Not-for-Profit Hospital Community Benefit Legislation

(Senate Bill 697)

Report to the Legislature

January 1998

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Dear Colleagues:

On behalf of the Office of Statewide Health Planning and Development (OSHPD), I am pleased to preface this report to the Legislature regarding community benefits provided by California's not-for-profit hospitals.

In 1994, Governor Wilson signed the not-for-profit community benefits legislation (SB 697 – Torres), which became effective on January 1, 1995. Noting that non-profit hospitals assume a social obligation in exchange for favorable tax treatment, SB 697 required that private non-profit hospitals report on the community benefits they provide. The legislation further required these hospitals to assess the health needs of their respective communities and to develop plans for addressing priority needs in collaboration with the community. OSHPD was asked to implement the legislation and to prepare this report to the Legislature.

The report details the implementation of the bill, summarizes the content of the community benefit plans submitted, and makes recommendations for further evolution of the process. In general, it is clear that not-for-profit hospitals across the state have responded to SB 697 in a positive and constructive manner. The bill has been very successful in bringing hospitals and their community partners together in a cooperative effort to build healthier communities. The community benefit plans prepared by the hospitals serve to describe and document the nature and scope of non-profit hospital contributions to their communities.

We at OSHPD look forward to continuing our work with non-profit hospitals and other local entities, as the community benefits planning and reporting process continues to evolve. It holds great promise for addressing community health needs throughout California.

Sincerely,

David Werdegar

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Hospitals by County	Chief Executive Officer	Plan Coordinator
Santa Barbara		
Goleta Valley Community Hospital	David C. Bigelow	Diane Wisby
Marian Medical Center	Charles Cova	Sister Janet Corcoran
Rehabilitation Institute at Santa Barbara	Ralph Pollock	Rusty Pollock
Santa Barbara Cottage Care Center*	James Ash	Gary Wilde
Santa Barbara Cottage Hospital*	James Ash	Gary Wilde
St. Francis Medical Center of Santa Barbara	Ron Biscaro	Melinda Chayra
Santa Clara		
Alexian Brothers Hospital	Steven Barron	Leslie Kelsay
El Camino Healthcare System	Gerald Shefren	Gina Sutherst
Kaiser Foundation Hospital - Santa Clara	John E. Mosher	Andrew Sun
Kaiser Foundation Hospital - Santa Teresa	John E. Mosher	Andrew Sun
Lucile Salter Packard Children's Hospital at Stanford	Lorraine Zippiroli	Sherri Sager
O'Connor Hospital*	William Finlayson	Cary Fox
St. Louise Health Center*	William Finlayson	Shelia Yuter
Stanford University Hospital	Peter Van Etten	Rebecca Partridge
Santa Cruz		
Dominican Santa Cruz Hospital - Soquel	Sr. Julie Hyer	Carol Adams
Watsonville Community Hospital	John Freil	Vicki Carlisle
Shasta		
Mercy Medical Center, Redding*	George Govier	Michael Borelli
Solano		
Kaiser Foundation Hospital - Vallejo	John E. Mosher	Andrew Sun
North Bay Medical Center*	Deborah Sugiyama	Sarah Jewel
Sutter Solano Medical Center	Patrick Brady	Alan Fritzshall
Vaca Valley Hospital*	Deborah Sugiyama	Sarah Jewel
Sonoma		
Kaiser Foundation Hospital - Santa Rosa*	John E. Mosher	Andrew Sun
Santa Rosa Memorial Hospital	Robert Fish	Sister Michaela Rock
Stanislaus		
Emanuel Medical Center	Robert Moen	David Jones
Memorial Hospital Modesto	David P. Benn	Steve Mitchell
Sutter		
Fremont Hospital*	Thomas P. Hayes	Deborah Coulter
Ventura		
Community Memorial Hospital - San Buenaventura	Michael D. Bakst	Michael Laurie
Santa Paula Memorial Hospital	Willam Greene	Laya Murphy
Simi Valley Hospital & Health Care Services*	Alan Rice	Alan Rice
St. John's Pleasant Valley Hospital*	Daniel Herlinger	Charles Padilla

Executive Summary

In response to increasing interest in the community benefit contributions of not-for-profit hospitals, the California Association of Catholic Hospitals and the California Healthcare Association co-sponsored Senate Bill 697 (Torres) which was signed into law by Governor Wilson in September, 1994. In the bill, the State Legislature noted:

> "Private not-for-profit hospitals meet certain needs of their communities through the provision of essential healthcare and other services. Public recognition of their unique status has led to favorable tax treatment by the government. In exchange, non-profit hospitals assume a social obligation to provide community benefits in the public interest."

How hospitals meet this "social obligation" has been the subject of discussion for many years. Since 1969, not-for-profit hospitals have been guided, to a large extent, by Internal Revenue Service (IRS) rulings concerning the "community benefit standard". The IRS standard, however, fails to encompass the full scope of benefits that hospitals provide to their communities. Therefore, various other approaches to recording community benefits have been proposed. SB 697 requires private not-for-profit hospitals in California to describe and document the full range of community benefits they provide in the State.

SB 697 extends beyond simple documentation and valuation of community benefits. A key feature of the legislation is its requirement of a community planning process. Hospitals must conduct community needs assessments and then develop annual community benefit plans -- with a view to the needs that have been identified.

The Office of Statewide Health Planning and Development (OSHPD) is responsible for the implementation of the legislation. OSHPD was asked to collect and evaluate the community benefit reports submitted by the hospitals and present recommendations regarding future community benefit planning and reporting. Over the last three years, OSHPD has played a facilitative role in assisting hospitals to meet the new legislative requirement. In addition, OSHPD has held discussions with hospitals and community stakeholders throughout the State about how best to achieve the intent of SB 697 in the years ahead. As was often observed in community forums and Advisory Group meetings, the community benefit planning process is relatively new and still evolving; the hospitals look to OSHPD for guidance.

Overall, California's not-for-profit hospitals have demonstrated serious commitment to fulfilling the requirements of the legislation. Many hospitals submitted plans ahead of schedule and some, that were exempt from the legislation, complied on a voluntary basis. Unquestionably, SB 697 has been very successful in heightening hospitals' awareness of their community benefit obligations and directing attention to a community benefit planning process.

Information gathered from the first cycle of community benefit plans provides a picture of the needs identified in individual communities and the range of community benefit activities supported by not-for-profit hospitals. The most frequently cited needs were for greater access to healthcare, and for new and expanded community health education and promotion services. Hospitals responded by providing services such as mobile health units, transportation, and home health services to enhance access, and by developing health education programs to address issues such as chronic disease management, family planning, accident prevention, and personal healthcare. Hospitals reported a broad range of prevention services including immunizations, prenatal care, and health screenings. Charity care was a leading community benefit contribution.

There is another dimension of "community benefit," that could not be as easily captured in the hospitals' formal community benefit plan. Based on public comments from community forums held throughout the State and discussions with the SB 697 Advisory Group, it was evident that SB 697 has served as a remarkable catalyst for collaborative relationships and efforts among hospitals, health-oriented organizations, local health departments, and other agencies in the community. The long-term benefits that result from such collaborations have yet to be evaluated, but the outlook is promising. To assess the total value of their contributions, one must consider how communities benefit when hospitals lend their organizational capacity and expertise in collaborative efforts to improve the health of the community.

This first reporting cycle documents the broad range of services provided by not-for-profit hospitals, and provides a basis to identify potential areas for improving the community planning process and the hospital reports. Suggestions for potential improvements in the community needs assessment, prioritization, and planning process mainly call for increased local community participation. In the first round of reports, many different methodologies were used to estimate the costs of providing community benefits. Economic valuations for community benefits would be improved by greater standardization of accounting procedures.

OSHPD was asked to provide recommendations to the Legislature on standardized formats for reporting and on benefits that should be emphasized. Recommendations include an outline to guide the community benefit planning process and to promote greater consistency in the reporting of benefits and benefit activities. The planning process should be a collaborative one between hospitals and their partners in the community, the local community should play a central role in identifying needs and priorities, and it should participate in the benefit planning process. Similarly, the community should be involved in monitoring the implementation of benefit activities and their impact on the identified needs. Hospitals should continue their work with OSHPD to improve and refine benefit planning methods including data collection, needs assessment, and outcome evaluation. Continued technical assistance from OSHPD and information-sharing conferences on community benefit issues should support continued improvement in community benefit planning and reporting. The flexibility permitted by

I. Introduction and Background

Introduction

In September 1994, Senate Bill 697 (Torres), the not-for-profit hospital community benefit bill, was signed into law by Governor Wilson. The legislation notes that not-for-profit hospitals assume a social obligation to provide community benefits in exchange for favorable tax treatment. Thus, the bill states, it is in the public interest for not-for-profit hospitals to review and report on their efforts to meet community health needs. The legislation required that private not-for-profit hospitals review their mission statements, conduct community needs assessments, and develop and implement community benefit plans. The hospitals were to submit their plans to the Office of Statewide Health Planning and Development (OSHPD).

OSHPD was asked to submit a report to the Legislature and provide the following information:

- Identify all hospitals that did not file plans on a timely basis.
- Provide a statement regarding the most prevalent characteristics of plans in terms of identifying and emphasizing community needs.
- Provide recommendations for standardization of plan formats, and recommendations regarding community benefits and priorities that should be emphasized.

This report to the Legislature describes the hospitals required to comply with the legislation and provides a review and analysis of the plans submitted and community benefits described. The report summarizes public comment obtained through community forums, written communication, and Advisory Group discussions. Recommendations regarding report standardization, prioritization of community benefits, and future SB 697 plans are also presented.

Senate Bill 697 has served as a remarkable catalyst, stimulating community planning and collaborative efforts to address community health needs. On examining their community benefit activities, hospitals found opportunities for increased collaboration with other hospitals, health agencies, and community groups. The SB 697 process revealed that not-for-profit hospitals are best held accountable by their own communities for their community benefit contributions. Thus, a focus on the community planning process and methods to measure the effectiveness of community benefit programs have been of special interest in reviewing the first round of hospital reports.

existing statute has been one of its key strengths; further progress toward meeting its objectives would, therefore, best be achieved through voluntary guidelines, highlighting of best practices, and accountability to involved communities.

SB 697 redefines the community benefit standard for California's not-for-profit hospitals. The legislation has encouraged the hospitals to work with community partners to build healthier communities. This is a challenging task given the rapidly changing healthcare environment, and the pressures hospitals face in a competitive market. With its emphasis on needs assessment, priority setting, and planning in collaboration with the community, the SB 697 legislation provides a conducive framework for meaningful community benefit contributions by non-profit hospitals.

Background

In exchange for favorable tax treatment, not-for-profit hospitals assume a social obligation to provide community benefits in the public interest. While it is important that not-for-profits generate a surplus in order to operate successfully, the surplus is invested back into the organization, to enhance performance and community services. Hospitals operating as not-for-profit facilities are expected to meet a "community benefit standard."

Internal Revenue Service's Community Benefit Standard

The community benefit standard was originally defined in 1969 by U.S. Internal Revenue Service Ruling 69-545 and subsequently revised in 1983. Ruling 83-157 provides the current IRS view of the charitable obligations of not-for-profit hospitals. The ruling states that "the promotion of health . . . is deemed beneficial to the community as a whole" and sets forth the following minimum criteria for tax exemption:

- Care is provided to all insured patients, including government-sponsored patients;
- A full-time emergency room is maintained, in which no one requiring emergency care is denied treatment (though this requirement may be waived under certain conditions);
- A board of trustees is composed of citizens selected from the community;
- Medical staff privileges are open to all qualified physicians; and,
- Operating surpluses are applied to capital replacement and expansion, debt amortization, improvement in patient care, and medical training, education, and research.

Except for these specific criteria, the IRS definition of community benefit is quite broad and could be construed to include virtually any hospital activity as "promoting health." Consequently, various other definitions have been proposed in an attempt to state the value of non-profit hospitals' contributions more precisely. Some have defined community benefit in terms of the level of charity care provided. However, others have suggested that such a narrow definition of community benefit understates the hospitals' total contribution to the community and have argued that the definition should include the full range of activities undertaken by not-for-profit hospitals to improve the well-being of the community.

Interest in Not-for-Profit Hospital Community Benefit Contributions

Increasingly, not-for-profit hospitals across the nation have been asked to articulate and measure the value of the benefits they provide in exchange for the privilege of tax exemption. This is understandable. In 1990, these exemptions were estimated at $8.5 billion in the United States, for all non-profit hospitals (Tax Notes, 1990). In 1996, the estimated annual federal and state income tax exemption for all SB 697 hospitals (excluding Kaiser Foundation hospitals) was $380 million. This estimate is based on a State corporate tax rate of 9.3% and an average federal tax rate of 35%, and it does not include property tax exemptions or the value of savings associated with tax-exempt financing.

Since communities continue to make investments in not-for-profit hospitals through tax exemptions, public entities have shown growing interest in the community benefits provided. New York and Texas passed legislation that requires hospitals to report community benefit plans and budgets. In Massachusetts, the Office of the Attorney General has encouraged all not-for-profit hospitals to implement voluntary community benefit guidelines. In Pennsylvania and Utah, there have been cases in which not-for-profit hospitals were required to defend their tax status in court.

To help facilitate better documentation of community benefits, the not-for-profit sector has developed various methodologies to assist hospitals in recording community service. For example, the Voluntary Hospital Association published a useful set of guidelines. The Catholic Health Association developed a "Social Accountability Budget" that categorized community benefits as follows: 1) operations that lose money; 2) unpaid costs of public programs; 3) education programs; 4) programs that address unmet needs; 5) cash and in-kind donations; 6) health-related research; and, 7) fundraising costs.

Through these and similar efforts, such as the Kellogg Foundation's Hospital Community Benefit Standards Program of the late 1980s, the community benefit standard for non-profit hospitals has been expanded in concept to encompass a much broader perspective than the provision of medical care services. There is a greater emphasis on:

- A comprehensive, planned approach to addressing community needs, in particular those of vulnerable populations;
- Collaborative efforts with community partners to implement effective programs that address root causes of disease and illness;
- Evaluation of resource allocation;
- Evaluation of short and long-term health outcomes; and,
- Organizational commitment to a community benefit process.

California's Not-for-Profit Hospitals

Not-for-profits have historically constituted the majority of California's hospitals. The total number of hospitals in California in 1995-1996 was 555 (Table 1). Of the total, 384 were not-for-profit hospitals and they accounted for over 80% of the available beds.

Of the not-for-profit hospitals, only 205 were required to comply with the SB 697 community benefit legislation (Appendix B). State, County, District, and University of California hospitals were all exempt from SB 697. In addition, 40 private not-for-profit hospitals were exempt by virtue of their designation as "small and rural" facilities, 8 private not-for-profit alcohol/drug rehabilitation facilities were exempt, and 2 children's hospitals operated by the Shriners were also exempt.

Table 1. California Hospitals Categorized by Ownership

Hospital Ownership	Number of Hospitals	Available Beds[1]
Not-for-Profit:	**384**	**83,584**
Private (Excluding Childrens)	247	51,122
Children's	8	1,465
State	12	11,806
County	50	9,989
District	57	6,202
University of California	10	3,000
For-Profit:	**171**	**19,057**
Total	**555**	**102,641**

1 The average daily complement of beds (excluding nursery bassinets) physically existing and actually available for overnight use.

SB 697 Legislation

Given the interest in not-for-profit hospitals in other states, and anticipating similar interest in California, the California Association of Catholic Hospitals (CACH) and the California Healthcare Association (CHA), sponsored SB 697 in 1993. The hospital community benefit bill was passed by the Legislature, signed by the Governor in September 1994, and became effective January 1, 1995.

In SB 697, the California Legislature acknowledged that "significant public benefit would be derived if private not-for-profit hospitals reviewed and reaffirmed

periodically their commitment to assist in meeting their communities' healthcare needs by identifying and documenting benefits provided to the communities which they serve."

A premise of the community benefit legislation is that not-for-profit hospitals provide substantial contributions to their communities in addition to charity care, but they have not been required, in the past, to document these community benefit activities. The legislation calls for collection, tracking, public reporting and dissemination of this information.

According to the legislation, a private not-for-profit hospital had to meet the following requirements:

- Reaffirm its mission statement by July 1995;
- Conduct a community needs assessment every three years, beginning in 1995;
- Develop and adopt a community benefits plan by April 1996, and annually update the plan; and,
- Annually submit a copy of the plan to the Office of Statewide Health Planning and Development (OSHPD) within 150 days after the hospital's fiscal year end.

II. Implementation of the Legislation

OSHPD's Role

The Legislature designated the Office of Statewide Health Planning and Development to be the administrative agency in State government responsible for the implementation of SB 697. In essence, this has entailed identifying the hospitals which are subject to the requirements of the bill, collecting the required community benefit plans, analyzing them, and making them available to the public on request. To date, OSHPD has collected, analyzed and made available to the public community benefit plans for 180 hospitals. As mentioned earlier, the Office is also required to prepare this report to the Legislature.

SB 697 initiated a new process within the not-for-profit segment of California's hospital industry. Not-for-profit hospitals are now required to conduct an assessment of health needs within their respective communities, to prioritize those needs, to develop a plan for addressing them, as feasible, and to assign economic value to the benefits provided. Early on, OSHPD staff noted that the affected hospitals were committed to meeting the requirements of the legislation -- but they were uncertain about how to proceed. Therefore, in partnership with hospital associations and community groups, OSHPD took a proactive approach to help not-for-profit hospitals develop their benefit plan reports. The Office:

- Provided recommended reporting formats and guidelines;
- Participated in educational sessions convened by hospitals, public health officials, and community organizations to discuss their responsibilities under the provisions of SB 697;
- Solicited public comment through ten public meetings held in communities throughout the state; and,
- Convened an Advisory Group to explore policy and program issues related to implementation of the legislation.

Overall, OSHPD has approached implementation of SB 697 with the understanding that the bill called for a process of meaningful collaboration between hospitals and other local entities focused on community health improvement. Accordingly, OSHPD served as a facilitator of that process rather than as a regulator, in the traditional sense.

Description of SB 697 Hospitals

In all, 205 not-for-profit hospitals in California were required to comply with the community benefit legislation. General characteristics of these hospitals are described below. Table 2 shows the distribution of the SB 697 hospitals by county. Table 3 displays the hospitals by bed size and type of care.

Table 2. Distribution of SB 697 Hospitals: by County

County	Hospitals	County	Hospitals	County	Hospitals
Alameda	8	Napa	2	Santa Barbara	6
Butte	3	Orange	14	Santa Clara	8
Contra Costa	6	Placer	2	Santa Cruz	2
Fresno	5	Riverside	5	Shasta	1
Humboldt	1	Sacramento	9	Solano	4
Kern	5	San Bernardino	7	Sonoma	2
Los Angeles	60	San Diego	16	Stanislaus	2
Madera	1	San Francisco	9	Sutter	1
Marin	3	San Joaquin	6	Ventura	5
Merced	1	San Luis Obispo	1	Yolo	2
Monterey	2	San Mateo	5	Yuba	1

Table 3. Distribution of SB 697 Hospitals: by Licensed Beds and Type of Care

Licensed Beds	Hospitals	Type of Care	Hospitals
< 100	25	General Acute Care	189
100 - 299	104	Children's	6
> 300	76	Psychiatric	6
		Specialty	4

The majority of the 205 hospitals are licensed for more than 100 beds. Most are general acute care hospitals. A complete listing of the SB 697 hospitals can be found in Appendix B. One-third of the hospitals reporting (60) were located in Los Angeles County. In thirteen counties, two or more hospitals in the same hospital system worked together to submit a consolidated community benefits plan. Larger hospital systems also submitted consolidated reports that included the benefit plans of their individual hospitals and an overview of the system's statewide benefit activity.

Status of Hospital Reports

As indicated previously, community benefit plans were expected from 205 not-for-profit hospitals. Because the due dates for submission of hospital benefit plans were set in law at 150 days after the end of each hospital's fiscal year, only 166 reports were due prior to the preparation of this report. All of these reports were received and are available to the public. Community benefit reports from an additional 39 hospitals are due by February 1998 (Table 4).

In an effort to give as many hospitals as possible an opportunity to have their plan included, OSHPD encouraged hospitals to submit their plans by June 2, 1996. The hospitals' response was overwhelmingly positive. Community benefit plans for 133 hospitals were submitted to OSHPD before the statutory due date.

While plans for 166 hospitals were received, these plans were included in 142 separate community benefit plan reports. A number of the reports contained the combined plans of two or more affiliated hospitals located in the same service area. For larger hospital systems, OSHPD requested that each hospital in the system report an individual community benefit plan, since their service areas differed.

Table 4. Status of SB 697 Hospital Reports

Total Hospitals Required to Submit Community Benefit Plans	**205**
Number of Hospitals Represented in the 142 Reports Received	**166**
Hospitals Reporting Early	133
Hospitals Reporting by Deadline	32
Hospitals Reporting Late	1
Hospital Plans Due by Febuary 1998	**39**

Certain not-for-profit hospitals were exempt from the legislation, as explained earlier. Fourteen of the exempt hospitals, nonetheless, voluntarily complied with the legislative requirements and submitted community benefit plans to OSHPD. They are listed in Table 5, to acknowledge their special efforts.

Table 5. Exempt Hospitals that Submitted Plans Voluntarily

Hospital	Designation	County
1. Frank R. Howard Memorial	Small/Rural	Mendocino
2. Hanford Community Medical Center	Small/Rural	Kings
3. CHW Mark Twain St. Joseph's Hospital*	Small/Rural	Calaveras
4. CHW Mercy Hospital of Folsom*	Small/Rural	Sacramento
5. Palomar Medical Center	District	San Diego
6. Pomerado Hospital	District	San Diego
7. Redwood Memorial Hospital	Small/Rural	Humboldt
8. San Gorgonio Pass Memorial Hospital	Small/Rural, District	Riverside
9. Santa Ynez Valley Hospital	Small/Rural	Santa Barbara
10. CHW Sierra Nevada Memorial Hospital*	Small/Rural	Nevada
11. Sonora Community Hospital	Small/Rural	Tuolumne
12. CHW St. Elizabeth Community Hospital*	Small/Rural	Tehama
13. Tuolumne General Hospital	Small/Rural	Tuolumne
14. Ukiah Valley Medical Center	Small/Rural	Mendocino

*Catholic Healthcare West

Analysis of Hospital Reports

Hospitals were required to submit a community benefit plan to OSHPD that included "a description of the activities that the hospital has undertaken to address the identified needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community." The following components of the plan were specified by the legislation:

1. Mission Statements: The Board of Trustees was required to review and reaffirm (or revise) the hospital's mission statement by July of 1995.

2. Needs Assessments: Hospitals were required to complete a community needs assessment by January 1, 1996.

3. Community Benefits: The plan submitted should include a description of the community benefits provided.

4. Measurable Objectives and Timeframes: The plan should contain a discussion of the measurable objectives and timeframes.

5. Economic Value: The plan should provide summary information on the economic value of community benefits reported.

1. *Mission Statements*

By July 1995, Boards of Trustees were required to review and reaffirm their hospital mission statements. While all hospitals included their mission statements in community benefit plans, some hospitals also provided valuable information on the organization's vision and values. The mission, vision and values statements provided insight into the goals, philosophy and priorities of the hospital. A majority of the 155 plans specifically cited the goal of improving the health status of the community; many spoke of a commitment to providing quality care; and a number expressed commitment to underserved populations. Other goals identified by hospitals were to provide cost-effective care, to collaborate with other healthcare organizations, to enhance the dignity and quality of life, and to increase access to care.

Related to the mission statement, OSHPD requested optional information about the hospital's organizational commitment to the community benefit process:

- To what degree does the Board of Trustees participate in the community benefit process?
- Is a commitment to community evident in the hospital's strategic plan?
- Is there a formal process to inform staff of the community benefit policies, programs, and progress?
- How are hospital physicians and staff involved in the process?

Of the hospitals responding, 62 indicated that the Board or a subcommittee of the Board participated in the planning process; 49 said that senior management participated; and 38 noted that the medical staff was involved. (These numbers are not mutually exclusive.) Forty-one hospitals also stated that their community benefit plans were supported by the goals of their strategic plan. Since this information was optional, it is incomplete. Nonetheless, the responses suggest that a substantial proportion of the hospitals involved key personnel to some degree in the community benefit process.

The mission statement of Catholic Healthcare West, excerpted from their systemwide report, illustrates how such statements can express the institution's fundamental commitments:

> "CHW's mission is to provide excellence in healthcare, through attention to physical, emotional, and spiritual needs of patients and their families, within the limits of our resources. ... CHW's 'core values' are: *dignity* (respecting the inherent worth of every person); *collaboration* (working with others to achieve shared goals); *justice* (advocating for just social structures); *stewardship* (cultivating resources to promote healing); *excellence* (exceeding expectations through teamwork and innovation). CHW strives to live out its mission in all of its decisions and activities. We embrace new programs and services designed to

treat the whole person with compassion and respect. We work to improve not simply the quality of the individual lives entrusted to us, but the health of communities. We actively seek to collaborate with like-minded partners of all beliefs who share this sense of mission."

2. *Needs Assessment*

Hospitals were required to complete a community needs assessment by January 1, 1996. In describing the needs assessment, each hospital was asked to provide information about its community, the individuals and organizations consulted in the assessment, data sources used to identify needs, and the findings.

In the legislation, "community" is defined as "...the service area or patient populations for which the hospital provides healthcare services." Many hospitals defined their community based on their primary service area, using existing patient origin data. More than half the hospitals included some information about race, ethnicity, income, education and age distribution of the population for their county, although this information did not necessarily correspond to the hospital's service area. Finding data at a sub-county level (e.g. zip code areas or census tracts) for more precise characterization of the community in the needs assessment process was a daunting task for most hospitals, as such data are generally not readily available. In addition, many of the hospitals recognized that they served multiple communities, not only their patient population.

With respect to involvement of the community, more than 100 of the 155 reports received listed various individuals and groups that participated, and described the various methods used to obtain their views, including surveys, focus groups, task forces, and interviews. This information is summarized in Tables 6 and 7.

Table 6. Community Needs Assessments: Methods Used to Obtain Information

Methods Used	Citations[1]
Survey	88
Interview	79
Focus Group	68
Task Force	48
Plans citing 2 or more of the above methods	75
Plans citing all methods	15
Plans that did not indicate method used	20

1. Number of hospital plans citing the methods listed.

Table 7. Community Needs Assessments: Groups Consulted

Groups Consulted for Assessment	Citations[1]
Community/Civic Organizations	
Churches	62
School Districts	84
Colleges	38
Chambers of Commerce	16
Cultural/Ethnic Organizations	44
Law Enforcement	52
Local Businesses/Agencies	
City or County Government	93
Health Department	66
Businesses	39
National & Community Non-profit Organizations	110
Other Health Care Providers	105
Individuals	
Physicians	50
In-hospital Staff	61
Members of the Community	102
Local Professionals	55
Board of Trustees	24
Patients: Inpatient/Outpatient	12

1. Number of hospital plans citing the group or agency as one they consulted.

Since it is the basis for developing the community benefit plan, the needs assessment process is critical. In some cases, it was not quite clear how the needs assessment was conducted or what process and criteria were used to prioritize the needs identified. Some hospitals, constrained by the lack of data specific to their service areas or communities, used countywide data, which may fail to reflect more localized needs at the sub-county or neighborhood level. Other hospitals initiated primary data collection efforts, such as telephone surveys, which may not have been statistically sound due to sampling methods or low response rates. Clearly, the limited resources available to many hospitals for the SB 697 planning process was a significant factor in determining what the hospitals were able to accomplish in performing their needs assessments. To a certain extent, local health departments were able to assist, but they, as well, were under resource constraints. These issues, along with guidelines for collecting data and analyzing needs, are discussed further in the Recommendations Section of this report.

All of the hospital reports provided information about the health needs identified in their respective communities. Identified needs most frequently cited were for greater

access to care and for community health education and promotion (Table 8). Over 80% of the reports cited these two broad areas of need.

A wide range of other needs were identified in various communities. They included needs for teen pregnancy prevention programs, mental health services and immunizations. Needs identified often varied across communities based on local factors, such as age of the population, socio-economic status, and existing programs.

Table 8. Community Needs Most Frequently Cited in Hospital Plans

Need	Citations[1]	Need	Citations[1]
Access to Care	133	Dental Care	42
Community Health Education/Promotion	124	Nutrition, Stress Reduction, Exercise Classes	40
Domestic Violence Prevention	96	Health Screenings	40
Substance Abuse Treatment	92	Smoking Cessation Programs	38
AIDS/HIV: Education, Treatment Services	80	Jobs and Job Training	37
Teen Pregnancy Prevention	80	Senior Services	33
Affordable Healthcare Coverage	79	Outreach Clinics, Primary Healthcare	28
Mental Health Services	75	Personal Safety Instruction	28
Prenatal Care	71	Counseling/Support Groups	24
Immunizations	71	Family Planning	24
Crime Prevention	60	Affordable Housing	22
Chronic Disease Management/Education Classes	58	Home Health Services	20
Women's Post-natal and Parent Instruction	56	Homeless Programs	19
Transportation	54	Recreation Activities for Youth	19
Language/Cultural Sensitivity	50	After Hours "Urgent" Care	18
Information and Referral Services	49		

1. Number of hospital plans citing the need listed.

3. *Community Benefits*

One of the main objectives of SB 697 is that non-profit hospitals document and report the community benefits they provide. The following definitions for "community benefit," "community benefit plan" and "community benefit categories" were provided in the legislation:

> **Community benefit**: "...a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status..."
>
> **Community benefit plan**: "...the written document prepared for annual submission ... shall include, but shall not be limited to, a description of the activities that the hospital has undertaken in order to address identified community needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community."
>
> **Community benefit categories**: "...1) Medical care services; 2) Benefits for vulnerable populations; 3) Benefits for the broader community; 4) Health research, education, and training; and 5) Nonquantifiable benefits."

All of the reports submitted described the community benefits which the hospitals provide. The community benefit most frequently reported was health education (Table 9). The second, charity care, was referenced in about 80% of the reports. Three-fourths of the reports cited counseling and support groups, and health information resources (e.g., health fairs and resource directories). Services targeted at improving access to care and health screenings were also cited in about three-fourths of the reports. Thus, in a general way, the community *benefits* most often provided appear to address greater access to healthcare and health education, which were the community *needs* most frequently cited in the hospital reports.

There were many other types of benefits reported that were unique to only one hospital or to a small number of hospitals. Some examples include: graffiti removal, operation of a thrift shop, estate planning for seniors, tattoo removal for ex-gang members, and counseling on health insurance. The variety of benefits provided suggests the degree of innovation and creativity found at the local level.

Many of the community benefits reported by hospitals linked back to their needs assessment. However, hospitals also reported services that were not necessarily linked to the community planning process, but were nonetheless considered beneficial to the community. The planning process outlined in SB 697 affords hospitals the opportunity to re-examine their existing services in relation to community needs.

Table 9. Community Benefits Most Frequently Cited in Hospital Plans

Benefits	Citations[1]	Benefits	Citations[1]
Community Health Education Classes such as parenting education, labor and delivery, smoking cessation, fitness, CPR and other educational programs.	135	Clinical Service Training Nursing programs, graduate medical education and continuing professional education.	74
Charity Care	128	Volunteers	50
Counseling & Support Groups Support groups for cancer patients and various other individuals.	117	Day Care	50
Health Information Resources Health fairs, community resource directories and helplines.	116	Medical Research	44
Access to Care Transportation and home health services.	114	Medicare Shortfalls	44
Health Screenings Mammogram, blood pressure and other health screenings.	114	Community Building Activities	39
Hospital Donations Donations of money, food, clothing, employee expertise and other contributions.	108	Skills Training Programs	34
Medi-Cal Shortfalls	104	Prenatal Care	32
Link to Schools Mentoring and career development and other support.	101	Social Activities	27
Immunizations	87	Dental Care	23

1. Number of hospital plans citing the benefits listed.

Historically, the description of not-for-profit hospital community benefits has most often focused on quantifiable benefits, such as charity care. Under SB 697, the definition and reporting of community benefit is viewed in much broader terms and a category of "nonquantifiable benefits" is specifically identified. Examples of some "nonquantifiable benefits" frequently reported in the plans were: 1) the hospital is the sole provider of a particular service in the community; 2) the hospital serves as a training site for allied health professionals; 3) the hospital is a major employer in the community and participates in community development programs; and, 4) the hospital provides assistance and back-up to community-based healthcare organizations.

Many examples of nonquantifiable benefits related to the community contribution of the hospital's organizational capacity and consulting resources. Working

collaboratively with community partners, the hospitals provided leadership and advocacy, assisted with local capacity building, and participated in community-wide health planning.

Often, the nonquantifiable activities cited were part of larger community-based efforts and, therefore, the individual hospital's role was even more difficult to quantify than traditional service programs. Nonetheless, they represented valuable contributions toward meeting community healthcare needs successfully.

4. *Measurable Objectives and Timeframes*

Hospitals were required by the legislation to develop measurable objectives and timeframes for community benefit activities. OSHPD reviewed the plans to determine if they included a means to measure progress toward objectives, and if there was a time reference. Only a third of the hospitals were able to describe the community benefit activities in terms of objectives that had both a means to measure progress and time frames for their achievement. This appears to be an area where technical assistance would be advantageous.

Hospitals engaged in collaborative efforts with community partners in broad-based health improvement projects found objectives especially difficult to express in measurable terms. Benefit activities targeted toward community-wide health improvement are not easy to ascribe to any one collaborative partner, nor is it reasonable to expect hospitals involved in such activities to be accountable individually for the progress toward meeting these types of objectives. However, without measurable objectives, determining progress and evaluating outcomes is problematic. Even broad-based initiatives, addressing complex issues, may allow a description in terms of a series of intermediary, measurable objectives, so as to determine progress toward their goals of improved health status in the community.

5. *The Economic Value of Community Benefits*

SB 697 asks that not-for-profit hospitals report an estimate of the economic value of the community benefits they provide, in addition to the descriptive information. The bill contains the following language with respect to economic value, unreimbursed costs, and financial capacity:

Economic value: "The hospital shall, to the extent practicable, assign and report the economic value of community benefits provided in furtherance of its plan."

Unreimbursed costs: Hospitals were asked to report the "unreimbursed cost of services..."

Financial capacity: Each hospital was also required to "Annually submit its community benefit plan, including, but not limited to, the activities that the hospital has undertaken in order to address community needs within its mission and financial capacity."

Hospitals faced a number of challenges in determining the value of community benefits. First, there currently are no standard accounting definitions or guidelines for SB 697 community benefit reporting. Therefore, accounting methodologies for unreimbursed costs and valuation of community benefits varied considerably among hospitals. Some reported budgeted expenditures, others reported actual expenditures. Some reported the economic value of charity care and government program shortfalls in terms of charges, others in terms of costs, and others in terms of cost-adjusted charges. Second, there are differences among hospitals in their ability to capture community benefit information. Organizations that had already adopted some form of community benefit budgeting system, such as the "Social Accountability Budget" of the Catholic Health Association, were in a better position to capture community benefit expenditures and categorize them. Despite these challenges, over 90% of the hospitals met the basic requirement of providing an economic value for quantifiable community benefits.

There was, as mentioned, considerable variation in reporting the economic value of community benefits. The summary below illustrates this variation:

- 114 hospitals separately reported values for charity care;
- 65 hospitals reported financial information according to the four SB 697 categories;
- 88 hospitals separately reported values for Medi-Cal shortfalls;
- 33 hospitals separately reported values for Medicare shortfalls;
- 27 hospitals reported both Medi-Cal and Medicare shortfalls;
- 10 hospitals reported bad debts as a community benefit;
- 13 hospitals provided a comparison between total community benefits provided and overall hospital operations or financial capacity; and,
- 8 hospitals provided an estimate of tax exemptions, as a comparison to the total benefits provided.

Most hospitals conscientiously invested staff time and resources in attempting to determine the value of community benefits provided. Unfortunately, these data cannot be meaningfully interpreted due to the accounting and reporting variations described. Owing to the lack of uniformity in reporting the economic value of community benefits, it would not be possible, for example, to attempt to provide an aggregate value of the benefits reported. Certain community benefits tie in closely with the financial reports which OSHPD collects routinely from hospitals – such as charity care, Medi-Cal shortfalls, and Medicare shortfalls. Valuation of these benefits could be standardized relatively easily, as indicated in Appendix C, Recommended Outline for Community

Benefit Reports. However, valuation of other community benefits may continue to vary due to individual facility data collection and estimation techniques.

To provide at least some aggregate measure of the value of not-for-profit hospital community benefits, OSHPD did use its existing hospital financial data base to estimate the total value of charity care costs and government program shortfalls for SB 697 hospitals. Using cost-to-charge ratios, OSHPD estimates the total economic value of these community benefits alone to have been $823 million in 1995-6. This estimate does not reflect any of the other community benefits provided by the hospitals.

Examples of SB 697 Community Benefit Planning

A recurring request from hospitals was that OSHPD identify best practices and illustrative case studies of hospital community benefit planning and implementation. By sharing information about community benefit planning efforts which were particularly well done, both the hospitals and their communities can identify opportunities to improve and expand on the processes initiated in response to SB 697. In this section, several hospital reports are highlighted because they exemplify integrated organizational approaches to community benefit planning and implementation. The reports demonstrate:

- Commitment to the hospital's mission;
- Board and top management leadership in the community benefit process;
- Hospital staff involvement in mission-driven strategies;
- Community benefit plan supported in the hospital's strategic plan;
- Vision of a healthier community;
- Collaboration with community partners;
- Involvement of the community in determination of community needs;
- Concern for vulnerable, underserved populations;
- Financial commitment to community benefits; and,
- Fair valuation of quantifiable community benefits.

We could not highlight all the hospitals that addressed these points in exemplary fashion, and selected only a few for illustrative purposes.

In the following pages, five hospital reports are reviewed. Also, the statewide summary plans submitted by several hospital systems are described, and a unique countywide planning effort in San Diego is discussed.

Hoag Memorial Hospital Presbyterian
Orange County

As part of their internal assessment of community benefit activities, Hoag Memorial requested staff to complete community benefit inventory worksheets. These worksheets gathered information on benefit activity objectives and outcomes, location, target audience, health issues addressed, health goals, and net expense. Hospital staff were provided guidelines to follow when gathering and reporting on community benefit activities. The following policy on determining whether hospital activities qualify as a community benefit for the purposes of SB 697 is excerpted from those guidelines:

> "The primary purpose of a service/program must be related to a community service (e.g., wellness, prevention, individual/family well-being, and education).
>
> If the substance of the program is primarily to describe the hospital's services ..., then the program does not qualify as Community Benefit, as the activity's intent is more closely related to marketing than education or community service."

For purposes of prioritizing and planning, Hoag took into account public health data and health status indicators, utilization rates for emergency services, public-funding reductions, community-stated needs, and the expressed needs of vulnerable populations. "Causation pathways" were developed to identify direct and indirect risk factors affecting community health. The components of the community benefit plan included program description, selection rationale, goals and objectives, and evaluation. Timeframes and measurement indicators were reported under evaluation.

Seton Medical Center and Seton Medical Center Coastside
San Mateo County

Seton Medical Centers' mission includes a commitment to serve vulnerable populations, and this goal is referenced in its strategic plan under "Sponsorship and Advocacy." The objectives, strategies, and results of actions implemented to achieve this goal are monitored and reported to the Board of Directors on a quarterly basis. Management is also responsible for the documentation of community benefit activities. Hospital staff are involved in developing and implementing the organization's community benefit goals and objectives through the annual update of the Medical Centers' strategic plan.

Seton participates in the San Mateo Healthier County Partnership, a planning group which includes hospitals, other providers, the county health department, and community based organizations throughout San Mateo County. Their process for

prioritizing needs included recommendations from task forces which gather ongoing information about the needs of population groups in the community.

Seton's plan identified target vulnerable populations, articulated objectives, discussed tactics and strategy for achieving the objectives with indicators of progress, and set a 1997 target for first year accomplishments. Since the hospitals use CHA's "Social Accountability Budget," they reported in four community benefit categories: medical services, benefits for vulnerable populations, benefits for the broader community, and, health education and research. The financial information reported for the hospitals represented net costs, less in-kind donations, volunteer hours, and contributions.

Daniel Freeman Memorial Hospital and Daniel Freeman Marina Hospital
Los Angeles County

Daniel Freeman Hospitals reported that the following assumptions were the basis for their planning process:

- Daniel Freeman's health services are mission driven;
- Daniel Freeman Hospitals are committed to prudent and careful stewardship of resources;
- Daniel Freeman embraces the concept of community; both its external and internal community; and,
- Collaboration with other agencies in the provision of health services is the preferred mode of operation.

This report described a process in which the Board of Directors, senior administration, medical staff, and hospital employees participate in fulfilling the goals of its mission. Two examples of the organization's commitment to mission and community benefit were: creation of a Director of Community Benefit Programs position, and creation of the Daniel Freeman Community Trust. Through the Community Trust, the hospitals will contribute ten percent of net operating income to fund community-based projects.

From the community needs assessment, the hospitals identified high priority areas to be addressed. Both existing and planned services were linked to the priority issues. The hospital also reported that the institution's strategic plan encompasses the community benefit plan.

The components of the community benefit plan include: description of the activity, rationale for selection, objectives and timeframes for achievement, and participating community organizations. For potential Community Trust programs, the hospital established funding criteria consistent with community benefit planning and evaluation. For example, organizations were asked to propose projects for Community

Trust support that: address urgent needs of people in the community; promote local agency/organization collaboration and partnership; produce definable, measurable outcomes; and are potentially self-sustaining.

Citrus Valley Health Partners
(Queen of the Valley Campus and Inter-Community Campus)
Los Angeles County

In its plan, Citrus Valley Health Partners (CVHP) described an organizational commitment to improving the health of its communities. A subcommittee of the Board, the Community Benefit Committee, was established in 1994. This committee is responsible for reporting community benefit activities and issues for Board review. Citrus Valley also established a senior management position responsible for assisting the Board and hospital administration in advancing CVHP's mission and developing partnerships with community organizations that help improve community health status.

CVHP implemented compensation packages for senior management that are in part tied to community benefit activities and involvement in advancing efforts to improve the health of the community. Employees are also encouraged to contribute time to the community and are eligible for financial rewards based on the organization's resources. Physicians, dentists and pharmacists on the staff contribute time to the community through various CVHP programs.

For the valuation of community benefit, CVHP first established as a community benefit "threshold" an estimated value of the organization's tax exemption. In identifying and valuing community benefit activities, CVHP included only those activities that: 1) a for-profit hospital would most likely not provide; and, 2) serve a vulnerable population. In some cases, CVHP weighted the value of the contribution, if the program served both vulnerable populations and the broader community. The total value of these community benefit activities was then compared to the community benefit threshold.

Finally, CVHP described the importance of leadership in the community and a commitment to basic principles for community benefit programs. These principles include accountability, sustainability, replicability, and reduction of government burden.

Tuolumne General Hospital
Tuolumne County

Tuolumne General Hospital is a county hospital in a rural setting. Although exempt from the community benefit legislation, it voluntarily fulfilled the SB 697 requirements. The hospital believes its charitable mission and traditions are consistent with the spirit of the legislation.

In its plan, the hospital stated that the needs assessment and community benefit planning process was valuable in developing its strategic plan. In addition, the process enabled the hospital to examine existing resources and services, to see if they could be made more accessible to the community - in particular, to underserved populations.

The hospital cited lessons learned from its collaborative planning efforts with the community:

- The value of direct communication with a broad cross section of the community, including the underserved and at-risk populations;
- The importance of identifying and prioritizing community benefit programs based on needs established by the community served;
- The need for the physician community to be more actively involved in the community benefit planning process; and,
- The value of a formal, ongoing process to track and assess charitable care and community needs, to share those findings with providers and consumers, and to integrate the results into an outcome-oriented strategic plan.

For an internal benchmark to guide community benefit expenditures, the Trustees and administration considered the amount of taxes that would have been paid. Future benchmarks will take into account evaluations of program effectiveness and outcomes.

Reports from Statewide Hospital Systems

(Kaiser Foundation Hospitals, Adventist Health Systems, and Catholic Healthcare West)

Given the level of consolidation of hospitals in California, it is pertinent to examine how SB 697 has been approached from a systemwide perspective. How are the collective capacities and resources of an entire hospital system utilized to support community health improvement efforts? Three large hospital systems, Kaiser Foundation Hospitals, Adventist Health Systems, and Catholic Healthcare West, submitted documents to OSHPD that included valuable information about their systemwide initiatives, as well as providing a summary of the contributions of their individual hospitals.

While each of the three organizations implemented SB 697 in ways that reflected its own mission and structure, there were significant commonalities. All expressed commitment to the community benefit process and described central administration support for the efforts of their individual hospitals. The organizations were conscious of their overall community impact, and incorporated community benefit planning in their systemwide strategic planning.

Kaiser Foundation Hospitals - 26 Hospitals Statewide:

Each of Kaiser's 26 hospitals conducted a community needs assessment and, with the information collected, each developed a community benefit plan. In addition, an advisory group systematically identified community needs common across all hospital service areas. For the Northern region, the common problems identified were: 1) access to care for underserved populations, 2) infectious disease prevention, including HIV and STD's, 3) violence prevention, and 4) youth and adolescent healthcare. For the Southern region: 1) access to primary care for medically indigent, working poor and children, 2) health education/prevention, and 3) maternal health/teen pregnancy prevention. Kaiser intends to focus on these common needs in future efforts to evaluate and enhance the effectiveness of community service projects.

The Kaiser Foundation Hospitals' report notes that, during the process of developing the hospital community benefit plans, it became increasingly apparent that the science of evaluating community health interventions remains underdeveloped. As there was a great deal of variation between the objectives and evaluation mechanisms among its 26 hospitals, Kaiser will be undertaking the development of a systemwide evaluation.

Kaiser established systemwide guidelines for reporting. Services provided exclusively to Kaiser members were not reported in the plans. The totals for quantifiable community benefits for the entire system, in 1995, were:

• Medical care services for vulnerable populations	$ 52.3 million
• Other benefits for vulnerable populations	4.1
• Benefits for the broader community	11.7
• Health research, education, and training	54.5
	$122.6 million

The following excerpt from the Kaiser report indicates the organization's perceptions of SB 697:

> "SB 697 has afforded Kaiser Foundation Hospitals in California the opportunity to inventory all of the community service it provides and to strengthen the evaluation of these programs and services against specifically defined community health needs. SB 697 has also inspired Kaiser Permanente as a whole to take a detailed and thoughtful look at its long-standing commitment to community service. As a result, the entire organization expects to better align current and future programs with needs identified by the communities we serve."

Adventist Health System - 12 Hospitals Statewide:

Adventist Health Systems (AHS) provided a systemwide report out of its conviction that it "operates as a single business enterprise and should be viewed as such." Given the diversity in geographic and demographic areas they serve, some of their hospitals do not have highly vulnerable populations while others have large vulnerable populations. They respond as a system to ensure that hospitals that have provided essential services to their communities will be able to continue serving those communities. "While it might have been prudent from a business sense to sell or close certain hospitals (in underserved areas), instead Adventist Health renewed its commitment to those communities. Because of the resources of a much broader system, we're able to remain in these vulnerable areas." Commenting further in this vein: "Adventist Health wishes for the State to see not just the isolated contributions an individual hospital may make to its community, but also the aggregate total contribution of Adventist Health as a system statewide." Of the quantifiable community benefits, AHS reported an aggregate of $61 million for unreimbursed costs.

Over the past several years, the AHS corporate office has made a concerted effort to establish systemwide community benefit policies, and has begun a process of standardizing the reporting from all its hospitals. A "Community Benefit Planning Guide" was developed and disseminated for staff training. All AHS hospitals are expected to participate in community benefit planning and reporting, including exempt AHS hospitals in California and, also, their hospitals out of state. Community benefit managers are assigned at each hospital.

The AHS corporate office intends to continue developing its support role for the individual hospitals in the system. Its Strategic Planning Department will monitor progress on needs assessment and community benefit implementation. The Budgeting and Reimbursement Department will monitor community benefit data gathering and reporting. The Communication Department will prepare and distribute an annual benefit report for general audiences and also help hospitals to prepare reports for their communities.

AHS also provided comments on lessons learned in preparing the SB 697 report. They state:

> "...the process required by SB 697 has helped Adventist Health hospitals to establish, implement, and track community benefit goals much more effectively than before. In this regard, OSHPD has been a good partner with Adventist Health."

Catholic Healthcare West - 33 Hospitals Statewide:

In the introduction to its insightful 26-page report entitled "Systemwide Perspective on Community Benefit Planning," Catholic Healthcare West (CHW) calls attention to the community benefit responsibilities of the entire organization:

"The system's commitment to providing community benefits cannot be completely told through hospital-specific plans. The missions and traditions of its sponsors call CHW as a whole to community service, to recognition that people who are poor and disenfranchised have a special claim on our care and resources. CHW welcomes SB 697 as a further opportunity to demonstrate that we provide community benefits that earn and warrant the public's trust."

CHW details the role and responsibilities of the systemwide organization in relation to the community benefit activities of its component hospitals. It utilizes three systemwide processes to encourage and support their hospitals in the context of an overall institutional mission: 1) strategic planning, 2) social accountability budgeting, and 3) a mission effectiveness program.

The description of their strategic planning reveals how closely community benefit activities are tied to the organization's plans:

"For CHW, strategic planning is the framework for addressing unmet community needs. We intertwine hospital-based strategic plans with the system strategic plan to make them mutually reinforcing in support of community benefits. At all organizational levels, the first of our mission-driven strategic goals is to improve the health of our communities."

Catholic-sponsored hospitals have pioneered the development of methodologies to categorize and, whenever possible, quantify the uncompensated costs of services provided for those in need, and for benefit of the broader community. The "Social Accountability Budget" is the instrument developed for this purpose and has been utilized by CHW for a number of years.

The report states that the community benefit expenses for CHW's California facilities totaled $174.5 million in 1996, of which $143.3 million represented "benefits for the poor" and $31.2 million "benefits for the broader community." Detailed accounting provides a clear picture of the allocations of the quantifiable benefits contributed by CHW hospitals. The report also describes additional contributions made by CHW, for example a grants program to support community-based health promotion and outreach projects, and an innovative "alternative investments" program "aimed at increasing access to jobs, housing, education and healthcare for people in low income and minority communities." CHW invests a portion of its resources in "alternative investments" that lack traditional investment characteristics, but are expected to preserve the invested capital while achieving positive social outcomes. They include, for example, below market-rate loans to community-based non-profits and capital investments in community development enterprises.

A special staff at the CHW System Office has the responsibility for the Mission Effectiveness Program. The purpose of the program is "to insure the integration of the CHW mission at all organizational levels and in every facet of operations." The

mechanisms utilized include a Leadership Development program for top executives, a Mission Orientation program for new managers, and educational seminars for board members, medical staff leaders and senior managers. Commitment to the community is a central theme of the CHW mission (see page 15) and through the Mission Effectiveness Program finds expression in all of the system's activities.

Much of the CHW systemwide report is devoted to an examination of the community benefits process in light of an over-arching goal of improving the health of the community. This part of the report could be read profitably by anyone interested in the field. Salient recommendations are offered for the future development of SB 697:

- Focus accountability on addressing unmet needs;
- Resist the temptation to measure benefits only in financial terms;
- Emphasize reporting of community coalition building;
- Emphasize the community's role in valuation of benefits; and,
- Permit development of regional community benefit plans.

CHW expressed interest in a continuing, cooperative effort with OSHPD "to improve and support community benefit planning that would not only benefit the citizens of California, but also result in a state-of-the-art model worthy of national attention."

Countywide Collaborative Health Planning
San Diego County

An unforeseen dividend of SB 697 was a stimulus for community-wide, collaborative health planning on a scale that has not been witnessed for many years. Perhaps this should not have been too surprising, for this broader-gauged planning is the natural extension of individual hospitals conducting needs assessments and benefit planning together with other interested parties in the community. Such collaborative planning took place in a number of counties: San Mateo, Santa Cruz, Santa Clara, Monterey, and in the Sacramento region. However, the countywide community health planning activity that took place in San Diego merits special mention.

In San Diego, SB 697 served as a catalyst for collaboration among the hospitals and health systems in the county. The objective of the initial working group, the San Diego 697 Coalition, was to produce a comprehensive countywide needs assessment for San Diego, and avoid duplication of efforts. Key to this collaborative endeavor was the leadership and contributions of the San Diego County Department of Health Services, the Hospital Council of San Diego and Imperial Counties, and the School of Public Health at San Diego State University. The resulting product from the Coalition was a very comprehensive community-wide needs assessment published as a 222 page document entitled "Charting the Course: A San Diego County Health Needs Assessment." Community health needs were studied in detail within the following categories:

the Course: A San Diego County Health Needs Assessment." Community health needs were studied in detail within the following categories:

- Selected Health Behaviors
- Access to Care
- Perinatal Health and Family Planning
- Major Diseases
- Violence and Emergency Services
- Special Health Needs
- Mental Health and Chemical Dependency, and
- Environmental and Occupational Health

Based on the success and momentum gained from producing "Charting the Course," the Coalition opted to continue working, to develop a countywide community benefit plan. "Setting Sail: San Diego's Coordinated Community Benefit Plan" was completed in October, 1996. Not-for-profit hospitals in San Diego all used these documents in preparing their individual community benefit plans.

Since these initial efforts, the Coalition has evolved into the Community Health Improvement Partners (CHIP). CHIP is a collaboration that includes the hospitals, health systems, community clinics, insurers, physicians, universities, and community organizations that are dedicated to a common vision. The objectives of CHIP are to: 1) conduct an ongoing assessment of the community's needs, 2) identify priority areas, and 3) support and coordinate programs and services that address priority areas.

The initial work of the Coalition provided an opportunity for hospitals and other stakeholders to build relationships and trust. The value of collaboration became evident. CHIP was able to avoid duplication of efforts and made efficient use of resources. They were able to capitalize on a broad range of skills and expertise, and were able to approach community health needs from a strategic planning perspective. The spirit of partnership between the private and public sectors, including managed care plans and public health, will be critical to the continuing success of the collaborative community benefit planning endeavor in San Diego County.

Public Comment

In developing recommendations for this report, OSHPD was responsible for consulting with hospitals, legislative staff from district offices, communities and local governments. To satisfy this requirement, OSHPD conducted ten statewide community forums (Table 10). These forums were intended to give the public an opportunity to comment on the SB 697 process. Attendance at the forums included hospitals, community-based organizations, public health officials, voluntary associations, representatives of local United Way chapters, consumers and other interested parties.

Table 10. SB 697 Community Forums[1]

Location	Hospitals	CBO	Leg Staff	Pbl.Hlth.	Oth. Gov.	Other	Total
LA West Covina	25	3		1	3	2	34
Sacramento	17	2	1	1	9	2	32
Oakland	20	13		2	3	6	44
San Francisco	11	12	1	4	1	7	36
San Jose	15	7	3		4	5	34
Fresno	9	5	1	2	3	2	22
Santa Barbara	15	2	1	2	1	4	25
LA-Pasadena	52	5	2	4	7	9	79
LA-Lynnwood	25	5	4	1		6	41
San Diego	14	1	1	1		4	21
Total	203	55	14	18	31	47	368

1. Key: CBO = Community-based organizations; Leg Staff = Legislative staff; Pbl.Hlth = Public health representatives; Oth.Gov. = Other government representatives; Other = Unable to determine affiliation

A mix of community participants attended the forums. Many of the participants had been involved in the implementation of SB 697, and attended the forums to publicly validate the hospitals' efforts. Some attendees had been notified about the forum, but were unaware of the legislation and its requirements. A number of those attending the forums observed that hospitals needed to improve their efforts to include the community in the assessment and planning process.

The ten forums around the state, yielded useful information about the diverse approaches, benefits, and lessons learned from implementation of SB 697. In contrast to the formal review of community benefit plans, the comments from forum participants shed light on strengths and weaknesses of the community planning process. While hospitals and communities were different in the ten locations, and the degree of progress varied, some common themes emerged statewide.

Needs Assessment. There were often lengthy discussions about the challenges of conducting a community needs assessment. The following are issues that were raised most often:

- Needs assessments are resource intensive (requiring both staff time and dollars).
- Hospitals may not always have the expertise to conduct a needs assessment.
- Hospitals should focus on the prioritization and benefit planning process and avoid the pitfall of devoting a disproportionate amount of resources on needs assessment.

- Data at the subcounty level are needed to identify "pockets of need" in the community; however, such data are often difficult to obtain.

- Healthcare needs identified are often the result of socio-economic conditions in the community reflecting problems broader than those targeted in the hospital's plan, and may be beyond the influence of the hospital acting alone.

- The expectations of the community are raised when hospitals conduct their needs assessments. However, communities must have an understanding of the limits of what a hospital can reasonably address and accomplish through its benefits plan.

- Not all of a community's needs can be identified through traditional data sources. Hospitals should be encouraged to use other methods of data collection in their needs assessments (such as interviews, focus groups).

- Community assets (such as available services and organizations) should be identified in the needs assessment process, as well as negative factors and lack of services.

- Community-based organizations that participate in a hospital's needs assessments can be an ongoing resource to the hospital and help it monitor the "pulse" of the community.

- Conducting a needs assessment every three years may be too frequent. Needs may not change that rapidly, and needs assessments require a substantial investment of hospital resources.

- Community partners, such as the United Way and local health department, are good sources of information for needs assessment purposes.

- Technical assistance from state and local government regarding data sources and needs assessment methodologies would assist hospitals in their planning efforts and could minimize the need for each hospital to "reinvent the wheel" at the local level.

Flexibility in Reporting Requirements: The key strength of SB 697, emphasized in all of the community forums, was the flexibility afforded by the legislative requirements. Hospitals stated that without prescriptive standards, they were able to implement the legislation in ways that best utilized their organizational capacity and resources. A "community process" should prevail over state-mandated requirements. Flexibility was necessary because so many variables impact hospital benefit planning (e.g., hospital size, resources, expertise, and community dynamics, politics, needs, and assets).

While recognizing that prescriptive statewide requirements could hinder innovation in addressing local community needs, a number of hospital representatives did point out that a better reporting structure would make their SB 697 task easier, and would also be helpful to management oversight. The following views were widely shared:

- Community benefit should not be defined solely in terms of costs that can be quantified, but also in terms of the benefits that accrue to the community from the hospital's programs.

- Limiting community benefit reporting to a "checklist exercise" may encourage hospitals to focus on activities that can be easily quantified, overlooking broader and more important community health improvement efforts.

- If minimum standards for community benefit contributions were established, hospitals may simply satisfy the minimum rather than aiming higher.

- The measurement of outcomes is often difficult, as is assigning credit to individual organizations engaged in collaborative, communitywide efforts.

- Hospitals need time to develop the skills and expertise to measure outcomes of their programs.

- Both short and long-term outcome measures should be used when reviewing efforts directed at improving community health.

Local Accountability: When forum participants were asked to distinguish between community benefit and marketing activities, most responded that the two types of activities are often intertwined. By virtue of its participation in a community benefit activity, a hospital may gain recognition in the community. Even if an activity primarily serves a marketing function, the services provided still ultimately benefit the community. For example, if a hospital participates in a health fair, participants benefit because the hospital provides health screening and information services. Perhaps the most important concept coming out of the community forums was this: the community itself should be responsible for defining benefits.

Collaboration: The forums were heavily attended by hospitals, many of whom cited SB 697 as a catalyst for collaboration among hospitals and other healthcare providers. These collaborative relationships occurred at both the assessment and planning stages, and allowed participants to pool resources, eliminate duplicative efforts, and identify existing services and assets in communities. The level of collaboration among hospitals appeared to depend on a number of factors, including existing relationships, organizations assuming leadership roles, coordination by regional hospital councils, and other local circumstances. Some specific examples of collaboratives include:

- Sacramento, El Dorado, Placer, and Yolo Counties: Not-for-profit hospitals in these counties contributed to a four county needs assessment. While each of the hospitals in the area developed an array of community benefit programs, as a group they have chosen to address childhood immunizations.

- San Francisco County: The not-for-profit hospitals conducted a countywide needs assessment in conjunction with the San Francisco Department of Health and the United Way.

- Santa Clara County: Many of the not-for-profit hospitals in the county were working collaboratively on projects prior to SB 697. They stated that the legislation served to formalize these relationships. This group has specifically targeted diabetes in the Hispanic community, as well as other services identified in each individual community benefit plan.

Coordination with Local Health Departments: Written comments were received from a number of county health departments. The experiences of local health departments with SB 697 varied across the state. The most common observation was that hospitals should work with local health departments in the areas of assessment and planning. In addition, standards or models should be developed in the future to measure hospitals' performance in regard to community benefit planning and implementation. Other points were:

- Hospitals should make better attempts to include community organizations and consumers in the assessment and planning process.

- Hospitals should involve their local health departments in both assessment and planning processes, and share plan information.

- There should be a logical link between the needs assessment and the subsequent plan developed by hospitals.

- Standards of accountability should be developed to assure that hospital programs are effective.

- Resources should be made available in local health departments to assist hospitals with assessment and planning.

- Care must be taken when regional plans are developed lest local problems and issues may be "diluted".

In general, commenters were supportive of the SB 697 process. Dr. Melton, Director of the Monterey County Department of Health, stated in a letter to OSHPD:

> " . . . it has been my overall impression that the SB 697 experience was most successful in those communities in which there was close and real collaboration between hospitals and local public health professionals. . . . There seems to be an opportunity in the SB 697 process for the convergence of interests between public health and the increasing community involvement by hospitals."

Expanded Role for OSHPD: A frequent request from hospitals was that OSHPD develop its role as facilitator of the SB 697 process. Specifically, hospitals stated they would benefit from training seminars and technical assistance in the areas of assessment, planning, and evaluation. In addition, participants recommended that OSHPD develop its information-sharing capacity by expanding its website and highlighting best practices and innovative models.

Advisory Group Discussions

During the summer of 1997, OSHPD convened an SB 697 Advisory Group whose views and comments were taken into consideration in developing recommendations for this report. The group was comprised of representatives from hospitals, public health, community organizations, and government. The membership of the SB 697 Advisory Group is presented in Appendix D. Their counsel is acknowledged with appreciation.

The Advisory Group discussed a number of issues, out of which certain consistent themes emerged. Advisory Group members stressed that it was important to recognize the evolving nature of SB 697 and the diversity of organizations and capacities involved. They stated that it was essential, therefore, to develop guidelines and expectations that would accommodate the *continuum* of hospitals. An over-emphasis on regulation and monitoring would adversely affect the current favorable dynamics of the SB 697 process. The Advisory Group was in agreement on these points:

- Hospitals have benefited as a result of the flexibility of the legislation, and this flexibility should be maintained.

- Hospitals shared the desire to improve their SB 697 efforts and reports by learning from "best practices" identified.

- The value of community benefits cannot be measured solely by quantifiable costs. Nonquantifiable benefits are significant and should be acknowledged and encouraged.

- The primary focus for hospitals' SB 697 efforts should be on the local community process: building community relationships, conducting community needs

assessments, planning, implementing programs/services, and evaluating outcomes.

- OSHPD should serve as "facilitator" in the community benefit process, by disseminating information and coordinating technical workshops.

- In developing future requirements or guidelines, OSHPD should strike an appropriate balance between encouraging the community benefit planning process and requiring detailed benefit reporting.

Following are brief summaries of the topics addressed by the Advisory Group. A number of complex issues were covered in a relatively short period of time. It is evident that OSHPD should continue its dialogue with stakeholders regarding issues of needs assessment, planning, implementing programs/services, outcomes measurement and valuation.

Public Trust Model for Not-for-Profit Hospitals: Dr. Kevin Barnett proposed that a Public Trust Model be considered as a framework for hospitals to understand the public expectations and assumptions associated with tax exemption. In this model, there are six underlying expectations: (1) *redistributive intent* – charitable resources are allocated in a redistributive manner to address unmet need; (2) *special skills/capacity* – recipient organizations have special skills and capacity to address targeted (health–related) concerns; (3) *efficiency/surplus value* – deferral of tax revenues is a cost-effective approach to program funding; (4) *protection from political influence* – public sector allocation of funds in a particular content area, health improvement in this case, is important enough to protect from annual budgeting debates; (5) *collaborative governance* – governance of resources is carried out in a collaborative manner reflecting the diversity of local stakeholders; and (6) *cost effectiveness/flexibility* – allocation of public resources to private sector organizations (through tax exemption) yields program activities more responsive to the specific concerns of local communities than large-scale public sector programs.

Some participants expressed support for the Public Trust Model as a set of underlying principles that could guide thinking in the design and implementation of community benefit plans. Others expressed reservations about applying this model too specifically to legal requirements associated with non-profit hospital tax exemption.

Healthier Communities: Citrus Valley Health Partners (CVHP) shared their experience in assessing needs in the community, and discussed how the organization defined its role in creating healthier communities in the east San Gabriel Valley. They stressed that "assessment" should be more than data gathering and analysis. The process is an opportunity for the hospital to engage the community, establish or enhance relationships, and identify community assets as well as needs. CVHP discovered opportunities to assist in building the capacities of existing local community-based organizations.

Valuation of Community Benefits: CVHP also discussed its conservative approach in determining the value of its community benefits. They defined community benefit as a service that met both of the following criteria: 1) service that a for-profit hospital would most likely *not* provide; and 2) service that addressed a vulnerable population. Given these criteria, CVHP excluded Medi-Cal shortfalls and weighted the value of other programs. While CVHP was commended for its approach to valuation, the Advisory Group cautioned against creating similar expectations for all hospitals. The legislation allows hospitals to value benefits for both vulnerable populations and the broader community.

Hospital's Articles of Incorporation: A representative of the Office of the Attorney General stated that hospitals developing community benefit plans should review their articles of incorporation to verify that the articles allow for the scope of activities included in the hospitals' community benefit plans.

Not-For-Profit versus For-Profit Hospitals: Comparisons between not-for-profit and for-profit hospitals emerged in various discussions. Some Advisory Group members said that not-for-profits should attempt to distinguish themselves from for-profits when planning for and reporting community benefits. The majority contended, however, that it was not the purpose of the legislation to compare or contrast the two forms of financial organization. Rather, the purpose of the legislation was to obtain information from not-for-profit hospitals about their community benefit plans and contributions.

Framework for Reporting: A number of recommended reporting elements were identified: 1) definition of community; 2) summary of assessment process; 3) community benefit program descriptions; 3) value of services that can be quantified; and, 4) description of benefits that are not easily quantified.

Recommended Tasks for OSHPD: The Advisory Group suggested that OSHPD: study and develop recommendations on measuring the impact of community benefit contributions; provide technical assistance; identify success stories and "case studies" of exemplary performance; and, develop standard accounting definitions and reporting guidelines.

Defining Community: The Advisory Group noted that "community" can be defined in various ways. For example, a community can be defined geographically, by patient origin, by vulnerable groups to be reached, by health status, or by some combination of descriptors. The majority of the Advisory Group believed that the current language in the legislation allowed enough flexibility for a hospital to define its community as circumstances warrant.

Medi-Cal and Medicare Shortfalls: A few members of the Advisory Group were of the opinion that government payor shortfalls should not be reported as community benefits in all cases. The basis for exclusion would depend on the hospital's market and competition

for such contracts. The majority, however, contended that individuals eligible for Medi-Cal and Medicare are, by definition, considered "vulnerable." Therefore, the shortfalls should be considered community benefits. Furthermore, not-for-profits are required (by IRS rules) to care for these patients. So, regardless of whether investor-owned hospitals in the same markets seek these contracts, not-for-profit hospitals should continue to receive community benefit recognition for the unreimbursed costs they absorb in the Medi-Cal and Medicare programs.

Community Benefit versus Marketing: The group advised that OSHPD not attempt a "black and white" distinction between the community benefits and marketing, because they are not mutually exclusive. They suggested that defining community benefit should be left to the community.

Measurable Objectives and Outcomes: The Advisory Group participated in an exercise in developing measurable objectives. It was clear from the exercise that developing such objectives can be a difficult process, especially if framed in terms of overall community health status. Implementation of SB 697 must strike a balance with respect to requirements for short-term measurable objectives and more general descriptions of long-range, collaborative, coalition-building efforts to improve community health status.

III. Recommendations to the Legislature

In addition to summarizing the characteristics of the community benefit plans submitted by hospitals, SB 697 required OSHPD to provide the Legislature with:

- Recommendations for standardization of plan formats; and
- Recommendations regarding community benefits and community priorities that should be emphasized.

As required, OSHPD consulted with representatives of hospitals, local governments, and communities. The recommendations listed below reflect comments and suggestions from public forums, the Advisory Group convened by OSHPD, and a broad range of planning participants including representatives of local voluntary organizations, churches, schools, law enforcement, and businesses.

Standardization of Plan Formats

Over the last year, there has been a considerable amount of discussion about the merits of developing standards for the content of community benefit plans. Initially, many hospitals expressed concern regarding the lack of specific guidelines for developing a plan that would comply with the statute. Others noted that the flexibility allowed by the statute encouraged creativity and innovation at the local level – an assertion clearly demonstrated in the variety and diversity of responses to the SB 697 mandate. Given these divergent points of view, the following recommendations are presented to establish a consistent framework in which to describe and report the results of local planning efforts and should be used by hospitals as a starting point in organizing and presenting their community benefit plans.

1. *Each community benefits report should include clear and specific definitions of the "communities" targeted by the plan.*

   While SB 697 defined community as "the service area or patient populations for which the hospital provides healthcare services", this definition is too narrow to encompass many of the creative and collaborative efforts that hospitals demonstrated in their first planning cycle. The statutory definition limits the hospital's view of its community only to those geographic areas or individuals that have been historically served by that hospital. It does not take into account that, through a collaborative needs assessment and planning process, a hospital may identify and target community needs that have not been part of its traditional service area. Consequently, plans should not necessarily be limited by the statutory definition, but instead, should

include a description (including geographic, demographic, and/or other descriptive factors) of the target communities identified as a result of the planning process.

2. *Each community benefits report should include the hospital's mission statement (including any "values" or "vision" statements) and a description of the organizational framework in which the planning and implementation process will take place.*

   A commitment to the hospital's mission is important in community benefit planning. Understanding the organizational framework may explain how plan objectives are integrated into ongoing operations or will be incorporated in future operations.

   Most hospitals engage in a strategic planning process to provide the organization, particularly the board of directors and executive staff, with benchmarks to measure performance. The community benefit plan should likewise be a tool to assess progress within the hospital and should be routinely reviewed by the governing structure of the institution.

3. *Each community benefit report should include a summary of the needs assessment process undertaken at the local level and the method used to prioritize needs for inclusion in the benefits plan.*

   The needs assessment should be the foundation for identifying the plans "targeted" community and the community benefits to be provided. While the statute does not expressly require that the needs assessment be included in the plan, it would be desirable to do so since it is critical to understanding and evaluating the benefits to be addressed. As such, the plan should include a summary of the needs assessment process undertaken which includes the methodologies and data sources utilized, individuals and organizations consulted, a listing of all needs identified, and a description of the method used to prioritize needs for inclusion in the plan.

   Hospitals should incorporate the "assets mapping" model into their needs assessments. This approach attempts to identify community residents and organizations that may contribute to health improvement and neighborhood self-sufficiency. Once needs or "deficits" are identified, it is important to identify the strengths the community has to offer and engage in a problem solving approach that secures the ongoing commitment and involvement of community partners. In large part, the scope and quality of the needs assessment process will determine the degree to which a benefit plan can effectively address community needs. Likewise, the method of prioritization should reflect the mission, values, and vision of the hospital as well as the importance and impact of addressing identified needs. Consequently, a community benefit plan should be able to demonstrate a logical progression from the needs assessment process and identification of priorities to the development of

activities (or benefits) related to those community needs. If a hospital's plan addresses needs not identified in the assessment, an explanation for the program should be provided.

4. *Each community benefit report should include a summary of all community benefits currently provided by the hospital as well as new benefit activities proposed in the plan. The benefits described in the plan should correspond to one or more needs identified in the community, and the plan should include an economic valuation of the benefit, where possible.*

   As stated previously, the hospital's community benefits should be explicitly linked to identified needs. It is also important that the hospital provide an explanation of why and how the benefit will address the need. In so doing, the hospital and the community can monitor not only the status of benefit activities, but also the impact of those activities in meeting the intended needs. Hospitals should regularly reexamine their existing community benefit programs along with their communities to reaffirm that the resources being expended are continuing to address a community need. It should be noted, however, that in many cases a hospital may also be providing a community benefit that is not a direct result of the needs assessment process associated with SB 697. These activities are important to include in the benefit plan in order to fully document a hospital's total contribution to its community.

   Methods for economic valuation should be clearly documented in the plan and should identify costs that can be reasonably attributed to the benefit activities proposed. Benefits that relate to the financial operations of the hospital (e.g., uncompensated or charity care) should be based on sound accounting principles consistent with uniform accounting standards established by OSHPD for annual hospital cost reporting purposes. It is clearly recognized that some of the benefits listed may not be amenable to economic valuation. Where a financial assessment is not possible, the role of the community in "accounting" for the value of the benefit becomes even more important.

5. *For each community benefit identified in the plan, hospitals should include in their report to OSHPD an implementation timetable that includes goals/objectives and timeframes/interim milestones for each benefit activity.*

   An implementation timetable establishes a mechanism for monitoring progress over time and can provide the hospital and community with valuable information for future planning cycles. It is important to note, however, that benefit plans should not be static and that milestones in the implementation timetable should be used as benchmarks, subject to change in subsequent plans as local conditions require. Likewise, timeframes in the implementation plan represent best estimates and serve as just one tool to evaluate progress. It is the role of the hospital and its community to

work together to use this information in a way that will ensure continued progress in meeting the goals and objectives of the plan.

6. *Each community benefit plan should include a description of the methods the hospital has used to publicize and distribute the plan to its local community.*

   The ten public forums conducted by OSHPD clearly demonstrated that many hospitals made concerted efforts to reach out to various segments of their communities that traditionally had not been part of the hospitals' planning efforts. However, even the most ambitious efforts could not include every constituency that might have an interest or stake in the results of the planning process. In some cases, once the plan had been completed, outreach to the community was discontinued and participants were unaware of what ultimately was included in the plan. SB 697 requires OSHPD to collect the plans and make them available to the public. This, however, is not an ideal mechanism for ensuring that local communities are aware of what benefits the hospitals have planned. Hospitals should consider taking an active role in identifying who, locally, should be part of the review and implementation of benefit plans. Local health departments could potentially assist since many of their activities coincide with the community benefits described by hospitals. The plan submitted to OSHPD should include a section that provides a description of how and when the plan was circulated for public review.

7. *At a minimum, hospitals should include in their plans elements listed in Appendix C of this report. OSHPD will continue to work with representatives of hospitals, local governments, and communities to refine and field test standardized reporting formats that can be used by hospitals, on a voluntary basis, to incorporate and articulate these elements.*

   As an aid to guide hospitals in submitting their community benefit plans, OSHPD has begun to develop proposed voluntary reporting formats that are consistent with the recommendations contained in this report. These formats are intended to create greater ease and standardization for including the data elements in Appendix C. However, until they are field tested, it would be premature to suggest their use on a broad scale. The next SB 697 planning cycle will provide an opportunity to implement these formats on a limited basis and to evaluate their effectiveness in improving the reporting process. Ultimately, the goal in developing standardized formats will be to assist hospitals in meeting their statutory reporting requirements while, at the same time, providing a method of reporting benefit activities in a way that is useful to the communities for which they are intended.

Community Benefits and Priorities to Be Emphasized

SB 697 anticipated various types of community benefits that might be reported by hospitals, ranging from "healthcare services rendered to vulnerable populations" to "food, shelter, clothing, education, transportation, and other goods or services that help maintain a person's health." The community benefit plans submitted by hospitals included these and many benefit activities not anticipated by SB 697. While the bill asked OSHPD to develop recommendations regarding benefits and priorities that should be emphasized by hospitals, giving such specific recommendations might inhibit the approach that has worked best identifying local needs and priorities, i.e., a strong, community-based process empowered to develop plans that reflect local consensus. Instead, the recommendations below focus on elements of a local planning process that will identify benefits and priorities most appropriate to communities and will provide a tool for monitoring benefits over time.

1. *The board of trustees and senior management of the hospital should be responsible for overseeing the development and implementation of the community benefits plan including the resources to be allocated to the process and the mechanism for periodic evaluation.*

   In their governance and administrative roles, boards of trustees and senior management are responsible for providing leadership that is consistent with the mission of the hospital. This should include integrating community benefit planning and implementation into the hospital's organizational framework. The involvement of the hospital's leadership in the community benefit process ensures that the benefit activities that result reflect an ongoing organizational commitment by the hospital.

2. *Hospitals should include the broadest possible representation of communities in their needs assessment and community benefits planning processes.*

   Not surprisingly, the SB 697 planning process has created a great deal of renewed interest in the role of hospitals within their communities. That interest was clearly demonstrated by the wide range of community constituencies who participated in the first planning cycle. However, not every plan submitted to OSHPD reflected a truly broad-based representation of those in the community who might be interested or affected by the plan. Without such a representation, it is difficult to determine how important the benefits provided by the hospital are to the community for which they are intended. While data can provide important information to hospitals as they conduct their needs assessment, participation of community representatives is essential to the prioritization process and in formulating the appropriate responses for meeting those prioritized needs.

3. *Hospitals should plan collaboratively with other organizations and facilities in their community that share their mission, service area/population, and/or scope of services.*

   Often, unmet community needs are the result of numerous factors that cannot be addressed by any one organization within that community. In addition, hospitals' missions and services often overlap with other organizations within their service area. Consequently, it makes sense for hospitals to use the opportunity of community benefits planning to identify potential collaborations with other related service organizations. This is particularly true of local health departments whose countywide target population is certain to overlap with that of hospitals in the county. Local community-based, non-profit organizations (such as the United Way, the local Heart/ Lung Associations, local Cancer Societies, churches, and community clinics) can also share in meeting the needs of the hospital's community. As such, working with these and other organizations in the planning process can serve to coordinate and maximize the use of existing resources to identify and address the community's priorities.

4. *Benefits and priorities in community benefit plans should not be limited to those services, service areas, or target populations that have been historically served by the hospital.*

   The development of community benefit plans not only has served to educate local constituencies about how hospitals may benefit their communities but also has prompted hospitals to think about ways they can provide services and benefits outside their traditional scopes of services (i.e., acute medical care). Planning with new community partners has encouraged hospitals to expand their perceived missions and venture into benefit activities (e.g., public safety, the homeless, domestic violence prevention) targeted toward the broader "health" of communities beyond the patients and geographic areas they have traditionally served.. These departures demonstrate the willingness of hospitals to rethink their community role in response to input received from planning participants.

5. *Benefits and priorities in community benefit plans should reflect a prioritization process based on community input, available data, and anticipated impact on the target community.*

   In the first planning cycle, it was clear that there was a good deal of variation in hospitals' abilities to conduct community needs assessments and in the resources that they were able to devote to this activity. Not every community benefit plan clearly delineated how the results of needs assessments led to the benefit activities described in the plan. More importantly, the method or criteria by which identified needs were prioritized was not always apparent. In reviewing the plans submitted by hospitals, it

is critical to be able to understand why particular needs have been targeted for benefit activities and how the community has been involved in developing the criteria for prioritization. In some cases, it may not always be the most "pressing" need that the hospital chooses to target - which may reflect financial limitations of the hospital, the fact that others in the community are addressing the need, the practical limits on what is achievable within the community, or other equally legitimate reasons. These types of considerations should be articulated in the assessment and priority-setting process.

6. *Hospitals should, at a minimum, conduct one public meeting to present their community benefit plan to the public.*

Even the most representative planning process is unlikely to include every possible interested party or constituency. Time or other resource limitations may also preclude participation of those who might have meaningful input to provide. Once the plan is completed by the hospital, it is important to know whether the document has taken into account the concerns of those who have participated in the development of the plan and whether the plan makes sense in the context of the broader community beyond that identified in the plan. To that end, the "general public" should be given an opportunity to comment on the needs, priorities, and proposed benefit activities described in the hospital's plan. This is most easily achieved through a well-noticed public meeting, but can also be done in conjunction with other public forums that are routinely scheduled such as meetings of county boards of supervisors, city councils, local planning commissions, etc.

A public meeting, particularly one in conjunction with some other local government body, can provide an excellent opportunity to educate the community with respect to the role of its hospital and to coordinate hospital community benefits planning with other related activities at the local level. Additionally, it may serve as an opportunity for hospitals to highlight the importance of community benefit activities that may not be linked back to the needs assessment.

Future Benefits Planning and Reporting

In future years, hospitals will continue to be required to annually submit community benefit plans to OSHPD. It is reasonable to expect that those hospitals who experienced difficulties in the first planning cycle will improve in future cycles and that those hospitals that exemplified the intent of SB 697 will provide a standard to strive toward for their colleagues. It is the intent of OSHPD to continue working with representatives of hospitals, local governments, and communities to encourage flexibility and innovation in planning at the local level while at the same time developing guidelines that facilitate community benefit reporting process. Over the last year, a number of suggestions have been made by members of the public regarding statutory changes that

might improve the community benefit planning process. At this point, however, changing the statute would be premature, particularly given the evolving nature of the various local planning efforts. The following recommendations reflect input received by OSHPD from its advisory committee and from those who attended the public forums.

1. *Hospitals should establish a community benefit planning process which does not end with the development of a plan, but becomes an ongoing mechanism to monitor implementation and to make future revisions to the plan.*

   The completion and submission to OSHPD of a community benefit plan should not be seen as the end of a hospital's obligation to confer and consult with members of the community regarding needs, priorities, and benefit activities. The completion of the plan should, instead, be seen as a transition to the equally important implementation phase of the community benefit process. Not only should the community be advised and consulted regarding the progress toward meeting goals and objectives identified in the plan, but it should also be involved in evaluating the planning and implementation process and suggesting improvements to that process. SB 697 requires that plans be submitted by the hospital on an annual basis, so it seems reasonable that the hospital establish an ongoing structure for obtaining community feedback.

2. *Hospitals should work with OSHPD to establish consistent methodologies for the economic valuation of community benefits.*

   The first planning cycle yielded not only a diversity of community needs and benefits described by the hospitals, but also equally diverse methods for assigning an economic value to the benefits and benefit activities provided by hospitals. Some benefits identified, such as the "shortfalls" between the cost and reimbursement for government payer programs (e.g., Medi-Cal, Medicare), are more easily valued than programs or services provided collaboratively with other organizations for broad community benefit (e.g., community health screenings). However, to the extent that these and other similar benefits are provided by many hospitals, a method for assigning economic value to these benefits should be developed and used consistently by the hospitals reporting such benefits. SB 697 recognized that it would not be possible to financially quantify all benefits; however, it did require that hospitals, to the extent practicable, "report the economic value of community benefits provided in furtherance of its plan." To that end, OSHPD will continue working with the hospital industry to establish reasonable cost accounting methods for assigning value to community benefits.

3. *Hospitals should work with OSHPD to facilitate and streamline the collection and analysis of sub-county health data.*

   Many hospitals have experienced difficulty in identifying sources of demographic, health status, utilization, and other related data that conform to their service areas or communities. Many times local health departments can provide countywide data, but are unable (due to staff or other resource limitations) to disaggregate data in smaller geographic increments. The State, through a number of its departments including OSHPD, is also a repository of much of this data and can be a resource to hospitals in their community planning efforts. As part of future planning cycles, hospitals should work with OSHPD to identify core data sets that can be compiled at a sub-county level and made routinely available for needs assessments and benefits planning.

4. *Future community benefit plans should focus on measuring progress toward meeting community benefit goals and objectives.*

   While the process of developing a community benefit plan is an important first step, it is equally important that the resources devoted to the planning process not preclude the ability of hospitals to actually carry out the benefit activities that have been proposed. To that end, once hospitals have completed a plan, subsequent plans should focus on providing a progress report on what benefit activities have taken place, whether those activities have addressed the community's priority needs, and what the impact or outcome has been. In some cases, the needs or the priorities of the hospital's community may change from one year to the next. In those instances, plans should be appropriately revised. Future plans submitted to OSHPD while focusing on the status of implementation activities, should also include changes in proposed benefit activities that have resulted from the community's review of the hospital's progress toward meeting its needs.

5. *The statutory requirement that hospitals conduct a needs assessment every three years should be reviewed.*

   SB 697 requires that community needs assessments "be updated at least once every three years". The practicality and cost/benefit of this requirement will need to be reviewed in light of what progress hospitals are able to report in subsequent planning cycles. Some hospital representatives have expressed concern that a three-year cycle for needs assessment might be too frequent and not allow sufficient time for the implementation and evaluation of benefit activities. Consequently, devoting a hospital's and a community's limited resources to updating a needs assessment might not always be the best use of the community's time and effort.

   On the other hand, extending the interval between needs assessments might fail to capture emerging health status trends or other data reflecting the community's ability

to access services. Given the developmental nature of the SB 697 planning process, it is premature, at this time, to make a recommendation regarding the appropriate interval between needs assessments; however, discussion regarding the scope and frequency of needs assessments should continue. At this point, hospitals should follow the legislative requirements and continue to plan for a second needs assessment in 1998.

6. *Hospitals should work with OSHPD to identify areas in which technical assistance is needed to improve the local planning process and to identify resources available to support technical assistance services.*

   During the public forums conducted by OSHPD, it became clear that many hospitals struggled to comply with the requirements of SB 697. In addition to resource limitations, hospitals often did not have the technical expertise necessary to conduct needs assessments, particularly with regard to identifying data sources and collecting primary data. Some hospitals had difficulty interpreting the requirements of the statute and applying those requirements to their particular institutions. Individuals who attended the public forums also asked about the availability of technical assistance beyond that which OSHPD was able to provide on an ad hoc basis during the first planning cycle. Communities were also interested in learning about how others had approached and solved some of the difficulties they faced during the planning process.

7. *Other non-profit hospitals (i.e., district hospitals, county hospitals, UC hospitals, and rural hospitals) currently not required to develop community benefit plans should be encouraged to participate in the planning process with other hospitals or develop plans of their own.*

   All not-for-profit hospitals have an obligation to their communities and could benefit from a community-oriented approach to the assessment of needs and provision of benefits and services. Many hospitals, not required to develop a plan under SB 697, have already chosen to do so. In some cases, hospitals not required to develop benefit plans exist in the same communities and may even share patients with hospitals that are required to report. In those communities, it makes sense to involve all hospitals in the planning process either directly through the development and submission of a plan or indirectly through participation in the community planning process. In this way, communities can be assured that local resources are being directed in a coordinated fashion toward prioritized needs.

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APPENDICES

APPENDIX A

Text of SB 697

Appendix A
Text of Senate Bill No. 697
Chapter 812

- An act to add Part 1.98 (commencing with Section 449.10) to Division 1 of the Health and Safety Code, relating to health facilities.

[Approved by Governor September 25, 1994. Filed with Secretary of State September 27, 1994.]

LEGISLATIVE COUNSEL'S DIGEST

SB 697, Torres. Health facilities.

Existing law establishes the California Health Policy and Data Advisory Commission to, in part, advise the Office of Statewide Health Planning and Development and the Health and Welfare Agency relating to health policy and the collection of health data.

Existing law, the Voluntary Health Facility and Clinic Philanthropic Support Act, declares that philanthropic support of health facilities and clinics is a strength which must be preserved and enhanced under any reform measure for certain reasons, including, but not limited to, that philanthropy allows voluntary nonprofit institutions to conduct research and to engage in other innovative efforts to improve healthcare, and that philanthropy pays for necessary expenditures that otherwise would have to be paid by patients or by government. The act declares the intent of the Legislature to create an environment in which philanthropy and voluntarism in the healthcare field is encouraged, and excludes certain items constituting gifts or grants from treatment as revenue to health facilities or clinics for the purposes of certain reporting requirements.

This bill would require each hospital, as defined, to reaffirm its mission statement, as defined, that requires its policies to integrate and reflect the public interest by July 1, 1995.

This bill would require each hospital, by January 1, 1996, to complete a community needs assessment, as defined, and by April 1, 1996, adopt a community benefits plan, and to thereafter annually update the community benefits plan.

The bill would require each hospital to file a report on its community benefits plan and the activities undertaken to address community needs with the Statewide Office of Health Planning and Development. The bill would require the statewide office to make the plans available to the public and to file a report with the Legislature by October 1, 1997.

The people of the State of California do enact as follows:

SECTION 1. Part 1.98 (commencing with Section 449.10) is added to Division 1 of the Health and Safety Code, to read:

PART 1.98. HOSPITALS: COMMUNITY BENEFITS

449.10. The Legislature finds and declares all of the following:

(a) Private not-for-profit hospitals meet certain needs of their communities through the provision of essential healthcare and other services. Public recognition of their unique status has led to favorable tax treatment by the government. In exchange, nonprofit hospitals assume a social obligation to provide community benefits in the public interest.

(b) Hospitals and the environment in which they operate have undergone dramatic changes. The pace of change will accelerate in response to healthcare reform. In light of this, significant public benefit would be derived if private not-for-profit hospitals reviewed and reaffirmed periodically their commitment to assist in meeting their communities' healthcare needs by identifying and documenting benefits provided to the communities which they serve.

(c) California's private not-for-profit hospitals provide a wide range of benefits to their communities in addition to those reflected in the financial data reported to the state.

(d) Unreported community benefits that are often provided but not otherwise reported include, but are not limited to, all of the following:

(1) Community-oriented wellness and health promotion

(2) Prevention services, including, but not limited to, health screening, immunizations, school exams, and disease counseling and education.

(3) Adult day care.

(4) Child care.

(5) Medical research.

(6) Medical education.

(7) Nursing and other professional training.

(8) Home-delivered meals to the homebound.

(9) Sponsorship of free food, shelter, and clothing to the homeless.

(10) Outreach clinics in socioeconomically depressed areas.

(e) Direct provision of goods and services, as well as preventive programs, should be emphasized by hospitals in the development of community benefit plans.

449.15. As used in this part, the following terms have the following meanings:

(a) "Community benefits plan" means the written document prepared for annual submission to the Office of Statewide Health Planning and Development that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken in order to address identified community needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community.

(b) "Community" means the service areas or patient populations for which the hospital provides health care services.

(c) Solely for the planning and reporting purposes of this part, "community benefit" means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status, including, but not limited to, any of the following:

(1) Health care services, rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Childrens Services Program, or county indigent programs.

(2) The unreimbursed cost of services included in subdivision (d) of Section 449.10.

(3) Financial or in-kind support of public health programs.

(4) Donation of funds, property, or other resources that contribute to a community priority.

(5) Health care cost containment.

(6) Enhancement of access to health care or related services that contribute to a healthier community.

(7) Services offered without regard to financial return because they meet a community need in the service area of the hospital, and other services including health promotion, health education, prevention, and social services.

(8) Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person's health.

(d) "Community needs assessment" means the process by which the hospital identifies, for its primary service area as determined by the hospital, unmet community needs.

(e) "Community needs" means those requisites for improvement or maintenance of health status in the community.

(f) "Hospital" means a private not-for-profit acute hospital licensed under subdivision (a), (b), or (f) of Section 1250 and is owned by a corporation that has been determined to be exempt from taxation under the United States Internal Revenue Code. "Hospital" does not mean any of the following:

(1) Hospitals that are dedicated to serving children and that do not receive direct payment for services to any patient.

(2) Small and rural hospitals as defined in Section 1188.855.

(g) "Mission statement" means a hospital's primary objectives for operation as adopted by its governing body.

(g) "Mission statement" means a hospital's primary objectives for operation as adopted by its governing body.

(h) "Vulnerable populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Childrens Services Program, or county indigent programs.

449.20. Each hospital shall do all of the following:

(a) By July 1, 1995, reaffirm its mission statement that requires its policies integrate and reflect the public interest in meeting its responsibilities as a not-for-profit organization.

(b) By January 1, 1996, complete, either alone, in conjunction with other health care providers, or through other organizational arrangements, a community needs assessment evaluating the health needs of the community serviced by the hospital, that includes, but is not limited to, a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangement. The community needs assessment shall be updated at least once every three years.

(c) By April 1, 1996, and annually thereafter adopt and update a community benefits plan for providing community benefits either alone in conjunction with other health care providers, or through other organizational arrangements.

(d) Annually submit its community benefits plan, including, but not limited to, the activities that the hospital has undertaken in order to address community needs within its mission and financial capacity to the Office of Statewide Health Planning and Development. The hospital shall, to the extent practicable, assign and report the economic value of community benefits provided in furtherance of its plan. Effective with hospital fiscal years, beginning on or after January 1, 1996, each hospital shall file a copy of the plan with the office not later than 150 days after the hospital's fiscal year ends. The reports filed by the hospitals shall be made available to the public by the office. Hospitals under the common control of a single corporation or another entity may file a consolidated report.

449.25. The hospital shall include all of the following elements in its community benefits plan:

(a) Mechanisms to evaluate the plan's effectiveness including, but not limited to, a method for soliciting the views of the community served by the hospital and identification of community groups and local government officials consulted during the development of the plan.

(b) Measurable objectives to be achieved within specified timeframes.

(c) Community benefits categorized into the following framework:

(1) Medical care services.

(2) Other benefits for vulnerable populations.

(3) Other benefits for the broader community.

(4) Health research, education, and training programs.

(5) Nonquantifiable benefits.

449.30. Nothing in this part shall be construed to authorize or require specific formats for hospital needs assessments, community benefit plans, or reports until recommendations pursuant to Section 449.35 are considered and enacted by the Legislature.

Nothing in this part shall be used to justify the tax-exempt status of a hospital under state law. Nothing in this part shall preclude the office from requiring hospitals to directly report their charity activities.

449.35. The Office of Statewide Health Planning and Development shall prepare and submit a report to the Legislature by October 1, 1997, including all of the following:

(a) The identification of all hospitals that did not file plans on a timely basis.

(b) A statement regarding the most prevalent characteristics of plans in terms of identifying and emphasizing community needs.

(c) Recommendations for standardization of plan formats, and recommendations regarding community benefits and community priorities that should be emphasized. These recommendations shall be developed after consultation with representatives of the hospitals, local governments, and communities.

APPENDIX B

Listing of SB 697 Hospitals

Appendix B
Listing of SB 697 Hospitals

I. SB 697 hospitals required to submit a community benefit plan for the first reporting cycle (May 1997- February 1998) based on their not-for-profit status as of October 1, 1997.

II. Hospitals with changes in status after October 1, 1997 that must now comply with SB 697.

III. Hospitals with changes in status after October 1, 1997 that are now exempt from SB 697.

I. SB 697 hospitals required to submit a community benefit plan for the first reporting cycle (May 1997- February 1998) based on their not-for-profit status as of October 1, 1997.

Hospitals by County	Chief Executive Officer	Plan Coordinator
Alameda		
Alameda Hospital	William Dal Cielo	Tony Corica
Alta Bates Medical Center	Al L. Greene	Alex Wilcox
Children's Hospital Oakland	Tony Paap	Peggy Baxter
Kaiser Foundation Hospital - Hayward	John E. Mosher	Andrew Sun
Kaiser Foundation Hospital - Oakland	John E. Mosher	Andrew Sun
St. Rose Hospital	Michael J. Mahoney	Monica Guevara
Summit Medical Center	Irwin Hansen	Nancy Happell
Valley Memorial Hospital	Richard E. Herington	Pam Friedman
Butte		
Feather River Hospital*	George Pifer	K.C. Fowler
N.T. Enloe Memorial Hospital	Philip R. Wolfe	Judy Cooper
Oroville Hospital	Robert J. Wentz	Sandy Slavin
Contra Costa		
John Muir Medical Center	J. Kendall Anderson	Libby Craig
Kaiser Foundation Hospital - Walnut Creek	John E. Mosher	Andrew Sun
Kaiser Foundation Hospital - Martinez	John E. Mosher	Andrew Sun
Kaiser Foundation Hospital - Richmond	John E. Mosher	Andrew Sun
Mt. Diablo Medical Pavilion	Elizabeth Stallings	Virginia Newell
Sutter Delta Memorial Hospital	Sharon Holmes-Johnson	Michael Blee
Fresno		
Clovis Community Hospital*		Mike Fleming
Fresno Community Hospital and Medical Center*	Terrence A. Curley	Patty Grays
Kaiser Foundation Hospital - Fresno	John E. Mosher	Andrew Sun
St. Agnes Medical Center	Sr. Ruth Marie-Nickerson	Bonnie Montivecci
Valley Children's Hospital and Guidance Clinic	Rex Riley	Melissa Goliti

Hospitals by County	Chief Executive Officer	Plan Coordinator
Humboldt		
St. Joseph Hospital - Eureka*	Paul Chodkowski	Catherine Krause
Kern		
Bakersfield Memorial Hospital*	C. Larry Carr	Tim Langeliers
Delano Regional Medical Center	Bryan Ballard	Christine Beyer
Memorial Center*	Deirdre Terleski	Bruce Hartsell
Mercy Healthcare - Bakersfield*	Bernard J. Herman	Debbie Hull
San Joaquin Community Hospital	Kenneth Gibb	Ruthie Montgomery
Los Angeles		
Barlow Hospital	Margaret W. Crane	Margaret W. Crane
Bay Harbor Hospital	Jack Weiblen	Kim Roberts
Beverly Hospital	Matthew S. Gerlach	Cathy Kitsman
California Hospital Medical Center	Melinda Beswick	Erelyn Navarro
Casa Colina Hospital for Rehabilitative Medicine	Judy Cummings	Judy Cummings
Cedars-Sinai Medical Center	Thomas M. Priselac	Allysunn Williams
Children's Hospital of Los Angeles	Walter W. Noce	Ellen Zaman
Citrus Valley Health Partners - Intercommunity *	Pete Makowski	Marcia Jackson
Citrus Valley Health Partners - Queen of the Valley*	Pete Makowski	Marcia Jackson
City of Hope National Medical Center	Charales M. Balch	Annette Mercurio
Daniel Freeman Marina Hospital	Joseph W. Dunn	Tara Westman
Daniel Freeman Memorial Hospital	J Duun,S Hargett	Tara Westman
Downey Community Hospital	Don Miller	Allen Korneff
Foothill Presbyterian Hospital	Larry Fetters	Miki Carpenter
Gateways Hospital and Mental Health Center	Saul Goldfarb	Saul Goldfarb
Glendale Adventist Medical Center-Wilson Terrace*	Robert Carmen	Bruce Nelson
Glendale Memorial Hospital and Health Center	Roger Seaver	Mike Clark
Granada Hills Community Hospital	Dennis Coleman	Dennis Coleman
Henry Mayo Newhall Memorial Hospital	David R. Tumilty	Lisa Foust
Holy Cross Medical Center	Michael Madden	Sheryl Rudie
Huntington East Valley Hospital	Brad Schultz	Sylvia Garcia-Novakoff
Huntington Memorial Hospital	Steven A. Ralph	Toni Cooke
Kaiser Foundation Hospital - Bellflower	James A. Vohs	Andrew Sun
Kaiser Foundation Hospital - Harbor City	James A. Vohs	Andrew Sun
Kaiser Foundation Hospital - Los Angeles	James A. Vohs	Andrew Sun
Kaiser Foundation Hospital - Panorama City	James A. Vohs	Andrew Sun
Kaiser Foundation Hospital - West Los Angeles	James A. Vohs	Andrew Sun
Kaiser Foundation Hospital - Woodland Hills	James A. Vohs	Andrew Sun
Kedren Community Mental Health Center	Gloria A. Nabrit	Author Dansby
Kenneth Norris Jr. Cancer Hospital	G. Peter Shostak	Peter Shostak
Little Company of Mary Hospital*	Peggy Christ	Blair Contratto
Long Beach Community Hospital	Janet Parodi	Annette Kashiwabara
Long Beach Memorial Medical Center	Fran Hanckel	Karie Lapetina
Methodist Hospital of Southern California	Dennis M. Lee	Elaine Van Deventer
Mission Community Hospital - San Fernando	Cathy Fickes	Heidi Lenards
Motion Picture & Television Hospital	William F. Haug	Carol Pfannkuche

Hospitals by County	Chief Executive Officer	Plan Coordinator
Los Angeles (continued)		
Northridge Hospital Medical Center	Jeffrey Flocken	David Burkhardt
Orthopaedic Hospital	James V. Luck Jr,	Anora Tracy
Pacific Hospital of Long Beach	Gerald Goldberg	Virginia Carson
Pomona Valley Hospital Medical Center	Richard Yochum	Judy Wilson
Presbyterian Intercommunity Hospital	Daniel Adams	Judy McAlister
Providence Saint Joseph Medical Center	Micheal J. Madden	Ronald Sorenson
Queen of Angels-Hollywood Presbyterian Med. Ctr.	Sy Graff	Robert Steward
Robert F. Kennedy Medical Center	Patricia E. Cunningham	Sr. Elizabeth Parham
San Gabriel Valley Medical Center	Makoto Nakayama	Makota Nakayama
San Pedro Peninsula Hospital*	John Wilson	Blair Contratto
Santa Marta Hospital	Wilfred Mallari	Arturo Franz
Santa Monica Hospital Medical Center	William Parente	Ted Braun
Santa Teresita Hospital	Michael J. Costello	Kathy Swindle
Sherman Oaks Hospital & Health Center	David Levinsohn	Mary Pratt
St. Francis Medical Center	Sister Margaret Keaveny	Angel Obregon
St. John's Hospital and Health Center	Sister Marie Madeleine Shonka	Lindi Funston
St. Mary Medical Center	Tammie Brailsford	Kathy Bullock
St. Vincent Medical Center	Vincent F. Guinan	Victor Hercules
Tarzana Treatment Center	Scott Taylor	Albert Senella
The Hospital of the Good Samaritan	Mirion Bowers	Trevor Law
Torrance Memorial Medical Center	George Graham	Kathryn Joiner
Valley Presbyterian Hospital	Robert Bills	Laurie Moore
Verdugo Hills Hospital	Bernard Glossy	Jacqueline Forsythe
White Memorial Medical Center*	Beth Zachary	Beth D. Zachary
Madera		
Madera Community Hospital	Robert C Kelley	Chris Watts
Marin		
Kaiser Foundation Hospital - San Rafael	John E. Mosher	Andrew Sun
Marin General Hospital	Henry J. Buhrmann	Sandra Boschen
Novato Community Hospital	Lowell Smith	Lowell Smith
Merced		
Mercy Hospital & Health Services*	Kelly Morgan	Peggy Joseph Potter
Monterey		
Community Hospital of the Monterey Peninsula*	Jay Hudson	Cynthia Peck
Community Hospital Recovery Center*	Jay Hudson	Cynthia Peck
Napa		
Queen of the Valley Hospital	Howard Levant	Pat Parker
St. Helena Hospital & Health Center*	Edward Mcdonald	Elaine John
Orange		
Anaheim Memorial Hospital	Christopher Van Gorder	Laura Parris

Hospitals by County	Chief Executive Officer	Plan Coordinator
Orange (continued)		
Children's Hospital at Mission	Kimberly Cripe	Debra Shaw
Children's Hospital of Orange County	Kimberly Cripe	Debra Shaw
Hoag Memorial Hospital Presbyterian	Michael D. Stevens	Mary Kay Payne
Kaiser Foundation Hospital- Anaheim	James A. Vohs	Andrew Sun
La Palma Intercommunity Hospital	Steve Dixon	Jack Ivie
Martin Luther Hospital Medical Center	Don Fleege	Nancy Goetsch
Mission Hospital Regional Medical Center	Peter Bastone	Becky Barney-Villano
Saddleback Memorial Medical Center	Nolan Draney	Jenise Reider
South Coast Medical Center	T. Michael Murray	Joe Orsak
St. Joseph Hospital - Orange	Larry K. Ainsworth	Judith Salgado
St. Jude Medical Center	Robert Fraschetti	Sr. Jayne Helmlinger
Western Medical Center - Anaheim	Richard Butler	
Western Medical Center - Santa Ana	Richard Butler	
Placer		
Sutter Auburn Faith Hospital*	Joel Grey	Kimberly Pittman-Schulz
Sutter Roseville Medical Center*	Joel Grey	Ruth Burgess
Riverside		
Corona Regional Medical Center	Marlene Woodworth	Marlene Woodwort
Desert Hospital	Robert Minkin	Kelly Green
Eisenhower Medical Center	Andrew Deems	Andrew W. Deems
Kaiser Foundation Hospital - Riverside	James A. Vohs	Andrew Sun
Parkview Community Hospital	Norm Martin	Norman Vance
Sacramento		
Kaiser Foundation Hospital - South Sacramento*	John E. Mosher	Andrew Sun
Kaiser Foundation Hospital - Sacramento*	John E. Mosher	Andrew Sun
Mercy American River Hospital*	Mike Uboldi	Mike Uboldi
Mercy General Hospital*	Tom Petersen	Tom Petersen
Mercy San Juan Hospital*	Mike Uboldi	Mike Uboldi
Methodist Hospital of Sacramento*	Stan Oppegard	Stan Oppegard
Sutter Center for Psychiatry*	Shahab Dadjou	Lee Boylan
Sutter General Hospital*	Doreen Hartmann	Lee Boylan
Sutter Memorial Hospital*	Doreen Hartmann	Marty Thomas
San Bernardino		
Community Hospital of San Bernardino	Bruce G. Satzger	M. Kimiko Ford
Kaiser Foundation Hospital - Fontana	James A. Vohs	Andrew Sun
Loma Linda University Behavioral Medicine Center*	Nolan Kerr	Ron Graybill
Loma Linda University Medical Center*	J. David Moorhead	Ron Graybill
Redlands Community Hospital	James Holmes	Marcia Williams
San Antonio Community Hospital	George Kuykendall	Monterey Bravinder
St. Bernardine Medical Center	Greg Adams	Sister Edith Judge

Hospitals by County	Chief Executive Officer	Plan Coordinator
San Diego		
Children's Hospital - San Diego	Blair Sadler	Barbara Ryan
Grossmont Hospital	Michele Tarbet	Jackie Hill
Green Hospital of Scripps Clinic*	Glenn Chong	Michael Bardin
Kaiser Foundation Hospital - San Diego*	James A. Vohs	Andrew Sun
Mercy Hospital and Medical Center, San Diego*	Bob Cooley	Sister Mary Jo Anderson
Mesa Vista Hospital	Donald K. Allen	Donald Allen
Scripps Hospital East County*	Robin Brown	Ann McGloughlin
Scripps Memorial Hospital - Chula Vista*	Tom Gammiere	Michael Bardin
Scripps Memorial Hospital - Encinitas*	Gerald Bracht	Peat Hasbrouck
Scripps Memorial Hospital - La Jolla*	Glen Chong	Nancy Lakier
Sharp Cabrillo Hospital	Dan Gross	Jackie Hill
Sharp Chula Vista Medical Center	Britt Berrett	Jackie Hill
Sharp Coronado Hospital & Healthcare Center	Marcia Hall	Harriet Shangrey
Sharp Memorial Hospital	Dan Gross	Jackie Hill
Villa View Community Hospital	Ruth Bolz	Peter Mabrey
Vista Hill Hospital		
San Francisco		
California Pacific Medical Center	Dr. Martin Brotman	Sarah Kelly
Chinese Hospital	Thomas M. Harlan	Thomas Harlan
Davies Medical Center	Greg Monardo	Mellisa Ridlon
Hebrew Home for the Aged Disabled	Jerry A. Levine	Sherrie Koshover
Kaiser Foundation Hospital - San Francisco*	John E. Mosher	Andrew Sun
Pacific Coast Hospital	Leonard Levy	Lisa Lewis
St. Francis Memorial Hospital	John G. Williams	Cheryl Fama
St. Luke's Hospital	Jack Fries	Duane Oshinomi
St. Mary's Medical Center	Mary Connick	L. Wade Rose
San Joaquin		
Dameron Hospital	Luis Aarismendi	Wanda Thayne
Lodi Memorial Hospital	J. Harrington	Carol Farron
St. Dominic's Hospital*	Richard Aldred	John Walton
St. Joseph's Behavioral Health Center*	James Sondecker	John Walton
St. Joseph's Medical Center of Stockton*	Lawrence A. Philipp	John Walton
Sutter Tracy Community Hospital*	L. Meyer	Gina Oltman
San Luis Obispo		
Arroyo Grande Community Hospital	Richard N. Woolslayer	Claryce Knupper
San Mateo		
Kaiser Foundation Hospital - Redwood City	John E. Mosher	Andrew Sun
Kaiser Foundation Hospital - South San Francisco	John E. Mosher	Andrew Sun
Mills Memorial Hospital*	Robert W. Merwin	Adel Dixon
Peninsula Hospital and Medical Center*	Robert W. Merwin	Adel Dixon
Seton Medical Center	John Williams	Judy Macias

Hospitals by County	Chief Executive Officer	Plan Coordinator
Santa Barbara		
Goleta Valley Community Hospital	David C. Bigelow	Diane Wisby
Marian Medical Center	Charles Cova	Sister Janet Corcoran
Rehabilitation Institute at Santa Barbara	Ralph Pollock	Rusty Pollock
Santa Barbara Cottage Care Center*	James Ash	Gary Wilde
Santa Barbara Cottage Hospital*	James Ash	Gary Wilde
St. Francis Medical Center of Santa Barbara	Ron Biscaro	Melinda Chayra
Santa Clara		
Alexian Brothers Hospital	Steven Barron	Leslie Kelsay
El Camino Healthcare System	Gerald Shefren	Gina Sutherst
Kaiser Foundation Hospital - Santa Clara	John E. Mosher	Andrew Sun
Kaiser Foundation Hospital - Santa Teresa	John E. Mosher	Andrew Sun
Lucile Salter Packard Children's Hospital at Stanford	Lorraine Zippiroli	Sherri Sager
O'Connor Hospital*	William Finlayson	Cary Fox
St. Louise Health Center*	William Finlayson	Shelia Yuter
Stanford University Hospital	Peter Van Etten	Rebecca Partridge
Santa Cruz		
Dominican Santa Cruz Hospital - Soquel	Sr. Julie Hyer	Carol Adams
Watsonville Community Hospital	John Freil	Vicki Carlisle
Shasta		
Mercy Medical Center, Redding*	George Govier	Michael Borelli
Solano		
Kaiser Foundation Hospital - Vallejo	John E. Mosher	Andrew Sun
North Bay Medical Center*	Deborah Sugiyama	Sarah Jewel
Sutter Solano Medical Center	Patrick Brady	Alan Fritzshall
Vaca Valley Hospital*	Deborah Sugiyama	Sarah Jewel
Sonoma		
Kaiser Foundation Hospital - Santa Rosa*	John E. Mosher	Andrew Sun
Santa Rosa Memorial Hospital	Robert Fish	Sister Michaela Rock
Stanislaus		
Emanuel Medical Center	Robert Moen	David Jones
Memorial Hospital Modesto	David P. Benn	Steve Mitchell
Sutter		
Fremont Hospital*	Thomas P. Hayes	Deborah Coulter
Ventura		
Community Memorial Hospital - San Buenaventura	Michael D. Bakst	Michael Laurie
Santa Paula Memorial Hospital	Willam Greene	Laya Murphy
Simi Valley Hospital & Health Care Services*	Alan Rice	Alan Rice
St. John's Pleasant Valley Hospital*	Daniel Herlinger	Charles Padilla

Hospitals by County	Chief Executive Officer	Plan Coordinator
Ventura (continued)		
St. John's Regional Medical Center*	Daniel Herlinger	Rita Schumacher
Yolo		
Sutter Davis Hospital	Larry Maas	Lee Boylan
Woodland Memorial Hospital	Scott Ideson	Gary Sandy
Yuba		
Rideout Memorial Hospital*	Thomas P. Hayes	Deborah Coulter

* Submitted a plan in collaboration with a related hospital.

II. Hospitals with changes in status after October 1, 1997 that must now comply with SB 697.

1. Orange Coast Medical Center, Orange County
2. French Hospital, San Luis Obispo County
3. Sequoia Hospital, San Mateo County
4. Community Hospital of Sonoma, Sonoma County

III. Hospitals with changes in status after October 1, 1997 that are now exempt from SB 697.

1. Western Medical Center – Anaheim in Orange County converted to investor-owned status.
2. Western Medical Center – Santa Ana in Orange County converted to investor-owned status.
3. Desert Hospital in Riverside County converted to investor-owned status.
4. Vista Hill Hospital in San Diego County closed.
5. Santa Monica – UCLA Medical Center is owned by the Regents of California and therefore exempt from SB 697. (Change in status occurred prior to October 1, 1997, but was not reported to OSHPD for SB 697 until after that date.)

APPENDIX C

Recommended Outline for Annual Community Benefit Reports

Appendix C
Recommended Outline for Annual Community Benefit Reports

SB 697 requires that OSHPD make recommendations for standardizing the community benefits report filed by not-for-profit hospitals. In approaching the question of standardization, there are two issues: first, the content or the types of information to be included in the report; and second, the format or the structure in which that information is displayed. Below is an outline of what a standard community benefits report should contain consistent with the reporting provisions of the statute. A format for reporting the information is currently under development and will be field tested in cooperation with hospitals.

1. General Identifying Information

General identifying information about the hospital should be presented: its name and location, the chief executive officer and board chair, and the hospital staff person(s) to contact for the community benefit report.

2. Organizational Structure

This section should provide a brief description of the hospital's governance and administrative structure and describe how the board of directors and medical staff participate in community benefit planning, implementation, and evaluation activities.

3. Mission Statement

The hospital should provide its most recent mission statement and the date it was adopted. If the mission statement has changed since the previous report, this section should include a description of the changes. If available, any values or visions statements should also be included. In addition, the hospital should delineate how the mission statement relates to the community benefits reported.

4. Community Needs Assessment

Information regarding the community needs assessment process should include at least the following elements:

Community: An identification of the community(ies) served by the hospital which may include geographic location, demographic characteristics, health status, health resources, healthcare utilization data, and any other relevant descriptive information.

Assessment Process: A listing of the community participants and a description of how (structure and process) the hospital and its community partners have conducted the community needs assessment. Data sources should be cited, and methods used to collect data (primary/secondary) should be described including any data gaps, difficulties in obtaining needed data, and areas where technical assistance would be useful.

Priority Needs: A prioritized list of the community needs identified and a description of the criteria and methods used to establish priorities.

5. Progress Report

In this section, the hospital should summarize the activities and accomplishments that have taken place since the submission of the previous community benefit report emphasizing the objectives and milestones that have been achieved for those community benefits that were planned in the previous report. The hospital should also indicate if the previously proposed community benefit activities should be amended and, if so, should include the amended benefits in the Community Benefit Plan section of the report.

6. Community Benefit Plan

This section should include a listing of community benefits or benefit activities planned by the hospital. For each community benefit planned, the following items should be included:

- A description of the benefit or benefit activity.
- The need to be addressed and target/affected population for the benefit.
- The goal(s) to be accomplished.
- Measurable objectives or interim milestones to be achieved with target dates.
- A description of the process for monitoring and evaluating progress.
- Identification of community partners (individuals and/or organizations) who will be working with the hospital to provide the community benefit.

7. Inventory and Economic Valuation of All Community Benefits

Community benefits that the hospital has provided during the reporting period and community benefits that the hospital plans to provide (as listed in 5, above) should be listed according to the following categories:

Medical Care Services	Includes, but is not limited to, charity care, uncompensated care, Medi-Cal/Medicare shortfalls, county shortfalls, prenatal care, dental care, immunizations, and other direct medical/clinical services.
Other Benefits for Vulnerable Populations	Includes, but is not limited to, counseling/support groups, violence prevention, services to the homeless, transportation, child/adult day care, donations of food, school mentoring programs, and other non-medical services provided to populations with special needs.
Other Benefits for the Broader Community	Includes, but is not limited to, community health screenings, community health education, health fairs, information and referral services, and other non-medical services of a communitywide nature.
Health Research, Education, and Training	Includes, but is not limited to, graduate medical education, training programs for other healthcare personnel, continuing medical education, contributions to research, and other activities generally associated with academic medicine.
Other Quantifiable Benefits	Includes any quantifiable benefits not listed in the previous categories.
Nonquantifiable Benefits	Includes all benefits, not reported in the above categories, that cannot be quantified in terms of goals, objectives, or economic valuation.

For each quantifiable benefit, the hospital should provide an economic valuation which identifies the unreimbursed cost to the hospital of providing the benefit and the method for calculating that cost. For benefits such as charity care, Medi-Cal/Medicare shortfalls, and county program shortfalls, it is recommended that hospitals use the data routinely reported to OSHPD in the "Hospital Disclosure Report" -- applying a cost-to-charge ratio for calculating unreimbursed cost.

8. Public Review

This section should describe the process for sharing the community benefit plan and report (draft and final versions) with the planning participants and the general public summarizing the comments, suggestions, and issues raised. In this section, a description of how the hospital proposes to distribute copies of the final report to the public should also be provided.

APPENDIX D

Advisory Group Members

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Advisory Group Members

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