Community Benefit in the Era of Health Reform: Opportunities for Hospital Leadership

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The signing of the Patient Protection and Affordable Care Act (PPACA) has launched a far-reaching set of reform processes that present healthcare stakeholders with an array of near-term challenges. Central goals are to move towards universal coverage, improve the quality of care, and reduce per capita healthcare costs. While there are both supporters and opponents of PPACA among healthcare stakeholders, there is general agreement that transformation of financing and delivery is both inevitable and necessary.

A new model of community benefit programming is emerging among leading-edge non-profit hospitals—one that is closely aligned with national health reform goals. It moves beyond the historical, defensive-minded strategy of tallying up small-scale, often unconnected services and activities, many of which have limited relevance to charitable purpose, and most of which do not yield measurable impacts.

> It is incorrect to suggest that the concentration of health problems in low-income and racially diverse communities is simply a function of lifestyle choice.

Our current, defensive strategy represents what we might refer to as the ***institutional model*** of community benefit, where the design and implementation of charitable services and activities is viewed as a competitive enterprise. Priority is given to program areas aligned with service lines where there is potential for competitive advantage, and programs are undertaken in a proprietary manner. Collaboration with other hospitals in the region is viewed as a "muddying of the waters" that makes it difficult to claim credit for an institution's charitable contributions.

In contrast, there is growing interest in a more ***geographic model*** of community benefit, where program placement is driven by a more granular analysis of data at the sub-county level, which ensures a primary focus in communities with disproportionate unmet health needs. The targeted analysis also establishes an evidence base from which to monitor progress towards achievement of measurable outcomes. Active and ongoing collaboration with other community stakeholders *and* hospitals is viewed as a way of leveraging limited charitable resources.

This approach involves investment in fewer but more comprehensive programs, concentrating the investment of stakeholder resources in a manner that is more likely to produce meaningful results. Near-term measures of progress include but are not limited to reductions in preventable emergency room and inpatient utilization, enhanced community support systems, improvement of neighborhood physical infrastructure, and increased productivity and capacity of community-based organizations. Continued efforts to build on near-term gains yield the desired longer-term outcomes of aggregate-level improvements in health status and quality of life. This more strategic investment and collaborative engagement positions hospitals and partners in the public health and business community to advocate for policy reforms that codify and sustain improvements.

The geographic model has considerable potential not just in urban areas, but also in rural areas, where hospitals are often the sole providers in the region. Experience to date, however, suggests a tendency towards the historical approach taken by urban hospitals, with a scattering of small-scale, uncoordinated services and activities. This is driven in large part by a lack of internal infrastructure and population health expertise, as well as a lack of attention at the senior leadership level.

This special section will provide an overview of this paradigm shift towards a geographic model of community benefit, and how it will help hospitals build the skills and competencies that will enable them to thrive in the era of health reform. Attention will also be given to emerging lessons in the establishment of governance structures and functions that ensure a focus on improvement in community benefit programming during this period of transformation.

National Health Reform and Community Benefit

Politics and Practical Realities

The PPACA reflects the scale and complexity of the healthcare finance and delivery system, with a final bill that exceeds 2,400 pages. Public understanding is incomplete at best, and often fundamentally flawed, thanks to inaccuracies and misinformation (e.g., "death panels") in media coverage, as well as less-than-optimal communication of key elements by public officials.

Even advocates acknowledge the bill is both flawed and incomplete, and additional amendments and elements will be needed to complete the reform process and achieve the stated aims. Given the scope of reforms required, it was concluded that some elements would need to be addressed in the future. As it is, the bill challenges some of America's most powerful political and economic interests, many of which have a stake in maintaining the status quo. Considerable resources were allocated in an effort to defeat the legislation, and more resources will be allocated in an effort to impede its implementation.

In the wake of the recent mid-term elections, the leadership of the new House Republican

majority has staked out the "repeal" of the health reform legislation signed by the Obama administration as a top priority. There is a likelihood that some existing elements will be eliminated, and new elements will be added. Most experts agree, however, that the calls for wholesale "repeal" of PPACA in the political arena are unlikely to be realized.

Saying Goodbye to FFS

As these struggles unfold in the legislative arena, providers and provider organizations at all levels now recognize one immutable reality: the fee-for-service system of financing is unsustainable. Our system, with a core incentive for hospitals to seek inpatients and for providers to conduct increasingly high-cost procedures, is gradually but inexorably pushing the cost of healthcare coverage beyond the reach of our general population.

The change process will be gradual and incremental, allowing time for experimentation, analysis, assessment, and institutional capacity building. The establishment of accountable care organizations (ACOs), for example, generally preserves the FFS model, but introduces the concept of prospective budgeting and distribution of savings based on achievement of quality clinical outcomes. Many non-profit health systems across the country are taking the next steps, developing team-based approaches to primary care and preventive services, and entering into shared risk contracts with payers. As stated by one health system CEO, "We have no choice but to operate in two worlds at the same time—the current FFS system of financing, and the system of the future, in which the core incentive is to keep patients and populations healthy, and provide high-quality care at the right time."

Profile of Future Enrollees

PPACA in its current form will enroll an additional 32 million Americans. Most of the people to be added to the rolls are low- to medium-income people who live in communities where living conditions serve as impediments to desired health behaviors. Many of

these communities are "food deserts," without grocery stores and other healthy food sources. They are also plagued by a lack of parks, playing fields, fitness facilities, sidewalks, and streetlights. If that isn't enough, they must contend with generally unsafe conditions in the streets. Further challenges are presented by deteriorating housing stock with unhealthy indoor environments, particularly in urban, inner-city neighborhoods.

Individual choice is undeniably a factor in the widespread engagement in unhealthy lifestyles. Sedentary lifestyles and consumption patterns, for example, have unleashed an epidemic of obesity, which has in turn contributed to dramatic increases in healthcare costs. It is both incorrect and inappropriate, however, to suggest that the concentration of these problems in low-income and racially and ethnically diverse communities is simply a function of lifestyle choice. Addressing these problems requires a combination of targeted education, financial incentives, and improvement in living conditions. These issues cannot be addressed by healthcare alone. No amount of clinical care management will succeed without parallel action in the community context.

Currently, most uninsured and underinsured populations enter our healthcare systems through the emergency rooms of our hospitals, as well as our community health clinics. In many cases, high-cost services are provided for conditions that could have been prevented with timely access to quality primary care and preventive services. At least one national study[1] estimates that hospitals spend nearly $40 billion per year, approximately 10 percent of total expenditures, to treat preventable conditions in emergency room and inpatient settings. Many, if not most, of these services are provided to uninsured and underinsured people. As such, the expenditure of limited charitable resources for high-cost medical services for preventable conditions represents poor stewardship. Clearly there must be a more efficient approach.

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It is extremely expensive and inefficient to simply address the symptoms of poor health among uninsured/underinsured patients in emergency rooms and inpatient settings. Between now and 2014, non-profit hospitals and health systems have a unique opportunity to care for these populations in a more cost-effective manner. Through application of the geographic model of community benefit, they can create an evidence-based, seamless continuum of care that links clinical care to comprehensive activities in the community context that address the underlying causes of persistent health problems. In the process, they will gradually build competencies that will enable them to thrive economically in a system of financing that incentivizes keeping populations healthy.

Obviously, hospitals cannot do this on their own. Their investments of resources and expertise must leverage the engagement of a diverse array of external stakeholders, including but not limited to local public

1 Allison Russo, et al., "Trends in Potentially Preventable Hospitalizations among Adults and Children, 1997–2004," Statistical Brief #36, Healthcare Cost and Utilization Project, AHRQ, August 2007.

health agencies, community health centers, community-based organizations, neighborhood associations, local businesses, health professions education institutions, health plans, and providers. Achieving the transformation we seek will require all hands on deck.

Community Benefit: Origins, Intent, and Evolution

In order to fully understand the potential role of community benefit in the transformation of the U.S. healthcare system, we must first understand its origins, intent, and evolution.

Origins and Intent

The term "community benefit" was first coined by the IRS in its 1969 ruling[2] to redefine the charitable obligations of non-profit hospitals. The redefinition language broadened the interpretation of charitable purpose beyond the historical concept of "relief of poverty" to "*the promotion of health for a class of persons sufficiently large enough to constitute benefit for the community as a whole*." The reference to community suggests the need to define the geographic parameters and populations served by the hospital. Perhaps more importantly, the call to identify a cohort of sufficient size to produce a tangible impact at the aggregate level suggests an emphasis on achieving measurable outcomes.

It is important, particularly in the current context of national health reform, to understand the historical context for the 1969 IRS Ruling. It came in the wake of the passage of Medicare and Medicaid legislation, the most ambitious federal legislation since the New Deal. At the time, many thought we had conquered the problem with the uninsured, and we were on our way to universal coverage. In retrospect, we were victims of what former Federal Reserve Chairman Alan Greenspan might have referred to as "irrational exuberance." Nevertheless, at that point in time, there was concern that a movement towards universal coverage would remove a key justification for retaining tax exemption

for non-profit hospitals (i.e., to provide charity medical care for the uninsured). The IRS Ruling redefined the charitable obligations of non-profit hospitals in a manner that encouraged proactive engagement to address the underlying causes of health problems.

Since the late 1960s, the promise of universal coverage faded and hospitals, clinics, and providers at all levels have assumed an increasingly large burden of charitable medical care for the growing number of uninsured people. As the numbers have grown, the cost for providing this care has been cross-subsidized by rising premiums among commercially insured populations and by growing indigent care allocations from federal and state budgets. As such, it is important to understand that there is no such thing as free care; the delivery of charity care to the growing pool of uninsured has contributed substantially to rapid increases in the cost of medical care.

To those who charge that expanding coverage will lead us to healthcare rationing, it must be understood that we already ration healthcare services. The current rationing method is to limit access to primary care and preventive services for the uninsured until they stagger into our emergency rooms. Aside from the fact that it is immoral, it is an extremely inefficient way to serve the people of the U.S. Given the fact that community benefit calls for non-profit hospitals to make optimal use of limited public resources, the provision of charity medical care in emergency room and inpatient settings for preventable conditions is simply poor stewardship.

Evolution of Practices

There are a plethora of community benefit programs undertaken by non-profit hospitals across the country that represent a commitment to a more proactive approach to addressing unmet health needs in local communities. Most programs, however, lack the evidence base, design elements, strategic targeting, monitoring capacity, collaborative orientation, and scale necessary to produce measurable outcomes. These are common shortcomings because in many hospitals, community benefit is a relatively marginal function. Staffing is typically minimal, and where present, managers often lack the competencies needed to effectively plan, manage, and monitor program activities.

To a significant degree, community benefit programming in many hospitals has escaped the application of quality improvement mechanisms employed in almost every other dimension of hospital operations. Efforts to address these shortcomings are often impeded by a lack of institutional alignment, formal policies and oversight structures and functions that facilitate broad engagement and shared accountability, attention to competencies, evidence-based planning, and transparency in decision making.

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The good news is that a growing number of hospitals and health systems with visionary leadership have taken definitive steps to enhance community benefit programming and increase institutional alignment. Hospitals engaged in these efforts have collected the data needed to create an evidence base, established systems to monitor progress, leveraged internal resources to develop comprehensive strategies through engagement of diverse community stakeholders, and are documenting measurable outcomes.

2 IRS Ruling 69-545.

Partner health systems in the original Advancing the State of the Art in Community Benefit (ASACB) demonstration[3] such as Catholic Healthcare West, St. Joseph Health System, and Texas Health Resources, and independent hospital partners such as Lucile Packard Children's Hospital and Presbyterian Intercommunity Hospital, have implemented a broad set of formal policies and established structures and functions to substantially strengthen community benefit functions.

Other health systems across the country such as Allina Hospitals & Clinics, Aurora Health Care, Baylor Health Care System, Fairview Health Services, St. Charles Health System, Summa Health System, Trinity Health, and UMass Memorial Health Care, and independent hospitals such as Children's Hospital Boston, Hennepin County Medical Center, Hoag Memorial Hospital Presbyterian, Massachusetts General Hospital, and Texas Children's Hospital, are all currently engaged in intensive efforts to strengthen programming and institutional alignment.

Examples of these kinds of programs are currently profiled at www.asacb.org, and approximately 40 additional profiles will be added in January 2011 as part of a project funded by the W.K. Kellogg Foundation. Additional resources are needed, however, to more systematically document and disseminate exemplary programs, policies, and practices in order to encourage innovation that is aligned with the goals of national health reform.

Community Benefit: New Rules and Future Potential

Non-profit hospitals are faced with two new sets of federal requirements that address community benefit responsibilities. Section 501(r) in the PPACA covers specific responsibilities of 501(c)3 hospitals, and the IRS has released a comprehensive set of reporting requirements in its revised Form 990, Schedule H. Key elements of each include:

PPACA, Section 501(r)

- Conduct a community health needs assessment (CHNA) every three years.[4]
- Integrate input from broad community interests, including those with public health expertise.
- Develop and adopt a formal implementation strategy to address identified unmet needs.
- Develop and broadly publicize charity care and financial assistance policies.

Revised Form 990, Schedule H

- Detailed reporting of program activities by content category.[5]
- Describe whether and how to conduct a CHNA.
- Provide evidence of community need in order to document as community benefit.
- Describe how the organization is addressing unmet health needs identified in the CHNA.
- Provide justification for identified unmet health needs that have not been addressed.
- Programs must seek to achieve identified objectives (e.g., increasing access, enhancing public health, advancing generalizable knowledge, and relieving government burden).

These sets of requirements dramatically increase public access to information on non-profit hospital community benefit program planning and implementation. In many cases, the requirements challenge hospitals to undertake activities they have not previously undertaken, such as community needs assessments, and the development of detailed implementation strategies. The requirement in the revised Form 990 to provide detailed

categorical reporting of program information and other categorical questions creates the opportunity for comparative analysis. In the coming years, these sources of data will likely be the focus for numerous doctoral dissertations.

While there is much to laud in the new community benefit reporting requirements, there are a few notable problems. First, both are silent on the issue of priority setting. Experience in the field clearly indicates that any reasonably well-executed CHNA will identify a large number of unmet health needs. It is unreasonable at best to expect any organization to address more than a substantial subset of the total. As such, the Form 990 requirement to provide justification for unmet needs not addressed by the reporting hospital is inappropriate, and likely to yield a variety of undesired consequences. For example, stakeholders in one major metropolitan area have suggested that they will limit the content scope of their needs assessment in order to minimize the identification of unmet needs that will not be addressed.

In the selection of that subset of unmet health needs, hospitals should be expected to identify what specific criteria are used in the selection of priorities, and who participated in the selection process. While, for example, it is appropriate for a hospital to consider organizational strategic priorities as a factor in the selection of priorities, it should not be the only criteria. Other criteria should include issues such as the size of the problem (e.g., number of people affected per 10,000 population), severity (e.g., health impacts), relative costs, and who else is engaged. Just as it is important to seek community input in the

3 Advancing the State of the Art in Community Benefit was a four-year, multi-state demonstration project (2002–2006) funded by a consortium of foundations that focused on the development and field testing of uniform standards to enhance community benefit programming and institutional alignment.

4 This can be based on current data/information collected by public health agency and/or other organizations, and can be done in collaboration with other organizations, including other non-profit hospitals.

5 Categories drawn from Community Benefit Inventory for Social Accountability framework developed by the Catholic Health Association of the United States.

CHNA, it is of equal importance to involve community stakeholders with diverse expertise in the priority setting process.

One of the most problematic decisions by IRS staff in the 990 was the delegation of the community-building category to Part II of the form, which prohibits inclusion of associated activities in financial totals. This includes primary prevention activities such as youth leadership development, strengthening social support systems, improvement of neighborhood physical infrastructure (e.g., housing renovation, streetlights, sidewalks, graffiti removal), and environmental improvements.

Exclusion of these kinds of activities sends a message that non-profit hospitals should not be seeking to address the underlying causes of persistent health problems. Yet movement in this direction is a core purpose in the implementation of national health reform. We should be encouraging, rather than impeding hospital engagement of diverse stakeholders to address the underlying causes of health problems in local communities. Increased awareness and joint advocacy between hospitals, public health institutions, and community stakeholders is needed to correct this error.

The Case for the Geographic Model

The movement towards a geographic model of community benefit in no way suggests a rejection of institution-based accountability. If anything, it reflects the establishment of a more explicit link between individual hospital accountability and specific communities with disproportionate unmet needs in their geographic proximity.

Until recently, CHNAs focused primarily on data collection at the county level, which effectively mask the concentration of unmet needs in low- to moderate-income communities within the larger geographic area. CHNAs at this level tend to show relatively little change over long periods of time. Not surprisingly, since many community benefit programs are represented as serving the population at the county level and are not strategically targeted to serve specific populations and/or communities, they tend not to produce measurable outcomes.

Increasing sophistication in the collection of utilization data, GIS mapping technologies, small area analyses, and the collection and mapping of data on social determinants presents the opportunity to develop and implement evidence-based community benefit programs at the community level. A growing number of hospitals are analyzing their own utilization with a focus on ambulatory care-sensitive conditions. These include chronic conditions such as asthma and diabetes, with the judgment that timely access to primary care and preventive services would eliminate the need for emergency room and/or inpatient care.

> Given that community benefit calls for hospitals to make optimal use of limited public resources, the provision of charity care in emergency room and inpatient settings for preventable conditions is simply poor stewardship.

At this juncture, the next level shift is to a shared analysis of utilization patterns across institutions by payer source and diagnosis. This is needed to better understand where uninsured and underinsured populations live, and how they interface with multiple institutions. These data can be linked to other measures such as social determinants, and serve as an evidence base for shared investment by local hospitals (and other stakeholders) in targeted communities. In San Francisco, for example, the Environmental Health Division in the Department of Public Health has developed a series of maps at the neighborhood level that document a broad spectrum of social determinants.[6]

One of the obvious benefits of the geographic model is the opportunity to concentrate stakeholder resources and complementary skills, and leverage the resources of non-profit hospitals. This remedies one of the fundamental shortcomings of community benefit programs to date—the tendency to spread resources and activities so thinly that they never build the critical mass needed to achieve measurable outcomes. Why are measurable outcomes so important? In this context, they provide the basis for stakeholders to build a shared platform for policy development that will sustain and support the replication of successful innovations.

Another key benefit of the geographic model is the establishment of a framework of shared accountability with diverse community stakeholders, as well as with other hospitals. As stated previously, a historical tendency with the institutional model is a disinclination to engage other hospitals. In many cases, this extends to community stakeholders; they may be sought out for input, but tend *not* to have a stake in the program. Establishing a framework of shared accountability strikes an appropriate balance, with shared commitment to address environmental obstacles to health, and shared commitment to change individual behaviors. Optimally, hospital and community stakeholders define and develop measures at multiple levels that reinforce and validate their shared commitment.

Two current initiatives, one each at the state and federal level, offer the potential to highlight the benefits and to advance the geographic model. A statewide initiative led by The California Endowment, entitled Building Healthy Communities, involves a 10-year investment in 14 urban and rural communities in California, with a primary focus on addressing social determinants of health. The parameters of each community are one or more zip codes within a city or rural area, each with a concentration of low-income residents and unmet health-related needs, and characteristics that offer potential for mobilization and community problem solving. The initiative began with a one-year planning process in which residents and community-based organizations selected priority outcomes and developed detailed implementation strategies to achieve those outcomes.

6 Maps, tools, and description of this approach are available at www.thehdmt.org.

A recently added component involves an analysis of hospital community benefit portfolios in the proximity of each of the 14 community sites to identify potential synergies. Preliminary findings suggest there is significant potential, where existing programs can be expanded, replicated, or relocated in a way that enhances program effectiveness and potential to achieve measurable outcomes. This strategy aligns programs explicitly with community priorities, leverages hospital resources through intensive investment in addressing social determinants, and links program objectives to long-term policy development goals.

At the national level, the U.S. Department of Health and Human Services launched a Public Health Quality Project to develop a set of priority areas and aims to strengthen the function of local public health agencies. Many of these priorities and aims are closely aligned with the goals of health reform, as well as the geographic model of community benefit. Examples include, but are not limited to the following:

- **Strengthen the development and use of population health metrics.** A key aim in this priority area is to reduce disparities. In most cases, communities with disproportionate unmet health needs tend to be our most racially and ethnically diverse, and should be the primary focus of community benefit programming. Hospitals and health systems such as Baylor Health Care System and Massachusetts General Hospital have developed units to develop information systems and targeted interventions to reduce disparities in access and quality of care. There is considerable potential for partnerships with local public health agencies to expand the scope of these efforts.
- **Expand evidence-based practices**. This priority area offers considerable potential for increased partnerships with hospitals to strengthen program evaluation and link data across disciplines.
- **Increase emphasis on workforce development**. The implementation of national health reform presents a "perfect storm" where there will be a dramatic increase in the demand for healthcare and public health professionals, many in disciplines where there are already substantial shortages. There is a need for a shift to coordinated, regional approach to workforce development that brings together employers, higher education, K-12, and other stakeholders to address current and projected needs at a time of major transformation.
- **Application of systems-level thinking**. Develop comprehensive approaches to health improvement, get beyond categorical funding orientation, and build a platform for shared advocacy. Local public health agencies could benefit from vocal support from the hospital community to eliminate categorical funding streams at the state level, and challenge federal agencies to support research demonstrations for comprehensive community health initiatives.

Expanding partnerships between hospitals and local public health agencies will often require substantial upfront effort to overcome historical dynamics. Local public health agencies may question non-profit hospital commitment to their charitable mission, and may have doctrinaire views of their respective roles. There is a need to understand and support hospital investment in population health as an opportunity for collaboration and an opportunity to build a common platform for shared advocacy. A good starting point at the federal level could be shared advocacy to challenge the IRS exclusion of community-building activities in the Form 990, Schedule H.

Community Benefit Governance: Guidelines and Emerging Lessons

At the core of the transition from the institutional model to the geographic model are the community benefit governance structures and functions in non-profit hospitals. The following section provides a brief review of a set of guidelines for governance developed in the Advancing the State of the Art in Community Benefit (ASACB) demonstration, and emerging lessons from the implementation of these guidelines by health

systems and hospitals across the country. Particular attention is given to ways in which lessons learned could inform the role of these governing bodies to help align community benefit programming with the goals of national health reform.

ASACB Guidelines for Governance

A set of 14 Institutional Policy Measures was developed, field tested, and refined in the original ASACB demonstration. Four of those 14 measures directly address the community benefit governance/oversight function:

- Establish a board-level committee to provide oversight and policy guidance for all charitable services and activities supported by the hospital.
- Clearly document specific roles and responsibilities of the community benefit committee and use these as guides for decision making.
- Establish explicit guidelines for recruitment of members of community benefit committee that address competencies related to the ASACB Five Core Principles.[7]
- Establish explicit criteria and process used by the community benefit committee and staff to select priority program areas of focus.

The intent of these measures is to create a governing body with the focus and breadth

7 The Five Core Principles serve as guidelines for community benefit programming, and include 1) emphasis in communities with disproportionate unmet health needs, 2) emphasis on primary prevention, 3) build a seamless continuum of care, 4) build community capacity, and 5) collaborative governance. Supporting language and practical strategies are provided at www.asacb.org.

of competencies[8] to fulfill the charitable mission of non-profit hospitals in a cost-effective manner. Typically, the committee is a 15–18 member body with one to two board members and a majority of external community stakeholders. Internal staff and leadership often serve as *ex officio* members.

A formal written charter is developed that describes the purpose, roles and responsibilities, guidelines for recruitment, criteria and process for decision making, as well as operational elements such as terms of service.

Emerging Lessons

The following emerging lessons have been drawn from assessments and developmental work with community benefit board committees across the country over the course of the last three years. In each case, health systems and hospitals used the ASACB guidelines to inform their implementation process.

System–Local Facility Committees. The ASACB guidelines for governance were intended to support the establishment of *facility*-level board committees, with the understanding that critical review and oversight of programs is needed at that level to ensure optimal quality and alignment with the needs and priorities of local communities; in essence, the application of the geographic model of community benefit. For regional health systems across the country with a large central facility and a few smaller facilities within the same metropolitan area, establishing board-level committees for each facility may not be cost-effective or appropriate. Health systems such as UMass Memorial Health Care and Summa Health System have established system-level board committees that provide oversight and support for all facilities in the region.

At UMass Memorial, the system-level committee is supplemented by community advisory committees at the smaller facilities in the region. The facility advisory committees ensure that the system committee is kept informed of changing dynamics, stakeholder concerns, and emerging challenges and opportunities, and designees to the system committee facilitate a two-way flow of information. At Summa Health, a facility advisory committee was established to ensure that the system committee is informed of facility dynamics, concerns, and challenges and opportunities, and two designees facilitate ongoing dialogue between the two bodies. The facility advisory committee creates a mechanism to ensure engagement and detailed input from facility leadership, yet preserves a broad, skills-based membership of external community stakeholders on the system level board committee.

It is difficult to assert at this juncture the optimal size of a regional health system to justify the creation of a system-level community benefit board committee as an alternative to facility-level committees. A key consideration, however, is the degree to which such a committee can provide critical oversight of major programs undertaken by individual facilities. For systems in larger metropolitan areas with more than two or three larger facilities (i.e., 100 beds or more), local community advisory committees are critically important sources of information for planning, assessment, and mobilization of community resources.

Role of the CEO/Senior Management Team. Ongoing participation of senior leadership on the community benefit board-level committee is critically important, and sends a clear message that the core mission of the organization is a central priority. Optimally, as is the case with most of the committees engaged during the last three years, the CEO serves as an *ex officio* member of the committee. Other key leaders who may participate include the CFO, general counsel, and vice presidents (or equivalent) in areas such as government/public affairs, human resources, and strategic planning. Physicians and nursing staff in key leadership positions are also key resources in many committees.

The key consideration in engagement of senior leadership is to ensure they understand their role to provide input (typically as *ex officio* members) to a carefully selected group of external experts charged with providing recommendations based upon objective evidence to the board of directors. The one or two directors who serve on the committee (typically one serves as the chair) are charged with presenting committee recommendations to the board.

One of the challenges to be proactively addressed in the committee development process is the potential for CEOs to supersede the critical review and oversight role of the committee by bringing decisions to be acted upon, rather than bringing issues for the committee's deliberation. For example, a common situation is for a hospital to experience periodic financial challenges. A CEO who does not fully understand the role of the board committee may inform members that he/she has decided to terminate a swath of community benefit programs, and asks them for their input. In contrast, a more informed CEO will present the committee with specifics on the financial challenges to be addressed, and ask for their recommendations of strategies that optimally preserve what is most important, yet help the hospital meet its immediate obligations.

This kind of problem emerges most commonly because the CEO has deferred participation in early developmental processes in which members deliberated on the structure and functions of the committee. Ensuring full participation of the senior leadership in these early processes is perhaps the most important consideration in the developmental process.

Understanding the Board Committee's Purpose

One of the most common pitfalls in the creation of the board-level community benefit

8 Competencies are in skill areas such as epidemiology, program evaluation, inter-sectoral collaboration, long-term residency in local communities with disproportionate unmet needs, and health-related fields such as education, social services, law enforcement, and the faith community. As a policy body, committee members are not selected to bring in specific content expertise (e.g., asthma, diabetes), which would create potential conflicts of interest. These individuals can be brought in to provide information and guidance if content areas are under consideration as priority areas of focus based upon available evidence.

committee is a conflation of the *critical review/oversight* purpose with a *communications* purpose. It's not surprising that this occurs; for years, we've heard a steady drumbeat from many of our hospital trade associations that we need to do a better job of "telling our story" to counter the intense public scrutiny experienced by hospitals across the country. Hospitals must do more than simply document the financial totals of charitable allocations.

In order to fulfill the critical review/oversight purpose, a group of stakeholders with defined competencies is needed to review available data and information on service utilization patterns, community needs and available assets,[9] current programs and activities, and research findings on emerging innovations. They must consider how potential programs relate to, inform, and support the provision of quality healthcare. In the current context, this includes, for example, how potential programs help to build population health capacity[10] in the organization. Based upon their critical review of this information, they recommend strategies that make optimal use of the hospital/health system's limited charitable resources. A deliberate and substantive process to assemble the breadth of competencies needed to make informed decisions presents a challenge in the effort to keep the committee within an optimal size of 15–18 members.

If the purpose is expanded to encompass communication of the hospital/health system's community benefit commitment to external audiences (what some might view as a marketing function), an entirely different set of competencies is needed. For example, rather than looking for individuals who bring expertise in areas such as epidemiology, program evaluation, and in depth knowledge of communities with disproportionate unmet needs, one looks for high-profile sector leaders with connections to public officials. There is nothing wrong with making these kinds of connections, but the purpose is inconsistent and in many ways subverts the intended purpose of the board-level community benefit committee. The good news is that if the committee does its work well, the resulting community benefit programs will provide a wealth of information and examples to be shared by the hospital in the public arena.

Hospital/Health System Foundation Links

A growing number of hospitals and health systems are basing their community benefit function, and in some cases, their board-level community benefit committee, in their foundation. There is some logic in this decision, to the degree that the foundation plays a substantive role in resource development for community benefit programming. In most hospitals and health systems, however, there is a lack of clarity about the degree to which it is the role of the foundation to raise funds for "bricks and mortar" and related hospital functions, versus raising funds to extend a hospital/health system's charitable purpose. If greater clarity can be secured (e.g., designate FTEs for community benefit resource development, set specific financial targets, establish percentage allocations of resources for community benefit purposes), these concerns may be effectively addressed.

On a number of occasions, however, community benefit managers/directors have expressed concern about a broader philosophical divide between the community benefit function and the role of foundations. In essence, the role of the foundation and its leadership is to bring in funds, and it is the role of the community benefit function to allocate resources to produce optimal benefit in the community. As such, a community benefit leader who reports to the foundation president may in some cases find their desire to approach specific funders to be in conflict with the priorities of their supervisor.

A significant concern in basing the community benefit function and board-level committee in the foundation is the potential to create the impression that the foundation "has it covered;" that attention to the charitable mission by hospital administrative and clinical leadership is no longer needed. Application of the geographic model of community benefit, the development of population health capacity, and positioning non-profit hospitals to thrive economically in a transformed system of healthcare finance and delivery will require institution-wide engagement. Specific policies are needed to ensure full and ongoing engagement of administrative and clinical leadership across all departments. Integration of community benefit-related goals as a major element of the hospital/health system's strategic plan is a key step in the right direction. Having established it as an organizational priority, the next step is to establish metrics that translate high-minded language into tangible (and measurable) responsibilities.

Moving Forward

This is a tumultuous but exciting time to work in healthcare and the broader community health arena. There are innumerable opportunities for collaboration and joint problem solving with diverse community stakeholders, other hospitals, and the public health community. The time is right to view the community benefit function as a key resource in the development of innovative models to address both the symptoms and underlying causes of health problems in our local communities. Our non-profit hospitals are in a great position to provide leadership through the transformation of our healthcare system.

The Governance Institute thanks Kevin Barnett, Dr.P.H., MCP, for contributing this special section.
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9 Not only internal hospital assets, but external community assets, including but not limited to community-based organizations, public and private sector institutions, local business, foundations, physical space (e.g., open lots that could be used to create usable public space), local coalitions, associations, and the skills of local residents.

10 The internal knowledge, understanding, and working relationships with external stakeholders that enable hospitals to more effectively address both the symptoms and underlying causes of health problems in local communities. In the process, they position themselves to thrive in a system of health care financing that incentivizes keeping populations healthy.