

# **The Status of Community Benefit in California**

*A Statewide Review of Exemplary Practices  
And Key Challenges*

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**Commissioned by:**



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## EXECUTIVE SUMMARY

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The purpose of the study is to document high-quality community health initiatives supported by nonprofit hospitals to address unmet health-related needs in local communities. A particular focus of the inquiry is to identify key elements of these initiatives that reflect a commitment to make optimal use of charitable resources. Findings are intended to inform the current policy dialogue by providing insights into the potential scope of charitable contributions by nonprofit hospitals, opportunities for enhancement of efforts to date, and challenges to be addressed.

Key elements documented in the inquiry include a) the content focus of program activities, b) the roles and contributions of hospitals, c) populations and communities served, and d) reported impacts to date. The study also documents challenges identified by hospital staff members who are responsible for planning and implementing community benefit activities.

The first phase of the study was a written survey mailed to 234 California nonprofit hospitals. There were 47 respondents representing 81 facilities, for a response rate of 34.6 percent. Respondents identified a total of 185 programs and activities in five categories of accomplishments. The five categories include a) programs producing measurable improvements in health status, b) programs producing measurable improvements in quality of life, c) institutional policy changes to strengthen organizational commitment, d) strategic investments to build community capacity, and e) ongoing partnerships with community stakeholders.

A 15-member statewide Advisory Committee selected 23 of the 185 activities for further documentation as exemplary practices. The second phase of the inquiry involved a series of telephone interviews and review of materials from the 23 sites selected as exemplary practices. Summaries of each activity are included in this report as Appendix A.

At the end of the inquiry, briefings were held with a variety of stakeholder groups to solicit feedback on study findings. Examples of stakeholders include Consumers Union, organized labor groups such as Service Employees International Union Local 250, and hospital groups such as the California Association of Public Hospitals and Health Systems and the California Healthcare Association. Briefings were also held with staff and leadership of the California Office of Statewide Health Planning and Development and the California Health and Human Services Agency. The discussion section of the report includes stakeholder group feedback

### **Key elements of community health initiatives selected as exemplary practices include:**

- Clear targeting of programs to serve populations and communities with disproportionate unmet health-related needs
- Meaningful engagement of diverse community stakeholders

- Strategic allocation of charitable resources to build on existing community assets
- Alignment of governance, management and operational functions with the charitable mission of the organization

**Key challenges identified by respondents include, but are not limited to:**

- A lack of dedicated staffing and resources
- A lack of sub-county data on health needs
- Obstacles to coordination with local public health agencies
- Competition and “turf” issues among community stakeholders
- A lack of internal policies and procedures that encourage quality improvement and foster increased accountability

Study recommendations are offered in four areas. The first set of recommendations calls for an expansion in the scope of nonprofit hospital accountability to encourage attention to the key elements of exemplary practices identified in this report. The second area identifies the need for uniform definitions and measures for charity medical care and the full scope of activities associated with planning and implementing community health initiatives. The third area calls for increased coordination between hospitals and local public health agencies. The fourth and final recommendation encourages the initiation of public dialogue at the local and regional level to increase public understanding and engagement in community benefit planning and implementation.

Given a response rate of 34.6 percent, the exemplary practices documented should not necessarily be viewed as the best in the field. Instead, they should be seen as among the best efforts reported by approximately one-third of California nonprofit hospitals that responded to the survey. It is important to note that the activities documented in this study are self-reported. Further inquiry is needed to validate these findings.

Also, it is not the intent of this study to suggest that community health initiatives alone should fulfill the charitable obligations of nonprofit hospitals. Without comprehensive reforms to ensure timely access to quality care for uninsured and underinsured populations, the provision of free medical care by nonprofit hospitals will remain an important component of their charitable contributions.

## **I. Introduction**

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### **A. Purpose / Description**

The purpose of this study is to document initiatives undertaken by California's nonprofit hospitals to improve health status and quality of life in local communities. These activities are one of several forms of charitable contributions made by nonprofit hospitals that are referred to as "community benefits."

There is a public expectation that nonprofit hospitals will operate in a manner that is consistent with their legal status as tax-exempt charitable organizations. An important dimension of public expectations is that hospitals will play a meaningful role in efforts to address unmet health needs in local communities. These charitable activities, known as community benefits, include but are not limited to a) the provision of free and/or reduced fee medical care to medically indigent populations, b) medical education, training, and research, c) the establishment and/or maintenance of unprofitable services, and d) community health initiatives.

Nonprofit hospital support of community health initiatives represents an attempt to address unmet health needs in a proactive manner through partnerships with community stakeholders. A common goal is to address the underlying causes of health problems and thereby reduce the demand for high cost emergency room-based care for preventable illnesses. For a variety of reasons, the full value and benefit of these kinds of initiatives are often difficult to define in strictly financial terms.

This study documents a variety of community health initiatives. It provides insights into the scope of current contributions and highlights key elements that may distinguish some activities as exemplary practices. Areas of focus include:

- Content focus of program activities
- Roles and contributions of hospitals and community partners
- Populations and communities served
- Reported impacts/outcomes to date

The study also documents challenges identified by hospital staff members who are responsible for planning and implementing community benefit program activities. Data presented examines both internal and external factors that influence the quality and sustainability of the programs.

The inquiry occurred in two stages. The first step was a written survey mailed to California nonprofit hospitals; the second step was a series of telephone interviews with a subset of hospitals whose activities were selected for further documentation. Hospital activities were selected for further documentation by a 15-member statewide Advisory Committee.

At the completion of the inquiry, briefings were held with a number of stakeholder groups to solicit feedback and suggestions. A summary of that input is included in the discussion section of the report.

It is important to note that it **is not** the intent of this study to suggest that community health initiatives alone should fulfill the charitable obligations of nonprofit hospitals. In the absence of a comprehensive solution to the systemic problem of limited access for uninsured and underinsured populations, the provision of free and/or reduced fee medical care by nonprofit hospitals will remain a significant component of charitable contributions in the near future.

It is also important to point out that it **is not** the intent of this study to represent the community initiatives documented as necessarily the best in the field. Given a survey response rate of 34.6 percent (see results, pg. 10), the programs documented can only be represented as some of the best examples of community health initiatives by approximately one-third of nonprofit hospitals in California.

In summary, the study's purpose is to identify key elements of community health initiatives that reflect a commitment to make optimal use of charitable resources to address the unmet health-related needs of local communities. In the process, the study's intent is to inform the current policy dialogue by identifying opportunities to enhance current efforts and address challenges experienced by hospitals and other local stakeholders.

## **B. Impetus for Inquiry**

The impetus for this study is a concern that the current policy debate may overlook substantive efforts by nonprofit hospitals to improve health status and quality of life in local communities. Anecdotal evidence suggests that many of these efforts are producing meaningful impacts that merit acknowledgment as an important component of nonprofit hospital charitable activity.

Anecdotal evidence also suggests that there are many community initiatives that are poorly designed and targeted. Some initiatives may duplicate and compete with services already provided by existing community-based agencies. Others may involve the delivery of services at locations that are more likely to be frequented by insured, middle class populations, rather than low-income, uninsured community residents. These kinds of efforts have led some observers to conclude that nonprofit hospitals lack a commitment to fulfill their charitable mission.

To date, there has been no systematic collection of information that would help to distinguish between high quality and poorly designed community initiatives. The lack of oversight serves as a disincentive for hospitals to invest in high quality activities, and allows the perpetuation of sub-optimal behavior. The net result is that community health initiatives may not be given adequate consideration as an important component of nonprofit hospital charitable contributions.

The current policy debate in California focuses almost exclusively on the volume of charity care provided by nonprofit hospitals on an annual basis. This is driven by the convergence of a number of factors, including:

- High number of uninsured under 65 yrs; 6.2 million, or 20 percent of CA residents<sup>1</sup>
- Suggestions that some nonprofit hospitals may be providing less charity care<sup>2,3</sup>
- Increasing financial pressures faced by hospitals
- Increased visibility and activism among consumer advocates and organized labor
- Lack of political consensus for comprehensive health care reform

It is clear that there is a need for increased clarity on what constitutes charity care and greater rigor and consistency in how it is documented in California. Current data submitted by hospitals to the California Office of Statewide Health Planning and Development (OSHPD) is flawed at best. There are substantial inconsistencies and gaps in information both across and within institutions on a year-to-year basis. While external analyses may yield useful information in the aggregate regarding macro level trends and patterns, evidence suggests that more specific findings should be viewed with caution.

A systematic and comprehensive review of charitable practices is needed to provide a more complete evaluation of nonprofit hospitals. Optimally, this would include both a calculation of the financial value and practical benefits associated with a full spectrum of charitable practices *and* an assessment of the institutional policies and practices that reflect the charitable intent of the organization. This study represents an attempt to provide a more complete picture for stakeholders at the state and local level.

### **C. Background**

The term “community benefit” is one of four legal dimensions of charity originally articulated in the wake of a 1891 legal challenge to the Church of the United Brethren in Great Britain.<sup>4</sup> The challenge was precipitated by the local tax commission’s refusal to defer the payment of local taxes by the church. The commission argued that the church’s activities were not charitable since they served the affluent as well as the poor. The four dimensions of charitable activities sanctioned in the law of trusts include:

- Relief of poverty
- Advancement of education
- Advancement of religion
- Other purposes beneficial to the community

This broad interpretation of charity was codified in the first U.S. federal taxation act of 1894.<sup>5</sup> Since most hospitals in existence at the beginning of the 19<sup>th</sup> century had been

established primarily to provide services to the poor, however, assessments of their charitable obligations were generally limited to the “relief of poverty” dimension.

As medical technology advanced in the 20<sup>th</sup> century, hospital services became more desirable to more affluent populations. The emerging focus on paying patients was viewed as a reasonable tool for the cross-subsidization of services to low-income patients.<sup>6</sup>

Despite this trend, the relief of poverty interpretation of charity was endorsed with IRS Ruling 56-185 in 1956. This ruling acknowledged that a nonprofit hospital “must be operated to the extent of its financial ability for those not able to pay for the services rendered,” and that it could not “refuse to accept patients in need of hospital care who cannot pay for such services.”<sup>7</sup>

The legal interpretation of charity as it applies to nonprofit hospitals was broadened in 1969 to include the community benefit dimension with IRS Ruling 69-545.<sup>8</sup> Ruling 69-545 was handed down shortly after the passage of Medicare and Medicaid legislation and in the context of a significant expansion in public sector poverty programs. It has been suggested that the IRS viewed the issue of access to medical care as a concern that would be addressed primarily through the allocation of public sector funds, and that nonprofit hospitals should be given the flexibility to address a broader scope of health needs.<sup>9</sup>

Ruling 69-545 was reaffirmed and expanded in 1983 with IRS Ruling 83-157,<sup>10</sup> which indicated that any combination of services and activities that benefited a class of persons broad enough to constitute benefit to the community is sufficient to meet the charitable obligations of a nonprofit hospital. Rulings 69-545 and 83-157 created an opportunity both for innovation and for opportunism. Responsible institutions could employ a variety of methods to address both the symptoms and underlying causes of health problems in low-income communities. Less responsible institutions could channel charitable resources into programs that enhance care for existing patients or are designed to attract new paying patients.

The lack of specificity and guidance from the IRS at the federal level, combined with declining public sector revenues to serve medically indigent populations, contributed to a series of legal challenges in the 1980s. The most well known legal case was the Utah State Tax Commission v. Intermountain Health Care in 1985.<sup>11</sup> Five years of court arguments in Utah produced the legal framework for the first state community benefit legislation in 1990.<sup>12</sup> A flurry of other state laws followed in the 1990s.

There are currently 11 states with guidelines or standards for community benefit reporting, and seven others with some form of reporting and financial structures to support medical care for medically indigent populations. Three of the states with community benefit laws include financial thresholds for nonprofit hospital provision of charity medical care; Utah, Pennsylvania,<sup>13</sup> and Texas.<sup>14</sup> Others in states such as California,<sup>15</sup> Massachusetts,<sup>16</sup> and New Hampshire<sup>17</sup> emphasize the engagement of community stakeholders to address unmet health needs.

In the six years since the passage of California's community benefit law, Senate Bill 697, there has been little progress in efforts to expand coverage to uninsured populations. Enrollment in California's Healthy Families has been less than optimal, due to a variety of financial and non-financial barriers.

At the same time, the combination of fierce competition, downward pressures on reimbursement by public and private sector payers, and rising costs have placed many hospitals at financial risk. While most hospitals benefited from high returns on investments in 1999 and 2000, market investments are less likely to serve as a buffer in 2001 and beyond. A recent report on hospital closures between 1995 and 2000 suggests that financial pressures for California hospitals are likely to result in additional closures in the next few years.<sup>18</sup> To further complicate matters, hospitals are faced with an estimated \$24 billion of capital expenditures in order to comply with current state earthquake standards.<sup>19</sup>

To compete with large investor-owned hospital chains a number of California nonprofit hospitals embarked on a campaign to acquire other hospitals and consolidate services during the last decade. In part, the intent was to gain leverage in contract negotiations with for-profit payers, pharmaceutical companies, and equipment manufacturers, and to increase efficiency by consolidating functions such as accounting, fundraising, and human resources. Unfortunately, many such efforts to consolidate functions have not yielded substantial savings. In some cases, investments have generated substantial losses.

In some cases, efforts by hospitals to address financial pressures and enhance long-term viability have had a negative impact upon workforce and community relations. Reductions in nurse-to-patient ratios and increasing patient loads for physicians have raised questions about quality of care and patient safety. The consolidation of services or closure of facilities in some communities has been opposed by local residents concerned about travel time to more distant facilities. Some groups have also raised concerns about the loss of decision-making power among local boards of hospitals that have been acquired by health systems.<sup>20</sup>

In this environment of uncertainty, there is considerable anecdotal evidence that SB 697 has contributed to a substantial increase in nonprofit hospital engagement in collaboration with diverse stakeholders to address health problems in local communities. A number of promising practices were documented in a report published by OSHPD in January 1998,<sup>21</sup> but OSHPD has lacked the resources to effectively monitor nonprofit hospital behavior or enhance the implementation of SB 697 since the original publication.

## II. Methodology

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### A. Survey Design / Dissemination

The survey instrument developed for this study is a ten-page, two-part questionnaire. The first section of the questionnaire focused on community benefit accomplishments and asked respondents to identify activities in one or more of five categories, including:

- Programs producing measurable improvements in health status
- Programs producing measurable improvements in quality of life
- Institutional policy changes to strengthen commitment to community benefit
- Strategic investments of charitable resources to build community capacity
- Ongoing partnerships to address the causes of health problems

Explanations were provided at the beginning of each section to describe the full meaning of the category. Examples were given to provide additional clarity. Respondents were then asked to identify their best example of an activity in each category, and were given explicit guidelines for their response. For the first two categories, respondents were asked to provide the following:

- Brief description of activity
- Specific role(s) and/or contributions of the hospital
- Targeted population(s) (e.g., ethnicity, socioeconomic status, coverage status)
- Measurable objectives
- Measurable impacts to date

For the third category (institutional policy changes), respondents were asked to address three questions:

- Key elements of policy change
- Intended impacts / objectives
- Impacts to date

For categories four and five, respondents were asked to provide similar information to categories one and two, with the following distinctions:

- Category 4 (strategic investments) - identify existing community assets
- Category 5 (ongoing partnerships) - describe governance and composition of partnership

The second section of the questionnaire focused on key challenges associated with planning and implementing community benefit programs. Respondents were asked to identify challenges in five categories, including:

- Community assessment
- Community outreach / engagement
- Setting priorities / program selection
- Program monitoring
- Organizational infrastructure

Respondents were given a series of categorical options for their responses to each question. An additional category of “other” was provided to allow for responses that were not included among the list of options. Each question was also followed by a space for additional information.

In the community assessment category, respondents were asked to identify challenges associated with the collection of data and information on health needs and existing community assets. In the community outreach / engagement category, respondents were asked to identify challenges associated with the engagement of community-based organizations and community residents. For setting priorities / program selection and program monitoring, respondents were asked to identify the most significant challenges in each category.

There were two questions in the organizational infrastructure category. The first asked respondents to identify the most important area for internal development to enhance the effectiveness of community benefit programming. The second asked respondents to identify the most significant overarching challenges faced by their hospital in its efforts to fulfill its charitable mission.

Two copies of the questionnaire and cover letters were mailed to each nonprofit hospital facility in the state; one to the facility administrator (e.g., CEO, COO), and one to the community benefit program manager. Contact information for the mailing was provided by OSHPD.

Respondents were asked to fax or email their completed questionnaires to the principal investigator of the study within a specified time period. Two weeks prior to the deadline, calls were made to non-respondents to confirm that they had received the information and to encourage completion and return of the survey. A copy of the survey and cover letter is provided as Appendix B.

## **B. Compilation and Analysis**

Survey responses in the accomplishments section were compiled in spreadsheet format for review by members of the Advisory Committee. Responses in each accomplishment category were also grouped for summary documentation. Activities were grouped by content, by population / community targeting, and by impacts to date.

Categorical responses from the challenges section were compiled for presentation in narrative and graphic format. Explanatory information provided at the end of categorical responses was compiled to document selected statements in narrative format.

## **C. Exemplary Practice Selection**

Survey responses from the accomplishment section were compiled in spreadsheet format and grouped in the five categories. A preliminary review was conducted to remove examples that lacked key information (e.g., targeted population / community, role of the hospital, measurable outcomes). The remaining activities were provided to the 15-member Advisory Committee for review. All identifiers, such as hospital, health system, and project names were removed from the compiled information to minimize potential biases in the selection process.

Advisory Committee members were asked to select what they viewed as the five most promising case examples in each category of accomplishments. They were also provided with a set of criteria to assist in the selection process. For the first two categories (i.e., programs producing measurable improvements in health status, programs producing measurable improvements in quality of life), Advisory Committee members were provided with the following criteria:

- Overall quality / innovation
- Importance of hospital role / contributions
- Population targeting (i.e., relative focus on unmet health needs)
- Clarity of objectives
- Potential or demonstrated impact

For the third category (institutional policy changes), criteria for review included:

- Impact upon program quality
- Impact upon governance / oversight
- Impact upon operations / management
- Impact upon staff / provider involvement
- Impact upon community involvement

Review criteria for category four (strategic investments to build community capacity) included:

- Relative benefit to community service-based organizations
- Relative benefit to community infrastructure (e.g., physical, social capital)
- Impact upon local public policy
- Impact upon program effectiveness and/or sustainability

Review criteria for category five (ongoing partnerships to address the cause of health problems) included:

- Diversity of stakeholder involvement (including community residents)
- Relative impact / accomplishments
- Neighborhood scale
- Importance of hospital role / contributions

Advisory Committee selections were compiled and a set of “finalists” were selected in each category. In cases where there were an equal number of votes, additional criteria were used to assist in the selection. The criteria were geared towards optimal representation of the following:

- Diversity of content (i.e., programs, policies)
- Rural / urban
- Geography (i.e., region of state)
- Size of institution

Advisory Committee members were then provided with a list of finalists, and given the opportunity to identify remaining gaps in representation or to make a case for inclusion of any particular case example.

#### **D. Exemplary Practice Information Collection**

The first step in the documentation of case examples was to contact hospital representatives identified in survey responses to secure permission to publish information and to schedule telephone interviews. Representatives were also asked to forward relevant written information for advance review.

Telephone interviews were approximately one hour in length, and focused on supplementing information in the initial survey response and written materials provided for advance review. Areas of particular emphasis included:

- Populations and communities served and/or involved in initiatives
- Impetus and inception of the initiative
- Hospital role(s) and contributions
- Impacts to date

Brief follow-up interviews were conducted with hospital contacts to verify and/or supplement information. Hospital representatives were given the opportunity to review draft summaries to correct factual errors and/or fill gaps in information.

### III. Results

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There were a total of 47 respondents to the survey representing 81 facilities. The survey targeted a total of 234 nonprofit facilities (including 28 Kaiser Permanente hospitals) yielding a response rate of 34.6 percent.

Fifteen survey respondents completed the questionnaire on behalf of multiple facilities; the number of facilities represented was from two to 10. Four of the 15 respondents reported on behalf of their entire health system; the other 11 represented two to four facilities in a particular region of their health system.

All but four respondents provided contact information for follow up, reflecting strong interest in having their institution's activities selected as exemplary practices and documented in the final report. In most cases, respondents provided examples of activities for each of the five categories of accomplishments; others provided examples in four categories or less.

There were a total of 185 program activities and policies cited as exemplary practices by respondents. The number of responses in each category was as follows:

|   |           |
|---|-----------|
| <b>Programs producing measurable improvements in health status</b>      | <b>42</b> |
| <b>Programs producing measurable improvements in quality of life</b>    | <b>38</b> |
| <b>Institutional policies that strengthen organizational commitment</b> | <b>32</b> |
| <b>Strategic investments to build community capacity</b>                | <b>38</b> |
| <b>Ongoing partnerships in local communities</b>                        | <b>35</b> |

This section is divided into three sub-sections that include accomplishments, key challenges, and summary of exemplary practices. The summary of accomplishments includes breakouts by content and geographic / population focus, as well as impacts to date cited by respondents.

#### **A. Accomplishments**

##### **1. Programs producing measurable improvements in health status**

The 42 program activities cited are divided into five content categories, including:

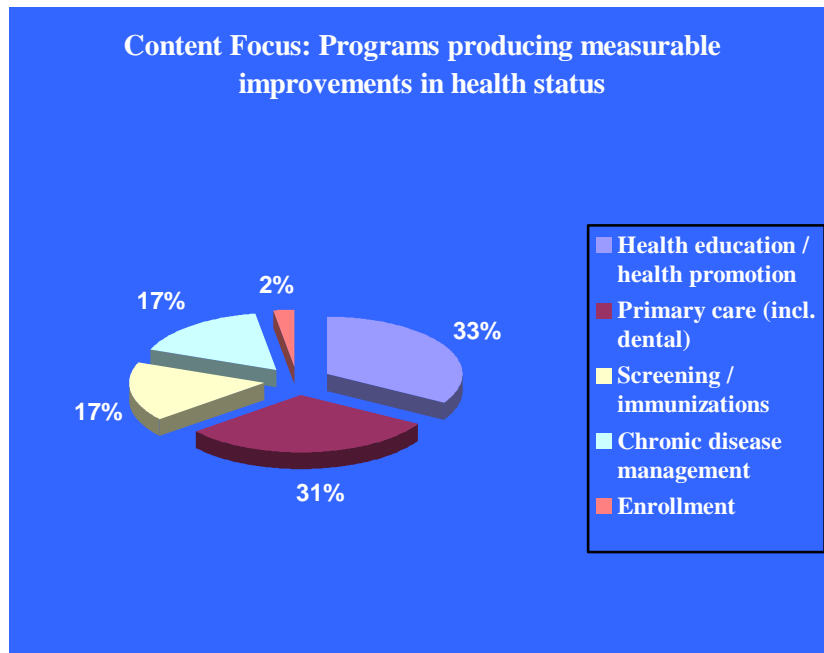
|  |           |
|--|-----------|
| <b>Health education / health promotion</b> | <b>14</b> |
| <b>Primary care (including dental)</b>     | <b>13</b> |
| <b>Chronic disease management</b>          | <b>7</b>  |
| <b>Screening / immunizations</b>           | <b>7</b>  |
| <b>Health insurance enrollment</b>         | <b>1</b>  |

Programs with a primary focus on health education / health promotion include school-based asthma education, violence prevention, and teen pregnancy prevention, training and support of Latino health promoters, and home visits to provide health information in low-income rural communities.

Primary care services are being provided through community clinics (2), hospitals (3), home visits (2), and mobile vans (2). Chronic disease management programs focused on asthma (3), diabetes (2), cardiovascular disease, and sickle cell anemia. Screening programs focused on memory testing, clinic-based mammography, church-based blood pressure testing, and diabetes. Immunization programs focused on children (2) and flu shots for seniors (2; 1 of the 2 programs serves both seniors and children).

Twenty-seven of the 42 programs in this category indicated a specific focus on low-income populations. Of the 27 with low-income targeting, six indicated a particular focus on Latinos, five on youth, three on African Americans, and one each on Samoans, seniors, women, and homeless populations. The remaining 15 programs indicated service to the community at large (2), and to targeted populations of diverse socioeconomic status, including seniors (4), pregnant women (2), youth, and people with diabetes (3), sickle cell anemia, cardiovascular disease, and HIV/AIDS. The distribution of program activities by content focus is provided as Figure 1.

**Figure 1 – Content Focus – Programs producing measurable improvements in health status**



Impacts cited by respondents include reductions in:

- Repeat hospitalizations
- Preventable injuries
- Teen pregnancy
- Blood pressure and weight loss
- ER pediatric visits
- ER use and admissions for seniors

- ER visits for non-emergent care
- Acuity of conditions among homeless populations presenting at ER

Respondents also cited the following increases:

- Immunization rates
- Screening and identification of early stage breast cancer
- Knowledge and management of chronic illnesses

## 2. Programs producing measurable improvements in quality of life

The 38 program activities cited are divided into 7 content categories, including:

|  |           |
|--|-----------|
| <b>Health education / health promotion</b> | <b>11</b> |
| <b>Life skills / employment training</b>   | <b>11</b> |
| <b>Support services</b>                    | <b>8</b>  |
| <b>Community organizing / development</b>  | <b>3</b>  |
| <b>Chronic disease management</b>          | <b>2</b>  |
| <b>Screening / immunizations</b>           | <b>2</b>  |
| <b>Health care advocacy</b>                | <b>1</b>  |

Programs with a primary focus on health education / health promotion include school-based fitness and nutrition programs for students and teachers (two), the establishment of health education resource centers at rural schools, prenatal education and services for pregnant mothers (three), and a comprehensive school-based program that includes stress management and conflict resolution in addition to traditional health education topics.

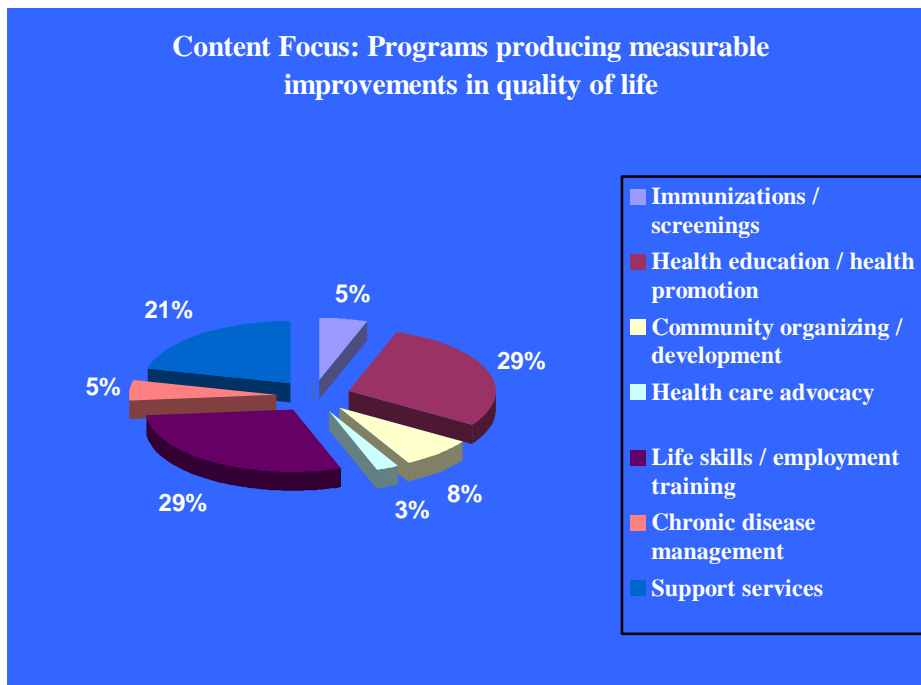
Life skills / employment training programs include a community center that provides comprehensive after-school training programs for Latino youth, a respite and training center for poor and homeless women, senior caretaker job training for former welfare recipients, and a life skills / career mentoring program for youth that are experiencing trouble in schools.

Support services include networks of local services to support senior independent living (three), a toll-free service for latchkey children, a visitation program for non-custodial parents, and psychological interventions and support services for students with behavioral problems.

Community organizing / development programs include a neighborhood initiative to build leadership and social capital to address resident-identified quality of life concerns, establishment of a neighborhood association that has conducted trash cleanups and graffiti removal, and the development of affordable housing for low-income residents.

The distribution of program activities by content focus is provided as Figure 2.

**Figure 2 – Content Focus: Programs producing measurable improvements in quality of life**



Twenty-two of the 38 programs cited a specific focus on populations in low-income neighborhoods; six of 22 on students, five on “at-risk” youth, four on women, one on Latinos, and six on all neighborhood residents. Another 12 programs cited a focus on specific populations in the larger community. Five cited a focus on seniors, five on students, one on caregivers, and one on parents of teens. The remaining four programs indicated a general emphasis on service to all populations regardless of coverage and economic status. Impacts cited by respondents included reductions in:

- School absenteeism
- School dropout rate
- Graffiti in local neighborhoods
- Dumping in local neighborhoods
- Gang violence and activities
- Criminal activities
- Burden upon senior caregivers

Respondents also cited the following increases:

- Life and employment skills (two)
- Academic performance
- Affordable housing
- Investment of tobacco settlement funds on health care
- Independent living for seniors
- Community resident leadership / civic engagement

- Support systems for “latchkey” children
- Parenting skills
- Parent-child bonding and attachment (teen parents)

### 3. Institutional policies that strengthen organizational commitment

Thirty-two respondents cited institutional policy changes to strengthen organizational commitment to community benefit principles and practices. Responses are divided into three content categories, including:

|   |    |
|---|----|
| Establish dedicated staff positions                 | 11 |
| Establish formal governance / oversight structures  | 12 |
| Establish performance monitoring systems / criteria | 15 |

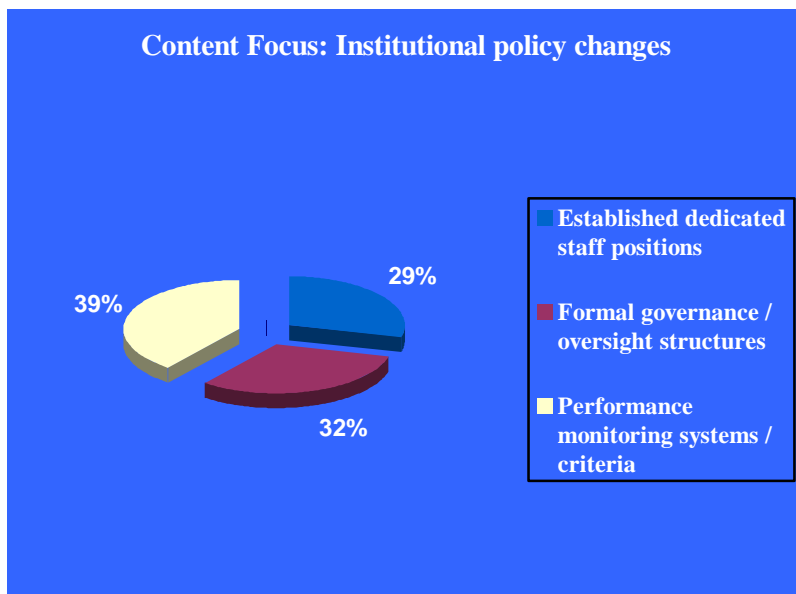
Twenty-six of the 32 respondents cited institutional policy changes in one of the three content categories, and six respondents cited changes in two of the three categories, yielding a total of 38 changes.

Six of the 11 respondents that cited the establishment of dedicated staff indicated that they were senior level positions with direct reporting responsibility to the CEO. Examples of position titles include, but are not limited to, Chief Community Health Officer, Community Clinical Manager, Director of Community Partnerships, and Community Benefit Manager.

Five of the 12 respondents that had established formal governance / oversight structures indicated that community members are involved as members of these bodies.

The distribution of policy changes by category is provided as Figure 3.

**Figure 3 – Content Focus: Institutional policy changes**



Examples of governance structures that were established include a Joint Boards Community Committee, a Healthier Communities Task Force, a Community Needs Committee, a Community Focus Committee, and an Executive Committee for Community Outreach. Four of the 12 structures were identified as sub-committees of the Board of Trustees. All 12 governance structures cited an ongoing role as the oversight body for community benefit activities. Specific areas of oversight include:

- Incorporate measurement and reporting
- Incorporate community benefit plans into hospital strategic planning
- Solicit input from diverse constituents
- Encourage community involvement
- Link programs to major community health needs
- Ensure compliance with OSHPD
- Link clinical services to community health improvement initiatives
- Provide education for hospital providers, staff, and leadership

Seven of the 15 respondents that cited the establishment of community benefit performance monitoring systems identified specific criteria used for resource allocation and program designation. Three of the seven indicated a focus on underserved populations, two indicated a focus on “Healthy Communities” initiatives, and two indicated a focus on capacity building for community organizations. Three of the 15 respondents said that they had integrated community benefit programming with organizational strategic planning.

Institutional impacts cited by respondents included increases in the following areas:

- Involvement of physicians
- Involvement of staff and leadership
- Awareness of community benefit activities (three)
- Effectiveness (e.g., planning, monitoring, oversight) (five)
- Scope and depth of partnerships with community stakeholders (five)
- Support and engagement in community health improvement (eight)
- Community involvement in decision making (two)

#### **4. Strategic investments to build community capacity**

Thirty-eight respondents cited a variety of efforts to strengthen the capacity of existing community organizations, informal groups, and initiatives.

Respondents were first asked to identify which of five forms of assistance they had provided as part of their community benefit program. The five forms include financial support, technical assistance, equipment, advocacy, and leveraged engagement. Fourteen of the 38 respondents indicated that they had provided all five forms of support; five respondents indicated that they provided all forms with the exception of equipment; and four respondents indicated that they had provided all forms with the exception of advocacy.

All but two of the 38 respondents indicated that they provided financial support; 32 of the 38 indicated that they provided technical assistance as a component of their assistance; 25

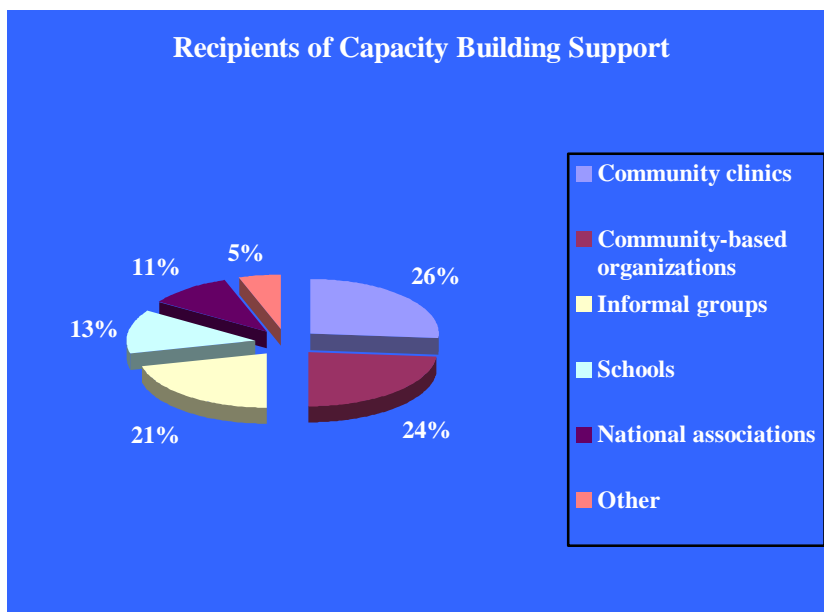
indicated that they provided equipment; 25 indicated that they leveraged the engagement of other stakeholders; and 24 of the 38 indicated that they provided advocacy assistance.

Examples include: fundraising to support neighborhood leadership development; donation and purchase of property to support low-income housing development; funding and technical assistance to establish a community clinic; funding and equipment to support a school-based clinic; funding, space, and equipment to preserve a community program for victims of sexual abuse, and; funding and technical assistance to sustain a community-based organization that provides mental health, dental, and food bank services. Recipients of strategic investments included:

- Community clinics 10
- Community-based organizations 9
- Informal groups 8 (neighborhood organizations, coalitions)
- Schools 5
- National associations 4 (Am. Heart Assoc., Am. Cancer Society)
- Other 2 (property for housing, child insur. program)

The distribution of strategic investments by recipient category is provided as Figure 4.

**Figure 4 – Recipients of Capacity Building Support**



Impacts cited by respondents included increases in the following areas:

- Involvement of seniors in local senior center
- Volume of available affordable housing and support services
- Public participation and fundraising capacity of local American Heart Association
- Coordination of services across county organizations
- Job placement and college entry among “at risk” youth

Financial support for

- Local community clinics
- 44 rural agencies
- Local school district

Increased capacity and sustainability of

- Community program for sexual assault survivors
- Agency providing mental health, dental, and food bank services
- Local community clinics

Respondents also cited the establishment of the following:

- Partnerships with 15 community-based organizations
- New community-based medical / dental clinic
- New school-based clinic
- Five family resource centers in low-income neighborhoods
- Seven community centers to address cardiovascular disease
- Eight neighborhood associations
- Citywide asthma task force; incr. power of African American and Latino residents
- Re-opening of closed community clinic

## **5. Ongoing partnerships with community stakeholders**

The 35 program activities cited in this category are divided into 6 content categories, including:

|  |           |
|--|-----------|
| <b>Health education / health promotion</b>       | <b>14</b> |
| <b>Community organizing / development</b>        | <b>7</b>  |
| <b>Strategic planning / service coordination</b> | <b>5</b>  |
| <b>Life skills / employment training</b>         | <b>4</b>  |
| <b>Primary care</b>                              | <b>4</b>  |
| <b>Support services</b>                          | <b>1</b>  |

Programs with a primary focus on health education / health promotion include smoking cessation for pregnant women and their families, a door-to-door breast self-exam campaign, a school-based education and support program for pregnant teens, a school-based behavioral modification and retention program for substance abusing teens, and the establishment of a wellness center to provide comprehensive health education services, among others.

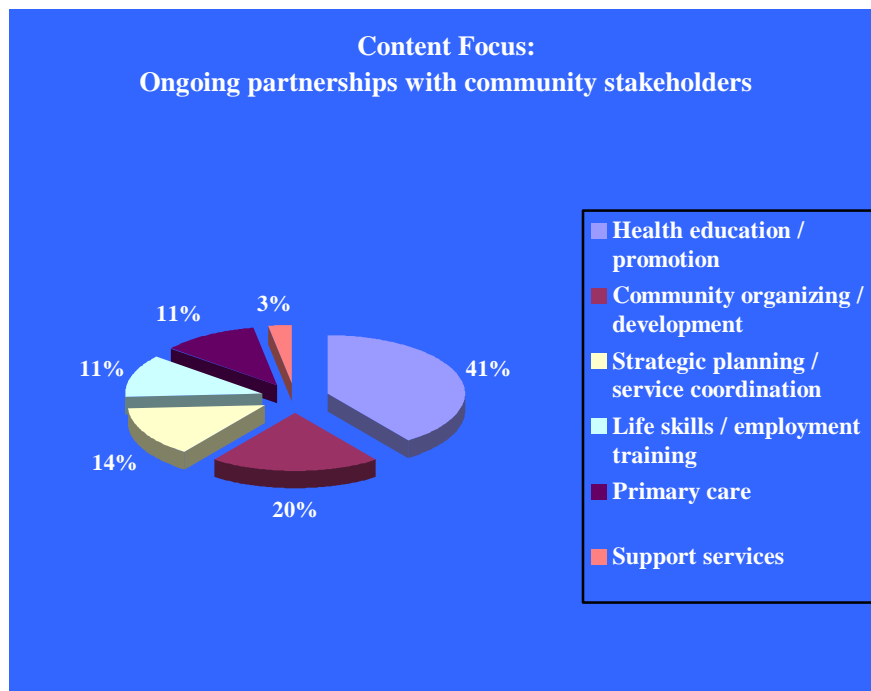
Community organizing / development programs include collaboration to establish a community development organization that supports participatory approaches to economic development in an inner city neighborhood; an assistance center for homeless residents in a rural county; a church-based initiative to provide services for homeless residents in an urban area, and; community action teams to address health concerns identified by neighborhood residents.

Programs with a focus on strategic planning / service coordination include a countywide assessment and service coordination process; establishment of a community council and a local service coordination process; a countywide effort to expand insurance coverage, and; a neighborhood initiative to enhance school-based services for youth.

Life skills / employment training programs include a neighborhood health ministries program that focuses on participatory approaches to health improvement; an after school program at five sites to reduce female involvement in juvenile delinquency; two citywide initiatives to provide mentoring and support services for youth development, and; transitional housing and skills training for pregnant teens.

Primary care services are being provided through four community clinics, three newly established, and one re-established clinic at an existing site. The one support service program cited in this category is an inner city neighborhood initiative to provide services for low-income seniors after hospital stays. The distribution of program activities by content area of focus is provided as Figure 5.

**Figure 5 – Content Focus: Ongoing partnerships with community stakeholders**



Sixteen of the 35 programs in this category cited a specific focus on low-income neighborhoods. Another 16 indicated a focus on specific populations. Four of those 16 focused on “at-risk” youth, three on pregnant women, two on underserved populations, two on homeless populations, two on Latinos, two on people with asthma, and one on seniors. The remaining three programs cited a general emphasis on strategic planning and service coordination, one at the county level, and two for a group of neighborhoods within a county.

Neighborhood partnership impacts cited by respondents included the following increases:

- Enrollment in public insurance programs
- Engagement of local stakeholders in efforts to increase access
- Physical activity and decreased injuries among seniors
- Bonding between teen mothers and their children

Respondents also cited reductions in the following areas:

- Pregnant women and families who smoke
- Teen pregnancy rate
- Drug use and criminal activity among youth

Respondents also indicated establishment of the following:

- A new community development agency
- A new community clinic in local Boys and Girls Club
- Two Community Action Teams
- Partnerships with churches to support primary care and health education activities
- Partnerships with 20 organizations to provide mentoring and skills training for youth
- Ten-year lease and construction of community wellness facility

## **B. Key Challenges**

There were a total of 47 survey respondents, but responses in some categories of the key challenges section were left blank. Response rates by category ranged from 43 for the questions addressing organizational infrastructure challenges to 36 responses for setting program priorities. Calculation of response percentages is tied to the total number of responses per category. Findings are limited to the top three rankings in each category.

### **1. Community Assessments**

Two questions addressed challenges associated with community assessments conducted by nonprofit hospitals. The first question focused on the collection and analysis of data on health needs; the second on the collection and analysis of data on community assets.

The most significant challenge in the collection and analysis of data on health needs cited by respondents is a lack of available data at the sub-county level. Thirty-two of 42 respondents, or 76 percent, ranked this issue as one of the top three issues of concern. An almost equal number, 31 of 42, or 74 percent of respondents, identified the high cost of primary data collection as one of the top three challenges.

Respondents identified three other issues as significant challenges. Thirteen of 42, or 31 percent of respondents, cited obstacles to coordination with local public health agencies as one of the top three challenges. Twelve of 42, or 29 percent of respondents, cited obstacles to coordination with other hospitals and a lack of clarity from OSHPD as top challenges.

Summary findings and totals for each of the top three rankings are included as Table 1.

**Table 1 – Challenges in the Collection and Analysis of Data on Health Needs**

| <b>Top 3 Rank Totals</b> | <b>Identified Challenges</b>                              | <b>#s for 1,2,3 Rankings</b> |
|--------------------------|---|------------------------------|
| <b>32 of 42 (76%)</b>    | Lack of available data at sub-county level                | <b>14, 11, 7</b>             |
| <b>31 of 42 (74%)</b>    | High cost of primary data collection                      | <b>16, 11, 4</b>             |
| <b>13 of 42 (31%)</b>    | Obstacles to coordination with local public health agency | <b>3, 6, 4</b>               |
| <b>12 of 42 (29%)</b>    | Obstacles to coordination with other hospitals            | <b>3, 3, 6</b>               |
| <b>12 of 42 (29%)</b>    | Lack of clarity from OSHPD                                | <b>3, 1, 8</b>               |

Two issues were identified as equally significant challenges in the collection and analysis of data on community assets: obstacles to coordination with local public health agencies, and a lack of internal expertise and capacity. Twenty-two of 40, or 55 percent of respondents, ranked obstacles to coordination with local public health agencies as one of the top three issues of concern, and 21 of 40, or 52 percent gave top rankings to the lack of internal expertise and capacity.

Three other issues were identified as key challenges by respondents. They included obstacles to coordination with other hospitals (19 of 40, or 47 percent); lack of community assets (12 of 40, or 30 percent); and, lack of understanding or support from leadership (9 of 40, or 22 percent). Ten of 40, or 25 percent of respondents, used the “other” category to cite issues such as lack of time, lack of access to information, and quality of data. Summary findings and totals for each of the top three rankings are included as Table 2.

**Table 2 – Challenges in the Collection and Analysis of Data on Community Assets**

| <b>Top 3 Rank Totals</b> | <b>Identified Challenges</b>                              | <b>#s for 1,2,3 Rankings</b> |
|--------------------------|---|------------------------------|
| <b>22 of 40 (55%)</b>    | Obstacles to coordination with local public health agency | <b>11, 6, 5</b>              |
| <b>21 of 40 (52%)</b>    | Lack of expertise / organizational capacity               | <b>11, 6, 4</b>              |
| <b>19 of 40 (47%)</b>    | Obstacles to coordination with other hospitals            | <b>8, 7, 4</b>               |
| <b>12 of 40 (30%)</b>    | Lack of community assets                                  | <b>1, 5, 6</b>               |
| <b>10 of 40 (25%)</b>    | Other (time, access to information, quality of data)      | <b>8, 1, 1</b>               |
| <b>9 of 40 (22%)</b>     | Lack of understanding / support from leadership           | <b>1, 5, 3</b>               |

## **2. Community Outreach**

There were also two questions that addressed challenges associated with hospital outreach and engagement of community stakeholders. The first focused on the engagement of service-based organizations and the second dealt with the engagement of community residents. Two related issues were identified as the most significant challenges to the engagement of service-based organizations: A lack of financial resources and a lack of staff time. Thirty-three of 41, or 80 percent of respondents, identified a lack of financial resources, and 32 of 41, or 78 percent, identified a lack of staff time.

Two other issues were identified as key challenges. They included competition, or “turf” issues among service-based organizations (21 of 41, or 51 percent), and antagonism and/or mistrust (10 of 41, or 24 percent). Summary findings and totals for each of the top three rankings are included as Table 3.

**Table 3 – Challenges in the Engagement of Service-Based Organizations**

| <b>Top 3 Rank Totals</b> | <b>Identified Challenges</b>                    | <b>#s for 1,2,3 Rankings</b> |
|--------------------------|---|------------------------------|
| <b>33 of 41 (80%)</b>    | Lack of financial resources                     | <b>12, 14, 7</b>             |
| <b>32 of 41 (78%)</b>    | Lack of staff time                              | <b>19, 8, 5</b>              |
| <b>21 of 41 (51%)</b>    | Competition / “turf” issues among organizations | <b>6, 9, 6</b>               |
| <b>10 of 41 (24%)</b>    | Antagonism / mistrust                           | <b>2, 4, 4</b>               |

The most significant challenge cited by respondents to the engagement of community members was a lack of staff time. Thirty-six of 38 respondents, or 94 percent, ranked this as one of the top three issues; 21 of those 36 ranked it as the most significant challenge. Another 28 of 38, or 74 percent of respondents, cited a lack of community member interest and/or time as one of the top three challenges.

The third-ranked issue fell under the title of “institutional concerns,” cited by 13 of 38, or 34 percent of respondents. Specific issues cited under this heading included financial pressures, aversion to long-term commitments, and aversion to involvement in broad-based health initiatives. As noted by one respondent, “[I am] *unsure of my authority or level of commitment I can negotiate on behalf of [my hospital]. It seems as if many CEO’s shy away from the “loose” collaborations that are not contract/finance based. The level of commitment is always greater with contractual agreements.*”

An equal number (9 of 38, or 24 percent) cited two additional issues; a lack of understanding and/or support from leadership, and a lack of knowledge and/or expertise as significant challenges to the engagement of community members. Summary findings and totals for each of the top three rankings are included as Table 4.

**Table 4 – Challenges in the Engagement of Community Members**

| <b>Top 3 Rank Totals</b> | <b>Identified Challenges</b>                    | <b>#s for 1,2,3 Rankings</b> |
|--------------------------|---|------------------------------|
| <b>36 of 38 (95%)</b>    | Lack of staff time                              | <b>21, 6, 9</b>              |
| <b>28 of 38 (74%)</b>    | Community member lack of interest / time        | <b>9, 15, 4</b>              |
| <b>13 of 38 (34%)</b>    | Institutional concerns                          | <b>6, 3, 4</b>               |
| <b>9 of 38 (24%)</b>     | Lack of understanding / support from leadership | <b>1, 4, 4</b>               |
| <b>9 of 38 (24%)</b>     | Lack of knowledge / expertise                   | <b>1, 4, 4</b>               |

### **3. Setting Program Priorities**

Twenty-seven of 36, or 75 percent of respondents, identified the lack of staff time as the most significant challenge in setting program priorities. The next two most challenging issues

identified by an equal number of respondents (21 of 36, or 58 percent) were the assertion of hospital interests and competing interests among community stakeholders.

On the assertion of hospital interests, one respondent cited an orientation towards a “sickness” model that made it difficult to involve the hospital in health improvement initiatives that may be priorities for community stakeholders. Another respondent identified existing programs as obstacles with the observation that “...*in an ideal world, priorities would be set without regard for programs that are currently in place, but that will rarely occur.*”

Ten of 36, or 28 percent of respondents, identified a lack of expertise as a major challenge in setting program priorities. Eight of 36, or 22 percent, identified a lack of diversity among community stakeholders as a problem. Summary findings and totals for each of the top three rankings are included as Table 5.

**Table 5 – Challenges in Setting Program Priorities**

| <b>Top 3 Rank Totals</b> | <b>Identified Challenges</b>                     | <b>#s for 1,2,3 Rankings</b> |
|--------------------------|--|------------------------------|
| <b>27 of 36 (75%)</b>    | Lack of staff time                               | <b>14, 9, 7</b>              |
| <b>21 of 36 (58%)</b>    | Assertion of hospital interests                  | <b>10, 6, 5</b>              |
| <b>21 of 36 (58%)</b>    | Competing interests among community stakeholders | <b>8, 7, 6</b>               |
| <b>10 of 36 (28%)</b>    | Lack of expertise                                | <b>2, 3, 5</b>               |
| <b>8 of 36 (22%)</b>     | Lack of diversity among community stakeholders   | <b>0, 4, 4</b>               |

#### **4. Program Monitoring**

Most respondents (38 of 40, or 95 percent) identified the lack of staff time as a significant obstacle to effective program monitoring. Along these lines, one respondent noted, “*Increasing demands of staff productivity to assume a wide range of responsibility limits the available time to commit to adequate monitoring of program outcomes to better demonstrate effectiveness.*”

A lack of expertise was cited by 27 of 40, or 67 percent of respondents. As noted by one respondent, “*Measuring community program outcomes is much more difficult than dealing with measurement in the sickness model.*” Two other issues were cited as among the most significant challenges; obstacles to coordination with local public health agencies (17 of 40, or 42 percent), and obstacles to coordination with local academic institutions (10 of 40, or 25 percent).

Five respondents used the “other” category to cite a variety of challenges, including a lack of external expertise (cited by two rural hospitals), a lack of coordination with hospital staff responsible for programs, and a lack of capacity among community partners. Four of the respondents using the “other” category cited these issues as the most important, and one ranked their issue (coordination with hospital staff) as the second most important. Summary findings and totals for each of the top three rankings are included as Table 6.

**Table 6 – Challenges in Program Monitoring**

| <b>Top 3 Rank Totals</b> | <b>Identified Challenges</b>                                | <b>#s for 1,2,3 Rankings</b> |
|--------------------------|---|------------------------------|
| <b>38 of 40 (95%)</b>    | Lack of staff time  | <b>29, 7, 2</b>              |
| <b>27 of 40 (67%)</b>    | Lack of expertise   | <b>4, 20, 3</b>              |
| <b>17 of 40 (42%)</b>    | Obstacles to coordination with local public health agency   | <b>2, 4, 11</b>              |
| <b>10 of 40 (25%)</b>    | Obstacles to coordination with local academic institutions  | <b>1, 1, 8</b>               |
| <b>5 of 40 (12%)</b>     | “Other” - Lack of external expertise; internal coordination | <b>4, 1, 0</b>               |

## 5. Organizational Infrastructure

There were two questions that addressed challenges associated with hospital governance, management, and operations. The first asked respondents to identify the most important areas for internal development to enhance the effectiveness of community benefit programming. The second asked respondents to identify the most significant overarching challenges for their organizations.

Thirty of 43 respondents, or 70 percent, identified the need for increased dedicated staff time as one of the three most important areas for internal development. Sixty percent cited the need for better alignment of community benefit programming and organizational strategic planning, and 51 percent identified the need for explicit criteria in the selection and development of community benefit program activities.

Three other areas for internal development were ranked among the top three concerns. Seventeen of 43 respondents, or 40 percent, called for performance incentives to increase support and engagement of staff and leadership. On a related issue, 12 of 43, or 28 percent called for stronger linkages between community benefit managers and senior leadership. Finally, 8 of 43, or 19 percent of respondents cited a need for increased involvement of community members. Summary findings and totals for each of the top three rankings are included as Table 7.

**Table 7 – Most important areas for internal development**

| <b>Top 3 Rank Totals</b> | <b>Identified Challenges</b>                               | <b>#s for 1,2,3 Rankings</b> |
|--------------------------|--|------------------------------|
| <b>30 of 43 (70%)</b>    | Increased dedicated staff time                             | <b>13, 4, 13</b>             |
| <b>26 of 43 (60%)</b>    | Alignment of CB and organizational strategic planning      | <b>8, 10, 8</b>              |
| <b>22 of 43 (51%)</b>    | Establish explicit criteria for community benefit programs | <b>8, 6, 8</b>               |
| <b>17 of 43 (40%)</b>    | Establish performance incentives to increase support       | <b>7, 9, 1</b>               |
| <b>12 of 43 (28%)</b>    | Stronger linkages to senior leadership                     | <b>4, 7, 1</b>               |
| <b>8 of 43 (19%)</b>     | Increased involvement of community members                 | <b>1, 3, 4</b>               |

On the second question, 39 of 42, or 93 percent of respondents cited low reimbursements from payers as one of the top three overarching challenges faced by their institutions; 33 of those 39 identified it as the most significant challenge. The rising cost of technology was cited by 69 percent as the second highest ranking overarching challenge.

Three other issues were given high rankings as significant overarching challenges: earthquake retrofitting, the threat of new regulatory action, and workforce issues. Summary findings and totals for each of the top three rankings are included as Table 8.

**Table 8 – Most significant overarching challenges**

| <b>Top 3 Rank Totals</b> | <b>Identified Challenges</b>        | <b>#s for 1,2,3 Rankings</b> |
|--------------------------|-------------------------------------|------------------------------|
| <b>39 of 42 (93%)</b>    | Low reimbursements from payers      | <b>33, 5, 1</b>              |
| <b>29 of 42 (69%)</b>    | Rising costs of technology          | <b>1, 14, 14</b>             |
| <b>19 of 42 (45%)</b>    | Earthquake retrofitting obligations | <b>2, 9, 8</b>               |
| <b>14 of 42 (33%)</b>    | New regulatory action               | <b>0, 8, 6</b>               |
| <b>11 of 42 (26%)</b>    | Workforce issues                    | <b>2, 2, 7</b>               |

### **C. Exemplary Practices**

There were 23 programs and policies selected for documentation as exemplary practices in the five categories of accomplishments. Practices selected in each category include:

|   |          |
|---|----------|
| <b>Programs producing measurable improvements in health status</b>      | <b>5</b> |
| <b>Programs producing measurable improvements in quality of life</b>    | <b>6</b> |
| <b>Institutional policies that strengthen organizational commitment</b> | <b>3</b> |
| <b>Strategic investments to build community capacity</b>                | <b>5</b> |
| <b>Ongoing partnerships in local communities</b>                        | <b>4</b> |

There are 13 individual hospitals, three multi-facility service areas, and two health system central offices represented among the exemplary practices. Three of the 13 hospitals and two of the three multi-facility service areas had two programs selected for documentation as exemplary practices.

There are ten health systems and three independent hospitals (two children’s and one research-based hospital) represented in the sample. At the time of the inquiry, the health systems ranged in size from two to 48 hospitals. The geographic distribution of exemplary practices is as follows:

|   |          |
|---|----------|
| <b>San Diego / Orange County Region</b> | <b>6</b> |
| <b>Los Angeles County</b>               | <b>6</b> |
| <b>Central California</b>               | <b>4</b> |
| <b>Bay Area</b>                         | <b>3</b> |
| <b>Northern California</b>              | <b>2</b> |
| <b>Sacramento / Sierras</b>             | <b>2</b> |

The following sections will identify the exemplary practices in each of the categories of accomplishments in the study. A complete description of each is provided as Appendix A.

## 1. Programs producing measurable improvements in health status

The five programs selected in this category, the sponsoring hospitals, the locations of the programs, and the ownership structures of the hospitals are as follows:

| Case | Program   | Hospital   | Location                | Structure                 |
|------|---|--|-------------------------|---------------------------|
| A.1  | Angelina Fortes Silva Medical and Dental Clinic | St. Rose Hospital  | Southern Alameda County | Via Christi Health System |
| A.2  | Spirit of Caring Mobile Health Care Clinic      | Sharp Chula Vista Medical Center                           | San Diego County        | Sharp Health              |
| A.3  | Project Dulce Diabetes Mgmt. Program            | Scripps Memorial La Jolla Hospital                         | San Diego County        | Scripps Health            |
| A.4  | House Calls / Home Sweet Home Program           | Santa Rosa Memorial Hospital                               | Sonoma County           | St. Joseph Health System  |
| A.5  | Health to Home / Community Wellness Program     | Bakersfield Memorial, Mercy, and Mercy Southwest Hospitals | Kern County             | Catholic Healthcare West  |

## 2. Programs producing measurable improvements in quality of life

The six programs selected in this category, the sponsoring hospitals, the locations of the programs, and the ownership structures of the hospitals are as follows:

| Case | Program                                    | Hospital   | Location            | Structure                |
|------|--|--|---------------------|--------------------------|
| B.1  | Affordable Housing Initiative              | St. Joseph Hospital  | Orange County       | St. Joseph Health System |
| B.2  | Homemaker Care Program                     | Bakersfield Memorial, Mercy, and Mercy Southwest Hospitals | Kern County         | Catholic Healthcare West |
| B.3  | Creating Healthy Environments for Children | Sutter Memorial Hospital                                   | Sacramento region   | Sutter Health            |
| B.4  | Casa de Amigos Community Center            | St. Vincent Medical Center                                 | Central Los Angeles | Catholic Healthcare West |
| B.5  | Youth Bridge Mentoring Program             | Alta Bates Summit Medical Center                           | Alameda County      | Sutter Health            |
| B.6  | Holy Cross Center for Women                | St. Agnes Medical Center                                   | Downtown Fresno     | Trinity Health System    |

**3. Institutional policies that strengthen organizational commitment**

The three policy initiatives selected in this category, the locations, and the ownership structures of the institutions are as follows:

| <b>Case</b> | <b>Program</b>  | <b>Location</b>         | <b>Structure</b>                          |
|-------------|---|-------------------------|---|
| <b>C.1</b>  | Developing a systemwide framework for community benefit | Statewide               | St. Joseph Health System                  |
| <b>C.2</b>  | Enhancing accountability and community engagement       | East Los Angeles County | Citrus Valley Health Partners             |
| <b>C.3</b>  | Expanding community involvement in a rural hospital     | Butte County            | Feather River Hospital / Adventist Health |

**4. Strategic investments to build community capacity**

The five programs selected in this category, the sponsoring hospitals, the locations of the programs, and the ownership structures of the hospitals are as follows:

| <b>Case</b> | <b>Program</b>                       | <b>Hospital</b>   | <b>Location</b>                    | <b>Structure</b>              |
|-------------|--------------------------------------|---|------------------------------------|-------------------------------|
| <b>D.1</b>  | South County Community Health Center | Lucile Packard Children’s Hospital                        | East Palo Alto<br>San Mateo County | Independent                   |
| <b>D.2</b>  | Healthy Neighborhood Coalition       | St. Agnes Medical Center                                  | Downtown Fresno                    | Trinity Health System         |
| <b>D.3</b>  | Neighborhood Family Resource Centers | Citrus Valley Medical Center                              | East Los Angeles County            | Citrus Valley Health Partners |
| <b>D.4</b>  | City Heights Urban Wellness Center   | Scripps Mercy Hospital                                    | City of San Diego                  | Scripps Health                |
| <b>D.5</b>  | Lawndale School Health Project       | Little Company of Mary, Torrance, and San Pedro Hospitals | Los Angeles County                 | Providence Health System      |

**5. Ongoing partnerships in local communities**

The four programs selected in this category, the sponsoring hospitals, the locations of the programs, and the ownership structures of the hospitals are as follows:

| <b>Case</b> | <b>Program</b>                                    | <b>Hospital</b>                      | <b>Location</b>            | <b>Structure</b>         |
|-------------|---|--------------------------------------|----------------------------|--------------------------|
| <b>E.1</b>  | CHOC Clinic at the Boys & Girls Club of Santa Ana | Children's Hospital of Orange County | City of Santa Ana          | Independent              |
| <b>E.2</b>  | Community Health Ministries Program               | St. Vincent Medical Center           | Central Los Angeles        | Catholic Healthcare West |
| <b>E.3</b>  | Communities of Promise Initiative                 | City of Hope Medical Center          | City of Duarte (LA County) | Independent              |
| <b>E.4</b>  | Circle of Sisters Program                         | Santa Rosa Memorial Hospital         | Sonoma County              | St. Joseph Health System |

## IV. Discussion

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### A. Accomplishments

#### 1. Strengths

One of the overarching strengths of the 185 community health initiatives described by survey respondents is the diversity in content focus and design. This diversity reflects a central intent of SB 697; that is, for nonprofit hospitals to work with community stakeholders to design programs and activities that take optimal advantage of the unique characteristics of their communities to address unmet health-related needs. It is not surprising that the configuration of local stakeholders and associated health priorities will be different in communities as diverse as Fresno, Feather River, East Palo Alto, and Chula Vista.

Here is a summary of the strengths found in the case summaries.

***Clear program targeting*** - A common strength among the exemplary practices selected for documentation is an ability to clearly target program activities. Each is guided by an imperative to address *disproportionate* unmet needs in their community that were identified in the needs assessment process. While the legal interpretation of community benefit allows for a more ambiguous targeting of “any class of persons broad enough to constitute benefit to the community” (Rev. Ruling 69-545), these programs reflect a commitment to focus charitable resources where they are most needed.

***Meaningful community engagement*** - Another common strength among the exemplary practices, as well as among many in the larger sample of community health initiatives, is meaningful engagement of diverse community stakeholders. This demonstrates an understanding by these institutions of the importance and value of community involvement in the design and implementation of substantive program activities.

***Strategic resource allocation*** - In the best examples, the charitable resources of the hospitals were strategically allocated to build upon existing assets in local communities. While there were five programs specifically recognized in this category, all 20 programs documented as exemplary practices demonstrated a commitment to this important principle. These institutions recognize that the development of sustainable programs to address persistent health problems requires the identification, mobilization, and enhancement of existing resources in local communities.

While this study focuses on documenting community health initiatives, it is important to note that six of the 20 programs documented as exemplary practices involve the delivery of primary care medical services. Another seven of the 20 involve the delivery of clinical preventive services and/or chronic disease management services.

The essential point is that these programs represent a proactive and strategic alternative to emergency room-based charity care. Rather than waiting until people experience conditions severe enough to compel visits and long waits in the ER, these hospitals work with local

stakeholders to bring services that will prevent illness and minimize suffering to the communities where they are most needed.

In the current system of market-based health insurance and service delivery, this is a more humane, cost-effective, and sustainable way of serving populations that are largely overlooked by private sector payers and who do not qualify for public sector coverage (e.g., Medicaid, Healthy Families). In the process, there is the potential to demonstrate that proactive, community-based approaches to service delivery can both improve health status and reduce health care costs.

***Institutional alignment*** - Survey responses suggest that SB 697 has stimulated the development of institutional policies in many hospitals to more closely align their governance, management, and operations with their charitable mission. SB 697 required nonprofit hospitals to review and reaffirm their mission statements. That is an important first step, but an increasing number of hospitals have recognized that additional steps are required to ensure that leadership and staff are fully engaged in efforts to carry out their organization's charitable mission.

Observations in the field suggest that a lack of attention to institutional policies can substantially undermine the quality, scale, and effectiveness of community benefit programming. As trustees and senior leadership become absorbed in efforts to deal with financial pressures, decision-making processes may be driven increasingly by market imperatives. Definitive action is needed to avert this form of service degradation and to encourage excellence at all levels of the organization.

For trustees, this involves a review of their composition, function, and role in preserving and enhancing their organization's charitable mission. For senior leadership, establishing performance measures tied to community health objectives and appointing dedicated staff with direct-line reporting responsibilities are key factors. For community benefit managers, developing explicit criteria for community benefit services and activities is of utmost importance. These and related actions have been taken by many California hospitals since the passage of SB 697. Policy makers should encourage replication of these efforts.

## **2. Areas for Improvement**

While further inquiry would be needed to offer a definitive assessment of the larger sample of 185 charitable practices described by survey respondents, the information provided suggests that many current efforts could be enhanced by attention to the strengths described in the last section.

To varying degrees, the 23 examples documented in this study illustrate the importance of attention to these areas, both in terms of benefit to local communities and as a demonstration of institutional commitment to serve as a good steward of charitable resources.

To summarize, areas for improvement among the larger sample of 185 practices include:

- **Clear targeting of populations to be served.** It is difficult to determine the extent to which many of the programs described serve populations who could most benefit. Given a lack of clear targeting, some might argue that the program is primarily a service enhancement for already insured populations.
- **Expand engagement of diverse community stakeholders.** Some programs appear to have been developed and implemented with minimal involvement of community stakeholders. More effort is needed to expand engagement of community stakeholders in the selection, design, and implementation of programs.
- **Build on existing community assets.** More emphasis is needed to strengthen existing programs, community-based organizations, and informal support systems in local communities. In some cases, this can be a more cost-effective alternative to the development of new programs.
- **Expand partnering with other institutions.** It is clear that many survey respondents lack the resources and expertise to effectively monitor the impact of community health initiatives. More effort is needed to leverage the expertise of other stakeholders such as local public health agencies and academic institutions to assist in the design of monitoring strategies for major program activities.

In general terms, it is important to note that not all programs and institutional policies selected for further documentation as exemplary practices met all criteria outlined in the five categories of accomplishments for the survey.

For example, in the fifth category (ongoing partnerships in local communities), some programs did not meet the criteria of a neighborhood scale or an emphasis on direct action (rather than professional service delivery) to address the underlying causes of health problems. In addition, some programs in the first and second categories are still in the process of documenting measurable improvements in health status or quality of life. However, the quality of the program activities as well as the potential for yielding measurable impacts in the near future justified their inclusion as exemplary practices.

## **B. Key Challenges**

### **1. Community Assessments**

The lack of data at the sub-county level is a problem that has plagued both public and private sector agencies in efforts to identify and address persistent health problems in local communities. Most population health statistics in California are available only at the county level. Data at this level can mask significant health problems experienced by populations and communities at the sub-county level. This problem can be particularly acute in counties with large, relatively affluent populations but with pockets of low-income residents in urban inner city neighborhoods or rural areas.

SB 697 requires nonprofit hospitals to identify measurable objectives for major program activities. It is difficult, if not impossible, for hospitals to produce measurable improvements in health status if available data is limited to county level statistics. Moreover, if there is an imperative to focus charitable resources on populations and communities with disproportionate unmet health needs, sub-county data is needed to document impacts at the appropriate level.

Given the absence of sub-county data for a variety of health statistics, hospitals are faced with the challenge of securing substantial resources to support primary data collection. Many hospitals and health systems are reluctant to devote large sums of charitable dollars for primary data collection. A commonly stated position is that the maximum amount of resources should be preserved for services and activities that directly impact people's lives.

Some local hospitals have overcome financial obstacles by pooling resources with other hospitals; others have contracted with local nonprofit organizations such as the United Way or local colleges and universities; still others have secured funding from foundations. While there are substantive partnerships with local public health agencies in some counties to leverage local resources and expertise, the level of engagement in most counties is superficial at best.

Most hospitals and health systems lack the internal expertise to effectively address the program monitoring requirements of SB 697. More effort is needed by hospitals, local public health agencies, and academic institutions to develop joint strategies that make optimal use of available resources and complementary expertise.

A number of respondents identified a lack of clarity from OSHPD as a challenge in the assessment process. For example, local hospitals that seek to focus future assessments in sub-county areas with disproportionate unmet health needs are unable to secure formal approval to adjust the scope of their inquiry. In most cases, OSHPD staff members are limited in their ability to provide specific guidance beyond the current language of SB 697. Section 449.30 of the law prohibits the promulgation of specific standards or reporting formats without specific action by the California Legislature.<sup>22</sup> Greater clarity is needed in the future development of reporting guidelines.

There is increasing interest in collecting and analyzing data on community assets. A number of hospitals and local public health agencies across the country have recognized the importance of identifying existing community-based organizations, coalitions, resident groups, and other strengths in communities that can serve as entry points for programs and activities to address unmet health needs. Identifying these groups enables hospitals and other local stakeholders to minimize duplication of effort, and explore the strategic allocation of resources that will yield the maximum impact and enhance sustainability.

As is the case in the collection and analysis of data on health needs, more in-depth engagement of local public health agencies and other local stakeholders with relevant expertise is needed. The identification and coordination of local health improvement programs and activities by local public health agencies is consistent with the general direction outlined in the 1988 Institute of Medicine report "The Future of Public Health."<sup>23</sup>

## 2. Community Outreach

The lack of staff time is a common refrain among community benefit managers and staff in all aspects of community benefit programming. As the results of this inquiry indicate, the lack of staff time and/or financial resources was the top-ranked concern cited by respondents in five of the eight questions in the challenges section of the survey.

Hospital staff experience particular time pressure in the area of community outreach. Given the relative paucity of staffing, formal products such as the community needs assessment and the annual report submitted to OSHPD may take precedence over less tangible activities such as community engagement.

Moreover, hospital staff may confront a number of issues in the community engagement process that discourage investing considerable professional and personal time. As indicated in the results, community stakeholders may be mistrustful of hospital intentions and commitment. Overcoming these sentiments requires both patience and consistency, and an ability to take criticism (both deserved and undeserved) in stride.

In addition, community stakeholders (as well as hospitals) often bring a variety of interests and agendas to engagement processes. For example, representatives of service-based organizations may feel that their organization is more capable than others are to serve particular populations or address specific content areas. Given the fact that many of these organizations often lack resources, it may be difficult to explore comprehensive approaches to community health improvement that involve collaboration and resource sharing.

Community stakeholders may be particularly sensitive if it appears that the local hospital is considering the development of programs that duplicate existing community-based efforts. In this context, it is important for hospital representatives to clearly indicate a commitment to support and build upon existing community assets.

Outreach to and engagement of local community residents is recognized as an important objective by many hospital community benefit staff, but there are a numerous obstacles. Low-income community residents are less likely to have free time and/or flexibility in their work schedules, and spend more time accessing services (e.g., groceries, banking) that are often unavailable in their community. Moreover, given daily struggles to meet basic family needs, participation in activities that are not likely to yield near-term benefits may be viewed as unwelcome distractions.

Many hospitals solicit input from local residents as health care *consumers* in focus groups and patient satisfaction surveys to identify areas for improvement in the design and delivery of medical services. In contrast, hospital leadership may view the ongoing engagement of residents as *partners* in community health initiatives as a risky and unproductive endeavor.

The survey showed considerable overlap in the comments of survey respondents who gave high rankings to “institutional concerns” and those who cited a lack of understanding / support from senior leadership. Visionary leadership is needed for local hospitals to invest time and resources in the ongoing engagement of local residents as partners. While some

activities may focus in areas outside of medical care delivery, the potential benefits for the community *and* for the hospital can be substantial.

Excellent examples documented in this study include St. Vincent Medical Center's Casa de Amigos Community Center in Central Los Angeles (B.4), St. Agnes Medical Center's support of the Healthy Neighborhood Coalition in Fresno (D.2), and Citrus Valley Health Partners' Family Resource Center initiative in the East San Gabriel Valley of Los Angeles County (D.3).

At all three of these sites, neighborhood residents play a major role in efforts to improve health status and quality of life through direct action.

### **3. Setting Program Priorities**

Priority setting is one of the most important steps in health planning. Unfortunately, it is also one of the most neglected. After spending considerable time collecting and reviewing health-related data, hospitals and local community stakeholders are often anxious to "get moving" with program activities. In some cases, local partners may select program content areas of focus that are not effective uses of available resources and are unlikely to garner broad support.

One of the most significant oversights by local partners is a failure to establish objective criteria for decision-making. Developing criteria requires time and expertise, but it is crucial in guiding the selection of program areas by diverse stakeholders. In the absence of objective criteria, stakeholders with the most influence will determine program selection, rather than basing selection on a critical assessment of where resources may produce the best results.

The challenges cited by survey respondents are predictable, given the absence of objective criteria in most decision-making processes. It is quite natural that hospitals would be inclined to continue existing programs, or limit selection to content areas where they may have the greatest competence and/or influence. It is also quite natural that priority setting will be strongly influenced by the scope of stakeholders at the table, their role in decision-making, and their relative forcefulness in advancing their particular interests.

Program selection should optimally be determined by criteria such as a) The size and/or severity of identified problems; b) Whether particular content areas have been neglected to date (or conversely whether there is duplication of local efforts); and, c) The relative salience of particular content areas to diverse stakeholders who could make substantive contributions. A variety of tools are available to assist this process,<sup>24</sup> and some local partnerships in California have employed them with positive results.

#### **4. Program Monitoring**

SB 697 includes a requirement for nonprofit hospitals to identify “measurable objectives to be achieved within specified timeframes.”<sup>25</sup> In practical terms, however, there are few local hospitals with the internal capacity and expertise to effectively comply with this requirement.

Many, if not most, hospitals have identified measurable objectives for major program areas of focus. In most cases, however, monitoring processes are limited to documenting the volume of services provided to targeted populations.

In the wake of the events of September 11, there is growing awareness that there is a critical need to strengthen the local public health infrastructure. An important element of such enhancement is ongoing collaboration between local public health agencies, hospitals, and other health and human service providers in the public and private sector.

This should involve “real time” sharing of data and information, coordination of community health initiatives, and joint monitoring of impacts. While some local hospitals have successfully engaged local public health agencies, academic institutions, and other local stakeholders with appropriate expertise, others have faced significant obstacles.

Many hospitals in rural counties face a lack of local expertise and capacity. In these situations, technical assistance may be needed from sources outside the community to strengthen local stakeholders in the public and private sector. In urban and suburban counties, greater leadership is needed from hospitals and public health agencies to explore content areas of common interest that may serve as pilots for joint monitoring.

#### **5. Organizational Infrastructure**

The most important areas for internal development identified by respondents highlight a practical reality faced by hospital community benefit staff. Many, if not most, are expected to manage a complex process of community engagement, assessment, program planning, implementation, monitoring, and reporting under less than optimal conditions. Not surprisingly, the top-ranked area was the need for increased investment in dedicated staff.

The high ranking for alignment of community benefit with organizational strategic planning reflects a desire to elevate the visibility of community benefit as a part of major decision making processes. By taking this step, hospitals send a message to senior leadership that community benefit is a core function of the organization. Similarly, the high ranking for establishing performance incentives and stronger linkages to senior leadership reflects a desire for increased accountability in efforts to fulfill the charitable mission of the organization.

For the last question in the challenges section of the survey, respondents reflected an understanding that the community benefit capacity of their organization is threatened by a variety of external forces. By far the most significant challenge identified by respondents is low reimbursement rates from payers. Respondents clearly understand that the ratcheting

down of reimbursements has reduced the operating margins of their organizations, and that this limits the funds available for community benefit.

While the saying “No margin, no mission” has been called into question by the practices of some health care organizations in the nonprofit sector,<sup>26</sup> it is a practical reality that financial constraints limit the ability of nonprofit hospitals to address unmet health needs in local communities. It is important to build an understanding of the factors that may limit the ability of nonprofit hospitals to carry out their charitable mission. In some cases, the causes may be linked to flawed organizational decision making; in others, the causes are both external and systemic.

### **C. Stakeholder Feedback on Study Findings**

Four briefings were held with representatives of nine stakeholder groups to share survey findings and solicit feedback. Three additional briefings were held with State agencies; two with staff and leadership of the Office of Statewide Health Planning and Development (OSHPD), and one with senior staff from the Director’s Office of the California Health and Human Services Agency. Briefing dates and participants are as follows:

|                    |  |
|--------------------|--|
| <b>August 8</b>    | Office of Statewide Health Planning and Development  |
| <b>October 5</b>   | Consumers Union  |
| <b>October 15</b>  | American Federation of State, County, and Municipal Employees<br>Union of American Physicians and Dentists<br>United Nurses Associations of California |
| <b>October 25</b>  | Service Employees International Union Local 250<br>California Physicians’ Alliance   |
| <b>November 13</b> | Office of Statewide Health Planning and Development  |
| <b>November 16</b> | California Healthcare Association<br>Alliance of Catholic Healthcare<br>California Association of Public Hospitals and Health Systems                  |
| <b>January 9</b>   | Calif. Health and Human Services Agency – Director’s Office<br>Office of Statewide Health Planning and Development                                     |

The following is a summary of feedback provided by various participants in the four stakeholder briefings. Summaries are provided in the order of the date of each briefing. Effort has been made to accurately capture all issues raised by stakeholders in the course of the briefings. No stakeholder, however, was given final editorial review and approval of the text as it is presented in this section.

## 1. Consumers Union

In addition to Consumers Union, there were two other stakeholder groups invited to participate in the first briefing, which was held in the Consumers Union San Francisco offices. Those organizations were Health Access, and PICO California (Pacific Institute for Community Organization). Both organizations indicated that they would be unable to attend the briefing.

One of the first concerns raised by representatives of Consumers Union (CU) is that the study did not significantly involve consumers. In responding to this concern, it is important to clarify the meaning of the term “consumers.” For hospitals, the term applies to patients, as *consumers of health care services*. A common step in local needs assessment processes is to hold one or more focus groups with consumers to get input on the types of services that are needed.

Some might suggest that *consumer advocates* usually staff organizations such as CU or Health Access and can best represent the interests of health care consumers. Still others<sup>27,28</sup> suggest that the term “consumer” reduces people to the role of being passive recipients of commodities (i.e., health services), rather than active stakeholders in their community. The *community stakeholder* seeks an ongoing role as a partner with the hospital and other stakeholders to address the symptoms and underlying causes of health problems in local communities. In this context, a role as a “consumer” is too limited.

Since the study’s intent was to document and examine key elements of existing community health initiatives, it was concluded that the composition of the Advisory Committee should include individuals who have relevant experience. At least four of the fifteen members have extensive experience working with and advocating for low-income community residents in the state of California. One of the four Advisory Committee members was also a former staff lawyer for CU and a longtime consumer advocate.

While the content focus, time frame, and budget for this study did not allow for extensive involvement of community stakeholders, findings from this study might be used to foster local engagement. Other stakeholder groups (see section IV.C.3) encouraged broad dissemination of study findings to increase public awareness and foster accountability at the local level.

CU representatives also noted that some hospital stakeholders have presented the issue of charity care and community health initiatives as a “zero sum” situation where demands for an increased volume of charity care will result in a corresponding reduction in community health initiatives.

In the most practical sense, there are a finite amount of resources available to nonprofit hospitals for charitable investment. That amount is directly related to the surplus funds available after subtracting total expenses from total revenues. While one might challenge some of the expenses accrued by nonprofit hospitals (e.g., for consultants, senior executive salaries, investments), the unavoidable reality is that somebody, somewhere, has to pay for the charitable services and activities that are provided.

Some have argued that the charitable obligations of nonprofit hospitals are directly related to the value of their tax exemption (e.g., property tax, sales tax, access to tax-free municipal bonds), and some states (i.e., Texas, Utah, Pennsylvania) have established financial thresholds that are directly related to this value.

While it is not within the scope of this study to examine this issue in detail, anecdotal evidence suggests that these laws have done little to increase access, and have at the same time undermined public pressure for hospitals to become more engaged in local communities. Moreover, it is unclear to what extent the value of tax exemption is returned in part by charitable practices that cannot be defined in financial terms.

Most community health initiatives do not require large financial investments by hospitals. As illustrated in the exemplary practices documented in this study, the hospitals have made optimal use of relatively small financial investments by leveraging the engagement of diverse stakeholders, building on existing community assets, and applying their expertise to secure substantial funding from outside sources.

As noted previously, six of the 20 community health initiatives documented in this study involve the delivery of charity medical care, and seven others involve clinical preventive and/or chronic disease management services. In this sense, the issue of charity care vs. community health initiatives **is not** a zero-sum game. There is an opportunity to view community health initiatives as a more strategic use of charitable resources to increase access for medically indigent populations *and* to address the underlying causes of persistent health problems.

Finally, CU representatives indicated that it is important to make clear that, given the sample size (i.e., 34.6 percent of all nonprofit hospitals), the study does not purport to be a comprehensive review of all nonprofit hospital charitable practices. In addition, it should be made clear that data from the surveys are self-reported, and have not been validated by independent sources.

## **2. American Federation of State, County, and Municipal Employees Union of American Physicians and Dentists United Nurses Associations of California**

Representatives of these stakeholder organizations indicated support for the findings of the study, and expressed interest in the involvement of their constituents as supportive partners in the assessment, community engagement, and program monitoring processes. In general, they viewed these practices as an area of focus for their organizations to engage hospitals in a positive, non-confrontational manner. They suggested that hospitals should look to organized labor structures as a part of communities and as an avenue for engaging diverse stakeholders.

One question raised by participants was the extent to which the passage of state community benefit laws is related to the presence/absence of public hospitals. While there has been no research to date that explores this relationship, observation of historical trends suggests that attention to the charitable contributions of nonprofit hospitals is linked to four related factors:

reductions in federal and state funding for municipalities; rising costs; expansion of investor-owned hospitals; and, persistently high numbers of uninsured. Research into these relationships and state-specific dynamics would provide important insights for policy makers, regulators, and other stakeholders in the field.

### **3. Service Employees International Union Local 250 California Physicians Alliance**

Participants expressed support for a broader framework of accountability that includes program design, community engagement, and institutional reforms. To the extent that these issues are addressed, they acknowledged the value of community health initiatives as a component of nonprofit hospital charitable contributions. They suggested, however, that hospitals should explore ways to increase the scale of current programs in order to produce measurable impacts in local communities.

Participants also took the position that charity care is an appropriate near-term measure of accountability for nonprofit hospitals. They agreed that greater clarity is needed to ensure consistency in defining and documenting charity care services by nonprofit hospitals. A key issue to be addressed in this area is how to classify and document free care provided for undocumented immigrants.

One participant noted that research to date does not clearly demonstrate that prevention is a cost-effective investment of resources. While there is some evidence that community-based approaches to address risk factors associated with chronic diseases such as diabetes and asthma may yield reductions in incidence and/or reduced severity, more research is needed to clearly demonstrate the financial and health benefits of prevention. This is somewhat of a “catch-22” situation — more research is needed to confer legitimacy, but there has been inadequate funding for prevention research.

An important factor for consideration in the issue of cost-effectiveness is the design of community health initiatives. Are charitable resources allocated strategically to strengthen existing community programs and organizations? Are hospitals using their influence to engage stakeholders who can bring complementary expertise and resources in support of comprehensive approaches to prevention? If the answer to these questions is yes, then there is considerable potential to produce measurable impacts and demonstrate cost-effectiveness.

On a related issue, participants also noted that there is a lack of clarity on empirical linkages between quality of life measures and health status improvement. As is the case for prevention research, complexities in determining the influence of diverse and often interacting causal factors on illness and health can make this type of field research a daunting and costly endeavor. A key question is whether measurable impacts such as reduced school dropout rates, reduced juvenile delinquency, or an increased volume of affordable housing have inherent value. If they do, the next question is whether it is desirable for nonprofit hospitals to play a leadership or supporting role in these endeavors as charitable institutions in local communities.

One issue raised in this briefing, as well as in the briefing of hospital stakeholders, is the need for engagement of all private and public sector health care providers. In many counties, public and investor-owned hospitals and other providers such as community clinics are not engaged in the needs assessment and health planning processes. This impedes the ability of those engaged to identify gaps in existing services, areas of overlap or duplication, and opportunities for joint action. Ongoing engagement would enable health care providers to take optimal advantage of these opportunities and address gaps in the local health care safety net. In this context, it was suggested that some elements of SB 697 might be applied to *all* health care institutions.

Participants suggested that broad dissemination of these study findings are needed to increase public awareness and local community engagement, and to encourage replication of positive practices. They suggested that the policy dialogue might explore what kinds of principles and practices might be regulated, and which might be encouraged through incentives. Finally, participants strongly supported increased funding for OSHPD to increase its capacity to provide oversight of nonprofit hospital community benefit activities.

**4. California Healthcare Association  
Alliance of Catholic Healthcare  
California Association of Public Hospitals and Health Systems**

Participants offered two recommendations regarding the study's findings. They suggested that the report make it clear that the activities documented are not sufficient to fulfill the charitable obligations of nonprofit hospitals. Second, the report should not offer recommendations that are not directly informed by study findings. They further suggested that a set of guiding principles on community benefit planning and implementation processes should be developed. They recommended broad dissemination of lessons from experience to date.

They pointed out that the central intent of SB 697 was to allow flexibility; to encourage local innovation that makes optimal use of unique local circumstances to address unmet health needs. At the same time, they acknowledged that increased accountability is an imperative in the current political environment. A key consideration is how to establish parameters that ensure charitable intent in process, yet preserve maximum flexibility in terms of program content.

In the context of this study, this might translate into establishing parameters for program targeting and community engagement, but allowing maximum flexibility in the selection of program content, scale, and scope. For example, local partners should have the flexibility to determine whether they develop a program to deal with juvenile delinquency, asthma, or senior accident prevention. There should be consistency across communities, however, in terms of the targeting of program activities to address disproportionate unmet needs, and the ongoing engagement of diverse stakeholders in planning and implementation. Moreover, hospitals should be encouraged to allocate resources in a strategic manner to build community capacity and institute policy changes that strengthen commitment to their charitable mission.

Participants also suggested that accountability should be based in part upon an assessment of the totality of services provided in counties and/or regions. It was noted that if a county is doing a poor job of implementing their obligations to provide health and human services to indigent populations,<sup>29</sup> there will be pressure on nonprofit hospitals to provide a larger volume of charity care. On a related note, one participant indicated that SB 697 does not encourage the documentation of local barriers to collaboration among health care providers and other relevant stakeholders.

Some participants shared their experiences in developing a comprehensive health planning process in San Diego County. An early imperative in this local process was to make sure all health care stakeholders in the county were at the table. While there have been many accomplishments, there have also been important lessons learned, and areas for further improvement identified. For example, there has been a significant increase in efforts to raise funds, but increased efforts are needed for ongoing coordination of services. At the same time, there are some institutions with unique capabilities that may be in a position to do some things on their own.

One nonprofit hospital representative acknowledged that there is a “*form of schizophrenia among the leadership of acute care hospitals.*” On one hand the driving force for the organization is to advance excellence in medicine; on the other hand, there is an acknowledgment of an obligation to be engaged in their communities. Participants noted that reluctance by some senior leadership to increase engagement and support of community health initiatives is reinforced by a perceived lack of understanding and support in the policy arena. A number of participants strongly supported expanding measures to accommodate non-financial contributions and developing a broader spectrum of measurable impacts.

One participant noted that county public health agencies have gained experience in documenting a variety of impacts in the last decade, and suggested that the time is right to establish working relationships with local hospitals. Participants agreed that this kind of activity would be an important area for foundation support.

## **D. Limits of the Inquiry / Areas for Further Inquiry**

### **1. Limits of the Inquiry**

One of the limits of this study is the relatively low response rate of 34.6 percent. This is primarily because completion of the survey was voluntary. In addition to the fact that the survey was discarded without close examination by some hospitals (see discussion in previous section, C.4), there were other reasons for the response rate cited by community benefit staff in phone calls made two weeks prior to the deadline for return of the survey. By far the most common reason cited was a lack of staff time. A few individuals cited other reasons, including:

- Lack of support from leadership
- Fear of scrutiny / misrepresentation of findings by advocates
- External communication of community benefit activities is a low priority

In some cases, a lack of clarity on jurisdictional responsibilities among staff may have made it difficult to determine how to respond to a survey that called for activities linked to other local facilities.

As acknowledged previously, the low response rate means that the study cannot be represented as a comprehensive review of all California nonprofit hospitals. Nevertheless, the sample of responses is large enough to identify key elements of high-quality community benefit practices. Survey results provide important insights into opportunities for enhancement and they identify challenges to be addressed.

Another limit of this inquiry is that the data is self-reported. In most cases, claims made by hospitals associated with programs and policies have not been validated by independent sources. However, hospitals represented among the 23 exemplary practices are aware that their information is being published and will be open to scrutiny by a variety of external stakeholders. In addition, survey responses in the challenges section demonstrated a high degree of candor. Respondents identified a number of different areas where their organizations need to improve both in terms of programs and institutional policy development.

## **2. Areas for Further Inquiry**

This study should be viewed as a first level inquiry to identify and document key elements of community benefit activities outside of traditional ad-hoc charity medical care. Further inquiry might focus on validating study findings with particular emphasis on the following:

- Hospital roles in community benefit programs and contributions to activities
- Community partner roles and contributions to activities
- Measurable impacts of activities
- Institutional policy changes

In addition, it may be appropriate to conduct a state-mandated inquiry (i.e., with required responses from nonprofit hospitals) that would provide a more comprehensive review of community benefit practices among California nonprofit hospitals.

Another area for inquiry is the relationship between the community benefit practices and policies of individual facilities and their sponsoring health systems. This inquiry might explore the impact of policies developed and promulgated by health systems to enhance community benefit practices of individual facilities. (Refer to St. Joseph Health System and Citrus Valley Health Partners exemplary practices, C.1 and C.2 in Appendix A.) Such an inquiry might also explore the impact of practices and policies initiated at the individual facility level on that facility's relationship with the larger health system. (Refer to Feather River Hospital exemplary practice, C.3 in Appendix A.)

There is growing interest in nonprofit hospital governance and policy issues, demonstrated most recently in Assembly Bill 2276, which calls upon the California Attorney General to determine if additional standards "should be established for public benefit corporations, religious corporations, and other private not-for-profit corporations that operate or control a

health facility.”<sup>30</sup> One of the three primary areas of focus in the law is determining “the role of the board of directors of private, not-for-profit hospitals in ensuring benefit to the community...” (Section 5930 (c) 3).

Steps that could be taken to enhance and ensure the sustainability of current program activities are a final area for additional inquiry. This would involve documenting alternative approaches taken under different local circumstances. Examples might include:

- Integrating program costs into existing reimbursement structures
- Technical assistance to expand the capacity of community-based organizations to assume responsibilities
- Public policy reforms that provide ongoing funding for successful program activities

Documenting the successes and challenges of hospitals and community partners in rural, suburban, and urban communities that have implemented community benefit programs would serve as a valuable resource for other hospitals and local partners, as well as for policy makers.

## V. Recommendations

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The following recommendations are based upon study findings and refined by discussions of findings with key stakeholders. Recommendations are also informed by observations of recent trends in community benefit policy, practices, and advocacy across the nation.

The recommendations are intended for consideration by hospitals, community groups, policy makers, and advocates. They are meant to enhance the quality of charitable practices and to increase public awareness of opportunities to participate in addressing the symptoms and underlying causes of health problems. While some recommendations may provide a framework for policy development, it is not clear that regulatory action is the best tool to enhance charitable practices. In many cases, increased public awareness, local coordination, and public and private sector incentives may yield more beneficial impacts.

There are four areas of focus for recommendations that address the issues raised by this study. Specific recommendations are provided within each area of focus.

### 1. **Expand the scope of nonprofit hospital accountability.**

- ***Community stakeholder involvement***  
Encourage ongoing involvement of diverse community stakeholders in community benefit planning and implementation. Specific areas for community involvement include the selection of program content areas, program design, facilitation of partner engagement, and program oversight. Mechanisms for increased involvement range from expanded community representation on boards of trustees to the establishment of board committees with diverse representation and specific decision-making responsibilities.
- ***Program targeting***  
Community benefit program activities should be **clearly targeted** to serve populations and communities with disproportionate unmet health-related needs. Mechanisms for targeting could include developing an institutional policy that establishes a specific threshold (e.g., majority of target population is uninsured or have incomes less than 200% of federal poverty limit). Or, targets can be established by creating explicit criteria in priority setting that give preference to communities where health-related problems are concentrated.
- ***Strategic investment in community capacity building***  
Encourage the strategic allocation of charitable resources (financial and in-kind) to build on existing community assets (e.g., community-based organizations, coalitions) to minimize duplication, increase effectiveness, and enhance sustainability. Given limited resources to address persistent health problems, it is essential for hospitals to *first* identify what is already going on in local communities, and what kinds of existing community assets might be available help to accomplish a health improvement objective.

Future reporting guidelines could call for the identification of local assets as a part of the community assessment process, and encourage hospitals to document enhancements of existing efforts that were leveraged by charitable investments.

- ***Institutional policy development***  
SB 697 or related regulatory statutes should acknowledge and encourage the development of institutional policies that align organizational governance, management, and operations with charitable mission.

## **2. Develop uniform measures to quantify community benefit activities.**

- ***Documentation and reporting of charity care***  
Create a uniform definition and methodology for documentation and reporting. This will improve analysis and comparison of the volume of charity care provided by nonprofit hospitals.
- ***Documentation and reporting of activities outside of medical care***  
Create uniform content categories and financial measures for the full spectrum of activities, including staff release time, equipment, and technical assistance provided by nonprofit hospitals. Some software tools developed by health care trade organizations offer promise for refinement and use as reporting mechanisms.

## **3. Increase coordination between local public health agencies and hospitals.**

The central goal is to enhance coordination of complementary skills and resources among local public health agencies, hospitals, and community stakeholders to address unmet health-related needs in a cost-effective and sustainable manner.

- ***Community health assessments***  
Facilitate collaborative approaches to assessment with an emphasis on sub-county areas with high concentrations of uninsured populations and unmet health-related needs. Assessments should include identifying existing community assets as entry points for strategic investment of stakeholder resources.
- ***Resource coordination***  
Local stakeholders have a responsibility to identify gaps in services and duplicated effort to assist in more effectively targeting resources. In the process, partners should clarify the roles of public and private sector providers in efforts to address health problems. Strategies that increase access to primary care and preventive services, and reduce the demand for ER-based charity medical care, should receive particular emphasis.
- ***Program monitoring***  
Encourage local public health agencies and academic institutions to get involved in the design and implementation of monitoring strategies. They have significant

amounts of untapped expertise that can assist hospitals and their partners in monitoring and improving community benefit programs.

**4. Facilitate region-wide public dialogue between hospitals and community stakeholders.**

A series of public meetings should be held in a selected number of California communities to review accomplishments to date and identify specific areas for improvement. Particular effort should be made to expand the scope of community stakeholder involvement and to reduce confrontational dynamics. Meetings might be followed by targeted technical assistance in some communities to help implement community benefit programs.

## **VI. Conclusion**

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Implementing these recommendations will require increased funding and support from public and private sector sources. Funding from the public sector might involve targeted grants and contracts to local public health agencies to build internal capacity for enhanced coordination. Additional support may be directed through re-formulation of categorical program funds from multiple state agencies. Examples of state agencies with health-related program funds range from the Health and Human Services Agency to the Department of Education and the Department of Transportation.

Private sector funds can be best used to develop management and governance structures in nonprofit hospitals that increase accountability and enhance the quality of program services and activities. In addition, the private sector has a role to play by contributing talent and time to this effort, especially in the area of management consulting.

While funding for direct services is important, equally important are the less tangible efforts documented by this study. Increased emphasis is needed to encourage institutional policy changes that codify organizational commitments. In addition, we must focus on public policy reforms that enhance community benefit programs for the long haul. The health and economic strength of our communities depends on a deeper and broader public policy commitment to this important area.

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# **APPENDIX A: Exemplary Practice Case Summaries**

**Category A:            Programs producing measurable  
                                 improvements in health status**

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- A1.    Angelina Fortes Silva Medical and Dental Clinic  
         St. Rose Hospital / Via Christi Health System**
  
- A2.    Spirit of Caring Mobile Health Care Clinic  
         Sharp Chula Vista Medical Center / Sharp Health System**
  
- A3.    Project Dulce Diabetes Management Program  
         Scripps La Jolla Hospital / Scripps Health System**
  
- A4.    House Calls / Home Sweet Home Program  
         Santa Rosa Memorial Hospital / St. Joseph Health System**
  
- A5.    Health to Home / Community Wellness Program  
         Bakersfield Memorial, Mercy, and Mercy Southwest Hospitals  
         Catholic Healthcare West**

**A1. Angelina Fortes Silva Medical and Dental Clinic**

**South Hayward / Alameda County  
St. Rose Hospital / Via Christi Health System**

**Community / Populations**

The population of South Hayward is 37,639. Latinos make up 41 percent of the local population; 23 percent are Asian/Pacific Islanders, 23 percent are Caucasians, eight percent are African Americans, and one percent are Native Americans. Between 1990 and 2000, the Latino and Asian/Pacific Islander populations grew by 76 percent and 73 percent, respectively.

The primary area of South Hayward served by the Silva Medical and Dental Clinic is the Harder-Tennyson neighborhood. Residents in the Harder-Tennyson neighborhood are low- to moderate-income, and approximately 65 percent are Latinos. More than 45 percent of the children in this area live in households that fall below the federal poverty level.

**Project Description**

In 1995 the Hayward Rotary Club approached the leadership of St. Rose to discuss expanding the scope of services provided at the Eden Youth and Family Center. The Eden Youth and Family Center was established in 1977 and provides a broad array of services and training for residents in the area. Until 1995, however, clinical health services were limited to child immunizations that were provided through a partnership with the Alameda County Public Health Department.

In the course of providing immunizations it became clear that there were a broader range of unmet health needs in the Harder-Tennyson community. These unmet needs ranged from poor nutrition to a lack of pediatric services for MediCal-certified recipients. While there are two clinics (Hayward Health Center, Tiburcio Vasquez) within five miles, neither clinic has the capacity to handle the growing volume of unmet health needs for youth.

The Rotary Club provided funding to renovate the center, and St. Rose provided clinical staff to deliver services for a total of six hours per day, four days per week. The clinic was named after a community leader that was a major benefactor of the Hayward Rotary Club and the wife of a former city councilman. The demand for services began to outstrip initial staffing levels within the first month of expanded operations. St. Rose gradually expanded staff support to full time over the course of the first six months.

Proposition 187 was passed not long after the clinic began operations. In order to minimize negative impact on utilization, St. Rose distributed flyers in the community making it clear that it was not in the business of checking immigration status.

After three years of operations it became apparent that the clinic had outgrown its physical space. In response, the Rotary Club and the St. Rose Foundation implemented a joint fundraising campaign. A video and a brochure were developed to support the fundraising process. Partners identified dentists who would volunteer their time to provide services and to advocate for support, and companies who would provide equipment and supplies. The fundraising effort secured \$475,000, and expansion of the facility was completed in May 2000.

The Silva Clinic also provides office space for Alameda County Public Health Department staff. County staff work with families to provide other needed support services, including welfare, maternal and child health, and mental health counseling.

### **Role of the Hospital**

St. Rose is a 175-bed nonprofit Catholic hospital located in Hayward, and part of the Via Christi Health System, which is based in Wichita, Kansas. St. Rose owns and operates the Silva Medical and Dental Clinic.

In the process of fundraising for the expansion of the clinic, St. Rose secured a total of \$291,576 in outside funding. In-kind contributions made by St. Rose in the fundraising and expansion process totaled \$44,400.

Clinic staff members include a full-time nurse practitioner, a full-time pediatrician, two licensed vocational nurses, one medical assistant, and three administrative support staff. Approximately 60 percent of clinic funding is covered by MediCal reimbursements, and St. Rose provides the remaining support. The total value of net contributions by St. Rose in fiscal year 2000-2001 was \$261,000.

### **Impacts to Date**

The clinic has doubled the number of annual visits from 3,499 in 1995 to 7,861 in 2000. Of the total number of visits, 6,288 were MediCal and Healthy Families, while 1,535 were uninsured. During the same period, pediatric visits to the St. Rose emergency room have decreased from 11,897 to 7,974. The dental clinic has also reduced the number of dental problem-related ER visits. Projections indicate that community members will make 8,500 visits in fiscal year 2001-2002.

## **A2. Spirit of Caring Mobile Health Care Clinic**

**City of Chula Vista / San Diego County  
Sharp Chula Vista Medical Center**

### **Community / Populations**

Chula Vista is a city of approximately 160,000 residents located south of the City of San Diego. The ethnic and cultural composition of the population is approximately 49 percent Caucasian, 38 percent Latino, eight percent Asian/Pacific Islander, and four percent African American.

The Spirit of Caring Mobile Health Care Clinic (SCMC) serves the children at elementary schools in the Chula Vista Unified School District. Selected schools were chosen because of high rates of absenteeism (1,086 in 2000-2001) and because 46 percent of the children qualify for the federal school lunch program. Of the children served by the SCMC, 84 percent are Latino. English is a second language for 57 percent of these children.

### **Project Description**

The need for a mobile clinic program was identified by an inter-disciplinary group of stakeholders convened by the South Bay Human Services Council to discuss health-related issues. In the course of discussions in early 1999, the school district expressed concern about the high rate of absenteeism in some schools, which was attributed primarily to poor access to primary and preventive care. At the same time, the Sharp Chula Vista hospital CEO lamented the high rate of emergency room use for children with non-emergent conditions. The group agreed that a targeted effort was needed to address these related issues.

In response, Sharp, the school district, and an array of public and private sector partners began a fundraising campaign. Sharp Healthcare Foundation took the lead in developing a number of proposals, and secured a total of approximately \$250,000 from a variety of foundations to purchase a specially equipped vehicle.

Mobile clinic staff include a bilingual nurse practitioner, a registered nurse, and a medical assistant. The clinic provides primary care, medications, and referrals to specialty and support services. Clinic staff members currently provide health education services on an individual basis, and are exploring ways to expand these services into a classroom format.

The clinic travels to five central school sites in the Chula Vista Elementary School District. Appointments are arranged by school nurses and/or other school health care personnel. Parents or other authorized school representatives are required to accompany students to examinations or treatment appointments. Staff also assist in enrolling children in MediCal, Healthy Families, or other health insurance programs.

## **Role of the Hospital**

Sharp Chula Vista provided approximately \$250,000 in seed funding to purchase and equip the mobile van, and Sharp Healthcare and Scripps share equally in the cost of operating the mobile clinic and managing fundraising efforts. The Spirit of Caring Mobile Clinic has an annual operating budget of \$300,000. Sharp Chula Vista Medical Center directs the program and provides staffing and benefits, at an annual net cost of \$200,000.

## **Impacts to Date**

Three measurable impacts have been documented to date. They include:

- Decreased non-urgent emergency room utilization for children five to 12 years of age, by 22 percent for Scripps Chula Vista, and by 12 percent for Sharp Chula Vista in year one.
- Increased school attendance and improved academic performance correlated with measurable reductions in illnesses such as asthma and ear, respiratory, and viral infections.
- Increased insurance coverage (children seen at the mobile clinic have increased coverage to 64 percent, including MediCal and Healthy Families).

## A3. Project Dulce Diabetes Management Program

### **San Diego County** **Scripps La Jolla Hospital / Scripps Health System**

#### **Community / Populations**

In 1997, the American Diabetes Association estimated that there were approximately 220,000 residents of San Diego County with diabetes (diagnosed and undiagnosed). It further estimated that 35 percent of those individuals were uninsured. Studies have also shown that Latinos and African Americans are two to three times as likely to acquire diabetes as Caucasians.

With these observations in mind, Scripps Health and a broad spectrum of health care providers in San Diego decided to develop and implement a comprehensive diabetes management and education program that targets predominantly low-income Latino populations.

#### **Program Description**

Project Dulce was initiated because of findings from the collaborative needs assessment conducted by hospitals, the county public health agency, universities, and community clinics. Partners agreed that diabetes was a major health concern in San Diego County that disproportionately affected low-income community residents.

There are two program components: one that focuses on clinical care management, and another that focuses on health promotion. Nurses who are certified diabetes educators implement the clinical component of the program. Medical assistants support the nurses. Clinical staff members have all completed training on the program model and are supervised by an endocrinologist. Services are provided in 17 community clinic settings.

The health education / promotion component was developed by Latino Health Access. The core of this component is peer education, involving the recruitment and training of diabetics from local neighborhoods as health “Promotores.” The training is a six- to nine-month process that includes formal certification. Participants receive stipends during the training process. There are three Promotores hired by Scripps Health, two by the community clinics, and six more that are currently being trained.

Initial funding for the project came from five local hospitals (a total of \$175,000, with Scripps providing \$50,000), the Alliance Health Care Foundation, and The California Endowment. Funding support and supplies have also been provided by a number of pharmaceutical companies.

Whittier Institute, a nonprofit subsidiary of Scripps Health, developed the clinical component of the program. Funding from The California Endowment focuses on program replication and supporting capacity building that will sustain the program over time. The Endowment also

advocates changes in MediCal funding because California doesn't pay for diabetes education while most other states do.

The county has adopted the model for indigent adult programs; this represents its first application outside of acute care. Project Dulce is also the first time the county has authorized one-year eligibility for populations. The program is now being implemented in 15 community clinic sites.

Partners are in the process of conducting key informant interviews and focus groups to adapt the program for the specific needs of Vietnamese, Filipino, and African American populations. Scripps Health is also replicating elements of the Dulce Program for all populations. Nurses and physicians are being trained in a variety of hospital sites to mainstream the clinical and educational approach at all health care delivery sites in San Diego. Scripps is also developing information systems that will support ongoing data collection.

### **Role of the Hospital**

Scripps provided \$50,000 in start up funds, intellectual capital (e.g., Whittier Institute development of the model and facilitation of efforts to translate the model into application), and leadership (leveraged engagement of key stakeholders). An estimate of total Scripps contributions and staff time to date is over \$200,000.

### **Impacts to Date**

A formal study conducted by the Whittier Institute did a pre / post test of health outcomes, patient knowledge and satisfaction, and health locus of control with 210 high-risk and 346 lower-risk Latino diabetics who participated in Project Dulce. Data were compared with chart reviews of 311 diabetic Latinos that did not participate.

After one year, patients enrolled in Project Dulce had significantly improved clinical outcomes, higher adherence to standards of care, higher internal locus of control, and fewer inaccurate culture-bound beliefs. The outcome data are among the best reported by clinics or medical groups in the state. Study findings have been published in the January 2001 issue of the *Journal of Ambulatory Care Management*.

## A4. House Calls / Home Sweet Home Program

**Southwest Santa Rosa / Sonoma County**

**Santa Rosa Memorial Hospital / St. Joseph Health System**

### **Community / Populations**

Findings from a community assessment conducted in 1996 by Santa Rose Memorial Hospital (SRMH) and community partners showed a concentration of unmet health-related needs in a cluster of low-income neighborhoods in the southwest quadrant of Santa Rosa. Challenges faced by this community of approximately 25,000 residents include poor housing, high rates of violence, isolation among elders, a lack of family-related support services, and a large transient population.

The ethnic/cultural composition is 76 percent Caucasian, 28 percent Latino (any race, therefore, the majority of Latinos identified as “Caucasian”), four percent African American, three percent Native American, and 13 percent other. Seventy percent of residents served by House Calls and the Home Sweet Home program are over 60 years of age.

### **Program Description**

The House Calls program was established by Santa Rosa Memorial Hospital (SRMH) in 1996 with a stated goal of reducing financial, physical and socio-cultural barriers to care for homebound low-income residents. The impetus for the program was the identification of a significant number of isolated frail elders in southwest Santa Rosa by neighborhood organizers that were conducting door-to-door outreach for SRMH.

Some seniors had families nearby, but these families often did not know how to care for their elderly relatives or how to access the health care system. Many are undocumented immigrants, residing in crowded and squalid housing conditions. Organizers found that some seniors didn't feel that they had the right to ask for better care.

Program personnel include bilingual nurse practitioners, registered nurses, and a patient care manager. Services are provided in a holistic manner, attending to body, mind, and spirit. Services include primary care, patient education, counseling, pastoral care, and referrals to local agencies. Ongoing outreach is conducted in cooperation with the county social services agency, the Area Agency on Aging, Adult Protective Services, In Home Support Services, hospital social workers, discharge planners, and Meals on Wheels. House Calls team members serve as advocates, linking seniors to everything from basic goods to mental health services. SRMH also developed and distributed a brochure to increase community awareness of available services.

In 1998, reductions in Medicare coverage contributed to a significant increase in requests for Home Health Aide assistance for seniors. Home Sweet Home was added to fill the gap in reimbursed services in order to maintain senior independence and reduce the risk of in-home injuries. A major focus in the home visits is health education and accident prevention, to foster independence and prevent early placement in assisted living facilities. Home health aides also

assist seniors with basic daily needs, including cleaning, cooking, grocery shopping, meal planning, caregiver's respite and personal hygiene. Nurses and Aides work in concert with SRMH and community agencies to secure additional services as needed.

SRMH has recently expanded its partnership with Sonoma State University School of Nursing to provide residencies for nursing students in the House Calls and Home Sweet Home programs. This partnership leverages additional resources and enhances the sustainability of both programs.

### **Role of the Hospital**

SRMH has provided core leadership for developing and implementing both programs. The early commitment of staff and resources for door-to-door outreach was critically important to identify and build an understanding of the barriers to access faced by homebound low-income residents. Developing partnerships with public and private sector agencies was also critical to leveraging available resources that expand services beyond the southwest quadrant of Santa Rose to serve frail, low-income seniors throughout the county.

Total annual operating cost for both programs is approximately \$436,000, of which \$356,000 is covered by Santa Rosa Memorial Hospital. Approximately \$80,000 was secured by SRMH in grants from external funders. The majority of expenses are in salaries and medications. Sustainability plans include billing MediCal and Medicare for primary care home visits by nurse practitioners, as well as continuing to seek grant funding and donations.

### **Impacts to Date**

SRMH has provided more than 10,000 visits in the House Calls program since its inception in 1996. There were 4,000 visits for 200 people in FY 99/00. SRMH staff estimate that these visits resulted in the prevention of 120 ER visits and/or admissions. House Calls also reduced the number of paid visits and home health services needed by Medicare patients. There were 3,780 visits for 300 patients in FY 00/01. It is estimated that 60 admissions were prevented for this cohort, primarily for diabetes, congestive heart failure, hypertension resulting in stroke, pneumonia, and cellulitis.

There were 25 seniors receiving services through the Home Sweet Home program in FY 00/01. SRMH is monitoring the impact; so far there have been no ER visits by participants.

## A5. Health to Home / Community Wellness Program

**Southeast Bakersfield / Kern County**

**Bakersfield Memorial Hospital / Mercy Hospital / Mercy Southwest Hospital**

**Catholic Healthcare West (CHW) – Kern Service Area**

### **Community / Populations**

The Health to Home and Community Wellness programs serve low-income, uninsured or underinsured residents of Southeast Bakersfield, Taft, Lake Isabella, Mojave, Arvin, Delano, and other outlying areas. These local residents lack access to timely preventive care and health education services. When educational programs are available in hospitals or other clinical or educational settings, transportation or cultural and language barriers often limit access for those who need it most.

Many local residents resort to hospital emergency rooms as their primary care providers, contributing to emergency room saturation. Bakersfield's emergency rooms were saturated 64 percent of the time in 2001, and at no time during the year did the average saturation rate dip below 52 percent, according to data from Kern County Emergency Medical Services.

Many clients served through the Health to Home Program are seasonal and migrant farm workers. Because they live and work in areas with high volumes of pollution, dust, and pesticides, there is a high incidence of respiratory ailments such as chronic asthma, valley fever, chronic bronchitis, and pneumonia. Most clients are African Americans and Hispanics, who are at high risk for heart disease and diabetes. The American Diabetes Association reports that African Americans are 1.7 times as likely to develop Type 2 diabetes as the general population, and that Hispanics are twice as likely. High blood pressure afflicts about 30 percent of African Americans over the age of 18, a rate that is among the highest in the world, according to the American Heart Association.

### **Program Description**

The Health to Home Program was established in October 2000 and is supported by a grant from the California Managed Risk Medical Insurance Board (MRMIB) through Blue Cross of California. The Community Wellness Program was established in July 2001 and is supported by a grant from Kern Family Health Care. Both programs are co-managed to bring health education directly to low-income community residents and to reduce risk factors for heart attacks, stroke, and diabetes among high-risk populations.

The Community Wellness program consists of three components: monthly screening clinics in five different communities, health education classes, and in-home instruction by Health Educators. Recent experience in the program has shown that residents are more inclined to take advantage of screening clinics than health education classes. In response, CHW increased the number of health screenings and one-on-one encounters between patients and the program's registered nurse and dietician. Clinics and classes are held in popular local social settings to minimize transportation barriers.

The Health to Home program provides in-home health education for people diagnosed with asthma, diabetes, high cholesterol and/or blood pressure, and other chronic conditions. Home-based service delivery provides an opportunity to identify and address an array of environmental factors that may impede and/or facilitate optimal management of illnesses.

A key lesson learned early on by CHW-Kern Service Area hospitals is that one of the greatest barriers to community engagement and health care access is trust. In 1991, CHW created a Department of Special Needs & Community Outreach, and two community outreach centers were established in the low-income neighborhoods of Southeast Bakersfield. More than a decade of presence in the low-income community has helped to earn the confidence of other social service providers and the trust of community residents.

## **Role of the Hospital**

CHW-Kern Service Area is the largest health care provider in the Southern San Joaquin Valley, serving a diverse population of urban and rural residents with five hospitals, urgent care and occupational health centers, childcare facilities, home health services, and two community outreach centers.

The community outreach centers administer more than 80 programs for low-income residents, including migrant farm workers and other disenfranchised populations. Last year, the department served more than 83,000 individuals, often in collaborative efforts with more than 35 private, public, and not-for-profit organizations.

In addition to \$160,000 annually to operate the outreach centers, not including donations of food, clothing, and other goods and services, CHW provides \$40,000 per year for the Health to Home/Community Wellness staff and associated expenses to supplement funding secured from outside sources. Additional assistance is provided through an institutional policy entitled "Share Mercy" that gives employees of area companies 80 hours of release time per year to support community programs.

## **Impacts to Date**

The Health to Home Program served 275 individuals with home visits between October 2000 and September 2001. There were small group presentations for 751 community members at the outreach centers during the same period, yielding a total of 1,026 patients served in the first year of the program. Between October and December 2001, there were an additional 62 individuals who received home visits, and 235 who participated in small group presentations. The Health to Home program is now in its second year of operation and CHW-Kern Service Area has secured two more years of funding commitment from Blue Cross of California.

In its first six months, the Community Wellness Program provided service to 969 individuals through its clinics and classes. During the same period, Health Educators served another 446 individuals through presentations and in-home visits. Data is currently being collected to determine the impact upon ER visits.

## **Category B: Programs producing measurable improvements in quality of life**

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- B1. Affordable Housing Initiative  
St. Joseph Hospital / St. Joseph Health System**
  
- B2. Homemaker Care Program  
Catholic Healthcare West (CHW) – Kern Service Area**
  
- B3. Creating Healthy Environments for Children (CHEC)  
Sutter Memorial Hospital / Sutter Health**
  
- B4. Casa de Amigos Community Center  
St. Vincent Medical Center / Catholic Healthcare West\***
  
- B5. Youth Bridge Mentoring Program  
Alta Bates Summit Medical Center / Sutter Health**
  
- B6. Holy Cross Center for Women  
St. Agnes Medical Center / Trinity Health System**

## **B1. Affordable Housing Initiative**

**Orange County**

**St. Joseph Hospital / St. Joseph Health System**

### **Community / Population(s)**

Orange County is home to a high concentration of middle- to upper-income residents. In the midst of this affluence are growing numbers of low-income residents in cities such as Anaheim, Santa Ana, and Orange. The recent economic expansion has increased the demand for housing, and rising costs have resulted in displacement and overcrowding for many of these residents.

Despite the need for low-wage workers, there is an acute shortage of affordable housing. This issue and its relationship to health status arose during the review of findings from the community needs assessment conducted by local hospitals and other community stakeholders.

### **Program Description**

Impetus for this initiative came from a member of the St. Joseph Health System (SJHS) leadership with prior experience in the housing and community development arena. After some preliminary outreach, SJHS convened a “Future Search” process that brought together more than 30 groups for two-and-a-half days of visioning and strategic planning.

One of the outcomes of the meeting was a decision to establish a collaborative with five working groups to focus on different aspects of the issue. For example, one working group provides technical assistance and input to cities for the development of public policy documents known as Housing Elements that are required of cities by the State of California. Another group focuses on building public support through presentations and other forms of communication in the media.

In the last 14 months, the collaborative has expanded to 70 members, representing a variety of sectors. There is significant involvement by local policymakers, including a State Senator who was recently appointed to the Chair of the Senate Housing Committee. At every quarterly meeting each member is asked to describe what she/he is doing to advance the agenda of increasing affordable housing for low-income families.

The collaborative works closely with a regional organization known as the Kennedy Commission. The Commission serves as an advocate for new affordable housing for those earning less than \$10 an hour and provides assistance to advocacy groups in a number of local communities. Commission meetings are hosted by the hospital; SJHS staff head the Fundraising Committee, which has raised more than \$60,000. The Commission just received approval to establish formal 501c3 status and has hired an executive director.

## **Role of the Hospital**

In addition to initial outreach and seed funding for the initiative (e.g., Future Search process), SJHS provides ongoing staff support. There are a minimum of four staff engaged in the process, including one with a legislative focus to advance the issue at the state and federal level, two from local SJHS facilities, and one member of the leadership that co-facilitates meetings with the county director of housing and community development. Several SJHS System Office staff have participated in public hearings in local cities. In addition, SJHS and Catholic Healthcare West have pooled resources to establish Southern California offices and subsidize staff salaries for Mercy Housing California, a nonprofit housing development agency.

An estimate of contributions from SJHS to support the affordable housing initiative includes approximately \$110,000 per year for in-kind staff support, and \$15,000 per year for office space. SJHS also donates interest from a \$5 million loan fund on an annual basis to Mercy Housing national headquarters to support capacity building in California and in other states.

## **Impacts to Date**

There are currently 82 low-income housing units for seniors under construction in Anaheim with plans to build developments for larger families in the near future. Funding for the senior housing was secured from the City of Anaheim, the County of Orange, Union Bank, and loan funding for the land from SJHS.

The Chair of the County Board of Supervisors has informed the partnership that their support resulted in the allocation of \$35 million from the general fund to support low-income housing during the next five years. The County has declared that affordable housing for local residents earning less than \$10 an hour is a long-term policy priority.

## B2. Homemaker Care Program

**Bakersfield / Kern County**

**Bakersfield Memorial Hospital / Mercy Hospital / Mercy Southwest Hospital  
Catholic Healthcare West (CHW) – Kern Service Area**

### **Community / Populations**

The Homemaker Care program serves seniors and unemployed men and women in Bakersfield and surrounding areas of Kern County. Approximately 10 percent of the population in Kern County is 65 years of age or older. Services for the elderly ranked among the highest ten priorities in the 1999 Kern County Needs Assessment.

Kern County's unemployment rate is 11 percent, five percent higher than average for the State of California. Nearly 21 percent of its population lives below poverty level. Figures for 1999 show that 56,514 individuals received assistance through California's Welfare Reform Program (CalWORKS) and Aid to Families with Dependent Children (AFDC). Of those, 15,791 are enrolled or have been sent a notice to participate in Welfare to Work activities.

### **Program Description**

The Homemaker Care Program is a partnership with Goodwill Industries that combines home-based support services for frail seniors with a caregiver training program to help unemployed low-income men and women transition from welfare to work. Program participants are trained for entry-level positions to gain valuable work experience necessary for higher paying jobs.

Caregiver training is provided in a three-week program that includes topics such as CPR, first aid, home safety, nutrition and food preparation, elder abuse, hospice care, and diversity education. The training program also covers job and life skills topics such as goal setting, time management, developing greater self-esteem, team building, conducting job searches, and improving personal hygiene. Graduates receive certifications for first aid and CPR, nutrition, as well as a letter of qualifications for future employment.

Many barriers exist for students to consistently attend class, including the need for childcare and transportation. Since they are required to come to class on a daily basis with 100 percent attendance, students must use resources that may be unfamiliar. Most students (85 percent) graduate at the conclusion of the three-week program. However, if they need additional time to complete all coursework, they may attend a different session to make up the classes missed. Students finishing in another session are eligible for graduation with that group.

One of the most important aspects of the program is that students become very close and supportive of one another. When students have transportation or childcare issues, classmates have often provided assistance to ensure that they can get to class. When a particular session or writing assignment is difficult for a student, other classmates offer encouragement. Students learn the value of teamwork and trust. The Homemaker Care Program provides incentives for full participation in classroom sessions, including a \$25 gift certificate to a local department store for perfect attendance. Students are also required to keep a journal.

Volunteer trainers are vital to the success of the program. A dietician from the University of California Extension teaches a session on nutrition and the special dietary needs of senior citizens; a senior advocate who is a registered nurse teaches students about senior issues that range from urinary incontinence to services available in the community; a health educator from CHW teaches a class in CPR; a senior from the Senior Collaborative shares stories from her own experiences about the needs and preferences of the elderly; and a representative from the local ambulance company teaches a class on emergency first aid.

Each three-week session concludes with a graduation ceremony designed to honor and celebrate student's achievements. Graduates invite family and friends to witness the event. The graduation ceremony is, in many ways, as significant as the training itself. At least three students are selected to prepare a speech on what the Homemaker Care Program has meant to them. Another student is chosen to present the invocation. While many students began the program wondering if they would ever successfully finish, many find a new sense of confidence and independence they did not know was possible. Their pride is evident as they receive their Certificates of Completion to the applause of family, friends and instructors.

Homemaker Care services are provided to seniors at below market rates. The services help seniors remain in their homes and assist in enhancing the quality of their lives. In addition to the support services provided by caregivers, regular contact reduces senior isolation and facilitates early identification of potential health problems.

### **Role of the Hospital**

CHW-Kern Service Area is the largest provider in the Southern San Joaquin Valley, serving a diverse population of urban and rural residents with five hospitals, urgent care and occupational health centers, childcare facilities, home health services and two community outreach centers.

In 1991, CHW-Kern Service Area established a Department of Special Needs and Community Outreach, and began operating two community outreach centers in the most impoverished neighborhoods in Southeast Bakersfield. The department and the centers administer more than 80 programs for low-income residents, including migrant farm workers and other disenfranchised populations. Last year, the department served more than 83,000 individuals, often in collaborative efforts with more than 35 private, public and not-for-profit organizations.

CHW provides staff to coordinate the Homemaker Care program and conduct trainings. It also provides space and conducts fundraising to supplement internal and partner support. The

average annual cost of the program to CHW is \$70,000. In FY 2000, the program was selected to receive \$100,000 in funding from Ernst and Young as one of CHW's top community health initiatives.

**Impacts to Date**

The program has enrolled 200 students and 153 individuals have graduated. Approximately 60 percent of graduates have been employed. A total of 90 seniors have received services from graduates so far.

## **B3. Creating Healthy Environments for Children (CHEC)**

**Greater Sacramento Region  
Sutter Memorial Hospital / Sutter Health System**

### **Community / Populations**

This program serves overburdened families in the Sacramento region that might be at risk for child abuse or neglect. Common factors associated with families that are enrolled in Creating Healthy Environments for Children (CHEC) include economic hardship, single parenthood, unemployment, lack of education, and youth (70 percent of parents are less than 26 years of age).

More than 42 percent of enrollees rely on public assistance as their primary source of income, and 41 percent do not have a high school diploma. About one-third indicate that they have transportation problems, 26 percent indicate a history of alcohol or other substance abuse, and 22 percent indicate a history of family violence. The ethnic/cultural composition of enrollees to date is 39.6 percent Latino, 34 percent Caucasian, 14.7 percent African American, 4.5 percent Asian/Pacific Islander, 1.1 percent Native American, and 4.4 percent other.

### **Project Description**

The impetus for CHEC goes back to data collected in the 1990s that identified child abuse as a major health problem in the Sacramento region. Sutter Memorial Hospital submitted a proposal to the California Office of Child Abuse Prevention (OCAP) for a project to address this issue, but did not secure funding. Sutter submitted another proposal the following year in partnership with the University of California Davis Medical Center and Stanford Research International. Again they were turned down.

Around the same time, a collaborative was formed in the Sacramento area to facilitate joint actions by hospitals and community-based organizations. After discussions, partners agreed that Sutter should take the lead in another effort to secure funding for a child abuse prevention initiative. A proposal submitted on behalf of three hospitals and four community-based organizations to The California Endowment under the newly established Children's Initiative was successful.

CHEC is modeled after the highly acclaimed Hawaii Healthy Start program, which is being replicated in other parts of the country as Healthy Families America. A regional program, it began to serve families in Sacramento, Placer, and Yolo counties in August 1997. CHEC provides "wrap around" services for families that lack the resources, expertise, and experience to provide an optimal environment for their children. Services include the following:

- Prenatal screening and assessment for pregnant women

- At-birth screening and assessment of parents
- Home visiting services
- Linkages to community-based support services

Program participants are identified for referrals by nursing personnel that conduct preliminary screenings as part of their prenatal visit. A subsequent screening designed for CHEC is conducted to determine if the expectant mother and family are appropriate candidates for CHEC services. Referrals may also be made during screenings conducted at birth. In addition to Sutter hospitals, designated enrollment sources for referrals include Catholic Healthcare West, Kaiser Permanente, Sacramento County Public Health Nursing, and community clinics.

Parents who accept the offer for CHEC services receive weekly home visits from Family Support Workers (FSWs) as the first phase in the process. FSWs are culturally competent, community-based workers employed by community clinics or child abuse prevention agencies that are CHEC program partners. They receive training on the Healthy Families America model as well as from prenatal, child development, and clinical nurse specialists at Sutter Memorial Hospital.

Early visits focus primarily on information collection, clarifying services to be provided, and building trust with family members. Another common area of focus during this period is linkage with community resources to assist with housing, food, and other basic needs. Each family is also given assistance with health insurance enrollment and with selecting a pediatric primary care provider. By the third month, the FSWs and parents develop an Individual Family Support Plan that incorporates the needs and interests of the family, as well as the expertise of the FSW, their supervisor, and program consultants. The plan includes a set of measurable objectives that are reviewed on a quarterly basis to assess progress.

Levels of service after the first three months are determined by the acuity of family needs. Home visits include activities that address issues identified in the plan, such as follow through on prenatal and well baby recommendations, discussion of emerging family concerns, assisting with bonding and attachment, and providing guidance on child development.


Additional funding for CHEC was provided by The California Endowment in 2000 to expand CHEC beyond Sacramento, Placer, and Yolo to include Nevada and San Joaquin counties. Proposition 10 funds have also enabled the expansion of the program to Amador County.

### **Role of the Hospital**

Sutter Memorial Hospital serves as the fiscal intermediary, provides trainings for FSWs, provides technical assistance and consultations to community-based partners, and assists with the evaluation. Sutter's annual in-kind contributions to maintain the program during the last five years have ranged between \$14,000-\$60,000. Sutter Medical Center Sacramento and collaborative partners have secured over \$4 million in grant funding to support this project.

## **Impacts to Date**

CHEC is now in its fifth year of operation. To date, a total of 1,086 women have been referred to CHEC, and a total of 899 have been enrolled in the program. Just under half of the families stayed in the program for a minimum of 12 months. Approximately 88 percent of the long-term families have been appointed a primary care provider, and 90 percent have had their children immunized by age two. Other data are being collected to document the practical benefits of this program for families and communities in the Sacramento region.



## **B4. Casa de Amigos Community Center**

Pico Union / Westlake Area of Central Los Angeles  
**St. Vincent Medical Center**

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### **Community / Populations**

The Casa de Amigos Community Center is located in the Pico Union / Westlake area of central Los Angeles. The population is primarily Latino, with a high percentage of uninsured day laborers, seniors on SSI, and undocumented immigrants with limited English proficiency. There are high levels of crime, school dropouts, mental illness, and substance abuse. It is one of five Community Improvement Project Areas (CIPAs) designated by the City of Los Angeles as needing improved services to assist lower-income residents.

### **Program Description**

The development of the center began in early 1993 as an outgrowth of a series of focus group meetings with community members. Local residents identified public safety as their primary concern. The first step to address this concern was the organization of Neighborhood Watch meetings. The meetings were well-attended and included adults, youth, children, and representatives of the Police Department. Building an ongoing working relationship between residents and law enforcement became a major focus of the program.

Local residents also indicated a strong interest in creating a place for youth to engage in organized after school activities. One of the first activities was the conversion of a vacant lot into a community garden. Youth were recruited through an agreement whereby a soccer program was created in exchange for their assistance. Other civic activities included a graffiti removal program. Ultimately, it was determined that a formal center was needed to provide a home for the growing number of programs.

Casa de Amigos is run by a staff of seven, including a director, a sports program coordinator, a computer tutor, a youth mentoring coordinator, an art instructor, a music instructor, and an administrative assistant. The total staff time commitment is approximately four FTEs. In addition to activities already described, current activities include a basketball program that includes four teams as well as a street beautification program. The facility includes five classrooms, a computer room with eight terminals linked to the Internet, a library, and a large room in the rear of the building for community meetings and sports activities.

Classes include English as a second language (ESL), conflict resolution, parenting, music, art for beginners, tutoring, reading, health education, and assistance in preparing for GED examinations. The ESL classes are provided on a year round basis through a partnership with the Los Angeles Unified School District. The average attendance for ESL classes is 30 students. The center also serves as a referral source for health services, counseling, housing, and legal support.

An important function of the center is to serve as an advocate for low-income community residents. This is carried out primarily through the work of a number of coalitions. Most notable is the Rampart Coalition. Rampart has a quality of life focus, and activities include neighborhood walks to identify and report drug activity, vacant buildings, and trash dumping. In the process, residents have developed a working relationship with city government.

### **Role of the Hospital**

St. Vincent Medical Center (SVMC) took a leading role in the organization of the Neighborhood Watch meetings and the development of the community garden. In 1994, SVMC donated the land and a 5,000 square-foot facility to establish the center. The estimated value of the original building was approximately \$200,000. The cost of facility renovations to date for SVMC is \$260,000. The annual financial contribution by SVMC for salaries is approximately \$100,000. It also provides in-kind support for operations, management oversight, equipment, and supplies.

The St. Vincent Foundation also contributes to the center. Recently, the foundation secured a grant from the Carrie Estelle Doheny Foundation for the purchase of 11 new computers to replace those originally donated by SVMC. The Daughters of Charity foundation also provides financial support.

### **Impacts to Date**

Tutoring and sports activities have reduced the school dropout rate and helped students to improve their academic performance (students have report cards reviewed each semester). The community garden has improved family interactions and helped to build a sense of community relatedness and interaction. ESL and computer classes have helped adults find better jobs (participants are given pre/post tests).

Casa de Amigos has reduced the number of latchkey children in the community by providing a safe and healthy environment. The children in the center are allowed to express their creativity and explore new horizons through the art, music, and computer programs. Community-building activities have reduced graffiti by 50 percent and dumping by 40 percent.

## **B5. Youth Bridge Mentoring Program**

**Berkeley & Oakland / Alameda County**

**Alta Bates Summit Medical Center / Sutter Health**

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### **Community / Populations**

Participants in Youth Bridge are recruited primarily from two schools in the Oakland / Berkeley area: Berkeley High School East Campus and Merritt Middle College High School. Berkeley East Campus is an alternative high school for students that were not performing well and/or were unhappy at the main campus. Merritt Middle College serves students who tested well on IQ tests in elementary school, but for a variety of reasons did not perform well in mainstream high school. Both schools have an enrollment of approximately 150 students.

A small number of students are also recruited each year from the main campus of Berkeley High School and other local schools. In addition, some participants are teen parents whose children are enrolled in day care through the Vera Casey Center in Berkeley. Program participants are predominately Latinos and African Americans from low- to moderate-income families. Common challenges reported by youth include daily exposure to drugs and violence in the community, limited adult supervision and guidance, and weak social support networks.

### **Project Description**

Youth Bridge was established in 1990 through a partnership between Alta Bates Summit Medical Center (ABSME) and the Berkeley Unified School District. The program began as a personal interest of an ABSME community benefit manager who wanted to move beyond traditional approaches to youth career development that were limited to “shadowing” opportunities for top students. The approach with Youth Bridge involved identifying students who experienced problems that prevented the realization of their potential and finding ways to provide ongoing mentoring for these young people.

Most students are referred to the program by school counselors. All have some difficulties to be addressed, but they are not failing their courses. Prospective participants are interviewed by Youth Bridge staff members to determine their readiness and commitment, and whether they would benefit from the program.

The program includes a ten-week career assessment and work readiness skills course, a nine-week career activities course, ten weeks with an adult mentor, and an eight-week summer internship program. The purpose of the Career Activities Class is to expose participants to a range of potential career opportunities and to build an understanding of optimal behavior in the workplace. Guest speakers are brought in from the hospital and a variety of other local employers. Students who complete the program receive academic credit for their participation.

Sites for summer internships provided by ABSMC include their occupational health center, inpatient rehabilitation unit, radiology department, business services, and perinatal center. External sites for summer internships include the offices of county supervisors and state assembly members, Habitat for Humanity, a veterinarian's office, local television stations, and the Center for AIDS Services.

At the completion of the program, a public "Celebration Luncheon" is held, typically at the Claremont Resort and Spa to recognize students for their accomplishments. Community leaders, as well as mentors and family members are invited to participate in the event. As part of the recognition process, six to 10 students receive "scholarships," monetary awards for distinctive performance in the program.

### **Role of the Hospital**

Annual operating expenses for Youth Bridge are approximately \$75,000; of which \$35,000 is directly supported by ABSMC, and the remaining \$40,000 is raised by ABSMC staff from outside sources. The hospital also provides approximately \$170,000 in in-kind services. Three staff members share primary responsibilities for recruitment, instruction, and management of the program. One of the staff members is the Director of the Vera Casey Day Care Center; the other two are employees of ABSMC.

One program enhancement under consideration is to expand Youth Bridge by having program graduates serve as mentors to middle school students, and to have adult mentors continue their support of youth in post-high school educational experiences. Another element under consideration is to expand linkages between Youth Bridge and a variety of health professional training programs. A likely partner in this expansion is Samuel Merritt College, which is an affiliate of ABSMC. Hospital staff members are currently engaged in fundraising efforts to support these enhancements.

### **Impacts to Date**

In the last decade, Youth Bridge has helped more than 425 students graduate from high school. Approximately 65 percent of program participants continued their education beyond high school.

An independent evaluation in 1999 found that all Youth Bridge participants indicated that they were more motivated in school; 95 percent indicated that the program had enhanced their self-esteem and goal orientation; and 84 percent said that the program was very helpful in the development of employability skills.

## **B6. Holy Cross Center for Women**

**Downtown Fresno  
St. Agnes Medical Center / Trinity Health System**

### **Community / Populations**

The Holy Cross Center for Women is located at Santa Clara and F Streets in downtown Fresno (Old Fresno) across the street from Poverello House, a community agency that serves working poor and homeless men. The immediate area around the two facilities is gated to provide a measure of security from drug abuse and other illicit activity.

Between 650 and 800 women come to the center each month for assistance. Approximately 85 percent are Latinas, and most are under 40 years of age and have children. Their lives are challenged with unemployment, poverty, lack of education, low self-esteem, and domestic violence. Due to financial constraints, some families share the same dwelling. Other women who come to the center suffer with mental illness, and/or addiction, psychological or physical impairment, and homelessness.

### **Program Description**

The Holy Cross Center for Women was established in 1984 by the Sisters of the Holy Cross at St. Agnes Medical Center to provide daytime respite care and basic services for poor and homeless women. The intent of the center was to complement the services of Poverello House, which was established primarily to provide services for homeless men.

The services provided at Holy Cross Center include counseling and referrals, classes in self-esteem, basic health, literacy, recreational activities, sewing and other fiber arts, and access to computer skills. Basic services include (but are not limited to) shower and laundry facilities, bi-weekly clothing distribution, and diapers and formula. All are without charge. Free medical and dental services are available for the uninsured across the street at Holy Cross Clinic. In 1992, the Gathering Place was built to provide supervised childcare for mothers who were on site.

In 1998, an educational and skills training facility entitled MaryHaven was opened to expand the scope of available services at the Holy Cross Center. Educational classes and skills trainings are provided in partnership with a variety of agencies, including IMECAL (Instituto Mexicano del Centro de California), Fresno Unified School District, Fresno Adult School, and the Fresno Fiber Arts Guild, among others.

IMECAL sponsors a literacy program, and Fresno Unified School District provides books and interactive educational programs. The Fiber Arts Guild members provide instruction in sewing, quilting, and other handwork. Volunteers from various groups give sessions on parenting, self-esteem, domestic violence, diet, health and other topics. In addition to a

classroom, the new facility includes a sewing room, a computer room, and a crafts/ceramics room.

The center has established referral relationships (in both directions) with over 30 public and private sector agencies, including the Poverello House, the Salvation Army, the Fresno Rescue Mission, University Medical Center, county health and social service departments, the Fresno Housing Authority, Legal Aid and other organizations, especially those assisting women. Women from the EOC (Economic Opportunity Commission) Foster Grandparent Program assist in caring for children in the day-care area. Other cooperative EOC programs are a summer lunch program for the children and the placement of high school-age youth in school-to-work programs.

Christmas gifts for children of families in need are solicited from St. Agnes, as well as from local business, social, and church community groups. During Christmas of 2001, 272 families, including 891 children and 50 homeless women, received gifts. Fresno City Firefighters Local 753 assists in the distribution of the gifts.

### **Role of the Hospital**

Annual funding support from Saint Agnes Medical Center for FY 2001-2002 amounts to \$343,000. This covers core operations of the Holy Cross Center for Women including four full-time and one part-time staff who assist with educational classes, outreach and engagement of other stakeholders, and resource development. The Center also receives donations of clothing, household items, toiletries and other items that are distributed to those seeking assistance.

Holy Cross Clinic at Poverello has annual funding support of \$318,405, including one full-time and four part-time staff in addition to 77 active medical, dental and clerical volunteers.

### **Impacts to Date**

The Holy Cross Center served 12,957 women and 6,599 children during the fiscal year ending in 2000. Women are provided with health, social, and educational services. One of the challenges faced by the center is to monitor success stories of women who secure employment, move on to a better economic situation, and establish a more secure life. Holy Cross leadership recently instituted a program to solicit testimonials from former clients.

During the same time period, Holy Cross Clinic conducted screenings at eight senior centers on a monthly basis, monitoring blood sugars, weight, and blood pressures for 1,990 persons. The clinic logged 5,980 medical and dental visits during FY 2000.

**Category C: Institutional policy changes to enhance  
community benefit practices**

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- C1. Developing a System-wide Framework for Community Benefit  
St. Joseph Health System**
  
- C2. Enhancing Accountability and Community Engagement  
Citrus Valley Health Partners**
  
- C3. Expanding Community Involvement in a Rural Hospital  
Feather River Hospital / Adventist Health System**

## **C1. Developing a System-wide Framework for Community Benefit**

**St. Joseph Health System**  
System Office – Orange County

### **Hospital / Organization**

St. Joseph Health System (SJHS) is based in Orange County, California, and was formally established in 1982. It includes 14 acute care hospitals, nine in California and five in West Texas and Eastern New Mexico. SJHS also operates two home health agencies, six permanent community clinics, and seven mobile clinics in California. SJHS employs over 18,000 people, and maintains approximately 3,600 licensed beds. There were a total of 143,060 discharges, 2,393,282 outpatient visits, and 534,081 home visits in FY 2000.

### **Policy Description**

SJHS has instituted a number of policies since the passage of Senate Bill 697 to enhance the practices of its local hospitals, increase community involvement, and facilitate an evidence-based, system-wide approach to community benefit that explicitly targets low-income populations and builds on existing community assets.

Each SJHS hospital board maintains a standing community benefit committee that reports to the full board on a quarterly basis. This committee determines how to distribute charitable funds and provides oversight for the community benefit planning process.

In 1998 SJHS produced a general vision for community benefit programming entitled “A Vision of Value” that declared a “conviction to actively seek out the truly needy and develop creative outreach responses.” Standards instituted as part of this vision included a requirement to establish local board committees that “develop policies and programs which address the identified needs of the poor in their sphere of influence.” Another standard indicates that local needs assessments should focus explicitly on the identification of “the health needs of the poor.”

The system office has encouraged all local boards to increase the diversity of their membership and to include community residents. Community representation in organizational decision-making is reviewed on an annual basis. Plans submitted by SJHS hospitals to the system office must include documentation of their local committee proceedings with their annual plan. The intent is to encourage meaningful community engagement and provide information for system-wide community benefit oversight.

SJHS recently initiated a process to evaluate local community benefit functions. Local representatives were asked to fill out a standard questionnaire to identify committee composition, eligibility, application and selection processes, as well as the typical meeting structure/frequency.

SJHS has implemented two system-wide initiatives that serve as guiding concepts for local hospital community benefit programming. The Community Building Initiative encourages investment in program activities that emphasize community leadership and address core poverty issues such as job creation. Local hospitals are encouraged to apply to the SJHS foundation for multi-year (three-year minimum) grants, and are required to develop a “logic model” that links specific objectives with measurable outcomes. The initiative requires applicants to involve neighborhood residents in all aspects of planning, implementation, and evaluation.

The Healthy Communities Initiative encourages investment to encompass stakeholders from a variety of economic sectors involved in engagement and primary prevention. A prime example is an affordable housing initiative (see example B-4) in Orange County that brings together over 20 diverse community partners to leverage available resources and expand the volume of affordable housing for low-income residents.

Leadership by the system office to establish the Community Building and Healthy Communities initiatives is intended to facilitate a more consistent and coherent approach to community benefit programming and at the same time encourage local innovation. These initiatives also reflect a stated commitment by SJHS to take a more comprehensive approach to health improvement that moves beyond access to health services to address the underlying causes of health problems.

The SJHS system leadership works with hospital CEOs each year to set measurable objectives that are tied to community health improvement. Each CEO is rated on his/her performance by system leadership, and recommendations are forwarded to the executive management team of the board to determine compensation based on this performance.

SJHS has also instituted a policy requiring each hospital to set aside 1.5 percent of operating expenses for community health and/or Healthy Communities activities. Examples include housing, education, water quality, and food and nutrition. SJHS also calls upon each hospital to set aside 10 percent of net income as an explicit “Care for the Poor” fund; 75 percent of that total is earmarked for direct allocation to local programs, with 25 percent to be allocated by the system office.

### **Impacts to Date**

To date, SJHS has invested \$20,726,000 for Healthy Communities and Community Health Initiatives (established FY 1999), and the SJHS Foundation has provided \$268,015 for the Community Building Initiative (established FY 2001). The system provided a total of \$237 million in 2000 for the two initiatives and Care for the Poor programs. SJHS has also allocated \$1.2 million in grants for targeted prevention programs in California in areas such as diabetes, alcohol/drug counseling, and case management for at-risk chronic congestive heart patients.

The three areas of policy development implemented by St. Joseph Health System, including a) linking executive compensation to community health objectives; b) system-wide initiatives that emphasize primary prevention and community building; and, c) establishing a formal

oversight process to encourage community involvement help to ensure that community benefit programming remains an organizational priority and a focus for quality improvement during difficult financial times.

## **C2. Enhancing Accountability and Community Engagement**

**Citrus Valley Health Partners  
East San Gabriel Valley / Los Angeles County**

### **Hospital / Organization**

Citrus Valley Health Partners (CVHP) is a small health system in eastern Los Angeles County that was formed in 1994 through the merger of two hospitals: Queen of the Valley, a 269-bed facility in West Covina, and Inter-Community Medical Center, a 235-bed facility in Covina.

These two facilities serve a population of approximately 450,000 in the East San Gabriel Valley with 2,400 employees and 800 physicians on staff. CVHP also has two affiliate health care facilities: Foothill Presbyterian Hospital, a 107-bed facility in Glendora, and Citrus Valley Hospice in West Covina.

### **Policy Description**

CVHP has distinguished itself at the state and national levels by an emphasis on strategic investment that builds on existing community assets as well as targeting charitable resources to support low-income communities. A number of policies instituted since the passage of SB 697 contribute to the engagement of community members and guide the design and implementation of community benefit programs.

A key early step was the appointment of a senior level administrator with the title of Vice President for Mission Effectiveness and Community Care. This individual has discretionary decision-making power and reports directly to the system CEO.

The annual salaries of all senior administrators and departmental managers are based in part upon their demonstrated ability to achieve objectives related to CVHP's charitable mission. Staff members are also encouraged to support these objectives, and are given public recognition and financial awards for distinctive efforts.

Physicians are actively recruited as participants in community benefit programs. More than 50 physicians, dentists, and pharmacists participate in a program entitled Every Child's Healthy Option (ECHO), volunteering as many hours a week as they can afford to provide services for children in 14 local school districts. ECHO was recently linked to another program entitled Getting Enrollment Moving (GEM), where uninsured children are referred directly to on site eligibility workers for same-day enrollment in MediCal or Healthy Families.

CVHP has established explicit criteria for designation of community benefit resources. The first criterion is that the service or activity under consideration is unlikely to be provided in

the absence of a nonprofit hospital; the second is that the program targets “vulnerable” or “at-risk” populations. Activities are analyzed and weighted by these criteria to determine if they will be included in CVHP’s community benefit portfolio.

In contrast to nonprofit hospitals that may place community benefit functions under the supervision of senior administrators in marketing and corporate development, CVHP maintains a clear separation between community benefit decision-making and marketing priorities.

As programs are implemented, CVHP makes a special effort to highlight the contributions and leadership of community partners. In a number of situations, CVHP marketing and public relations staff members have helped community-based organizations develop written materials and videos to enhance their visibility and fundraising capacity.

In 1994, CVHP formed a Community Benefit Committee composed primarily of community members. Six of the committee members are also members of CVHP’s corporate board. The committee meets six times per year. Its responsibilities include:

- Review and provide input on the design of proposed program activities
- Determine the content focus of charitable resource allocations
- Monitor/ provide oversight of program activities and staff
- Facilitate community outreach and engagement process

CVHP also solicits community member input through periodic sponsorship of community “summits” and regular invitations to community groups to make presentations during committee and administrative leadership meetings.

### **Impacts to Date**

The appointment of a senior level administrator with discretionary decision-making power enables CVHP to be responsive to changing dynamics among community partners. It also provides significant opportunities for leveraging innovation.

Instituting performance measures for community health objectives encourages ongoing attention and accountability among senior leadership. Accountability is reinforced by the establishment of a Community Benefit Committee with diverse representation, explicit responsibilities, and direct linkages to the health system board.

The development of explicit criteria for the allocation of charitable resources helps to focus resources where they are most needed, and distinguishes CVHP’s activities from those that may be viewed primarily as organizational marketing. Emphasizing strategic investment to build community capacity has resulted in substantive engagement and strong support from a broad spectrum of community members in the East San Gabriel Valley.

To date, CVHP has provided seed funding, resource development assistance, advocacy support, and staff support for more than 100 activities that are led by community-based organizations and local coalitions.

### **C3. Expanding Community Involvement in a Rural Setting**

#### **Paradise, California (Butte County) Feather River Hospital / Adventist Health System**

#### **Hospital / Organization**

Feather River Hospital is a 122-bed acute care facility established in 1950 through the leadership of local physicians. It is one of 20 hospitals that are part of Adventist Health, a regional health system based in Roseville, California, with hospitals, clinics, and home health agencies in California, Oregon, Washington, and Hawaii.

The primary service area for Feather River Hospital is the Paradise Ridge area of Butte County that includes a population of just over 40,000. The city of Paradise is located 92 miles north of Sacramento in the foothills of the Sierra Nevada Mountains. Seniors comprise approximately 32 percent of the population in Paradise Ridge, more than twice the state percentage. Almost half of the population in Feather River's primary service area lives in unincorporated areas.

#### **Policy Description**

Feather River Hospital has instituted a number of policy changes since the passage of Senate Bill 697. Its primary objective is to increase community involvement and include more diverse stakeholders in hospital decision-making and community benefit program development.

Feather River Hospital has a 12-member Board of Trustees that reviews the annual budget developed by the chair and the Vice President for Finance. The Board Chair is a member of the Adventist Health System corporate board. The Feather River Board has discretionary power to develop the community benefit budget and select program activities. Board oversight responsibilities are formalized in the Adventist Health System Board Policy on Community Benefit. The policy mandates ongoing collaboration with community members, regular evaluation of data collection and reporting effectiveness, as well as providing regular updates.

In an effort to increase community representation, the local board added two new community members in the last year. The current board includes a local pastor, the Superintendent of Schools, two lay community members (one woman, one senior), a former board member of the local Hospice care agency, a local CPA, and a local real estate agent.

Feather River has also formed a Community Focus Committee (with broad representation of providers and staff) to assess unmet health needs, set priorities, and develop strategies to improve community health and quality of life. Typical of a rural hospital, Feather River staff are also residents and active members of the local community, and are in a position to assess

both local health needs and institutional strengths and weaknesses. The committee meets weekly to initiate, coordinate, and evaluate the effectiveness of community benefit activities.

One of the most important policy changes was the establishment of a senior level position entitled the Director of Community Relations. This individual has direct reporting responsibilities to the CEO, and meets with other senior staff to discuss community benefit issues on a regular basis. The creation of a dedicated position that is directly linked to the CEO is intended to ensure that fulfillment of Feather River's charitable mission is a high priority function that requires ongoing attention.

Selection of program activities is based on input from community stakeholders and findings from the community needs assessment. The needs assessment includes a series of 50 key informant interviews with community leaders where they are asked to rate 24 different measures of quality of life. Feather River is also the founding member of the Paradise Valley Community Network, a diverse group of community agencies that focuses on coordinating services.

### **Impacts to Date**

Impacts to date include expanded board composition and increased community input in organizational decision-making, increased volume of services provided to local community members, and increased awareness and support of community benefit activities among hospital staff.

## **Category D: Strategic investments to build community capacity**

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- D1. South County Community Health Center  
Lucile Packard Children's Hospital**
  
- D2. Healthy Neighborhood Coalition  
One by One Leadership Organization  
St. Agnes Medical Center / Trinity Health System**
  
- D3. Neighborhood Family Resource Centers  
Citrus Valley Medical Center / Citrus Valley Health Partners**
  
- D4. City Heights Urban Wellness Center  
Scripps Mercy Hospital  
Scripps Center for Community Health and Advocacy / Scripps  
Health**
  
- D5. Lawndale School Health Project  
Little Company of Mary, Torrance and San Pedro Hospitals**

## **D1. South County Community Health Center**

### **East Palo Alto / San Mateo County Lucile Packard Children's Hospital**

#### **Community / Populations**

East Palo Alto is a highly diverse city of 29,506 residents in southern San Mateo County. This historically African American city has seen a dramatic shift in its population in the last decade. Latinos now comprise the largest proportion of local residents (59 percent which includes Latinos of mixed heritage), followed by Caucasians (27 percent), African Americans (23 percent), and Asian/Pacific Islanders (9.8 percent). To the displeasure of East Palo Alto residents, the city is best known as the low-income, socially troubled neighbor to highly affluent Palo Alto and Stanford.

Due in part to the lack of economic vitality in East Palo Alto, access to health and social services is limited. Even though this small city is only three miles from hospitals in Palo Alto and Stanford, the division created by the freeway and the routing of the transit system results in a situation where it takes as much as an hour for community members to reach these hospitals. Health-related problems experienced by members of East Palo Alto include a high rate of sexually transmitted diseases, homelessness, substance abuse, teen pregnancy, and crime.

#### **Program Description**

In early 1998, Drew Health Center, a federally-licensed community clinic serving the City of East Palo Alto lost its federal section 330 funding and closed its operations. The loss of this important primary care provider created an immediate crisis in the community, forcing residents of East Palo Alto, Belle Haven, and North Fair Oaks to seek care from providers outside the community who were not easily accessible.

In response, a collaborative partnership was formed that included Lucille Packard Children's Hospital (LPCH), Stanford Hospital and Clinics, the San Mateo Health Services Agency, El Concilio of San Mateo, the City of East Palo Alto, and Peninsula Community Foundation. The San Mateo Health Services Agency served as the lead agency. El Concilio of San Mateo is a Latino council with 23 member organizations that provide services and advocacy in south San Mateo County.

At the request of the federal Bureau of Primary Health Care (BPHC), partners initiated a planning process to provide information on populations to be served, the elements of an organization to receive federal funding, and service priorities to address community health needs. The planning body, known as the Blue Ribbon Advisory Planning Group, was composed of 13 representatives of community organizations. The group released a report in

November 1998, and secured the re-activation of federal funding in early 1999. Planning committee tasks included:

- Initiate the application process to form a new 501(c)(3) tax exempt organization
- Develop Board of Directors and organizational governance structure
- Establish Clinical/Medical Advisory Committee (meets monthly)
- Develop Memorandum of Understanding with the county
- Conduct search and hire Executive Director and Medical Director
- Identify and develop site for the delivery of interim clinical and support services
- Coordinate the delivery of interim clinical and support services
- Develop plans for the selection and construction of permanent clinic facilities

In the meantime, LPCH sponsored the provision of obstetric and pediatric services at the East Palo Alto Municipal Building. Other clinic services were expanded to serve adults in March 2001 when the new South County Community Health Center began overseeing the clinic under the county's license. In addition, the San Mateo County Health Services Agency provided a shuttle to transport community residents to county clinics and services at LPCH and Stanford Hospital. The David and Lucile Packard Foundation provided additional seed funding to cover the cost of building and installing modular buildings.

The City of East Palo Alto provided property for the new clinic with a rental charge of \$1 per year. Peninsula Community Foundation provided seed funding for land preparation and for construction of a multi-service center next to the new clinic that would provide space for a number of community agencies. Residents of the new space will include Big Brothers/Big Sisters, Family Support Center, Pacific Islander Outreach Center, El Concilio, and New Perspectives.


### **Role of the Hospital**

LPCH is an independently licensed 501(c)(3) organization with its own board, but it is under the general ownership of Stanford University. It has been operated as a children's hospital since the beginning of the 20<sup>th</sup> century; it was operated first as a convalescent center, with chronic care services added in the 1950s. In June of 1991, thanks to a large donation from Lucile Packard to Stanford and the consolidation of pediatric acute care (previously handled by Stanford Hospital) and chronic care services formerly provided by Children's Hospital of Stanford, LPCH began offering services as a full spectrum children's medical center.

LPCH had established a relationship with Drew Health Center before the recent closure. In 1995, it secured \$5 million in funds from the David and Lucile Packard Foundation to support the delivery of comprehensive services at Drew. Following the collapse of operations at Drew, the majority of funds were returned to Packard, and a portion went to LPCH to supplement outreach efforts and services in East Palo Alto. The total financial support provided by LPCH to date for the establishment of the expanded community health center is in excess of \$2 million.

## **Impacts to Date**

The South County Community Health Center officially opened on December 20, 2001. It will have the capacity to provide a full spectrum of primary care services, and maintains a contractual relationship with LPCH and San Mateo County General Hospital for the provision of inpatient care. Services to be provided by the co-located multi-service center include primary care for adults, pediatrics, family planning, perinatal services, chronic disease management, immunizations, health education, WIC (Women, Infants and Children program) as well as referrals to other agencies.



## D2. Healthy Neighborhood Coalition

One by One Leadership Organization  
Jefferson Neighborhood / City of Fresno  
St. Agnes Medical Center / Trinity Health System

### **Community / Populations**

This project focuses on revitalization and health improvement in the city of Fresno, with particular focus in downtown areas such as the Jefferson neighborhood. The Jefferson neighborhood is home to an ethnically and culturally diverse population of low- to moderate-income residents. Many are recent immigrants, most are renters, and all reside in a physical infrastructure that has steadily deteriorated during the last three decades. Impetus for the project was provided by data from local assessments in the early '90s that indicated that Fresno had the highest per capita rates of violent crime in the state in every category except murder.

During the last five years, local residents have come together with business, government, clergy, and other sector leaders to mobilize resources for civic renewal. As projects connecting many organizations have emerged, partners recognized a need for a broad-based intermediary organization to create multi-sector collaboration focused on at-risk youth, disenfranchised neighborhoods, and a spectrum of other community building issues. One by One Leadership has served that role since 1997.

### **Program / Organization Description**

One by One Leadership (OOL) is a faith-based nonprofit organization serving Fresno and the San Joaquin Valley since 1994, with particular focus in low-income areas such as the Jefferson neighborhood. A central philosophy for OOL is a commitment to the concept of community building. This orientation places it in a role to facilitate community member leadership and to coordinate strategic use of local resources to enhance existing strengths.

In 1997 the group began to focus on health as a major issue and looked into SB 697 as a motivating force for hospital engagement. OOL began to engage local hospitals in a dialogue to explore developing partnerships to address a range of local health-related, quality of life concerns. While One by One did not secure financial support directly from hospitals in the beginning, it did receive a number of financial contributions from various hospital trustees.

In 1998 St. Agnes became one of OOL's largest private sector supporters. The entry point for St. Agnes was poor health in disenfranchised communities resulting in high incidences of adolescent pregnancy, youth gang violence, substance abuse, and academic failure. St. Agnes staff and leadership determined that the approach to this issue needed to be broad in scope to effectively address the many factors contributing to the problem.

A “Healthy Neighborhoods” team was formed. It engaged a range of community leaders in an ongoing dialogue with resident leaders from several local neighborhoods. The basic philosophy was that there are four sectors that need to be engaged in health improvement and community revitalization — public, private, service, and community. The community sector forms the core of mediating institutions (e.g., families and youth, community groups, congregations, schools) that play a key role in determining the best ways to improve quality of life.

An initial strategy was the use of funding from welfare reform programs as leverage to move beyond an individualistic approach and to strengthen local communities. This strategy was implemented by weaving together social services and skill development. Six resource centers were formed in neighborhoods to provide mentoring, skills training, and employment assistance. Many of the job coaches used in the program are drawn directly from local neighborhoods.

Another strategy was the use of urban architectural planning to connect neighborhood leaders with institutional leaders. OOL convened two groups in the Jefferson neighborhood. The first group is composed of organizations such as the school district, the city, an adjacent medical center, and the local re-development agency. The second group is the Jefferson Area Neighborhood Association (JANA). After a period of dialogue and relationship building, the groups came together to form a community development corporation. Activities now focus on a fundamental re-design of the neighborhood as well as specific housing and economic development efforts. The Mayor of Fresno has just offered a strong endorsement of the process.

### **Role of the Hospital**

In addition to providing core support and advocacy for OOL, St. Agnes has also played a key role in securing funding from foundations, such as a grant for the development of a Geographic Information Systems-based project to identify and track a variety of health-related indicators. Fresno Community Medical Center has also been a significant supporter. St. Agnes has given OOL \$180,000 to date.

### **Impacts to Date**

In the last five years, OOL has leveraged a total of \$6.9 million in local and outside funding to support the transformation of neighborhoods and communities in Fresno. The involvement of St. Agnes, Fresno Community Medical Center, and other key institutions has been very important in efforts to secure outside funding. Participation by these partners has also helped advance a “healthy community” vision that mobilizes institutions and community members. A sampling of impacts to date include:

- Established neighborhood associations in 12 elementary school service areas.
- Trained 608 neighborhood resident leaders in community organizing, community development, neighborhood asset mapping, and public meeting facilitation.

- Trained nine job coaches to serve Welfare to Work participants.
- Trained and matched 56 Job Mentors with Welfare to Work participants.
- Trained 515 Welfare to Work participants and placed over 300 in unsubsidized jobs.
- Established a network of 15 nonprofits serving “at-risk” youth.

### **D3. Neighborhood Family Resource Centers**

#### **East San Gabriel Valley / Los Angeles County** **Citrus Valley Health Partners**

#### **Community / Populations**

The neighborhoods served by the Family Resource Centers are ethnically and culturally diverse and composed of low- to moderate-income residents. Of the combined population of 254,009 people living in the cities of El Monte, South El Monte, Baldwin Park, and La Puente, over 77 percent are Latino and almost 14 percent are Asian or Pacific Islander. One in six area residents speak a language at home other than English.

Eleven percent of the households in these communities have a total annual income of \$30,000 or less and more than 24 percent fall below the federal poverty level. More than 55 percent of the population has incomes below 200 percent of the federal poverty level. These cities are targeted because they represent the most needy and least served areas in the San Gabriel Valley in terms of health access and service delivery.

Key issues of concern raised by community members in dialogue with CVHP and other organizational stakeholders include increased access to health care, support and training for local leaders, and assistance for community-based organizations to build capacity and to secure public and private sector funding.

#### **Program Description**

In 1994 Citrus Valley Health Partners initiated a process to expand its engagement of community stakeholders and develop an organizational infrastructure that would support the development of high quality community benefit program activities (see summary C.2.). A core guiding principle in program development is a commitment to the strategic allocation of charitable resources to enhance the capacity of existing community assets.

As CVHP engaged community stakeholders, the partners agreed that they should focus on filling gaps between existing services and avoid creating programs that would compete with community-based organizations. CVHP leadership suggested that efforts concentrate on how to strengthen rather than duplicate existing services. Partners also agreed that community members should be directly engaged in activities that would improve local health.

One option strongly supported by community stakeholders was the establishment of neighborhood family resource centers that would serve as local clearinghouses for health improvement activities. After approximately 18 months of preliminary development, CVHP hired a senior executive on leave from a major corporation to assist in developing a series of Family Resource Centers (FRCs) in local neighborhoods.

There are five FRCs, each with a central goal of strengthening local support systems. Each FRC serves as central hub for multiple projects. Numerous public and private organizational partners operate at each site. Sites include a local school, a converted senior center, a Healthy Start clinic, a city building, and a county public health clinic. The FRCs rely heavily upon volunteers, many in formal roles as community health outreach workers (CHOWs). Two of the FRCs have become formal 501(c)3 nonprofit organizations.

Examples of services and activities at FRCs, include:

- Primary care services
- Health education
- Employment / life skills training
- Parenting / family skills training
- Health insurance and social service enrollment assistance
- Mental health counseling
- Food distribution
- Legal services referrals

### **Role of the Hospital**

To date, CVHP has provided funding and assistance for more than 90 FRC projects. Some of the assistance has involved leveraging the engagement of other stakeholders. The primary funding objective for all FRC programs is to enhance community capacity, rather than to expand existing CVHP services.

CVHP financial contributions to date for the development of the five FRCs and associated projects is over \$200,000. However, it is important to acknowledge the limitations of financial measures in assessing the value of CVHP's role in this process. Many contributions made by the health system in terms of leadership, leveraged engagement of other stakeholders, and efforts to establish an environment of trust and mutual support are not easily quantified.

### **Impacts to Date**

Establishing the FRCs has directly engaged neighborhood residents as leaders in efforts to improve health and quality of life. These centers have also provided a useful template for a wide range of community-based agencies to emulate as they enhance their services through an ongoing process of coordination and shared learning.

The success of CVHP's community engagement and capacity building process has had a significant influence on the LA County Department of Health Services. They have integrated

the FRC concept into their strategic planning process as a mechanism to bring resources and services to the community. A large number of these resource centers are now under development in neighborhoods throughout the county.

#### **D4. City Heights Urban Wellness Center**

##### **City Heights, Mid-City Area / City of San Diego**

**Scripps Mercy Hospital / Scripps Center for Community Health and Advocacy  
Scripps Health**

#### **Community / Populations**

The urban neighborhood of City Heights is a highly diverse community of approximately 70,000 residents, with 38 percent Latinos, 22 percent African Americans, 21 percent Caucasians, and 19 percent Asian/Pacific Islanders. This community has the highest concentration of low-income residents in the county, with a median household income of less than \$21,000 per year, and an unemployment rate of greater than eight percent.

The health assessment conducted in San Diego County identified the most significant health concerns as access to care, mental health, substance abuse, and violence. City Heights leads the county in having the most categories related to these health concerns. It also has the highest concentration of uninsured residents. At the same time, counterbalancing these problems, City Heights shows signs of economic and social recovery with an array of redevelopment projects in progress.

#### **Program Description**

Scripps leadership convened a meeting of local health providers in 1999 to discuss unmet health needs in the City of San Diego. In the course of discussions, it emerged that community-based providers felt that there was no need to establish a new clinical care facility that would provide traditional primary care services.

Instead, community clinics reported a need for mental health services, transportation, and public information on available health and social services. They also expressed a strong interest in workforce training in areas such as health education and health promotion. Community residents expressed a need for education in disease prevention and early screening in areas such as cancer, cardiovascular disease, and diabetes. They also expressed concerns about the cost of care, and access to services such as dental care and parenting classes.

Partners ultimately agreed that a facility was needed to coordinate services that would fill the gaps in the existing safety net. The prime consideration was to provide a spectrum of services

that will “enrich but not compete with patient care already in existence.” Partners also agreed that the facility should be located in neighborhoods where the concentration of health-related problems is greatest.

Scripps Health and Children’s Hospital of San Diego came together as the lead agencies for the City Heights Wellness Center (CHWC), signing a ten-year lease for 4,500 square feet of space in a newly constructed shopping center. Other partners include Mid-City for Youth Collaborative, the City Heights Town Council, City Links, City Heights Community Development Corporation, community clinics, schools, county public health nursing, law enforcement, Price Charities and other philanthropic organizations, faith-based organizations, and other social services organizations. Another key partner in the effort is a local real estate company (led by a former city council member) that has demonstrated a commitment to revitalizing local neighborhoods.

The facility includes several small multi-purpose rooms that can be used for counseling, health education and screening, eligibility and enrollment assistance, mentoring and computer workstations for staff. There are also larger community rooms with an adjoining teaching kitchen for nutrition, weight management, and meal preparation classes, health promotion activities (e.g., CPR, first aid), asthma education, childbirth preparation, and community meetings. The various partners also decided to include a child development area with an observation window to be used for parenting and early intervention education and to provide on-site childcare for program participants.

Partners have been collecting data from multiple sources and are in the process of developing an information system to monitor progress toward identified outcomes for each category of services. A CHWC Community Advisory Committee is being formed with a minimum of 10 members representing a broad spectrum of community stakeholders. An Operations Committee will establish a long-term funding and sustainability plan during the first six months of operations.

Sustainability will be a challenge for the center, since very few of the services are reimbursable by public and private payers. Partners applied for Community Development Block Grant funds in 2000, but were unsuccessful, in part because there were \$8 million in funds available and \$72 million in requests. Partners have also asked the county to play a more significant role, but current commitments are limited to in-kind services. Resource development activities will be ongoing to supplement core funding provided by Scripps and Children’s.


### **Role of the Hospital**

Scripps provides two-thirds of the funds for the ten-year lease, and Children’s is contributing one-third. For Scripps, this represents an investment of \$760,928 over the course of the lease. In addition, a minimum of \$200,000 per year will be needed to fund ongoing programs. Core staff (employed by Scripps) include a Center Coordinator and a receptionist.

The total estimate of contributions to date by Scripps, including a year of collaborative planning and resource development assistance, is \$140,000.

## **Impacts to Date**

The new center is now operational and serves as a locus for culturally appropriate prevention and support services that will address both the symptoms and underlying causes of persistent health problems in this underserved community. Ongoing partnerships have been established between Scripps, Children's, and more than 15 community-based organizations to create a more viable and healthy community.



## **D5. Lawndale School Health Project**

### **Lawndale Community / L.A. County**

**Little Company of Mary, Torrance and San Pedro Hospitals**

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#### **Community / Populations**

The City of Lawndale is an ethnically diverse community of 31,000 residents in an area of 1.8 square miles and is one of 14 municipalities in the Little Company of Mary (LCM) service area. Located immediately east of one of the most affluent communities (Manhattan Beach) in Los Angeles County, the Lawndale school population is comprised of Latinos (63 percent), African Americans (18 percent), Caucasians (10 percent) and Asian Americans (6.5 percent, primarily Vietnamese) and 2.5 percent other minorities. About three-fourths of students receive free or reduced fee lunches.

#### **Program Description**

Little Company of Mary (LCM), a member of the Providence Health System, began its work with the Lawndale Elementary School District (LESD) in 1994 by sponsoring a mobile van. The van was co-funded by LCM and the Crail-Johnson Foundation, and brings free medical care, immunizations, health screenings, and insurance enrollment assistance to uninsured Lawndale students. LESD is a K-8 system comprised of seven schools with an enrollment of 6,000. Each week the van travels to an LESD school as well as three other school sites in the Los Angeles Unified School District.

Investment in the mobile van was viewed as an important first step in developing a community partnership for LCM. Given the absence of an accessible community-based clinic structure, bringing services into Lawndale was a tangible way for LCM to build credibility.

Capacity building is an integral component of LCM community benefit programming. In Lawndale this translates into resource development and skills-based prevention for the student population. Each milestone has been built upon better data resulting from process evaluation, which informs program development. This data is a key element in attracting external funding.

In 1997 LCM and LESD secured funding from The California Endowment for a two-year physical education training program for 1,500 K-6<sup>th</sup> grade students and 50 teachers. LCM also secured funds from the Crail-Johnson Foundation to support an eight-class series on youth issues (e.g., anger management, communication, and decision-making) for all 7<sup>th</sup> graders. This Adolescent Coping Education Series (ACES) was expanded to the 8<sup>th</sup> grade in 1999-2000.

The hospital participated in a community-based strategic planning process led by the elementary school in 1998. Partners reached a consensus that there was a need for an up-to-date K-8 health curriculum and an after-school program that would include enrichment and

achievement activities. As a first step, LCM developed a funding proposal directed to the California Department of Education and secured \$1.8 million in funding for four schools. The hospital also facilitated a role for Richstone Family Center (RFC), a local child abuse prevention agency as co-manager of the grant. After-school services are now available for 520 children at four school sites five days a week until 6 p.m. As a result of the grant award, RFC began offering counseling services to students and families.

In 2000, LCM and the school district secured demonstration funding from the California Community Foundation to support and coordinate follow-up medical and dental care for uninsured children, develop and implement a skills-based health curriculum for all 6,000 students, and sponsor health promotion events at each school. Parents and students are jointly engaged in wellness activities as part of the program design.

In 2001 the hospital secured additional primary care services for LESD and expanded the scope of collaborative partners by adding the Lawndale site as a clinical rotation for second- and third-year residents from the Department of Family Medicine at Harbor-UCLA Medical Center.

### **Role of the Hospital**

The role of LCM in the Lawndale School Health Project has been to work as an ongoing partner with teachers, administrators, school nurses, students, and parents. The scope of the project includes a comprehensive system of health services for uninsured children as well as providing seven classroom-based health lessons for all 6,000 students. Specific contributions include:

- Fund the pediatric mobile van and hiring bilingual medical and health education staff.
- Screen, hire and pay local medical, dental and counseling providers to provide follow-up care to uninsured children with chronic or specialty health care needs.
- Offer technical assistance, referral coordination, and screening support for school nurses.
- Provide LCM staff with specialized skills to train school staff.
- Resource development assistance resulting in \$2.5 million in external grants to LESD.
- Initiate engagement of key community-based and institutional partners.

LCM has invested \$385,000 in the Lawndale School Health Project to date, with approximately 65 percent of that amount coming from external sources. There are six FTE's committed to this project. LCM adopted a ten-year Community Benefit Plan in 1998 with the goal of establishing a collaborative network of care for vulnerable populations by 2008. The emphasis on collaboration comes from the recognition that no single organization can meet all the health needs of underserved residents.

### **Impacts to Date**

The following tangible results have emerged from the partnership process to date:

- In FY 2000, 1,917 students (including 317 in LESD) were served by the mobile van.

- In FY 2001, 520 students participated in daily after-school programs. (External evaluation results show high parent satisfaction and improved test scores for students.)
- In FY 2001, 1,000 students participated in the ACES program. (External evaluation results show a high degree of student and teacher satisfaction with students able to apply the skills acquired.)
- In the last three years, LCM has helped LESD secure \$2.5 million in outside funding.
- A new counseling resource is available in Lawndale through Richstone Family Center.

## **Category E: Ongoing partnerships in local communities**

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- E1. CHOC Clinic at the Boys and Girls Club of Santa Ana  
**Children's Hospital of Orange County**
  
- E2. Community Health Ministries Program  
**St. Vincent Medical Center / Catholic Healthcare West\***
  
- E3. Community of Promise Initiative  
**City of Hope Medical Center**
  
- E4. **Circle of Sisters Program**  
**Santa Rosa Memorial Hospital / St. Joseph Health System**

## E1. CHOC Clinic at the Boys and Girls Club of Santa Ana

**Pio Pico - Lowell Neighborhood / City of Santa Ana  
Children's Hospital of Orange County (CHOC)**

### **Community / Populations**

The Pio Pico-Lowell neighborhood in Santa Ana is densely populated, with approximately 26,000 children within a one-mile radius of the Boys and Girls Club. It has the highest concentration of children and youth on the West Coast, and the second highest in the nation. (El Paso is the highest.) The median income in the neighborhood is \$12,000, compared to \$36,000 for Santa Ana and \$62,000 for Orange County.

Priority health issues for children in the neighborhood include, but are not limited to, high rates of diabetes, asthma, kidney disorders, poor nutrition, dental problems, and vision, hearing, and speech problems. In addition to financial barriers to health care, language and cultural barriers present challenges to access for local residents. CHOC assessment findings indicated that 95 percent of mothers in the neighborhood do not speak English, and 90 percent are functionally illiterate in English and Spanish.

### **Program Description**

A widely publicized case of a local child who died of meningitis due to a lack of access to health care in 1998 provided the impetus for the establishment of the clinic. A board member of the Boys and Girls Club (BGC) contacted CHOC, and the two organizations began to explore options to increase access in the Pio Pico-Lowell neighborhood.

There are two elementary schools near the BGC, Pio Pico and Lowell; they share a single school nurse, but this individual is overwhelmed by the scope of unmet health needs among students.

CHOC began providing mobile clinic services in the neighborhood in September 1999. The services were provided on Tuesdays and Thursdays from 4:00-8:00 p.m. This preliminary service helped CHOC staff to get to know the local community and understand the scope and depth of challenges to be addressed.

The next stage in the process was to establish an on-site clinic. BGC and CHOC broke ground on the clinic in June of 2000 and opened the doors on Halloween. CHOC leases land from BGC for the clinic. This is the first partnership in the U.S. between a Boys and Girls Club and a pediatric hospital to provide direct services.

The choice of BGC was logical in the sense that there is a self-identified neighborhood that lacks access to primary care and preventive services. While there is a community clinic approximately three miles from BGC, it is operating at full capacity and many people are

reluctant to travel to that site. BGC is also a logical site in that it already provides a range of support services, and the establishment of primary care and preventive health services is an important complement to these existing services.

The clinic operates on Monday and Friday from 9:00 a.m.-5:00 p.m., Tuesday and Thursday from 1:00 p.m.-8:00 p.m., Wednesday from 1:00 p.m.-6:00 p.m. (with an immunization clinic), and Saturdays from 9:00 a.m.-3:00 p.m. All of the staff are bilingual, including physicians, nurses, and technicians. In addition to primary care, clinic services include:

- Care management services to link patients to a range of support services.
- Assistance with enrollment in Healthy Families and other public insurance programs.
- Between 15-20 health education / health promotion classes (through BGC and schools).
- Injury prevention through a mobile safety house, a 32-foot trailer that is set up like a house with an array of optimal safety features.

In addition to BGC, supporting partners at the clinic include St. Joseph Hospital, which accepts referrals for adult services, and Maternal Outreach Management Systems (MOMS). Both partners help to make sure that prospective mothers receive quality prenatal care and support services after birth. Collaborative efforts with neighborhood residents have resulted in health fairs, immunization campaigns, and asthma screenings. A particular focus for CHOC is the integration of health services with existing neighborhood programs.

CHOC staff members have noted that they are “still learning about the community” and they acknowledge that neighborhood engagement is critical to the long-term success of the clinic. The goal this year is to establish a community liaison that can serve as a community advocate, rather than rely primarily on BGC to facilitate engagement. CHOC also works with Latino Health Access to increase awareness and effectiveness in addressing health concerns among these populations.

## **Role of the Hospital**

CHOC and the hospital’s foundation provided approximately \$75,000 in cash and in-kind resources to provide mobile clinic services, plan and develop the BGC clinic site, and carry out a resource development campaign. Annual operating costs for the clinic are approximately \$450,000. The CHOC Foundation raised \$336,438 for the first year of operations and the remaining \$113,562 was provided by the hospital.

## **Impacts to Date**

Between the opening of the clinic in October 2000 and April 2001, there were 1,800 pediatric visits for 950 children. The clinic currently sees approximately 25 patients per day. Enrollment assistance to date has generated approximately 200 applications for Healthy Families, providing coverage for approximately 400 children.

Over the next three years, CHOC and its partners plan to provide over 21,000 pediatric care visits, 2,500 wellness care visits, and 6,300 parenting education visits. Baseline data has been collected in order to document reductions in the use of area emergency rooms for primary care visits, as well as improvements in health status and quality of life for Pico-Lowell residents.



## E2. Community Health Ministries Program

Pico Union / Westlake Area of Central Los Angeles  
**St. Vincent Medical Center / Catholic Healthcare West\***

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### **Community / Populations**

The Community Health Ministries program is located in the Pico Union-Westlake area of central Los Angeles. The population is primarily Latino, with a high percentage of uninsured day laborers, seniors on SSI, and undocumented immigrants with limited English proficiency. There are high levels of crime, school dropouts, mental illness, and substance abuse. Pico Union is one of five Community Improvement Project Areas (CIPAs) designated by the City of Los Angeles as needing improved services to assist lower income residents.

### **Program Description**

The Community Health Ministries program began in September 2000. Its initial goal was to close gaps in services identified by the community needs assessment conducted by St. Vincent Medical Center (SVMC). In the process of providing these services, providers became aware of a high rate of repeat and inappropriate utilization at SVMC that could be traced to residents of the Pico Union community. SVMC staff realized that the program in its early stages was not reaching many of the neighborhood residents who were most in need.

After dialogue with community stakeholders, it was determined that the program needed to be reformulated as a community partnership effort. SVMC staff began to conduct outreach in the neighborhoods and subsequently established partnerships with a number of local churches. Early faith community partners included two Catholic churches and one Christian evangelical church. More recently, links have been forged with five community service agencies, two elementary schools, and three more faith-based organizations.

In the process of conducting outreach, SVMC staff found a low level of trust among many community members. A common view was that community-based organizations “have been burned before” by provider groups, and therefore, they were reluctant to put much effort into partnership development. SVMC staff concluded early on that it would be critically important to follow through on any promises made to community stakeholders.

A key strategy in the outreach effort was to employ Promotores de Salud, or community health outreach workers, and to coordinate with community-based agencies that employ them. A program for training and deploying Promotores was first initiated at California Hospital Medical Center through a three-year project funded by the Good Hope Foundation. The intention was for a number of local hospitals to share in staffing and sponsoring the program.

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\* SVMC ownership shifted from CHW to the Daughters of Charity Health System in January 2002.

While the title of the initiative is the Community Health Ministries program, the clear focus is on population-based health improvement. Parish nurses who participate in the program express a commitment to focus on health and quality of life, and work with the faith community to provide spiritual inspiration. Helping residents become empowered to manage their own health is a key focus of the project.

Activities include health fairs specifically designed to serve Latino, Filipino, and Korean communities; weekly health education classes that are combined with social activities (e.g., Salsa dancing, lunch) at local churches; screening and education at neighborhood clinics; assistance with transportation (e.g., taxi and bus vouchers); and referrals (e.g., Casa de Amigos, Community Center for the Aging).

### **Role of the Hospital**

Direct costs for staffing of Promotores, a nurse practitioner, a public health nurse, and registered nurses is supported by grants from external funders. SVMC secured a total of \$331,000 in grant funding in the first year of operations, and fundraising efforts proceed on an ongoing basis.-SVMC provides office space and furniture, supplies, storage space, parking, and phone and Internet access. Annual in-kind costs are approximately \$26,500.

### **Impacts to Date**

The program served 5,698 persons in these neighborhoods between September 2000 and June 2001; 3,200 through health education programs, 1,709 in screenings and/or flu shots, and 789 through Meals on Wheels. Efforts are being made to expand partnerships with public and private sector health and social service agencies.

## **E3. Community of Promise Initiative**

### **City of Duarte City of Hope Medical Center**

#### **Community / Populations**

The City of Duarte is a town of 22,015 residents in the northeast corner of Los Angeles County. The ethnic/cultural composition of the city is 46 percent Caucasian, 34.6 percent Latino, 11 percent Asian, and 8.5 percent African American. The median household income is \$37,695, with a home ownership rate of just under 70 percent.

Almost one-third of Duarte residents are under 18 years of age, and the local school district has a student population of approximately 4,500. Local assessment findings indicate a need to enhance the social support system for youth because they experience high rates of unemployment, a shortage of after-school programs, and a lack of adult mentors. Findings also show a need to increase youth involvement in community service activities. Currently, less than 10 percent of the youth population participates in such activities.

#### **Project Description**

The City of Duarte has distinguished itself as a leader in its commitment to direct involvement in community health improvement. As one of the charter members of the California Healthy Cities program, Duarte has provided ongoing leadership for the development and implementation of the local Community of Promise Initiative. Major supporting partners include the City of Hope National Medical Center (COH), local businesses, community agencies, and faith-based organizations.

Duarte's Community of Promise initiative is part of America's Promise campaign, a national volunteer-based initiative to support youth development. In Duarte's application to become a designated city in the America's Promise campaign, local stakeholders made a commitment to plan and carry out a broad range of activities that would provide youth with the following:

- Ongoing mentoring from a caring adult
- Safe places and supportive social structures
- Marketable employment skills
- An opportunity to serve their community
- A healthy start.

There are a total of 40 measurable objectives developed by partners that are tied to the five promises. Examples include a commitment to increase participation in youth mentoring

programs by 15 percent, and to increase involvement of adults in after school programs. The Steering Committee for the initiative is chaired by the City of Duarte, and includes youth members, as well as the organizational partners listed above.

Initiative partners hosted a community kickoff in February 2001 with 150 attendees, including representatives of more than 75 organizations. This event represented the formal start of the initiative. Participants ranged from service-based organizations to car dealers and manufacturers. COH and the City of Duarte co-sponsored and underwrote the cost of the lunch.

The first annual youth summit was held in July. It brought together youth to discuss their future and to explore options for action. Young people were asked a series of questions about challenges they faced in their lives and were invited to identify the kinds of activities and skills they need to succeed in the future.

The city is currently seeking support from COH for the establishment of a youth-run television program on a local cable station to increase public awareness and support for the initiative. Partners are also exploring the development of a second program that is run by youth.

### **Role of the Hospital**

COH is a specialty care institution with a focused mission (i.e., cancer treatment and research), but has demonstrated a commitment to support a range of health improvement initiatives that are viewed as priorities by community stakeholders.

It has a longstanding working relationship with the city government in Duarte, and was recruited by the city as an early member of the initiative Steering Committee. One of the first tasks for COH was to provide findings from its community assessment (both needs and assets) for the application. Other COH contributions include:

- Resource development assistance
- Support of the project planning process
- Pledge to recruit and support volunteers from Duarte schools
- Contribute guest speakers to high school career preparation programs
- Participate in Career Day at Duarte High School
- Provide job placements through the Regional Occupational Training Program
- Career mentoring placements with stipends (currently under development)

A substantial proportion of COH's contributions to the Community of Promise initiative are difficult, if not impossible, to calculate in financial terms (e.g., staff time, material contributions). The estimated value of contributions to date that can be calculated in financial terms is \$7,500.

### **Impacts to Date / Next Steps**

In the wake of the youth summit, a Teen Center has been established, and serves as a locus for youth-led activities. One new initiative is a tutoring program where teens assist elementary school students. A number of family-centered activities are currently under development.



## **E4. Circle of Sisters Program**

**City of Santa Rosa / Sonoma County**

**Santa Rosa Memorial Hospital / St. Joseph Health System**

### **Community / Populations**

Participants in the Circle of Sisters program are 5th through 8th grade females (ages 10-14) in Sonoma County. Data on female juvenile delinquency shows that Sonoma is well above the state average for arrests, offenses/misdemeanors, alcohol consumption, sexual activity, and involvement in gang activity. Data also indicate that substance abuse and suicide rates increased in the 1990s. There are 18 middle schools and 22,448 middle school-age children in the county.

### **Program Description**

Circle of Sisters is an after school enrichment program to foster positive social behaviors and personal development among young women. The program is an outgrowth of an outreach initiative sponsored by Santa Rosa Memorial Hospital (SRMH) in 1996 that deployed community organizers to carry out neighborhood-based health promotion and education. A major concern raised by parents in these neighborhoods was difficulty communicating with their daughters about a range of health and social-related issues. In 1997 SRMH staff began to work with mothers and a variety of stakeholders to formulate the Circle of Sisters concept.

Efforts often began with a series of group dialogues, usually organized by one or more mothers in a particular neighborhood. SRMH sponsored approximately three evening and weekend meetings per week over a period of two years, supporting dialogues between a total of 1,500 pairs (daughter / mother-grandmother-guardian).

In 2000 SRMH began to engage local schools as partners and hired additional staff to support the process. Schools were viewed as optimal partners because they would provide a “captive audience” and would be more attractive than SRMH to external funders. Proposals had previously been submitted to a number of foundations, but SRMH had been unable to secure support. The new partnership secured over \$1 million in funding from the Federal Office of Juvenile Justice under the project title of ESCAPE (Eliminating Social Conditions that Promote Crime). The proposal was strengthened by extensive primary data collection to validate anecdotal findings that had been compiled during the two years of neighborhood dialogues.

The program starts at the end of the school day with a short period for “decompression.” A snack is provided, and students have a few minutes for informal discussion. Participants are then given time to journal on a daily topic such as self-esteem, anger management, or personal hygiene. The core of the session is “circle time” when participants and facilitators discuss the daily topic.

Discussions include a “check in” time for each participant to talk about personal issues that may be triggered by the discussion of the topic. Topics often include Life Learning Tracks, which are experiential activities to facilitate positive development. Examples include walks, art projects, presentations and discussions with female role models that attend as guests, as well as exposure to community-based civics projects. The program emphasizes identifying and enhancing individual strengths or “assets” through positive feedback, leadership opportunities, and role modeling.

After securing agreements with selected schools to initiate programs, SMRH staff members attend PTA meetings, Parents Nights, and Back to School events to connect with parents and familiarize them with the program. The next step is a general assembly meeting for all 5<sup>th</sup> and 6<sup>th</sup> grade girls to present the program. Participants are taken for the program on a first come, first served basis. The ratio of participants is kept to a minimum of one adult for every 10 girls.

There are two facilitators for every circle. The program is run by two of the facilitators. One has an MSW graduate degree and the other has 20 years of youth counseling experience. Other facilitators are women recruited from the local community that have experience working with this age group and/or facilitation experience. Monthly meetings are held with facilitators for in-service learning, a “train the trainers” approach. Program staff are currently developing a formal, 32-hour training, a “gender-competent” curriculum, and lesson plans for the future.

An important dimension of the program is to intervene with young women who may be experiencing some difficulties before they enter the juvenile justice system, and to guide them towards an optimal future. While the program could be an effective way to help young women that have entered the juvenile justice system, issues of confidentiality have made it difficult to make referral arrangements. By starting at the 5<sup>th</sup> and 6<sup>th</sup> grade, partners believe they are getting a “leg up” on problems before they become serious. Nevertheless, they are exploring ways to target the identification and referral process to focus on young women who are most in need.

The central measurable objective of the program is to reduce the percentage of young women in the Sonoma County juvenile justice system in the next three years. SRMH staff members are in the process of developing a comprehensive monitoring strategy.

### **Role of Hospital**

SRMH provided funding, staffing, and leadership to build support and awareness in local communities, and intellectual capital to develop the program concept. Total support during the first three years of program development was approximately \$250,000.

There are 8.5 FTE staff in the program, of which 7.5 FTE are offset by the federal grant. SRMH currently provides approximately \$150,000 per year, which pays for the one FTE (includes partial administration, clerical, fiscal, research and evaluation support) as well as certain indirect and minor operating costs not offset by the grant.

## **Impacts to Date**

In the three years prior to the development of the school-based “Circle of Sisters” program, 1,500 daughter-parent pairs participated in dialogues to enhance communication and explore adolescent developmental issues. There were two “Circle of Sisters” sites in operation in 2000 with 55 participants. By mid-2001, there were 125 young women in programs at five school-based sites. The goal is to have eight school sites and 11 groups in operation by the end of 2002.

# **APPENDIX B – Cover Letter and Survey Instrument**

May 1, 2001

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Dear -----:

The enclosed questionnaire is part of a study being conducted by the Public Health Institute, a nonprofit research, technical assistance, and training organization based in Berkeley, California. The study is funded by The California Endowment, and endorsed by the California Healthcare Association and the Alliance of Catholic Health Care. The purpose of the survey is to document accomplishments and challenges faced by California nonprofit hospitals since the enactment of Senate Bill 697, the hospital community benefit legislation. Impetus for this inquiry has been generated by two observations:

- Current dialogue in the policy arena regarding the charitable obligations of nonprofit hospitals focuses narrowly on the volume of charity care provided by these institutions. There is a need for a systematic inquiry to document a broader spectrum of activities supported by nonprofit hospitals.
- Practical application of the principles and processes outlined in SB 697 requires skills, understanding, commitment, and resources that may or may not be present in every hospital. Objective information is needed to identify areas where technical assistance and other forms of support may enhance the efficacy and sustainability of efforts by hospitals to address unmet health needs in local communities.

Findings from the survey will be reviewed by an advisory panel of key stakeholders from health care, public health, state government, and the community. The advisory panel will select 15 – 20 examples of exemplary practices for further documentation through a series of follow up interviews. Findings will be published and disseminated to key stakeholders, and presented in a series of policy briefings.

Individual survey findings will be held strictly confidential, to preserve the rights of individual and organizational respondents. Hospitals selected for documentation of case examples will be given the opportunity to review draft findings prior to publication for the purpose of correcting factual errors.

We request that you complete the enclosed questionnaire and return it by fax to 925-939-9104 by Friday, May 25th. If your local hospital is selected as a case example for documentation of exemplary practices, we will contact you in mid-June. If you have any questions about the study or any aspect of the survey, please call us at 925-939-3417. Thank you for your assistance.

Sincerely,

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

**The Status of Community Benefit in California:  
A Statewide Review of Exemplary Practices and Key Challenges**

**Survey of California Nonprofit Hospitals**

**A Project of the Public Health Institute  
Supported by The California Endowment**

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**I. Exemplary Practices**

Five categories of community benefit practices are provided in this section to accommodate the diversity of accomplishments by nonprofit hospitals. For each category, an explanation and series of examples are provided to assist in the identification of appropriate examples. Categories include:

- A. Programs that are producing measurable improvements in health status
  - B. Programs that are producing measurable improvements in quality of life
  - C. Institutional policy changes that strengthen hospital commitment to community benefit
  - D. Strategic investments that increase the capacity of existing community assets
  - E. Ongoing partnerships to address the underlying causes of health problems
- 

**Programs that are producing measurable improvements in health status**

This refers to any local hospital community benefit programs that are producing a measurable impact upon the health status of defined populations. Examples include, but are not limited to the following: a screening program for prostate cancer that is reducing death rates; an asthma management program that is reducing the severity of symptoms; an immunization program that is reducing the incidence of influenza; a youth education program that is reducing the rate of sexually transmitted disease; a home visiting program that is reducing the rate of elder accidents.

**1. Are any of your local hospital community benefit programs producing reductions in the following categories? (Please check all that apply for current programs)**

- Hospitalizations
- Emergency room visits
- Illness/disease incidence (new occurrences)
- Illness/disease prevalence (# of diagnosed cases in a defined population)
- Morbidity (health status measures only)
- Mortality
- Other (Please specify) \_\_\_\_\_

**2. Please describe your best example of a current program that is producing a measurable improvement in health status in the format and space provided.**

- a. program services / activities
-

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b. specific role(s) and/or contributions of the hospital

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c. targeted population(s) (e.g., culture/ethnicity, socioeconomic status, coverage status)

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d. measurable objectives and time frames

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e. health status impacts to date

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***Programs that are producing measurable improvements in quality of life***

This refers to any local hospital community benefit program activity that is having a measurable impact upon factors indirectly related to health status, often referred to as “quality of life” measures. These impacts may not meet strict criteria as outcomes, but can be presented as indicators of progress towards achievement of health outcomes. Program categories include: *economic development / opportunity* (e.g., career/job skills training, business development); *physical environment* (e.g., housing, parks, community gardens, transportation); *educational* (e.g., tutoring); *social support* (e.g., after school programs, child care, elder support, youth civic development); and *psychological* (e.g., parenting, child development).

Examples of measurable impacts include, but are not limited to the following: improved school performance (e.g., absence, dropout rates, grades); reduced juvenile delinquency, increased social support (e.g., increased per capita volume of school programs, neighborhood watch programs, affordable child care slots); economic vitality (e.g., increased low income housing, jobs, support services); institutional change (e.g., public policy development, institutional reforms, inter-organizational linkages).

**1. Are any local hospital community benefit programs producing measurable impacts upon the following quality of life indicators?** (Please check all that apply for current programs)

- Economic development/opportunity
- Physical environment
- Educational
- Social support
- Psychological
- Other (Please specify) \_\_\_\_\_

**2. Please describe your best example of a program that is producing measurable impacts upon quality of life in the format and space provided.**

a. program services / activities

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b. specific role(s) and/or contributions of the hospital

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c. targeted population(s) (e.g., culture/ethnicity, SES, coverage status)

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d. measurable objectives and time frames

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e. quality of life impacts to date

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***Institutional policies that strengthen hospital commitment to community benefit***

This refers to any institutional policy changes made by your local facility *since September 1994* to enhance community benefit governance, management, and/or operations. Examples include, but are not limited to the following: establish community benefit committee with budgetary discretion; change composition of trustees to reflect community diversity; establish dedicated community benefit manager position with direct reporting relationship to CEO; establish formal criteria to evaluate existing and establish new programs; establish policies to increase community involvement; establish practice guidelines that link clinical services to community health improvement initiatives.

**1. Please identify the intended impact of any institutional policy changes made by your facility since 1994: (Please check all that apply)**

- Improve program quality
- Improve governance / oversight
- Improve operations / management
- Increase staff / provider involvement
- Increase community involvement
- Other (Please specify) \_\_\_\_\_

**2. Please describe your best example of an institutional policy currently in effect in the format and space provided.**

- a. key elements of the policy change

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- b. intended impacts/objectives

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- c. impacts to date

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**D. Strategic investments to enhance the capacity of existing community assets**

This refers to any charitable contribution that is intended to increase the effectiveness, efficiency, and/or sustainability of an *external* program, organization, community group, or support system in a local community. Contributions include financial investments, equipment donations, technical assistance, public advocacy, and leveraged engagement (i.e., leadership to secure the support of key stakeholders).

Examples include, but are not limited to the following: funding for organizational development, disaster recovery, community group operations, neighborhood revitalization, or public awareness campaigns; technical assistance to enhance service delivery, financial management, information systems, resource development, marketing, and strategic planning of community-based organizations; advocacy to support community groups or encourage local public policy reforms; leveraged engagement of local financial institutions to support local economic development or secure contributions for comprehensive health improvement initiatives.

1. Please check any of the following forms of strategic investment by your hospital that are intended to enhance the capacity of existing community assets:

- Financial support
- Technical assistance
- Equipment donation
- Advocacy
- Leveraged engagement
- Other (Please specify) \_\_\_\_\_

**2. Please describe your best example of a strategic investment strategy in the format provided.**

- a. existing community asset(s)

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b. form of hospital strategic investment

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c. targeted population(s) (e.g., culture/ethnicity, SES, coverage status)

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d. measurable objectives

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e. impacts to date

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**E. Ongoing partnerships to address the underlying causes of health problems.**

This refers to ongoing partnerships between hospitals, community-based organizations, and neighborhood residents to address the underlying causes of health problems. Key criteria include a) a neighborhood scale/focus, b) the selection of activities is determined by community partners, c) a multi-year commitment by the hospital, and d) emphasis on direct action to improve local conditions (rather than professional service delivery).

**1. Please describe your best example of this type of partnership in the format provided.**

a. description of the neighborhood (e.g., demographics, size, physical characteristics)

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b. governance and composition of the partnership

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c. primary focus of activities

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d. objectives defined by partnership

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e. accomplishments to date

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## **II. Key Challenges**

The purpose of this section is to document key challenges faced by California nonprofit hospitals in the planning and implementation of community benefit program activities. Findings from this inquiry will highlight areas where technical assistance and other forms of support are needed to enhance local efforts.

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### **A. Community Assessment**

The community assessment is a tool to identify unmet health needs in local communities, locate existing assets that serve as points of entry, and establish a baseline to monitor the impact of program activities.

**1. What are the most significant challenges you confront in the collection and analysis of data on health needs?** (Please rank in order of importance, with 1 as the highest and 7 as the lowest, or “n.a.” if not applicable).

- \_\_\_ a. Lack of internal expertise
- \_\_\_ b. Lack of available data at the sub-county level
- \_\_\_ c. Obstacles to coordination with local public health agency
- \_\_\_ d. Obstacles to coordination with other local hospitals
- \_\_\_ e. High cost of primary data collection
- \_\_\_ f. Lack of clarity on what is needed for submittal to OSHPD
- \_\_\_ g. Other (Please specify) \_\_\_\_\_

Please explain.

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**2. What are the most significant challenges you confront in the collection and analysis of information on community assets?** (Please rank in order of importance, with 1 as the highest, and 6 as the lowest, or “n.a.” if not applicable.)

- \_\_\_ a. Lack of organizational expertise/capacity
- \_\_\_ b. Lack of understanding/support from senior leadership
- \_\_\_ c. Obstacles to coordination with local public health agency
- \_\_\_ d. Obstacles to coordination with other local hospitals
- \_\_\_ e. Lack of community assets
- \_\_\_ f. Other (Please specify) \_\_\_\_\_

Please explain.

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**B. Community Outreach / Engagement**

Outreach and engagement of diverse community stakeholders is essential for the development of effective and sustainable community benefit program activities. Community organizations and individuals possess valuable resources that can serve as the entry point for program planning. Meaningful engagement of diverse stakeholders also helps to keep charitable contributions aligned with community concerns.

**1. What are the most significant challenges you face in efforts to engage service-based organizations in the community?** (Please rank the in order of importance, with 1 as the highest and 8 as the lowest, or “n.a.” if not applicable.)

- \_\_\_ a. Lack of staff time
- \_\_\_ b. Lack of knowledge/expertise
- \_\_\_ c. Lack of authority from senior leadership
- \_\_\_ d. Competition/”turf” issues among community-based organizations
- \_\_\_ e. Antagonism/mistrust
- \_\_\_ f. Lack of interest among hospital providers
- \_\_\_ g. Lack of financial resources
- \_\_\_ h. Other (Please specify) \_\_\_\_\_

Please explain.

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**2. What are the most significant challenges you face in efforts to engage community members as ongoing partners?** (Please rank in order of importance, with 1 as the highest, and 6 as the lowest, or “n.a.” if not applicable.)

- \_\_\_ a. Lack of staff time
- \_\_\_ b. Lack of knowledge/expertise
- \_\_\_ c. Community member lack of interest/time
- \_\_\_ d. Institutional concerns (please specify) \_\_\_\_\_
- \_\_\_ e. Lack of understanding/support from senior leadership
- \_\_\_ f. Other (Please specify) \_\_\_\_\_

Please explain.

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C. Setting Priorities / Program Selection

The community assessment and outreach processes provide both quantitative and qualitative information that are used to determine the focus of program activities. The use of objective criteria for priority setting and the engagement of diverse community stakeholders in the decision making process helps to ensure the optimal use of available resources to address priority concerns.

**1. What are the most significant challenges you face in the selection of program areas of focus?**

(Please rank in order of importance, with 1 as the highest value and 6 as the lowest, or “n.a.” if not applicable.)

- \_\_\_\_\_ a. Lack of staff time
- \_\_\_\_\_ b. Lack of internal expertise
- \_\_\_\_\_ c. Assertion of hospital/health system interests
- \_\_\_\_\_ d. Competing interests among community stakeholders
- \_\_\_\_\_ e. Lack of diversity among community stakeholders engaged in process
- \_\_\_\_\_ f. Other (Please specify)

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Please explain.

**D. Program Monitoring**

Monitoring the impact of programs is one of the most challenging, yet one of the most important components of the community benefit process. The information collected in program monitoring provides a basis for periodic adjustments to increase effectiveness and contribute to the optimal use of charitable resources. As indicated in the first section of this questionnaire, measurable impacts can range from health status outcomes to more broadly-defined indicators of progress towards long term improvements in health status and quality of life.

**1. What are the most significant challenges you confront in the area of program monitoring?**

(Please rank in order of importance, with 1 as the highest value and 5 as the lowest, or “n.a.” if not applicable.)

- \_\_\_\_\_ a. Lack of staff time/resources
- \_\_\_\_\_ b. Lack of internal expertise
- \_\_\_\_\_ c. Obstacles to coordination with local public health agency
- \_\_\_\_\_ d. Obstacles to coordination with local academic institution
- \_\_\_\_\_ e. Other (Please specify) \_\_\_\_\_

Please explain.

**E. Organizational Infrastructure**

1. What would you identify as the most important areas for internal development to enhance the effectiveness of community benefit programming? **(Please rank in order of importance, with 1 as the highest and 8 as the lowest.)**

- \_\_\_\_\_ a. Performance incentives to increase internal involvement/support
- \_\_\_\_\_ b. Increased staff time
- \_\_\_\_\_ c. Alignment of CB and organizational strategic planning
- \_\_\_\_\_ d. Stronger linkages between CB manager and senior leadership
- \_\_\_\_\_ e. Establish explicit criteria for CB programs (e.g., process, targeting)
- \_\_\_\_\_ f. Increased involvement of community members in decision making
- \_\_\_\_\_ g. Knowledge/expertise (Please specify)

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- \_\_\_\_\_ h. Other (Please specify)

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Please explain.

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2. **What would you identify as the most significant overarching challenges to your hospital's ability to fulfill its charitable mission in the future?** (Please rank in order of importance, with 1 as the highest and 9 as the lowest, or "n.a." if not applicable.)

- \_\_\_\_\_ a. Low reimbursements from payers
- \_\_\_\_\_ b. Increasing costs of technology (e.g., equipment, pharmaceuticals)
- \_\_\_\_\_ c. Earthquake retrofitting obligations
- \_\_\_\_\_ d. Competition with other local hospitals
- \_\_\_\_\_ e. Public pressure from advocacy groups
- \_\_\_\_\_ f. New regulatory action
- \_\_\_\_\_ g. Resistance to change (Please specify)

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- \_\_\_\_\_ h. Workforce issues (Please specify)

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- \_\_\_\_\_ i. Other (Please specify)

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Please explain.

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**Thank you for your time!**

**Facility name and location:** \_\_\_\_\_

**Person completing form: ...** \_\_\_\_\_

**Phone/fax/email:** \_\_\_\_\_

(Please include your name and contact information if you would like any program or activity to be considered as a case example of an exemplary practice. If not, feel free to return the questionnaire without contact information. As indicated in the cover letter, individual questionnaires will be held strictly confidential.)

