Improving Community Health:

Leading Governance Practices to Catalyze Change

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Executive Summary

Not-for-profit hospitals have been exempt from various federal, state, and local taxes for roughly a century. The policy dates back to the first federal income tax code enacted in 1913, which created exemptions for charitable institutions.

IN ADDITION, STATE AND LOCAL GOVERNMENTS HAVE GENERally exempted not-for-profit hospitals from various taxes (including sales, property, and corporate taxes).[1] Increasingly, however, the tax-exempt status of not-for-profit hospitals seems to be at risk, as evidenced by three key lessons gleaned from a review of the history of tax-exempt status for not-for-profit hospitals:

- Lesson #1: Tax-exempt status is worth a lot to hospitals, but skepticism exists as to whether it is justified.
- Lesson #2: Legislative and regulatory changes and market forces are pushing not-for-profit hospitals to focus more on community health improvement.
- Lesson #3: Despite these pressures, spending has been disproportionately targeted at free and discounted care (not community health improvement).

While tax-exempt status can be critical for financial solvency, the responsibility of hospitals and health systems to address community health needs in ways that might be outside the purview of clinical care is increasing rapidly. Going beyond the traditional measuring of "community benefit" for the purposes of IRS reporting and meeting ACA requirements related to community health needs assessments (CHNAs), organizations are recognizing a need to embrace the more encompassing term "community health" and develop leadership and governance around efforts to better serve the community by addressing social determinants of health. As such, we refer to the term "community health" as the focus of this white paper.

Leading Practices for Improving Community Health

This white paper is intended to help not-for-profit hospitals and health systems become a major catalyst for health improvement in the local community, particularly with underserved, at-risk populations. It includes information to assist in abiding by ACA requirements and maintaining tax-exempt status. More importantly, the impetus for these practices goes well beyond ACA regulations, but rather is part of the organization's larger response to payment reform (i.e., the movement from fee-for-service to value- and risk-based reimbursement) and the transformation from reactive, episodic acute care to proactive management of chronic disease and population health.

Step 1: Create the Right Policies, Structures, and Infrastructure

The first step is to put in place appropriate policies, structures, and infrastructure to ensure that the organization has the right culture and sufficient resources to make a difference in the area of community health improvement. This section details leading practices in these areas.

Practice #1: Develop an Organization-Wide Community Health Policy

Boards should consider developing and approving a community health policy for the organization consistent with its mission and vision statements. This policy statement serves as a way to formalize the organization's—and the board's—commitment to engaging in activities to address identified community health needs. The policy can also specify the role of the board and organization with respect to community health, and in some cases may speak to the type of infrastructure (e.g., staffing, dedicated department/office, reporting relationships) and activities (e.g., community-based partnerships, community health needs assessments [CHNAs], performance measurement) the hospital and health system has or will put in place as part of this commitment.[2]

1 "Health Policy Brief: Not-for-profit Hospitals' Community Benefit Requirements," *Health Affairs,* February 25, 2016.
2 Elements of Governance®: *Community Benefit,* The Governance Institute, 2008.

Practice #2: Make a Concrete Monetary Commitment to Community Health Improvement

Some not-for-profit hospitals and health systems have made public commitments to spend a certain minimum dollar amount or percentage of operating expenses or profits on community activities or initiatives intended to improve health and benefit the community. In many cases, these pledges are separate from the amount spent to provide discounted or charity care to the uninsured/underinsured.

Practice #3: Create a Board-Level Community Health Committee

Most boards lack the breadth and depth of competencies and dedicated time needed to offer more than a cursory review of CHNAs and related implementation strategies, and to ensure the optimal use of charitable resources.[3,4] To address this knowledge and resource deficit, The Governance Institute and other organizations recommend that boards of not-for-profit hospitals and health systems create a standing committee with oversight responsibility for community health policies and programs (traditionally called a community benefit committee, for the purposes of this white paper we will refer to it as a community health committee, which should have a more encompassing role to include programs to comply with regulations and tax-exempt status as well as addressing social determinants of health and health disparities).[5,6,7]

Practice #4: Create a Dedicated Department, with a Leader Accountable to the CEO for Performance

Many not-for-profit hospitals and health systems do not have dedicated departments, divisions, or other permanent bodies focused on community health initiatives. Instead, such activities reside within the finance department (with a particular focus on overseeing compliance with government rules and requirements) and/or the marketing department.[8] However, outside experts suggest that boards and CEOs consider creating leadership positions, functions/departments, and other expertise dedicated to community health improvement, and integrating this infrastructure into core business practices.[9] In addition, any leadership positions created should report and be accountable directly to senior administrators (ideally the CEO) and be available as appropriate to the full board and/or board-level community health committee.[10]

Practice #5: Create Senior Leader Accountability through Incentive Compensation

Community health responsibilities should be a part of the formal job descriptions of CEOs and other senior leaders, with formal goals and incentives explicitly tied to these responsibilities.[11]

Practice #6: Set Aside Dedicated Time for Full Board Discussion and Education

Experts recommend that boards set aside dedicated time to discuss their organization's commitment and performance in improving community health. Where available, board community health committees can shoulder much of the burden. These committees will typically report to the full board less frequently, perhaps once or twice a year. Along with time to discuss community health, we recommend that boards include community health education in their ongoing board education program, including the organization's commitment to improving it.

Practice #7: Require Board Members to Have Expertise in Community Health and/or Encourage Participation in Related Activities

While educational efforts can be helpful, few things are more useful than hands-on experience when it comes to learning about community health issues and opportunities for hospitals and health systems to help address them. Recognizing this fact, some boards put in place requirements for board members related to community health. For example, no one can be elected board chair at Lancaster General Hospital without having previously served as the chair of the board's Mission and Community Benefits Committee.[12] Similarly, some hospitals and health systems actively encourage their board members to be visibly involved in community health-related activities.

Practice #8: Consider a Periodic "Audit" of Community Benefit/Health Function

Outside companies with expertise in the area of community health are available to conduct a thorough review of an organization's internal capabilities with respect to community benefit

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3 K. Barnett, *Beyond the Numerical Tally: Quality and Stewardship in Community Benefit, Uniform Standards and Lessons from the Advancing the State of the Art in Community Benefit Demonstration,* Public Health Institute, 2009.

4 K. Barnett, "Building Population Health Capacity: Issues and Opportunities for Board Consideration," *BoardRoom Press,* The Governance Institute, June 2015.

5 Center for Healthcare Governance, *The Evolving Accountability of Not-for-profit Health System Boards,* American Hospital Association, 2013.

6 L. Prybil, S. Levey, R. Killian, et al., *Governance in Large Not-for-profit Health Systems: Current Profile and Emerging Patterns,* Commonwealth Center for Governance Studies, Inc., 2012. Available at www.americangovernance.com/resources/reports/governance-reports/2012/2012-prybil-report.pdf.

7 *Maximizing Community Benefit: A Six-Point Program,* Alliance for Advancing Nonprofit Health Care, April 2009. Available at www.nonprofithealthcare.org/uploads/Alliance_Report-Six-Point_Community_Benefit_Program.pdf.

8 St. Luke's Health Initiatives, "Connecting the Dots: A Health Community Leader's Guide to Understanding the Not-for-profit Community Benefit Requirements," *Arizona Health Futures,* July 2015.

9 K. Barnett, 2015.

10 Alliance for Advancing Nonprofit Health Care, 2009.

11 *Ibid.*

12 M.K. Totten, "Governing to Address Community Health Needs: Deepening Board Engagement," *Great Boards,* Issue 2, Summer 2012.

and community health improvement. Such audits can generate useful feedback on opportunities for improvement.

Step 2: Execute Effectively in Meeting ACA Community Benefit Requirements

Once an organization has the right policies, structures, and infrastructure in place, the next step is to execute effectively in meeting the specific requirements laid out in the ACA. This section describes practices that can assist in this area, with a focus on those related to community health improvement, such as the CHNA and accompanying implementation plan. (This section does not specifically address practices related to the billing and collection requirements contained in the ACA; the practices laid out in the previous section can help in ensuring compliance with those requirements.)

Practice #9: Meaningfully Engage Stakeholders throughout the Process

Hospitals need to engage community stakeholders not just as sources of input upfront, but also as ongoing, equal partners in prioritizing and addressing identified health concerns.[13] Community stakeholders should be more than "watchdogs" that hold the hospital/health system accountable for performance. Rather, they must be intimately involved and have shared accountability at all stages of the process—developing the CHNA; setting priorities; creating the implementation plan; and planning, implementing, and evaluating specific programs.[14]

Practice #10: Partner with Other Stakeholders as Equals

Hospitals and health systems can and should convene, fund, and/or facilitate community partnerships to promote health improvement. However, they should not control or lead such partnerships, but rather be seen as equal to the other partners. Success depends on all partners having good working relationships with each other and a sense of shared ownership and accountability for health.[15] Moreover, the governance of such partnerships requires the collective input of the partners and an entrepreneurial culture, not the more traditional executive governance culture employed by hospitals and health systems.[16]

Practice #11: Define Service Area and Priorities Broadly, with a Focus on Disparities

The ACA requires that the CHNA define the community that the hospital/health system serves (e.g., going beyond current patients). To make a true difference in community health, the CHNA should define the service area to include underserved communities. Experts from a panel at a 2011 public forum emphasized the importance of using U.S. census, hospital utilization data, and geographic information system technology to identify areas where health disparities exist and are leading to preventable emergency department and inpatient utilization.[17]

Practice #12: Selectively Tackle Social Determinants of Health in Areas Where the Hospital Can Make a Difference

Not surprisingly, most non-profit hospitals and health systems leaders feel most comfortable and confident in addressing problems that relate to clinical care. A handful of innovative organizations are starting to move beyond clinical care when developing their community health-related programs. These organizations are selectively focusing on social determinants of health, focusing resources and efforts on areas where the organization is positioned to make a real difference. As part of this calculation, hospitals and health systems will sometimes decide to play a lead role in addressing the issue, and other times play an active supporting role to other partners in a better position to affect meaningful change.

Practice #13: Set Clear Metrics and Monitor Progress on an Ongoing Basis

Mechanisms should exist to hold the organization and its leaders accountable for performance of community health programs, both overall and for individual programs; as noted earlier, consideration should also be given to tying a meaningful portion of CEO and senior leader compensation toward achievement of objectives.[18]

Practice #14: Share Results in a Transparent, Accessible Manner, Including Both Data and Stories

Not-for-profit hospitals and health systems need policies and programs to increase the level of transparency about community health programs and activities with both internal and external constituencies. The American Hospital Association recommends going beyond reporting of dollars spent on community health activities to tell the full story of a hospital's commitment. The effort should highlight community health activities and their impact on local residents, including the number of lives affected and individual stories of those who have benefited.[19] Ideally, hospitals and health systems should think more strategically about how to tell their stories, and consider going beyond written reports and information posted to Web sites.

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13 K. Barnett, *Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential,* Report of Proceedings from a Public Forum and Interviews of Experts, The Centers for Disease Control and Prevention, February 2012. Available at www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf.

14 The Governance Institute, 2008.

15 K. Barnett, 2015.

16 Center for Healthcare Governance, *Learnings on Governance from Partnerships that Improve Community Health: Lessons Learned from Recipients of the Foster G. McGaw Prize for Excellence in Community Service,* American Hospital Association, February 2016.

17 K. Barnett, 2012.

18 K. Barnett, 2015.

19 *AHA Guidance on Reporting of Community Benefit,* American Hospital Association. Available at http://www.aha.org/content/00-10/061113cbreporting.pdf.

Allocating Community Health Responsibilities in Health Systems: System Versus Local Boards

The boards of regional and multi-state systems have to determine whether to keep community health responsibility and accountability at the system level, allocate them to subsidiary hospital boards, or share them between the two. This decision is being made in a macro environment where many systems have been moving from a "holding-company" model of governance that relies heavily on local subsidiary boards to an "operating-company" model that diminishes the role of such boards, and in some cases eliminates them altogether.

For a variety of reasons, The Governance Institute recommends that the boards and leaders of not-for-profit healthcare systems should consider the need to keep meaningful responsibility and accountability for community health activities at the local level, at least as a shared responsibility. First and foremost, the ACA requires that CHNAs and related implementation plans be developed based on local data and local input. Moreover, as discussed throughout this white paper, the most effective plans and programs are developed and implemented in true partnership with local stakeholders. In addition, keeping primary or at least shared responsibility for community health at the local level allows system leaders to keep their local boards engaged. In an era where many other responsibilities are migrating to the system level—making local board members question the value of their involvement—keeping meaningful, important community health responsibilities at the local level may be the best way to avoid disenfranchising the many talented individuals who now serve on these local boards.

Discussion Questions for Boards and Senior Leaders

1. What do the terms "community benefit" and "community health" mean to our organization? How are they incorporated into our mission?
2. How do community health initiatives help our organization respond to payment reform and the movement towards population health management?
3. What policies, structures, and infrastructure (e.g., resource allocation, staff, leadership accountability, board-level committee) do we have in place to ensure the right culture and resources to make a difference in community health? What needs to be removed, improved, or put in place?
4. What are our short- and longer-term goals related to community health? Are they focused on underserved communities and ways in which the organization can make a meaningful difference? How do these goals fit into the strategic plan and help our population health management efforts?
5. Do the charter and work accomplished by our board-level community health/benefit committee meet the necessary requirements and will they allow us to meet short- and longer-term goals?
6. Is our full board sufficiently engaged in discussing community health concerns and making decisions related to the organization's role in improving community health?
7. What community partnerships should we pursue in order to help meet our community health goals, and what roles should we play (lead or supporting) in those partnerships?
8. How are we measuring the success of our programs, and are the metrics we are using appropriate?
9. For health systems: What is the role of our local/community board vs. the system board in determining goals and decision making regarding community health programs?

Introduction

This white paper is intended to help not-for-profit hospitals and health systems become a major catalyst for health improvement in the local community, particularly with underserved, at-risk populations.

IT INCLUDES INFORMATION TO ASSIST IN ABIDING BY AFFORDable Care Act (ACA) requirements and maintaining tax-exempt status. More importantly, the impetus for these practices goes well beyond ACA regulations, but rather is part of the organization's larger response to payment reform (i.e., the movement from fee-for-service to value- and risk-based reimbursement) and the transformation from reactive, episodic acute care to proactive management of chronic disease and population health.

While tax-exempt status can be critical for financial solvency, the responsibility of hospitals and health systems to address community health needs in ways that might be outside the purview of clinical care is increasing rapidly. Going beyond the traditional measuring of "community benefit" for the purposes of IRS reporting and meeting ACA requirements related to community health needs assessments (CHNAs), organizations are recognizing a need to embrace the more encompassing term "community health" and develop leadership and governance around efforts to better serve the community by addressing social determinants of health. As such, we refer to the term "community health" as the focus of this white paper. We refer to board-level community benefit committees as community health committees—we consider this term to be more encompassing of the true purpose of the organization in improving health, and that "community benefit" investment for IRS calculations on the Form 990 are included within the more encompassing term of "community health."

The following section covers issues related to tax-exempt status and IRS community benefit reporting requirements to serve as a backdrop and provide context regarding the increasing importance of community health and the role of hospitals and health systems in improving it. The remainder of the white paper identifies leading practices for improving community health and provides case examples from organizations innovating in leadership and governance structures to support community health improvement and build competencies and strategies to connect community health initiatives to population health management.

Potential Risks to Not-for-Profit Hospitals' Tax-Exempt Status

Not-for-profit hospitals have been exempt from various federal, state, and local taxes for roughly a century. The policy dates back to the first federal income tax code enacted in 1913, which created exemptions for charitable institutions. In addition, state and local governments have generally exempted not-for-profit hospitals from various taxes (including sales, property, and corporate taxes).[20] Increasingly, however, the tax-exempt status of not-for-profit hospitals seems to be at risk, as evidenced by four key lessons gleaned from a review of the history of tax-exempt status for not-for-profit hospitals.

Lesson #1: Tax-Exempt Status Is Worth a Lot to Hospitals, but Skepticism Exists as to Whether It Is Justified

In 2011, tax-exempt status at the federal, state, and local levels saved not-for-profit hospitals an estimated $24.6 billion, roughly double the value of the exemption in 2002.[21] In exchange for this tax exemption, not-for-profit hospitals unquestionably spend a significant amount of money on activities designed to benefit the community. A landmark study found that in 2009 hospitals spent roughly 7.5 percent of their operating expenses on community benefit.[22] An American Hospital Association (AHA) study came up with a slightly higher figure, finding that 8.2 percent of hospital expenditures went to activities that met the IRS

20 *Health Affairs,* 2016.

21 *Ibid.*

22 G. Young, C.H. Chou, J. Alexander, et al., "Provision of Community Benefits Tax-Exempt U.S. Hospitals," *The New England Journal of Medicine,* Vol. 368, No. 16, 2013; pp. 1519-1527.

definition of community benefit; including bad debt and Medicare shortfalls (something the IRS no longer allows) raises this figure to 11.3 percent.[23]

What is less clear, however, is whether this level of spending on community benefit meets the value of the tax exemption and/or minimum spending thresholds that have been established in some states, or whether not-for-profit hospitals do significantly more than their for-profit counterparts and hence "deserve" the tax exemption. Two state-specific studies suggest that community benefit spending by not-for-profit hospitals more than justifies the tax exemption. One comes from Maryland, where a study covering the period between 2010 and 2012 found that the hospitals provided substantially more in community benefit than the financial support provided by governments to the hospitals (including the value of their tax-exempt status).[24] A second comes from California, where a 2009 review of not-for-profit hospitals found that very few meet minimum spending thresholds when community benefit is narrowly defined as charity care, but most meet them when the definition is broadened to match the activities laid out on Schedule H of IRS Form 990.[25]

Comparisons between not-for-profit and for-profit hospitals paint a less clear picture, however. A 2009 study of 193 short-term, private, acute-care community hospitals in California found that ownership type (for-profit versus private not-for-profit) did not make a significant difference in the provision of uncompensated care.[26] A more recent study of California hospitals found that not-for-profit hospitals spent a significantly greater portion of operating expenses on charity care than did for-profit facilities, but found no significant difference in spending on total uncompensated care (charity care plus bad debt).[27] A study of 3,317 hospitals in 2006 found that not-for-profit hospitals spent significantly more on community benefit activities (other than uncompensated care) than do for-profit facilities.[28]

Perhaps most troubling to external stakeholders is the wide cross-hospital variation in spending on community benefit activities. The aforementioned landmark 2009 study found that community benefit spending varied dramatically across not-for-profit hospitals, ranging from 1 to 20 percent of operating expenses. These wide variations do not appear to be related to community need (e.g., per-capita income, insurance status), but rather to the presence of state-level requirements for broad reporting on community benefit activities.[29] Consequently, it is no surprise that some stakeholders at the national, state, and local levels are calling for increased scrutiny and regulations related to the tax-exempt status of not-for-profit hospitals. They are also questioning the degree to which hospitals are in fact offering free or discounted care to those who need it, given the many well-publicized stories of financial hardship due to medical bills, and the sobering fact that more than 60 percent of personal bankruptcies and roughly half of residential foreclosures in the United States have historically been due to medical debt.[30]

While the bylaws, mission and vision statements, and/or corporate policies of most not-for-profit hospitals and health systems usually speak to the organization's commitment to identifying and meeting the healthcare needs of the local communities, seldom are these commitments formalized in an explicit manner, and this gap invites scrutiny by the media and the public.[31] This heightened scrutiny could lead to more challenges to the tax-exempt status of not-for-profit hospitals and health systems.[32] For example, a judge ruled that Morristown Medical Center was no longer entitled to its property tax exemption because for-profit medical services were provided throughout the hospital, with no separate accounting between not-for-profit and for-profit activities. This ruling became a driver for several other local jurisdictions to add not-for-profit hospitals to their tax rolls. These rulings and actions have become the subject of multiple lawsuits filed by not-for-profit hospitals, and have spurred the introduction of legislation to provide greater clarity on what not-for-profit hospitals must do to maintain their tax-exempt status in the state.[33] Another example comes from Illinois, where the state Supreme Court is reviewing a case on the constitutionality of exempting not-for-profit hospitals in the state from paying property taxes.[34] Finally, another well-known case comes from Pennsylvania, where in 2013 the city of Pittsburgh filed a suit challenging UPMC's tax-exempt status, claiming that the medical center should pay an estimated $20

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23 S. Rosenbaum, A. Rieke, and M. Byrnes, "Hospital Community Benefit Expenditures: Look Behind the Numbers," *HealthAffairs* Blog, June 11, 2013.

24 J.S. Turner, K.D., Broom, J.A. Goldner, and J.F. Lee, "What Should We Expect? A Comparison of the Community Benefit and Projected Government Support of Maryland Hospitals," *Medical Care Research and Review,* Vol. 73, No. 2, 2016; pp. 205-226.

25 S.R. Singh, "Community Benefit in Exchange for Not for Profit Tax Exemption: Current Trends and Future Outlook," *Journal of Health Care Finance,* Vol. 39, No. 3, 2013; pp. 32-41.

26 T.H. Kim, M.J. McCue, and J.M. Thompson, "The Relationship of Financial and Mission Factors to the Level of Uncompensated Care Provided in California Hospitals," *Journal of Healthcare Management,* Vol. 54, No. 6, Nov/Dec 2009; pp. 383-402.

27 E. Valdovinos, S. Le, and R.Y. Hsia, "In California, Not-for-Profit Hospitals Spent More Operating Expenses on Charity Care Than For-Profit Hospitals," *Health Affairs,* Vol. 34, No. 8, August 2015; pp. 1296-1303.

28 P.H. Song, D.L. Shoou-Yih, J.A. Alexander, and E.E. Sieber, "Hospital Ownership and Community Benefit: Looking Beyond Uncompensated Care," *Journal of Healthcare Management,* Vol. 58, No. 2, March/April 2013; pp. 126-42.

29 G. Young, et al., 2013.

30 M.H. Somerville, "Community Health Needs Assessment: Legal Requirements, Practical Opportunities," The Hilltop Institute, presentation at AcademyHealth Annual Research Meeting, June 25, 2013.

31 Center for Healthcare Governance, 2013.

32 *Ibid.*

33 B. Inniss, B. Tan, and C.H. Woodcock, "Hospital Community Benefits after the ACA: Trends in Community Benefit Legislation, November 2015–May 2016," Issue Brief, The Hilltop Institute, June 2016.

34 B. Inniss, et al., 2016.

million a year in payroll and property taxes.[35] UPMC later filed a countersuit and by mid-2014 both sides agreed to drop their respective lawsuits.[36]

Lesson #2: Legislative and Regulatory Changes Are Pushing Not-for-Profit Hospitals to Focus More on Community Health Improvement

For well over half a century, hospitals typically qualified for tax exemptions by providing free or discounted care to patients unable to pay for it on their own. However, beginning in 1969, the federal government began what has become a slow but steady series of changes designed to get not-for-profit hospitals to focus more broadly on promoting community health improvement. That year, the IRS broadened the definition of community benefit activities to include not only the provision of free/discounted care, but also general activities designed to benefit the communities that not-for-profit hospitals serve. The impetus for this 1969 change came in large part from the passage of Medicare and Medicaid legislation earlier in the decade, which significantly increased the number of insured individuals and hence created an expectation that hospitals would face a reduced need to provide charity care and discounted services.[37]

While little else happened at the federal level over the next several decades, many states began to enact their own regulations and standards related to the provision of community benefit activities, with at least some of the focus being on investing in community health improvement activities. Then, in 2008, the IRS narrowed the definition of what kinds of free and discounted patient care services can be considered community benefit activities. In that year, the IRS began requiring a new Schedule H worksheet (attached to the Form 990) that provides greater clarity on which activities do and do not qualify. Of note, while Schedule H includes a place to report bad debt (nonpayment by patients who do not qualify for charity care) and gaps between Medicare payments and costs, it explicitly does not consider either of them to be a part of a hospital's community benefit activities.[38] Many hospitals historically reported these figures as part of community benefit activities, but Schedule H ended this practice.

A few years later in 2010, the ACA signaled the beginning of a new era with respect to the tax-exempt status of not-for-profit hospitals. The ACA created an expectation that there would be many fewer uninsured individuals in this country, due both to state Medicaid expansions and the combination of the individual mandate and tax subsidies for those unable to afford coverage on their own. With many fewer uninsured, lawmakers felt that not-for-profit hospitals would no longer need to provide the same level of charity and discounted care. In addition, as noted, most states have some standards and regulations related to the provision and reporting of community health-related services and activities. In some states, the ACA standards overlap with these standards, while in others the state standards either exceed or are less stringent than those at the federal level.[39]

While debate over the impact and future of the ACA continues, there is no doubt that external stakeholders, including regulators, lawmakers, and the public at large, increasingly believe that not-for-profit hospitals and health systems must do more in the area of community health improvement in order to justify their tax-exempt status. Part of these demands comes from simple math—with fewer uninsured individuals, these organizations face less of a need to provide charity and discounted care. Nationally, the estimated percentage of Americans without insurance fell from 17.1 percent in the fourth quarter of 2013 to 11.0 percent in the first quarter of 2016;[40] applying this decline to the population as a whole (roughly 320 million in 2015) suggests that nearly 20 million more Americans have insurance than they did four years ago. This fact is not lost on federal and state regulators. For example, the U.S. Department of Health and Human Services estimates that Medicaid expansions alone will reduce the level of uncompensated care spending by roughly $4.7 billion, thus creating an opportunity for not-for-profit hospitals to shift community benefit spending away from charity care to other activities.[41] In a related example, Arizona officials have noted that 300,000 residents have secured coverage through Medicaid as a result of

35 E. Rosenthal, "Benefits Questioned in Tax Breaks for Nonprofit Hospitals," *The New York Times,* December 16, 2013.
36 R. Zullo, "UPMC, city drop legal fight over taxes," *Pittsburgh Post-Gazette,* July 29, 2014.
37 The Governance Institute, 2008.
38 *Health Affairs,* 2016.
39 M.H. Somerville, G.D. Nelson, and C.H. Mueller, "Hospital Community Benefits after the ACA: The State Law Landscape," Issue Brief, The Hilltop Institute, March 2013.
40 S. Marken, U.S. Uninsured Rate at 11%, Lowest in 8-Year Trend," Gallup, April 7, 2016. Available at www.gallup.com/poll/190484/uninsured-rate-lowest-eight-year-trend.aspx.
41 St. Luke's Health Initiatives, 2015.

ACA, which means that Arizona hospitals have a reduced burden to provide charity care.[42]

Historically, tax-exempt hospitals have not altered their spending on community health initiatives in response to changes in more traditional charity care activities. For example, a review of the activities of Maryland hospitals between 2006 and 2010 found no evidence that hospitals trade-off between charity care and activities targeted at the health and well-being of the community at large. In other words, hospital spending on charity care did not affect spending on other community-benefit activities.[43] Going forward, external stakeholders may begin to demand such a change—with the number of uninsured having fallen significantly, they will likely begin to expect an increased commitment from not-for-profit hospitals and health systems to community benefit activities that have traditionally received relatively little attention: community health improvement.

Lesson #3: Despite These Pressures, Spending Has Historically Been Disproportionately Targeted at Free and Discounted Care (Not Community Health Improvement)

For the most part, the 1969 change did not have a major impact on the kinds of community benefit activities undertaken by not-for-profit hospitals, with the vast majority of such expenditures still being comprised of free and discounted care to the uninsured and underinsured, including to Medicaid and Medicare beneficiaries. Even by the time Schedule H came along in 2008 and the ACA became law in 2010, the story remained largely the same. In fact, a, review of 2009 spending by not-for-profit hospitals found that 85 percent of total community benefit expenditures related to such care, with 25 percent being charity (i.e., "free") care for those unable to pay for services, 45 percent being the unreimbursed costs of means-tested government programs (such as Medicaid), and 15 percent being subsidized health services or discounts to those unable to pay "full" price. Only 15 percent went to activities that more generally benefited the local community, such as education, research, social programs and services, and supporting community groups and activities.[44] Similarly, a 2011 study found that not-for-profit hospitals spent less than 10 percent of total expenses on community benefit activities, with over half of this activity being free or discounted care and approximately 40 percent being other community benefits, including 5 percent directed toward community health improvement.[45] Analysis of spending in individual states shows a similar pattern. For example, in 2007, Arizona hospitals spent almost $1.65 billion on community benefit, with the vast majority going to the provision of charity care and only $10 million being spent on community-building or health improvement activities.[46] In 2009, Wisconsin hospitals spent over $1 billion in total on community benefit, but only 4.4 percent of that money went to services and activities designed to improve community health.[47] Even in communities with greater health needs, not-for-profit hospitals and health systems continue to focus community-benefit activities on the provision of discounted and charity care. For example, a study of 2009 data from 1,522 private, tax-exempt hospitals throughout the U.S. found that those located in communities with greater health needs spent more as a percentage of their operating budgets on community benefit directly related to patient care; the same study found no relationship between spending on community health improvement and actual community health needs.[48]

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42 St. Luke's Health Initiatives, 2015.

43 S.R. Singh, "Not-for-Profit Hospitals' Provision of Community Benefit: Is There a Trade-off Between Charity Care and Other Benefits Provided to the Community?" *Journal of Healthcare Finance,* Vol. 39, No. 3, 2013; pp. 42-52.

44 G. Young, et al., 2013.

45 *Health Affairs,* 2016.

46 St. Luke's Health Initiatives, 2015.

47 E. Bakken, D.A. Kindig, "Is Hospital 'Community Benefit' Charity Care?" *Wisconsin Medical Journal,* Vol. 111, No. 5, October 2012; pp. 215-219.

48 S.R. Singh, G.J. Young, D.L. Shoou-Yih, et al., "Analysis of Community Health Benefit Expenditures' Alignment with Community Health Needs: Evidence From a National Investigation of Tax-Exempt Hospitals," *American Journal of Public Health,* Vol. 105, No. 5, May 2015; pp. 914-921.

Leading Practices for Improving Community Health

Given the heightened scrutiny and new state and federal regulations related to community health activities, we charge boards and senior executives at not-for-profit hospitals and health systems to examine their organization's commitment to community health improvement, including a review of related policies, structures/infrastructure, and processes.

THIS EXAMINATION SHOULD KEEP IN MIND THE ACA-MANdated requirements, along with state and/or local regulations. The ACA does not specify a dollar amount for community health activities that a not-for-profit hospital or health system must provide. However, it adds several major requirements that must be fulfilled to avoid fines and penalties and maintain tax-exempt status. While several of these requirements relate to policies and processes for charity/discounted care for the uninsured and underinsured[49] (a familiar topic for most non-profit hospitals/health systems), the ACA does establish three requirements related to broader community health improvement:

- Conduct a community health needs assessment (CHNA) at least every three years, with broad input from the community, including but not limited to public health officials. This assessment must address financial and other barriers to care, prevention of illness, and non-medical, social determinants of health (e.g., nutrition, housing, health-related behaviors).
- Document the CHNA in a written report made widely available to the public, including on a Web site.
- Develop an implementation plan to address the documented needs, including a review of which documented needs will and will not be addressed (with explanations for those that will not be addressed). The implementation plan must be completed and submitted by the end of the same tax year in which the CHNA was conducted.[50]

This white paper is intended to help not-for-profit hospitals and health systems not only abide by these new ACA requirements, but, more importantly, position their organizations to be a major catalyst for health improvement in the local community, particularly with underserved, at-risk populations. In many cases, the impetus for these practices goes well beyond ACA regulations, but rather is part of the organization's larger response to payment reform (i.e., the movement from fee-for-service to value- and risk-based reimbursement) and the transformation from reactive, episodic acute care to proactive management of chronic disease and population health.

The following sections of the white paper feature examples from several organizations that are following leading practices to improve community health. We conducted interviews with three organizations for original case studies for this white paper: Dignity Health, Providence Health & Services, and Boston Children's Hospital. Examples from these case studies are included throughout the relevant sections of this white paper. The complete case studies can be accessed at www.governanceinstitute.com/whitepapers.

Step 1: Create the Right Policies, Structures, and Infrastructure

The first step is to put in place appropriate policies, structures, and infrastructure to ensure that the organization has the right culture and sufficient resources to make a difference in the area of community health improvement. This section details leading practices in these areas.

Practice #1: Develop an Organization-Wide Community Health Policy

Boards should consider developing and approving a community health policy for the organization consistent with its mission and vision statements. This policy statement serves as a way to formalize the organization's—and the board's—commitment to engaging in activities to address identified community health needs. The policy should specify the role of the board and organization with respect to community health, and in some cases may speak to the type of infrastructure (e.g., staffing, dedicated department/office, reporting relationships) and activities (e.g., community-based partnerships, collaborative CHNAs, performance measurement) the hospital/health system has or will put in place as part of this commitment.[51] For example, Dignity Health's system-level board approved a central policy that lays out its role and that of local hospital community boards with respect

49 These policies include: developing and publicizing a written financial assistance policy related to the provision of free or discounted care; abiding by limitations on what patients eligible for financial assistance can be charged for emergency and medically necessary care; and avoiding extraordinary collection activities before making reasonable efforts to determine if the patient is eligible for financial assistance under the hospital's stated policy.

50 G.D. Nelson, "Community Health Needs Assessment: A Tool for Improving Community Health," The Hilltop Institute, presentation as part of National Association of Counties Webinar entitled, *Using the Community Health Needs Assessment to Inform Policymaking,* May 30, 2013.

51 The Governance Institute, 2008.

to community health related activities. The policy charges each of Dignity's community hospital boards with participating in the process for establishing priorities, plans, and programs; approving the CHNA and implementation plan; and monitoring progress toward identified goals. The same policy speaks to the level of staffing and resource infrastructure that Dignity will devote to community health improvement and discusses the organization's commitment to meeting all state and federal regulatory requirements. By design, this policy explicitly references the organization's overall mission and values, including reference to Dignity's five guiding principles: collaboration with other organizations, promoting a seamless continuance of care, emphasizing prevention, addressing unmet health needs, and building community capacity to build and promote health.[52,53] Along with the central policy, the Dignity system board has approved several "subsidiary" policies that relate to community health, including policies focused on financial assistance, charity care, and accounting for community health activities for reporting purposes.[54] (A sample community health and benefit policy is available at www.governanceinstitute.com/templates.)

Practice #2: Make a Concrete Monetary Commitment to Community Health Improvement

Some not-for-profit hospitals and health systems have made public commitments to spend a certain minimum dollar amount or percentage of operating expenses or profits on community health improvement. These pledges are usually separate from the amount spent to provide discounted or charity care to the uninsured/underinsured. Examples include the following:

- **Beacon Health System**: Located in South Bend, IN, Beacon pledges 10 percent of its prior year's operating profits to be invested in community health initiatives that align with the organization's mission, vision, and values, and that address one or more health priorities identified in the CHNA. Investment decisions are guided by a Tithing and Community Benefit Investment Policy that requires investments in activities that generate a measurable impact on the community.[55]
- **Dignity Health**: Dignity commits to dedicating .05 percent of each facility's prior-year audited expenses to its community grants program, which supports local collaborative programs focused on community health improvement. In aggregate, this figure translates to approximately $5 million a year in support. Dignity also allocates up to $750,000 a year to serve as "seed money" to stimulate innovation in low-income communities.[56]
- **Providence Health & Services**: Providence[57] has for many years committed to spending 10 percent of its net operating revenues on community benefit activities. While much of that spending has historically been "reactive" in nature (e.g., providing charity care for the uninsured), the organization's board and senior leaders have committed to increasing the amount focused on proactive community health improvement.[58]
- **Palmetto Health**: After merging to form Palmetto Health in the late 1990s, privately owned Baptist Hospital and county-owned Richland Memorial Hospital each pledged $750,000 to be dedicated to high-priority community health initiatives identified by members of the community. Each year, the five-hospital system commits to spending 10 percent of its bottom-line on such initiatives. Over 15 years, the total amount spent has been roughly $50 million.[59]
- **St. Joseph's/Candler Health System**: The board finance committee at St. Joseph's/Candler allocates funds to community health outreach programs, and, as a matter of policy, the committee will not reduce this budget. In addition, the full board and its committees place investments in community health at the same priority as those targeted at medical technology and equipment.[60]

Another strategy is to dedicate a portion of investment portfolio funds to community development activities that address social determinants of health, such as access to healthy food, hunger, and housing. Several not-for-profit systems, including Bon Secours Health System, Dignity Health, ProMedica, and Trinity Health, work with other stakeholders and sectors to improve community health through investments in community development, including dedicating a portion of their investment portfolios to the provision of low-interest community development loans. Often these relatively small loans are made available at the pre-development phase—when other sources of funding are scarce—to support planning, securing of permits, and infrastructure development.[61] At Dignity, for example, the system board approves up to 5 percent of the organization's depreciated investment pool to be invested in the local community to address social determinants of health. System leaders typically ask for an allocation from this pool each year. While, in theory, the 5

52 M.K. Totten, 2012.

53 Telephone interview conducted on October 5, 2016, with Pablo Bravo, Vice President of Community Health, and Michael Bilton, Senior Director of Community Health and Benefit, Dignity Health.

54 *Ibid.*

55 Center for Healthcare, 2016.

56 Telephone interview conducted on October 5, 2016, with Pablo Bravo, Vice President of Community Health, and Michael Bilton, Senior Director of Community Health and Benefit, Dignity Health.

57 Renton, Washington-based Providence is part of Providence St. Joseph Health, the new parent organization created by Providence and Irvine, California-based St. Joseph Health in 2016. Because the two health systems recently came together, the information in this white paper focuses on community health activities at Providence Health & Services.

58 Telephone interview with Dora Barilla, D.P.H., Executive Leader of Community Investment, Providence Health & Services, conducted on October 7, 2016.

59 Center for Healthcare Governance, 2016.

60 *Ibid.*

61 K. Barnett, 2015.

percent figure could translate into a $300 million annual investment, the typical requested allocation is $100 million a year.[62]

Practice #3: Create a Board-Level Community Health Committee

Most boards lack the breadth and depth of competencies and dedicated time needed to offer more than a cursory review of CHNAs and related implementation strategies, and to ensure the optimal use of charitable resources.[63,64] In fact, boards themselves seem to recognize that they are less well-equipped to handle oversight of community health activities than other core duties and responsibilities. The Governance Institute's Biennial Survey of Not-for-Profit Hospitals and Healthcare Systems has consistently found that boards rank their overall performance on community benefit oversight relatively low compared to other core duties—typically last or second-to-last[65] in a list of nine areas.[66]

To address this knowledge and resource deficit, The Governance Institute and other organizations recommend that boards of not-for-profit hospitals and health systems create a standing committee with oversight responsibility for community health policies and programs.[67,68,69] To date, however, most not-for-profit hospitals and health systems have not put such committees in place. In the most recent Governance Institute Biennial Survey (2015), just over a quarter (26 percent) of respondents had formed such a committee. While substantially higher than the 15 percent that reported having done so in 2009, almost three quarters of respondents still do not have such committees in place, even with the new ACA requirements.[70] Among hospitals that are subsidiaries of larger systems the prevalence of board-level community health committees is a bit higher (34 percent)—but still fairly low overall. This is consistent with the general view that oversight for community health activities should reside locally whenever possible.[71]

In creating this committee, the board should lay out its specific roles and responsibilities and ensure that they are used to guide its decision making.[72] A formal charter should outline specific areas of oversight.[73] The charter should also lay out the roles of committee members and the criteria and process for selecting members, setting priorities for and allocating resources to community health activities, and monitoring the impact of these activities.[74,75] The committee should include several board members, but the majority of members should be representatives of external stakeholders and have relevant competencies and skills in areas such as public health, health disparities, and population health management (PHM).[76] This expertise is becoming increasingly important as many boards (roughly 60 percent in 2015) add new population health-related goals; to date, however, very few (roughly 4 percent in 2015) have added board members with expertise in PHM.[77]

Brief descriptions of organizations that have established board-level community health committees include the following:

- **Boston Children's Hospital**: Over a decade ago, Boston Children's board created a formal board committee focused on community service activities. The committee is made up of a mix of individuals from inside and outside Boston Children's Hospital. Meeting at least four times a year, this committee has overall responsibility for approving the community health needs assessment and implementation plan, reviewing compliance and reporting to regulatory agencies; and it regularly performs, along with the full board, a review of major community health programs.[78]
- **Presbyterian Intercommunity Hospital**: The board of this hospital, located in Whittier, CA, established a Community Benefit Oversight Committee made up of board members, community stakeholders (including from public health), and hospital senior administrators. This committee develops the hospital's Community Health Improvement Plan, which details strategies for addressing priority areas. A recent plan highlighted three such areas: healthy living, health management, and health access. The full board approves the plan and allocates resources to support its execution. The committee holds an annual meeting

62 Telephone interview conducted on October 5, 2016, with Pablo Bravo, Vice President of Community Health, and Michael Bilton, Senior Director of Community Health and Benefit, Dignity Health.
63 K. Barnett, 2009.
64 K. Barnett, 2015.
65 K. Peisert, *21st Century Care Delivery: Governing in the New Healthcare Industry,* 2015 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.
66 The nine areas are: duty of care, duty of loyalty, duty of obedience, quality oversight, financial oversight, management oversight, strategic direction, community benefit and advocacy, and board development.
67 Center for Healthcare Governance, 2013.
68 L. Prybil, et al., 2012.
69 Alliance for Advancing Nonprofit Health Care, 2009.
70 K. Peisert, 2015.
71 *Ibid.*
72 K. Barnett, 2009.
73 K. Barnett, 2015.
74 K. Barnett, 2009.
75 The Governance Institute, 2008.
76 K. Barnett, 2015.
77 K. Peisert, 2015.
78 Telephone interviews conducted with Josh Greenberg, Director of Government Relations (on October 10, 2016), and Sandra Fenwick, CEO (on October 12, 2016), Boston Children's Hospital.

to evaluate the hospital's community health programs, including their impact on measurable outcomes. These results are reported to the full board, along with committee recommendations for ongoing resource allocations and program changes or enhancements.[79]

- **Kaiser Foundation Health Plan**: The board of Kaiser Foundation Health Plan created a Community Benefit Committee that consists of at least four board members and may also include up to three others as full voting members. The chair of the committee must have an understanding of community and government expectations for not-for-profit healthcare organizations, federal requirements related to tax exemption, and community health approaches such as improving care and access for vulnerable populations, promoting community health, and engaging in research and education.[80] (The committee's charter, which includes additional details on its composition, authority, and duties, can be found at: www.americangovernance.com/resources/tools/kaiser-community-benefit.pdf.)
- **Allegiance Health**: The board of Allegiance Health, located in Jackson, MI, created a Health Improvement Organization (HIO) Committee of its board that has voting members from the board and the community, along with several non-voting members (the board chair, CEO, chief of staff, and director of prevention and community health). The committee oversees the system's investment in community health improvement, including a review of community health metrics that are part of a balanced scorecard. A coordinating council made of over 30 community stakeholders takes the lead in planning and reports to the HIO Committee.[81]
- **Beacon Health System**: Each hospital within Beacon Health System has created a Community Benefit Council or Community Health/Engagement Council that plays an advisory role, bringing forward opportunities in the community, evaluating and making recommendations regarding funding applications, and reviewing the results of already-funded projects. Made up of board members, hospital staff, and non-medical community representatives, these councils report to the system board.[82]
- **St. Joseph's/Candler Health System**: The system board set up a mission and ethics committee to oversee community health initiatives. The committee is not guided by a separate charter, but rather by the mission and vision for the entire organization. The committee reviews the results from the CHNA (conducted in collaboration with another area hospital) and monitors progress toward achieving stated goals and objectives. [83]

(A sample community health and benefit committee charter is available at www.governanceinstitute.com/templates.)

Practice #4: Create a Dedicated Department, with a Leader Accountable to the CEO for Performance

Many not-for-profit hospitals and health systems do not have dedicated departments, divisions, or other permanent bodies focused on community health initiatives. Instead, such activities reside within the finance department (with a particular focus on overseeing compliance with IRS/ACA rules and requirements) and/or the marketing department.[84] However, outside experts suggest that boards and CEOs of not-for-profit hospitals and health systems consider creating leadership positions, functions/departments, and other expertise dedicated to community health improvement, and integrating this infrastructure into core business practices. This investment should likely include geographic information systems (GIS) that provide coded demographic and related data to help identify the specific needs of individual communities and populations.[85] In addition, any leadership positions created should report and be accountable directly to senior administrators (ideally the CEO) and be available as appropriate to the full board and/or board community health committee.[86]

79 M. K. Totten, 2012.
80 www.americangovernance.com/resources/tools/kaiser-community-benefit.pdf.
81 Center for Healthcare Governance, 2016.
82 *Ibid.*
83 *Ibid.*
84 St. Luke's Health Initiatives, 2015.
85 K. Barnett, 2015.
86 Alliance for Advancing Nonprofit Health Care, 2009.

ASACB Recommendations

The Advancing the State of the Art in Community Benefit (ASACB) Demonstration project, a Public Health Institute-supported collaboration of 70 not-for-profit hospitals from California, Texas, Arizona, and Nevada, developed the following recommendations that may be relevant to hospitals and health systems interested in setting up departments dedicated to community health activities: [87]

- Establish formal mechanisms to integrate community health planning and budgeting with organizational strategic planning to ensure continuity and proactive investment.
- Develop job description(s) that outline specific responsibilities and competencies needed for staff.
- Have a minimum of one full-time equivalent employee dedicated to ongoing management.
- Ensure that senior managers who supervise community benefit staff have the appropriate competencies.
- Develop formal mechanisms to inform and encourage the involvement of key leaders and employees.
- Develop formal plans that outline strategies to be implemented for a minimum of three years.

What follows are brief descriptions of organizations that have dedicated significant resources—including management and staff—to community benefit-related activities:

- **Dignity Health**: At the system level, Dignity Health has a Community Health Department with five full-time employees. The department is run by a vice president who reports to the Executive Vice President of Mission Integration and oversees all community health related activities. The department's senior director focuses on supporting the activities of the local hospitals, including identifying and rolling out effective, evidence-based programs; coordinating across communities; providing operational support and technical assistance; and developing and disseminating standardized templates, protocols, and other infrastructure. This individual also spends substantial time forging partnerships with other stakeholders and educating members of the system and local boards about community health activities and requirements. In addition to this system-level department, larger Dignity hospitals typically have their own dedicated community health director, while smaller hospitals either share a community health director or have an individual in this position who also has other, related responsibilities.[88]
- **Boston Children's Hospital**: Approximately seven years ago, Boston Children's separated its government relations and community health functions into two distinct areas. (Previously, both were part of the Office of Child Advocacy.) This change was made in recognition of the heightened importance of both functions and the increased responsibilities faced by department leaders and staff. At present, the community health function is overseen by an executive director who is also a practicing physician in one of the hospital's primary care centers. Her staff of roughly half a dozen individuals work on major initiatives approved by the board community service committee and also handle all reporting requirements related to community benefit at the local, state, and federal levels. In addition, one staff member takes responsibility for developing internal and external communications related to the hospital's community health programs. The executive director reports directly to the Senior Vice President of Network Development, and routinely updates the CEO, the COO, and the board community service committee.[89]
- **Henry Ford Health System**: Henry Ford created a Community Pillar Team that develops the CHNAs and accompanying implementation plans, which then become part of the system's overall strategic plan. Co-chaired by senior-level executives, this team meets quarterly to discuss strategies and review performance against an established dashboard. A system-level Community Benefit Team takes charge of data collection and prioritization of activities that come out of the CHNAs. It also oversees development of business unit-level implementation plans. Each business unit has its own community benefit committee that meets quarterly and ensures that community health improvement initiatives are built into operational plans. These committees report to local operating boards, which in turn report to the system board.[90]
- **Palmetto Health**: Palmetto has a chief community health services officer who reports directly to the CEO and the board's community health committee. This individual has six direct reports who collectively manage roughly 100 full-time staff within the community health services division. The chief community health services officer leads the Community Outreach Task Force that determines how to spend the annual allotment (10 percent of profits) dedicated to community health activities.[91]
- **Crozer-Keystone Health System**: Located in Springfield, PA, this system has a Community Health Education Department with dedicated staff who work on CHNAs, data analyses, development of priorities, and implementation activities. Department leaders sit at the executive level, allowing them to keep

87 K. Barnett, 2009.

88 Telephone interview conducted on October 5, 2016, with Pablo Bravo, Vice President of Community Health, and Michael Bilton, Senior Director of Community Health and Benefit, Dignity Health.

89 Telephone interviews conducted with Josh Greenberg, Director of Government Relations (on October 10, 2016), and Sandra Fenwick, CEO (on October 12, 2016), Boston Children's Hospital.

90 Center for Healthcare Governance, 2016.

91 *Ibid.*

the board aware of community needs, existing health system activities, and progress to date.[92]

- **St. Joseph Hospital and Medical Center**: This Phoenix-based hospital created a division known as Community Health Integration that works to fulfill the hospital's community benefit requirement through community engagement and partnerships with key stakeholders.[93]
- **Mt. Ascutney Hospital and Health Center**: The board of this 35-bed facility in Vermont created a Community Health Foundation Advisory Board that serves as a financial agent for many local not-for-profit organizations, managing and reporting on grant funding to support community health initiatives. The foundation reviews and approves need-based allocations to maintain the financial viability of community initiatives. Grants secured by the foundation support 4.7 full-time equivalent staff dedicated to community health services.[94]
- **Mercy Health Partners**: In 1997, this large hospital-based system created its own community health benefit office. Known as the Muskegon Community Health Project, this initiative works with 38 local organizations (e.g., public health, education, law enforcement, substance abuse) to address key issues such as tobacco, alcohol, and prescription drug abuse. [95]

Embedding Department Staff on Teams Making Resource Allocation Recommendations

Senior leaders should consider embedding community health department staff at the system and local levels on system and business unit teams that make recommendations to senior management about resource allocation decisions. For example, Providence Health & Services integrates members of its community benefit team with new business and resource allocation groups. The goal of this hybrid design is to ensure community and population health issues are considered when making business and resource allocation recommendations. This collaborative environment helps team members identify opportunities to fund and support investments aimed at improving community health, such as the creation of homeless shelters, behavioral health centers and job training programs.[96]

Practice #5: Create Senior Leader Accountability through Incentive Compensation

Community health responsibilities should be a part of the formal job descriptions of CEOs and other senior leaders, with formal goals and incentives explicitly tied to these responsibilities.[97] The ASACB project recommends that senior leaders of an organization be made directly accountable for performance related to community benefits and community health. [98] To that end, the board should consider tying a meaningful portion of incentive compensation for the CEO and other senior executives to achievement of specific objectives and targets laid out in the CHNA.[99] (These objectives can work in conjunction and/or overlap with population health metrics that are tied to the incentive compensation as well.) For example:

- **Boston Children's Hospital**: The board and the CEO hold the executive directors and vice presidents of community health and government relations accountable for meeting specific performance goals within the four aforementioned priority areas as a component of their overall evaluations, and their performance review and level of incentive compensation depends in large part on their ability to meet those goals. At the programmatic level, staff members are responsible for seeing that actions are completed consistent with programmatic goals, as well as attending to and reporting back on objectives to the board and CEO. A special emphasis is placed on establishing this work with their teams. Programmatic goals include improvement within a specific area, such as a program's ability to get children to engage in more physical activity or eat more healthfully. In other cases, program goals may relate to maintaining a positive impact that has already been achieved and/or spreading a successful small-scale program broadly throughout the community.[100]
- **Providence Health & Services**: Community benefit spending is one of a handful of metrics used at the system level to inform incentive compensation. This metric aims to bring visibility to the impact and value of community benefit and encourage executive leadership to support activities that enhance the well-being of their communities.[101]

Practice #6: Set Aside Dedicated Time for Full Board Discussion and Education

Just as boards routinely carve out scarce meeting time to talk specifically about the quality and safety of patient care, experts recommend that boards set aside dedicated time to

92 *Ibid.*
93 St. Luke's Health Initiative, 2015.
94 Center for Healthcare Governance, 2016.
95 "Partner with Not-for-profit Hospitals to Maximize Community Benefit Programs' Impact on Prevention," Issue Brief, Trust for Health, January 2013. Available at http://healthyamericans.org/assets/files/Partner%20With%20Nonprofit%20Hospitals04.pdf.
96 Telephone interview with Dora Barilla, D.P.H., Executive Leader of Community Investment, Providence Health & Services, conducted on October 7, 2016.
97 Alliance for Advancing Nonprofit Health Care, 2009.
98 K. Barnett, 2009.
99 The Governance Institute, 2008.
100 Telephone interviews conducted with Josh Greenberg, Director of Government Relations (on October 10, 2016), and Sandra Fenwick, CEO (on October 12, 2016), Boston Children's Hospital.
101 Telephone interview with Dora Barilla, D.P.H., Executive Leader of Community Investment, Providence Health & Services, conducted on October 7, 2016.

discuss their organization's commitment to and performance in improving community health. While recent data is not available, it is not clear whether boards are heeding this advice. In 2008, CEOs of not-for-profit community health systems reported that their boards spent only 7.2 percent of their time on community benefit oversight, including community health improvement.[102]

Some organizations, however, do set aside time during full board meetings to discuss community health related activities. For example, at the beginning of each board meeting at St. Joseph's/Candler Health System (located in Savannah, GA), the board hears a report from the CEO on how the system is doing in fulfilling its mission. A significant portion of that report is an in-depth review of community health initiatives.[103]

Where available, board-level community health committees can shoulder much of the burden when it comes to devoting dedicated time to discussing and reviewing community health initiatives. As described earlier, these committees typically meet frequently (as often as monthly), often for several hours at a time. These committees will typically report to the full board less frequently, perhaps once or twice a year.

Along with time to discuss community health, boards need dedicated time to be educated on it. In 2012 Dignity Health revised its board orientation manual to include a comprehensive description of the organization's community health commitment, policies, and programs, and added a list of questions that board members can ask about these issues. Dignity also intensified its board education efforts around community health.[104] Similarly, Good Samaritan Hospital in Kearney, NE, revamped its board orientation process to focus more on the board's oversight role with respect to community health assessment, evaluation, and improvement, and made the CHNA the subject of a board education program.[105]

Practice #7: Require Board Members to Have Expertise in Community Health and/or Encourage Participation in Related Activities

While educational efforts can be helpful, few things are more useful than hands-on experience when it comes to learning about community health issues and opportunities for hospitals and health systems to help address them. Recognizing this fact, some boards put in place requirements for board members related to community health. For example, no one can be elected board chair at Lancaster General Hospital without having previously served as the chair of the board's Mission and Community Benefits Committee. This requirement ensures the board chair understands community health-related issues and assessment data.[106]

Similarly, some hospitals and health systems actively encourage their board members to be visibly involved in community health related activities. For example, board members at Presbyterian Intercommunity Hospital in Whittier, CA, regularly participate in conversations with community stakeholders to gather input on local needs. Board involvement in this process sends a highly visible signal to the community that the hospital and the board understand the importance of community health issues and are committed to addressing them.[107] Similarly, administrative leaders, board members, and Community Health Education Department staff from Crozer-Keystone Health System regularly serve on multiple community boards, which both strengthens the organization's community partnerships and provides those involved with a first-hand understanding of the community's needs and assets.[108]

Practice #8: Consider a Periodic "Audit" of the Community Benefit/Health Function

Outside companies with expertise in the area of community health are available to conduct a thorough review of an organization's internal capabilities with respect to community benefit and community health improvement, including how the organization partners with and relates to external stakeholders. In 2008, Boston Children's decided to hire such an organization, and this proved to be quite useful. After examining internal governance, planning, and operations related to community health activities, the firm encouraged the hospital to instill more rigor into the functioning of its board community service committee and made recommendations related to how the organization thought about allocating and deploying scarce resources.[109]

102 L. Prybil, et al., *Governance in Not-for-profit Community Health Systems: An Initial Report on CEO Perspectives,* W.K. Kellogg Foundation and Grant Thornton LLP, February 2008.
103 Center for Healthcare Governance, 2016.
104 M.K. Totten, 2012.
105 *Ibid.*
106 *Ibid.*
107 *Ibid.*
108 Center for Healthcare Governance, 2016.
109 Telephone interviews conducted with Josh Greenberg, Director of Government Relations (on October 10, 2016), and Sandra Fenwick, CEO (on October 12, 2016), Boston Children's Hospital.

Allocating Community Health Responsibilities in Health Systems: System Versus Local Boards

THE BOARDS OF REGIONAL AND MULTI-STATE SYSTEMS HAVE to determine whether to keep community health-related responsibility and accountability at the system level, allocate them to subsidiary hospital boards, or share them between the two. This decision is being made in a macro environment where many systems have been moving from a "holding-company" model of governance that relies heavily on local subsidiary boards to an "operating-company" model that diminishes the role of such boards, and in some cases, eliminates them altogether.

Survey data suggests that, over the past few years, more system-level boards have been taking community benefit responsibilities away from local boards, although perhaps to a lesser extent than they are taking away other responsibilities. In 2015, 35 percent of subsidiary boards reported having responsibility for measuring the value of the organization's community benefit activities, down from 44.3 percent two years earlier. In some cases, the responsibility has become a shared one between the local and system boards (45 percent, up from 41.8 percent in 2013), but in many instances the system board has taken it over altogether (20 percent, up from 13.9 percent in 2013).[110] A similar, though less pronounced, shift has occurred when it comes to setting community benefit goals.[111]

For a variety of reasons, The Governance Institute recommends that the boards and leaders of not-for-profit healthcare systems should consider the need to keep meaningful responsibility and accountability for community health activities at the local level, at least as a shared responsibility. This responsibility can be fulfilled with dedicated community health staff at the local level, and/or as a primary responsibility of the local/subsidiary board. The system can determine a baseline or standards that should be applied across the system (potentially related to how the activities should align with the mission, how to measure outcomes, and the expected level of resource allocation), and then the individual programs, priorities, and decisions about such programs can be made at the local level based on the CHNA.

First and foremost, the ACA requires that CHNAs and related implementation plans be developed based on local data and local input. Moreover, as discussed throughout this white paper, the most effective plans and programs are developed and implemented in true partnership with local stakeholders. It is hard to imagine that a regional or multi-state system that does not rely heavily on local subsidiary boards would be able to develop actionable CHNAs, implementation plans, or programs, and hence would be able to have a meaningful impact on the health of the local community. In addition, keeping primary or at least shared responsibility for community health at the local level allows system leaders to keep their local boards engaged. In an era where many other responsibilities are migrating to the system level—making local board members question the value of their involvement—keeping meaningful, important community health responsibilities at the local level may be the best way to avoid disenfranchising the many talented individuals who now serve on these local boards.

The accompanying case studies provide examples of how two health systems—Dignity Health and Providence Health & Services—handle the allocation of community health responsibilities between the system and local level. Both organizations have seemingly found an effective balance between the two. (The case studies are available at www.governanceinstitute.com/whitepapers.)

110 K. Peisert, 2015.
111 *Ibid.*

Step 2: Execute Effectively in Meeting ACA Community Health Requirements

Once an organization has the right policies, structures, and infrastructure in place, the next step is to execute effectively in meeting the specific requirements laid out in the ACA. This section describes practices that can assist in this area, with a focus on those related to community health improvement, such as the CHNA and accompanying implementation plan. (This section does not specifically address practices related to the billing and collection requirements contained in ACA; the practices laid out in the previous section can help in ensuring compliance with those requirements.)

Practice #9: Meaningfully Engage Stakeholders throughout the Process

Panelists and participants in a 2011 public forum emphasized the importance of engaging community stakeholders not just as sources of input upfront, but also as ongoing, equal partners in prioritizing and addressing identified health concerns.[112] Community stakeholders should be more than "watchdogs" that hold the hospital/health system accountable for performance. Rather, they must be intimately involved and have shared accountability at all stages of the process—developing the CHNA; setting priorities; creating the implementation plan; and planning, implementing, and evaluating specific programs.[113]

Despite these recommendations, hospitals appear to be engaging with community stakeholders and eliciting input only as part of the initial CHNA development process, not in the priority-setting, program implementation, or program evaluation processes that follow. In addition, it is not clear whether the opportunities available to provide input are in fact meaningful ones.[114] A review of 44 hospital CHNAs found that 75 percent (33 of 44) secured direct input from lay community members and 64 percent (28 of 44) secured input from representatives of medically underserved individuals during the CHNA development process.[115] However, only 11 percent (5 of 44) involved community members in the priority-setting process, and a similar percentage (3 of 27) of hospitals with implementation strategies indicated an intent to partner with community stakeholders in the planning and implementation of community benefit activities.[116] In a similar vein, the same review of 44 CHNAs found that relatively few (36 percent) set the priorities collaboratively with other stakeholders; many (35 percent) relied on institution-specific (rather than external) criteria; and only 55 percent used criteria of sufficient specificity to support the selection of one priority over another.[117]

These findings highlight the need for a greater effort to collaborate with other stakeholders when setting priorities and making investment- and program-related decisions so as to build the critical mass necessary to have a meaningful impact.[118] A few hospitals and health systems have embraced collaboration throughout all aspects of the process—and these efforts appear to be working. For example:

- **Sonoma County (CA) hospitals**: Since 2000, the three largest hospitals in Sonoma County have worked with the county health department as part of the Sonoma County Community Health Needs Assessment Collaborative. Since its founding, the group has expanded to include smaller hospitals in the region. In creating its most recent CHNA, the collaborative conducted multiple focus groups with stakeholders throughout the county in high-need neighborhoods and interviewed 20 key informants (e.g., local leaders) to learn about their experiences and observations regarding important health issues in these communities. This qualitative input was merged with numerous quantitative data to develop a preliminary list of priorities. This list was winnowed down during a "prioritization day" that involved discussions with several dozen community members, including hospital staff, public health officials, social service providers, and local residents. The net result was the development of three tiers of priorities and a consensus decision by the collaborative to address the three biggest priorities—early childhood development, access to education, and economic and housing security.[119]
- **Boston Children's Hospital**: Boston Children's systematically and rigorously gathers input and feedback from a broad array of stakeholders within the community, including residents, healthcare providers, and representatives from the public schools, government agencies (e.g., public health, public safety, public housing), and various community-based organizations focused on health related issues such as housing, nutrition, domestic violence, behavioral health, and substance abuse. Through surveys, focus groups, key informant interviews, listening sessions, and various other forums, Boston Children's gathers meaningful input from these stakeholders in an attempt to understand their top priorities, concerns, challenges, and opportunities in their day-to-day lives and work. To supplement this qualitative input, staff gather a wide array of data and comb the literature on related topics to identify strategies and best practices being deployed elsewhere. This

112 K. Barnett, 2012.
113 The Governance Institute, 2008.
114 *Supporting Alignment and Accountability in Community Health Improvement: The Development and Piloting of a Regional Data-Sharing System,* Public Health Institute, April 2014.
115 Public Health Institute, 2014.
116 *Ibid.*
117 *Ibid.*
118 *Ibid.*
119 M. Ingram, A. Wolpoff, and J. Lewis, "Evolving Community Benefit Could Be Next Big Development in Health Philanthropy," *HealthAffairs* Blog, June 8, 2016.

iterative, collaborative process occurs not just during the CHNA development process, but also during the prioritization of identified needs, development of the implementation plan, and planning, launch, and evaluation of specific programs.[120]

- **Taylor Regional Hospital**: A rural hospital in Pulaski County, GA, Taylor partnered with the University of Georgia (UGA) College of Public Health and the Archway Partnership (a public service/outreach unit of UGA focused on 12 rural Georgia communities, including Pulaski County) to conduct a CHNA over a nine-month period from July 2015 to March 2016. The CHNA team included students and faculty from UGA and a public service and outreach professional who worked in the community. The team used a five-step process to create a community health profile for the hospital's service area. Using these findings, the community identified four main areas in need of improvement, prioritized these issues, and created an implementation plan for the hospital and community. This approach transformed a legal requirement (to conduct the CHNA) into an opportunity for the hospital to engage with the community and improve public health.[121]

Practice #10: Partner with Other Stakeholders as Equals

Boards and board-level community health committees must take full responsibility for internal oversight of the organization's community health activities and be accountable for their results. However, at the operational/programmatic level, activities the organization is involved in will not be effective unless they are done as part of true, collaborative partnerships with other community-based stakeholders. To that end, hospitals and health systems can and should convene, fund, and/or facilitate community partnerships to promote health improvement. However, they should not control or lead such partnerships, but rather be seen as equal to the other partners. Success depends on all partners having good working relationships with each other and a sense of shared ownership and accountability for health.[122] Moreover, the governance of such partnerships requires the collective input of the partners and an entrepreneurial culture, not the more traditional executive governance culture employed by hospitals and health systems.[123] Examples of organizations that have been successful in creating these types of "equal" partnerships include the following:

- **Good Samaritan Hospital**: Good Samaritan participates in a community coalition to assess, prioritize, and address local health needs. The coalition includes other healthcare providers, along with leaders from local businesses, schools, churches, government agencies, and other community organizations and groups. The hospital provides resources to support the coalition and address identified priorities, but does not dominate it. Funding is shared equally across members.[124]
- **Palmetto Health**: As noted, Palmetto Health dedicates 10 percent of its profits to community health activities. However, the system allows a Community Outreach Task Force to decide how to spend that money. Chaired by Palmetto's chief community health services officer but made up of representatives from throughout the community, the task force disburses money based not on the services performed, but rather on the expected impact programs will have on measurable outcomes.[125]

(Note: The Health Research and Educational Trust and Robert Wood Johnson Foundation have developed a guide to developing effective hospital-community partnerships, available at: www.hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf.)

Practice #11: Define Service Area and Priorities Broadly, with a Focus on Disparities

The ACA requires that the CHNA define the community that the hospital/health system serves (e.g., going beyond current patients). To make a true difference in community health, the CHNA should define the service area to include underserved communities. In fact, experts from a panel at a 2011 public forum emphasized the importance of using U.S. census, hospital utilization data, and GIS technology to identify areas where health disparities exist and are leading to preventable emergency department (ED) and inpatient utilization.[126]

Unfortunately, many hospitals and health systems continue to define their service areas very narrowly, often limiting it to where current patients reside. A review of 44 hospital CHNAs found that all of them defined their primary service areas in this manner, and over half (23 of the 44) did not offer any methodology/reasoning behind the selection of the geographic parameters.[127] Only 23 percent (10 out of 44) identified geographic areas of health disparities within the service area; a parallel review highlighted ways in which facilities may be overlooking sub-county areas with geographic concentrations of health disparities.[128] Limiting the service area in this way creates a risk

120 Telephone interviews conducted with Josh Greenberg, Director of Government Relations (on October 10, 2016), and Sandra Fenwick, CEO (on October 12, 2016), Boston Children's Hospital.
121 "UGA-community partnerships offer model for CHNAs in rural communities," The University of Georgia College of Public Health, July 13, 2016. Available at www.publichealth.uga.edu/node/3504.
122 K. Barnett, 2015.
123 Center for Healthcare Governance, 2016.
124 M.K. Totten, 2012.
125 Center for Healthcare Governance, 2016.
126 K. Barnett, 2012.
127 Public Health Institute, 2014.
128 Public Health Institute, 2014.

of missing underserved areas where residents face barriers to accessing the organization's facilities, perhaps due to a lack of insurance, transportation barriers, and the like. It also opens up the organization to (often legitimate) criticism from external stakeholders.

The same focus on disparities and underserved areas should guide the process for prioritizing health needs identified in the CHNA. Yet the evidence would suggest that hospitals and health systems are not consistently taking this approach. In a review of 27 hospital CHNAs, 38 percent (10 hospitals) did not indicate any intention to focus on populations or geographic areas with health disparities for any community benefit program. Among those that did, the vast majority indicated an intention to do so for only a few programs, with only one CHNA planning to focus all programs on geographic areas and populations with health disparities.[129]

Practice #12: Selectively Tackle Social Determinants of Health in Areas Where the Hospital Can Make a Difference

Not surprisingly, most non-profit hospital and health system leaders feel most comfortable and confident in addressing problems that relate to clinical care. This fact, combined with the aforementioned tendency to define service areas and priorities in terms of current patients, leads most organizations to tailor their community health programs toward the provision of clinical care. In fact, a review of 17 hospital CHNAs that collectively listed 88 priorities found that 73 percent of these priorities focused on clinical care, with only 19 percent being focused on health-related behaviors and 8 percent on social and economic factors that influence health. None of the priorities related to the physical environment affecting health.[130]

A handful of innovative organizations are starting to move beyond clinical care when developing their community health programs. These organizations are selectively focusing on social determinants of health, focusing resources and efforts on areas where the organization is positioned to make a real difference. As part of this calculation, hospitals and health systems will sometimes decide to play a lead role in addressing the issue, and other times play an active supporting role to other partners in a better position to affect meaningful change. Brief examples include the following:

- **Boston Children's Hospital:** As a relatively small, specialized hospital in a market with many major academic medical centers with large pediatric programs, Boston Children's recognizes that there are limits to how effective the organization can be in addressing the social determinants of health. Consequently, when assessing any potential program, leaders consider the degree to which Boston Children's has expertise in the area that can be applied in community settings. This strategy led to the decision to place a special emphasis on five areas where the hospital has clinical expertise (youth employment, behavioral/mental health, obesity, asthma, and early childhood developmental/readiness for the classroom). In other areas, the organization may seek to support others rather than take on an issue, such as reducing violence by getting guns off the streets. The same principle guides the nature of the support that the hospital provides and the degree of leadership it takes within a specific area. For example, within the housing arena, Boston Children's decided to play a leadership role in helping to stabilize at-risk families in their current homes, but intentionally plays a minor "behind-the-scenes" role in the development of new affordable housing (through the provision of seed money to local housing organizations).[131]
- **Providence Health & Services**: Providence has a long history of tackling "upstream" problems that affect health, including access to affordable and safe housing, nutritious food, and mental health services. Recognizing the impact of social determinants on the health of a community was the mission of health system's founders (the Sisters of Providence) and continues to be an important focus of Providence's leadership today. The root causes of many avoidable Emergency Department visits and inpatient admissions stem from non-health issues such as food insecurity and homelessness. For example, Providence has a dedicated division focused on supportive housing, as well as programs to address food insecurity and mental health. When working on these types of issues, Providence leaders understand the value of partnering with local stakeholders in social service and government agencies, charitable foundations, community organizations and universities. They carefully consider the appropriate role of the hospital in those partnerships in advancing local community health. In many cases, the hospital will play a supporting role, letting stakeholders with greater expertise and existing community relationships take the lead.[132]
- **Dignity Health**: Dignity Health has long recognized the need to take a proactive role in addressing the social determinants of health. In 2004, Dignity Health partnered with a vendor to create a Community Need Index™ that assigns scores to ZIP codes based on nine indicators that fall within the five socioeconomic factors that affect health: income, culture/language, education, insurance, and housing.[133] At the system level, Dignity uses this index to identify geographic areas that have significant needs and to get a sense of what social determinants of health need to be addressed in these areas. Local Dignity hospitals then work in partnership with other stakeholders to conduct the CHNA and

129 *Ibid.*
130 *Ibid.*
131 Telephone interviews conducted with Josh Greenberg, Director of Government Relations (on October 10, 2016), and Sandra Fenwick, CEO (on October 12, 2016), Boston Children's Hospital.
132 Telephone interview with Dora Barilla, D.P.H., Executive Leader of Community Investment, Providence Health & Services, conducted on October 7, 2016.
133 C.H. Woodcock and G.D. Nelson, 2015.

figure out more specifically where the problems lie. In recent years, Dignity has used this process to make access to affordable housing a key priority; programs include donating unused buildings and vacant land and providing low- and no-interest loans to non-profit organizations that develop affordable housing for at-risk individuals and families.[134, 135]

- **St. Vincent Healthcare**: Since the mid-1990s, St. Vincent Healthcare, located in Billings, MT, has been working with a large clinic and the local health department to identify and address complex, community-wide health issues such as improving access to medications and mental health services and changing health related behaviors, including physical activity and diet.[136]
- **ProMedica**: This 12-hospital system in Michigan and Ohio identified food security as a critical issue for many of its patients. The system began screening patients for food security and helping those at risk access healthy food. Support includes counseling about healthy food choices and various programs to provide at-risk individuals with access to free or low-cost food. The system went as far as to open a grocery store in an abandoned storefront in a "food desert" neighborhood.[137]
- **Bon Secours**: Bon Secours, which operate 20 hospitals in six states, is working with other community stakeholders to address poverty by focusing on improving access to affordable, safe housing and good-paying jobs.[138]
- **Trinity Health**: This large Catholic system in Michigan has dedicated $80 million to support six community coalitions that are addressing teen smoking and obesity.[139]

Overcoming Board Reluctance to Investing in the Social Determinants of Health

Some boards may be reluctant to invest in addressing the social determinants of health out of concern that the organization will not get "credit" for such investments with the IRS, believing they must be reported as "community building" initiatives rather than more traditional community benefit activities. (The IRS distinguishes between the two.) However, experts suggest that hospitals and health systems are generally on firm ground in reporting them as community benefit activities as long as they address an important need identified in the CHNA.[140]

Boards may also be reluctant to invest in the social determinants of health because of the long time lag between such investments and their impact on measurable health outcomes. To overcome this reluctance, the CEO and others should share available data showing the clear link between health and housing, nutrition, and other social factors. But they should also be honest about the long-term nature of the relationship and hence not over-promise when it comes to their near-term impact on familiar health outcomes such as ED visits. Failing to be realistic about the timeline creates the risk that boards will "pull the plug" on these initiatives before they have a chance to have a positive impact.[141]

134 Telephone interview conducted on October 5, 2016, with Pablo Bravo, Vice President of Community Health, and Michael Bilton, Senior Director of Community Health and Benefit, Dignity Health.
135 M. Hostetter and S. Klein, "In Focus: Hospitals Invest in Building Stronger, Healthier Communities," Transforming Care, The Commonwealth Fund, September 27, 2016. Available at: www.commonwealthfund.org/publications/newsletters/transforming-care/2016/september/in-focus.
136 Trust for Health, 2013.
137 M. Hostetter and S. Klein, 2016.
138 *Ibid.*
139 *Ibid.*
140 *Ibid.*
141 *Ibid.*

Practice #13: Set Clear Metrics and Monitor Progress on an Ongoing Basis

Mechanisms should exist to hold the organization and its leaders accountable for community health performance, both overall and for individual programs; as noted earlier, consideration should also be given to tying a meaningful portion of CEO and senior leader compensation toward achievement of objectives.[142] For each program, measurable objectives should be set, with ongoing monitoring of progress toward achieving them.[143] The ASACB demonstration project recommends that hospitals and health systems require staff to provide periodic verbal and written reports to the board that document progress towards identified, measurable objectives. [144]

Yet a review of 27 CHNA implementation strategies suggests that most organizations do not do a good job in following these guidelines. Only one hospital identified metrics for all listed programs, and 15 percent did not list any metrics for any planned program; on a positive note, 78 percent provided metrics for at least one program. This finding underscores the need for assistance in developing metrics and monitoring programs. Many hospitals lack internal staff with the required competencies and skills in this area, and hence need to engage with external stakeholders that can help.[145] Too often, however, organizations take a proprietary approach to monitoring and evaluation, and experts cite the need for more collaborative, transparent efforts.[146]

Examples of organizations that are proactively identifying measures, setting performance goals, and monitoring progress on an ongoing basis include the following:

- **Boston Children's Hospital**: For every community health program, Boston Children's establishes concrete performance goals for defined short- and long-term process and outcomes measures. In fact, the existence of such measures is generally a prerequisite to convincing leaders to invest in a program. Mechanisms are always put in place to assess performance on these metrics at baseline and over time, and a detailed analysis of performance on every program is reported to the board community service committee throughout the year, with a summary version shared at full board meetings at least once a year.[147]
- **Providence Health & Services**: To inform local hospital programming, Providence is creating a platform to merge internal data with external community and population health data. Hospitals will use the data to determine program goals and monitor progress. In the near term, the focus will shift from the measurement of processes (e.g., whether at-risk individuals are being referred to and enrolling in needed programs) to behavior change (e.g., whether those who enroll in programs actually change behaviors). Over the long run, the focus will shift to whether these programs are having an impact on health outcomes, such as body mass index and avoidable ED visits and admissions. Providence has a data workgroup in place that includes external stakeholders, with the goal of identifying and implementing "best-practice" metrics for specific interventions.[148]

> "Seeing that we have 100 or 300 kids in a program is not my idea of success. I want a scorecard for every program we put in place. I want to know baseline performance and then track the numbers over time so I can be sure we are actually moving the dial."
>
> *—Sandra Fenwick, CEO, Boston Children's Hospital*

Practice #14: Share Results in a Transparent, Accessible Manner, Including Both Data and Stories

Not-for-profit hospitals and health systems need policies and initiatives to increase the level of transparency about community health programs with both internal and external constituencies. To date, many not-for-profit hospitals (and other not-for-profit providers) have not done a good job in telling both internal and external audiences about their community health programs and their positive impact on the community.[149]

To address this issue, the AHA recommends going beyond reporting of dollars spent on community benefit activities to tell the full story of a hospital's commitment to improving the health of the local community. The effort should highlight community health activities and their impact on local residents, including the number of lives affected and individual stories of those who have benefited.[150] At a minimum, this effort should include both a written CHNA report that is broadly distributed in the community and through the organization's Web site. For example, the board and senior executives at Kaiser Foundation Hospitals and Health Plan in Oakland, CA, mandated development of a publicly available Web site (www.kp.org/communitybenefit) that

142 K. Barnett, 2015.
143 *Ibid.*
144 K. Barnett, 2009.
145 Public Health Institute, 2014.
146 K. Barnett, 2012.
147 Telephone interviews conducted with Josh Greenberg, Director of Government Relations (on October 10, 2016), and Sandra Fenwick, CEO (on October 12, 2016), Boston Children's Hospital.
148 Telephone interview with Dora Barilla, D.P.H., Executive Leader of Community Investment, Providence Health & Services, conducted on October 7, 2016.
149 B. McPherson, *Why Nonprofit Home Care & Hospice Leaders Need a Community Benefit Strategy…And 10 Key Steps to Get You There,* Kinnser Software. Available at: www.nonprofithealthcare.org/uploads/Community_Benefit_Strategy_Why_and_How.pdf.
150 American Hospital Association, *AHA Guidance on Reporting of Community Benefit.*

provides a detailed description of the organization's community benefit activities and their impact.[151]

Ideally, hospitals and health systems should think more strategically about how to tell their stories, and consider going beyond written reports and information posted to Web sites. Recognizing this need, Providence Health & Services has put a new communications framework in place to ensure consistent storytelling for community health activities. As part of this initiative, leaders within the Community Partnership Division have asked local hospital leaders to partner with communities to report on how local programs have made a difference in the lives of individual residents. These stories are then uploaded to the organization's Web site.[152] Beyond Web sites, other vehicles for communicating this information include local media stories and advertisements (e.g., newspaper, television, radio), billboards, presentations at community events, and newsletters and press releases.[153] In addition, consideration should be given to holding formal events where the hospital can tell its community benefit story in an effective, engaging manner, featuring the stories of those helped by individual programs. For example, Palmetto Health holds an annual town-hall meeting attended by board members and members of a task force dedicated to community outreach. During the first hour, the chair of the board's community health committee reviews an annual report that details the system's community health activities. During the second hour, community members provide valuable feedback to the board and task force on how the system is doing and what could be done better.[154]

151 Center for Healthcare Governance, 2013.

152 Telephone interview with Dora Barilla, D.P.H., Executive Leader of Community Investment, Providence Health & Services, conducted on October 7, 2016. See www.providence.org/cares.

153 B. McPherson, *Why Nonprofit Home Care & Hospice Leaders Need a Community Benefit Strategy…And 10 Key Steps to Get You There.*

154 Center for Healthcare Governance, 2016.

Conclusion

Community health can be broad, vague, and difficult to define. Within this context, hospitals and health systems have historically left most community health issues up to local public health agencies and non-profit community organizations to address.

THE HOSPITAL FOCUS HAS PREVIOUSLY BEEN ON "COMMUNITY benefit" programs to meet IRS tax-exemption standards, which primarily have been narrowly defined as providing free and discounted care to those without the means to pay. But the responsibility for providing such care still resides within the boundaries of the traditional role of the hospital, addressing "downstream," reactive healthcare needs rather than the "upstream" social health issues that lead many underserved to develop health problems and thus need to seek care in the hospital.

The ACA expanded the scope of requirements for hospitals beyond the IRS focus on calculating a certain dollar amount of community benefit programs to maintain tax-exemption. By requiring CHNAs and the implementing of programs to address the needs identified in the CHNA, the ACA has essentially made the non-medical care issues affecting health the responsibility of hospitals and health systems to address. As payment structures move further along the risk spectrum, hospitals and health systems have more impetus than ever before to identify and address problems that cause increased spending and utilization of the healthcare system that can be prevented. These problems are the social determinants of health, as described in this white paper, and they require hospitals and health systems to go beyond community benefit, to a more encompassing focus on community health. As leaders and board members consider the steps laid out in this white paper to improve community health, they should no longer consider non-clinical programs to be outside their responsibility. By aligning with community partners and taking on the appropriate roles where the hospital can make a meaningful difference, hospitals and health systems can improve community health in various ways, which will help reduce preventable illness and go hand in hand with meeting population health goals. As risk-based payment models become more pervasive, such programs will create essential savings and benefit not only the community but also the hospital.


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