



**Community Benefit: Moving Forward with  
Evidence-Based Policy and Practice  
Proceedings of a National Conference**

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# Table of Contents

<b>Executive Summary</b> .....	<b>4</b>
<b>Part I: The Conference and Outcomes</b> .....	<b>6</b>
Background .....	6
Goals .....	8
Methods .....	8
Priority Questions .....	11
<b>Part II: Salient Community Benefit Topics</b> .....	<b>12</b>
Governance and Leadership .....	12
Ethics .....	13
Finance and Economics .....	14
Planning, Organization and Evaluation .....	16
Community Assessment and Engagement .....	18
Public Policy .....	19
<b>Appendices</b> .....	<b>22</b>

## Executive Summary

“Community benefit” is a highly charged topic poised on the brink of change. The significance of community benefit (CB) varies with stakeholder perspective, as noted below. Yet it is clear that in the future, CB needs to be shaped according to objective data, not subjective preference. This report describes the results of a June 27, 2009, preconference to the Annual Research Meeting of Academy Health. The goal of the Chicago conference was to identify the key questions to be addressed during the next three years to move the practice and policies of community benefit toward an evidence-driven approach. The conference was convened by the Saint Louis University School of Public Health.

The “Community Benefit Standard” is described in Revenue Ruling 69-645, 1969-2. C.B. 117 of the Internal Revenue Service (IRS) that gives guidance to nonprofit hospitals about the conditions of tax exemption.<sup>1</sup> In addition, 18 states have implemented laws or regulations pertaining to hospital tax exemption based on the provision of community benefit activities.<sup>2</sup>

Since the initial Revenue Ruling in 1969, community benefit has periodically surfaced in the limelight. This is one of those times. The IRS has implemented a new reporting requirement, and beginning with the 2008 fiscal year, nonprofit hospitals are required to fill out a Schedule H of the Form 990 submitted by nonprofit entities. Reporting is phased in, but the form must be completed in its entirety beginning with a hospital’s 2009 fiscal year. Schedule H will document, for the first time with national consistency, the detailed CB activities of every nonprofit hospital. The emerging data set will provide opportunities for confirmation, challenges and change.

The issues that arise around the topic of community benefit reflect the perspective of the stakeholder. Those responsible for ensuring the payment of taxes, whether at the state or federal level, question whether nonprofits are doing enough to justify the amount of their tax obligation. Hospital CEOs would like to assure their communities that hospitals are indeed contributing to the community beyond the care of the individual patient. Those on the front lines of implementing community benefit programming ponder which, among many possible community benefit activities, should receive priority. They also struggle to evaluate programs appropriately and gather input into future decisions for resource allocation. Health care systems debate how to manage CB across their multiple institutions, some of which may not even be hospitals. Board members of hospitals, health care systems and community agencies may look at how the hospitals interact with the community from the perspective of a particular group. Meanwhile, with health reform sparking lively debate, public health and health services researchers are examining which types of activities are most cost-effective in improving the public’s health, and policy analysts are searching for programs that represent the most cost-effective use of resources to contribute to collective well being.

Until the new IRS reporting requirements, these diverse perspectives had little reason or opportunity to come together. The \$12 billion to \$24 billion estimated to be spent on community benefit each year by nonprofits has been spent primarily at the level of the individual hospital.<sup>3</sup> The conference convened by Saint Louis University in June 2009 was intended to bring together 50 experts approaching community benefit from an array of perspectives to move the practice

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1 <http://www.irs.gov>

2 *Health Care Community Benefits: A Compendium of State Laws*. Boston, MA: Community Catalyst. November 2007.

3 “On the Hot Seat,” *Modern Healthcare*, February 16, 2009.

of hospital community benefit programming toward cohesion, consistency and predictability. The ultimate goal is to use the resources to maximize the hospitals' contributions to their communities based on evidence rather than happenstance.

This document reports on the process used by the conference and identifies the practical outcome from the conference. It includes a list of questions about the practices and policies of community benefit that can be addressed with evidence over the next three years. Answers to these questions will help move the field toward evidence-based decision making. The final list of questions identified and prioritized by conference participants is as follows:

- How do we define "community"?
- What incentives, including reimbursement structures, result in a hospital's maximizing its contribution to the community?
- What evidence can be used to change the perception of CB from a financial liability to a contribution to the financial and moral viability of the organization?
- What is the relationship between CB outcomes and community involvement in decision making?
- What exemplary planning practices result in resource allocation (structure, dollars, resources, etc.) that matches community need?
- What are the characteristics of leadership and governing boards in hospitals that are doing CB well? What methods are used to engage hospital boards in CB more effectively?
- In states with CB requirements and more active public health infrastructure, do hospitals provide different charity care or CB programs than states that have a weak public health system or no specific CB requirements?
- What methods can be used to measure the effectiveness and efficiency of a hospital's CB program?
- What methods or data can be used to evaluate CB programs to see if they improve health outcomes, increase effectiveness and decrease costs, recognizing that direct causation may require time to determine and may be affected by a variety of intervening factors?

Many of the questions contain terms or concepts that warrant clarification in order to formulate relevant research methods and identify appropriate data. Some of the questions may be answered with existing, cross-sectional information. Others require longitudinal analysis. The ability to evaluate activities with appropriate methodologies; allocate the resources required for evaluation; and allow for sufficient time for an activity to make a difference before evaluating it were all reinforced as essential methodological issues for answering any of the questions.

We acknowledge that there are additional issues beyond those raised at the conference. This is an initial list that we hope will spark interest and a commitment of time, insight and resources by experts from an array of disciplines, as well as members of the lay community, representing the many facets of community benefit.

# Part I: The Conference and Outcomes

Hospitals in the United States have been intertwined with their communities since Benjamin Franklin and Dr. Thomas Bond started Pennsylvania Hospital in 1751. Over the years, the American Hospital Association, Hospital Research and Educational Trust, Catholic Health Association, VHA Inc., Robert Wood Johnson Foundation and various other organizations have launched programs to explore or document how hospitals are engaged with their communities. These efforts continue today.

A foundational issue is the definition of “community.” According to Robert Sigmond, a national leader in the field of community benefit for the past 40 years, a hospital’s community can be defined as “All persons and organizations within a reasonably circumscribed geographic area with a sense of interdependence and belonging.”<sup>4</sup> This allows for wide interpretation and commensurate action. In recent years, the field of public health has become highly sophisticated in its definition of “community,” reaffirming that there are multiple templates for doing so.

Yet despite definitions, demonstrations and a variety of studies, the role of the hospital in the community remains controversial. As the debate about health reform raises the issue of how to define, measure and improve the health of a community, the role of the hospital is once again salient. New reporting requirements for nonprofit hospitals bring discussions of the hospital’s role in the community to the forefront and demand answers based on evidence.

## Background

The concept of a “community benefit” as it is applied in the health care field sounds like it should emanate from the world of public health, i.e., the health of the community. However, the derivation of the “community benefit standard” is from a 1969 Revenue Ruling of the Internal Revenue Service (IRS), 69-645,1969-2. C.B. 117.<sup>5</sup> Over the years this has been refined with judicial and executive agency interpretations and rulings on the issue, as well as laws and regulations of individual states.<sup>6</sup> Nonprofit community hospitals are expected to take responsibility for enhancing the health of the community in addition to caring for individual patients.

How hospitals should do this, however, has not been specified. Based on Revenue Ruling 69-645, community benefit (CB) is organized, operationalized, regulated and evaluated as the responsibility of an individual hospital. No broad, community-wide approach has been taken by hospitals or regulatory authorities. Even the role of nonprofit multi-hospital systems is not clear. The result is that billions of dollars annually that could be used in a systematic way to improve the health of the public are spent based potentially on unilateral decisions.

Over the past 25 years, various federal entities have questioned whether hospitals are serving their communities to the extent warranted by their tax exemption. More detailed histories

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4 Sigmond, R. In First Person: An Oral History Part 2. Chicago: American Hospital Association. 2009, p. 14.

5 Lunder, E., and Liu, E. “Tax-Exempt Section 501(c)(3) Hospitals: Community Benefit Standard and Schedule H.” Congressional Research Service Report for Congress. July 31, 2008.

6 Wood, K. “Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make any Difference?” *The Review of Litigation* 20:3, Summer 2001, 709-742.

document federal and state initiatives pertaining to CB (see Resources in the Appendix). Most recently, the U.S. Senate has convened hearings and challenged hospitals' contribution to the health of the public. As a result, the IRS added Schedule H to the Form 990 that nonprofit hospitals are required to complete annually, and added questions to other components of Form 990 that must be completed by all nonprofit entities. Schedule H reporting is phased, with Part V due for FY 2008 and all components due with the filing of the hospital's FY 2009 tax return. Schedule H asks hospitals to report how they define their communities, how they document the needs of the community and how they measure impact of activities on the health of the community, and provide a detailed delineation of the types of activities in which they engage.<sup>7</sup> An entire section of Schedule H is titled "Community Building." In the eyes of some, it is clear that hospitals have an obligation to improve the health of the public. Whether and how that obligation is fulfilled are pertinent questions. So is the extent to which public policy can shape hospitals' actions and the extent to which those actions can impact the community's health.

A parallel development in the field of health care management is a focus on evidence-based practice. Health care management is increasingly driven by the need to measure change, improvement and multi-dimensional problems, and to base decisions on concrete evidence. Evidence-based management is defined as "the systematic application of the best available evidence to the evaluation of managerial strategies for improving the performance of health services organizations ... Whenever possible, health services managers should incorporate into their decision making evidence from well-conducted management research."<sup>8</sup>

The need to instill management practices with a grounding in evidence-based decision making coincides well with the public's need to have CB activities based on community need and community health improvement. Ideally, hospital executives will make decisions about the role, resources and priorities of their CB programs using evidence instead of history, personal preference or gut feel. To get to this point, CB must be perceived by health care executives and board members as an important function that can and should be guided by solid management decision making. This is not necessarily the state of the field at the present time. Unless and until hospital and health system leaders establish evidence-based guidelines and hold everyone in their organizations accountable for an evidence-based approach to their activities, CB programming will be allowed to wander in directions that may not ultimately be best for the communities or the institutions.

The theme of the conference was to bring the tools of evidence-based health care management to bear on the practices and policies pertaining to community benefit. To do this, we asked the simple questions, "What do we need to know about community benefit over the next three years to move the field toward evidence-based decision making?" and "What information or measures do we need to answer these questions?"

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7 [www.irs.gov/non-profits/Form 990/Schedule H/Instructions](http://www.irs.gov/non-profits/Form%20990/Schedule%20H/Instructions)

8 Kovner, A., and Rundall, T., (Chapter 5) in Kovner, Fine, D/Aquila, *Evidence-Based Management in Healthcare*. Chicago: Health Administration Press, 2009.

## Goals

The goals of the June 27, 2009, meeting were:

- 1) To articulate questions pertaining to CB that could be examined by health services research, policy analysis to advance the field, and specific topics that should be addressed as priorities to secure the field of CB as evidence-driven.
- 2) To excite health services researchers and policy analysts about examining issues pertaining to the practice of community benefit.
- 3) To encourage foundations and other funding organizations to commit funds to further the agenda of evidence-based CB.
- 4) To introduce practitioners to health services researchers and policy analysts, and lay the groundwork for future collaboration.
- 5) To compile evidence-based resources and disseminate the proceedings and results of the conference to the academic community, CB practitioners, health care executives, policy makers and grantmakers.

## Methods

### Participants

The purpose of the conference was to bring together 50 individuals from a variety of key perspectives to identify the most salient questions about community benefit that need to be answered to move the field toward evidence-based policy and practice. The key stakeholder groups represented included senior health care executives, front-line directors of nonprofit hospital community benefit programs, health services researchers, policy analysts, foundations, government funding agencies, nonprofit community agencies and advocacy organizations.

A 20-person Planning Committee was formed approximately six months prior to the meeting. Its composition was split evenly between academicians and practitioners. Members are noted on the list of Conference Participants in the Appendix. The Planning Committee met as a group several times by phone and extensively by e-mail, and there were numerous exchanges among various individuals.

Invitations were mailed to select mailing lists, and e-mail invitations were widely disseminated by members of the Planning Committee. Announcements were also posted on websites of national organizations such as the Association of Schools of Public Health. Sponsorships were arranged, and sponsors also disseminated invitations to the conference.

Finally, students from the health administration programs of three universities were invited to support the work groups, as described below. We wanted to offer students a rare opportunity to participate in a conference analyzing a topic of national policy debate and initiate the future generation of hospital leaders into the world of community benefit.

Attendees included representatives from all of the desired stakeholder groups. A list of participants, their organizations and other affiliations is included in the Appendix.

## Content

The broad topic of community benefit has been broken into a dizzying array of components. The Catholic Health Association first created an initiative called a “Social Accountability Budget” to document the extent to which Catholic health care organizations contribute to their communities.<sup>9</sup> This approach was adopted by VHA Inc. as well. The IRS accepted the CHA/VHA definition of CB in large part, and this is reflected in the new IRS Form 990 Schedule H. However, the 2008 IRS articulation of community benefit is not identical to the CHA/VHA definition of CB or the definition used by the American Hospital Association (AHA). Therefore, CB must be analyzed as a complex set of activities, not a one-dimensional activity.

For the purposes of the conference, we identified 10 sets of CB activities. This initial list included Community Leadership and Engagement; Community Needs and Health Status; Economics, Finance, Charity Care and Bad Debt; Ethics; Evaluation and Program Effectiveness; Governance; Quality and Performance Measurement; Role of Health Professions Education; State and Federal Policy; and Structure and Staffing.

For each type of CB activity, we identified both an academician and a health care executive who were experts in that particular area. They led the development of questions, resources and bibliography pertaining to their topics. As the conference planning progressed, these 10 areas were collapsed and reorganized into five areas:

- Governance, Leadership and Ethics
- Community Assessment and Engagement
- Planning, Organization and Evaluation
- Finance and Economics
- Public Policy

## References and Resources

As part of the planning for the conference, we conducted an extensive literature search on research and policy studies relevant to each of the 10 initial topics. This in itself proved a challenge, as the term “community benefit” is not a discrete concept in library literature. We also created a website ([communitybenefit.slu.edu](http://communitybenefit.slu.edu)) to foster communication and establish links with other organizations engaged in activities related to various aspects of community benefit.

To move the field toward evidence-based decision making, one must be able to find the evidence. Searching the Internet for “community benefit” results in many articles, most not written as research studies or policy analysis. They pertain to employment benefits and health benefits, and a huge body of literature pertains to the broad topic of community health. We have subsequently recommended to librarians how they might search for material pertaining to community benefit in order to obtain the small body of relevant research and policy studies rather than the large body of extraneous information.<sup>10</sup>

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9 Catholic Health Association. *Social Accountability Budget: A Process for Planning and Reporting Community Service In a Time of Fiscal Constraint*. St. Louis, MO: Catholic Health Association, 1989.

10 Tao, D., Freeman, M., Evashwick, C. “Evidence-Based Policy and Practice on Community Benefit: Information Support for Developing a Bibliography.” *Journal of the Medical Library Association*. Accepted for publication in 2010.

For each of the 10 topics, we identified and selected up to 10 articles that would be useful for conference participants to read prior to the meeting. Planning Committee members helped identify a number of white papers and institutional reports that were not available in the literature covered by traditional academic search engines. We posted relevant articles on the website, categorized as those without copyright restrictions (links or PDFs provided), and those that must be requested directly due to copyright release constraints.

With the assistance of the Planning Committee members, we further identified and limited the number of reference articles to one or two per topic. This bibliography was updated again following the conference and is available at [communitybenefit.slu.edu](http://communitybenefit.slu.edu).

Conference organizers and Planning Committee members requested that participants read at least one or two articles pertaining to their Work Group topics prior to the meeting so that the discussions could dig deeply, assuming attendees had a basic knowledge of community benefit and greater knowledge in their particular fields of expertise.

## **On-Site Process**

The Agenda for the meeting (see Appendix) was structured so that morning presentations by experts presented a foundation of the key issues pertaining to CB from a variety of perspectives. Experts included Mr. Robert Sigmond (who was honored for lifetime contributions to the field of CB), Dr. Connie Evashwick, Ms. Eileen Barsi, Mr. Bruce McPherson, Dr. Lawrence Prybil, Dr. Gary Filerman, Dr. Tony Sinay, Dr. Jeffrey Mayer and Dr. Donna Meyer. These presentations have all been posted online.<sup>11</sup>

The afternoon was then devoted to discussions in Work Groups, led by the academician and practitioner pairs who had participated on the Planning Committee. Participants were preassigned to Work Groups based on preferences expressed during the registration process so that they could read up in advance and so that each Work Group would represent varying perspectives and roles.

The five Work Groups focused on Governance, Leadership and Ethics; Finance and Economics; Community Assessment and Engagement; Planning, Organization and Evaluation; and Public Policy. Each group discussed the critical issues pertaining to its given topic, often building upon the comments of the morning speakers. The charge to each Work Group was to identify four to six major questions that could be answered by concrete data to help advance the practice of community benefit.

At the end of the Work Group discussions, each group reported out, identified essential issues and listed its questions on butcher paper that was posted around the room.

All conference participants voted on the most critical questions from across all groups. Each person had five votes, to be used separately or combined on any question from any Work Group.

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<sup>11</sup> <http://communitybenefit.slu.edu/presentations.html>

## Priority Questions

The practical outcome of the conference was to identify and prioritize questions about the practices and policies of community benefit that can be addressed with evidence — questions whose answers will help move the field toward evidence-based decision making. In the final voting, participants crossed all Work Group lines, and questions from all five Work Groups received votes from members of other Work Groups. Thus discipline and role bias did not seem to influence the results. The final questions are as follows:

- How do we define “community”?
- What incentives, including reimbursement structures, result in a hospital’s maximizing its contribution to the community?
- What evidence can be used to change the perception of CB from a financial liability to a contribution to the financial and moral viability of the organization?
- What is the relationship between CB outcomes and community involvement in decision making?
- What exemplary planning practices result in resource allocation (structure, dollars, resources, etc.) that matches community need?
- What are the characteristics of leadership and governing boards in hospitals that are doing CB well? What methods are used to engage hospital boards in community benefit more effectively?
- In states with CB requirements, do hospitals provide different charity care or CB programs than they do in states that have no specific CB requirements?
- What methods can be used to measure the effectiveness and efficiency of a hospital’s CB program?
- What methods and data can be used to evaluate CB programs to see if they improve health outcomes, increase effectiveness, and decrease costs, recognizing that direct causation may require time to determine and may be affected by a variety of intervening factors?

Note that many questions contain terms or concepts that warrant clarification in order to formulate the relevant research methods and identify appropriate data. Some of the questions may be answered with existing, cross-sectional information. Others require longitudinal analysis. The importance of evaluating activities with appropriate methodologies, allocating the resources required for evaluation, and allowing sufficient time for an activity to make a difference prior to a formal evaluation were all reinforced as essential methodological issues for answering any of the questions.

# Part II: Salient Community Benefit Topics

## Record of the discussion of Work Groups, including key questions identified by each group and issues discussed by experts as part of the Panel Presentations

### Governance and Leadership

Executive leadership and governance are at the core of community benefit programming. However, in a recent study, Prybil et al found that only 70% of community health system boards reported having regular, formal discussions about their organizations' community benefit responsibilities; only 40% had formal standing committees for community benefit; and only 34% had adopted formal plans spelling out the organizations' objectives for their CB programs.<sup>12</sup>

Senior leadership and governing board members must understand the importance of CB to an organization in order to allocate the essential resources. Responsibilities, authorities and structure that affect front-line operations are controlled by the organization's leaders. Yet, unlike other management functions, CB is not universally regulated by state licensing authorities, JCAHO organizations or any other external entity, except for the recent reporting requirements implemented by the Internal Revenue Service (IRS). An internal champion is vital for CB to receive the visibility and recognition it warrants. Support of senior management and boards of trustees underlies the ultimate success of CB as an integral part of a hospital's fulfillment of its mission.

**Key Themes** that this group discussed included:

- Regarding boards:
  - Composition is critical—is the community represented?
  - Board engagement in CB is essential; how to make this happen is an issue.
  - Health systems' board responsibility versus responsibility of each member hospital's board.
- Responsibility for CB extends beyond the board; CB should be recognized as consistent with the mission of the organization and the responsibility of all staff and departments, not activities done in isolation.
- CB is not just for hospitals; all nonprofit organizations should contribute to their communities.
- The hospital's obligation to serve the community should be differentiated from charity care, but this confusion persists, partially due to IRS reporting requirements.
- The U.S. system for paying hospitals shapes and limits the hospital's role in providing the community with health-related activities such as health education, prevention and primary care. Until the payment system is changed, hospitals' community-oriented activities will be constrained.

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12 Prybil, L. et al. *Governance in High-Performing Community Health Systems*. Chicago: Grant Thornton LLP, 2009.

**Questions** that can be addressed with evidence, and whose answers will help move the practices and policies pertaining to CB forward toward evidence-based decision making:

- What are the characteristics of leadership and governing boards (and their members) in hospitals that are doing CB well? What methods are used to engage hospital boards in community benefit more effectively?
- What is the role of multi-hospital health care systems in community benefit?
- What can we learn from the history of CB and how can these lessons inform our current and future efforts?
- How do we define “community”? What elements of the community are represented in governance, and how well are they represented?
- What incentives, ranging from mission to reimbursement, result in a hospital’s maximizing its contribution to the community?
- What evidence can be used to change the perception of CB from a financial liability to a contribution to the financial and moral viability of the organization?
- What makes the good examples of CB successful? Can we identify the most important variables and translate these lessons and approaches to other health care organizations?

## Ethics

The theme of ethics was discussed in concert with the themes of leadership and governance, but ethics represents its own issues and questions. Dr. Gary Filerman gave a presentation on the ethical issues related to community benefit.

## Background

The ethical framework underlying nonprofit health care, including hospitals, establishes the significance of community benefit for the organization. It guides both policy and operational decisions. A basic premise on which tax exemption rests is that a nonprofit health care organization will provide charity care to those in need and other forms of benefit to the community it serves. The mission of the organization expresses what the organization commits to delivering to the community.

Fulfillment of institutional mission is the responsibility of senior management and boards of trustees. However, in many hospitals, CB programming is so far removed from institutional priorities that the ethical underpinning is not central to decision making. Issues of social justice do not arise. For example, charity care policies typically emanate from finance or accounting, not mission. Institutional ethics committees tend to focus on decision making as it pertains to the individual patient, not the community.

Dr. Filerman concluded with a poignant question that all nonprofit institutions need to answer: Why are we doing this? In the answer lies the organization’s approach and commitment to community benefit.

**Key Themes** that this group discussed included:

- Board issues: It's the role of the board to advocate for CB.
- Governance is more than just the role of the board; it is accountability. Thus, accountability for CB should extend beyond the board.
- CB is a moral and ethical imperative that some hospitals may not be fulfilling.
- Collaboration and strong relationships among leaders of community organizations contribute to the hospital's definition and enactment of a CB program that improves the well being of the community.
- Being able to measure impact on the community and removing the financial constraints tied to reimbursement issues would remove pragmatic barriers and enable hospitals to act according to moral priorities.

**Questions** that can be addressed with evidence, and whose answers will help move the practices and policies pertaining to CB forward toward evidence-based decision making, were wrapped into the questions pertaining to Leadership and Governance.

## Finance and Economics

Economics provide a framework for organizing a broad field of inquiry.<sup>13</sup> Four basic questions are asked: *What* should be produced? *How* should it be produced? *How much* should be produced? And *for whom* should it be produced?

To answer the question, "How much?", the dollar value of CB is at once the easiest and most complicated aspect of CB. In its simplest form, the rationale for nonprofit hospitals to be exempt from taxes is that they return to the community benefits equal to the amount of their tax exemption. Calculating the amount of taxes owed is straightforward, assuming which taxes are at issue. However, determining what contributes to the community and how the value of the contributions is measured is much more difficult.

Beyond the dollars, "What" and "How" are also tough questions. Policies, practices and structures become relevant. Charity care versus bad debt is a thorny issue on which consensus is lacking. A hospital can affect the amounts in these categories through its internal policies and staff training to interact with patients in obtaining relevant information. Healthcare Financial Management Association's (HFMA) Policy No. 15 is available but not universally used. Charity care policies should be posted for ease of patient access, and boards should approve such policies.

"What" should be produced remains a fundamental issue. Under the new IRS Schedule H reporting requirements, the structures and practices of a hospital accounting department go far beyond initial interaction with patients. They involve determining ways to integrate into a single report the revenue and expenses associated with as many as a dozen different departments.

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13 Sinay, T. "Economic and Financial Aspects of Community Benefit." Presented at *Community Benefit: Moving Forward with Evidence-Based Policy and Practice*. Chicago, IL. June 27, 2009.

The IRS is looking for a basis for comparing organizations so that economic questions can be addressed and answered immediately. In short, despite the recognition of a desire for standardized accounting practices, much additional information is needed to determine how to shape financial policies and practices so that nonprofit hospitals contribute to their communities in a meaningful way.

**Key Themes** that this group discussed included:

- Economic theory and methods provide one way for hospitals to choose among alternatives. But do hospitals use a rational method for evaluating, comparing, and selecting from the various types of activities characterized by the IRS as CB?
- Charity care as a measure of CB is not a perfect measure.
- Many hospitals have very weak CB programs beyond charity care.
- The typical CB program department in most hospitals is not really connected to charity care. CB is not managed as a total program. If it were managed proactively as a comprehensive package of activities, hospitals and the community would be better off in terms of finance and health status.
- There needs to be much more transparency of data. Researchers cannot answer basic questions without data.
- For-profit and nonprofit hospitals. Do they act any differently with regard to serving the community?

**Questions** that can be addressed with evidence, and whose answers will help move the practices and policies pertaining to community benefit forward toward evidence-based decision making:

- How much uncompensated care is currently provided? How much CB is currently provided?
- Is there a business case for CB? What are the differences between for-profit and nonprofit hospitals in terms of community benefit? Should they be different?
- How do we align incentives in order to make CB more of a priority for a hospital? What hospital incentives are most related to providing charity care?
- What are the pros and cons of specifying a particular financial requirement that hospitals should devote to charity care or to all CB activities? What are the key factors that must be considered in assessing this approach as a governmental policy?
- What tools and metrics can be used to measure the efficiency and financial impact of a CB program on the hospital? On the community?

## Planning, Organization and Evaluation

Where community benefit operations are located in an organizational structure, how programs are planned, what resources are available to implement programs, and which methods and criteria are used for evaluation should all flow from the hospital's mission, strategic plan and policies. Ideally, the department and staff responsible for day-to-day CB activities are tightly connected to the mission and performance reporting of the institution, with careful oversight by senior management and the board of trustees. However, the evolution of CB programs has not necessarily led to this logical structure.

Historically, CB programming grew out of other hospital units, including mission, marketing, community health education, outreach and public relations. Moreover, the largest dollars considered to be CB are those associated with charity care, which often has been a default function lodged in the finance or patient accounts department. Defining community benefit broadly, as hospital advocacy groups, the IRS and others have done, includes health profession education, research and an array of other potentially major activities that operate under very different, often unrelated, organizational units. At this point in time, there is a serious mismatch between what is expected of hospitals by external authorities and communities, and how CB programs are organized, operated and reported.

The disjointed structure and lack of clear goals make evaluating CB programs problematic. Rigorous evaluation methodologies are available, but applying them in retrospect is typically not a good idea. If it is done, it may end up wasting resources or producing inconclusive or negative findings. The goals of an organizational unit or specific activity should be articulated in advance, with the design or plan for the evaluation incorporated from the outset. In terms of specific CB activities, particularly those targeted at the general community, the Centers for Disease Control (CDC) and other national organizations have sophisticated methodologies and considerable data readily available to show which programs are effective. Hospitals should obtain existing evidence on program effectiveness and outcomes whenever it is available and applicable.

Clearer purpose is needed so that programming, resource allocation, collaboration and evaluation can bring an evidence-based approach to community benefit.

**Key Themes** that this group discussed included:

- The structure and resources of CB should flow from the types of programs that a hospital offers to the community.
- Assessing community need is an essential foundation for developing CB programming, even without IRS mandates. Collaboration among community organizations in doing so is desired. To do this, first there must be consensus or determination of how the community is defined. A hospital may serve multiple communities.
- Community assets are important to consider, as well as community needs.
- Once community need is documented, a variety of programs may meet those needs. How does a hospital choose which needs to meet and which activities to perform?
- There is a great deal of evidence, especially drawing from public health, on which types of

programs have an impact. Often CB staff are not aware of comparative data that could help them choose among alternative programs to optimize the impact on community need.

- Beyond selecting a single CB activity, coming up with the right mix of CB programs is very important from the institutional perspective. Has anyone developed models or guidelines for shaping and evaluating a hospital's overall CB portfolio?
- Program evaluation is a highly sophisticated field, with a variety of methods that are applicable in different circumstances. CB programs should make use of expert consultants, appropriate methodologies and tools tested for validity.
- Internal buy-in is also essential. Finance, management and other departments need to be convinced about the value of CB. Evaluation is one way to sell the business case for CB.
- Evaluation methods and criteria should be established when a program is created, based on what the hospital is trying to accomplish. Not all activities can or should undergo resource-intensive evaluation. For example, logic models may be helpful in revealing the relationships among the components of CB activities, short-term impacts and long-term outcomes.

**Questions** that can be addressed with evidence, and whose answers will help move the practice and policies pertaining to CB forward toward evidence-based decision making:

- How are current community benefit programs defining "community," and how does this impact their planning practices? Can a hospital serve multiple communities?
- What exemplary planning practices result in resource allocation (structure, dollars, resources, etc.) that matches community need?
- Does the way CB units are structured relate to CB activities that are performed or the outcomes that are achieved?
- What methods and data can be used to evaluate CB programs to see if they improve health outcomes, increase effectiveness and decrease costs, recognizing that direct causation may require time to determine and may be affected by a variety of intervening factors?
- What models document effective ways for hospitals to collaborate with community organizations to ensure success in implementing CB programs that meet community need?
- What are the outcomes of well run CB programs (e.g. the balance between dollar amounts of charity care and proactive programming with the use of quality evaluation methods)?

## Community Assessment and Engagement

Community is obviously central to the goals of community benefit. How “community” is defined is critical to identifying community partners, assessing needs, shaping programs and evaluating impact. At this time, there is no standardized method for a hospital to define its community, and nothing prevents hospitals from defining different communities for different CB activities.

However “community” is defined, assessing community needs and assets is an essential foundation for a hospital’s CB programming. Collaboration among community agencies to assess community needs comprehensively is ideal. A variety of techniques for conducting needs assessments are well documented and readily available.

Engaging the community can be done in many ways. Hospitals and health systems tend to have community advisory boards, as well as governing boards comprising representatives of the community. However, which segments of the community should be engaged or represented depends on the definition of community, the mission of the hospital and the priorities under which segments of the community are to be served. Who is engaged may also be affected by the hospital’s role in a multi-health care system.

Outreach to the community ranges from holding health fairs in community venues to inviting the community in for health education and wellness programs. Outreach may cause hospital staff to interact with members of the community, but it should not be equated to being “engaged” with the community. Moreover, members of the lay community may have differing loyalties that do not reciprocate the hospital’s willingness to serve them.

Working with community stakeholders is complex. It takes time, resources and patience, as well as mutual clarity of purpose. It can be challenging to ensure that all appropriate voices are heard but do not divert focus from the hospital’s mission. Collaboration requires commitment, good will, trust and shared goals.

**Key Themes** that this group discussed included:

- No standardized definition of “community” is specified for hospitals, making it a challenge to hold hospitals responsible for assessing the needs of the community and affecting its health status.
- Many hospitals serve multiple communities; which communities should be the focus of CB activities? Or should different CB activities address different communities?
- Assessing community needs to design CB programs and engaging the community in designing those CB programs are two different processes, but both are important.
- Distinguishing between community needs and community wants is important. Vocal elements of the community may want certain services, but these may not be the most important based on an objective analysis of community need. What methodologies can be used to clarify need while assuaging local political will? Community needs assessments should be done as collaborative efforts representing the many perspectives of the community.

- Collaboration with community agencies is a broad mandate that can take many forms. If there are too many partners, the mission of a hospital may get lost among competing interests.
- CB programs must balance the benefits of working with the community and a potential loss of purpose if local politics dominate decisions about hospital programs.
- Physicians and clinical partners in the community need to be brought into CB as well. Physicians in particular like evidence, so an evidence-based approach to making decisions about CB fits with their mindset.
- In dealing with internal or external groups, communication may need to be modified. Different groups use different types of research, language, criteria and media.

**Questions** that can be addressed with evidence and whose answers will help move the practices and policies pertaining to CB forward toward evidence-based decision making:

- Are CB resources applied to areas of the community where there are gaps in access?
- What is the relationship between community involvement in decision making and CB outcomes?
- Are there relationships among community needs, CB activity outcomes and community health status?
- Are there relationships among expressed community wants, documented community needs and community engagement?
- Are there hospital models that have expanded from strictly acute care to a focus that incorporates community health?

## Public Policy

Although the IRS has instituted standardized reporting, the nation lacks a formal policy on CB at this time. Public policies pertaining to CB, either as laws or regulations, exist today in select states. Congress has held hearings, and several federal government agencies have made reports on CB, but to date, the federal government has not implemented any laws pertaining to hospital CB activities.

The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) does not have any formal hospital accreditation requirements that address CB. The major associations representing nonprofit hospitals, including the Catholic Health Association, VHA Inc. and the American Hospital Association's Association for Community Health Improvement, have been engaged in encouraging members to be involved with their communities. However, at the present time, the industry has a variety of guidelines but no fixed standards carrying incentives for compliance and penalties for noncompliance.

This highly unregulated situation speaks to the need for evidence about "what works and what doesn't work," based on assumption of desired outcomes on which there is consensus of general

direction and specific metrics. The lack of consistent public policies on CB makes it timely for hospitals and health care institutions to apply evidence in defining this field; policies and practices then can be built on valid, objective data. In the absence of external policies, internal policies, particularly within large health care systems, may serve to bring consistency to CB.

**Key Themes** that this group discussed included:

- Who is the “community?” It is necessary to define the community in order to determine its political will and assess representation, obligation and authority.
- At the societal level, do we have incentives for for-profit as well as nonprofit hospitals to have CB programs?
- Is the individual hospital the right place for CB responsibility to rest? What is the role of health care systems, especially if they cross state lines?
- Perhaps the community needs assessment should be the responsibility of another entity such as the public health department or a consortium of community agencies. Data on needs also could be drawn from standardized sources such as the CDC. Then it would be the hospital’s responsibility to act on one or more components of the community plan.
- Due to the structure of the health care delivery system, government data on needs, such as CDC data sets, do not link to government data on resource use or costs, such as that available from CMS. Private companies are not willing to share data, or it must be purchased. Public policies could be developed to enable access to data to inform the process from planning through outcome evaluation.
- It is not clear what evidence, if any, the new Form 990 Schedule H is based on. Why are categories such as community collaboration listed in the “does not count” section? Schedule H is perhaps based more on industry convention than hard data. Its components should be evaluated once data become available.
- If every hospital and every state uses different data, there is no way to get the overall picture of the impact of CB on a community or the nation. This disparity could be dealt with through public policy.
- Hospitals may respond better to the JCAHO than to government regulation.
- Could or should CB be added to JCAHO standards as a way of bringing accountability and consistency to CB practices?

**Questions** that can be addressed with evidence, and whose answers will help move the practice and policies pertaining to CB forward toward evidence-based decision making:

- In states with CB requirements, do hospitals provide different charity care or CB programs than they do in states that have no specific CB requirements? Do the states with CB requirements have better health outcomes or costs?

- Do hospitals in regions with more active public health infrastructure provide different charity care or CB than states that have weak public health systems?
- What is the impact of state CB laws on a hospital or a hospital system that spans state lines?
- What are the best ways to convene community representatives and ensure there is a voice for all stakeholders in CB programming?
- What mechanisms are available to standardize the community assessment process? What are the mechanics, and the pros and cons, of having this done by government or the private sector?

# Appendices

## Appendix I: Agenda

### **Community Benefit: Moving Forward with Evidence-Based Policy and Practice June 27, 2009 • Chicago IL**

- 9:00 **Welcome and Introductions** – Dr. Nancy Zweibel and Dr. Connie Evashwick  
*Special recognition of Mr. Robert Sigmond, trailblazer in hospital-community relations*
- 9:15 **The Background and Current Status of Applying an Evidence-Based Approach to Community Benefit**  
Dr. Connie Evashwick and Robert Sigmond
- 10:00 **Evidence-Based Community Benefit: The CHW Experience**  
Eileen Barsi, Catholic Healthcare West
- 10:30 **Break**
- 10:45 **Highlights of Critical Topics Panel** – Dr. Kanak Gautam, Chair  
*Update from Washington* – Bruce McPherson  
*Governance and Leadership* – Dr. Lawrence Prybil  
*Ethics* – Dr. Gary Filerman  
*Finance* – Dr. Tony Sinay  
*Community Assessment and Engagement* – Dr. Donna Meyer  
*Evaluation* – Dr. Jeffrey Mayer
- 12:00 **Lunch**
- 1:00 **Breakout Groups**  
*Governance, Leadership and Ethics* – Dr. Dan Gentry  
*Finance and Economics* – Dr. Kathleen Gillespie and Dr. Thomas Miller  
*Community Assessment and Engagement* – Veronica Gutierrez  
*Planning, Organization and Evaluation* – Ed jj Olson  
*Public Policy* – Dr. William Kincaid  
*Charge: Achieve consensus on most important questions and issues for which evidence is needed over the next three years to guide policy and practice. Delineate evidence that may exist, evidence needed and relevant methodologies.*
- 2:30 **Break**
- 2:45 **Report Out** – Each group reported its top three to five questions and issues.
- 3:15 **Voting** – Each participant had three votes. Participants circulated the room to vote. Votes were tallied and winners noted.
- 3:45 **Concluding remarks and next steps**
- 4:00 **Adjournment**

## Appendix II: Participants

\* Denotes Member of Planning Committee

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## **Appendix III: Select Resources Pertaining to Community Benefit**

Department of Health Management  
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[communitybenefit.slu.edu](http://communitybenefit.slu.edu)

American Hospital Association  
Association for Community Health Improvement  
[www.communityhlth.org](http://www.communityhlth.org)  
[www.assesstoolkit.org](http://www.assesstoolkit.org)

Advancing the State of the Art of Community Benefit  
<http://www.communityhlth.org/communityhlth/projects/asacb/asacbuserguide.html>

Catholic Health Association  
[www.chausa.org](http://www.chausa.org)

Hospital Coalition (CHA, VHA, Inc., HFMA, NHLA)  
Has links to IRS Form 990 Schedule H  
[www.990forhospitals.org](http://www.990forhospitals.org)

Alliance for Advancing Non-Profit Health Care  
[www.nonprofithealthcare.org](http://www.nonprofithealthcare.org)

[www.sigmondpapers.org](http://www.sigmondpapers.org)

Evidence-Based Public Health and Evidence-Based Management  
National Collaborating Centre for Methods and Tools (NCCMT)  
McMaster University, Hamilton ON - Public Health Agency of Canada - 2008  
PDF file at: [http://www.nccmt.ca/pubs/eiph\\_backgroundunder.pdf](http://www.nccmt.ca/pubs/eiph_backgroundunder.pdf)

Introduction to Evidence-Informed Decision Making  
Canadian Institutes of Health Research - April 2009  
<http://www.learning.cihr-irsc.gc.ca/course/view.php?id=10>  
or  
<http://www.cihr.ca/e/39201.html>

Center for Disease Control and Prevention  
Evidence-Based Public Health Programs  
[www.thecommunityguide.org](http://www.thecommunityguide.org)





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