GREAT BOARDS
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Compliance or Leadership: The Governance Role in Community Benefit

By Elaine Zablocki

For some hospitals, Schedule H of the new Form 990, which virtually all not-for-profit hospitals must file annually with the Internal Revenue Service, will present major challenges. That's because they haven't routinely assembled much of the detailed information the form requires about charity care and other forms of community benefit and community development activities. For other hospitals that have already incorporated community benefit reporting into their operations and governance work, the Schedule H will be just the next step on a well-paved path.

Great Boards looked at eight such hospitals and health systems. Representing a range of religious and secular, academic and community-based institutions, these organizations and boards don't just collect community benefit data — they use the information to both plan and oversee community outreach efforts. They've made a strategic choice that others must now make as well: whether to approach community benefit as a matter of compliance or as one of mission-based leadership.

The hospitals we examined are, on the whole, viewing community benefit through a leadership lens. They are challenging themselves to meet community needs with programs that extend outside hospital walls and expand the definition of healthcare. They are gathering data on the effectiveness of community benefit programs, and making community benefit an integral aspect of all major governance decisions.

From 2002 to 2006, the Advancing the State of the Art in Community Benefit (ASACB) demonstration project worked to develop and implement reforms to enhance hospitals' investments in community benefit. Kevin Barnett, DrPH, MCP, was the principal investigator. A key lesson was that top-level leadership truly powers the work of dedicated staff working at the community level.

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"We learned through years of work on community benefit that we could give middle managers all the skills in the world, but if they didn't have sufficient understanding and support from the hospital's senior leadership and board, they were dead in the water," he says. "Unfortunately, this happens in many hospitals. The community benefit function tends to become a marginal enterprise focused on reporting, rather than planning and strategic leveraging of the hospital's limited charitable resources."

How does a board organize itself to oversee community benefit? ASACB's standards call for a board-level subcommittee that includes trustees, senior management, and in most cases, a majority of external community stakeholders. "It's a skills-based committee that includes people who have lived for many years in communities with disproportionate unmet needs, and are in a position to make informed decisions," Barnett says. "While the board of trustees makes final decisions, the subcommittee focuses on oversight and monitoring of all the hospital's charitable resources. Typically, the full board has too much on its plate to deal effectively with these issues."

WHAT'S INSIDE SCHEDULE H?

What is Schedule H? It's one of the schedules that accompany IRS Form 990 released by the IRS December 20, 2007. Schedule H will be phased in.

What is included? Part I, "Charity Care and Certain Other Community Benefits at Cost," includes questions on a hospital's charity policy and eligibility criteria. It is based on the Catholic Health Association's community benefit reporting model and gathers data on charity care, unreimbursed Medicaid, community health improvement services, research, and contributions to community groups.

Part II, "Community Building Activities," enables hospitals to report services such as coalition building, community health improvement advocacy, leadership development and training, housing, and economic development.

Part III, "Bad Debt, Medicare & Collection Practices," requires hospitals to report bad debt and Medicare shortfalls, including their own estimates of how much should be treated as community benefit.

Part IV requires hospitals to list management companies and joint ventures in which they participate, including a description of each entity's primary activity, the percentage of ownership the hospital has, and the percentages owned, if any, by officers, directors, and physicians.

Part V requires the organization to list all of its facilities.

The IRS notes that many hospitals "may need to establish or modify record-keeping systems to compile or report information for [some] parts of the schedule. The additional burden could be substantial for many hospitals, particularly for the first year of reporting."

Is filing mandatory? Only identifying information (Part V) will be required for the 2008 tax year; other sections are optional. The entire schedule must be completed for the 2009 tax year, to be filed in 2010.

Are disclosure rules clear? Not yet. Even though the IRS made extensive changes in response to concerns expressed by hospitals about an earlier draft (released June 2007), hospital financial managers will have to wait until the IRS issues instructions (expected this spring) on how to answer many questions accurately.

Several boards we studied, including Saint Francis Memorial Hospital and St. Bernardine Medical Center, discussed below, have community benefit committees, but not all do.

At Hospital Sisters Health System (HSHS), a 13-hospital system based in Springfield, Ill., the whole board (not a committee) deals with community benefit. It is one of the system's six strategic initiatives, discussed regularly at every board meeting.

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John R. Combes, MD, serves on the HSHS board and is also president and CEO of the American Hospital Association's Center for Healthcare Governance. "The system has a Franciscan heritage, and we look at community benefit as part of our rigorous mission integration strategy," he says. "Over the past several years,

hospitals have learned that quality shouldn't be a matter of isolated reports or a single committee within the board structure; instead it should be an aspect of our mindset as we approach almost any issue. In the same way, community benefit should be an integral part of all the board's work."

Beth Israel Deaconess Medical Center (BIDMC), in Boston, has had a board-level community benefits committee for many years, on a par with finance, patient care, and other standing board committees. It has two subcommittees, one for maintaining relations with seven affiliated health centers and one on equitable care. BIDMC has three layers of governance, with boards of directors, trustees, and overseers. All of them are represented on the 14-member board committee: two directors, five trustees, and seven overseers.

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That means that unlike most community benefit committees, everyone on the committee is a board member; no one is a nonboard community representative. "We made a conscious decision to have a diverse board, including community representatives," says Ediss Gandelman, director of community benefits. "If someone is good enough to sit on the committee, they are good enough to be an overseer, trustee, or director."

Presbyterian Intercommunity Hospital (PIH), in Whittier, Calif., has a Community Benefits Oversight Committee (CBOC) that includes two board members, five hospital managers, and eight community representatives. The committee is empowered to make programmatic and budgetary decisions on community benefit, without referring the matter to the full board. "The hospital board of directors has granted CBOC this authority," says Dawn Marie Kotsonis, director of community benefit development. "At present there are no budgetary limitations. The hospital has been willing to say, 'Let's work with the situation and see how it goes; we won't set any restrictions until the need arises.'"

Saint Francis Memorial Hospital (SFMH), a Catholic Healthcare West hospital that participated in ASACB, serves the homeless population of San Francisco's Tenderloin district. It values broad community representation and includes a majority of nontrustees on its 24-member Community Advisory Committee (CAC), says Abbie Yant, senior director of ambulatory and community benefit. The committee oversees the community benefit plan and includes four board members as well as medical staff, management, foundation representatives, and ten community leaders. It is an expertise-based committee, with a charter that defines criteria for committee membership, committee responsibilities, and priorities used to assess community benefit projects (see charter, next page).

MEASURING RESULTS

Community benefits reports are by definition "after the fact." They report what's been accomplished to meet community needs, but they don't try to assess community needs to design future efforts. That's why some boards ask for detailed information on community needs and healthcare disparities in order to set

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priorities, make rational decisions about community benefit programs, and evaluate the results against community needs.

For example, Lucile Packard Children's Hospital at Stanford (LPCH), an ASACB participant and the pediatric division of Stanford University Medical Center, makes grants to other organizations that share LPCH's community service mission. LPCH includes specific outcome measures in its community-benefit investment plan.

"We negotiated the measures with the organizations receiving our funding," says Candace Roney, executive director for community partnerships. "We selected outcomes that were important to the hospital and that the grant recipients also wanted to work on and felt reasonably able to achieve. In August, when our new funding cycle began, we got progress reports on those outcomes, and then in most cases set new ones for this year."

For instance, LPCH provides pediatric and obstetrics staff for the Ravenswood Family Health Center in East Palo Alto, a federally qualified health center. One goal which was achieved was to maintain a 90 percent childhood immunization rate for all children in the local school district, relying on a mobile van LPCH supplied. A second goal was to streamline processes and increase clinic visits by an average of 18 per day. Ravenswood achieved an increase of 12 per day, but was hampered by a high no-show rate for

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SAINT FRANCIS MEMORIAL HOSPITAL COMMUNITY ADVISORY COMMITTEE CHARTER

Membership Recruitment Criteria

Members will reflect a breadth of knowledge, experience, and expertise in the following areas:

- Characteristics, dynamics, and history of communities with disproportionate unmet health-related needs in SFMH's catchment areas
- Education
- Social services
- Analysis of service utilization and population health data
- Finance and accounting
- Housing
- Youth and family services
- Physical infrastructure (concern for public and private space)
- Community-based organizations in SFMH's catchment areas
- Public sector agencies and policy issues in San Francisco
- Clinical service delivery
- Primary prevention
- Legal issues (health law expertise a plus)
- Immigration
- Addiction
- Faith community

Committee Responsibilities

- Community benefit plan
- Program content/design
- Program monitoring
- Program continuation/termination
- SFMH Community Hero Award
- Budgeting decisions
- Geographic/population targeting
- Advocacy
- Secure outside funding
- Oversee Catholic Healthcare West community grants

Criteria for Priority Setting

- Size of problem (i.e., number of people per 1,000, 10,000, or 100,000)
- Seriousness of problem (i.e., health impact at individual, family, and community level)
- Economic feasibility (i.e., program cost, internal and potential external resources)
- Available expertise (i.e., can we make an important contribution?)
- Time commitment (i.e., overall planning, implementation, and evaluation)
- External salience (i.e., evidence that it is important to community stakeholders)

Source: Saint Francis Memorial Hospital

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well-child visits as well as by limited exam space. This year, the clinic is converting to an open access scheduling system and expects to reduce cycle time and improve patient flow.

The Dana-Farber Cancer Institute, in Boston, benefits from its Center for Community-Based Research, which rigorously evaluates community-based interventions. For example, a recent NCI-funded study focused on a program using peer leaders in low-income housing sites to educate residents about the benefits of colorectal screening. The center evaluated its effectiveness over a three-year period. "Colorectal screening rates went way up," says Anne L. Levine, vice president for external affairs. "Now we're working together with the center to ensure that the program is sustained at the existing sites and expanded to other Boston locations."

At PIH, the hospital board has embraced a philosophy it calls "right care, right time, right place." That means focusing not on what's best for the hospital, but on what the community needs," explains Kotsonis. "That's why we've built additional community clinics. We now have a team of enrollment coordinators who proactively seek out uninsured and underinsured people in the community and help them connect with an appropriate medical home so they receive care before it becomes an emergency." ER usage is declining, and Kotsonis is in the process of compiling formal statistics.

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>
> — John R. Combes, MD, Board Member, Hospital Sisters Health System

INFLUENCING STRATEGIC AND POLICY DECISIONS

When community benefit becomes a board priority, it can drive strategy and policy decisions. For example, Baptist Health South Florida, a six-hospital system, serves some affluent areas of Miami as well as Homestead, which lost substantial population after being devastated by hurricane Andrew. The system is doing well overall financially, says president and CEO Brian E. Keeley, and has been deeply involved in community benefit. An eight-member community benefit committee (of the 23-member system board) oversees community benefit policy, and the committee chair presents recommendations to the full board.

In Homestead, community benefit helped drive the board to make a strategic decision to replace the existing, outdated hospital, recalls Keeley. "It was losing about $11 million a year. We replaced it with a brand-new, $135-million facility. Now we lose $30 million a year." He adds, "We expect that over the next five to 10 years, as the area recovers, the hospital's financial performance will improve. However, no for-profit corporation would ever have considered building a hospital there." The system board carefully considered this decision, Keeley says. "While a couple of board members were concerned about the financial implications, most felt that we're a community-driven, faith-based organization, and our mission is to serve the community." Keeley cites a number of other board-driven decisions on community benefit. Although Florida sets the threshold for charity care at two times the federal poverty level, the board approved offering 100-percent financial assistance to those at three times the federal poverty level. Community benefit is a key element in the management incentive program; all executives must meet or exceed community benefit targets each fiscal year. The system also provides funding and services for five free clinics.

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St. Bernardine Medical Center (SBMC), a Catholic Healthcare West hospital in San Bernardino, California, was one of the ASACB pilot sites, and as part of that process it formed a board committee on community benefit. "We've always been very mission oriented, but in the past our planning process was informal," says Linda S. McDonald, vice president for mission integration. "Today, it is much more rigorous and accountable."

For example, when SBMC started a parenting skills course for pregnant and parenting teens, called Teen Choices, it first brought the program to the board committee for input. The program offers eight weekly sessions at a local high school, with topics including nutrition, baby care, job search skills, family relationships, and how to deal with emergencies.

"Five years ago, I'd have talked it over with my project coordinator, and if it seemed like a good idea, we'd go ahead and do it," recalls McDonald. Instead, the community benefits committee reviewed the proposal and made a number of recommendations that reshaped the program. "Because we gathered data beforehand, involved all the relevant people, and strategically considered various options, we have increased the sustainability of this program," says McDonald.

IMPLICATIONS FOR OTHER BOARDS

So, what will be the impact of the new community benefit reporting requirements to the IRS and to state government agencies? "I think it's inevitable that an increased focus on community benefit will occur nationwide, whether it's legislated or regulated or through voluntary compliance," says Levine. "For hospital boards that aren't familiar with these issues, the best first step would be to familiarize themselves with community benefit guidelines, such as those developed by the Catholic Hospital Association."

In the end, though, the decision on whether community benefit is a matter of compliance or helps drive strategic and policy decisions at a governance level is up to the board.

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> *— Candace Roney, Executive Director for Community Partnerships, Lucile Packard Children's Hospital*

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For community benefit resources for boards and examples of hospitals' community benefit reports, please go to http://www.greatboards.org/resources/cbr.asp

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