Elements of GOVERNANCE®

Providing CEOs, board chairs, directors, and support staff with the fundamentals of healthcare governance

A SERIES BY THE GOVERNANCE INSTITUTE

COMMUNITY HEALTH

SECOND EDITION

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Elements of Governance® is designed to provide CEOs, board chairs, directors, and support staff with the fundamentals of not-for-profit governance. These comprehensive and concise governance guides offer quick answers, guidelines, and templates that can be adapted to meet your board's individual needs. Whether you are a new or experienced leader, the *Elements of Governance*® series will help supply you and your board with a solid foundation for quality board work.

Acknowledgements

This edition is based on our Fall 2016 white paper, *Improving Community Health: Leading Governance Practices to Catalyze Change* by **Larry Stepnick,** Vice President and Director of The Severyn Group, a Virginia-based firm that specializes in conducting qualitative and quantitative research, and writing and producing publications on a wide range of healthcare management issues. In addition to printed materials, The Severyn Group creates Web site content and electronic presentations for training and education purposes. Severyn's clients include a broad spectrum of organizations that represent virtually all aspects of healthcare, including financing, management, delivery, and performance measurement. The Severyn Group assists clients in resolving their most critical strategic concerns.

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The Governance Institute

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Background and Overview

Serving the community remains the cornerstone of the mission for today's hospitals. Some hospitals claim to fulfill this mission simply by keeping their doors open in service areas with an unfavorable payer mix (i.e., high concentrations of uninsured, underinsured, and Medicaid certified recipients). Some develop additional programs and services for the residents of underserved communities.

An increasing number of these programs involve partnerships with community organizations. Still others explore more strategic approaches that emphasize building community capacity to improve health status and community quality of life.

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

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

More recently, the passage of the ACA highlighted the need for organizations to go further in fulfilling their commitment to improving community health and providing benefit to the community by mandating a community health needs assessment (CHNA) every three years, along with action plans to address the needs identified. Moreover, the industry's increasing focus on population health and value-based care has created initiative overlap in which efforts to improve the health of the community, for the purposes of maintaining tax-exempt status as well as fulfilling the charitable mission, intersects with efforts to improve the health of targeted, at-risk populations within the organization's service area.

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" in this *Elements of Governance.*

This *Elements of Governance* includes information to assist organizations in their efforts to improve community health, going beyond ACA regulations as a part of the larger response to payment reform and the transformation from reactive, episodic acute care to proactive management of chronic disease and population health. It also discusses how not-for-profit hospitals and health systems can become a major catalyst for health improvement in the local community, particularly with underserved, at-risk populations.

The Context for Today's Community Health Initiatives

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

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

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

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

In the context of growing costs and demographic trends that suggest fairly dramatic increases in the demand for treatment of chronic illness, the question becomes one of stewardship. How do we move beyond a simple compilation of charitable expenditures and begin to ask whether we are making optimal use of our limited resources?

Two key steps in the process include:

1. The identification of communities with disproportionate unmet health-related needs, and the targeting of resources to reduce the demand for high cost medical services to treat preventable illnesses and improve the management of chronic illnesses.
2. Addressing social determinants of health that may be outside the purview of hospital or clinical care, such as access to healthy food, safe and healthy housing, exercise facilities, dental care, and education on healthy living.

Communities with disproportionate unmet needs typically are those regions or sub-regions in a hospital's service area where there may be a higher prevalence or acuity for a particular health issue and/or there are other proxy measures that clearly

demonstrate that these populations experience health problems disproportionately. (Household income or unemployment rates are common proxy measures.) Hospitals and health systems can use claims/billing data and publicly available data to identify such communities and implement actions to address clinical care and access needs for these areas.

Addressing social determinants of health requires partnering with community organizations outside of healthcare. Having a strong governance and leadership infrastructure to address community health will allow organizations to succeed in such efforts.

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.[1]

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.

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. 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.

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. Perhaps most importantly, as more and more community health initiatives overlap with population health efforts, these will prove essential in continuing to further the industry's move towards value-based care, which will be necessary to sustain healthcare costs, regardless of potential changes to federal legislation.

1 The Governance Institute, 2008.

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?

Leading Practices for Improving Community Health

Boards and senior executives of not-for-profit hospitals are required 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. (Most likely these regulations will stay in place or similar ones will replace them, if the ACA is repealed; regardless, the CHNA represents a best practice approach to help fulfill a core responsibility of non-profit hospitals and health systems that will not go away.) The board has 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.[2]

The following are examples of best practices for improving community health in your organization. For case studies regarding these practices, view The Governance Institute's *Improving Community Health: Case Studies.*

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.

2 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.

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

Boards should develop and approve 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.[3] See **Appendix 1** for a sample community health and benefit policy.

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.

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.

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.[4,5]

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.[6,7,8] 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.[9]

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.[10] A formal charter

3 The Governance Institute, 2008.
4 K. Barnett, 2009.
5 K. Barnett, 2015.
6 Center for Healthcare Governance, 2013.
7 L. Prybil, et al., 2012.
8 Alliance for Advancing Nonprofit Health Care, 2009.
9 K. Peisert, 2015.
10 K. Barnett, 2009.

should outline specific areas of oversight.[11] 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.[12,13] The majority of committee 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).[14] See **Appendix 2** for a sample Community Health & Benefit Committee Charter.

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

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.[15] 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.[16]

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.[17] 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.[18]

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 to and performance in improving community health. 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.[19]

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. Along with time to discuss community health, boards need dedicated time to be educated on this topic.

11 K. Barnett, 2015.
12 K. Barnett, 2009.
13 The Governance Institute, 2008.
14 K. Barnett, 2015.
15 *Ibid.*
16 Alliance for Advancing Nonprofit Health Care, 2009.
17 *Ibid.*
18 The Governance Institute, 2008.
19 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.

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

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. Some hospitals and health systems actively encourage their board members to be visibly involved in community health related activities. 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.[20]

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.

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:[21]

- 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.

20 M.K. Totten, 2012.
21 K. Barnett, 2009.

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.

Practice #9: Meaningfully Engage Stakeholders throughout the Process

It is essential to engage community stakeholders not just as sources of input upfront, but also as ongoing, equal partners in prioritizing and addressing identified health concerns.[22] Rather, they must be intimately involved and have shared accountability at all stages of the process: priority-setting, program implementation, and program evaluation processes that follow. There is a need for organizations to make 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.[23]

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. Hospitals and health systems can and should convene, fund, and/or facilitate community partnerships to promote health improvement. Success depends on all partners having good working relationships with each other and a sense of shared ownership and accountability for health.[24]

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

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 GIS technology to identify areas where health disparities exist and are leading to preventable emergency department (ED) and inpatient utilization.[25]

Unfortunately, many hospitals and health systems continue to define their service areas very narrowly, often limiting it to where current patients reside. Limiting the service area in this way creates a risk 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. The same focus on disparities and underserved areas should guide the process for prioritizing health needs identified in the CHNA.

22 K. Barnett, 2012.
23 Public Health Institute, 2014.
24 K. Barnett, 2015.
25 K. Barnett, 2012.

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. 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.

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.[26] For each program, measurable objectives should be set, with ongoing monitoring of progress toward achieving them.[27]

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 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.

26 K. Barnett, 2015.
27 *Ibid.*

Conclusion

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 has essentially made the non-medical care issues affecting health the responsibility of hospitals and health systems to address. 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 and they require hospitals and health systems to go beyond community benefit, to a more encompassing focus on community health. Leaders and board members should no longer consider non-clinical programs to be outside their responsibility. 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 and create essential savings and benefit not only the community but also the hospital.

Appendix 1:
Sample Community Health and Benefit Policies

1. Sample Community Health and Benefit Policy: Establishment

Board Policy No.:____

Subject: Establishment of Community Health and Benefit Committee

Effective Date: _____

Application: Community Health and Benefit Committee

Purpose:
To increase transparency with respect to the organization's charitable activities and to foster a culture of social accountability in keeping with the organization's mission and strategic plan.

Policy:
It is the policy of the organization to establish and integrate into its strategic direction a community health and benefit committee.

Procedure:

2.1 The community health and benefit committee shall function as a committee that reports up to the board of directors and will act under a charter defining its role and responsibilities. (Refer to Charter of the Community Benefit Oversight Committee.)

2. Sample Community Health and Benefit Policy: Charter

Board Policy No.:____

Subject: Charter of the Community Health and Benefit Committee

Effective Date: _____

Application: Community Health and Benefit Committee

Policy:

1.1 The community health and benefit committee, acting under authority from the board of directors, will oversee the implementation and enhancement of programs aimed at improving community health and will ensure that programs and activities claimed as community benefits meet at least one or more of the core principles of community benefits adopted by the organization. Specifically, any program or activity claimed as community benefit must address needs of populations with a disproportionate unmet health need.

Procedure:

2.1 Commitment:

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

2.2 Committee Composition:

The community health and benefit committee will be comprised of members who represent diverse sectors of the community and bring specific competencies essential to the provision of community benefit. Specifically, the committee will be comprised of:

- Five or more community members—which may include representatives from local public health agencies, local school districts, area helping agencies, and physicians;
- The CEO/president, vice president, and director responsible for community benefits as well as foundation and clinic operations;
- And, at least one member of the board of directors—who will serve as a liaison between the board of directors and committee.

Community representation should outweigh staff representation by at least two members. Ad hoc members from other departments such as business services and marketing may report to meetings on an as-needed basis.

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

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

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

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

2.7 Confidentiality:
Members agree to respect the confidentiality of the committee and the organization such that everything said within the group stays within the group.

2.8 Responsibilities:
The community health and benefit committee will be responsible for:
Assessment of Community Needs and Reporting of Community Benefits: Community needs assessments and community benefit reports/plans are the responsibility of the community benefits department. Community health and benefit committee members may be asked to participate or provide expertise specific to data compilation or other such activities to ensure that community needs are accurately assessed.

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

Evaluating & Approving Programs: Proposed programs and enhancements, along with proposed budgets, may originate from various sources such as hospital departments, senior leadership, the board of directors, or the community health and benefit committee itself. After initial vetting by the community benefits department, proposed programs and enhancements will be submitted to the committee for evaluation and detailed discussion. All programs and activities to be counted as community benefit require approval of the committee. While programs not approved by the committee may continue, they must be reclassified and not counted as community benefits. The community health and benefit committee may also review programs not previously counted as community benefit to determine if, with further enhancement, they may qualify under the guidelines.

Key criteria to be considered in evaluating new or existing programs include:

- Geographic/population (number of people affected per 1,000)
- Gravity of problem (health impact at individual, family, community level)
- Economic feasibility (program cost, internal/external resources needed)
- Available expertise (Can we make an important contribution?)
- Time commitment (overall planning, implementations, evaluation)
- External salience (evidence of importance to community stakeholders)

Monitoring Programs: The community benefit department staff is responsible for monitoring the progress being made with community benefit programs and activities. Specifically, the staff is responsible for examining progress as it relates to implementation and achievement of measurable program goals and objectives and for presenting periodic updates to the community health and benefit committee.

Program Funding: The securing of internal and external funding for community benefit programs is the responsibility of the CEO/president and organization's foundation with support from the community benefits department. Community health and benefit committee members may recommend sources for external funding and may also provide letters of support or assistance with external donors when appropriate.

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

2.10 Staff Support:
The community health and benefit committee is to be staffed by the community benefits department which shall be responsible for such activities as scheduling meetings, preparing agendas, maintaining and distributing meeting minutes, preparation and presentation of programs, and service descriptions for review and approval by the committee, submission of names of prospective new members, and preparing reports as needed for community health and benefit committee review.

3. Sample Community Health and Benefit Policy: Recruitment

Board Policy No.:____

Subject: Recruitment of Community Health and Benefit Committee Members

Effective Date: _____

Application: Community Health and Benefit Committee

Purpose:
To establish guidelines for the recruitment of community health and benefit committee members, to outline specific member competencies and to establish the membership approval process.

Policy:

1.1 Recognizing that optimal use of charitable resources through informed community benefit decision-making requires diverse skills and expertise beyond hospital administration and clinical service delivery, prospective members will be evaluated for specific competencies and approved for membership by a consensus vote of the committee.

Procedure:

2.1 The community health and benefit committee, or its established membership sub-committee, will develop a formal interview process to evaluate candidate competencies to ensure that the membership reflects a breadth of knowledge, experience and expertise in the following areas:

- Characteristics, dynamics, and history of communities with disproportionate unmet health needs
- Disease causal factors and primary prevention
- Analysis of population health data and service utilization
- Clinical service delivery
- Local community-based organizations
- Public sector agencies and regional policy issues
- Area-specific expertise such as education, social services, immigration, housing, addiction, youth, and family services

2.2 Prospective members will be given a printed copy of the charter of the community benefits oversight committee to ensure their understanding of the committee's roles and responsibilities.

2.3 Prospective members will be presented to the community health and benefit committee for final approval.

4. Sample Community Health and Benefit Policy: Charter Review

Board Policy No.:____

Subject: Charter Review for the Community Health and Benefit Committee

Effective Date: _____

Application: Board of Directors, Community Health and Benefit Committee, CEO/President

Purpose:
To allow for modification of the charter of the community health and benefit committee in order to maintain alignment with the organization's strategic plan and/or identified changes within the communities served.

Policy:

1.1 The charter for community health and benefit committee will be reviewed and updated as necessary in a manner consistent with periodic review of the organization's policies and procedures.

Procedure:

2.1 Proposed modifications to the charter will be presented to the community health and benefit committee or its designated sub-committee for preliminary review and consideration.

2.2 Preliminarily approved modifications are presented to the CEO/president; if CEO/president rejects proposed modifications, proposal returns to the committee for further discussion and resolution.

2.3 All modifications require final approval by the board of directors.

Appendix 2: Sample Community Health and Benefit Committee Charter

Sample Committee Charter: Community Health and Benefit Committee (including mission fulfillment and advocacy)

Purpose

The purpose of the community benefit committee is to ensure the hospital/system executes its mission and provides benefit to the communities it serves based on an assessment of community health needs.

Responsibilities

In fulfilling its charge, the community benefit committee is responsible for the following activities and functions:

- Ensure focus on the mission
- Assess community health needs at least every three years
- Ensure results of community health needs assessments are used in setting organization's strategies and plans
- Develop community benefit goals, parameters, and metrics
- Monitor community engagement plans and programs that serve to strengthen ties to the communities served
- Engage with other organizations to foster improvements in community health and well-being, especially regarding behavioral health
- Oversee the organization's annual community benefit reporting
- Coordinate with the community outreach staff to identify and address important and relevant community issues
- Oversee educational programs to help the community understand behavioral health issues and to reduce stigma
- Advocate for the hospital/system and the communities served
- Assist with public policy initiatives (as requested by management)
- Keep abreast of major state and national issues relating to healthcare

Composition

The committee should consist of seven to nine members; the senior-most person in charge of mission is often staff to the committee; should include non-board members with connections to the community and needed expertise.

Meeting Schedule

The committee should meet two to four times a year.