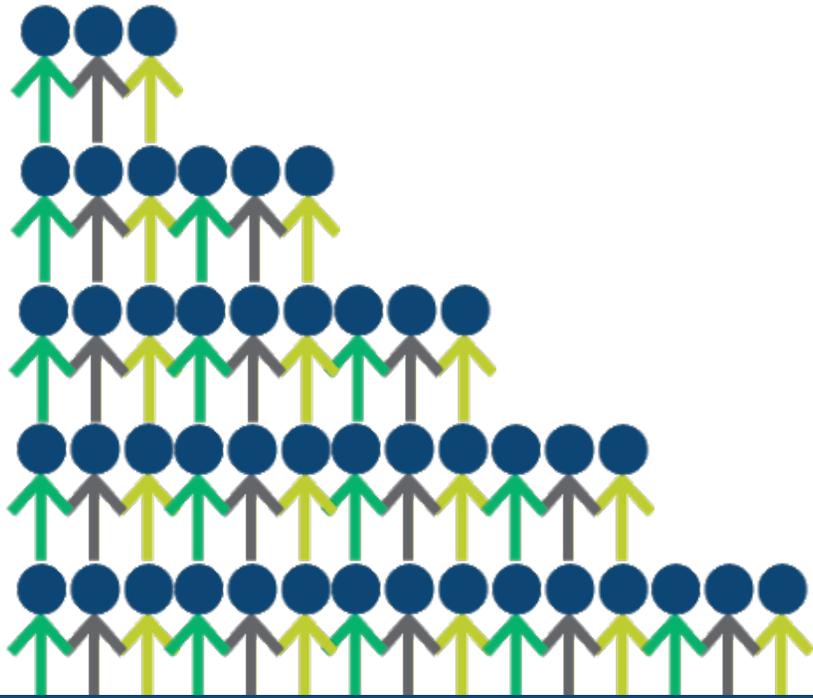


HOSPITALS & COMMUNITY HEALTH

Moving Beyond the Numerical Tally



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It is obvious by now that we as a culture spend far too much of our time, treasure, and talent treating the downstream impacts of inadequate investments in prevention. Changing these practices requires working together in ways that we haven't in the past, resisting the temptation to undertake small bore, proprietary approaches that may move the needle for individuals or a small cohort, but do not alter conditions at the community level. An important starting point is to examine current expenditures, and then we must be willing to ask the right questions that move us towards how we work together, leveraging our assets to improve health at scale in our communities.

Hospitals are key players, but most are relatively new to community health, and lack the knowledge and experience to lead in many areas. As demonstrated by a growing number of examples, however, they have the visibility, influence, and strategic assets to help drive efforts in the right direction. With the right encouragement and engagement, they can help galvanize others across sectors to align and focus assets in communities where health inequities are concentrated. The bottom line is that we share ownership for the challenges we currently face, and for the solutions we design and implement. Now is not the time for finger pointing; it is the time to come together in a spirit of collaboration and commitment.

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1.0 Asking the Right Questions

A frequently stated concern of community stakeholders is that they don't know how to meaningfully engage local hospitals in efforts to improve community health. When they engage hospital community benefit leaders, they find receptivity, but limited capability to adjust programs and expenditures. The hospital representatives may share the passions of community stakeholder colleagues but lack the access to senior leader decision making and business strategy to explore options with the potential to adjust historical patterns of resource allocation.

This resource is intended to help community stakeholders identify key questions informed by the use of **Community Benefit Insight (CBI)** tool, a searchable platform with tax-exempt hospital data from IRS Form 990 Schedule H to shift dialogue towards a more strategic allocation of assets in communities where health inequities are concentrated. It also supports more targeted use of data from **Community Health Needs Assessments (CHNAs)**, which hospitals are required to post on their websites, and **Implementation Strategies**, which are voluntarily posted by most hospitals.

Recent shifts in financial incentives in health care financing offer new opportunities for generative dialogue among hospitals and community stakeholders on how to better align and focus assets across health and related sectors to eliminate health inequities. We seek to inform that dialogue and help to build an ethic of shared ownership for health.

2.0 The Big Picture: Social Equity Gap Widening

Our country is faced with an unprecedented level of economic inequality. We have the largest proportion of the world's billionaires, yet half of Americans lack the discretionary income to invest in the stock market, and nearly a third struggle to make ends meet with less than a livable wage. These inequities are felt particularly by Americans who have experienced generations of institutional racism, limiting access to career opportunities, property, and wealth generation. These challenges have been exacerbated by policy decisions to establish restrictions and/or reduce public sector social spending.

Reduced support at the federal level has driven local and state public officials and community advocates to look increasingly to other sources of support. In the late 1970s and 1980s, many states began to ask what support they receive from nonprofit hospitals in exchange for millions of dollars per year in local property tax exemption. A flurry of state statutes were passed to require annual reporting, and in some cases, to establish minimum financial thresholds. As socioeconomic inequities deepen and health care costs continue to increase, it is not surprising that public scrutiny of hospitals is once again on the rise.

The most significant difference between health care in the 1980s and 2019 is the current trend towards value-based reimbursement. While the movement is both gradual and uneven across the country, health care providers and payers are assuming increasing financial risk for keeping people healthy and out of acute care facilities. The trend is forcing our health care sector to come to grips with an alarming reality; that we as a country do not invest sufficiently in addressing the drivers of poor health in our communities. There is a need to retool the health sector and work across sectors to address issues of housing and food insecurity, early childhood education, the lack of a livable wage, and other factors that contribute to poor health.

3.0 Transparency and Equity

While much of current media coverage in health care focuses on price transparency, a broader public scrutiny of health care practices is emerging. The imperative to shift health sector expenditures towards prevention is causing many to look once again at what is reported by tax-exempt hospitals in fulfillment of their charitable obligations. Tax-exempt hospitals' Form 990 Schedule H provides useful, but incomplete information about their expenditures to address unmet health needs in local communities. Community Health Needs Assessments (CHNAs) and Implementation Strategies (IS) also provide useful information, but there are still important information gaps. Sorting through these data sources is painstaking, particularly for the non-academic, and local stakeholders often lack the expertise to interpret and use data to engage hospitals in efforts to advance practices.

In communities served by multiple hospitals, there are often significant variations in the populations served, driven to a significant degree by the location of the facility and the demographic profile of proximal communities. These tax-exempt hospitals tend to have a less favorable payer mix than others, with higher volumes of uninsured and Medicaid patients, and lower volumes of commercially insured patients. These hospitals have higher volumes of low-income individuals in their emergency rooms with preventable conditions, many of whom are homeless and with behavioral health issues. In many ways, the economic profile of these hospitals mirror the inequities in the demographic profile of the residents they serve. Like low income families, these hospitals have less discretionary income to invest in services and activities that offer the potential to improve health and well-being, even though the needs of their patient populations and proximal communities are significantly greater. Hospitals with a more favorable payer mix and fewer Medicaid and uninsured patients in their emergency rooms have higher financial margins and significantly greater capacity to direct resources towards prevention. Unfortunately, these types of investments are often not sufficiently targeted to communities where they are most needed, in part because they are viewed as outside the primary service area of the hospital.

A comparative analysis of the charitable contributions of hospitals in municipalities would appropriately examine not only what is invested and where, but how these resources are aligned with and leverage other assets, including priorities in the municipal general plan. A failure to examine these issues represents a missed opportunity to align and focus assets where they are most needed.

There is growing evidence of hospitals within regions coming together to assess the health needs of their populations and communities. In most cases, however, such assessments have not translated into aligned resource allocations in communities where health inequities are concentrated. How do we build the capacity and commitment to move in this direction? What is needed to stimulate an open dialogue among these institutions and diverse stakeholders in the public and private sector about how we improve health and well-being in our communities?

4.0 Data Sources: IRS Form 990 Schedule H, CHNAs, & Implementation Strategies

The CBI¹ (Community Benefit Insight) platform provides user friendly access to data reported by tax-exempt hospitals through the IRS Form 990, Schedule H in fulfillment of their charitable obligations. Developed by RTI International, in partnership with CACHE, the CBI platform provides a variety of tools to enable data access to users who seek to compare contributions, institutional policies, and related information of hospitals at the local, regional, state, and national level.

Parallel reviews of CHNAs and Implementation Strategies provide supplemental information that support and inform dialogue with local stakeholders into how best to leverage, align, and focus the assets of hospitals and the full spectrum of community stakeholders to improve health and well-being in local communities.

¹ www.thecachecenter.org and www.hospitalcommunitybenefit.org

5.0 Data Elements

This section examines selected data elements in the 990 Schedule H, identifying opportunities for generative dialogue focusing on key questions, interpretations and associated implications in examining alternative approaches to resource allocation, and offering practical next steps for those who are ready to take action.

5.1 Data Element: **Charity Care and Medicaid Shortfalls**

These two data elements typically comprise by far the largest proportion of hospital community benefit expenditures, with the charity care numbers having shifted significantly towards Medicaid shortfalls in states that have implemented Medicaid expansion as part of the Affordable Care Act.



Key Question

- **What proportion of these expenditures were directed towards emergency room (ED) and inpatient treatment of preventable illnesses?**

Interpretation

This question raises issues of stewardship, equity, and the business case for investment in prevention. It should be the goal of all tax-exempt hospitals to be good stewards of their charitable resources, making ongoing efforts to produce the greatest good per unit of expenditure. Part of that commitment to stewardship should lead to targeting resource allocations in communities where health inequities are concentrated. Careful design, integration of prevention and clinical care strategies, meaningful engagement of diverse stakeholders, and leveraging of assets across stakeholders and sectors are essential for hospitals to build the institutional capacity needed to thrive in a system of health care financing that is moving towards global budgeting.

Taking Action

Hospitals in the region should conduct a geocoded analysis of Prevention Quality Indicators (PQIs), which include a set of ICD10 diagnosis codes for which ED and inpatient care would have been prevented by timely access to primary care and preventive services. Geocoding typically shows that these diagnoses are 2-5 times higher in census tracts where poverty and related socioeconomic challenges are concentrated. This analysis helps hospitals make the business case to build capacity through more proactive investment in prevention to reduce the demand for high cost ED and inpatient care as hospitals assume increasing financial risk. Conducting these analyses across institutions highlights the shared interest in targeted and aligned investments that go beyond patient care to address the social determinants of health in these specific communities.

5.2 Data Element: Health Professions Education

Teaching hospitals often report large financial shortfalls associated with graduate medical education (GME), a significant proportion of which is for faculty education and oversight of interns and residents providing patient care. In larger teaching hospitals, these shortfalls may represent the largest proportion of what they report in terms of net community benefit spending. Teaching hospitals receive supplemental Medicare payments based upon the assumption that they care for a higher concentration of patients with complex medical conditions given faculty expertise and GME training in medical specialties. They are required to subtract these supplemental payments from the net totals reported.



Key Questions

- What is the percentage and number of GME residents who are a) trained in primary care and b) who upon completion of their training choose to practice in underserved communities?
- What is the racial and ethnic composition of trainees in your GME program in comparison to that of the residents in the communities served by your program?
- What are the categorical elements of shortfalls in health professions education expenditures?

Interpretation

Teaching hospitals are not held to expectations in the first three questions by the IRS as a formal standard to validate the inclusion of health professions education expenditure shortfalls as community benefits. At the same time, some have questioned whether such expenditures represent the charitable intent of tax exemption, particularly given that they represent such a large proportion of what is reported by these hospitals. The questions raised here are part of a set of social mission standards for medical schools developed by Fitzhugh Mullan in 2010² and are currently advanced as part of the Beyond Flexner Alliance³. While teaching hospitals and graduate medical education is different from undergraduate medical education, carrying forward the vision outlined by Mullan and colleagues at the GME level calls for attention to these critically important issues.

While the case can be made that the training of the next generation of medical specialists is a social good, the practical reality is that there are acute shortages of primary care and behavioral health providers in the socioeconomically challenged neighborhoods in urban areas served by teaching hospitals, and under-investment in building health career pathways to increase the pool of health care providers who are under-represented in the health professions. An open public discussion of how these societal and locally relevant priorities are addressed as part of these institutions' fulfillment of their charitable obligations is both appropriate and much needed.

As for the fourth question, it is appropriate for the public to know the specific components of expenditures by these institutions that are often in the tens of millions of dollars per year.

Taking Action

Ideally, the leadership of teaching hospitals would be responsive and timely in responding to these questions and engage thoughtfully in exploring with municipal and community leaders what may be appropriate objectives that help address significant challenges in building a health workforce that includes addressing local and regional health needs.

² Mullan, Fitzhugh, et al, "The Social Mission of Medical Education: Ranking the Schools," *Annals of Internal Medicine*, Vol. 152 (12): 804-811.

³ www.beyondflexner.org/

5.3 Data Element: **Community Health Improvement Services & CB Operations**

Community health improvement services are the most significant category of expenditures reported by tax exempt hospitals that reflect a commitment to prevention (with the potential exception of community building expenditure (addressed below). The IRS combined this category with community benefit operations expenses, which cover staffing costs. In most cases, there limited detail provided in the reporting, both in terms of specific program and staffing expenditures.



Key Questions

- **What services and activities are funded in this category?**
- **What is the geographic focus of the services and activities?**
- **Which community assets are leveraged?**
- **What portion of expenditures in this category are devoted to CB Operations?**

Interpretation

Given a growing interest in a more strategic allocation of resources to address the social determinants of health, the single financial figure reported in the 990H and broad summaries in most published Implementation Strategies are of limited utility. Larger institutions may spend millions of dollars in this category, and it is impossible to explore how to align, leverage, and scale current efforts in the absence of more detailed information. That information should include the geographic focus of activities, community partners, and contributions leveraged. Breaking out the portion of expenditures for staffing, program management, and the CHNAs provides insights into the relative commitment of hospitals to dedicated staffing and quality in the management of programs and services.

Taking Action

This kind of inquiry requires a “deeper dive” into current programs and activities, with a serious commitment to quality improvement. There is immense opportunity to reduce duplication of effort and focus services and activities in a way that makes optimal use of resources and offers the potential to achieve measurable improvements at the community level. Moving to this level of engagement is an ideal focus for investment by local and regional philanthropy.

5.4 Data Element: **Essential Services**

These services are those that are inadequately reimbursed and viewed as essential for populations within generally defined geographic regions regardless of ability to pay. Examples include, but are not limited to burn units, blood banks, mental health services, and dental services. The provision of these services by tax-exempt hospitals is a clear expression of the original intent of tax-exemption; that it is more efficient to encourage and subsidize (through tax deferrals) the provision of services through charitable organizations in the private sector than establishing public sector institutions. They are most often reported in rural areas and smaller urban areas where there are limited health care assets. For many rural hospitals, this may be the largest category of reported community benefit expenditures.



Key Questions

- What are specific services included in the reporting, and the portion of the expenditures for each?
- What are current gaps between the current service capacity (for this hospital and others who may be delivering similar services) and the needs of community members?

Interpretation

Knowing what is reported as subsidized services, the resources allocated for each, and the gap between what is provided and what may be needed is an important starting point to an informed public dialogue about how better to serve geographic communities. It may be that some services currently provided by local hospitals are more cost effectively delivered through other avenues, and an important examination of what we agree is needed to better serve members of our communities.

Taking Action

Once hospitals have provided the detail of services and expenditures in each category, it would be appropriate for local philanthropy and institutional stakeholders to support a gap analysis that provides insights into creative ways to better coordinate and build capacity across organizations to deliver identified essential services in the most cost-effective manner.

5.5 Data Element: **Community Building**

Hospitals are instructed to report these activities in Part II of the 990 Schedule H, with the initial acknowledgment in 2011 that “some activities may meet the definition of community benefit” and that some community building costs “are reportable as a community health improvement service.” After receiving input from a broad spectrum of stakeholders, the IRS issued an Executive Order Update in December 2015 indicating that “some housing improvements and other social determinants of health that meet a documented community health improvement need may qualify as community benefit...”

This guidance is vague at best, leaving it to hospitals whether to take a chance and claim credit for a community building activity in the community health improvement services category. At present, less than half of all tax-exempt hospitals report any community building activities, and some of those which are reported include both activities that could be counted, and others that should clearly not be counted.

CACHE is completing a separate report that documents current reporting, categories, and proposes criteria for more robust and legitimate reporting **and counting** of community building activities in the future. A first step towards legitimizing these important investments is the inclusion of community building as a countable category in the new reporting guidelines in HB3076,⁴ Oregon’s recent community benefit legislation. Their movement in this direction reflects an understanding of the importance of encouraging expenditures to address the SDOH.

5.6 Data Element: **CHNA & Implementation Strategy Selected Priorities**

With important exceptions, CHNAs and Implementation Strategies are increasingly generic, ensuring compliance with IRS/Treasury guidelines, but with insufficient data and information to support a quality improvement approach that makes optimal use of limited resources. Such an approach requires an analysis of the size and cost of health-related problems, an analysis of utilization patterns across institutions with a focus on emergency room and inpatient treatment of preventable conditions, and length of stay, with a focus on people who have been identified as food and/or housing insecure.

In the development of their CHNAs, hospitals are required to define their communities, and to do so in a way that does not exclude proximal communities and populations with health inequities. If a hospital has, for example, selected its county as the geographic area of focus for its CHNA in partnership with other hospitals, and there is a low-income community that is proximal, but in an adjacent county, it may be viewed as problematic. Hospitals are also required to identify priority health issues to address and select among those priorities those which will be the focus for their Implementation Strategy. In some cases, they may identify specific populations and/or geographic sub-regions where they will focus the priorities, but they may also just indicate that the priority will be a focus across a large geographic area. In the selection of priorities, hospitals are required to seek input from people with public health expertise and community stakeholders in communities where health inequities are concentrated. While they are not required to engage community stakeholders in the design, implementation, and evaluation of strategies, more forward thinking hospitals have done so, in recognition of the need for shared commitment and optimal leveraging of institutional and community assets.

⁴ www.olis.leg.state.or.us/liz/2019r1/downloads/measuredocument/hb3076/introduced

5.6 Data Element: CHNA & Implementation Strategy Selected Priorities *(continued)*



Key Questions

- How is community defined in your CHNA, and based upon what reasoning?
- What criteria were used to select priorities?
- Which community stakeholders were involved in the selection of priorities?
- Which community stakeholders were involved in the design of strategies, and in what ways?
- How do the selected priorities leverage existing community assets?

Interpretation

Full transparency is optimal in assessing how priorities are selected, based upon what criteria, and involving which community stakeholders. It is also important to understand the degree to which key stakeholders which may have the potential to make significant contributions to addressing a priority are engaged, and in what manner, in the planning, implementation, and evaluation of programs and services. Finally, a key issue to be addressed that is often overlooked is the degree to which the assets of key community stakeholders are leveraged, consistent with a commitment to optimal stewardship of available resources.

Taking Action

Use GIS mapping technology to identify the locations of hospitals and federally qualified health centers, jurisdictional boundaries such as municipalities and counties, use metrics that serve as proxies for health inequities such as census tract level percentages of the population under the federal poverty line and high school noncompletion rates, and map health care utilization patterns at the zip code or census tract level with a focus on metrics such as PQIs (see 5.1). Mapping these metrics help make a compelling case for alignment of efforts across sectors and targeted focus in communities where health inequities are concentrated.

6.0 Conclusion

There is a clear need for targeted support at the regional and community level to address the kinds of follow up questions outlined in this document. All too often, the release of public data on hospital community benefit expenditures yields less than satisfying outcomes. Hospital leaders are frustrated that community stakeholders don't understand the growing challenges faced in running these large, complex organizations in a rapidly changing environment, and community stakeholders are frustrated that current efforts fall well short of community health needs.

Regional and state philanthropy is particularly well positioned to support the kinds of targeted local analysis to identify gaps and develop strategies to align and focus assets across sectors. CACHE addresses these questions as a part of regional analyses that build on CBI data analyses to support the alignment and focus of health and related sector assets in urban and rural areas across the country. We welcome the opportunity to support your efforts to advance practices and eliminate health inequities in your community.

7.0 Technical Assistance Services

CACHE offers training and a suite of technical assistance services to support hospitals and community organizations in their effort to address Social Determinants of Health (SDOH).

CACHE supports hospitals in building Organizational Capacity to realign internal resources and strategies to achieve their community health improvement initiatives. CACHE supports Community Partnerships through strengthened cross-system and cross-stakeholder partnerships to identify those areas where health inequities are concentrated and develop solutions to alleviate them.

To learn more about how we can partner with your organization in support of your community health goals, please contact us at cache@phi.org. Or visit us online at www.thecachecenter.org/technical-assistance to learn more about our technical assistance services for hospitals, community organizations and stakeholders.

About Center to Advance Health & Equity

The Center to Advance Health & Equity (CACHE) is housed at the Public Health Institute and uses evidence-informed tools and technical assistance to support strategic approaches to health improvement in communities where health inequities are concentrated. CACHE is promoting collaboration through data and dialogue to inspire action.

8.0 Resources & Tools

CBI

The **Community Benefit Insight** (CBI) tool is an easy to use online platform that increases transparency in tax-exempt hospital community benefit spending by making it easy for community stakeholders to access information about how local hospitals spend community benefit dollars. With this tool you can easily identify and graphically visualize data for any tax exempt nonprofit hospital, including the following data points:

- Total hospital expenditure;
- Total community benefit expenses — and percent of total expenditure;
- Breakdown of hospital spending by community benefit category (and by percent).

CBI also easily displays descriptive information such as hospital size (bed count), and whether or not it's a teaching hospital, or affiliated with a church. Hospital data can easily be compared to similar hospitals. Compare community benefit expenditures to similar hospitals, choosing from 14 hospital characteristics, to put the data in context.

The CBI platform was developed by RTI International with the Milken Institute School of Public Health at George Washington University. It continues to be managed by RTI through the generous support of the Robert Wood Johnson Foundation (RWJF). RTI partners with CACHE for support in responding to inquiries. *Access the CBI platform at www.thecachecenter.org and www.hospitalcommunitybenefit.org.*

CHNA

Community Health Needs Assessment (CHNA) document provides detailed information regarding:

- How the hospital defined it's service area for the purpose of the assessment;
- How the hospital identified significant needs;
- How the hospital then prioritized significant needs.

Access CHNA documents through your hospital website.

Implementation Strategies

Hospitals are not required to publicly post the **Implementation Strategy** that results from the CHNA process, though many do. Reviewing the Implementation Strategy shows you how the hospital decided to act on the information identified in the assessment process. Consider if and how the hospital acted on priority needs identified in the CHNA, and whether or not there was an emphasis on equity in the actions that were identified to address community health needs.

Taken together, these three data sources allow you to present an overview of hospital spending, identify how and what was prioritized in the needs assessment process, and how and what actions were taken as a result.

Vulnerable Population Footprint

The **Vulnerable Population Footprint** tool from CARES Engagement Network is a helpful resource for identifying vulnerable populations based on percent of population below the poverty line and with less than a high school education. The tool allows users to map vulnerable populations by geographic location in relation to hospital locations. *Access the [Vulnerable Population Footprint](http://www.engagementnetwork.org) tool at www.engagementnetwork.org under Maps.*