB core principles. In the process, the organizations themselves were much better prepared to showcase what they were doing in the public policy arena.

Successes from the ASACB Demonstration

The ASACB demonstration has yielded significant accomplishments through its efforts with leadership/governance and through its management/programming activities. A partial list of these accomplishments appears below. The consensus from project leaders was that these successes are easily "transportable" to hospitals and health systems across the country.

Leadership/Governance

- CEOs and other senior leaders are directly accountable for community benefit performance; accountability is reflected in their job descriptions and compensation. For example, it has become a standard practice to tie incentive compensation for all hospital CEOs in one participating system to a 5 percent reduction in preventable hospitalizations by the self-pay population participating in the hospital intervention. The CEOs have directed hospital resources to focused efforts in this regard.
- The board-level community benefit committee serves as an extension of the board of directors to provide direct oversight for all charitable activities and ensure alignment with ASACB Core Principles. Whereas it is not realistic to expect the full board to provide this oversight directly, the committee does so effectively—it serves as an intermediary to the board.
- Community benefit committee membership includes diverse community stakeholders.
- Board members on the community benefit committee serve as "board-level champions" to keep community benefit planning on the board agenda.

Management/Programming

The demonstration proved that by working through ASACB Core Principles and Uniform Standards, the participant hospitals/health systems:

- Increased understanding and investment in competencies and FTE commitment needed for quality programming
- Increased investment in data collection, tracking tools, and evaluation
- Developed specific outreach strategies to access identified DUHN populations
- Increased coordination with clinical departments to reduce inappropriate ER utilization
- Increased capacity of department directors/managers to advocate for community benefit to senior leadership
- Increased investment in programs to reduce health disparities
- Increased coordination between community benefit and finance departments on reporting and planning

Collaborative "Governance"

Board community benefit committees have been fundamentally important to hospitals in moving the community benefit agenda forward. The committee's vision must be geared towards internal oversight and ***not*** geared toward simply how to elevate the hospital's visibility. That's more the role of the marketing department. It is critically important to elevate the oversight of community benefit practices inside the organization with a board-level policy body.

On the programmatic level, hospitals should have advisory committees for larger initiatives. These advisory committees should bring together many stakeholders to ensure shared accountability. If community stakeholders perceive their role as that of a "watchdog"—that is, "We're going to make sure you do it right"—then the hospital is in a difficult situation. It should emphasize ***shared accountability***.

So collaborative "governance" involves advisory committees at the programmatic level, set up within the context of the larger policy body—the community benefit committee. Both of these levels of "governance" are critical.

Appendix 1

State Position on Hospital Reporting of Community Benefit (as of December 2007)

States	Voluntary Reporting	Mandated Reporting	Minimum Contribution*
Alabama			
Alaska	X		
Arizona	X		
Arkansas			
California		X	
Colorado			
Connecticut	X	X	
Delaware	X		
Florida			
Georgia	X		
Hawaii	X		
Idaho		X	
Illinois		X	
Indiana	X	X	
Iowa	X		
Kansas	X		
Kentucky			
Louisiana			
Maine			
Maryland		X	
Massachusetts	X		
Michigan	X		
Minnesota	X	X	
Mississippi			
Missouri			
Montana	X		
Nebraska	X		
Nevada	X	X	
New Jersey	X		
New Hampshire			
New Mexico			
New York		X	
North Carolina	X		
North Dakota			
Ohio	X		
Oklahoma			
Oregon		X	
Pennsylvania		X	X
Rhode Island		X	
South Carolina	X		
South Dakota			
Tennessee	X		
Texas		X	X
Utah		X	X
Vermont			
Virginia	X		
Washington	X		
West Virginia			
Wisconsin	X		

*Utah: Hospitals must meet a community benefit threshold up to the value of the tax exemption.

Pennsylvania: Community benefit contribution must be at least the value of tax exemption.

Texas: Most stringent requirement—hospitals have to meet at least one of several tests (value of tax exemption is one of the tests).

Appendix 2

Partners in the original ASACB Demonstration

- Catholic Healthcare West (including its 41 hospitals in California, Arizona, and Nevada)
- St. Joseph Health System (including its 14 hospitals in California, Texas and New Mexico)
- Texas Health Resources (13 hospitals in northern Texas)
- Lucile Packard Children's Hospital at Stanford
- Presbyterian Intercommunity Hospitals

A growing number of hospitals and health systems across the country have or are in the process of implementing ASACB standards. Some of those have contracted with ASACB team members to facilitate and/or assess their implementation of the standards, including:

- Provena Health (7 hospitals in Illinois)
- Saddleback Memorial Medical Center (Orange County, California)
- Massachusetts General Hospital
- Children's Hospital of Boston

In 2008 the City and County of San Francisco Charity Care Project recommended continued work with San Francisco's hospitals to promote the principles of the ASACB project and to improve local programs for those populations otherwise served by charity care.

Appendix 3

Sample Community Benefit Policies

Sample 1: Community Benefit Policy for a Hospital

Purpose: To establish community benefit standards consistent with the hospital's mission and with nationally accepted guidelines for community benefit activities.

Policy: This hospital is committed to community benefit activities that respond to identified community health needs and improve the health of the region. The hospital's community benefits activities will, to the extent possible, align with the following Advancing the State of the Art in Community Benefit principles:

1. Emphasis on programs to meet a significant unmet health need including efforts to identify and include vulnerable populations or those most at-risk as determined by risk factors that predispose those populations toward a higher incidence of disease and/or barriers to obtaining appropriate healthcare.

2. Emphasis on primary prevention and including at least one of three primary prevention strategies: health promotion, disease prevention, and health protection.

3. Programs should develop evidence-based links between clinical services and health improvement activities delivered both inside and outside the hospital; e.g., targeting populations with higher rates of ambulatory care sensitive hospitalizations with prevention programs and improved access to primary care services will reduce avoidable hospitalizations and result in more appropriate use of healthcare resources.

4. Programs should focus on targeting charitable resources that mobilize and build capacity within existing community assets while minimizing duplication of effort.

5. Programs should emphasize collaboration with community stakeholders.

Definitions:

A **community benefit** is a clinical or non-clinical program or activity that provides treatment and/or promotes health and healing that is:

- Responsive to identified health priorities determined in collaboration with community stakeholders

- Focused on persons who are poor, disenfranchised, or located in an area with disproportionate unmet health-related needs

- Integrated into the facility's strategic planning and budgeting process

- Planned and implemented with program objectives and measurable outcomes that are beneficial to community stakeholders

Community benefits also include charity care…as well as health profession education, research, efforts to build upon the community's capacity, and the costs associated with community benefit operations.

The hospital's definition of **community** especially includes areas and populations with disproportionate unmet health-related needs.

Health is defined as a state of physical, mental, and social well being, not merely the absence of disease or infirmity.

Procedure and infrastructure supporting community benefits:

1. **Staff**

   The hospital shall establish and maintain a Community Health, Outreach, and Partnership Office with the competencies needed to fulfill work requirements in collaboration with the planning, community relations, and finance departments and with community stakeholders. The lead person accountable for community benefits shall report to the Vice President of Development and Community Relations.

2. **Community-based partnerships**

   From planning the community health assessment to establishing priorities, implementing, monitoring and evaluating programs, the hospital will work with other private and public organizations in the hospital's service area. Collaborators include, but are not limited to, public health agencies, school systems, faith-based organizations, local employers, and other non-profit health and social service agencies.

3. **Community health assessment**

   Alone or in collaboration with community partners, the hospital will participate in regular assessments of community health assets and needs with special attention to geographical areas and population sectors with disproportionate unmet health-related needs.

4. **Resource allocation**

   The hospital's operating budget shall include adequate financial resources to hire competent and effective staff to assess, plan, develop, implement, manage, and report on community benefit initiatives.

5. **Program development**

   The hospital's community benefit programs are developed in response to the health issues identified in the community health assessments and prioritized by a representative group of hospital/service area and community stakeholders. The hospital's planning, finance, and community relations departments collaborate to ensure successful outcomes of community benefit programs. Oversight is provided by the board's community benefit committee.

6. **Performance measurement**

   Recognizing that impact on health status is usually realized in the long term, the hospital will develop clinical and administrative objectives for community benefit initiatives that are measurable and that can serve as indicators of progress toward the achievement of desired health outcomes.

7. **Uniform reporting**

   Hospital staff will use the Community Benefit Inventory for Social Accountability (CBISA) or comparable instrument endorsed by the state hospital association for systematic collection and reporting of data and for analysis of activities.

8. **Dissemination of community benefit reporting**

The hospital shall develop an annual community benefit report, and shall assure that diverse community stakeholders are aware of the report. The report may also be posted on the Web site for the general public.

(This sample is from Lawrence & Memorial Hospital, New London, Connecticut.)

Sample 2: Community Benefit Policy for a Health System

Purpose: The hospitals in the system have a proud history of service to their communities. People's needs prompted the origins of our hospitals and remain our chief concern today. Benefiting the communities we serve is an essential expression of our mission. We dedicate our resources to:

- Delivering compassionate, high-quality affordable health services
- Serving and advocating for our sisters and brothers who are poor and disenfranchised
- Partnering with others in the community to improve the quality of life

The health system integrates community benefit into ongoing processes of planning, budgeting, and reporting. At both systemwide and local levels, it explicitly uses its resources to benefit those who are poor and to promote health and healing in the community. The system's community benefit process addresses:

- Organizational infrastructure
- Community health assessment
- Community-based partnerships
- Resource allocation
- Program development
- Performance measurement
- Reporting

Definitions:

A **community benefit** is a clinical or non-clinical program or activity that provides treatment and/or promotes health and healing that is:

- Responsive to identified health priorities determined in collaboration with community stakeholders
- Focused on persons who are poor, disenfranchised, or located in an area with disproportionate unmet health-related needs
- Integrated into the facility's strategic planning and budgeting process
- Planned and implemented with program objectives and measurable outcomes that are beneficial to community stakeholders

Community benefits also include charity care…as well as health profession education, research, efforts to build upon the community's capacity, and the costs associated with community benefit operations.

In addition to its immediate geographical areas, a hospital's definition of **community** ought to include neighboring areas and populations with disproportionate unmet health-related needs.

Health is defined as a state of physical, mental and social well being, not merely the absence of disease or infirmity.

Policy:

A. Hospital/Service Area

1. Organizational Infrastructure

a. **Executive Leadership**: Hospital/service area presidents are accountable for a demonstrated commitment to improving community health status and addressing the societal issues that contribute to poor health, as well as personally working for the betterment of the community-at-large. In addition, hospital/service area presidents ensure that their hospitals allocate adequate resources to assess, develop and implement community benefit initiatives that respond to the unmet health priorities selected in collaboration with their community partners.

b. **Hospital Community Boards and Subsidiary Boards**: Hospital community boards and subsidiary boards ("hospital board(s)") are responsible for ensuring the hospital develops programs to address the disproportionate unmet health-related needs of the communities it serves. In addition, hospital boards ensure the development of community benefit initiatives to promote the broader health of the community. In fulfilling these responsibilities the hospital board may designate a community health committee of the board to include at least two board members, with a majority representation from a range of community stakeholders who have knowledge of the community. The hospital board, or board committee, participates in the process of establishing program priorities based on community needs and assets, developing the hospital's community benefit plan, and monitoring progress toward identified goals. If applicable, board members of the committee will ensure that the board is regularly briefed on activities and developments and will also ensure that the committee has information from the board and management needed to make informed decisions. The hospital board is also responsible for review and approval of the annual hospital community benefit plan and report.

c. **Staff**: Each hospital/service area shall establish and maintain a community benefit staff person with the competencies needed to fulfill work requirements in collaboration with the planning and finance departments and with community stakeholders. The person accountable for community benefit shall report to the hospital president/service area president or member of the senior management team who has understanding of and competency in community benefit planning and programming.

2. Community-Based Partnerships

From planning the community health assessment to establishing priorities, implementing, monitoring and evaluating programs, hospitals/service areas work with other private and public organizations in their communities. Collaborators include, but are not limited to, the public health agency, the school system, faith-based organizations, local employers, and other non-profit health and social service agencies.

3. **Community Health Assessment**

   In collaboration with community partners, hospital/service areas participate in regular assessments of community health assets and needs with special attention to geographical areas and population sectors with disproportionate unmet health-related needs.

4. **Resource Allocation**

   Hospital/service area budgets shall include adequate financial resources to hire competent and effective staff to assess, plan, develop, implement, manage, and report on community benefit initiatives.

5. **Program Development**

   Community benefit programs are developed in response to the health issues identified in the community health assessments and prioritized by a representative group of hospital/service area and community stakeholders. The hospital's/service area's planning, finance, and community benefit departments collaborate to ensure successful outcomes of community benefit programs.

6. **Performance Measurement**

   Recognizing that impact on health status is usually realized in the long term, hospital/service areas develop clinical and administrative objectives for community benefit initiatives that are measurable and that can serve as indicators of progress toward the achievement of desired health outcomes.

7. **Uniform Reporting**

   Hospitals shall conform to a uniform method of accounting community benefit expenses.

8. **Dissemination of Community Benefit Reporting**

   Each hospital shall develop an annual community benefit report, and shall assure that diverse community stakeholders are aware of the report. The report may also be posted on the facility Web site for the general public.

B. System-wide

1. **Organizational Infrastructure**

   a. **Senior Executive Leadership**: The system senior vice president of sponsorship and mission integration leads systemwide community benefit initiatives, aligns systemwide strategic objectives with community benefit, and ensures that adequate resources are allocated to community benefit planning and programming system-wide.

   b. **Board of Directors**: The system board of directors establishes key measures of system-wide community benefit performance and receives regular reports on progress toward established goals.

   c. **Staff**: The system vice president of community health directs and oversees system-wide community benefit initiatives. The system director of community benefit is responsible for planning, developing, coordinating, and overseeing community benefit initiatives, standards, programming, and reporting.

2. **Program Development**

   The system also coordinates the following systemwide programs to address the health needs identified in community health assessments.

   a. **Community Grants**: Each hospital annually contributes to a fund through which non-profit community-based health and human service agencies apply for and receive grant funding.

   b. **Community Investments**: System Community Investments provides direct loans to community-based, non-profit enterprises and loan guarantees, linked deposits, and capital investments in projects devoted to affordable housing and community economic development.

   c. **Public Policy Education and Advocacy**: The system coordinates its public policy advocacy with diverse stakeholders to address issues that impact community health.

   d. **Shareholder Activism**: The system uses its investment portfolio to engage in dialogue with management of the corporations in which it owns stock on corporate practices impacting the health of individuals and communities.

   e. **Ecology**: The system is committed to improving environmental management in its hospitals and to partnering with others in its communities to safeguard the environment.

3. **Reporting**

   The system provides quarterly reports on facility/service area community benefit activities to the financial operations group to ensure accuracy in reporting. The system provides an annual report on systemwide community benefit performance to the system board of directors. The system issues and disseminates to diverse community stakeholders an annual Web-based, system-wide report on its community benefit initiatives and performance.

(This sample is from Catholic Healthcare West, San Francisco, California.)

Appendix 4

Sample Community Benefit Committee Charter

Roles of the Community Benefit Committee

The roles of the community benefit committee are to provide recommendations and guidance to the board of directors for carrying out the hospital's community benefit mission and responsibilities, to provide oversight and guidance to the community benefit activities of the organization, and to implement the hospital's community benefit grants program.

Committee Structure

The community benefit committee shall at minimum consist of:

- One [or two] members of the board of directors
- The chief executive officer
- The chief financial officer
- The vice president of program development
- The president of the foundation
- One chief of staff or chief of staff elect
- One chief nurse executive
- Five members of the community

One of the board members shall be appointed by the chair of the board of directors as chair of the community benefit committee.

The committee shall meet as often as necessary to transact its business, but *not less than quarterly*.

The committee reports to the full board. Any member of the board may attend the committee meetings. Minutes of each committee meeting shall be prepared by a person designated as recording secretary of the meeting.

Responsibilities and Authority of the Community Benefit Committee

Committee responsibilities encompass the following:

- Safeguarding the organization's attention to mission.
- Reviewing and approving the organization's community benefit plan.
- Ensuring the organization's community benefit plan is based on findings from a comprehensive community assessment.
- Establishing and monitoring criteria for community benefit program selection and oversight.
- Guiding and monitoring planning, development, and implementation of major programs to improve the health of the community.

- Developing and implementing the hospital's community grants program including determination of grant priorities, selection of grant recipients, and monitoring of grant expenditures. The budget for grants shall be approved by the board and a report of grants made shall be provided to the board annually.
- Establishing criteria for scalability of community benefit programs to ensure expansion (or, if necessary, compression) needs are balanced with the overall organization's financial performance.
- Recommending financial assistance policies for approval by the board.
- Advising on communication plans and strategies about the organization's community benefit activities.
- Providing oversight and monitoring of the hospital's compliance with state and federal laws or regulations regarding the community benefit requirements of not-for-profit hospitals and health systems and shall report to the board its conclusions at least annually. The committee shall review the community benefit report submitted annually to the state.

(This sample is a composite of several samples from Governance Institute members.)