CHA
Catholic Health Association of the United States

A Guide for Planning & Reporting Community Benefit

2022 Edition

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THE CATHOLIC HEALTH ASSOCIATION

Developed in collaboration with Vizient

CHA
Catholic Health Association of the United States

COMMUNITY BENEFIT

The Catholic Health Association of the United States advances the Catholic health ministry of the United States in caring for people and communities. Composed of more than 600 hospitals and 1,600 continuing care facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. Every day, more than one in seven patients in the United States are cared for in a Catholic hospital.

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About Us

The Catholic Health Association of the United States

The Catholic Health Association of the United States (CHA), founded in 1915, supports the Catholic health ministry's commitment to improve the health of communities and provide quality and compassionate health care.

CHA is recognized nationally as a leader in community benefit planning and reporting. In collaboration with member hospitals, health systems and others, CHA developed the first uniform standards for community benefit reporting by not-for-profit health care organizations. These standards were used by the Internal Revenue Service to develop Form 990, Schedule H for Hospitals.

www.chausa.org

Vizient

Vizient is a member-driven, health care performance improvement company committed to optimizing every interaction along the continuum of care. Vizient was founded in 2015 as the combination of VHA Inc., a national health care network of not-for-profit hospitals; the University HealthSystem Consortium, an alliance of the nation's leading academic medical centers; and Novation, the health care contracting company they jointly owned.

Vizient has a long track record of working to ensure that community-based, not-for-profit health care is supported. Congress, the White House and federal regulatory agencies, such as the Internal Revenue Service, regularly examine the merits of tax exemption for not-for-profit hospitals and look to ensure that exemption is justified by activities that provide meaningful benefits to their communities.

www.vizientinc.com

Foreword to the 2022 Edition

The COVID-19 pandemic has exposed the fragility of our communities' health. Historically marginalized and underserved communities have been especially vulnerable, experiencing disproportionate incidents of serious illness, deaths and financial hardship. For all of us in health care today, this has been a wake-up call.

This 2022 edition of *A Guide for Planning & Reporting Community Benefit* comes as America's Catholic and other not-for-profit health care organizations commit to achieving health equity and eliminating racial disparities. This edition of the *Guide* helps carry out that commitment.

The challenges of the COVID-19 pandemic have confirmed that the principles in this *Guide*, published first over 30 years ago, are more important than ever: that we must be truly present in our communities and work as equal partners to address needs. This means going to neighborhoods to witness how our neighbors work, learn and live; to work with them to know what is most needed and important to them; and to be strategic in addressing those needs. This edition reinforces the importance of including the social determinants of health in our assessments and implementation plans and incorporates what we have learned about listening to diverse community voices and working in partnership to address community disparities.

It is our pleasure and privilege to share this updated edition. The underlying philosophy of this edition continues to be that we work with communities to make them healthier and more resilient not because of laws or rules, but because it is the right thing to do and is what we have always done. Our communities need for us to do it well.

Sister Mary Haddad, RSM
President and Chief Executive Officer
The Catholic Health Association of the United States

Incorporating Equity into All Aspects of Community Benefit

"We cannot tolerate or turn a blind eye to racism and exclusion in any form."

POPE FRANCIS

The events of the last few years have shone a spotlight on the long-standing impacts of systemic racism on all aspects of our society, including the health of historically marginalized populations. As a result, we have seen organizations, businesses and government agencies across the country undertake programs to understand and address racism and disparities.

The Centers for Disease Prevention and Control has reported:

> A growing body of research shows that centuries of racism in this country has had a profound and negative impact on communities of color. …The data show that racial and ethnic minority groups, throughout the United States, experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts. Additionally, the life expectancy of non-Hispanic Black Americans is four years lower than that of White Americans. https://www.cdc.gov/healthequity/racism-disparities/index.html

Because of the importance and urgency of the problem, this 2022 edition of the *Guide* has been updated with what we have learned about health equity, disparities, and the social and environmental determinants of health in all aspects of community benefit and community health improvement programming.

The *Guide* calls on community benefit leaders and their colleagues to fully engage with our communities, to be present, to listen intently, to effectively partner with community members and to be accountable for their health equity efforts.

Being present involves developing long-term community relationships, encountering community members where they work and live. Listening means going beyond required three-year assessments. It calls for continually monitoring health, economic and social factors and demonstrating the organization is working with the community to act on these conditions and community concerns.

Incorporating Equity

"People closest to injustice are also those closest to the solutions to that injustice. Listen to people in your community. They have deployed survival tactics and strategies for decades — centuries, even."

https://www.aamc.org/trustworthiness

Addressing the complexities of health inequities is beyond the scope of any one organization or entity. To make a difference, we must work with community members whose voices have not been heard and who experience disparities. This *Guide* describes how we can work with diverse populations in all aspects of our community benefit framework. Here are some ways.

Building a Sustainable Infrastructure

- Establish a commitment to equity in critical documents, including mission and values statements, strategic and organizational plans, and policies.
- Work toward building diversity among community benefit staff, consultants and advisory bodies.
- Participate in coalitions with community organizations working with persons who experience disparities and discrimination.
- Allocate resources to addressing the social determinants of health and disparities.

Community Engagement

- Work with community groups and members to understand the history of discrimination and structural racism in the community.
- Assess current partnerships for diversity and whether they include cross-sector organizations and persons who experience disparities and discrimination.
- Assess and address any barriers to community engagement, such as past negative experiences with the organization and other trust issues.
- Hold meetings and conduct activities at times and places convenient to the community, and provide transportation and childcare if needed.

Assessment

- Gather data using culturally appropriate tools and methodologies that consider factors such as the population's language needs, literacy levels and trust of institutions.
- Collect and analyze data on health outcomes, risk behaviors and other factors impacting health by income, disability status, geography, and race and ethnicity.
- Involve community members in collecting and analyzing assessment information.
- Make assessment findings available to community members and groups who experience disparities, and request their feedback. Make sure to report back on actions taken and outcomes.

Planning

- Build on community strengths and assets, and value community expertise.
- Look at your existing programs: Are they addressing racial and ethnic disparities identified in the community?
- Develop implementation strategies collaboratively with community members who experience disparities, and get feedback from them to ensure services meet their stated needs.
- Consider factors that contribute to diverse populations' higher health risks and poorer outcomes, and revise implementation strategies if community demographics and circumstances change dramatically prior to the next assessment planning cycle.

Program Implementation

- Focus the implementation strategy on health disparities in the community, and ensure that programs and activities address health inequities.
- Collaborate with diverse community organizations to identify and address issues that might prevent programs from achieving desired impacts.
- Maximize the use of community health workers in assessment, planning, implementation and evaluation.
- Use advocacy to address laws and regulations that enable structural racism in the community.

Evaluation

- Engage stakeholders reflecting the diversity of the community in evaluation planning. Ensure that all stakeholder voices are heard when making judgments on how to improve programs or continue offering them.
- Incorporate health equity into evaluation goals, questions and design.
- Gather data using culturally appropriate tools and methodologies that consider factors such as the population's language needs and literacy levels.
- Look at the impact of interventions across different population groups.

Communications

- Use language that is accessible and meaningful to your audience, avoid jargon, and tailor communications to different populations.
- Look beyond traditional or commonly used methods of delivering content. For example, for younger populations, social media can be an effective communication tool.
- Work with trusted messengers in the community, such as places of worship or schools, to communicate content.
- Emphasize the value of ensuring that everyone has an equal opportunity for health care and that reducing disparities contributes to the common good and benefits all.

A core objective of the CDC's Healthy People 2030 initiative is to "eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all." For community benefit leaders, this is the essence of our work — the reason we work within our organizations and with community partners in pursuit of health equity. Our communities are healthier when all community members are healthy. Health equity is necessary for this to happen.

Terminology Related to Equity

When working on issues of equity and disparities, it is important for all involved to have the same understanding of commonly used terms. We are offering these definitions from the CDC to explain health equity and disparities. No one set of definitions is correct. What is important is to find definitions that work for your organization and community.

Health equity: Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally, with focused and ongoing societal efforts to address avoidable inequalities and historical and contemporary injustices and to eliminate health and health care disparities.

Health disparities: Health disparities are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental and geographic attributes.

Health inequalities: Health inequalities is a term sometimes used interchangeably with the term health disparities. It is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual- or group-specific attributes (e.g., income, education or race and ethnicity).

Health inequities: Health inequities are a subset of health inequalities that are modifiable, associated with social disadvantage and considered ethically unfair.

Social determinants of health: Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Source: *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*, National Center for Chronic Disease Prevention and Health Promotion, Division of Community Health, Centers for Disease Control and Prevention https://www.cdc.gov/nccdphp/dch/pdf/healthequityguide.pdf.

Resources on Equity

- *County Health Rankings & Roadmaps, Action Learning Guide: Develop Strategies to Promote Health & Equity,* University of Wisconsin Population Health Institute, https://www.countyhealthrankings.org/resources/action-learning-guide-develop-strategies-to-promote-health-equity
- *The Groundwater Approach: Building a Practical Understanding of Structural Racism,* Racial Equity Institute, https://www.racialequityinstitute.com/groundwaterapproach
- *Health Equity Guiding Principles for Inclusive Communication,* Centers for Disease Control and Prevention, https://www.cdc.gov/healthcommunication/Health_Equity.html
- *Health Equity in Healthy People 2030 Questions & Answers,* Office of Disease Prevention and Health Promotion, https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers
- *Levers of Transformation,* The American Hospital Association Institute for Diversity and Health Equity, https://equity.aha.org/the-six-levers-of-transformation and https://equity.aha.org/levers/community-collaboration-solutions
- *A Practitioner's Guide for Advancing Health Equity for Community Strategies for Preventing Chronic Disease,* National Center for Chronic Disease Prevention and Health Promotion, Division of Community Health, Centers for Disease Control and Prevention https://www.cdc.gov/nccdphp/dch/pdf/healthequityguide.pdf
- *Principles of Trustworthiness,* Association of American Medical Colleges https://www.aamchealthjustice.org/resources/trustworthiness-toolkit#principles
- *We Are Called: To Heal. To Unite. To Justice,* The Catholic Health Association of the United States https://www.chausa.org/cha-we-are-called
- *Working Principles for Health Justice and Racial Equity Organizational Self-Assessment,* The Praxis Project, https://www.thepraxisproject.org/resource/2020/principles-self-assessment

Executive Summary

The goal of this updated publication, *A Guide for Planning & Reporting Community Benefit*, is to help not-for-profit, mission-driven health care organizations develop, improve and accurately report on their community benefit programs.

More specifically, it will help organizations:

- Identify community health needs and plan to address those needs.
- Make prudent choices for using scarce resources and evaluate the impact of those resources.
- Understand the characteristics of programs and activities that are and are not reportable as community benefit.
- Budget proactively for community benefit programs and activities.
- Use standardized accounting and reporting approaches.
- Build and strengthen relationships in the community for community health improvement.
- Demonstrate accountability and transparency to their communities.

Providing community benefit demonstrates that not-for-profit health care organizations are fulfilling their mission of community service and meeting their charitable tax-exempt purpose.

In 1989, CHA published the *Social Accountability Budget*, which offered guidelines on how to inventory community benefit programs and services, assess community need, set priorities for community benefit planning, account for community benefit and tell the community benefit story.

Over the years, with the leadership of Catholic health care systems and the support of our partners and government and academic experts, these guidelines have been updated and refined to become a systematic and standardized approach to planning and reporting community benefit. They have been used as the basis for requirements in the Affordable Care Act's provisions for tax-exempt hospitals and by the Internal Revenue Service (IRS) for reporting community benefit on IRS Form 990, Schedule H for Hospitals (Schedule H).

Foundational Beliefs

The *Guide* is based on six foundational beliefs:

1. Those who live in poverty and are vulnerable have a moral priority for services.
2. Not-for-profit health care organizations have a responsibility to work toward improved health in the communities they serve.
3. Health care facilities should work collaboratively with community members, organizations and agencies in their community benefit programs to achieve shared goals for community health improvement.
4. Health care organizations must demonstrate the value of their community benefit programs.
5. A commitment to community health improvement should be reflected throughout health care organizations.
6. A leadership commitment is required for effective community benefit programs.

These foundational beliefs are fully described in the Introduction.

Essential Components

An effective community benefit program builds on the foundational beliefs and consists of several interrelated and essential components. These components of community benefit programs should be integrated with other key functions of the organization — governance, planning, budgeting, communications and clinical services. Board members, senior leaders and staff from throughout the organization should be informed of and involved in all aspects of the organization's community benefit program.

Getting Started

Health care organizations can begin to implement a more organized and strategic approach by understanding the definition of community benefit and the requirements associated with the tax-exempt status, conducting an inventory of current programs and policies, learning more about their communities and their needs, and developing partnerships inside and outside of their organizations.

Understanding What Counts and Does Not Count as Community Benefit

Defining community benefit and developing standard approaches to reporting are essential to program credibility. This *Guide* presents standard definitions and guidelines developed by community benefit, mission and finance leaders, and agreed upon by many national organizations and the IRS.

Building a Sustainable Infrastructure

Sustaining community benefit programs requires that health care organizations have a clear mission to serve their communities and have a community benefit program infrastructure. Maintaining this infrastructure includes building collaborative relationships with community members and organizations, securing adequate staffing and financial resources, and developing policies that are clearly understood and consistently practiced.

Accounting for Community Benefit

Standardized accounting ensures that financial reports of community benefit are credible, accurate and comparable to reports from other health care organizations.

Planning and Implementing Community Benefit

The planning and implementation of community benefit programs should be as rigorous and visible as planning for any other strategic initiative. It requires assessing community health needs and assets, identifying priority areas, and selecting appropriate interventions. Community benefit needs to be integrated into other organization planning and community efforts for health improvement.

Evaluating Community Benefit Programs

Evaluation is fundamental to understanding whether community benefit programs are making a difference. Drawing from program evaluation theory and practice from the field of public health, this *Guide* presents a framework to evaluate community benefit programs.

Communicating the Community Benefit Story

All phases of community benefit programs should be closely connected with an organization's communications program. Communications, finance and community benefit staff should work together to promote accountability and tell the community benefit story.

How to Use This Guide

This *Guide* is designed to help not-for-profit health systems, hospitals and other facilities develop and strengthen their community benefit programs, from initial budgeting and planning to evaluation and reporting.

This resource is primarily for staff who plan, develop and implement community benefit programs. However, in most organizations, the planning, implementation and reporting of community benefit involves many departments. This resource can be used by board and executive leaders, as well as staff, in mission, finance, organizational planning, population health management, communications, patient registration, patient advocacy, pastoral care, social services, and clinical and legal offices involved in community benefit and outreach.

The *Guide* is organized around the basic components in community benefit planning, implementation and reporting:

- Getting Started.
- Understanding What Counts and Does Not Count as Community Benefit.
- Building a Sustainable Infrastructure.
- Accounting for Community Benefit.
- Planning and Implementing Community Benefit Programs.
- Evaluating Community Benefit Programs.
- Communicating the Community Benefit Story.

These components are interdependent and are often conducted simultaneously. The *Guide* provides guidelines for each component based on the experiences and expertise of community benefit leaders and advice from public health experts. The guidelines should not be considered rigid instructions for carrying out a community benefit program. Rather, health care systems, hospitals and other facilities should adapt the guidelines to best meet the needs of the organizations and communities they serve.

These guidelines should not be considered legal advice. Health care organizations should consult the most recent guidance from their states and the IRS regarding required reporting of community benefit information and other relevant laws and regulations.

The appendices provide additional resources to help community benefit professionals plan and deliver effective community benefit programs. References to relevant appendices are provided throughout this resource. The appendices, sample materials and tools are also available in the community benefit section on CHA's website, https://www.chausa.org/guideresources, including an online resource that long-term care organizations can use to create a streamlined community benefit process that meets their needs.

Introduction

Foundations of Community Benefit

CHA broke new ground with its 1989 document, *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint.* That document provided, for the first time, guidelines for assessing community needs, planning and delivering unreimbursed clinical and community outreach services, and accounting for and reporting community benefit.

Since the *Social Accountability Budget* appeared, community benefit programs have evolved and improved:

- Community benefit programs have become increasingly professional, with recognized competencies, career tracks and authorities.
- Community benefit is the subject of federal and state requirements.
- Health care organizations have recognized their role in improving community health by working with public health and community health partners.
- Greater standardization in how community benefit is defined and valued has led to greater consistency in reporting. Software tools are now available to help with data management and accounting for community benefit.
- Experience has proven that every step of community benefit programming is enhanced by involvement, partnership and collaboration with community members and organizations.

Community benefit leaders in Catholic and other not-for-profit health care organizations have deepened their understanding of the mission, the accountability and the legal imperative of community benefit programs, and the basic beliefs upon which their programs have been built. These imperatives call us to both act and advocate for persons living in poverty, to seek out those in need, to provide health and preventive services that keep our communities healthy, and to advance knowledge that is of benefit to the public.

The Catholic Mission Imperative

Catholic health care has its origins in a faith-based response to the health needs of those living in poverty and other vulnerable persons. This follows the example of Jesus, who had special affection for the poor and others at the margins of society. In this country, Catholic health care began a mission of responding to community needs in 1727, when 12 Catholic sisters arrived in New Orleans to minister to persons who were ill or living in poverty.

The obligation to reach out to those in need and improve community health flows directly from Catholic health care's identity. Mission-driven organizations provide community benefit because they are committed to:

- Promoting and defending human dignity.
- Caring for persons living in poverty and vulnerable populations.
- Promoting the common good.
- Ensuring the effective stewardship of charitable resources.

Mission-driven organizations do not provide community benefit because of external pressures, such as challenges to tax-exempt status. They do it because it is right, because it arises from Catholic identity and because it ensures that they are who they say they are.

The Accountability Imperative

Before the *Social Accountability Budget* was released, few organizations reported their community benefit contributions. The idea of boasting about charitable activities was seen as inappropriate, with many recalling this Gospel message, "Take care not to perform righteous deeds in order that people may see them," in Matthew 6:1.

Reporting community benefit is not a boastful act but, rather, a duty because:

- Sponsoring organizations want to know that the early founders' tradition of serving those living in poverty and responding to community need is being continued.
- Board members and other volunteers want to know they are offering their services to organizations rooted in missions and values that guide their operations.
- Physicians and staff want to know they are part of an important community service, in which decisions and priorities are made according to what is best for persons in need and for the community at large.
- Local, state and federal government agencies want to know that the organization deserves preferential tax status.

The Legal Imperative

Not-for-profit health care organizations are exempt from paying federal income taxes because they fall into a category recognized by the federal tax code as charitable organizations. In a 1969 revenue ruling, the IRS concluded that hospitals can qualify as charitable if they engage in the promotion of health, which includes activities that benefit their communities.

Beginning with tax year 2008, tax-exempt hospitals have been required to file an IRS Form 990, Schedule H, to report their community benefit activities and other information related to tax exemption. With passage of the Affordable Care Act (ACA) in 2010, these organizations must also conduct CHNAs, develop implementation strategies, and meet other requirements related to financial assistance, billing and collections.

For information on federal and state tax exemption requirements, go to https://www.chausa.org/guideresources.

Foundational Beliefs

Community benefit programs are rooted in a core set of beliefs.

Those who live in poverty and are vulnerable have a moral priority for services.

While community benefit programs address the needs of the overall community, low-income and other disadvantaged individuals and families deserve special attention and priority. Therefore, programs designed to improve access to health care and improve the health and lives of low-income persons, and those who are marginalized, should be a top priority and be included in all community benefit services.

Not-for-profit health care has a responsibility to work toward improved health in the communities they serve.

While providing quality medical treatment to sick, injured and disabled persons is the major focus of today's highly sophisticated acute and long-term care facilities, another important role has been recognized: a responsibility to improve public health through a focus on health promotion and prevention. Community benefit programs rightly focus on the underlying causes of health problems, including the social determinants of health. Health care organizations should work with public health experts and others to address those problems, making the community a healthier place to live, work and raise families.

Health care facilities should work collaboratively with community members, organizations and agencies to achieve shared goals for community health improvement.

Collaboration is essential for effective community benefit programs. Health care organizations should seek the counsel and involvement, through board and advisory committee participation as well as ongoing dialogue, of recipients of services and community partners. These persons are front-line experts on what they want and need as well as how they will use services. These community members can *validate* the need for services, *implement* services collaboratively and help *assess* the outcome of those services. Collaboration also maximizes the use of available resources.

Health care organizations must demonstrate the value of their community programs.

In these times of limited financial and human resources, it is necessary to know whether community benefit programs are having the desired result and contributing to improved health in the community. If they are providing value, they are likely to gain funding and support. If they are not providing value, they should be reassessed, adjusted or canceled so that resources are used in more effective ways.

A commitment to community health improvement should be reflected throughout health care organizations.

Attention to improving community health should be integrated into core organizational functions, such as clinical services, patient financial services, communications, budgeting and planning. Staff throughout the organization should be involved in the community benefit program and understand their roles in improving community health. Strategic and operational plans should recognize community needs, and the community benefit plan should be integrated into other organization plans.

A leadership commitment is required for effective community benefit programs.

Community benefit programs need the active support of senior management and governing bodies. Boards, chief executive officers and senior managers should view access to health care, improved public health and the advancement of knowledge as important strategic initiatives. This commitment includes knowledge about community need, working collaboratively with other leaders in the community and being accountable for community health improvement.

Notes:

Chapter One: Getting Started

1

Chapter One: Getting Started

Planning and reporting community benefit requires a variety of skills and experience, much of it already present — and often untapped — within health care organizations.

Not-for-profit health care organizations have become more strategic and effective at using their resources to meet community needs. This is important due to demands for greater accountability and the recognition that the community benefit program, working collaboratively with community partners, can have a significant impact on community health.

In this chapter, you will learn how to do the following:

Guideline 1: Understand community benefit and requirements for tax-exempt hospitals.
Guideline 2: Establish responsibility and accountability for community benefit.
Guideline 3: Conduct an inventory of community benefit programs and activities and key policies.
Guideline 4: Understand your community and its needs and assets.
Guideline 5: Identify partnerships inside and outside of your organization.

Guideline 1
Understand community benefit and requirements for tax-exempt hospitals

It is critical for an organization's community benefit leader to have a very clear understanding of what constitutes community benefit and the requirements of hospital tax exemption. This understanding will affect every aspect of the leader's responsibilities, from assessing the community's needs and planning programs to accurately reporting community benefit information to government agencies and the larger community.

The founders of mission-driven health care organizations were called by their faith, values and civic duty to meet pressing health needs in their communities. Government recognizes the benefits that these charitable organizations provide and has granted them exemption from taxes so that those resources can be used to benefit the public. In return for this tax exemption, hospitals are expected to provide certain community benefits and meet other legal requirements.

At the federal level, community benefit is defined in the instructions for the IRS Form 990, Schedule H. This schedule is used to report a hospital's community benefit activities and other information related to tax-exemption. Schedule H is part of IRS Form 990, a form which nongovernmental tax-exempt health care organizations must file to report information about their charitable activities. Community benefit and tax exemption requirements also may be promulgated by state and local governments.

Schedule H defines community benefit as activities or programs that respond to community health needs and that seek to achieve one or more of the following objectives: improving access to health services, enhancing public health, advancing generalizable knowledge and relieving the government burden to improve health.

See Chapter 2, Guideline 1, for more information on how to determine if a service is a true community benefit.

In 2010, the ACA added new requirements for tax-exempt hospitals in the areas of the community health needs assessment (CHNA), the implementation strategy, billing and collections, and reporting. In 2014 the IRS issued final rules implementing these requirements. The goals of these provisions are to ensure that tax-exempt hospitals are meeting the health needs of their communities and that there is greater transparency and accountability.

See Chapter 5 for definitions of a CHNA and an implementation strategy.

For more information on federal and state tax-exemption requirements, IRS Form 990 and the ACA's provisions, visit the CHA website at https://www.chausa.org/guideresources.

Guideline 2
Establish responsibility and accountability for community benefit

An essential step in building an organized and sustainable community benefit program is to ensure that staff, executives and board members understand and embrace responsibility for community benefit and are committed to achieving community benefit objectives.

Appoint Staff and a Core Working Team

Community benefit management responsibility should be assigned to an established position. This position may be shared by more than one staff member, dependent upon the community benefit tasks assigned. Job qualifications should include a clear understanding of what constitutes community benefit, a basic knowledge of public health, program planning, finance, and implementation skills, and good collaboration skills. The person primarily responsible for community benefit should have a role in or report directly to senior management.

Responsibilities of the community benefit leader include the following: educating others in the organization about community benefit and tax-exemption requirements, conducting an inventory of current programs and activities, overseeing the planning and implementation of community benefit programs, understanding the community, and developing partnerships both inside and outside of the organization.

The community benefit leader also coordinates the organization's activities related to assessing community health needs, addressing priority community needs, evaluating program quality and effectiveness, and reporting community benefit.

See Chapter 3, Section 3.2, Guideline 1, for more information on the competencies needed by community benefit professionals.

WHEN YOU LACK RESOURCES FOR A FULL-TIME COMMUNITY BENEFIT LEADER

Organizations with fewer resources, such as small rural hospitals and long-term care organizations, may be unable to assign full-time staff to community benefit. Often, senior management or other staff may manage community benefit, among their other "hats."

Appoint a community benefit team. The team may include representatives from strategic planning, communications, government relations and advocacy, legal, finance and patient financial services, clinical or patient care, and executive leadership.

An initial role of the team will be to champion community benefit in the organization, to promote collaboration internally and externally, and to develop the plan for getting started.

This team can also help assess the current state of the organization's community benefit commitment by looking at its activities, policies and infrastructure and identifying ways to strengthen that commitment.

See Chapter 3, Section 3.2, Guideline 2, for more information on forming an internal community benefit workgroup.

Engage Executive Leaders

A successful community benefit program has the full support and backing of the executive team and is part of the strategic plan, so gaining executive commitment is an important step. It is also extremely helpful to have a community benefit champion among executive leadership who actively engages in efforts to sustain the organization's community benefit mission, such as raising awareness of community benefit, building relationships (internal and external) and aligning community benefit efforts across departments and groups.

If senior leaders are new to community benefit, plan an education process about what community benefit is, its importance and how it can be put into action.

For sample orientation presentations, visit the CHA website at https://www.chausa.org/guideresources and see the heading **Getting Started**.

Get the Board on Board

Ultimately, the governing board is responsible for ensuring that the tax-exempt organization's community benefit mission is fulfilled. While board members are selected on the basis of many talents and skills, their primary role is to ensure that the community's interest is paramount in all decisions.

The board, or an advisory group that reports to the board, should review and approve all major documents about community benefit, including financial assistance, billing and collections policies, the CHNA, the implementation strategy, the community benefit report and Schedule H. The IRS requires that financial assistance policies, the CHNA and the implementation strategy be approved by an authorized body of the hospital.

If the concept of community benefit is new to the board and other advisory groups, begin with an orientation.

For sample orientation presentations, visit the CHA website at https://www.chausa.org/guideresources and see the heading **Getting Started**.

Discussions or information sharing about community benefit should be a regular part of board meetings. For instance, board members could learn about successful programs, ask questions about whether to embark on a new program, discuss and weigh budgets for community benefit services versus other priorities, and receive evaluation findings. Board members also should see community benefit programs and services in action.

Also consider sharing information about community benefit with leaders of any related or affiliated organizations, such as the foundation board and any other key advisory groups on which board members and executive managers serve.

Guideline 3
Conduct an inventory of community benefit programs and activities and key policies

A community benefit inventory is a systematic identification of community benefit services being provided by your organization and community-benefit-related policies and procedures. It should begin with a clear understanding of the definition of community benefit and what should be reported.

See Chapter 2 for more information on what should be counted as community benefit.

How Detailed Should the Inventory Be?

The scope and amount of detail in the inventory will depend on what you hope to accomplish. If the goal is to take a broad look at programs and services to gain an understanding of what is currently happening across the organization, you may simply list all current programs and activities. If the goal is to have complete and comprehensive information about current programs to help make planning decisions or to develop a community benefit report, you will want to collect information on the numbers of persons served or other units of service, why the program was started, community partners, outcomes, and program costs and revenues.

Where Does the Information Come From?

Community benefit leaders often find themselves playing detective, uncovering little-known — sometimes even hidden — and usually unsung programs and services. Here are some suggestions for collecting information:

- Ask clinical and ancillary departments about any community services or outreach they provide. You could make a presentation at department meetings about community benefit and the importance of reporting and ask staff members to develop lists of services.

See Appendix A for a template that departments can use to list their community benefit services.

- Cast as wide a net as possible as you try to uncover community benefit programs and services. Include nursing, medicine, pharmacy, dietary, social services, education, research administration, community relations, pastoral care, and diversity and inclusion departments in this assessment.

- Interview key department heads and persons who are particularly involved in community service and outreach.
- Review grant applications and reports for research and other programs that are designed to benefit the community. These may be found in the foundation or finance office.
- Review newsletters and reports to the community for stories about community benefit activities.

What Services Should Be Included in the Inventory?

Collect information on the following community benefit services and activities.

See Chapter 2 and the Community Benefit Categories and Definitions reference in the Appendix for full descriptions and examples of community benefit programs and activities.

Financial assistance – Include free and discounted inpatient and outpatient care to persons who meet the eligibility criteria of your organization's financial assistance policies. Report the actual cost of the discounted services, not the charges that have been written off to financial assistance. Information about financial assistance can be obtained by finance and admissions offices.

Means-tested public programs – Include government health programs for low-income persons. Examples of such programs include:

- Medicaid.
- Other state or local health care programs for which consumers qualify on the basis of their means (income or assets), such as a state children's health insurance program.

See Chapter 4 for guidelines on how to account for these programs.

These programs, like financial assistance, are reported in terms of total and net cost, not on the basis of the difference between gross charges and payments. Information about means-tested public programs can be obtained by the finance office.

Community health improvement services – These activities are carried out to improve community health and include community health education, outreach and prevention services.Such services do not generate patient bills, although they may involve a nominal fee. Information about community health improvement services can be obtained from staff across the organization including communications, public relations, strategic planning, community outreach (if separate from community benefit), finance, and diversity and inclusion offices.

Health professions education – Include all educational programs the organization is involved with that result in degrees or necessary training to practice as a health professional. Information about health professions education can be obtained by medical and nursing education departments and academic and finance offices.

Subsidized health services – Include clinical services that are provided despite a financial loss (measured after removing losses from Medicaid, financial assistance and bad debt) because they meet a community need. Examples of subsidized services include mental health, substance abuse programs and burn units. Information about subsidized health services can be obtained by finance, strategic planning and medical staff offices.

Research – Include studies or investigations designed to generate knowledge that will be made available to the public. Studies funded by the government (such as the National Institutes of Health) and other tax-exempt entities (such as foundations or the organization itself) are reportable as community benefit. Industry-sponsored research that is intended for publication is not reportable as community benefit on Schedule H but may be described in Part VI of the form. Information about research can be obtained by clinical or research departments.

Cash and in-kind donations – Include contributions made by the organization that support community benefit activities provided by others. In-kind contributions include the cost of staff time and other nonmonetary resources donated for community benefit. Examples include finance staff helping a free clinic set up an accounting system, donation of needed medical or IT equipment to the free clinic, and donating the time of an employed physician to conduct physicals for people at a homeless shelter. Information about cash and in-kind donations can be obtained by various departments, including public relations and communications.

Community benefit operations – Include the cost of assigned staff, consultants and activities of the community benefit team, such as community assessments and program evaluations and community benefit planning. Information about community benefit operations can be obtained by community benefit or community health departments.

Community-building activities – These activities seek to address the root causes of health problems, such as discrimination, poverty, homelessness and environmental hazards. They include programs such as housing, economic development and environmental improvement. These activities are reported either as community health improvement in Part I or in Part II on Schedule H. Information about community-building activities can be obtained by various departments, executive office, planning, and public relations.

When the Inventory of Services Is Complete, the Next Steps Are To:

- Review activities to see if they meet the criteria for community benefit and should be counted and reported.

See Chapter 2 for guidelines on what counts and the Community Benefit Categories and Definitions reference in the Appendix for examples.

- Compare current activities with community needs.
- Look for whether some or all of the programs address racial and ethnic disparities.

See Chapter 5 for more information about CHNAs.

- Consider using software, such as Lyon Software's Community Benefit Inventory for Social Accountability, to track your community benefit activities and programs.

Visit https://www.lyonsoftware.com for more information.

- Report and celebrate your community benefit program.

See Chapter 7 for details about how to communicate information about your community benefit efforts to internal and external audiences.

- Brief senior leaders and the board about your progress and plans so that they can use the information for planning and budgeting.

Conduct an Inventory of Policies Related to Community Benefit

During the inventory process, review policies to assess how they support your organization's community service orientation and community benefit program.

Here are some policies you might want to review right away.

Mission and values statements – This review would include determining whether attention to community health and well-being is explicit in mission and value statements and whether these statements guide planning and operational decision-making.

Financial assistance and collection policies required by the Affordable Care Act – Review whether your policies meet all legal requirements, are clearly written and are widely available to the public. Make sure they provide reasonable eligibility criteria, a defined process for granting financial assistance and a respectful patient experience. Also review whether there is a plan for communicating financial assistance policies internally and externally.

Emergency medical care policies required by the Affordable Care Act – Review whether policies regarding providing care for emergency medical conditions regardless of an individual's ability to pay are in writing and meet all legal requirements.

Employee and physician policies – Review whether staff members and physicians are oriented on the organization's mission of community health improvement. Are employees incentivized, through time off or recognition, to provide community service (it should be noted that community service activities performed during time off are not reportable as community benefit)? Are physicians encouraged to serve uninsured or Medicaid patients and invited to participate in community benefit programs? Do job descriptions for key staff clearly state their community benefit responsibilities?

Community benefit policies – Review whether the organization has a community benefit policy that explains that it will work to improve health in the community, increase access to health care services, reduce disparities and achieve other community benefit objectives.

Board policies – Review whether policies explicitly describe the governing or advisory board's role in furthering community benefit and items that the board is legally required to approve.

See Chapter 3 for more information on policies related to community benefit, and see Appendix C for checklists that can be used to assess your organization's policies.

Guideline 4
Understand your community and its needs and assets

A deep understanding of the community served by the hospital should be the basis of all community benefit work. Find out how the organization defines its "community," the services that are being provided, the unmet needs and the assets on which you can build.

See Chapter 5 for more information about community assessments and related resources.

To get a general sense of your community, first find the results of the CHNA prepared either by your organization or with another community entity. Hospital CHNA reports must be publicly available. Assessments by other organizations may be available through the United Way, state or local health departments, or websites for other hospitals in the community.

Next, take a "walk and talk" approach.

Walk

Tour your community, even if you have lived and worked in the area for many years. Consider taking along a tour guide, such as a public or elected official, school principal, community organizer, social worker, police officer, or other persons knowledgeable about the community and its needs.

You may also want to take an "electronic tour" and tap into https://www.countyhealthrankings.org, https://www.cdc.gov/CommunityHealth or other data-rich sites for a scan of community health issues.

MISSION NOTE

At a Texas Catholic hospital founded more than 100 years ago by the ministry of three young sisters from France, staff periodically tour the community and ask themselves:

If those three sisters were here today, what would they see, and what would they do that we are not?

Talk

Interview people inside and outside of the organization who are knowledgeable about the community. This might include, among others:

Inside:

- Emergency department staff.
- Attending physicians.
- Discharge planners.
- Nurses.
- Social workers.
- Interpreter services staff.
- Strategic planners.
- Diversity and inclusion staff.

Outside:

- School officials and staff.
- Clergy.
- Community leaders.
- Public health officials.
- Community mental health officials.
- Area Agency on Aging staff.
- United Way staff.
- Clinic executive directors.
- Emergency responders, including emergency medical technicians and police.
- Representatives from groups working on issues of poverty and exclusion.

This process of talking to persons inside and outside of the organization will also help identify current and potential community benefit champions and partners.

In these initial efforts to understand the community and its health needs, make sure to learn about assets — persons, organizations or agencies that can help to meet those needs. This information can help identify potential partners for community benefit efforts.

Information on CHNAs is included in Chapter 5.

Guideline 5
Identify partnerships inside and outside of your organization

EQUITY NOTE

Partnerships and coalitions can help organizations amplify the often-unheard voices of populations most directly affected by health inequities.

- Engage partners from multiple fields and sectors that have a role in advancing health equity.
- Include partners working with population groups experiencing health inequities. Establish mechanisms to ensure new voices and perspectives are heard.
- Develop a common language among partners from different sectors and backgrounds.
- Acknowledge and manage turf issues.
- Recognize and address the power dynamics in a partnership.

For more information, see the CDC's *A Practitioner's Guide for Advancing Health Equity* at https://www.cdc.gov/nccdphp/dch/pdf/healthequityguide.pdf.

Successful community benefit programs involve collaboration both inside and outside of the organization. Partnerships expand the capacity of an individual department or the organization, maximizing impact and extending the reach of community benefit efforts.

Internal Partners

Planning and reporting community benefit requires a variety of skills and experience, much of it already present — and often untapped — within health care organizations.

Identify knowledgeable and interested coworkers who will champion and facilitate the work of the community benefit program. Some of these people will be part of your core team. Others will help in different ways.

When looking for internal partners, seek out representatives from:

- Executive leadership
- Finance and patient financial services
- Legal and compliance
- Communications and public relations
- Government relations and advocacy
- Strategic planning
- Population health, equity, and inclusion programs
- Foundation
- Community outreach
- Marketing
- Clinical services (e.g. the Emergency Department)

These coworkers can also play an important role in increasing awareness of community benefit throughout the organization.

See Chapter 3, Section 3.2, Guideline 2, for more information on community benefit internal workgroups and Chapter 5 for information on forming an assessment and planning workgroup.

External Partners

There are at least two potential (and probably overlapping) sources for identifying external partners.

First, scan the community benefit services inventory for current partners. With which groups or individuals is the organization already collaborating? These could include schools, social service organizations, physicians, community clinics and other providers.

Next, look for "natural partners" — that is, organizations and individuals who share common values and a mission and who are likely to be eager to help improve health and access to health in your community.

In addition to those already mentioned, consider community leaders, public health officials, parishes and other religious congregations, consumer groups, representatives of other government programs, and community-based organizations working with low-income or disadvantaged groups.

See Chapter 3, Section 3.2, Guideline 5, for more information on collaborating with community partners.

Conclusion: Next steps

At this point, staff has been assigned responsibility for community benefit, a core team has been named, and the organization's leaders are on a learning trajectory that will lead to a systematic and effective community benefit strategy.

You have a general idea of programs and activities that currently are underway and some of the policies that support community benefit. You have at least a beginning picture of your community's needs and assets. You have identified potential internal and external champions and partners.

It is now time to determine how to build and strengthen your organization's overall community benefit strategy and approach.

Chapter 3, Building a Sustainable Infrastructure, will provide guidelines for renewing commitment and putting in place basic structures. Chapter 5, Planning for Community Benefit, will help you plan the community benefit program by providing guidelines for doing a community assessment, setting priorities and developing plans.

Notes:

Chapter Two: Understanding What Counts and Does Not Count as Community Benefit

2

Chapter Two: Understanding What Counts and Does Not Count as Community Benefit

The guiding principle in determining a community benefit is that the activity or program responds to an identified community health need and is not provided primarily for organizational benefit.

Over the last 25 years, CHA and others in the field of community benefit have worked to create standard definitions and categories for community benefit programs and activities. Parts I and II of the IRS Form 990, Schedule H, are based on the community benefit definitions and categories developed by CHA and its partners.

The use of standard definitions and categories has many benefits:

- Helps organizations identify what activities and programs are and are not considered community benefit.
- Allows organizations and oversight agencies to reliably assess activities over time.
- Improves comparability across organizations.
- Allows health care systems to consolidate and report on community benefit amounts reliably.
- Improves the integrity of reported numbers, both internally and externally.

In this chapter, you will learn how to do the following:

Guideline 1: Determine if a program or activity is a true community benefit.
Guideline 2: Determine the programs that should not be counted and reported as community benefit.
Guideline 3: Distinguish programs and services for persons living in poverty from those for the broader community.
Guideline 4: Categorize community benefit programs and activities.

The guidelines in this chapter are recommendations only. They are not legal advice. Be sure to check the most recent requirements from your state and the IRS regarding the reporting of community benefit information.

Guideline 1
Determine if a program or activity is a true community benefit

Community benefits are programs or activities that provide treatment or promote health and healing in response to identified community health needs and meet at least one of these community benefit objectives:

- Improve access to health services.
- Enhance public health.
- Advance increased general knowledge.
- Relieve the burden on government to improve health.

This includes activities or programs that do the following.

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial or cultural barriers to accessing health services.
- Address federal, state or local public health priorities, such as eliminating disparities in access to health care services or disparities in health status among different populations.
- Leverage or enhance public health department activities, such as childhood immunization efforts.
- Strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies.
- Become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

The following section provides guidance on how to determine whether a program or activity is addressing a community health need and meets one or more community benefit objectives.

Community Need

The instructions for IRS Form 990, Schedule H, state that community health needs can be demonstrated through one of the following:

- A CHNA developed or accessed by the organization.
- Documentation that demonstrates community need or a request from a public agency or community group as the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

KEEP RECORDS ON THE NEEDS THAT DRIVE PROGRAMS

Records should document the community health need that the program seeks to address. This information can help to identify whether programs offer true community benefit and help tell the community benefit story. Check with your organization's tax, legal or finance departments for policies regarding maintaining and retaining records.

Community Benefit Objectives

In addition to addressing a community health need, a community benefit program or activity must meet at least one community benefit **objective.**

Improve access to health care services — demonstrated when at least one of these criteria is met:

- The participants include underserved persons.
- The program reduces or eliminates a barrier to access.
- The program is available broadly to the public and not only to insured persons and patients.
- The community would lose access to a needed service if the program ceased to exist.

Enhance public health — demonstrated when at least one of these criteria is met:

- The program is designed around public health goals or initiatives, such as eliminating health disparities or achieving goals described in *Healthy People 2030, The National Prevention Strategy* or similar publications.
- The program yields measurable improvements in health status.
- The community's health status would decline if the program ceased to exist.
- A public health agency provides comparable services. (However, a community benefit program should not unnecessarily duplicate or compete with a public program.)
- The program is operated in collaboration with public health partners.

Advance increased medical knowledge — demonstrated when these criteria are met:

- The program results in a degree, certificate or training that is needed to practice as a health professional.
- The organization does not require trainees to work for the organization after completing training.
- Health professional continuing education programs are open to professionals in the community, not exclusively for the organization's employees and physicians.
- The program involves health-related research that is funded by a tax-exempt source (e.g., the National Institutes of Health, a foundation or the organization itself) and that is intended to be made publicly available and to be useful to other providers.

Relieve the burden on government to improve health — demonstrated when at least one of these criteria is met:

- The program or activity relieves a government financial or programmatic burden for improving community health or for providing access to care for vulnerable or medically underserved persons.
- The government provides the same or a similar service (e.g., immunizations or Medicaid enrollment services).
- The government provides financial support of the activity (e.g., funding from the CDC).
- The health-related cost to government or another tax-exempt organization would increase if the program ceased to exist.

Guideline 2
Determine what programs should not be counted and reported as community benefit

Reporting programs that are clearly not community benefit or are questionable can jeopardize the credibility of the health care organization's community benefit report and undermine its community benefit efforts and the organization's tax-exempt status.

Do not report programs and services as community benefit under the following circumstances:

- The program is provided primarily for marketing purposes (e.g., a seminar on hip replacements to motivate patients needing surgery to choose the hospital for the procedure).
- The program benefits the organization more than the community (e.g., a flu clinic available only to the hospital's employees designed to reduce absenteeism).
- An objective, "prudent layperson" would question whether the program truly benefits the community (e.g., a health fair located in or proximate to an upscale shopping mall).
- The program or contribution is unrelated to health or the organization's mission (e.g., donating a scoreboard to a local high school).
- The program represents a community benefit provided by another entity or individual (e.g., activities performed by employees on their own time).
- The program only serves the hospital's patients post-discharge and has return on investment to the hospital as its primary purpose (e.g., targeted case management available exclusively to recently discharged patients and designed to reduce readmissions penalties).
- The program is targeted only to the organization's "covered lives," or individuals for whom the organization bears financial risk (e.g., a community health worker who visits only individuals who represent covered lives in an Accountable Care Organization (ACO) affiliated with the organization).
- Access to the program is restricted to hospital employees or physicians (e.g., education program available only to your medical staff or emergency funds for employees and their families).

- The activity represents a normal "cost of doing business," is associated with the current standard of care, or is required for licensure or accreditation (e.g., staff development activities, such as training and facility licensure, or accreditation requirements, such as routine discharge planning or translation services, provided at levels designed to meet minimum regulatory requirements).

Additional questions that may help determine whether a program is a community benefit or primarily represents organizational benefit include:

- Is there a cost to the organization, and can the expense for the activity be found in the organization's financial statements (e.g., the Statement of Functional Expenses on IRS Form 990, Part IX)?
- Is the activity designed to address an identified community health need?
- Will the activity produce a measurable health outcome?
- Is the activity accessible to uninsured and low-income persons?

A RESOURCE FOR DETERMINING WHAT COUNTS AS COMMUNITY BENEFIT

Visit CHA's website at https://www.chausa.org/whatcounts for questions that have been raised and recommendations for whether and how to report community benefit.

See Appendix B for examples of activities or programs that should and should not be reported as community benefit.

IRS

IRS NOTE

The instructions for Schedule H give guidance as to what cannot be reported as community benefit:

"Activities or programs cannot be reported if they are provided primarily for marketing purposes and the program is more beneficial to the organization than to the community. For example, if the activity or program is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization)."

Guideline 3
Distinguish programs and services for persons living in poverty from those for the broader community

When planning and reporting community benefit, some organizations separate programs and activities that assist low-income persons from those directed to the broader community. This is especially important for organizations that have a mission to serve low-income and other vulnerable persons so that the organizations can demonstrate they are living that mission.

Programs for Persons Living in Poverty

To determine who is considered a low-income or medically indigent person, a commonly used income benchmark is 200 percent of the federal poverty level (https://www.aspe.hhs.gov/poverty-guidelines).

Community benefit programs designed to reach persons living in poverty may include one or more of the following characteristics:

- Most program users are in households that would qualify for financial assistance under your organization's financial assistance policy or other means-tested public programs.
- Most program users cannot afford needed health care services.

- Most program users are uninsured or underinsured persons, or experience barriers accessing health care.
- Most program users are beneficiaries of Medicaid or state or local programs for medically indigent persons.
- The program is intended to reduce health problems caused by or related to poverty.
- The program is physically located in and draws most of its participants from an area known as low income or identified as a medically underserved area (MUA) or a health professional shortage area (HPSA). Visit https://www.muafind.hrsa.gov/ to find information on MUAs, HPSAs and medically underserved populations.

Programs for the Broader Community

Programs for the broader community are not focused on specific, low-income population groups and are aimed at improving the health and welfare of everyone living in the community.

Programs offered to the broader community should always be accessible to and involve outreach for low-income and other vulnerable persons.

Guideline 4
Categorize community benefit programs and activities

Standardized categories enable uniform reporting so that community benefit can be reliably reported internally and externally. This allows health systems to consolidate community benefit amounts and improves comparability among organizations.

See Community Benefit Categories and Definitions in the appendix for a comprehensive list of community benefit services.

ACCOUNTING FOR COMMUNITY BENEFIT

Refer to Chapter 4, Accounting for Community Benefit, for guidelines on how to account for and report expenses in each category of community benefit.

Categories of Community Benefit

Refer to the instructions for Schedule H for IRS definitions of these categories. The instructions can be accessed at https://www.irs.gov and on the CHA website at https://www.chausa.org/form990.

Financial Assistance

Financial assistance (charity care) is free or discounted health services provided to persons who cannot afford to pay all or portions of their medical bills and who meet the criteria specified in the organization's financial assistance policy.

Financial assistance is to be reported in terms of costs, not charges. Financial assistance does not include bad debt, which may be reported in Part III of Schedule H but not as community benefit. Financial assistance also does not include prompt-payment discounts or self-pay discounts made available to all uninsured patients regardless of income.

Unpaid co-pays for Medicaid and other low-income patients (e.g., those covered by health insurance purchased on https://www.healthcare.gov) can be reported as financial assistance if so specified in the organization's financial assistance policy. Patients in these circumstances are referred to as "underinsured."

REVIEW FINANCIAL ASSISTANCE POLICIES

Be sure your organization's policies are consistently applied, comply with federal and state requirements (including relevant provisions in 501(r) of the Internal Revenue Code), and allow sufficient flexibility to grant assistance for all persons unable to pay, even in the absence of complete information about their household means.

See Chapter 4 for additional recommendations.

Medicaid and Other Means-Tested Public Programs

Government-sponsored (public) means-tested programs have eligibility requirements tied to the recipient's income and assets.

Means-tested public programs may include:

- Medicaid.
- Other means-tested government programs, including:
  - State Children's Health Insurance Programs (SCHIP).
  - Local and state government programs for low-income persons not eligible for Medicaid.

Means-tested public program revenues and costs are reported in terms of total and net expense (with "net community benefit expense" determined by subtracting net patient revenue from total expense).

MEDICARE SHOULD NOT BE REPORTED AS COMMUNITY BENEFIT

Medicare is not a means-tested program and thus is not included in this category of community benefit. Medicare-funded programs are reportable as subsidized health services and in the health professions education and research categories. Other Medicare revenues and costs may be reported on Parts III and VI of Schedule H but not as community benefit.

Community Health Improvement Services

These activities are carried out to improve community health. Community health improvement activities do not generate inpatient or outpatient bills, although they may involve a nominal fee (e.g., $5 payment for flu shots provided in a community setting).

Community health improvement activities may not be counted as community benefit if they are available only to individuals affiliated with the organization (e.g., employees and members of the medical staff).

Examples of community health improvement services include:

- Community health education outreach, such as:
  - Classes or lectures on disease conditions.
  - Support groups that go beyond the current standard of care.
  - Self-help programs for persons and families facing health problems.
- Community-based clinical services for which there is no patient bill, including:
  - Screenings.
  - One-time or occasionally held clinics.
- Health care support services, such as:
  - Enrollment assistance for health insurance through the health insurance marketplace, Medicaid and other means-tested government-funded health programs.
  - The cost of software tools that support decision-making for granting financial assistance, if these tools are applied at the beginning of the patient experience

or revenue cycle rather than at the end of the revenue cycle (e.g., as a means of reclassifying bad debt write-offs into financial assistance).

- Information and referral, but not exclusively to the organization or its affiliated physicians.
- Transportation to improve access for low-income persons to health care in the community and not for the purpose of increasing referrals to the organization or its affiliated physicians.

- Social and environmental improvement activities, such as:
  - Removing materials, such as asbestos and lead, that harm residents in public housing.
  - Working to improve the availability of fresh fruits and vegetables in areas known as "food deserts."
  - Preventing violence.

See community-building category definition later in this chapter for more guidance on what types of community-building activities may count as community health improvement.

POST-DISCHARGE CARE AND COMMUNITY BENEFIT

Do not report routine discharge planning and most chronic disease and care management services (such as home visits or calls) for persons who have been hospitalized when those services are in follow-up to the hospitalization. Do not report services when the primary purpose of the service is to benefit the hospital organization, such as cost reduction or penalty avoidance.

However, in the following circumstances, chronic disease and care management services (such as screening for social needs, referrals to community programs, and health coaching and educational programs) should be reported as community benefit if they include all of these characteristics:

- Respond to an identified community need.
- Include outreach to persons who are vulnerable, disadvantaged or face barriers to accessing such health care services.
- Go beyond routine discharge planning and standards of care.

Health Professions Education

Educating future and current health care professionals is a distinguishing characteristic of not-for-profit health care and constitutes a community benefit recognized by IRS Revenue Ruling 69-545 that is reportable on Schedule H. This category includes educational programs for physicians, interns and residents; medical students, nurses and nursing students; pastoral care trainees and other health professionals when that education is necessary for a degree; and a certificate or training that is required by state law, an accrediting body or a health profession specialty.

Do not include programs provided exclusively for the organization's employees or medical staff, such as orientation programs or routine professional development. Include continuing medical and nursing education and education for other professionals only if such programs are open to other professionals in the community and the program is deemed eligible for continuing education credit by an accrediting or health care professional society (or other appropriate standard-setting or accrediting body).

Report activities designed to interest students in health professions as "workforce development" in the community-building category. This would include mentoring high school and other students.

IRS NOTE

IRS

From the Schedule H instructions:

"Health professions education" means educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law, or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education or training programs available only to the organization's employees and medical staff or scholarships provided to those individuals. However, it does include education programs if the primary purpose of such programs is to educate health professionals in the broader community. Costs for medical residents and interns can be included, even if they are considered "employees" for purposes of Form W-2, Wage and Tax Statement.

Subsidized Health Services

Subsidized health services are patient care programs provided despite a financial loss so significant that losses remain after removing the effects of financial assistance, Medicaid

shortfalls and bad debt. The services are provided because they meet identified community health needs, and if these services were no longer offered, they would be unavailable in the area, the community's capacity to provide the services would be below the community's need, or provision of the services would become the responsibility of government or another not-for-profit organization.

Subsidized health services can, if they meet the above qualifying criteria, include:

- Inpatient programs (such as addiction recovery and psychiatric units).
- Outpatient programs (emergency and trauma services, satellite clinics designed to serve low-income communities, and home health programs).
- Services or care provided by physician clinics and skilled nursing facilities if such clinics or facilities satisfy the criteria for subsidized health services. Physician clinics should not be reported as subsidized health services if the hospital earns positive income (technical fees) from the work of those clinicians.

IRS

IRS NOTE

The Schedule H instructions state that if stand-alone physician clinics are included as subsidized services in Part I of Schedule H, the hospital must report the amount of those costs in Part VI.

Subsidized health services exclude ancillary services that support inpatient and ambulatory programs, such as anesthesiology, radiology and laboratory departments. Also, when reporting the service, be sure to report the whole service, not a subset of the service. For example, the emergency department might be reported as a subsidized health service, but the costs of retaining on-call physicians within the department should not be reported separately if the emergency department as a whole does not qualify as a subsidized health service.

Do not report a program as a subsidized health service if it:

- Is not meeting an identified community health need.
- Experiences loss due to inefficiency or volatile reimbursement.
- Has many competitors or excess capacity in the market and is not accessed by patients in need.

Research

Engaging in medical and health care research indicates the organization is concerned about the long-term welfare of the community at large and wants to generate and share knowledge that enhances the future of health care.

The instructions for Schedule H provide many examples of research activities that may be reported as community benefit, including activities to increase general knowledge about the underlying biological mechanisms of health and disease; natural processes or principles affecting health or illness; epidemiology, health outcomes and effectiveness; and studies related to changes in the health care delivery system.

The IRS asks hospitals to report only research that produces increased general knowledge and that is funded by government or tax-exempt sources, such as the National Institutes of Health, foundations or the organization itself. Information about industry-sponsored research that provides public benefit (e.g., for which protocols call for broad publication of results) can be included in Part VI.

Cash and In-Kind Contributions for Community Benefit

This category includes the value of cash and in-kind services donated by the health care organization to support community benefits provided by others. Examples of in-kind services include hours spent by staff members as part of their work assignment while on the organization's work time, the cost of meeting space provided to community groups, and donations of food, equipment and supplies.

Cash and in-kind contributions may include:

- Cash donations to tax-exempt entities and other organizations that provide community benefits.
- In-kind donations, such as meeting rooms, supplies, equipment and parking vouchers.

For a cash contribution to be reportable as community benefit expense on Schedule H, the organization granting the funds must restrict in writing that the contribution is to be used for an activity or program that meets the criteria for a community benefit. Community organizations that receive these restricted cash contributions can use them for community-benefit-related expenses (e.g., supporting medical education) or capital expenditures (e.g., renovating free clinic space). Cash and in-kind contributions that support community-building activities are to be reported in the community-building category.

RESTRICTING CONTRIBUTIONS

Contributions from health care organizations to community organizations should be accompanied by a letter or comparable written communication restricting the funds to be used to carry out a community benefit activity, as defined in Schedule H instructions.

Contributions should not be reported as community benefit if they:

- Are unrestricted and thus may be used by the recipient for activities other than community benefit.
- Involve a *quid pro quo*, such as a Payment in Lieu of Taxes (PILT), that benefits the organization that provides the contribution. Providing loans or funds that represent an investment in another organization ("contributions to the capital of another organization") are other examples of *quid pro quo* arrangements that are not reportable as community benefit.

As with all community benefit programs, contributions must be intended to address community health needs. For example, the hospital should ensure that any donated equipment and supplies are needed by the receiving organization or the community served by that organization before sending the contribution.

See Guideline 1 in this chapter for more information about how the organization can demonstrate community need for a program or activity.

Contributions that themselves are funded by a restricted grant received by the organization may be reported as community benefit expense. For example, if an affiliated foundation provides a restricted grant to a hospital for a diabetes health education program, and the hospital shares a portion of that grant with a community partner, the contribution to the partner is reportable as community benefit, and the amount of the grant used for that purpose is reported as "direct offsetting revenue."

Do not report as community benefit time spent by volunteers and staff members engaged in an activity on their own time.

DO NOT REPORT VOLUNTEER EFFORTS

Volunteer efforts not on paid time are not an expense to the organization and, therefore, cannot be counted.

Example: A camp for children who have cancer is supported by the hospital. Each year the hospital sends a team of nurses to work at the camp and pays the nurses their regular salaries.

Other staff members use vacation days to volunteer at the camp. The nurses' time, which is an expense to the organization, can be reported as an in-kind community benefit expense but not the time of the other staff members who are working as volunteers during their vacations.

CONTRIBUTIONS TO THE CAPITAL NEEDS OF OTHER ENTITIES

Questions frequently arise regarding whether contributions made by tax-exempt hospital organizations to help other entities (e.g., community health centers or free clinics) with their capital needs are reportable as community benefit. Such contributions can be in the form of cash grants that are used by the other entities for new buildings or equipment or in the form of capital assets, such as land or buildings donated by hospitals to others.

Contributions of this nature may be counted as community benefit under certain circumstances, as follows:

- Any cash contributions for capital needs are restricted *in writing* to a community benefit purpose. For example, if a hospital contributes $500,000 to a community clinic that will be used for a new building, the clinic is required to use the new building in a manner that enhances access to care for uninsured or Medicaid patient, offers subsidized health services, facilitates health professional education or other purposes that are defined as a community benefit.
- The hospital is able to document its intent that in-kind contributions (e.g., donating a building or land) also are to be used by the recipient entity for a community benefit purpose.
- The accounting for the cash or asset contributions yields an expense borne by the hospital organization that is reported in Part XI of the core Form 990 (Statement of Functional Expenses). For example, if the hospital donates a building with a remaining “book value” of $500,000, the loss associated with donating this asset is reported in Part XI of the core Form 990.
- Any asset (land, buildings) contributions are valued for community benefit purposes based on the accounting value placed on the asset when donated. For example, the value of a donated building is based on its “book value” (original cost minus accumulated depreciation) rather than a fair market value or appraisal estimate.
- The hospital organization does not retain a financial interest in the contributed assets but instead has provided them out of a sense of “disinterested generosity.” Said another way, these cash or in-kind contributions may not be reported if they represent loans or advances or, as stated in, Schedule H instructions, are “contributions" to the capital of another organization that are reportable in Part X of the core Form 990.” Part X of the core Form 990 is the organization’s balance sheet. Thus, contributions that result in a balance reported as an asset or investment on the organization’s balance sheet are not reportable as contributions for community benefit on Schedule H.

CONTRIBUTIONS TO THE CAPITAL NEEDS OF OTHER ENTITIES *(continued)*

Some organizations are finding it straightforward to lease buildings to other entities rather than to donate them outright. Leases can incorporate terms that help ensure the lessee provides community benefit in the leased space. Instead of providing leases with nominal (e.g., $1 per year) lease payments — a structure that requires estimating and reporting as community benefit the expense borne by the hospital in maintaining the property — some organizations are providing leases based on fair market value and then are making a separate community benefit grant to the lessee organization.

For example, a hospital leases a building to a free clinic for $100,000 per year. It then makes an annual community benefit grant to the clinic of $100,000 (or more) that is restricted to a community benefit purpose. On a net basis, the free clinic is able to occupy the building in a budget-neutral fashion. The hospital is able to report the $100,000 community benefit grant on Schedule H as a cash contribution — rather than valuing the arrangement solely as an in-kind transaction.

Contributions may be made outside of the community, for example, in response to global poverty or a natural disaster. However, contributions outside the community should not constitute a substantial proportion of the organization's community benefit. Also, be aware that many taxing authorities do not consider funds used outside of the community as community benefit. Additionally, to be reported on Schedule H, the contributions must be restricted to a community benefit purpose.

Community Building

IRS

IRS NOTE

The Schedule H instructions require hospitals to report community-building activities in Part II of the form rather than in the Part I community benefit table. Part VI requires hospitals to describe how these activities protect or improve the health of the communities served. The instructions also state that some community-building activities may also meet the definition of community benefit and instruct that organizations may report those activities under Part I, line 7(e) as community health improvement and not in Part II.

See callout on page 62 titled "Community building or community health improvement?" for more guidance.

Community-building activities are programs that address the underlying causes of health problems and thus improve health status and quality of life. They focus on the root causes of health problems, such as poverty, homelessness and environmental hazards. These activities enhance community assets by offering the expertise and resources of the health care organization.

Examples of community-building activities include:

- Physical improvements and housing.
- Economic development.
- Community support.
- Environmental improvements.
- Leadership development and training for community members.
- Coalition building.
- Community health improvement advocacy.
- Workforce development.

The Schedule H instructions say that the organization should not report as environmental improvement "expenditures it made to reduce the environmental hazards caused by, or the environmental impact of, its own activities" **unless the activity (i) is provided for the primary purpose of improving community health; (ii) addresses an environmental issue that is known to affect community health; and (iii) is subsidized by the organization at a net loss, and so long as the organization does not "engage in the activity primarily for marketing purposes."**

Visit https://www.chausa.org/whatcounts for more detailed guidance on environmental activities that can be reported as community benefit.

COMMUNITY BUILDING OR COMMUNITY HEALTH IMPROVEMENT?

An activity that might otherwise fit into one of the categories of community building is reportable as community health improvement when the activity meets all IRS criteria for community health improvement.

Public health resources should be used to provide evidence that a community-building activity meets a community benefit objective and can be reported as community health improvement. These resources include, among others:

- *Healthy People,* Office of Disease Prevention and Health Promotion
- *The Guide to Community Preventive Services,* Centers for Disease Control and Prevention.
- *Aims of Public Health Quality,* U.S. Department of Health and Human Services (HHS).
- *National Prevention Strategy,* National Prevention Council, HHS.
- *Consensus Statement on Quality in the Public Health System and Priority Areas for Improvement of Public Health Quality,* HHS.

Links to these resources can be found on the CHA website at https://www.chausa.org/guideresources.

These and other public health resources contain examples of activities that improve the health of people in the community by addressing the social and physical determinants of health. They can be referenced in hospitals' community benefit records to document why the activity is being reported as community health improvement.

Visit https://www.chausa.org/whatcounts for examples of activities that are reportable as community health improvement (as long as the activity or program is carried out for purpose of improving community health and meets other criteria for community health improvement) and that are reportable as community building.

Community Benefit Operations

Community benefit operations include costs associated with planning and operating community benefit programs.

Examples of community benefit operations include:

- Costs of assigned staff and other community benefit administration costs.
- CHNAs.
- Evaluation of individual programs and activities.
- Software that supports the community benefit program, such as the Community Benefit Inventory for Social Accountability.
- The organization's costs incurred in writing grants or raising funds specifically for community benefit activities and programs.
- Dues and program expenses for organizations that specifically support the community benefit program, such as the Association for Community Health Improvement and the American Public Health Association.

IS IT COMMUNITY BENEFIT?

The following questions can help determine whether a program or activity should be reported as a community benefit in the following categories: community health improvement, health professions education, subsidized health services, research, or cash and in-kind contributions.

STEP ONE:

Does the program or activity:

- Address a demonstrated community health need?
- Seek to address at least one of the following community benefit objectives?
  - Improve access.
  - Enhance public health.
  - Advance generalizable knowledge.
  - Relieve the government burden to improve health.

Does the program or activity:

- Primarily benefit the community rather than the organization?
- Result in measurable expense to the organization?

IF "NO" TO ANY OF THE QUESTIONS IN STEP I, IT IS NOT A COMMUNITY BENEFIT.

IF "YES" TO ALL QUESTIONS IN STEP I, PROCEED TO STEP TWO.

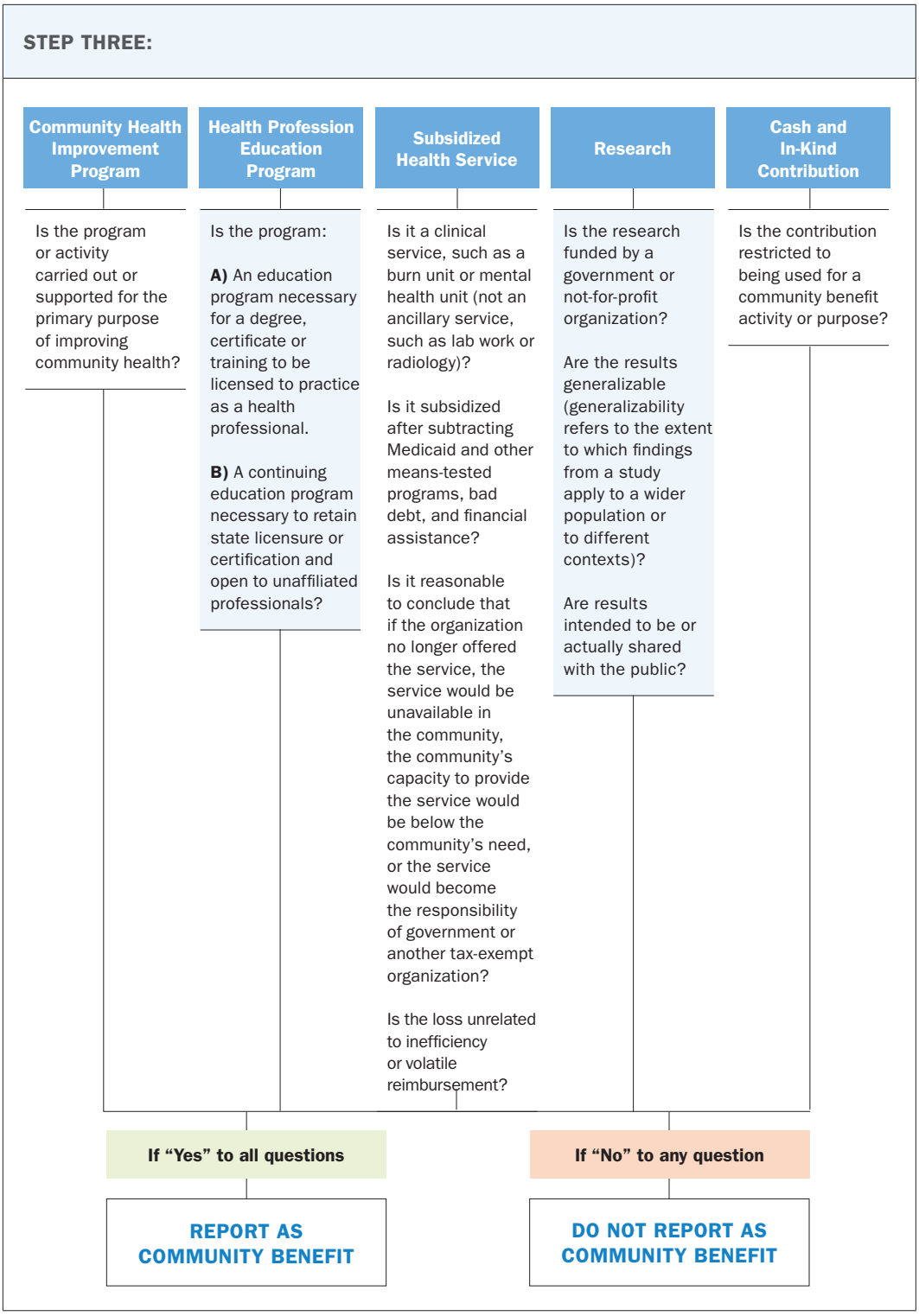
STEP TWO:

Is the program or activity:

- Provided primarily for marketing purposes?
- Standard practice, expected of all hospitals (such as activities required for accreditation, licensure or participation in Medicare)?
- Provided primarily for the organization's "covered lives"?
- Provided primarily for employees (not including interns, residents and fellows) or affiliated physicians?

IF "YES" TO ANY OF THE QUESTIONS IN STEP II, IT IS NOT A COMMUNITY BENEFIT.

IF "NO" TO ALL QUESTIONS IN STEP II, PROCEED TO STEP THREE.


STEP THREE:
Community Health Improvement Program
Is the program or activity carried out or supported for the primary purpose of improving community health?
Health Profession Education Program
Is the program:
A) An education program necessary for a degree, certificate or training to be licensed to practice as a health professional.
B) A continuing education program necessary to retain state licensure or certification and open to unaffiliated professionals?
Subsidized Health Service
Is it a clinical service, such as a burn unit or mental health unit (not an ancillary service, such as lab work or radiology)?
Is it subsidized after subtracting Medicaid and other means-tested programs, bad debt, and financial assistance?
Is it reasonable to conclude that if the organization no longer offered the service, the service would be unavailable in the community, the community's capacity to provide the service would be below the community's need, or the service would become the responsibility of government or another tax-exempt organization?
Is the loss unrelated to inefficiency or volatile reimbursement?
Research
Is the research funded by a government or not-for-profit organization?
Are the results generalizable (generalizability refers to the extent to which findings from a study apply to a wider population or to different contexts)?
Are results intended to be or actually shared with the public?
Cash and In-Kind Contribution
Is the contribution restricted to being used for a community benefit activity or purpose?
If "Yes" to all questions
REPORT AS COMMUNITY BENEFIT
If "No" to any question
DO NOT REPORT AS COMMUNITY BENEFIT

Notes:

Chapter Three: Building a Sustainable Infrastructure

3

Chapter Three: Building a Sustainable Infrastructure

The role of the organization's leaders is to establish and promote the organization's community benefit vision and ensure an overall culture of commitment to community benefit.

Laying the groundwork for a successful community benefit program begins with two steps. The first step is to establish or renew a commitment to community benefit so the entire organization is ready culturally and philosophically. The second step is to build basic structures that will sustain the program: staffing, partnerships, a budget and policies.

In Section 3.1, Establish or Renew the Commitment, you will learn how to do the following:

Guideline 1: Use your history, mission, vision and values.
Guideline 2: Integrate community benefit into key organizational plans and initiatives.
Guideline 3: Hold leaders accountable.
Guideline 4: Create the right culture.

In Section 3.2, Build Basic Structures, you will learn how to do the following:

Guideline 1: Commit staff to community benefit.
Guideline 2: Form an internal community benefit workgroup.
Guideline 3: Budget for community benefit.
Guideline 4: Establish policies that support community benefit.
Guideline 5: Collaborate with community partners.
Guideline 6: Evaluate the organization's overall community benefit approach and strategy.

EQUITY NOTE

- Establish a commitment to equity in critical documents, including mission and values statements, strategic and organizational plans, and policies.
- Work toward building diversity among community benefit staff, consultants and advisory bodies.
- Participate in coalitions with community organizations working with persons who experience disparities and discrimination.
- Allocate resources to addressing the social determinants of health and disparities.

ESTABLISH OR RENEW COMMITMENT

SECTION 3.1

Guideline 1
Use your history, mission, vision and values

The organization's history, mission, vision and values statements set the framework for the community benefit program. Look for explicit reference to community health improvement, community services, access to health care, and concern for those living in poverty and other vulnerable people. The following information can help all within an organization gain a common understanding that this is a community benefit organization:

- Know your organization's origin story, and make sure it is known to your executive and board leaders as well as to new and experienced associates. The story of how and why your organization was started can help guide and motivate them to support the organization's community health efforts.
- Review the organization's mission, vision and value statements. Is the word "community" there? Do the statements speak to issues related to community benefit? Work with your communications staff to widely disseminate these statements to internal and external audiences.
- Include your organization's commitment to community benefit when managers, physicians, board members and staff receive orientation about your organization, mission and values.
- Find out if your organization has conducted consumer or market research on how your organization is perceived by others. If this has not been done, suggest that your marketing or planning staff assess whether the organization is perceived as a mission-driven, community-oriented organization.

Guideline 2
Integrate community benefit into key organizational plans and initiatives

An organization's strategic plan lays out the organization's priorities and goals for the next three to five years. Organizations should include attention to community needs and community benefit in the strategic plan to ensure that community benefit programs receive the required resources and leadership commitment.

In addition, operational, financial and communication plans lay out the specific strategies and resources that will be used to achieve strategic goals. These plans, too, should explicitly describe the financial and personnel resources for the organization's strategic community benefit goals.

Many organizations include one or more community benefit goals in their strategic plans, communications plans and budgets to ensure visibility and commitment for community benefit activities.

In addition to integrating community benefit into key organizational plans, also look for ways community benefit can support strategic initiatives, such as in population health management, equity and inclusion, care integration and other programs focused on improving health outcomes while lowering the cost of care. Community benefit, with its focus on community health needs, community-focused interventions and community partnerships, can be a valuable and essential building block for these initiatives.

Integrating the efforts of population health management and community benefit programs can positively impact the health and well-being of members served by population health programs as well as the overall community and its most vulnerable members. When assessing how community benefit might be integrated with your organization's population health management strategy, consider the following:

- ***Population health management can build on community benefit access initiatives***. Access to health care is a priority for most community benefit programs, and population health management programs can benefit when more persons are insured and can enroll in these programs. Community benefit programs often have enrollment strategies for uninsured and underinsured persons.

- ***Population health management and community benefit programs can collaborate on prevention and health promotion programs***. Population health management and community benefit programs can share strategies related to prevention and work to improve health behaviors. Community benefit programs often offer screening and other prevention programs and have expertise and community connections for addressing tobacco and other drug use, unhealthy eating, inactive lifestyles, and other risky behaviors.

- ***Population health management and community benefit programs can share relationships***. Population health management and community benefit programs can work and build on community relationships established by each other to secure community-based services for those they serve. By coordinating their work through these relationships, both programs can contribute to community health improvement.

- ***Community benefit programs can address the determinants of health that impact the health of population health management patients***. Community benefit programs and their community partners can address social, economic and environmental determinants of health, which are important to population health management programs because these factors impact the health of their participants. Addressing determinants of health is usually beyond the scope of population health programs because it requires community-wide efforts to achieve systemic change in nonmedical areas, such as economic development, affordable housing and educational attainment.

- ***Population health management can contribute to and use the findings from community benefit programs' CHNAs***. Community benefit programs work with public health and other agencies and community organizations to assess and address community health needs and to identify community assets. Population health management programs can use the findings and can contribute information from their data sources and data analyses to the CHNA. Community relationships formed during needs and assets assessments can help population health management programs develop strategies for coordinating the care of their members by identifying community resources for their participants.

Guideline 3
Hold leaders accountable

Leaders should be as responsible for meeting community benefit goals as they are for achieving other performance measures. Executive leaders and program managers should consider working with others in the community toward community health improvement goals and making community benefit integral to their work. Board members should understand that the governing body is ultimately responsible for ensuring that the organization responds to community needs and complies with government mandates related to community benefit:

- Use commitment to access and community health as criteria for selecting executive leaders and board members.
- Include expectations about community involvement and community benefit as part of performance evaluations. Some organizations review key performance indicators related to community benefit and community health improvement when assessing leadership performance.
- Have the board and chief executive officer approve the CHNA, implementation strategy (community benefit plan) and community benefit reports, including IRS Form 990, Schedule H, and any state-required community benefit report.

AFFORDABLE CARE ACT REQUIREMENT – IMPLEMENTATION STRATEGY

The Affordable Care Act (ACA) requires tax-exempt hospitals to adopt an implementation strategy to meet the community health needs identified through a community health needs assessment (CHNA). Regulations implementing the ACA state how and when the implementation strategy is adopted: "An authorized body of the hospital facility must adopt the implementation strategy on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility completes the final step for the CHNA." Treas. Reg. § 1.501(r)-3(c)(5). To view the final regulations, visit https://federalregister.gov/a/2014-30525.

Health care organizations take different approaches for involving their boards in community benefit. These approaches include the following:

- The full board takes responsibility for advising on the community benefit program and reviewing and approving community benefit-related plans and other documents.
- A board committee on community benefit reports to the full board.
- A separate community benefit advisory group reports periodically to the board.

To help the community benefit program interface with the organization's governing board, you need to understand who is on the board and how it operates. Knowing the following can help you work more effectively with your board:

- Board members and their areas of interest, especially persons who are affiliated with community benefit partners or potential partners.
- The organization of the board, including board committees and their areas of responsibilities.
- How often the board meets and how the agenda is set.
- Department or staff members who support the board.
- Policies that define board roles and responsibilities.

THE ROLE OF BOARDS

"The historic roles of hospitals and health systems and public health agencies are evolving as all parties recognize that prevention of illness and injuries, early detection and treatment, and intentional promotion of wellness in all sectors of the population are imperative. Better communication and closer collaboration among health systems and public health agencies increasingly are essential.

"Therefore, if they haven't already done so, the [report] team recommends that board leaders and CEOs of nonprofit health systems and other healthcare organizations charge a standing board committee with oversight responsibility for system-wide community benefit policies and programs and the organization's role and priorities in the realm of population health. It is time for a fresh look at traditional practices and relationships – and for new approaches that will serve our communities better and more efficiently."

Source: Prybil et al., *Governance in Large Nonprofit Health Systems: Current Profile and Emerging Patterns* Commonwealth Center for Governance Studies, 2012, p. 56 https://www.hallrender.com/wp-content/uploads/2012/10/Governance_booklet.pdf

Guideline 4
Get the culture right

An organization's commitment to community benefit is reflected in a culture that welcomes persons of all backgrounds. This culture should be visible and evident to employees, patients and the community.

Health care providers may assume, because of their tradition and values, that they have a strong culture of caring for vulnerable persons and offering community service. However, as new staff and leaders come on board and financial constraints increase, the culture of caring that was originally put into place can erode:

- Orientation programs should be explicit about "going the extra mile" for persons who are vulnerable because of income, language or other factors. This includes providing training across the organization at every level of the organization, including the billing and finance office staff who work directly with patients and their families. For sample orientation presentations, visit the CHA website at https://www.chausa.org/guideresources.
- Review the organization's consumer information, including financial assistance notices, to determine if persons with either limited literacy skills or who do not speak English can understand them. Periodically test whether this information is easily accessible.
- Be alert for any practices that may intimidate or discourage people who have lower incomes or lack insurance from accessing the services offered by the organization, such as encouraging uninsured persons to seek care elsewhere or any effort toward redirection or transfer for financial reasons.
- Work to ensure your organization is committed to eliminating health disparities and achieving health equity in your community. For resources on how to build a diverse, culturally competent organization and to gather and use patient racial, ethnic and language data to improve quality, go to https://www.chausa.org/disparities/equity-of-care.

BUILD BASIC STRUCTURES

SECTION 3.2

Guideline 1
Commit staff to community benefit

Health care organizations differ on how to staff community benefit programs. However, there is agreement that a point person should be named and made responsible for the community benefit program, keeping in mind that other persons from throughout the organization also will be involved.

Most hospitals find they need a full-time staff member to coordinate efforts within the organization. A growing number of hospitals and health systems are developing a full staff of public health and other professionals to work in community benefit and community health improvement.

MODELS FOR STAFFING AT SMALL HOSPITALS AND LONG-TERM CARE ORGANIZATIONS

Small hospitals and long-term care organizations often assign a staff member who has administrative or other responsibilities to be the point person for the community benefit program. When this is the case, it is advised that a substantial amount of this person's time be assigned to community benefit so this function does not get lost. Another model used in smaller facilities is to form a team with representatives from various departments to work on community benefit, with one team member taking lead responsibility.

Many health care systems have found that to be most effective, the leader of the community benefit program should be at a senior level, with planning and budgeting authority and direct access to the CEO. It is preferable that this person report directly to the CEO or COO, at least for community benefit issues, and occasionally have visibility with the board.

Another model is for a senior leader — one who reports to the CEO — to be assigned responsibility for community benefit, with a community benefit program director reporting to this person. The program director would be supported by a team representing various departments from throughout the organization.

Community benefit staff may be located in a separate community benefit department, in the executive office, or in the mission, planning, finance or population health management departments. At some organizations, the community benefit department is known by a different name, such as community health improvement or community outreach. To keep a clear distinction between community benefit and marketing activities, it is recommended that community benefit staff not be assigned to the marketing department.

Competencies needed by community benefit professionals include:

- Experience carrying out community benefit or public health and community health improvement initiatives, particularly assessment and program planning, implementation, and evaluation.
- An understanding of public health, such as knowledge of the health status of populations, health disparities, determinants of health and illness, prevention, and health promotion strategies.
- The ability to work collaboratively with community members and other organizations.
- The ability to work collaboratively with the other departments or groups in the organization that are essential to carrying out the organization's community benefit work, including finance, planning and communications.
- The ability to use technology to increase the effectiveness of community benefit efforts, including use of web-based public health resources in assessment and planning, software for tracking and reporting community benefit, and social media to share information about the organization's community benefit work.
- Knowledge and experience in working with minority and vulnerable populations.

COMMUNITY BENEFIT ROLES AND RESPONSIBILITIES

Several colleagues and departments have important roles to play in ensuring the success of community benefit efforts.

Community Benefit Leader

- Lead the community benefit team.
- Oversee the CHNA and development of an implementation strategy.
- Coordinate community benefit planning, and participate in integrating it into the organization's strategic planning process.
- Involve executive and board leaders in the community benefit program: Keep them informed of community needs, program successes, issues and community collaboration.
- Oversee implementation of community benefit programs and activities. Manage community benefit operations, such as hiring and training staff, budgeting, and maintaining documentation that confirms community need for programs.
- Be responsible for evaluating the organization's overall approach and strategy as well as evaluating individual programs.
- Work with finance staff to budget for community benefit and track programs and costs.
- Work with communications staff to prepare reports and tell the community benefit story.
- Work with population health management staff to share information about community health needs, community benefit programs and relationships in the community that could enhance the organization's population health management efforts.
- Build and maintain relationships with public health departments and other community organizations committed to improving community health, working toward strategic partnerships that support shared goals and outcomes.

Finance

- Be part of the community benefit team.
- Include the community benefit budget in the organization's budget.
- Advise on the budget implications of community benefit proposals and plans.
- Track, maintain and report information about community benefit costs.
- Ensure that financial information in IRS Form 990, Schedule H, and other community benefit reports is complete, accurate and consistent.
- Maintain a cost accounting system, and provide and review needed data.
- Develop and oversee the implementation of financial assistance policies and procedures.
- Help assess "how much is enough," comparing the value of community benefits to the organization's tax benefits.
- Develop long-range strategic financial plans that include community benefit targets.

COMMUNITY BENEFIT ROLES AND RESPONSIBILITIES *(continued)*

Communications

- Be part of the community benefit team.
- Coordinate efforts to tell the community benefit story.
- Contribute to community assessment, including the development, identification and use of information-gathering tools, such as surveys, focus groups and interviews.
- Coordinate development of a community benefit report.
- Use print, online and social media to get word out about community benefit to the community.
- Find opportunities to tell the community benefit story.
- Identify a point person for media inquiries related to Schedule H and other community benefit issues.
- Maintain a community benefit website.

Planners

- Be part of the community benefit team.
- Contribute statistical data and other information to the CHNA.
- Use community assessment information in the organization's strategic and operational plans.
- Understand local, regional and national public health priorities.
- Recommend priorities for community benefit action based on the organization's goals and strategic directions.
- Include community benefit goals, objectives and strategy in organization plans (or integrate community benefit into organization's goals, objectives and strategies).

Legal, Compliance and Audit Control

- Monitor government requirements related to community benefit and tax exemption.
- Work with the community benefit leader and finance leader to ensure compliance with requirements.

COMMUNITY BENEFIT ROLES AND RESPONSIBILITIES *(continued)*

CEO and Administration

- Appoint a qualified person(s) to lead and staff community benefit operations.
- Ensure that all entities affiliated with the organization share community benefit goals and related policies, such as those for financial assistance.
- Hold key staff accountable for participation in community benefit.
- Provide adequate financial and other resources for the community benefit program.
- Report to the governing body about community need and the organization's response to those needs.
- Ensure that community benefit initiatives are more than reactive (financial assistance, means-tested programs) but include proactive efforts as well (outreach to low-income persons, prevention of illness and injury, attention to root causes of health problems).
- Be accountable for setting community benefit goals and objectives.
- Ensure that financial assistance and billing and collection policies meet government requirements and are followed.
- Require the same level of excellence and oversight of community benefit as other key functions of the organization.
- Be an advocate for community benefit inside and outside of the organization.

Board

- Develop a community benefit committee of the board, or make oversight of community benefit an ongoing responsibility of the board.
- Contribute information to the CHNA.
- Review results of the community assessment, and advise on priorities for community benefit activities.
- Approve financial assistance and debt collection policies.
- Approve the implementation strategy and any other community benefit plans and reports.
- Ensure that community benefit efforts align with community needs identified through assessment and other means.
- Visit or participate in a community benefit activity.
- Represent the community's interest to the organization in general and specifically when advising on priorities for community benefit activity.
- Ensure that the organization is complying with government requirements related to community benefit and tax exemption.

Guideline 2
Form an internal community benefit workgroup

Form an internal workgroup composed of representatives from key departments to help steer the organization's community benefit and community-wide programs. As a whole, the workgroup will have the background and expertise to make effective planning and implementation decisions.

In addition to community benefit staff, the workgroup typically has representatives from the following departments:

- Administration.
- Planning.
- Mission.
- Finance.
- Patient financial services.
- Communications.
- Patient care and clinical services.
- Population health management.

Other departments you may want to consult with include:

- Social work.
- Research administration.
- Government relations and advocacy.
- Foundation or fundraising.
- Medical and nursing services and education.
- Legal.
- Grant administration.
- Compliance.
- Health equity, diversity and inclusion.

The workgroup members should:

- Monitor key policies, including financial assistance and billing and collections.
- Help develop and sustain community relationships.
- Participate in the CHNA.
- Develop the implementation strategy.
- Monitor implementation of community benefit programs.
- Participate in evaluation.
- Be advocates for the community benefit program, both internally and externally.
- Help tell the community benefit story.

Some organizations include persons from outside the facility to participate in its community benefit workgroup. This could include representatives from:

- Public health and other public agencies.
- Community organizations.
- Consumer groups.

Organizations might also consider forming subgroups to focus on important topics, such as:

- ***Schedule H*** – Ensures the organization understands the requirements, is prepared to meet them and is accurately collecting the information to report on the form.
- ***Finance*** – Establishes clear roles and responsibilities for finance in regard to financial assistance policies and procedures and budgeting for and accurately reporting community benefit.
- ***Assessment*** – Ensures the organization's CHNA process uses data effectively to identify disparities and other community health needs.
- ***Planning and Implementation*** – Provides guidance on selecting interventions to address needs and plans to carry out and evaluate those interventions.
- ***Evaluation*** – Ensures that information about health disparities, equity and social determinants of health are included in all aspects of the program evaluation process.
- ***Communications*** – Coordinates efforts to tell the organization's community benefit story.

Guideline 3
Budget for community benefit

A viable community benefit program needs sufficient funds. Community benefit budgets should be set prospectively, early in the community benefit planning process. It is not effective to attempt to find funds as needs emerge and programs are initiated. The complexity of the budget depends on the complexity of the program it supports. However, there are basic considerations to create an effective and complete budget for your community benefit program.

EQUITY NOTE

In addition to budgeting for community benefit programs, another way to fund community health improvement and reduce disparities is to use the assets of the organization to support community investment. Health care organizations have an array of assets — land, financial resources, relationships and expertise — that can be harnessed to support community investment. These types of investments can have a significant impact on areas that have suffered from redlining and disinvestment because of past racist policies. For more information, visit the CHA website at https://www.chausa.org/communitybenefit/social-determinants-of-health/cha-resources and see the resource "Investing in Community Health."

When Creating the Budget:

- Make the community benefit budget part of the organization's overall budget to give it visibility equal to other major functions.
- Factor in addressing community needs as priorities in the organization's overall budget.
- Understand how the organization's budgets are set so that you can get the necessary information to the right people at the right time.
- Include:
    - Total expected costs.
    - Expected sources of revenue (including reimbursement, payments, grants and gifts).
    - Any expected shortfall or surplus of revenue over costs.
    - Staffing requirements (both paid and volunteer).

When Setting the Budget Amounts, Consider

- Who sets and controls the budget:
  - Are community benefit staff or executive or board leaders familiar with community needs?
  - Are they familiar with the community benefit program involved in budget decisions?
- Responsiveness to needs:
  - Is the level of effort consistent with the needs identified in the community-wide assessment?
  - What are trends in poverty, unemployment and the extent of insurance coverage?
- Other providers in the community:
  - Is the organization providing a fair share of the community benefit? Review the scope of activities and amount spent by other health care organizations in the community.
  - If the organization's financial assistance costs or Medicaid census are significantly lower than other not-for-profit facilities in the community, determine the reasons for this and consider whether the organization should be doing more.
- Available revenues:
  - Some health care organizations apply a minimum amount of expense or net income to financial assistance. The goal of these requirements is to ensure a base of activity that reflects the financial capacity of the facility.
- Any regulatory requirements in your state.
- The Value of tax exemption:
  - Many health care organizations calculate the value of their tax exemptions by adding together all the categories of taxes they would have paid as taxable entities.
- Past efforts:
  - How much was spent in prior years?
  - Should you set a higher goal?

EXAMPLES OF BENCHMARKS USED IN BUDGETING

Multi-facility systems sometimes ask their member facilities to commit a specified percentage of revenues or a similar indicator to community and financial assistance services. Examples of these allocation policies include:

- Allocating X percent total expenses to community health initiatives, Y percent net revenue to outreach care initiatives to those living in poverty and Z percent of a health system's investments to an alternative investment program.
- Setting a community benefit budget at a percentage of operating income.
- Setting a goal that the financial value of community benefit is greater than what would have been tax liability.
- Devoting at least X percent of gross patient and resident revenues to community and financial assistance services.

Even given these numerical yardsticks, most community benefit leaders agree: It is not a matter of how much is spent on community benefit activities that is important, but the impact these activities have.

Guideline 4
Establish policies that support community benefit

Organizational policies can support the community benefit program and encourage commitment to access and community health. Here are some guidelines to consider when evaluating organizational policies, procedures and practices.

See Appendix C for a checklist you can use to assess a facility's policies.

Community benefit policies should include:

- Mission statements and other documents should describe the organization's commitment to community benefit and community health improvement.
- Policies should describe the organization's community benefit structure.
- Policies should describe how the organization will assess community health needs, identify priorities among identified needs and develop implementation strategies for addressing prioritized needs.
- Policies should include responsibilities and reporting relationships. Include the role of finance, strategic planning, communications, and other key departments and staff.
- Policies should include the approval process needed for CHNAs, implementation strategies, budgets and reports.
- Policies should include how the organization works with community organizations and individuals in the community, including at-risk populations.
- Policies should describe how the organization makes decisions about contributions and investments to community organizations.
- Policies should describe how programs will be evaluated to ensure quality and measure effectiveness.
- Policies should describe how community benefit is reported internally and externally, including in annual reports, CHNAs, implementation strategies (community benefit plans) and Schedule H.

Financial Assistance and Discounting and Billing Policies

- Policies should describe eligibility criteria (income and assets, if applicable) for granting financial assistance for medically necessary health services.
- Policies should include a process for granting exceptions to established criteria for unusual circumstances.
- Clear and uniformly applied procedures should determine financial assistance eligibility.
- Eligibility should be determined prospectively whenever possible.
- Financial assistance paperwork should be processed promptly so people determined eligible are not billed.
- Efforts should be made to enroll eligible patients and families in public financial assistance programs.
- Financial assistance policies should be written in the languages of the community, easy to read by members of the community, and publicly and accessibly displayed.
- Policies should be communicated both internally and externally.
- Unpaid bills should be monitored to determine if patients become eligible for financial assistance or government-sponsored programs.
- Any billing or collection agencies should be given clear instructions that all persons are to be treated with respect. These collection processes should be monitored regularly.
- A consistent procedure should be used to convert a bill to charity or financial assistance status if billed patients cannot pay or if their employment circumstances change during the revenue cycle.
- Billing and collection staff should be familiar with eligibility criteria for the organization's financial assistance program and available government-sponsored means-tested programs.

FEDERAL REQUIREMENTS

Financial Assistance and Emergency Medical Care Policies and Billing and Collections Requirements

The Affordable Care Act (ACA) requires tax-exempt hospitals to establish a written financial assistance policy that includes "eligibility criteria for financial assistance, and whether such assistance includes free or discounted care; the basis for calculating amounts charged to patients; the method for applying financial assistance; in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of nonpayment, including collections action and reporting to credit agencies; and measures to widely publicize the policy within the community to be served by the organization."

Tax-exempt hospitals are also required to have "a written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act 42 U.S.C. 1395dd) to individuals regardless of their eligibility" under the financial assistance policy required by the ACA. The organization meets the requirements of the law if the organization "limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance" under the financial assistance policy required by the ACA "to not more than the lowest amounts charged to individuals who have insurance covering such care, and prohibits the use of gross charges."

Finally, the ACA requires tax-exempt hospitals to "not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy."

If the community benefit department is not directly responsible for these policies, make sure that the responsible department is aware of these requirements. Visit the CHA website at https://www.chausa.org/guideresources for IRS regulations on this topic.

IRS

IRS NOTE

Schedule H defines a financial assistance policy (sometimes referred to as a charity care policy) as "a policy describing how the organization will provide financial assistance at its hospital(s) and other facilities, if any. Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. Financial assistance does not include: bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay, or the cost of providing such care to such patients; the difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom; self-pay or prompt pay discounts or contractual adjustments with any third-party payers."

Physician Involvement Policies

- Identify a physician champion to be active in planning and carrying out the community benefit program and recruiting others to be involved. Physicians should reflect the demographic makeup of the community.
- Encourage attending physicians to take emergency calls for Medicaid and uninsured patients.
- Be sure that written agreements specify that if facilities must pay physicians to accept emergency calls, the purpose of the arrangement is to improve access to care, especially for low-income and uninsured persons.
- Orient all new attending and staff physicians, medical students, interns, and residents to the organization's charitable tradition and commitment to community health, and give them specific examples of how they can get involved.
- Routinely report to the medical staff and any affiliated medical schools the organization's efforts to improve access and community health and its other community benefit activities.
- Be alert to opportunities to publicly recognize physicians' community service — but always ask permission from physicians before publicly recognizing their services.

Employee Policies

- All employees should be aware of the organization's mission of service and commitment to access and community health.
- All employees, especially those involved with admissions and billing, should be aware of the organization's historical and continuing concern for low-income and other vulnerable persons.
- The organization recognizes and celebrates community service contributions of all staff, whether conducted within or outside of the organization. (However, report these as an organization's community benefit contribution only if services were provided during paid time.)

Advocacy Policies

- The agenda should include the expansion of health care coverage and access to health care.
- The agenda should include attention to the financing of health care for low income persons, such as the preservation of Medicaid and other state and local indigent care programs.
- The agenda should focus on policies that promote physical and mental health and well-being through improved housing, nutrition programs, preventive health programs and environmental health.
- The agenda should focus on policies that address equity and the social determinants of health.
- Advocacy teams should work in coalition with other like-minded organizations in the community.
- Advocacy teams should be a voice in the business, philanthropic and general communities for improved health and access to health care for all.

Guideline 5
Collaborate with community partners

Early in the process of building a community benefit infrastructure, develop relationships with government agencies, other providers (including competitors), community organizations and individuals interested in the needs of low-income and vulnerable populations and community health improvement. These people and groups are knowledgeable resources that can inform and support your community benefit efforts. They may also be interested in sharing ownership in community benefit activities.

These potential partners can include the following:

Health and Service Providers

- Physicians.
- Leaders in other not-for-profit health care organizations, such as hospitals, clinics, nursing homes, and home- and community-based services.
- Leaders from Catholic Charities and other faith-based service providers.
- Mental health providers.
- Administrators of housing programs: homeless shelters, low-income-family housing and senior housing.
- Health insurers.
- Parish and congregational nursing programs.
- Local community assistance programs.
- Community health workers.
- Social workers.

Community Leaders and Groups

- Local clergy and congregational leaders.
- Consumer advocates.
- Organization board members.
- Neighborhood and civic associations.
- Representatives from businesses and other employers.
- Political and elected leaders.

- Foundations.
- United Way organizations.
- Groups that work on issues of equity and discrimination.

Public Organizations

- Welfare and social service agency staff.
- School officials and staff.
- Public health departments.
- Staff from state and area agencies on aging.
- Law enforcement agencies.

Consumers

- Uninsured persons.
- Members of at-risk populations.
- Other consumers of health care in the community.
- Consumer advocacy organizations.
- Organizations representing those with chronic illness and other patient groups.

In developing relationships with community members and groups, be aware of how the organization is perceived. Stay conscious of any historical background or barriers among community agencies that could affect the collaboration. As the collaboration progresses, be careful not to dominate the process. Instead, make sure all parties are involved and heard.

HOSPITAL ROLE IN COLLABORATIONS

The Health Research & Educational Trust (in partnership with the American Hospital Association) and the Robert Wood Johnson Foundation have developed resources to help hospitals understand their role in building "a culture of health" in which all people have the opportunity to live longer, healthier lives, whatever their backgrounds. The resources discuss factors hospitals should consider when entering into collaborations and, once in a collaborative relationship, how their role may be defined by the scope of their interventions and degree of collaboration (see below). Hospitals and health care systems may play one of these roles for all their community health improvement initiatives, or their role may vary based on the intervention or specific prioritized community need. Visit the Hospitals in Pursuit of Excellence website at www.HPOE.org to access these resources.

Factors to consider as hospitals collaborate with community partners to foster a culture of health:

Hospital

- Mission alignment
- Leadership commitment
- Resources

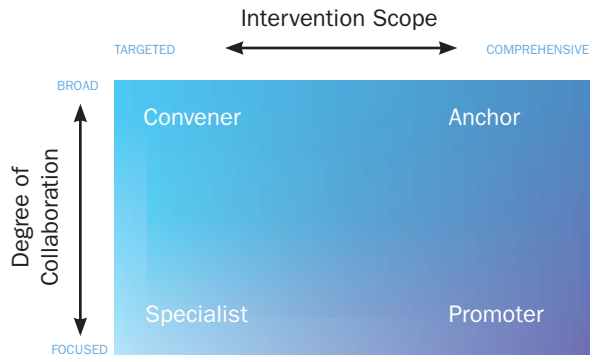
Community

- Needs
- Readiness
- Shared goals

Stakeholders & Partners

- Availability
- Resources
- Shared goals

Hospitals can decide the scope of their interventions and degree of collaboration to determine their role in building a culture of health.



Specialist: Concentrates on a few specific issues

Promoter: Supports other organizations' initiatives

Convener: Brings together hospital and community stakeholders

Anchor: Leads initiatives to build a culture of health

Source: *Hospital-based Strategies for Creating a Culture of Health,* Robert Wood Johnson Foundation and Health Research & Educational Trust, 2014 https://www.hpoe.org/Reports-HPOE/hospital_based_strategies_creating_culture_health_RWJF.pdf

Guideline 6
Evaluate the organization's overall community benefit approach and strategy

Organizations should evaluate their overall community benefit programs and infrastructures at least every three years — or after the overall community benefit program has undergone substantial change. This will help ensure that the organization's infrastructure supports its community benefit mission and that its resources are being used effectively to accomplish community benefit goals.

COORDINATE EVALUATIONS AND ASSESSMENTS

Some organizations coordinate the review of their overall community benefit programs with their CHNAs. After needs are assessed and prioritized, this information is compared to the organization's current community benefit efforts. The alignment of the assessment and the evaluation of the overall program allows the organization to refocus resources on new priorities in a timely manner and to make changes to current community benefit efforts to ensure that existing needs are addressed effectively.

Some questions to consider when evaluating the overall community benefit approach and strategy:

- Are policies related to community benefit up to date and appropriate for our community (including financial assistance policies and billing and collection policies and procedures)?
- Are needs of vulnerable and historically disenfranchised communities given priority?
- Does the program have administrative and governing board support?
- Is there sufficient involvement with the community? How might collaborations and partnerships be improved? *Visit https://www.chausa.org/guideresources for links to collaboration assessment tools.*
- Are staffing, budget and other resources adequate to support all required program components?
- Are there opportunities for improving the CHNA and the implementation strategy processes?

Use the checklists in Appendix C for additional questions.

MISSION NOTE

A values-driven community benefit program will ask, Are we being good stewards of our community benefit resources by spending them where most needed? Are participants in our programs treated with respect? Do we engage community partners and build on community strengths? Are we reaching out to persons most in need? These questions may best be answered through interviews or focus groups of program staff and participants.

Notes:

Notes:

Chapter Four: Accounting for Community Benefit

4

Chapter Four: Accounting for Community Benefit

Standardized accounting of community benefit allows policymakers, regulators and the public to compare hospital community benefit efforts accurately and improves the acceptance of reported information.

Tax-exempt hospital organizations are being asked to become more transparent and accountable. Standardized community benefit accounting is important in achieving these goals.

Standardized accounting of community benefit allows policymakers, regulators and the public to perform an accurate comparison of hospital community benefit reports and enhances the acceptance of reported information. Standardized accounting also allows organizations to assess their community benefit activities over time and permits multi-hospital systems to aggregate and analyze information from their facilities more reliably.

In this chapter, you will learn:

- How to adopt standardized principles and practices to account for community benefit.
- How to account for and report community benefit.
- How these guidelines compare to IRS Form 990, Schedule H, reporting requirements.

Throughout this chapter, the terms "cost" and "expense" are used interchangeably. Definitions for a number of terms relevant to community benefit accounting and reporting are included at the end of this chapter.

EQUITY NOTE

- In community benefit reporting, call out programs that address disparities and promote equity.
- Reach out to racial and ethnic minority community members with information about financial assistance policies.
- Align community benefit budget decisions with equity goals.
- As part of the organization's investment strategy, include investments in community organizations that will improve social determinants of health and advance equity.

The chapter is organized into four sections:

In Section 4.1, *Introduction*, you will learn why standardized accounting and reporting is important.

In Section 4.2, *Adopt Standardized Principles and Practices to Account for Community Benefit,* you will learn how to do the following:

Community Benefit Cost Measurement Principles

Guideline 1: Measure actual financial cost, not opportunity cost.
Guideline 2: Account for total and net community benefit expenses.
Guideline 3: Account for indirect costs as well as direct costs.
Guideline 4: Use the organization's most accurate cost accounting methods.
Guideline 5: Split program costs between community benefit and other purposes if warranted.

Community Benefit Accounting Principles

Guideline 6: Avoid double-counting community benefit expenses.
Guideline 7: Follow generally accepted accounting principles unless IRS instructions override those principles.
Guideline 8: Report zero net community benefit expense to the IRS for any category in which offsetting revenue exceeds the total community benefit expense.
Guideline 9: Maintain an audit trail.

Community Benefit Reporting Principles

Guideline 10: Report consistent counts for "number of programs or activities" and for "number of persons served."
Guideline 11: Develop appropriate community benefit accounting and reporting strategies for related organizations.
Guideline 12: Disclose accounting methods in community benefit reports.
Guideline 13: Reconcile and report differences in community benefit reports.

In Section 4.3, *Account for and Report Community Benefit*, you will learn how to do the following:

Guideline 1: Establish an effective administrative and accounting process.
Guideline 2: Calculate the cost of community health improvement services.
Guideline 3: Calculate the cost of community benefit operations.
Guideline 4: Determine the cost of health professions education.
Guideline 5: Include the cost of research that provides community benefit.
Guideline 6: Quantify cash and in-kind contributions for community benefit.
Guideline 7: Measure the cost of community-building activities.
Guideline 8: Calculate the ratio of patient care cost to charges.
Guideline 9: Establish the cost of subsidized health services.
Guideline 10: Determine the cost of Medicaid and other means-tested government programs.
Guideline 11: Determine the cost of financial assistance.

In Section 4.4, *Align Reporting with IRS Form 990, Schedule H,* you will learn how to do the following:

Guideline 1: Review and understand how CHA's community benefit accounting guidelines supplement and vary from IRS requirements.
Guideline 2: Value Medicare consistent with Schedule H instructions.

This chapter also is supported by the two-part **Appendix D**:

- Part I includes updated worksheets for community benefit accounting and reporting.
- Part II provides additional discussion of two topics:
  1. Approaches to developing indirect cost factors.
  2. How related organizations can approach community benefit reporting.

Tax-exempt hospital organizations *must* follow IRS instructions for purposes of completing Form 990, Schedule H. This *Guide* is not a substitute for those instructions. This *Guide* helps explain the principles behind community benefit accounting and provides help in navigating the accounting and reporting process.

INTRODUCTION

SECTION 4.1

Why Standardized Accounting and Reporting is Important

Since 1989, when the *Social Accountability Budget* was published, CHA has encouraged hospital organizations to adopt standardized community benefit accounting and reporting principles. There are several reasons why standardization is important:

- Standardization improves the comparability of reported community benefit information across hospital organizations.
- Standardization provides consistent valuation of community benefit amounts through time — allowing organizations to reliably assess trends in their community benefit investments.
- Multi-entity hospital systems frequently consolidate their community benefit results. Several state and national hospital associations also prepare association-wide community benefit reports. Consolidated reports are unreliable unless all participating entities have followed standardized accounting methods.
- Accounting principles that are standardized and well understood improve the reliability and acceptance of reported numbers — for both internal and external stakeholders.
- Standardization also facilitates staff education and training regarding the community benefit accounting and reporting process.

In 2007, the IRS released a redesigned Form 990, the annual information return filed by all tax-exempt entities. The redesigned form included a new Schedule H, which must be filed by all 501(c)(3) organizations that operate one or more hospitals. This form has been updated in subsequent years.

The community benefit accounting methods in Schedule H will be familiar to those who have followed past editions of this *Guide*, as Schedule H is derived from CHA's accounting framework. Schedule H requires hospital organizations to follow a common set of instructions for reporting the dollar value of the community benefits they provide. The incorporation of community benefit reporting into Schedule H thus also promotes standardization.

SECTION 4.2

ADOPT STANDARDIZED PRINCIPLES AND PRACTICES TO ACCOUNT FOR COMMUNITY BENEFIT

The following principles underlie the community benefit accounting framework.

Community benefit cost measurement principles

Guideline 1
Measure the actual financial cost borne by the organization, not the opportunity cost

The financial value of community benefit is measured and reported on the basis of actual cost. Community benefit accounting measures the auditable financial cost of activities and programs, not "opportunity costs." Opportunity costs, based on value or forgone revenue, are theoretical and not treated as actual cost in financial statements.

Examples of how the costs of community benefit activities are determined differently under the two approaches can be seen in the following table.

ACTIVITY	OPPORTUNITY COST (DO NOT REPORT)	ACTUAL FINANCIAL COST (REPORT)
Space provided to a community group	Market rate the community group would pay at a local hotel	Actual cost of the space (building depreciation, utilities, security) while in use by the community group
Financial assistance	"Gross charges" that could have been collected if financial assistance had not been granted	Patient care cost associated with the charges written off to financial assistance
Parking vouchers given by the hospital to low-income patients	Face value of the parking vouchers given to low-income patients	Actual cost of the parking garage per space while in use

Why are the actual financial costs used? Because they represent the amounts that the organization actually spends on community benefit. These costs are objective, auditable and less subject to judgment. They also are easily found and quantified in a hospital's general ledger (e.g., the remaining book value on a piece of equipment donated to a community clinic), a cost accounting system or cost report. This guideline is important to assuring that both the numerator (Net Community Benefit Expense) and the denominator (Total Expense) are determined based on the same accounting principles.

Community benefit accounting reports do not measure the *value* of community benefit programs. For example, an evaluation may show that an immunization program for low-income children substantially reduces health spending; however, community benefit accounting includes only the cost of the program itself. Reductions in spending and improvements in health achieved by the community benefit programs can be highlighted in the narrative that accompanies the community benefit report.

CAPITAL EXPENDITURES

Note that capital "expenditures" are not reportable as "expense" all in one year. Capital expenditures (e.g., amounts spent to construct or renovate a clinic building that houses a community benefit program) are not reported as community benefit expense or in total operating expense all at once in the year the expenditure is made. Under GAAP, a capital expenditure is expensed (reported as depreciation expense) over the years that the asset has a useful life (e.g., over five, seven or 30 years depending on the asset). Example:

- In 2012, a hospital spends $1 million to renovate a clinic building that houses a community benefit program. The full $1 million is not reported as "expense" in the hospital's financial statements for 2012, nor is the full amount reportable as community benefit expense in that year.
- According to the accounting records, the remaining "useful life" of the clinic building is 10 years.
- The hospital thus would record $100,000 annually ($1 million divided by 10 years) as depreciation expense and thus would spread the cost associated with the $1 million expenditure over the 10 years it provides use.
- The full $100,000 would be reportable as community benefit expense each year, if 100 percent of the building continues to be used exclusively to house a community benefit program. If only a portion of the building is used for a community benefit purpose, then a relevant proportion of the $100,000 amount would be reportable during each of the 10 years.

If, at some point, the building no longer is used for community benefit, then the organization no longer would report the depreciation expense as community benefit.

Guideline 2
Account for total and net community benefit expenses

Community benefit accounting establishes both the *total* amount organizations spend in providing community benefit and the *net* community benefit expense associated with each activity. The two categories of community benefit expense can help answer two different questions:

1. What amount and proportion of the organization's total expenses are devoted to community benefit programs?
2. How much of the organization's total community benefit expense is being funded by its own surplus?

The IRS provides the following definitions of these terms in the Schedule H instructions.

IRS NOTE

IRS

From the Schedule H instructions:

"Total community benefit expense" means the total gross expense of the activity incurred during the year. "Total community benefit expense" includes both "direct costs" and "indirect costs."

"Direct costs" means salaries and benefits, supplies, and other expenses directly related to the actual conduct of each activity or program. "Indirect costs" means costs that are shared by multiple activities or programs, such as facilities and administrative costs related to the organization's infrastructure.

"Direct offsetting revenue" means revenue from the activity during the year that offsets the total community benefit expense of that activity. "Direct offsetting revenue" includes any revenue generated by the activity or program, such as reimbursement for services provided to program patients.

"Direct offsetting revenue" also includes restricted grants or contributions that the organization uses to provide a community benefit, such as a restricted grant to provide financial assistance or fund research. "Direct offsetting revenue" does not include unrestricted grants or contributions that the organization uses to provide a community benefit.

"Net community benefit expense" is calculated by subtracting "direct offsetting revenue" from "total community benefit expense."

Use the categories and data elements shown in the following table to report quantifiable community benefits for persons living in poverty and for the broader community.

	Number of Programs or Activities	Persons Served	Total Community Benefit (CB) Expense	Total CB as Percent of Total Expense	Direct Offsetting Revenue	Net CB Expense	Net as Percent of Total Expense
BENEFITS FOR PERSONS LIVING IN POVERTY							
Financial assistance at cost							
Means-tested public programs • Medicaid • Other indigent programs							
Community health improvement services							
Health professions education							
Subsidized health services							
Cash and in-kind contributions for community benefit							
Community-building activities							
Total quantifiable community benefits for persons living in poverty							
(continued)							

	Number of Programs or Activities	Persons Served	Total Community Benefit (CB) Expense	Total CB as Percent of Total Expense	Direct Offsetting Revenue	Net CB Expense	Net as Percent of Total Expense
BENEFITS FOR THE BROADER COMMUNITY							
Community health improvement services							
Health professions education							
Subsidized health services							
Research funded by tax-exempt or government sources[1]							
Cash and in-kind contributions for community benefit							
Community-building activities[2]							
Community benefit operations							
Total quantifiable community benefits for the broader community							
TOTAL QUANTIFIABLE COMMUNITY BENEFITS							

[1] The tax-exempt organization can include the cost of internally funded (not donor restricted) research it conducts as long as the results of the research are made publicly available. Not to be included in Part I, Line 7 of Schedule H unless instructions change.

[2] To be reported in Part II of Schedule H.

Notes: Completing the columns for "Number of Programs or Activities" and for "Persons Served" is optional on Schedule H. The column "Total CB as Percent of Total Expense" is not included on Schedule H.

Guideline 3
Account for indirect costs as well as direct costs

Both direct costs and reasonable indirect (or "overhead") costs should be included in the accounting for each type of community benefit. The IRS supports this view.

IRS

IRS NOTE

From the Schedule H instructions:

"Total community benefit expense" includes both "direct costs" and "indirect costs."

"Direct costs" means salaries and benefits, supplies, and other expenses directly related to the actual conduct of each activity or program.

"Indirect costs" means costs that are shared by multiple activities or programs, such as facilities and administration costs related to the organization's infrastructure (space, utilities, custodial services, security, information systems, administration, materials management, and others).

Direct costs typically are *directly assigned* to each unique community benefit activity. Because indirect costs typically are shared, they need to be *allocated* across multiple activities or programs. The statistics used to allocate indirect costs vary, depending on the type of indirect cost involved. For example, building depreciation expense can be allocated based on the square footage occupied by each program, while the cost of a hospital business office can be allocated based on patient revenue.

Cost accounting systems allocate indirect costs to programs based on sophisticated techniques. In the absence of a cost accounting system, indirect cost factors can be derived from the Medicare Cost Report or from values provided by the finance department. These factors are applied to direct costs as follows.

The indirect cost factor typically is expressed as a percentage:

(Total Indirect and Direct Costs)/Direct Costs – 1 = Indirect Cost Factor

The factor then is applied as follows:

Direct Costs × (1 + Indirect Cost Factor) = Total Community Benefit Expense

See Appendix D for additional information and examples on how organizations can develop indirect cost rates for community benefit programs.

CHA recommends having at least two indirect cost rates for community health improvement services and for community-building activities – one rate for "hospital-based" programs and a second, lower rate for programs that are "community-based." One program might be housed in hospital space (thus absorbing utilities, maintenance, and other costs) and for that program a higher, "hospital-based" rate would be appropriate. Another program might be based in a non-hospital community setting and rely much less on the hospital for support and administrative services, and a lower "community-based" rate would apply.

Whatever indirect cost rates are used, they should be reasonable and supportable.

Guideline 4
Use the organization's most accurate cost accounting methods

Community benefit accounting requires assigning costs to individual programs and to services provided to specific patient groups (e.g., Medicaid recipients).

Organizations have several options for how costs are determined, including using cost accounting systems (if available), applying a cost-to-charge ratio (*see Section 4.3, Guideline 8, on how to calculate a cost-to-charge ratio*) to relevant charges or using program cost reports (e.g., the Medicaid Cost Report). Each of these options has strengths and weaknesses:

- Cost accounting systems generally provide the most accurate portrayal of the true cost of community benefit activities if the systems have been kept up to date; however, not all organizations have these systems in place.
- Overall cost-to-charge ratios are comparatively simple to calculate but can be inaccurate when they are applied to small product lines or programs.
- Medicaid and Medicare Cost Reports exclude certain costs as "non-allowable" and thus typically understate the full cost of services provided.

CHA encourages organizations to use their most accurate cost accounting method for community benefit. The IRS adopted this principle in the Schedule H instructions.

IRS

IRS NOTE

From the Schedule H instructions, regarding Part I, Line 7:

Use the organization's most accurate costing methodology (cost accounting system, cost-to-charge ratio, or other) to calculate the amounts reported on the table.

Many organizations use a blend of the above approaches to obtain the most accurate values, such as cost accounting systems for Medicaid shortfalls and subsidized health services and a cost-to-charge ratio to determine the cost of financial assistance.

Guideline 5
Split program costs between community benefit and other purposes, if warranted

Some programs and activities serve dual purposes: They provide both community benefit and organizational benefit. While organizations should use caution in this area, it is appropriate to split program costs between community benefit and other purposes (e.g., marketing) if you can document that the program **primarily** serves a community benefit purpose.

IRS

IRS NOTE

From the Schedule H instructions:

Activities or programs may not be reported if they are provided primarily for marketing purposes and the program is more beneficial to the organization than to the community. For example, if the activity or program is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

For example, a hospital provides a cash donation to help build an athletic field in a low-income neighborhood. The hospital's recent CHNA identified obesity among children and adults as a high-priority health need, and through conversations with community groups, the hospital found that there were no places for residents to exercise or play sports. While the primary purpose of the athletic field is to meet a community benefit need, the hospital will have its name displayed on a small sign as a donor so there is a slight marketing benefit. The hospital reports the donation amount in the "cash and in-kind donation" category and subtracts the actual costs of marketing, such as the sign.

Community benefit accounting principles

Guideline 6
Avoid double-counting community benefit expenses

Community benefit costs may not be double-counted. For example:

- If a hospital accounts for the cost of research in full as a discrete community benefit program, yet does not adjust research costs out of the numerator of the "ratio of patient care cost to charges" applied to financial assistance and subsidized health services, a portion of research costs would be counted twice.
- Double-counting also occurs if a hospital reports financial assistance costs or Medicaid shortfalls in full but then includes Medicaid and financial assistance losses again when accounting for the cost of subsidized health services.

The "ratio of patient care cost to charges" in this *Guide* includes adjustments designed to prevent double-counting community benefit expenses. Accounting guidelines for valuing subsidized health services also adjust for double-counting by subtracting financial assistance, Medicaid and bad debt from the total revenues and costs of each qualifying program.

Organizations that rely on a cost accounting system to determine the cost of various community benefit categories (e.g., Medicaid or subsidized health services) should use care to avoid double-counting. For example, a cost accounting system may allocate the cost of health professions education programs to Medicaid; however, health professions education costs are reported in full on another line in community benefit reports. Adjustments to amounts allocated by cost accounting systems may be needed to avoid double-counting.

Guideline 7
Follow generally accepted accounting principles (GAAP) unless IRS instructions override those principles

As much as possible, community benefit accounting should follow the same rules as the GAAP that guide preparation of financial statements. This makes it easier for accounting and finance professionals to support their community benefit program colleagues and also promotes standardization.

Community benefit accounting in Schedule H varies from GAAP in notable ways:

- First, "total expense" on Schedule H (used to calculate community benefit as a percent of expense) is to come from the IRS Form 990 and not from the organization's audited financial statements (prepared using GAAP). "Total expense" also must include relevant proportions of the total expense of joint ventures in which the organization maintains an ownership interest.
- Second, community benefit activities provided by joint ventures must be included based on the "proportionality rule" rather than following GAAP (which indicates using the "equity method" of accounting if ownership interests are below 50 percent).

Additionally, Schedule H requires community benefit to be reported on an "EIN-by-EIN" basis (aggregating results for hospitals and any other activities that operate under the same federal employer identification number [EIN]). On Schedule H, community benefits are reported for the entire organization (EIN), not only the hospital facility. This means that Schedule H results may not match system-wide or some individual hospital community benefit reports that do not follow the EIN approach.

CHA recommends following the Schedule H instructions for measuring community benefits provided by joint ventures but also recommends the following refinements:

- It should be noted that the IRS requires "total expense" to be derived from the IRS Form 990. "Total expense" reported on IRS Form 990 is different from total expense reported based on GAAP — even after subtracting bad debt expense. Organizations may decide to derive "total expense" from GAAP-prepared financial statements for their annual community benefit reports or for reporting interim (or stub) period results. Organizations should disclose how "total expense" was determined in community benefit reports.

Guideline 8

Report zero net community benefit expense to the IRS for any category in which offsetting revenue exceeds the total community benefit expense.

If offsetting revenue exceeds the total community benefit expense (e.g., if Medicaid net patient service revenue exceeds the cost associated with treating Medicaid patients), the result is a gain — or a negative net community benefit expense.

The IRS instructs filers not to report negative numbers in Schedule H, Part I, column (e) ("Net community benefit expense") or in column (f) ("Percent of total expense"); instead, negative net community benefit expense is to be reported as zero in column (e). Likewise, a negative percent of total expense is to be reported as zero.

The IRS has not yet provided instructions as to whether hospitals should exclude or include any gains for a particular community benefit category when calculating and reporting total net community benefit expense. For example, if a hospital's direct offsetting revenue for Medicaid ($20 million) exceeds its Medicaid expense ($18 million) for a particular year, resulting in zero net community benefit expense for Medicaid being reported on Schedule H, Part I, line 7b, column (e), it's not clear whether the hospital should subtract that $2 million gain from any gross community benefit expense in calculating and reporting its net community benefit expense for financial assistance and means-tested government programs (reported on Schedule H, Part I, line 7d, column (e)) or whether it should disregard that $2 million gain.

CHA recommends continuing to prepare community benefit reports based on the guidelines throughout this chapter. However, when reporting to the IRS, any negative numbers for net community benefit expense (and net community benefit expense as a percent of total expense) should be reported as zero. CHA recommends that, to maximize transparency in the community benefit report, any gains should be carried into overall totals (lines 7d and 7j of the community benefit table) so that the total net community benefit expenses reported in column (e) for lines 7d and 7j should be calculated by subtracting the direct offsetting revenue in column (d) from the total (gross) community benefit expense in column (c), rather than adding the totals in lines 7a–c and 7e–i. However, because the IRS has not provided specific instructions regarding this issue, hospitals with negative net community benefit expense in any community benefit category should use their best judgment when calculating and reporting totals and use the same methodology consistently in its Schedule H, Part I, community benefit reporting.

If gains result from extraordinary events, such as the receipt of substantial prior-year revenue (e.g., from a Medicaid Cost Report settlement), these circumstances should be explained in the Schedule H, Part VI, narrative section so readers understand the basis for reported community benefit amounts.

Guideline 9
Maintain an audit trail

Organizations are encouraged to maintain an audit trail for reported community benefit information so internal staff and external reviewers can understand the basis for reported information. An audit trail can be maintained using worksheets, such as those included in this Guide and in the Schedule H instructions, and supporting work papers and community benefit software, such as the Community Benefit Inventory for Social Accountability, and values should reconcile with the organization's general ledger.

Guideline 10
Report consistent counts for "number of programs or activities" and for "number of persons served"

The Summary of Quantifiable Community Benefits table (Appendix D, Worksheet A) includes columns in which organizations can report the number of community benefit programs or activities they provide and also the number of persons served. Schedule H also includes these columns, but reporting these values on Schedule H is optional. The Schedule H instructions define "persons served" as the number of patient contacts or encounters in accordance with the hospital's records.

To improve standardization and assist organizations with reporting these statistics, the table on the following page recommends metrics that organizations can use if they choose to report these counts.

COMMUNITY BENEFIT	NUMBER OF PROGRAMS OR ACTIVITIES	NUMBER OF PERSONS SERVED
Financial Assistance	One for each hospital or facility	Number of inpatient and outpatient accounts
Medicaid	One for each state Medicaid program (whether fee-for-service or managed care) in which each hospital or facility participates	Number of inpatient and outpatient accounts
Other Means-Tested Government Programs	One for each means-tested government program	Number of inpatient and outpatient accounts
Community Health Improvement Services	One for each discrete program A "program" has the following characteristics: same target audience, same purpose, same approach (including an activity with multiple facets)	Options: • Number of attendees at each program event • Number of registrants or enrollees in ongoing programs For broad community and public education programs, "one" unless there is a response mechanism to gauge actual attendance
Community Benefit Operations	Usually "one" for each dedicated community benefit department	N/A
Community Building	One for each discrete program	When program is for individuals, use enrollment, attendance or encounters; when program is for overall community, use "one" unless there is a mechanism to indicate how many benefited

COMMUNITY BENEFIT (*continued*)	NUMBER OF PROGRAMS OR ACTIVITIES (*continued*)	NUMBER OF PERSONS SERVED (*continued*)
Subsidized Health Services	One for each qualifying program or service	Number of inpatient and outpatient accounts (for each hospital and facility, including appropriate proportions of joint ventures)
Health Professions Education	One for each separately accredited education program (e.g., family practice residency, radiology technician program), one for each continuing medical education program open to the public and one for each scholarship program	Number of students Number of attendees at approved continuing medical education programs Number of persons receiving scholarships
Research	One for each qualifying research study or investigation	N/A or, alternatively, the number of subjects in the study
Contributions for Community Benefit	One for each grant made by the organization	N/A

Organizations that are part owners of one or more joint ventures can include each community benefit program provided by the joint venture as a "one" and then also include a proportion of each joint venture's "number of persons served." The proportion should be based on the organization's ownership interest in each venture.

Guideline 11
Develop appropriate community benefit accounting and reporting strategies for related organizations

Some organizations operate multiple entities within the same EIN, including hospitals, one or more foundations, wholly owned taxable corporations, and joint ventures. Many include operations for a single hospital only. These differences in corporate structure can make comparing one Schedule H to another a challenge.

Hospital organizations also can be affiliated with other entities that provide community benefit (e.g., community clinics, medical schools, faculty practice plans, research institutes and Graduate Medical Education consortia). These corporate structures can be complex and create issues when reporting community benefit — both on Schedule H and elsewhere.

The following principles are offered to support appropriate community benefit accounting and reporting:

- Each tax-exempt organization that has an ownership interest in one or more joint ventures should report community benefit, bad debt, Medicare and other values from those entities based on the "proportionality rule." However (pursuant to IRS instructions), if the organization makes a grant to be used for community benefit to a joint venture in which it has an ownership interest, it should not include the organization's proportionate share of the amount spent by the joint venture on such activities to avoid double-counting.
- As a general goal, it is appropriate to ensure that the hospital organization (the EIN that files a Schedule H) is able to report as much of the community benefit provided by the organization and its affiliates as possible. For example, if a hospital pays a management fee that helps to support a system office community benefit department, the hospital can report an appropriate portion of the management fee as a community benefit expense. In these circumstances, documentation is necessary to show that such amounts were actually used for community benefit purposes. If the hospital has a separate, related foundation that files its own Form 990, contributions for community benefit can be made by the hospital organization rather than by the foundation. The foundation can provide unrestricted funds to the hospital for this purpose.

- If a hospital operates a foundation under the same EIN, transfers of funds from the foundation to the hospital for community benefit activities will not be separately reported as community benefit expense because they are "intra-company" transfers. When the organization then spends the funds to support community benefit activities, it can report the expense on its Schedule H as community benefit, with no offsetting revenue unless the funds are restricted when received by the foundation.
- When the hospital and foundation exist in separate but related organizations, each with its own EIN, grants or transfers of funds from the foundation to the hospital that are restricted to being used for community benefit activities will be separately reported by the hospital organization in "direct offsetting revenue." The foundation then will report such grants to the hospital as an expense on its core Form 990 and the hospital will report the receipt of the funds as grant revenue on its core Form 990. When the hospital uses such funds to support community benefit activities, it will report the total community benefit expense on its Schedule H and would report the amount of the grants used during the period for these expenses as direct offsetting revenue.

Guideline 12
Disclose accounting methods in community benefit reports

Organizations also are encouraged to include footnotes (or endnotes) in their published community benefit reports that summarize the accounting methods used to prepare the report. Notes can indicate, for example, whether the report was prepared based on these CHA guidelines or whether exceptions were made. This is so readers of the information understand how reported amounts were determined. The IRS requires similar disclosures in Part VI of Schedule H.

CHA also encourages organizations to include information about financial assistance policies and the CHNAs they have conducted in published community benefit reports. These reports provide another opportunity to "widely publicize" the financial assistance policy and the CHNA, as required by federal law.

Guideline 13
Reconcile and report differences in community benefit reports

Many states require hospitals to prepare and submit community benefit reports. In other states, hospitals prepare reports voluntarily. Community benefit amounts reported on Schedule H can vary from the values reported in state community benefit reports. Differences between amounts reported on Schedule H and amounts in other reports will be present because:

- The IRS requires reporting on an EIN-by-EIN basis rather than on a hospital facility-by-facility basis.
- Many states have different definitions of community benefit and different accounting methods.

It's always important to follow state requirements when preparing state-required forms and reports. Complying with state and federal regulations often requires producing two sets of community benefit reports: one that meets state requirements and a second that follows Schedule H instructions.

Organizations should explain and quantify differences among the various reports so stakeholders can understand why such differences are present and what they mean.

SECTION 4.3

ACCOUNT FOR AND REPORT COMMUNITY BENEFIT

Appendix D contains worksheets that support accounting for community benefit based on the principles discussed in Section 4.2. The worksheets are organized as follows:

COMMUNITY BENEFIT WORKSHEETS	
These worksheets can be used to account for and report community benefit programs and services, bad debt expense, and Medicare.	
A	Summary of Quantifiable Community Benefits
1	Financial Assistance at Cost
2	Ratio of Patient Care Cost to Charges
3	Medicaid and Other Means-Tested Government Programs
4a	Community Health Improvement Services
4b	Community Benefit Operations
5	Health Professions Education
6	Subsidized Health Service
7	Research
8	Cash and In-Kind Donations for Community Benefit
B	Community Building
C	Medicare

The worksheets are numbered to align with those included in the Schedule H instructions. The worksheets in Appendix D include several enhancements to those in the Schedule H instructions. The modifications are designed to help organizations with the accounting process.

The accounting values produced by the worksheets in Appendix D are equivalent to those produced by using Schedule H. The worksheets can be completed for each entity that provides community benefit and can be aggregated at an EIN or system level.

See Chapter 2 for definitions and examples of each community benefit category.

Guideline 1
Establish an effective administrative and accounting process

Each organization should establish a robust administrative process for compiling community benefit program, statistical and accounting information. Although Schedule H is filed on an annual basis, many organizations find that preparing community benefit reports on a more frequent, interim basis enhances the accuracy and completeness of their information. Some have developed approaches to gathering program statistics and accounting information monthly or quarterly. Organizations also are finding it valuable to have one or more designated finance staff members become an expert in community benefit accounting and serve as an ongoing resource to their other community benefit colleagues.

More frequent data compilation can help programs avoid being missed or forgotten, allows active community benefit program monitoring, and facilitates midyear course corrections. On the other hand, monthly procedures can be resource intensive both for accounting and community benefit staff and for staff who supply information.

The community benefit worksheets should be completed in a specific sequence. To help avoid double-counting, the "ratio of patient care cost to charges" should be determined as one of the last calculations, as described in Guideline 8 of this section.

Guideline 2
Calculate the cost of community health improvement services

Worksheet 4a in Appendix D can be used to calculate the net cost of each community health improvement service. Unlike Worksheet 4 in the Schedule H instructions, CHA's Worksheet 4a includes separate columns for direct expense and indirect expense. Worksheet 4a also provides the opportunity to document community health improvement services separately from community benefit operations expense.

Organizations frequently quantify direct expense by multiplying the number of hours employed staff members have worked on each program by an hourly wage statistic and then by adding in factors for employee benefit costs, direct supply costs and other costs that should be directly assigned to the program. The "hourly wage statistic" is most accurate if it is department or program specific rather than hospital-wide.

Indirect expense is included based on the indirect cost factors discussed in Section 4.2, Guideline 3.

Guideline 3
Calculate the cost of community benefit operations

In Worksheet 4b, include the costs of community benefit operations, such as:

- Salaries and benefits for staff assigned to community benefit program administration.
- The cost to prepare CHNAs and develop associated implementation strategies.
- The cost of community benefit accounting software.
- The portion of the cost of the organization's grant writing and fundraising functions designed to yield revenue that supports community benefit.
- The portion of any system overhead or management fees used by the system office to support community benefit activities.
- The other costs associated with community benefit operations, such as participation in related educational programs.

Multi-hospital systems are finding it helpful to allocate the cost of any community benefit operations incurred by the system office to system hospitals. This allows each affiliated hospital to include these costs in community benefit reports and Schedule H.

Guideline 4
Determine the net cost of health professions education

In Worksheet 5, include the cost of health professions education programs. Health professions education that is reportable as community benefit is defined in the Schedule H instructions.

IRS

IRS NOTE

From the Schedule H instructions:

"Health professions education" means educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law, or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education or training programs available only to the organization's employees and medical staff or scholarships provided to those individuals. However, it does include education programs if the primary purpose of such programs is to educate health professionals in the broader community. Costs for medical residents and interns can be included, even if they are considered "employees" for purposes of Form W-2, Wage and Tax Statement.

Continued on next page ...

IRS

IRS NOTE *(continued)*

Direct costs of health professions education include:

- Stipends and fringe benefits for interns, residents and fellows in accredited graduate medical education programs.
- Salaries and fringe benefits for faculty directly related to intern and resident education.
- Salaries and fringe benefits for faculty directly related to teaching:
  - Medical students,
  - Students enrolled in nursing programs that are licensed by state law or, if licensing is not required, accredited by the recognized national professional organization for the particular activity.
  - Students enrolled in allied health professions education programs, licensed by state law or, if licensing is not required, accredited by the recognized national professional organization for the particular activity, including programs in pharmacy, occupational therapy, dietetics and pastoral care.
  - Continuing health professions education that is open to all qualified individuals in the community, including payment for development of online or other computer-based training that is accepted as continuing health professions education by the relevant professional organization.
- Scholarships provided by the organization to community members.

Direct costs of health professions education do not include costs related to doctoral students and postdoctoral students, which are to be reported on Worksheet 7, Research.

The above definition means that care should be taken not to report costs for unaccredited programs or for training that is not required to obtain or maintain professional licensure.

Direct offsetting revenue for health professions education does not include indirect medical education (IME) payments provided by Medicare, Children's Hospital Graduate Medical Education payment or Medicaid. IME revenue is considered by the Association of American Medical Colleges and by the IRS to be "clinical dollars" that should be accounted for either as Medicare revenue (in Part III of Schedule H) or as Medicaid revenue (in Part I of Schedule H) as appropriate. This treatment follows the view that graduate medical education programs have certain "indirect" effects on the costs of patient care (e.g., more laboratory tests ordered). Estimates for these "indirect" patient care costs are not to be included in the cost of health professions education and are not to be confused with "indirect costs" that represent hospital overhead and administrative expense allocated to community benefit programs.

Hospitals incur health professions education costs when nursing or other undergraduate medical education students who are enrolled in an accredited education program obtain clinical experience on-site. These students are mentored by nurses and other professionals on the hospital staff. The teaching that occurs (e.g., didactic or classroom training) can pull hospital staff away from normal clinical duties and can increase hospital staffing needs. The costs associated with mentoring trainees can be challenging to estimate.

Care should be taken not to overstate the actual cost of these activities. Having students on-site may not materially affect staff productivity. Students may perform work that otherwise would fall to staff. Costs associated with program administration and didactic training should be counted. Other cost implications should be estimated based on consensus reached by staff interacting directly with the students. More information about accounting for these community benefits is available on the CHA website at https://www.chausa.org/whatcounts on the What Counts Q&A page under the category of Health Professions Education.

Guideline 5
Include the costs of research that provides community benefit

Worksheet 7 portrays community benefit accounting for research. Only studies funded by tax-exempt or government entities are to be included in Part I of Schedule H. Costs reported for these studies are to be offset by any license fees or royalties associated with research that has been reported as community benefit. Direct offsetting revenue also includes Medicare or other third-party reimbursement for patients participating in studies (such as clinical trials) that have been reported as community benefit.

The cost of industry-sponsored research designed to yield generalizable knowledge (i.e., intended for publication) is not reportable on Part I of Schedule H but can be described in Part VI of the form. Such industry-sponsored research costs are not to be reported in the total community benefit costs in the organization's financial statements or annual reports. CHA encourages hospital organizations to report separately the costs they incur for research studies that are intended for publication and that are funded by the industry.

CHA's Worksheet 7 therefore includes two columns. The first accounts for costs incurred by the hospital organization for research studies that are funded by tax-exempt entities (e.g., foundations or the hospital's own funds) or by government (e.g., NIH) — and thus qualify to be reported as community benefit on Schedule H. Costs reported in the second column

would not be reported on Part I, Line 7, of Schedule H unless the IRS changes the definition of reportable research. Costs in that column can be reported in Part VI of Schedule H and in the hospital organization's own community benefit reports.

See Chapter 2 for more information about what research activities should count as community benefit.

The second column accounts for the cost of industry-sponsored research that the organization believes yields generalizable knowledge because research protocols call for publication. That amount currently is not reportable on Schedule H, but the instructions indicate that this type of research may be described in Part VI of Schedule H.

Worksheet 7 (and other worksheets) include a line for "direct offsetting revenue" provided by restricted grants or contributions received by the organization for a community benefit purpose, such as NIH research grants. Restricted grant revenue for community benefit is to be based on the amount of such revenue actually used for the activity or program during the year (rather than recording the full amount of the grant when received or when receipt is assured).

Said another way, direct offsetting revenue for restricted grants is to be determined based on "net assets released from restrictions." Spending the funds on a designated purpose (e.g., research or a community health improvement program) releases the restrictions and leads to being recognized as revenue that offsets community benefit activities.

Guideline 6
Quantify cash and in-kind contributions for community benefit

Tax-exempt hospitals provide financial or in-kind contributions to support community benefit activities provided by other organizations. In-kind contributions include noncash goods and services donated by the organization to another organization that provides community benefit, such as hours worked by staff at a community clinic or food or supplies given to a homeless shelter.

IRS instructions indicate that, in order to be reported on the Form 990 Schedule H, cash contributions for community benefit must be documented in writing that the organization restricted each cash contribution to a community benefit purpose (e.g. by including a restrictions letter with the contribution).

Unrestricted grants or gifts may not be reported as a community benefit (e.g. contributions to the capital of another organization that are reported in Part X of the core Form 990 (the organization's Balance Sheet)). Any payments the organization makes in exchange for a service, facility, or product, or any payment that the organization makes primarily to obtain an economic or physical benefit may not be reported.

Some organizations have raised questions about whether payments in lieu of taxes (PILT) are reportable as community benefit contributions. While PILTs relieve government burden, Form 990 Schedule H instructions explicitly do not allow reporting them if they are made "to prevent local or state property tax assessments." In CHA's view, PILTs may be counted as community benefit only if they are provided voluntarily (our of a sense of "disinterested generosity") and are used by the government for community benefit purposes.

In-kind contributions should be valued reasonably and based on actual cost. For example, meeting room costs would not be valued based on what a community group would need to pay at a local hotel for comparable space. Actual cost is based on utilities, depreciation, security and other carrying costs to maintain the space — in other words, the “break-even rate” the organization would charge the community group.

In Worksheet 8, include the costs of all qualifying cash contributions and grants and the value of all qualifying in-kind donations, such as meeting rooms, supplies and staff time (salaries and benefits).

To be consistent with community benefit accounting on Schedule H, cash and in-kind contributions that support community-building activities should be reported on Worksheet B of this *Guide* and on Part II of Schedule H.

The value of in-kind contributions should be established reasonably, and the expense should be included on Schedule H only if the expense also is included in Part XI of the core Form 990 (Statement of Functional Expenses). For example, if donated equipment has been fully depreciated or if supplies have no accounting value in inventory, only transportation and handling costs for delivery to recipients of the contributions should be reported.

Staff time for employees who have assisted other organizations while on the hospital's payroll can be valued based on their hourly compensation rates (including benefits and an allowance for indirect costs). The value of time donated by salaried (exempt) employees also can be based on the average hourly compensation for these employees — if the employees are participating during paid work time rather than on their own time and if participation in these activities is part of their job responsibilities. The case for inclusion is stronger if job descriptions for these employees indicate that involvement in these types of activities is expected.

Guideline 7
Measure the cost of community-building activities

Worksheet B can be used to account for the cost of community-building activities that are not reported on Worksheet 4a. IRS instructions state that community-building activities that meet the definition of community benefit are to be reported as community health improvement.

Guideline 8
Calculate the ratio of patient care cost to charges

Worksheet 2 or equivalent calculations can be used to determine the "ratio of patient care cost to charges." While calculating an overall ratio of cost to charges is a relatively simple matter (total expense divided by total gross charges), a simple approach would result in double-counting community benefit expenses. As a result, several adjustments are made both to the numerator and the denominator of this ratio, as follows:

- The "non-patient-care" adjustment in Line 2 accounts for the cost of activities that generate "other operating revenue." Organizations are allowed to use "other operating revenue" as a proxy for the cost of these activities. Organizations are encouraged to use the most accurate approach they have available.
- Record in Line 3 of Worksheet 2 any bad debt expense that is in the "total operating expense" from the organization's Statement of Revenues and Expenses prepared based on GAAP so bad debt expense is not allocated to the cost of financial assistance or to other community benefit categories to which the ratio is applied.
- Line 4 accounts for any Medicaid or provider taxes (sometimes referred to as assessments or fees) if those amounts also are included in the "total operating expense." These taxes or fees are subtracted from the numerator of the ratio of patient care cost to charges (if they have been included in total operating expense) because they are included in full as a community benefit expense in the Medicaid and financial assistance worksheets.
- Line 5 is where the total costs of community benefit activities and programs that have been determined without using the ratio of patient care cost to charges are recorded (such as health professions education, research, community benefit operations and others). These costs are deducted from the numerator of the ratio of patient care costs to charges so that they also are not double-counted in the cost of financial assistance or other programs to which the ratio is applied. Once again, if amounts (e.g., contributions for community benefit) have not been included in the "total operating expense," they should not be adjusted out of the numerator of that ratio.
- Line 9 is where any gross patient charges for programs not relying on the ratio are recorded so both the numerator and denominator of the ratio are adjusted appropriately.

The resultant ratio aligns with Schedule H instructions.

Guideline 9
Establish the cost of each subsidized health service

Worksheet 6 can be used to establish the total and net community benefit expense for programs that qualify as "subsidized health services." Chapter 2 (and also the Schedule H instructions) describes the criteria for classifying programs such as behavioral health units, burn units, trauma services and others as subsidized health services.

A worksheet should be completed for *each* program. Worksheets for each qualifying program then should be added together to provide values for Worksheet A (the Summary of Quantifiable Community Benefits). Worksheets that document the net cost of physician clinics included in subsidized health services can be used for Part VI of Schedule H as well. The IRS requires organizations to disclose whether any physician clinic costs have been included in subsidized health services and also requires that the hospital generate losses both on the hospital (technical) component of the service and on the physician (professional) component of the service before physician clinics can be reported.

IRS

IRS NOTE

From the Schedule H instructions:

An organization that includes any costs associated with stand-alone physician clinics (not other facilities at which physicians provide services) as subsidized health services in Part I, line 7g must describe that it has done so and report in Part VI the amount of such costs included in Part I, line 7g.

Note: The organization can report a physician clinic as a subsidized health service only if the organization operated the clinic and associated hospital services at a financial loss to the organization during the year.

Worksheet 6 begins with the total gross charges, cost and revenue for each program. Costs can be established by using the "ratio of patient care cost to charges" or another cost accounting method if more accurate.

Charges, costs and revenues associated with Medicaid and other means-tested government programs, financial assistance, and bad debt amounts are then subtracted to quantify the net cost of subsidized health services reportable as community benefit. The subtractions are made to prevent double-counting of amounts that have been reported in full elsewhere on Schedule H and in other community benefit reports.

CHA's Worksheet 6 also includes a separate column for recording Medicare charges, costs and revenue for each subsidized health service. Values in this column are not to be subtracted from the revenues and costs for subsidized health services but are designed to help organizations with their accounting for Medicare on Part III of Schedule H. As specified in the IRS instructions, Medicare amounts reported in Part III are to exclude any amounts reported in Part I as community benefit. This includes amounts reported in the subsidized health services category.

Guideline 10
Determine the net cost of Medicaid and other means-tested government programs

Losses incurred when caring for patients with Medicaid or other public program coverage for which patients qualify based on their household means are to be included in community benefit reports. Worksheet 3 can be used to account for these community benefits. Services reimbursed on a fee-for-service basis *and* those reimbursed through managed care plans are included in the accounting. Medicaid and other means-tested government programs from *all* states, not only the organization's home state, should be reported.

If revenue is greater than cost, then net community benefit expense should be set to zero. However, subtotals and totals are to include total community benefit expenses and revenue values.

Zero values may occur for organizations with substantial amounts of Medicaid disproportionate share hospital (DSH) revenue, large delivery system reform incentive payments (DSRIP), or significant prior-year revenue.

To be consistent with Schedule H accounting, CHA recommends applying GAAP when accounting for patient revenue (i.e., recording prior-year and other revenue when collection is reasonably assured and in alignment with amounts included in audited financial statements). Including a footnote in community benefit reports (and statements in Part VI of Schedule H) explaining why the organization is reporting zero net community benefit expense is important.

Worksheet 3 thus includes a row for recording prior-year revenue.

Include any Medicaid DSH, Upper Payment Limit (UPL) funding and DSRIP payments in revenue (and any associated provider taxes, assessments or fees) if the primary purpose of those funds is to fund Medicaid services. If DSH or UPL funds are designated to offset the cost of financial assistance in your state, those amounts should be recorded on Worksheet 1 (financial assistance). If the primary purpose of the funds is not specified or is unclear, then allocate the revenue and associated fees to Medicaid and financial assistance using a reasonable method. The same approach should be used for uncompensated care pool revenues and assessments.

Guideline 11
Determine the cost of financial assistance

Worksheet 1 can be used to determine the cost of financial assistance provided pursuant to the organization's financial assistance policy. Unlike Schedule H, CHA's Worksheet 1 includes one column for "free care," under which patients receive a 100 percent discount, and a second column for "partially discounted care," granted pursuant to a sliding-fee scale.

Hospitals establish financial assistance policies under which they forgive (and do not bill patients) all or portions of gross charges. These policies specify criteria for identifying patients who are *unable* to pay for all or part of their care and include a sliding-fee scale of partial discounts at different levels of household means and size.

Criteria typically consider a patient's (or guarantor's) annual household income in relation to federal poverty or other well-established guidelines, such as those published by the U.S. Department of Housing and Urban Development. Some policies consider household assets in qualifying patients for assistance. Many hospitals grant free or discounted care for patients with large (or "catastrophic") health care bills in relation to income. These patients are considered "medically indigent."

The Affordable Care Act (ACA) established Section 501(r) in the Internal Revenue Code and added several requirements for financial assistance and collections policies and practices to be followed by 501(c)(3) hospital organizations.

The law requires that tax-exempt hospital facilities must have a written financial assistance policy that includes:

- Eligibility criteria for financial assistance and whether such assistance includes free or discounted care.
- The basis for calculating amounts charged to patients.
- The method for applying for financial assistance.
- The actions the organization may take in the event of nonpayment, including collections action and reporting to credit agencies.

The ACA also requires all 501(c)(3) hospital organizations "to limit amounts charged for emergency or other medically necessary care that is provided to individuals eligible for assistance under the organization's financial assistance policy to not more than amounts generally billed to individuals who have insurance covering such care." Once the hospital knows that a patient qualifies for financial assistance, that patient is not to be billed an amount greater than what the hospital generally receives for care provided to insured individuals.

Importantly, the ACA also requires an exempt hospital to forgo "extraordinary collection actions … before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the … financial assistance policy." Regulations for Section 501(r) indicate the following represent "extraordinary collection actions:"

- Taking actions that require a legal or judicial process (liens, foreclosures, garnishments, seizure of bank accounts or property, civil action, arrest, body attachment).
- Selling debt to third parties.
- Reporting adverse information to credit agencies or bureaus.
- Deferring or denying (or requiring a payment before providing) medically necessary care because of nonpayment for previously provided care that is covered under the financial assistance policy.

Please check the IRS or CHA websites for updates regarding the 501(r) regulations.

The Healthcare Financial Management Association (HFMA), American Hospital Association and other organizations have sponsored efforts to help hospitals examine and refine their financial assistance policies. These associations recommend that:

- The organization should have clear and publicly accessible policies on financial assistance, discounts, payment plans and collection practices.
- The decision to grant financial assistance should be made as early as possible in the patient experience: pre-service, at time of service or post-service. However, the determination can be made at any time during the revenue cycle.
- Financial assistance should be reported on the basis of cost, not gross charges.

MISSION NOTE

Financial assistance should be granted as early in the patient experience as possible. Early financial assistance determinations are best for patients, who benefit from knowing about their financial obligations as early as possible, and for the hospital, which can avoid a costly, fruitless collections process if patients are unable to pay.

Many health care organizations struggle with maintaining a clear distinction between financial assistance and bad debt, particularly when patients do not provide all required documentation.

The HFMA Principles and Practices Board issued Statement 15 in December 2006 (and updated in June 2019) to help organizations with this process: https://www.hfma.org/content/dam/hfma/Documents/policies-and-practices/pp-board-statement-15-061519.pdf.

ALIGN REPORTING WITH IRS FORM 990, SCHEDULE H

SECTION 4.4

Sections of Schedule H were based on CHA's community benefit reporting guidelines. The guidelines in this chapter are closely aligned with Schedule H but supplement Schedule H requirements in a few ways.

Guideline 1

Review and understand how CHA's community benefit accounting guidelines supplement and vary from IRS requirements

CHA's guidelines differ from Schedule H requirements in the following ways.

CHA recommends reporting both "total" and "net community benefit as a percent of total expense."

- When calculating community benefit as a percent of total expense in reports other than Schedule H, derive "total expense" from the organization's GAAP-prepared financial statements (excluding bad debt) rather than obtaining "total expense" from the core Form 990. This allows tracking "community benefit as a percent of total expense" throughout the year rather than needing to wait until the core Form 990 is prepared.
- Organizations can continue reporting community benefit in two overall categories, for "persons living in poverty" and "benefits for the broader community," and then consolidate these two categories for purposes of Schedule H reporting.
- Worksheets can include additional details not present in worksheets included in the Schedule H instructions that support the community benefit accounting process:
    - Separate columns for direct and indirect costs.
    - Separate columns for "free care" and "partial discounts" in the financial assistance care worksheet.

- Separate disclosure of prior-year revenue.
- The amount of Medicare revenues and costs included in each subsidized health service.
- Separate rows for restricted grant revenue used for a community benefit purpose (net assets released from restrictions).

Guideline 2
Value Medicare consistent with IRS requirements

CHA recommends that if organizations want to include Medicare in community benefit reports, it should be reported "below the line" and also net of amounts already reported as community benefit (e.g., in health professions education, subsidized health services and research). Worksheet C can be used to report Medicare revenues and costs for this purpose.

Accounting-Related Definitions

Audited Financial Statements

An organization's statements of revenue and expenses and balance sheet, or similar statements prepared regarding the financial operations of the organization, accompanied by a formal opinion or report prepared by an independent, certified public accountant with the objective of assessing the accuracy and reliability of the organization's financial statements.

Source: Adapted from Glossary to IRS Form 990.

Control

One or more persons (whether individuals or organizations) *control* a nonprofit organization if they have the power to remove and replace a majority of an organization's directors or trustees. Such power can be exercised directly by a (parent) organization through one or more of the (parent) organization's officers, directors, trustees or agents, acting in their capacity as officers, directors, trustees or agents of the (parent) organization. Also, a (parent) organization controls a (subsidiary) nonprofit organization if a majority of the subsidiary's directors or trustees are trustees, directors, officers, employees or agents of the parent.

Source: Adapted from Glossary to IRS Form 990.

Cost Accounting

Measurement of the costs associated with specific activities and programs to provide information meaningful to management. For example, cost accounting is used to determine the amount of an organization's total expense that reasonably can be attributed to community benefit, to assign indirect (overhead) expense to the direct cost of a program, and to estimate the cost associated with serving a subset of patients, such as Medicaid recipients. Unlike financial accounting, cost accounting rules are not dictated by the Financial Accounting Standards Board (FASB) or the American Institute of Certified Public Accountants (AICPA).

Source: Instructions for Schedule H (IRS Form 990).

Depreciation

Represents the usage of an asset over time (its useful life). For example, a hospital purchases a piece of equipment that has a useful life of seven years. Under GAAP, the full cost of this equipment is not recorded as expense in the year it was purchased; instead, the cost of the equipment is depreciated (or "amortized") over time. Under the straight line method, the amount of expense would be one-seventh of the purchase price each year. The value of the equipment on the hospital's balance sheet would be reduced each year by the amount of the depreciation expense.

Direct Costs

Salaries and benefits, supplies, and other expenses directly related to the actual conduct of each activity or program.

Source: Instructions for Schedule H (IRS Form 990).

Direct and Indirect Medical Education Reimbursement

The Medicare program (and the Children's Hospital Graduate Medical Education program and Medicaid programs in certain states) provides two categories of reimbursement to hospitals with graduate medical education (GME) programs: direct GME and indirect GME (referred to as IME). The formula for direct GME payments is based in part on historical costs incurred by teaching hospitals for intern and resident salaries and fringe benefits and the costs for faculty supervision. The formula for IME is based in part on the number of interns and residents in relation to the number of hospital beds. In community benefit accounting, direct GME payments are included in "direct offsetting revenue" for health professions education programs. IME payments, however, are viewed as a resource that offsets increased patient care costs at teaching hospitals. These increased patient care costs are not the same as "indirect cost" (overhead including administrative expense). IME payments thus are included in direct offsetting revenue for Medicaid or Medicare patient care services.

Source: Instructions for Schedule H (IRS Form 990).

Disregarded Entity

An entity that is *wholly owned* by the organization and that is generally not treated as a separate entity for federal tax purposes (e.g., a single-member limited liability company of which the organization is the sole member). Revenues, expenses and other activities of the disregarded entity flow to the owner.

Source: Adapted from Glossary to IRS Form 990. See IRS Regulations sections 301.7701-2 and 301.7701.3 for more information.

Generally Accepted Accounting Principles (GAAP)

The principles set forth by the FASB and the AICPA that guide the work of accountants in reporting financial information and preparing audited financial statements for organizations.

Source: Adapted from Glossary to IRS Form 990.

Gross Patient Charges

The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Source: Instructions for Schedule H (IRS Form 990).

Indirect Costs

Costs that are shared by multiple activities or programs, such as facilities and administration costs related to the organization's infrastructure (space, utilities, custodial services, security, information systems, administration, materials management and others). Indirect costs do not include the estimated cost of "indirect medical education." Because the costs are shared, they are allocated to activities or programs using various cost accounting methods.

Source: Instructions for Schedule H (IRS Form 990).

In-Kind Contributions

Donations made (or received) using resources that are not legal tender (e.g., cash, checks, credit cards). Donations of supplies (e.g., pharmaceuticals), equipment or staff time that benefits another organization are examples of in-kind contributions. In community benefit accounting, in-kind contributions should be valued fairly. For example, the hospital donates a two-year-old computer to a community clinic. The hospital purchased the computer for $3,000, but it has been used for two years. As a result, it has depreciated to $1,000 in the hospital's books and thus should be reported as a $1,000 community benefit.

Joint Venture

An entity or contractual undertaking that involves two or more parties. Unless otherwise provided, a partnership, limited liability company, or other entity treated as a partnership for federal tax purposes. Hospital organizations that file Schedule H are to include in Parts I, II and III their proportionate shares of community benefit, total expense, community building, bad debt, and Medicare from joint ventures in which they participate.

Source: Adapted from Glossary to IRS Form 990. See IRS Regulations sections 301.7701-1 through 301.7701-3.

Medicaid Provider Taxes, Fees and Assessments

Almost all states have some form of Medicaid provider tax (or fees and assessments) in place. Hospital provider taxes are assessed in over 30 states. Through these arrangements, providers pay funds to states that then are appropriated to Medicaid agencies and serve as a source of matching funds that yield federal Medicaid revenue. These taxes, fees and assessments are included in community benefit accounting as a Medicaid cost, and any revenues they yield also are included in Medicaid "direct offsetting revenue."

Source: *Medicaid financing issues: Provider taxes.* Kaiser Commission on Medicaid and the Uninsured. https://www.kff.org/wp-content/uploads/2013/01/8193.pdf.

Notes to Audited Financial Statements

Additional information added to the end of audited financial statements. Notes to financial statements help explain specific items in the financial statements as well as provide a more comprehensive assessment of a company's financial condition. Notes to financial statements can include information on debt, going concern criteria, accounts, contingent liabilities or contextual information explaining the financial numbers (e.g., to indicate a lawsuit).

Source: Adapted from definition provided by Wikipedia.

Opportunity Cost

"Opportunity cost" represents the value of an activity or program based on the cost of something else that has been given up. For example, if a hospital provides free access to meeting space to a community group, the "opportunity cost" is the amount the hospital could have received if instead it had rented the space (at full market value) to someone else.

Organization

The entity that files IRS Form 990. Note that an "organization" may include one or more hospitals *and non-hospital* entities, such as a foundation, physician practices, a research institute and others. Schedule H requires community benefit amounts to be reported for the entire organization and (on a proportionate basis) for joint ventures in which it participates, not only for the hospital.

Payments In Lieu of Taxes (PILT)

Payments made by an organization "in lieu of taxes." These payments generally are made to local governments in lieu of paying property taxes. They frequently are determined after negotiations and may be calibrated to a percentage of the amount of property tax that the organization would pay if taxable or the amount of public services (e.g., fire and police protection) the organization uses. Because they generally represent a *quid pro quo* arrangement, they are not to be reported on IRS Form 990, Schedule H.

Prompt-Pay Discount

A discount offered to patients if they pay their out-of-pocket liabilities "promptly" — that is, within 30 days or less. The cost of prompt-pay discounts is not reported as financial assistance (charity care).

Related Organization
An entity that has one or more of the following relationships to the organization at any time during the year:

- Parent: an entity that **controls** the filing organization.
- Subsidiary: an entity **controlled** by the organization.
- Brother or Sister: an entity **controlled** by the same person or persons that control the filing organization.

Source: Adapted from Glossary to IRS Form 990.

Restricted Contributions (Grants)
Donations, gifts, bequests and other transfers of money or property made by a donor or grantor that has stipulated a temporary or permanent use for the resources provided. Donors or grantors provide restricted contributions with the intent of supporting a particular activity or program. Restrictions generally are stated in writing by the donor or grantor when they make the gift or grant.

Self-Pay Discount
A discount from gross patient charges provided to uninsured patients, including those that do not qualify for financial assistance. The cost of self-pay discounts provided is not reported as financial assistance (charity care).

SILOTs
Similar to PILTs, SILOTs are "services in lieu of taxes." Instead of monetary payments, SILOTs involve organizations providing free or low-cost services generally in lieu of paying property taxes.

Unrestricted Contributions (Grants)
Donations, gifts, bequests and other transfers of money or property that are free from any external restrictions and are available for general use.

Notes:

Chapter Five: Planning and Implementing Community Benefit Programs

5

Chapter Five: Planning and Implementing Community Benefit Programs

The needs assessment and the planning and implementation of community benefit programs should be as rigorous and visible as for any other strategic initiative.

To effectively address the most pressing health needs of your community, your organization will need systematic approaches to work with public health and other community partners to assess and prioritize community health needs and to develop community benefit programs that address those priorities.

The importance of CHNA and planning was reinforced by the Affordable Care Act of 2010 (ACA). The law added requirements for tax-exempt hospitals to conduct CHNAs and to adopt implementation strategies to meet the community health needs identified through the assessments.

The needs assessment and the planning and implementation of community health improvement programs are dependent on effective engagement with community members and groups. This requires building trust over time, understanding the local history and culture, being truly present in the community, and respecting strengths and assets within the community. Community engagement means being in rather than looking at the community. Doing with rather than trying to do for. Asking, learning and listening, not telling.

EQUITY NOTE

- Work with community groups and members to understand the history of discrimination and structural racism in the community.
- Assess current partnerships for diversity and whether they include cross-sector organizations and persons who experience disparities and discrimination.
- Assess and address any barriers to community engagement, such as past negative experiences with the organization and other trust issues.
- Hold meetings and conduct activities at times and places convenient to the community, and provide transportation and childcare if needed.

In Section 5.1, *Assess Needs and Assets*, you will learn how to do the following:

Guideline 1: Plan and prepare for the assessment.
Guideline 2: Define the community.
Guideline 3: Identify data that describes the health needs of the community.
Guideline 4: Understand and interpret the data.
Guideline 5: Define and validate priorities.
Guideline 6: Document and communicate results.

In Section 5.2, *Develop an Implementation Strategy*, you will learn how to do the following:

Guideline 1: Plan and prepare for the implementation strategy (also known as a community benefit plan).
Guideline 2: Develop and prioritize intervention options.
Guideline 3: Select interventions.
Guideline 4: Develop a written implementation strategy.
Guideline 5: Adopt the implementation strategy.
Guideline 6: Update and sustain the implementation strategy.

In Section 5.3, *Develop and Implement Program Plans*, you will learn how to do the following:

Guideline 1: Develop program plans.
Guideline 2: Determine implementation readiness.
Guideline 3: Develop a management plan.
Guideline 4: Promote the program.
Guideline 5: Put plans into action.
Guideline 6: Monitor and evaluate progress.
Guideline 7: Sustain the program.

SECTION 5.1

ASSESS NEEDS AND ASSETS

A CHNA is a systematic *process* involving the community that identifies and analyzes community health needs and assets to plan and act upon priority community health needs. This process results in a *product:* a report used to plan community benefit activities.

This section will cover the basic steps of conducting a CHNA, including how to prepare for the assessment, how to collect and analyze data, how to prioritize identified health needs, and how to document and share the results of the assessment.

CHA RESOURCE ON ASSESSMENT AND PLANNING

While this chapter provides an overview of the CHNA and community benefit planning, please refer to the CHA's resource *Assessing and Addressing Community Health Needs* for a comprehensive look at these processes. This resource can be accessed on the CHA website at https://www.chausa.org/communitybenefit.

Federal law and laws in many states require tax-exempt hospitals to conduct periodic CHNAs and adopt plans to meet assessed needs, so be sure to review all federal and state requirements.

To comply with federal tax-exemption requirements in the ACA, a tax-exempt hospital facility must:

- Conduct a CHNA at least every three years. The assessment must do the following:
  - Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.
  - Be made widely available to the public.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how it is addressing the needs identified in the CHNA and describe needs that are not being addressed with the reasons why such needs are not being addressed.

Check the Compliance/Public Policy section of CHA's community benefit website (https://www.chausa.org/communitybenefit) for federal regulations and instructions and a description of state requirements.

EQUITY NOTE

- Gather data using culturally appropriate tools and methodologies that consider factors such as the population's language needs, literacy levels and trust of institutions.
- Collect and analyze data on health outcomes and risk behaviors and other factors impacting health by income, disability status, geography, and race and ethnicity.
- Involve community members in collecting and analyzing assessment information.
- Make assessment findings available to community members and groups who experience disparities and request their feedback. Make sure to report back on actions taken and outcomes.

Guideline 1
Plan and prepare for the assessment

The success of your organization's assessment will depend upon proper planning, which includes securing the right resources and engaging key stakeholders.

The following actions will lay the foundation for the assessment.

Form an assessment team. Select a hospital staff person to lead the assessment effort or to be the hospital's lead in a community-led process. Ideally, the individual chosen to lead this process should have knowledge of state and federal hospital assessment requirements as well as the hospital's current community benefit portfolio. They should also be aware of any health system-level assessment requirements that must be met as part of their local process. The duties of the staff leader can include forming an internal team, working with community groups and public health experts, developing a plan and a budget for the assessment, and communicating progress and results to internal and external stakeholders.

The internal team should be staffed with people from departments across the organization, including strategic planning, communications, admissions, finance, emergency, community relations, social services, population health management and clinical areas. To be responsive to the diversity of your community, also include the diversity and inclusion officer, translation services, and community health workers or *promotoras*.

Also invite community members, public health department representatives and other community partners to join the team. These team members will bring key skills (planning, analysis, communications) and knowledge of the community to the assessment process. A community-inclusive process can foster alignment with external stakeholders, promote common goals and objectives, encourage data sharing, and elevate opportunities for joint investment during the implementation phase.

Plan for community engagement. If the assessment will not be a community partnership effort (which is preferred), involve members of the community and representatives from public health at the beginning of the CHNA process. Many hospitals that have an internal assessment team also use an external advisory committee that includes community stakeholders and representatives of organizations knowledgeable about community health issues to provide guidance on the process. Make sure to include persons from vulnerable or minority populations to ensure that the assessment is sensitive to cultural and other issues of importance to these groups.

CONSIDERATIONS FOR RURAL AND CRITICAL ACCESS HOSPITALS

Critical Access Hospitals can face additional challenges when engaging community members as participants or soliciting input for their CHNAs. The geographic isolation of residents being served, as well as limited hospital capacity to reach and engage people, can present a significant barrier to the process.

Given these challenges, local nonprofits, communities of faith, Federally Qualified Health Centers, Community Action Agencies and government entities serving rural populations can become important partners in the planning process. External partners often have greater access to rural populations and may have locally sourced data that the local hospital does not.

Critical Access Hospitals serve many diverse communities, including Indigenous populations, migrants and communities of faith, some of whom may adhere to traditions of self-reliance. Soliciting input from people for whom tradition or travel barriers restrict engagement may not be possible or, at best, may be limited. Reference any specific efforts undertaken to solicit this input in the CHNA even if these efforts were unsuccessful or limited.

Engage the hospital board and executive leadership. Involve your organization's executive leaders and board members from the beginning of the assessment process. Their advice and approval will be needed in the prioritization process. Their support is needed to integrate assessment findings into the organization's strategic and operational plans as well as to secure sufficient resources for the assessment and community benefit programs.

Determine purpose of the CHNA. Identify all the reasons why you are doing the assessment to help define the scope of the assessment, particularly the community and indicators to be assessed. The primary purpose of doing a CHNA is to improve community health. Central to this purpose is helping the hospital and broader community identify local areas with the greatest need, in which vulnerable populations, including communities of color, marginalized groups and those in rural areas, can face significant barriers to achieving health equity and well-being.

Related purposes include community-based or hospital strategic planning, gathering information for grant applications, or to fulfill tax-exemption requirements and other obligations, such as achieving nurse "magnet" status or receiving the Malcolm Baldrige National Quality Award.

Determine how the CHNA will be conducted. Decide if your organization will conduct the assessment on its own or in collaboration with others and whether outside consultation will be needed. Under ideal circumstances, the assessment will be approached as a partnership with other hospitals, community groups, and public health and other public agencies, but this approach may not be feasible for all hospitals. Choose the approach consistent with your organization's and community's goals, resources and capabilities.

If you contract out the assessment, be careful not to miss important opportunities for building relationships and gaining insights. Many health care organizations discover that community assessment is about developing relationships and partnerships as much as it is about uncovering health needs. The assessment process can be used to develop consensus about problems and priorities and to gain the commitment of organizations to work together. In short, the process can be as important as the product.

IRS NOTE

IRS regulations allow unrelated hospitals and other organizations (such as state or local public health departments) that identically define their communities to prepare a joint CHNA and a joint implementation strategy. Further, the regulations allow hospitals that have overlapping but not identical communities to jointly prepare parts of their CHNAs, providing guidance that should be followed by such hospitals in such cases. Treas. Reg. §§ 1.501(r)-3(b)(6)(v) and 1.501(r)-3(c)(4).

IRS

Begin with a team orientation. When convening the assessment team — whether internal or external — begin the process with a brief orientation so participants understand what a CHNA is, why it is required and how it will be used in the hospital's community benefit function.

This is also a good time to review existing community benefit programming and previous assessment material, along with any community feedback. Both staff and community members should be informed of existing community investments and how these investments continue to fulfill a significant community need.

Identify and obtain available resources. Explore what resources are needed and available for the assessment. Make sure to look at both organizational and community resources. Organizational resources may include previous CHNAs or other information on the community collected by the strategic planning office. Also, seek out staff with degrees in public health who are interested in population health and who can help with various aspects of the assessment.

Community resources may include existing assessments or coalitions concerned with community health improvement. Reach out to organizations already conducting or planning an assessment that would be willing to partner with your hospital or share results.

Develop a preliminary timeline. Develop a reasonable timeline to conduct the assessment. The timeline will be dependent on the approach selected, the size of your hospital and its community, the number of partners involved, and the availability of required resources.

Identify the internal hospital board or committee that will have responsibility for review and approval of the CHNA as well as the group's projected meeting schedule. Not all internal boards or committees meet on a monthly basis. When possible, the timeline should specify a date when the CHNA will be available for review. That date should align with the approving entity's meeting schedule.

Note: For hospitals operating on a calendar year basis, it it is very important to remember that, often, meeting dates, times and sometimes agendas can be subject to change during the end-of-year holidays.

Guideline 2
Define the community

The community is the geographic area, priority populations and the range of issues that will be examined by the needs assessment. You may use the previous needs assessment as a guide in defining the community of the current assessment, or you may decide to change the definition. For example, you may expand the geographic area covered or focus on a smaller at-risk area or vulnerable populations.

AGREE ON THE DEFINITION OF COMMUNITY

If the assessment is being conducted with other organizations, it is important to agree on the definition of the community to be assessed or to agree on how to proceed if there are differences.

In defining your community, you should consider your hospital's:

- Primary service area.
- Secondary service area.
- Patient categories (e.g., general population, children only or rehabilitation only).

For all non-specialty hospitals, the assessment should begin by looking at the overall community. After the broad view, the assessment can focus on priority geographic areas or populations. In the case of specialty hospitals, the community may be a subset of the population (e.g., children or those with a specific disease or condition). A specialty hospital's CHNA may focus exclusively on these populations.

Priority areas and populations may extend beyond your hospital's traditional service boundaries:

- Areas and populations served by your hospital's community benefit programs.
- Neighborhoods and other geographic areas that:
  - Have at-risk populations.
  - Have limited access to health care resources or professionals.
  - Have been impacted by adverse social, economic or environmental factors, such as high unemployment, unsafe housing, failing schools or the presence of high levels of toxic materials.

- Populations that are commonly considered to be at risk, such as:
  - Homeless individuals and families.
  - Low-income seniors.
  - Children and pregnant women.
  - Immigrants and migrant workers.
  - Members of ethnic or minority groups.
  - Uninsured and underinsured persons.
  - Persons with certain disabilities or medical conditions.
  - Members of the LGBTQIA+ community.
  - Veterans.

Your organization's CHNA should examine both health issues and risk factors for the geographic areas and populations covered by the assessment. It should also consider social, economic and environmental conditions that influence health (such as high unemployment rates, low graduation rates, the accessibility of healthy food, unsafe housing, and the presence of persistent toxic materials). These are commonly known as the social determinants of health.

IRS

IRS NOTE

IRS regulations state that in defining the community, the hospital may take into account all of the relevant facts and circumstances, including the geographic area served by the hospital, the target population(s) served and principal function. However, a hospital may not define its community to exclude medically underserved, low-income or minority populations who live in the geographic areas from which the hospital draws its patients (unless such populations are not part of the hospital's target patient population(s) or affected by its principal functions) or otherwise should be included based on the method the hospital uses to define its community. In addition, in determining its patient populations for purposes of defining its community, a hospital must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital financial assistance policy. Treas. Reg. § 1.501(r)-3(b)(3).

Guideline 3
Identify data that describes the health needs of the community

Your CHNA process will use data to describe the health needs of your community. Needs can vary from specific adverse health outcomes (e.g., high incidence of asthma) to poor quality-of-life indicators (e.g., high poverty rates).

A significant amount of data can be found using existing public health data (secondary data), while other types of information require new data collection (primary data). Data are often classified as either quantitative or qualitative. Quantitative data are expressed in numbers and help answer the "what" question (what is the problem), while qualitative data are expressed in words and help understand or explain quantitative data by answering the "why" question (contributing factors).

Source: Brownson, R. C., Fielding, J. E., & Maylahn, C. M. (2009). Evidence-Based Public Health: A Fundamental Concept for Public Health Practice. (p. 106).

Many CHNA processes incorporate community surveys, focus groups and stakeholder sector meetings to solicit resident input. This data can be incorporated into the text of the CHNA and used to highlight resident opinions or perceptions about health or social determinant factors.

USE RELIABLE AND CURRENT DATA

To accurately understand and quantify the health and quality of life of your community, it is necessary to use data that is both reliable and current. Outdated data or data not collected properly may inaccurately describe your community.

Review and Evaluate Prior Assessments and Reports

Identify existing needs assessments and any reports focused on the general population and special populations, such as children, seniors and minorities in your community. In addition to internal documents, resources may be available from public health departments, nonprofit organizations such as your local United Way, universities or community organizations.

Even though existing needs assessments and reports may have been published by respected organizations, it is necessary to review and evaluate all data and conclusions for timeliness, validity and relevance to the scope of your CHNA.

Consider the following questions in your review:

- Who conducted the assessment or report, and which community organizations were involved?
- When was the report published? What time period does the data cover?
- What populations and subpopulations do the data describe?
- What data sources were used?
- What were the findings?
- How was the assessment or report used?
- Were any priority areas or populations excluded?

These questions will help you determine whether the information from previous assessments will be useful.

Each subsequent assessment should build upon the last one by tracking and trending indicators related to priority issues that your hospital is addressing, either alone or in partnership with others. This will help your hospital understand what impact its community benefit and collaborative efforts are having on the health needs that it has chosen to address.

While subsequent assessments should track current priorities, they should also take a step back and ensure that new needs are not missed.

Describe Community Demographics

To conduct a CHNA, it is necessary to understand the population characteristics of your community. Examples of demographic information include population size, age structure, racial and ethnic composition, population growth, and density.

The U.S. census is an important source of demographic information. Census QuickFacts (https://www.census.gov/quickfacts/fact/table/US/PST045221) provides county-level demographic information for all U.S. counties and compares county values to state values. Visit the website of the U.S. Census Bureau (https://www.census.gov/) to view a complete list of online data access tools that can be used to access census data. On that site, you can also sign up to receive recurring census updates as new demographic information is released.

Other census resources include Household Pulse Surveys. The Pulse Survey is a point-in-time survey tool that tracks community impact measures, such as employment, food access, housing instability, etc., that are key to understanding national and regional social determinants of health trends. The Census Bureau now sponsors free online tutorials to help individuals and organizations access and use the vast amounts of the Bureau's demographic data and charting.

Also check with your hospital administration or strategic planning office to see if it has purchased demographic files for market research or business planning purposes. It may be able to share this data with you for use in your needs assessment. The benefit of using demographic data from a third-party vendor is that it may be available at the zip code or census-tract level.

Select Indicators

Indicators are measurements that summarize the state of health and quality of life in your community. A broad set of health and quality-of-life indicators should be included in the CHNA.

Because each community is different, the indicator list you select for your community may differ from the indicator lists from other communities; however, there are certain categories of indicators that should be included in all assessments:

- Demographics and socioeconomic status.
- Access to health care, including access to behavioral health and dental service.
- Health status of the overall population and priority populations.
- Risk factor behaviors, including the social determinants of health.
- Maternal and child health.
- Infectious diseases.
- Social environment.
- Natural environment.
- Resources and assets.

See Appendix E for suggested indicators for each of these categories.

Consider the following when selecting indicators for your assessment:

- ***Standards and benchmarks*** – The Department of Health and Human Service's Healthy People initiative provides national disease prevention and health promotion targets spanning many topic areas. Many states and county health departments also have set specific community health improvement goals for their jurisdictions. Also consider how your community compares to traditional standards, such as federal poverty standards and alternate standards, such as benchmarks for a livable wage.

- ***Community and organizational needs and priorities*** – Perceived needs of the community should be a factor in the selection of indicators. Hospital needs or priorities may also influence which indicators you will select for the assessment. For example, a hospital with a large oncology program may want to look at the risk factors and incidence of cancer and access issues related to screening and treatment. A health care system might ask each of its hospitals to address a specific issue, such as violence, aging or homelessness, in addition to broader health needs.
- ***Quality and usability of data indicators*** – Indicator data should be valid and reliable for both the target population and for subgroups of interest. The indicator data should be easily accessible and updated regularly since multiple data points are necessary for analysis of trends and evaluation of interventions.

Identify Relevant Secondary Data

You will need to identify existing quantitative data that support the indicators you have selected. This data will help you better understand the size and seriousness of issues, as well as the trends, and summarize the health and quality of life of your community.

Begin your data-gathering efforts by reviewing trusted sources of secondary data. Information about the health status of the U.S. population at the state, county and zip code level is routinely collected by governmental and nongovernmental agencies through surveys and surveillance systems. Most of these secondary data sources will be accessible online. Hospital data is another important source of information about community health.

A note on data limitations: Population health and demographic data are often delayed in their release, so be sure to let readers know the exact time period for any given data source. Additionally, gaps and limitations persist in data systems for certain community health issues, such as mental health and substance use disorders, crime reporting, environmental health, and education outcomes.

You will need to revisit your indicator list after the available data sources have been identified and may need to add or remove indicators based on data availability.

National-Level Data

There are many national data sources that provide community health information. Examples of these sources include: the U.S. Census Bureau's American Community Survey; the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System and the National Health and Nutrition Examination Survey; and the County Health Rankings model (https://www.countyhealthrankings.org).

State-Level data

State Health Data

Nearly every state public health department operates surveillance systems, disease reporting systems and behavioral health surveys. Additionally, almost all states have population-based cancer reporting systems. These sources often provide county- and, at times, municipal-level data. Contact your state health department to determine what survey and surveillance data are available.

State Vital Records

Vital records include birth certificates and death, marriage and divorce records. Because state law dictates vital records reporting, this information varies by state. Vital records can provide valuable information, including birth and death rates, causes of death, birth outcomes, and socioeconomic risk factors. Data is often available at the county level. Many state health departments provide vital record databases, which can be a valuable data source for your CHNA. If your state health department does not regularly release vital statistics data, you can use the CDC's Wonder dataset to explore rates for different causes of mortality at the state and county levels.

County and Other Local Data Sources

County and local public health departments collect data in varying degrees. Check your local public health agency websites to see what information is available.

There are many web-based data platforms that do a very good job of reporting county and sometimes local data that can highlight areas in which health disparities are significant. Community Commons is an excellent example, which can be accessed at https://www.communitycommons.org, as is the County Health Rankings and Roadmaps site, which can be accessed at https://www.countyhealthrankings.org.

Examples of local organizations and services that also conduct assessments and implement action plans:

- Head Start Agencies.
- Housing Assistance Programs, like the Coordinated Entry System.
- Federally Qualified Health Centers.
- City and county Public Health Departments.
- Area Agencies on Aging.
- Certified Community Behavioral Health Clinics.
- Food Access Organizations.

Local philanthropies, including the United Way, rely heavily on community data when directing investments or making grants. They can also be important strategic partners during the implementation phase following the assessment period. By aligning the use of common

data elements, these investment partners can work with the hospital to foster opportunities for shared measurement, evaluation and tracking impact.

United Way as a Data Source

- United Way publishes a state- and county-based index of financial insecurity data that targets low-wage, employed individuals. The index uses the acronym ALICE, which stands for Asset Limited, Income Constrained, Employed. State and local United Ways publish this community-based cost-of-living data on a biannual basis. For more information, check out state or local United Way websites or the United Way national website: https://unitedforalice.org/national-comparison.
- United Way also supports Call 211. Call 211 agencies are locally based resource and referral call centers located in communities throughout the United States. These call centers help individuals access local human service support and other resources. Call 211 centers aggregate and often publish their data. Besides being a good source for the CHNA, this data can help the assessment and implementation teams pinpoint problems in local resource capacity, including seasonal trends, when prioritizing local need.

Hospital Information

Whenever possible, hospital utilization data should be included in your CHNA. Your state hospital association or health department typically collects statewide data on hospital and emergency department utilization.

Within the hospital, quality assurance, medical records, strategic planning, marketing and business intelligence (decision support) departments are likely to have access to hospitalization and emergency visit utilization data for your facility.

This health care utilization data can highlight health problems in the community, particularly information about preventable hospitalizations and the need for increased primary or preventive health services and interventions.

Also review your organization's current community benefit and community health improvement activities. What needs are they addressing, and do the needs persist? Information about these needs should be factored into your CHNA as long as they reflect true community needs, regardless of whether they have been identified as issues by other data sources collected during the assessment.

PREVENTION QUALITY INDICATORS (PQIs)

The Agency for Healthcare Research and Quality (AHRQ) has set the standard for defining preventable causes of hospital admission. PQIs can be used to identify quality of care for ambulatory care sensitive conditions, which are defined by AHRQ as "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease." For more information on PQIs, visit https://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx.

Primary Care Data

Many primary care offices and networks use social determinants of health assessment screening tools as part of patient entry. Social needs screening helps ascertain if individual patients may be at higher medical risk because of income inequality, education, racial and ethnic disparities and other factors.

Tools that screen for social needs typically list between eight and 12 areas of need. This data can be de-identified, aggregated and stratified to help target specific areas of community need, such as food access, housing insecurity and lack of transportation, to inform the CHNA.

Collect Primary Data Through Community and Public Health Input and Feedback

Input obtained directly from community members, community groups and public health experts can be used to collect information about geographic areas or populations when such information is not available from secondary sources or to help explain findings from those sources. It also helps to determine the perceived needs of the community and the community assets available to address these needs. Collecting community input also allows you to directly connect with specific populations in your community, such as disadvantaged or minority populations, and to establish or strengthen relationships with partners. Data gathered directly by you or your assessment partners is considered primary data.

Here are a few examples of information you can collect:

- What health problems are most troubling to community members?
- What are issues of concern to public officials — school principals, emergency responders and the health department?
- Are any community-based organizations or community coalitions already addressing these issues?
- What factors may be contributing to health problems? These factors could be safety concerns, systemic racism, environmental or housing issues, and others.
- What do you think defines a healthy community?

Soliciting Input from Key Demographic Groups

Determine how and where you will capture the voice of low-income and marginalized populations. Ask faith and other leaders from these communities for suggestions as well as opportunities to solicit feedback. Avoid using input from nonprofit service providers or government agencies as a proxy for resident input.

Consider gathering resident input through a short neighbor-to-neighbor survey. Using this approach, the CHNA team can partner with a local church or trusted neighborhood entity to engage, train and deploy local volunteers to implement the survey with their friends and neighbors. This outreach approach can help the assessment team identify or affirm opportunities to impact issues. Remember to build any costs associated with this approach into the CHNA budget.

The needs of senior citizens and disabled populations should always be included in the CHNA process. Meet seniors and those with disabilities where they already congregate to solicit their input. Consider Programs of All-Inclusive Care for the Elderly (PACE), retiree groups, veterans' groups, faith communities or senior meal sites to ensure that the concerns and priorities of elders are solicited and heard. Consider community-based organizations serving the needs of the disabled community, again focusing on existing programs, job training and rehabilitation programs, along with services supporting disabled veterans and their families.

IRS

IRS NOTE

Provisions in the ACA require CHNAs conducted by tax-exempt hospitals to take into account "input from persons who represent the broad interest of the community serviced by the hospital facility, including those with special knowledge of or expertise in public health."

IRS regulations indicate that to meet this requirement, the CHNA must, at a minimum, solicit and take into account input from all of the following sources:

1. At least one state, local, tribal or regional governmental public health department (or equivalent departments or agencies) with knowledge, information or expertise relevant to the health needs of that community.
2. Members of medically underserved, low-income and minority populations in the community served by the hospital facility or individuals or organizations serving or representing the interests of such populations. Medically underserved populations include populations experiencing health disparities or who are at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial or other barriers.
3. Written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy.

In addition to the sources described above, the IRS regulations note that hospitals may solicit and take into account input received from a broad range of persons located in or serving its community, including health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives.

STATE AND LOCAL HEALTH DEPARTMENT PARTNERSHIPS

Many state and local health departments also conduct CHNAs to meet voluntary accreditation requirements. These agencies can be valuable resources and partners in all aspects of the hospital's or community coalition's CHNA, such as helping to design the assessment, collecting and analyzing data, and planning for collaborative action to improve community health.

There are a number of methods to collect community input and feedback. You will want to select at least one approach for collecting this information. Also select at least one method for collecting input from those with special knowledge or expertise in public health. Public health expertise may be available from your local or state health department, a university school of public health, or public health consulting groups, such as a public health institute. This will ensure you have not overlooked any community priorities and have met legislative requirements.

Surveys

Surveys are generally targeted to a larger population than interviews or focus groups. They can be used to collect information from community members, stakeholders, providers and public health experts for the purpose of understanding community perception of needs. Surveys can be administered in person, over the telephone or using a web-based program. Surveys can consist of both forced-choice and open-ended questions. Be aware that many under-resourced populations don't have access to computers, so tailor the type of survey to those in the community you want to hear from.

When using surveys or questionnaires, test the tool first with community members prior to posting or implementation. Is the tool easy to understand, and are unfamiliar terms clearly described? Are there questions that lead a reader to respond in a certain way? Will translation of the survey tool be necessary, and who will do this?

Once posted or implemented, continuously check incoming survey data to affirm that communities of color, ethnic groups and rural populations are responding in a manner that will result in a valid survey sample size. If not, identify ways to conduct the survey differently to improve the level of response.

Questionnaires

Questionnaires can be devised for the general community and for specific groups, such as those in homeless shelters or in clinics. Some hospitals and CHNA partnerships sample attendees at major events, such as health fairs and county fairs. Keep in mind, however, that results from these approaches may not be generalizable to the broader community.

Interviews

Key informant interviews are a method of obtaining one-on-one input from community members, leaders and public health experts. Interviews can be conducted in person or over the telephone.

In structured interviews, questions are prepared and standardized prior to the interview to ensure that consistent information is solicited on specific topics. In less-structured interviews, open-ended questions are asked to elicit a full range of responses.

Key informants may include leaders of community organizations, service providers and elected officials. Individuals with special knowledge or expertise in public health may include representatives from your state or local health department, faculty from schools of public health, and providers with a background in public health. Emergency responders can also identify unmet needs of vulnerable populations.

Also, consider interviews with staff from the hospital's emergency department and social services and discharge planning offices.

Community Forums

Community forums are meetings that provide opportunities for community members to provide their thoughts on community problems and service needs. Community forums can be targeted toward priority populations or involve the broader community. Community forums may require a skilled facilitator. It is recommended to hold these forums in the community and not at the hospital.

Focus Groups

Community focus groups are small-group discussions with selected individuals. A skilled moderator is needed to lead focus group discussions. Members of a focus group can include internal staff, the staff of human service and other community organizations, users of health services, and members of minority or disadvantaged populations.

TIPS FOR HOLDING FOCUS GROUPS AND FORUMS

- Be creative in reaching out to priority populations, and consider holding multiple events to attract these groups.
- Hold focus groups and forums at convenient times (after traditional work hours).
- Record the discussion. Ideally, take notes and use a voice recorder.
- Explore multiple points of view. Try not to let a single issue dominate the discussion.
- Clearly define the hospital's role. Set expectations about what the hospital or partnership conducting the assessment can and cannot do.
- Monitor the time, and use time efficiently.
- Use a skilled facilitator to moderate focus groups and forums. Look among your advisory group and hospital staff for a person with this skill set. If not available, you will find it is a good investment to hire someone with this skill set.
- Hold multiple sessions to ensure you are getting a broad set of viewpoints.
- Pay attention to the demographic profile of individuals participating. Consider gender, race, ethnicity, zip code and age, at a minimum. Do participants reflect community makeup?
- Budget for refreshments and, possibly, travel vouchers for focus groups if feasible. It can also be helpful to provide a stipend for participation.

Identify Community Assets

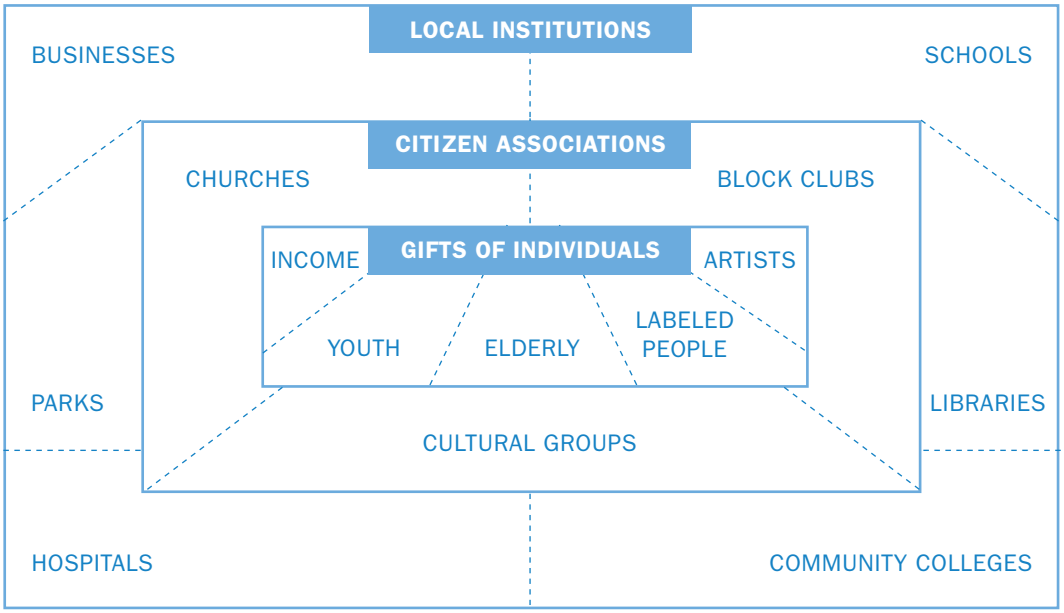
It is also important to receive input about community resources or assets that may be available to respond to the health needs of the community. Your community's assets include other providers, individual community members, local agencies, religious congregations, neighborhood associations and coalitions as well as public agencies. Assessing assets allows you to focus on the strengths of your community, including capacity, skills and the resources available to address identified needs.

IRS

IRS NOTE

IRS regulations indicate that hospitals should include in their CHNA documentation a description of the resources potentially available to address the significant health needs identified through the assessment. The IRS regulations also note that hospitals should solicit and take into account from persons representing the broad interests of the community in identifying these resources. See above for more details on IRS regulations related to what hospitals must do to meet the requirement to solicit and take into account this input.

The asset map below provides a framework from which to consider your community's assets. Consider including questions about community assets in your efforts to collect community input.



Source: Kretzman, J.P., & McKnight, J. (2004). Building communities from the inside out: A path toward finding a mobilizing a community's assets. Langara College.

Once you have collected asset information, it's often helpful to put it on a map. Asset mapping is a process intended to identify and then physically locate a community's strengths and resources. The process involves conducting an inventory that targets a community's human, cultural, economic and other infrastructure resources. This is typically done in a geographically defined area, such as a census tract, zip code, local neighborhood, school district or other geographical subset. Information is then mapped to both inform and support community decision-making.

Guideline 4
Understand and interpret the data

After you have gathered the indicator data and community input necessary to meet the scope of your assessment, you will analyze the information to identify health needs.

Analyze and Interpret the Indicator Data

There are several ways to consider and interpret the indicator data you have identified. Three methods for data analysis and interpretation are discussed below: comparisons, trends and benchmarks.

As you analyze the data, keep in mind that primary (original) and secondary (from other sources) data are reported in a variety of formats (counts, proportions and other types of measurements). It is critical to fully understand the measures reported to accurately interpret the data. Consider seeking someone with experience in epidemiology to assist you in analyzing and interpreting the data.

Comparisons

How does your community compare to other communities, your state, and the U.S.?

To monitor the health and well-being of a community, it is often desirable to compare an indicator from your community to that of another community. Moreover, it may be informative to compare a measure of disease from your community to the number of cases or rate of disease at the national level or state level.

Comparisons showing areas which your community is doing worse than other communities, the state value or the national value, may point to needs in your community that should be addressed. However, there are some conditions and risk factors present in all or most communities that may deserve attention, even if your community does not seem to be doing worse than others. These conditions include heart disease, stroke, obesity, diabetes and cancer. These conditions are often noted in national health improvement initiatives, such as Healthy People 2030, or are among the leading causes of death at the national level.

Trends

Is the indicator data increasing, decreasing or remaining the same over time?

To consider trends, you will need to have values for more than one time point. Often, secondary data sources publish data annually, which allows for the determination of trends.

Indicators that become more unfavorable over time may demonstrate priority needs in your community. Indicators showing no improvement despite efforts to address associated needs may also warrant attention, such as modifying interventions.

Benchmarks

Does the community meet benchmarks?

National benchmarks are standards against which something can be measured or judged. Examples of national benchmarks include Healthy People and the Environmental Protection Agency Air Quality Standards. If available, collect information about any state and local benchmarks. Consider how your community compares to these benchmarks for a variety of indicators.

Data platforms, such as the County Health Rankings and Road Maps (https://www.countyhealthrankings.org), integrate federal and state benchmark data into their reporting. County Health Rankings also include measures of health equity when verifiable data from government sources is available.

Indicators for which your community fails to meet benchmarks may demonstrate needs in your community.

Identify Disparities

When possible, data grouped by demographic factors such as race, ethnicity, language, gender, economic status and age should be evaluated to identify disparities. You will find that some areas or populations experience a greater burden of disease. Consider possible disparities among both geographic areas and subpopulations.

An issue may not appear to be a significant problem until you examine the incidence among groups. For example, maternal and infant mortality rates may not seem significant until you find there are much higher rates among African American mothers and babies when compared to other racial groups.

Identify and Understand Causal Factors

To understand why observed problems exist, consider social, environmental and physical factors that may be influencing the observed needs.

For example, the data may show that your community has a higher rate of obesity than neighboring communities. You can better understand the problem by looking at potential causal factors. For example:

- The density, availability or number of parks and community gardens.
- The availability of healthy food.
- Access to a built environment (sidewalks, bike or walking paths, pools, playgrounds and sports clubs) that increases physical activity.

Some neighborhoods have experienced years of environmental burdens due to racist zoning and land use policies that permitted factories, industrial plants, major transportation arteries and dumping sites to be located close by. As a result, many residents may have respiratory problems and cancers.

Understanding causal factors will allow you to better understand the problem and will enable you to identify opportunities for improvement.

Identify Major Community Health Needs

After analyzing your indicator data and taking into account community input, hospital information related to community need (including needs being met by existing community benefit programs and hospital utilization data) and other information, you will be able to identify and summarize the most important needs facing your community. These needs should be documented in a data summary.

Every indicator included in your assessment should not be included in this summary. Instead, the assessment team should select a manageable number of the most important needs. You may further refine this data summary during the CHNA priority-setting process.

Be as specific to your community as possible. While nationally we see heart disease, cancer, diabetes and behavioral health problems as top health issues, try to dig deeper into your assessment to the issues that might be specific to your community and the factors that contribute to these problems.

IRS

IRS NOTE

IRS regulations state that health needs include the requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as neighborhoods or populations experiencing health disparities). The regulations also note that these needs may include the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral and environmental factors that influence health in the community. Treas. Reg. § 1.501(r)-3(b)(4).

Guideline 5
Define and validate priorities

Your hospital and its partners probably will not have the resources to address all the community needs identified in the assessment. Therefore, it will be necessary to identify and prioritize the needs the hospital will address itself, the needs the hospital will address with others and the needs the hospital will refer to others.

The data summary developed during the data analysis process should help guide the prioritization process.

You may be part of two priority-setting processes: one that is led by a community coalition that sets community-wide priorities and another that is conducted by the hospital to identify priorities for the organization.

Alternatively, there may be one community-wide priority-setting process, and the hospital will select priorities from that process to address — either on its own or with partners.

It is important for the community's voice to be included in setting priorities. Include persons who represent the diversity of your community in terms of race, age, language and other factors to be sure the community being served has a say in the priorities selected.

IRS NOTE

IRS regulations state that input from persons representing the broad interests of the community should be taken into account in prioritizing significant health needs and identifying resources potentially available to address those health needs.

IRS

Determine Who Will be Involved in the Setting of Priorities

For most hospitals, an internal assessment team, the assessment advisory committee and key partners will conduct an initial review of data and identify preliminary priorities. Key partners might include public health officials, other service providers, and community members and leaders.

Priorities should be shared with the hospital board, executive leadership and others in the community for validation and consensus.

Establish Criteria for Priority Setting

Establish criteria for prioritizing the needs identified in the CHNA. You may wish to revisit the original purpose of the assessment and ensure that the criteria selected reflect your original purpose.

Examples of criteria that can be used include the following:

- Magnitude of the problem (i.e., the number of people impacted).
- Severity of the problem (i.e., the risk of associated morbidity and mortality).
- Historical trends.
- Alignment of the problem with the organization's strengths and priorities.
- Impact of the problem on vulnerable populations.
- Importance of the problem to the community.
- Existing resources addressing the problem.
- Relationship of the problem to other community issues.
- Feasibility of change and availability of tested approaches.
- Value of immediate intervention versus any delay, especially for long-term or complex threats.
- Impact of the problem on local health disparities.

EXAMPLE OF CRITERIA FOR PRIORITY SETTING

One coalition considers six criteria when examining the county's leading health problems. Each criterion is ranked on a scale ranging from "completely disagree" to "completely agree":

1. The problem is greater in the county compared to the state or region.
2. We can reduce long-term cost to the community by addressing this problem.
3. We can create a major improvement in the quality of life by addressing this problem.
4. We can solve this problem.
5. We can do something about this problem with existing leadership and resources.
6. We can make progress on the problem in the short term.

Identify Priorities

There is not one generally accepted method for priority identification; instead, there are several processes that can be used to apply the criteria you established to determine priorities for action. You should choose the approach best suited to your organization.

Two commonly used prioritization methods are:

1. ***Ranking***: The priority-setting group is asked to rank identified needs with a numerical score based on the criteria established earlier.
2. ***Discussion and debate***: The needs identified in the data summary are discussed, and criteria (which can be weighted to assign greater importance to certain factors) are applied to these needs to identify priorities.

IRS NOTE

IRS regulations state that documentation of the CHNA should include a prioritized description of the significant health needs of the community along with a description of the process and criteria used in identifying those needs.

IRS

Validate Priorities

Once your priority-setting group has decided on initial priorities, it is necessary to validate the prioritized needs with community members and interested persons and organizations.

Describe the process used for setting priorities, and present conclusions to community groups, hospital executives and board leaders, key stakeholders, and individuals with expertise in public health to confirm that prioritization decisions are understood and supported by the community.

Also identify opportunities to share priorities with marginalized populations to solicit their input. Neighborhood associations, block clubs, senior citizen meal sites, social clubs, school and parent associations, and communities of faith can be important partners in this effort to obtain feedback on priorities.

VALIDATE PRIORITIES

"Validate means to confirm that the need that was identified is the need that should be addressed...Validation amounts to 'double checking,' or making sure that an identified need is the real need."

Source: McKenzie, J.F., Neiger, B.L., & Smeltzer, J.L. (2004). Planning, Implementing, and Evaluating Health Promotion Programs: A Primer. (4th Edition). (p. 95)

Reconciling Priorities

Needs identified as priorities in the priority-setting process may differ from the views of community members. For example, high rates of diabetes leading to poor health and death may be evident from a review of mortality and morbidity data, but community members may cite gang violence as the most pressing health problem, despite statistical evidence to the contrary.

This can be addressed using the following strategies:

- Addressing the community's concern first, building trust and buy-in from community members.
- Embarking on an educational campaign to raise awareness of the priority needs identified by the data.
- Addressing the problem clearly identified by public health data and the problem identified by community members.

The final list of validated priorities will serve as input for the implementation strategy development process described in the next section.

Guideline 6
Document and communicate results

The CHNA should be presented in a manner easily understandable and accessible to your community.

At a minimum, your hospital should develop an assessment report that includes the following as required by the IRS:

- **A definition of the community served by the hospital** and a description of how it was determined.
- **A description of the process and methods used to conduct the assessment.** The description must include the following:
    - A description of the data and other information used in the assessment, including citations on data sourcing and, if possible, the exact time period for any given data source.

- The methods of collecting and analyzing this data and information. In the case of data obtained from external source material, the report may cite the source material rather than describe the method of collecting the data.
- Any parties the hospital collaborated with to conduct the CHNA.
- All third parties the hospital contracted with to assist it in conducting the CHNA.

- **A description of how the hospital took into account input from persons who represent the broad interests of the community it serves.** The description must include:
  - A general summary of any input provided by such persons, including how and over what time such input was provided (e.g., whether through meetings, focus groups, interviews, surveys and written comments and between what approximate dates).
  - The names of any organizations providing input and a summary of the nature and extent of their input.
  - A description of the medically underserved, low-income and minority populations being represented by organizations or individuals that provide input. The regulations note that the report does not need to name or otherwise identify any specific individual providing input on the CHNA.
  - In the event a hospital solicits, but cannot obtain, input from a required source, the hospital's CHNA report must describe the hospital's efforts to solicit input from such source.
- **A prioritized description of the significant health needs of the community along with a description of the process and criteria used in identifying those needs.**
- **A description of resources potentially available to address the significant health needs identified through the CHNA.**
- **An evaluation of the impact of any actions that were taken since the hospital's previous CHNA to address the significant health needs identified in that previous CHNA.**

See a template of an assessment summary report on the CHA website at https://www.chausa.org/guideresources.

Share CHNA Results Widely

After you have summarized the assessment findings, you need to disseminate the information to appropriate groups and individuals. This would include the hospital's board and executive leadership, the assessment team, assessment partners, the local public health department, and others who contributed to the assessment or could use this information. As you share the CHNA information with your community members, be sure to use methods and language accessible to them.

See the list of community partners in Chapter 3, Guideline 5, for possible groups or people to include in the assessment distribution.

Most health care organizations have a communications department that coordinates all of the organization's communications efforts. A staff member from this department can be a valuable asset in helping to prepare assessment findings that are clearly understood and, when appropriate, tailored for specific key audiences. Often, your communications department will have worked with these user groups and will know the most effective ways to share the findings of your CHNA. Before releasing your assessment report, ask the communications department to check it for readability and identify any possible ideas that may need to be clarified or expanded upon.

As you share results with your local community:

- Consider developing an executive summary for community distribution.
- Identify opportunities to talk about the CHNA.
- Share copies of the CHNA at local libraries, as many people may not have access to the internet.
- Take advantage of the community's regular schedule of monthly meetings and events.
- Ask members of the CHNA committee for suggestions, and solicit their help.

IRS

IRS NOTE

Federal law states that a CHNA must be made "widely available to the public." IRS regulations state that this requirement is met when the hospital:

- Makes the report widely available on a website at least until the date the hospital has made widely available on a website its two subsequent CHNA reports.
- Makes a paper copy of the report available for public inspection upon request and without charge at the hospital at least until the date the hospital has made available for public inspection a paper copy of its two subsequent CHNA reports.

Refer to regulations for the definition of "widely available on a website."

DEVELOP AN IMPLEMENTATION STRATEGY

SECTION 5.2

An implementation strategy is the hospital's plan for addressing community health needs, including health needs prioritized in the CHNA and through other means.

IRS

IRS NOTE

Ways to demonstrate community need:

The instructions for IRS Form 990, Schedule H, state that community need may be demonstrated through the following:

- A CHNA developed or accessed by the organization.
- Documentation that demonstrates community need or a request from a public agency or community group as the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or programs.

This section focuses on how to develop your hospital's implementation strategy. Your hospital may also work with others in the community to develop community-wide strategies to address health needs. There are many public health texts and other references that provide excellent guidance for such community health planning.

See the CHA website for more information and references at https://www.chausa.org/guideresources.

The implementation strategy, like the CHNA, is a ***process*** that will result in a ***product***.

The process for developing an implementation strategy starts with assessing readiness to begin planning and securing the right resources. It then moves to developing goals and objectives and identifying indicators for addressing prioritized needs, evaluating and selecting approaches to meet those goals, and documenting the strategy. For the implementation strategy to be most effective, it should be integrated with community-wide health improvement plans and other hospital plans, such as the strategic and operations plans.

EQUITY NOTE

- Build on community strengths and assets, and value community expertise.
- Look at your existing programs: Are they addressing racial and ethnic disparities identified in the community?
- Develop implementation strategies collaboratively with community members who experience disparities, and get feedback from them to ensure services meet their stated needs.
- Consider factors that contribute to diverse populations' higher health risks and poorer outcomes, and revise implementation strategies if community demographics and circumstances change dramatically prior to the next assessment or planning cycle.

Guideline 1
Plan and prepare for the implementation strategy

Before you begin the process of developing or updating the implementation strategy, you should first assess your readiness to begin the process and form an implementation team to carry out the development of the strategy and oversee its implementation.

Assess Your Readiness to Develop the Implementation Strategy

Here are some questions to ask about your readiness to develop an implementation strategy:

- Does the organization have a sustainable community benefit infrastructure — adequate staffing, budget, policies and leadership commitment — to support the implementation strategy?

  See Chapter 3 for more information on key elements of a sustainable infrastructure.

- Has the CHNA been completed and priority issues identified and validated?
- Does the organization have relationships with community members and groups that include persons knowledgeable about the community and public health? This should include public health experts and persons or groups that represent priority populations.
- Has the organization reviewed all federal and state requirements for implementation strategies and community benefit planning?

Form the Implementation Strategy Team

Form a team (internal, external or combination) to oversee the development and implementation of the strategy.

Team Leader

As with the internal assessment team, one person should be selected to lead the effort to develop and oversee the execution of the implementation strategy.

Hospital staff who may be assigned responsibility to lead the implementation strategy team include:

- A senior leader responsible for community benefit.
- A community benefit or outreach program director or staff member.
- A mission director or staff member.
- Someone from the organization's strategic planning office.

Team Members

Consider including the following people on the implementation strategy team.

Hospital representatives:

- Staff responsible for overseeing and coordinating the hospital's community benefit efforts.
- Strategic planning staff.
- Population health management staff.
- Staff from finance to help with budget or resource issues.
- Staff from the diversity and inclusion office.

Others:

- People knowledgeable about the community, including representatives from community groups and representatives of the priority populations identified in the assessment.
- People with public health expertise, including public health officials and staff, faculty from schools of public health, or others with knowledge of public health.

If your hospital formed an assessment team to conduct the assessment, evaluate the team membership to determine who from that group should be asked to be part of the implementation strategy team and who should be added. If your hospital has an existing community benefit team that oversees the planning and implementation of the community benefit program, this team should be used as the basis to develop and update the implementation strategy.

Team Responsibilities

The implementation strategy team is responsible for carrying out key aspects of the strategy development, including:

- Reviewing and advising on budgets, timelines and other implementation details.
- Collecting information about existing assets and programs that the implementation strategy can build upon.
- Establishing and maintaining community partnerships and relationships.
- Identifying measurable outcomes when selecting interventions.
- Being a champion for the implementation strategy inside and outside the hospital.
- Ensuring there is community need data to support all interventions, avoiding any "pet projects."

Guideline 2
Develop and prioritize intervention options

Next, gather information on various interventions (also known as strategies or approaches) to address selected community health needs identified in the CHNA and through other means (noted at the start of this section).

EQUITY NOTE

Without an intentional focus on health equity in the strategy development process, strategies may unintentionally widen health inequities. Well-designed strategies can include supportive activities to address barriers or unintended consequences underserved populations may face during implementation. Such efforts can help ensure maximum impacts across communities experiencing health inequities. Consider these ideas to enhance strategy development efforts.

Balance community input and the best available evidence. Without community input, there can be challenges with strategy design, implementation and evaluation. Build in community ownership at the very beginning of this process to increase the effectiveness and sustainability of strategies.

Establish a process to ensure strategies are linked to identified inequities. Given the multiple factors involved in developing and implementing strategies, efforts can sometimes unintentionally shift away from identified population groups. Ensure strategies are aligned with desired outcomes by writing goals that incorporate identified inequities.

Select a comprehensive set of strategies. Consider selecting a comprehensive set of strategies that work together, as one strategy in isolation has limited reach and impact.

Account for the diversity within the community. Understand the diversity within your community (e.g., age, disability status, geographic area, race and ethnicity, sexual orientation, socioeconomic status). Subpopulations may have different needs that should be considered and accounted for in strategy selection, design and implementation.

Understand Selected Health Needs and Their Causes

The implementation strategy team should review the selected community health needs identified during the assessment process to better understand their root causes.

To identify root causes linked to need, ask what the contributing factors are to the problem:

- Is the problem related to access to needed health services or resources? Are services available but not when and where they can be accessed by priority populations?
- Are public policies exacerbating the problem, such as a lack of environmental safeguards?
- Are there long-standing community norms, mindsets or attitudes that, while not policy based, represent barriers to change?
- What social, economic or environmental factors are at play, such as poverty, low-performing schools, racism, inadequate housing or other social determinants of health?

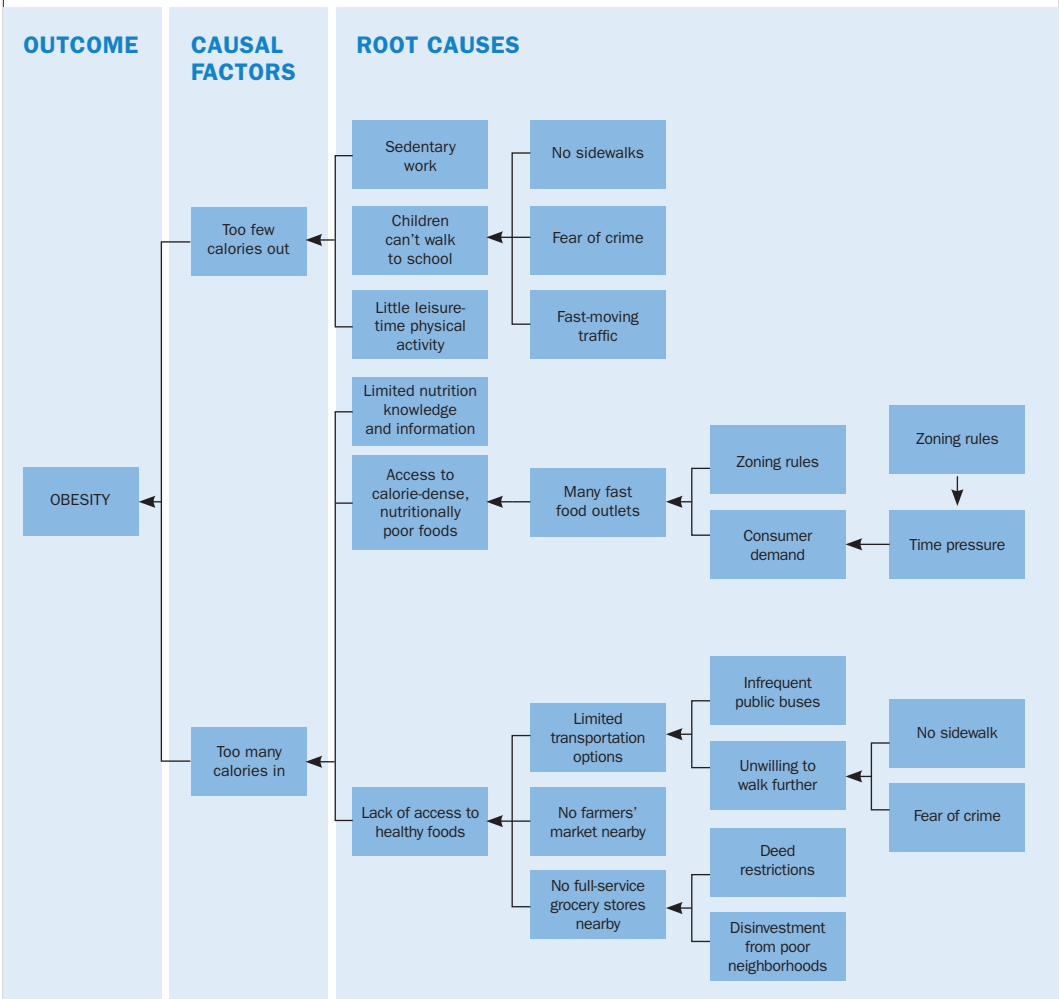
If sufficient data is not available from the assessment process to fully understand the problem, the implementation strategy team may need to collect additional information.

HEALTHY PEOPLE, IRS REGULATIONS AND THE SOCIAL DETERMINANTS OF HEALTH

The U.S. Department of Health and Human Services recognizes that individual and population health is influenced by the relationships between policymaking, social factors, health services, individual behavior, and biology and genetics. For this reason, it has chosen social determinants of health as one of its topics for Healthy People. To learn more, visit https://www.healthypeople.gov. IRS regulations also note that health needs identified in the CHNA may include ensuring adequate nutrition or addressing social, behavioral and environmental factors that influence health in the community.

ROOT CAUSE MAPPING

Health in All Policies: A Guide for State and Local Governments defines root cause mapping as "a structured process for identifying key factors contributing to community health problems, and can help identify methods for addressing these underlying factors and promoting improved outcomes. This method involves repeatedly asking 'Why?' to help people identify the 'causes of causes,' or the social determinants of the issues they seek to address." The process is helpful in identifying possible solutions that can affect the root causes of identified needs and the roles that various community partners can play. This can be useful in the beginning of a collaborative process because it can help people see the mutual benefits that could arise from working together. Below is an example of a root cause map for obesity.



Source: Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). *Health in All Policies: A Guide for State and Local Governments.* Washington, D.C., and Oakland, CA: American Public Health Association and Public Health Institute.

Consider Using a Collective Impact Framework

The complex economic, environmental and social problems that often underlie health needs in a community cannot be solved by one organization. As you develop a better understanding of the factors that are at the root of your community's health needs, consider how your organization might lead or be part of a collective impact approach to addressing those factors.

The collective impact framework is a structured form of collaboration that brings together different sectors to solve specific social problems. As defined by the Collective Impact Forum website, the framework has five elements:

1. **Common agenda** – A common understanding of the problem to be solved, agreed-upon goals for the initiative as a whole and a joint approach for taking agreed-upon action.
2. **Shared measurement** – Agreed-upon way to measure and report progress of the initiative. Shared measurement ensures that all efforts are aligned and supports accountability and continuous improvement.
3. **Mutually reinforcing activities** – Participants focus on activities that are in their areas of expertise, and those activities to support and coordinate with the action of others.
4. **Continuous communication** – Regular meetings to build up trust and relationships among participants.
5. **Backbone organization** – An organization, separate from participating groups, with the staff and skills to plan, manage and support the initiative. Activities performed by the backbone organization could include facilitation and mediation, technology and communication support, data collection and reporting, and logistical and administrative activities.

Visit the Collective Impact Forum website at https://collectiveimpactforum.org/ for more information about collective impact and for tools to help implement the collective impact approach. To learn about changes that have been made to the model since its inception, please visit https://ssir.org/collective_impact_10_years_later#.

Identify a Range of Possible Interventions

After studying the possible causes of health needs, identify potential interventions. It will be helpful for the implementation strategy team to have a discussion of the full range of interventions and to consult with public health experts to select the most appropriate approach.

Address the Levels of Prevention

The three levels of prevention are primary, secondary and tertiary. Your intervention approach may focus on one, two or all three levels of prevention.

- **Primary prevention** aims at preventing a particular disease from occurring. Examples include risk assessments for specific diseases, health education about preventing illness and immunizations against specific illnesses. *Will you try to prevent the health problem or risk related to the need?*
- **Secondary prevention** focuses on finding and treating the disease early. Examples include screening for specific illness, such as cancer or high blood pressure, and rapid initiation of treatment to stop the progression of identified illnesses. *Will you work toward early detection and treatment of the problem, with an emphasis on reducing progression?*
- **Tertiary prevention** targets persons who already have symptoms of a particular disease and attempts to make them healthy again. Examples include teaching someone who has asthma how to manage their disease and prevent attacks. *Will you concentrate on managing the health problem?*

CONSIDER THE LEVELS OF PREVENTION

If lead poisoning of children from lead-based paint in low-income housing has been identified as a priority problem, possible approaches include:

- Working to prevent the risk (primary prevention). In the case of lead paint, collaborate with community partners to test paint in apartments and repaint when needed.
- Working for early identification of the problem (secondary prevention). This could include testing children and treating them as early as possible after exposure.
- Treating acute illness related to the problem (tertiary prevention). This could include providing clinics to treat lead poisoning or conducting research on new treatment approaches.

Address the Multiple Factors that Impact Health

Public health experts believe that complex health needs are most effectively addressed with a multi-strategy approach, factoring in individual behavior, social supports and community and health policies. Keep this in mind as you consider your intervention approach for selected problems.

Source: Brownson, R. C., Fielding, J. E., & Maylahn, C. M. (2009). *Evidence-Based Public Health: A Fundamental Concept for Public Health Practice.* (p. 210)

For example, if childhood obesity is identified as a priority problem in your community, your intervention approach may include the following strategies: offering a weight management class that targets individual behaviors, working with a community youth group to form a sports camp that provides social support and an opportunity for exercise, and providing education for local schools on ways to increase student activity and advocating for policies that increase neighborhood safety so children can play outdoors and that increase access to fresh, healthy foods.

A BALANCED PORTFOLIO OF INTERVENTIONS

The Centers for Disease Control and Prevention's (CDC) Community Health Improvement Navigator (CHI Navigator) recommends a "balanced portfolio of interventions" across four actions areas: 1) socioeconomic factors, 2) physical environment, 3) health behaviors and 4) clinical care. The CDC recommends that as you identify and select interventions for your community's health needs, you consider using interventions that work across all four action areas and, over time, increase investments in socioeconomic factors since these factors have the greatest impact on health and well-being. For more information, visit https://www.cdc.gov/chinav/index.html.

Investigate Evidence-Based Interventions

To effectively use hospital and community resources, select approaches that are tested and likely to successfully address targeted needs. These are known as evidence-based interventions.

Public health resources are available for finding evidence-based approaches. Examples of web-based sources for evidence-based approaches include:

- Evidence-Based Practice Centers, Agency for Healthcare Research and Quality (AHRQ) https://www.ahrq.gov/prevention/guidelines/index.html.
- The Community Guide, CDC https://www.thecommunityguide.org/.
- The Cochrane Collaboration https://www.cochrane.org/.
- County Health Rankings and Roadmaps, University of Wisconsin Population Health Institute https://www.countyhealthrankings.org/.
- Healthy People interventions and resources, U.S. Department of Health and Human Services https://health.gov/healthypeople.
- Community Health Improvement Navigator, CDC https://www.cdc.gov/chinav/.
- 6|18 Initiative – Accelerating Evidence into Action, CDC https://www.cdc.gov/sixeighteen/docs/6-18-factsheet.pdf.

- Legacy Guidelines and Measures Clearinghouse, AHRQ https://www.ahrq.gov/prevention/guidelines/index.html.
- Evidence-Based Practices Resource Center, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services https://www.samhsa.gov/resource-search/ebp.

When looking at evidence-based practices that have been successful elsewhere, consider the following questions:

- Do the characteristics of the population where the program was used match your community?
- Is the evidence based on credible public health research?
- Has the approach been proven to be very effective? Somewhat effective? Are results still pending?
- Has the program been effectively replicated elsewhere?
- Is it a cultural fit in your community?
- Do you have or can you obtain resources needed to use the approach?

CONSIDER ALL INFORMATION WHEN SELECTING INTERVENTIONS

"While 'evidence' can be essential in evaluating effectiveness of healthcare interventions, well-informed decisions also require information, and judgments about needs, resources and values, as well as judgments about the quality and applicability of evidence. Relying only on evidence about the effects of health care alone can be inappropriate. Care and compassion are vital, and understanding the nature and basis of disease and the way that interventions work remains important." (Evidence-based health care and systematic reviews, *The Cochrane Collaboration)*

Review Community Assets and Existing Hospital Programs

As you determine what approach to take to address a community health need, consider building upon community assets or refocusing existing programs to meet prioritized health needs.

Asset mapping is a process intended to identify and then physically locate a community's strengths and resources. The process involves conducting an inventory that targets a community's human, cultural, economic and other infrastructure resources. This is typically done in a geographically defined area, such as a census tract, zip code, local neighborhood, school district or other geographical subset. Information is then mapped to both inform and support community decision-making.

Here are some examples of possible expansions to existing assets or programs:

- Parish nurses are taking blood pressures and doing hypertension education after Sunday services adding diabetes testing and education.
- A hospital pediatric dentistry program expands to serve adults.
- Local schools with self-esteem classes for girls from low-income families incorporate diet and exercise education into the classes.

Determine the Feasibility of Proposed Approaches

The implementation team should discuss key aspects of implementing each proposed approach. There may be situations when the discussion of implementation details reveals that the approach is unfeasible because the organization cannot easily obtain certain key elements (such as skilled staff, time frames, required organizational or policy changes, community support).

Here are some factors to consider when determining the feasibility and appropriateness of an approach:

- Community support.
- Actions that will need to be taken.
- Time frames.
- Staff, including who will lead and implement the approaches selected.
- Infrastructure, including the need for steering committees, policies and leadership support.
- Budget, including sources of funding.
- Knowledge and expertise needed to carry out the strategy.
- Partnerships that will be needed to implement the strategy.
- Any possible need for outside experts and consultants.
- Sustainability of the program or service.
- Availability of indicator data to evaluate and report on program outcomes.

If there is a gap between what you think you will need and what is available, consider how the approach could be modified to fit your resources without diminishing effectiveness or how to augment available resources through community collaborations, partnering with a school of public health or securing outside funding. Also consider how the organization can reallocate internal resources for these approaches. For example, the organization could redistribute funds that were previously earmarked for financial assistance but that may no longer be needed because of decreasing requests for charity care, or it could redirect community donations that

were previously not targeted to groups or efforts aligned with the community health needs the hospital is addressing.

Guideline 3
Select interventions

Considerations in selecting interventions to be used to address community health needs include:

- Is there a current community benefit program in place that could be continued or built upon?
- Is the intervention an appropriate fit for the priority population?
- Which approach or intervention will provide short-term results? While some approaches may be geared to the longer term, seeing early success will be important, especially for hospitals and coalitions new to community health improvement.
- Does the approach lend itself to partnerships, and can it generate community support? Can it build on an existing community program?
- Is the approach consistent with your hospital's organizational strengths and community capabilities?
- Are there adequate hospital or community resources to carry out the approach or intervention? If not, can additional resources be obtained?
- What barriers might exist? Are there sufficient resources, or is there a lack of community support? Are there legal, cultural or policy impediments or technological difficulties?
- Does the approach include an equity lens?

Solicit community input to validate possible interventions and to assess the community's capacity to support those interventions. When seeking input on the proposed strategy, the hospital should clarify expectations with the community about what approaches the hospital can and cannot implement due to limitations (e.g., resource constraints, lack of expertise).

The hospital should also plan to come back to the community to share the final strategy and to involve community groups and members in implementing and evaluating the strategy. This can be one way to maintain and strengthen community involvement throughout the assessment and planning cycle.

Guideline 4
Develop a written implementation strategy

A written implementation strategy is a summary describing what your hospital plans to do to address community health needs. The IRS requires hospitals to formally adopt the implementation strategy and to attach it to the Schedule H.

The written summary will be used by the organization's leaders to understand and communicate the goals, objectives and approaches its hospital will undertake to address community needs, and will be used by community members to understand the health care organization's role in addressing community health problems.

The written summary will also serve as a resource for community organizations that want to work with the health care organization on community-based approaches. A written plan is also required by some state laws.

Written hospital implementation strategies can include:

- ***The organization's mission*** – Describe the organization's mission, including its commitment to access, community health improvement and the needs of those living in poverty.
- ***The organization's commitment*** – Describe the organization's commitment to addressing structural racism and other systemic issues, such as a lack of good jobs, schools, health care access and safety, that contribute to health disparities.
- ***The community served*** – Specify the geographic areas and populations that will be addressed.
- ***A description of how the implementation strategy was developed and adopted*** – Explain how the implementation strategy was developed, including who advised or participated in the process. Also, describe how the implementation strategy was adopted by the governing body of the hospital.
- ***The significant health needs and how priorities were determined*** – Summarize the significant community health needs identified through the CHNA or through other means. Describe the assessment process and criteria used to identify priorities.

- ***What the organization will do to address community health needs*** – Describe the actions that will be undertaken to address selected community health needs and the anticipated impact of these actions. This description should include any planned collaboration between the hospital and other facilities or organizations. Also describe the resources the hospital plans to commit to address community health needs.
- ***Community health needs not addressed in the implementation strategy and any reason(s) they are not being addressed*** – Describe which community health needs identified in the CHNA are not being addressed in the implementation strategy but which are expected to be a continuing concern in the community. Explain the reasons the hospital will not address these issues.

See a template of an implementation strategy summary report on the CHA website at https://www.chausa.org/guideresources.

DOCUMENT NEEDS THAT WON'T BE ADDRESSED

Federal law requires hospitals to report needs not being addressed and the reasons why those needs are not being addressed. Comprehensive assessments of community need will inevitably identify more needs than the hospital and community partners can or should address. It would not be prudent to spread hospital and community resources across too many initiatives; instead, focus attention on priority areas to ensure that sufficient resources are available.

Some reasons the hospital might decide not to address certain needs include the following;

- The need being addressed by others.
- Insufficient resources (financial and personnel) exist to address the need.
- The issue is not a priority for community members, and therefore, the approach is unlikely to succeed.
- An evidence-based approach for addressing the problem is lacking or does not exist.
- The need is not as pressing as other problems.
- The need is not as likely to be resolved as other problems.
- The hospital does not have expertise to effectively address the need.

Most hospitals will produce the CHNA and implementation strategy as separate documents, although there may be overlap of some information. This allows for the assessment information to be available as soon as possible.

Guideline 5
Adopt the implementation strategy

To be considered adopted, the implementation strategy must be approved by the hospital's governing board or by a committee or group authorized by the board. In addition to being required by the IRS, board approval demonstrates that the board is aware of the findings from the CHNA, endorses the priorities identified and supports the strategy that has been developed to address prioritized needs.

Hospital policies should specify how the implementation strategy will be adopted, and hospitals should document in the implementation strategy how the strategy was formally adopted.

IRS

IRS NOTE

IRS regulations indicate that the implementation strategy:

- Is considered adopted on the date the implementation strategy is approved by an authorized governing body of the hospital organization.
- Should be approved on or before the 15th day of the fifth month after the end of the taxable year in which the hospital completes the final step for the CHNA.
- Should be a separate document for each individual hospital unless a joint CHNA is conducted.

Guideline 6
Update and sustain the implementation strategy

The CHNA and the implementation strategy development process are usually conducted on a three-year cycle. (Federal law requires CHNAs to be conducted at least every three tax years.)

However, implementation strategies may need to be updated more frequently based on:

- ***Changing community needs and priorities***. Community health needs are not static and can change in the time between assessment cycles. New, high-priority needs can arise, existing needs can become significantly less pressing, or new community resources or programs can become available that help address health needs already being addressed by the hospital.

  Some ways the hospital may become aware of these changes include:

  - Work with community groups and partners.
  - Significant changes in patient populations served or demand for services provided by the hospital.
  - Information gathered by the hospital's strategic planning department.
  - An environmental or unanticipated event, including acts of nature that directly impact the health and physical safety of the entire community or a subset of the community.
  - Information provided by public health agencies relating to enhanced risk of illness or disease based upon emergent pathogens or other risk factors.

- ***Changes in hospital resources***. Reviews and updates of the implementation strategy should be part of the organization's overall planning and budget cycles. This will ensure that changes in hospital resources that may impact the implementation strategy are identified and addressed in a timely manner.

  If all needed resources cannot be obtained (e.g., if hospital financial status has changed or if grant funds are not renewed), the implementation strategy will need to be revised to reflect how available resources will be redistributed among the different approaches in the implementation strategy.

Subsequently, if new resources are made available by the hospital, if community partners are able to contribute funds or personnel, or if new grant funds are obtained, the implementation strategy may need to be updated to reflect new or expanded programs.

- ***Evaluation results.*** Evaluate individual community benefit programs within the implementation strategy to see if they are being carried out as planned and achieving desired results.

  Refer to Chapter 6 in this Guide *and CHA's resource* Evaluating Community Benefit Programs *for more information on how to evaluate community benefit programs. For more information about this resource, visit https://www.chausa.org/communitybenefit.*

  As the programs are evaluated, the implementation strategy team may make recommendations to:

  - Change a program to improve its quality or effectiveness.
  - Expand a program to other geographic areas or populations.
  - Eliminate or replace a program with an alternative approach.

DEVELOP AND IMPLEMENT PROGRAM PLANS

SECTION 5.3

Once you have developed your implementation strategy, your organization (alone or with your partners) will develop and implement program plans for selected interventions. The program plans described in this section most often will be for community health improvement programs or community-building activities.

Program plans (also known as action plans) describe the interventions and what they are intended to accomplish. Implementation includes promoting the program to priority populations, delivering the program to those groups, evaluating and refining the program, and sustaining it into the future.

Guideline 1
Develop program plans

There are numerous program planning frameworks in the public health literature. This guideline summarizes the steps and terms common across various planning models.

KEY PROGRAM PLANNING PRINCIPLES

- ***Use data to guide program development***. Ensure that information about the community's health status, needs and assets are considered in program development.
- ***Encourage community participation***. Involve community members — including representation from individuals for whom the service is intended — in all aspects of program planning, from assessment and priority setting to intervention development and implementation, to enhance the success and sustainability of programs.
- ***Address a range of factors that impact health***. Develop programs that address individual behavior, interpersonal interactions (social support networks), organizational programs and policies, community (structures or processes), and health policy.
- ***Increase community capacity to address community needs***. Promote a systematic planning process within the community that can be repeated for various health priorities.
- ***Evaluate programs.*** Evaluation should emphasize feedback and program improvement.

Source: Brownson, R. C., Fielding, J. E., & Maylahn, C. M. (2009). *Evidence-Based Public Health: A Fundamental Concept for Public Health Practice.* (p. 218)

Developing a Program Plan Can Include These Steps:

1. Define the Problem Being Addressed

Defining the problem accomplishes two purposes: It establishes that the community benefit program is indeed addressing a community need and articulates the problem so that everyone involved in the program knows its purpose. The problem's definition should also identify root causes or related issues impacting the problem.

Root cause analysis is a good way to engage community members in program decision-making. Asking residents why they feel a particular problem exists can elicit a variety of disparity drivers, including multiple social factors that need to be addressed.

2. Determine the Target Population

Who will the program serve? Include geographic area, demographics and other important characteristics of intended program participants and the estimated number of persons who would be served.

3. Develop the Program Theory

The program theory is a simple, direct statement that lays out both desired outcomes and the strategies needed to achieve them. In other words, what is your program aiming to change and how? It is easiest to think of program theory in terms of "if-then" statements: *If* something is offered to program participants, *then* participants will change in a certain way.

Program theories can be developed out of:

- Existing evidence-based programs.
- Research findings.
- Your program staff's experience and ideas.

When developing the program theory, ask:

- *If* a program is provided, *then* what changes are anticipated for participants?
- Why do you believe the program will cause the expected change in participants?
- What evidence do you have that this activity will lead to this result (e.g., data from published literature or experience)?

4. Develop Goals and Objectives

A program goal is the overall broad intent of the program, focusing on who will be affected and what will change as a result of the program. Goals provide direction for the program and are the foundation for the specific objectives and activities that will define the program.

Here are some sample goals:

- Increase safety awareness among children at an elementary school.
- Improve quality of life among chronically ill, low-income persons in an identified neighborhood.
- Prevent falls among the residents of a senior housing complex.
- Increase birth weight, and reduce premature births of infants born to teen mothers in the school district.

Objectives are more precise than goals; they illustrate the steps the program will take to reach goals and therefore should be logically linked to supporting the attainment of the goal. Objectives are the program's intended outcomes (or results), usually expressed in terms of who and what will change. They are also expressed in terms of short, intermediate and long term. Objectives are often related to changes in knowledge, attitudes, skills or behaviors.

Objectives should be written in a "SMART" format: specific, measurable, achievable, realistic and time-bound. SMART objectives can be crafted by answering the following questions:

- What will be done (by program staff) to achieve this change?
- What will change?
- Who will change as a result of the program?
- By how much?
- When will the change occur?

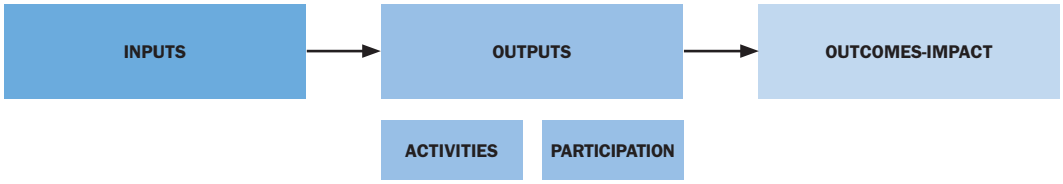
Objectives may relate to the implementation of a program or its outcomes. An implementation (or process) objective may address the number of participants from a targeted population or whether the program replicated an evidence-based program in certain ways. It may also consider participant satisfaction with the program or services. An impact or outcome objective can be short, intermediate and long term.

While most community benefit programs focus on short-term and intermediate objectives, it is critical to align program objectives with long-term, state and national objectives (such as Healthy People) to ensure that the program's strategies are focused, targeted and relevant — and, ultimately, contributing to the collective efforts for improving population health.

5. Develop a Logic Model, and Identify Indicators

A logic model is a graphic description of a program, describing what the program does and what is expected to result from it. In other words, it illustrates the program's theory, showing how planned activities connect to the results or outcomes the program is trying to achieve.

Developing a logic model has many benefits. A logic model can reveal gaps and challenges in a program (e.g., missing resources or activities). It can be used to ensure that all stakeholders have a common understanding of the program. Finally, it can serve as a basic framework for the program's evaluation.



The logic model includes:

- ***Inputs*** – Financial, human and other resources needed to operate the program, sometimes called resources.
- ***Outputs*** – What is done (activities) and who is reached (participants) through the program.
- ***Outcomes*** (also known as impact or results) – Intended changes or benefits resulting from the program. Outcomes can be broken down into short, intermediate and long term.

Indicators are measures that show progress toward meeting intended objectives and outcomes. An indicator answers this question: How will I know it?

Indicators can measure inputs, outputs and outcomes. Indicators for implementation (or process) questions can include the level of participant satisfaction, the number of people reached by the program, the number of materials distributed, etc. Indicators for outcomes questions can include changes in participant knowledge, changes in behavior, and changes in health status or clinical findings.

Here are some questions to consider as you choose your indicators:

- Will the indicator allow you to know the expected result or outcomes (valid)?
- Is the indicator defined and data collected in the same way over time (reliable)?
- Will data be available for the indicator?
- Is data for the indicator currently being collected, or can it be collected with reasonable cost and effort?
- Will the indicator provide information about outcomes to effectively inform program stakeholders?

6. Develop a Work Plan and Timetables

Develop a schedule based on when resources will be available and when activities will take place.

7. Determine What Resources Will Be Needed

Resources to consider:

- ***Staffing*** – Including paid staff, volunteers and consultants.
- ***Supplies and materials*** – Such as educational resources, in appropriate languages.
- ***Equipment*** – Such as audiovisual equipment for educational programs or exercise equipment for fitness classes.
- ***Facilities*** – Such as clinics, hospitals or mobile vans.
- ***Financial*** – Based on a budget, including total expected costs, expected sources of revenue, total expected reimbursements or payments, and expected shortfall or surplus in revenues over costs.

STAFFING CONSIDERATIONS

Program staff – Determine the skills and knowledge needed to implement the program, such as clinical skills, facilitation skills, or language or other communications skills. Discover whether there are persons with these skills available in your organization or partner organizations. If none are available, you will have to recruit new people. Staffing should reflect the diversity of the community being served.

Volunteers – Volunteers can bring needed skills, energy and time to the program. As community members, volunteers can also foster community ownership. Keep in mind that successful volunteer experiences — success for the program and for the volunteers — will require the same rigor used for the implementation team in hiring, orienting, training, supervising and recognizing performance.

Consultants – Consultants may be used to provide specific skills needed for program implementation, such as program design, financial management, facilitation, problem resolution or evaluation. Before engaging a consultant, be sure you identify what you need to have done, the skills needed and how much you can afford.

Community health workers – Many hospitals and primary care networks now employ community health workers (CHWs) and promotoras. These front-line public health workers are trusted members of the community who have deep understanding of the community's needs and challenges. This trusted relationship allows CHWs to serve as a link between health care and the community to facilitate access and improve the quality and cultural competence of service delivery.

8. Design the Evaluation Before Program Implementation

As you plan a program, begin thinking about how you will evaluate it. Evaluation should be considered an extension of program planning because evaluation results are critical to making effective decisions about program improvement, the use of program resources and future community benefit programming.

Designing the evaluation before program implementation will allow you to choose among several evaluation approaches and select the one that best fits your needs. Determine what you will want to know about the program's implementation and impact. This will give you greater flexibility in specifying the information you want to collect and will ensure that it is collected at the appropriate times during program implementation.

See Chapter 6 for more information about program evaluation.

IRS

IRS NOTE

Planning for evaluation will also help the organization prepare to meet the following IRS requirements:

- Implementation strategies must include anticipated impact of planned actions.
- CHNA reports must include an evaluation of the impact of any actions that were taken, since the hospital finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital's prior CHNAs.

See Appendix F for a sample Community Benefit Planning Form.

Guideline 2
Determine implementation readiness

Review some of the key steps in the planning process to ensure that you have done all the necessary background work required for successful program implementation.

Have You Selected a Program Likely to Meet Your Goals?

Before implementing a program or activity, ask the following questions to determine if the program has a good chance of meeting its intended goals and objectives:

- Is the program a response to a community health need?
- Is the program likely to achieve the desired result because there is sufficient evidence it will be successful in your situation, with the population the program will serve?
- Will you use a single strategy or multiple strategies to achieve the goal?
- Are necessary resources available, or can you obtain them to implement the program as planned?

Have You Engaged Program Users?

A successful initiative has buy-in from program users from the start. This comes from involving people who will use the program in the CHNA process and during the early planning stage.

During the planning stage, make sure you have asked potential users how the program should be designed (location, hours of service, cost, perceived benefit) to encourage their participation.

Be respectful of program users' situations. Are they taking time off from hourly wage jobs? Can they attend meetings during the day? Night? Do they need childcare? Ask them what they need to be able to be involved and participate.

Have You Engaged Community Leaders and Partners?

During the assessment and planning stages, you should have established and strengthened relationships with community leaders and program partners. They can help you connect with the population you want to reach and promote the program.

To determine if you have sufficiently engaged the community, the program implementation team should determine whether community leaders and partners were engaged in the assessment, prioritization of needs or planning for the program.

Is the Program Adequately Planned?

The planning stage should have established anticipated impact of the program, including program goals, objectives (at least short term and midterm) and identified indicators of program success.

The planning stage should also have identified the major activities that will be involved, estimated the resources that will be needed to carry them out, and determined whether the resources are available or can be obtained.

Guideline 3
Develop a management plan

EQUITY NOTE

- Focus the implementation strategy on health disparities in the community, and ensure that programs and activities address health inequities.
- Collaborate with diverse community organizations on managing implementation of programs and identifying and addressing issues that might prevent programs from achieving desired impacts.
- Maximize the use of community health workers in assessment, planning, implementation and evaluation.
- Use advocacy to address laws and regulations that enable structural racism in the community.

Develop a plan for how you will set up and manage the program. This will involve determining a structure for the program, developing a recordkeeping system, firming up the timetable and setting up a management system.

Determine the Structure of the Program

The program structure will define:

- ***The sponsorship or ownership of the program*** – Decide whether your organization will be the sole sponsor or owner of the program or whether the program will be a joint effort with others. If sponsorship will be shared with other organizations, make sure the roles and responsibilities of each sponsor, including financial commitments and reporting, are documented and clearly communicated to all.
- ***The oversight of the program*** – Determine whether the program will have its own organizational governing body or an advisory group or if an existing group will have oversight over the program. The purpose of an oversight structure is to ensure that the program is meeting its goals and objectives and, when needed, to provide guidance to program managers in resolving implementation issues.
- ***The program leader*** – Staffing will be dependent on the nature of the program. However, all programs should have an administrative champion — the person on staff responsible for all aspects of the implementation (monitoring, budgeting and evaluation).

Develop a Recordkeeping System

You will need to put in place a recordkeeping system for when the program is launched, Consider the following: What information should be collected at registration? Will medical information about participants be needed? How will you track participants' progress? Who do you need to keep informed, and what do they want to know?

Update the Planning Timetable

In the earlier planning phase, a rough timeline may have been developed to identify when key milestones would be completed. In the implementation stage, the timetable should be updated to include the tasks required to implement the program and who will be responsible for carrying them out. These tasks, often referred to as logistics, include the following:

- ***Program administration*** – Hiring and training staff and volunteers, including interpreters if needed; securing resources; setting up the recordkeeping system; convening staff; meeting with partners and advisors; and overseeing and managing of the budget.
- ***Program development and rollout*** – Pilot testing, updating the program and program delivery.
- ***Program evaluation*** – Implementation and impact evaluation.
- ***Program sustainability*** – How sustainability is being planned and addressed.
- ***Communication*** – Ongoing messaging to the broader community, nearby residents and the individuals receiving services.

Lay out all the tasks in a timeline, making sure to sequence activities in the right order. This will help in prioritizing tasks that need to be completed before others can begin. The timeline will also be helpful in monitoring the program progress so that timely corrections can be made, if needed.

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Step 1											
	Step 2										
		Step 3									
			Step 4	Step 4							
					Step 5						
						Launch					
							Step 7	Step 8			
									Step 9	Step 9	
											Plan Next Steps

Develop a Management System

A system of management will describe how you will organize the program's human, financial and technical resources.

Determine the following:

- How will the program hire, orient and train staff, volunteers and consultants? Be sure your system of management includes the time and resources needed to train, supervise and monitor performance.
- How will the performance of staff, volunteers, consultants and the director be reviewed?
- Who will be responsible for or supervise day-to-day activities?
- Who will be responsible for each of the steps in the timeline?
- Who can make program changes? Approve spending?
- What policies and procedures will guide the program?
- What recordkeeping and documentation will be needed?
- How will the program be evaluated in terms of quality and impact?

Guideline 4
Promote the program

The goal of program promotion is to attract participants from the priority population and keep them engaged until desired outcomes are achieved. As you promote the program among the people you want to reach, consider addressing these factors.

Your Message

Make sure your message is related to what the intended population wants and needs and is culturally appropriate. Focus on how the program will impact the community and those served by the program.

Select the Right Communications Vehicles

Various media can be used to promote interest and deliver your message: electronic, print, posters, displays and ads. Know the media habits of those you want to reach, as well as the

cost and benefit of various tools. Remember that not all intended audiences have computers. Be sure the communications vehicles are right for intended users and will reach a significant portion of the population you want to reach.

Use of Direct Contact

Depending on the need you are addressing, and the program being promoted, you may want to contact intended users directly. For example, a childhood asthma program could contact families who have visited the emergency department for asthma over the past year. You can also contact physicians and other clinicians who know and are trusted by the people you want to reach and ask them to promote the program.

Community health workers (CHWs) and promotoras can also help with program promotion. CHWs and *promotoras* are often recruited from the same communities they will serve. As such, they are viewed by members of the community as trusted sources of information and support, whereas others from outside the community may not be.

Engage Participants and Other Community Members

As you promote the program, be sure to listen carefully to the reaction of potential users and others. Ask if they have suggestions for how to attract and motivate participation. Keep community members informed about the program, and invite them to endorse as well as participate. Talk to community members about what success of the program would look like.

Guideline 5
Put plans into action

1. Determine How the Program Will Be Implemented

Some programs begin with a pilot program; others are phased in or implemented all at once.

Pilots

Pilots are small-scale or field-test versions of your program. Pilots allow you and your team to work out any of the bugs in the program before it is offered to the larger population. Pilots will let you know if the program is accepted by intended program users, has the needed resources, seems to run smoothly and is ready for wider implementation.

When piloting a program:

- Use a similar setting and similar population to that of the full program. Look for whether the strategies are implemented and work as planned.
- Assess resources to determine if you have the right materials, space, staffing and skills.
- Involve participants in critiquing all aspects of the program: content, approach, facilitator and staff effectiveness, space and timing.

If you make major changes in the program as a result of the pilot, you may want to pilot again.

Phasing In

Phasing in means partially implementing the program. There are several ways to phase in a program: by limiting the number of participants, adding more locations as implementation proceeds and identifying participants' abilities (for example, a beginner or advanced exercise program) or level of need (for example, creating a dental clinic program that starts with treatment of major problems and then phases into prevention and maintenance services).

Total Implementation

Total implementation involves implementing the entire program at the same time. Public health experts advise against this approach because it is often difficult to quickly and efficiently identify and resolve issues across a whole program, particularly a complex program with many components.

CAUTION ABOUT TOTAL IMPLEMENTATION

"Implementing the total program all at once would be a mistake. Rather, planners should work toward total implementation through the piloting and phasing-in processes. The only exceptions to this might be "one-shot programs, such as programs designed around a single lecture, and possible screening programs, but even then piloting would probably help."

Source: McKenzie, Neiger, Smeltzer 279

2. Launch the Program

As you prepare to launch the program, here are some decisions to be made:

- Consider launching the program so it coincides with another special event that can help promote the program (e.g. starting a weight loss program at the beginning of the year or offering an immunization clinic prior to the start of the school year).
- How will you publicize the program with the media? Materials should focus on who the program is for and what it is expected to accomplish. Make it timely by connecting the program with recent studies, introduced legislation or a local policy issue.

3. Anticipate Implementation Issues

A number of issues may arise that you will want to be sure to anticipate. These include:

- ***Legality*** – Reduce the risk of liability by meeting with your legal staff to understand potential legal issues (such as negligence, informed consent, confidentiality and privacy) and put in place policies and procedures to address these issues.
- ***Program safety*** – Make sure the space and location is safe and free of hazards.
- ***Program quality*** – Make sure staff and facilitators are knowledgeable and skilled at what you are asking them to do.
- ***Ethics*** – Be sure that all participants, staff and partners are treated with respect. Make sure the program does no harm and has a reasonable chance of improving health. Maintain confidentiality.
- ***Problem-solving*** – Be ready for problems, and know who will be responsible for addressing the unexpected. Identify and review problems on a regular basis, especially early in program implementation (e.g., after the first session, first week or first month).
- ***Diversity*** – Staffing diversity is very important to the success of the program, particularly when serving an ethnic or racially diverse community.

Guideline 6
Monitor progress

Monitor the program as it is implemented, especially in the beginning. After the first session, first month or other designated time frame, identify what is going right and what could be improved.

Some things to ask as you monitor your program:

- Are we following our plan?
- What can we do better?
- What is going right with the implementation?
- Are we getting the participation we expected in terms of number of participants and attendance?
- Are we getting the results we expected?
- Are there unanticipated results or side effects?

See Chapter 6 for guidelines on assessing the quality and effectiveness of a community benefit program.

Guideline 7
Sustain the program

The decision as to whether to sustain, change or end the program involves asking:

- Have participants' goals been met? If yes, the program may no longer be needed, unless there are other potential participants who could benefit from the program. If goals have not been met, why not? Does this mean that the program should continue or be changed or that another approach should be tried?
- If the need for the program continues, do we have the funds and other needed resources to continue the program? Can they be obtained?

To sustain the program:

- ***Institutionalize it.*** If the program will be long term, make it a permanent part of your organization or partnership. Give it ongoing attention in the organization's planning, governance and communications processes.

- ***Obtain stable funding***. Funding can become a permanent line item of your organization's (or partnership's) budget or could be incorporated into the budget of another organization. You may also apply for grants or public funding. Other funding sources are philanthropy or charging fees for the service.
- ***Nurture relationships and partnerships.*** Programs are built on relationships with participants, partners, community members, staff and volunteers. Communicate regularly, and take time to meet with and listen to what each of these stakeholders has to say about the program.
- ***Utilize feedback and evaluation findings.*** Strengthen programs through continuous improvement. What are participants and staff members saying about how the programs could be improved? Is the program getting desired outcomes?
- ***Ensure community buy-in and partnership support.*** Sustainability will depend on whether the community finds value in the program and whether partners agree it is worth the time and other investments needed. On an ongoing basis, take the pulse of your participants and partners to guage their support.
- ***Build community capacity.*** Community engagement requires doing with, not for, our communities and building on their strengths and assets. Be sure your program is not duplicating or competing with community efforts. Work with the leaders recognized and trusted by their communities, and use CHWs to ensure program success.

Definitions in This Chapter

Ambulatory care sensitive conditions
Illnesses for which timely primary care services would reduce the need for hospitalization.

Morbidity
The incidence rate or the prevalence rate of a disease.

Mortality
A measure of the number of deaths in a given population.

Primary data
Information you have collected yourself.

Priority area
Geographic area experiencing significant socioeconomic, health or other needs.

Priority population
Population most impacted by priority health issues.

Qualitative data
Types of information that are described in terms of words rather than numbers.

Quantitative data
Types of information using numerical measurement.

Reliability
Reliability refers to consistency of measurements. A reliable measure will give identical or nearly identical values when measuring the same thing over time.

Secondary data
Existing information, collected by someone else.

Validity
Validity refers to the accuracy of measurements. A valid measure accurately measures what it is intended to measure.

Sources: Brownson et al. (2010); McKenzie et al. (2004).

Notes:

Chapter Six: Evaluating the Community Benefit Program

6

Chapter Six: Evaluating the Community Benefit Program

A values-driven community benefit program will ask, Are we being good stewards of our community benefit resources by spending them where they are most needed and can make a difference?

Community benefit program evaluation is a systematic process for asking and answering questions about a program's quality and effectiveness. Evaluation involves collecting information about the activities, characteristics and outcomes of a program and using that information to make decisions about program implementation and improve program effectiveness.

In this chapter, you will learn how to:

Guideline 1: Understand the building blocks of individual program evaluation.
Guideline 2: Plan for the evaluation.
Guideline 3: Evaluate the community health improvement programs and activites.

Because community benefit programs have become more complex and designed to meet the strategic goals of the organization and its community, evaluation processes need to become more structured to ensure that the programs are using resources wisely, to bring greater credibility to the programs and to make future programming decisions.

Community benefit program evaluation is important for compliance reasons as well. The Affordable Care Act added requirements for tax-exempt hospitals to assess the health needs of their communities every three years. The federal regulations implementing those requirements specify that hospitals need to include in their current CHNA reports an evaluation of the impact of actions taken to address the significant health needs from their immediately preceding CHNA reports (Treas. Reg. § 1.501(r)–3). The intent of these requirements is to increase transparency and accountability around tax-exempt hospitals' obligation to improve community health.

CHA RESOURCE ON EVALUATION

While this chapter provides an overview of evaluation, please refer to CHAs resource *Evaluating Your Community Benefit Impact* for a comprehensive look at the evaluation process. This resource can be accessed on the CHA website at https://www.chausa.org/communitybenefit.

EQUITY NOTE

- Engage stakeholders to reflect the diversity of the community in evaluation planning. Ensure that all stakeholder voices are heard when making judgments on how to improve programs or continue offering them.
- Incorporate health equity into evaluation goals, questions and design.
- Gather data using culturally appropriate tools and methodologies that consider factors such as the population's language needs and literacy levels.
- Look at the impact of interventions across different population groups.

Guideline 1
Understand the building blocks of individual program evaluation

Program evaluation is an extension of program planning. The planning components prepared when the program was being developed (e.g., program theory, goals, objectives and indicators) will serve as input into the evaluation planning process. If these components were not developed during the planning of the program, they should be put in place during the evaluation process because they will serve as the foundation of the evaluation.

See Chapter 5, Section 5.3, Guideline 1, for an explanation of these components as they are used in program planning. They are also described in this section, in the context of program evaluation.

Building Blocks of Program Evaluation

Almost all program evaluations will involve:

- Program theory.
- Goals.
- Objectives.
- Indicators.
- A logic model.

To understand these components of evaluation, it is useful to look at them in action in a community benefit program setting. Here, the example of a flu clinic in a senior housing complex is used to examine each evaluation building block.

Program Theory: Program theory is an "if-then" statement that lays out the desired outcome and strategies. It can help the evaluation team formulate questions about the program by increasing its understanding of how the program is supposed to achieve its goals and objectives.

> ***Example:*** *If we implement a flu immunization program in a senior housing complex, then the rate of flu and flu-related complications will decrease.*

Goals: Goals convey the overall, broad intent of the program, focusing on who will be affected and what will change as a result of the program. Reviewing program goals can help all stakeholders develop a common understanding of what the program is trying to accomplish. This common understanding can help those doing the evaluation work more effectively with stakeholders to identify what they need to know from the evaluation.

> ***Example:*** *Our goal is to decrease the incidence of flu and its complications among residents of the senior housing complex.*

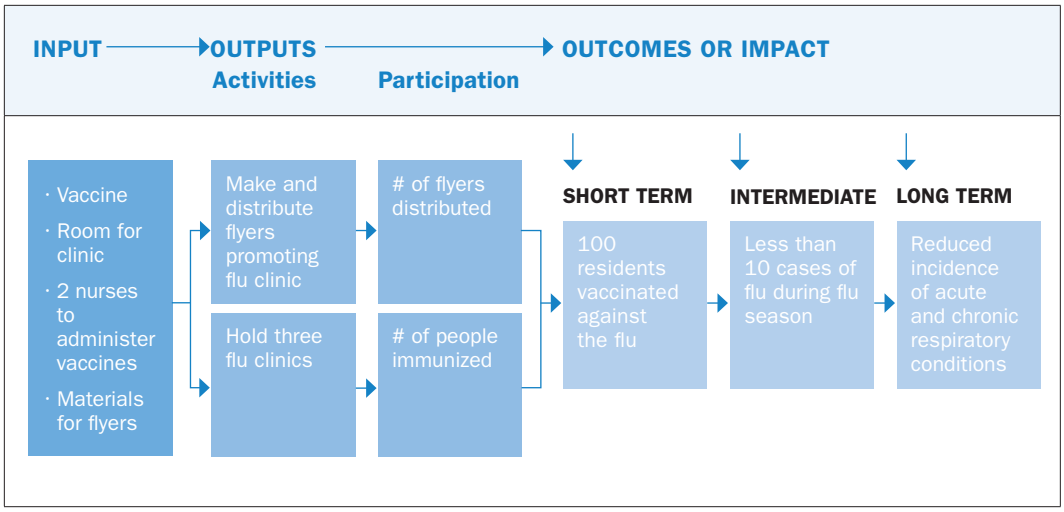
Objectives: Objectives are the program's intended results. They are usually expressed in terms of what will change in the short, intermediate and long term.

> ***Example:***
> - *Short-term objective: One hundred residents will be immunized against the flu.*
> - *Intermediate objective: Flu rates in the complex will be lower this year than last.*
> - *Long-term objective: Mortality rates from the flu and flu complications among residents will be reduced.*

Indicators: Indicators are measures of whether an objective has been met. An indicator answers the question, How will I know? For each objective, ask, How will I know if this objective has been accomplished? The answer is your indicator.

> ***Example:***
> - *Number of residents immunized.*
> - *Number of residents diagnosed with the flu.*
> - *Number of fatalities from flu-related illnesses.*

Logic Model: A logic model is a graphic description of a program, describing what the program does and what is expected to result from it. By depicting how your program's actions are expected to impact health needs, a logic model clarifies assumptions about relationships between different program components — and thereby supports program planning, implementation and evaluation.



Guideline 2
Plan for the evaluation

Community benefit program evaluation will require planning and managing the evaluation process across several programs. You should consider the following.

Organize Evaluation and Reporting by Significant Health Needs from the CHNA

Your implementation strategy can serve as the foundation of your community benefit evaluation efforts. Each program or activity in the implementation strategy should be linked to a significant health need identified in your CHNA or in other ways and include anticipated impacts. These anticipated impacts are identified during the program planning process. Each of these programs and activities will need to be evaluated, with information collected and analyzed before, during and after the program implementation. The next cycle of the CHNA will include the results of these evaluations to describe the impact of the hospital's actions since the previous CHNA.

To address community health needs, most organizations carry out many types of community benefit programs and activities, including community health improvement programs, subsidized services, financial assistance, and cash and in-kind contributions. The guidance presented in this chapter can be used to evaluate any type of community benefit. It will help you identify the information that needs to be collected to report impact as well as what information will be useful to help with quality improvement for a specific program.

Time and Resources

- ***People*** – For individual programs, who will be available to plan the evaluation, collect data, analyze the results and share the evaluation findings? Who will coordinate evaluation efforts for all programs that will be evaluated? This coordination could include ensuring that all evaluation efforts have the right people and resources and developing a plan to aggregate and report evaluation information for the hospital's overall community benefit evaluation efforts.
- ***Expertise*** – What skill set(s) or knowledge base exists in your organization to plan and implement the evaluation (such as survey design, data collection and analysis, cost-benefit analysis, graphic design, communications, etc.)? If you do not have the skill set(s) in your department, you may find the required expertise in other departments, such as finance, strategic planning or quality assurance. In some instances, it may make sense to engage outside resources to help with the evaluation.
- ***Money*** – After you determine what programs will need to be evaluated, find out for each program what evaluation activities require financing. Identify what funding is needed and available for costs, such as printed questionnaires, postage and data analysis. Large programs with complex evaluation designs might plan to set aside a portion of the program budget for evaluation. This ensures that resources for evaluation are available.
- ***Scheduling*** – What is the timetable or timeline? For evaluation purposes, a graphic such as a Gantt chart is a useful time-management tool that illustrates task time proportionately and chronologically. A master schedule that shows the timelines for all community benefit program evaluations may be helpful to ensure that evaluation information required for CHNA reports and other required reporting is collected and analyzed on time.

Links to evaluation planning checklists and worksheets can be found on the CHA website at https://www.chausa.org/communitybenefit on the Resources page.

Decide Who Will Conduct the Evaluation

Some evaluations will be conducted in-house, while others will use an outside evaluator or use a combination of internal staff and external evaluation consultants. External evaluations use an evaluator or team of evaluators from an academic center or consulting organization.

An organization may choose to hire an external evaluation consultant for some programs and perform internal evaluations for others. Often, it is wise to bring in outside evaluation expertise with programs that involve complicated logic models, multiple intervention strategies, and multiple short- and long-term outcomes. Some grant-funded programs require independent evaluations.

Consider and identify ways to collaborate with your local public health department or rural health department, to build internal capacity to conduct program evaluations. Staff in these government agencies have hands-on experience and skills in planning, implementing and evaluating community health programs.

Academic centers with graduate schools of public health are excellent sources for finding outside evaluators or consultants. Look for a school and faculty with the knowledge and an orientation toward community-based programs and applied public health. A school more tightly focused on research may not be a good fit.

Note: Regardless of whether the evaluator is internal or external, it is critical for the evaluator to be objective and unbiased so that the evaluation results are viewed as credible and useful.

Evaluating Collaborative Efforts

Many of the evaluation tools and techniques described in this chapter will apply to programs and services offered in collaboration with community partners.

In examining the impact of collaborative efforts, it is often difficult, and not always necessary, to determine what impact each collaborating partner has had. In most cases, organizations should look at the results of the overall program that the collaboration is sponsoring.

Guideline 3
Evaluate the community health improvement programs and activites

The evaluation process described in this guideline follows the evaluation framework developed by the Centers for Disease Control and Prevention (CDC). While the CDC's framework is designed for public health programs, it can also be adapted and used for community benefit programs, particularly community health improvement programs. Visit https://www.cdc.gov/eval to learn more about the CDC's evaluation efforts.

Step 1: Engage Stakeholders

The first step in evaluation is to engage stakeholders. The following questions can help identify stakeholders: Who asked for the evaluation? Who funded the program? Who ran it, participated in it or could use the results? Involving stakeholders throughout the evaluation will help them take ownership of the results and help ensure that the evaluation is useful.

Evaluation stakeholders include:

- ***Those involved in program operations:*** Program managers and staff, coalition and other partners.
- ***Those served by or affected by the program:*** Program participants, advocacy or consumer groups, community members and elected officials.
- ***Those who use the evaluation results:*** Persons in a position to make decisions about the program, such as program planners; those who allocate resources; and those who have to report required evaluation information to regulators or oversight agencies, senior staff, board members and outside funders.

Discuss the evaluation with these persons, impressing upon them that the primary purpose of the evaluation is to improve the program being evaluated. Be aware that to some stakeholders, evaluation may erroneously signal plans to discontinue or radically change a program. They will be reassured if they are involved from the start and kept informed throughout the evaluation process.

It can be helpful to develop a stakeholder engagement plan that lists evaluation stakeholders, the aspects of the program they want to evaluate, their roles in the evaluation and their

preferred methods of communications. Stakeholders can help describe the program, develop evaluation questions and disseminate the evaluation results.

Step 2: Describe the Program to Be Evaluated

The second step in evaluation is to understand how the program was intended to work and the context in which it operates.

As discussed in Guideline 1 of this chapter, reviewing the program components (program theory, program goals, objectives and the logic model) can help ensure that all persons involved in the evaluation have a clear understanding of the program being evaluated.

The program description will include:

- ***Need:*** What community health need is the program addressing? How was the need determined? What documentation do you have of the need?
- ***Expected effects:*** This is where you will identify the key evaluation components: the program theory, goals, objectives and indicators.
- ***Activities:*** Activities are the specific events that must take place or actions that must be completed by program staff or partners to produce the desired outcomes. It is what the program is doing.
- ***Resources:*** Identify the resources that have been invested into the program. This could include funding sources, partners, staff and program materials.
- ***Stage:*** Assess the program's maturity or stage of development. For example, is it in the planning stage, is it in the beginning of implementation, or is it ongoing and for how long?
- ***Context:*** Describe the environment in which the program is operating. For example, are there political, social, economic or other considerations that need to be taken into account?

Step 3: Focus the Evaluation Design

Once you have started the process of engaging stakeholders and understanding how the program was designed to work, you can begin to identify the aspects of the program you need to evaluate and how the evaluation will be conducted.

You cannot — and should not — evaluate all aspects of a program. Reaching consensus with your stakeholders on a few key questions about a program will focus your efforts on what is most important to know about the program. To begin the process of focusing the evaluation, work with stakeholders to determine the purpose and uses of the evaluation:

- ***Clarify the purpose of the evaluation***. A clear purpose serves as the basis for the evaluation questions, design and methods. All evaluations should examine whether the program's intended impact was achieved. Other common evaluation purposes include improving the way the program is being carried out or responding to questions about the program's effectiveness.
- ***Identify the evaluation users, and make sure the evaluation plan meets their needs***. Users are the people or groups that will use the evaluation findings. In this step, involve users in the design of the evaluation and the selection of the evaluation questions.
- ***Understand how the evaluation results will be used***. Here are some examples of how evaluation results might be used: to document whether program objectives have been achieved, to identify how program implementation can be improved, to decide how to allocate resources, to decide to expand the program or to build support for the program.

Next, identify the explicit questions you want answered about the program. This will most likely concern how the program was implemented and whether it achieved its anticipated impact.

Implementation Evaluation

By evaluating the way community benefit programs are being carried out, community benefit managers can improve the use of resources and the flow of activities. Implementation evaluation (also known as process evaluation) gathers information about whether the program is progressing (or was carried out) as planned, whether the materials used were adequate, and how the program could be fine-tuned or improved if provided again.

Implementation evaluations ask questions such as:

- Did the program reach the intended group?
- Did we meet participation goals?
- What was the cost per person?
- Was the program faithful to the program design?
- What problems were encountered?

Impact Evaluation

Are you making a difference? This is the question that drives many evaluations. Impact evaluation assesses the changes that result from the community benefit program.

Three types of results (also referred to as outcomes) can be assessed:

- ***Short term*** – These are the immediate, observable effects of the program, such as changes in knowledge, attitudes or skills. For example, in a diabetes management program, participants could be assessed to see if they learned more about their condition and whether they believed they could prevent complications.
- ***Intermediate*** – These are changes in risk factors or behaviors. For example, in a diabetes management program, participants could report on whether they were eating more fruits and vegetables or have had a recent eye exam. Changes in blood glucose and body mass index would also be examples of intermediate results.
- ***Long term*** – These results tie back to the ultimate goals of the program, such as decreased morbidity or mortality, fewer complications and health costs related to diabetes, or improved attendance at work or school.

FOCUS EVALUATION ON PROGRAM PARTICIPANTS

Evaluate the impact of the program on participants or those who received the intervention to determine if the program was successful. You might be asked if your program has had an impact on overall community health. This can be very hard to evaluate because your program is only one factor out of many that can affect community health.

Select the Evaluation Design

Most community benefit programs use an intervention (planned, coordinated actions) to effect a change (impact or result) in program participants. There are several evaluation designs that can be used to assess whether an intervention helped meet objectives. Different evaluation designs call for collecting information at different times during the evaluation process:

- ***Before and after interventions*** (often called pretest and posttest designs). Example: A quiz is given to participants before and after the program to assess change in knowledge.
- ***Soon after the intervention is started*** (such as pilot study). Example: A survey is given to participants to assess whether they thought the program materials were helpful or if the location was convenient.
- ***After the intervention is underway or over*** (often called posttest-only design). Example: A self-assessment of knowledge or behavior change gained from the program is administered to participants after the program is completed.

As part of selecting an evaluation design, you will need to decide what type of data you will collect — qualitative, quantitative or both. A quantitative evaluation will produce numeric data, such as counts, ratings, scores or classifications. It can also look at clinical and financial data. A qualitative evaluation will produce narrative data, such as descriptions.

Most evaluations will combine quantitative and qualitative methods.

The following questions can help in the selection of an evaluation design (McKenzie, Neiger and Smeltzer 315):

- How much time do you have to conduct the evaluation?
- What financial resources are available?
- How many participants can be included in the evaluation?
- Are you more interested in quantitative or qualitative data?
- Do you have data analysis skills or access to computers and statistical consultants?
- In what ways can validity be increased?
- Is it important to be able to generalize your findings to other populations?
- What are the definitions for the independent variables (the factors that contribute to the expected outcomes), dependent variables (indicators that will demonstrate the outcome has been achieved) and confounding variables (other factors outside the program that could explain the expected outcome)?

These questions can help you assess what resources are available, what the possible constraints are, what is to be expected from the program and what can be observed.

Step 4: Gather Credible Evidence

Collecting credible information will answer your evaluation questions and provide an overall picture of the program you are evaluating. It will require developing a data collection plan and implementing data collection procedures.

Data Collection Plan

A data collection plan will help you organize the activities and engage key people in the data collection. It will also help to ensure the consistency and credibility of the evaluations. The plan will describe the timing of the data collection and procedures for collecting and managing the information.

The data collection plan should identify:

- Indicators that will address the evaluation question.
- Data to be collected (new and existing).
- Data collection methods.
- Schedule and timing for collecting information.
- Person(s) responsible.
- Procedures for submitting and managing the data.

As discussed earlier, indicators are one of the building blocks of program planning and evaluation. They are the measurements used to answer the evaluation questions and determine whether your objectives were met. For each objective, indicators answer this question: How will I know the anticipated impact has been achieved?

Next, with your evaluation stakeholders, determine potential data sources and data collection methods that can help you gather the information needed to answer your evaluation questions.

The chart below describes some types of data and methods for data collection.

Data Collection Procedures

There are various data collection methods you can use; select the one that best meets your evaluation needs and constraints.

TYPES OF EVALUATION	TYPES OF DATA	METHODS OF COLLECTION AND ANALYSIS
Quantitative	• Survey questionnaire • Indicator data	• Telephone, in-person, mail or online questionnaire • Review of relevant records (e.g., hospital, clinic, program records)
Qualitative	• Open-ended questions • Individual interviews • Diaries • Group interviews and focus groups • Observations and environmental assessments	• Telephone, in-person, mail or online questionnaire • Telephone, in-person • Self-administered • In-person, telephone or video conference calls • Single or multiple observation, structured and unstructured

Source: Adapted from Brownson, Baker, et al. (245)

The CDC's WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation) evaluation toolkit recommends the following questions to help plan the timing of the data collection:

- When will you need to report your evaluation findings?
- When do the data need to be analyzed?
- What data collection resources will be available (staff availability, funding)?
- From how many participants will you collect data?
- How long will it take to collect the data from the desired number of participants using each specified data collection activity (e.g., surveys, interviews)?
- How often will data be collected?

To whom the responsibility for data collection is assigned will impact the quality of your evaluation. If you are working with an evaluation consultant, such as a school of public health, the consultant may be responsible for data collection. If you are involving staff in data collection, identify persons who are organized, detail oriented, familiar with your program and experienced in the specified data collection activities.

USE PROVEN INSTRUMENTS

Whenever possible, use existing data collection instruments that have demonstrated usefulness for programs such as yours. Even if the instruments you are considering have been shown to be valid and reliable in one population, it may be important to assess the reliability and validity of measures in the particular population being served by your program. This becomes particularly important if the instruments need to be translated into other languages or if methods of collecting the data need to be modified to reflect the needs of a diverse population.

Whatever methods are used, you will need to establish clear procedures for the data collection and train those who will be collecting the data. Instructions for any guides or instruments should be clear and easy to follow.

Monitor the data collection process periodically to assess the quality of the information obtained and take steps as needed to improve quality.

Another consideration is ensuring the security of your data and patient confidentiality. Protected health information includes individually identifiable health information, such as demographic information and health conditions. When certain identifiers, such as name, address, birth date or Social Security numbers, are associated with health information, they represent protected health information and must be removed to help protect confidentiality.

Step 5: Justify Conclusions

This step calls for analyzing the information collected, interpreting the significance of results, making judgments about the results and developing recommendations.

Analyze and Interpret Information

Data analysis turns the data collected into meaningful and useful information for action. It calls for organizing and examining the information collected and presenting the results so they can be easily understood.

Decide how to frame the analysis questions. Evaluation analysis involves asking questions such as, Was there a change from a previous time period? From one group to another? Were goals met?

Some other questions to ask during the analysis include:

- Was the program implemented as planned? What external or internal problems interfered with carrying out the program?

- If there was a change among participants, was the change measurable? Was it because of our program?
- Did anything else happen that might have influenced results?
- Were there any unusual or unexpected results?

Organize your information. When organizing the information you have collected, keep the purpose of the evaluation in mind. This will help to focus on the questions you wanted to answer at the onset.

An evaluation designed to improve the way the program is implemented might organize its information according to:

- Program strengths.
- Program weaknesses.
- Areas for improvement.

An evaluation focused on what impact the program was having in the community would list the program's:

- Objectives.
- Indicators.
- Actual performance.

Analyze and organize information as you collect it. You can maximize the benefits of the analysis and the evaluation by calling your team together and analyzing and organizing information at regular intervals throughout the evaluation. This avoids information pileup and lets you use results to improve programs sooner.

Focus first on what stands out. Look for patterns in the data. Unusual or unexpected results or changes can be important to an analysis.

Ask, what else? Don't forget to ask, What else happened? Often, there are unintended consequences (both good and bad) that fall outside of the program's original goals and objectives. This additional information can help improve the program, make decisions about it or tell the story about the program.

IRS

IRS NOTE

Hospitals are required by the IRS to report two sets of information:

1. On IRS Form 990, Schedule H, each year, a hospital must describe how it is addressing significant needs identified in its most recently conducted CHNA and any needs not being addressed and the reasons why.
2. In CHNA reports, hospitals must include an evaluation of the impact of any actions that were taken since the hospital finished conducting its immediately preceding CHNA) to address the significant health needs identified in the hospital's prior CHNA.

Draw Conclusions

The group assigned the task of drawing conclusions and making judgments about the findings should ask:

- What does the information collected suggest about the community benefit program?
- Was the program carried out as planned?
- Is there any surprising information you have learned? What might explain the surprises?
- What have you learned?
- What are the positive findings? Negative findings?
- Did these findings differ from those of similar programs?

Be aware that external factors can influence the program and its results. For example, news stories about possible ties between childhood immunizations and autism that run prior to or during a childhood immunization program could have a significant impact on participation. Your evaluation should take such factors into consideration before acting on evaluation findings.

Make Recommendations

Recommendations take the information learned in the evaluation and convert it into action statements. These statements can suggest how to change the program to run more smoothly or to achieve better results. The action statements may also suggest the future direction of the program — to continue, discontinue, expand or replicate the program.

Recommendations could include the following:

- More or different resources are needed.
- The program should be relocated to different areas in the community or should focus on a different population.
- The program should be expanded or replicated in other areas.
- Findings about the program are significant enough to be published.
- Resources could be better spent on another program.

Be careful not to jump to conclusions and make recommendations to discontinue a program that has encountered problems or has not achieved the desired results. Go back and look for reasons for the problems and lack of achievement. Consider whether the program could be improved or modified to get better results.

CRITERIA FOR USABLE RECOMMENDATIONS

Recommendations should be:

- Based on information collected.
- Feasible and realistic.
- Delivered at the right time for decisions to be made.
- Specific in terms of what should happen.

Step 6: Ensure Use, and Share Lessons Learned

The next step in evaluation is to get the message out about what you learned and make sure that the findings are used to inform program decisions and actions.

Involve your communications department early in the evaluation to plan how to report, disseminate and explain the findings. Communications specialists have experience in presenting information and can help answer questions about how to convey findings and disseminate the information to reach different audiences. Determine who needs to know what. In particular, identify the decision-makers and make sure they get key findings that will help them make informed decisions about how to improve the program or to plan for future programming.

Information should be as concise as possible, clear and well presented. Keep in mind what the various audiences want to know, and tailor your reports to their needs.

For example:

- Program managers and staff will want to know how the programs can be improved.
- Communications specialists may want success stories about the program participants.
- Board members may want to know the overall success of the program, including whether the program achieved its overall goals, how it will be improved, future activities and the impact on participants and the community.
- Executive leaders will want to know if resources are being used where they will make the biggest impact or if new or different resources are needed.
- Community benefit leaders will want to know the impact programs are having on needs identified in the hospital's CHNA. Program impact will be reported on the next CHNA report.
- Community members will want to know how the program is improving access or health in the community.
- Grant funders will want to know whether the program was carried out as planned and whether objectives and outcomes were met.

Throughout the program evaluation process, provide continuous feedback to stakeholders about findings and decisions that might affect them and the program.

In follow-up, schedule meetings with intended users to facilitate the transfer of evaluation findings and conclusions so that appropriate actions or decisions can be made. Steps should also be taken to make program decision-makers accountable for ensuring the results are used.

IRS

IRS NOTE

Tax-exempt hospitals must include in their current CHNA reports an evaluation of the impact of programs or activities taken to address significant health needs identified in the immediately preceding CHNA. Using the example of the senior center flu clinic presented in Guideline 1 of this chapter, the hospital might report the following impact on its CHNA report: There were fewer flu cases and incidents of acute or chronic respiratory conditions this year than the previous year because a greater number of residents were immunized.

Use Evaluation Findings to Improve Programs and Make Decisions

The purpose of collecting and analyzing information and making recommendations is to put the findings into action.

The first use of findings is to improve programs. For example, if attendance is low and analysis showed that publicity for the program was inadequate, develop a new publicity strategy.

Program planning is the other major use of evaluation findings. After evaluating a pilot project, decide whether to go ahead with full implementation or to revise the program and pilot-test it again.

When a program is found to be highly effective, you may want to expand or replicate the program. If a program is not having the results hoped for, search for evidence-based or promising interventions and put the resources previously used into a new program.

Another important use of community benefit evaluations is to tell the community benefit story. Evaluation can be used as tangible documentation that the community is being served by your organization and that your community benefit program is making a difference.

When you make program decisions based on evaluation findings, consider these factors:

- ***Views of executive and board leadership*** – Have senior leaders reviewed the findings and recommendations, and do they agree with the proposed course of action?
- ***Transparency and objectivity*** – Have the evaluation process and discussion of findings and recommendations been open so stakeholders are aware of the information being used to make decisions? Can you assure stakeholders that the process was objective and dispassionate and that there were no vested interests?
- ***Strategic planning*** – How do the findings and recommendations from the evaluation fit in with the overall strategic direction of the organization and with the overall approach for community benefit?
- ***Strength of evidence*** – Is there a strong case for continuing, expanding or discontinuing the program or for investing more or different resources?
- ***Buy-in*** – What may be the consequences of the action? Who will be affected, and how are they likely to react? Should steps be taken to ease any potential transition problems?
- ***Budget implications*** – Will changes recommended for the program, such as expansion or replication, have budget implications? How will they be addressed?

Definitions in This Chapter

The following definitions are from the Evaluation Toolkit developed for the CDC's WISEWOMAN program. The toolkit can be accessed at https://www.cdc.gov/wisewoman/docs/ww_evaluation_toolkit_sect4.pdf.

Activities
Activities are the specific events or actions undertaken by program staff or partners to produce desired outcomes (i.e., what you do).

CDC evaluation framework
The CDC Framework for Program Evaluation in Public Health has provided a set of steps and standards for practical evaluation by programs and partners. While the focus is public health programs, the approach can be generalized to any evaluation effort.

Contextual factors
Contextual factors are characteristics of the political, social, economic and physical environment surrounding your program that may interact with or influence program participants. For example, contextual factors might be similar initiatives being implemented by other agencies, changes in health care or public health policies, and social norms and values held by program participants.

Data accuracy
Data accuracy (or measurement validity) means that the data measure what you intend them to measure.

Data collection instrument
A data collection instrument is a tool or method used to collect data (e.g., survey, questionnaire).

Data collection plan
A data collection plan or protocol is a tool that can help you organize data collection activities, engage stakeholders involved in data collection, and ensure consistency and fidelity in data collection activities. It should specify who is responsible for collecting the data; the timing of data collection; the procedures for collecting the data; the procedures for cleaning, submitting and managing data; and data security measures.

Data reliability
Data reliability means that the data provide consistent measurements over time.

Data sources
Data sources are the entities or individuals from which or whom you will obtain data. Data for your evaluation activities may come from existing sources or from new sources (e.g., databases, electronic medical records).

Dependent variable
A dependent variable is often synonymous with an effect or outcome. Typically, evaluators are interested in observing changes in dependent variables and in determining whether a treatment or program intervention may be associated with or has had an influence on the observed change.

Dissemination plan
A dissemination plan describes who you will share your evaluation findings with, how you will share the findings and when you will share your findings.

Evaluation
The CDC defines evaluation as a systematic approach to collecting, analyzing and using data to determine the effectiveness and efficiency of programs and to inform continuous program improvement.

Evaluation plan
An evaluation plan is a detailed description of how the evaluation will be implemented and includes the program description, evaluation goals and questions, evaluation methods, analysis and interpretation plan, and dissemination plan.

Evaluation stakeholders
Evaluation stakeholders are individuals and organizations with a stake or vested interest in the evaluation process or findings from the evaluation.

Evaluation stakeholder group
The members of the evaluation stakeholder group are the primary users of the evaluation results and generally act as a consultative group throughout the entire planning process as well as the implementation of the evaluation.

Evaluation questions
Evaluation questions define the issues that will be explored during the evaluation. The evaluation questions should be developed and prioritized with your evaluation stakeholders.

Focus group
A focus group is a type of qualitative research in which a group of people are asked their perceptions or opinions about a service or program.

Impact
An impact is the ultimate effect you expect to see from the program. Sometimes this is referred to as a program "aim." Impacts of community benefit programs are usually presented in terms of an effect on program participants or people who are touched by the program. Generally, it takes many years or decades before you can expect to see the impacts of chronic disease prevention and control programs.

Impact evaluation
Impact evaluation refers to an assessment of the program in achieving its ultimate goals.

Independent variable
An independent variable is a variable that is believed to have an influence over another variable (or variables). An independent variable may be a treatment or program intervention.

Indicator
An indicator is a specific, observable and measurable marker of change or accomplishment. An indicator should be something that is observed (e.g., a change in behavior), heard or reported (e.g., shared by program participants), or read (e.g., program records). This is somewhat similar to how you might identify SMART objectives for your program.

Inputs
Program inputs are resources that are invested into the program (e.g., funding sources, partners, staff, program materials).

Intermediate outcomes
Intermediate outcomes are effects of the program that take longer than short-term outcomes to produce an observable change. Logically, you would expect your intermediate outcomes to take place sometime after you observe changes in short-term outcomes — the specific time frame will be dependent on the nature of your intervention (e.g., duration and number of intervention points) and the specific intermediate outcomes to be assessed. Typically, you will find changes in behaviors among the intermediate outcomes of a program.

Interviews
Interviews are a form of data collection in qualitative research and usually involve semi-structured interview guides.

Logic model
A program logic model visually illustrates the linkages between program activities and outcomes. Logic models can help in guiding evaluation activities and in interpreting the findings.

Long-term outcomes
Long-term outcomes can take months or years to accomplish (depending on the nature of your intervention and the specific long-term outcomes to be assessed). These changes likely would be observed after short-term and intermediate outcomes are determined.

Outcomes
Outcomes are the desired results of the program or what you expect to achieve. Program outcomes may be observed at an organization, system or participant level.

Outcome evaluation
Outcome evaluation focuses on the short-term, intermediate and sometimes long-term outcomes of the program. Outcome evaluation is used to determine the effectiveness of the program on your expected outcomes.

Outputs
Outputs are the direct and tangible results or products of program activities — often things that can be counted. These are typically represented by documented progress on implementing program activities (e.g., program materials developed, partnerships formed, number of providers trained, women screened).

Pretest
A pretest is an assessment administered to program participants to determine their baseline upon entry into the program.

Posttest
A posttest is an assessment administered to program participants after they have participated in the program to make comparisons against the baseline (e.g., readiness to change) over time.

Process evaluation
Process evaluation is used to determine whether a program is being implemented as intended.

Protected health information
Protected health information is information, including demographic information, which relates to a person's health condition or provision of health care. Protected health information includes many common identifiers (e.g., name, address, birth date, Social Security number) when they are associated with health information.

Qualitative methods
Qualitative methods are used to gather data in the form of notes, verbal responses, transcripts and written responses. These methods generally allow you to capture thoughts, feelings and perspectives.

Quantitative methods
Quantitative methods are methods used to gather numerical data to make calculations and draw conclusions.

Short-term outcomes
Short-term outcomes are expected to occur within a relatively short time frame following the intervention. Short-term outcomes should logically lead to intermediate and long-term outcomes.

SMART objectives
SMART objectives are specific, measurable, achievable, relevant and time-bound.

Stakeholder engagement
Stakeholder engagement is the process by which a program or organization involves stakeholders who may be affected by the evaluation or findings from the evaluation.

Survey
A survey is data collection generally through the use of a questionnaire. Surveys or questionnaires are useful for gathering different kinds of information in a consistent fashion from many participants.

Notes:

Notes:

Chapter Seven: Communicating the Community Benefit Story

7

Chapter Seven: Communicating the Community Benefit Story

Why do we report community benefit? Not merely because of state or federal government requirements. We report community benefit to be accountable — to our staff, physicians, donors, boards and, most of all, our communities.

Tax-exempt hospitals are entrusted with community resources to ensure the health of their communities. By telling their community benefit stories to their communities and other important constituencies (policymakers, donors, hospital staff, physicians and boards) these hospitals are fulfilling their obligation to be transparent and accountable about how these resources are used to meet their charitable goals.

In this chapter, you will learn how to do the following:

Guideline 1: Understand why community benefit should be reported.
Guideline 2: Work with communications and marketing.
Guideline 3: Develop a community benefit communications plan.
Guideline 4: Develop an annual community benefit report.
Guideline 5: Report community benefit on IRS Form 990, Schedule H.

Guideline 1
Understand why community benefit should be reported

Reporting community benefit is necessary to fulfill government requirements to maintain tax-exempt status, but it also addresses a number of other needs. The most important reasons to report community benefit are:

- To demonstrate accountability.
- To fulfill legal requirements.
- To strengthen relationships.
- To foster dialogue on health care policy.

Accountability

Not-for-profit health care organizations are accountable for meeting internal and external expectations. These include:

- ***Organizational commitments*** – The mission and values of the organization guide its goals and activities. Reporting community benefit can demonstrate that the organization "walks the talk."
- ***Community and policymakers' expectations*** – By being granted tax exemption, communities and policymakers demonstrate a level of trust and expectation that the exempted organization will fulfill a vital community need. Reporting community benefit and other information related to tax exemption demonstrates that the organization is accountable, deserves community trust and is meeting expectations.

Legal Requirements

Federal and state government regulatory and oversight bodies are increasingly asking not-for-profit health care organizations to justify their preferred tax status and tax-exempt benefits.

See the CHA website, https://www.chausa.org/communitybenefit, under Compliance/Public Policy for federal and state reporting and other requirements.

The benefits of tax exemption to not-for-profit health care organizations are significant: tax savings, access to tax-exempt bonds and philanthropy. These privileges deserve an accounting that clearly shows that preferential tax treatment is appropriate.

Strengthening Relationships and Support

Boards, employees, donors, physicians, volunteers and community partners want to know they are part of and working with an organization that is faithful to its mission.

The boards of not-for-profit health care organizations are responsible for ensuring that the organization's mission is being carried out, that its tax-exemption requirements are being met and that the organization's resources are being used wisely. Reporting community benefit helps fulfill each of these board responsibilities.

Community benefit reporting helps donors, volunteers, community partners and other supporters understand the impact of their contributions and the important role the health care organization plays in the community.

Understanding the community benefit contribution of the health care organization can enhance employees' level of commitment and can lead to improved recruitment, higher retention and overall higher job satisfaction.

When physicians and other clinical partners are aware of the community service orientation of the organization, they may be willing to help participate in and support this community service role.

Reporting community benefit also builds awareness among all these audiences for health equity initiatives that may not be reported in other formats. It also brings attention to community health needs, such as housing, food security and other issues impacting the health of communities.

Fostering Dialogue on Health Care Policy

Policymakers will be interested in up-to-date information and statistics on community health and your organization's efforts to increase access and improve health. This can lead to ongoing dialogue with community leaders and policymakers on how to improve the health care delivery system. It can also generate discussions about fundamental health needs, such as access, disparities, prevention and health promotion.

Guideline 2
Work with communications and marketing

Most health care organizations have a communications department that coordinates the organization's communications efforts. Community benefit staff should work with this department to determine how community benefit communications can be integrated into the organization's broader communications framework. The marketing department is also an important resource that can provide market information and other data about the community.

FORM A COMMUNICATIONS TEAM

Some organizations have found it effective to form a community benefit communications team composed of the organization's community benefit leader and persons from the communications, marketing, finance and advocacy offices. Since organizations need to communicate with many different audiences, a multidisciplinary communications team can help ensure that messages are tailored to effectively inform these different audiences about the organization's community benefit efforts.

Communications and marketing department staff has an important role in communicating community benefit. Responsibilities could include:

- Being active members of the community benefit planning team.
- Contributing to the CHNA, including the development, identification and use of information-gathering tools (surveying techniques) and development of the CHNA report. They can also help ensure that the community voice is being heard and that survey and interview questions are clear and appropriate.
- Developing the community benefit communications plan and identifying goals, objectives, tactics, messages and mediums.

- Coordinating the development of an annual community benefit report — with special attention to inclusive language and appropriate imagery.
- Continually looking for opportunities to communicate information about community benefit activities and programs to all audiences.
- Advising the community benefit staff on how to communicate information about programs and service in an inclusive and image-appropriate manner.
- Working with print and electronic media to promote community benefit offerings, programs or events, and to ensure the community feels invited and welcome.
- Utilizing social media channels to report on events as they are happening live and to show engagement at the event in real time.
- Identifying a point person for media inquiries on IRS Form 990, Schedule H, any community benefit reports required by the state, and any other publicly available information related to community benefit and tax exemption.
- Being informed about community benefit evaluation efforts to communicate the impact of these activities on the health of individuals and the community.
- Communicating across channels and audiences the outcomes of the community benefit strategy's programs and outcomes individually and collectively in annual or quarterly wrap-ups.

Guideline 3
Develop a community benefit communications plan

ESSENTIAL ELEMENTS OF A YEAR-ROUND COMMUNICATIONS PROGRAM

- A communications plan with clear and effective messages.
- Communications staff who understand community benefit.
- Internal communications with staff, patients and others.
- External communications with the broader public.
- Media relations.
- Crisis communications.

A well-crafted community benefit communications plan can help a health care organization effectively tell its community benefit story and also ensure that it is inclusive and culturally appropriate. The plan will help set priorities and ensure that consistent messages are directed to the right audiences.

EQUITY NOTE

- Use language that is accessible and meaningful to your audience, tailoring communications based on the unique circumstances of different populations.
- Consider ways to improve the accessibility of content, and offer materials in languages spoken in the community.
- Avoid jargon and use straightforward, easy-to-understand language.
- Emphasize the value of ensuring that everyone has an equal opportunity for health and that reducing disparities contributes to the common good and benefits all.

The community benefit communications plan may be a section of the organization's overall communications plan or a freestanding document. Either way, it should contain the same components as other organizational plans: an initial assessment, goals, objectives, strategy and tactics, and an evaluation of effectiveness. Also, as with other plans, the community benefit communications plan will include a budget, required resources and a timeline.

The steps to develop a plan follow.

Step 1. Find Out How the Organization is Perceived

Understanding how key external and internal audiences perceive the organization and what they know about its community benefit efforts will help shape the community benefit message and help with community benefit planning. Valuable information can come from program users, community leaders, policymakers and elected officials, and the organization's leaders and staff (physicians, nurses and others). The marketing department might have valuable information to share as well. Also, through the CHNA process, valuable insights on public perception may have surfaced.

Some questions to ask:

- Does the community know that the hospital is a not-for-profit organization?
- Is the organization known as a good community partner?
- Do people in the community feel that the organization works to promote the best interests of the community?

- Do people in the community feel that the organization works to promote equity?

You can gather this information in several ways:

- **Formal research** is the most effective way to assess public opinion. Communications departments use public opinion research, such as telephone and electronic surveys and focus groups. If you hire researchers, be sure to evaluate their effectiveness in reaching out to all the communities served.
- **Informal research** allows organizations to gauge public opinion through community advisory committee meetings and discussions with program users, public officials, community members, board members and donors. Social media is also a valuable tool. Facebook, Twitter, LinkedIn, Instagram and more of these channels offer insights into public opinions.
- **Internet surveys** can be a quick and easy way to gather information. However, be aware that this information-gathering approach may primarily reach those whose jobs and homes have internet access and those who have smartphones. Surveys might have to be augmented with additional sources to gain feedback from elders or those without internet access and know-how.
- **Internal information gathering** from physicians, nurses and other employees can be very helpful in assessing how the organization is perceived.

Step 2. Define Communications Goals and Objectives

Goals

The goal of the community benefit communications plan reflects changes the organization expects to see in target audiences as a result of its communications efforts. The goal does not have to be measurable but is a statement of overall intent. For example, the goal may be the following: Community and government leaders will understand and appreciate the magnitude and range of community benefit programs and their impact on the lives of the people we serve.

Objectives

Once the goal is defined, develop objectives that spell out exactly what you wish to accomplish. Objectives are measurable elements that support the achievement of a goal.

The objectives of a communications plan for community benefit should answer these questions: How is the organization improving the health of the community it serves, and how will you effectively communicate that message to key stakeholders?

Objectives should be specific and measurable. Rather than focusing on what you will do, objectives should express what the result will be.

For example:

- By Dec. 31, 10 percent more adult community members responding to a survey will say they know that St. Mary's Hospital is a not-for-profit, tax-exempt institution.
- By the end of the fiscal year, local media will feature five positive articles about St. Mary's community benefit programs.

Step 3. Develop a Communications Strategy

BE PROACTIVE ABOUT COMMUNICATIONS

Develop a comprehensive communications strategy before an issue arises or a new reporting requirement is mandated.

A communications strategy describes how the objectives in the community benefit communications plan will be achieved. A strategy will identify key messages, key audiences, how messages will be tailored for those audiences and the communications vehicles that will be used to convey messages.

A strategy for all communications about community benefit should include the elements outlined here.

Collecting Information About Community Benefit Activities

The communications efforts outlined in the plan will rely on comprehensive information about the organization's community benefit efforts. This includes the following:

- ***The CHNA results*** – How is the organization assessing and addressing community health needs? How is the organization tying its community benefit programs back to the needs identified in the assessment? Is the organization addressing disparities and other inequities?
- ***Community benefit activities and programs*** – Chapter 2, Determining What Counts as Community Benefit, describes the community benefit efforts that should be reported.
- ***Impact information*** – Track community benefit evaluation efforts for information on how activities are making a difference in the community.

See Chapter 6, Evaluating the Community Benefit Program, to learn how to evaluate the impact of community benefit programs.

STRATEGIES FOR ENCOURAGING REPORTING

Uncovering all of an organization's community benefit programs and activities can pose a challenge, especially in large medical centers with various departments, clinicians and researchers who may have numerous projects throughout the organization.

Even smaller organizations, however, may have below-the-radar community benefit activities.

It is necessary, therefore, to motivate staff and physicians to contribute information about their community benefit activities and programs. Some strategies for encouraging reporting of information include:

- Updating employee orientation programs to include how to contribute to and report community benefit information.
- Giving regular reports to staff and physicians about how programs are making a difference in the health of people in the community.
- Incorporating the reporting of community benefit activities into job descriptions.
- Making submission of data as easy as possible and reporting back on all data collected.
- Developing creative ways to celebrate the information received.

Identifying Key Messages

Use the organization's mission, core values, community benefit program results and information about public perception to shape your community benefit messages.

Messages should be simple and to the point. They should be culturally appropriate, accessible to the various groups in the community and available in various formats, such as audio, video, large print, and visual or graphic imagery.

They should describe:

- The organization's mission and its commitment to serve the community.
- How the organization fulfills its commitment to help address the health needs of vulnerable persons and improve community health.
- The organization as a valuable community resource that deserves tax exemption.

Specialty hospitals (such as children's hospitals or rehabilitation facilities) may have unique community benefit efforts they want to highlight.

SAMPLE KEY MESSAGES ABOUT TAX-EXEMPT, NOT-FOR-PROFIT HEALTH CARE

- Not-for-profit health care is a sign of a just and caring society, demonstrating the value of voluntary organizations providing public good.
- The roots of not-for-profit health care are in community service — not economic opportunity.
- Tax exemption is a privilege, and not-for-profit health care organizations are accountable for that privilege.
- Tax exemption enables not-for-profit health care organizations to serve the community.
- Community benefit is more than financial assistance. It includes efforts to improve health in the community; to increase access to services; to educate future physicians, nurses and other health professionals; to conduct health research; and to subsidize clinical services needed in the community.

Identifying Key Audiences

"Audiences" is the communications term for the specific groups you would like to reach with your messages. As you develop your communications plan for community benefit, consider all of the audiences — both external and internal — you may want to inform and influence.

External audiences encompass both potential partners and persons to whom the organization is accountable. They include policymakers who grant tax exemption, donors who contribute to the organization's charitable mission and potential partners who can help the organization carry out its mission. Often, the same partners you work with to assess and address community health needs are also part of your external audience. External audience can include:

- Community organizations and faith groups:
  - United Way and other service organizations.
  - Parishes and congregations of all denominations.
  - Catholic Charities and other social service groups.
  - Groups working on equity and justice issues.
- Public agencies and offices:
  - Federal, state and local elected officials.
  - Public agencies, such as health departments and law enforcement.
  - Regulatory agencies.

- Other policymakers.
- Schools.

- Health-related groups:
  - The medical community.
  - Health professions schools, including medical schools, schools of nursing, schools of allied health professionals and schools of public health.
  - Hospitals, nursing homes and community health centers.

- Organization partners and supporters:
  - Foundations and other funding organizations.
  - Donors.
  - Organized labor.
  - Contractors and vendors.

- Others:
  - Patients and their families.
  - Media.
  - The business community.

Internal audiences include individuals who work for or with the organization and who need to understand and promote the organization's community benefit efforts. Internal audiences also include departments that support community benefit programs. Internal target audiences include:

- Individuals:
  - Board members.
  - Volunteers.
  - Employees.
  - Physicians.

- Departments:
  - Management.

- Medical staff.
- The strategic planning team.
- Operations.
- Care management and social services staff.
- Population health management staff.
- Diversity and inclusion staff.
- Legal, compliance and advocacy staff.
- The development office.

Tailoring Messages for Specific Audiences

Gather information about specific audiences to help you tailor your messages. Some of this information will come from the data you gathered about how your organization is perceived. However, once you have identified key audiences, you may need to gather more-specific information.

It may be helpful to collect information on expectations the audience has for your organization's community benefit efforts, as well as attitudes, biases, interests or concerns that could affect how messages are perceived.

You will also want to know what information your audience already has about the organization's community benefit efforts. Knowing this information will allow you to tailor your communications to provide the information they need.

Work with the communications department to develop the best approach for gathering information about target audiences.

Examine how key messages are appropriate to each audience, and identify ways to communicate messages in language familiar to each audience. For example, consider:

- Is the audience more interested in statistics and financial information or case studies and human-interest stories?
- Will narrative statements and personal testimonials be effective?
- What words and phrases will resonate with each audience?
- What is important to each audience?

Human-interest stories are a valuable element of any communications strategy, especially when attempting to illustrate how a program is of value to a community. A story puts a face on statistics and program costs. It also illustrates the health care organization's understanding of the diverse community it serves and of the community's needs.

Communications Tactics: Using Effective Vehicles

Communications professionals can use many vehicles to convey information about community benefit. Using the results of your audience analysis, determine what vehicle will be most effective with a given audience and the most effective timing for each method. For each vehicle used, develop communications tools, such as talking points, slides and fact sheets.

Communications vehicles include:

- Information filed to meet government oversight requirements, including CHNA and implementation strategy reports and IRS Form 990, Schedule H.
- Existing organizational publications, newsletters, e-newsletters and blogs.
- Reports (annual reports, reports to community).
- Point-of-service displays (such as bulletin boards, flyers).
- Closed-circuit programming.
- Website articles, banners and links.
- On-hold messages.
- Orientation and in-service programs.
- Press releases and advisories.
- Fact sheets.
- Feature magazine and newspaper articles.
- Advertising.
- Op-ed articles.
- Direct mailings.
- Parish and congregational communications.
- Patient handbooks.
- Social media.
- Video testimonials and program highlights.

Step 4: Develop a Media and Public Policy Strategy

Working with your communications and advocacy departments, develop an overall strategy for regular contact with media and policymakers. Lay the groundwork to establish the health care organization as a credible source of information about community health needs and efforts to address those needs. On a daily basis, consider how communications tools can be used to educate the community, media and policymakers about community benefit.

Social media is one of the best means for getting word out about upcoming events, results and the overall commitment of the organization to improving the health and wellness of the community, so be sure to consider social media channels and bloggers in your strategy.

Media Strategy

In conjunction with your communications staff:

- Regularly reach out to meet with traditional and social media reporters (and consider following their social channels) so that you know them and they know you. Include cultural and other than English publications and outlets. Maintain that relationship throughout the year.
- Find out what topics members of the media are interested in and what experts they might like to interview.
- Invite members of the media, including trusted and respected bloggers and social media reporters, to visit community benefit sites and events and to meet staff of effective and innovative programs. Share videos and photos.
- Have a special section on your website for media, updated regularly with community benefit information and your organization's Twitter, YouTube and Facebook feeds as well as any blogs or other social media.
- Meet with the publisher and editorial board of the local press to talk about community health problems and community benefit programs. Also reach out to local television and radio stations.
- Use media advisories, including electronic media toolkits with ready-to-use video and photo assets, to announce events, program results or the release of reports.

Public Policy Strategy

In conjunction with your advocacy or government relations staff:

- Meet with elected officials — including taxing authorities and health care policymakers — to learn what they know about the organization's community benefit efforts. Keep these individuals informed of the organization's work, and listen to their concerns.
- Invite officials and policymakers to tour a site where the organization is delivering community benefits. Arrange for them to meet with some of the people who have been helped (with participants' permission).
- Develop relationships with community partners who could speak on the organization's behalf. If an issue arises around tax exemption, ask them to express their support of the organization to elected officials and the community.
- Include community benefit in all interactions with policymakers. Whenever representatives of the organization meet with elected officials and other policymakers, begin the discussion with information about community need and how the organization is working on its own and with others to address the need.

For Both Media and Public Policy Strategies

- Be sure that all information and reports about community benefit are accurate and consistent. For example, information on IRS forms should match the community benefit report. If not, explain any discrepancies.
- Use human-interest stories, putting a face on the programs you are describing.
- Focus on the impact programs are having, rather than how much they cost.
- Regularly update your colleagues in the communications and advocacy departments about the organization's community benefit activities and successes. Communications staff members often "sell" stories to news organizations, and advocacy staff members like to discuss real-life examples of effective programs with policymakers to reinforce policy recommendations.

Visit the CHA website at https://www.chausa.org/guideresources for a list of communications strategies, plans and tools.

GUIDE TO BASIC MEDIA RELATIONS

Working with Print Media

Print media can bring your messages to a wide range of readers. The key is tailoring your message to the publication.

- Business journals are likely to be interested in statistics about health problems and program accomplishments. Provide information on how health issues affect employers and employees.
- Daily newspapers' interests will vary with different departments:
  - Financial: Share how the data translates into economic and community impact. For example, collect statistics on premature births and their costs and how a community benefit program is making a difference in reducing the incidence of low-birth-weight babies.
  - Health or medical: Collect human-interest stories about community benefit program leaders and community members being served.
  - Religion: Faith-based organizations can communicate the mission and ministry implications of community benefit and how addressing community need continues the tradition of the organization's founders.
- Minority or ethnic publications: Tailor stories to special audiences, and contact these media to share success stories and spread the word about programs to eliminate disparities.
- Monthly magazines: Get to know editors' interests. Most magazines have editorial calendars that describe special reports or sections over a 12-month period; plan ahead to coordinate story ideas with the editorial calendars.
- State associations: Participate in your state hospital and long-term care association data collection and reports.
- Suburban and weekly newspapers: Translate national problems (asthma, diabetes, disparities) into local needs and programs. Use these publications to announce availability of community benefit programs and the need for volunteers.

Note: The majority of print media now have 24-hour coverage on their websites.

GUIDE TO BASIC MEDIA RELATIONS (*continued*)

Taking Your Messages to Electronic and Online Media

Electronic media (radio, TV and cable) and online media have some unique considerations because the ways they communicate with their audiences differ from that of print media. Print media appeals to the eyes, radio to the ears, and television to the eyes and ears.

Online communications, and social media in particular, can be used to turn one-way communication into an interactive dialogue with your key audiences. These needs should be considered when preparing messages for electronic and online media.

Radio: Talk shows can present opportunities to discuss community health issues, health promotion information and efforts underway to improve community health. Public service announcements can introduce new and continuing programs. You should know the audiences of various stations when delivering community health messages to target groups, such as seniors or teens.

Television: Provide photos and videos about programs and information about people available for interviews for community benefit stories. Get to know the news, medical and general assignment editors. Offer to provide guests and topics for cable access channels.

Website: The organization's website is an excellent place to share information about community benefit efforts. Some of the items that should be posted on the website include a report of the organization's CHNA; the hospital's financial assistance policy; the organization's implementation strategy; the community benefit report; and any stories that describe the impact of community benefit efforts. The website can also be used to collect information from visitors, such as asking for comments on a posted item.

Social media: Social media is a great tool for engagement with plenty of ways to share your information about community benefit efforts. It may include social networking websites, blogs, video platforms, podcasts and discussion forums. Some examples include Facebook, LinkedIn, Instagram, Twitter and YouTube.

Note about online communications: Work with your communications department to ensure that online community benefit communications are in line with the organization's online and social media policies. Also monitor all imagery through an equity and inclusion lens.

GUIDE TO BASIC MEDIA RELATIONS (*continued*)

Suggestions for How to Write an Effective News Release

A news release should have details, quotes and background information about events or issues. It is written in the style of a news story. Make sure your release does the following:

- Has a timely and interesting story.
- Uses meaningful quotes.
- Avoids jargon.
- Is no more than two pages — and ideally no more than one.
- Ends with a basic summary about the health care organization.
- Is sent to all applicable media outlets at the same time.
- Answers the questions, Who? What? Where? When? And why?
- Consider an electronic release with video and photography and quotes from community leaders.

Suggestions for Writing Media Advisories

A media advisory is a one-page or shorter announcement about an event. Use these to help the media get the word out about your community benefit–related events open to the public or special communities or about groups and programs for which you are seeking participants.

- Include details about the time, date and place as well as contact information.
- Mention the visual elements of the program.
- Explain why readers and viewers might be interested.
- Distribute the advisory two to three weeks in advance.
- Post and tag reporters.

Step 5. Evaluate the Community Benefit Communications Plan's Effectiveness

Develop a set of metrics to evaluate the effectiveness of the communications plan and efforts, starting with goals and objectives:

- Look at goals and measurable objectives; determine what was successful and worth repeating.
- Track media and press items.
- Talk to people who have read the organization's community benefit report. Do they have a more favorable impression of the organization? Was it helpful to them?
- Assess how social media was used and whether it was effective.

- Talk with specialists in the communications and advocacy departments. Ask them what worked well in terms of communication with the media and policymakers and what improvements should be made to better inform key audiences.

Based on the evaluation, update the plan for communicating the community benefit story. For example, after reviewing key audiences, goals and objectives, the organization may decide to create a community benefit section on its website or prepare a community benefit fact sheet for advocacy staff members to include in their "leave-behinds" — materials that are left with elected officials after a visit.

Guideline 4
Develop an annual community benefit report

In addition to its IRS Form 990, Schedule H, many tax-exempt health care organizations also publish an annual community benefit report that demonstrates how human and financial resources have been used to meet community needs. This report may be part of the organization's annual report or a separate community benefit report. It should be available on the organization's website and also made available to persons who do not have web access.

Most Community Benefit Reports Include the Following Components:

- A one-page executive summary.
- A description of core values or a mission statement that guides the organization.
- A history of an organization's commitment to the community and its development over time.
- A description of the community served and its needs and resources.
- A description of how the organization engaged the community in planning and implementing services.
- A description of how community benefit priorities were established.
- Descriptions of community benefit programs and the people who were served.
- Objective measures of community benefit, including dollars spent and numbers served (from the community benefit accounting forms).

- The impact on the community and how lives were touched.
- A narrative report to explain the value of the services provided beyond the dollars spent or numbers served.

PUBLIC REPORTING REQUIREMENTS

CHNA – The Affordable Care Act (ACA) specifically requires that the CHNA be "made widely available to the public. IRS regulations specify what must be in the CHNA report and criteria that a hospital must follow to make the CHNA report widely available in hard copy and on the Web." Treas. Reg. § 1.501(r)-3(b)(6)(i) and 1.501(r)-3(b)(7)(i).

Implementation strategy – The IRS requires a hospital organization to attach the most recently adopted implementation strategy for each hospital it operates to its annual Form 990 or include the URL of each webpage on which the hospital organization has posted each implementation strategy along with or as part of the report documenting the CHNA to which the strategy relates. Treas. Reg. § § 1.6033–2(a)(2)(ii)(l).

Financial assistance policies – To implement ACA requirements, the IRS directs hospitals to make their financial assistance policies, applications and plain-language summaries available on their websites; to make paper copies available upon request and without charge, both by mail and in public locations in the hospital; and to notify and inform members of the community about the financial assistance policies "in a manner reasonably calculated to reach those members who are most likely to require financial assistance." Treas. Reg. § 1.501(r)–4.

Check your state's community benefit tax-exemption laws to see if your organization needs to report this information to meet state requirements.

Numbers or Narrative? Best Practices in Annual Reports

Quantitative Information

Health care organizations track quantifiable (financial) information associated with the community benefit services and activities they provide. This information is important for budgeting purposes to budget for the services in subsequent years. It is also needed by governing boards and executive leaders who want to know the financial investment in community benefit services. Some government oversight bodies also require financial information.

The community benefit report should include financial information on:

- Charity care and financial assistance.
- Medicaid and other means-tested programs.
- Research.
- Health professional education.
- Community benefit programs that:
  - Resulted in a financial loss to the organization and required subsidization.
  - Are best described in terms of dollars spent or numbers of persons served.

See Chapter 4, Accounting for Community Benefit, for guidelines on accounting and reporting community benefit financial information.

Quantitative community benefit information, however, has limitations. Financial information may underestimate the impact a program has on a community. A low-cost program may make a significant impact on the lives of many people. Because financial information tells only a part of the story, it is important to report both quantitatively and qualitatively in a narrative report.

Narrative Information

Some community benefit services are better described in a narrative report that tells the story beyond the numbers. A narrative report can demonstrate how the organization impacts the community in ways that cannot be quantified. Include in a narrative report activities that:

- Demonstrate the leadership and collaborative role of the organization in improving health and access.
- Are not easily quantifiable.
- Provide significant community benefit but financially break even or involve minimal cost.
- Are best described in terms of benefit provided or numbers served rather than by dollars spent.
- Involve staff and volunteers who donated their free time to the program.

COMMUNICATIONS SHOULD GO BEYOND THE ANNUAL REPORT

Although the annual report is important, reporting benefits provided to the community should be an ongoing process. Supplement the annual report with other means of communication. Constantly look for opportunities to tell your story to persons inside and outside of the organization.

Guideline 5
Report community benefit on IRS Form 990, Schedule H

Nongovernmental, tax-exempt organizations are required to file an IRS Form 990 each year. Hospitals are required to report their community benefit activities and other tax exemption–related information on Form 990, Schedule H. Although it is only required of hospitals, other health care organizations should consider including community benefit information on Form 990, Schedule O, which is used to provide the IRS with supplemental information reported on the Form 990.

Form 990, including Schedule H, is a public document. Not only does the IRS review what is reported, but the form can easily be obtained by others interested in the organization, friends and critics alike — using the public service website, GuideStar, at https://www.guidestar.org. Therefore, all not-for-profit health care organizations should carefully complete Form 990 and take advantage of the opportunity it provides for describing how the organization benefits its community.

The IRS provides detailed instructions for completing Schedule H at https://www.irs.gov/forms-pubs/about-form-990. The Schedule H instructions are based on CHA's original community benefit reporting framework. This *Guide* updates the framework so it is consistent with the current Schedule H. The Community Benefit Inventory for Social Accountability, the companion software to this *Guide* (available from https://lyonsoftware.com/), is also consistent with the Schedule H instructions.

An excellent opportunity for telling the full community benefit story appears in Part VI of Schedule H, which instructs hospitals to "provide any other information important to describing how the organization's hospitals or other health care facilities further its exempt purpose by promoting the health of the community." Here, hospitals can report their leadership activities and the ways they work with the community toward improving community well-being.

These include:

- *Responding to the needs of the community*. This includes opportunities for community involvement in the organization, such as governance, advisory groups and community meetings, as well as the organization's role in planning and supporting community activities.
- *Advocating for persons and policies that improve public health and eliminate disparities*. Describe your organization as a responsible citizen. This may include serving on government advisory committees, meeting with policymakers on issues related to the uninsured or underinsured, building coalitions with community groups, and working with state and national organizations on important policy matters.
- *Serving as a vehicle for attracting and effectively using donated funds*. Document the amount of philanthropy received each year and the portion designated for low-income persons and other populations with special needs and for other community benefit activities.
- *Offering opportunities for volunteer activity*. Report the numbers of volunteer hours and types of services.
- *Partnering* with other organizations to improve health in the community.
- Leading efforts to *improve the quality, safety and efficiency* of health care for patients and the community.
- Lacking efforts to make the organization *environmentally responsible*, such as decreasing waste and energy use.
- *Being a low-cost, low-charge provider*. Document if the organization takes steps to make health care affordable and to minimize community health care costs.
- Identifying whether the organization is a *sole provider, critical access or safety net hospital.*

SUMMARY CHECKLIST OF BEST PRACTICES FOR REPORTING COMMUNITY BENEFIT

- Use the advice and counsel of your communications and marketing departments as part of the community benefit team. Be an ongoing source of community benefit information for colleagues in advocacy, fundraising, communications, governance and planning.
- Work with advocacy/government relations staff to plan community benefit communications to policymakers.
- Use community benefit information internally to build support for programs and to encourage collaborative efforts.
- Develop a community benefit communications plan before it is needed.
- Develop community benefit communications goals, and integrate them into the overall communications and operational plans.
- Develop communications objectives that are specific, realistic and measurable.
- Develop a proactive media strategy that includes traditional and social media.
- Identify all audiences for community benefit information, and determine how best to reach each one and how to tailor the message.
- Develop an annual community benefit report using both quantifiable financial and qualitative narrative information.
- Include in your report information about the organization's mission, vision and history.
- Consult the most recent instructions for IRS Form 990, Schedule H, for guidance on publicly reporting community benefit.
- Be accurate and thorough (but also conservative) as to what is reported as community benefit.
- Measure and evaluate the effectiveness of the community benefit communications plan and efforts.
- Make sure all community benefit information is consistent, including in Schedule H, the annual report and state-required reports — or that any differences have a clear, well-documented explanation.
- Be prepared to respond to media and other inquiries about IRS Form 990, Schedule H, and other reports of your organization's community benefit.

Notes:

Appendices

Appendices

Appendix A: Reference for Chapter 1

A

COMMUNITY BENEFIT INVENTORY TEMPLATE

The instructions and template below can be downloaded at https://www.chausa.org/guideresources.

Instructions: Use this form to document programs or services that your department provides for the benefit of the community. Here are some criteria you can use to determine if the program or service is a community benefit:

- The program or activity addresses a community need. The IRS states that community need can be demonstrated through the following:
  - A CHNA developed or accessed by the organization.
  - Documentation that demonstrated community need or a request from a public agency or community group that was the basis for initiating or continuing the activity or program.
  - The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program.
- The program or activity addresses a community benefit objective:
  - Improve access to health services.
  - Enhance public health.
  - Advance increased general knowledge.
  - Relieve or reduce the burden on government to improve health.
- The program was started or is provided primarily to benefit the community as opposed to benefiting the organization (such as marketing or case-finding).

Find specific examples in the Community Benefit Categories and Definitions section of the appendix.

A

Name and brief description of the program:
Community health need being addressed and how the need was demonstrated:
Sponsoring department:
Target population:
Program site (community, hospital, campus):
Number of persons served or other unit of service:
Cost (if known):
Funding/revenue (if known):
Contact person name, phone number and email address:
Community partners:
Comments:

Appendix B: Reference for Chapter 2

DETERMINING WHAT COUNTS AS COMMUNITY BENEFIT

B

The following table provides examples of activities and programs that should and should not be counted as community benefit, along with a supporting rationale for the determination. The examples are shown by community benefit category.

This table can be downloaded from the CHA website at https://www.chausa.org/guideresources.

Examples of ***community health improvement*** services that should and should not be reported are as follows:

COMMUNITY HEALTH IMPROVEMENT SERVICES		
ACTIVITY OR PROGRAM	**REPORT**	**EXAMPLE RATIONALE**
Immunization for low-income children	Yes	Public health priority, relief of government burden
Flu shots for employees	No	Cost of doing business, more benefit to organization than community
Health screening program in low-income community	Yes	Enhances access, health education
Health screening program in upscale mall for marketing purposes	No	More benefit to organization than community
Health education regarding diabetes	Yes	Public health priority
Marketing material for orthopedic program	No	Marketing focus, more benefit to organization than community
Outreach to help seniors remain independent in their homes	Yes	Public health priority

COMMUNITY HEALTH IMPROVEMENT SERVICES (*continued*)		
Discharge planning function	No	Represents the current standard of care, required for licensure
Taxi vouchers for low-income persons	Yes	Provides access to care for vulnerable persons
Van service between wealthy retirement community and only the organization	No	Benefits the organization more than the community

Examples of ***health professions education activities or programs*** that should and should not be reported are as follows (currently appears in the instructions for IRS Form 990, Schedule H):

HEALTH PROFESSIONS EDUCATION ACTIVITIES OR PROGRAMS		
ACTIVITY OR PROGRAM	**REPORT**	**EXAMPLE RATIONALE**
Scholarships for community members	Yes	More benefit to community than organization
Scholarships for staff members	No	More benefit to organization than community
Continuing medical education for community physicians	Yes	Accessible to all qualified physicians
Continuing medical education for own medical staff	No	Restricted to own medical staff members
Nurse education if graduates are free to seek employment at any organization	Yes	More benefit to community than organization
Nurse education if graduates are required to become the organization's employees	No	Program designed primarily to benefit the organization

Examples of ***subsidized health services*** that should and should not be reported are as follows:

SUBSIDIZED HEALTH SERVICES		
ACTIVITY OR PROGRAM	**REPORT**	**EXAMPLE RATIONALE**
Clinics for low-income persons	Yes	Enhances access
Prenatal classes for mostly insured persons	No	Current standard of care
Mental health service with high census and Medicaid patients	Yes	Responds to need and provides access for low-income consumers
Mental health service with low census that loses money	No	Need not established and may reflect poor business decision
Cosmetic surgery and other elective care for which financial assistance is not available	No	Difficult to establish community need and inaccessible for patients needing financial assistance

Examples of ***research programs*** that should and should not be reported are as follows:

RESEARCH PROGRAMS		
ACTIVITY OR PROGRAM	**REPORT**	**EXAMPLE RATIONALE**
Research on how to reduce disparities in cancer	Yes	Community need
Study on whether to open a new cardiac unit	No	Market research
Study on how to triage ER patients, results published in professional journal	Yes	Results shared with others
Quality assurance study on reducing medication errors	No	Finding used solely by the organization

Examples of ***cash and in-kind contributions*** that should and should not be reported are as follows:

B

CASH AND IN-KIND CONTRIBUTIONS		
ACTIVITY OR PROGRAM	**REPORT**	**EXAMPLE RATIONALE**
Donation to community clinic	Yes	Enhances access
Executive time at a charity golf outing	No	Unrelated to health/mission
Cost of staff working in a free clinic while on hospital payroll	Yes	Commitment of organization's resources
Value of staff time when volunteering on their own time	No	Benefit provided by the staff, not the organization
Equipment with remaining useful life donated to community clinic	Yes	Equipment has financial value, and donation results in net financial cost
Equipment that has been fully depreciated	No	Equipment has been fully expensed — only new cost for delivery can be reported
Emergency funds provided to local Red Cross	Yes	Benefits the community more than the organization
Emergency funds provided **a)** to employee support fund or **b)** by employees	No	**a)** Benefits only persons internal to the organization and **b)** not an expense of the organization

Examples of ***community-building activities*** that should and should not be reported are as follows:

COMMUNITY-BUILDING ACTIVITIES		
ACTIVITY OR PROGRAM	**REPORT**	**EXAMPLE RATIONALE**
Housing for low-income seniors	Yes	Community need/access to housing
Housing for employees	No	Restricted to individuals affiliated with the organization
Crime prevention program	Yes	Public health/social need
Staff in-service education on domestic abuse	No	In-service education is a cost of doing business and of the standard of care
Advocacy on access to transportation, affordable housing, early childhood development programs	Yes	Community need
Advocacy for enhanced reimbursement	No	Benefits the organization
Proper disposal of radioactive waste	No	Required by law
Waste reduction to minimize incineration	Yes	Contributions to improved air quality and related asthma prevention

Note: If any of the reportable community-building activities meet the IRS definition of community benefit, they can be reported as community health improvement.

Examples of ***community benefit operations*** that should and should not be reported are as follows:

B

COMMUNITY BENEFIT OPERATIONS		
ACTIVITY OR PROGRAM	**REPORT**	**EXAMPLE RATIONALE**
Costs of conducting a CHNA	Yes	Critical for an effective community benefit program
Consultant fees for a feasibility study of a new service line	No	Related to operations of the organization
Fundraising for organization community benefit activities	Yes	Related to community need
Fundraising for new technology	No	Related to operations of the organization
Attending a workshop of community benefit program evaluation	Yes	Directly related to the community benefit program
Attending a workshop on management skills	No	Not related to the community benefit program

Appendix C: Reference for Chapter 3

CHECKLIST FOR HOSPITAL POLICIES AND PRACTICES

C

Use this checklist of yes or no questions to assess whether organizational policies support the community benefit program and encourage commitment to access. This checklist can also be downloaded from the CHA website at https://www.chausa.org/guideresources.

Mission and Values Statements:

Y N 1. Do our mission and values statements explicitly reference a commitment to access, community health, and fulfilling the needs of low-income and vulnerable persons?

Y N 2. Are these statements used as criteria for making strategic planning decisions?

Y N 3. Are they used in making long-range planning decisions?

Y N 4. Are new leaders, staff and board members oriented to and kept informed about the organization's community benefit mission?

Y N 5. Are physicians oriented to and kept informed about the organization's community benefit mission?

Y N 6. Do we explicitly condemn racism and discrimination and commit to achieve health equity for all?

Governing Board and Executive Leadership Policies:

Y N 1. Are processes in place to obtain board review and approval of the CHNA, the prioritization of health needs and the implementation strategy?

Y N 2. Does board orientation include education on the mission and legal aspects of community benefit and what it means to be a charitable organization?

Y N 3. Is a commitment to access and community health part of the criteria for selecting executive leaders and board members?

Y N 4. Is community benefit or community health improvement specified in the responsibilities of senior leaders?

Y N 5. Are outcomes related to community involvement and community benefit part of executive leader performance evaluations?

Y N 6. Do the executive staff, board and advisory committees reflect the diversity of your community?

Administrative Policies:

Y N 1. Is community benefit explicit in the organization's strategic/organizational plan and budget?

Y N 2. Does the overall community benefit program have adequate human and financial resources?

Y N 3. Does the organization assign staff knowledgeable about public health and community engagement to be responsible for planning and implementing the community benefit program?

Financial Assistance, Billing and Collections Policies:

Y N 1. Are our emergency medical care, financial assistance, billing and collection policies in line with related federal and state rules and regulations?

Y N 2. Are these policies approved by the hospital's governing body?

Y N 3. Are our policies widely publicized within the facility and in our community?

Y N 4. Do we reach out to the members of the community who might need financial assistance with information about eligibility requirements and how to apply for assistance?

Y N 5. Does our financial assistance policy describe all required documentation and include contact information patients can use for assistance?

Y N 6. Does our policy regarding emergency care specify that the hospital provides care for emergency medical care regardless of ability to pay?

Y N 7. Do our policies specify what action the hospital and any contractors may take in the event of nonpayment?

Y N 8. Has the billing and collections staff or any agency contracted to conduct billing and collections actions on behalf of the hospital been instructed to treat all persons they contact with respect?

Y N 9. Does the organization monitor collection practices?

Y N 10. Are our policies written in languages that the patient or consumer can understand (understandable in both English and other languages spoken in the community)?

Y N 11. Is there a mechanism for identifying patients who may be Medicaid eligible but who are not currently enrolled?

Physician Involvement Policies:

1. Do our medical staff bylaws or other policies require or encourage physicians to:

Y N a. Take emergency calls?

Y N b. Provide a minimum amount of service to Medicaid and uninsured patients?

2. Do medical staff organizations or individual physicians participate in:

Y N a. Assessing community needs?

Y N b. Reviewing community benefit plans and reports?

Y N c. Developing services to improve access to health care?

Y N d. Developing services to improve community health?

Y N 3. Are physicians, medical students and residents oriented to our community benefit mission?

Y N 4. Do we publicly recognize the voluntary community service of physicians?

Y N 5. Do we make efforts to recruit physicians committed to access and physicians who reflect the demographic makeup of our community?

C

Employee Policies:

Y N 1. Are all employees oriented to the organization's mission of service and commitment to access and community health?

Y N 2. Are all employees, especially those involved with admissions, billing and collections, aware of the organization's historical and continuing concern for low-income and other vulnerable persons?

Y N 3. Are staff members offered time off (paid or unpaid) for staff volunteer activities?

Y N 4. Do we recognize and celebrate the community service contributions of staff members?

Y N 5. Are managers and staff assigned or encouraged to participate in collaborative activities with other community organizations?

Advocacy Policies:

Y N 1. Do we advocate for access to health care for all persons?

Y N 2. Do we advocate for responsible policies for financing the care of low-income persons, including preserving Medicaid for those most in need?

Y N 3. Do we advocate for policies that will improve health in our communities (such as environmental improvement, tobacco control, nutrition programs and public-safety measures)?

Y N 4. Do we advocate for policies that will improve the well-being of our community, especially for persons who are low income and vulnerable in other ways (in areas of transportation, environmental improvement, economic development and housing)?

Y N 5. Do we participate in community coalitions for advocacy?

Y N 6. Do we advocate for increased public and private investment into distressed communities to improve the health and well-being of residents?

Environmental Responsibility Policies:

Y N 1. Do we have policies regarding energy conservation, energy efficiency, renewable energy and reducing greenhouse gas emissions consistent with what the best available science indicates is required to address the climate emergency?

Y N 2. Do we have policies regarding waste management, including minimizing medical waste and mechanical device reprocessing?

Y N 3. Do we have policies regarding reusing, recycling and minimizing the use of disposable products?

Y N 4. Do we use environmental-friendly, nontoxic and safe materials, including cleaners and pest control products?

Y N 5. Do we follow CHA's guidance from *Responsible Redistribution of Medical Supplies & Equipment: Leading Practices for Hospitals & Health Systems* when donating surplus?

Y N 6. Do we use seasonal, local and/or organic produce; dairy products; and meat in food for patients, staff and visitors?

Y N 7. Do we buy local food and products when available?

Y N 8. Do we have investment policies that include divesting from fossil fuel industries and corporations that exacerbate the climate emergency?

Y N 9. Do we address environmental issues that are part of the root causes of health problems in our needs assessment and implementation strategies?

C

Community Benefit Program Policies:

EQUITY NOTE

Is equity reflected in our community benefit work through:

- Diversity among community benefit staff, consultants and advisory bodies?
- Outreach to community organizations working with persons who experience disparities and discrimination?
- Alignment of funding decisions with equity goals?
- Investment of financial resources in community organizations dedicated to improving social determinants of health and advancing equity?
- Data collection that uses culturally appropriate tools and methodologies considering factors such as the populations' language needs, literacy levels and trust of institutions?
- Involvement of community members in collecting and analyzing assessment information, program planning, and evaluation?
- Programs that address racial, ethnic and other disparities?
- Effective use of community strengths and assets and community expertise?

Y N 1. Have we made a formal commitment to a community benefit program through our mission statement, staff assignments, job descriptions or board responsibilities?

Y N 2. Does the community benefit program meet all legal requirements?

3. Does the scope of the program include projects to:

Y N a. Improve health in the community?

Y N b. Address health problems of medically underserved persons?

Y N c. Address the social and environmental determinants of health?

Y N d. Reduce emergency department use?

Y N e. Advance knowledge?

Y N 4. Does the program consult with public health experts?

Y N 5. Is there community involvement in the community benefit program?

Y N 6. Are persons who reflect the racial, ethnic and economic diversity of the community involved in the assessment and community benefit planning process?

Y N 7. Do programs designed to serve the broad community include outreach to those with low incomes and other persons with unmet needs?

Y N 8. Was a health equity lens used while completing the CHNA?

Y N 9. Does the CHNA look at the root causes of health problems?

Y N 10. Do program activities build on identified community assets?

Y N 11. Do all activities include a monitoring and evaluation strategy?

12. Does the community benefit program include collaborations with:

Y N a. Local health departments?

Y N b. Other public agencies?

Y N c. Community organizations?

Y N d. Vulnerable populations?

Y N 13. Is there a policy that programs should be evidence based, if possible?

Y N 14. Does the organization prepare a community benefit report and make it available to the public?

Appendix D: Reference for Chapter 4

COMMUNITY BENEFIT ACCOUNTING WORKSHEETS AND SUPPLEMENTAL INFORMATION

D

These worksheets can be used to account for and report community benefit programs and services and Medicare.

Part 1

Worksheets

A Summary of Quantifiable Community Benefits

- **1** Financial Assistance at Cost
- **2** Ratio of Patient Care Cost to Charges
- **3** Unreimbursed Medicaid and Other Means-Tested Government Programs
- **4a** Community Health Improvement Services
- **4b** Community Benefit Operations
- **5** Health Professions Education
- **6** Subsidized Health Service
- **7** Generalizable Research
- **8** Cash and In-Kind Donations for Community Benefit

B Community Building

C Medicare

Worksheet A: Summary of Quantifiable Community Benefits

REPORTING PERIOD:

Use the categories and data elements shown in this form to report quantifiable community benefits.

	Community Benefit Category*	Schedule H Part and Line	See Worksheet	Number of Activities or Programs	Persons Served	Total Expense		Direct Offsetting Revenue	Net Expense	
						Amount	Percent of Total Expense		Amount	Percent of Total Expense
BENEFITS FOR PERSONS LIVING IN POVERTY										
Financial assistance at cost	I	I, 7a	1			$	%	$	$	%
Unreimbursed costs of public programs • Medicaid • Other means-tested programs	 II II	 I, 7b I, 7c	 3 3							
Community health improvement services	III. A	I, 7e	4a							
Health professions education	III. B	I, 7f	5							
Subsidized health services	III. C	I, 7g	6							
Cash and in-kind contributions for community benefit	III. E	I, 7i	8							
Community-building activities	III. F	II	B							
Total quantifiable benefits for persons living in poverty						$	%	$	$	%
BENEFITS FOR THE BROADER COMMUNITY										
Community health improvement services	III. A	I, 7e	4a							
Health professions education	III. B	I, 7f	5							
Subsidized health services	III. C	I, 7g	6							
Generalizable research	III. D	I, 7h	9							
Cash and in-kind contributions for community benefit	III. E	I, 7i	10							
Community-building activities	III. F	II	B							
Community benefit operations	III. G	I, 7e	4b							
Total quantifiable benefits for the broader community										
TOTAL QUANTIFIABLE COMMUNITY BENEFITS										

**Refer to "Categories and Definitions" for additional information.*

Worksheet 1: Financial Assistance at Cost

	Total
GROSS PATIENT CHARGES	
1. Amount of gross patient charges written off under financial assistance policies	$
TOTAL COMMUNITY BENEFIT EXPENSE	
2. Ratio of patient care cost to charges (from Worksheet 2, if used)	
3. Estimated cost (multiply line 1 by line 2, or obtain from cost accounting)	$
4. Medicaid or provider taxes, fees, and assessments	$
5. Total community benefit expense (add lines 3 and 4)	$
DIRECT OFFSETTING REVENUE	
6. Revenues from uncompensated care pools or programs	$
7. Net assets released from restrictions	$
8. Other direct offsetting revenue	$
9. Total direct offsetting revenue (add lines 6 through 8)	$
10. Net community benefit expense (subtract line 9 from line 5)	$
11. Total expense	$
12. Total community benefit percent of total expense (divide line 5 by line 11)	%
13. Net community benefit percent of total expense (divide line 10 by line 11)	%

Worksheet 2: Ratio of Patient Care Cost to Charges

PATIENT CARE COST	
1. Total operating expense (including bad debt expense)	$
LESS ADJUSTMENTS	
2. Non-patient-care activities	$
3. Bad debt expense	$
4. Medicaid or provider taxes, fees, and assessments (if an operating expense)	$
5. Total community benefit expense	$
6. Total community-building expense	$
7. Total adjustments (add lines 2 through 7)	$
8. Adjusted patient care cost (subtract line 7 from line 1)	$
PATIENT CARE CHARGES	
9. Gross patient charges	$
LESS ADJUSTMENTS	
10. Gross charges for community benefit programs	$
11. Adjusted patient care charges (subtract line 9 from line 10)	$
CALCULATION OF RATIO OF PATIENT CARE COST TO CHARGES	
12. Ratio of patient care cost to charges (divide line 8 by line 11)	

Worksheet 3: Medicaid and Other Means-Tested Government Programs

	Government Programs	
	Medicaid	Other means-tested government programs
GROSS PATIENT CHARGES		
1. Gross patient charges from the programs	$	$
TOTAL COMMUNITY BENEFIT EXPENSE		
2. Ratio of patient care cost to charges (from Worksheet 2, if used)		
3. Cost (multiply line 1 by line 2, or obtain from cost accounting)	$	$
4. Medicaid or provider taxes, fees, and assessments	$	$
5. Total community benefit expense (add lines 3 and 4)	$	$
DIRECT OFFSETTING REVENUE		
6. Net patient service revenue	$	$
7. Payments from uncompensated care pools or programs	$	$
8. Prior-year revenue	$	$
9. Net assets released from restrictions	$	$
10. Other revenue	$	$
11. Total direct offsetting revenue (add lines 6 through 10)	$	$
12. Net community benefit expense (subtract line 11 from line 5)	$	$
13. Total expense	$	$
14. Total community benefit percent of total expense (divide line 5 by line 13)	%	%
15. Net community benefit percent of total expense (divide line 12 by line 13)	%	%

Worksheet 4a: Community Health Improvement Services

	Direct Expense	Indirect Expense	Total Community Benefit Expense	Direct Offsetting Revenue	Net Community Benefit Expense
	(A)	(B)	(C)=(A)+(B)	(D)	(E)=(C)-(D)
1. COMMUNITY HEALTH IMPROVEMENT SERVICES					
a.	$	$	$	$	$
b.					
c.					
d.					
e.					
f.					
g.					
h.					
i.					
j.					
2. TOTAL (ADD LINES 1A–1J)	$	$	$	$	$
3. Total expense					$
4. Total community benefit percent of total expense (divide line 2, column C, by line 3, column E)					%
5. Net community benefit percent of total expense (divide line 2, column E, by line 3, column E)					%

Worksheet 4b: Community Benefit Operations

	Direct Expense	Indirect Expense	Total Community Benefit Expense	Direct Offsetting Revenue	Net Community Benefit Expense
	(A)	(B)	(C)=(A)+(B)	(D)	(E)=(C)-(D)
1. COMMUNITY BENEFIT OPERATIONS					
a.	$	$	$	$	$
b.					
c.					
d.					
2. TOTAL (ADD LINES 1A–1D)	$	$	$	$	$
3. Total expense					$
4. Total community benefit percent of total expense (divide line 2, column C, by line 3, column E)					%
5. Net community benefit percent of total expense (divide line 2, column E, by line 3, column E)					%

Worksheet 5: Health Professions Education

	Totals
TOTAL COMMUNITY BENEFIT EXPENSE	
1. Medical students	$
2. Interns, residents and fellows	$
3. Nurses	$
4. Other allied health professions students	$
5. Continuing health professions education	$
6. Other students	$
7. Total community benefit expense (add lines 1–6)	$
DIRECT OFFSETTING REVENUE	
8. Medicare reimbursement for direct GME	$
9. Medicaid reimbursement for direct GME	$
10. CHGME reimbursement for direct GME	
11. Continuing health professions education reimbursement/tuition	$
12. Net assets released from restrictions	
13. Other revenue	$
14. Total direct offsetting revenue (add lines 8 through 13)	$
15. Net community benefit expense (subtract line 7 from line 14)	$
16. Total expense	$
17. Total community benefit percent of total expense (divide line 7 by line 16)	%
18. Net community benefit percent of total expense (divide line 15 by line 16)	%

Worksheet 6: Subsidized Health Services

Service Name:

	Total Subsidized Health Service Program	Bad Debt	Medicaid and Other Means-Tested Government Programs	Charity Care	Total Reported	Medicare
	(A)	(B)	(C)	(D)	(E)=(A)-(B)-(C)-(D)	Exclude from Part III of Schedule H
GROSS PATIENT CHARGES						
1. Gross patient charges from program(s)	$	$	$	$	$	$
TOTAL COMMUNITY BENEFIT EXPENSE						
2. Ratio of patient cost to charges (from Worksheet 2, if used)						
3. Cost (multiply line 1 by line 2, or obtain from cost accounting)	$	$	$	$	$	$
DIRECT OFFSETTING REVENUE						
4. Net patient service revenue	$	$	$	$		$
5. Net assets released from restrictions	$	$	$	$		
6. Other revenue	$	$	$	$		$
7. Total direct offsetting revenue (add lines 4 through 6)	$	$	$	$	$	$
8. Net community benefit expense (subtract line 7 from line 3)	$	$	$	$	$	$
9. Total expense					$	
10. Total community benefit percent of total expense (divide line 3 by line 9)					%	
11. Net community benefit percent of total expense (divide line 8 by line 9)					%	

Worksheet 7: Research

	Research Funded by Tax-Exempt Sources	Other Research Studies (Intended for Publication)
TOTAL COMMUNITY BENEFIT EXPENSE		
1. Direct costs	$	$
2. Indirect costs	$	$
3. Total community benefit expense (add lines 1 and 2)	$	$
DIRECT OFFSETTING REVENUE		
4. License fees and royalties for research reported as community benefit	$	$
5. Medicare reimbursement for research reported as community benefit	$	$
6. Net assets released from restrictions	$	$
7. Other revenue	$	$
8. Total direct offsetting revenue (add lines 4 through 7)	$	$
9. Net community benefit expense (subtract line 8 from line 3)	$	$
10. Total expense	$	$
11. Total community benefit percent of total expense (divide line 3 by line 10)	%	%
12. Net community benefit percent of total expense (divide line 9 by line 10)	%	%

Worksheet 8:
Cash and In-Kind Donations for Community Benefit

	Cash Contributions	In-Kind Contributions	Total
	(A)	(B)	(C)=(A)+(B)
1. Total community benefit expense	$	$	$
DIRECT OFFSETTING REVENUE			
2. Net assets released from restrictions	$	$	$
3. Other revenue	$	$	$
4. Total direct offsetting revenue (add lines 2 and 3)	$	$	$
5. Net community benefit expense (line 1 minus 4)			$
6. Total expense			$
7. Total community benefit percent of total expense (divide line 1 by line 6)			%
8. Net community benefit percent of total expense (divide line 5 by line 6)			%

Worksheet B: Community-Building Activities

Community-Building Category	Number of Activities or Programs	Persons Served	Total Community-Building Expense					Direct Offsetting Revenue	Net Community-Building Expense	
			Cash and In-Kind Donations	Other Direct Expense	Indirect Expense	Total Community-Building Expense	Percent of Total Expense		Amount	Percent of Total Expense
			(A)	(B)	(C)	(D)=(A)+(B)+(C)		(E)	(F)=(D)-(E)	
1. Physical improvements and housing			$	$	$	$	%	$	$	%
2. Economic development										
3. Community support										
4. Environmental improvements										
5. Leadership development and training for community members										
6. Coalition building										
7. Community health improvement advocacy										
8. Workforce development										
9. Other community building										
10. Total (add lines 1–9)			$	$	$	$	%	$	$	%

Worksheet C: Medicare

Medicare	Medicare Cost Report	Subtract: Amounts Reported as Community Benefit (Part I)		Subtotal (For Part III, Schedule H)	Other Medicare Services (Non-Cost Report)					Total Medicare
		Subsidized Health Service	Health Professions Education		Medicare Advantage	Professional Fees	Clinical Laboratory	Other	Subtotal (For Part VI of Schedule H)	
	(A)	(B)	(C)	(D)=(A)-(B)-(C)	(E)	(F)	(G)	(H)	(I)=(E)+(F)+(G)+(H)	(J)=(A)+(I)
1. Medicare-allowable costs	$	$	$	$	$	$	$	$	$	$
2. Medicare revenue										
3. Total amount	$	$	$	$	$	$	$	$	$	
4. Medicare Advantage IME	($)	($)		($)	$				$	
5. Total Revenue	$	$	$	$	$	$	$	$	$	$
6. Shortfall or (surplus) (subtract line 5 from line 1)	$	$	$	$	$	$	$	$	$	$

Part 2

The material in this part of the Appendix covers the following topics:

- Developing indirect cost rates.
- Who reports what: How related organizations should report community benefit.

How to Develop Indirect Cost Rates

Cost accounting systems assign indirect costs to programs based on sophisticated and highly detailed allocation techniques. In the absence of a cost accounting system, indirect cost factors can be derived from the Medicare Cost Report, or special studies conducted by the finance department can be used to incorporate these costs.

The cost factor or rate typically is expressed as a percentage:

(Total Indirect and Direct Costs)/Direct Costs – 1 = Indirect Cost Factor

The factor is then applied as follows:

Program Direct Costs × (1 + Indirect Cost Factor) = Total Community Benefit Expense

The following table provides recommendations for how indirect cost factors can be developed for each category of community benefit.

ACTIVITY OR PROGRAM	INDIRECT COST FACTOR
Financial Assistance	Indirect costs are included in the numerator of the "ratio of patient care cost to charges"; a separate indirect cost factor is not needed.
Medicaid and Other Means-Tested Government Programs	Indirect costs are included in the "ratio of patient care cost to charges" in an organization's cost accounting system or the program cost reports, so separate factors are not needed.
Community Health Improvement	Develop two indirect cost rates, one for community health initiatives that are sited at the hospital and a second for initiatives sited in non-hospital, community settings. The "hospital-based" rate can be derived from Medicare Cost Reports or from an indirect cost model built into the hospital's cost accounting system. The Medicare Cost Report includes six categories of "cost centers": (1) General Service, (2) Inpatient Routine, (3) Ancillary, (4) Outpatient, (5) Other Reimbursable, (6) Special Purpose (capital-related) and Non-reimbursable. Indirect (overhead) costs are accounted for in two of these cost centers: General Service and Special Purpose. An indirect cost rate can be calculated by summing the expenses for cost centers within each category and then calculating the following ratio: ***Total of General Service and Special Purpose Costs (Excluding Education-Related Cost Centers and the Costs of Community Benefit Operations) / Total Expense = Indirect Cost Rate*** Education and community benefit operations costs are excluded from this rate because they are captured in full elsewhere in the accounting framework. Costs should be derived from Worksheet A, Column 5, of the Medicare Cost Report (which shows costs for each cost center after reclassifications).

ACTIVITY OR PROGRAM (*continued*)	INDIRECT COST FACTOR (*continued*)
Community Health Improvement *(continued)*	The "community-based" rate should be lower than the "hospital-based" rate and should exclude the costs of hospital buildings, the billing office, laundry and other cost centers that should apply only to hospital-based programs. If an organization has a cost accounting system, indirect costs can be determined for community health improvement and other services based on the allocations made by that system.
Community Benefit Operations	Community Benefit Operations is itself an overhead function. A reasonable indirect cost rate that accounts for space used by this activity and also for administrative oversight is appropriate.
Community Building	See Community Health Improvement section.
Subsidized Health Services	Organizations with a cost accounting system can rely on that system to derive total costs for each subsidized health service (direct and indirect costs). Organizations without a cost accounting system can develop a "hospital-based" rate from the Medicare Cost Report or from a special study.
Health Professions Education	The Medicare Cost Report is a preferred source for indirect cost factors for health professions education activities. In the Medicare Cost Report, Worksheet B, Part I, column 0 includes the direct cost (before overhead) of programs for interns and residents, paramedical education programs and any nursing school programs. Columns later in Worksheet B show the total cost of these programs after indirect cost allocations.
Research	Indirect costs for research programs should be based on rules established by the National Institutes of Health (NIH). Some organizations include indirect costs based on amounts or factors they submit for approval. Others include these costs based on rates actually approved by NIH. The rate based on the amount submitted for approval is the most appropriate statistic for purposes of community benefit accounting, so long as the rate follows NIH cost-finding rules.
Financial and In-Kind Donations	This indirect cost rate should be minimal or zero if the organization has separately accounted for the cost of the grant-making function as part of its community benefit operations.

CHA recommends having at least two indirect cost rates to be applied to community health initiatives and for community-building activities — one rate for "hospital-based" programs and a second, lower rate for "community-based" programs.

- One program might be housed in hospital space (thus absorbing utilities, maintenance and other costs), and for that program a higher, hospital-based rate would be appropriate.
- Another program may be based in a non-hospital community setting and rely much less on the hospital for support and administrative services, so a lower community-based rate would apply.

If a cost accounting system is available, indirect costs can be allocated based on statistics that are unique to that type of cost. The following table shows the types of statistics used by one multi-hospital system to allocate indirect cost within its cost accounting system.

INDIRECT COSTS	ALLOCATION STATISTIC
Building depreciation and interest expense on debt	Square footage
Employee benefits that have not been directly assigned to activities or programs	Paid hours or salary expense
Human resources	Paid hours or salary expense
Materials management	Square footage or supplies expense
Hospital administration	Total expense
Finance and accounting	Total expense
Planning and marketing	Total expense
Information technology	Total expense
Communications	Total expense
Plant operations and maintenance	Square footage
Security	Square footage
Laundry	Pounds of laundry
Utilization review	Total expense
Quality management	Total expense
Nursing administration	Paid hours
Patient registration	Gross charges
Patient billing	Gross charges

INDIRECT COSTS (*continued*)	ALLOCATION STATISTIC (*continued*)
Medical records	Gross charges
Dietary and nutrition services	Meals served
Research	Total expense
Laboratory administration	Laboratory revenue
Radiology administration	Radiology revenue
Service lines administration	Revenue for each service line
Ambulatory clinic administration	Ambulatory revenue
Depreciation on equipment, patient care	Directly assigned to patient care departments based on fixed asset ledger
Employee benefits, patient care	Paid hours in patient care areas

Who Reports What: How Related Organizations Should Report Community Benefit

Many health care organizations operate more than one corporate entity. Chapter 4 provides the following guidelines for how related organizations should report community benefit:

- If a hospital operates a foundation under the same federal employer identification number (EIN) (e.g., foundation activities and hospital activities are "housed" in the same nonprofit corporation), transfers of funds from the foundation to the hospital for community benefit activities will not be separately recognized or reported, as they are "intracompany" transfers. When the hospital uses funds provided by the foundation for community benefit activities, it will report the associated expense on Schedule H as community benefit expense. If the funds received by the foundation were restricted by a third party, they will need to be reported as direct offsetting revenue when used for a community benefit purpose.
- If the hospital and foundation activities are conducted by different related organizations, each with its own EIN (e.g., the foundation activities and hospital activities are operated in different nonprofit corporations), transfers of funds from the foundation to the hospital for community benefit activities will be separately recognized and reported, as they are "intercompany" transfers. In this case, the foundation will report the transfer of the funds to the hospital as an expense on its core Form 990, and the hospital will report the receipt of such funds as grant revenue on its core Form 990. However, when the hospital uses such funds to support community benefit activities, it will report the associated expense in the appropriate column of the Community Benefit Table on its Form 990, Schedule H. If the foundation has placed

a restriction on how the funds are to be used, the hospital will need to report the transfer as direct offsetting revenue on Schedule H.

This demonstrates how these guidelines can be followed:

A foundation is controlled by the same system that controls the hospital. The foundation receives a restricted grant of $1 million (intended to be transferred over two years) and then transfers $500,000 of the grant (pursuant to the restrictions) to a system hospital. The system hospital then uses the transferred funds pursuant to the restrictions and spends them to support a community benefit program that costs $600,000 during the year. As a result, the hospital is using $100,000 of its own funds to help finance the program.

The following table demonstrates how accounting and reporting should be handled both under GAAP (generally accepted accounting principles) and in Form 990, Schedule H. Note that the results under GAAP and Form 990 are the same.

	SEPARATE EIN REPORTS				CONSOLIDATED EIN REPORT	
	FOUNDATION		HOSPITAL			
A. GAAP						
Grant Revenue	$1,000,000	1	$500,000	3	$1,000,000	5
Total Community Benefit Expense	$500,000	2	$600,000	4	$600,000	6
Net Community Benefit Expense	$ 500,000		$100,000		$100,000	
B. 990 Accounting						
1. Amounts in Core Form Grant	$1,000,000		$500,000		$1,000,000	
Revenue Expense	$500,000		$600,000		$600,000	
2. Schedule H						
Direct Offsetting Revenue	N/A	7	$500,000	8	$500,000	10
Total Community Benefit Expense			$600,000	9	$600,000	11
Net Community Benefit Expense			$100,000		$100,000	

GAAP Accounting and Reporting

Under GAAP, the following would occur. The superscripts reference examples on the chart.

If the foundation and the hospital are publishing *separate* community benefit reports:

- [1]The $1 million raised by the foundation would be reported as revenue for that entity.
- [2]The $500,000 transferred by the foundation to the hospital would be included in the foundation's operating expense.
- [3]That same $500,000 would be reported as revenue by the hospital.

- [4]The hospital's community benefit program cost of $600,000 would be reported as part of its total community benefit expense.
- Net community benefit expense for the hospital would be the difference between [3]revenue and [4]expense, or $100,000.
- The two, separate, unconsolidated reports would have a total combined revenue of $1.5 million[1, 3] and a total community benefit expense of $1.1 million[2, 4].

If the foundation and the hospital were publishing a *consolidated* (e.g., system-wide) community benefit report, the "intracompany" transfer from the foundation to the hospital (the $500,000 amounts in italics[2, 4]) would not be recognized or reported (in accounting terms, it would be "eliminated"):

- [5]Only the $500,000 originally raised by the foundation[1] and used by the hospital during the year for the designated community benefit purpose would be reported as revenue on the Schedule H.
- [6]Only the $600,000 community benefit program cost[4] incurred by the hospital would be reported as expense.

In this case, the foundation and hospital would not be considered separate entities for accounting purposes. The consolidated community benefit report would have $500,000 in direct offsetting revenue (the original amount received from the donors or grantors and actually used for the designated community benefit purpose during the year) and $600,000 in total community benefit expense (for the cost of the community benefit program). Net community benefit expense would be $100,000.

The values included in revenues and expenses reported in Form 990 are the same as those reported under GAAP.

Form 990, Schedule H

In Schedule H, the following would occur:

If the foundation and the hospital have *separate* (unique) EINs:

- [7]Schedule H would not be filed by the foundation.
- [8]The hospital would file Schedule H but, pursuant to IRS instructions, would not include the grant dollars transferred from the foundation and used for a community benefit purpose in "direct offsetting revenue."
- [9]The hospital's Schedule H would include the $600,000 cost to operate the community benefit program.

- Net community benefit expense would be $100,000 because the restricted grant dollars are to be included in "direct offsetting revenue."

If the foundation and the hospital share *the same* EIN:

- [10]Schedule H would not include any funds collected by the foundation from donors or grantors in direct offsetting revenue until those funds are used for their designated purpose(s).
- [11]The hospital's Schedule H would include the $600,000 cost to operate the community benefit program.
- Net community benefit expense would be $100,000 because the restricted grant dollars are to be included in direct offsetting revenue when used pursuant to the restriction(s).

Appendix E

SUGGESTED INFORMATION TO BE INCLUDED IN A COMMUNITY HEALTH NEEDS ASSESSMENT

The availability and cost of data may vary by region/county.

Demographics and Socioeconomic Status

- Community overview:
  - Age, sex, race, and socioeconomic status of community members.
  - Poverty by age and racial/ethnic subgroups.
  - Unemployment rate.
  - Educational attainment.

Access to Health Care

- Accessibility of behavioral health and dental services.
- Health staffing shortages by Health Professional Shortage Area (HPSA), Primary Care HPSA and Dental HPSA.
- Number of Primary Care Physicians (M.D.s and D.O.s) per 10,000 people.
- Number of hospitals and beds per 10,000 people.
- Percent of uninsured patients.
  - Uninsured adults (ages 18+).
  - Uninsured children (ages 17 and under).
- Percent of patients receiving Medicaid and Medicare.

Health Status of Overall Population and Priority Population (Uninsured, Low-Income and Minority Groups)

- Leading causes of death (age-adjusted rates if available).
- Inpatient admission rates and the top 10 causes of admission.
- Rates of "preventable" hospitalization (congestive heart failure, asthma, diabetes, chronic obstructive pulmonary disease, and pneumonia).

Risk Factor Behaviors and Conditions Related to Top 10 Causes of Death

- Tobacco use rates.
- Obesity rates.
- Substance misuse disorders.
- Incidence rate.
- Screenings utilization rates.

Maternal and Child Health

- Infant mortality rate.
- Low-birth-weight rates.
- Proportion of women who receive late or no prenatal care.
- Teen pregnancy rate.

Infectious Diseases

- Sexually transmitted infection incidence rates (chlamydia, gonorrhea, syphilis).
- HIV incidence rate.
- Tuberculosis incidence rate.
- Rates of COVID-19, flu and pneumonia vaccination.

Natural Environment

- Air quality.
- Drinking water quality.
- Seasonal food access and sufficiency.

Social Environment

- Violent crime rate.
- Child abuse rate.
- Housing affordability rate.
- Social connectivity and isolation rates.

Resources/Assets

- Resources potentially available to address community health needs (such as federally qualified health clinics or school clinics).

Appendix F: Reference for Chapter 5

PROGRAM PLANNING WORKSHEET

This worksheet can be used to plan a community benefit program. Download this worksheet from the CHA website at https://www.chausa.org/guideresources.

Program name:
STEP 1: The problem: Define the problem that the program will address.
Community need being addressed:
How need was determined: ☐ Community health need assessment ☐ Documentation demonstrating need or a request from a public agency or community group is the basis for initiating or continuing the program ☐ Unrelated, collaborative tax-exempt or government organizations are partners in the program ☐ Information from emergency department admissions ☐ Other (please explain):
Community benefit objective being addressed: ☐ Improving access ☐ Enhancing public health ☐ Advancing medical or health care knowledge ☐ Relieving or reducing government burden to improve health

STEP 2: Target population: Describe the target population of the program.

Category:

☐ Primarily for persons living in poverty ☐ Primarily for the broader community

Special needs populations:

☐ Persons with disabilities

☐ Racial, cultural and ethnic minorities

☐ Uninsured/underinsured persons

☐ Other

Ages of targeted audience:

☐ Infants ☐ Adults ☐ Children

☐ Seniors (65–80) ☐ Seniors (over 80) ☐ Teenage ☐ All Ages

Gender: ☐ Male ☐ Female ☐ Both

STEP 3: Goals: Goals are general statements about what changes your program hopes to achieve. They answer the question, What will be different in people's lives or the community as a result of the program?

List goals for the program:

1.

2.

STEP 4: Objectives and indicators: Objectives are more precise statements of a goal that clearly state the name of the program; the primary client or target population; the behavior or condition that will be changed; and how it will be changed, by how much and the time frame for the change.

Objectives can be short, intermediate or long term.

You can use the following template to develop your objectives.

The_____program will_____(increase, decrease, add, create, modify)_____(a condition or behavior) among (whom)_____through or by (how)_____% (how much) from a baseline of _____by June 30, 20XX (specific date).

Indicators are a measure of whether an objective has been met. For each objective, ask, How will I know if this objective has been accomplished? The answer is your indicator.

List objectives and indicators for the program goals:

Goal 1:	**Objective(s)** *A goal may have one or more objectives.*	**Indicator(s)** *An objective may have one or more indicators.*
_____	_____	_____
_____	_____	_____
_____	_____	_____
Goal 2:	**Objective(s)** *A goal may have one or more objectives.*	**Indicator(s)** *An objective may have one or more indicators.*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Plan for evaluation: Ask yourself what you need to know to show that you have achieved the objective. For example, will you need to compare program results to baseline data? What changes would you like to see as a result of implementing your strategy? This will help you identify data to be collected and when it needs to be collected.

F

STEP 5: Program theory/strategy: A programs theory/strategy describes the strategies that the program will undertake to achieve stated objectives. Statements of theory are usually expressed as follows: If we do this, then this will happen (e.g., objective achieved).

State the program theory for your program:

Evidence-based programs: When dealing with problems without clear solutions, look for evidence-based programs — that is, approaches that have been tried and proven successful. Sources for evidence-based programs include the Centers for Disease Control and Prevention, the public health literature and other published articles about successful programs.

STEP 6: Activities: The specific activities your program will complete to achieve your objectives.

List the activities:

1.

2.

3.

4.

STEP 7: Program outputs: Outputs describe the type and amount of items the program will produce, provide or generate, and the number of persons who will be served or who participated. For example, the number of booklets produced, workshops held or people who were educated.

Identify the outputs of the program's activities and who was reached or targeted by the program.

Outputs	Who was reached/targeted

STEP 8: Inputs: What elements are invested into the program (e.g., funding, staff, volunteers, materials, evidence-based programs).

List the program investments:

1.

2.

3.

4.

STEP 9: Identify partners

1. Is this a collaborative effort? If so, who are your partners, and what are their respective roles?
2. If not, are there potential partners you could join with to extend the reach of the program or make it more effective?

(OPTIONAL) STEP 10: Develop a logic model

You now have the information necessary to develop a **logic model**. A logic model can reveal gaps and challenges in a program (e.g., missing resources or activities). It can also be used to ensure that all stakeholders have a common understanding of the program.

Inputs: Use information from Step 8 to complete this box. Tie resources to the activities they will support.

Outputs: Use information from Steps 6 and 7 to complete this box. Tie outputs to the specific activities that will produce them.

Outcomes: These are the intended results of the program. They can be short, intermediate or long term. Use information from Step 4 to complete this box.

Notes:

Community Benefit Categories and Definitions

Community Benefit Categories

Category 1: Financial Assistance

Category 2: Government-Sponsored Means-Tested Health Care

Category 3: Other Community Benefit Programs and Activities

This reference can be downloaded from the CHA website at https://www.chausa.org/guideresources.

This section provides recommendations for what counts as community benefit. It is not legal advice. Health care organizations should consult the most recent instructions to IRS Form 990, Schedule H, and similar guidelines published by states regarding how to report community benefit information.

General Reporting Criteria

To be reported as a community benefit, a community health need for the activity or program must be established.

Community benefit activities or programs also seek to achieve a community benefit objective, including:

- Improving access to health services.
- Enhancing public health.
- Advancing increased general knowledge.
- Relieving the government burden to improve health.

This includes activities or programs that:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial or cultural barriers to accessing health services and that, if ceased, would result in access problems (e.g., longer wait times or increased travel distances).
- Address federal, state or local public health priorities, such as eliminating disparities in access to health care services or disparities in health status among different populations.

- Leverage or enhance public health department activities, such as childhood immunization efforts.
- Strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies.
- Would otherwise become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

FINANCIAL ASSISTANCE

CATEGORY 1

Financial assistance is free or discounted health care services provided to persons who cannot afford to pay and who meet the eligibility criteria in the organization's financial assistance policy (FAP). For community benefit purposes, financial assistance is reported in terms of costs, not charges. Financial assistance does not include bad debt and discounts not described by the FAP (e.g., discounts provided to self-pay patients and/or services ineligible for financial assistance).

Do Count:

- The cost of free and partially discounted care provided based on the financial assistance policy.
- Provider taxes, assessments or fees if Medicaid Disproportionate Share Hospital (DSH) funds in your state are used in whole or in part to offset the cost of financial assistance.
- The cost of care associated with out-of-pocket liabilities (copayments and deductibles) for Medicaid and other low-income patients, if the organization's financial assistance policy grants financial assistance to these types of underinsured patients.

Do Not Count:

- Bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay.
- Medicaid or Medicare losses (reported elsewhere).
- Self-pay or prompt-pay discounts.
- Contractual adjustments with any third-party payers.

CATEGORY 2

GOVERNMENT-SPONSORED MEANS-TESTED HEALTH CARE

This category includes losses incurred in providing access to health care for Medicaid recipients and for low-income individuals participating in other government-sponsored means-tested insurance programs. Losses (net community benefits) are reported as the difference between net patient revenue recorded by the organization and the cost of providing health care services. Medicaid costs include Medicaid provider taxes, fees and assessments paid by the organization, as these amounts generate Medicaid revenue. These community benefits are not valued in the same way as contractual allowances (the difference between gross charges and net patient revenue).

Do Count:

Net patient revenues and costs related to:

- Medicaid (fee-for-service and managed care, from all states).
- Other means-tested government programs, including:
  - Children's Health Insurance Programs (CHIP).
  - State and local indigent care medical programs for low-income or medically indigent persons ineligible for Medicaid.

Do Not Count:

- Medicare shortfalls. Note, however, that some Medicare-related losses are reportable under subsidized health services and Health Professions Education (Graduate Medical Education).
- Government health care programs that are not means-tested, such as the Department of Veterans Affairs and the Indian Health Service.

OTHER COMMUNITY BENEFIT PROGRAMS AND ACTIVITIES

CATEGORY 3

Other community benefit programs and activities include the following:

- Community health improvement services.
- Health professions education.
- Subsidized health services.
- Research.
- Cash and in-kind contributions for community benefit.
- Community-building activities.
- Community benefit operations.

Do Count:

- Programs that respond to an identified community health need and are designed to accomplish one or more community benefit objectives (see the General Reporting Criteria section).
- Programs and activities directed to or including at-risk persons, such as underinsured and uninsured persons.
- Programs offered to the broad community (including at-risk persons) designed to improve community health.

Do Not Count:

- Programs intended primarily for marketing or promotion purposes.
- Activities that don't generate expense to the hospital, such as time spent by volunteers and employees on their own time.
- Routine or required care and services.
- Activities or programs required for licensure or accreditation (e.g., cancer or trauma registries).

A. Community Health Improvement Services

These activities are carried out to improve community health, extend beyond patient care activities and are subsidized by the health care organization. Such services do not generate patient care bills, although they may involve a nominal fee.

Specific community health programs and activities to quantify (if they satisfy the General Reporting Criteria) include:

- Community health education.
- Support groups.
- Community-based clinical services, such as health services and screenings for underinsured and uninsured persons.
- Health care support services, such as enrollment assistance in public programs and transportation efforts.
- Self-help programs, such as smoking cessation and weight loss programs.
- Community-based chaplaincy programs and spiritual care, including pastoral outreach programs.
- Programs that focus on addressing social and environmental determinants of health (with evidence of community health improvement effects).
- Community health initiatives addressing specific health needs and goals.

A1. Community Health Education

Community health education includes lectures, presentations, other group programs and activities, and development and dissemination of materials that focus on prevention and health behaviors. Education activities can be provided in multiple formats, including resources made available to communities through support groups and through initiatives with a self-help emphasis.

Such programs are not focused on marketing and are conducted apart from clinical services delivery. Direct and indirect costs for staff time, travel, materials and staff preparation are reportable.

Do Count if the Program Addresses a Community Health Need and Meets a Community Benefit Objective:

- Caregiver training for persons caring for family members at home.
- Education on specific diseases or conditions, such as diabetes or heart disease.
- Health fairs that respond to community health needs.
- Consumer health libraries.
- Parish and congregational health–related programs.
- Community health promotion and wellness programs, including newsletters primarily intended to educate the community about health issues and available health and social services, and health education lectures and workshops provided to community groups.
- Information provided through news releases and other modes to the media to educate the public about health issues (such as wearing bike helmets, treatment news, health resources in the community, etc.).
- School health education programs. (School-based health services are reportable in category A2, Community-based clinical services.)
- Work site health education programs when not performed as goodwill and provided in response to community health need.

Do Not Count:

- Community calendars and newsletters if a prudent layperson would conclude that they focus primarily on marketing.
- Patient education that is part of comprehensive patient care (e.g., diabetes education provided only for patients).
- Health education sessions that are offered for a fee and that result in a profit.
- Advertisements with health messages when the primary purpose is marketing.
- Childbirth and parenting education classes that are reimbursed or designed to attract paying or insured patients.

Support Groups

Support groups typically are established to address social, psychological or emotional issues related to specific diagnoses or occurrences.

Do Count if the Program Addresses a Community Health Need and Meets a Community Benefit Objective:

- Support groups related to community need, such as for prevention of child abuse or managing chronic disease.
- Costs to run support groups.

Do Not Count:

- Services routinely given to patients and families in the course of their inpatient or outpatient encounters.

Self-help Programs

These include wellness and health-promotion programs and classes for the community, such as those for smoking cessation, exercise and weight loss.

Do Count if the Program Addresses a Community Health Need and Meets a Community Benefit Objective:

- Anger management programs.
- Exercise classes.
- Smoking cessation programs.
- Stress management classes.
- Weight loss and nutrition programs.

Do Not Count:

- Employee wellness and health promotion provided by the organization as an employee benefit.
- The use of facility space to hold meetings for community groups (reportable in category E3, In-Kind Donations).

A2. Community-Based Clinical Services

These are clinical services provided on a periodic basis or as special events in the community. They include screenings, one-time or occasionally held clinics, clinics for underinsured and uninsured persons, and mobile units.

They do not include permanent subsidized hospital outpatient services, which are reportable as Hospital Outpatient Services in category C3. As with other categories of community benefit, these programs and activities should be counted only if they are designed to meet identified community health needs.

Screenings

Screenings are health tests conducted in the community as a public service, such as blood pressure measurements, cholesterol checks and school physicals. They are a secondary prevention activity designed to detect the early onset of illness and disease. Referrals to any community health or social services providers should be available if necessary. To be considered community benefit, screenings should provide follow-up care as indicated and should provide access to services for all, including individuals who are uninsured and underinsured.

Do Count if the Program Addresses a Community Health Need and Meets a Community Benefit Objective:

- General screening programs and health-risk assessments.
- Behavioral health screenings.
- Screenings for high blood pressure, lipid profiles, cholesterol levels and stroke risks.
- Eye examinations and hearing screenings.
- Mammography screenings.
- Prostate screenings.
- Osteoporosis screenings.
- School and sports physical examinations (only if there is a demonstrated need for vulnerable populations).
- Skin cancer screenings.
- Colon cancer screenings.

Do Not Count:

- Health screenings associated with conducting a health fair (reportable in category A1, Community Health Education).
- Screenings for which a profit is realized.
- Screenings when the primary purpose is to generate referrals to the organization or its physicians.
- Screenings provided primarily for public relations or marketing purposes.

One-Time or Occasionally Held Clinics

Do Count if the Program Addresses a Community Health Need and Meets a Community Benefit Objective:

- Blood pressure and/or lipid profile/cholesterol screening clinics.
- Cardiology risk factor screening clinics.
- Dental care clinics.
- Immunization clinics.
- One-time or occasionally held primary care clinics.
- School physical clinics to increase access to health care for vulnerable populations.

Do Not Count:

- Free school team physicals, unless there is a demonstrated need for this service.
- Flu shots or physical exams for the organization's employees.
- Clinics for which a fee is charged and/or patient bills are generated and for which a profit is realized.
- Subsidized, permanent, ongoing programs and outpatient services (reportable in category C3, Hospital Outpatient Services).

Clinics for Underinsured and Uninsured Persons

These programs, which in the past may have been called "free clinics," provide free or low-cost health care to medically underinsured and uninsured persons through the use of volunteers, including physicians and health care professionals who may donate their time.

Do Count if the Program Addresses a Community Health Need and Meets a Community Benefit Objective:

- Clinic operating costs.
- Facilities and overhead costs.
- Lab and medication costs.

Do Not Count:

- Grants to an unrelated free clinic or Federally Qualified Health Centers (reportable in category E1, Cash Donations).

Mobile units

Do Count if the Program Addresses a Community Health Need and Meets a Community Benefit Objective:

- Mobile units that deliver primary care, dental care and related services to underserved populations on an occasional or one-time basis.
- Vans and other vehicles used to deliver primary care services.

Do Not Count:

- Subsidized, mobile specialty care services that are an extension of the organization's outpatient department, such as mammography, radiology or lithotripsy (reportable in category C3, Hospital Outpatient Services).
- Costs for marketing associated with the mobile unit. For example, if 30 percent of the mobile unit's time is spent on marketing or goodwill efforts and the remainder of the time is spent addressing community health needs, then 30 percent of the cost of the mobile unit would not be reported as a community benefit expense.

A3. Health Care Support Services

Health care and social support services are provided by the hospital to enhance access to and the quality of health care services for vulnerable populations, especially persons living in poverty.

Do Count if the Program Addresses a Community Health Need and Meets a Community Benefit Objective:

- Costs to screen and refer low-income persons for needs associated with social determinants of health when community health need has been established (for example, housing and food insecurity issues are present in community) and the activities are above and beyond the standard practice of patient registration or discharge planning.
- The cost of screening and referral tools (e.g., incremental costs to add screening and referral capabilities to electronic health records systems or the cost of stand-alone screening and referral platforms).
- Chronic disease management and case management of underinsured and uninsured persons that goes beyond routine discharge planning.
- Telephone information services, such as Ask a Nurse, medical and mental health service hotlines, and poison control centers, not provided for marketing purposes.
- Physician referral programs for Medicaid and uninsured persons.
- Transportation programs for patients and families to enhance patient access to care (include cab vouchers provided to low-income patients and families but not to increase the use of the facility's services).
- Assistance to enroll patients in governmental health insurance programs for low-income persons, such as CHIP and Medicaid.
- Assistance to enroll patients in health insurance marketplace programs.
- Costs of navigator services.
- Personal response systems, such as Lifeline.
- Assistance for homeless patients following discharge, such as meals, transportation and clothing.

Do Not Count:

- A physician referral program intended primarily for marketing purposes or only for hospital-affiliated physicians (unless for Medicaid or uninsured persons).
- Routine discharge planning.
- Translation and interpreter services otherwise required of all providers.

A4. Social and Environmental Improvement Activities

These are programs and activities that improve the health of persons in the community by addressing social and environmental determinants that impact health. They include programs that address social and community factors, poverty and economic stability, education, and neighborhood and the built environment.

Report in this category initiatives that address social and environmental determinants if they are provided in response to an identified community health need and meet a community benefit objective. It would strengthen the case that an initiative satisfies the Schedule H definition of a community health improvement service if evidence exists that the initiative improves community health.

Community-building activities (see Category F) that are provided in response to an identified community health need and that meet the definition of community health improvement services also should be reported here.

Below are examples of efforts that can be reported as community benefit. They are organized by the social determinants of health categories used by the Centers for Disease Control and Prevention Healthy People 2020, which can be found here: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

Do Count:

1. Social and community factors:
   - Support for at-risk youth activities.
   - Reentry programs for persons who have been incarcerated.
   - Activities related to community resiliency and disaster preparedness (beyond requirements expected of all organizations).
   - Advocacy related to health care access.

2. Education:
    - Support of local schools when education-related community needs have been identified.
    - Support or provision of early childhood education and development programs.
    - Efforts to reduce truancy and improve graduation rates.
    - Efforts to improve literacy and health literacy.
3. Neighborhood and the built environment:
    - Neighborhood improvements in low-income areas (e.g., sidewalks to encourage walking and lighting for safety).
    - Removal of harmful materials (such as lead and asthma triggers) in low-income housing.
    - Violence and crime prevention.
    - Development of bike lanes, playgrounds and walking trails in response to needs related to obesity and lack of exercise.
4. Poverty and economic stability:
    - Job creation and training programs for economically poor and vulnerable populations.
    - Participation in an economic development council to revitalize a depressed community.
    - Activities to address food insecurities.
    - Expenses and losses incurred for initiatives that expand access to affordable housing.

Do Not Count:

- Activities unrelated to community health needs.
- Neighborhood events (parties, festivals) not related to a community health need.
- Sponsorship of teams and clubs unrelated to community health needs; contributions that can't be restricted to a community benefit purpose.
- Neighborhood improvements designed to make the health care organization's facilities more attractive.
- Contributions to the arts (unless part of a comprehensive plan for economic development in an at-risk community).

- Participation in economic development not specifically related to poverty or the needs of low-income people.
- Activities for employees.
- Development of housing and investments made for community development when a return is expected.
- Advocacy specific to a health care organization's operations and financing.

B. Health Professions Education

This category includes educational programs for physicians, interns and residents, medical students, nurses and nursing students, pastoral care trainees, and other health professionals when that education is necessary to retain state licensure or certification by a board in the individual's health profession specialty.

B1. Graduate and Undergraduate Medical Education and Continuing Medical Education for Physicians

Do Count:

Be sure to subtract direct graduate medical education revenue received from Medicare (and possibly Medicaid) from these costs before counting. You may count:

- Total expenses for graduate medical education considered allowable by the Medicare program (salaries for interns and residents, costs associated with faculty supervision, and other allowable program expenses).
- Expenses attributable to training and precepting medical students.
- Continuing medical education (CME) required for state licensure or certification if CME programs are made available to practitioners on a community-wide basis.

Do Not Count:

- Expenses for the organization's physician and medical student in-service training.
- CME programs limited to members of the organization's medical staff only.

B2. Nurses/Nursing Students

Do Count:

- Costs to operate a nursing school, if any.
- Costs associated with clinical staff hours when staff are unavailable to perform clinical duties because they are devoting time solely to instructing, training or precepting students.
- Additional compensation, if any, paid to nurses and other staff members to serve as preceptors for nursing and other allied health professions students.
- Costs to train staff nurses to serve as preceptors.
- Costs of time spent by instructors when they interact with students in classroom settings and simulation labs.
- Administrative costs associated with having nursing and other allied health professions students and faculty in the facility.
- Restricted cash contributions made to schools of nursing to underwrite faculty positions in schools of nursing in response to shortages of nurses and nursing faculty (reportable in category E1, Cash Contributions).

Do Not Count:

Expenses associated with:

- Education required by the organization rather than by state or third-party accrediting organizations, such as staff orientation, in-service programs (e.g., regarding how to use electronic health records systems) and similar training.
- Expenses for standard in-service training and in-house mentoring programs.
- In-house nursing and nurse's aide training programs.
- Costs if nursing students are required to work for the organization.

B3. Other Health Professions Education

Do Count:

- Expenses borne by the organization to train other allied health professionals when such training is necessary for them to retain state licensure or certification by a board in the professional's health profession specialty. These professions may include physical therapist, occupational therapist, respiratory therapists, public health official,emergency medical technician, lab technician, clinical pastoral educator (chaplain), registered dietician, or pharmacist. Also see guidance above regarding reliably estimated costs or impacts on productivity.

Do Not Count:

- Expenses not required for state licensure or board certification, including:
  - Education required by both licensed and non-licensed staff, such as orientation and standard in-service programs.
  - On-the-job training, such as pharmacy technician and nurse's assistant programs.
- Programs that require trainees to work for the organization after training.
- Training for non-health-related professions, such as accounting.

B4. Scholarships/Funding for Health Professions Education

Do Count:

- Scholarships or tuition payments for nursing and other health professions education to nonemployees with no requirement to work for the organization as a condition of the scholarship.
- Specialty in-service and videoconferencing programs required for certification or licensure made available to professionals in the community.

Do Not Count:

- Costs for staff conferences and travel other than those listed above.
- Financial assistance for employees who are advancing their own educational credentials.
- Staff tuition reimbursement costs provided as an employee benefit.
- Financial assistance for which students/trainees are required to work for the organization.

C. Subsidized Health Services

Subsidized health services are clinical services provided despite a financial loss to the organization. The financial loss is measured after removing losses associated with bad debt, financial assistance, Medicaid and other means-tested government programs. To qualify as a subsidized health service, the organization must provide the service because it meets an identified community health need.

If it is reasonable to conclude that one of the following would happen if the organization no longer offered the service, then it meets an identified community need:

- The service would be unavailable in the community.
- The community's capacity to provide the service would be below the community's need.
- The service would become the responsibility of government or another tax-exempt organization.

Subsidized health services generally exclude ancillary services that support inpatient and ambulatory programs, such as anesthesiology, radiology and laboratory services.

Do Count:

- Clinical programs or service lines that the organization provides at a financial loss after any losses for financial assistance, bad debt, Medicaid and other means-tested government programs have been removed.
- Subsidized health services that generally include entire product lines (e.g., inpatient psychiatry, trauma program) rather than narrowly defined subcomponents (e.g., psychiatric emergency room service).

Do Not Count:

- Ancillary services (such as lab, radiology and pharmacy).
- Services that:
    - Are not needed by the community.
    - Experience losses due to inefficiency.
    - Have many competitors in the market and are not accessed by patients in need.

CAREFULLY EXAMINE SUBSIDIZED SERVICES

The category of subsidized services is not a catchall category for services that operate at a loss. Care needs to be taken to ascertain whether the service satisfies all criteria for being included as a subsidized health service that provides community benefit.

Examples of Services That Frequently Qualify as Subsidized Health Services

C1. Emergency and Trauma Services

Do Count:

- Air ambulances/helicopters.
- Trauma centers.
- Emergency departments.

Do Not Count:

- Ancillaries that support these services, such as imaging.
- Subsets of the service, such as geriatric, pediatric or psychiatric emergency rooms, if the overall emergency department does not need to be subsidized.

C2. Neonatal Intensive Care

C3. Hospital Outpatient Services

Do Count:

- Safety-net clinics that do not bill patients.
- School-based clinics.
- Satellite and ambulatory services designed to serve low-income persons.
- Physician clinics.*

C4. Burn Units

C5. Women's and Children's Health Services

C6. Renal Dialysis

C7. Subsidized Continuing Care

Do Count:

- Hospice.
- Adult day programs.
- Skilled nursing facilities.*

C8. Behavioral Health Services

Do Count:

- Addiction recovery.
- Other substance abuse programs.
- Inpatient psychiatric services.

C9. Palliative Care

Do Count:

- Outpatient and community-based palliative care.

Do Not Count:

- The organization's inpatient palliative care program.

**From IRS Instructions for Form 990, Schedule H: "Subsidized health services include services or care provided at physician clinics and skilled nursing facilities if such clinics or facilities satisfy the general criteria for subsidized health services. An organization that includes any costs associated with stand-alone physician clinics (not other facilities at which physicians provide services) as subsidized health services in Part I, line 7g, must describe that it has done so and report in Part VI such costs included in Part I, line 7g. Note. The organization can report a physician clinic as a subsidized health service only if the organization operated the clinic and associated hospital services at a financial loss to the organization during the year."*

D. Research

Research means any study or investigation for which the goal is to generate increased generalizable knowledge made available to the public (e.g., knowledge about underlying biological mechanisms of health and disease, natural processes, or principles affecting health or illness; evaluation of the safety and efficacy of interventions for disease, such as clinical trials and studies of therapeutic protocols; laboratory-based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care or prevention; studies related to changes in the health care delivery system; and communication of findings and observations, including publication in a medical journal).

The organization can include the cost of internally funded research it conducts, as well as the cost of research it conducts funded by a tax-exempt or government entity.

D1. Basic and Applied Clinical Research

Do Count:

Direct and indirect costs for studies funded by a tax-exempt or government entity and intended to be made available to the public, including:

- Basic research.
- Translational research.
- Clinical trials.
- Other types of clinical research (e.g., studies regarding nutrition, quality improvement or information technology).
- Costs borne by the organization to conduct research, including an appropriate portion of costs associated with research administration — unless those costs already have been included in indirect costs.

Do Not Count:

- Research findings that are used only internally.
- Research that is funded by a for-profit entity or source or that yields knowledge used for proprietary purposes.

D2. Community-Based Research

Do Count:

Direct and indirect costs for studies funded by a tax-exempt or government entity and intended to be made available to the public, including:

- Studies on health issues for economically poor and vulnerable persons.
- Studies on community health, such as incidence rates of conditions for special populations (e.g., children, older adults or persons with a disability).
- Research papers prepared by staff for professional journals or presentations.
- Studies on innovative health care delivery models.
- Creation of partnerships for community-based research projects.

Do Not Count:

- Costs to prepare CHNAs (reportable in category G2, Community Benefit Operations).
- Market research.
- Research findings that are only used internally or by the funder.

E. Cash and In-Kind Contributions

This category includes cash contributions or grants and the cost of in-kind contributions that support financial assistance, health professions education and other community benefit activities described in the other community benefit categories.

Cash contributions are made by the organization to health care organizations and other community groups and are restricted, in writing, so the amounts are used by recipients for one or more community benefits. If the contribution is used for a community-building activity or program, it should be reported as community building.

In-kind donations include hours contributed by staff to the community while on health care organization work time, the cost of meeting space provided to community groups, and the book value of donations of food, equipment and supplies. (Report contributions to provide support services to individuals in category A3, Health Care Support Services).

E1. Cash Contributions for Community Benefit

Do Count:

Contributions restricted by another entity to be used for one or more of the following community benefit activities and programs, as defined in the Schedule H instructions:

- Financial assistance.
- Medicaid.
- Other means-tested government programs.
- Community health improvement services.
- Health professions education.
- Subsidized health services.
- Research.
- Community benefit operations.

Do Not Count:

- Payments that the organization makes in exchange for a service, facility or product or that the organization makes primarily to obtain a benefit, such as payments made in lieu of taxes that the organization makes to prevent or forestall local or state property tax assessments or a teaching hospital's payments to its affiliated medical school for intern or resident supervision services by the school's faculty members.
- Unrestricted sponsorships.
- Other donations that have not been restricted, in writing, to a community benefit purpose.
- Employee-donated funds.
- Emergency funds provided to employees.
- Fees for sporting event tickets.

E2. Grants for Community Benefit

Do Count:

- Grants made by the organization to health care organizations and other community groups restricted, in writing (e.g., by letter, contract or grant agreement), to one or more of the community benefit activities, as defined in the Schedule H instructions.

Do Not Count:

- Unrestricted grants.
- Other grants that have not been restricted, in writing, to a community benefit purpose.

E3. In-Kind Donations

Do Count:

- Noncash donations of goods, services and resources for community benefit purposes. Examples include:
    - The cost of staff hours donated by the organization to the community while on the organization's payroll.

- The cost of space donated to tax-exempt community groups (such as for meetings based on space per square foot and not market value).
- The financial value (generally measured at cost) of donated food, equipment and supplies.
- Equipment and medical supplies (includes national and international donations, with the greatest proportion of donations being local) for health-related programs.
- Emergency medical care at a health-related community event.
- The costs of coordinating community events for a community benefit purpose not sponsored by the health care organization.
- Employee costs associated with board and other community involvement while on work time or on behalf of the organization.
- Food donations to organizations such as Meals on Wheels and homeless shelters.
- Laundry services for community organizations.
- Ancillary services, such as lab, radiology and pharmacy services, provided at low or no cost to other providers in the community, such as clinics or shelters.
- Technical assistance to community organizations, such as information technology, grant writing, accounting, human resource support, planning and marketing.

Do Not Count:

- Employee costs associated with board and community involvement when these occur on an employee's own time, not on behalf of the organization, or not related to a community benefit objective.
- Volunteer hours provided by hospital employees on their own time for community events.
- Salary expenses paid to employees deployed on military services or jury duty (considered employee benefits).
- Time spent at golf outings or other primarily recreational events.

F. Community-Building Activities

Community-building activities are activities the organization engages in to protect or improve the health and safety of its residents. If a community-building activity is undertaken in response to an identified community health need and meets a community benefit objective, it is reportable as a community health improvement service in IRS Form 990, Schedule H, Part I. If reported as a community health improvement service in Part I, it should not be reported as a community-building activity in IRS Form 990, Schedule H, Part II, therefore this section does not include specific "do count" and "don't count" recommendations.

Categories of community-building activities as defined in IRS Form 990, Schedule H, Part II, follow.

F1. Physical Improvements and Housing

- May include the provision or rehabilitation of housing for vulnerable populations, such as removing building materials that harm the health of residents; neighborhood improvement or revitalization projects; provision of housing for vulnerable patients upon discharge from an inpatient facility; housing for low-income seniors; and the development or maintenance of parks and playgrounds to promote physical activity.

F2. Economic Development

- May include assisting small business development in neighborhoods with vulnerable populations and creating new employment opportunities in areas with high rates of joblessness.

F3. Community Support

- May include childcare and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, and disaster readiness and public health emergency activities, such as community disease surveillance or readiness training beyond what is required by accrediting bodies or government entities.

F4. Environmental Improvements

- May include activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards.
- Do not report expenditures made to reduce the environmental hazards caused by the organization unless they are provided to improve community health or to address environmental issues known to affect community health and are subsidized.

F5. Leadership Development and Training

- May include training in conflict resolution; civic, cultural or language skills; and medical interpreter skills for community residents.

F6. Coalition Building

- May include participation in community coalitions and other collaborative efforts with the community to address health and safety issues.

F7. Community Health Improvement Advocacy

- May include efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment and transportation.

F8. Workforce Development

- May include recruitment of physicians and other health professionals to medical shortage areas or other areas designated as underserved and collaboration with educational institutions to train and recruit health professionals needed in the community (other than the health professions education activities reported in IRS Form 990, Schedule H, Part 1).

G. Community Benefit Operations

Community Benefit Operations include costs associated with assigned staff and community health needs and/or assets assessment, as well as other costs associated with community benefit strategy and operations.

G1. Assigned Staff

Do Count:

- Staff costs for managing or overseeing community benefit program activities that are not included in other categories of community benefit.
- Staff costs for internal tracking and reporting of community benefit.

Do Not Count:

- Staff time to coordinate in-house volunteer programs.
- Volunteer time of individuals for community benefit programs.

G2. Community Health Needs/Implementation Strategy

Do Count:

- Costs related to the organization's CHNA.
- Contributions for conducting a collaborative assessment with other organizations.
- Costs related to developing the implementation strategy.
- Costs of producing reports that describe the progress of the implementation strategy.

Do Not Count:

- Costs of a market share analysis.
- Marketing surveys.

G3. Other Resources

Do Count:

- Costs associated with community benefit evaluation.
- Costs of fundraising for hospital-sponsored health improvement programs.
- Grant writing and other fundraising costs related to equipment used for hospital-sponsored community benefit services and activities.
- Costs associated with developing a community benefit plan, conducting community forums and reporting community benefit.
- Overhead and office expenses associated with community benefit operations.
- Dues to and participation in an organization that specifically supports the community benefit program, such as the Association for Community Health Improvement.
- Software that supports the community benefit program, such as Community Benefit Inventory for Social Accountability (CBISA) by Lyon Software.
- Costs associated with attending educational programs to enhance community benefit program planning and reporting, such as the portion of system assessments or fees that support community benefit activities performed by the system office.

Do Not Count:

- Grant writing and other fundraising costs of hospital capital projects (such as funding of buildings and equipment) that are not hospital community benefit programs.
- Dues or employee time contributed to hospital and professional organizations not specifically and directly related to community benefit.
- Grant writing for community organizations (reportable in category E3, In-Kind Donations).

COMMUNITY BENEFIT

A Mission to Care: A Commitment to Community

From the very beginning, civic leaders and congregations of religious women and men courageously responded to the needs of the communities they were called to serve.

Today, that same call to provide health and hope is being answered in unique and creative ways through community benefit programs.

For more information about community benefit and Catholic health care, go to **https://www.chausa.org/communitybenefit.**

As Community Benefit Leaders,

We are concerned with the dignity of persons.
We are committed to improving health care access for all persons at every stage of life, regardless of race, culture or economic status, and to eliminating disparities in treatment and outcomes.

We are concerned about the common good.
We design community benefit programs to improve health through prevention, health promotion, education and research.

We have special concern for vulnerable persons.
We put a priority on programs that address the most vulnerable in our communities and ensure that all programs reach out to persons most in need.

We are concerned about stewardship of resources.
We use resources where they are most needed and most likely to be effective.

We are called to justice.
We advocate health care for all and work to improve social conditions that lead to improved health and well-being.

We care for the whole person.
We engage partners in our communities so that together we can improve health and quality of life through better jobs, housing and natural environment.

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