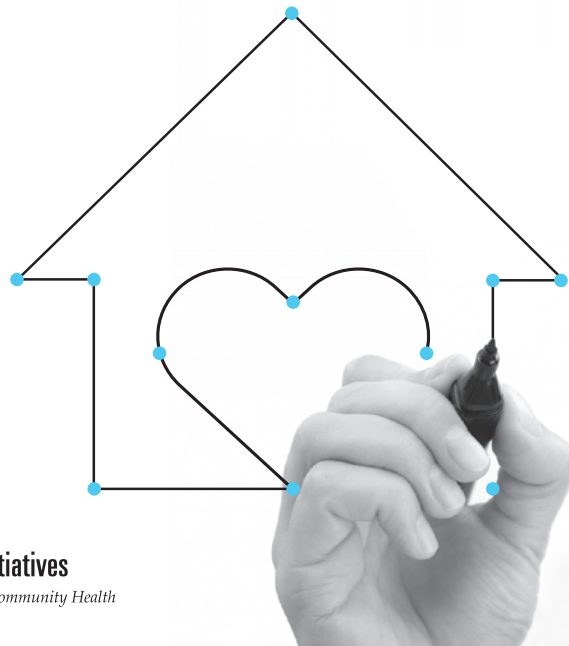


*ARIZONA HEALTH FUTURES  
Policy Primers: a nonpartisan  
guide to a better understanding  
of key terms and issues in the  
Arizona health policy landscape.*

## Connecting the Dots: A Healthy Community Leader's Guide to Understanding the Nonprofit Hospital Community Benefit Requirements

Imagine a healthy community as a connect-the-dots landscape painting. Each "dot" has its place and purpose: affordable housing, a vibrant economy, safe streets and public transportation, a high quality public education system, easy access to fresh food and safe recreation, and a healthcare system that provides both preventative and responsive services. When connected as designed by "artists" – community developers, business owners, school administrators, urban planners, traffic engineers and health professionals – the dots become a vibrant work of art that is a healthy community.

Today, we stand before a huge canvas with the challenge to collaborate on a shared vision for something creative and grand, as well as practical and effective – a healthy community.



St. Luke's Health Initiatives

*A Catalyst for Community Health*

The revised nonprofit hospital *community benefit* requirements in the federal *Affordable Care Act (ACA)* are an opportunity for us to help connect the dots, which are often referred to as “determinants of health.” They are an impetus for healthy community design leaders and nonprofit hospitals to form partnerships that define, design and implement plans for healthy communities.

## Determinants of Health<sup>1</sup>

Scientists have found that the environments in which we live, learn, work and play have an enormous impact on our health, long before we ever see a doctor. These factors outside the health or medical care system are often called determinants of health. By some accounts, these non-medical care factors account for at least 80 percent of our health. They include things such as:

- High quality and affordable housing;
- Education;
- Access to healthy and affordable food;
- Income and employment;
- Public safety;
- Social interactions and relationships; and
- Lifestyle choices.

*Now is the time for healthy community leaders to engage with nonprofit hospitals about how to fulfill the requirements in broad, impactful ways.*

Bolder strokes in ACA requirements raise the performance bar for nonprofit hospitals. To keep an essential tax-exemption status, nonprofit hospitals are expected to do bigger and more creative things to advance community health, to think differently – beyond medical care – to fulfill community benefit requirements.

The more expansive view of community benefit activities changes the landscape for the design and implementation of healthy community strategies. It also presents an opportunity for nonprofit hospitals and healthy community leaders, who represent a myriad of professions and backgrounds, to form partnerships and coordinate efforts and resources that are essential to improving overall community health.

Now is the time for healthy community leaders to engage with nonprofit hospitals about how to fulfill the requirements in broad, impactful ways. Constructive conversations begin with a solid understanding of terms, historical context of public policy and current practices.

Our findings should help guide those outside of the medical care industry through the community benefit requirements and suggest some factors to consider when approaching a nonprofit hospital to talk about healthy community investments.

We begin with a brief review of the regulatory basis and history of the community benefit requirement. We end with practical findings and action items about how leaders of healthy community design and policies can start a discussion with nonprofit hospitals in Arizona.

*Italicized terms* are defined in the glossary, on page 19 of this primer.

# Connecting the Dots

Some hospitals are government entities, some are private for-profit businesses and some are nonprofit public charities. As public charities, nonprofit hospitals carry legal expectations and demands to provide public benefit.

Nonprofit organizations receive preferential treatment through local, state and federal tax codes. Public charities, the most privileged type of nonprofit, gain their status under section 501(c)(3) of the Internal Revenue Code. In addition to exemption from federal and state income taxes, public charities may gain exemption from property and sales taxes and receive contributions that donors can deduct from individual and corporate income taxes. In exchange for this preferential tax treatment, public charities must provide a public benefit that relieves “the government of responsibilities that otherwise would have to be met at public cost.”<sup>2</sup>

And the value of this favorable tax status is sizable. In 2002, nonprofit hospitals nationwide received an estimated \$12.6 billion in federal, state and local tax benefits.<sup>3</sup>

Over the past 70 years, the tax code has become more clear-cut about what sort of community benefit is expected from nonprofit hospitals. As the sole regulator of the community benefit requirement, the Internal Revenue Service (IRS) has molded much of the hospital community benefit definition.

Two IRS rulings laid the foundation for how we define community benefit and activities that will fulfill this requirement. A 1956 IRS ruling established that nonprofit hospitals are required to provide free or reduced-cost care for those who face financial challenges. This is often called *charity care*. For a decade, providing charity care was the only way hospitals could fulfill their community benefit requirement.<sup>4</sup>

A 1969 IRS ruling expanded the kinds of activities and expenses that could fulfill this requirement.<sup>5</sup> According to the ruling, a hospital will meet its community benefit obligation if it promotes the health of “a class of persons that is broad enough to benefit the community.” Yet in spite of this expanded definition, hospitals continued to rely on charity care to fulfill the community benefit requirements.<sup>6</sup> While these rulings helped to set expectations, they were still vague, leaving hospitals to determine their own standard.

Adding complexity, some states have additional community benefit requirements.<sup>7</sup> Arizona, however, does not have such requirements.

*In exchange for this preferential tax treatment, public charities must provide a public benefit that relieves “the government of responsibilities that otherwise would have to be met at public cost.”*



# Nonprofit Hospitals in Arizona by County

## APACHE

White Mountain Regional Medical Center (Springerville)

## COCHISE

Benson Hospital (Benson)  
Copper Queen Community Hospital (Bisbee)  
Northern Cochise Community Hospital (Wilcox)

## COCONINO

Flagstaff Medical Center (Flagstaff)  
Banner Health Page Hospital (Page)

## GILA

Cobre Valley Regional Medical Center (Globe)  
Payson Regional Medical Center (Payson)

## GRAHAM

Mount Graham Regional Medical Center (Safford)

## LA PAZ

La Paz Regional Hospital (Parker)

## MARICOPA

### Dignity Health

- Chandler Regional Medical Center (Chandler)
- Mercy Gilbert Medical Center (Gilbert)
- St. Joseph's Hospital and Medical Center (Phoenix)
- St. Joseph's Westgate Medical Center (Glendale)
- Arizona General Hospital (Laveen)

### Banner Health

- Banner Baywood Medical Center (Mesa)
- Banner Behavioral Health Hospital (Scottsdale)
- Banner Boswell Medical Center (Sun City)
- Banner Del E. Webb Medical Center (Sun City West)
- Banner Desert Medical Center (Mesa)
- Banner Estrella Medical Center (Phoenix)
- Banner Gateway Medical Center (Gilbert)
- Banner University Medical Center Phoenix (Phoenix)
- Banner Heart Hospital (Mesa)
- Banner MD Anderson Cancer Center (Gilbert)
- Banner Thunderbird Medical Center (Glendale)
- Cardon Children's Medical Center (Mesa)

## HonorHealth

- HonorHealth Deer Valley Medical Center (Phoenix)
- HonorHealth John C. Lincoln Medical Center (Phoenix)
- HonorHealth Scottsdale Osborn Medical Center (Scottsdale)
- HonorHealth Scottsdale Shea Medical Center
- HonorHealth Scottsdale Thompson Peak Medical Center

Maricopa Integrated Health System (Phoenix)\*  
Mayo Clinic – Arizona (Phoenix)  
Phoenix Children's Hospital (Phoenix)  
Wickenburg Community Hospital (Wickenburg)

## MOHAVE

Kingman Regional Medical Center (Kingman)  
Kingman Regional Medical Center – Hualapai Mountain Campus (Kingman)

## NAVAJO

Little Colorado Medical Center (Winslow)  
Summit Healthcare Regional Medical Center (Show Low)

## PIMA

Carondelet St. Joseph's Hospital (Tucson)  
Carondelet St. Mary's Hospital (Tucson)  
Tucson Medical Center (Tucson)  
Banner University Medical Center Tucson (Tucson)  
Banner University Medical Center South (Tucson)

## PINAL

Banner Goldfield Medical Center (Apache Junction)  
Banner Ironwood Medical Center (San Tan Valley)  
Banner Casa Grande Medical Center (Casa Grande)  
Gila River Health Care (Sacaton)

## SANTA CRUZ

Carondelet Holy Cross Hospital (Nogales)

## YAVAPAI

Verde Valley Medical Center (Cottonwood)  
Yavapai Regional Medical Center – East Campus (Prescott Valley)  
Yavapai Regional Medical Center – West Campus (Prescott)

## YUMA

Yuma Regional Medical Center (Yuma)

\* While this primer focuses on the requirements of nonprofit hospitals, it is important to note that other hospitals do provide benefits to the communities they serve although they are not required to do so. "Safety net" hospitals, like Maricopa Integrated Health System, function similarly to nonprofit hospitals in their commitment to serving lower income patients. This financial commitment can run into the hundreds of millions of dollars in a given year. Because of uncompensated care costs and Medicaid and Medicare reimbursement rates that do not fully cover the true costs, these hospitals provide an important community benefit.

*As public charities, nonprofit hospitals carry legal expectations and demands to provide public benefit.*

## A New Century, New Scrutiny

The nonprofit hospital community benefit requirements remained unchanged until the 2000s when congressional hearings raised questions about the types of activities used to fulfill the requirements, as well as hospital reporting practices. The IRS Hospital Compliance Project, which reviewed hospital practices and issued several reports, grew out of these hearings.

The Project found that hospitals were not using a consistent definition of community benefit and priced the medical services used to fulfill the requirements differently. Inconsistent definitions and service costs made it impossible to enforce or compare the output, outcome or impact of activities across the sector.<sup>8</sup>

Additionally, according to the Project, hospitals reported that *uncompensated care* was the largest and most frequent community benefit, representing 56 percent of the total community benefit expenditures.<sup>9</sup>

The IRS Hospital Compliance Project's final report in 2008 announced forthcoming reforms that would standardize community benefit reporting procedures with the intent to prevent overstatement of practices and charges.<sup>10</sup> As a result, the IRS revised *Form 990*, which is the annual reporting form used by all nonprofit organizations.<sup>11</sup> The addition of *Schedule H* was the most notable change. Schedule H provided a form for all nonprofit hospitals to report community benefit activities, among other data.<sup>12\*</sup>

The Catholic Health Association has compiled a useful but non-exhaustive list of “what counts” as community benefit activities and investments.<sup>13</sup> Of particular importance for leaders of healthy community design, implementation and policy, the Catholic Health Association lists the following as acceptable community benefit investments:\*\*

- Transportation;
- Food access or food policy coalition work;
- Donated food;
- Medical respite facilities that serve the homeless;
- Housing costs;
- Non-medical equipment or supplies;
- Donated office or meeting space;
- Donated fitness equipment;
- Advocacy;
- Child care;
- Free assistance with tax preparation, such as Volunteer Income Tax Assistance (V.I.T.A); and
- Costs associated with developing a community needs health assessment or applying for a grant.



\* Other data that are reported on Schedule H include: (1) financial assistance policies, (2) bad debt, Medicare shortfall and collection practices, (3) management companies and joint ventures, (4) facility information and (5) supplemental information.

\*\* The Catholic Health Association repeatedly cautions that in order for an activity to “count” towards a hospital’s community benefit requirement, the activity should be directly linked to a health priority addressed in the hospital’s community health needs assessment.

Should a nonprofit hospital fail to complete or file a CHNA, implementation plan or Schedule H, it must pay a fine of \$50,000 per hospital location or risk the hospital's tax-exempt status.

Hospitals were operating under an interim Schedule H regulation until December 2014. As a result, most hospitals have been reluctant to venture far beyond traditional charity care practices because of the uncertain regulatory expectations.<sup>14</sup>

### ACA Sets Expectations

While the 2008 IRS revisions set a new standard for how nonprofit hospitals report their community benefit investments and activities, the Affordable Care Act clarified how hospitals should assess the health needs of those in the community. The ACA requires all nonprofit hospitals to complete a *community health needs assessment (CHNA)* once every three years.<sup>15\*</sup>

In a CHNA report, a nonprofit hospital must:

- identify the community it serves,
- receive input from a diverse group of people who represent the broad interests of the community,
- tap into the knowledge of public health officials,
- collect and analyze data, and
- identify and prioritize the most pressing health challenges facing the community it serves.

The ACA requires that the hospital take into account input received by those that represent the broad interests of the community and, once adopted by the hospital, that the CHNA “is made widely available to the public.”<sup>16</sup> Following this process, nonprofit hospitals must create an *implementation strategy* to document how it will address the selected health needs.<sup>17</sup>

Should a nonprofit hospital fail to complete or file a CHNA, implementation plan or Schedule H, it must pay a fine of \$50,000 per hospital location or risk the hospital's tax-exempt status.<sup>18</sup> We have been unable to find an instance where the IRS has fined a hospital for noncompliance; however, one complaint was filed against a Florida hospital system in October 2014.<sup>19</sup>

### Arizona's CHNA Landscape

In 2012, nonprofit hospitals throughout the country responded to the ACA requirements by completing a CHNA. We performed a rapid scan of the following Maricopa County nonprofit hospitals' CHNAs to better understand the scope of issues explored: Banner University Medical Center Phoenix, Dignity Health St. Joseph's Hospital and Medical Center, Mayo Clinic Hospital-Arizona, Phoenix Children's Hospital and John C. Lincoln-North Mountain.

According to the CHNAs of the five Maricopa County-area hospitals, health priorities include:

- access to medical care,<sup>20</sup>
- diabetes,<sup>21</sup>
- behavioral health,<sup>22</sup>
- stable housing,<sup>23</sup> and
- injury prevention.<sup>24</sup>

\* Additionally, *Section 9007* of the ACA requires nonprofit hospitals to (1) establish a written financial assistance policy, (2) place limits on the amount charged for medical care depending on a patient's financial situation and (3) adjust billing and collection practices to fall in line with patients eligible for financial assistance.

## Hospital *Community Benefit Investments* 2009<sup>25</sup>

### DIGNITY HEALTH – ST. JOSEPH’S HOSPITAL AND MEDICAL CENTER

|  |              |
|--|--------------|
| Uncompensated Care Cost:                         | \$9,110,133* |
| Health Profession Education & Training Programs: | \$15,921,570 |
| Unpaid Costs of Public Programs (Medicaid):      | \$53,493,294 |
| Charity Care (at cost):                          | \$16,394,788 |

\* Community Health Improvement Services; Community Benefit Operations; Community Building Activities; Financial: In-kind contributions; Subsidized Health Services.

### BANNER UNIVERSITY MEDICAL CENTER PHOENIX *Formerly Banner Good Samaritan Medical Center*

|  |               |
|--|---------------|
| Uncompensated Care Cost:                         | \$17,333,100* |
| Health Profession Education & Training Programs: | \$15,714,897  |
| Unpaid Costs of Public Programs (Medicaid):      | \$11,667,922  |
| Charity Care (at cost):                          | \$9,955,690   |

\* Total uncompensated care – reported at cost – for Banner Good Samaritan Medical Center was \$17,333,100, which includes \$9,995,690 in charity care and \$7,337,410 in bad debt.

Bad debt was not calculated as part of Banner Health’s community benefit. Bad debt includes services that were provided but for which there was no payer available. Charity care included services provided at no cost or reduced cost under Banner Health’s charity care policy.

### MAYO CLINIC – ARIZONA

|  |              |
|--|--------------|
| Uncompensated Care Cost:                         | \$14,913,945 |
| Health Profession Education & Training Programs: | \$17,140,000 |
| Unpaid Costs of Public Programs (Medicaid):      | \$26,168,000 |
| Charity Care (at cost):                          | \$4,292,855  |

### PHOENIX CHILDREN’S HOSPITAL

|  |              |
|--|--------------|
| Uncompensated Care Cost:                         | \$11,838,180 |
| Health Profession Education & Training Programs: | \$1,428,294  |
| Unpaid Costs of Public Programs (Medicaid):      | \$33,165,497 |
| Charity Care (at cost):                          | \$9,393,999  |

### HONORHEALTH

*Formerly John C. Lincoln Health Network (Deer Valley Hospital and North Mountain Hospital)*

|  |              |
|--|--------------|
| Uncompensated Care Cost:                         | \$29,688,503 |
| Health Profession Education & Training Programs: | \$1,202,248  |
| Unpaid Costs of Public Programs (Medicaid):      | \$10,475,785 |
| Charity Care (at cost):                          | \$17,641,444 |



Several national organizations are closely monitoring the implementation of the community benefit requirements; some are advocating for change at the national level.

## Evolving Partnership

Similar to the ACA requirements for nonprofit hospitals, the Maricopa County Department of Public Health must also complete a community health assessment (CHA) every five years to maintain professional accreditation.\*<sup>26, 27</sup>

Because both the CHNA (developed by individual hospitals) and the CHA (developed by the county health department) require an analysis of the health of the community it serves, the Maricopa County Department of Public Health and Maricopa County-area nonprofit hospitals reached an agreement to share health data in 2014. Included in the partnership are the four nonprofit hospital systems in Maricopa County – Banner Health Systems, Scottsdale Healthcare, Dignity Health and Mayo Clinic Hospital. This partnership around shared data will allow for a more meaningful assessment that echoes the influence of the community and public health officials.<sup>28, 29</sup>

This is an evolving partnership and sharing data is a promising first step. This collaborative effort is the type of partnership envisioned for the ACA's CHNA requirement. If this data sharing partnership goes smoothly, further collaboration could be possible, such as a shared investment strategy or pooling resources to address shared health challenges.

## Comparisons to CRA

Some observers draw parallels between hospital community benefit requirements and the *Community Reinvestment Act (CRA)* requirements of financial institutions.<sup>30</sup> Both must define the geographic community it serves and is required to make investments in that community. Both prohibit “redlining,” practices where particular neighborhoods – typically low-income or predominantly minority neighborhoods – are seen as too risky for investment. The investment amount or threshold and activities or investments that “count” can be unclear – allowing for both creativity and some uncomfortable ambiguity. Finally, documents and reports from both processes are made available to the public with the expectation that residents will help oversee the institution's responsiveness.

However, two conditions set a slightly different tone for hospitals than what banks experienced at the advent of CRA. The regulatory environment for banks was quite different and a regulatory framework already existed. While expansion of those regulatory mechanisms was substantial, the organizational structure had been in place for at least four decades. Moreover, CRA regulators solely focused on financial institutions and knew that industry well.

In contrast, the IRS is the community benefit regulator. Its expertise is taxation – not health, medical care or community benefit activities. The IRS budget has been cut just as expectations for the community benefit regulation increased. Although the IRS has been responsible for regulating community benefit for decades, there have been few recorded punitive actions. Overall, the regulatory environment for hospitals is weaker than the one banks experienced at the advent of CRA in the 1970s.

Additionally, public advocacy, organization and mobilization are not as robust for community benefit as they were for CRA. In part because of its philosophic connection with civil rights, community groups monitored CRA implementation by the regulators and

\* Like the Maricopa County Department of Public Health, the Arizona Department of Health Services must also complete a health assessment to maintain its Public Health Accreditation. This State Health Assessment (SHA) covers the entire population of Arizona and is based on the CHAs conducted by the 15 county health departments in Arizona. In June 2014, the statewide effort launched to complete the Arizona Health Improvement Plan, which was informed by the SHA. Health priorities were set and a plan will be created to achieve the desired outcomes of each priority over the next five years.



performance of individual banks.<sup>31</sup> Having concrete experience from the civil rights movement, these CRA advocates were successful in getting banks to invest in lower-income communities. Public protests and other publicity strategies led to gains in CRA implementation and enforcement. This public advocacy was on behalf of communities that were poised for CRA investment.

Several national organizations are closely monitoring the implementation of the community benefit requirements; some are advocating for change at the national level. However, the advocacy passion and focus on the local neighborhoods and residents are largely missing from the community benefit environment. Whereas it was not unusual to find protesters in front of banks in the 1970s and 1980s, similar organized grassroots mobilization around community benefit is unusual to nonexistent. This is largely because nonprofit hospitals have served the community by spending millions treating uninsured or underinsured patients inside the hospital.

As a result of these two external pressures – neither a sophisticated regulatory infrastructure nor an organized and passionate advocacy network – the evolution of the community benefit activities and investments may differ substantially from that of CRA.

## Let These Findings *Be Your Guide*

Connecting the dots in the intricate healthy community portrait is not a quick and simple endeavor. The full effects of the Affordable Care Act and a more robust and transparent IRS reporting system for nonprofit hospital systems will take time to emerge – likely years. In the meantime, some trends and promising practices have emerged that can help guide leaders of healthy community design, implementation and policy in approaching and developing partnerships with hospitals.

**WHERE CAN I FIND THE COMMUNITY BENEFIT DEPARTMENT?** Hospitals were not immune to the recent economic crisis. Jobs were cut and departments were consolidated. Over time, some hospitals were left with one employee focused on community benefit initiatives or the initiatives found their way into strategies of other departments. As a result, community benefit initiatives are often found in one of two departments: the finance department, to oversee compliance with IRS rules; or the marketing department, to oversee promotion and positioning and image of the organization within the community. As administrative departments, there can be a disconnect between finance and marketing professional staff, community benefit investing and the complex web of factors that affect health.

However, some hospitals do have a department dedicated to fulfilling the community benefit requirement. St. Joseph Hospital and Medical Center in Phoenix has a community benefit “department” – Community Health Integration. It creates meaningful community engagement and cultivates partnerships with various stakeholders. Among its goals is to ensure that the hospital is fulfilling its community benefit requirements.

Because of divergent hospital strategies in fulfilling the community benefit requirements, it may take some time and perseverance to find the right person or department to engage in a discussion about community benefit investments and priorities.

**TALK THEIR TALK.** The IRS and hospitals have their own language around the community benefit requirements. Be familiar and comfortable with this language and the legal requirements. This primer, including the glossary and resources sections, provides a solid foundation to understand the community benefit requirements.

*Because of divergent hospital strategies in fulfilling the community benefit requirements, it may take some time and perseverance to find the right person or department to engage in a discussion about community benefit investments and priorities.*

The IRS is clear that hospital facilities may not exclude low-income or minority populations living “in geographic areas from which the hospital facility draws patients,” and not only those receiving care from the facility – a policy that seeks to prevent a health version of redlining.

**CHNAs CAN BE DIFFICULT TO FIND.** The ACA requires hospitals to make their CHNAs available to the public. However, hospital CHNAs are often difficult to find, especially for those with little familiarity with these documents. Hospitals rely heavily on their websites as the means of distribution and access to these documents, but in reality, they are often difficult to find in the large website architecture of most hospitals.

We could not find a regional or national repository for CHNAs. A list of Maricopa County CHNAs are listed in the Resources section.

**WHO ARE THE PEOPLE IN YOUR COMMUNITY?** Each CHNA must define the community that the hospital serves and use data to better understand the challenges residents face in being healthy. The IRS gives individual hospitals great leeway to define the community it serves. For some hospitals, the service area may be the entire state, while others may designate just a portion of a city. The IRS is clear that hospital facilities may not exclude low-income or minority populations living “in geographic areas from which the hospital facility draws patients,” and not only those receiving care from the facility<sup>32</sup> – a policy that seeks to prevent a health version of redlining.

**DO YOUR HOMEWORK.** Two documents are key to understanding a hospital’s community health priorities and how it is meeting its community benefit requirements – the CHNA and Schedule H. In theory, the health challenges described in a hospital’s CHNA should be reflected in the community benefit investment and activities in the hospital’s Schedule H.

Use the information in the CHNA and Schedule H to tailor your discussion. The implementation strategy may also be a helpful resource. If a hospital has identified obesity and injury prevention as priorities, a discussion about childcare facilities or air quality may not be fruitful. Schedule H will reinforce what types of activities the hospital has supported in the past and, therefore, be a predictor of the types of activities it may be willing to support in the future.

The CHNA will indicate the health challenges facing the community the hospital serves. This will help set the parameters for the discussion with the hospital.



### Case Study: Linking Healthy Community Design Activities with CHNA

*Physical improvements and housing*

**Example:** Desert Mission Neighborhood Renewal

**Hospital:** John C. Lincoln – North Mountain Hospital

**Location:** North Phoenix, Arizona – Sunnyslope

**CHNA Identified Need:** Stable housing

**Description:** Desert Mission Neighborhood Renewal is a community development corporation dedicated to the development of housing, neighborhoods and businesses in North Phoenix. Core programs and services include: (1) Housing counseling and home-buyer assistance, (2) infill affordable housing and homeowner rehabilitation and (3) commercial development and redevelopment.

## Case Study: Linking Healthy Community Design Activities with CHNA

### *Food security*

**Example:** Supplemental Nutrition Assistance Program (SNAP) Double Dollars Program

**Hospital:** Inova Health System

**Location:** Northern Virginia and Washington, DC

**CHNA Identified Need:** Food insecurity

**Description:** The SNAP Double Dollars Program is an incentive program designed to encourage SNAP recipients to purchase fresh, local foods at farmers markets. Shoppers at participating markets receive \$10 in matching funds for SNAP purchases of fresh fruits and vegetables.

Two documents are key to understanding a hospital's community health priorities and how it is meeting its community benefit requirements – the CHNA and Schedule H. Use the information in the CHNA and Schedule H to tailor your discussion.

## Case Study: Linking Healthy Community Design Activities with CHNA

### *Economic development*

**Example:** Evergreen Cooperatives

**Hospital:** Greater University Circle Initiative – Cleveland Clinic Health System, University Hospitals System

**Location:** Cleveland, Ohio

**CHNA Identified Need:** Economic opportunity

**Description:** Cleveland, Ohio has suffered from high unemployment rates since the Great Recession. The Greater University Circle Initiative is a collaborative effort dedicated to leveraging the economic strength of the urban anchor institutions. The Evergreen Cooperative Initiative was developed to create living wage jobs for the low-income neighborhoods within the Greater University Circle. The Cooperatives include three separate businesses: (1) Evergreen Cooperative Laundry, (2) Evergreen Energy Solutions and (3) Green City Growers Cooperative. The employee-owned businesses are tapping into the supply chain of Cleveland's anchor institutions to provide products and services.



## Case Study: Linking Healthy Community Design Activities with CHNA

### Physical Activity

**Example:** Prescribe-a-Bike

**Hospital:** Boston Medical Center

**Location:** Boston, Massachusetts

**CHNA Identified Need:** Transportation barriers accessing healthcare

**Description:** Boston Medical Center teamed up with the City of Boston for the Prescribe-a-Bike program. The initiative builds on Boston's bike share program, Hubway, to offer low-income patients access to an annual membership and a free helmet.

IRS Form 990, Schedule H can be found through a number of online resources; a list of these resources can be found at the end of this primer.

In contrast to CHNAs, which can be difficult to find on a hospital's website, the IRS Form 990, Schedule H can be found through a number of online resources; a list of these resources can be found at the end of this primer.

Two parts of Schedule H have particular relevance to leaders for healthy community design, implementation and policy (see figures 1 and 2.) *Part I: Financial Assistance and Certain Other Community Benefits at Cost, line 7e* is where hospitals list community benefit investments and activities that are not medical care. *Part II: Community Building Activities* provides more specific information about investments and activities that are outside the medical care industry, such as affordable housing development and coalition building.

**Figure 1: IRS Form 990, Schedule H, Part I**

Financial Assistance and Certain Other Community Benefits at Cost, Line 7e provides a space for non-profit hospitals to document community benefit investments that relate to the factors outside the medical care industry.

| 7 Financial Assistance and Certain Other Community Benefits at Cost  |   |                               |                                     |                               |                                   |                              |
|--|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| Financial Assistance and Means-Tested Government Programs  | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
| <b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .   |   |                               |                                     |                               |                                   |                              |
| <b>b</b> Medicaid (from Worksheet 3, column a)   |   |                               |                                     |                               |                                   |                              |
| <b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .              |   |                               |                                     |                               |                                   |                              |
| <b>d Total</b> Financial Assistance and Means-Tested Government Programs                                     |   |                               |                                     |                               |                                   |                              |
| Other Benefits   |   |                               |                                     |                               |                                   |                              |
| <b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . . |   |                               |                                     |                               |                                   |                              |
| <b>f</b> Health professions education (from Worksheet 5) . . . . .   |   |                               |                                     |                               |                                   |                              |
| <b>g</b> Subsidized health services (from Worksheet 6) . . . . .   |   |                               |                                     |                               |                                   |                              |
| <b>h</b> Research (from Worksheet 7) . . . . .   |   |                               |                                     |                               |                                   |                              |
| <b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .                   |   |                               |                                     |                               |                                   |                              |
| <b>j Total.</b> Other Benefits . . . . .   |   |                               |                                     |                               |                                   |                              |
| <b>k Total.</b> Add lines 7d and 7j . . . . .  |   |                               |                                     |                               |                                   |                              |

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Cat. No. 50192T

Schedule H (Form 990) 2014

**Figure 2: IRS Form 990, Schedule H, Part II**

*Community Building Activities provides more in-depth information of community benefit investments that focus on factors outside the medical care industry.*

| <b>Part II Community Building Activities</b> Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves. |   | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|---|---|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1   | Physical improvements and housing                         |   |                               |                                      |                               |                                    |                              |
| 2   | Economic development                                      |   |                               |                                      |                               |                                    |                              |
| 3   | Community support   |   |                               |                                      |                               |                                    |                              |
| 4   | Environmental improvements                                |   |                               |                                      |                               |                                    |                              |
| 5   | Leadership development and training for community members |   |                               |                                      |                               |                                    |                              |
| 6   | Coalition building  |   |                               |                                      |                               |                                    |                              |
| 7   | Community health improvement advocacy                     |   |                               |                                      |                               |                                    |                              |
| 8   | Workforce development                                     |   |                               |                                      |                               |                                    |                              |
| 9   | Other   |   |                               |                                      |                               |                                    |                              |
| 10  | <b>Total</b>  |   |                               |                                      |                               |                                    |                              |

**THE FOCUS IS ON INDIVIDUAL BEHAVIORS AND MEDICAL CARE.** The health needs identified in the Maricopa County-area CHNAs tend to focus on health behaviors and medical care, such as cardiovascular disease and access to care.<sup>33</sup> This follows national hospital trends.<sup>34</sup> Given that the business model of hospitals centers on providing medical care, this should not be surprising; medical care is what hospitals essentially do.

As a point of reference, in 2007, Arizona hospitals spent almost \$1.65 billion on community benefits. Of that investment, just \$10 million went to community building activities, such as affordable housing. The vast majority of community benefit funds is spent on charity care.

While important, individual behaviors and medical care do not begin to tell the entire story of overall health needs – often explained as determinants of health – of area residents. Many of these factors are addressed by leaders of healthy community design and implementation, such as practitioners in urban planning, community development, housing and transportation.

The key is to link these behaviors and medical care challenges to your programs and look for win-win opportunities. For example, if a hospital identifies overuse of the emergency room services by the homeless population, then perhaps focus the discussion on creating affordable housing and wrap-around social services. If the hospital identifies diabetes as a challenge for its community, perhaps discuss access to healthy food and using farmers markets as a strategy.

**THE IMPACT OF INCREASED INSURANCE COVERAGE IS UNCLEAR.** The ACA has spurred the biggest overhaul of the United States’ health care system since the passage of *Medicaid* and *Medicare*. In Arizona, 300,000 people have benefited from Medicaid expansion.<sup>35</sup> The result of expanded insurance coverage has the potential to ease the financial burden of uncompensated care and charity care for some nonprofit hospitals. Some hope that this decreased demand on uncompensated care will allow hospitals to shift the community benefit focus to broader determinants of health.

It is promising to note that the U.S. Department of Health and Human Services estimates that national uncompensated care spending will be down \$4.7 billion given the expansion of Medicaid.<sup>36</sup> This leaves room for some nonprofit hospitals across the country to shift their community benefit investments from uncompensated care to other activities, including community building activities.

*The health needs identified in the Maricopa County-area CHNAs tend to focus on health behaviors and medical care, such as cardiovascular disease and access to care.*

*Other than demonstrating a benefit to the community, the IRS does not provide any guidance on the extent to which a hospital should provide benefits; there is not a formula or dollar amount of benefit that it must meet.*

However, others caution that while the ACA provides expanded insurance coverage, it also cuts the amount that hospitals receive from the federal government for uncompensated care, making some hospitals even more financially vulnerable. Arizona's Medicaid restoration/expansion was also financed by a sizable hospital provider assessment, which also impacted hospitals' bottom line. Moreover, in Arizona, where we have a sizable population of undocumented immigrants, we are likely to continue to see a larger portion of our population remain uninsured.

Bottom line: because of the sweeping changes and litigation environment around the ACA, it may take several years to know if or by how much the increased number of insured people will affect a hospital's uncompensated care spending.

### ***What does the IRS mean when it says...?***<sup>37</sup>

Schedule H can be confusing. Below are a few IRS terms, corresponding definitions and examples that may be helpful in understanding how a hospital reports its community benefit activities and investments. The IRS is clear that the community benefit activities described are just examples and hospitals should not limit themselves to these activities alone.<sup>38</sup>

**PHYSICAL IMPROVEMENTS AND HOUSING** The provision or rehabilitation of housing for vulnerable populations, such as removing building materials that harm the health of the residents, neighborhood improvement or revitalization projects, provision of housing for vulnerable patients upon discharge from an inpatient facility, housing for low-income seniors and the development or maintenance of parks and playgrounds to promote physical activity.

**ECONOMIC DEVELOPMENT** Assisting small business development in neighborhoods with vulnerable populations and creating new employment opportunities in areas with high rates of joblessness.

**COMMUNITY SUPPORT** Child care and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs and disaster readiness and public health emergency activities, such as community disease surveillance or readiness training beyond what is required by accrediting bodies or government entities.

**ENVIRONMENTAL IMPROVEMENTS** Activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products and other activities to protect the community from environmental hazards.

**LEADERSHIP DEVELOPMENT AND TRAINING FOR COMMUNITY MEMBERS** Training in conflict resolution; civic, cultural or language skills; and medical interpreter skills for community residents.

**COALITION BUILDING** Participation in community coalitions and other collaborative efforts with the community to address health and safety issues.

**COMMUNITY HEALTH IMPROVEMENT ADVOCACY** Efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment and transportation.

**HOW MUCH IS ENOUGH?** Other than demonstrating a benefit to the community, the IRS does not provide any guidance on the extent to which a hospital should provide benefits; there is not a formula or dollar amount of benefit that it must meet. The IRS is silent on how much is enough.

As a result, total community benefit investment varies even among hospitals of similar size. Some spend as much as 20 percent of their operating costs on community benefit activities and others as little as one percent.<sup>39</sup>

**BE OPEN ABOUT THE TYPE OF INVESTMENT.** Hospital community benefit investments can come in many forms. While a direct financial grant may be the gold standard, other investment types can be equally valuable. Cash donations for a community benefit purpose, staff time and expertise, facility use and other in-kind donations – such as office space, printing and equipment – count toward a hospital’s community benefit requirement.

Further, think about leveraging resources from the community development sector. Use existing community development funding, such as grants or *community development financial institution* investment, to attract community benefit investment.

**LEADERSHIP COMMITMENT TO CHNAs IS EVOLVING.** It is important to note that successful and sweeping community benefit initiatives cannot be implemented within one hospital department. Successful initiatives need the commitment of hospital leadership. Implementation and connection of CHNAs to community benefit investments varies between hospitals, in part because of varying degrees of leadership commitment.<sup>40</sup>

**MONITORING OF COMMUNITY BENEFIT COMPLIANCE IS LIMITED.** There appears to be only peripheral monitoring and regulation of the community benefit requirement. As stated previously, the IRS provides the sole regulatory oversight and we have been unable to find an example of a hospital failing to comply with the community benefit requirement.

At the national level, the Catholic Health Association, Community Catalyst and The Hilltop Institute monitor the progress of the regulatory environment and performance at an industry level, such as changes to regulations and promising practices around community benefit. No such infrastructure exists in Maricopa County or Arizona to monitor or advocate for progress.

These national organizations can be useful in understanding the impact of changes to Schedule H or regulations governing CHNAs. Monitoring the discussion at the national level may help inform partnership opportunities in Arizona.

*Successful and sweeping community benefit initiatives cannot be implemented within one hospital department. Successful initiatives need the commitment of hospital leadership.*



## Community Health Needs Assessments and Priorities

### St. Joseph's Hospital and Medical Center Community Needs and Priorities<sup>41</sup>

- Access to care issues
- Obesity
- Diabetes
- Lung cancer
- Cardiovascular disease
- Cancer prevention
- Reduce injury and trauma

### Banner University Medical Center Phoenix Community Needs and Priorities<sup>42</sup>

- Access to care
- Chronic disease management, with a focus on diabetes and heart disease
- Behavioral health, including mental health and substance abuse
- Obesity, with a focus on nutrition and physical activity
- Smoking and other tobacco use

### Mayo Clinic – Arizona Community Needs and Priorities<sup>43</sup>

- Obesity
- Diabetes
- Lung cancer
- Cardiovascular disease
- Access to care

### Phoenix Children's Hospital Community Needs and Priorities<sup>44</sup>

- Injury prevention
- Nutrition and obesity prevention
- Oral health care
- Prenatal outreach
- Developmental and sensory screening

### John C. Lincoln – North Mountain Hospital<sup>45</sup>

- Stable housing
- Affordable and accessible health care
- Health care coverage
- Access to primary care services
- Prevention
- Chronic disease management
- Integrate behavioral health with primary care
- Dental health
- Personal care and transitional support following hospital stay
- Family caregiver education
- Tools to support personal responsibility

Although the IRS is expected to provide oversight of the community benefit requirements, its budget has been cut by 18 percent, after accounting for inflation, since 2010.<sup>46</sup> As IRS responsibilities have increased, its staff and overall funding have declined, which has caused some to worry about enforcement of regulations, including the community benefit requirements.

**DON'T EXPECT THEM TO REACH OUT TO YOU. PROACTIVELY CONTACT NONPROFIT HOSPITALS AND THE MARICOPA COUNTY DEPARTMENT OF PUBLIC HEALTH.** The Maricopa County CHA provides the data foundation for the development of hospital CHNAs. In turn, CHNAs lay the foundation for setting priorities and subsequent community benefit investments for individual hospitals. In other words, by affecting change in the County CHA, leaders will influence hospital CHNAs and community benefit investments.

Nonprofit hospitals are required to take “into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health” when developing the CHNA.<sup>47</sup>

The leaders of healthy community design, implementation and policy are poised to provide unique insights on the determinants of health during the development of the CHA and CHNAs. By providing data and knowledge early in the data-gathering and priority-setting stages, you can influence how hospitals meet their community benefit requirement. Ideally, the benefits are twofold: nonprofit hospitals are fulfilling a federal requirement and communities have a seat at the table to improve overall community health.<sup>48</sup>

Leaders in healthy community design, implementation and policy may also have data of which hospitals are unaware, such



as information gathered for programmatic use. While these data sources may not report explicitly on specific health outcomes, they help provide a bigger picture of the neighborhoods and environment in which certain outcomes are produced. Similarly, while the data may not have the same geographic boundaries as the hospital's, it may illuminate broader contextual issues.

**LOOK FOR CROSS-SECTOR LEVERAGE.** At the sector level, creating partnerships among hospitals to meet the community benefit requirements can be difficult. The collaborative effort between the Maricopa Department of Public Health and the Maricopa-area nonprofit hospitals holds promise, but we must remember the competitive nature in the business of medical care. It may take years – if ever – before nonprofit hospitals come together as a sector to make a unified and coordinated impact on community health.

**DO NOT EXPECT IMMEDIATE RESULTS.** Cultivating relationships with hospitals will take time, but this is vital to developing partnerships. Many hospitals are new to healthy community design, implementation and policy issues, so have the long game in mind. Act as a partner in educating how your programs and services affect the overall health of the community and link those to the hospital's CHNA priorities.

Connecting the dots in the intricate  
healthy community portrait is not a  
quick and simple endeavor.  
But there is opportunity to form partnerships  
with healthy community leaders  
to create and sustain a fact-based,  
consensus-driven, comprehensive  
community health solutions.

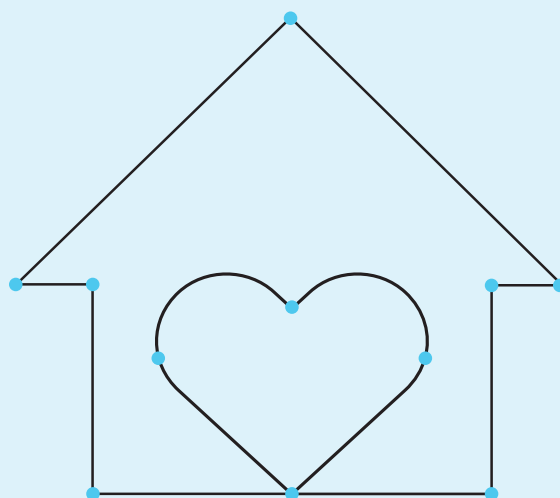


## Final Thoughts

The expanded community benefit requirements for nonprofit hospitals present an opportunity to form partnerships with healthy community leaders to create and sustain a fact-based, consensus-driven, comprehensive community health solutions. They raise expectation levels in ways that should allow nonprofit hospitals to partner in local initiatives that impact community health.

Some nonprofit hospitals have deep-rooted community benefit traditions<sup>49</sup> and some have already explored broader initiatives that fulfill the ACA requirement.<sup>50</sup> The community benefit requirements encourage hospitals to collaborate with public health professionals, community members and grassroots organization to influence significant change within their service area.<sup>51</sup>

In the new realm of possibilities for community benefit compliance, nonprofit hospitals are encouraged to focus on factors that affect our health outside of the medical care system.<sup>52</sup> That richer, more detailed portrait of healthy communities will require coordination and strategic planning with healthy community design leaders. It requires a commitment to connect the dots.



## Acknowledgements

This primer would not have been possible without the kind support and help of many individuals and organizations. We would like to extend our sincere thanks to all of them: **Meghanne Bearden**; **Sheila Sjolander** at the Arizona Department of Health Services; **Debbie Johnston** at the Arizona Hospital and Healthcare Association; **Kimberly Schraven** at Banner Health; **Dean Brennan**; **Colby Dailey** and **Renee Roy Elias** at Build Healthy Places Network; **Jon Brodsky** and **Curt Upton** at the City of Phoenix; **Marisue Garganta** and **Kristina Robinson** at Dignity Health St. Joseph's Hospital and Medical Center; **Elizabeth Sobel Blum** at the Federal Reserve Bank of Dallas; **John Moon** at the Federal Reserve Bank of San Francisco; **Eileen Eisen-Cohen**, **David Dube** and **Kate Goodin** at the Maricopa County Department of Public Health; **Mark Martz**; and **Suzanne Pfister**, **Kim VanPelt**, **Roy Pringle**, **Stephanie Gallegos** and **Jon Ford** at St. Luke's Health Initiatives.

## Glossary

The **Patient Protection and Affordable Care Act**, often referred to as **the Affordable Care Act (ACA)** or Obamacare, is a comprehensive health care law designed to: (1) expand health insurance coverage, (2) increase accountability for insurance companies, (3) lower health care costs, (4) guarantee more choice and (5) enhance the quality of care for all Americans.<sup>53</sup>

**Section 9007 of the ACA** establishes new requirements for nonprofit hospitals, which include: (1) completing a community health needs assessment, (2) providing a written financial assistance policy and providing emergency medical services without prejudice, (3) placing limitations on charges for emergency and other medically necessary care and (4) not engage in extraordinary collection practices before determining an individual's financial status.<sup>54</sup>

All public charities must file **Form 990** with the Internal Revenue Service (IRS) each year. The Form 990 provides an overview of the organization's finances and activities that substantiate the tax-exempt status.

The passage of the ACA requires all nonprofit hospital organizations to complete Schedule H in conjunction with the annual filing of the Form 990. **Schedule H** contains six parts, which outline (1) the cost of charity care and other community benefits at cost, (2) community building activities, (3) bad debt, Medicare and collection practices, (4) management companies and joint ventures, (5) facility information and (6) supplemental information.<sup>55</sup>

**Community Building Activities**, a reporting section within Schedule H, encourages nonprofit hospitals to engage in initiatives that focus on social and economic determinants of health. Activities include physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building and workforce development.

The ACA requires all nonprofit hospitals to complete a **community health needs assessment (CHNA)** once every three years. The CHNA utilizes data to better understand the health needs of a community. This new opportunity allows nonprofit hospitals, public health officials and community stakeholders the chance to identify and prioritize health needs.

In conjunction with a CHNA, nonprofit hospitals must complete an **implementation plan (IP)**. This plan outlines the initiatives that will address the priority health needs identified in the CHNA.

**Medicaid** is a joint federal and state program that assists with medical costs for people with limited income and resources.<sup>56</sup> Arizona's Medicaid program, the **Arizona Health Care Cost Containment System (AHCCCS)**, serves Arizona residents that meet certain income and other requirements for services.<sup>57</sup>

**Medicare** is a federal insurance program for people aged 65 or older and certain younger people with disabilities.<sup>58</sup>

Nonprofit hospitals provide support through initiatives and programs to demonstrate their commitment to the community. Known as **community benefit**, nonprofit hospitals provide services to patients not able to afford care, offer care to Medicaid and Medicare recipients,

*Use this glossary to familiarize yourself with common terms and acronyms.*

and implement programs designed to improve community health and access to health care.<sup>59</sup> **Community benefit** is also defined by the Internal Revenue Service (IRS) to determine the tax-exemption of nonprofit hospitals. Section 9007 of the ACA outlines these new requirements that nonprofit hospitals must demonstrate to sustain their 501(c)(3) status.<sup>60</sup>

**Uncompensated care** includes medical services provided by a hospital that are not reimbursed by an insurer nor paid for by a patient. Included within the overall sum are charity care and bad debt. **Charity care (or financial assistance)** refers to the services provided by a hospital where the hospital does not expect payment. **Bad debt** refers to care provided to patients that are unable to pay for services and do not apply for charity care or refuse to pay for care. Bad debt goes through the collection process and may affect the patient's credit rating; charity care does not go through the collection process.<sup>61</sup>

**Community development** is a “multi-billion dollar sector of the American economy that invests in low- and moderate-income communities through the development and financing of affordable housing, businesses, community centers, health clinics, job training programs and services to support children, youth and families. Community development is a self-defined sector involving organizations from multiple fields that share a common focus on improving low-income communities. These organizations come from fields including real estate, city planning, law, social work, public policy, public health, affordable housing developers and finance and generally identify themselves as being part of the community development industry.”<sup>62</sup>

**Community Development Financial Institutions (CDFIs)** are “private financial institutions that are 100% dedicated to delivering responsible, affordable lending to help low-income, low-wealth, and other disadvantaged people and communities join the economic mainstream.”<sup>63</sup> CDFIs include both for-profit and non-profit institutions. These institutions invest in communities by financing small businesses, microenterprises, nonprofit organizations, and commercial real estate and affordable housing. CDFIs also serve as intermediaries that help commercial banks invest in low-income communities in order to meet their Community Reinvestment Act (CRA) requirements.<sup>64</sup>

Enacted by Congress in 1977, the **Community Reinvestment Act (CRA)** is a federal law that requires banks to meet the credit needs of the communities they serve, particularly individuals and businesses in low- and moderate-income neighborhoods. CRA was developed in response to “redlining” practices in which banks deemed particular neighborhoods – typically low-income or predominantly minority neighborhoods – unfit for investment. CRA compliance is monitored by three bank regulatory agencies: the Federal Reserve System, the Federal Deposit Insurance Corporation (FDIC), and the Office of the Comptroller of the Currency (OCC). CDFIs serve as the financial intermediaries between low-income communities and commercial banks to ensure that the banks can meet their CRA requirements. CRA-funded projects have traditionally focused on affordable housing and business development but today increasingly include investments such as grocery stores, charter schools, health clinics and other community facilities that address the social determinants of health.<sup>65</sup>

## Resources

### **Catholic Health Association**

[www.chausa.org/communitybenefit](http://www.chausa.org/communitybenefit)

### **Community Catalyst**

[www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/community-benefit-tools-and-resources-for-chna](http://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/community-benefit-tools-and-resources-for-chna)

### **The Hilltop Institute, Hospital Community Benefit Program**

[www.hilltopinstitute.org/hcbp.cfm](http://www.hilltopinstitute.org/hcbp.cfm)

### **Foundation Center Form 990 Finder**

[foundationcenter.org/findfunders/990finder/](http://foundationcenter.org/findfunders/990finder/)

### **Community Benefit Connect**

[www.communitybenefitconnect.org](http://www.communitybenefitconnect.org)

### **Catholic Health Association, What Counts Q & A**

[www.chausa.org/communitybenefit/what-counts-q-a](http://www.chausa.org/communitybenefit/what-counts-q-a)

### **IRS Schedule H Form and Instructions**

[www.irs.gov/pub/irs-pdf/i990sh.pdf](http://www.irs.gov/pub/irs-pdf/i990sh.pdf)

### **Build Healthy Places Network**

[www.buildhealthyplaces.org](http://www.buildhealthyplaces.org)

### **Maricopa County Department of Public Health**

[www.maricopa.gov/publichealth/](http://www.maricopa.gov/publichealth/)

### **Maricopa County Department of Public Health Community Health Assessment**

[www.maricopa.gov/PublicHealth/programs/OPI/cha.aspx](http://www.maricopa.gov/PublicHealth/programs/OPI/cha.aspx)

### **Banner Health University Medical Center Phoenix**

[www.bannerhealth.com/Locations/Arizona/Banner++University+Medical+Center+Phoenix/Patients+and+Visitors/Community+Resources/CHNA+Banner+University+Medical+Center.htm](http://www.bannerhealth.com/Locations/Arizona/Banner++University+Medical+Center+Phoenix/Patients+and+Visitors/Community+Resources/CHNA+Banner+University+Medical+Center.htm)

### **Dignity Health (all hospitals – AZ, CA, NV)**

[www.dignityhealth.org/cm/content/pages/community-benefit.asp](http://www.dignityhealth.org/cm/content/pages/community-benefit.asp)

### **HonorHealth (all hospitals)**

[www.honorhealth.com/community/community-benefit/archive](http://www.honorhealth.com/community/community-benefit/archive)

### **Mayo Clinic (all hospitals – AZ, MN, FL)**

[www.mayoclinic.org/about-mayo-clinic/commitment-to-community/community-health-needs-assessment](http://www.mayoclinic.org/about-mayo-clinic/commitment-to-community/community-health-needs-assessment)

### **Phoenix Children's Hospital**

[www.phoenixchildrens.org/sites/default/files/PDFs/community-health-needs-2013v2.pdf](http://www.phoenixchildrens.org/sites/default/files/PDFs/community-health-needs-2013v2.pdf)

## Sources

- 1 Robert Wood Johnson Foundation. (September 2011). "How does where we live, work, learn and play affect our health?" Health Policy Snapshot Issue Brief. Retrieved from [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2011/rwjf1339](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf1339).
- 2 Somerville, M.H. et al. (2012, February). Hospital Community Benefit After the ACA – Partnerships for Community Health. The Hilltop Institute. Retrieved from <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief3-February2012.pdf>.
- 3 Congressional Budget Office. (2006, December). Nonprofit Hospitals and Tax Arbitrage. Retrieved from <http://www.cbo.gov/sites/default/files/12-06-hospitaltax.pdf>.
- 4 Internal Revenue Service. Revenue Ruling 56-185, 1956-1 C.B. 202. Retrieved from <http://www.irs.gov/pub/irs-tege/rr56-185.pdf>.
- 5 Internal Revenue Service. Revenue Ruling 69-545, 1969-2 C.B. 117. Retrieved from <http://www.irs.gov/pub/irs-tege/rr69-545.pdf>.
- 6 Stoto, M.A., et al. (2015, April 5). Community Health Needs Assessments – Aligning the Interest of Public Health and the Health Care Delivery System to Improve Population Health. Institute of Medicine of the National Academies. Retrieved from <http://iom.edu/~media/Files/Perspectives-Files/2015/CHNAalignment.pdf>.
- 7 United States Government Accountability Office. (2008, September). Nonprofit Hospitals – Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements. Report to the Ranking Member, Committee on Finance, U.S. Senate. Retrieved from <http://www.gao.gov/assets/290/280709.pdf>.
- 8 United States Government Accountability Office. (2008, September). Nonprofit Hospitals – Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements. Report to the Ranking Member, Committee on Finance, U.S. Senate. Retrieved from <http://www.gao.gov/assets/290/280709.pdf>.
- 9 Internal Revenue Service. (2008, November). IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report. Retrieved from <http://www.irs.gov/pub/irs-tege/frepthosproj.pdf>.
- 10 Internal Revenue Service. (2008, November). IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report. Retrieved from <http://www.irs.gov/pub/irs-tege/frepthosproj.pdf>.
- 11 Internal Revenue Service. (2008, November). IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report. Retrieved from <http://www.irs.gov/pub/irs-tege/frepthosproj.pdf>.
- 12 Internal Revenue Service. (2008, November). IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report. Retrieved from <http://www.irs.gov/pub/irs-tege/frepthosproj.pdf>.
- 13 Catholic Health Association. (n.d.) What Counts Q&A. Retrieved from <http://www.chausa.org/communitybenefit/what-counts-q-a>.
- 14 Kabel, C. (2013, June 5). What is The Future of Hospital Community Benefit Programs? Health – Stanford Social Innovation Review. Retrieved from [http://www.ssiireview.org/blog/entry/what\\_is\\_the\\_future\\_of\\_hospital\\_community\\_benefit\\_programs](http://www.ssiireview.org/blog/entry/what_is_the_future_of_hospital_community_benefit_programs).
- 15 Patient Protection and Affordable Care Act, 9 U.S.C § 9007 (2010).
- 16 Patient Protection and Affordable Care Act, 9 U.S.C § 9007 (2010).
- 17 Community Commons. (n.d.) CHNA Process. About CHNA Toolkit – Community Health Needs Assessment (CHNA). Retrieved from <http://assessment.communitycommons.org/chna/About.aspx#processmap>.
- 18 Patient Protection and Affordable Care Act, 9 U.S.C § 9007 (2010).
- 19 Florida Legal Services. (2014, October.) Re: Jackson Health System's Failure to Comply with the Requirements of 26 U.S.C. § 501(r). [Memorandum]. Retrieved from [http://op.bna.com/hl.nsf/id/psts-9nej5d/\\$File/IRS%20Complaint%208.25.14.pdf](http://op.bna.com/hl.nsf/id/psts-9nej5d/$File/IRS%20Complaint%208.25.14.pdf).
- 20 Dignity Health, St. Joseph's Hospital and Medical Center. (2013). 2013 Community Health Needs Assessment Summary. 2013-2016 Community Health Implementation Plan. Retrieved from [http://www.dignityhealth.org/stellent/groups/public/@xinternet\\_con\\_sys/documents/webcontent/235067.pdf](http://www.dignityhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/235067.pdf).
- 21 Mayo Clinic Arizona. (2013, September 30). Community Health Needs Assessment. Retrieved from <http://www.mayoclinic.org/documents/2013-az-chna-pdf/doc-20079505>.
- 22 Banner Good Samaritan Medical Center. (2013). Community Health Needs Assessment Report 2013. Retrieved from [http://www.bannerhealth.com/NR/rdonlyres/B798346A-9D97-4C7C-AB5C-4D910FB3019B/0/GoodSamCHNAREport\\_FINAL.pdf](http://www.bannerhealth.com/NR/rdonlyres/B798346A-9D97-4C7C-AB5C-4D910FB3019B/0/GoodSamCHNAREport_FINAL.pdf).
- 23 John C. Lincoln – North Mountain Hospital. (2014, August). Community Health Needs Assessment, Implementation Plan 2012-2014. Retrieved from <http://www.jcl.com/file%20library/hospitals/north-mountain-hospital-community-health-needs-assessment-2012.pdf>.
- 24 Phoenix Children's Hospital. (2013). Community Health Needs Assessment 2013-2015. Retrieved from <http://www.phoenixchildrens.org/sites/default/files/PDFs/community-health-needs-2013v2.pdf>.
- 25 Arizona Hospital and Healthcare Association.
- 26 Interview with Eileen Eisen-Cohen & Kate Goodin. (2014, October 23).
- 27 Interview with Sheila Sjolander. (2014, October 20).
- 28 Interview with Eileen Eisen-Cohen & Kate Goodin. (2014, October 23).
- 29 Interview with Kimberly Schraven. (2015, March 18).
- 30 Nolte, C. (2014, October 1). Collaboration versus Competition: Lessons from a Banker for Hospitals. Federal Reserve Bank of San Francisco. Retrieved from <http://www.frbsf.org/community-development/blog/collaboration-versus-competition-lessons-from-a-banker-for-hospitals/>.
- 31 Leadership Conference on Civil Rights. (n.d.). Community Reinvestment Act and the Financial Modernization Movement. Retrieved from [http://www.protectcivilrights.org/pdf/reports/healthy\\_communities/cra\\_report\\_chapters.pdf](http://www.protectcivilrights.org/pdf/reports/healthy_communities/cra_report_chapters.pdf).
- 32 Department of the Treasury – Internal Revenue Service. (2014, December 31). Final Register. Rules and Regulations. Volume 79, Number 250. Retrieved from <http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf>.
- 33 Maricopa County Department of Public Health. (2014). Maricopa County Community Health Assessment 2012. Pg. 52,54. Retrieved from <http://www.maricopa.gov/PublicHealth/programs/OPI/pdf/CHA-2012.pdf>.

- 34 Young, G.J., et al. (2013, April 13). Provision of Community Benefits by Tax-Exempt Hospitals. *The New England Journal of Medicine*, Volume 368, Issue 16. Retrieved from <http://www.nejm.org/doi/pdf/10.1056/NEJMs1210239>.
- 35 Medicaid.gov. (n.d.) Medicaid. By State. Arizona Retrieved from <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-State/arizona.html>.
- 36 DeLeire, T., et. al. (2014, September 24). ASPE Issue Brief: Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014. Retrieved from [http://aspe.hhs.gov/health/reports/2014/uncompensatedcare/ib\\_uncompensatedcare.pdf](http://aspe.hhs.gov/health/reports/2014/uncompensatedcare/ib_uncompensatedcare.pdf).
- 37 Internal Revenue Service. (2014). Instructions for Schedule H (Form 990). Retrieved from <http://www.irs.gov/pub/irs-pdf/ig990sh.pdf>.
- 38 Internal Revenue Service. (2013). Schedule H (Form 990) Hospitals. Retrieved from <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>.
- 39 Singh, S. R., et al. (2015, May). Analysis of Hospital Community Benefit Expenditures' Alignment with Community Health Needs: Evidence from a National Investigation of Tax-Exempt Hospitals. *American Journal of Public Health*, Volume 105, No. 5. Retrieved from: <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302436>.
- 40 Stoto, M.A., et al. (2015, April 5). Community Health Needs Assessments—Aligning the Interest of Public Health and the Health Care Delivery System to Improve Population Health. Institute of Medicine of the National Academies. Retrieved from <http://iom.edu/~media/Files/Perspectives-Files/2015/CHNAalignment.pdf>.
- 41 Dignity Health St. Joseph's Hospital and Medical Center. (2013). 2013 Community Health Needs Assessment Summary, 2013-2016 Community Health Implementation Plan.
- 42 Banner Good Samaritan Medical Center. (2013). Community Health Needs Assessment Report 2013.
- 43 Mayo Clinic Arizona. (2013, September 30). Community Health Needs Assessment.
- 44 Phoenix Children's Hospital. (2013). Community Health Needs Assessment 2013-2015
- 45 John C. Lincoln – North Mountain Hospital. (Modified August 2014). Community Health Needs Assessment Implementation Plan 2012-2014.
- 46 Marr, C., Friedman, J. and Debot, B. (2015, April 1). IRS Funding Cuts Continue to Compromise Taxpayer Service and Weaken Enforcement. Retrieved from <http://www.cbpp.org/research/federal-tax/irs-funding-cuts-continue-to-compromise-taxpayer-service-and-weaken-enforcement?fa=view&id=4156>
- 47 Patient Protection and Affordable Care Act, 9 U.S.C § 9007 (2010).
- 48 Somerville, M.H. et al. (2012, February). Hospital Community Benefit After the ACA – Partnerships for Community Health. The Hilltop Institute. Retrieved from <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief3-February2012.pdf>.
- 49 Trocchio, J. (2006, November-December). Community Benefit – A Wondrous History of Community Benefit. *Health Progress*, Volume 87, Number 6. Retrieved from <http://www.chausa.org/docs/default-source/health-progress/community-benefit-continuing-the-tradition---a-wondrous-history-of-community-benefit-pdf.pdf?sfvrsn=0>.
- 50 St. Joseph Health Sonoma County. (2014). Healthy Communities. Retrieved from [http://www.stjoesonoma.org/For-Community/Community-Outreach/Healthy-Communities.aspx?redirect\\_referrer=http%3a%2f%2fhealthaffairs.org%2fblog%2f2014%2f05%2f08%2fan-extraordinary-opportunity-hospital-community-benefits%2f](http://www.stjoesonoma.org/For-Community/Community-Outreach/Healthy-Communities.aspx?redirect_referrer=http%3a%2f%2fhealthaffairs.org%2fblog%2f2014%2f05%2f08%2fan-extraordinary-opportunity-hospital-community-benefits%2f).
- 51 Somerville, M.H. et al. (2012, February). Hospital Community Benefit After the ACA – Partnerships for Community Health. The Hilltop Institute. Retrieved from <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief3-February2012.pdf>.
- 52 Nelson, G.D. et al. (2014, May). Hospital Community Benefit After the ACA – Addressing Social and Economic Factors the Shape Health. The Hilltop Institute. Retrieved from <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-ShapeHealthIssueBrief9-May2014.pdf>.
- 53 U.S. Department of Health & Human Services. (2014.) About the Law. Retrieved from <http://www.hhs.gov/healthcare/rights/>.
- 54 Patient Protection and Affordable Care Act, 9 U.S.C § 9007 (2010).
- 55 Internal Revenue Service. (2013.) Schedule H (Form 990) Hospitals. Retrieved from <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>.
- 56 Centers for Medicare & Medicaid Services. (n.d.) Medicaid. Retrieved from <http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html>.
- 57 Arizona Health Care Cost Containment System. (2014.) Welcome. Retrieved from <http://www.azahcccs.gov>.
- 58 Centers for Medicare & Medicaid Services. (n.d.) Retrieved from <http://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html>.
- 59 Catholic Health Association. (n.d.) Defining Community Benefit. Retrieved from <http://www.chausa.org/community-benefit/defining-community-benefit>.
- 60 Department of the Treasury - Internal Revenue Service. (2014, December 31). Final Register. Rules and Regulations. Volume 79, Number 250. Retrieved from <http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf>.
- 61 American Hospital Association. (2013, January). Uncompensated Hospital Care Cost Fact Sheet. Retrieved from <http://www.aha.org/content/14/14uncompensatedcare.pdf>.
- 62 Build Healthy Places Network. (2015). "Community Development." Jargon Buster. [www.buildhealthyplaces.org](http://www.buildhealthyplaces.org). (forthcoming)
- 63 Opportunity Finance Network. (n.d.). What is a CDFI? Retrieved from <http://ofn.org/what-cdfi>.
- 64 Build Healthy Places Network. (2015). "Community Development Financial Institution." Jargon Buster. [www.buildhealthyplaces.org](http://www.buildhealthyplaces.org). (forthcoming)
- 65 Build Healthy Places Network. (2015). "Community Reinvestment Act." Jargon Buster. [www.buildhealthyplaces.org](http://www.buildhealthyplaces.org). (forthcoming)



2929 N Central Avenue  
Suite 1550  
Phoenix Arizona 85012

[www.slhi.org](http://www.slhi.org)  
[info@slhi.org](mailto:info@slhi.org)

602.385.6500  
602.385.6510 fax

NONPROFIT ORG.  
U.S. POSTAGE  
PAID  
PHOENIX, ARIZONA  
PERMIT NO. 4288

## ***Our Mission***

*To improve well-being in Arizona by addressing root causes and broader issues that affect health.*

For a complete list of *Arizona Health Futures* publications, conferences and other public education activities, visit the SLHI web site at **[www.slhi.org](http://www.slhi.org)**. If you would like to receive extra copies of a publication or be added to our mailing list, please call 602.385.6500 or email us at [info@slhi.org](mailto:info@slhi.org).

### **Author:**

*C.J. Eisenbarth Hager,  
St. Luke's  
Health Initiatives*

### **Graphic Design:**

*Chalk Design*

[www.slhi.org](http://www.slhi.org)

©2015  
All Rights Reserved.

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. For a comprehensive overview of our programs and activities to advance a healthy, vital and resilient Arizona, please visit our web site. We welcome your comments and involvement.

Material may be reproduced without permission when proper acknowledgment is made.