

BEYOND THE QUALITY AND STEWARDSHIP IN COMMUNITY BENEFIT NUMERICAL TALLY

Uniform Standards and Lessons from the Advancing the
State of the Art in Community Benefit Demonstration

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INTRODUCTION

What does the public expect from our nation's 2,900 nonprofit hospitals in return for providing exemptions from local, state and federal taxes? Policymakers, advocates and academicians have raised this question periodically over the last three decades, but our current economic crisis brings new urgency to the call for a definitive response. While the case has been made that there are important distinctions between nonprofit and investor-owned hospitals,¹ revelations in 2003² of aggressive billing and collection practices among some nonprofit hospitals created strong impetus for action by policymakers and advocates. More recent coverage of high profits among selected nonprofit hospitals³ and growing medical debt⁴ among consumers ensures continued public scrutiny.

The most closely examined measure of a nonprofit hospitals' accountability is the reported cost of charity medical care services

services provided to uninsured and underinsured populations. Attention to hospital expenditures on medical care for these populations has intensified as the number of uninsured has exceeded 47 million people. In 1969, the IRS expanded the legal parameters of charity for nonprofit hospitals to encompass a broader range of activities under the heading of “community benefit.” Included are not only charity medical services but also a wide range of services and activities that focus on improving health status and quality of life in local communities. While the focus to date in the policy and public arena remains limited to charity medical care provided in emergency room and inpatient settings, there is growing awareness that other measures are needed.

A September 2008 report from the Government Accountability Office cited an estimate by the Joint Committee on Taxation that nonprofit hospitals received approximately \$12.6 billion in federal, state, and local tax benefits in 2002. Senator Charles Grassley, Ranking Member of the Senate Finance Committee, requested this report, and he and Committee Chair Max Baucus indicated that they would introduce legislation in the coming session to increase nonprofit hospital accountability. State and local governments are also taking action, some by seeking payments in lieu of

DEFINING COMMUNITY BENEFIT

Community benefit was introduced in IRS Ruling 69-545 (1969) and defined in IRS Ruling 83-157 (1983) as “the promotion of health for a class of persons sufficiently large so the community as a whole benefits.” This definition represented an important step to encourage nonprofit hospitals to fulfill their charitable obligations through more proactive approaches to health improvement in local communities. Close reading of the language suggests important considerations relevant to ASACB and the larger goal of comprehensive health reform. The reference to a defined community suggests a population health orientation where geographic parameters are the unit of analysis, and one must determine the minimum size of the “class of persons” required to produce measurable improvement “for the community as a whole.”

taxes from nonprofit hospitals to help cover budget shortfalls caused by the economic crisis.

An important part of a sustainable economic recovery for the U.S. will be the development and implementation of comprehensive health reform. The continued rise in health care costs puts American companies at a competitive disadvantage with foreign companies. An important driver of these rising costs is a profoundly dysfunctional system of financing and delivery. More than 16 percent of our Gross Domestic Product is devoted to a system in which an increasingly large number of people have limited access. Incentives in the current system encourage spending on high-cost medical care rather than keeping communities healthy. Many of these expenditures could have been prevented with timely access to clinical

and community-based prevention. A recent report estimated the costs for preventable hospitalizations in 2004 at \$29 billion, approximately 10 percent of total hospital expenditures. The scope and scale of inefficiency and ineffectiveness, and its impact upon a growing number of Americans has contributed to a consensus that something must be done.

The central assertion of this brief is that nonprofit hospitals can play an important role in supporting the national health reform process through a more strategic approach to community benefit resource allocation. For too long, policymakers, regulators, and advocates have limited their focus to the numerical tally of charity medical services provided by these institutions, without consideration of the quality and cost-effectiveness

of their interventions, as well as the measurable outcomes that are produced. These considerations were a driving force in the design and implementation of a multi-state demonstration project entitled Advancing the State of the Art in Community Benefit (ASACB) that involved more than 70 nonprofit hospitals in California, Texas, Arizona and Nevada between 2002 and 2006. During that four-year period, partners developed, field tested and refined a set of uniform standards to enhance the quality of community benefit programming and build institution-wide accountability.

■ ASACB OVERVIEW

ASACB builds on the considerable contributions of national groups such as the Catholic Health Association of the United States, VHA, Inc., the Health Research and Educational Trust, and the Association for Community Health Improvement, and was informed by lessons from national initiatives such as the Hospital Community Benefit Standards Program and the Community Care Network Demonstration.¹⁰

The ASACB standards address two parallel but equally important functions: community benefit program design, implementation and evaluation, and institutional governance, management and operations. On the programming side, ASACB draws from public health

principles, with a strong emphasis on primary prevention, intersectoral engagement and community capacity building. On the institutional side, the standards focus on alignment of governance and management structures with the charitable mission of the hospital.

The central programmatic goal is to produce measurable improvements in health status through a more

significant cost savings in more proactive management of Medicaid^{12,13,14} Medicare¹⁵ and uninsured patients for ambulatory-care-sensitive conditions such as diabetes and asthma.

Moving in this direction reflects a commitment to move beyond the simple tallying of dollars for charity care to a focus on making optimal use of limited charitable resources; in essence, good

“It’s really all about engaging the community and investing what you can in the quality of life around you...what is most important is the quality of the investment...the result it achieves.”

John O’Brien, CEO, UMASS Memorial Health System

strategic and evidence-based allocation of charitable resources. The five ASACB Core Principles provide a framework to achieve this goal through more precise geographic targeting, collaborative engagement of diverse community stakeholders, and shared accountability for results. An important part of moving toward a more strategic approach involves reducing preventable emergency room and inpatient utilization for uninsured and underinsured populations.

These preventable hospitalizations disproportionately impact ethnic minorities such as African Americans and Latinos, and contribute to the perpetuation of health disparities.¹¹ A growing body of research documents

stewardship. In the process, nonprofit hospitals will build the capacity to apply population health principles with insured populations. This supports the larger goal of health reform through an ultimate shift to a financing model that gives providers and hospitals the incentive to improve health rather than simply fill hospital beds. As noted by Steve Barron, CEO of St. Bernardine Medical Center in San Bernardino, California:

“It just makes sense to spend proactive dollars on educational programs, partnerships with clinics, schools, and other organizations rather than spending reactive dollars through unnecessary visits to the emergency room, preventable admissions, or charity care that could

have been contained through an effective community benefit program.”

The central institutional goal of ASACB is to establish a governance infrastructure that increases accountability and a management function that is driven by a commitment to ongoing quality improvement. In the broadest terms, the intent is to de-marginalize the community benefit function. In many if not most nonprofit hospitals, the community benefit function — in essence, the fulfillment of the institution’s charitable mission — is carried out by a middle manager, with little attention at the senior staff and board level. The common result is a lack of objective analysis of quality and

for the benefit of the community to differentiate the tax exempt hospital from a for-profit operation.” In late 2004, the Senate Finance Committee called for an independent national panel on the nonprofit sector “to consider and recommend actions that will strengthen good governance, ethical conduct and effective practice of public charities and private foundations.”¹⁷ One of the panel’s recommendations calls for “strong and effective mechanisms to ensure that the board carries out its oversight functions and that board members are aware of their legal and ethical responsibilities in ensuring that the organization is governed properly.”¹⁸

The most important element in

participate, but in most cases, serve as ex officio (i.e., non-voting) members.

The establishment of this committee is driven by a practical reality. Given the range of complex issues addressed in the governance of modern hospitals, it is unrealistic to expect the board of trustees to provide the critical oversight needed to ensure optimal stewardship of charitable resources. In a 2008 study¹⁹ of nonprofit community health systems, CEOs report that their boards of trustees spend an average of 7.2 percent of their time on community benefit oversight. Even if they had the time, most boards of trustees lack the breadth of competencies needed to facilitate the optimal use of charitable resources.

“... By implementing consistent community benefit policies across different healthy systems and hospitals, we hope to demonstrate that a proactive approach to community health improvement is an important and tangible component of not-for-profit hospitals’ charitable commitment.” Lloyd Dean, CEO, Catholic Healthcare West

outcomes, minimal links with hospital operations, strategic planning, and clinical staff, and insufficient staffing support to ensure optimal stewardship.

In efforts to increase the accountability of nonprofit hospitals, federal officials have begun to examine the role of governance. As stated by then-IRS Commissioner Mark W. Everson in 2005,¹⁶ “More and more, the IRS looks to the independent board exercising its fiduciary duty to operate

the ASACB standards to strengthen governance is the establishment of a community benefit board committee. The committee is skills-based, rather than representational, with a focus on ensuring the breadth of competencies for informed decision making. While there is board representation, there is typically a majority of external community stakeholders. Selected senior staff members with appropriate competencies (including the CEO)

Boards of trustees establish a variety of committees to provide ongoing oversight for important functions. Ensuring optimal stewardship in the fulfillment of the charitable mission of the organization certainly qualifies as one of those important functions. A growing number of hospital leaders readily understand the value of taking this step, as reflected in the statement of Christopher Dawes, CEO of Lucile Packard Children’s Hospital at Stanford

in Palo Alto, California:

“Placing oversight responsibility for community benefit at the board level gives this function equal value as the fiduciary, quality assurance, policy direction, and other responsibilities of the board.”

■ ASACB CORE PRINCIPLES

The guiding framework for program design and oversight by the community benefit board committee is the five ASACB Core Principles. They are as follows:

Core Principle #1

Emphasis in Communities With Disproportionate Unmet Health-Related Needs (DUHN)

This Core Principle closely reflects the intent of the IRS community benefit definition. Any activity documented as a community benefit must ensure access for DUHN communities. In implementing this principle, a hospital must first define the geographic parameters of its charitable responsibilities (e.g., primary service area, city, county). Within those parameters, a variety of data can be used to determine which communities have disproportionate unmet health-related needs. Such communities might be zip codes, census tracts, or neighborhoods where there is a higher prevalence or acuity for a particular health concern than the general population within the larger geographic boundaries. In the absence of health data, proxy measures

TABLE 1: ASACB CORE PRINCIPLES

Emphasis in Communities With Disproportionate Unmet Health Needs
Emphasis on Primary Prevention
Build a Seamless Continuum of Care
Build Community Capacity
Collaborative Governance

(e.g., household income, employment, insurance coverage, ethnic/cultural composition) provide evidence that residents within these smaller areas are more likely to face health problems and/or have limited access to health care. Nonprofit hospitals then ensure access to community benefit activities through a variety of steps, including the development of targeted outreach strategies, coordinating the timing and location of services and activities, and ensuring that program content is relevant to specific needs and characteristics of population(s) and community(ies).

Core Principle #2

Emphasis on Primary Prevention

The intent of Core Principle #2 is to encourage proactive efforts to address the underlying causes of persistent health problems in DUHN communities. Ongoing engagement in this area is an essential component of reducing health care costs and achieving sustainable improvements in health status. Senior leadership understanding and commitment to address practical

challenges in DUHN communities is critically important, as reflected in the comment of Doug Hawthorne, president and CEO of Texas Health Resources:

“Most of our community benefit efforts target vulnerable populations who on a daily basis have many decisions to make regarding basic survival. As such, health care usually is not a priority. By addressing the underlying causes of persistent health problems, communities are in a better position to make healthier choices.”

There are three components to primary prevention: health promotion, disease prevention and health protection.²⁰ While it was likely the intent of the IRS to define health promotion more broadly, it is used more narrowly in public health to describe health education and social marketing, in essence, telling people to change their behavior. Disease prevention involves targeted interventions with people at risk for diseases; a common example is efforts to work with obese adolescents who are at risk for diabetes. The third component, health protection, is an

area where much more investment is needed in order to achieve sustainable improvements in health status and quality of life. It involves working in partnership with communities to address physical, social, economic and political obstacles to changes in behavior. Work at this level can range from community organizing and policy advocacy to direct action and problem solving with diverse stakeholders. In many cases, hospitals play a supportive rather than a central role, using their influence and visibility to facilitate the engagement of public and private sector partners. For example, ASACB partner St. Bernardine Medical

support systems. For example, ASACB partner Saint Francis Memorial Hospital in San Francisco, California, developed an expanded referral system with community clinics to provide discharged homeless patients with case management and transitional housing; CHW-Kern Service Area in Bakersfield, California, created a referral system with insurance providers to provide in-home preventive health education in DUHN communities; and Presbyterian Intercommunity Hospital in Whittier, California, establishes medical homes and provides primary prevention education for uninsured people as part

charitable resources²³ to mobilize and build upon what is already in place in local communities. This approach reinforces an ethic of shared accountability with community stakeholders, reduces duplication of effort, and increases the effectiveness and viability of community-based organizations (CBOs). To build community capacity, hospitals must first identify existing community “assets,” including CBOs, businesses, physical infrastructure, local coalitions, and the skills of individual community members. These assets can serve as sites for program activities, implement

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Center (CHW) collaborates with government officials and housing service providers to develop housing and social services for homeless people.

Core Principle #3 **Build a Seamless Continuum of Care**

This Core Principle calls for the development of evidence-based links between clinical services and community-based prevention. Building these links will help to reduce the demand for treatment of preventable illnesses and reduce re-admissions that result from medical discharges into communities with inadequate

of expanded mobile health services. Building an evidence base and support systems demonstrates to the provider community that strategic investment in prevention helps solve problems that emerge in the medical care delivery process. It is also important to build understanding of the value of hospital investment in primary prevention among external audiences, including federal agencies such as the IRS.²¹

Core Principle #4 **Build Community Capacity**

Community capacity building²² involves the strategic allocation of

important program components, and provide other sources of support to help achieve program objectives. For example, Lucile Packard Children’s Hospital at Stanford provided technical assistance to help establish a local community health center in East Palo Alto, secure legal status and federal funds, and expand the scope of services; and St. Jude Medical Center (SJHS) in Fullerton, California, provided resource development assistance and influence with funders to help a local obesity collaborative secure grant funding.

TABLE 2: ASACB INSTITUTIONAL POLICY MEASURES

1. Establish a board-level committee to provide oversight and policy guidance for all charitable services and activities supported by the hospital.
2. Specific roles and responsibilities of CB committee are clearly documented and used as guides for decision making.
3. Establish explicit guidelines for recruitment of members of CB committee that address competencies related to the Core Principles.
4. Establish explicit criteria and process used by CB committee and staff to select priority program areas of focus.
5. Establish formal mechanisms to integrate CB planning and budgeting with organizational strategic planning to ensure continuity and proactive investment.
6. Ensure that senior leader (e.g., president, CEO) is directly accountable for CB performance.
7. Establish a formal mechanism that requires periodic verbal and written staff report to trustees of progress towards identified measurable objectives.
8. Revise job description(s) to outline specific responsibilities and competencies needed for CB staff. Establish minimum 1 FTE dedicated time for ongoing CB management.
9. Include language in job description that gives CB managers the authority to make design changes in program activities to align with Core Principles.
10. Develop formal documentation to ensure that senior managers who supervise CB staff have appropriate competencies and support application of Core Principles.
11. Develop formal mechanisms to inform and encourage involvement of key leaders and employees.
12. Develop formal plans that outline strategies to be implemented for a minimum of three years.
13. Engage and leverage the expertise of local public health agencies and academic institutions.
14. Develop and document strategy to seek periodic input from diverse community stakeholders on proposed CB activities.

Core Principle #5 **Collaborative Governance**

This Core Principle emphasizes a collaborative approach to plan, implement and evaluate community benefit activities. In practical terms, community stakeholders are engaged as full partners with shared accountability for results. They have equal standing with the hospital regarding the design, direction and focus of a program. As such, they are invested in the success

and equally share the responsibility if the program is not successful. Collaborative governance operates at the programmatic and institutional policy level. Community stakeholders engaged at the program level bring content knowledge (e.g., asthma, violence prevention), and associated assets, and those engaged in an institutional policy role as members of the community benefit board committee bring a broader set of competencies

(e.g., epidemiology, local experience, inter-sectoral collaboration, program evaluation).

In applying the Core Principles, a number of ASACB hospitals developed formal written policies that apply to entire categories of community benefit activities. For example, St. Joseph Health System Sonoma County and St. Bernardine Medical Center²⁴ revised their community benefit grant programs by using the Core Principles as criteria in the application process, and Texas Health Resources developed a systemwide policy requiring alignment with the Core Principles for participation in community health fairs.

■ **ASACB INSTITUTIONAL POLICY MEASURES**

There are 14 *ASACB Institutional Policy Measures* to increase alignment, formalize commitment, and facilitate institution-wide engagement (see Table 2). Governance level (1-7) Institutional Policy Measures (IPMs) are to be documented as formal written policies by the board of trustees. Management and operations level IPMs (8-14) may be approved by senior management and adopted at the departmental level. The written policies and other relevant information are compiled as a formal policy manual to ensure institutional continuity. In the original ASACB demonstration, implementation of IPMs often involved simply the codification of informal practices

carried out by current staff members.

The first four IPMs focus on 1) the establishment of the board-level community benefit committee, 2) clarification of specific roles and responsibilities, 3) guidelines for committee recruitment, and 4) criteria and process for decision-making. These elements and other relevant information (e.g., terms of service, conflict of interest) are documented as a formal written charter, and reviewed and approved by the board of trustees.

The 5th IPM addresses the need for a formal written policy that outlines concrete steps taken to ensure alignment of community benefit budgeting and organizational strategic planning. The intent is to encourage proactive community benefit budgeting through mechanisms such as including a community benefit metric as an institution-wide strategic goal. Further reinforcement is provided by IPM #12, which calls for the development of minimum three-year plans for major community benefit programs.

The 6th IPM clarifies the need for CEO direct accountability for institutional community benefit performance. This is accomplished most often by adding explicit language to the CEO job description. A recent systemwide policy implemented by Catholic Healthcare West provides an

excellent example. The policy changes the title of hospital presidents to Service Area Leaders, reflecting a need to project an identity and responsibility that transcends the institutional walls. The job description also outlines the responsibility for a community benefit

community benefit managers to the board of trustees on progress towards achieving performance targets.

The 11th IPM calls for formal mechanisms that encourage institution-wide engagement. The general

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strategy that “addresses a broad range of factors that impact population health,” including “environment, social structure, resource distribution, etc., that contribute to poor health.” Senior leader accountability is also addressed in IPM #10, which calls for formal language that ensures alignment of the priorities of senior leaders who supervise community benefit staff with ASACB Core Principles.

The 8th and 9th IPMs address the need to ensure the breadth of competencies, dedicated staff time, and authority for community benefit managers to fulfill their responsibilities with attention to optimal quality. The 7th IPM calls for a formal policy requiring regular reporting from

expectation is that all administrative and clinical departments take tangible steps to help the hospital fulfill its charitable responsibilities. An excellent example is a systemwide policy by Texas Health Resources that encourages broad staff and physician engagement, and provides formal release time to support the achievement of specific community benefit program objectives.

The last two IPMs focus on relationships between nonprofit hospitals and external stakeholders. IPM #13 encourages the engagement of academic institutions and local public health agencies to secure their expertise on issues ranging from community engagement to program evaluation. IPM #14 calls for formal mechanisms to

solicit input from diverse community stakeholders on proposed community benefit programs and activities. This serves as an additional resource for input beyond the community benefit board committee.

■ SHIFTING THE PUBLIC DIALOGUE: ASACB AND HEALTH REFORM

In moving forward, a number of issues associated with the public expectations of nonprofit hospitals merit closer examination. First, it is important to acknowledge that nonprofit hospitals operate in an investor-owned environment, ranging from physician groups and insurance companies to pharmaceutical companies and medical equipment manufacturers. The driving imperative for these associated entities is profit maximization and quarterly returns.

purposes are generated primarily through cross-subsidization from commercially insured patients, and downward pressure on reimbursement in a competitive environment gradually but steadily reduces the volume of resources available for this purpose. In addition, significant variation in payer mix for hospitals in different communities dramatically reduces the profitability of those located in communities with high percentages of uninsured, and hence the ability to cross-subsidize medical care to serve these populations.

Third, it is important to understand some of the factors and dynamics that contribute to the current narrow focus on charity medical care services. Lawyers point to the articles of incorporation of hospitals as a legal justification for a narrow focus, and this bias is reinforced by a predilection

social justice issue, often with positive results at the regional and statewide level. Some advocacy efforts, however, tend to focus more on short-term tactical gain than long-term meaningful engagement. Public officials seeking political support from these advocates see considerable advantage and few risks in taking up the cudgel on their behalf.

Many advocates agree with the wisdom of taking a more strategic and proactive approach to health improvement that reduces the demand for medical care. The problem is that the argument for prevention is more complex, and hence more difficult to make, particularly in a public arena driven by 30-second sound bites. Prevention lacks the imagery to produce the visceral emotions that come with stories of individual tragedy caused by a lack of access to medical services. These individual stories of tragedy anchor

Moving in this direction reflects a commitment to move beyond the simple tallying of dollars for charity care to a focus on making optimal use of limited charitable resources, in essence, good stewardship.

Federal policies and exhortations from leaders in the public sector over the last three decades²⁵ have also encouraged nonprofit hospitals to embrace a competitive business model in the operation of their organizations.

Second, it is important to know that surplus revenue used for charitable

towards metrics that are easier to monitor and quantify. Advocates focus on medical care as the most immediate and often life-dependent need for individuals, and the urgency of these needs provides compelling evidence to demand action by policymakers. Labor has taken on community benefit as a

headline news articles, but are often framed only in medical terms, and lead us away from core health issues that have been neglected for far too long.

Fourth, addressing the underlying causes of health problems has historically been viewed as the responsibility of local public health

agencies. Unfortunately, due to a lack of funding, political influence, and a cultural reluctance to invest in prevention, local public health agencies have been unable to fulfill their broader population health mission. Where innovation has occurred, it is rarely sustained. Urban and rural public health agencies are particularly under-resourced and over-burdened. The lack of support to move beyond categorical services to more proactive, population health investments is a fundamental shortcoming that must be addressed through more definitive leadership in the policy arena. In the meantime, there is an opportunity to build capacity at the local level through a more collaborative approach to health improvement in which nonprofit hospitals play an important role, in partnership with local public health agencies and the full spectrum of diverse community stakeholders. This understanding and leadership is reflected in the statement by John O'Brien, president and CEO of the UMASS Memorial Health System:

“It happens that in our local market we are actually investing significant dollars these days because of underfunding of public health and other public programs. We’re stepping in to fill the void. It’s really all about engaging the community and investing what you can in the quality of life

around you...what is most important is the quality of the investment — the result it achieves.”²⁶

Experience in the implementation of ASACB standards is consistent with research suggesting that the most cost-effective and sustainable approach to community health improvement is achieved through broad engagement of diverse stakeholders and strategic leveraging of available resources. As persistent health problems in our

financial gains from reduction of per capita costs are shared among those who pay for care and those who can and should invest in further improvements.”

The integrator required for this shift is a “Pay for Population Health Performance System,” which goes beyond medical care to include financial incentives for the non-medical care determinants of population health. Taking these steps will require building consensus on population health

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communities are a product of many factors, strategies to improve health must both consider and accommodate such complexity and intervene at multiple levels.

In making the case for health reform, Don Berwick and his colleagues at the Institute for Healthcare Improvement²⁷ identify “three aims,” including: “1) improve individual experience of care, 2) improve health of populations, and 3) reduce per capita costs of care for populations.” An important feature in achieving the third aim is to implement “changes in payment such that the

measures and financial incentives, as well as the development of strategies for intersectoral coordination. Pay for performance must factor in challenges and costs of addressing the social determinants of health problems, to avoid disincentives for providers to serve residents in DUHN communities.

In his 1997 book,²⁸ David Kindig called for the establishment of a “Health Outcomes Trust,” an organization that with financial incentives to coordinate public and private sector resources (including social services, education, environment and public health) and

policies to improve health. His vision called for an external organization on equal footing with the medical care sector as a necessary dynamic to ensure a broader focus on health improvement. His proposed entity was a variation on the health promotion accountability regions (HPAR) proposed by Steve Shortell in 1992,²⁹ a state-level public/private system where reimbursement is driven by measurable improvements in health status at the population health level. Kindig acknowledged more recently that this idealized vision has not come to pass,³⁰ but the vision outlined by Berwick and his colleagues may represent movement in the right direction, one consistent with his own call for financial mechanisms between integrated delivery systems and health plans that reward measurable improvements in an index of health adjusted life expectancy (HALE).

The national implementation of the ASACB principles and practices led by visionary nonprofit hospitals and health systems will complement and facilitate movement towards a more integrated, cost-effective and sustainable approach to health care finance and delivery. Of equal importance, it provides an opportunity to advance a more definitive vision of the role of nonprofit hospitals in the 21st century. ASACB provides both the means and flexibility for hospitals and health systems across the country to play a leadership role in advancing this

transformational vision. ASACB partner Lloyd Dean, president and CEO of Catholic Healthcare West, describes this leadership role well:

“We understand that circumstances vary in different states and communities across the country, but we must become more unified in the clarity of our message, the consistency of our commitment, and the quality of our actions...By implementing consistent community benefit policies across different health systems and hospitals, we hope to demonstrate that a proactive approach to community health improvement is an important and tangible component of not-for-profit hospitals’ charitable commitment.”

■ MOVING FORWARD

The ASACB standards as well as implementation tools and an array of model policies and practices are available online on a Web site established by the Association for Community Health Improvement at www.ASACB.org. Since the end of the original demonstration in 2006, a growing number of hospitals and health systems are implementing the standards, and have made considerable strides towards achieving some of their initial goals. Some, such as Children’s Hospital of Boston, Provena Health System (Illinois) and Massachusetts General Hospital, have requested formal assessments to evaluate their implementation of ASACB standards and identify areas for further enhancement.

The Public Health Institute is currently in dialogue with funders and leading-edge hospitals and health systems across the country to develop a national dissemination and implementation strategy. Partnerships are also being formed with key organizational partners such as The Access Project, a national technical assistance resource for community and consumer advocates. For more information, please contact Kevin P. Barnett, Dr.P.H., M.C.P., Senior Investigator, Public Health Institute, at kevinpb@pacbell.net or 925-939-3417.

ENDNOTES & REFERENCES

- 1 See May 26, 2005, testimony to the House Ways and Means Committee by Mark Schlesinger and Bradford Gray for an extensive cataloging of comparative research on nonprofit and investor-owned hospitals which suggests that investor-owned hospitals are more likely to mark up prices over costs, make misleading claims, or terminate unprofitable service centers, and nonprofit hospitals are more likely to serve vulnerable populations with more complex medical needs, provide services for which payment systems have not been established, and conduct research and education activities that benefit the broader community.
- 2 In January 2003, the Connecticut Center for a New Economy released the report "Uncharitable: Yale New Haven Hospital's Charity Care and Collections Practices by Grace Rollins, which laid the groundwork for an article in the Wall Street Journal on March 13, 2003, entitled "Twenty Years and Still Paying" by Lucette Lagnano.
- 3 Carreyou, J., and Barbara Martinez, "Nonprofit Hospitals, Once for the Poor, Strike it Rich," Wall Street Journal, April 4, 2008.
- 4 Bennett, J., "The Other Credit Crunch," Newsweek, November 24, 2008.
- 5 U.S. Government Accounting Office GAO-08-880, "Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements," Report to the Ranking Member, Committee on Finance, U.S. Senate, September 2008.
- 6 A recent article in the Wisconsin State Journal (David Wahlberg, January 23, 2009) outlines actions taken by a number of municipalities in the state to demand funds from nonprofit hospitals whose documented charity medical care financial contributions fell short of the value of their estimated tax benefits.
- 7 With the exception of vertically integrated health systems like Kaiser Permanente.
- 8 Russo, Allison, et al, "Trends in Potentially Preventable Hospitalizations Among Adults and Children, 1997-2004," Statistical Brief #36, Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality, August 2007.
- 9 ASACB health system and hospital partners include Catholic Healthcare West (CHW), with 40 hospitals in California, Arizona, and Nevada; St. Joseph's Health System (SJHS), with 9 hospitals in California and 5 in Texas; Texas Health Resources (THR), with 13 hospitals in northern Texas; Hoag Memorial Hospital Presbyterian, an independent hospital located in Newport Beach, California; Lucile Packard Children's Hospital at Stanford, an independent hospital based in Palo Alto, California; and Presbyterian Intercommunity Hospital, an independent hospital based in Whittier, California.
- 10 Both national initiatives were funded by the W.K. Kellogg Foundation.
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- 12 Bindman, et al, "Preventable Hospitalizations Among MediCal Beneficiaries and the Uninsured," California Health Care Foundation, Primary Care Research Center, San Francisco General Hospital, University of California, San Francisco, 2007.
- 13 Falik, Marilyn, et al, "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers," Medical Care, 39(6), pp. 551-561, June 2001.
- 14 Basu, Jayasree, et al, "Managed Care and Preventable Hospitalization Among Medicaid Adults," Health Services Research, Vol. 39 (3), pp. 489-510, 2004.
- 15 Niefeld, M., et al, "Preventable Hospitalizations Among Elderly Medicare Beneficiaries With Type 2 Diabetes," Diabetes Care, Vol. 26, pp. 1281-1282.
- 16 Testimony before the House Ways and Means Committee, May 26, 2005.
- 17 September 22, 2004, letter from Senators Charles Grassley and Max Baucus to Diana Aviv, President and CEO of Independent Sector.
- 18 Panel on the Nonprofit Sector, "Strengthening Transparency, Governance, Accountability of Charitable Organizations," a final report to Congress and the Nonprofit Sector, June 2005, convened by Independent Sector.
- 19 Prybil, Lawrence, et al, "Governance in Nonprofit Community Health Systems: An Initial Report on CEO Perspectives," W.K. Kellogg Foundation and Grant Thornton LLP, February 2008.
- 20 Wallack, Lawrence, and Marilyn Winkleby, "Primary Prevention: A New Look at Basic Concepts," Social Science and Medicine, Vol. 25, No. 8, pp. 923-930, 1987.
- 21 The recent revised IRS Form 990, Schedule H for nonprofit hospitals uses the categorical framework developed by CHAUSA and VHI, Inc. (with substantial input from ASACB), but currently excludes the category entitled "community building," an important set of health protection activities that include the development of community support systems.
- 22 This concept is drawn from the research and fieldwork of John McKnight and John Kretzmann at Northwestern University. One of their many publications is the resource guide "Building Communities from the Inside Out: A Path Towards Finding and Mobilizing a Community's Assets," Center for Urban Affairs and Policy Research, Northwestern University, 1993.
- 23 Not only financial contributions, but staffing, equipment, technical assistance, and advocacy.
- 24 St. Bernardine Medical Center is part of Catholic Healthcare West, which has since revised the grants process on a systemwide basis.
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