

# NOT-FOR-PROFIT HOSPITALS AND COMMUNITY BENEFIT

## WHAT WE DON'T KNOW CAN HURT US

Justin Rausa, MPH • Health Program Manager

Sydney Fang • Health Associate

Carla Saporta, MPH • Health Policy Director



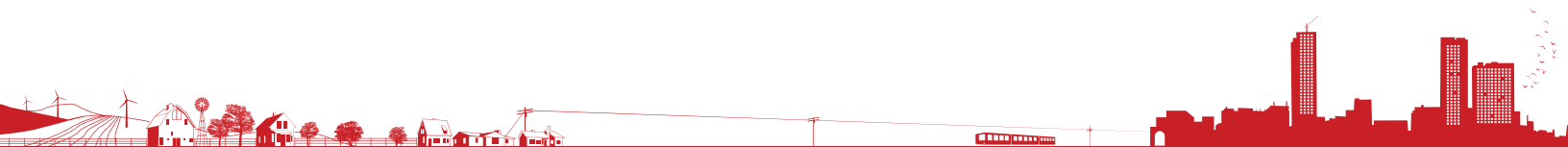
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# ACKNOWLEDGEMENTS

## About The Greenlining Institute

Founded in 1993, The Greenlining Institute is a policy, research, organizing, and leadership institute working for racial and economic justice. We work to bring the American Dream within reach of all, regardless of race or income. In a nation where people of color will make up the majority of our population by 2040, we believe that America will prosper only if communities of color prosper.

## Bridges to Health Program

Nothing is more essential than our health. Everybody should have access to good health regardless of race or income. Health care must be responsive to the nation's growing communities of color, but health care isn't enough. People also need access to the things that lead to good health such as safe neighborhoods, healthy foods, clean environments and decent jobs. Greenlining brings the voices of communities of color into critical decisions that affect all of our lives and health.

## About the Authors

### Justin Rausa, MPH, Greenlining Health Program Manager

Justin brings a decade of social justice activism to the Bridges to Health team, where he focuses on innovative, equitable, and healthy public policy. He graduated with honors from the University of California at Riverside with a B.S. in Biology, and received his M.P.H. from the University of California at Berkeley. Prior to Greenlining, he served in the Peace Corps in Namibia, as a graduate intern for California Food Policy Advocates, and as an interagency health policy intern for the state of California. Justin has been recognized multiple times for his work with low-income and marginalized communities.

### Sydney Fang, Greenlining Health Associate

Sydney is a native of the Bay Area and graduated in 2012 from the University of California, Berkeley with a degree in Public Health and a minor in Public Policy. Sydney's commitment to social justice and activism stems from her experiences as the daughter of immigrant parents. She has long worked with multicultural coalitions to advocate for student-of-color resources at UC Berkeley. Sydney also organized monolingual Chinese home care workers, served on the City of Berkeley Community Health Commission and was a 2012 Public Policy International Affairs (PPIA) Fellow at UCB. She is currently an Emerson National Hunger Fellow working on local and national anti-hunger initiatives. As a former Summer Associate, she takes a deliberate approach to promoting health equity by uplifting underrepresented voices in the decision-making process.

### Carla Saporta, MPH, Greenlining Health Policy Director

Before joining Greenlining as Health Policy Director, Carla Saporta educated and mobilized community members on policy issues and worked with policymakers to create and implement policy that benefits the community. She currently represents the community's interest as an advisory member on Covered California's Small Business Health Options Program Advisory Group. In her role at Greenlining, Carla leads advocacy efforts to ensure that implementation of the Affordable Care Act will benefit communities of color. This entails working with policymakers to pass and implement state reforms, increasing health workforce diversity, increasing access to care for boys and young men of color, and finding solutions to covering those who will not benefit from the ACA. Carla also oversees Greenlining's community benefit advocacy, which focuses on increasing funding for upstream programs that improve public health. Carla received her B.A. from Occidental College and her Master of Public Health at Portland State University through the Oregon Master of Public Health Program.

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## EXECUTIVE SUMMARY

- **Not-for-profit hospitals receive tax-exempt status in exchange for fulfilling a duty to improve community health.** Essentially, society makes a bargain with these institutions: They operate in a way that provides “community benefit,” and in exchange we exempt them from corporate income and property taxes.
- **California’s low-income communities and people of color consistently show disproportionately poor health outcomes.** This inequitable status quo is a result not only of inadequate access to health care, but also of the conditions in which people live, work, and play. Hospital community benefit activities present an opportunity to improve these conditions via community benefit spending in the community, outside hospital walls – known as “upstream” activities.
- **In order to assess the status of these activities, we examined publicly available records for the seven largest not-for-profit hospital systems in California.** We examined the relevant portions of IRS Form 990 and the community benefit plans submitted to California’s Office of Statewide Health Planning & Development (OSHPD). Because the data in these forms is often so incomplete as to make it impossible to form a clear picture, we contacted the hospital systems seeking the data needed to fully understand these activities. *None of the hospital systems were willing to provide additional data, and the California Hospital Association dismissed our request as “irrelevant.”*

### **With the data available, we were able to estimate that in Fiscal Year 2010 and 2011, the seven largest not-for-profit hospital systems in California:**

- Spent on average approximately 7.2 percent of their operating budgets on community benefit. This percentage varied widely between hospitals within each system, and across systems.
- Spent approximately 1.1 percent, on average, of the 7.2 percent spent on community benefit on programs that seek to improve health beyond the hospital walls, in the community.
- Reported varying levels of data that made it impossible to conduct across-the-board assessment of specific upstream investments, financial assistance and billing collection policies, the rigor of Community Health Needs Assessments, and the diversity of decision-making bodies related to community benefit.

### **Based on our findings, we make the following policy recommendations:**

- **The California Legislature should pass parity legislation** that will, at the very least, update California’s community benefit laws to align with some of the newer requirements instituted by the Affordable Care Act.
- **Governor Brown and Secretary Dooley should allocate more budgetary support to OSHPD, and the Legislature should increase its regulatory authority,** to enforce transparency in community benefit reporting and ensure accountability. Alternatively, this authority could be assigned to another agency so long as responsibility is clear and funding is adequate.
- **The California Legislature should pass legislation that ensures public health stakeholders and medically underserved, low-income and minority community members have a place at the table** of Community Health Needs Assessment-authorized bodies. This will help to build in accountability of these bodies as decision-makers, and help ensure that they reflect the demographics of their respective community.

- **As the Affordable Care Act succeeds in reducing the number of uninsured, it should reduce the need for charity care, referred to as “financial assistance,” freeing up funds for additional upstream investments.** This should be encouraged, but any such reallocation of funds *must not come at the expense of financial assistance needed by the community.* Communities, advocates, and policy makers can use the analysis in this report as a benchmark to assess whether or not the hospitals in this study are fulfilling their community benefit duty.
- **Hospitals should voluntarily make diversity data regarding key decision-makers connected to community benefit publicly available.** This should include hospital executives, hospital community benefit leadership, and CHNA-authorized bodies.

## INTRODUCTION

Nothing is more essential than our health. Everyone should have access to what they need to maintain good health — not just medical care, but everything else that contributes to health: nutritious food, exercise, clean air and water, safe neighborhoods, and quality jobs. In California, 5 percent of patients with multiple chronic conditions generate 53 percent of the health care costs — conditions that hospitals could better manage through investments that prevent people from getting catastrophically sick in the first place.<sup>1</sup> When it comes to health care, decades of the status quo suggest that an ounce of prevention is worth a pound of cure.

The U.S. has one of the most advanced health care systems in the world in terms of technology, a massive research and industrial establishment to refine and improve that technology, and a highly trained workforce that uses it. And yet, paradoxically, as of 2011, people in Kuwait had better health outcomes at the population level — including longer life expectancies — than in the U.S.<sup>2</sup> Health disparities like these exist within the U.S. too, with communities of color and low-income communities inequitably shouldering the burden of preventable illness and death.<sup>3,4,5</sup>

This status quo of health inequities and underperforming health care spending<sup>6</sup> will continue to exist unless America’s health care system approaches the conditions where people live, work, and play as opportunities for strategic investment and engagement with partners from other sectors (e.g. finance, education, etc.). California cannot realistically maintain its status as one of the largest economies in the world if a majority of its workforce is sick or dying.

California was already a majority-minority state in 2010, with people of color comprising almost 60 percent of the population<sup>7</sup> and projected to be more than 70 percent of the state’s population by 2060.<sup>8</sup> Unless the health care system adapts to the complexity of modern health needs for this population, California’s present and future do not look promising.

In general, when state and federal governments give a tax exemption to nonprofits, they make a bargain with them: Nonprofits get a break on their taxes because their primary purpose is to do good in the world, not to make profits for themselves. In exchange for not-for-profit hospitals’ tax exemption, they provide “community benefit” — programs and services that fulfill hospitals’ duty to improve community health. Thirty years ago, the Internal Revenue Service (IRS) defined community benefit as “the promotion of health for a class of persons sufficiently large so the community as a whole benefits.”<sup>9</sup>

Community benefit includes financial assistance for the medical care of low-to-moderate-income patients, the shortfall for providing care to patients in public means-tested programs (e.g. Medi-Cal), and spending on public health programs and activities beyond the hospital walls — in the community.

To justify their not-for-profit hospital tax exemptions, these corporations should transparently show that they are improving community health in meaningful ways, not just checking off boxes on a form and submitting an annual report. Right now the idea of community benefit, what it is and how it works, is neither clearly defined nor transparent, and neither is California's vision of what it should be. California community benefit regulations precede and sometimes exceed new requirements introduced by the Patient Protection and Affordable Care Act (ACA), but the ACA promotes more standardized community benefit-related definitions and transparency in community needs assessments, community benefit accounting, and reporting. It is still unclear whether the newer regulations go far enough to improve transparency. As outlined below, publicly available information regarding these expenditures remains sketchy and incomplete.

New federal guidelines also require hospitals to be more accountable to community in the development of their community benefit priorities through Community Health Needs Assessments (CHNAs) and subsequent implementation strategies. ACA requirements that increase transparency and community engagement enable community leaders to advocate for community benefit spending that could actively improve health outcomes outside of hospital walls.<sup>10</sup> State law enacted in 1994 states that community benefit includes both “direct provision of goods and services” and “preventive programs.”<sup>11</sup>

**Upstream public health approaches address the root causes of disease and disability and focus on prevention rather than treatment. Just as changes in the upstream portion of a river — like building or tearing down a dam — affect everything that happens downstream, upstream spending on community health needs can impact the root causes of illness and help to promote wellness.**

In the recent past and present, policy makers and advocates have strongly associated “charity care,” which is public program shortfall (e.g. Medi-Cal) and financial assistance, as central to community benefit. While medical care is extremely important and the need for financial assistance will remain, health care alone does not address the root causes of Californians’ disparate health outcomes. Hospitals now have more incentive to invest further upstream to prevent illness and promote healthy environments because of 2012 IRS instructions.<sup>12</sup> Policy makers, advocates, and community members can take advantage of the ACA and the promise it brings for community benefit, and drive hospitals to shift the focus to upstream investments as a valid and more effective method for improving community health, while maintaining essential financial assistance.

In discussions and interviews with national community benefit experts and hospital community benefit staff, both types of stakeholders emphasized that a lack of organizational capacity, understanding and support from executive leadership, and dedicated funding limit the ability of individual hospitals to implement community benefit in a manner that prevents illness and disease. However, not-for-profit hospital systems must be held accountable to these same communities as they are lawfully required to do. Upstream spending can bridge hospital systems’ community benefit duty with investments that promise better returns on investments and more significant improvements in health.

The ACA will free up community benefit dollars for more upstream spending going forward, as more of California’s uninsured and underinsured population receive coverage through Covered

California, the state’s health benefit exchange, and Medi-Cal expansion.<sup>13</sup> At the same time, community benefit dollars for financial assistance will continue to be vital, since an estimated four million Californians will still be uninsured in 2019.<sup>14</sup> Even as we look to increase upstream spending, financial assistance dollars needed by communities must not be diverted. In addition, county and Disproportionate Share Hospital (DSH) funding will gradually decrease in the future due to the Medi-Cal expansion and the ACA, so hospitals will continue to be an important source of financial assistance.

Hospital systems' financial assistance care for the uninsured can and should be well managed to reduce expenditures on preventable Emergency Department and inpatient utilization. In addition, as coordinated care supplants the old fee-for-service model for health care delivery under the ACA, one way for these institutions to stay financially viable will be to boost their investments beyond their walls in order to improve community health outcomes. Not investing newly available community benefit dollars upstream in meaningful ways will perpetuate inequitably poor health among people of color and low-income communities.

The analysis below will establish a benchmark for how California's seven largest hospital systems' community benefit practices measure up. The Office of Statewide Health Planning & Development (OSHPD), the state agency that monitors compliance with California's community benefit regulations, last reported on this topic in 1998.<sup>15</sup> Advocates and policymakers need to look at how community benefit impacts local communities in the era of post-ACA requirements, as well as in the years leading up to the ACA, in order for local communities to better advocate for themselves through the CHNA process, and for policymakers to understand community benefit based on current data. Such data can also help to determine whether California's 1994 community benefit laws requiring community benefit plans, financial assistance policies, community needs assessments, and community benefit seize the opportunity for health promotion in the 21st century.

## METHODOLOGY

To select the hospital systems for our study, we initially used the 2011 Pivot Profiles from OSHPD to rank hospital systems based on figures listed under "Operating Expenses."<sup>16</sup> "Operating Expenses," listed as "Total Expenses" in IRS Form 990, served as the most accurate proxy for a hospital system's budget.

Seven hospital systems emerged as the most resourced: Kaiser Foundation Hospitals, Dignity Health, Sutter Health, St. Joseph Health, Adventist Health, Sharp HealthCare, and Scripps Health. These systems are more capable of boosting upstream spending to achieve more impactful and sustainable gains for community health because of the budgets and organizational capacity available for community benefit:

Operating Expenses for the Seven Largest Hospital Systems in California, Calendar Year 2011 <sup>17</sup>	
Hospital System	Operating Expenses
Kaiser Foundation Hospitals	\$16,443,912,529 <sup>18</sup>
Dignity Health	\$6,454,116,374
Sutter Health	\$5,721,716,146
St. Joseph Health	\$2,623,486,527
Adventist Health	\$2,038,553,569
Sharp HealthCare	\$1,647,520,889
Scripps Health	\$1,526,596,417



While the scale of our analysis is at the hospital system level, we also sought hospital-level data to understand how community benefit spending impacts population-level health outcomes. A holistic assessment of community benefit practices across hospital systems requires the following overall calculations:

**According to IRS Form 990 Schedule H instructions, financial assistance (often referred to as “charity care”) is defined as “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.”**

- 1) Total community benefit spending of each individual hospital relative to each hospital’s operating budget.
- 2) Amount and breakdown of community benefit allocated towards upstream public health investments, in addition to financial assistance and public assistance shortfall for treating patients in Medicaid (Medi-Cal in California) and other government means-tested programs.
- 3) Evaluation of each individual hospital’s CHNA process.

In order to detect longitudinal trends for each hospital system, we reviewed reported community benefit figures for years 2008, 2009, 2010, 2011, and 2012. This five-year window would give us an idea of practices pre- and post-ACA reporting requirements for these hospitals.<sup>19</sup> Our approach required the following data for every hospital in each system in the study’s time range:

- 1) Operating expenses reported to the IRS.
- 2) Data on financial assistance and other community benefits at cost, community-building expenditures, the hospital’s Community Health Needs Assessment, financial assistance policies, billing and collections, and emergency medical care policies.

- 3) Community benefit plans from every hospital in each system.

### **Data Collection**

Financial and community benefit figures are considered to be publically available through hospitals’ Form 990s filed with the IRS, and annual community benefit plans (CBPs) submitted to OSHPD. We searched for individual or consolidated 990s using the Foundation Center’s 990 Finder ([foundationcenter.org/find-funders/990finder/](http://foundationcenter.org/find-funders/990finder/)). If our search yielded no results, we referred to GuideStar ([www.guidestar.org](http://www.guidestar.org)) for potential access before terminating the search for a specific hospital’s 990. There were major differences between 990 formats for our period of interest, during which hospitals filed three versions: 990s without Schedule H, Schedule H prior to 2012, and the Schedule H for the 2012 Form 990.<sup>20</sup>

**Interim IRS rules allow not-for-profit hospital systems with multiple hospital facilities to report financial and community benefit data in a consolidated format.**

In addition to collecting 990s, we requested CBPs from OSHPD’s Healthcare Information Division. However, we were unable to collect a complete set of CBPs from OSHPD because some hospitals’ plans were missing from OSHPD’s database, either for previous

years or for the most recent year — 2012. Therefore, we also requested data from each of the hospital systems in the study in order to build a comprehensive data set for our analysis.

We sent the data request letter via U.S. mail and electronically to each system’s lead community benefit officer and chief executive officer, and provided a window of three weeks to respond. Kaiser Permanente, Sutter Health, Dignity Health, and St. Joseph Health provided varying response letters without the requested data, and Adventist Health informed us by phone that they declined to participate in the survey. Scripps Health and Sharp Healthcare did not respond. The California Hospital Association (CHA), the hospitals’ trade association, proactively responded on behalf of the hospital systems in the study by refusing to participate in our data collection process. C. Duane Dauner, CHA’s President/CEO, stated in a letter:

Even if it were possible to reproduce this historical data to your specifications, it would not provide meaningful information to local communities or policymakers... Asking hospitals that are already struggling with limited resources and multiple priorities to expend enormous resources to create a report with a trend line from irrelevant data in this context will do little to assist local communities and policymakers in developing meaningful community benefit programs in the future.

— C. Duane Dauner, President/CEO, California Hospital Association

The ACA is both an unprecedented challenge and opportunity for these hospital systems. Consequently, without their full participation, we had to rely solely on the 990s we downloaded through Foundation Center and GuideStar, and the CBPs that we received from OSHPD. To benchmark the state of community benefit, our methodology asks whether these hospital systems provide basic data in standard categories. Due to varying availability of CBPs, differences in Schedule H, and hospital systems’ IRS filing extensions, the scope of this analysis is limited to 2010 and 2011.

Federal and state regulations define community benefit spending in distinct ways, using the following categories:

Community Benefit Spending Categories	
<p><b>Form 990 Schedule H Categories<sup>21</sup></b></p> <ul style="list-style-type: none"> <li>• Charity care</li> <li>• Shortfall from Medicaid and other means-tested government programs</li> <li>• Community health improvement services and community benefit operations               <ul style="list-style-type: none"> <li>• Health professions education</li> <li>• Subsidized health services</li> <li>• Research</li> </ul> </li> <li>• Cash and in-kind contributions for community benefit</li> </ul>	<p><b>Community Benefit Plan Categories<sup>22</sup></b></p> <ul style="list-style-type: none"> <li>• Medical care services</li> <li>• Other benefits for vulnerable populations</li> <li>• Other benefits for the broader community               <ul style="list-style-type: none"> <li>• Health research, education, and training programs</li> <li>• Nonquantifiable benefits</li> <li>• Medical care services</li> </ul> </li> </ul>

### Calculating Total Community Benefit Spending

Data sources for analyzing total community benefit spending by hospital system consist of:

- CBPs for all hospitals in the systems studied provided community benefit spending figures based on the calendar year.<sup>23</sup>
- 990s provided Operating Expenses for the analysis.
- Schedule H, Part I provided community benefit spending for fiscal years<sup>24,25</sup> at individual hospitals or consolidated by region or system, if available.

While CBPs provided details for specific community benefit expenditures,<sup>26</sup> we primarily used the Schedule H to determine total community benefit spending because of the variability in reporting in CBPs. For example, community benefit plans for Sharp HealthCare hospitals included bad debt in their medical financial assistance figures, as well as including the unreimbursed cost of Medicare in total community benefit spending. However, both bad debt and Medicare shortfall are no longer considered community benefit for purposes of Schedule H, and must now be reported in a different part of the 990.<sup>27</sup>

## Calculating Upstream Public Health Investments

We assessed the level of upstream public health investments using information from Schedule H, Part I, under “Other Benefits.”<sup>28</sup> For Kaiser Foundation Hospitals and Dignity Health, we had to calculate estimates of total community benefit spending and upstream public health investments using CBPs since these two systems submitted consolidated Form 990s that included hospitals from other states, which means we could not disentangle operating budget and community benefit expenditures to be California-specific.

We had to use a combination of CBPs and 990s for this analysis since the hospital systems in question did not respond to our data request and because some publicly available 990s included figures from other states or were unavailable entirely. Thus, in some cases, we could only estimate the level of upstream community benefit spending,<sup>29</sup> not the exact value of upstream expenditures. We were unable to score individual hospitals’ level of upstream investments due to these data constraints, even though we did create a scoring guide based on “Community Building” categories from Schedule H Part II,<sup>30,31</sup> disease prevention activities,<sup>32</sup> systematic reviews from the Community Preventive Services Taskforce,<sup>33,34</sup> and Healthy People 2020’s<sup>35</sup> objectives to “create social and physical environments that promote good health for all.”<sup>36</sup>

## Evaluating CHNA

The ACA requires that individual hospitals complete one CHNA every three years, and make public an “implementation strategy to meet the community health needs identified through the assessment.”<sup>37</sup> An assessment of CHNA practices would enable us to understand how hospitals are engaging the communities in their service areas to identify and meet community health needs. We sought to evaluate CHNAs using two measures:

- (1) A score evaluating the narrative included in hospitals’ CBPs.
- (2) A score generated from boxes checked on Schedule H, Part V related to CHNAs.

Since the hospital systems in this study refused to provide information for this analysis, the primary source for CHNA information was the CBPs, not the 990s. Since CBP reporting for CHNAs is highly variable, we were unable to accurately and fairly score the hospitals’ CHNA process, even though we did develop evaluative criteria based on best practices for CHNA and its implementation.<sup>38,39</sup> The list prioritized engagement and inclusion of multi-ethnic communities, attention to the social determinants of health, and plan implementation.<sup>40</sup> We were limited in our ability to use a similar process for evaluating other community benefit requirements reported in Schedule H, including financial assistance, billing and collections, emergency medical care policies, and charges to financial-assistance-eligible individuals.

## FINDINGS

Our findings, detailed below, demonstrate that on average, community benefit spending is low among the hospital systems studied, and that the proportion of upstream spending is extremely limited.

Even though our analysis used data from two sources, CBPs and 990s, our findings are generally consistent with those from a recent peer-reviewed study showing that hospital costs for patients in government assistance programs, financial assistance, and subsidized health services comprise the largest deductions from a hospital’s revenue as community benefit.<sup>41</sup> In 2009, medical care in hospitals was a large proportion of community benefit spending at more than 85 percent nationally — providing important medical care for the uninsured and underinsured, but little for community health improvement.<sup>42</sup>

However, community benefit, as it is used now, does not give communities access to what they need to maintain good health beyond medical care, such as nutritious food, exercise, clean air and water, safe neighborhoods, and quality jobs. Beginning in 2014, when millions of Californians can purchase affordable health insurance under the ACA or are newly eligible for Medi-Cal through the Medi-Cal expansion, community benefit dollars that had been needed for charity care will be freed up. The community benefit dollars and funds from any revenue growth moving forward should be invested towards upstream spending — promoting health instead of putting Band-Aids on health issues that could have been prevented.

At the same time, financial assistance will continue to be vital, since an estimated four million Californians will still be uninsured in 2019, a quarter of whom will be undocumented.<sup>43</sup> Needed financial assistance dollars should not be diverted towards upstream spending if community members need the aid. In addition, county and DSH funding will gradually decrease in the future due to Medi-Cal expansion and the ACA, so hospitals will continue to be an important source for uninsured care.

The 990s we downloaded from The Foundation Center and GuideStar offered a more consistent metric for analyzing community benefit spending than CBPs. This analysis excludes one hospital for both Sutter Health and Adventist Health that did not file a Schedule H in 2011, and an illegible community benefit spending table for a Dignity Health hospital in a 2010 CBP, resulting in missing data. The lack of data and the variability in available data make it difficult for communities and other stakeholders to assess whether community benefit is having sustainable, positive health impacts for people of color and low-income communities.

Although the following charts and tables present figures for hospital systems' level and type of community benefit spending, it is still difficult to assess the transparency and validity of these values. Both federal and state statutes allow hospitals to use payer-specific calculation methodology to compute community benefit expenditures. In addition, community benefit spending tabulations for financial assistance, shortfall for means-tested public programs, and subsidized health services are based on a hospital's overall chargemaster, which "contains the prices of all services, goods, and procedures for which a separate charge exists."<sup>44</sup> As a result, these values are highly dependent on internal payment accounting methodology that is neither audited nor regulated.<sup>45,46</sup>

The following pie charts were calculated using data from CBPs, while the tables were primarily calculated using 990s. For the pie charts, community benefit spending is categorized into two overall categories: "BC" (Broader Community) and "VP" (Vulnerable Populations). Sub-categories include "Research & Education," "Shortfall & Financial Assistance," and "Upstream." Graduate medical residencies, medical research, health workforce pathways, and health professions education are examples of expenditures claimed under the sub-category of education and research spending. The sub-category of shortfall and financial assistance includes community benefit spending on means-tested public programs (e.g. Medi-Cal and county indigent programs) and financial assistance, which provides free or discounted medical care for low-to moderate-income uninsured and underinsured. Upstream expenditures in the CBPs for almost all of the hospital systems analyzed (except for Scripps Health) sort spending by BC and VP.

The maps in this section show hospital footprints of the systems in question, represented by red dots. The green background layer is shaded in by county, from dark green to light yellow, which depicts whether the county has a higher or lower median household income.<sup>47</sup>

Median household income at the county level can paint a broad picture of the distribution of income on a regional scale, to show where upstream community benefit can have the biggest impact due to these communities' historically limited access to what they need to maintain good health. However, using county-level income data can statistically mask details at the neighborhood level. As a result, some of the maps (e.g. Scripps, Sharp) show only a higher median household income, even though the county does have neighborhoods with significant numbers of low-income individuals and families.

## Kaiser Foundation Hospitals



### Map Legend

#### Median Household Income

Data Unavailable

\$35,991 - \$44,018.9

\$44,019 - \$52,598.9

\$52,599 - \$63,153.9

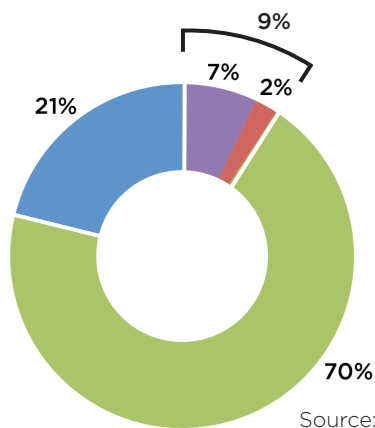
\$63,154 - \$84,895

Data by: County (2010)

In 2011, Kaiser Foundation Hospitals operated 35 hospitals. Kaiser hospitals' footprint, as shown in the map, is primarily in the San-Francisco Bay Area, greater Los Angeles area, and western edges of the Inland Empire. In California, Kaiser operates separately as two regions: Northern California and Southern California. Unlike the other hospital systems in this study, Kaiser Foundation Hospitals are complemented by Kaiser-Permanente, which includes both its plan members and its own medical provider group. Kaiser Foundation Hospitals do not have sister foundations that do grant-making, but all individual Kaiser Foundation Hospitals allocate some of their community benefit dollars to the "National Board of Directors Fund," which supports its national community benefit program to "support national nonprofit organizations and initiatives."<sup>48</sup>

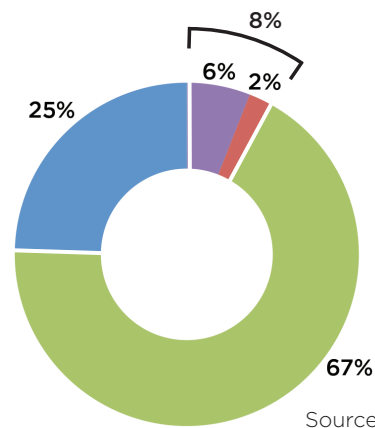
### Kaiser's Upstream Spending was 9% of Community Benefit in 2010

- VP - Upstream
- BC - Upstream
- VP - Shortfall and Financial Assistance
- BC - Research and Education



### Kaiser's Upstream Spending was 8% of Community Benefit in 2011

- VP - Upstream
- BC - Upstream
- VP - Shortfall and Financial Assistance
- BC - Research and Education



**Note:** The downloaded 990s for Kaiser Foundation Hospitals report consolidated financial data and community benefit expenditures from hospitals within and outside of California. Thus, Total Operating Expenses and Total Community Building (C1 in the appendix) expenditures are greater than actual California-specific totals. In addition, while other systems' data in this section were taken strictly from the 990, Kaiser's data for Total Community Benefit Spending and Upstream Investments were calculated using CBPs. The data for this system are in parentheses to signify that they are approximations calculated from a combination of both CBP and 990 data.

	Total Operating Expenses	Total Community Benefit Spending (A1)	Percentage of Operating Expenses (A2)	Upstream Investments – Subtotal* (B1)	Percentage of Operating Expenses (B2)
<b>2010</b>	(\$15,220,547,445)	(\$806,809,569)	(5.3%)	(\$74,386,343)	(0.5%)
<b>2011</b>	(\$16,443,912,529)	(\$785,723,087)	(4.8%)	(\$63,226,395)	(0.4%)

### Additional Key Findings

As part of Kaiser’s upstream community benefit spending, Kaiser Foundation Hospitals spent three times more on research and health professions education than they did on its upstream community benefit investments. In 2009, the IRS made the decision to allow hospitals to claim external grants as their own community benefit dollars, which allows hospitals with large research facilities to claim tens of millions of dollars in grants received from the National Institutes of Health as their own community benefit spending. While some hospitals have claimed that they are not going to report these external research dollars as community benefit, it is unclear which hospitals and/or hospital systems take advantage of this loophole.

Using 990 figures as proxies, it also appears that Kaiser’s hospitals spend a smaller proportion of their operating budget on community benefit than either of the next two highest grossing systems, at 5.1 percent. However, it is unclear whether or not CBP figures are net community benefit expenditures.

Kaiser’s consolidated Form 990s would be a functional data source if the Schedule Hs included only California hospitals, but its 990s included data from hospitals in Hawaii and Colorado. Thus, it is impossible based only on the Schedule H to calculate the budget of Kaiser Foundation Hospitals in California, how much is spent on community benefit, and how much is invested into community-building activities. Thus, we could only calculate proxies for what is spent using data from the consolidated 990 and information from individual community benefit plans.

However, from the CBPs, it appears that some hospitals in the Los Angeles area (KFH Downey, KFH Los Angeles, and KFH West Los Angeles) coordinate community benefit spending to fund a community center in Watts, which may be a step towards strategically targeting dollars upstream in a manner that is more likely to improve measurable health outcomes.<sup>49</sup> On the other hand, as with other hospitals in the study, the lack of detail and transparency in reported data preempt any analysis of whether this activity measurably improves population health. More detailed impact evaluation of these expenditures is needed.

\*Note: Not-for-profit hospitals’ spending on upstream programs is a way of assessing a hospital’s commitment to improve health beyond its walls, in the community. The figures in columns B1 and B2 are a sub-total of columns A1 and A2, respectively, and cannot be summed together. For example: Of a system’s “A1” spending, “B1” was spent on upstream investments. Please note that this note applies to all the tables in the Findings Section.

## Dignity Health



### Map Legend

#### Median Household Income

▨ Data Unavailable

□ \$35,991 - \$44,018.9

□ \$44,019 - \$52,598.9

□ \$52,599 - \$63,153.9

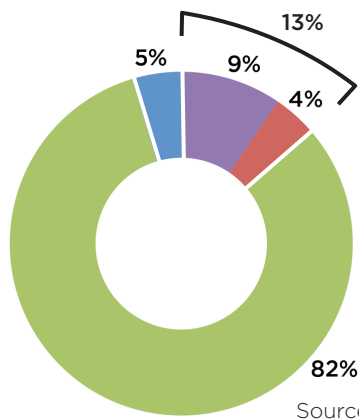
□ \$63,154 - \$84,895

Data by: County (2010)

In 2011, Dignity Health (formerly called Catholic Healthcare West) operated 30 hospitals. Dignity's footprint, as shown in the map, is primarily in the greater Sacramento Area and greater Los Angeles, with some hospitals spread across the central coast, central valley, and northern parts of the state. Dignity Health operates sister foundations to its hospitals, but this report does not analyze whether its foundations' grant-making is aligned with its community benefit programs.

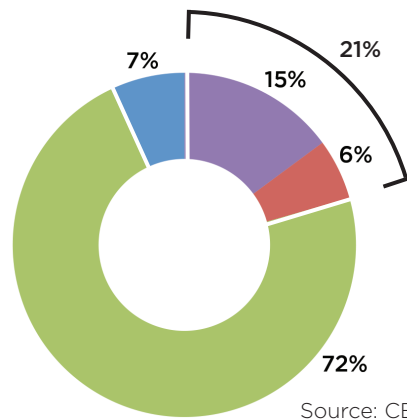
### Dignity's Upstream Spending was 13% of Community Benefit in 2010

- VP - Upstream
- BC - Upstream
- VP - Shortfall and Financial Assistance
- BC - Research and Education



### Dignity's Upstream Spending was 21% of Community Benefit in 2011

- VP - Upstream
- BC - Upstream
- VP - Shortfall and Financial Assistance
- BC - Research and Education



**Note:** The downloaded 990s for Dignity Health reports consolidated financial data and community benefit expenditures from hospitals outside of California. Thus, Total Operating Expenses and Total Community Building expenditures are greater than actual California-specific totals. In addition, while other systems' data in this table were taken strictly from the 990, Dignity's data for Total Community Benefit Spending and Upstream Investments were calculated using CBPs. The data for this system are in parentheses to signify that they are approximations calculated from a combination of both CBP and 990 data.

	Total Operating Expenses	Total Community Benefit Spending (A1)	Percentage of Operating Expenses (A2)	Upstream Investments – Subtotal (B1)	Percentage of Operating Expenses (B2)
<b>2010</b>	(\$7,975,342,391)	(\$778,295,043)	(9.8%)	(\$98,211,671)	(1.2%)
<b>2011</b>	(\$8,701,072,466)	(\$671,755,716)	(7.7%)	(\$138,615,252)	(1.6%)

### Additional Key Findings

Dignity Health submitted consolidated 990s for 2010 and 2011 that included hospitals located in Arizona, which is why we were only able to calculate proxies for its community benefit spending. In addition, it is unclear whether data from 2010 community benefit plans include bad debt, which is no longer reportable as community benefit under the ACA. Dignity Health’s upstream investment figures for 2010 are incomplete since Mercy Medical Center’s reported CBP numbers are illegible in its respective CBP. According to the estimated values in the table, Dignity’s upstream community benefit spending increased from 2010 to 2011, but overall community benefit expenditures decreased despite an increase in operating budgets. Dignity should have devoted more dollars in 2011 towards upstream spending since its estimated operating budget increased by almost \$726 million in 2011 and because there was less of a need for financial assistance that year (See pie charts above).

Faith-based missions for not-for-profit hospital systems (e.g. Dignity Health, St. Joseph Health, Adventist Health) may enable some hospital systems to invest in more innovative public health programs like affordable housing and other community-building activities. Although Dignity spends a small amount on Community Building activities such as youth leadership development, it also spends the most on this category (see Appendix; C1 and C2) relative to the other hospital systems in this study.<sup>50</sup> However, our analysis also shows that Sharp HealthCare spends the greatest proportion of its dollars, 2.2 percent, on upstream investments as defined in this report.



## Sutter Health



### Map Legend

#### Median Household Income

- Data Unavailable
- \$35,991 - \$44,018.9
- \$44,019 - \$52,598.9
- \$52,599 - \$63,153.9
- \$63,154 - \$84,895

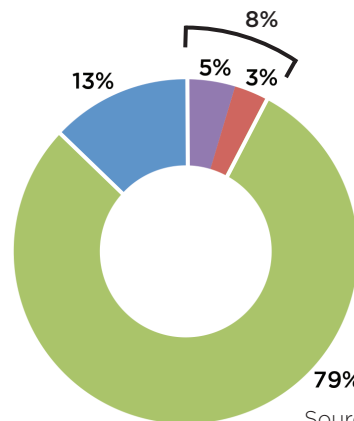
Data by: County (2010)

In 2011, Sutter Health operated 27 hospitals. Sutter's footprint, as shown in the map, is primarily in the Bay Area and the greater Sacramento region. Sutter Health operates sister foundations to its hospitals, but this report does not analyze whether its foundations' grant-making is aligned with its community benefit programs.

We could not analyze Sutter Health's community benefit spending by vulnerable population and broader community for 2010. OSHPD only provided four CBPs for this year, including Sutter Delta Medical Center, Sutter Medical Center of Santa Rosa, Sutter Tracy Community Hospital, and a consolidated CBP for Sutter Health's Sacramento Sierra Region. The publicly available data was too incomplete to generate a pie chart.

### Sutter's Upstream Spending was 8% of Community Benefit in 2011

- VP - Upstream
- BC - Upstream
- VP - Shortfall and Financial Assistance
- BC - Research and Education



Source: CBP

**Note:** The CBPs we received from OSHPD for Sutter Health in 2011 were also incomplete. It is difficult to assess whether figures reported for its five regions in a consolidated format include other hospitals under its ownership (e.g. Eden Medical Center) or not, thus the percentages in these pie charts are only estimates of actual system-wide spending.

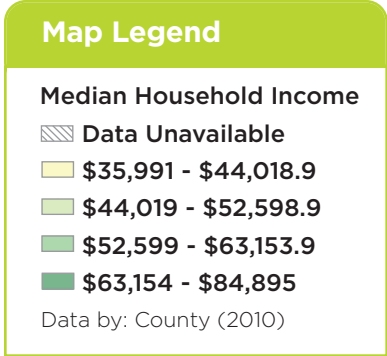
	Total Operating Expenses	Total Community Benefit Spending (A1)	Percentage of Operating Expenses (A2)	Upstream Investments – Subtotal (B1)	Percentage of Operating Expenses (B2)
<b>2010</b>	\$6,239,348,999	\$378,140,183	6.1%	\$53,473,979	0.9%
<b>2011</b>	\$6,238,201,467	\$644,794,323	10.3%	\$47,879,526	0.8%

### Additional Key Findings

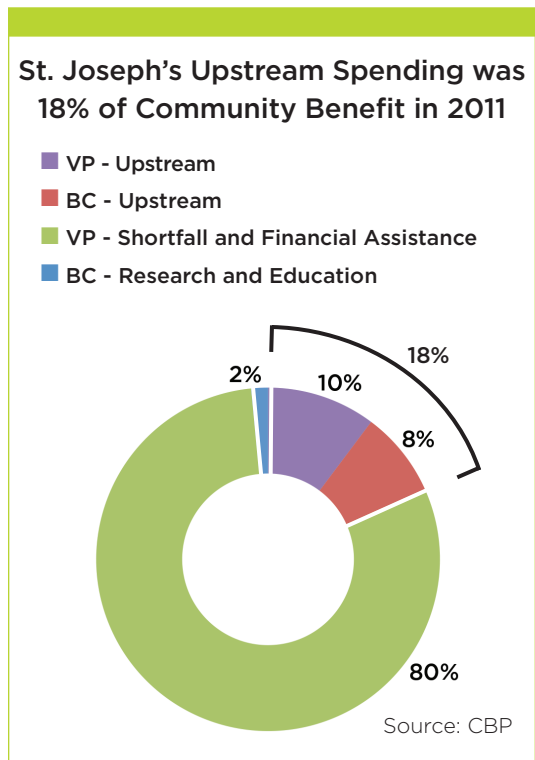
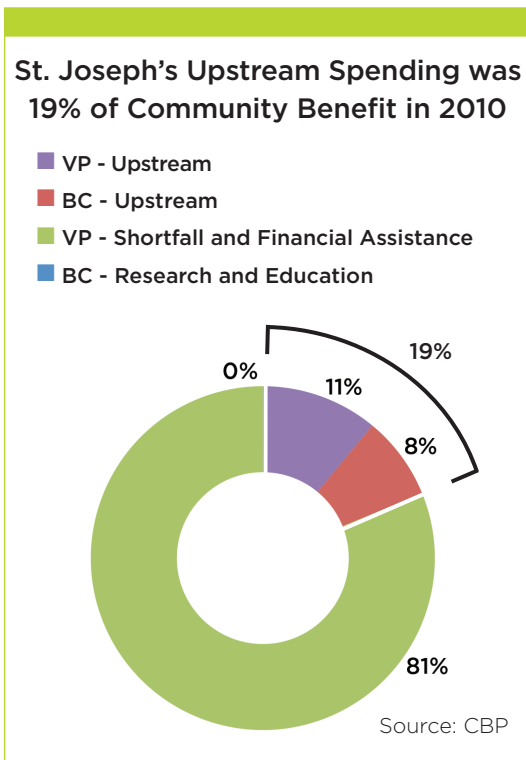
Sutter Health submitted a combination of consolidated 990s and individual 990s, depending on whether a given hospital belonged to one of five Sutter Health regions in California.<sup>51</sup> Furthermore, Sutter Health reported its community benefit expenditures only at the regional scale in its CBPs, which made this publicly available information difficult to analyze since there was little to no detail on community benefit expenditures at the hospital level. It was also unclear whether CBP figures were net expenditures or if they included bad debt. Sutter Health also had the lowest proportion of community benefit plans available through OSHPD, though it did have 990s for both years that were specific only to California.

While Sutter Health’s average community benefit expenditures were relatively higher than average in 2011, Sutter Coast Hospital generated revenue from its care for patients in Medi-Cal and other government-assistance programs to the point where this hospital posted negative community benefit expenditures in 2010 — i.e. its community benefit program was profitable that year. Sutter Coast is in Crescent City, in the far northwest of the state near the California-Oregon border. In 2010, Crescent City had 7,643 total residents, 79 percent of whom were people color, and a median household income of \$30,058.<sup>52</sup> Almost 60 percent of the households in Crescent City made less than \$35,000 in 2010,<sup>53</sup> which is why Sutter Coast’s community benefit spending is so striking. Although the U.S. has one of the most advanced health care systems in the world, this type of community benefit spending does not go far enough to address community health needs, let alone improve them.

## St. Joseph Health



In 2011, St. Joseph Health operated 10 hospitals. St. Joseph's footprint, as shown in the map, is primarily in the greater Bay Area and Los Angeles region, with a couple of facilities in far northern California. St. Joseph Health operates a Community Partnership Fund, but this report does not analyze whether its grant-making is aligned with its community benefit programs.



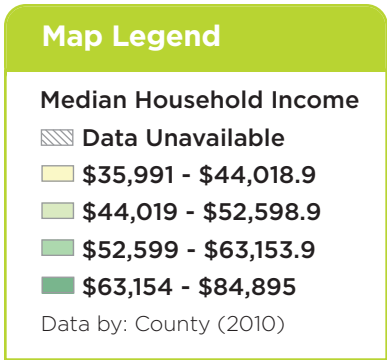
	Total Operating Expenses	Total Community Benefit Spending (A1)	Percentage of Operating Expenses (A2)	Upstream Investments – Subtotal (B1)	Percentage of Operating Expenses (B2)
<b>2010</b>	\$2,644,245,753	\$210,844,336	8.0%	\$37,723,538	1.4%
<b>2011</b>	\$2,673,750,026	\$238,580,741	8.9%	\$45,333,337	1.7%

### Additional Key Findings

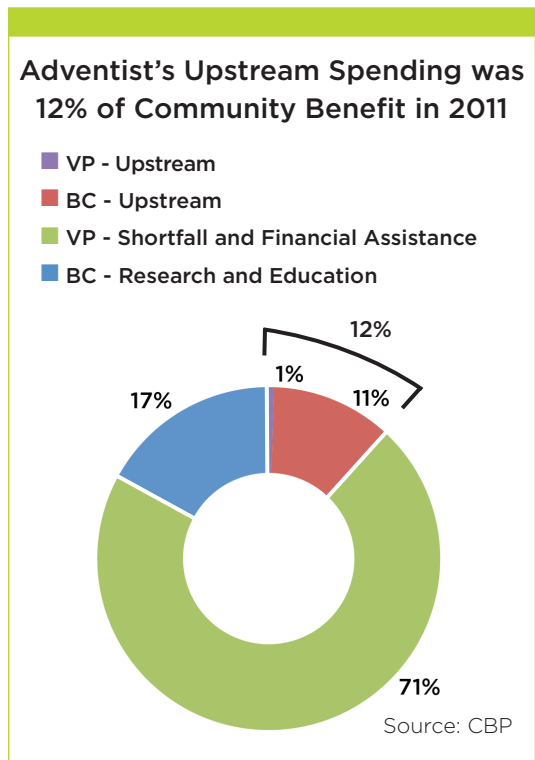
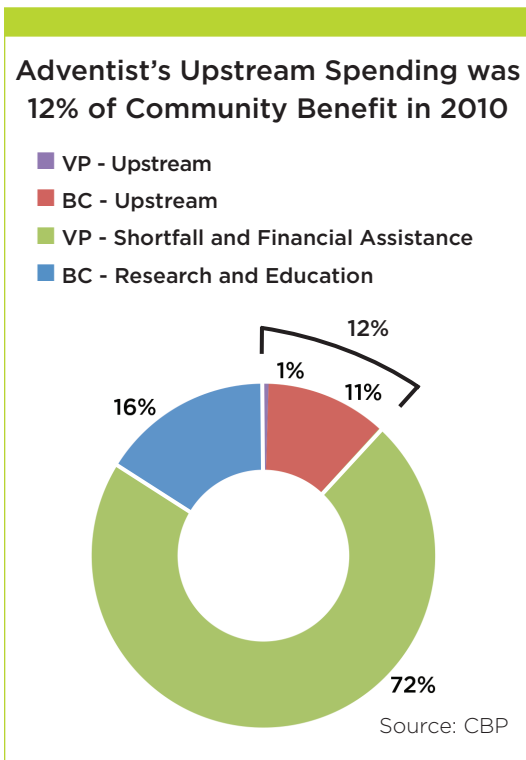
All 2010 and 2011 Form 990s for hospitals in the St. Joseph Health system were available for download. St. Joseph’s hospitals maintained consistent community benefit spending for both years. However, it is not clear how or if operating budgets for Northern and Southern California medical groups fit into the budget for community benefit, and whether or not this is any different from how Kaiser-Permanente operates relative to the Kaiser Foundation Hospitals — i.e. if a hospital corporation includes under its corporate umbrella many different pieces beyond just hospitals, does the revenue from these non-hospital pieces still contribute towards community benefit spending? St Joseph also spent the least amount of its community benefit budget on the Research and Education category out of all the hospital systems studied, dedicating its dollars toward medical care, and a smaller amount to upstream expenditures.

St Joseph’s dollar amounts invested in upstream efforts provide insight into how hospital systems are proactively investing in their communities to improve health. Using Schedule H data, it is possible to demonstrate a relationship between upstream investments, total community benefit spending, and operating expenses. However, while it is possible to calculate the dollar amount spent on upstream public health investments, little data exists to assess whether these investments are effectively impacting community health, especially at the hospital-by-hospital level. This finding also holds true for other hospital systems analyzed in this report.

## Adventist Health



In 2011, Adventist Health operated 12 hospitals. Adventist’s footprint, as shown in the map, is spread throughout the state, with the most significant concentration in the Los Angeles region. Adventist Health operates sister foundations to its hospitals, but this report does not analyze whether its foundations’ grant-making is aligned with its community benefit programs.



	Total Operating Expenses	Total Community Benefit Spending (A1)	Percentage of Operating Expenses (A2)	Upstream Investments – Subtotal (B1)	Percentage of Operating Expenses (B2)
<b>2010</b>	\$1,954,473,145	\$24,343,993	1.2%	\$11,584,411	0.6%
<b>2011</b>	\$1,951,560,619	\$54,258,271	2.8%	\$8,971,765	0.5%

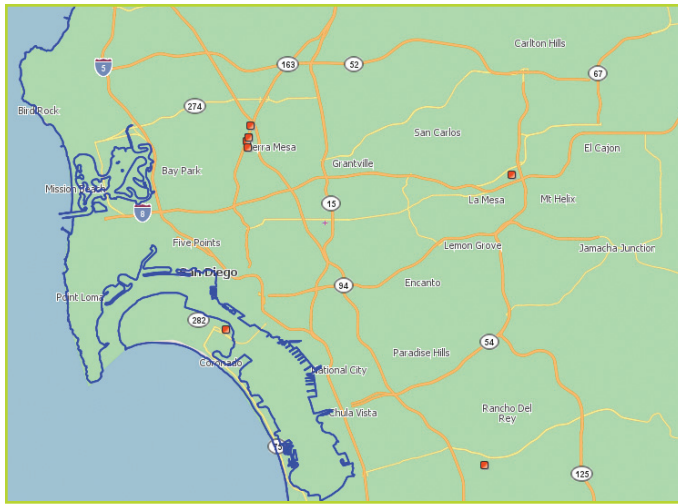
### Additional Key Findings

Adventist Health, like some of the other hospital systems in this analysis, still includes Medicare spending as part of community benefit in its CBPs, an accounting method no longer allowed under the ACA. In addition, similar to Sutter Health, a significant proportion of Adventist Health hospitals generated a profit through their community benefit programming, according to Schedule H data. In 2010, six hospitals generated enough revenue through care for those in Medi-Cal or other public insurance programs that they reported negative community benefit expenditures.<sup>54</sup> In 2011, that number decreased to two hospitals.<sup>55</sup> It is clear that the reporting of expenditures under current community benefit law is problematic and that improved reporting systems need to be explored to increase transparency and accountability.

Based on some of Adventist's 990s, there were discrepancies regarding financial assistance and billing and collection policies at the system-wide level compared to individual hospitals, wherein boxes were checked to signify that there was a uniform financial assistance policy (FAP) for multiple hospitals. However, our analysis found that the Federal Poverty Levels (FPL) used to qualify for free and discounted care were not uniform for all the hospitals in Adventist Health's system.

Despite Adventist Health's faith-based mission, it spent the lowest among the systems analyzed on community benefit. This is likely correlated with the significant number of its hospitals that reported negative community benefit spending, decreasing the overall contribution to the communities it serves. Of the limited amount spent on upstream community benefit, Adventist inequitably invested 11 times more in the broader community than in vulnerable populations, even though the map above shows that its hospitals are mainly located in low-income areas.

## Sharp HealthCare



### Map Legend

#### Median Household Income

▨ Data Unavailable

☐ \$35,991 - \$44,018.9

☐ \$44,019 - \$52,598.9

☐ \$52,599 - \$63,153.9

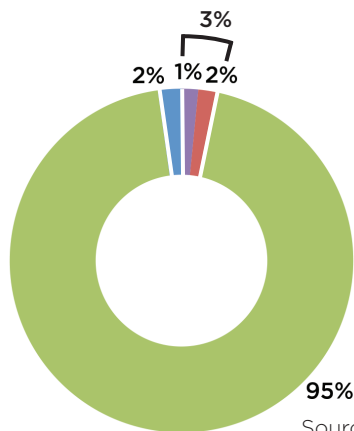
☐ \$63,154 - \$84,895

Data by: County (2010)

In 2011, Sharp HealthCare operated eight hospitals. Sharp's footprint, as shown in the map, is only in San Diego County. Sharp HealthCare operates sister foundations to its hospitals, but this report does not analyze whether its foundations' grant-making is aligned with its community benefit programs.

### Sharp's Upstream Spending was 3% of Community Benefit in 2010

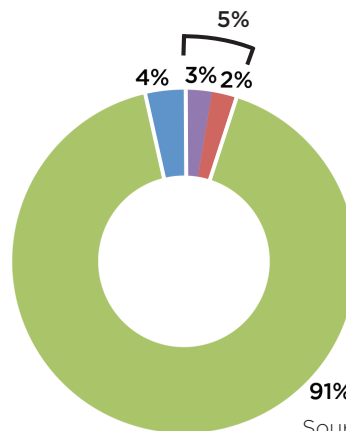
- ▨ VP - Upstream
- ▨ BC - Upstream
- ▨ VP - Shortfall and Financial Assistance
- ▨ BC - Research and Education



Source: CBP

### Sharp's Upstream Spending was 5% of Community Benefit in 2011

- ▨ VP - Upstream
- ▨ BC - Upstream
- ▨ VP - Shortfall and Financial Assistance
- ▨ BC - Research and Education



Source: CBP

**Note:** For both 2010 and 2011, Sharp HealthCare's CBP community benefit expenditures combine bad debt with its spending for financial assistance. While this is still legal under current California community benefit law, it is no longer allowed for federal reporting, and inflates Sharp's spending on vulnerable populations through financial assistance and public program shortfall when using only CBP data.

	Total Operating Expenses	Total Community Benefit Spending (A1)	Percentage of Operating Expenses (A2)	Upstream Investments – Subtotal (B1)	Percentage of Operating Expenses (B2)
<b>2010</b>	\$1,540,570,133	\$212,682,516	13.8%	\$29,951,528	1.9%
<b>2011</b>	\$1,651,950,101	\$139,109,547	8.4%	\$40,474,462	2.5%

### Additional Key Findings

The 990s for Sharp HealthCare system were also consolidated, which hindered a hospital-by-hospital analysis of community benefit spending.<sup>56</sup> Furthermore, it is unclear whether Sharp’s CBP for Sharp Metropolitan Medical Campus double counts community benefit expenditures reported for individual hospitals that the medical campus includes (based on the 990): Sharp Mary Birch Hospital for Women and Newborns, Sharp Memorial Hospital, and Sharp Mesa Vista Hospital.

Sharp’s CBPs also reported community benefit spending associated with Sharp Health Plan, though it does not report expenditures in a similar format on the 990 since a health plan or foundation is not required to fill out a Schedule H. According to California’s community benefit reporting law, health plans are not required to develop CBPs.<sup>57</sup> Furthermore, according to Sharp HealthCare’s CBPs, Sharp Health Plan did not participate in the most recent CHNA in 2007, meaning that Sharp Health Plan’s “community benefit” spending (\$198,529 in FY 2010; \$175,667 in FY 2011) is not necessarily informed by community health priorities, nor is it accountable to recent community health needs, even though it is presented as community benefit in the CBPs submitted to OSHPD.

As noted for the other hospital systems in question, this disconnect in transparency and accountability in the operating budgets of foundations and related funds, and how it does or does not align with community benefit, requires further investigation. Where these dollars come from, and whether or not this spending can be counted towards community benefit and therefore be used to justify tax-exemption, is currently a gray area.



## Scripps Health



### Map Legend

#### Median Household Income

▨ Data Unavailable

■ \$35,991 - \$44,018.9

■ \$44,019 - \$52,598.9

■ \$52,599 - \$63,153.9

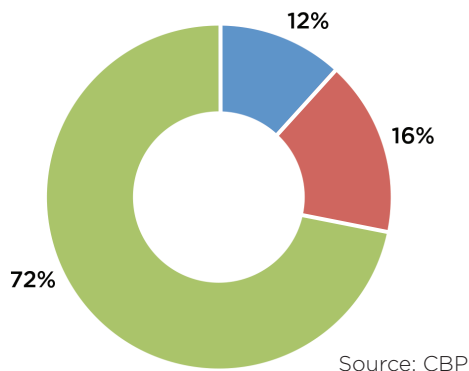
■ \$63,154 - \$84,895

Data by: County (2010)

In 2011, Scripps Health operated four hospitals in five separate locations. Scripps' footprint, as shown in the map, is only in San Diego County. Scripps Health operates sister foundations to its hospitals, but this report does not analyze whether its foundations' grant-making is aligned with its community benefit programs.

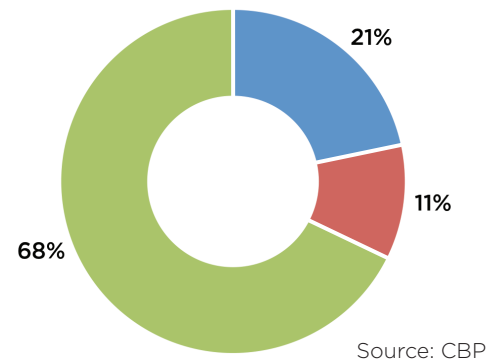
### Scripps' Upstream Spending was an Unknown Percentage of Community Benefit in 2010

- BC - Upstream
- VP - Shortfall and Financial Assistance
- BC - Research and Education



### Scripps' Upstream Spending was an Unknown Percentage of Community Benefit in 2011

- BC - Upstream
- VP - Shortfall and Financial Assistance
- BC - Research and Education



	Total Operating Expenses	Total Community Benefit Spending (A1)	Percentage of Operating Expenses (A2)	Upstream Investments – Subtotal (B1)	Percentage of Operating Expenses (B2)
<b>2010</b>	\$2,076,994,550	\$152,376,842	7.3%	\$15,837,963	0.8%
<b>2011</b>	\$2,158,297,038	\$130,310,694	6.0%	\$16,401,613	0.8%

### Additional Key Findings

The 990s for Scripps Health were also consolidated for 2010 and 2011. Scripps also includes Medicare shortfall and bad debt in its community benefit spending as part of its CBP, though the data is reported in a manner that allowed for exclusion of these expenditures for this analysis. It is unclear how Scripps Medical Foundation is accounted for in Scripps’ community benefit, even though it does submit a CBP to OSHPD. Moreover, Scripps’ CBP reports community benefit spending for “System-Wide Programs,” which includes Scripps Home Health Services, Scripps Mobile Medical Unit, Scripps Cancer Center, Scripps Clinical Research Center, and Scripps System Community Benefit Services. If this spending is reported as community benefit in the CBP, it should be accountable to community needs through the CHNA process.

Unlike other hospital systems’ CBPs in this study, Scripps Health provides a relatively more detailed breakdown of the research projects it is undertaking under community benefit, which can help its communities determine whether the research it is claiming as community benefit is responsive to its CHNA implementation strategy. According to IRS instructions, research claimed under community benefit is supposed to have a goal of “generat[ing] increased generalizable knowledge made available to the public” — however, this appears to be more of a goal than practice.

## EVALUATION AND LIMITATIONS

### Evaluating CHNA

A rigorous evaluation of CHNA for the hospital systems was not possible because none of the hospital systems in this study have yet reported on their CHNA under Schedule H, Part V “Facility Information: Community Health Needs Assessment.” The evaluation depended upon standardized CHNA metrics that the IRS did not require until 2012 and thus were not yet available during the study period. The CHNA is integral to keeping community benefit spending accountable to the goal of improving community health. Unfortunately, the minimum reporting requirements for this section of the Schedule H suggest that it will stay a box-checking exercise, and that CHNA data will have to be found in the implementation strategies, where there may once again be variability and subjectivity in the details.

Interim IRS guidelines require that a hospital designate a CHNA-“authorized body” that will oversee the process, and that a CHNA not exclude the health needs of medically underserved, low-income, or other minority populations.<sup>58</sup> There will still be limitations to the CHNA process moving forward despite additional accountability measures introduced by the ACA. For instance, there are limited to no requirements for impact evaluation. In addition, hospitals are not legally required to perform primary research for their CHNAs (e.g. focus groups, interviews, surveys, etc.), and can use secondary data as long as the hospital appoints the CHNA-authorized body. This decision-making body, for better or worse, could influence community benefit spending over a three-year period because, even though medically underserved, low-income, or other minority populations must be included in the CHNA, the prioritization of health needs that the hospital will address rests primarily with the CHNA-authorized body.

Hospitals reported previous CHNAs in the “Supplemental Information” free-response section of the 990 (Part VI), since state community benefit laws have required these hospitals to perform community needs assessments pre-ACA. However, because this section is not standardized, hospitals offered varying levels of detail, as they do in CBPs. Some hospitals included a detailed narrative in their CBPs, while others merely indicated the year of their most recent CHNA. This lack of standardization limited our ability to analyze CHNA processes, since hospitals’ responses and their level of detail differed even within hospital systems.

Californians deserve more transparency in how hospitals develop their community benefit strategies to address the unique health needs of diverse communities. The CHNA process, including the development of implementation strategies, is an opportunity for hospitals to align investment and expertise with community input to maximize returns on community benefit spending. Nonetheless, a robust assessment of CHNA quality indicators from Schedule H will require more reporting periods after 2012 because hospitals only conduct one CHNA every three years.

### Evaluating Diversity

Evaluation of hospital systems’ diversity was not possible because the hospital systems studied did not provide requested data on executive officer diversity, board diversity, and diversity information on ACA-mandated, CHNA-authorized bodies. The diversity of executive leadership for hospitals and hospital systems should internally mirror the diversity of California as one of many starting points for addressing perpetual health inequities that disproportionately impact communities of color. This is an issue of today, not the future: California has been a majority-minority state for over two decades, with people of color comprising almost 60 percent of the population in 2010.<sup>59</sup> Diversity among hospital leadership could also help build trust with the community as well as improve accountability and responsiveness to community health needs.

## Limitations

Because of the absence of data, community benefit reporting in its current publicly accessible format effectively limits analysis to evaluating measures such as money spent and percentages, as this assessment accomplished. This analysis was most limited in assessing upstream investment, CHNA, and diversity, the areas which create the most opportunities for community health improvement, and ultimately savings for these hospital systems.<sup>60,61,62,63,64</sup> The public should not have to rely on specialized case studies to holistically understand the state of community benefit. Yet, systems' reporting practices are vastly different from one another and even inconsistent with existing law. Not-for-profit hospital systems must be more transparent in reporting their community benefit and accountable to community health needs.

The hospital systems in question did not provide the data requested for the analysis, limiting the scope of the study. Some CBPs for specific hospitals were not available for the entire five-year window from OSHPD, and only Dignity Health, Sharp HealthCare, and St. Joseph Health had submitted complete sets of CBPs for all hospitals from 2008-2012 during the data collection period. Furthermore, 990s were missing or unfiled for several hospitals of interest during the five-year timeframe. It was not possible to investigate community benefit practices for these hospitals in 2008 when Schedule H did not exist and in 2009 when Schedule H was optional, contributing to a lack of comparable data using 990s within the study window.

Hospital systems that filed consolidated data for multiple hospitals also limited the ability to determine spending and community benefit practices at an individual hospital level using 990s. Kaiser Foundation Hospitals and Dignity Health barred calculation of any community benefit numbers beyond just estimates since the 990s included community benefit and financial data from hospitals outside of California.

Another challenge to data analysis was the changes in Schedule H from year to year. 2012 Schedule H informed the methodology of this investigation, which relied on additional information regarding CHNA, FAP, billing and collections, emergency medical care, and charges to FAP-eligible individuals. However, Schedule H forms filed in previous years either do not provide a sufficient level of detail, are optional, or lack standardization for hospitals' reporting as the 2012 version has.

While California's community benefit law and the 990's Schedule H standardize community benefit reporting through the use of general categories, both are insufficient in the level of detail required. The lack of responses to optional questions and varying emphases in CBPs also preempted any analysis of the rigor of CHNAs. In addition, the lack of hospital-specific (i.e. facility level) data will not be solved through the updated 990, and is a significant barrier towards achieving transparency in community benefit. These issues together raise the question of whether publically available information allows policymakers, advocates, and community members to determine the extent to which a hospital or hospital system is fulfilling its community benefit obligations.

A review of CBPs clearly demonstrated the lack of community benefit data available despite state reporting requirements, and what information is publicly available is difficult to interpret. For example, the categories of spending in community benefit plans for many of the hospitals in this study were too broad to dissect upstream public health investments. Some hospitals provided little to no description. Many hospital systems also reported the unreimbursed cost of Medicare and bad debt as part of their community benefit total. This type of reporting practice violates requirements established by the ACA but is still allowable under current California law, making consistent analysis of community benefit across systems nearly impossible.

All of these issues in community benefit reporting (incomplete submissions of CBPs from OSHPD and IRS Form 990s, consolidated IRS reporting that include hospitals outside of California, changes in Schedule H from year to year, and insufficient detail on community benefit plans and IRS reporting) restrict a holistic assessment of community benefit spending from 2008-2012. Even though data is publicly available, the condition in which systems report it does not allow for an understanding of community engagement, equitable investment, and responsiveness to community needs.

## RECOMMENDATIONS

- **The California Legislature should pass parity legislation** that will, at the very least, update California's community benefit laws to align with some of the newer requirements instituted by the ACA (e.g. no longer allowing not-for-profit hospitals to report Medicare shortfall and bad debt in community benefit plans submitted to OSHPD, additional CHNA standards, etc.). California gives not-for-profit hospitals tax breaks based on the good-faith assumption that these hospitals' primary purpose is to improve community health. However, as demonstrated by this analysis, current reporting requirements do not foster transparency.
- **Governor Brown and Secretary Dooley should allocate more budgetary support to OSHPD, and the Legislature should increase its regulatory authority to enforce transparency in community benefit reporting and ensure accountability.** OSHPD, the state agency that oversees community benefit, currently does not have the capacity or the statutory authority to enforce existing policies. If data is missing, OSHPD does not follow up with hospitals, and currently lacks the means to audit data that is submitted. Alternatively, this authority could be assigned to another agency so long as responsibility is clear and funding is adequate.
- **The state Legislature should pass legislation that ensures "state, local, tribal, or regional governmental health department or equivalent department or agency" and "members of medically underserved, low-income and minority populations in the community served by the hospital or representative organizations"<sup>65</sup> have a place at the table of CHNA-authorized bodies** to build in accountability and that these stakeholders reflect the demographics of their community. Hospitals must perform CHNAs every three years to inform their community benefit strategies. However, analysis of the CBPs demonstrates that hospitals have a wide range of practices, some of which use only secondary data to determine community health needs — data which may not be current or reflect actual health needs.
- **Hospitals should voluntarily make diversity data on key decision-makers related to community benefit publicly available.** This should include hospital executives, hospital community benefit leadership, and CHNA-authorized bodies. While diversity data on key decision-makers is not required by the IRS, it could be an indicator of whether the internal hospital budgetary process and community benefit spending reflect the priorities of California's diverse communities at the highest leadership levels.
- **The ACA will free up hospitals' community benefit dollars for more upstream spending going forward, as more of California's uninsured and underinsured population receives coverage through Covered California and the Medi-Cal expansion, and hospitals should actively pursue such opportunities.** As demonstrated in this report, the current state of community benefit does not maximize returns on investments that these hospital systems could achieve through upstream spending, or reflect the body of research on the cost-savings of prevention. However, because significant financial assistance spending will still be necessary, *any such reallocation of funds must not come at the expense of financial assistance needed by the community.* Communities, advocates, and policy makers should use the data assembled in this report as a benchmark to assess whether or not these hospitals are fulfilling their community benefit duty.

## CONCLUSION

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Nothing is more essential than our health. All Californians should have equitable access to what they need to maintain good health — needs that go well beyond medical care. Even though the U.S. has one of the most advanced health care systems in the world, population health outcomes have not improved along with rising costs of health care. Community benefit dollars will still be needed for financial assistance for the uninsured moving forward and should not be diverted towards upstream spending if there is community need. Nevertheless, community benefit should be an opportunity for not-for-profit hospitals to invest upstream in health prevention, but hospitals currently fall short in this regard. The variability and lack of transparency in publically available community benefit data bars rigorous assessment of whether hospitals' community benefit spending aligns with community health needs, and low-income communities and people of color will likely be the ones to pay the price in the end. In exchange for the tax breaks these hospital systems receive, newly freed community benefit dollars should be directed towards upstream spending and California reporting requirements should be updated to reflect the realities of health care delivery in the 21st century.



# APPENDIX

## Summary Tables of Budgets, Community Benefit Spending, and Community Building Expenditures for 2010 and 2011

2010	Total Operating Expenses	Total Community Benefit Spending (A1)	Percentage of Operating Expenses (A2)	Upstream Investments - Subtotal <sup>1</sup> (B1)	Percentage of Operating Expenses (B2)	Total Community Building <sup>2</sup> (C1)	Percentage of Operating Expenses (C2)
Kaiser Foundation Hospitals**	(\$15,220,547,445)	(\$806,809,569)	(5.3%)	(\$74,386,343)	(0.5%)	(\$5,985,913)	(0.02%)
Dignity Health**	(\$7,975,342,391)	(\$778,295,043)	(9.8%)	(\$98,211,671)	(1.2%)	(\$8,381,723)	(0.13%)
Sutter Health	\$6,239,348,999	\$378,140,183	6.1%	\$53,473,979	0.9%	\$747,898	0.01%
St. Joseph Health	\$2,644,245,753	\$210,844,336	8.0%	\$37,723,538	1.4%	\$1,636,956	0.06%
Adventist Health	\$1,954,473,145	\$24,343,993	1.2%	\$11,584,411	0.6%	\$1,156,522	0.06%
Sharp HealthCare	\$1,540,570,133	\$212,682,516	13.8%	\$29,951,528	1.9%	\$323,349	0.02%
Scripps Health	\$2,076,994,550	\$152,376,842	7.3%	\$15,837,963	0.8%	\$868,738	0.04%

2011	Total Operating Expenses	Total Community Benefit Spending (A1)	Percentage of Operating Expenses (A2)	Upstream Investments - Subtotal <sup>1</sup> (B1)	Percentage of Operating Expenses (B2)	Total Community Building (C1)	Percentage of Operating Expenses (C2)
Kaiser Foundation Hospitals**	(\$16,443,912,529)	(\$785,723,087)	(4.8%)	(\$63,226,395)	(0.4%)	(\$5,985,913)	(0.02%)
Dignity Health**	(\$8,701,072,466)	(\$671,755,716)	(7.7%)	(\$138,615,252)	(1.6%)	(\$9,790,539)	(0.13%)
Sutter Health <sup>3</sup>	\$6,238,201,467	\$644,794,323	10.3%	\$47,879,526	0.8%	\$1,118,799	0.02%
St. Joseph Health	\$2,673,750,026	\$238,580,741	8.9%	\$45,333,337	1.7%	\$683,100	0.03%
Adventist Health <sup>4</sup>	\$1,951,560,619	\$54,258,271	2.8%	\$8,971,765	0.5%	\$3,518,607	0.18%
Sharp HealthCare	\$1,651,950,101	\$139,109,547	8.4%	\$40,474,462	2.5%	\$186,050	0.01%
Scripps Health	\$2,158,297,038	\$130,310,694	6.0%	\$16,401,613	0.8%	\$871,015	0.04%

\*\*Kaiser Foundation Hospitals and Dignity Health report consolidated 990s that include financial data and community benefit expenditures from hospitals outside of California. Thus, Total Operating Expenses and Total Community Building expenditures are greater than actual California-specific totals. In addition, while other system's data in this table is strictly from the 990, Kaiser's and Dignity's data for Total Community Benefit Spending and Upstream Investments were calculated using CBPs. Thus, the data for these two systems are in parentheses to signify that they are approximations of actual figures due to their reporting practices.

<sup>1</sup>Not-for-profit hospitals' community benefit spending on upstream public health programs is a way of assessing a hospital's commitment to improve health beyond its walls, in the community. For Table 1 and 2, the figures in columns B1 and B2 are a sub-total of columns A1 and A2, respectively, and cannot be summed together. For example: "Of a system's "A1" spending, "B1" was spent on upstream investments.

<sup>2</sup>Community Building expenditures are not considered community benefit spending under federal reporting law (Part II of Schedule H), but represent upstream investment opportunities. Columns C1 and C2 are included in this table to show how much a system spent on public health programming that did not qualify as community benefit for IRS purposes, such as "Physical improvements and housing," "Economic development," "Community support," "Environmental improvements," "Leadership development and training for community members," "Coalition building," "Community health improvement advocacy," and "Workforce development" (Form 990, Schedule H).

<sup>3</sup>It is unclear whether Sutter Medical Center of Castro Valley did not submit a Schedule H for 2011 because it merged with Eden Medical Center, a Sutter affiliate.

<sup>4</sup>Simi Valley Hospital did not have a 990 available for 2011, even though it did submit a CBP for the same year. Therefore Adventist Health's overall figures are less than the actual figures due to inadequate records.



## REFERENCES

- <sup>1</sup> Vesely R. (August 2013). ACOs Expand Amid Uncertain Futures. *California Healthline*. Retrieved from <http://www.californiahealthline.org/insight/2013/acos-expand-amid-uncertain-futures>
- <sup>2</sup> World Health Organization. (2013). *World Health Statistics 2013. Part III Global health indicators*. Geneva, Switzerland. Retrieved from: [http://www.who.int/gho/publications/world\\_health\\_statistics/EN\\_WHS2013\\_Part3.pdf](http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Part3.pdf)
- <sup>3</sup> Centers for Disease Control and Prevention. (2000). *Health disparities affecting minorities: African Americans*. Atlanta, GA: Office of Minority Health and Health Disparities.
- <sup>4</sup> Grantmakers in Health. (2002). *Weighing in on obesity: America's growing health epidemic. Issue Brief No. 11*. Washington D.C.
- <sup>5</sup> Geronimus AT & Thompson JP. (2004). To Denigrate, Ignore, or Disrupt: Racial Inequality in Health and the Impact of a Policy-induced Breakdown of African American Communities. *Du Bois Review*; 1(2):247-79.
- <sup>6</sup> Cooper R. (October 2013). *Inequality Is At the Core of High Health Care Spending: A View From the OECD*. Health Affairs Blog. Retrieved from <http://healthaffairs.org/blog/2013/10/09/inequality-is-at-the-core-of-high-health-care-spending-a-view-from-the-oecd/>
- <sup>7</sup> United States Census Bureau. (2012). *American FactFinder*. Washington, D.C.: U.S. Department of Commerce. Retrieved from <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>
- <sup>8</sup> California Department of Finance. (January 2013). *Report P-1 (Race): State and County Population Projections by Race/Ethnicity, 2010-2060*. Sacramento, CA. Retrieved from <http://www.dof.ca.gov/research/demographic/reports/projections/P-1/>
- <sup>9</sup> IRS Ruling 83-157 (1983). Community benefit was first defined in IRS Ruling 69-545 (1969).
- <sup>10</sup> Barnett K & Somerville MH. (October 2012). *Hospital Community Benefits after the ACA: Schedule H and Hospital Community Benefit – Opportunities and Challenges for the States*. Baltimore, MD: The Hilltop Institute. Retrieved from <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefit-sAfterTheACA-ScheduleHIssueBrief4-October2012.pdf>
- <sup>11</sup> Torres. (1993-1994). *SB 697 – Hospitals: Community Benefits*. Sacramento, CA: California State Senate. Retrieved from <http://www.oshpd.ca.gov/HID/SubmitData/CommunityBenefit/SB697CommBenefits.pdf>
- <sup>12</sup> Barnett K & Somerville MH. (October 2012). *Hospital Community Benefits after the ACA: Schedule H and Hospital Community Benefit – Opportunities and Challenges for the States*. Baltimore, MD: The Hilltop Institute. Retrieved from <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-ScheduleHIssueBrief4-October2012.pdf>
- <sup>13</sup> Medi-Cal, California's Medicaid program, is expanding to cover eligible adults up to 138 percent FPL, which is approximately \$15,856 for an individual or \$32,499 for a family of four (adjusted for 2013). Medi-Cal expansion will start January 1, 2014, and will also include childless adults, who were not previously eligible for Medi-Cal. To learn more, go to <http://www.dhcs.ca.gov/Pages/Medi-CalExpansionInformation.aspx>
- <sup>14</sup> Lucia L, Jacobs K, Dietz M, et al. (September 2012). *After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured?* UC Berkeley Center for Labor Research and Education & UCLA Center for Health Policy Research. Retrieved from [http://laborcenter.berkeley.edu/healthcare/aca\\_uninsured12.pdf](http://laborcenter.berkeley.edu/healthcare/aca_uninsured12.pdf)
- <sup>15</sup> Werdegar D, Simonson L, Murphy EO. (January 1998). *Not-for-Profit Hospital Community Benefit Legislation (Senate Bill 697): Report to the Legislature*. Sacramento, CA: Office of Statewide Health Planning & Development. Retrieved from: <http://www.oshpd.ca.gov/HID/SubmitData/CommunityBenefit/notforprofitlegislation.pdf>
- <sup>16</sup> Office of Statewide Health Planning and Development. (2012). Annual Financial Data Pivot Profiles. Sacramento, CA. Retrieved from <http://oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/PivotProfles/default.asp>
- <sup>17</sup> Office of Statewide Health Planning and Development. (2012). Annual Financial Data Pivot Profiles. Sacramento, CA. Retrieved from <http://oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/PivotProfles/default.asp>
- <sup>18</sup> This figure is from Kaiser Foundation Hospitals' Form 990, rather than the OSHPD pivot table. Kaiser is not required to report its financial data to OSHPD like the other hospital systems because of a regulatory exemption described in Health and Safety Code §128760 Paragraphs (f) and (g). Kaiser is exempt because it is an HMO that primarily receives its revenue from members enrolled in its health plan. Also, this figure is greater than Kaiser's system budget in California because Kaiser submits a consolidated Form 990 that also includes service areas in Hawaii and Colorado.
- <sup>19</sup> Barnett K and Somerville MH. (October 2012). *Hospital Community Benefits after the ACA: Schedule H and Hospital Community Benefit—Opportunities and Challenges for the States*. Baltimore, MD: The Hilltop Institute. Retrieved from <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-ScheduleHIssueBrief4-October2012.pdf>
- <sup>20</sup> The Schedule H is a section on the Form 990 that a nonprofit organization must complete if it operates a hospital.
- <sup>21</sup> Internal Revenue Service. (November 2012). *2012 Instructions for Schedule H (Form 990)*. Washington, D.C.: Department of the Treasury. Retrieved from <http://www.irs.gov/pub/irs-pdf/i990sh.pdf>
- <sup>22</sup> Torres. (1993-1994). *SB 697 – Hospitals: Community Benefits*. Sacramento, CA: California State Senate. Retrieved from <http://www.oshpd.ca.gov/HID/SubmitData/CommunityBenefit/SB697CommBenefits.pdf>
- <sup>23</sup> Calendar years span from January 1st to December 31st.
- <sup>24</sup> Federal Fiscal years begin October 1st of the previous year and end September 30th of the year for which it is numbered.
- <sup>25</sup> The difference between fiscal-year reporting and calendar-year reporting results in different community benefit spending totals between IRS Forms 990 and California community benefit plans.

<sup>26</sup> Community benefit plans report community benefit spending according to categories outlined in SB 697 (Torres):

- (a) Medical care services
- (b) Other benefits for vulnerable populations
- (c) Other benefits for the broader community
- (d) Health research, education, and training programs
- (e) Nonquantifiable benefits

<sup>27</sup> Lunder EK & Liu EC. (July 2012). *501(c)(3) Hospitals: Proposed IRS Rules under § 9007 of the Affordable Care Act*. Washington, D.C.: Congressional Research Service. Retrieved from <http://www.naccho.org/topics/infrastructure/mapp/loader.cfm?csModule=security/getfile&pageID=237458>

<sup>28</sup> Categorized as “Other Benefits” in Schedule H Part I, upstream expenditures include “Community health improvement services and community benefit operations,” “Subsidized health services,” and “Cash and in-kind contributions for community benefits” (lines e, g, and i). These “other benefits” are our best available proxy for upstream community benefit spending, even though subsidized health services do not always represent upstream investments.

<sup>29</sup> For example, we had to estimate upstream spending for Kaiser Foundation Hospitals using CBP figures, instead of using data from the 990s. We summed subtotals from each hospital’s CBP table that details how much community benefit resources were provided for 2010 and 2011, categorized as “Other Benefits for Vulnerable Populations” and “Benefits for the Broader Community.” We also included a sub-category of “Grants and donations for medical services,” even though it is categorized under “Medical Care Services for Vulnerable Populations” because KFH’s explanation in the CBP cited that funding was used to support programs like community health centers. Since CBP data is not as standardized as the 990, nor is it necessarily transparent, we could only consider these values as estimates.

<sup>30</sup> Internal Revenue Service. (November 2012). *2012 Instructions for Schedule H (Form 990)*. Washington, D.C.: Department of the Treasury. Retrieved from <http://www.irs.gov/pub/irs-pdf/i990sh.pdf>

<sup>31</sup> Community building activities in the criteria list included (Note: activities (a) through (h) are directly from Part II of the Schedule H, “Community Building Activities”):

- (a) physical improvements and housing
- (b) economic development
- (c) community support
- (d) environmental improvements
- (e) leadership development and training for community members
- (f) coalition building
- (g) community health improvement advocacy
- (h) workforce development (including nursing and caregiver training provided without assessment of fees or payment of tuition)
- (i) community-based mental health and outreach and assessment programs for low-income families
- (j) community building activities
- (k) research connected with reducing health disparities
- (l) contributions to community groups in alignment with fulfilling community health needs identified in CHNA

<sup>32</sup> Disease prevention activities in the criteria list included:

- (a) vaccination programs and services for low-income families (defined as 350 percent FPL),
- (b) school health centers, as defined in California Health & Safety Code, Section 124174,
- (c) chronic illness prevention programs and services,
- (d) home-based health care programs for low-income families

<sup>33</sup> “The Community Preventive Services Task Force is an independent, nonfederal, unpaid panel of public health and prevention experts that provides evidence-based findings and recommendations about community preventive services, programs, and policies to improve health” (The Guide to Community Preventive Services).

<sup>34</sup> Community Preventive Services Task Force. (2013). *The Community Guide. The Guide to Community Preventive Services: What Works to Promote Health*. Atlanta, GA. Retrieved from <http://www.thecommunityguide.org/index.html>

<sup>35</sup> “Healthy People provides science-based, 10-year national objectives for improving the health of all Americans” (U.S. Department of Health and Human Services).

<sup>36</sup> U.S. Department of Health and Human Services. (2013). *Healthy People 2020*. Washington, D.C. Retrieved from <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=39>.

<sup>37</sup> Patient Protection and Affordable Care Act. (2010). *Title IX—Revenue Provisions; Subtitle A—Revenue Offset Provisions; Section 9007. Additional Requirements for Charitable Hospitals*. Pub. L. No. 111-148. Washington, D.C. Retrieved from <http://www.healthcare.gov/law/full/>

<sup>38</sup> Barnett, K. (February 2012). *Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential*. Oakland, CA: The Public Health Institute.

Retrieved from <http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf>

<sup>39</sup> The Catholic Health Association of the United States. (February 2012). *Assessing and Addressing Community Health Needs*. St. Louis, MO.

Retrieved from: [http://www.healthytampabay.com/javascript/htmleditor/uploads/CB\\_AssessingAddressing.pdf](http://www.healthytampabay.com/javascript/htmleditor/uploads/CB_AssessingAddressing.pdf)

<sup>40</sup> CHNA criteria list to evaluate hospital responses:

0 – Hospital has a poor CHNA. Missing two of the following:

- community and public health stakeholder feedback and input, considering ethnic diversity
- use public health data and incorporating social determinants of health
- strategies for updating CHNA
- strategies for community involvement

1 – Hospital has a lacking CHNA. Missing one of the following:

- community and public health stakeholder feedback and input, considering ethnic diversity
- use public health data and incorporating social determinants of health
- strategies for updating CHNA
- strategies for community involvement

2 – Hospital has a reasonably strong, equitable CHNA. Meets all the following core criteria:

- community and public health stakeholder feedback and input, considering ethnic diversity
- use public health data and incorporating social determinants of health
- strategies for updating CHNA
- strategies for community involvement

3 – Hospital has a comprehensive, well-developed, and equitable CHNA process. Meets all listed criteria:

- collaborating with others
- use public health data and incorporating social determinants of health
- strategies for updating CHNA
- strategies for community involvement
- engaging hospital leadership
- selecting indicators for success
- methods for evaluation
- community and public health stakeholder feedback and input, considering ethnic diversity

<sup>41</sup> Young GJ, Chou C, Alexander J, et al. (April 2013). Provision of Community Benefits by Tax-Exempt U.S. Hospitals. *N Engl J Med*; 368(16):1519-27.

<sup>42</sup> Ibid.

<sup>43</sup> Lucia L, Jacobs K, Dietz M, et al. (September 2012). *After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured?* UC Berkeley Center for Labor Research and Education & UCLA Center for Health Policy Research.

Retrieved from [http://laborcenter.berkeley.edu/healthcare/aca\\_uninsured12.pdf](http://laborcenter.berkeley.edu/healthcare/aca_uninsured12.pdf)

<sup>44</sup> Health Information Division. (June 2013). *Annual Financial Data General Information About the Hospital Chagemaster Program*. Sacramento, CA: OSHPD.

Retrieved from <http://www.oshpd.ca.gov/HID/Products/Hospitals/Chrgmstr/index.html>

<sup>45</sup> Ibid.

<sup>46</sup> Brill S. (March 2013). *Bitter Pill: Why Medical Bills Are Killing Us*. New York, NY: *Time Magazine*.

<sup>47</sup> HealthyCity. (2011). Los Angeles, CA: The Advancement Project. Retrieved from <http://www.healthycity.org/>

<sup>48</sup> Kaiser Foundation Hospitals in California. (2011). *Consolidated Community Benefit Plan 2011*. Oakland, CA.

Retrieved from an information request to the Healthcare Information Division at OSHPD.

<sup>49</sup> Hanleybrown F, Kania J, and Kramer M. (January 2013). Channeling Change: Making Collective Impact Work. *Stanford Social Innovation Review*.

Retrieved from <http://www.fsg.org/tabid/191/ArticleId/561/Default.aspx?srpush=true>

<sup>50</sup> Recent adjustments in the 2012 IRS 990 Schedule H instructions allow inclusion of these expenditures if certain criteria are met. Before 2012, the IRS did not view this type of upstream investment as health related and therefore it was not reportable as community benefit (i.e. it was not spending that could be used to justify a hospital's tax-exempt status).

<sup>51</sup> Sutter Health's five regions include the Sutter Health East Bay Region, Sutter Health Sacramento Sierra Region, Sutter health West Bay Region, Sutter Health Peninsula Coastal Region, and Sutter Health Central Valley Region. Sutter Health affiliates that filed individual 990s include: Eden Medical Center/San Leandro Hospital, Sutter Medical Foundation (Sutter Surgical Hospital- North Valley), and Sutter Medical Center- Castro Valley (which did not submit a 990 in 2011).

<sup>52</sup> United States Census Bureau. (2012). *American FactFinder*. Washington, D.C.: U.S. Department of Commerce.

Retrieved from <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

<sup>53</sup> Ibid.

<sup>54</sup> These hospitals include Feather River Hospital, Frank R. Howard Memorial, Sonora Regional Medical Center, St. Helena Hospital Clear Lake, Ukiah Valley Medical Center, and White Memorial Medical Center.

<sup>55</sup> The two hospitals include: Central Valley General Hospital, and Feather River.

<sup>56</sup> 2010 and 2011 990s for Sharp Memorial Hospital included consolidated community benefit data for several hospitals in the Sharp HealthCare system: Sharp Memorial Hospital, Sharp Mary Birch Hospital for Women and Newborns, Sharp Mesa Vista Hospital, and Sharp Vista Pacific (Sharp McDonald Center).

<sup>57</sup> Torres. (1993-1994). *SB 697 – Hospitals: Community Benefits*. Sacramento, CA: California State Senate.

Retrieved from <http://www.oshpd.ca.gov/HID/SubmitData/CommunityBenefit/SB697CommBenefits.pdf>

- <sup>58</sup> Internal Revenue Service. (April 2013). *Community Health Needs Assessments for Charitable Hospitals. Notice of proposed rulemaking [REG-106499-12]*. Washington, D.C.: Department of the Treasury. Retrieved from <http://www.irs.gov/PUP/newsroom/REG-106499-12.pdf>
- <sup>59</sup> United States Census Bureau. (2012). *American FactFinder*. Washington, D.C.: U.S. Department of Commerce. Retrieved from <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>
- <sup>60</sup> Vesely R. (August 2013). ACOs Expand Amid Uncertain Futures. *California Healthline*. Retrieved from <http://www.californiahealthline.org/insight/2013/acos-expand-amid-uncertain-futures>
- <sup>61</sup> Barnett, K. (February 2012). *Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential*. Oakland, CA: The Public Health Institute. Retrieved from <http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf>
- <sup>62</sup> Institute of Medicine. (June 2011). *For the Public's Health. Revitalizing Law and Policy to Meet New Challenges*. Washington, D.C.: National Academy of Sciences. Retrieved from <http://www.iom.edu/Reports/2011/For-the-Publics-Health-Revitalizing-Law-and-Policy-to-Meet-New-Challenges.aspx>
- <sup>63</sup> McGinnis JM, Williams-Russo P, & Knickman JR. (2002). The Case for More Active Policy Attention to Health Promotion. *Health Affairs*; 21(2):28-93.
- <sup>64</sup> Joynt KE, et al. (June 2013). Contribution of Preventable Acute Care Spending to Total Spending for High-Cost Medicare Patients. *JAMA*; 309(24):2572-78.
- <sup>65</sup> Internal Revenue Service. (April 2013). *Community Health Needs Assessments for Charitable Hospitals. Notice of proposed rulemaking [REG-106499-12]*. Washington, D.C.: Department of the Treasury. Retrieved from <http://www.irs.gov/PUP/newsroom/REG-106499-12.pdf>

## NOTES

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THE GREENLINING INSTITUTE  
1918 UNIVERSITY AVENUE, 2ND FLOOR  
BERKELEY, CALIFORNIA 94704  
WWW.GREENLINING.ORG

T: 510.926.4001 | F: 510.926.4010