

Published by  
Bader & Associates  
Governance Consultants,  
Potomac, MD



# COMMUNITY BENEFIT

By Elaine Zablocki

## Time for Board Leadership

---

**How much do not-for-profit hospitals benefit their communities?**

**How much should they be expected to provide?**

**Do their charitable activities justify their tax exemptions?**

---

Today, federal and local leaders – and most visibly, Senate Finance Committee Chair Charles Grassley (R-Iowa) — are casting a skeptical eye on tax-exempt organizations and asking whether not-for-profit hospitals offer sufficient community benefits. Around the country, some hospitals have lost or been threatened with loss of their tax exemption, and others have negotiated settlements with local tax authorities, making “payments in lieu of taxes.”

In this environment, it is essential for governing boards to be aware of the storms brewing over community benefit, to monitor their hospital’s community benefit planning process and activities, and to ensure that information about their community benefits reaches their patients, legislators, the business community, and the general public. Just what does “community benefit” mean, and how much are hospitals required to provide to be deemed tax-exempt? The answers are not straight-forward.

## Growing Scrutiny

In 1969, believing that the recently enacted Medicare and Medicaid programs would make uncompensated care passé, the Internal Revenue Service adopted Revenue Ruling 69-545. It set a broad and somewhat vague “community benefit standard” for hospitals to qualify for tax exemption. In 1991, several House members introduced legislation to set minimum charity care and community service requirements, but the bills went nowhere.

Now, the issue is back on a variety of fronts. In 2004, the Illinois Department of Revenue revoked the local tax exemption of Provena Covenant Medical Center, Urbana, IL. Subsequently, the Scruggs law firm of tobacco settlement fame sued hospitals across the country alleging they scrimped on charity care to uninsured patients and overcharged the uninsured with inflated prices. (Most of the suits were dismissed; a few systems settled.) Ohio’s attorney general has proposed new rules for charitable organizations, including community benefit reporting.

*continued on page 2 →*

→ continued from page 1

This spring, the Internal Revenue Service conducted a voluntary survey of 600 not-for-profit hospitals around the country, asking questions on community programs, billing practices, and uncompensated care. In June, Sen. Grassley asked the IRS to report back to his committee on hospitals' pricing, billing and debt collection policies, and their definition and calculation of charity care and community benefit. "Some individuals are exploiting vagueness or silence or a lack of enforcement of the laws governing tax-exempt groups to enrich themselves rather than serve the public," he said.

### An Emerging Definition

Until now, there hasn't been any agreement on what constitutes community benefit. In June, the Catholic Health Association moved community benefit reporting a giant step forward. In cooperation with VHA Inc., it released a 142-page report, *A Guide for Planning and Reporting Community Benefit*. This guide includes a general description of what constitutes community benefit and criteria for determining whether a program or service should be counted.

We want these guidelines to be extremely conservative.

— Julie Trocchio, Catholic Health Association

CHA says more than 90% of its member hospitals have formally adopted the guidelines, and Sen. Grassley commended CHA's efforts at a September press conference.

"Our goal was to develop a standardized, extremely credible set of guidelines," says Julie Trocchio, CHA's senior director for continuing care ministries. For example, CHA says the definition of community benefit should include charity care as well as:

- Community health education programs such as caregiver training, consumer health libraries, health fairs and web-based consumer health information
- Healthcare support services such as information and referral services, Ask-a-Nurse, or cab vouchers for low income patients

- Most disease screening programs.

By contrast, CHA says community benefit tallies should not include:

- Health education classes designed to increase market share, or fee-based education sessions which earn a profit
- Screening programs that earn a profit or make referrals only to the sponsoring healthcare organization
- Routine discharge planning or enrollment assistance programs designed to increase facility revenue.

Three financial standards in the CHA guidelines are particularly important and controversial. CHA recommends that bad debt and Medicare shortfalls *not* be counted as part of community benefit, and that cost figures (not charges) should be used to measure the value of charity care.

"We're saying that community benefit programs should respond to community needs and improve community health," Trocchio says. "Any hospital that participates in Medicaid knows they're going to lose money; it is a gift to the community. Medicare, on the other hand, is supposed to cover costs for an efficient provider." CHA is encouraging its members to continue to report Medicare losses, but not count them as part of their community benefit contribution.

CHA also says hospitals should separate bad debt from charity care, and report charity care (but not bad debt) as part of community benefit. When totaling charity care, the CHA guide says hospitals should use figures that reflect the costs of offering that care, not their official charges. "If we say something is a community benefit, we want it to truly be our gift to the community, with no padding. We want these guidelines to be extremely conservative," Trocchio says.

→ continued from page 2

The American Hospital Association's response to the CHA guidelines has been an enthusiastic "yes, but." AHA credits CHA's leadership and calls upon not-for-profit hospitals to calculate community benefit using the CHA guidelines. However, AHA recommends including charity care, bad debt, and the unpaid costs of Medicare AND Medicaid when hospitals calculate community benefit.

Spectrum Health, a seven-hospital, not-for-profit system in western Michigan, follows the CHA guidelines for the most part, but does include Medicare losses when calculating community benefit. "The argument for excluding them is that Medicare is supposed to cover hospitals, costs, so losses must be a sign of inefficiency. We disagree," says David Leonard, general counsel and secretary to the Spectrum board. "We're a very efficient organization – we are in the lowest quartile of cost benchmarks for health systems in the United States – yet we post a significant loss on Medicare services. For example, our projected Medicare loss for fiscal year 2007 is \$38 million."

## Boards Exert Leadership

Boards are the connection between the hospital and its community owners, and so directors need to be knowledgeable and exert leadership on community benefit issues. Three challenges are central for hospital or health system boards:

- Approving a definition of community benefit based on one of the emerging national standards
- Planning and monitoring community benefit activities
- Communicating community benefit accomplishments accurately and clearly to patients, the news media, public officials, regulators, opinion leaders and the general public.

For this issue of Great Boards, we talked with seven hospitals and health systems about their boards' oversight of community benefit. Each has defined community benefit. Some focus a governing board meeting once or twice a year on community benefit. Some have an educational session on community benefit, such as a panel discussion among the heads of county minority health programs, or a

presentation by the head of the county coalition of safety net clinics.

Reports to the board on community benefit may take many forms. Hospitals participating in the Advancing the State of the Art in Community Benefit (ASACB) project [SEE SIDEBAR] prepare detailed reports for their governing boards, including quantified progress towards community benefit goals during the past year, as well as prioritized goals for the coming three years based on community needs assessments.

St. Joseph Health System of Orange, Calif., is an ASACB participant, with pilot programs at two hospitals, and a rollout planned throughout the system. "One aspect of ASACB is clarifying what are the right things for the board to ask, and how frequently," says CEO Deborah Proctor, who also is on the CHA Community Benefit Task Force. "We believe there should be a clear tie your board can see between your needs assessment and the programmatic responses you've developed, and also an evaluation of their effectiveness. In healthcare we are very good at developing programmatic responses, but we're not so good at demonstrating

that those programs have actually led to change. For example, it's not enough to offer mobile clinic visits, you also need to demonstrate those visits have improved people's health."

St. Jude Medical Center, Fullerton, CA, a member of the St. Joseph system, recently presented a 28-page report on community benefit to its board. It included a three-year plan for future efforts, with a description of community needs and demographics in various parts of their service area. For each major planned initiative, the document summarizes strategies, desired three-year outcomes, and baseline measures.

Holy Cross Hospital in Silver Spring, Maryland has prepared a prospective community benefit plan every year since 2001. Once the plan is approved, a mission strategy committee, which includes board members as well as non-board members from the community, reviews progress each quarter.

The PeaceHealth Oregon Region board looks closely at community benefit issues twice a year. In addition, a community

continued on page 4 →

## Advancing the State-of-the-Art

Some 70 not-for-profit hospitals in California, Texas, Arizona, and Nevada have formed a partnership to help make charitable resources more effective in addressing unmet health needs.

Called Advancing the State of the Art in Community Benefit (ASACB), the project's first phase (fall 2002 to October 2004) focused on developing accounting tools and performance measures to guide institutional reforms. The second phase (January 2004 to March 2006) focused on pilot implementation of reforms in partner hospitals.

ASACB project participants don't only measure costs. In addition to asking "how much money was spent?" they also ask, "was the money spent in the best possible way?" and they propose a rigorous framework for evaluating achieved community benefit. "In philosophical terms, the goal is to shift from a view of community benefit contributions as 'uncompensated costs' to one where they are viewed as returns on the investment of assets by public 'shareholders,'" says the ASACB User's Guide. "[This approach] obligates the organization's trustees, leadership and staff to pursue the maximum health benefit for each dollar invested by public shareholders."

→ *continued from page 3*

health subcommittee meets monthly to oversee PeaceHealth-funded community outreach programs. "In many ways, it's like a foundation that allocates funds for community benefit programs, oversees their effectiveness and tries to move them towards self-sufficiency," says Karen Shepard, CFO for the region. She cites "Success by Six," an education and counseling program that works with parents and families to prevent domestic violence against young children. PeaceHealth started the program and supported it for several years; now the program has found other funding sources. The region also supports a birthing center, a health information library, and several clinics serving the uninsured and underinsured.

At Presbyterian Intercommunity Hospital (PIH) in Whittier, Calif, the community benefits oversight committee includes one board member, three additional hospital staffers, and five or six community members representing local not-for-profit agencies. The committee closely examines all the hospital's community benefit programs. As an ASACB participant, the hospital finds some of its current programs may need

We believe that to be really committed to community benefit, you need to take a risk for it. It isn't something you do only in the good years.

— Roseanne Pajka, Holy Cross Hospital,  
Silver Spring, Maryland

enhancements to bring them up to the ASACB standard. "The number one principle we have agreed to meet, as part of the ASACB project, is that anything we call community benefit must be readily available to the poor and the un- and under-insured," says Patricia Bray, vice president for continuing care.

Some hospitals find they're doing things that qualify as community benefit but haven't been reported as such. "Many people didn't understand that what they were doing was 'countable,'" says Bray. For example, PIH offers a refresher course to nurses who've been out of the field, at the hospital's expense. The hospital sometimes pays for nursing home care for patients who are ready to leave the

hospital, but don't have insurance coverage for a lesser level of care. These expenses should be counted as part of community benefit, she says.

## Telling the Story

Another common theme: hospitals and health systems realize they must do more to publicize their community benefit efforts. "When you look at the origins of Catholic healthcare, and other faith-based healthcare, you see that the founders weren't seeking attention," says Deborah Proctor. "Over the years we've been humble about our activities, but now, we can no longer afford that. It's important for

*continued on page 5* →

**CHA/VHA community benefit guidelines,**  
<http://www.chausa.org/communitybenefit>

**Advancing the State of the Art in Community Benefit Project,**  
<http://www.communityhlth.org/communityhlth/projects/asacb/asacbhome.html>

**Examples of hospitals' community benefit reports find links on the Great Boards web site,**  
[www.GreatBoards.org](http://www.GreatBoards.org)

## GREAT BOARDS

is published by  
Bader & Associates  
Governance Consultants,

12225 Seline Way  
Potomac, Maryland  
20854

Phone: 301-340-0903  
Fax: 301-340-1345

E-mail:  
[bbader@GreatBoards.org](mailto:bbader@GreatBoards.org)  
[www.GreatBoards.org](http://www.GreatBoards.org)

Graphic Design by:  
Ruzow Graphics, Inc.  
[www.ruzowgraphics.com](http://www.ruzowgraphics.com)

→ *continued from page 4*

people to know what we're doing, and I don't mean just presenting a dollar figure, but also sharing stories about what we're doing."

Many hospitals are using their website or mailings to spread the word. Spectrum Health posts a breakdown of its community benefit expenses and an annual report to the community on its website and mails the report to 100,000 area homes. Community benefit is on page one. Spectrum also holds two public meetings each year. One focuses on financial expenditures and the budget for the coming year (including costs and charges.) The second meeting focuses on programs administered by its healthier communities department, and is attended by the media, healthcare activists and local healthcare organizations.

### *The Question only the Board Can Answer*

Lucille Packard Children's Hospital (LPCH), the pediatric hospital of Stanford University Medical Center, uses the ASACB definition of community benefit. A board public policy/community services committee has been integral to shaping

community benefit programs, says Candace Roney, executive director for community partnerships. "We are fortunate to have a wonderfully qualified committee chair, a physician with a public health background," she says. "She reviewed our (community benefit) investment plan for the coming year and suggested that we add outcome measures. For example, we provide funding for the 'healthy kids' insurance program in two counties, and she wanted us to include HEDIS measurements. Each of the health plans involved has a slightly different emphasis, so I worked with each of them to find goals that would work for them, and would also work for us. A year from now, when our board looks at this, they'll be able to look at measured results.

One question Roney often hears from her board is, "Are we doing enough?"

"When I get that question I'm pleased, because it tells me the board is concerned. The problem is, there is no answer. I end up asking, 'Do *you* feel we're doing enough?'"

The community benefit debate – how to define and measure it and how much should be required — is one aspect of growing expectations for public accountability and transparency on the part of not-for-profit organizations. Many observers believe that before long, community benefit performance data will be publicly available in a standardized format, just as quality and financial data are today.

In some states, that's already happening.

Provena (like other not-for-profit hospitals in Illinois) submitted a 1000-page report on the health system's community benefit activities to the state Attorney General on July 30. Those reports are available to the general public. In Maryland, the Health Services Cost Review Commission gathers mandatory hospital reports on community benefit, relying on a standardized five-page Excel worksheet, and the state hospital association posts a summary on its web site. "We say public reporting with common guidelines is great," says Holy Cross Hospital's Roseanne Pajka, senior vice president, corporate development. "We are doing a lot, and we're happy to tell people about it."

*continued on page 6* →

→ continued from page 5

Mel Pyne, CEO of PeaceHealth Oregon Region, who chairs the public policy committee of the Oregon Association of Hospitals and Health Systems, says the association is considering a common statewide format for reporting community benefit. Neighboring Washington and California already require community benefit reporting. “We’re trying to take the initiative to develop a common format so we’re ahead of any potential regulation,” Pyne comments. “The broad trend towards accountability and transparency is healthy, but only when the information is accurate and the comparisons are really comparable.”

At present, elected officials or tax regulators may target one or several hospitals’ tax-exempt status at any time, even though the rules of the game are still being defined. The stakes are huge. Loss of tax exemption can increase a hospital’s expenses on everything from supply purchases to the costs of debt. The mere challenge to charitable status can damage the hospital’s image and take a toll on philanthropic donations.

## Questions Boards Should Ask

The best defense is a good offense. Boards should review an annual community benefit report. Directors need to be sure their hospitals and health systems are doing the right things, can measure and compare their activities to evolving norms, and are prepared to communicate all that they do clearly and accurately. As they approve goals, set policy, oversee performance and play their external advocacy role, boards need to raise these questions and support the effort to get good answers:

- How do we define community benefit?
- How much is spent annually on community benefit, in dollars and as a percentage of gross revenues?
- Do we spend more on community benefit than we gain from our tax exemption?
- How does our community benefit budget compare with other, similarly situated hospitals in our state or region?
- Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?
- Is the plan based on a community health needs assessment? Does the board discuss the assessment?
- Does the plan target specific, evidence-based areas of community need?
- Who was involved in developing the community benefit plan?
- Were community leaders included?
- How does the hospital participate in community partnerships and/or joint efforts to plan and implement community benefits activities?
- Are we viewed as a good partner dedicated to community service?
- How do we keep the community, legislators, regulators, and key opinion leaders informed about our community benefit work?
- Do we know their perceptions of our efforts?
- Who on staff directs and monitors community benefit activities, and does this person have the authority and resources needed to do so effectively?
- How should we as a board monitor community benefit activities?
- Do we need a community benefit dashboard?
- Should we review regular progress reports?

Sen. Grassley calls tax exemption “a privilege” – and he is right. He also says some charities have abused the privilege, and that’s probably true as well. However, most not-for-profit community hospitals and health systems do a great job for their communities, but they have not been as focused and disciplined in planning, measuring and publicly communicating those efforts as they need to be. In an era of increased accountability and transparency, the governing body needs to elevate the attention paid to community benefit at the leadership level.

*Elaine Zablocki, an Oregon-based freelance writer, is the editor of Great Boards.*

# Selecting & Preparing a Chair Elect

By Barry S. Bader

If hiring and overseeing the CEO is a governing board's "number one" responsibility, as Peter Drucker once said it was, then number two has to be selection and evaluation of the Board Chairperson.

A chairperson plays a powerful role as the individual who sets meeting agendas, determines board work, and presides over the executive committee. The chair is the primary liaison with and sounding board for the CEO, and leads the CEO evaluation process. The chair is a role model, enforces the code of board conduct, appoints committee members and committee chairs subject to board approval, and acts as the external "voice" of the Board. A board chair leads the board – and in turn must have the confidence of the board and the respect of the CEO.

Despite the importance of the role, many boards do not give selection and preparation of the board chair the attention they should. In a recent survey by The Governance Institute, 64% of boards said they had established an explicit process for selection of the board chair but these processes often are little more than a thoughtful conversation among the executive or governance committee about the next chair. Just 28% formally name a "chair-elect" at least a year in advance to allow time for preparation. Only 29% have identified a "pipeline" of potential future chairs and support their development.

## Selecting the Next Chair

Today, governance experts recommend that the selection process for a Chair embody these principles:

- 1. Recruitment.** Seek individuals with the ability to serve as a chair one day. Some boards make this a criterion for *every* new member.
- 2. Transparency.** Document the process for selecting the chair in a policy so it's known to all members.
- 3. Inclusion.** Give all board members an opportunity for input into the process. For example, the current chair can interview board members about their preferences and personal aspirations, and then make a report to a

governance committee or special nominating committee.

**4. Criteria.** Choose a chair based on objective criteria, such as exemplary service on the board, integrity, executive leadership experience, and communications ability.

**5. Succession planning.** Maintain a "pipeline" of members who have expressed their willingness to serve as chair in the future if asked. Give these members receive appropriate development, such as important committee chairmanships, education or special assignments. At least a year in advance of an anticipated vacancy in the office, the board should formally name a chair-elect.

## Preparing the Next Chair

It's easy to assume that an individual so highly regarded that she's named chair-elect is ready to accept the torch with little fuss. The assumption is risky. The failure to plan for a new chair can result in many problems, such as:

- The new chair and CEO differ on important process matters, such as how often to confer and how they'll plan board meeting agendas.
- The new chair lacks a deep appreciation of the work of committees on which she hasn't served.

- The new chair is unaware of some confidential projects or problems.

Different individuals will require different types and amounts of preparation. In addition to committee chairmanships or special assignments, the chair-elect's preparatory year also may include:

- Meeting with the CEO to craft their working relationship
- Meeting with the outgoing chair and CEO to be briefed on confidential matters
- Attending at least one meeting of each committee, and meeting with each of the committee chairs to discuss their future plans
- Attending an outside educational conference with the CEO (The Governance Institute's Board Chair-CEO conference offers members one such opportunity).

Sound like a lot of work? It is, but spaced over a year, it's workable.

The homework is critical and can facilitate a seamless transition from one leader's watch to the next.

Barry S. Bader is a governance consultant based in Potomac, Maryland and is the publisher of Great Boards.