CHA advances the Catholic health ministry of the United States in caring for people and communities. Comprised of more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. Every day, one in six patients in the U.S. is 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 the Form 990, Schedule H for Hospitals.

www.chausa.org

VHA

Founded in 1977, VHA serves nearly 1,400 not-for-profit hospitals and more than 30,000 non-acute care providers nationwide. As a member-owned health care alliance, VHA has long supported and protected the value of not-for-profit hospitals.

VHA members work together and with VHA to drive maximum savings in the supply chain arena, set new levels of clinical performance, identify and implement best practices to improve operational efficiency and clinical outcomes, and improve the health status of the communities they serve. In the early 1990s, VHA introduced its voluntary community benefit standards followed by a series of resources and tools for effectively implementing an organization-wide community benefit strategy.

www.vha.com
Foreword to the Revised 2015 Edition

In the midst of profound change in health care, a constant has been the commitment of America’s Catholic and other not-for-profit health care organizations to meet the health needs of their communities, especially the needs of persons who are most vulnerable.

The Affordable Care Act (ACA) has expanded access to affordable health insurance to millions of Americans and introduced new incentives for health care providers to deliver greater value.

The law also put into place requirements to ensure that charitable hospitals meet their obligation to improve community health. The law requires tax-exempt hospitals, working with their communities and public health experts, to conduct community health needs assessments and plan for community health improvement and to provide great transparency and accountability on their efforts to improve community health.

Essentially the ACA put into law the best practices of hospitals for community health improvement. Since CHA began its work in community benefit over 25 years ago, we have been gratified to see how community benefit programs have matured and relationships have flourished among hospitals, public health departments and community partners. We are fortunate to have new public health tools and evidence-based strategies for improving health in our communities. In addition, we have a greater understanding of the role of social, economic and environmental factors in the health of individuals and communities.

Yes, there has been profound change in the law, incentives, tools and knowledge, but at the same time, we have seen a reaffirmation of the commitment to community health that was established by our religious and civic founders. These pioneers brought health care to America’s early communities by identifying needs and doing something about them. They didn’t call their work community benefit or community health needs assessment. They didn’t refer to their plans as implementation strategies. But they did assess community needs and assets, they were strategic and they did profoundly benefit their communities.

It is our pleasure and privilege in the 2015 edition of A Guide for Planning and Reporting Community Benefit to bridge the old and the new by building on our tradition and sharing innovative and effective approaches. The underlying philosophy of this edition continues to be: we provide community benefit, not because of any new laws or rules, but because it is the right thing to do and it is what we have always done.

Sister Carol Keehan, DC
President and Chief Executive Officer
The Catholic Health Association of the United States
Acknowledgements

This Guide reflects the successful practice and creativity of community benefit and public health leaders throughout the United States. CHA is grateful to all who contributed to this Guide, with special thanks to:

- The staff at Lyon Software, who, with CHA and VHA, developed the Community Benefit Inventory for Social Accountability (CBISA) which is a companion to this document.

- The staff at the Healthy Communities Institute who have been working with CHA to revise guidance on community benefit evaluation so that it reflects leading practices in public health and community health improvement.

- Keith Hearle of Verité Healthcare Consulting, LLC, the author of the accounting chapter and worksheets and major contributor to the criteria for what counts as community benefit.
Executive Summary

The goal of this updated publication, *A Guide for Planning and 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, including Lyon Software, VHA 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 the IRS Form 990, Schedule H for Hospitals.
Foundational Beliefs

*A Guide for Planning and Reporting Community Benefit* is based on six foundational beliefs:

- Those who live in poverty and are vulnerable have a moral priority for services.
- Not-for-profit health care has a responsibility to work toward improved health in the communities they serve.
- 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.
- Health care organizations must demonstrate the value of their community benefit programs.
- Commitment to community health improvement should be reflected throughout health care organizations.
- 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 requirements associated with tax-exempt status, conducting an inventory of current programs and policies, learning more about their communities and their needs and developing partnerships within and outside of the organization.
Executive Summary

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 for determining “what counts” that have been developed by community benefit, mission and finance leaders, and agreed upon by many national organizations and the Internal Revenue Service (IRS).

Building a Sustainable Infrastructure

Sustaining community benefit programs requires that health care organizations have a clear mission to serve their communities and 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 assures 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. Planning also needs to be integrated into other organizational planning as well as 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, 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 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 state and the Internal Revenue Service (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 on the community benefit section on CHA’s website, 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.
- Assuring 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 contribution. The idea of boasting about charitable activities was seen as inappropriate, with many recalling the 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 mission and values that guide their operations.
- Physicians and staff want to know they are part of an important community service, where 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 community.

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 in 2010, these organizations must also conduct community health needs assessments, 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 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 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.

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.

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 community public health and advancing knowledge as important strategic objectives. This commitment includes knowledge about community need, working collaboratively with other leaders in the community and being accountable for community health improvement.
Chapter One: Getting Started
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 to:

1. Understand community benefit and requirements for tax-exempt hospitals.
2. Establish responsibility and accountability for community benefit.
3. Conduct an inventory of community benefit programs and activities and key policies.
4. Understand your community and its needs and assets.
5. Identify partnerships within 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 Internal Revenue Service Form 990, Schedule H for Hospitals (Schedule H). This schedule is used to report a hospital’s community benefit activities and other information related to tax-exemption. The Schedule H is part of the IRS Form 990, a form which non-governmental 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 laws and regulations.

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 relief of 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 Affordable Care Act added new requirements for tax-exempt hospitals in the areas of community health needs assessment (CHNA), 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 to ensure greater transparency and accountability.

See Chapter 5 for definitions of a CHNA and implementation strategy.
For more information on federal and state tax exemption requirements, the IRS Form 990 and ACA provisions, visit the CHA website at 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, basic knowledge of public health, program planning and implementation, finance 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: 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 within 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 competencies needed by community benefit professionals.*
WHEN YOU LACK RESOURCES FOR A FULL-TIME COMMUNITY BENEFIT MANAGER

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/advocacy, legal, finance and patient financial services, clinical/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 work group.

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/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 www.chausa.org/guideresources and see the heading labeled 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, a primary role is to assure 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, implementation strategy, the community benefit report and the 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 www.chausa.org/guideresources and see the heading labeled 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 and pastoral care 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 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.

Source: 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 where consumers qualify on the basis of their means (income and/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.

Source: 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.

Source: Staff from throughout the organization, including communications, public relations, strategic planning, community outreach (if separate from community benefit) and finance offices.
Health professions education – Include all educational programs the organization is involved with that result in degrees or training necessary to practice as a health professional.  
Source: Medical and nursing education departments, 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.  
Source: Finance, strategic planning office 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.  
Source: Clinical and/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 non-monetary resources donated for community benefit. Examples include finance staff helping a free clinic set up an accounting system, donation of needed medical and/or IT equipment to the free clinic and donating the time of an employed physician to conduct physicals for people at a homeless shelter.  
Source: Various departments including public relations/communications.

Community benefit operations – Include the cost of assigned staff, consultants and activities of the community benefit department/team, such as community assessments and program evaluations and community benefit planning.  
Source: Community benefit or community health departments.

Community-building activities – These activities seek to address root causes of health problems, such as 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 the Schedule H.  
Source: 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 for examples.

- Compare current activities with community needs.

  See Chapter 5 for more information about community health needs assessments.

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

  Visit 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 with 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 (*)** – Review whether your policies meet all legal requirements, are clearly written and 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 (*)** – Review whether policies regarding providing care for
emergency medical conditions regardless of individuals’ 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 encouraged, through time off or recognition, to provide community service (activities done on 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 boards’ roles in furthering community benefit and items that the board is legally required to approve.

* Required by the Affordable Care Act.

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.

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**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 community health needs assessment 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 countyhealthrankings.org, wwww.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.

**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.
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 community health needs assessment is included in Chapter 5.*

**Guideline 5**

**Identify partnerships within and outside of your organization**

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, mission, finance and patient financial services, legal/compliance, communications/public relations, government relations/advocacy, strategic planning, foundation, community outreach and marketing offices and from clinical services such as the emergency department (ED). 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 that 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 and representatives of other government programs.

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 under way 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
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 Internal Revenue Service Form 990, Schedule H for Hospitals 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 integrity of reported numbers, both internally and externally.

In this chapter, you will learn how to:

1. Determine if a program or activity is a true community benefit.
2. Determine the programs that should not be counted and reported as community benefit.
3. Distinguish programs and services for persons living in poverty from those for the broader community.
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 Internal Revenue Service 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 of 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, and if they ceased would result in access problems (for example, 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.
- Otherwise would 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 the IRS Form 990, Schedule H for Hospitals (Schedule H) state that community health need can be demonstrated through the following:

- A community health needs assessment developed or accessed by the organization,
- Documentation that demonstrated community need or a request from a public agency or community group was the basis for initiating or continuing the activity or program, or
- 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, justify continuing the programs, 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.
- If the program ceased to exist, the community would lose access to a needed service.
Chapter 2: Understanding What Counts and Does Not Count as Community Benefit

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, 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 at least one of 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. NIH, a foundation or the organization itself) and intended to be made publicly available and to be useful to other providers.

Relieve the burden of 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 (for example, immunizations or Medicaid enrollment services).
- The government provides financial support of the activity (for example, funding from the Centers for Disease Control and Prevention).
- If the program ceased to exist, health-related cost to government or another tax-exempt organization would increase.
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.
  - Example: 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.
  - Example: 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.
  - Example: 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.
  - Example: Donating a scoreboard to local high school.

- The program represents a community benefit provided by another entity or individual.
  - Example: 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.
  - Example: Targeted case management available exclusively to recently discharged patients and designed to reduce readmissions.

- The program is targeted only to the organization’s “covered lives,” or individuals for whom the organization bears financial risk.
• Example: Community health worker who visits only individuals who represent covered lives in an ACO affiliated with the organization.

• Access to the program is restricted to hospital employees or physicians.

• Example: Education program available only to/for 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.

• Example: Staff development activities such as in-service training and facility licensure or accreditation requirements such as 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?

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**A RESOURCE FOR DETERMINING WHAT COUNTS AS COMMUNITY BENEFIT**

Visit CHA's website at 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.
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 (FPL, http://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 and/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 http://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 the Community Benefit Categories and Definitions reference at the end of this Guide, for a comprehensive list of community benefit services.
Categories of community benefit include the following:

Refer to the instructions for the Schedule H for IRS definitions of these categories. The instructions can be accessed at www.irs.gov and on the CHA website at 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 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.”

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<tr>
<th>REVIEW FINANCIAL ASSISTANCE POLICIES</th>
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<td>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.</td>
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<td>See Chapter 4 for additional recommendations.</td>
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Medicaid and other means-tested public programs

Government-sponsored (public) means-tested programs have eligibility requirements tied to the recipient’s income and/or 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 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 where 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 availability of fresh fruits and vegetables in areas known as “food deserts.”
  - Violence prevention.

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

Services provided as part of a patient’s post-discharge care plan should not be reported as community benefit. Do not report routine discharge planning and most chronic disease/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 avoiding penalties.

However, in the following circumstances, chronic disease/care management services (such as peer counseling, 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 and face barriers to accessing such health care services; and
- Go beyond routine discharge planning and standards of care.
Chapter 2: Understanding What Counts and Does Not Count as Community Benefit

**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 and 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, certificate or training that is required by state law, accrediting body or 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.

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**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.”

**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 needs.
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 NOTE**

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 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., where 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 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, with community benefit 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 (PILOT) 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 assure 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.

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<tr>
<th>DO NOT REPORT VOLUNTEER EFFORTS</th>
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<td>Volunteer efforts not on paid time are not an expense to the organization and therefore, cannot be counted.</td>
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<td>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 salary. 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 who are working as volunteers during their vacation.</td>
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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 than enhances access to care for uninsured or Medicaid patients, subsidized health services, or for health profession education, or for other purposes that are defined as community benefit.
- The hospital is able to document its intent that in-kind contributions (for example, 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, advances or, as stated in Schedule H instructions: “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 (CONT.)

Some organizations are finding it straightforward to lease buildings to other entities rather than to donate them outright. Leases can incorporate terms that help assure the lessee provides community benefit in the leased space. Instead of providing leases with nominal (e.g., $1/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

<table>
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<th>IRS NOTE</th>
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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 call out on page 54 titled “Community-building or Community health improvement?” for more guidance.

Community-building activities are programs that address 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.

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 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 in 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.
- The Guide to Community Preventive Services, Centers for Disease Control and Prevention.
- 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 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 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.
- Community health needs assessment.
- Evaluation of individual programs and activities.
- Software that supports the community benefit program, such as the Community Benefit Inventory for Social Accountability (CBISA).
- 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 and
- Seek to address at least one of the following community benefit objectives:
  - Improve access.
  - Enhance public health.
  - Advance generalizable knowledge.
  - Relieve 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 to participate in Medicare)?
- Provided primarily for the organization’s “covered lives”?
- Primarily for employees (not including interns, residents and fellows) and/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.**
<table>
<thead>
<tr>
<th>Community Health Improvement Program</th>
<th>Health Profession Education Program</th>
<th>Subsidized Health Service</th>
<th>Research</th>
<th>Cash and In-Kind Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the program or activity carried out or supported for the primary purpose of improving community health?</td>
<td>Is the program: A) An education program necessary for a degree, certificate or training to be licensed to practice as a health professional or B) Continuing education necessary to retain state licensure or certification and open to unaffiliated professionals?</td>
<td>Is it a clinical service such as a burn unit or mental health unit (not an ancillary service such as lab 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 services 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?</td>
<td>Is research funded by 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?</td>
<td>Is the contribution restricted to being used for a community benefit activity or purpose?</td>
</tr>
</tbody>
</table>

**STEP THREE:**

- If "Yes" to all questions: **REPORT AS COMMUNITY BENEFIT**
- If "No" to any question: **IT IS NOT A COMMUNITY BENEFIT**
Chapter Three: Building a Sustainable Infrastructure
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 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, budget and policies.

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

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

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

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

Guideline 1
Use your mission, vision and values

The organization’s 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. These documents help all within the organization gain a common understanding that this is a community benefit organization.

- Review mission 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/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 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 plan, communications plans and budgets in order to ensure visibility and commitment for community benefit activities.

<table>
<thead>
<tr>
<th>COMMUNITY BENEFIT IN ACTION</th>
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<tbody>
<tr>
<td>From Holy Cross Hospital (Silver Spring, Md.) Strategic Plan 2015 – 2018</td>
</tr>
<tr>
<td>Strategic Principle: Improve individual and community health through innovation, alignment and partnership.</td>
</tr>
<tr>
<td>Strategic Actions:</td>
</tr>
<tr>
<td>• Improve the health status of our community, particularly those at most risk, by targeting identified community health needs.</td>
</tr>
<tr>
<td>• Provide health services and care coordination to people who lack insurance.</td>
</tr>
<tr>
<td>• Address outcome disparities by linking underserved populations to services and self-care programs.</td>
</tr>
<tr>
<td>• Lead in community health improvement through education, advocacy, innovation and resource commitment.</td>
</tr>
<tr>
<td>Benchmarks of Success:</td>
</tr>
<tr>
<td>• Provide leading levels of financial assistance for those unable to afford care. The community will benefit from recognized best practices in improving the health of at-risk populations and increased community benefit investment linked to demonstrated needs.</td>
</tr>
</tbody>
</table>

In addition to integrating community benefit into key organizational plans, also look for ways community benefit can support strategic initiatives, such as a population health management, 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 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 their 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 programs can work with and build on community relationships established by community benefit programs to secure community-based services for those they serve. Working through the hospital’s community benefit program’s partnerships, population health management staff can contribute to community-wide efforts to improve community health by contributing their time and expertise and offering technical assistance.

• **Community benefit programs can address 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 non-medical areas such as economic development, affordable housing and educational attainment.

• **Population health management can contribute to and use the findings from community benefit programs’ community health needs assessments** – 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. Findings from the assessments can be used by population health management programs and these programs can contribute information from their data sources and data analysis. 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 assuring that the organization responds to community need and for ensuring compliance 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.
- Have the board and chief executive officer approve the community health needs assessment, implementation strategy (community benefit plan) and community benefit reports, including Internal Revenue Service (IRS) Form 990, Schedule H for Hospitals (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 full board takes responsibility for advising on the community benefit program and reviewing/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.
- Organization of the board, including board committees and their areas of responsibilities.
- How often the board meets, 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.”

(Prybil et al., 56)
Guideline 4
Get the culture right

An organization's commitment to community benefit is reflected in a culture that welcomes persons of all economic, racial and ethnic 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 training of billing and finance office staff.

- 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 [http://www.chausa.org/disparities/equity-of-care](http://www.chausa.org/disparities/equity-of-care).

For sample orientation presentations, visit the CHA website at [www.chausa.org/guideresources](http://www.chausa.org/guideresources).
Chapter 3: Building a Sustainable Infrastructure

BUILD BASIC STRUCTURES

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.

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<tr>
<th>MODELS FOR STAFFING AT SMALL HOSPITALS AND LONG-TERM CARE ORGANIZATIONS</th>
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<tr>
<td>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.</td>
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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 reports directly to the CEO or COO, at least for community benefit issues, and occasionally has 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 or in the executive office, mission, planning, finance or population health management department. At some organizations, the community benefit department is known by a different name, such as community health improvement or community outreach. In order 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 and/or public health and community health improvement initiatives, particularly assessment and program planning, implementation and evaluation.

- Understanding of public health, such as knowledge of health status of populations, health disparities, determinants of health and illness, prevention and health promotion strategies.

- Ability to work collaboratively with community members and other organizations.

- 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.

- Ability to use technology to increase 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 departments have important roles to play in ensuring the success of community benefit efforts.

**Community Benefit Leader**

- Lead community benefit team.
- Oversee community health needs assessment and development of implementation strategy.
- Coordinate community benefit planning and participate in integrating it into the organization’s strategic planning process.
- Involve executive and board leaders with 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 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 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.

**Finance**

- Be part of the community benefit team.
- Include community benefit budget in organization’s budget.
- Advise on budget implications of community benefit proposals/plans.
- Track, maintain and report information about community benefit costs.
- Assure that financial information in IRS Form 990, Schedule H and other community benefit reports is complete, accurate and consistent.
- Maintain cost accounting system and provide/review needed data.
- Develop/oversee 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 development/identification/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 for telling the community benefit story.
- Identify a point person for media inquiries related to Schedule H and other community benefit issues.
- Maintain community benefit website.

**Planners**

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

**Legal/Compliance/Audit Control**

- Monitor government requirements related to community benefit and tax-exemption.
- Work with community benefit leader and finance leader to ensure compliance with requirements.
### COMMUNITY BENEFIT ROLES AND RESPONSIBILITIES (continued)

#### CEO/Administration

- Appoint qualified person(s) to lead and staff community benefit operations.
- Assure 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 within 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 community assessment.
- Review results of 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 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 comprised 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/clinical services.
- Population health management.

Other departments you may want to consult with include:

- Social work.
- Research administration.
- Government relations/advocacy.
- Foundation/fund raising.
- Medical/nursing education.
- Legal.
- Grant administration.
- Compliance.
- Physician services.
The workgroup members should:

- Monitor key policies, including financial assistance and billing and collections.
- Help develop and sustain community relationships.
- Participate in community health assessment.
- 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 work group. 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 regards to financial assistance policies and procedures and budgeting for and accurately reporting community benefit.

- **Assessment** – Ensures the organization’s community health needs assessment process is effective in identifying and prioritizing community health needs and meets government requirements.

- **Planning and Implementation** – Provides guidance on selecting interventions to address needs and plans to carry out and evaluate those interventions.

- **Evaluation** – Establishes, monitors and refines, as needed, an evaluation process for community benefit activities and for the overall community benefit program.

- **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.

Budgeting basics:

- 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.
- The budget should include:
  - Total expected costs.
  - Expected sources of revenue (including reimbursement, payments, grants and gifts).
  - Expected shortfall or surplus of revenue over costs.
  - Staffing requirements (both paid and volunteer).

When setting the budget amounts, consider:

- 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 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.

• Value of tax exemption:
  ° Many health care organizations calculate the value of their tax exemption by adding together all the categories of taxes they would have paid as a taxable entity.

• Past efforts:
  ° How much was spent in prior years?
  ° Should you set a higher goal?

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<tr>
<th>EXAMPLES OF BENCHMARKS USED IN BUDGETING</th>
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<tbody>
<tr>
<td>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:</td>
</tr>
<tr>
<td>• Allocating X% total expenses to community health initiatives, Y% net revenue to outreach care initiatives to those living in poverty and Z% of a health system’s investments to an alternative investment program.</td>
</tr>
<tr>
<td>• Setting a community benefit budget at a percentage of operating income.</td>
</tr>
<tr>
<td>• Setting a goal that the financial value of community benefit is greater than what would have been tax liability.</td>
</tr>
<tr>
<td>• Devoting at least X% of gross patient and resident revenues to community and financial assistance services.</td>
</tr>
</tbody>
</table>

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.

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

Community benefit policies:

• 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 approval process needed for community health needs assessments, 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 programs will be evaluated to assure quality and measure effectiveness.

• Policies should describe how community benefit is reported internally and externally, including annual reports, community health needs assessments, implementation strategy (community benefit plan) and the 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.

• Process all financial assistance paperwork 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.

• Communicate policies both internally and externally. Ensure that practices follow policy.

• Unpaid bills should be monitored to determine if patients become eligible for financial assistance or government-sponsored programs.

• Give clear instructions to any billing or collection agency that all persons are to be treated with respect. Monitor collection practices.

• A consistent procedure should be used to convert a bill to charity/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 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 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, 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 www.chausa.org/guideresources for IRS regulations on this topic.

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**

Physician involvement is critically important to effective community benefit programs, especially efforts to improve access to primary care and specialty services. To help engage community or facility physicians, identify a physician champion to be active in planning and carrying out the community benefit program and to recruit others to be involved.

- Encourage attending physicians to take emergency calls for Medicaid and uninsured patients.

- If facilities must pay physicians to accept emergency calls, be sure that written agreements specify that 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.

- Recruit physicians to reflect the demographic makeup of the community.

**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.

- Recognize and celebrate the 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 organization's public policy advocacy agenda should include attention to:

- Expansion of health care coverage and access to health care.
- Health care financing for low-income persons, such as the preservation of Medicaid and other state and local indigent care programs.
- Advocating for policies that promote physical and mental health and well-being through improved housing, nutrition programs, preventive health programs and environmental health.
- Working in coalition with other like-minded organizations in the community.
- Being a voice in the business, philanthropic and general community 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 access to care, 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:

**Other 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 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.

**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.

**STRATEGIES FOR WORKING WITH COMMUNITY ORGANIZATIONS**

According to consultant Arthur T. Himmelman’s *Collaboration for a Change: Definitions, Decision-Making Models, Roles and Collaboration Process Guide*, there are four strategies through which community organizations and larger institutions can work together:

- **Networking** – Exchanging information for mutual benefit.
- **Coordinating** – Exchanging information and altering activities for mutual benefit and to achieve a common purpose.
- **Cooperating** – Exchanging information, altering activities and sharing resources for mutual benefit and to achieve a common purpose.
- **Collaborating** – Exchanging information, altering activities, sharing resources and enhancing the capacity of another for mutual benefit and to achieve a common purpose.

More information is available in the 2004 revised edition of *Collaboration for a Change*, available free of charge from Himmelman Consulting. Contact ArthurTHimmelman@aol.com.
The Health Research & Educational Trust (in Partnership with AHA) and the Robert Wood Johnson Foundation have developed resources to help hospitals understand their role in building “a culture of health” where all people have the opportunity to live longer, healthier lives, whatever their background. 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 HPOE.org to access these resources.

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

- **Mission Alignment**
- **Leadership Commitment**
- **Resources**
- **Needs**
- **Readiness**
- **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
Guideline 6
Evaluate the organization’s overall community benefit approach and strategy

Organizations should evaluate their overall community benefit program and infrastructure 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 program with their community health needs assessment. 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)?

- Does the program have administrative and governing board support?

- Is there sufficient involvement with the community? How might collaborations and partnerships be improved? Visit 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.*

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**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 reach out to 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:
Chapter Four: Accounting for Community Benefit
Chapter Four: Accounting for Community Benefit

Standardized accounting of community benefit allows policy makers, 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 policy makers, regulators and the public to compare hospital community benefit reports accurately, 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 Internal Revenue Service (IRS) Form 990, Schedule H for Hospitals (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.
Chapter 4: Accounting for Community Benefit

The chapter is organized into four sections:

In Section 4.1, **Introduction**, you will learn about:

- Why standardized accounting and reporting is important.
- How these guidelines have been updated since the 2012 edition of *A Guide to Community Benefit Planning and Reporting*.

In Section 4.2, **Adopt Standardized Principles and Practices to Account for Community Benefit**, you will learn about the principles that underlie this accounting framework, including guidelines to:

**Community Benefit Cost Measurement Principles**

- Measure actual financial cost, not opportunity cost.
- Account for total and net community benefit expenses.
- Account for indirect costs as well as direct costs.
- Use the organization’s most accurate cost accounting methods.
- Split program costs between community benefit and other purposes if warranted.

**Community Benefit Accounting Principles**

- Avoid double-counting community benefit expenses.
- Follow “Generally Accepted Accounting Principles” (GAAP) unless IRS instructions override those principles.
- Report surpluses if offsetting revenue exceeds total community benefit expense.
- Maintain an audit trail.

**Community Benefit Reporting Principles**

- Report consistent values for “number of programs or activities” and for “number of persons served.”
- Develop appropriate community benefit accounting and reporting strategies for related organizations.
- Disclose accounting methods in community benefit reports.
- Reconcile and report differences in community benefit reports.
In Section 4.3, **Account for and Report Community Benefit**, you will learn how to:

- Establish an effective administrative and accounting process.
- Calculate the cost of community health improvement services.
- Calculate the cost of community benefit operations.
- Determine the cost of health professions education.
- Include the cost of research that provides community benefit.
- Quantify cash and in-kind contributions for community benefit.
- Measure the cost of community-building activities.
- Calculate the ratio of patient care cost to charges.
- Establish the cost of subsidized health services.
- Determine the cost of Medicaid and other means-tested government programs.
- Determine the cost of financial assistance.

In Section 4.4, **Alignment with IRS Form 990, Schedule H**, you will learn about how the CHA guidelines clarify and compare to certain Schedule H community benefit reporting formats and instructions:

- Review and understand how CHA’s community benefit accounting guidelines supplement and vary from IRS requirements.
- 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:
  - Approaches to developing indirect cost factors.
  - 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 principles behind community benefit accounting and provides help in navigating the accounting and reporting process.
INTRODUCTION

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 reliably to assess trends in their community benefit investments.
- Multi-entity hospital systems frequently “roll up,” or 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, that 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 and calculations for reporting the dollar value of the community benefits they provide. The incorporation of community benefit reporting into Schedule H thus also promotes standardization.
Changes in the 2015 edition

The guidelines in this edition incorporate several updates from the 2012 edition of the Guide. Schedule H and the Schedule H instructions have changed since the form first was published.

The updates included in this edition of the Guide reflect changes incorporated into tax year 2014 Schedule H instructions that were released in final form by the IRS in December, 2014.

What has not changed

Many core accounting guidelines have remained the same:

- Community benefit is to be measured on the basis of actual cost to the organization.
- Organizations should avoid double-counting community benefit costs. For example, revenues and costs associated with Medicaid and financial assistance should be subtracted from values reported for subsidized health services because Medicaid and financial assistance are reported elsewhere in full.
- Indirect (overhead) costs are to be included in every category of community benefit, except cash and in-kind contributions.
- Organizations are encouraged to use the most accurate cost-accounting methods they have available.
- The total and net costs of community-building activities are to be accounted for and reported as community benefit (except on Schedule H, where community-building activities are to be recorded in Part II).
- In their own community benefit reports, organizations continue to have the option of reporting community benefit in two categories:
  - Community benefit primarily for persons living in poverty.
  - Community benefit primarily for the broader community.

See Chapter 2 for guidelines on distinguishing between these categories.

Some organizations do not distinguish between these categories when they report quantifiable community benefits. Others find the distinction provides valuable focus on resources devoted to persons in the community who are living in poverty.

Schedule H does not report community benefits in these two categories.
• Organizations are to include their proportionate share of community benefits provided by joint ventures in which they participate. This “proportionality rule” also applies to the “total expense” figure that is the denominator for calculating “percent of total expense” and to Medicare and bad debt amounts reported in Part III of Schedule H. To avoid double counting, organizations may not report their proportionate shares of community benefit or community-building amounts provided by joint ventures, if those activities have been funded by a community benefit grant from the same organization (e.g., if the hospital has provided a reportable grant to a joint venture in which it participates).

• Only cash and in-kind donations that have been restricted to be used for community benefit activities and programs (as specified in Chapter 2) may be reported as community benefit. Even if the recipient is an organization whose sole purpose is to provide hospital community benefit (e.g., a free clinic), the donations may not be reported on Schedule H as community benefit unless the funds are restricted by the organization to a community benefit purpose. To facilitate alignment with Schedule H requirements, donations that support community-building activities are to be reported in that category, rather than as a “cash and in-kind donation for community benefit.”

• In community benefit reports, Medicare and bad debt are not to be reported as community benefit but can be disclosed “below the line.” On Schedule H, Medicare-funded community benefit activities are included as community benefit on a programmatic basis (e.g., in subsidized health services, health professions education, and research) and bad debt is not to be reported under any circumstances. On Schedule H, organizations are to report Medicare revenues and costs net of any amounts already properly reported as community benefit. That means subtracting from the Medicare revenues and costs reported in Part III of Schedule H any amounts included in Part I (in the subsidized health services, health professions education, research and any other categories). The guidelines in this chapter align with that requirement.
What has changed

Those familiar with the 2012 edition will notice that the guidelines in this chapter incorporate several changes to assure that they align with Schedule H requirements as of tax year 2014:

- The CHA guidelines clarify that financial assistance does not include self-pay or prompt-pay discounts.

- Restricted grants and contributions used for a community benefit purpose ("net assets released from restrictions") must be included as “direct offsetting revenue” and subtracted from total community benefit expense when calculating net community benefit expense.

- Physician clinics only may be reported as subsidized health services if the hospital generates losses both on the hospital (technical) component of the service as well as the physician (professional) component of the service.

- To be reported on Schedule H, contributions or grants made by hospitals for community benefit must be restricted in writing to a community benefit purpose.
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 actual financial cost borne by the organization, not 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 revenue forgone, are theoretical and not treated as actual cost in financial statements.

Examples of how community benefit activities are valued differently under the two approaches can be seen in the following table.
<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>OPPORTUNITY COST (DO NOT REPORT)</th>
<th>ACTUAL FINANCIAL COST (REPORT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space provided to a community group</td>
<td>Market rate the community group would pay at a local hotel</td>
<td>Actual cost of the space (building depreciation, utilities, security) while in use by the community group</td>
</tr>
<tr>
<td>Financial assistance</td>
<td>“Gross charges” that could have been collected if financial assistance had not been granted</td>
<td>Patient care cost associated with the charges written off to financial assistance</td>
</tr>
<tr>
<td>Parking vouchers given by the hospital to low-income patients</td>
<td>Face value of the parking vouchers given to low-income patients</td>
<td>Actual cost of the parking garage per space while in use</td>
</tr>
</tbody>
</table>

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 also is important to assuring that both the numerator and the denominator of the statistic – “Net Community Benefit Expense as a percent of 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 accounting report.
Chapter 4: Accounting for Community Benefit

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 neither reported as community benefit expense nor 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 $1,000,000 to renovate a clinic building that houses a community benefit program. The full $1,000,000 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 ($1,000,000 divided by 10 years) as depreciation expense, and thus would spread the cost associated with the $1,000,000 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:

- Total community benefit expense: What amount and proportion of the organization’s total expenses are devoted to community benefit programs?

- Net community benefit expense: How much of the organization’s total community benefit expense is being funded by its own surplus?

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

“Direct offsetting revenue” is generated directly by the activity or program, e.g., payer reimbursement or user fees and also includes restricted grants or contributions used to support the activity or program. The IRS provides definitions of these terms in the Schedule H instructions.
**IRS NOTE**

*From the Schedule H instructions:*

“Total community benefit expense” means the total gross expense of the activity incurred during the year.

“Net community benefit expense” is “total community benefit expense” minus “direct offsetting revenue.”

“Direct offsetting revenue” means revenue from the activity during the year that offsets the total community benefit expense of that activity, as calculated on the worksheets for each line item.

“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.
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.

<table>
<thead>
<tr>
<th>Number of Programs or Activities</th>
<th>Persons Served</th>
<th>Total Community Benefit (CB)</th>
<th>Total CB as Percent of Total Expense</th>
<th>Direct Offsetting Revenue</th>
<th>Net CB Expense</th>
<th>Net as Percent of Total Expense</th>
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</thead>
<tbody>
<tr>
<td><strong>BENEFITS FOR PERSONS LIVING IN POVERTY</strong></td>
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<td>Financial assistance at cost</td>
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<td>Means-tested public programs</td>
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<tr>
<td>• Medicaid</td>
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<tr>
<td>• Other indigent programs</td>
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<td>Community health improvement services</td>
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<td>Health professions education</td>
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<td>Subsidized health services</td>
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<td>Cash and in-kind contributions for community benefit</td>
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<tr>
<td>Community-building activities</td>
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<tr>
<td><strong>Total quantifiable community benefits for persons living in poverty</strong></td>
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(continued)
## Chapter 4: Accounting for Community Benefit

### BENEFITS FOR THE BROADER COMMUNITY

<table>
<thead>
<tr>
<th>Description</th>
<th>Number of Programs or Activities</th>
<th>Persons Served</th>
<th>Total Community Benefit (CB) Expense</th>
<th>Total CB as Percent of Total Expense</th>
<th>Direct Offsetting Revenue</th>
<th>Net CB Expense</th>
<th>Net as Percent of Total Expense</th>
</tr>
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<tbody>
<tr>
<td>Community health improvement services</td>
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<td>Health professions education</td>
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<tr>
<td>Subsidized health services</td>
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</tr>
<tr>
<td>Research funded by tax-exempt sources</td>
<td></td>
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</tr>
<tr>
<td>Other research studies intended for publication(^1)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cash and in-kind contributions for community benefit</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Community-building activities(^2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Community benefit operations</td>
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</tr>
</tbody>
</table>

**Total quantifiable community benefits for the broader community**

**TOTAL QUANTIFIABLE COMMUNITY BENEFITS**

---

1. 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 indirect (or “overhead”) costs should be included in the accounting for each type of community benefits except cash and in-kind contributions. The IRS supports this view.

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 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 studies conducted by the finance department. These factors are applied to direct costs as follows.

The indirect cost factor typically is expressed as a percentage:

\[
\frac{\text{Total Indirect and Direct Costs}}{\text{Direct Costs}} - 1 = \text{Indirect Cost Factor}
\]

The factor then is applied as follows:

\[
\text{Direct Costs} \times (1 + \text{Indirect Cost Factor}) = \text{Total Community Benefit Expense}
\]
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 patient populations 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 Schedule H instructions.
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.

For example, if during the course of a year, a hospital foundation operating under the same EIN (Employer Identification Number) as the hospital commits 60 percent of funds raised to community benefit and invests the other 40 percent in a new wing, then 60 percent of the foundation's administrative costs can be reported in the “community benefit operations” category.
Community benefit accounting principles

Guideline 6
Avoid double-counting community benefit expenses

Community benefit costs should 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 recommended “ratio of patient care cost to charges” includes adjustments designed to prevent double-counting community benefit expenses. The recommended accounting for subsidized health services also adjusts 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 Generally Accepted Accounting Principles (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 990 Core Form 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 be reported on an “EIN by EIN” basis (aggregating results for hospitals and any other activities operated 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 990 Core Form. “Total expense” reported on the 990 Core Form is different than 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 gains if offsetting revenue exceeds total community benefit expense

If offsetting revenue exceeds total community benefit expense resulting in a gain, Schedule H requires it to be reported as “negative net community benefit expense.” To align with Schedule H, CHA recommends that organizations follow this practice in all community benefit reports. For example, if the Medicaid net patient service revenue exceeded the cost associated with treating Medicaid patients, the net community benefit expense would be negative.

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 footnoted carefully so readers understand why “negative community benefits” are being reported.

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, supporting work papers and community benefit software such as CBISA and must reconcile to the organization’s general ledger.
Guideline 10
Report consistent values 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 where 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 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 values.
<table>
<thead>
<tr>
<th>COMMUNITY BENEFIT</th>
<th>NUMBER OF PROGRAMS OR ACTIVITIES</th>
<th>NUMBER OF PERSONS SERVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assistance</td>
<td>One for each hospital/facility</td>
<td>Number of inpatient and outpatient accounts</td>
</tr>
<tr>
<td>Medicaid</td>
<td>One for each state Medicaid program (whether fee-for-service or managed care) in which each hospital/facility participates</td>
<td>Number of inpatient and outpatient accounts</td>
</tr>
<tr>
<td>Other Means-Tested</td>
<td>One for each means-tested government program</td>
<td>Number of inpatient and outpatient accounts</td>
</tr>
<tr>
<td>Community Health Improvement Services</td>
<td>One for each discrete program</td>
<td>Options:</td>
</tr>
<tr>
<td></td>
<td>A “program” has the following characteristics: same target audience, same purpose, same approach (including an activity with multiple facets)</td>
<td>• Number of attendees at each program event</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ongoing program: number of registrants or enrollees</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For broad community/public education programs, “one” unless there is a response mechanism to gauge actual attendance</td>
</tr>
<tr>
<td>Community Benefit Operations</td>
<td>Usually “one” for each dedicated community benefit department</td>
<td>NA</td>
</tr>
<tr>
<td>Community-Building</td>
<td>One for each discrete program</td>
<td>When program is for individuals, use enrollment, attendance or encounters</td>
</tr>
<tr>
<td></td>
<td></td>
<td>When program is for overall community, use “one” unless there is a mechanism to indicate how many benefited</td>
</tr>
<tr>
<td>COMMUNITY BENEFIT (continued)</td>
<td>NUMBER OF PROGRAMS OR ACTIVITIES (continued)</td>
<td>NUMBER OF PERSONS SERVED (continued)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Subsidized Health Services</td>
<td>One for each qualifying program or service</td>
<td>Number of inpatient and outpatient accounts (for each hospital and facility, including appropriate proportions of joint ventures)</td>
</tr>
<tr>
<td>Health Professions Education</td>
<td>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, one for each scholarship program</td>
<td>Number of students Number of attendees at approved continuing medical education programs Number of persons receiving scholarships</td>
</tr>
<tr>
<td>Research</td>
<td>One for each qualifying research study or investigation</td>
<td>NA or alternatively the number of subjects in the study</td>
</tr>
<tr>
<td>Contributions for Community Benefit</td>
<td>One for each grant made by the organization</td>
<td>NA</td>
</tr>
</tbody>
</table>

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 other organizations 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, do 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 assure 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 community benefit expense. In these circumstances, the system office (or recipient organizations) should be sure to provide the paying hospital organizations with adequate documentation to show that such amounts were actually used for community benefit purposes. If the hospital has a separate, related foundation entity that files its own 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 (e.g., foundation activities and hospital activities are “housed” in the same non-profit corporation), transfers of funds from the foundation to the hospital for community benefit activities will not be separately recognized or 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.

• Where the hospital and foundation activities are conducted by separate but related organizations, each with its own EIN (e.g., the foundation activities and hospital activities are “housed” in different non-profit corporations that share common governance), grants or transfers of funds from the foundation to the hospital that are restricted to be used for community benefit activities will be separately recognized and reported as they are “inter-company” transfers. In this case, the foundation will report the grant to the hospital as expense on its 990 Core Form and the hospital will report the receipt of such funds as grant revenue on its 990 Core Form. 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 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 principal accounting methods used to prepare the information. Such notes can indicate, for example, whether the report was prepared pursuant to CHA guidelines or whether certain exceptions were made. This is so readers of the information understand how reported amounts were determined. The IRS requires such disclosures in Part VI of Schedule H.

CHA also encourages organizations to include information about financial assistance policies and the community health needs assessments 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 frequently 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 is important always to follow state requirements when preparing state required forms and reports. Complying with state and federal instructions may well require 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.
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:

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

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.

*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 expert in community benefit accounting and serve as an ongoing resource to other community benefit colleagues.

More frequent data compilation helps programs from being missed or forgotten, allows active community benefit program monitoring and facilitates mid-year course corrections. On the other hand, monthly procedures can be resource-intensive both for accounting/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 the Worksheet 4 included in the Schedule H instructions, CHA's Worksheet 4a includes columns for direct expense and indirect expense.
Organizations frequently establish direct expense by multiplying the number of hours staff worked on each program while on the organization's payroll by an hourly wage statistic, and then by adding in factors for employee benefit costs, adding direct supplies costs, and then by adding any other costs that can be directly assigned to the service. The “hourly wage statistic” is most accurate if it is department- or program-specific, rather than facility-wide.

Indirect expense is included based on the indirect cost factors discussed in Section 4.2, Guideline 3. Donations made by the organization to support community health improvement services are reported as cash and in-kind contributions for community benefit.

**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 fund raising 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 operations or other activities.
- The other costs associated with community benefit operations such as educational programs.

Some hospital organizations are able to assign the cost of community benefit department staff directly to programs on which they work. In those circumstances, care should be taken not to count the cost of those staff twice – once as community benefit operations expense and again as part of the direct cost of one or more programs.

Multi-hospital systems are finding it helpful to allocate the cost of any community benefit operations incurred by the system/corporate to system hospitals. This allows each affiliated hospital to include these costs in its community benefit reports, including 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 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 ...
Direct costs of health professions education include:

- Stipends, fringe benefits of interns, residents, and fellows in accredited graduate medical education programs.
- Salaries and fringe benefits of faculty directly related to intern and resident education.
- Salaries and fringe benefits of faculty directly related to teaching:
  - of 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 but not limited to programs in pharmacy, occupational therapy, dietetics, and pastoral care,
  - continuing health professions education 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 post-doctoral 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 (CHGME), 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 true cost implications of these activities. Having students on-site may not materially affect staff productivity. The 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.

Guideline 5
Include the costs of research that provides community benefit

Worksheet 7 portrays community benefit accounting for research. For the time being, 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 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. CHA encourages hospital organizations to report separately the costs they incur for research studies that are intended for publication and that are funded by 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 organizations’ 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 in the community benefit table on Schedule H, but the instructions indicate that this type of research may be described in Part VI of Schedule H.

As of this 2015 version of the Guide, Worksheet 7 (and other worksheets) include a new 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 valued 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 is to be valued in terms of “net assets released from restrictions.” Spending the funds on their designated purpose (e.g., research or a community health improvement program) releases the restrictions.

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

Many 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 group 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 to be reported on Schedule H, contributions for community benefit:

- Must be restricted in writing by the organization to a community benefit purpose. That means the hospital has provided a letter or other documentation that requires the recipient of the contribution to use the support for an activity or program that meets the definition of “community benefit.” Unrestricted grants or gifts may not be reported as community benefit.

- May not include loans, advances or, as stated in Schedule H instructions:
“contributions to the capital of another organization that are reportable in Part X of the core Form 990.” Part X of 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.

• Also may not include “any payments the organization makes in exchange for a service, facility, or product, or that the organization makes primarily to obtain an economic or physical benefit.” Some organizations have raised questions about whether PILOTs (payments in lieu of taxes) are reportable as community benefit contributions. PILOTs payments generally are made to local governments in lieu of paying property tax. 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 and/or the amount of public services (e.g., fire and police protection) the organization uses.

While paying PILOTs relieves government burden, these payments generally do not explicitly address a community health or public health need, and Schedule H instructions explicitly do not allow reporting them if they are made “to prevent or forestall local or state property tax assessments.” In CHAs view, these payments may be counted as community benefit only if you can demonstrate that they are provided voluntarily (i.e., out of a sense of “disinterested generosity”) and that they are used by government for a program or service that the hospital otherwise might provide as part of its community benefit program – for example, if the organization pays the city to support or sponsor a clinic for the uninsured. If there is any “quid pro quo” involved – meaning that by providing the PILOT, the hospital is reducing or eliminating the risk that it will be assessed property taxes or fees for government services, then the amounts are disqualified from being reported as community benefit.

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).

You must be able to document in writing that the organization restricted each contribution to one or more community benefit purposes (for example by including a letter with the contribution). 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.
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 that are incurred by the organization to maintain the space – in other words, the “break-even rate” the organization would charge the community group.

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 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 could be reported.

Staff time for hourly employees that 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 employee is participating during paid work time rather than on his or her own time, and if participation in these activities is part of the individual’s job responsibilities. The case for inclusion is stronger if job descriptions for salaried 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 some community-building activities that meet the definition of community benefit may be reported as community health improvement. Cash and in-kind contributions made by the organization for community-building activities should be reported on Worksheet B.
Guideline 8
Calculate the ratio of patient care cost to charges

Worksheet 2 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 is designed to account for the cost of activities that generate “other operating revenue.” Some organizations use “other operating revenue” itself as a proxy for the cost of these activities, and Schedule H instructions support that approach. Others are able to account explicitly for these costs and do not need to rely on a proxy value. Organizations are encouraged to use the most accurate approach they have available.

• Record in Line 3 any bad debt expense that is in “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 when 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 “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/or financial assistance worksheets.

• Line 5 is where the total cost of certain community benefit activities and programs that have been determined without using the ratio of patient care cost to charges is recorded (such as health professions education, qualifying research, community benefit operations and others). These costs are deducted from total expense 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 “total operating expense,” they should not be adjusted out of the numerator of the 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 requirements.

**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 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 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 is requiring organizations to disclose whether any physician clinic costs have been included in subsidized health services, and also requires that the hospital generates losses both on the hospital (technical) component of the service as well as the physician (professional) component of the service before physician clinics can be reported.

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<th>IRS NOTE</th>
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*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 also bad debt amounts then are 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 Schedule H and “below the line” as recommended in the CHA guidelines. As specified in 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**

The losses or gains 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 Worksheet 3 will yield a negative net community benefit expense. This may occur for organizations with substantial amounts of Medicaid Disproportionate Share Hospital revenue, large Delivery System Reform Incentive Payments (DSRIP), or with 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 any negative net community benefit expense is important. Worksheet 3 thus includes a row for recording prior-year revenue.

Include any Medicaid Disproportionate Share Hospital (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 in your state DSH or UPL funds are designated to offset the cost of financial assistance, those dollars are 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 Patient Protection and Affordable Care Act of 2010 (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 a hospital organization exempt under 501(c)(3) of the Internal Revenue Code “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.” Final regulations for Section 501(r) indicate the following represent “extraordinary collection actions:”

- Taking actions that require 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 (FAP).

Please check the IRS and/or CHA websites for updates regarding the 501(r) regulations.
The Healthcare Financial Management Association (HFMA), American Hospital Association (AHA) 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 truly have the inability 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.


HFMA also has developed an Example Financial Assistance Policy, which is available at [http://www.hfma.org/workarea/DownloadAsset.aspx?id=21436](http://www.hfma.org/workarea/DownloadAsset.aspx?id=21436).
ALIGN REPORTING WITH IRS FORM 990, SCHEDULE H

Schedule H was 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 including community-building activities in community benefit reports, in particular since it now is clear that certain activities are allowed to be reported on Schedule H, Part I.

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 990 Core Form. This allows tracking “community benefit as a percent of total expense” throughout the year rather than needing to wait until the 990 Core Form 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 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.

• Separate column for industry-funded research studies that are intended for publication or that have been published.

• The amount of Medicare revenues and costs included in each subsidized health service.

• Separate columns for research studies that are funded by tax-exempt sources and for industry funded studies intended for publication.

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.

Definitions in this Chapter

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
According to the IRS, 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 FASB (Financial Accounting Standards Board) or the AICPA (American Institute of Certified Public Accountants).

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

Source: Schedule H instructions.

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.

**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 (for example, single-member limited liability company of which the organization is the sole member). Revenues, expenses, other activities of the disregarded entity flow to the owner.

*Source:* Adapted from Glossary to IRS Form 990. See Regulations sections 301.7701-2 and 3 for more information.

**GAAP (Generally Accepted Accounting Principles)**
The principles set forth by the Financial Accounting Standards Board (FASB) and the American Institute of Certified Public Accountants (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**
“Gross Patient Charges” means the total charges at the organization’s full established rates for the provision of patient care services before deductions from revenue are applied.

*Source:* Schedule H instructions.

**Indirect Costs**
“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). Indirect costs do not include the estimated cost of “indirect medical education.” (Source: Schedule H instructions). Because the costs are shared, they are allocated to activities or programs using various cost accounting methods.

**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 community benefit expense would be $1,000 if the computer was purchased for $3,000 and after two years of use it has depreciated to a value on the books of the hospital of $1,000.
Joint Venture
An entity or contractual undertaking that involves two or more parties. The IRS Form 990 Glossary defines Joint Venture as: “unless otherwise provided, a partnership, limited liability company, or other entity treated as a partnership for federal tax purposes, as described in Regulations sections 301.7701-1 through 301.7701-3.” 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.

Medicaid Provider Taxes, Fees, and Assessments
Almost all states have some form of Medicaid provider tax (or fees and assessments) in place. As of May 2011, hospital provider taxes are assessed in over thirty 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 yields 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.”

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 (EIN)
The entity that files IRS Form 990. Note that an “organization” may include one or more hospitals and non-hospital activities such as a foundation, physician practices, 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.
PILOTs
Payments made by an organization “in lieu of taxes.” These payments generally are made to local governments in lieu of paying property tax. 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 and/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,” e.g., 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 (Source: Adapted from Glossary to IRS Form 990):

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

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 PILOTs, 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 tax.

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:

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Chapter Five: Planning and Implementing Community Benefit Programs

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 community health needs assessment and planning was reinforced by the Affordable Care Act, enacted March 2010. The law added requirements for tax-exempt hospitals to conduct community health needs assessments and to adopt implementation strategies to meet the community health needs identified through the assessments.

In Section 5.1, Assess Needs and Assets, you will learn how to:

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

In Section 5.2, Develop an Implementation Strategy, you will learn how to:

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

In Section 5.3, Develop and Implement Program Plans, you will learn how to:

1. Develop program plans.
2. Determine implementation readiness.
3. Develop a management plan.
4. Promote the program.
5. Put plans into action
7. Sustain the program.
ASSESS NEEDS AND ASSETS

A community health needs assessment (CHNA) is a systematic process involving the community, to identify and analyze community health needs and assets in order 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.

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.

In order 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:
  - 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; and
  - 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 (www.chausa.org/communitybenefit) for federal regulations and instructions and a description of state requirements.

**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 internal assessment team** – Select a hospital staff person to lead the assessment effort or to be the hospital’s lead in a community-led 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. Some hospital organizations also invite community members, public health department representatives and other community partners to join their internal team. These team members will bring key skills (planning, analysis, communications) and knowledge of the community to the assessment process.

**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 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.

**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 community health needs assessment is to improve community health. Related purposes include community-based planning or hospital strategic planning, gathering information for grant applications or to fulfill tax-exemption and other obligations such as achieving nurse “magnet” status and/or the Baldrige 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 uncovering health needs. The assessment process can be used to develop consensus about problems and priorities and to gain 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, and provide 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).

**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 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.

### 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.

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<th>AGREE ON THE DEFINITION OF COMMUNITY</th>
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<td>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.</td>
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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 (for example, 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:
  • Having at-risk populations.
  • With limited access to health care resources/professionals.
  • Impacted by adverse social/economic/environmental factors such as high unemployment, unsafe housing, failing schools or presence of high levels of toxic materials.

• Populations that are commonly considered to be at-risk or vulnerable, such as:
  • 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.

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, accessibility of healthy food, unsafe housing, and the presence of persistent and/or toxic materials). These are commonly known as the determinants of health.

IRS NOTE

In defining the community IRS regulations state that the hospital may take into account all of the relevant facts and circumstances, including the geographic area served by the hospital, 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) (Brownson, et al. 106).

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 does 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 ([http://quickfacts.census.gov/](http://quickfacts.census.gov/)) provides county-level demographic information for all U.S. counties and compares county values to state values. Visit the website of U.S. Census Bureau ([http://www.census.gov/main/www/access.html](http://www.census.gov/main/www/access.html)) to view a complete list of online data access tools that can be used to access census data.

Also check with your hospital administration or strategic planning office to see if they have purchased demographic files for market research or business planning purposes. They 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.
- Health status of overall population and priority populations.
- Risk factor behaviors and conditions related to top 10 causes of death.
- Child health.
- Infectious diseases.
- Social environment.
- Natural environment.
- Resources/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.

- **Organizational needs and priorities** – 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 to 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 and county level is routinely collected by governmental and non-governmental 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.

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.

For a comprehensive list of national, state and local data sources visit the website of Partners in Information Access for the Public Health Workforce, a collaboration of U.S. government agencies, public health organizations, and health sciences libraries which provides timely, convenient access to selected public health resources, at http://phpartners.org/health_stats.html.

National level data

Examples of national data sources include the Center for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System and National Health and Nutrition Examination Survey as well as national data initiatives that provide community health through a standard interface such as County Health Rankings (www.countyhealthrankings.org) and the Community Health Data Initiative (www.healthindicators.gov).

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-level data. Contact your 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.
County and other local data sources

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

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, or 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/community health improvement activities. What needs are they addressing and do the needs persist? Information about these needs should be factored into your community health needs assessment 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 http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx.

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 a community coalition already addressing these issues?
- What factors may be contributing to health problems?

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**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.”

Internal Revenue Service (IRS) regulations indicate that in order 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 health (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 at risk of not receiving adequate medical care as a result of being uninsured or under insured 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 but not limited to, 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 community health needs assessments 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 a 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.

There may be instances where your organization may need to use surveys to collect quantitative health data about your community that is not available from secondary data sources. However, public health experts recommend caution in using original unproven surveys for documentation of quantitative information, such as the prevalence of obesity in your community. To produce statistically valid results an original survey would need to use validated questions and scientific sampling methods, which can be very difficult and expensive to do.

**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 input from community members, leaders and public health experts one-on-one. 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 in order to elicit a full range of responses.

Key informants may include leaders of community organizations, service providers, and elected officials. Individuals with a 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, 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 towards priority populations or involve the broader community. Community forums may require a skilled facilitator.

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.

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, associations and institutions. Assessing assets allows you to focus on the strengths of your community, including capacity, skills and the resources available to address identified needs.

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 developed by Kretzmann and McKnight provides a framework from which to consider your community’s assets. Consider including questions about community assets in your efforts to collect community input.
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 in order 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/the state/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 and/or state level.

Comparisons showing areas where 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 2020 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?

In order 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 indicate 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 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.

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

**Identify disparities**

When available, data grouped by demographic factors such as race, income 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.

**Identify and understand causal factors**

In order 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:

- Density/availability/number of parks and community gardens.
- Availability of healthy food.
- Physical activity level of residents in the community.

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, 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.

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 needs the hospital will address itself; the needs the hospital will address with others; and those 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 the other 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.
Chapter 5: Planning and Implementing for Community Benefit Programs

**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.

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**Determine who will be involved in the setting of priorities**

For most hospitals, its 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 and 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:

1. Magnitude: the number of people impacted by the problem.
2. Severity: the risk of morbidity and mortality associated with the problem.
3. Historical trends.
4. Alignment of the problem with the organization’s strengths and priorities.
5. Impact of the problem on vulnerable populations.
6. Importance of the problem to the community.
7. Existing resources addressing the problem.
8. Relationship of the problem to other community issues.
10. Value of immediate intervention vs. any delay, especially for long-term or complex threats.
EXAMPLE OF CRITERION 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”:

- Problem is greater in the county compared to state or region.
- We can reduce long-term cost to the community by addressing this problem.
- We can create a major improvement in the quality of life by addressing this problem.
- We can solve this problem.
- We can do something about this problem with existing leadership and resources.
- 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 include:

- **Ranking** – The priority-setting group is asked to rank identified needs with a numerical score based on the criteria established earlier.

- **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 identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs.

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.

**VALIDATE PRIORITIES**

Validation 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 (McKenzie, Neiger and Smeltzer 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 both needs, 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 to 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 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.
  
  - 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 (for example, whether through meetings, focus groups, interviews, surveys, 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 identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health 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 the hospital’s prior CHNA(s).

See a template of an assessment summary report on the CHA website at 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.

See list of community partners in Chapter 3, Guideline 5 for possible groups/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.

Finally, 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.

**IRS NOTE**

Federal law states that assessment 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 Web site at least until the date the hospital has made widely available on a Web site its two subsequent CHNA reports; and

- 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 definition of “widely available on a Web site.”
DEVELOP AN IMPLEMENTATION STRATEGY

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

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<thead>
<tr>
<th>IRS NOTE</th>
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<tbody>
<tr>
<td><strong>Ways to demonstrate community need:</strong></td>
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<tr>
<td>The instructions for the IRS Form 990, Schedule H for Hospitals state that community need may be demonstrated through the following:</td>
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<tr>
<td>• A community needs assessment developed or accessed by the organization.</td>
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<tr>
<td>• Documentation that demonstrated community need or a request from a public agency or community group as the basis for initiating or continuing the activity or program.</td>
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<tr>
<td>• The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or programs.</td>
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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 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. In order 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.
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 including 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:

• Senior leader responsible for community benefit.

• Community benefit or outreach program director or staff member.

• 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/resource issues.

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, time lines and other implementation details.
- Collecting information about existing assets/programs that the implementation strategy can build upon.
- Establishing and maintaining community partnerships and/or relationships.
- Selecting interventions to address community health needs.
- Being a champion for the implementation strategy within and outside the hospital.
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).

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 are the contributing factors 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?
- What social, economic or environmental factors are at play, such as poverty, low performing schools, inadequate housing or other “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.

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**HEALTHY PEOPLE, IRS REGULATIONS AND THE SOCIAL DETERMINANTS OF HEALTH**

The U.S. Department of Health and Human Services recognizes that individual and population-level health is influenced by the relationships between policymaking, social factors, health services, individual behavior and biology and genetics. For this reason, they have chosen social determinants of health as one of its topics for Healthy People. To learn more visit [www.healthypeople.gov](http://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.
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.


OUTCOME | CAUSAL FACTORS | ROOT CAUSES
--- | --- | ---
OBESITY | Too few calories out | Sedentary work, No sidewalks, Fear of crime, Fast moving traffic
 | | Too many calories in | Lack of access to healthy foods, No farmers’ market nearby, Limited transportation options
 | | | Limited nutrition knowledge and information
 | | | Access to calorie-dense, nutritionally poor foods
 | | | Childen can’t walk to school
 | | | Little leisure-time physical activity
 | | | Disinvestment from poor neighborhoods
 | | | Infrquent public buses
 | | | unwilling to walk further
 | | | Deed restrictions
 | | | No sidewalk
 | | | Fear of crime
 | | | Consumer demand
 | | | Time pressure
 | | | Zoning rules
 | | | Many fast food outlets
 | | | Limited transportation options
 | | | No farmers’ market nearby
 | | | No full service grocery stores nearby
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:

- **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.

- **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.

- **Mutually reinforcing activities** – Participants focus on activities that are in their area of expertise and those activities are coordinated in a way to support and coordinate with the action of others.

- **Continuous communication** – Regular meetings to build up trust and relationships among participants.

- **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.


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 towards 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:

- Work 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.
- Work for early identification of the problem (secondary prevention). This could include testing children and treating them as early as possible after exposure.
- Treat 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 that addresses the different factors that affect health. These factors include individual behavior, social supports and community and health policies (Brownson et al. 210). Keep this in mind as you consider your intervention approach for selected problems.
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, 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, 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 http://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:

- Community Health Improvement Navigator, CDC (http://www.cdc.gov/chinav/database/index.html).
- Evidence-based Practice Centers, AHRQ (http://www.ahrq.gov/clinic/epc/).
- Guide to Community Preventive Services, CDC (www.thecommunityguide.org).
- The Cochrane Collaboration (http://www.cochrane.org/).
- County Health Rankings and Roadmaps (www.countyhealthrankings.org/).
- Healthy People interventions and resources (www.healthypeople.gov).
- Healthy Communities Institute (www.healthycommunitiesinstitute.com).

When looking at evidence-based practices that have been successful elsewhere, consider:

- Characteristics of the population where the program was used; do those characteristics 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?

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<tr>
<th>CONSIDER ALL INFORMATION WHEN SELECTING INTERVENTIONS</th>
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<td>“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, <em>The Cochrane Collaboration</em>)</td>
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**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 and/or refocusing existing programs to meet prioritized health needs. Collect information about community assets and hospital programs at this time if it was not done earlier in the assessment process.

Examples of existing assets/programs that could be expanded to meet prioritized needs include:

- If parish nurses are taking blood pressures and doing hypertension education after Sunday services, could they add diabetes testing and education?
- If the hospital has a pediatric dentistry program, could it be expanded to serve adults?
• If the local schools have self-esteem classes for low-income girls, could education about diet and exercise be incorporated 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/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.

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 by securing outside funding. Also consider how the organization can reallocate internal resources for these approaches. For example, redistributing funds previously earmarked for financial assistance but that may no longer be needed because of decreasing requests for charity care, or redirecting 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 result in 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 and/or community resources to carry out the approach/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?

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 (for example, 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 their Schedule H.

The written summary will be used by the organization’s leaders to understand and communicate the goals, objectives and approaches their hospital will undertake to address community needs, and 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.

- **Community served** – The geographic areas and populations that will be addressed by the implementation strategy.

- **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.

- **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 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:

- Need being addressed by others.
- Insufficient resources (financial and personnel) to address the need.
- Issue is not a priority for community members and therefore approach is unlikely to succeed.
- Lack of evidence-based approach for addressing the problem.
- Need is not as pressing as other problems.
- Need is not as likely to be resolved as other problems.
- 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/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.

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| 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 implementation strategy development process is 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:

- Through work with community groups and partners.
- Significant changes in patient populations served or demand for services provided by the hospital.
- From information gathered by the hospital’s strategic planning department.

- **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 (for example, hospital financial status has changed or 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, or if community partners are able to contribute funds or personnel, or 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 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 or
- Eliminate or replace a program with an alternative approach.
DEVELOP AND IMPLEMENT PROGRAM PLANS

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 in all aspects of program planning, from assessment and priority setting to intervention development and implementation, in order 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.

(Brownson et. al. 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.

2. Determine the target population

Who will the program serve? Include geographic area, demographics and other important characteristics of intended program participants and 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 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's 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 Mystic 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 expressed in terms of short-term, intermediate-term 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-specific. 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 and/or services. An impact/outcome objective can be short-term, intermediate or 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) in order to ensure that the program’s strategies are focused, targeted and relevant—and ultimately, contributing to 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 (participation) 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-term, intermediate and long-term.

Indicators are measures that show progress towards meeting intended objectives and outcomes. An indicator answers the 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?

• Are 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 audio-visual 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, 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.

*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.

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 ensure that it is collected at the appropriate times during program implementation.

*See Chapter 6 for more information about program evaluation.*

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 we obtain them in order 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 community health need assessment 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.

*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- and mid-term) 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**

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 will the program 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, 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: 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 of recordkeeping system, convening staff; meeting with partners and advisors; oversight and management of budget.

- **Program development and rollout** – Pilot testing, updating program and program delivery.

- **Program evaluation** – Implementation and impact evaluation.

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.
Develop a management system

A system of management will describe how you will organize the program’s human, financial and technical resources.

Determine:

- 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 director be reviewed?
- Who will be responsible for and/or supervise day-to-day activities?
- Who is 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. Be sure the communications vehicle is 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.

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 had the right materials, space, staffing, and skills.

- Involve participants in critiquing all aspects of the program: content, approach, facilitator/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 placing a limit on the number of participants, by location (adding more locations as implementation proceeds), or by participants’ ability (for example, beginner or advanced exercise program) or level of need (dental clinic program starts with treatment of major problems then phases in 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.

<table>
<thead>
<tr>
<th>CAUTION ABOUT TOTAL IMPLEMENTATION</th>
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<tbody>
<tr>
<td>“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.”</td>
</tr>
<tr>
<td>(McKenzie, Neiger, Smeltzer 279)</td>
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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. For example, starting a weight loss program at the beginning of the year or offering an immunization clinic just 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:

- **Legal issues** – Reduce the risk of liability by meeting with your legal staff to understand potential legal issues (such as negligence, obtaining informed consent, maintaining confidentiality and privacy) and put in place policies and procedures to address these issues.

- **Program safety** – Make sure the space/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.

- **Ethical issues** – 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 (for example, after the first session, first week or month).

**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 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 the program should continue, be changed or 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?

In order 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.

• **Attain 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** – 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.
Definitions in this Chapter

**Ambulatory Sensitive Condition**
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 socio-economic, 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 accuracy of measurements. A valid measure accurately measures what it is intended to measure.

*Sources:* Brownson et al. (2010) and McKenzie, Neiger, Smelzer (2005).
Chapter Six: Evaluating the Community Benefit Program
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:

1. The building blocks of program evaluation.
2. How to plan for the evaluation.
3. How to evaluate community health improvement programs and activities:
   - Step 1: Engage stakeholders.
   - Step 2: Describe the program.
   - Step 3: Focus the evaluation design.
   - Step 4: Gather credible evidence.
   - Step 5: Justify conclusions.
   - Step 6: Ensure use and share lessons learned.
As community benefit programs have become more complex and designed to meet 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 community health needs assessment (CHNA) reports an evaluation of the impact of actions taken to address the significant health needs from their immediately preceding CHNA (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 the Catholic Health Association’s (CHA) resource, Evaluating Your Community Benefit Impact, for a comprehensive look at the evaluation process. This resource can be accessed on the CHA website at www.chausa.org/communitybenefit.

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 their 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-term, 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.

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**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.

In order 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 analyzing data. 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 which shows the timelines for all community
benefit program evaluation may be helpful in order 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 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 knowledge and 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
How to evaluate community health improvement programs and activities

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 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/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 which lists evaluation stakeholders, the aspects of the program they want to evaluate, their role in the evaluation, and their preferred methods of communications. Stakeholders can help describe the program, develop evaluation questions, and disseminate the evaluation results.
Chapter 6: Evaluating the Community Benefit Program

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 or actions that must take place 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 on-going 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** – 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 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 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 on participants of the program 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: quiz given to participants before and after program to assess change in knowledge.
• Soon after the intervention is started (such as pilot study). Example: survey is given to participants to assess whether they thought the program materials were helpful or location was convenient.

• After the intervention is under way or over (often called posttest only design). Example: self-assessment of knowledge or behavior change gained from 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 definitions for independent variables (what factors contribute to the expected outcomes), dependent variables (what 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, possible constraints, 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/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 the 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.

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<thead>
<tr>
<th>TYPES OF EVALUATION</th>
<th>TYPE OF DATA</th>
<th>METHOD OF COLLECTION/ANALYSIS</th>
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<tbody>
<tr>
<td>Quantitative</td>
<td>• Survey questionnaire</td>
<td>• Telephone, in-person, mail or online questionnaire</td>
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<tr>
<td></td>
<td>• Indicator data</td>
<td>• Review of relevant records (e.g., hospital, clinic, program records)</td>
</tr>
<tr>
<td>Qualitative</td>
<td>• Open-ended questions</td>
<td>• Telephone, in-person, mail or online questionnaire</td>
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<td></td>
<td>• Individual interviews</td>
<td>• Telephone, in-person</td>
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<td></td>
<td>• Diaries</td>
<td>• Self-administered</td>
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<td></td>
<td>• Group interviews/focus groups</td>
<td>• In-person, telephone</td>
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<tr>
<td></td>
<td>• Observations/ environmental assessments</td>
<td>• Video conference calls</td>
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</tbody>
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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 condition. 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 NOTE**

Hospitals are required by the Internal Revenue Service to report two sets of information:

- On the IRS Form 990 Schedule H, each year a hospital must describe how it is addressing significant needs identified in its most recently conducted community health needs assessment and any needs not being addressed and the reasons why.
- On community health needs assessment reports, an evaluation of the impact of any actions that were taken since the hospital finished conducting its immediately preceding community health needs assessment (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:

- More or different resources are needed.
- The program should be relocated to different areas in the community or focused 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**

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<tr>
<th>Recommendations should be:</th>
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<tr>
<td>• Based on information collected.</td>
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<td>• Feasible and realistic.</td>
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<tr>
<td>• Delivered at the right time for decisions to be made.</td>
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<tr>
<td>• Specific in terms of what should happen.</td>
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**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.

Involving 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 community health need assessment. 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 that results are used.

**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 their CHNA report: the number of residents immunized, that there were fewer flu cases from the previous year, and the incidence of acute or chronic respiratory conditions from the previous year was reduced.
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 recommendation, 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 implication** – 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 (Well-Integrated Screening and Evaluation for WOMen Across the Nation) program. The toolkit can be accessed at [http://www.cdc.gov/wisewoman/docs/ww_evaluation_toolkit_sect4.pdf](http://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**

CDC’s 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; timing of data collection; procedures for collecting the data; 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 evaluation findings.

Evaluation
CDC defines evaluation as a systematic approach to collecting, analyzing, and using data in order 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 stakeholder(s)
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 in 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 may expect to see 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 before a change is observed. 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
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 often represented by documentation of 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 (PHI) 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, measureable, 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:
Chapter Seven: Communicating the Community Benefit Story
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 to our communities.

Tax-exempt hospitals are entrusted with community resources to ensure the health of their communities. By telling their community benefit story 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:

• Why community benefit should be reported.

• How to utilize your communications and marketing departments.

• How to develop a community benefit communications plan.

• How to develop an annual community benefit report.

• How to report community benefit on Internal Revenue Service (IRS) Form 990, Schedule H for Hospitals (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 answers a number of other needs. The most important reasons to
report community benefit are:

• Accountability.

• Legal requirements.

• Strengthening relationships.

• Fostering 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 granting tax-exemption,

  communities 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.

MISSION NOTE

Why do we report community benefit? Not merely because of state or federal government

requirements. We report community benefit to be transparent and accountable – to our staff,

physicians, donors, boards – and most of all, to our communities.
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, 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.

Fostering dialogue on health care policy

Policy makers 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 policy makers 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.

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<th>FORM A COMMUNICATION TEAM</th>
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<td>Some organizations have found it effective to form a community benefit communication 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 multi-disciplinary communications team can help ensure that messages are tailored to effectively inform these different audiences about the organization’s community benefit efforts.</td>
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Communications 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 community health needs assessment (CHNA), including development/identification/use of information-gathering tools and development of the CHNA report.
- Developing the community benefit communications plan, identifying goals, objectives, tactics, messages and mediums.
- Coordinating the development of an annual community benefit report.
- 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 services.
- Working with print and electronic media to get word out about community benefit to the community.
• Utilizing social media channels to promote community benefit programs before, during and after events.

• Identifying a point person for media inquiries on IRS Form 990, Schedule H for Hospitals (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 in order to communicate the impact of these activities on the health of individuals and the community.

**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. The plan will help set priorities and ensure that consistent messages are directed to the right audiences.

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 developing 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, policy makers 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 or 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?

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.

- **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 and more of these channels offer 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 more affluent computer users and should be supplemented with outreach to low-income persons and non-computer users.

- **Internal information gathering** from physicians, nurses and other employees can be very helpful in assessing how the organization is perceived.
Step 2. Define communication 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: “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 communication plan for community benefit should answer the 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 focus 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 non-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

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:

- **Results of community health needs assessment** – 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?

- **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 where various departments, clinicians and researchers may have numerous projects throughout the organization.

Even smaller organizations, however, may have community benefit activities that are “below the radar screen.”

It is necessary, therefore, to motivate staff and physicians to contribute information about their community activities and programs. Some strategies for encouraging reporting of information include:

- Update employee orientation programs to include how to contribute/report community benefit information.
- Give regular reports to staff and physicians about how programs are making a difference in the health of people in the community.
- Include the reporting of community benefit activities in job descriptions.
- Make submission of data as easy as possible and report back on all data collected.
- Develop 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, then repeated over and over again. They should describe:

- The organization’s mission and its commitment to serve the community.
- How the organization fulfills its commitment to help address 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.

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<tr>
<th>SAMPLE KEY MESSAGES ABOUT TAX-EXEMPT, NOT-FOR-PROFIT HEALTH CARE</th>
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<tr>
<td>• Not-for-profit health care is a sign of a just and caring society, demonstrating the value of voluntary organizations providing public good.</td>
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<td>• The roots of not-for-profit health care are in community service – not economic opportunity.</td>
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<tr>
<td>• Tax-exemption is a privilege, and not-for-profit health care is accountable for that privilege.</td>
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<tr>
<td>• Tax-exemption enables not-for-profit health care to serve the community.</td>
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<tr>
<td>• 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.</td>
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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 policy makers 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.

• Public agencies and offices:
  ° Federal, state and local elected officials.
  ° Public agencies, such as health departments and law enforcement.
  ° Regulatory agencies.
  ° Other policy makers.
  ° Schools.

• Health-related groups:
  ° 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/supporters:
  ° Foundations and other funding organizations.
  ° Donors.
  ° Organized labor.
  ° Contractors and vendors.

• Others:
  ° Patients and their families.
  ° Media.
  ° 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.
  - Strategic planning team.
  - Operations.
  - Care management/social services staff.
  - Population health management staff.
  - Legal/Compliance/Advocacy staff.
  - 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/knowledge 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, report to community).
- Point-of-service displays (such as bulletin boards and fliers).
- 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 policy makers. 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 policy makers 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 meet with traditional and social media reporters so that you know them and they know you. 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.
• 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 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/government relations staff:

• Meet with elected officials – including taxing authorities and health care policy makers – 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 policy makers 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 policy makers. Whenever representatives of the organization meet with elected officials and other policy makers, 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 communication and advocacy departments about the organization’s community benefit activities and successes. Communication staff often “sell” stories to news organizations, and advocacy staff like to discuss real-life examples of effective programs with policymakers to reinforce policy recommendations.

Visit the CHA website at 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. 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 editor: How 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 writer: Human interest stories about community benefit program leaders and community members being served.
  • Religion editor: 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 which describe special reports or sections over a 12-month period; plan ahead to coordinate story ideas/pitches 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. Know audiences of various stations in 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 widely share information about community benefit efforts. Some items that should be posted on the website include a report of the organization’s community health needs assessment and the hospital’s financial assistance policy. CHA also recommends posting the organization’s implementation strategy. You can also use the website to post the community benefit report and 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: The use of web-based and mobile technologies can turn communication into an interactive dialogue. Social media may include Internet forums, weblogs, social blogs, microblogging, wikis, podcasts, video, rating and social bookmarking. Some examples include Facebook, 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/social media policy.
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.

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 time, date, place and contact information.
• Mention visual elements of the program.
• Explain why readers/viewers might be interested.
• Distribute two to three weeks in advance.
• Call reporters the day before to remind and gauge their interest.

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 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

• One page executive summary.

• Description of core values or mission statement that guide the organization.

• A history of an organization’s commitment to the community and its development over time.

• A description of the community served, its needs and resources.

• 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**

**Community Health Needs Assessment** – The Affordable Care Act (ACA) specifically requires that the community health needs assessment “is 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 Web page where 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 in order 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/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 or video report or electronic report that links to video narratives 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.
- Involved 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 within and outside of the organization.

Guideline 5
Report community benefit on Schedule H

Non-governmental, tax-exempt organizations are required to file an IRS Form 990 each year. Hospitals are required to report their community benefit activity and other tax-exemption related information on the Form 990, Schedule H. Although it is only required of hospitals, other health care organizations should consider including community benefit information on the Form 990, using Schedule O.

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 www.guidestar.org. Therefore, all not-for-profit health care organizations should carefully complete the 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 www.irs.gov/form990. 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 (CBISA), the companion software to this Guide (available from www.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 the Schedule H, where hospitals are instructed 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 ways they work with the community toward improving community well-being.
These include:

- **Evidence of the organization's responsiveness to 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.

- **Advocacy.** Describe your organization as a responsible citizen. This may include serving on government advisory committees, meeting with policy makers on issues related to the uninsured or underinsured, building coalitions with community groups and working with state and national organizations on important policy matters. Include advocacy for health care for all persons, for policies that improve public health and to eliminate disparities.

- **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.

- 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.

- 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, fund raising, 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 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 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: Community Benefit Inventory Template
Appendix B: Determining What Counts as Community Benefit
Appendix C: Checklist for Hospital Policies and Practices
Appendix D: Community Benefit Accounting Worksheets and Supplemental Information
Appendix E: Suggested Information to be Included in a Community Health Needs Assessment
Appendix F: Program Planning Worksheet
Appendix A: Reference for Chapter 1

COMMUNITY BENEFIT INVENTORY TEMPLATE

The instructions and template below can be downloaded at 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/service is a “community benefit.”

• The program or activity addresses a community need. The Internal Revenue Service states that community need can be demonstrated through the following:
  • A community health needs assessment developed or accessed by the organization.
  • Documentation that demonstrated community need or a request from a public agency or community group 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 of government to improve health.

• The program was started/provided primarily to benefit the community as opposed to benefiting the organization (such as marketing or case-finding).

Also attached is a document, Community Benefit Categories and Definitions, that provides specific examples.
| 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 e-mail address: |
| List community partners: |
| Comments: |
Appendix B: Reference for Chapter 2

DETERMINING WHAT COUNTS AS COMMUNITY BENEFIT

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 www.chausa.org/guideresources.

Examples of community health improvement services that should and should not be reported are as follows:

<table>
<thead>
<tr>
<th>COMMUNITY HEALTH IMPROVEMENT SERVICES</th>
<th>REPORT</th>
<th>EXAMPLE RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization for low-income children</td>
<td>Yes</td>
<td>Public health priority, relief of government burden</td>
</tr>
<tr>
<td>Flu shots for employees</td>
<td>No</td>
<td>Cost of doing business, more benefit to organization than community</td>
</tr>
<tr>
<td>Health screening program in low-income community</td>
<td>Yes</td>
<td>Enhances access, health education</td>
</tr>
<tr>
<td>Health screening program in upscale mall for marketing purposes</td>
<td>No</td>
<td>More benefit to organization than community</td>
</tr>
<tr>
<td>Health education regarding diabetes</td>
<td>Yes</td>
<td>Public health priority</td>
</tr>
<tr>
<td>Marketing material for orthopedic program</td>
<td>No</td>
<td>Marketing focus, more benefit to organization than community</td>
</tr>
<tr>
<td>Outreach to help seniors remain independent in their homes</td>
<td>Yes</td>
<td>Public health priority</td>
</tr>
</tbody>
</table>
### COMMUNITY HEALTH IMPROVEMENT SERVICES (continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Report</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge planning function</td>
<td>No</td>
<td>Represents the current standard of care, required for licensure</td>
</tr>
<tr>
<td>Taxi vouchers for low-income persons</td>
<td>Yes</td>
<td>Provides access to care for vulnerable persons</td>
</tr>
<tr>
<td>Van service between wealthy retirement community and only the organization</td>
<td>No</td>
<td>Benefits the organization more than the community</td>
</tr>
</tbody>
</table>

Examples of *health professions education activities or programs* that should and should not be reported are as follows. (Currently appears in Instructions for IRS Form 990 H)

### HEALTH PROFESSIONS EDUCATION ACTIVITIES OR PROGRAMS

<table>
<thead>
<tr>
<th>Activity or Program</th>
<th>Report</th>
<th>Example Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scholarships for community members</td>
<td>Yes</td>
<td>More benefit to community than organization</td>
</tr>
<tr>
<td>Scholarships for staff members</td>
<td>No</td>
<td>More benefit to organization than community</td>
</tr>
<tr>
<td>Continuing medical education for community physicians</td>
<td>Yes</td>
<td>Accessible to all qualified physicians</td>
</tr>
<tr>
<td>Continuing medical education for own medical staff</td>
<td>No</td>
<td>Restricted to own medical staff members</td>
</tr>
<tr>
<td>Nurse education if graduates are free to seek employment at any organization</td>
<td>Yes</td>
<td>More benefit to community than organization</td>
</tr>
<tr>
<td>Nurse education if graduates are required to become the organization’s employees</td>
<td>No</td>
<td>Program designed primarily to benefit the organization</td>
</tr>
</tbody>
</table>
Examples of *subsidized health services* that should and should not be reported are as follows:

<table>
<thead>
<tr>
<th>SUBSIDIZED HEALTH SERVICES</th>
<th>REPORT</th>
<th>EXAMPLE RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinics for low-income persons</td>
<td>Yes</td>
<td>Enhances access</td>
</tr>
<tr>
<td>Prenatal classes for mostly insured persons</td>
<td>No</td>
<td>Current standard of care</td>
</tr>
<tr>
<td>Mental health service with high census and Medicaid patients</td>
<td>Yes</td>
<td>Responds to need and provides access for low-income consumers</td>
</tr>
<tr>
<td>Mental health service with low census that loses money</td>
<td>No</td>
<td>Need not established and may reflect poor business decision</td>
</tr>
<tr>
<td>Cosmetic surgery and other elective care for which financial assistance is not available</td>
<td>No</td>
<td>Difficult to establish community need and inaccessible for patients needing financial assistance</td>
</tr>
</tbody>
</table>

Examples of *research programs* that should and should not be reported as follows:

<table>
<thead>
<tr>
<th>RESEARCH PROGRAMS</th>
<th>REPORT</th>
<th>EXAMPLE RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research on how to reduce disparities in cancer</td>
<td>Yes</td>
<td>Community need</td>
</tr>
<tr>
<td>Study on whether to open a new cardiac unit</td>
<td>No</td>
<td>Market research</td>
</tr>
<tr>
<td>Study on how to triage ER patients, results published in professional journal</td>
<td>Yes</td>
<td>Results shared with others</td>
</tr>
<tr>
<td>Quality assurance study on reducing medication errors</td>
<td>No</td>
<td>Finding used solely by the organization</td>
</tr>
</tbody>
</table>
Examples of *cash and in-kind contributions* that should and should not be reported are as follows:

<table>
<thead>
<tr>
<th>ACTIVITY OR PROGRAM</th>
<th>REPORT</th>
<th>EXAMPLE RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donation to community clinic</td>
<td>Yes</td>
<td>Enhances access</td>
</tr>
<tr>
<td>Executive time at a charity golf outing</td>
<td>No</td>
<td>Unrelated to health/mission</td>
</tr>
<tr>
<td>Cost of staff working in a free clinic while on hospital payroll</td>
<td>Yes</td>
<td>Commitment of organization’s resources</td>
</tr>
<tr>
<td>Value of staff time when volunteering on their own time</td>
<td>No</td>
<td>Benefit provided by the staff, not the organization</td>
</tr>
<tr>
<td>Equipment with remaining useful life donated to community clinic</td>
<td>Yes</td>
<td>Equipment has financial value and donation results in net financial cost</td>
</tr>
<tr>
<td>Equipment that has been fully depreciated</td>
<td>No</td>
<td>Equipment has been fully expensed – only new cost for delivery can be reported</td>
</tr>
<tr>
<td>Emergency funds provided to local Red Cross</td>
<td>Yes</td>
<td>Benefits the community more than the organization</td>
</tr>
<tr>
<td>Emergency funds provided <strong>a)</strong> to employee support fund or <strong>b)</strong> by employees</td>
<td>No</td>
<td><strong>a)</strong> Benefits only persons internal to the organization and <strong>b)</strong> not an expense of the organization</td>
</tr>
</tbody>
</table>
Examples of *community-building activities* that should and should not be reported are as follows:

<table>
<thead>
<tr>
<th>COMMUNITY-BUILDING ACTIVITIES</th>
<th>REPORT</th>
<th>EXAMPLE RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing for low-income seniors</td>
<td>Yes</td>
<td>Community need/access to housing</td>
</tr>
<tr>
<td>Housing for employees</td>
<td>No</td>
<td>Restricted to individuals affiliated with the organization</td>
</tr>
<tr>
<td>Crime prevention program</td>
<td>Yes</td>
<td>Public health/social need</td>
</tr>
<tr>
<td>Staff in-service education on domestic abuse</td>
<td>No</td>
<td>In-service education is cost of doing business and standard of care</td>
</tr>
<tr>
<td>Advocacy on access to transportation, affordable housing, early childhood development programs</td>
<td>Yes</td>
<td>Community need</td>
</tr>
<tr>
<td>Advocacy for enhanced reimbursement</td>
<td>No</td>
<td>Benefits the organization</td>
</tr>
<tr>
<td>Proper disposal of radioactive waste</td>
<td>No</td>
<td>Required by law</td>
</tr>
<tr>
<td>Waste reduction to minimize incineration</td>
<td>Yes</td>
<td>Contributions to improved air quality/related asthma prevention</td>
</tr>
</tbody>
</table>

*Note: if any of the reportable community building activities meet the IRS definition of community benefit, they can be reported at community health improvement.*
Examples of *community benefit operations* that should and should not be reported are as follows:

<table>
<thead>
<tr>
<th>COMMUNITY BENEFIT OPERATIONS</th>
<th>REPORT</th>
<th>EXAMPLE RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs of conducting community assessment</td>
<td>Yes</td>
<td>Critical for effective community benefit program</td>
</tr>
<tr>
<td>Consultant fees for feasibility study of new service line</td>
<td>No</td>
<td>Related to operations of the organization</td>
</tr>
<tr>
<td>Fundraising for organization community benefit activities</td>
<td>Yes</td>
<td>Related to community need</td>
</tr>
<tr>
<td>Fundraising for new technology</td>
<td>No</td>
<td>Related to operations of the organization</td>
</tr>
<tr>
<td>Attending workshop of community benefit program evaluation</td>
<td>Yes</td>
<td>Directly related to community benefit program</td>
</tr>
<tr>
<td>Attending workshop on management skills</td>
<td>No</td>
<td>Not related to community benefit program</td>
</tr>
</tbody>
</table>
Appendix C: Reference for Chapter 3

CHECKLIST FOR HOSPITAL POLICIES AND PRACTICES

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 www.chausa.org/guideresources.

Mission and values statements:

☐ 1. Do our mission and values statements explicitly reference commitment to access, community health and fulfilling needs of low-income and vulnerable persons?

☐ 2. Are these statements used as criteria for making strategic planning decisions?

☐ 3. Are they used in making long-range planning decisions?

☐ 4. Are new leaders, staff, and board members oriented to and kept informed about the organization’s community benefit mission?

☐ 5. Are physicians oriented to and kept informed about the organization’s community benefit mission?

Governing board and executive leadership policies:

☐ 1. Are processes in place to obtain board review and approval of the following: community health need assessment, prioritization of community health needs, and implementation strategy?

☐ 2. Does board orientation include education on the mission and legal aspects of community benefit and what it means to be a charitable organization?

☐ 3. Are commitment to access and community health part of the criteria for selecting executive leaders and board members?
4. Is community benefit or community health improvement specified in the responsibilities of senior leaders?

5. Are outcomes related to community involvement and community benefit part of executive leader performance evaluations?

### Administrative policies:

1. Is community benefit explicit in the organization’s strategic/organizational plan and budget?

2. Does the overall community benefit program have adequate human and financial resources?

3. Does the organization assign staff knowledgeable about public health to be responsible for planning and implementing the community benefit program?

### Financial assistance, billing and collection policies:

1. Are our emergency medical care, financial assistance, billing and collection policies in line with related federal and state rules and regulations?

2. Are these policies approved by the hospital’s governing body?

3. Are our policies widely publicized within the facility and in our community?

4. Does our financial assistance policy describe all required documentation and include contact information patients can use for assistance?

5. Does our policy regarding emergency care specify that the hospital provides care for emergency medical care regardless of ability to pay?

6. Do our policies specify what action the hospital and any contractors may take in the event of nonpayment?

7. Have the billing/collection staff and/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?

8. Does the organization monitor collection practices?
Physician involvement policies:

1. Do our medical staff bylaws or other policies require or encourage physicians to:
   - [ ] a. Take emergency calls?
   - [ ] b. Provide a minimum amount of service to Medicaid and uninsured patients?

2. Do medical staff organizations or individual physicians participate in:
   - [ ] a. Assessing community needs?
   - [ ] b. Reviewing community benefit plans and reports?
   - [ ] c. Developing services to improve access to health care?
   - [ ] d. Developing services to improve community health?

3. Are physicians, medical students, and residents oriented to our community benefit mission?

4. Do we publicly recognize the voluntary community service of physicians?

5. Do we make efforts to recruit physicians committed to access and physicians who reflect the demographic makeup of our community?

Employee policies:

1. Are all employees oriented to the organization’s mission of service and commitment to access and community health?

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?

3. Are staff members offered time off (paid or unpaid) for staff volunteer activities?

4. Do we recognize and celebrate community service contributions of staff members?

5. Are managers and staff assigned or encouraged to participate in collaborative activities with other community organizations?
Advocacy policies:

☐ ☑ 1. Do we advocate for access to health care for all persons?

☐ ☑ 2. Do we advocate for responsible policies for financing the care of low-income persons, including preserving Medicaid for those most in need?

☐ ☑ 3. Do we advocate for policies that will improve health in our communities (such as environmental improvement, tobacco control and nutrition programs and public-safety measures)?

☐ ☑ 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)?

☐ ☑ 5. Do we participate in community coalitions for advocacy?

Environmental responsibility policies:

☐ ☑ 1. Do we have policies regarding energy conservation, energy efficiency, renewable energy and reducing greenhouse gas emissions?

☐ ☑ 2. Do we have policies regarding waste management, including minimizing medical waste and mechanical device reprocessing?

☐ ☑ 3. Do we have policies regarding re-use, recycling and minimizing the use of disposable products?

☐ ☑ 4. Do we use environmental-friendly, non-toxic and safe materials, including cleaners and pest control products?

☐ ☑ 5. Do we follow CHA’s guidance from Responsible Redistribution of Medical Supplies & Equipment: Leading Practices for Hospitals & Health Systems when donating surplus?

☐ ☑ 6. Do we use seasonal, local and/or organic produce, dairy products and meat in food for patients, staff and visitors?

☐ ☑ 7. Do we buy local food and products when available?
Community benefit program policies:

1. Have we made a formal commitment to a community benefit program through our mission statement, staff assignments, job descriptions, or board responsibilities?

2. Does the community benefit program meet all legal requirements?

3. Does the scope of the program include projects to:
   a. Improve health in the community?
   b. Address health problems of medically underserved persons?
   c. Address the social and environmental determinants of health?
   d. Reduce emergency department use?
   e. Advance knowledge?

4. Does the program consult with public health experts?

5. Is there community involvement in the community benefit program?

6. Are persons who reflect the racial, ethnic and economic diversity of the community involved in the assessment and community benefit planning process?

7. Do programs designed to serve the broad community include outreach to those with low incomes and other persons with unmet needs?

8. Do program activities build on identified community assets when possible?

9. Do all activities include a monitoring/evaluation strategy?

10. Does the community benefit program include collaborations with:
    a. Local health departments?
    b. Other public agencies?
    c. Community organizations?
    d. Vulnerable populations?

11. Is there a policy that programs should be evidence-based, if possible?

12. 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

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
## BENEFITS FOR PERSONS LIVING IN POVERTY

<table>
<thead>
<tr>
<th>Community Benefit Category*</th>
<th>Schedule H Part and Line</th>
<th>See Worksheet</th>
<th>Number of Activities or Programs</th>
<th>Persons Served</th>
<th>Total Expense</th>
<th>Direct Offsetting Revenue</th>
<th>Net Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Amount</td>
<td>Percent of Total Expense</td>
<td>Amount</td>
</tr>
<tr>
<td>Financial assistance at cost</td>
<td>I</td>
<td>I, 7a</td>
<td>1</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Unreimbursed costs of public programs</td>
<td>II</td>
<td>I, 7b</td>
<td>3</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• Medicaid</td>
<td>II</td>
<td>I, 7c</td>
<td>3</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>• Other means-tested programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health improvement services</td>
<td>III. A</td>
<td>I, 7e</td>
<td>4a</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Health professions education</td>
<td>III. B</td>
<td>I, 7f</td>
<td>5</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Subsidized health services</td>
<td>III. C</td>
<td>I, 7g</td>
<td>6</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Cash and in-kind contributions for community benefit</td>
<td>III. E</td>
<td>I, 7i</td>
<td>8</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Community-building activities</td>
<td>III. F</td>
<td>II</td>
<td>B</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total quantifiable benefits for persons living in poverty</strong></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

## BENEFITS FOR THE BROADER COMMUNITY

<table>
<thead>
<tr>
<th>Community Benefit Category*</th>
<th>Schedule H Part and Line</th>
<th>See Worksheet</th>
<th>Number of Activities or Programs</th>
<th>Persons Served</th>
<th>Total Expense</th>
<th>Direct Offsetting Revenue</th>
<th>Net Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Amount</td>
<td>Percent of Total Expense</td>
<td>Amount</td>
</tr>
<tr>
<td>Community health improvement services</td>
<td>III. A</td>
<td>I, 7e</td>
<td>4a</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Health professions education</td>
<td>III. B</td>
<td>I, 7f</td>
<td>5</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Subsidized health services</td>
<td>III. C</td>
<td>I, 7g</td>
<td>6</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Generalizable Research</td>
<td>III. D</td>
<td>I, 7h</td>
<td>9</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Cash and in-kind contributions for community benefit</td>
<td>III. E</td>
<td>I, 7i</td>
<td>10</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Community-building activities</td>
<td>III. F</td>
<td>II</td>
<td>B</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Community benefit operations</td>
<td>III. G</td>
<td>I, 7e</td>
<td>4b</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total quantifiable benefits for the broader community</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

## TOTAL QUANTIFIABLE COMMUNITY BENEFITS

*Refer to “Categories and Definitions” for additional information
### Worksheet 1: Financial Assistance at Cost

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROSS PATIENT CHARGES</strong></td>
<td></td>
</tr>
<tr>
<td>1. Amount of gross patient charges written off under financial assistance</td>
<td>$</td>
</tr>
<tr>
<td>policies</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL COMMUNITY BENEFIT EXPENSE</strong></td>
<td></td>
</tr>
<tr>
<td>2. Ratio of patient care cost to charges (from Worksheet 2, if used)</td>
<td></td>
</tr>
<tr>
<td>3. Estimated cost (multiply line 1 by line 2, or obtain from cost accounting)</td>
<td>$</td>
</tr>
<tr>
<td>4. Medicaid or provider taxes, fees, and assessments</td>
<td>$</td>
</tr>
<tr>
<td>5. Total community benefit expense (add lines 3 and 4)</td>
<td>$</td>
</tr>
<tr>
<td><strong>DIRECT OFFSETTING REVENUE</strong></td>
<td></td>
</tr>
<tr>
<td>6. Revenues from uncompensated care pools or programs</td>
<td>$</td>
</tr>
<tr>
<td>7. Net assets released from restrictions</td>
<td>$</td>
</tr>
<tr>
<td>8. Other direct offsetting revenue</td>
<td>$</td>
</tr>
<tr>
<td>9. Total direct offsetting revenue (add lines 6 through 8)</td>
<td>$</td>
</tr>
<tr>
<td>10. Net community benefit expense (subtract line 9 from line 5)</td>
<td>$</td>
</tr>
<tr>
<td><strong>11. Total expense</strong></td>
<td>$</td>
</tr>
<tr>
<td>12. Total community benefit percent of total expense (divide line 5 by line 11)</td>
<td>%</td>
</tr>
<tr>
<td>13. Net community benefit percent of total expense (divide line 10 by line 11)</td>
<td>%</td>
</tr>
</tbody>
</table>
## Worksheet 2: Ratio of Patient Care Cost to Charges

<table>
<thead>
<tr>
<th><strong>PATIENT CARE COST</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total operating expense (including bad debt expense)</td>
<td>$</td>
</tr>
<tr>
<td><strong>LESS ADJUSTMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>2. Non-patient-care activities</td>
<td>$</td>
</tr>
<tr>
<td>3. Bad debt expense</td>
<td>$</td>
</tr>
<tr>
<td>4. Medicaid or provider taxes, fees, and assessments (if in operating expense)</td>
<td>$</td>
</tr>
<tr>
<td>5. Total community benefit expense</td>
<td>$</td>
</tr>
<tr>
<td>6. Total community building expense</td>
<td>$</td>
</tr>
<tr>
<td>7. Total adjustments (add lines 2 through 7)</td>
<td>$</td>
</tr>
<tr>
<td>8. Adjusted patient care cost (subtract line 7 from line 1)</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PATIENT CARE CHARGES</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Gross patient charges</td>
<td>$</td>
</tr>
<tr>
<td><strong>LESS ADJUSTMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>10. Gross charges for community benefit programs</td>
<td>$</td>
</tr>
<tr>
<td>11. Adjusted patient care charges (subtract line 9 from line 10)</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CALCULATION OF RATIO OF PATIENT CARE COSTS TO CHARGES</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Ratio of patient care cost to charges (divide line 8 by line 11)</td>
<td></td>
</tr>
</tbody>
</table>
### Worksheet 3: Medicaid and Other Means-Tested Government Programs

<table>
<thead>
<tr>
<th>Description</th>
<th>Medicaid</th>
<th>Other means-tested government programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROSS PATIENT CHARGES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Gross patient charges from the programs</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>TOTAL COMMUNITY BENEFIT EXPENSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Ratio of patient care cost to charges (from Worksheet 2, if used)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3. Cost (multiply line 1 by line 2, or obtain from cost accounting)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4. Medicaid, provider taxes, fees, and assessments</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5. Total community benefit expense (add lines 3 and 4)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>DIRECT OFFSETTING REVENUE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Net patient service revenue</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>7. Payments from uncompensated care pools or programs</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>8. Prior year revenue</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>9. Net assets released from restrictions</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>10. Other revenue</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>11. Total direct offsetting revenue (add lines 6 through 10)</strong></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>12. Net community benefit expense (subtract line 11 from line 5)</strong></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>13. Total expense</strong></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>14. Total community benefit percent of total expense (divide line 5 by line 13)</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td><strong>15. Net community benefit percent of total expense (divide line 12 by line 13)</strong></td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>
### Worksheet 4a: Community Health Improvement Services

<table>
<thead>
<tr>
<th></th>
<th>Direct Expense</th>
<th>Indirect Expense</th>
<th>Total Community Benefit Expense</th>
<th>Direct Offsetting Revenue</th>
<th>Net Community Benefit Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
<td>(D)</td>
<td>(E)</td>
<td></td>
</tr>
</tbody>
</table>

1. **COMMUNITY HEALTH IMPROVEMENT SERVICES**

<table>
<thead>
<tr>
<th>a.</th>
<th>$</th>
<th>$</th>
<th>$</th>
<th>$</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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) %

---

**To calculate:**

- Total Community Benefit Expense = Direct Expense + Indirect Expense
- Direct Offsetting Revenue
- Net Community Benefit Expense = Total Community Benefit Expense - Direct Offsetting Revenue
### Worksheet 4b: Community Benefit Operations

<table>
<thead>
<tr>
<th></th>
<th>Direct Expense</th>
<th>Indirect Expense</th>
<th>Total Community Benefit Expense</th>
<th>Direct Offsetting Revenue</th>
<th>Net Community Benefit Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(A)</td>
<td>(B)</td>
<td>(C)=(A)+(B)</td>
<td>(D)</td>
<td>(E)=(C)-(D)</td>
</tr>
</tbody>
</table>

#### 1. COMMUNITY BENEFIT OPERATIONS

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>c</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>d</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

#### 2. TOTAL (ADD LINES 1A – 1D)

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>TOTAL COMMUNITY BENEFIT EXPENSE</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical students</td>
<td>$</td>
</tr>
<tr>
<td>2. Interns, residents and fellows</td>
<td>$</td>
</tr>
<tr>
<td>3. Nursing</td>
<td>$</td>
</tr>
<tr>
<td>4. Other allied health professions students</td>
<td>$</td>
</tr>
<tr>
<td>5. Continuing health professions education</td>
<td>$</td>
</tr>
<tr>
<td>6. Other students</td>
<td>$</td>
</tr>
<tr>
<td><strong>7. Total community benefit expense (add lines 1-6)</strong></td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DIRECT OFFSETTING REVENUE</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Medicare reimbursement for direct GME</td>
<td>$</td>
</tr>
<tr>
<td>9. Medicaid reimbursement for direct GME</td>
<td>$</td>
</tr>
<tr>
<td>10. CHGME reimbursement for direct GME</td>
<td>$</td>
</tr>
<tr>
<td>11. Continuing health professions education reimbursement/tuition</td>
<td>$</td>
</tr>
<tr>
<td>12. Net assets released from restrictions</td>
<td>$</td>
</tr>
<tr>
<td>13. Other revenue</td>
<td>$</td>
</tr>
<tr>
<td><strong>14. Total direct offsetting revenue (add lines 8 through 13)</strong></td>
<td>$</td>
</tr>
<tr>
<td><strong>15. Net community benefit expense (subtract line 7 from line 14)</strong></td>
<td>$</td>
</tr>
<tr>
<td><strong>16. Total expense</strong></td>
<td>$</td>
</tr>
<tr>
<td><strong>17. Total community benefit percent of total expense (divide line 7 by line 16)</strong></td>
<td>%</td>
</tr>
<tr>
<td><strong>18. Net community benefit percent of total expense (divide line 15 by line 16)</strong></td>
<td>%</td>
</tr>
</tbody>
</table>
### Worksheet 6: Subsidized Health Services

#### Service Name:

<table>
<thead>
<tr>
<th>Total Subsidized Health Service Program</th>
<th>Bad Debt</th>
<th>Medicaid and Other Means-Tested Government Programs</th>
<th>Charity Care</th>
<th>Total Reported</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
<td>(D)</td>
<td>(E)=(A)-(B)-(C)-(D)</td>
<td>Exclude from Part III of Schedule H</td>
</tr>
</tbody>
</table>

#### 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

<table>
<thead>
<tr>
<th>TOTAL COMMUNITY BENEFIT EXPENSE</th>
<th>Research Funded by Tax-Exempt Sources</th>
<th>Other Research Studies (Intended for Publication)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Direct costs</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2. Indirect costs</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>3. Total community benefit expense (add lines 1 and 2)</strong></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>DIRECT OFFSETTING REVENUE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. License fees and royalties for research reported as community benefit</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5. Medicare reimbursement for research reported as community benefit</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>6. Net assets released from restrictions</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>7. Other revenue</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>8. Total direct offsetting revenue (add lines 4 through 7)</strong></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>9. Net community benefit expense (subtract line 8 from line 3)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>10. Total expense</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>11. Total community benefit percent of total expense (divide line 3 by line 10)</strong></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td><strong>12. Net community benefit percent of total expense (divide line 9 by line 10)</strong></td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>
## Worksheet 8:
### Cash and In-Kind Donations for Community Benefit

<table>
<thead>
<tr>
<th></th>
<th>Cash Contributions</th>
<th>In-Kind Contributions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A)</td>
<td></td>
<td></td>
<td>(C)=(A)+(B)</td>
</tr>
<tr>
<td>1. Total community benefit expense</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

**DIRECT OFFSETTING REVENUE**

<table>
<thead>
<tr>
<th></th>
<th>Cash Contributions</th>
<th>In-Kind Contributions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A)</td>
<td></td>
<td></td>
<td>(C)=(A)+(B)</td>
</tr>
<tr>
<td>2. Net assets released from restrictions</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3. Other revenue</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4. Total direct offsetting revenue (add lines 2 and 3)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5. Net community benefit expense (line 1 minus 4)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>6. Total expense</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>7. Total community benefit percent of total expense (divide line 1 by line 6)</td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>8. Net community benefit percent of total expense (divide line 5 by line 6)</td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
</tbody>
</table>
### Worksheet B: Community-Building Activities

<table>
<thead>
<tr>
<th>Community-Building Category</th>
<th>Number of Activities or Programs</th>
<th>Persons Served</th>
<th>Total Community-Building Expense</th>
<th>Net Community-Building Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cash and In-Kind donations</td>
<td>Other Direct Expense</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(A)</td>
<td>(B)</td>
</tr>
<tr>
<td>1. Physical improvements and housing</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2. Economic development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Community support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Environmental improvements</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Leadership development and training for community members</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Coalition-building</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Community health improvement advocacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Workforce development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Other community-building</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Total (add lines 1-9)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
### Worksheet C: Medicare

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicare Cost Report</th>
<th>Subtract: Amounts Reported as Community Benefit (Part I)</th>
<th>Subtotal (For Part III, Schedule H)</th>
<th>Other Medicare Services (Non-Cost Report)</th>
<th>Total Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
<td>(D)=(A)-(B)-(C)</td>
<td>(E)</td>
<td></td>
</tr>
<tr>
<td><strong>1. Medicare-allowable costs</strong></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>2. Medicare revenue</strong></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>3. Total amount</strong></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>4. Medicare Advantage IME</strong></td>
<td>( $ )</td>
<td>( $ )</td>
<td>( $ )</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>5. Total Revenue</strong></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>6. Shortfall or (surplus)</strong></td>
<td>(Subtract Line 5 from Line 1)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
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.

**Developing 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:

\[
\frac{\text{Total Indirect and Direct Costs}}{\text{Direct Costs}} - 1 = \text{Indirect Cost Factor}
\]

The factor then is applied as follows:

\[
\text{Program Direct Costs} \times (1 + \text{Indirect Cost Factor}) = \text{Total Community Benefit Expense}
\]
The following table provides recommendations for how indirect cost factors can be developed for each category of community benefit.

<table>
<thead>
<tr>
<th>ACTIVITY OR PROGRAM</th>
<th>INDIRECT COST FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assistance</td>
<td>Indirect costs are included in the numerator of the “ratio of patient care cost to charges”; a separate indirect cost factor is not needed.</td>
</tr>
<tr>
<td>Medicaid and Other Means-Tested Government Programs</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 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” – General Service, Inpatient Routine, Ancillary, Outpatient, Other Reimbursable, 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:  

  \[
  \frac{\text{Sum of General Service and Special Purpose Costs (Excluding Education-Related Cost Centers and the costs of Community Benefit Operations)}}{\text{Total Expense}}
  \]

  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). |
<table>
<thead>
<tr>
<th>ACTIVITY OR PROGRAM (continued)</th>
<th>INDIRECT COST FACTOR (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Initiatives (continued)</td>
<td>• 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.</td>
</tr>
<tr>
<td>Community Benefit Operations</td>
<td>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.</td>
</tr>
<tr>
<td>Community-Building</td>
<td>See discussion for “community health improvement.”</td>
</tr>
<tr>
<td>Subsidized Health Services</td>
<td>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.</td>
</tr>
<tr>
<td>Health Professions Education</td>
<td>The Medicare Cost Report (MCR) is a preferred source for indirect cost factors for health professions education activities. In the MCR, 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.</td>
</tr>
<tr>
<td>Research</td>
<td>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.</td>
</tr>
<tr>
<td>Financial and In-Kind Donations</td>
<td>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.</td>
</tr>
</tbody>
</table>
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 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 may 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.

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.

<table>
<thead>
<tr>
<th>INDIRECT COSTS</th>
<th>ALLOCATION STATISTIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building depreciation and interest expense on debt</td>
<td>Square footage</td>
</tr>
<tr>
<td>Employee benefits that have not been directly assigned to activities or programs</td>
<td>Paid hours or salary expense</td>
</tr>
<tr>
<td>Human resources</td>
<td>Paid hours or salary expense</td>
</tr>
<tr>
<td>Materials management</td>
<td>Paid hours or salary expense</td>
</tr>
<tr>
<td>Hospital administration</td>
<td>Total expense</td>
</tr>
<tr>
<td>Finance and accounting</td>
<td>Total expense</td>
</tr>
<tr>
<td>Planning and marketing</td>
<td>Total expense</td>
</tr>
<tr>
<td>Information technology</td>
<td>Total expense</td>
</tr>
<tr>
<td>Communications</td>
<td>Total expense</td>
</tr>
<tr>
<td>Plant operations and maintenance</td>
<td>Total expense</td>
</tr>
<tr>
<td>Security</td>
<td>Total expense</td>
</tr>
<tr>
<td>Laundry</td>
<td>Total expense</td>
</tr>
<tr>
<td>Utilization review</td>
<td>Total expense</td>
</tr>
<tr>
<td>Quality management</td>
<td>Total expense</td>
</tr>
<tr>
<td>Nursing administration</td>
<td>Paid hours</td>
</tr>
<tr>
<td>Patient registration</td>
<td>Gross charges</td>
</tr>
<tr>
<td>Patient billing</td>
<td>Gross charges</td>
</tr>
</tbody>
</table>
### 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 non-profit 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 non-profit 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 Internal Revenue Service (IRS) 990 Core Form and the hospital will report the receipt of such funds as grant revenue on its 990 Core Form. 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 IRS Form.
990, Schedule H for Hospitals (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 $1,000,000 (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.

<table>
<thead>
<tr>
<th></th>
<th>SEPARATE EIN REPORTS</th>
<th>CONSOLIDATED EIN REPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FOUNDATION</td>
<td>HOSPITAL</td>
</tr>
<tr>
<td><strong>A. GAAP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grant Revenue</td>
<td>$1,000,000</td>
<td>$500,000</td>
</tr>
<tr>
<td></td>
<td>$500,000</td>
<td>$600,000</td>
</tr>
<tr>
<td>Total Community Benefit Expense</td>
<td>$500,000</td>
<td>$600,000</td>
</tr>
<tr>
<td>Net Community Benefit Expense</td>
<td>$500,000</td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>B. 990 Accounting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Amounts in Core Form Grant Revenue Expense</td>
<td>$1,000,000</td>
<td>$500,000</td>
</tr>
<tr>
<td></td>
<td>$500,000</td>
<td>$600,000</td>
</tr>
<tr>
<td>2. Schedule H Direct Offsetting Revenue</td>
<td>NA</td>
<td>$500,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$600,000</td>
</tr>
<tr>
<td>Total Community Benefit Expense</td>
<td>$500,000</td>
<td>$600,000</td>
</tr>
<tr>
<td>Net Community Benefit Expense</td>
<td>$100,000</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

**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:

- 1The $1,000,000 raised by the foundation would be reported as revenue for that entity.
- 2The $500,000 transferred by the foundation to the hospital would be included in the foundation’s operating expense.
• That same $500,000 would be reported as revenue by the hospital.

• 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 revenue and expense, or $100,000.

• The two, separate, unconsolidated reports would have total combined revenue of $1.5 million and total community benefit expense of $1.1 million.

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) would not be recognized or reported (in accounting terms, it would be “eliminated”).

• Only the $500,000 originally raised by the foundation and used by the hospital during the year for the designated community benefit purpose would be reported as revenue on the Schedule H.

• Only the $600,000 community benefit program cost 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:

• Schedule H would not be filed by the foundation.

• 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.”
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:

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).

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

Availability and cost of data may vary by region/county.

Demographics and socioeconomic status

- Community overview, age, sex, race, socioeconomic status and academic attainment.
  - Poverty by age and racial/ethnic subgroups.
  - Unemployment rate.

Access to health care

- Health staffing shortages by Health Professional Shortage Area (HPSA), Primary Care HPSA, Dental HPSA.
- Physicians (M.D.s and D.O.s), Primary Care per 10,000 population.
- Hospitals and number of beds per 10,000 population.
- Percent uninsured.
  - Uninsured adults (Ages 18+).
  - Uninsured children (≤17).
- Percent 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 admissions rates, top 10 causes.
- Rates of “preventable” hospitalization (CHF, asthma, diabetes, COPD, and pneumonia).
Risk factor behaviors and conditions related to top 10 causes of death

- Tobacco use, obesity rates, and related behaviors.
- Screenings utilization rates.

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.

Natural environment

- Air and water quality ratings.

Social environment

- Violent crime rate.
- Child abuse rate.
- Housing affordability rate.

Resources/Assets

- Resources potentially available to address community health needs (such as federally qualified health clinics, 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 [www.chausa.org/guideresources](http://www.chausa.org/guideresources).

<table>
<thead>
<tr>
<th><strong>Program name:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**STEP 1: Define the problem:** Define the problem that the program will address.

<table>
<thead>
<tr>
<th><strong>Community need being addressed:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>How need was determined:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health need assessment</td>
</tr>
<tr>
<td>Documentation demonstrating need or request from a public agency or community group is basis for initiating or continuing the program</td>
</tr>
<tr>
<td>Unrelated, collaborative tax-exempt or government organizations are partners in the program</td>
</tr>
<tr>
<td>Other. Please explain.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Community benefit objective being addressed:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving access</td>
</tr>
<tr>
<td>Enhancing public health</td>
</tr>
<tr>
<td>Advancing medical or health care knowledge</td>
</tr>
<tr>
<td>Relieving or reducing government burden to improve health</td>
</tr>
</tbody>
</table>

**STEP 2: Target population:** Describe the target population of the program.

<table>
<thead>
<tr>
<th><strong>Category:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primarily for persons living in poverty</td>
</tr>
<tr>
<td>Primarily for the broader community</td>
</tr>
</tbody>
</table>
**Special needs populations:**
- Persons with disabilities
- Racial, cultural and ethnic minorities
- Uninsured/underinsured
- Other

**Ages of targeted audience:**
- Infants
- Adults
- Children
- Seniors
- 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, how it will be changed, by how much and the time frame for the change.

Objectives can be short-term, 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:

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<tr>
<th>Goal 1:</th>
<th>Objective(s) A goal may have one or more objectives.</th>
<th>Indicator(s) An objective may have one or more indicators.</th>
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<th>Goal 2:</th>
<th>Objective(s) A goal may have one or more objectives.</th>
<th>Indicator(s) An objective may have one or more indicators.</th>
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Plan for evaluation: Ask yourself what you need to know in order 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.
**STEP 5: Program theory/strategy:** A program’s theory/strategy describes the strategies that the program will undertake to achieve stated objectives. Statements of theory are usually expressed as: 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 in order 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, generate, 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.

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Who was reached/targeted</th>
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**STEP 8: Inputs**

What is invested in the program (e.g., funding, staff, volunteers, materials, evidence base).

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?
   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 Step 6 and 7 and 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-term, intermediate or long-term. Use information from Step 4 to complete this box.
Community Benefit Categories and Definitions

Community Benefit Categories

**Category 1:** Financial Assistance

**Category 2:** Government-Sponsored Means-Tested Health Care

**Category 3:** Community Benefit Services

This reference can be downloaded from the Catholic Health Association (CHA) website at www.chausa.org/guideresources.

This section represents recommendations for what counts as community benefit. It is not legal advice. Health care organizations should consult the most recent guidance from their state and the Internal Revenue Service (IRS) regarding required reporting of community benefit information.

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

- Improve access to health care services.
- Enhance public health.
- Advance increased general knowledge.
- Relieve or reduce the burden of government to improve health.

Following are recommendations for how programs and activities should be categorized and examples of what should and should not be reported as community benefit. It is advised that health care organizations keep a record of the rationale for why a program or activity is a community benefit. What community need is it responding to? Does the need continue? What community benefit objective is being met?
FINANCIAL ASSISTANCE

Financial assistance is free or discounted health services provided to persons who cannot afford to pay and who meet the eligibility criteria of the organization’s financial assistance policy. Financial assistance is reported in terms of costs, not charges. Financial assistance does not include bad debt, which may be reported in Part III of the IRS Form 990, Schedule H for Hospitals (Schedule H) but not as community benefit.

Count:

- Free and partially discounted care (discounted from cost, not charges).
- Expenses incurred by the provision of financial assistance.
- Provider taxes, assessments or fees if Medicaid DSH funds in your state are used in whole or in part to offset the cost of financial assistance.
- Unpaid co-pays for Medicaid and other low-income patients 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.”

Do not count:

- Bad debt.
- Discounts provided to self-pay patients who do not qualify for financial assistance.
- Contractual allowances or quick-pay discounts.
GOVERNMENT-SPONSORED MEANS-TESTED HEALTH CARE

Government-sponsored means-tested health care community benefit includes unpaid costs of public programs for low-income persons – the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and government payments.

**Count:**

Revenues and costs related to:

- Medicaid.

- Other means-tested government programs, including:
  - State Children’s Health Insurance Programs (SCHIP).
  - State and local indigent care: Medical programs for low-income or medically indigent persons not eligible for Medicaid.

**Do not count:**

- Medicare shortfall (this can be included in other financial reports but not as a community benefit).

- Other government programs that are not means-tested, such as VA and Indian Health Service.
COMMUNITY BENEFIT SERVICES

As a general rule:

Count:

- Programs that respond to an identified community health need and are designed to accomplish one or more community benefit objectives.
- 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 primarily designed for marketing or promotion purposes.
- Time spent by volunteers and employees on their own time.
- Routine or required care and services.

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 include:

- Community health education.
- Community-based clinical services, such as health services and screenings for underinsured and uninsured persons.
- Support groups.
- 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.

• Community health initiatives addressing specific health targets and goals.

A1. Community Health Education

Community health education includes lectures, presentations, and other group programs and activities apart from clinical or diagnostic services. Community benefit in this area can include staff time, travel, materials, staff preparation and indirect costs.

*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.

• Community newsletters primarily intended to educate the community about health issues and free community health programs.

• Consumer health libraries.

• Education on specific diseases or conditions, such as diabetes or heart disease.

• Health fairs in response to community need (not primarily for marketing).

• Health promotion and wellness programs.

• Health education lectures and workshops by staff to community groups.

• Parish and congregational health-related programs.

• 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.).

• Radio call-in programs with health professionals to address community health need.

• School health-education programs (Note: Report school-based programs on health care careers and workforce enhancement efforts in Community Building, Workforce Development, F8. Report school-based health services for students in community-based clinical services, A2.).
• Web-based consumer health information related to community health needs. Report costs associated with developing or making information available, including costs to translate into languages spoken in the community.

• Worksite health education programs when not performed as “good will” and provided in response to community health need.

_Do not count:_

• Community calendars and newsletters, if they are primarily used as marketing tools.

• Patient education services that are part of comprehensive patient care (e.g., diabetes education provided only for patients).

• Health education sessions offered for a fee, for which a profit is realized.

• Volunteer time for parish and congregation-based services.

• Advertisements with health messages when the 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: diseases and disabilities, grief, infertility, support for patients’ families and the community.

_Count if the program addresses a community 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 given to patients and families in the course of their inpatient or outpatient encounter.
Self-help programs

These include wellness and health-promotion programs for the community, such as those for smoking cessation, exercise, and weight loss.

*Count if the program addresses a community 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 your organization as an employee benefit.
- The use of facility space to hold meetings for community groups (Report in In-kind Donations, E3).

A2. Community-Based Clinical Services

These are health services and screenings provided on a one-time basis or as a special event in the community. They do not include permanent subsidized hospital outpatient services; report these in Hospital Outpatient Services, 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 and can result in a referral to any community medical resource. To be considered community benefit, screenings should provide follow-up care as needed, including assistance for persons who are uninsured and underinsured.
**Count if the program addresses a community need and meets a community benefit objective:**

- Behavioral health screenings.
- Blood pressure screening.
- Lipid profile and/or cholesterol screening.
- Eye examinations.
- General screening programs.
- Health-risk appraisals.
- 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.
- Stroke risk screenings.

**Do not count:**

- Health screenings associated with conducting a health fair (report in Community Health Education, A1).
- Screenings for which a fee is charged and a profit is realized.
- Screenings when the primary purpose is to generate referrals to the health care organization or its physicians.
- Screenings provided primarily for public relations or marketing purposes.

**One-time or occasionally held clinics**

**Count if the program addresses a community need and meets a community benefit objective:**

- Blood pressure and/or lipid profile/cholesterol screening clinics.
Community Benefit Categories and Definitions

- Cardiology risk factor screening clinics (take care not to include if screening is really marketing or case-finding).
- Colon cancer screenings.
- Dental care clinics.
- Immunization clinics.
- Mobile units that deliver primary care to underserved populations on an occasional or one-time basis.
- 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 (not good will).
- Flu shots or physical exams for organization employees.
- Clinics for which a fee is charged and a profit is realized.
- Subsidized, permanent, ongoing programs and outpatient services (report in Hospital Outpatient Services, C3).

**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 donate their time.

_Count if the program addresses a community need and meets a community benefit objective:_

- Costs for staff time, equipment, and overhead costs.
- Lab and medication costs.

_Do not count:_

- Volunteers’ time and contributions by other community partners.
- Grants to an unrelated free clinic or Federally Qualified Health Centers (report in Cash Donations, E1).
**Mobile units**

Count staff time, supplies and other operational costs if the program addresses a community need and meets a community benefit objective:

- 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, and lithotripsy (report in Hospital Outpatient Services, C3).

- Costs for marketing associated with the mobile unit. For example, if 30% 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% of the cost of the mobile unit would not be reported as community benefit expense.

**A3. Health Care Support Services**

Health care support services are provided by the hospital to increase access and quality of care in health services to individuals, especially persons living in poverty and those in other vulnerable populations.

**Count if the program addresses a community need and meets a community benefit objective:**

- Information and referral to community services for community members (not routine discharge planning).

- Chronic disease 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 in public programs, such as SCHIP and Medicaid.

- Assistance to enroll in health insurance marketplace programs, including the costs of navigator services.
• Personal response systems, such as Lifeline.

• Translation/interpreter services that go beyond what is required by state or federal rules or law or for accreditation. For example, translation services for a group that comprises less than a prescribed percentage of the population.

• Cash assistance for emergency housing following discharge of homeless patient.

**Do not count:**

• A physician referral program if it is primarily an internal marketing effort or only for hospital affiliated physicians (unless for Medicaid or uninsured persons).

• Health care support given to patients and families in the course of an inpatient or outpatient encounter.

• Routine discharge planning.

• Enrollment assistance programs specifically designed to increase facility revenue.

• Translation/interpreter services 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 the determinants of health, which includes the social, economic and physical environment. They may be related to activities in Category F: Community-Building (physical improvements and housing, economic development, community support, environmental improvements, leadership development, coalition building, community health improvement advocacy and workforce development). These activities can be reported as community health improvement under A4 when they meet the criteria for community benefit described in Chapter 2, Guideline 1 and are not reported in Category F.

**Count:**

• Removal of harmful materials (such as asbestos, lead) in public housing.

• Improving availability of fresh fruits and vegetables in areas known as “food deserts.”

• Violence prevention.

• Coalitions involved in task-specific projects and initiatives that address community health needs.

• Participation in community coalition to increase jobs with health insurance.
• Participation in economic development council to revitalize depressed community by addressing factors that affect health.

• Neighborhood improvement in low-income area to address public safety issues.

**Do not count (report as F. Community-Building):**

• Neighborhood improvement to address blight.

• Participation in an economic development council to revitalize depressed community.

• Participation in community-wide effort to decrease litter and graffiti.

• Job creation and training programs in communities with high unemployment or for vulnerable population.

### 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 for a degree, certificate, or training that is required by state law, accrediting body or health profession society.

### B1. Physicians/Medical Students

**Count:**

Be sure to subtract government subsidies from these costs before counting. You may count the unpaid costs of:

• A clinical setting for training.

• Internships, residencies and fellowships.

• Continuing medical education (CME) required for medical credentialing offered to physicians outside of the medical staff on subjects for which the organization has special expertise.

**Do not count:**

• Expenses for physician and medical student in-service training.

• Joint appointments with educational institutions and medical schools (unless for a specialty where there is a documented shortage).
B2. Nurses/Nursing Students

Count:

• Providing a clinical setting for students enrolled in an outside organization (count time
  that staff nurses are taken away from their routine duties).

• Costs associated with underwriting faculty positions in schools of nursing in response
  to shortages of nurses and nursing faculty.

Do not count:

Expenses associated with:

• Education required by nursing staff, such as orientation, in-service programs,
  and new graduate training.

• Expenses for standard in-service training and in-house mentoring programs.

• In-house nursing and nurse’s aide training programs.

• Programs where nurses are required to work for the organization.

• Contributions to an unaffiliated school of nursing (report in Cash Donations, E1).

B3. Other Health Professions Education

Count:

• A clinical setting for student training and internships for dietary professionals,
  technicians, chaplaincy/pastoral care, physical therapists, social workers, pharmacists,
  and other health professionals – when there is no work requirement tied to training.

• Training of health professionals in special settings, such as occupational health
  or outpatient facilities.

Do not count:

Expenses associated with:

• Education required by staff, such as orientation and standard in-service programs.

• On-the-job training, such as pharmacy technician and nurse’s assistant programs.
• Programs where trainees are required to work for the organization after training.
• Training for non-health related professions such as accounting.

**B4. Scholarships/Funding for Health Professions Education**

**Count:**

• Scholarships or tuition payments for nursing and health professions education to nonemployees with no requirement to work for the organization as a condition of the scholarship.

• Specialty in-service and video conferencing 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 where students/trainees are required to work for the organization.
C. Subsidized Health Services

Subsidized health services are clinical programs that are provided despite a financial loss so significant that negative margins remain after removing the effects of financial assistance, bad debt and Medicaid shortfalls. Nevertheless, the service is provided because it meets an identified community need and if no longer offered, it would either be unavailable in the area or fall to the responsibility of government or another tax-exempt organization to provide.

Subsidized services do not include ancillary services that support service lines, such as lab and radiology (if these services are provided to persons meeting the hospital’s financial assistance eligibility criteria, they should be reported as financial assistance).

**CAREFULLY EXAMINE SUBSIDIZED SERVICES**

The category of subsidized services is not a catch-all 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.

Exclude from subsidized health services amounts that already have been accounted for, such as financial assistance or Medicaid losses. In addition, the IRS in instructions for the Schedule H require excluding the shortfall from bad debt.

**Count:**

- Clinical programs or service lines that the organization subsidizes.
- The amount the health care organization subsidizes to provide these services. Report the amount of the subsidy for the whole program, not just for components of the program that are losing money. For example, if a component of the emergency room service, such as physician services, is losing money but the overall service is not losing money and does not need to be subsidized, then the service would not be reported as a subsidized service.

**Do not count:**

- Ancillary services (such as lab, radiology). (Note: free or discounted ancillary services for persons who meet the organization’s financial assistance policy criteria should be reported as financial assistance.)
- Financial assistance.
• Bad debt.
• Medicaid shortfall.
• 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.

Examples of Services that Frequently Qualify as Subsidized Health Services

C1. Emergency and Trauma Services

*Count:*

• Air ambulance.
• Emergency department.
• Trauma center.

*Do not count:*

• Payment for routine on-call physician services.

C2. Neonatal Intensive Care (if subsidized)

C3. Hospital Outpatient Services

*Count:*

• Subsidized permanent outpatient services and primary/ambulatory care centers, whether they are within the hospital facility or separate, freestanding facilities (e.g., urgent care center).
• Mobile units, including mammography and radiology units.
  (Note: IRS instructions require describing subsidies to free-standing physician clinics.)
C4. Burn Units

C5. Women’s and Children’s Services

Report services designed to increase access and quality of care for women and children, especially those living in poverty, and other vulnerable populations. As with all community benefits in the subsidized care category, count only those for which an identified community need exists and for which not providing the service would result in a shortage within the community.

**Count:**

- Freestanding breast diagnostic centers.
- Obstetrical services.
- Pediatrics.
- Women’s services.

**Do not count:**

- Services provided in order to attract physicians or health plans.

C6. Renal Dialysis Services

C7. Subsidized Continuing Care

**Count:**

- Hospice care.
- Home care services.
- Skilled nursing care or nursing home services.
- Adult day health programs.
- Durable medical equipment.

**Do not count:**

- Step-down or post-acute services provided in order to discharge outlier patients, to the financial advantage of the facility.
C8. Behavioral Health Services

**Count:**

- Inpatient and outpatient behavioral health services.

C9. Palliative Care

**Count:**

- Outpatient and community-based palliative care programs.

**Do not count:**

- The organization’s inpatient palliative care program.

D. Research

Research that may be reported as community benefit includes clinical and community health research, as well as studies on health care delivery that are generalizable, shared with the public and funded by the government or a tax-exempt entity (including the organization itself). Do not report as community benefit research where findings are used only internally or are proprietary. Count the total cost of the qualifying research programs, including direct and indirect costs. Per IRS 990 Schedule H instructions, grant funding must be reported as offsetting revenue.

D1. Clinical Research

**Count:**

- Research development costs.
- Studies on therapeutic protocols.
- Evaluation of innovative treatments.
- Research papers prepared by staff for professional journals and presentations.
Do not count:

- Research where findings are used only internally.
- Research that yields knowledge used for proprietary purposes.

D2. Community Health Research

Count:

- Studies on health issues for vulnerable persons.
- Studies on community health, such as incidence rates of conditions for special populations.
- Research papers prepared by staff for professional journals or presentation.
- Studies on innovative health care delivery models.

Do Not Count:

- Market research.
- Research where findings are only used internally or by the funder.

E. Cash and In-Kind Contributions

This category includes funds and in-kind services donated to community organizations or to the community at large for a community benefit purpose. In-kind services include hours contributed by staff to the community while on health care organization work time, the cost of meeting space provide to community groups and the donations of food, equipment, and supplies. (Note: contributions to provide support services to individuals should be reported in category A3. Health Care Support Services.)

Donations in this category must be restricted, in writing, to programs or activities that would qualify as community benefit if provided by the organization itself. If the contribution is used for a community-building activity or program, it should be reported as community-building.

E1. Cash Donations

Only count those donations to organizations and programs that are for the same type of activities and programs that would count as community benefit provided by the hospital:
• Contributions provided to health care organizations and other community organizations.

• Contributions for providing technical assistance or evaluation of community coalition efforts.

• Contributions to charity events of not-for-profit organizations, after subtracting the market value of participation by the employees or organization.

• Financial assistance within and outside the local community in response to natural disasters or poverty or catastrophic events (e.g., terrorism).

• Event sponsorship.

Do not count:

• Employee-donated funds.

• Emergency funds provided to employees.

• Fees for sporting event tickets.

• Time spent at golf outings or other primarily recreational events.

E2. Grants

These include grants made by the organization to community and other not-for-profit entities, projects, and initiatives.

Count if contribution will address a community need and meets a community benefit objective:

• Program, operating, and education grants.

• Matching grants.

Do not count:

• Grants passed through from a related organization.

E3. In-Kind Donations

Count:

• Meeting room overhead and space for not-for-profit organizations and community groups (such as coalitions, neighborhood associations, and social service networks).
Community Benefit Categories and Definitions

• 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.

• Costs of coordinating community events not sponsored by the health care organization, such as March for Babies.

• Employee costs on work time associated with community health-related boards and other community involvement.

• Food donations, including Meals on Wheels subsidies and donations to food shelters.

• Laundry services for community organizations.

• Other free ancillary services such as lab, radiology and pharmacy services 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 and planning and marketing.

Do not count:

• Employee costs associated with board and community involvement when these are done 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).

F. Community-Building Activities

Community-building activities improve the community’s health and safety by addressing the root causes of health problems, such as poverty, homelessness, and environmental hazards. These activities strengthen the community’s capacity to promote the health and well-being of its residents by offering the expertise and resources of the health care organization. Costs for these activities include cash and in-kind donations and expenses for the development of a variety of community-building programs and partnerships.
Schedule H requires hospitals to report community-building activities in Part II of the form rather than in the Part I community benefit table. The IRS also requires hospitals to describe in Part VI how these activities promote the health of the communities served. The instructions also state that some community-building activities may meet the definition of community benefit and direct organizations to report those activities as community health improvement.

See Chapter 2, Guideline 1 for community health improvement criteria.

**F1. Physical Improvements and Housing**

**Count:**

- Neighborhood improvement and revitalization projects.
- Public works, lighting, tree planting, and graffiti removal.
- Housing rehabilitation, contributions to community-based assisted living, and senior and low-income housing projects.
- Habitat for Humanity activities.

**Do not count:**

- Housing costs for employees.
- Health facility construction and improvements, such as a meditation garden or parking lot.

**F2. Economic Development**

**Count:**

- Participation in an economic development council or chamber of commerce on issues impacting the community’s health and safety.
- Grants to community businesses for the purpose of economic development to revitalize depressed community.

**Do not count:**

- Routine financial investments.
- Contribution to the arts (unless part of a comprehensive plan for economic development of the community).
F3. Community Support

This includes efforts to establish or enhance community support networks, such as neighborhood watch groups and childcare cooperatives. Activities include both community-based initiatives and facility-based initiatives.

**Count:**

- Child care for community residents with qualified need.
- Mentoring programs (other than for health professions, which are counted in Workforce Development, F8) to improve graduation rates.
- Neighborhood systems, such as watch groups.
- Youth asset development.
- Disaster readiness over and above state and federal licensure requirements. Be careful not to double-count with in-kind donations or grants.

*See What Counts Q & A section of the CHA website (Community-Building Activities/Disaster Preparedness) for full recommendation of what to count.*

**Do not count:**

- Costs associated with subsidizing salaries of employees deployed in military action (considered employee benefits).
- Costs associated with routine and mandated disaster preparedness.

F4. Environmental Improvements

**Count:**

- Training community members to monitor and reduce environmental hazards.
- Neighborhood and community improvements to decrease litter.
- Safe removal or treatment of garbage and other waste products.
- Activities that reduce the environmental hazards caused by the organization, if their primary purpose is to improve community health, addresses an issue known to affect community health and must be subsidized by the organization, including:
  - Waste reduction to minimize incineration, which presents hazards to local community health by triggering asthma and other problems.
- Purchasing cleaner energy from power plants in order to reduce harmful emissions that impact community health.

- Eliminating use of toxic materials such as mercury.

- Buying regionally grown or organic food to reduce transport-related emissions, non-organic pesticides and herbicides.

**Do not count:**

- Activities where the primary purpose addresses the health of persons affiliated with the organization, i.e., patients and staff (for example, use of green cleaning products).

- Expenditures to comply with environmental laws and regulations such as medical radiological waste disposal.

- Activities provided for marketing purposes, such as distribution of “green” items with organization’s name and logo.

- Activities that are an extension of good/excellent patient care, such as replacing DEHP intravenous bags and tubes.

- Activities that recover costs or payback in future filing years, such as facility purchase of low emission/improved mileage vehicles.

**F5. Leadership Development and Leadership Training for Community Members**

**Count:**

- Conflict resolution training.

- Community leadership development.

- Cultural skills training.

- Language skills development.

- Life or civic skills training programs.

**Do not count:**

- Above services for employees.

- Interpreter competency testing and/or training programs for hospital staff to meet government requirements.
F6. Coalition Building

**Count:**

- Hospital representation to community coalitions that address economic revitalization or affordable housing.
- Collaborative partnerships with community groups to improve economic stability of the community.
- Costs for task force-specific projects and initiatives.

F7. Advocacy for Community Health Improvements and Safety

**Count:**

- Local, state, and national advocacy on behalf of such areas as:
  - Transportation.
  - Crime.
- Advocacy for Social Justice and Human Rights, including:
  - Dues, grants, and gifts to organizations that support social justice.
  - Costs associated with advocating for social justice, environmental responsibility, and human rights (such as fair treatment of workers) through investments as shareholders, including:
    - Dues to organizations such as the Interfaith Center for Corporate Responsibility.
    - Voting proxy management fees.
    - Consultant fees.
    - Staff time.

_Do not count:_

- Advocacy specific to hospital operations and financing.
- Normal investing costs (only additional costs specifically related to socially responsible investing should count as community benefit).
**F8. Workforce Development**

These programs address community-wide workforce issues – not the workforce needs of the health care organization, which should be considered human resource activities rather than community benefit.

**Count:**

- Recruitment of underrepresented minorities.
- Job creation and training programs.
- Participation in community workforce boards, workforce partnerships, and welfare-to-work initiatives.
- Partnerships with community colleges and universities to address the health care work force shortage.
- Workforce development programs that benefit the community, such as English as a Second Language (ESL) training.
- School-based programs on health care careers.
- Community programs that drive entry into health careers and nursing practice.
- Health career mentoring projects such as job shadowing.

**Do not count:**

- Routine staff recruitment and retention initiatives.
- Programs primarily designed to address workforce issues of the health care organization.
- In-service education and tuition reimbursement programs for current employees.
- Scholarships for nurses and other health professionals (report in Health Profession Education, B).
- Employee workforce mentoring, development, and support programs.
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

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 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

Count:

- Costs related to the organization’s community health needs assessment.
- Contribution for conducting a collaborative assessment with other organizations.
- Costs related to developing the implementation strategy.

Do not count:

- Costs of a market share analysis.
- Marketing surveys.

G3. Other Resources

Count:

- Costs associated with community benefit evaluation.
- Cost 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 CBISA by Lyon Software.

• Costs associated with attending educational programs to enhance community benefit program planning and reporting.

**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 (counted under In-kind Donations, E3).
Works Cited


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.

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 outcome.

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 improve health and quality of life through better jobs, housing and the natural environment.

For more information about community benefit and Catholic health care, go to www.chausa.org/communitybenefit

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