Community Benefit Planning

Community Benefit Planning: Strengthening Commitment to Mission

A VHA Inc., Concept Brief 2002
Acknowledgements

This concept brief was created by VHA member health care organizations, and recommendations are based upon their unique perspectives and implementation experiences. We would especially like to acknowledge the hard work and dedication of the following members for their contributions:

Bozeman Deaconess Hospital — Bozeman, Mont.
Community Medical Center — Missoula, Mont.
Clarian Health Partners — Indianapolis, Ind.
Deaconess Billings Clinic — Billings, Mont.
Exempla Healthcare — Denver, Colo.
Frances Mahon Deaconess Hospital — Glasgow, Mont.
Ivinson Memorial Hospital Foundation — Laramie, Wyo.
Massachusetts General Hospital — Boston, Mass.
Magic Valley Regional Medical Center — Twin Falls, Idaho
Memorial Hospital — Colorado Springs, Colo.
Poudre Valley Hospital — Fort Collins, Colo.
Scripps Health — San Diego, Calif.
St. Luke’s Regional Medical Center — Boise, Idaho
St. Peter’s Hospital — Helena, Mont.
Sutter Health — Sacramento, Calif.
Wyoming Medical Center — Casper, Wyo.
Yakima Valley Memorial Hospital — Yakima, Wash.
Yakima Valley Memorial Foundation — Yakima, Wash.

For more information, please contact:

Joanne T. Clavelle R.N., M.S.
VHA Mountain States
1401 17th Street, Suite 850
Denver, CO 80202
(303) 308-4144

Patsy Matheny M.A.P.A., M.S.W.
VHA Inc.
220 E. Las Colinas Blvd.
Irving, TX 75039
(614) 871-4171
# Table of Contents

Overview and Rationale .................................................. 1

VHA Community Benefit Standards ...................................... 3

Process for Developing a Community Benefit Plan ..................... 7
  Value of the Process ...................................................... 7
  Internal and External Assessment ....................................... 7
  The Planning Committee .................................................. 7

Template for a Community Benefit Plan ................................ 9
  I.  Introduction and Background ........................................ 9
  II.  Assessment of Community Health Needs, Goals and Assets .... 10
  III.  Projects to Address Identified Community Needs ............... 11
  IV.  Charity Care Policies ................................................ 11
  V.  Evaluation .................................................................... 11
  VI.  Committed Resources ................................................ 12
  VII.  Community Benefit Report/Communication ..................... 12
  VIII. Conclusion .............................................................. 13

Merits and Considerations .................................................. 15

Examples from the Field ..................................................... 17

Resources and Tools .......................................................... 29
  Self-Appraisal Questionnaire .......................................... 29
  Perception Survey on Health Care Organization Community Benefits ......................... 32
  Sample Charity Care Policies .............................................. 35

References ................................................................. 41
Community Benefit Planning

Overview and Rationale

A **community benefit plan** is a document, usually produced in conjunction with the health care organization’s annual strategic plan, that explicitly details how an organization intends to fulfill both its mission of community service and its charitable, tax-exempt purpose. It includes a description of community benefit priorities, projects, staffing, resources, evaluation procedures and anticipated outcomes, and a description of the nature and extent of community involvement.

**Community benefit strategy** is a planned, managed and measured organizational approach to meeting identified community health needs. VHA member health care organizations’ mission statements cite a deep-rooted commitment to community benefit and health improvement. Members are challenged to identify how their missions, visions and values link to community programs and initiatives. Of paramount concern is how best to align community benefit initiatives with strategic, operational, clinical, environmental and business objectives. Developing a community benefit plan helps you effectively address these areas by integrating community benefits into annual strategic planning, goal formation and budgeting processes.

Over the past decade, VHA has been a national leader in the field of community benefits, developing community benefit standards, programs and evaluation methods. Through community benefit programs, VHA members have demonstrably improved the health of populations, enhanced access to care, fostered self-management of medical illness and disease, and promoted health and wellness across the country.

VHA has developed community benefit standards and worked with members to standardize community benefit definitions, categories, cost-accounting practices and reporting. We’ve also provided assistance with communications and reporting, board and staff education, and health care advocacy.

Increasingly, health care organizations recognize the value of community benefit programs in enhancing clinical and financial outcomes as well as meeting consumer expectations, enhancing donor share, and increasing market share.

Members ask:

- Do we offer community programs based upon need and alignment with our strategic objectives, or do we randomly pepper the community with acts of kindness?
- Do we annually revisit our community benefit inventory and examine programs for outcomes effectiveness, relevance, and evaluation of...
continued staffing and funding?

• Do we have a process that asks for community engagement and input in what programs we should offer, and who we should partner with? How is our board involved? What leadership roles do or should our board members play?

• Do we have an easy way for employees to contribute to our organization’s community benefit programs and efforts? How are they engaged?

• Do we consider how community benefit programs relate to relationship marketing efforts, positioning as a provider of choice, and market share enhancement? Do we measure this?

Members have expressed interest in further implementing their community benefit programs by developing a planning process that explicitly defines how community benefit needs are identified, what programs will be supported and why, what outcomes are expected, and how the programs link to clinical priorities. This concept brief provides a framework for action for your health care organization.
Developed in 1991, VHA’s voluntary community benefit standards provide a framework and benchmarks that help to guide and evaluate not-for-profit health care organizations’ efforts to address community needs. The standards serve as a guide in reviewing current initiatives and setting goals for future efforts. Embracing them requires nonprofit organizations to explicitly review, organize, manage and communicate their benefits to the community and maintain a commitment to collaboration with them.

The standards advocate the community benefit planning process and relate to every aspect of health care organization operations, including:

- development of the mission statement and function of the governing board
- fiscal and investment decision-making
- relating to employees and medical staff members
- clinical priority areas and scope
- affiliations with other community health organizations; businesses; and civic, religious, social and educational organizations

These standards suggest the application of total quality management principles to providing of community benefits, calling upon the organization to:

- explicitly state standards to strive toward and regularly review performance on standards
- achieve total organizational buy-in to the organization’s community benefits philosophy
- base efforts and services provided on expectations and the community’s assessed needs
- adopt a process orientation to community benefits
- use team problem-solving and partnership approaches
- build in mechanisms for community feedback and measuring value
- view itself as seamlessly connected to the larger community, and embrace a shared community vision

As the nation’s largest alliance of non-profit hospitals and health systems, VHA created standards that relate to all aspects of your organization’s community benefit and tax-exempt status obligations. Other community benefit standards have also been developed by state and local governments, the
federal government, health care associations and foundations, as well as individual health care organizations. We encourage you to adopt standards within your own organization so you can evaluate, organize, manage and maximize your community benefit strategy.
## VHA’s Health Care Organization Community Benefit Standards

### Standard 1: Demonstrate Leadership as a Charitable Institution

**Minimum Guidelines:**
- Assert leadership in organizing communitywide efforts for the needy.
- Reach out to the underserved to provide needed primary and preventive health care services and health education.
- Attract and use donated funds to serve the needy.
- Participate in Medicaid and other federal, state and local health care reimbursement programs for the needy.
- Formally plan for and provide charity care or maintain an open-door policy to the extent of financial ability.

### Standard 2: Provide Essential Health Care Services

**Minimum Guidelines:**
- Cooperate with other community health care providers to optimally meet essential community health needs.
- Render health care and educational services specifically designed to meet assessed community needs and improve community health status.
- Operate a 24-hour emergency room to the extent needed by the community.

### Standard 3: Be Accountable to the Community

**Minimum Guidelines:**
- Form a volunteer governing board composed of members of the community.
- Invite and respond to community input and involvement in the planning and review of organizational activities.
- Publicly disclose information about your health care organization’s services, financial status, community benefit activities and charity care.
- Advocate health care cost-containment efforts and promote the efficient use of health care resources within the community.

### Standard 4: Evidence Commitment to Community Benefit

**Minimum Guidelines:**
- Embrace a mission statement and by-laws that reflect a commitment to a charitable purpose and community benefit.
- Provide leadership for organizing communitywide efforts that enhance community health.
- Integrate into your organization’s overall strategic plan a community benefit plan based on assessments of community health needs.
- Educate and involve employees and medical staff members in providing community benefits.

### Standard 5: Operate Free From Private Profit

**Minimum Guidelines:**
- Maintain a corporate and legal structure that meets all requirements for not-for-profit status.
- Ensure that affiliated business enterprises serve the health care organization’s charitable purpose and present no conflicts of interest with its not-for-profit, charitable mission.
- Employ financial surpluses to further the institution’s charitable purpose and not to promote private inurement to any individual.
Process for Developing a Community Benefit Plan

**Value of the Process**

The process of developing an organization-specific community benefit plan is valuable in that it:

- establishes a parallel process and linkage to your organization’s strategic plan
- renews your organization’s commitment to an action-based agenda based on its mission, vision and values
- positions community benefit as a systematic program rather than a series of isolated community health activities
- generates internal dialogue and discussion, engaging employees in defining targeted community health needs, refining target populations, creating synergy with strategic clinical and operational priority areas, and defining just-in-time allocation of resources
- sustains ongoing financial and human resource commitment to community benefits and community health improvement
- nurtures collaboration with community partners in assessing and prioritizing community health goals and identifying community assets
- builds trust and promotes a positive community image

**Internal and External Assessment**

A self-appraisal questionnaire can help you assess your health care organization’s stance as a community benefit provider and identify necessary actions to include in your community benefit plan. The questionnaire does not indicate whether your organization is “passing” or “failing,” but serves as a gauge to help set priorities and trigger action. A VHA Self-Assessment Questionnaire can be found under Resources and Tools.

Surveys that capture various constituencies’ perceptions of community benefits can give helpful insight on how they view your health care organization as a community benefit organization. The survey instrument, Perception Survey on Health Care Organization’s Community Benefits (included in the Resources and Tools section) can be given to employees, physicians, board members, community advisory and focus groups, official and grassroots community leaders, and other community representatives. The results can help you map communication messages and target constituencies as part of your community benefit plan.

**The Planning Committee**

Community benefit plan development
can be an important aspect of building both internal and external partnerships. Convening as a planning committee, key organizational stakeholders and community representatives can work together to identify priority areas for action and drive the process.

The ideal planning committee consists of representatives from senior management and the board of trustees; finance; quality assurance; community health improvement and community benefits; and community professional and lay representatives, including representation from the target populations.

The roles of the planning committee are to:

- develop an ongoing process for the health care organization and community to exchange ideas about health needs, program design and implementation
- review available community health assessment results and request additional data as needed
- review organizational strategic priority areas and recommend appropriate linkages between community benefits and clinical strategies
- identify available staff and monetary resources
- recommend continuation or elimination of current community benefit programs, based on program objectives and actual outcomes
- outline action steps, timelines, accountability and budget
- evaluate the process using quality-improvement principles
- develop and monitor implementation of the annual community benefit plan
- review the annual community benefit report, and use it as a framework for subsequent community benefit plans
A community benefit plan, usually produced in conjunction with the health care organization’s annual strategic plan, explicitly details how an organization intends to fulfill both its mission of community service and its charitable, tax-exempt purpose. It includes descriptions of community benefit priorities, programs, staffing, resources, evaluation procedures, anticipated outcomes, and the nature and extent of community involvement. This outline discusses the basic components of a written community benefit plan.

I. INTRODUCTION AND BACKGROUND

A. Health Care Organization: Description, Mission, Vision and Values

Include descriptive information that provides a snapshot of your organization for different audiences. Include, for example, location, bed size, number of employees, major service lines and history of community involvement.

State the organization’s mission, vision and value statements. If these statements do not express the organization’s commitment to serving identified community needs, describe the organization’s efforts to regularly review and revise principles of community benefit.

B. VHA Inc. Membership

VHA Inc., a network of leading community-owned health care organizations and their affiliated physicians, is recognized nationally as a leader in the field of community benefits. Mentions VHA membership in your community benefit plan establishes your organization as a community-minded health care organization that is responsive to identified community health needs and goals. Through shared knowledge and commitment, VHA builds strength to improve community health and achieve market success.

C. Target Communities and Populations

Explicitly defining the communities and populations targeted in your community benefit strategy gives your community benefit program boundaries, determines the data collected, and provides direction for choosing which community benefit projects are implemented. It also helps to identify community organizations that should be included in community benefit program planning and implementation. A clear definition of “community” prevents unfocused, ineffective interventions that try to be all things to all people. A community definition identifies target populations within specific geographic boundaries. Target communities and populations may include:

- a geopolitical subset (such as
neighborhood, township, census tract)

- ethnic or economic class group (such as Hispanic, poverty-level)
- gender- or age-specific
- disease-specific (such as persons with diabetes)

**D. Plan Development and Adoption**

Delineate the purpose of the plan, how it will be used, and how it is integrated with the organization’s overall strategic and operational plans. In particular, portray how the community benefit strategy links to clinical and operational strategies.

Describe the process used to gain participation from people within the organization, including the medical staff and line employees. Specifically state the role of the board of trustees in community benefit planning and implementation.

Outline the process used to elicit community participation in plan development. Describe the composition of a community advisory committee and its role.

Include a list of individuals, organizations and government officials who actively participated in developing the plan, and note participation by members of the target populations to be served by the plan, individuals who work with specific populations, local health and public officials, and other community providers. The list should reflect the community’s racial, cultural and ethnic makeup.

**II. ASSESSMENT OF COMMUNITY HEALTH NEEDS, GOALS AND ASSETS**

**A. Process**

Describe the dynamic, ongoing process used to identify and prioritize the community’s health needs, goals and assets. Specifically include:

- a review of previous or current assessments by other community groups
- partnerships with other community organizations and individuals in conducting the assessment
- data-collection methodology
- data-synthesis methodology
- process and criteria used to prioritize identified issues

**B. Identified Community Needs, Goals and Assets**

Summarize the quantitative and qualitative data gleaned from the community health assessment. Indicate which issues are being addressed in this plan, issues being addressed by others in the community, and which issues will be addressed in the future.

Describe the criteria used for selecting
focus areas and program activities. Explain the rationale for distinguishing between priorities rated most-important and those that should be addressed with programs first.

Identify the community’s role in identifying and mobilizing existing assets.

III. PROJECTS TO ADDRESS IDENTIFIED COMMUNITY NEEDS

A. Project Categories

Describe the projects that the health care organization intends to provide in the following year — either alone or in partnership with other community groups — to address the community health needs identified through the community health assessment. The list of programs should be categorized under the same topics that will be used in the annual Community Benefit Report.

Common reporting categories are:

- Community Education and Outreach
- Medical Education
- Subsidized Health Services
- Research
- Cash and In-kind Donations
- Community-Building Activities
- Government-Sponsored Health Care (Medicare, Medicaid and public health program shortfalls)

B. Project Description

Individual community benefit projects should be described on one page:

- project description
- contact person
- target population
- project aim
- measurable objectives
- overview and activity highlights
- community need
- annual budget/inputs
- funding sources
- staff
- evaluation methods
- timelines and accountability

IV. CHARITY CARE POLICIES

Include in the plan charity care policies and procedures for your entire organization. Describe how and where charity care is reported. Examples of charity care policies are included in the Resources and Tools Section.

V. EVALUATION

Describe the mechanism and process to evaluate the overall effectiveness of the community benefit plan, including
a procedure for soliciting community members’ comments. Show the operational structure that is in place to ensure quality-improvement and continuity.

VI. COMMITTED RESOURCES

Outline the budget committed for the organization’s overall community benefit program. The budget should cover financial and staffing resources for the organizational community benefit infrastructure as well as the total financial outlay for individual projects.

A Note on Foundation-Funded Community Benefits

Many health care organizations have separate 501c(3) foundations that raise funds. A foundation can support core hospital and health system operations and research, and it may fund community benefit projects. Aligning foundation activities with community benefits is an emerging strategy that demonstrates commitment to mission and advances business goals while improving community health.

The organization has a choice of developing one community benefit plan for both the health care organization and the foundation, or developing two community benefit plans. If two plans are developed, we recommend concurrent community benefit planning processes. This will engage health care organization and foundation leadership, board members and program staff members in a community benefit process that makes the most efficient use of resources, reduces duplication, and maximizes use of staff resources and financial allocations.

An example is VHA Partner Yakima Valley (Wash.) Memorial Hospital and the Memorial Foundation, recipients of the 1998 AHA Nova Award for innovative collaborative programs focused on community health status. Their Children’s Village project was a collaborative effort of the Yakima Valley Memorial Hospital and the Memorial Foundation to create single site family access to coordinated health, education, and social services for children with special health care needs and their families. Parallel community benefit planning, implementation and evaluation processes between the hospital vice president of Community Initiatives and the foundation president/chief executive officer is rooted in their desire to provide “benefits as a mission-driven community hospital.”

For more information on Yakima Valley Memorial Hospital and the Memorial Foundation, contact Gail Weaver, president of Community Initiatives, 509-574-5891 at gail.weaver@yvmh.org and Anne Caffery, president, Memorial Foundation at 509-576-5794, anne@memfound.org

VII. COMMUNITY BENEFIT REPORT/COMMUNICATION

Note when and how a community benefit report will be distributed to provide details of the current plan’s results and impact.
Describe other modes of communicating community benefit results to various audiences, including internal methods and broader community exposure.

VIII. CONCLUSION

Emphasize your organization’s continued commitment to community benefits. Highlight environmental trends, such as patient safety and quality, that are enhanced by community benefit initiatives, as well as financial returns on investment. Address identified needs not undertaken in this plan, and note steps for addressing these needs with others in the community at a future time. Provide phone, fax and e-mail information for a person who can answer questions and provide more information.
Merits and Considerations of Developing a Community Benefit Plan

Developing a systematic community benefit process and plan can be time-consuming and complex. Integrating community benefit planning into your organization’s strategic planning framework necessitates engagement of top executives and board leaders in your organization, as well as the ability to build internal capacity and “make the case” with your colleagues.

The following merits and considerations list may help you create talking points to communicate value and secure buy-in.

**Merits**

- positions community benefits as a systematic program vs. isolated projects
- raises awareness of community benefits both internally and externally
- rekindles passion for the organization’s mission
- provides a specific budget for community benefits
- engages internal constituencies
- aligns community benefit strategy with clinical strategies
- eliminates projects being “grandfathered in” by starting with new priorities each year
- fosters board of trustees involvement
- stimulates focus on annual planning and communication
- aligns planning with reporting community benefits
- provides opportunities to get the community more involved in dialogue

**Considerations**

- raises organizational and community expectations for which you may not have the capability to deliver
- elevates the debate on whether charity care satisfies community benefit responsibility
- forces resource allocations among community benefit projects, eliminates potentially needed programs
- leads to the elimination of some activities that staff members enjoy
- time-consuming to engage the community in decision-making
- positions your organization in a way that necessitates strategic diplomacy and political savvy
Examples from the Field

Clarian Health Partners, Indianapolis, Indiana

VHA Shareholder, Clarian Health Partners, located in Indianapolis, consists of three hospitals – Methodist, Indiana University and Riley Children’s Hospital. The system completes one community benefit plan for the system which is developed in accordance with Indiana’s General Assembly House Engrossed Act 1023.

Clarian’s Board Committee on values, ethics, social responsibility and pastoral services along with the Community Benefits Advisory Committee are key components of the communication network. These groups jointly provide the guidance for selecting community initiatives and for assuring they are represented in the Community Benefits Plan. Clarian then determines availability of resources and collaborative opportunities available to support the view of the group. The decision to develop and implement health initiatives is a partnership with input from the public agencies, private sector (community leaders) and the Clarian Board.

The Clarian Community Benefits Advisory Committee is a cross section of community leaders and medical personnel with a common goal of identifying health issues in the community that need to be addressed or supported. This group meets two times per year to discuss Clarian’s involvement in community health issues.

Community needs are identified through the Marion County Community Health Assessment, health initiatives from the state and other county health agencies and through established Clarian communication networks with non-profit agencies and board members.

Serving as a complement to the more formal needs assessment surveys and other activities, Community Plunges are made available to the Community Benefits Advisory Committee and Board members. Community Plunges are used as an effective way to find out “what’s going on out there” by participating in learning about the community at the grass roots level. The idea is to find the strengths in the community, to identify assets and opportunities for forming the linkages that will be essential to creating a healthier community.

For more information on Clarion Health’s community benefit process and plan, please contact Don Deutsch, director Health Promotions, Clarian Health Partners, (317) 962-6110, ddeutsch@clarian.org
Exempla Healthcare, Denver, Colorado

VHA Shareholder-controlled, Exempla Lutheran Medical Center and VHA Share-controlled, Exempla Saint Joseph Hospital, with 5,300 employees and 974 combined beds, provide a broad continuum of health care services including preventive, diagnostic, treatment and rehabilitation. Ambulatory through tertiary services are provided primarily to the Denver metropolitan community and surrounding counties.

The Board of Directors, Medical Executive Council and Senior Management collaborate to establish overall goals for Exempla Healthcare through a two-tiered approach. First the Integrated Strategic Plan summarizes multiple variables such as the organization’s mission, consideration of the community, and the current health care environment to assist in identifying critical strategies. Second, the strategies identified through the Integrated Strategic Planning Process are operationalized at all levels of the organization through the Balanced Scorecard. The four major areas of focus – patients and partners, employees and organizational development, internal structure and financial stewardship require balance in order to meet the needs and expectations of all stakeholders.

Planning programs and services to address community need is accomplished through an assessment and evaluation processes. Assessment of community need is accomplished through the following mechanisms: review of public health indicators, demographic data and census information; focus groups; and collaborations with multiple organizations and agencies.

Priorities and funding streams are identified annually, and are evaluated through customer satisfaction measurements, assessment of the program’s relationship to Exempla core services, assessment of the number of people impacted, public perception surveys, and availability of alternative resources in the community.

The Community Accountability Committee is a committee of the Exempla Board of Directors who helps assess community need and evaluates Exempla programs through its broad community representation. “Exempla has a deep interest in our surrounding community”, states Jeff Selberg, president and chief executive officer, “Through Exempla’s community benefit programs and partnerships, we hope to better the lives of our patients and the people of our communities. We want to better their lives by teaching them how to achieve a healthy lifestyle. We want to assist underserved women to take charge of their careers. We want to teach new fathers to care of their newborns. We want to give dignified and quality medical care to the medically underserved. We want to make a difference.”

A recipient of VHA’s 2001 Leadership Award Finalist in Community Health Improvement, Exempla’s community benefit programs demonstrate outstanding efforts to forge community health partnerships, base initiatives upon documented health needs, and achieve tangible health improvement outcomes for the community they serve. For example, the Baby Bootique program achieved outcomes of reducing the incidence of low birth weight babies born to medically underserved women by half, from 15.2 percent to 7.1 percent, in just two years.
Community Benefit Planning

Sustaining community benefit strategy in times of fiscal stress has been achieved through strong senior leadership, linkages with the foundation, alignment with the Balanced Scorecard, community partnership strategy, and community health care work force initiative that includes a welfare-to-work program. This initiative, called “Workstart” provides basic job-skills training, post employment support, and continuing vocational education for participants. Eligible candidates then apply for permanent positions with Exempla.

For more information on Exempla Healthcare’s community benefit strategy, please contact Sandy Cavanaugh, vice president of Community Development/Corporate Communications at (303)813-5335, cavanaugh@exempla.org. To access the Exempla Healthcare Community Benefit Report online, go to www.exempla.org/about/community/.
Ivinson Memorial Hospital, Laramie, Wyoming

VHA Partner Ivinson Memorial Hospital is an inaugural hospital of the national 1989 Hospital Community Benefit Demonstration project funded by the W.K. Kellogg Foundation, a member of the American Hospital Association’s national CCN rural community care network, and winner of the 2000 VHA Leadership Award in Community Health Improvement, hospital division. Ivinson understands that focusing on community health requires a local effort to improve health status through readily identifiable indicators, as well as a relationship between community partners to achieve measurable outcomes. Thomas Nord, former chief executive officer of Ivinson during these formative years, said, “The linkage that we feel is probably more important is within the community; that is, linking the hospital, the public health, the nursing homes, all the activities of the community — anything related to health or public service — through our community program.”

Located in the southeast corner of Wyoming, Ivinson is a 99-bed, not-for-profit facility. Ivinson coordinates Well Aware, a 40-member community committee that works to identify data sources, improve community health and accountability, and incorporate essential health services and risk sharing. Ivinson excels at engaging the community in making choices about health services. Programs involving ad hoc task forces include a physician/hospital task force, an employer task force, a community relations committee, a task force to work on the Wyoming Integrated Network, a suicide task force, and many others.

Ivinson’s board has a vision of continuous quality improvement and supports the community benefit planning, implementation and evaluation process. The annual community benefit plan identifies core initiatives, outcomes, objectives, target groups, programs and staffing resources.

For more information about Ivinson Memorial Hospital’s community benefit process and plan, contact Dee Bott at dee@ivinsonhospital.org or (307) 742-2141, ext. 5662; or Lynn Erickson at lynne@ivinsonhospital.org or (307) 742-2141, ext. 6289.
Magic Valley Regional Medical Center, Twin Falls, Idaho

VHA Partner, Magic Valley Regional Medical Center used the template provided in this briefing and added information on its Hospital of Promise Designation and three core strategic initiatives: service excellence, affiliations and regionalization. Its target population includes eight counties in South Central Idaho and parts of northern Nevada.

The organization’s plan is formulated by actively engaging the health care organization board’s Planning and Community Relations Committee, composed of board members, MVRMC staff members and physicians, and community leaders. This committee is the advisory board for aligning and evaluating the effectiveness of the organization’s strategic plan and community benefit plan. The group is also responsible for eliciting community input and participation.

The process used to identify and prioritize community health needs includes collection of shelf data, including reports from Idaho Vital Statistics; the youth and adult behavioral risk factor assessments; Kids Count; Safe Kids; United Way Needs Assessment; Search Institute data; and MVRMC patient system data, with emphasis on emergency department utilization. Community focus group input supplemented this information and was used to formulate priority issues for MVRMC to address in its community benefit plan.

Although many issues were prevalent in the community, Magic Valley focused on six main areas: coronary heart disease, child health, cancer, senior health, accidents and unintentional injury, and substance abuse.

Internally, the team conducted a comprehensive review of related, current programs and projects, including departments engaged as well as prospective projects for consideration. A priority list resulted, summarizing key 2002 strategies, objectives and actions. MVRMC’s four strategic objectives are to:

1. provide a systematic program for community benefit and community health improvement
2. demonstrate stewardship and accountability for MVRMC as a community resource
3. enhance the sustainability and effectiveness of the broader community health mission
4. link community benefit activities to strategic and operational plans

Objectives and actions clearly linked to the strategies were outlined in a written document that also included a grid of implementation steps, a timeline, responsible individuals and budget.

For more information about Magic Valley Regional Medical Center’s community benefit planning process, contact Rhonda Bright at (208) 737-2807.
VHA Shareholder-controlled, Massachusetts General Hospital, one of the founding institutions of Partners HealthCare, serves the metropolitan Boston area through its main campus and four health centers. An integrated part of Partners overall community benefit plan, MGH created community benefit advisory committees in Revere and Chelsea, two of its communities served by the 820-bed organization. The committees, comprised of representatives from local government, schools, the police force, the community and health and human service providers, was charged with identifying key community health concerns to address collaboratively.

Each committee spent approximately a year conducting a community health assessment. The assessments examined data on health status indicators from the Massachusetts Department of Public Health, city health departments, and other sources while gathering community input through public forum and informal surveys. As a result of this assessment, a comprehensive set of initiatives emerged designed to reduce family and community violence and to prevent substance abuse.

The assessment process is updated on a regular basis and is guided through a newly formed Community Benefit Advisory Committee comprised of key community and senior hospital leaders. There is also an annual presentation of the Community Benefit program to the hospital’s General Executive Committee, the senior leadership and decision-making body of the hospital.

In addition to the collaboration of the Revere and Chelsea communities, the MGH Community Benefit Program conducted a strategic planning effort. Initially, over fifteen key community and hospital leaders were interviewed. The results of the interviews indicated that to reinforce the link between community health improvement projects and hospital-based patient care, MGH should focus on the needs of underserved patients.

For example, it is a natural fit when working to prevent youth substance use in the community, to also examine how to deal with substance abuse among MGH patients in the inpatient and outpatient settings. The change can't all take place "out there," but rather has to be integrated and connected to overarching health system and community goals. This principle is predominant throughout Massachusetts General’s Community Benefit Program.

Finally, an imperative for any Community Benefit Program is to continuously evaluate the outcomes of programs by asking the question, "are we making a difference?" To that end, the Community Benefit program works with the MGH/Partners Institute of Health Policy that conducts evaluation and measurement of most of the programs.

For more information on Massachusetts General’s community benefit process and plan, please contact Joan Quinlan, Director Community Benefits, Massachusetts General Hospital, (617) 724-2763, jquinlan1@partners.org.
VHA Partner, Poudre Valley Hospital has an annual process to develop community benefit projects that align with core organizational priority areas. The hospital’s annual community benefit plan emphasizes development of effective health-promotion and disease-management projects in the areas of orthopedics, trauma services, cardiovascular, neurosciences, oncology, family health and mental health services.

The annual plan has two levels within each clinical area. Level 1 emphasizes prevention of disease and illness, and the hospital’s role in educational and awareness-building efforts. Level 2 focuses on active involvement in health maintenance and/or improvement of health, with an emphasis on community health education, advocacy and policy change.

For instance, in the area of trauma services, the following plan is outlined, including date of implementation and individual accountable.

**Level 1 – Prevention**

**Children**

1. Continue to use Strap and Snap Program, disseminating helmets to those who cannot afford to buy, and provide educational program to third graders on the importance of helmet use through the Kids Club.

2. Research promising projects to determine program to reduce the number of motor vehicle accidents for teens.

3. Incorporate “Reduce Intoxicated Driving/Smart Ride” programs into community, including fatal vision goggles and work with restaurants.

**Seniors**

1. Focus on fall reduction, including gait stability and vision issues.

2. Offer Tai Chi programs.

3. Conduct a sidewalk-safety program that includes bags of “Ice-Melt” given to seniors, with emphasis on homebound elders.

4. Offer the fall-prevention program through the Aspen Club annually.
5. Offer strength and flexibility classes.

6. Collaborate with the American Association of Retired Persons on its annual seniors’ forum.

7. Assemble travel display for businesses about safety and fall prevention.

**Level 2 – Intervention**

**Seniors**

1. Develop instructional program to teach seniors about fall prevention and walking safety, in particular the importance of picking up the feet and not shuffling.

2. Implement program in conjunction with discharge teaching of inpatients.

For more information about Poudre Valley Hospital’s community benefit planning process, contact Ruth Lytle-Barnaby, (970) 495-7512, rlb@libra.pvh.org.
VHA Shareholder, Scripps Health ties together in one document its annual Community Benefit report for the prior year and the current year’s Community Benefit plan. The report details the progress that Scripps has made in benefiting the community through its programs and lays out the plans for future action. The Scripps Center for Community Health and Advocacy subplan to the California Office of Statewide Planning and Development as a requirement of SB 697.

Scripps Health is a large system comprised of five hospitals, two convalescent centers, home health and an extended ambulatory care network. The organization developed the Center for Community Health and Advocacy to promote wellness, collaborate with others, partner with Scripps caregivers, foster volunteerism and advocate for public health policy. Acting as a consultative board to this Center, the Scripps Joint Boards Community Benefit Committee provides leadership in establishing criteria for selecting and endorsing community benefit programs. The committee involves community stakeholders representing various regions and population groups within the County including the CEO of the Council of Community Clinics, the Director of the Area Agency on Aging, the Dean of Nursing at San Diego State University and the CEO of Community Health Group.

The Community Benefit report/plan is a system wide document for the 12 facilities in the system. The report gives a summary of the health issues and health improvement activities carried out in each of six geographic regions. Through these programs Scripps seeks to improve the health of its patients and enhance the collective health and vitality of San Diego’s communities. In particular, Scripps seeks to support and protect the vulnerable or disadvantaged populations as an intrinsic part of the organization’s mission.

Each of the regions activities support the system’s overall community benefit program’s goals, priorities and objectives under the following strategies:

- region development and partnership
- partnering with Scripps’ caregivers
- strengthening community partnerships
- fostering volunteerism
- advocacy and public policy leadership

For more information on Scripps Health’s community benefit process and plan, please contact Rebekah Kramer, manager, Community Relations, (858) 678-7095 or kramer.rebehak@scrippshealth.org
St. Peter’s Hospital, Helena, Montana

VHA Partner, St. Peter’s Hospital is an independent, non-profit, 99-bed facility in the state capitol of Montana. It serves the 75,000 residents of the five-county service area surrounding Helena.

St. Peter’s Community Benefit Plan was developed to align with the organization’s strategic initiatives: physician’s and strategic partners, quality, culture formation, financial performance, and community accountability. It is also coordinated with the St. Peter’s Hospital of Promise program. The target audience is 75,000 residents of the five-county service area surrounding Helena.

The plan is developed by the Public Relations and Marketing Department using the template described in this workbook. A Community Relations Committee, an advisory group comprised of Board members and community leaders, provides guidance to the process, evaluates the effectiveness of the Hospital’s community benefit plan and elicits the community’s input. Approval of the plan is also required from the hospital’s Board of Directors.

The process used to identify and prioritize community health needs include compiling data from the Lewis & Clark County Health Profile, Helena Healthy Communities Health Report, and School District Health Risk Assessment. Community focus group input and survey information was used to prioritize issues to address in the community benefit plan.

For more information on the St. Peter’s Hospital community benefit process and plan, please contact Peggy Stebbins, (406) 444-2135 or pstebbins@stpetes.org.
VHA Shareholder, Sutter Health, a health care system with care centers in more than 100 northern California communities, includes 26 acute care hospitals, region-wide home health, hospice and occupational health networks, and long term care centers. Sutter Health has relationships with approximately 5,000 physicians, and has a work force of more than 35,000.

Sutter Health Central Services (Sutter Medical Center, Sacramento; Sutter Roseville Medical Center; Sutter Auburn Faith Hospital; and Sutter Davis Hospital) submits a Community Benefit Plan annually to the State of California, Office of Statewide Health and Planning Division. Every three years, Sutter Health Central collaborates with Catholic Healthcare West, Kaiser Permanente, University of California at Davis Health System and Marshall Hospital to produce a Community Needs Assessment. The Community Needs Assessment helps the community benefit committees for each affiliate identify the top community needs and then choose community-based efforts to address those needs.

The Community Benefit Plan has three components:

- A Findings report from the Community Needs Assessment.
- A Detailed description of the community benefit committee planning process for selecting and crafting programs and objectives to meet those needs.
- A Report on the objectives and programs listed in the previous Sutter Health Central Community Benefit Plan.

Funding for community benefit programs is available through a “request for proposal” process and subsequent grants from each of the Sutter Health Central affiliates’ Community Benefit Committees.

Continued funding is determined through an evaluation process as follows:

1. Review the Community Needs Rankings identified by the committee from the findings of the Community Needs Assessment.
2. Review each program’s ability to address one or more of the identified Community Needs Rankings.
3. Review each program’s ability to reach the established measurable objectives.
4. Evaluate the need for new programs or expansion of existing programs.
5. Determine the hospital’s annual level of support for community benefit programs.

For more information on Sutter Health’s community benefit process and plan, please contact Keri Thomas Cavner, Community Benefit Coordinator, Sutter Health Central, (916) 454-6697, thomask@sutterhealth.org.
A self-appraisal questionnaire can help you assess your health care organization’s stance as a community benefit provider and identify necessary actions to include in your community benefit plan. The questionnaire does not indicate whether your organization is “passing” or “failing,” but serves as a gauge to help set priorities and trigger action.

This short “yes or no” questionnaire can be completed as-is or used as a model for developing your own self-appraisal tool. It can be administered to multiple people within your organization to stimulate discussion as part of the planning process.

A. Explicit Process for Planning Community Benefits

1. Does your organization reflect its community benefits commitment in its:
   a. Mission statement?  
      Yes  No
   b. Vision statement?  
      Yes  No
   c. Values statement?  
      Yes  No

2. Are target communities and populations clearly defined?  
   Yes  No

3. Do community members regularly participate in planning and evaluating your community benefit programs?  
   Yes  No

4. Have you conducted or participated in an assessment to determine community assets, health goals and needs?  
   Yes  No

5. Does your organization have a dynamic, ongoing process to identify and prioritize action?  
   Yes  No

6. Do you have a written community benefits plan?  
   Yes  No

7. Is there a person(s) in your hospital or health system responsible for planning and monitoring community benefits?  
   Yes  No

8. Are community benefits given explicit consideration in the health care organization budget process?  
   Yes  No

9. Does your board give explicit consideration to community benefits?  
   Yes  No

   a. Does it receive and discuss a periodic report?  
      Yes  No

Resources and Tools

Self-Appraisal Questionnaire:  
How Do You Rate in Providing Community Benefits?
b. Does it discuss community benefits as a part of budget decisions?
   Yes  No

c. Has it adopted a set of community benefits standards?
   Yes  No

10. Do you have a regular process in place for assessing the impact and effectiveness of your community benefit programs?
   Yes  No

B. Awareness of Community Benefits

1. Do you know what your current community benefit activities are? Could you list them?
   Yes  No

2. Have your community benefits been documented (are they described and/or quantified in a written document)?
   Yes  No

   a. Community benefit reports?
      Yes  No

   b. IRS federal tax form 990?
      Yes  No

   c. Internal written communiqués?
      Yes  No

3. Could members of your organization describe what is meant by “community benefits” and describe major initiatives?
   Yes  No

   a. Board of trustees?
      Yes  No

   b. Senior management?
      Yes  No

   c. Employees?
      Yes  No

   d. Community volunteers?
      Yes  No

4. Would members of your staff agree that yours is a “community benefit” organization?
   Yes  No

5. Would the following groups agree that yours is a “community benefit” organization, and could they give explicit examples?
   a. Directors of major community organizations?
      Yes  No

   b. Local businesses?
      Yes  No

   c. Politicians?
      Yes  No

   d. Newspaper editors?
      Yes  No

   e. Radio and TV news editors?
      Yes  No

C. Health Care Organization Relationship to the Community

1. Do you believe that your hospital or health care system has a responsibility
Community Benefit Planning

for improving the health status of your community beyond providing on-site care and medically oriented services?  
Yes  No

2. Is your hospital or health system involved in partnerships or coalitions aimed at:
   a. Improving community health status?  
      Yes  No
   b. Other community improvements?  
      Yes  No

3. Is your health care organization engaged in service-delivery or educational efforts with other community organizations?  
   Yes  No

4. Do you have a process in place (other than your board) for obtaining input from the community on how well your health care organization is meeting its needs?  
   Yes  No

5. Do you regularly inform your community of your organization’s efforts to improve community wide health status and address other health-related issues?  
   Yes  No
The Perception Survey on Community Benefits can help you gain important insight on whether your organization is viewed as a community benefit organization. The survey can be given to employees, physicians, board members, community advisory and focus groups, official and grassroots community leaders, and other community representatives. The results can help you map communication messages and targeted constituencies as part of your community benefit plan.

Please circle the number for each question that comes closest to your perception of the health care organization. If you agree strongly, circle “1.” If you disagree strongly, circle “5.” Use other numbers to express opinions between these two extremes.

1. People who run this health care organization understand the health needs of the surrounding community.

   Agree 1 2 3 4 5
   Disagree

2. This organization is actively involved in efforts to improve the health status of the community.

   Agree 1 2 3 4 5
   Disagree

3. This institution contributes a great deal to its community in addition to caring for the sick.

   Agree 1 2 3 4 5
   Disagree

4. This health care organization works closely with other organizations in the community.

   Agree 1 2 3 4 5
   Disagree

5. People living in this community have a voice in how this organization responds to community needs.

   Agree 1 2 3 4 5
   Disagree

6. I am aware of many activities at this institution aimed at helping people in the community, beyond caring for the sick.

   Agree 1 2 3 4 5
   Disagree

7. This health care facility is an important part of this community — it would be hard to imagine the community without it.

   Agree 1 2 3 4 5
   Disagree
8. This organization is often involved with other organizations that are trying to solve community problems.

Agree Disagree
1 2 3 4 5

9. People who run this institution are interested in improving the overall health status of the community, beyond the medical care provided at the facility.

Agree Disagree
1 2 3 4 5

10. This health care organization is a leader in efforts to help the community with health and health-related programs.

Agree Disagree
1 2 3 4 5

11. This organization is known for helping to raise money for community activities other than inpatient hospital care.

Agree Disagree
1 2 3 4 5

12. People who run this organization seem to understand the problems of this community.

Agree Disagree
1 2 3 4 5

13. People who run this health care organization are concerned about the needs of low-income people and other community members who have special needs.

Agree Disagree
1 2 3 4 5

14. This health care organization is known for sponsoring volunteer activities in the community.

Agree Disagree
1 2 3 4 5

15. I can name at least five activities of this organization, in addition to providing quality medical care, that are aimed at improving the health status of the community.

Agree Disagree
1 2 3 4 5
Dear Patient:

St. Luke’s is a non-profit organization that has an “open door” policy. This policy means that we provide necessary basic hospital care to everyone, regardless of their ability to pay for their care.

To help patients who cannot pay their hospital bill, we have several employees who are trained to help you. They will confidentially review your situation to see if you might qualify for some form of government assistance, wish to establish some type of payment plan, (typically over a 12-month period) or be eligible for charity care.

So that our staff can help you in the best possible way, we urge you to call us at (208) 381-1425 to arrange a time to meet with one of our Financial Counselors, or stop by the hospital Business Office Patient/Financial Services during normal business hours.

In preparation for your visit, or if you cannot come to the hospital for this visit, please fill out the attached financial information form (Statement of Income and Expenses) and return it to us. This will help us begin to help you in the most appropriate way.

To help you more fully understand St. Luke’s philosophy regarding charity care and our “open door” policy, we suggest you read the attached documents entitled “St. Luke’s Free Care and Financial Assistance Process” and “Free Hospital Care: Guiding Principles of Understanding and Responsibilities.”

Sincerely,

Ed Dahlberg, President & CEO
St. Luke’s Regional Medical Center
General Guiding Principles

St. Luke’s Regional Medical Center uses a consistent process to consider an individual’s need for charity care based upon the inability of a patient to pay for their services or have their services covered by another payment source. General guidelines are utilized which take into account a person’s currently outstanding and/or anticipated expenses for routine medical services at St. Luke’s, as well as the total services that the patient may require, and the patient’s potential resources that could be applied towards reimbursement for services.

The Medical Center will assist patients in making a determination regarding whether or not the patient may be able to qualify for some form of entitlement through a governmental program. St. Luke’s expects the patient to assist in this determination and potential application process.

The application of charity care is not and cannot serve as a substitute for existing government entitlement or other assistance programs. When it is determined that the patient has minimal resources and cannot qualify for assistance from one of the entitlement programs, either total or partial charity is granted. However, in the event that an individual has significant assets, the hospital may secure its interest in those assets as appropriate.

Overview of Charity Eligibility Determination Process

An evaluation is made to see if an individual has the ability to pay off the account in a timeframe that meets the St. Luke’s guidelines. The hospital typically establishes payment plans of 12 months or less when feasible. However, an extended monthly payment plan will be considered based upon the level of account balance and available disposable income. Typically, payment levels below $15 a month and longer than 60 months, will not be considered.

Since each case involves many individual factors, the information gathering process is designed to allow the staff to obtain detailed information when making a charity recommendation to the Director of Patient Financial Services.

St. Luke’s does not process charity applications for persons who do not have current or anticipated accounts with St. Luke’s.
Community Benefit Planning

Process

1. Staff will work with individuals to gather the necessary information.
2. The applicant’s eligibility for government assistance or entitlement programs will be reviewed.
3. The income chart, contained in this guideline, disposable income computations, and the availability of other assets will all be used to help determine if the person qualifies for charity.
4. Charity care decisions will be made by the Director of Patient Financial Services to ensure, in so far as possible, consistency and continuity.
5. Generally, within two days of the receipt of all necessary information, the hospital will inform the applicant of any options that may exist for government assistance, payment plans, or charity care write-off. Once these options no longer exist, the hospital will inform the applicant of its charity decision.
6. With a significant change in circumstances individuals who are actively paying their accounts may re-apply for charity care write-off considerations.

General Income Guidelines

1. For accounts over $500, a household meeting the federal poverty guideline may qualify to have their bill written off as charity when:

- They are not able to qualify for any other assistance; and
- They have cooperated in attempting to qualify; and
- They do not have other resources to cover the bill

2. Medical center accounts under $500 will be considered for charity write-off on an individual basis considering the patient’s available resources.

Information used to Evaluate Determination of Charity

In order to fairly administer these guideline, applicants will be asked to provide and the hospital shall verify (when necessary) the following information:

- Types of services received or anticipated (i.e. is it a chronic condition that may qualify for other forms of Government assistance or other significant expenses anticipated?)
- What is the health condition necessitating treatment and is it medically necessary?
- What is the composition of the household – family size?
- What is the gross monthly income of the household and from what sources?
- What are the reasonable monthly expenses of the household?
- What kind of other resources/assets does the household have?
• Can the patient qualify for one of the assistance programs available in the community? (Coverage considered will include but not be limited to Medicaid, Medicaid via SSI, County Assistance.)

• Is there an opportunity for the patient to be covered by insurance that they are able to afford or have paid by an entitlement or other program? (i.e. Cobra or open enrollment)

Monthly household income is evaluated against the monthly expenses

In determining an individual’s ability to pay some or all of their bill and/or their eligibility for charity write-off, the following expenses will be reviewed: *

• Monthly rent or mortgage payments including space rent if appropriate.
• Additional housing expenses (i.e. property taxes and homeowners insurance)
• Utility costs – gas, electric, water, sewer, garbage, telephone, cable
• Transportation expenses – car payments, insurance, gas, maintenance, public transportation costs, parking fees.
• Educational expenses including children’s school expenses
• Grocery items
• Child support/alimony
• Medical expenses including health insurance, prescriptions, physician bills, necessary therapy
• Other established creditors and payments
• Allowance will be made for reasonable minimum living expenses for food and other basic living needs when appearing understated.

Other Assets/Resources

In considering other assets or resources which an individual might be able to apply to pay their bill, a review of the patient’s assets will be conducted. However, St. Luke’s Regional Medical Center will not expect that the following assets/resources be liquidated in order to qualify for charity care:

• Federally qualified Personal Retirement Funds of less than $50,000
• Sole residence
• Automobile(s) required to maintain family income.
• Savings or similar assets (i.e. CD’s, stocks, etc.) with a value of less than two months of federal poverty guideline income.

NOTE: Any funds being purposely diverted into one of these above noted assets, or in some other manner, will be subject to consideration.
2000 MONTH’S INCOME LIMITS

BASED ON FEDERAL POVERTY GUIDELINE
Effective March 2000 to 2001 FPG Change

<table>
<thead>
<tr>
<th>Family Size</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ 696</td>
</tr>
<tr>
<td>2</td>
<td>$ 938</td>
</tr>
<tr>
<td>3</td>
<td>$1,179</td>
</tr>
<tr>
<td>4</td>
<td>$1,421</td>
</tr>
<tr>
<td>5</td>
<td>$1,663</td>
</tr>
<tr>
<td>6</td>
<td>$1,904</td>
</tr>
<tr>
<td>7</td>
<td>$2,146</td>
</tr>
<tr>
<td>8</td>
<td>$2,388</td>
</tr>
<tr>
<td>9</td>
<td>$2,630</td>
</tr>
</tbody>
</table>

Each Additional Person +242
ST. LUKE’S FREE CARE and FINANCIAL ASSISTANCE PROCESS

The process to apply for free care from St. Luke’s is as easy as A-B-C:

As part of our non-profit mission, St. Luke’s provides free care to patients who are unable to afford to pay for medically necessary basic hospital care. Please contact our Patient Financial Services (billing) office for information about the options available to help with your hospital bill. Confidential information and assistance including language translation services are available with advance arrangements.

A) Please arrange a visit with a Financial Counselor in our Patient Financial Service office.

B) Our Financial Counselors will confidentially review your situation to see if you can qualify for some form of government or other financial assistance.

C) We will confidentially review your income and assets to determine your free care needs or whether other forms of assistance are available. We will provide you with a letter stating “you will not need to pay for your (recent or planned) hospital care”, if you cannot qualify for government assistance and we determine you qualify for free hospital care.

Please note: St. Luke’s can only provide free hospital services. You must arrange for other health services (such as physician care, dental care, eyeglasses or prescription drugs) with individual doctors or other non-profit or government agencies for those services.
References


Catholic Health Association of the United States. (314) 253-3458

- Community Benefit Planning: A Resource for Nonprofit Social Accountability. St. Louis, MO 2002
- Community Benefit Program: A Revised Process for Social Accountability. St. Louis, MO 2001


CBISA (Community Benefit Inventory for Social Accountability). Lyon Software. Sylvania, OH info@lyonsoftware.com

- CBISA Product Group. Social Accountability: Reporting Community Service [Computer program]. 1999


Massachusetts Hospital Association. Public Accountability Kit. 1995


VHA Inc., Irving, TX. Materials available to VHA members through vhastrategies@vha.com:  


• Community Accountability: Meeting the Challenge (1996)

• Community Health Assessment: A Process for Positive Change (1993)

• Community Health Improvement as a Bridge to Effective Population Management: Preparing for Medicaid/Medicare Managed Care (1997)

• Community Partnerships: Taking Charge of Change Through Partnership (1993)

• Determining the Value of Community Health Improvement (1997)

• Getting Started: Initiating Community Health Improvement in Your Organization (1994)

• Health Status Indicator Workbook: A Practical Guide to Using Health Status Indicators (1995)

• Improving Community Health: The Leadership Role (1995)

• Links to Community Health (1999)

• Measuring Program Outcomes: Evaluating the Impact of Community Health Improvement (2001)

• Realizing the Broader Vision: The Continuing Role of America’s Community-Owned Health Care Organizations (1996)

• Sustaining Community Health Improvement Initiatives: A Focus on Resource Development and Use

• The Evolution of Community Health Improvement Within Health Care Delivery Systems (1998)

• The Politics of Exemption: Tax Revenue Vs. Community Benefit-Not-for-Profit Hospitals Under Pressure (1999)

• Voluntary Standards: A Framework for Meeting Community Needs (1992)

VHA Mountain States.
• Community Benefit Reporting: 2001 Recommendations and Standard Definitions, Denver, CO 2001 cahelp@vha.com

• Messages and Strategies for Community-Owned Health Care Organizations: A Guide to Communicating Value. Denver, CO, 2001 cahelp@vha.com
