HOSPITAL COMMUNITY BENEFIT DASHBOARD: ADVANCING HEALTH EQUITY AND COMMUNITY ENGAGEMENT

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INTRODUCTION

Hospital community benefit can be a vital tool for achieving health and economic equity at the local level. Whether by investing in affordable housing and food security, subsidizing health clinics or offering financial assistance to people who would otherwise be priced out of care, hospitals can be powerful allies in the fight to end health and economic injustice. Federal rules encourage non-profit hospitals to focus their community benefit resources on neighborhoods and population groups experiencing significant health barriers, including health disparities and financial barriers to care. But the key decisions about community engagement and investment – including which neighborhoods to target, how to use community input in decision-making, and priorities ripe for strategic intervention – still rest with hospitals.

Community Catalyst believes that hospital community benefit programs will do more to advance health equity and justice when the people who are most directly impacted by discrimination and disparities are directly engaged with decision-making roles in naming priorities, identifying and implementing solutions and allocating resources.[1] The Affordable Care Act (ACA) creates new pathways for non-profit hospitals to engage community residents and public health experts in planning and executing their community benefit strategies. As non-profit hospitals prepare to enter their third round of community benefit planning, we see opportunities for them to forge stronger partnerships with community-based organizations that are led by, grounded in, and working directly in key neighborhoods of interest. These organizations can bring into the deliberative process people with lived experience of injustice and disparity. We believe these community-centered partnerships are necessary to ensure hospitals' limited community benefit resources are appropriately targeted to achieve equity and rectify longstanding injustices.

COMMUNITY CATALYST

[1] For guiding questions and a thoughtful approach on ways to center on communities that have experienced and are still experiencing injustice and disparity, we recommend PolicyLink's excellent resource, *Getting Equity Advocacy Results: Build the Base for Health Equity Advocacy*. While focused on building advocacy initiatives, many of the guiding questions listed here are transferable to building community benefit and community health collaborations.

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About This Dashboard

This dashboard lays out an ideal state of activities, programs and governance for addressing the root causes of poor health in direct partnership with the communities most impacted by health disparities and injustice. It outlines five principles for hospital community benefit programs:

- ✓ **Principle 1:** Target neighborhoods and population groups experiencing health disparities and address the root causes of poor health, including structural injustice and social/economic health determinants.
- ✓ **Principle 2:** Center community engagement efforts on community residents who have long borne the brunt of health inequities and structural injustice, and take steps to make their involvement in the community benefit process meaningful to them.
- ✓ **Principle 3:** Adopt financial assistance and billing policies that promote economic security, build racial and gender wealth equity, and preserve access to care for low- and moderate-income community residents.
- ✓ **Principle 4:** Invest in governance structures to ensure staff and programs have the internal resources and funding they need to effectively address community priorities.
- ✓ **Principle 5:** Evaluate health equity and community engagement efforts and share findings with internal and community stakeholders.

The array of program indicators within this dashboard exceed basic requirements found in the ACA. Community Catalyst developed this dashboard to reflect the lived experiences and recommendations of community-based leaders, advocates and hospital leaders within our network who share our vision for using community benefit to achieve health equity. Our methodology included an extensive literature review; a qualitative analysis of a convenient sample of hospital community health needs assessments (CHNAs); and interviews with hospital community benefit staff and community partners.

While many hands and minds contributed to this dashboard, we wish to express our deep gratitude to the community residents, leaders, and professional staff at Waite House-Pillsbury United Communities; the Northwest Bronx Community and Clergy Coalition; and the Asian Pacific American Network of Oregon and their partners in the Oregon Health Equity Alliance. We remain inspired by their visions for their neighborhoods, and for the strength and power of their voices and commitment to building a better world. We thank The Kresge Foundation for its leadership and support of that collaboration. Primary authors for this Dashboard are Jessica Curtis, Senior Advisor for the Hospital Accountability Project at Community Catalyst; and Holly Lang, Consultant.

How You Can Use This Dashboard

Community organizations and hospitals can use the dashboard to:

- ✓ Gain insight about how local hospitals are using community benefit to address health inequities and structural injustices
- ✓ Understand how local hospitals currently seek and use input from community residents to drive community benefit investments and identify areas for improvement
- ✓ Make recommendations to hospital staff and leadership, community residents and other partners
- ✓ Identify potential opportunities to partner on health equity and community engagement initiatives

It is important to note the limitations of this dashboard. First, the tool does not address other factors that can impact community benefit decisions, including hospital size and ownership; overall revenue and profit margins; geographical constraints and competition; and percentage of patients who are uninsured or low-income. No two hospitals are the same, and each serves unique patient populations in different geographical areas governed by varying state and local laws. This dashboard will also be easiest to complete for privately-owned non-profit hospitals. While we believe it is reasonable for hospitals owned by public entities and for-profit corporations to provide community benefit, public reporting standards and legal requirements for these institutions are generally more lax. Information about these hospitals' community benefit investments may be harder to find, when they exist.

Second, several indicators can only be answered by hospital staff and partners with knowledge about internal decision-making and programs. Community partners may want to complete as much of the dashboard as possible using publicly available data, and use the gaps to populate agenda items for conversation with hospital leadership and staff. As a first step, we recommend reaching out directly to hospital community benefit staff. Often, these staff are identified on the community health needs assessment (CHNA) report that is typically found on the hospital's website. Other hospital departments that may oversee the community benefit process include community health, mission, or community/public affairs departments.

Finding Information and Documenting Results

Where to Find Information

Most non-profit hospitals are required to make certain information about community benefit available to the public. Free public sources for community benefit information include:

- ✓ **IRS Form 990, Schedule H:** Most hospitals with tax-exempt status have to file an annual tax return, called the IRS Form 990. Hospitals must include a detailed report, Schedule H, that includes financial and narrative information about their past community benefit spending and programs. This is what Schedule H looks like before it is completed. Blank versions of the most recent Schedule and its Instructions are available free on the IRS's website. To find a hospital's or health system's completed Schedule H, visit Guidestar.org. Subscriptions are free and will give you access to the most recent Form 990s. Schedule H usually appears within this filing about halfway through (the Schedules are filed in alphabetical order). Community organizations can also request the most recent IRS filing directly from the hospital.
- ✓ **Community Benefit Insight** – This free platform, a project of the Center to Advance Community Health & Equity, provides historical community benefit information and additional resources to advance community health practices. It extracts the community benefit data hospitals file on their Schedule H forms and allows users to compare similar hospitals.
- ✓ **The Hospital's Community Health Needs Assessment (CHNA) Reports:** Federal law requires non-profit hospitals to plan and implement their community benefit programs through a community health needs assessment (CHNA) and implementation strategy. The CHNA process takes place every three years and must be documented in a public report that describes:
    - How the hospital defined its community;
    - Collected data and input from public health and community representatives;
    - Developed its list of community health priorities; and
    - Evaluated its impact on community health priorities identified in previous CHNAs.

  Hospital CHNA reports must be made available to the public both in person and online. Usually, community groups can find a CHNA report by searching the hospital's website or the broader Internet, using the hospital's name and the phrase "community health needs assessment." The CHNA report's "methodologies" section is a likely source for answering questions about the hospital's process for engaging community or choosing health priorities.
- ✓ **The Hospital's Implementation Strategies:** Hospitals must also develop and adopt a written plan for addressing significant health needs identified in the CHNA. This plan, called an implementation strategy, spells out specific resources a hospital will commit to addressing these health needs. Hospitals must file annual reports with the IRS relaying their progress on their implementation strategies along with their IRS Form 990 Schedule H. Often, these strategies are available on the hospital's website or upon request. Reviewing the implementation strategy may be helpful for identifying how hospitals have committed resources to invest in health equity.
- ✓ **Patient Financial Services and Billing Departments:** Copies of the hospital's formal financial assistance, billing and collections policies and application forms should be available online and upon request.

Documenting and Tallying Results

Each Principle is broken down into indicators to evaluate how a non-profit hospital's community benefit program currently works to achieve health equity and engage the community. Indicators are scored on a scale of zero to five, with five representing strong performance in an area and a zero reflecting no progress (and in some cases, a lack of transparency or information). This free worksheet will automatically tally up scores to enable quicker comparisons across principles and among hospitals. We recommend documenting the dates on which the dashboard is completed, in order to measure progress over time and note where conversations have yielded better or more accurate information. Similarly, we recommend documenting the sources used to find information and score a particular indicator. This will help streamline your research and allow you to back up your findings with others.

SCALE	DESCRIPTION OF PROGRESS FOR INDICATOR
0	No progress or activities in this area, or the hospital refused or declined to provide information
1	The hospital has demonstrated little progress or action on this, but has indicated a willingness to do so
2	The hospital has shown some progress on this indicator, though there is opportunity to increase activities or efforts
3	The hospital somewhat meets this indicator
4	The hospital mostly meets the indicator
5	The hospital fully meets the indicator and could be considered a model for other hospitals
N/A	Information was not received in a timely manner or it is unclear if the hospital has met the indicator

PRINCIPLES AND INDICATORS

Principle One: Hospital community benefit programs intentionally target the neighborhoods and demographic groups experiencing health disparities and address the root causes of poor health, including structural injustices and the social/economic determinants of health (SDH).			
Indicator	**Where to find information**	**Scale (0 to 5)**	**Notes**
1. Within the CHNA report, the hospital **defines its community** through relevant geographical measures (such as the hospital's primary service area, a zip code, neighborhood block, city or a county) and narrows its focus on **vulnerable populations** within that geographical area where there is a higher prevalence or severity for a health concern. *Sources include: "Advancing the State of the Art in Community Benefit," Public Health Institute* **Vulnerable populations** include communities experiencing disproportionately poor health outcomes and/or high levels of need on key social and economic determinants of health, such as poverty, income, interpersonal violence, limited transportation, food insecurity, housing instability, housing segregation, and/or high school graduation rates. They also include communities facing discrimination and **structural injustices like sexism or racism.**	CHNA report		
2. The hospital's CHNA process includes **data collection** on health disparities, structural injustices, and social and economic determinants of health impacting vulnerable populations within its community. *Sources include: "Innovative Population Health Model Associated with Reduced Emergency Department Use and Inpatient Hospitalizations," Health Affairs* (Sources for this data may include qualitative information gathered by community and public health partners through community surveys, focus groups, and roundtable discussions or forums; or, de-identified patient utilization data the hospital has collected during routine screenings and health-risk assessments.)	CHNA report		

PRINCIPLE ONE (continued)

Indicator	Where to find information	Scale (0 to 5)	Notes
3. The hospital's CHNA report identifies at least one health disparity, social and economic determinant of health, or structural injustice as a **significant community health priority**.	CHNA report		
4. The hospital's **implementation strategy** describes how the hospital will commit resources, independently or in partnership with others, to address health disparities, structural injustices, or the social and economic determinants of health through community benefit programming. *Sources include: "Can Hospitals Heal America's Communities?" Democracy Collaborative*. (Examples could include investments in affordable housing, job training, community leadership development and advocacy, neighborhood revitalization, provision of needed medical services, and building economic wealth in underserved communities.)	CHNA report, implementation strategy; annual community benefit reports (if available); IRS Form 990 Schedule H		
5. The hospital community benefit budget includes direct allocations that target the reduction of health disparities in geographic neighborhoods and among demographic groups experiencing health disparities, discrimination, and structural injustice.	IRS Form 990 Schedule H; implementation strategy; hospital disclosure		

Principle Two: The hospital centers its community engagement efforts on community residents and organizations that bear the brunt of health inequities and structural injustices, and takes steps to make their involvement in the community benefit process meaningful to them.[2]			
Indicator	**Where to find information**	**Scale (0 to 5)**	**Notes**
1. The hospital **seeks input during the CHNA process** from community residents and community-based organizations that is proportionate and representative of the neighborhoods and demographics within its service area that are experiencing the greatest health inequities.	CHNA report, hospital disclosure		
2. The hospital uses **culturally, linguistically, and physically appropriate methods** to increase participation of community residents and community-based organization in community benefit and CHNA processes. Sources include: "*Consumer Engagement in Medicaid Accountable Care Organizations," Community Catalyst and "Engaging Community Members to Improve Community Health," Catholic Health Association* Examples include: • Translating survey instruments and other primary data collection tools into the languages spoken by vulnerable populations in the community • Offering focus groups and community forums in the primary languages spoken by vulnerable populations • Holding meetings at times and places that are convenient and comfortable for community residents • Providing transportation, child or elder care, food, and interpretation services • Ensuring meetings are held in locations that support full access and participation for people living with disabilities • Using virtual conferencing (Skype, Google Hangouts) and other non-traditional ways to involve community residents • Providing stipends for participation	CHNA report, hospital disclosure		

[2] We credit PolicyLink for this language.

PRINCIPLE TWO (continued)

Indicator	Where to find information	Scale (0 to 5)	Notes
3. The hospital recruits **community benefit advisory bodies and/or workgroups that have proportionate representation** from community residents and organizations from the neighborhoods and populations experiencing the greatest health inequities. *Sources include: Assessing & Addressing Community Health Needs, Catholic Health Association*	CHNA report, community benefit webpage, hospital disclosure		
4. The hospital observes **best practices in meeting design and facilitation** with community benefit advisory boards and workgroups. These include: Sharing agendas and notices in advance; providing translation and interpretation services; supporting community resident attendees who may lack technical knowledge and expertise; and supporting professional volunteers to honor the wisdom of community residents and to help lift their perspectives and voices. *Source: "Consumer Engagement in Medicaid Accountable Care Organizations," Community Catalyst*	Hospital disclosure		
5. The hospital is **clear and transparent about the process it will use to make community benefit decisions**, with explicit roles for internal hospital staff and descriptions on how community input will inform decision-making, including the designation and prioritization of "significant community health needs" and investment of hospital resources in the implementation strategy. *Sources include: "Partnerships, Coalitions and Collaborations," CDC*	CHNA report, implementation strategy, hospital disclosure		
6. The **CHNA report and implementation strategy both reflect community-identified priorities.**	CHNA report, implementation strategy, community benefit materials, hospital disclosure		

Principle Three: The hospital adopts financial assistance, billing, and collections policies that promote economic security, build racial and gender wealth equity, and preserve access to care for low- and moderate-income community residents.			
Indicator	**Where to find information**	**Scale (0 to 5)**	**Notes**
1. The hospital **annually reviews** its financial assistance, billing and collections policies and procedures to ensure they adequately reflect and respond to shifting community demographics, financial status and health access trends in its geographic service area.	FAP materials, hospital disclosure		
2. As part of its regular review, the hospital **actively solicits and incorporates community feedback on its financial assistance policy (FAP)** to ensure the financial assistance and billing processes are working well for low- and moderate-income community members. Examples of solicited input may include requests for patient feedback on bills, surveys, and websites, or the inclusion of prompts about health care affordability and hospital financial assistance programs in CHNA surveys and community forums.	FAP materials, CHNA report, hospital disclosure		
3. The hospital **provides adequate staffing throughout the financial assistance program process**, and patients have adequate access to staff support throughout their application and any subsequent follow-up, which is demonstrated through reasonable response and resolution time.	Hospital disclosure		
4. The hospital **adopts quality control measures to ensure staff and third-party vendors adhere** to the financial assistance policy and related processes. Examples include monitoring, spot checks, and a periodic review of patient records. *Source: "Patient Financial Communications Best Practices," HFMA*	Hospital disclosure		

PRINCIPLE THREE (continued)

Indicator	Where to find information	Scale (0 to 5)	Notes
5. The hospital **partners with community based organizations, low-income housing offices, charitable clinics and community health centers** to provide culturally and linguistically appropriate information and financial assistance application support to their members and patients as to streamline the financial assistance enrollment process.	Hospital disclosure, FAP materials		
6. The hospital **widely publishes and regularly updates cost- and financial policy-related information**, including any shifts in requirements for financial assistance, changes in prepayment policies or changes in network providers. *Source: "Why Price Transparency Matters Now," HFMA*	FAP materials, other billing materials available online or through the financial counseling office, hospital disclosure		

Principle Four: Hospital leadership establishes governance structures that ensure community benefit programs and staff have the resources and funding they need to effectively address community priorities.			
Indicator	**Where to find information**	**Scale (0 to 5)**	**Notes**
1. The CHNA report and implementation strategy are **explicitly referenced and meaningfully integrated** across various areas of the hospital, such as organizational strategic planning, capital expansions and service line development.	Hospital disclosure		
2. There is **direct board- and executive-level oversight of community benefit activities**. The board regularly discusses community benefit policy and practice, and reviews measures that indicate success. *Source: Catholic Health Association – Charting a Course to Community Health: A Governance Priority*	IRS Form 990 Schedule H, hospital disclosure, CHNA		
3. The community benefit budget **meets or exceeds at least 7.5 percent of the hospital's operating expense.** *Source: Figure drawn from average amount of community benefits rendered in 2009, as reported in the 2016 article Nonprofit Hospitals' Community Benefit Requirements, Health Affairs*	IRS Form 990 Schedule H, community benefit webpage, other community benefit materials, hospital disclosure		
4. The hospital provides **clear, comprehensive public reports about its community benefit programs and budgets** that trace the connection between priority community health needs identified in the CHNA report and implementation strategy, and the financial or human resources the hospital has committed to address that need.	IRS Form 990 Schedule H, hospital disclosure		

PRINCIPLE FOUR (continued)

Indicator	Where to find information	Scale (0 to 5)	Notes
5. Hospital marketing materials **clearly exclude patient bad debt and Medicare shortfall** from their community benefit totals. (While some states permit hospitals to report **bad debt and Medicare shortfall** as community benefit, the IRS prohibits this practice. However, many hospitals and state hospital associations still issue marketing reports that include these categories as part of their "benefit to the community." Strong arguments can be made for excluding both categories.)	Hospital website and other community benefit materials		
6. The hospital hires and trains a **community benefit and community health workforce that reflects the populations its community benefit programs serve**, including staff from low-income communities or census tracts identified in the CHNA, and invests in regular skill-building and training for community benefit staff that includes health equity, cultural competency, and structural injustices like racism. *Sources include: "Achieving Health Equity: A Guide for Healthcare Institutions," Institute for Healthcare Improvement; and "Can Hospitals Heal America's Communities?" Democracy Collaborative.*	Hospital disclosure		

Principle Five: The hospital routinely evaluates its health equity and community engagement efforts using process and outcome measures and shares findings with internal and community stakeholders.			
Indicator	**Where to find information**	**Scale (0 to 5)**	**Notes**
1. The hospital provides community partners and committee members with **access to evaluation data** and opportunities to inform the design and implementation of a community benefit evaluation. *Source: "Tools for Partnership Evaluation" CDC*	IRS Form 990 Schedule H, implementation strategies, hospital disclosure		
2. The community benefit evaluation plan includes specific goals, outcomes and metrics to **measure improvements in health disparities** and the impact of its interventions through valid, evidence-based mechanisms. *Sources include:* CDC, the World Health Organization, the Association for Community Health Improvement and the Catholic Health Association.	IRS Form 990 Schedule H, implementation strategies, CHNA reports, hospital disclosure		
3. The community benefit evaluation plan includes specific goals, outcomes and metrics to **measure effectiveness of community engagement and collaborations** with external partners across the CHNA and implementation strategy. *Sources include: Scottish Community Development Centre; The Massachusetts Attorney General's Community Benefit Guidelines for Non Profit Hospitals (note the Hospital and Community Representative Self-Assessment forms); and "Tools for Partnership Evaluation" CDC. See also* PolicyLink, *Getting Equity Advocacy Results: Build the Base for Health Equity Advocacy*.	Hospital disclosure, community benefit information, partnership information (if provided)		

PRINCIPLE FIVE (continued)

Indicator	Where to find information	Scale (0 to 5)	Notes
4. The hospital **uses the evaluation findings to inform future interventions** and to increase engagement and depth of partnership with community residents and partners from the neighborhoods and population groups experiencing the brunt of health inequities. *Sources include: Scottish Community Development Centre; The Massachusetts Attorney General's Community Benefit Guidelines for Non Profit Hospitals (note the Hospital and Community Representative Self-Assessment forms); and "Tools for Partnership Evaluation" CDC. See also* PolicyLink, *Getting Equity Advocacy Results: Build the Base for Health Equity Advocacy*.			
5. The hospital **updates its evaluation plan annually and makes progress reports and outcomes available** to the public. *Source: The Massachusetts Attorney General's Community Benefit Guidelines for Non Profit Hospitals*	Hospital disclosure, community benefit information		