# Community Benefits: The Need for Action, an Opportunity for Healthcare Change

**A Workbook for Grassroots Leaders and Community Organizations**

**the access project**

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The Access Project is a national initiative of The Robert Wood Johnson Foundation, in part-
nership with Brandeis University's Heller Graduate School and the Collaborative for Com-
munity Health Development. It began its efforts in early 1998. The mission of The Access
Project is to improve the health of our nation by assisting local communities in developing
and sustaining efforts that improve healthcare access and promote universal coverage with a
focus on people who are without insurance.

If you have any additional questions, or would like to learn more about our work, please con-
tact us.

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## SECTION I: Community Benefits Policy Issues and Concerns <span style="float:right">1</span>

**Section I** both explains basic issues and provides technical information for the experi-
enced health advocate. It is designed to assist an individual or a group of people to
explore and refine the concept of community benefits.

## SECTION II: Organizing for Community Benefits <span style="float:right">33</span>

**Section II** provides insight into the basics of organizing including: why organizing is
important, how to build a campaign or coalition, who to contact, and strategies for
building and sustaining interest. More experienced organizers may find the adaptable
organizing tools useful.

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**The Access Project**

# Preface

This resource guide has been produced by The Access Project, which is assisting communities to develop and sustain resources to address health access problems. With the failure of national health reform, responsibility to improve access to health care has shifted not only to states, but also to local communities. Across the country, communities are responding to the challenge of providing healthcare access to increasing numbers of people who have inadequate insurance.

At the same time, the increasing pace of change and ongoing competitive pressures in the health sector are influencing institutional policies governing what hospitals and health plans are willing and able to give to their communities. Maintaining resources for essential community services and community benefits, including free care for the uninsured, is a growing concern. As a result, more community coalitions and community-based organizations are initiating efforts designed to protect health services and expand community benefits.

With this in mind, and a strong belief that healthcare institutions must work in collaboration with their communities to meet community-identified health needs and concerns, The Access Project has placed a priority on providing coalitions, and other community-based organizations, relevant, timely, and comprehensive information. Our goal is to assist their community benefits resource and service expansion efforts.

Our decision to assist in the dissemination of materials on community benefits was facilitated by the expertise of two committed partners of The Access Project, Community Catalyst and Health Care For All. The experience and knowledge of these two organizations in this arena are well known among healthcare activists around the country. It seemed like a perfect marriage of our resources and their expertise to work together on creating this manual.

**Community Catalyst** is a national nonprofit advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality, affordable health care for all. It provides organizations with assistance in policy analysis, community organizing, and resource development to help expand consumer influence on healthcare decisionmaking. Among other initiatives, Community Catalyst works with state and local groups and policymakers across the country to expand community benefits resources and to protect community service and financial assets at

risk in health acquisitions and mergers, conversions, bankruptcies, and closures. It carries out its activities in close collaboration with a wide range of other groups, including its organizational partner in Massachusetts, Health Care For All, and The Access Project.

**Health Care For All (HCFA),** founded in 1985, is a nonprofit organization committed to building a movement of empowered people and communities with the goal of creating a healthcare system that is responsive to the needs of all people, particularly the most vulnerable. Its organizational strategy combines public education, personal and legal advocacy, community organizing, and policy analysis. Health Care For All unites diverse groups of people around critical healthcare issues including children's health coverage and outreach, nongroup insurance reform, cultural competency, free-care and community benefits, and hospital mergers and conversions. It is dedicated to making quality health care a right of all people.

We are fortunate to have the know-how of these two organizations available to us so we could create what we hope will be a useful and informative resource for all community leaders involved in the effort to provide health care to the uninsured as well as the underinsured.

# Acknowledgments

The authors wish to thank all of the community groups that allowed their work to be cited in this manual. The community benefits organizing examples and the tools that these groups have developed and that we cite in the manual are excellent training pieces, whether you are new to community benefits or have had some organizing experience in this field.

Specifically, we would like to thank:

> Boston Health Access Project
>
> Brockton Interfaith Community (Massachusetts)
>
> Building Parent Power (Hartford, Connecticut)
>
> Cambridge Health Alliance (Massachusetts)
>
> Central Massachusetts Community Health Coalition
>
> Health Law Advocates (Massachusetts)
>
> Idaho Citizen's Network
>
> Illinois Campaign for Better Health Care
>
> Local 1199, Northwest, SEIU (King County, Washington)
>
> Lynn Health Task Force (Massachusetts)
>
> Maine Consumers for Affordable Health Care
>
> Maine People's Alliance
>
> Neponset Valley Community Health Coalition (Massachusetts)
>
> New Hampshire Minority Health Coalition
>
> The Northwest Federation of Community Organizations (Washington)
>
> Oregon Health Action Campaign
>
> Pajaro Valley Coalition to Save Community Health Care (California)
>
> Universal Health Care Action Network–Ohio
>
> Washington Citizen Action

Specific information on how to contact these groups is found on pages 123–124.

## ACKNOWLEDGMENTS

**INTRODUCTION**

# Community Benefits—
# The Need for Action, An Opportunity
# for Healthcare Change

## THE NEED FOR ACTION, THE OPPORTUNITY FOR HEALTHCARE CHANGE

Today, changes in the healthcare system threaten what is already insufficient and unstable access for those most at risk in our communities. But the changes also present community leaders with exciting opportunities to advance and protect community interests. The upheaval happening in many local health delivery systems is educating regulators and lawmakers about the dangers of unchecked health system change. Community leaders are facing great potential losses, but at the same time, decisionmakers are more aware of what is at stake. In other words, the environment is ripe for change.

All across the country, from New Hampshire to California, community groups have created various opportunities to improve community benefits and community-institution relationships. For example, community groups have raised the issue of community benefits in the context of nonprofit institution conversions or institutional mergers. Others have built a base of community support and taken action to respond to a pressing health need. Still other local groups have participated in joint efforts with institutions to improve and strengthen their community benefits programs. Community power, roles, and tactics were different in all of these instances. But the common factor is that these communities have worked to become partners with institutional decisionmakers in choosing priorities, designing programs, and allocating health resources.

## Change and Challenge for Communities

Over the past few years the healthcare system in this country has undergone many dramatic changes, including:

- the spread of managed care
- mergers and consolidations in the hospital and HMO industries
- an increase in the number of for-profit hospitals and health plans
- the sale or privatization of public hospitals

These changes have affected healthcare institutions in several ways. For example, managed care and for-profit companies are pumping up competition and the fight for market share in many local communities. The results can be downsizing, the closing of facilities, and changes in the types of services that institutions provide. In turn, competition itself is causing a wave of mergers and consolidations among healthcare companies. The mergers often span state lines—one cause of consolidation is the trend among large national companies to acquire small local ones. As a result, local institutions can be managed from a distant state or by newcomers, creating the potential that important local circumstances may be left out of health planning and the allocation of resources. Considering all these factors, one overarching theme is that many health institutions have become more isolated from the communities they serve, whether it is through distance or through the need to focus more on the bottom line. In the end, many institutions have become less willing to serve community interests, particularly the needs of the underserved.

In the aftermath of industry restructuring, grassroots leaders, particularly those from the underserved segments of our communities, are facing new challenges to health access and quality. For the uninsured, the disabled, people of color, and others who already face significant barriers to good health status, these challenges can be overwhelming. At-risk populations get health care through a last-resort patchwork of essential community services such as free care, local health clinics, health screenings, and health education campaigns. These are the same services, often called "community benefits," that can get lost in the restructuring shuffle.

## Community Benefits: An Evolving Concept

Despite the critical nature of community benefits, there is no federal law or mandate that requires all health institutions to provide for community health needs. To date, decisionmakers in most states have not put specific requirements in the law.[1] Instead, they have assumed that nonprofits, primarily nonprofit hospitals, will fulfill their legal charitable obligations in a way that will automatically address community health needs. But while nonprofit community obligations exist in the law, there are no standards for institutional behavior. Basically, nonprofits (again primarily hospitals) decide

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1. See the Resource Materials Section of this publication for a list of the 14 community benefit laws, regulations, and guidelines.

on their own how much money to dedicate and what benefits to provide. Some institutions provide a lot while others provide very little. As it stands, whether the 44 million uninsured people get health care unfortunately depends on the particular institutions that serve their community.

Relying on the voluntary efforts of nonprofit hospitals for essential community services is not a great "system" to begin with. And the situation could get worse as the behavior of nonprofit hospitals is affected by changes in the industry. For-profits, HMOs, and other types of institutions often possess tremendous power and financial resources that cause changes to the incentives and dynamics in local health systems. Although the power dynamics are shifting, community benefits continue to be viewed as the somewhat exclusive responsibility of nonprofit hospitals. As the health system evolves, the concept of community benefits must evolve with it. Perhaps legislatures and regulators should clarify the requirements for nonprofits and design community benefits processes to include many other types of healthcare institutions. Most importantly, communities and institutions should work together to improve communication, giving the community at large some role in the changing landscape.

## Community Benefits: Are We Focusing on the Right Issues?

Community benefits *are* critical for many. But, it is important to recognize that even the best community benefits efforts won't resolve all of the health needs in our communities.  In fact, many may argue that community benefits are a limited approach to problems in the health system. People may believe that the real issue community leaders should focus on is getting universal insurance coverage through national health reform. But building support for such an abstract and complex goal can be a difficult way to engage new people and organizations in healthcare advocacy.

From an organizer's perspective, community benefits campaigns are an effective means to orient and energize new people and organizations around healthcare issues. Health care and its financing are complex—and the problems and solutions are not always obvious. Engaging people on local and immediate health issues will do two things for your community. First, it will get people working toward real solutions to pressing health needs and provide the impetus for local change. Second, it will serve to demystify the health system, giving people the knowledge and confidence to seek widespread reform.

Additionally, having an insurance card in hand does not always translate into real access and better health status. For example, even though they are insured, Medicaid beneficiaries continue to be at great risk of poor health status.[2] Part of the reason may lie in barriers such as:

- complex enrollment procedures
- discriminatory treatment
- lack of interpreters

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2. See Margo L. Rosenbach et al., "Access for Low-Income Children: Is Health Insurance Enough?" *Pediatrics* 103 (June 1999): 1167 .

- inadequate transportation

- providers who will not take Medicaid patients

- cultural differences between patients and providers

- education and access to information

So, national health reform or universal coverage is only part of the solution to existing health needs.

## Advancing Community Interests

Though not a panacea for all community health woes, improving community benefits can establish important building blocks to create healthier individuals and communities. When people hear the term "community benefits," they probably think of health services for traditionally disenfranchised populations. But the concept transcends the service component; ideally, it also means strengthening strained or disconnected institution-community relations. It means strong communities engaging in collaborative problem solving with institutions on both short-term goals (e.g., better free-care policies and removing existing barriers like those listed above) and long-term goals (e.g., systemic health reform). Of course, this is the ideal. But communities that engage in community benefits campaigns are likely to see health institutions in their areas become more familiar with the needs of vulnerable populations as well as more open to community participation. Both this familiarity and openness are necessary ingredients to ensure that any reform actually translates into greater access and better quality health care.

## Getting Institutional Accountability

The general theme throughout this workbook is on improving the community responsiveness of healthcare institutions, whether hospital or health plan, nonprofit or for-profit. Another important focus is ensuring that vital health care resources are not lost or whittled away as health care continues to change. A third theme is encouraging and stressing the importance of community involvement, particularly of traditionally disenfranchised populations, in any community benefits planning process.

This manual is intended to help community leaders foster discussion and take action around the following questions:

- What are appropriate community benefits for my community and neighborhood?

- Which institutions should be responsible for providing resources for community benefits programs?

- How should community benefits programs be designed and who should be involved?

- What organizing opportunities exist in our local health system to raise this important issue?

- What are the ways we can create opportunities if none exist?

- How can healthcare institutions be held accountable over the long term?

- Who are our potential allies?

- Where do we go from here?

For each community, the answers to these questions may be slightly different. This manual is designed to encourage community-determined goals and strategies.

**SECTION I**

# Community Benefits Policy Issues and Concerns

**IN THIS SECTION**

This section provides both an introduction to basic community benefits concepts as well as more technical information to assist the experienced health advocate. This section also contains a number of group exercises intended for use in community benefits trainings.

## **A.** Defining Community Benefits

In any community benefits effort, an important step for your group is to reach a common understanding of the term community benefits. At a minimum, community benefits are something that a healthcare institution provides to the community above and beyond what it ought to provide as a normal part of quality care.

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**A more complete definition of community benefits might be:**

The **unreimbursed goods, services, and resources** provided by **healthcare institutions** that address **community-identified health needs and concerns,** particularly those of people who are traditionally uninsured and underserved.

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The bold terms deserve special attention.

**1. Unreimbursed goods, services, and resources:** Community benefits are community-critical goods, programs, and resources an institution provides the public *without* expecting or receiving payment in return.

**2. Healthcare institutions:** While most commonly associated with hospitals, community benefits may be provided by *all* healthcare institutions that serve your community. In developing a community benefits strategy, your community may consider all of the institutions that currently provide health care (e.g., HMOs, nursing homes).

**3. Community-identified health needs and concerns:** An essential element of an effective community benefits program is defining the community that will be served. The traditional way to define community is as a geographical area, but community can also be defined in a number of other ways. An institution with specialty services or populations might define its community in a manner consistent with its areas of expertise such as women, children, a particular ethnic group, or persons with diabetes or AIDS. The target community could differ from the institution's traditional service area.

**4. Particularly [the needs] of people who are traditionally uninsured and underserved:** Above all, effective community benefits programs must be focused on health needs and priorities developed through a process in which the institution is open to collaboration with the community, particularly those who are traditionally uninsured and underserved such as people with disabilities, low-income people, and people of color.

The definition on the previous page is very basic and broad. Ideally, it provides a framework in which a community can self-determine the goods and services that will best address community health needs. But defining what should and should not be a community benefit requires some extra attention. Throughout the remainder of this section, we will examine each of these concepts more closely.

## B.  Health vs. Health Care

Too often health is equated with traditional services provided by doctors and hospitals. Is this perception accurate? Before your group begins to think about community benefits and what it will seek from local healthcare institutions, it may want to reexamine the concepts of "health" and "health care."

**EXERCISE I-1**

✔ **GROUP EXERCISE: What Does It Take to Be Healthy?**[3]

To begin brainstorming about what might be an appropriate community benefit, it may be helpful to answer the following questions: What does it take for a person or a community to be healthy? What role does the environment play in making people healthy? What contributes to physical health? Is being healthy limited to physical health? Write your answers in the space below.

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3. This exercise is taken from a series of exercises designed to establish a broader and nonmedical discussion of health and health care. For the complete set of exercises, see "Boston at Risk 2000: Facilitator Manual" and "Boston at Risk 2000: Six Principles for a New Health Care System: A Blueprint for Action" (October 1994). Copies are available from Community Catalyst.

Notice the great variety of answers you came up with. Of course, there is no "right" answer to this question. Each community will have different needs, concerns, and priorities. But the theme is clear. Traditional healthcare services might more accurately be described as "sick care." In reality, 80 percent of "health" is determined by a complex mix of factors like education, income, environment, violence, and other factors not traditionally associated with "access to health care." This broader view of health can and should be applied to community benefits. Institutional health resources can be used to address many of the issues you identified in your list, in addition to the important traditional services, with the goal of improving and promoting health.

## C.  Evaluating Community Benefits Activity

Understanding what it takes to be healthy and knowing your community's priority health needs will become important when your group begins to craft an agenda for its work. It will also be important when your group begins to evaluate institutional community benefits programs. In the absence of community input or regulatory oversight, institutions have claimed a wide range of activities as community benefits. Some of the more questionable institutional community benefits claims include:

- employees' personal United Way contributions
- setting up a maternity wing in a hospital serving an elderly population
- executives' time served on the board of a local charity
- allowing community organizations to use hospital rooms for meetings

In these cases it is easy to determine that these activities should not constitute valid community benefits activity. Sometimes the answer is less obvious. For example, if your local hospital reported the list on the following page as its community benefits program, how would you respond and why?

✓ **GROUP EXERCISE: Which of the Following Are "True" Community Benefits?**[4]

In the box at the left, indicate whether you think each of the following items is or is not a community benefit and explain your answer in the space provided. If you aren't sure, explain why. If your answer depends on certain conditions, please list them.

☐ **1.** Requiring board members to meet annually with focus groups of the uninsured or vulnerable populations to discuss health needs

_____

_____

☐ **2.** Providing cholesterol screenings at the mall

_____

_____

☐ **3.** Donating to the Olympics

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☐ **4.** Supporting the symphony

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_____

☐ **5.** Serving Medicaid patients

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☐ **6.** Providing a free clinic for the homeless

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☐ **7.** Providing free services to those who can afford to pay, but don't

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4. Based on an exercise developed by the Northwest Federation of Community Organizations.

☐   **8.** Supporting a religious institution, like a church

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☐   **9.** Convening a committee to study free-care policies

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☐   **10.** Paying livable wages to the hospital staff

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☐   **11.** Supporting medical education and research

_____

☐   **12.** Executive participation in a community benefits policy roundtable

_____

☐   **13.** Holding a "get to know you" open house

_____

☐   **14.** Running an emergency room

_____

☐   **15.** Providing interpreter services

_____

☐   **16.** Supporting a community youth recreation program

_____

## Is there such a thing as a "true" community benefit?

If one hundred people completed this exercise, there would probably be one hundred different answers. Because healthcare priorities differ among communities, the "appropriate" community benefits program will also differ. Answers will also vary because people have different perspectives within the community. Additionally, people will have had different experiences and relationships with local health institutions.

## Look back at the list and consider the following:

**Requiring board members to meet annually with focus groups of the uninsured or vulnerable populations to discuss health needs**

IS **a community benefit**

- If the process is collaborative and leads to results.

IS NOT **a community benefit**

- If nothing results from the meetings, or the meetings are more public relations than substance. Community leaders should clarify what the goals of the meeting are, what their role will be in the process, and what follow-up and evaluation there will be.

**Supporting the symphony**

IS **a community benefit**

- If the community defines spirituality as a component of what it takes to be healthy, and sees the symphony as improving its quality of life.
- If resources are dedicated to scholarships for disadvantaged youths.

IS NOT **a community benefit**

- If the symphony is not closely enough related to the healthcare needs of the community.
- If the support is not specifically targeted to disadvantaged youths or a similar program.

### Convening a committee to study free-care policies

#### IS a community benefit

- If people are empowered and supported to participate in the committee, the institution is forthcoming with data, and change results.

#### IS NOT a community benefit

- If no action results, and the committee is nothing more than a roundtable discussion.

- If the institution convenes a committee that is not inclusive of the community.

### Supporting medical education and research

#### IS a community benefit

- If vulnerable communities rely heavily on the free goods and services provided by teaching and research facilities.

- If teaching institutions operate their education programs in the red.

- If research leads to breakthroughs that enable providers to serve the entire community better.

#### IS NOT a community benefit

- If these institutions do not provide opportunities for students and researchers to serve at-risk populations directly.

- If these institutions focus exclusively on research at the expense of communities with immediate health needs.

- If teaching hospitals train more specialists where there is a shortage in primary care physicians.

**Executive participation in a community benefits policy roundtable**

IS **a community benefit**

- If the community has a long-standing relationship with institution executives and they collaborate around policy positions.

- If the institution is seeking more information on how to better structure programs and incorporates this information into the program.

IS NOT **a community benefit**

- If the institution will not be providing any services to the community; it will only be discussing issues with policy experts.

- If there is no change in policy. If barriers are not removed. If the institution does not reach out into the community as a result of participation.

- If the community, particularly vulnerable populations, are not involved.

**Holding a "get to know you" open house**

IS **a community benefit**

- If genuine efforts to open lines of communication are made.

IS NOT **a community benefit**

- If it does not further community input: Was outreach done to vulnerable populations? How will time be spent? Will there be an opportunity for people to voice their concerns? Is the meeting place and time designed to be conducive to participation?

**Running an emergency room
(and other similar critical, but costly, services)**

IS **a community benefit**

- If a hospital staffs an emergency room, even though there is no legal requirement to do so.[5]

IS NOT **a community benefit**

- If the entire community agrees that this is an essential service that must be given to the most vulnerable populations.

- If emergency room services are reimbursed.

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5.   The laws in most states do not delineate what services (e. g., emergency care) hospitals need to provide in order to be licensed.

### Providing interpreter services

#### IS a community benefit

- If translation services are generally not provided on a widespread basis.

- If the institution provides translation services over and above the norm.

- If the institution does not receive reimbursement for the translation services.

#### IS NOT a community benefit

- If the hospital only meets the minimum standards under the Civil Rights Law but no more.[6]

- If clear communication and informed consent are not possible without interpretive services. Anything essential to basic quality care should not be considered a community benefit.

### Supporting a community youth recreation program

#### IS a community benefit

- If youth violence is a problem in the community and is a major cause of death or injury for young people. Finding activities for young people will help remedy a serious community health problem.

#### IS NOT a community benefit

- If youth recreation programs are too disconnected from health care to be considered a community benefit. While youth recreation programs are important, the health needs in the community may be so great that a different community benefit may be preferable.

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6.  42 United States Code § 2000d. For a detailed discussion of how the Civil Rights Law requires translation services, see Jane Perkins et al., National Health Law Program, *Ensuring Linguistic Access in Healthcare Settings: Legal Rights and Responsibilities* (1998); available through the National Health Law Program by calling (202) 289-7661.

## Is It Unreimbursed?

One factor communities may consider in deciding whether any good or service is a community benefit is whether the healthcare institution is being paid for that service. Some institutions may claim full credit for a program or service for which they receive partial or full payment. Some examples include the following:

- Cholesterol screenings at the mall administered by an HMO but funded by the American Cancer Society.

- Treating Medicaid recipients. Some hospitals would suggest that simply treating Medicaid patients is a community benefit in itself. While most would disagree with that proposition, states that have regulated community benefits generally allow hospitals to credit the difference between the cost of care and the payment received (often called the shortfall or unreimbursed portion) as a community benefit.[7] But the *actual* cost of care can be unclear, since it includes all the things the hospital spends its money on—for instance, high executive salaries, fancy marble foyers and furniture, and money spent on mergers and acquisitions. So, whether this "shortfall" should be calculated as a community benefit depends on how the cost itself is calculated and what it includes.[8] Additionally, keep in mind that more and more hospitals are giving discounts to private health plans as a result of managed care. Losses from these discounts are then shifted to other payers, including Medicaid and Medicare.

## What Is NOT a Community Benefit?

To help grasp the concept of community benefits, it is useful to think about what types of activities are NOT community benefits. There were some items on the list that most people would probably agree were not community benefits. It may be noble for healthcare entities to support the Olympics. But does that support have local impact? Is it related to health care? Is it a priority need? Does it serve the traditionally uninsured and underserved? Likewise, providing free services (such as blood pressure monitoring) to those who can afford to pay for their own care may improve a hospital's public relations, but does it serve those community members who are most in need of free services?

In analyzing your answers it may be useful to determine some common characteristics. The reasons behind your choices are the same criteria to use when examining the community benefits claims of healthcare institutions in your community. Essentially, you have defined the criteria for your community.

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7.  Four of the states that have community benefits laws require community benefits to be unreimbursed (California, Idaho, Indiana, and Texas). See the Resource Materials: Community Benefits Laws and Regulations for a list of these laws.

8.  The community benefits law in Utah counts "[t]he reasonable value of unreimbursed care for patients covered by Medicare, Medicaid, or other similar government entitlement programs" as a community benefit. On the other hand, at least one state, Massachusetts, does not include Medicaid shortfalls as a community benefit.

# D. The Argument for Institutional Responsibility

You now have a sense of what should and should not be a community benefit. But which institutions are responsible for providing community benefits and participating in community benefits processes? Traditionally, community benefits have been associated with nonprofit "general" or acute-care hospitals. Improving on this traditional "community benefits system" is the first necessary step, but at the same time other healthcare institutions can and should be engaged in community benefits processes.

Think of some of the health needs that individuals in your group have identified as important. Prescription drugs, dental care, mental health care, substance abuse care, and long-term care are examples of prevalent health needs. The common characteristic of all of these is that they are not strictly hospital-based services. Some needs such as mental health and substance abuse are only partially addressed by hospital care. In these two cases, hospital care must be combined and coordinated with public health programs that emphasize prevention. Other needs, such as dental and long-term care, are not hospital-based at all.

And as the healthcare industry creates different types of specialty institutions (for example, maternity and heart hospitals) will hospitals continue to offer the traditional range of services that they now offer in competition with these newer institutions?

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**Boutique, or niche, hospitals**

are specialty, for-profit hospitals that are designed to offer a specific, profitable service such as ear, nose, and throat; maternity services; or cardiac surgery to low-risk, well-insured patients. Boutique hospitals undermine the ability of local nonprofit hospitals to provide needed services by: 1) cherry-picking low-risk, well-insured patients; and 2) offering only high-revenue services. Nonprofit hospitals are thus deprived the income generated from these high-revenue cases and are less likely to pay for vital, but money-losing, services for the community.

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Community vigilance is also needed as hospitals continue to consolidate and often pare down or close facilities. According to research by Professor Alan Sagar at the Boston University School of Public Health, "hospitals that close, nationally, tend to be in communities with higher percentages of African-American or Latino-American residents."[9] In these instances it becomes even more important for community leaders to consider the various types of health institutions operating in their community that could provide resources to promote community health. In the context of community benefits, is relying exclusively on the resources of nonprofit hospitals the way to go?

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9. Alan Sager, Deborah Socolar, and Jasprit Deol, *Before It's Too Late: Why Hospital Closings Are a Problem Not a Solution* (June 2, 1997, 2nd ed.), 8. Available by request by e-mail: asager@bu.edu.

✔ **GROUP EXERCISE: Which Local Healthcare Institutions Should Be Providing Community Benefits?**

What kind of healthcare institutions are in your community? Which do you believe are legally required to provide community benefits? Which should be?

| INSTITUTION | YES | NO |
|---|---|---|
| Nonprofit hospitals | ☐ | ☐ |
| For-profit hospitals | ☐ | ☐ |
| Nonprofit health insurers and HMOs | ☐ | ☐ |
| For-profit health insurers and HMOs | ☐ | ☐ |
| Banks | ☐ | ☐ |
| Pharmacies | ☐ | ☐ |
| Mental health facilities | ☐ | ☐ |
| Doctors' offices | ☐ | ☐ |
| Nursing homes | ☐ | ☐ |
| Medical supply companies | ☐ | ☐ |
| Dentists | ☐ | ☐ |
| Chemical dependency treatment centers | ☐ | ☐ |
| Drug companies | ☐ | ☐ |
| Other _____ | ☐ | ☐ |

**EXERCISE I-3**

## CONSIDER THE FOLLOWING

### BANKS

Surprisingly, of all these institutions, only banks have an enforceable fifty-state obligation to their communities. Under the federal Community Reinvestment Act[10] (often referred to as "CRA"), every bank must demonstrate that it is taking steps to serve its community, not just its customers.

There is no equivalent mandate for any type of healthcare institution. Only some of the various health institutions on the preceding list have enforceable community requirements in *some* states. Banks are classic bottom-line institutions. The existence of the CRA supports the interesting notion that a similar mandate could be applied to health institutions.

### NONPROFIT INSTITUTIONS

The traditional and historic obligation of nonprofit healthcare institutions to provide community benefits is derived from several sources.

- **Nonprofit institutions are mission-driven.** By law they cannot be owned by any person or entity and are often thought of as "community institutions."[11] In fact, one regulator declared that the public is the only true shareholder (or owner) of a nonprofit.[12] The community has a right to expect that its institutions will serve community needs.

- **Nonprofit healthcare institutions are created with an explicit charitable or social welfare mission to serve their community by providing health care or healthcare coverage to the community.** An argument can be made that nonprofit institutions are violating their missions by failing to meet the needs of the underserved adequately.

- **Nonprofit organizations have benefited from years of favorable governmental treatment, including tax breaks, tax exemptions, and other advantages.** For all these reasons, nonprofit healthcare institutions should be accountable to all of the people they were created to serve, particularly those who cannot otherwise afford health care.

- **Nonprofit healthcare institutions should provide community benefits in order to be good corporate citizens.**

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10. 12 United States Code § 2901, et. seq.

11. Howard Oleck, "Proprietary Mentality and the New Non-Profit Corporation Laws," Cleveland State Law Review 20, (1971): 145, 146.

12. Letter from California Corporations Commissioner Gary Mendoza to J. Kendall Anderson, May 6, 1994.

The problem is that while this community obligation exists in the law, the standards for fulfilling it generally are vague. As a result, institutions create their own standards. Additionally, more has traditionally been expected from hospitals and less has been expected from nonprofit HMOs and nonprofit insurers. Some states have taken steps to correct this situation by defining the standards and process by which *all* nonprofit institutions must meet their public obligations. For example, in 1997, Pennsylvania enacted The Institutions of Purely Public Charity Act which outlines the obligations of all nonprofit corporations.[13]

### FOR-PROFIT INSTITUTIONS

Even though your community benefits efforts likely will begin by focusing on non-profits, there are other potential benefit providers in the community to consider. For-profit healthcare institutions should also have a community interest obligation to the public because:

- **Health care is a social good.** Health care is different from other for-profit industries because it is so basic and essential for ALL people. And while we would not expect the only car dealership within one hundred miles to give out free or reduced-cost cars to people who could not otherwise afford one, we do require hospitals to treat people in emergency situations regardless of ability to pay.[14] The concept of "community benefits" applies this "social good" view of health care to nonemergency situations in an effort to improve community health as well as assure basic access to health care.

- **Market and industry changes make it necessary that for-profit institutions contribute to community health and community benefits.** In many communities, for-profit healthcare institutions are becoming more common, even dominant. Their strong position in many local markets creates an uneven playing field. While they have great resources, they generally service a smaller percentage of the at-risk population.[15] This may shift responsibility to public and nonprofit institutions or more people may go unserved. From a public policy perspective, it makes sense to require for-profit institutions to provide free care and community benefits to the communities they serve in order to even the competition. Of course, there may be a greater community obligation for tax-exempt nonprofits than for tax paying for-profits. In order to level the playing field, a few state legislatures and regulators are taking cutting edge steps to restore balance:

  For example, in Massachusetts all acute care hospitals and insurers must contribute to the Free Care Pool. The funds in the pool are then redistributed to disproportionate-share hospitals to help pay for the cost of providing free care.[16]

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13. 10 Pa. Const. Stat. § 371, et. seq.

14. See the federal law, 42 United States Code § 1395dd.

15. See Julio Mateo, Jr. and Jaime Rossi, *White Knights or Trojan Horses? A Policy and Legal Framework for Evaluating Hospital Consolidations in California* (Consumers Union West Coast Regional Office, April 1999).

16. Mass. Gen. Laws, ch. 118G, §§ 18, 18A.

● **For-profit institutions should provide community benefits in order to be good "corporate citizens" of the community (discussed on page 15).** The prime example of this concept is the Community Reinvestment Act, which puts community service requirements on banks. In the healthcare context, an example of the good corporate citizen rationale is contained in the Massachusetts Attorney General's Community Benefit Guidelines for Health Maintenance Organizations.

Former attorney general Scott Harshbarger states reasons for extending community obligations to all HMOs regardless of for-profit or nonprofit status.

"The healthcare marketplace . . . is evolving quickly and dramatically. . . . In **Massachusetts,** HMOs have made major gains in recruiting new members, and as a result, have become a critical component in the delivery of healthcare services to a significant portion of consumers across the state. Given their increasingly important role in providing or arranging for the provision of health care in the Commonwealth, HMOs, irrespective of their model type or organizational status, have acknowledged their corporate responsibility to do all that they can to improve and maintain the health status of members of the communities they serve."[17]

The HMO industry in Massachusetts eventually supported these guidelines, thereby acknowledging their corporate responsibility to the community.

### THE CONVERSION OF NONPROFIT HEALTHCARE INSTITUTIONS TO FOR-PROFIT STATUS

Many for-profit institutions were once nonprofit. And today many nonprofits are considering merging, partnering with, or becoming for-profit companies. In every state, regulators such as attorneys general, insurance commissioners, or public health officials must approve these changes. Because of this heightened scrutiny, conversions and mergers offer opportunities to raise community benefits issues, to examine the community benefits record of converting institutions, and to think about community needs for the future. In many states, community activism has led regulators and legislators to impose community benefits conditions on converting for-profit institutions. Typically, regulators in these instances have required for-profit successors to provide community benefits at the same level as the selling nonprofit. These requirements have generally been imposed either as a condition of regulatory approval or pursuant to new laws meant to address conversion and merger trends.[18]

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17. The Attorney General's Community Benefit Guidelines for Health Maintenance Organizations, February 1996, 1.

18. A report entitled "Protecting Health, Preserving Assets," which analyzes conversion laws, is available from Community Catalyst.

It is important to note that community benefits gains can be made outside of the legislative arena. Regulators, such as an attorney general or commissioner of public health, can approve private agreements reached directly between a community coalition and an institution. Such certified agreements can be very effective if the community and/or regulator are given the appropriate role, resources, and power to monitor institutional behavior over the long term. (See page 23, "Key Elements of Institutional Responsibility.") Overall, conversion and merger transactions are tremendous opportunities for advancing community health interests because community and regulatory leverage is so strong. Many for-profits view community benefits in this context as a cost of getting the deal done.

- For-profit Tenet Healthcare Corporation purchased nonprofit Deaconess Incarnate Word Health System (DIWHS) in Missouri in 1997. As a result of pressure from the community, Tenet agreed to maintain, as long as it owned the hospital system, the same aggregate level of free care and community benefits as DIWHS had provided. The parties agreed that the level was approximately $5,231,582.

- In the last two years, six states have passed laws requiring for-profit acquirers to submit a community benefits plan or to maintain levels of free care.

- An additional four states put provisions into law requiring regulators to consider the acquirer's commitment to free care as a factor relevant to the approval or disapproval of the transaction.

- In nine states, laws contain provisions requiring regulators to monitor the impacts of these transactions on health care.

**NONHOSPITAL-BASED ENTITIES**

Whether for-profit or nonprofit, there are many other institutions that can and should be held responsible for community benefits obligations, and some states and state regulators have taken that step.

- A law in Massachusetts requires *hospitals, HMOs, and insurers* to contribute to a free-care pool.[19]

- A law in Minnesota requires "any acute care institution or *outpatient surgical center*" to provide community benefits and file an annual report detailing its efforts.[20] In some states, for-profit specialty surgical centers, called "boutique hospitals," are becoming increasingly common. The Minnesota community benefits law is an important tool for healthcare organizers in states that have a large number of boutique hospitals.

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19. Mass Gen. Laws, ch. 118G, §§ 18, 18A.

20. Minn. Stat. § 144.698 (emphasis added).

- Another law in Minnesota requires *insurance companies, including HMOs,* to file annual "action plans" with the insurance commissioner. The action plan "must include a detailed description of the health plan company's policies and procedures for enrolling and serving high risk and special needs populations. This description must also include the barriers that are present for the high risk and special needs population and how the health plan company is addressing these barriers in order to provide greater access to these populations."[21]

- In 1990, Utah passed a law called the Nonprofit Hospital and *Nursing Home* Charitable Property Tax Exemption Standards (emphasis added). Under the law, nonprofit nursing homes are required to provide community benefits, including free care and issue a report annually about its activities.[22]

- In 1997, Maine passed a law requiring *hospital service plans* (a.k.a. Blue Cross and Blue Shield plans) to provide community benefits and report annually on their activities.[23]

## CONSIDER THE FOLLOWING

Many physician groups are closely affiliated with nonprofit and for-profit hospitals. The affiliation often will allow the physician group to use the hospital's name in its advertising and marketing. Its doctors will have admitting privileges at the hospital and may even have offices located within a hospital's campus. Yet while the hospital may be required to provide community benefits, these physician groups are not. For example, if an indigent patient is treated within a hospital by a doctor in an affiliated physician group, the patient will likely be billed by the physician group even if the patient is receiving "free care" from the hospital. Seeking payment from people qualified for free care doesn't make much sense. Should physician groups, particularly those closely affiliated with hospitals, be required to provide free care to those indigent patients who qualify for free services from the hospital? Particularly for nonprofit institutions with a charitable mission, shouldn't charitable obligations extend to any affiliated and partner organizations that benefit from the use of the valuable name and image of the hospital?

Also consider drug companies. In 1992, during hearings held by the U.S. Senate Special Committee on Aging, pharmaceutical companies agreed to set up a voluntary program to provide necessary medications free of charge to people who cannot afford them. Reports on the program's effectiveness are unfavorable. But can the program be evaluated and made to work? Or can community leaders revitalize the debate of 1992?[24]

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21. Minn. Stat. § 62Q.07, Subd. 2(e).

22. Nonprofit Hospital and Nursing Home Charitable Property Tax Exemption Standards (December 18, 1990), Utah State Tax Commission.

23. 1997 Me. Laws 344.

24. For more information on the free prescription drug program, call Health Care For All at (617) 350-7279.

**LOOKING FOR PUBLIC PROCESS AND OPPORTUNITY IN THE LAW**

Most institutions described on the preceding pages must receive licenses from the state in order to operate. Licensing may also become relevant in the sale of an institution because some states require new licenses for changes in ownership. Looking at the law is useful, even if the law itself is weak. For example, hospital licensing laws in most states contain only broad and unspecific licensing requirements.[25] But whether you are focusing on hospital licensing or licensing laws for other institutions (e.g., nursing homes or HMOs), the key is to look for public process. Often the relevant regulator will be required to hold a public hearing or other public process prior to approval of the license.[26] If a public hearing is not automatic, there may be a mechanism for your group to request a public hearing or raise concerns about institutional behavior.[27] Licensing laws may also require annual or biennial performance reviews or license renewal.[28] Public hearings or other review processes, even if not specifically focused on community benefits, are good opportunities to raise questions publicly about a particular institution's community benefits activities. Because the state is approving or renewing an application, community leaders have increased leverage.

## CONSIDER THE FOLLOWING

States often grant licenses and in return put demands and requirements on the regulated institutions.

- How do health institution licensing requirements and oversight processes compare to other industries in your state (e.g., liquor licenses, taxis, building contractors, hairdressers)? For many other types of industries, state licensing is very stringent. Is there an issue to raise here?

- There may be other laws that regulate health institutions and provide for public process. If the institution is a hospital or nursing home and is constructing a new building it may also need to get zoning approval.[29] If a public hospital is involved in any sale or other major change, there may be a county or city council process or at least the opportunity to try to get a public hearing. These regulatory handles may not yet be "tried and true" methods of making community benefits advances, but they have been used creatively and effectively by some communities.

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25. Most hospital licensing laws have very basic requirements for institutions, such as submitting an application containing the names of the owners, establishing that they are of reputable and responsible character, and that they operate the hospital in a safe and efficient manner. See, for example, Ind. Code § 16-21-2-11; 210 Ill. Comp. Stat. § 85/6(a).

26. See R.I. Gen. Laws § 23-17-14.4(a) (within ten working days of receiving an application for an initial license or a license in connection with a change in ownership, the Department must notify and afford the public an opportunity to comment on the application).

27. A regulation of the Department of Public Health in Massachusetts allows a group of ten residents of the institution's service area to request a public hearing on a determination of need (same as certificate of need) application. See 105 Code of Massachusetts Regulations 100.603(B).

28. See Oreg. Rev. Stat. § 441.025(2) (each license must be renewed annually).

29. In Columbus, Ohio, community members were forced to express their concerns over the building of a new hospital at a planning commission meeting.

In Massachusetts, the **Neponset Valley Community Health Coalition** (NVHC) formed after it was announced that the Neponset Valley Health System (NVHS) would be sold to Columbia/HCA. Under the terms of the deal, Columbia had required NVHS to sign a confidentiality document, and thus, information was not forthcoming. But, NVHC used the Department of Public Health's Determination of Need process (same as "certificate of need") and the Attorney General's public hearings to push Columbia for responses to its concerns. Ultimately, NVHS merged with nonprofit Caritas Christi Health Care System. NVHC continued to use the determination of need process to secure commitments on free care and services. It also worked out an agreement with Caritas whereby two of the six positions on the Caritas Board of Directors are chosen from the community.

## E. Developing Your Group's Definition of Community Benefits

The definition of community benefits presented at the beginning of this section on page 2 is very basic. After your group has had time to consider this baseline definition, identified its own criteria for "true community benefits," and thought about the institutions in the community, you should return to this definition and refine the concept of community benefits to fit your community.

✔ **GROUP EXERCISE: Modify the Definition**

What would you add, delete, or change in the definition of community benefits pro-vided below to match your understanding? Your group may choose to start entirely from scratch or to change nothing at all. But this exercise will ensure that everyone in your group starts from the same reference point.

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**Community Benefits**

The unreimbursed goods, services, and resources provided by healthcare institu-tions that address community-identified health needs and concerns, particularly those of people who are traditionally uninsured and underserved.

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## F.   Community Benefits: Key Elements of Institutional Responsibility

There is a significant history to community benefits. Your group is building upon a foundation derived from the work and leadership provided by key institutions such as the Catholic Health Association, the W. K. Kellogg Foundation, and countless community organizations across the country. Additionally, certain policymakers, analysts, and regulators have played important roles in refining the concept of community benefits, and this section incorporates many of their ideas.[30] From a review of this history and the 14 existing community benefits laws and guidelines, we have put together a list of important issues you will want to consider in your work.

Because circumstances will be different for each community, not every community benefits effort will look the same or achieve the same results. Some efforts will follow formal regulations while others will be less formal; not all of these elements will be important or achievable in your work. But looking through the broad categories will give you a sense of the elements you will want to consider.

The following section is a more detailed look at the elements of institutional responsibility. You may treat it as a reference in case your group is facing a particular issue and needs a more detailed and in-depth discussion.

Community process is an overarching and critical component to community benefits efforts, so under each element, we have highlighted important process considerations.

## 1.   The Definition of Community Benefits

We have crafted a working definition of community benefits for purposes of discussion and group thinking. It is an important conceptual framework for thinking about this work. Additionally, some states have defined the term legislatively. Often these definitions will include a list of specific types of services that can qualify as community benefits. Generally, these definitions also echo the themes of improving health status, disease prevention, charity and unreimbursed care, and improving health access to communities in need.

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30. For example, Kevin Barnett of The Public Health Institute; Bradford Grey of the New York Academy of Medicine; Scott Harshbarger, former attorney General of Massachusetts; Paul Hattis, the Senior Medical Advisor to the Department of Community Benefit Programs of the Partners Healthcare System of Boston, Massachusetts; Mark Schlesinger of Yale University School of Medicine.

For example, the **California community benefits law** defines community benefits as "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. Charity and unreimbursed care

2. The unreimbursed cost of providing community-oriented wellness and health promotion programs; prevention services; adult day care; child care; medical research and education; nursing and other professional training; home-delivered meals; sponsorship of free food, shelter, and clothing to the homeless; and outreach clinics

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

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

5. Healthcare cost containment

6. Enhancement of access to healthcare 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

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

Cal. Health & Safety Code § 127345(c)

## 2.   The Health-Needs Assessment

It makes sense to study and agree on community health needs before trying to craft solutions.[31] The needs assessment may also present an important opportunity to begin institution–community collaboration on a subject where there will likely be some agreement and consensus. Institutions sometimes claim the needs assessment as a community benefits activity. The needs assessment should not be the ultimate activity, but rather, a first step to identify where resources are needed. Your group may want to consider the following:

- Does the needs assessment make use of existing data from community health agencies?[32]

- Will the assessment contain a component aimed at identifying barriers and systemic reasons for poor health status?

- Will the assessment be targeted enough (e.g., ethnic groups, traditionally uninsured and underserved people, neighborhoods, income levels) yet broad enough (e.g., the hospital service area, or community–wide) to give sufficient information to craft a focused community benefits plan?

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31. The California, Connecticut, Indiana, Massachusetts, New Hampshire, Texas, and Utah community benefits laws and guidelines require a community health-needs assessment.

32. For an explanation on how to analyze health data, see "Using Data: A Guide for Community Health Activists," published by The Access Project.

- Will the assessment inventory and reexamine existing community benefits efforts by the institution and by other institutions?

- Should collaboration and sharing of expenses among institutions be encouraged?

- How often will an assessment be conducted?

**Process Issues:** Community organizations should be involved in the planning and implementation of any health-needs assessment. The assessments, whenever possible, should have qualitative (data collection through interviews, focus groups, and surveys) and quantitative (statistical public health data) aspects. Key questions for the planning stage include how the community will be involved in answering the following questions:

What type of data will be collected?
Who will be interviewed, surveyed, etc.?
What will the interviews and surveys consists of?
Who will conduct the surveys?
How will barriers to care be identified?
Who will analyze and write the assessment?

After the data-collection phase is complete, there is another important process issue. Community groups should seek to have public review and comment of the assessment before it is finalized.[33] Community members should consider the following questions when reviewing the final assessment:

Does the assessment square with community perception of unmet need?
Do interviewees feel the assessment accurately reflects their views?
How were needs prioritized?
How were data analyzed and presented?

## 3.   The Community Benefits Plan

It is important to remember that no two community benefits efforts will look the same. Below are some of the potential components of an institutional community benefits plan. Community leaders can advocate for a less formal version of some of these components as part of a negotiated agreement. In this situation, groups should determine which of these is a priority. Legislative proposals, on the other hand, should address as many of the components as possible:

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33. The California, Massachusetts, New Hampshire, and Texas community benefits laws and guidelines discuss public participation in the community health-needs assessment.

*A community benefits mission statement.* Seven states require institutions to create new mission statements or amend existing ones to reflect a commitment to serving community interests in their community benefits laws. This can be very effective since the mission will likely have to be approved by the board of directors, thereby involving the highest levels of institutional power in a community benefits effort. Also, in the case of nonprofits there is a legal duty for the board of directors to govern the institution in order to fulfill its mission. So, explicitly adding a community benefits component to the institution's mission can be effective from a legal perspective for enforcement purposes.

For example, in **Massachusetts, St. Elizabeth's Medical Center** community benefits mission statement reads, "St. Elizabeth's Medical Center . . . is committed to serving the entire community, including the uninsured, underinsured, poor, and disadvantaged. We are dedicated to providing accessible, high-quality healthcare services to all within our culturally diverse community, particularly our host communities of Allston and Brighton; the well-being of our community by providing excellence in healthcare through preventative health, education, and wellness services; and collaborating with our community in identifying and responding to issues by fulfilling the physical, spiritual, emotional, and social needs of the people we serve." *Commitment to Care, Commitment to Community,* St. Elizabeth's Medical Center of Boston Third Annual Community Benefits Report, 1997–1998, 4.

**Process Issues:** Again the ever present issue of community process should be considered. Will the community be involved in creating that mission statement? At a minimum, will the community have an opportunity to review and comment on it? The attorney general is charged with enforcing charities and it is difficult for the community to be in a legal position to enforce the law. Even so, it will be easier for the attorney general to enforce (and for the community to encourage the attorney general to enforce) if the healthcare entity has a clear community benefits component in its mission statement.

*A clear definition of plan beneficiaries.* Who is this plan meant to serve? Of course, the plan should focus on those that are traditionally at risk for poor health, but the plan should be more specific than that. Focusing on a clearly defined and identifiable segment of the community makes it easier to evaluate and measure the effect of a community benefits program or service. Measurable outcomes will mean that community leaders and institutions will be better able to determine the strengths and weaknesses of a particular community benefit and make corrections. A clear definition of plan beneficiaries will also ensure that resources are targeted to needs.

Beneficiaries can be defined in several different ways:

- by geography
- by race/ethnicity
- by income
- by demographic groups such as children or the elderly
- by disease affinity groups (e.g., people with AIDS or diabetes)[34]

*A list of measurable objectives, goals, and time frames.* The plan should be very clear on what the institution hopes to accomplish, how it will achieve those goals, and how long it will take to do so.[35]

*Explanation of the institutional and community process by which the goals and objectives were chosen.* Five of the existing community benefits laws reinforce the idea of community-institution collaboration by requiring institutions to detail the process it used or will use to consult the community. Requiring an explanation of the internal institutional process is also helpful to ensure that, for example, the board of directors approved the objectives, potentially giving more institutional priority to the success of the plan.

*Explanation of the institution's plan for outreach and notice to the public at large of its community benefits efforts and any new programs and services that are available.*

*A detailed institutional and community benefits budget.* How much of its budget is the institution committing to this effort? Is it getting any reimbursement for the community benefits it is providing? What is its level of bad debt and is that detailed separately from the level of charity care? In the Catholic Health Association's Social Accountability Budget, the following items are part of the budget: patient costs to charges, traditional charity care, unpaid costs of public programs, nonbilled services, education and research, and fund raising.[36] The budget should also include other costs such as outreach workers, needs assessment, and community process.

*An annual report.* The report should detail all of the elements described in this section, The Community Benefits Plan. Additionally, it should be widely available to the public, and the hospital should notify the public that the report is available.

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34. The California, Connecticut, Massachusetts, New Hampshire, Texas, and Utah community benefits laws and guidelines contain provisions explaining how the "community" should be defined.

35. The California, Indiana, Massachusetts, and Texas community benefits laws and guidelines require the community benefits plan to state measurable objectives within specified time frames.

36. See the Resource Materials for a sample community benefits budget produced by the Catholic Health Association.

> The **Indiana community benefits law** states, "Each nonprofit hospital shall prepare a statement that notifies the public that the annual report of the community benefits plan is: 1) public information; 2) filed with the state department; and 3) available to the public on request from the department. This statement shall be posted in prominent places throughout the hospital, including the emergency room waiting area and the admissions office waiting area. The statement shall also be printed in the hospital patient guide or other material that provides the patient with information about the admissions criteria of the hospital."[37]

All community benefits plans should be submitted by a certain date. For example, nonprofit hospitals in California must submit an annual report of their community benefits plan no later than 150 days after the hospital's fiscal year has ended.[38]

## 4. Evaluation Methods and Process for Ongoing Planning and Modification of a Plan

Community involvement in priority setting, decisionmaking, evaluation, and modification of the community benefits plan is crucial to program success. Institutions should seek and communities should encourage an approach that builds upon the assets of the community in order to leverage existing and new resources to maximum impact. Constituency and community leaders bring a wealth of information, not only about health needs but also about barriers to access, particular cultural differences, outreach techniques, and existing community infrastructure.[39]

**Process Issues:**

- Does the program supplement and not seek to replace existing community health assets such as clinics, and so forth?

- How will participation by community and constituency leaders be structured?

- Will there be a collaborative approach, such as a community benefits committee with diverse and broad representation, or will there be an opportunity to review the plan via a public hearing?

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37. Ind. Code § 16-21-9-7(c).

38. Cal. Health & Safety Code § 127350(d). California also allows hospital systems to file a single report. Cal. Health & Safety Code § 127350(d).

39. The California, Connecticut, Indiana, Massachusetts, New Hampshire, New York, and Texas community benefits laws and guidelines require public participation in program design and priorities. For example, the Massachusetts Hospital Guidelines provide: "In order to form a bridge to community leaders and representatives of the medically underserved, hospitals should establish a Community Benefits Advisory Group, or other similar mechanism, which includes members of the population to be served and which reflects the racial, cultural, and ethnic diversity of the community." Attorney General's Community Benefit Guidelines for Nonprofit Acute Care Hospitals, June 1994, 8.

# 5.   Accountability and Enforcement

The community has a tremendous role to play in long-term monitoring. Whether there are laws or guidelines to enforce and a regulator to push, or a less formal negotiated agreement, community vigilance will be necessary. Some of the tasks groups will need to attend to are:

- review annual reports (where they are required) or periodically seek new and updated information on institutional activities
- continue to monitor health access and community benefits from the community perspective
- continue to assess community health needs
- continue communication with the institution(s)
- continue to work to expand participation and increase base of support

Keeping abreast of this information will give the group tools to use to enforce community benefits obligations, whether or not there is a specific law and penalties. Inadequate annual reports, insufficient community benefits activity, and other community dissatisfaction can be the subject of:

- media reports
- formal written reports issued by community groups
- formal or informal communication with regulators
- formal letters or interviews with institutional leaders and board members

If there is some formal regulatory oversight, or formal oversight is achievable through laws or regulation, then you may want to consider the following issues when evaluating new or proposed laws or regulations:

**Which regulator is charged with monitoring and enforcement?**[40] Public health officials will have the most relevant health information and expertise, but other regulators may be more appropriate depending on the type of institution and circumstances. It may be more efficient to attach oversight responsibilities onto existing regulatory responsibilities and processes. For example, if HMOs have to file annual financial reports with the commissioner of insurance, perhaps the commissioner may be the appropriate overseer. Consider making efficient use of existing resources and frameworks.

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40. Nearly all the community benefits laws and guidelines name a state official to oversee the community benefits process. The state regulators represent a variety of different offices: public health officials (California, Connecticut, Minnesota, New York, Texas), attorneys general (Massachusetts, New Hampshire, Pennsylvania), the tax department (Idaho, Utah, West Virginia), the state department (Indiana), or the Superior Court (Georgia).

**How will a violation be brought to the attention of the regulator?** Regular reporting is the easiest method to ensure that the regulator gets up-to-date information to evaluate. But community leaders may want to consider seeking some mechanism by which members of the community can raise issues independently of an annual report. (Of course, any annual report should be available and subject to public scrutiny.)

**What penalties are in place for healthcare entities that violate community benefit requirements?** This piece of enforcement is one of the key areas where many of the laws fall short. Only four states have penalties for noncompliance—Indiana, New Hampshire, Pennsylvania, and Texas.[41]

**Process Issues:**

- Once the plan is in place, monitoring and ensuring accountability become critical for the community and regulators. Paying attention to these issues now will help to give community leaders the power and resources necessary in the future to ensure that community benefits will continue effectively.

- Is it clear in the plan/law/agreement what the role of the community will be over the long term? For example, will there be a proactive community benefits committee? Or will there be a less formal reactive role for the community in a periodic review process?

- Once the role is clear, what infrastructure exists or should be created within the community to ensure that that role will be fulfilled? For example, if your coalition is an ad hoc coalition, you may want to consider what sort role it can play in long-term monitoring.

- Tying into the two questions above, what specific authority or power will the community have? Again, the range can be very broad.

- Lastly, what funding and resources should the institution provide or the community seek in order to maintain this effort or infrastructure? Another component of effective long-term monitoring is institutional infrastructure. Who in the institution will be in charge of community benefits? Is it someone who carries significant weight and decisionmaking authority? How or will the board of directors be involved? In the absence of a formal community benefits committee, how will the community communicate effectively with the institution?

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41. In Indiana and Texas, hospitals are assessed a penalty not to exceed $1,000 for each day they fail to file a community benefits annual report. Ind. Code § 16-21-9-8; Tex. Health & Safety Code § 311.047. In Pennsylvania a penalty not to exceed $500 is imposed on any entity that does not file an annual report. 10 Pa. Cons. Stat. §379(I). In New Hampshire, healthcare charitable trusts may be fined $1,000 plus attorneys' fees and costs for not providing an annual report. N.H. R.S.A. §7:32-gIII.

## 6. A Baseline Standard for Contribution

In addition to a community benefits budget, there is also the issue of a base standard for contribution. This is one of the most contentious issues your group will face, particularly if you are considering a legislative agenda. Only two of the laws/guidelines set standards or factors to consider on this question.[42]

## 7. Specific Obligations for All Health Institutions

For groups considering a legislative campaign, an additional issue might be determining the types of institutions that should provide community benefits. Traditionally, communities think of nonprofit hospitals when they think of community benefits. However, some of the most recent community benefits laws apply to institutions such as nursing homes (Utah) and outpatient surgical centers (Minnesota). For-profit hospitals and other institutions in a number of states are also subject to free-care and community benefits requirements because of new conversion laws (Connecticut, District of Columbia, Rhode Island, and Washington). Moreover, in at least four states, Blue Cross/Blue Shield plans are now subject to some community benefits review pursuant to new laws, most of which were the result of restructuring or conversion activity (California, District of Columbia, Maine, and Rhode Island).

## 8. Free Care

For millions of uninsured people, free care represents critical and last-resort access to health care. Yet there are no federal laws, and state laws mandating how, when, and how much free care healthcare institutions must provide are nonexistent or weak. Because free care is such a critical part of community benefits, it requires extra attention. Understanding free care and improving access to free care will likely be a priority in your community for any one of a number of reasons. Perhaps you live in a small town and the town's largest employer has recently closed its doors, leaving hundreds unemployed and uninsured. Or the local public hospital that provides 80 percent of services to the underserved and uninsured is about to be sold to a large for-profit hospital chain. Or people in your community who have relied on free care for years suddenly find that the local hospital has changed its policy and services are no longer available.

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42. Only the Pennsylvania and Texas laws provide a financial benchmark, but neither should be considered a model. See Tex. Health & Safety Code Ann. § 311.042; 10 Pa. Cons. Stat. § 375(D).

Community leaders/coalitions have successfully brought about change in the free-care policies of individual hospitals or even state law by simply raising the issue to the public's attention. Because these free-care campaigns highlight need, and the expense of treating health needs that have gone unaddressed, they have often been the impetus for a look at the issue of community benefits. Free-care campaigns that have expanded to community benefits often examine issues such as institution-community relations, nonhospital-based services, primary care, and prevention and health resource allocation on a broader scale. Raising free-care issues as a precursor to or highlight during a community benefits campaign is strategically effective. Once hospitals and health institutions are explicitly and financially responsible for care for the uninsured they tend to develop an interest in lower-cost preventative services and programs for the uninsured. For a hospital in particular, the drive to lower costs becomes a tremendous incentive to think proactively about community benefits and public health initiatives to benefit the underserved.

You can read more about Free Care in the Resource Material section at the back of the book.

# SECTION II

# Organizing for Community Benefits

**IN THIS SECTION**

**This section provides insight into the basics of organizing, including: why organizing is important, how to build a campaign or coalition, who to contact, and strategies for building and sustaining interest. In addition to exercises designed to help answer these questions, this section also contains a number of sample organizing tools to assist in organizing community benefits campaigns.**

## A. Building Community Leverage: Identifying and Engaging Participants

## 1. Making the Connection—Identifying Participants

Often the people making decisions about what healthcare institutions should do to address unmet community needs are people with a certain perspective on who the community is and what it actually needs. Consider the following: Who on the following list currently controls health resources and decisionmaking?

- institutional executives, such as a hospital or HMO chief executive officer
- legislators
- public health officials, such as the commissioner of the department of health
- community health outreach workers or advocates
- a working family with insurance
- Medicaid beneficiaries
- an uninsured person

Of course, it is members of the first category who usually determine how healthcare resources are used. Usually, though there are exceptions, these executives and administrators are disconnected from the needs of vulnerable populations. Institutional leaders do take "community" into account in their decisionmaking. But if they are unfamiliar or isolated from vulnerable populations, then their idea of "community" is not complete. Because of this reality, a truly effective community benefits process must involve the people most affected by the deficiencies of our health system. They should be involved as partners who are recognized for the important insights they bring to community needs and crafting solutions that will work. In fact, community benefit work, in large part, is about changing this dynamic and "making the connection" between the institutional leaders and the traditionally disenfranchised.

Take a second look at the list above. There are basically four categories to consider.

- the "people," including community-based organizations and their leaders
- health and social service agency workers and leaders
- legislators and regulators
- institutional leaders

In the context of community benefits all four groups are potential participants. Community benefits efforts can originate from any of these sectors. For example, some institutions are currently participating in the W. K. Kellogg Foundation funded Community Care Network, a proactive institutional effort to improve community benefits. Other campaigns have been community-driven efforts. The range of participants makes community benefits processes dynamic. Each group has different needs and interests, as well as varying levels of power. Complex interrelationships exist among them. One commonality is that they all have valuable resources and information to bring to the table. One important difference, however, is that the community will probably have the least infrastructure and resources to draw from and to support participation in the community benefits process.

This section addresses two important tasks: engaging people and developing leadership in order to "make the connection" between "people" (particularly the underserved) and institutional leaders, in order to build community infrastructure to support and ensure strong and long-term community participation. Again, your community may be well organized and this section may not be as critical for your group. However, if you or your group want to reach out to new segments of your community, or to those new to community organizing, you may find this section helpful.

## 2.   Engaging People

No two communities are the same, and each community has different degrees of organization and involvement. Therefore, the methods your group chooses to engage people and develop leadership among organizations and individuals will vary. The common theme in all of these methods is that of active listening and building of relationships. Willingness to seek out people and organizations and to learn from their experiences will foster their participation. Developing understanding and trust among individual participants and coalition partners, and between leaders and constituents, will build and strengthen relationships. In general, the approaches suggested here should be undertaken using principles of popular education that aim to empower people by building on knowledge they already possess and treating their experience as an asset. In order to "make the connection," community leaders will need to move beyond gaining "input" from community members, to involving them in identifying, designing, and implementing solutions to the problems. The following exercise represents an approach to systematically identify members of your community who most probably will have a direct stake in expanding community benefits.

To read more about Community Organizing, refer to any of the following sources:

"Citizen Monitoring" (Center for Community Change, October, 1996).

Sally Covington and Larry Parachini, "Community Organizing: Democratic Revitalization Through Bottom Up Reform," in *Foundations in the Newt Era* (Washington, D.C.: National Committee for Responsive Philanthropy, September, 1995), 44.

Pablo Eisenberg, "Monitoring Government: Issues/Challenges/Approaches" (*Foundation News,* March/April 1979), 43–47.

Gilda Haas, with Kent Wong, "Popular Education: Building a Bridge Between Social Action and Public Policy" (prepared for the Rockefeller Foundation, July 8, 1996).

Denise Nadeau, *Counting our Victories: Popular Education and Organizing* (New Westminster, BC, Canada: Repeal the Deal Productions, 1996).

Kim Bobo, Jackie Kendall, and Steve Max, *Organizing for Social Change* (Santa Anna, CA: Seven Locks Press).

Lee Staples, *Roots to Power* (New York: Praeger, 1984); and several sources in *Action and Knowledge: Breaking the Monopoly with Participatory Action-Research* (New York: The Apex Press, 1991).

✔ **GROUP EXERCISE: Who in Your Community Has Unmet Healthcare Needs or Is Most Likely NOT to Have Access to Health Services?**

## Identifying the Constituency

Across the country, diversity and depth have been the hallmarks of successful community benefits efforts. Therefore, a good place to begin organizing efforts is to think explicitly about the groups and constituencies that you might not already work with but who should be involved in this effort. This simple exercise is a framework for identifying those people and will result in a sort of "to do" list for expanding participation. If done in a group setting, this exercise provides a structured way to identify segments of your community who should be part of your group's core constituency. Consider the following questions:

Who in your community are uninsured?

Who in your community are underinsured?

What industries employ uninsured workers?

What populations should the community benefits program serve?

Should the community benefits serve particular neighborhoods, groups, or types of people such as children or the elderly?

What populations do you care most about and want to see benefit?

Who has unmet healthcare needs or bears a disproportionate burden of illness?

Write your answers in the spaces below, being as specific as possible.

_____

_____

_____

_____

_____

_____

_____

This list gives us a sense of who is most "at risk" if community benefits are not improved or, worse, are decreased. As you continue your outreach efforts, this list is likely to grow as new people join your group and bring new information and relationships.[44]

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44. Additional information about at-risk populations and health status is available from your local health department or from interviewing clinic providers or social service agencies.

**EXERCISE II-1**

## B.   Outreach and Organizing Techniques

Now that you have an initial "to do" list, it may be helpful to think of the various methods or approaches that other community groups have effectively used to engage people. Each of these outreach tools also offers your group an opportunity and method to gather valuable information about health access issues and barriers. Groups have adapted the following seven traditional organizing techniques to the unique nature of healthcare issues:

1. Building on Existing Community Networks

2. Connecting One-on-One

3. Completing Questionnaires and Surveys

4. Responding to Calls for Assistance

5. Convening Community Forums

6. Conducting Community Needs Assessments

7. Utilizing Community-based Research

## 1.   Building on Existing Community Networks

There are probably a number of formal networks of people in your community. For example, churches, unions, senior groups, disability groups, children's groups, ethnic organizations, and neighborhood organizations are just a few. There are also informal social networks such as your coworkers, friends, classmates, and neighbors. Whether informal or formal, building on these networks is an outreach technique that is efficient and particularly useful to groups in the early stages of organizing, groups working in a new area, and well-established groups doing outreach to expand participation. There are two ways to build upon this community infrastructure: banding groups together and reaching out through an existing network.

### a) BANDING NETWORKS/ORGANIZATIONS TOGETHER

Usually it is fairly easy to identify leaders for a particular network like a neighborhood group. Meeting with these leaders can be an important step in understanding the health needs of the people the organization represents, but also to engage its leadership for the long term. Banding groups together in the name of community benefits can be effective as well as efficient.

In Columbus, Ohio, the **Universal Health Care Action Network of Ohio (UHCAN-Ohio)** recruited leaders of local organizations that work in safety-net communities. Together this group of eleven leaders from neighborhood health centers, churches, and legal services wrote letters to the CEOs of local hospitals and were successful in arranging meetings with them. As a result of these meetings, there has been increased communication between the community and the hospitals, and unmet health needs have been identified and addressed. For example, in the case of one hospital, the free-care policy has become more user friendly, and more individuals are aware of it. The hospital has also agreed to continue meeting with community representatives on a regular basis.

## b) REACHING OUT THROUGH AN EXISTING NETWORK

The networks/organizations in your community will have established ways to communicate to people in the organization and its allies. Providing and gathering information and cultivating interest can be done efficiently through existing newsletters (e.g., a brief article or questionnaire), monthly or periodic meetings (e.g., a shortened community training or question-and-answer session), or via mailing lists (e.g., an introductory letter from an organization with a questionnaire). If there is a strong interest within the network, you may be able to arrange a briefing session dedicated to the issue of community benefits.

In Brockton, Massachusetts, a diverse low-income city of one hundred thousand, members of the **Brockton Interfaith Community (BIC)** initiated a community benefits campaign with two local hospitals. A multi-issue group dedicated to building power in low-income communities, BIC had previously won benefits from banks and the city. Through its social and organizing networks, it periodically conducts household meetings throughout the eighteen congregations in its coalition to identify community issues. In these household meetings, members identified lack of health insurance, lack of prescription drug benefits, and youth violence as major concerns. BIC conducted a year-long campaign, culminating in a public meeting of six hundred people, at which hospital officials committed specific resources for health programs, youth outreach, and free medications. The outline used by BIC members at its household meetings can be found on the following page.

# Sample: Outline House Meeting[45]

**VALUE OF HOUSE MEETING**

**1.** Identify new talent/potential leaders both within your congregation and in its extended community.

**2.** Identify and cultivate networks of people (groups, associations, families, youth, neighbors, etc.) within the congregation and around it.

**3.** Spot "issues" that people are willing to research and act on.

**4.** Test leaders'/potential leaders' ability to convene a meeting, make the contacts, build relationships within the group, and spot other leaders and networks.

**HINTS FOR HOSTING**

Because the culture of these meetings is RELATIONAL (not geared to a TASK or JOB) there are things the host/hostess should encourage and things to avoid:

| You Want | Not |
|---|---|
| Trust, relationship | Information |
| Stories, feelings | Opinions |
| To be a listener | Dominate |
| To understand (why?) | React or defend |
| To probe | Pry |

**SUGGESTED OUTLINE**

**1.** Introduce yourself. It's important to share something about yourself, what your concerns are, what your values are. And it's very important to make clear to your group that the focus of the gathering is to discover how they see and feel about themselves and the church community. The focus is them.

**2.** Do the rounds. Have everyone introduce themselves with a story, or the response to a question on which you've chosen to focus the gathering.

**3.** Focused discussion. Having heard the stories, initiate a discussion of specific concerns about family, church, community—flowing out of the rounds.

**4.** Summary/next steps. Be sure to lift up common concerns, a potential issue to come back to, research (who?), follow-up meeting.

**A NOTE ON "STEWARDSHIP OF TIME"**

Best to keep these meetings to one hour. In any case, agree on a time period and stick to it! Better to leave people eager to reconvene, knowing you respect their busyness, than tired and not wanting to come back.

SAMPLE

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45. Developed by the Organization, Leadership, and Training Center, Dorchester, Massachusetts, and the Industrial Areas Foundation.

## 2. Connecting One-on-One

### a) RELATIONSHIP-BUILDING DISCUSSIONS

Some groups organize systematic one-on-one discussions between community members in order to build relationships, expand participation, and gain a deeper understanding of community opinions.

## Sample: One-to-One Outline[46]

### WHAT'S A 1 TO 1?

A 1 to 1 is a 30-minute face-to-face conversation with someone in their home. It's 30 minutes because you are just starting a relationship and don't want to overstay your welcome. (And if you run into someone who's very talkative, it gives you an excuse to leave!)

### HOW DO I GET SOMEONE TO SIT DOWN WITH ME FOR 30 MINUTES?

Call them on the phone.

> "Hi, could I please speak with Jane Doe?"
>
> "Hi, Jane, this is _____ from (name of your congregation). (Rev./Fr./Rabbi _____) suggested I call you. Do you have a couple of minutes right now?" (If not, find out when you can call her back.)
>
> "A team of us in (name of your congregation) is working to find out what people at (name of your congregation) are most concerned about and interested in. I'd like to find a time that's convenient for you when we could get together for a half an hour to talk. Is that possible?"

The purpose of the phone call is to set up the 1 to 1. (Do not do the 1 to 1 over the phone).

The three basic parts of a 1 to 1 are:

**1.** Breaking the ice and establishing your "credentials."

- Begin by breaking the ice: "Hi, how are you? Hasn't the weather been awful? Is that a picture of your children?" And by re-establishing your credentials: "I think I mentioned on the phone that (Rev./Fr./Rabbi _____) suggested I meet with you. I'm part of the team of people in the congregation meeting with members to find out what their interests and concerns are."

**SAMPLE**

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46. Based on an exercise developed by the Organization, Leadership, and Training Center, Dorchester, Massachusetts and the Industrial Areas Foundation.

**2.** Finding out people's self-interest: how they see the community, what they're concerned about and why.

- To find out their self-interest, ask them "what and why" questions. Begin with questions like: "You've been in this neighborhood a long time—how have you seen it change?" "Tell me a little about your involvement at (the congregation)." "What are your concerns as a parent trying to raise your children in this city?" These are all basically "what" questions. The answers people give will tell you what issues they care about, what pressures they are facing.

- If you then ask them "why" questions ("Why are you concerned about that? Why is that important to you? How does that issue affect you and your family?") the answers will tell you about their values and self-interest. They will also tell you what networks they are part of.

**3.** Closing by thanking them for their time and offering them an invitation.

- In closing, always thank people for their time. Then make clear what the next step is. In this case you might say something like: "We'll be doing this kind of 1 to 1 outreach for the next several weeks. After that we plan to have a big public meeting to address some of the main concerns that people have (such as . . . something they mentioned earlier in the 1 to 1). If we do that, would you be interested in coming?" It's important to offer people a choice, something they can say "yes" to if they choose. Whether they say "yes" or "no," thank them again, and you're on your way. (**Note:** your goal is not to get them to come to your next meeting. Your goal is to get to know them and find out their self-interest.)

Back in your car, or as soon as you get home, jot some quick notes about the meeting and what you learned about that person, the issues they care about, their self-interest, their networks, and their values. Bring notes to your next team meeting.

**b) DOOR-TO-DOOR OUTREACH**

Through door-to-door outreach or canvassing in targeted neighborhoods, organizers can connect with individuals who are not yet involved with their coalition or its organizations. While gathering information about access issues and problems, organizers can do public education as well and begin the process of developing a relationship with potential new members of their effort.

> The **Idaho Community Action Network** and **Maine People's Alliance** have both used door-to-door canvassing successfully. A sample script to use in such an effort can be found below.

## Sample Script for Canvassing: Idaho Community Action Network Membership Recruitment Doorknocking

Why doorknock?

**1.** To find good issues

**2.** To find angry and concerned people

**3.** To sign up new members

**4.** To let folks know about the basic philosophy of the organization

## The Rap

The rap has five parts that logically follow each other:

**Get in the door:** Introduce yourself and tell the person at the door whom you are with. People are generally suspicious of people coming to their door, so let the person know you are here to talk about neighborhood issues. It is important that you get in the door. That is the first indicator that you have both interested them and they have some trust of you.

> "Hi, how are you today? My name is _____. I'm with _____. People in the neighborhood are getting together to discuss issues like _____, _____, and _____. Are you concerned about the neighborhood? Do you have a minute to sit down and talk?"

**Find the Issue:** First get to know whom you are talking to. Ask questions like "How long have you been in the neighborhood?" and "Has the neighborhood changed a lot since you first moved here?" etc. Second, find out what their biggest neighborhood concern is. People get involved initially because of self-interest, so you need to find out why they invited you in and what the issue is in which they are most interested. Third, explore the issue. For example, if they mention crime, find out what kind of crime—break-ins, street crime, assaults, rapes, drug deals on the corner, crack houses, etc. Essentially, what you are doing here is "cutting" the issue more specifically. This will help make it visible and winnable with a clear target.

**SAMPLE**

**Polarize:** Anger is a key motivator. In order to feel really angry about an issue, people must feel justified in their concerns:

> "So where are the cops at when these corner deals are going down?"
> "It seems like there are plenty downtown where all the tourists are."
> "If this were Magnolia (a rich neighborhood) do you think the cops would allow this kind of blatant drug activity?"
> "Why do you think they allow it here?"
> "We pay our taxes, right? Don't you think we deserve the same services as other neighborhoods?"

**Build the Vision:** In this part of the rap, you want them to understand some of the basic principles of the organization, such as strength in numbers, direct action, use of the media, and so on.

> "So what do you think it's going to take to get more patrols in our neighborhood?"

### c) KEY-INFORMANT INTERVIEWS

Conducting one-on-one interviews with community leaders who might be interested in a community benefits effort can be both a planning tool and an opportunity to foster interest among potential members or allies. Such "key informants" may be leaders of particular constituencies who have not necessarily focused on health issues but who work with people (such as organized tenants or public housing residents) who may have health access problems. They may be local health or social service providers who have insights into the way the local health system operates as well as into the experiences of their clients.

> The **Oregon Health Action Campaign (OHAC)** completed a two-county survey by interviewing approximately fifteen people ranging from local church outreach workers to a hospital chief financial officer. Interviews lasted for 45 minutes to an hour. Interview scripts used by OHAC are on the following pages.

# Sample: Oregon Health Action Campaign's Key Informant Questions

**QUESTIONS FOR COMMUNITY LEADERS/COMMUNITY-BASED ORGANIZATIONS**

(Material following each question is intended to serve as prompts for the interviewer.)

**1.** Tell me about your organization's mission, current work, and constituency.

**2.** What health issues do you see among your community?

- Health may be defined broadly—violence prevention, AIDS education, etc.

- What are different issues for different segments of the population?

- Are there transportation, language translation, cultural, etc., issues?

**3.** Where do people go for care? For primary care? Pediatricians? Dentists? Emergency care? Mental health? For prescriptions? For specialists?

- Does coverage, like Medicaid or uninsured, influence where people go?

**4.** What is the experience of uninsured people in terms of access and paying for care at local hospital/clinic/other (get specific answers for each site)?

- Do low-income uninsured people receive free care in a respectful and open manner?

- Do people know free care is available?

- Are low-income uninsured people who obtain care subject to billing and collection actions? From hospital? For physician services received at hospital?

**5.** What is the experience of Spanish-speaking people in terms of language translation and cultural competency of the health delivery system?

- Is translation available at the hospital? At clinics?

- Are translators adequately trained? Are translators professionally trained?

- Is translation available for scheduling and phone questions? At appointments? After hours? How much notice is necessary? Are written materials available in Spanish?

- How do people find out what they have to do to get translation? Does facility/site ask?

**6.** Could you share any data or reports that describe your constituency and the issues we have been discussing? (We don't want to reinvent the wheel.)

**7.** Are there constituency members or other community groups who you think we should talk to about this effort?

**8.** Have we covered everything you think is important?

**SAMPLE**

**QUESTIONS FOR INSTITUTIONAL HEALTH PROVIDERS**

**1.** Tell me about your institution and its services—your mission, size, services, who you serve.

**2.** What are the major health issues you see in the community? How has your institution responded to these? What community benefits programs do you have?

**3.** What challenges do you face in meeting community health needs?

**4.** Where do uninsured/Medicaid/Medicare people go for care in community? For primary care? Pediatricians? Dentists? Emergency care? Mental Health? For prescriptions? For specialists?

- Does coverage, like Medicaid, influence where people go?

- If given a choice, would people continue going where they do?

- What is the quality of care like? Do people seek the same physician in clinic? Are hours and location accessible?

- What is the waiting time for clinic? For free-care referrals? Triage system?

**5.** Do you have a charity care policy and/or sliding fee scale for low-income people?

**6.** How do you mange the need for language translation services?

- Staff translators? ATT service?

- How do people find out what to do to get translation?

**7.** Could you share any data or reports that describe your organization and the issues we have been discussing?

**8.** Are there other people in your institution or in the community you think we should talk to about this effort?

**9.** Have we covered everything that you think is important?

**SAMPLE**

## 3.  Completing Questionnaires and Surveys

Questionnaires are another tool to perform outreach and systematic information gathering. Community groups have used brief surveys to ask community members about major health problems in their area (e.g. asthma, drug use, family violence, etc.) and barriers to care (e.g., lack of insurance, no interpreters, no transportation). More complex survey projects usually require support from the hospital, a state or local health department, or other institution. Whether the questionnaire is conducted by community organizations or by an institution as part of a formal needs assessment, it should contribute to the process of engaging people in the community benefits effort.

Brief written questionnaires about access to care can be distributed through fuel assistance programs, Head Start, churches, and locations in specific communities. It can be publicized in local newspapers, in church bulletins, and at community meetings. The survey cover sheet and the people distributing it should communicate that the questionnaire is part of a project to both identify needs and address them. Finally, the results should be reported back to the community, which is an ideal opportunity to organize further discussion about needs and solutions through public meetings, the media, or other forums.

**Maine Consumers for Affordable Health Care (MCAHC)** distributed two thousand two-page questionnaires about health access issues. Distribution was conducted through Head Start programs, Community Action programs, Area Agencies on Aging, churches, and other low-income organizations. The distribution effort was not labor intensive—the forms were made available through each organization's existing outreach efforts. After three months, over seven hundred questionnaires were returned (this represented twenty-one hundred individuals since one form often covered an entire family).

Through the returned questions, MCAHC learned about the broad extent of prescription-drug access problems and found that the parents of children enrolled in children's health access programs were uninsured. At least fifteen families who filled out questionnaires have become active health advocates in a parent health advocacy network. MCAHC continues to use the questionnaire respondent list to inform people about new community health or access programs and to notify them of opportunities to support improved health access. A copy of the questionnaire can be found on the following page.

## Sample Survey:
## Consumers for Affordable Health Care Foundation

**DO YOU OR A FAMILY MEMBER NEED HEALTH CARE OR
HEALTH INSURANCE?**

We are a nonprofit consumer organization working to make health care affordable and available for you and your community. To do so, we need current information from consumers. This survey is **entirely confidential.** No personal information will be released without your express permission.

**ABOUT YOU AND YOUR FAMILY**

In the following chart, please write the age of each household member. Then, put a check under each category that is true for that person.

| Person | Age | Has Medicaid | Has Private Insurance | Has No Insurance | Has a Doctor | Sees Doctor Regularly | Has a Dentist | Sees Dentist Regularly |
|--------|-----|--------------|----------------------|------------------|--------------|----------------------|---------------|------------------------|
| 1 | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| 2 | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| 3 | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| 4 | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| 5 | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| 6 | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |

If anyone in your household is covered by Medicaid and has problems finding a dentist or doctor to treat them, list their ages: _____

If anyone in your household has health problems, please list their ages and conditions:

Age: ____    Conditions: _____

Age: ____    Conditions: _____

Age: ____    Conditions: _____

In the space below, please tell us about problems you or a family member had getting or paying for health care or health insurance. (Please continue on reverse side if needed.)

_____

_____

Have you had problems paying for or obtaining prescription drugs? ____yes ____no
If so, please describe:

_____

_____

**SAMPLE**

**OTHER COMMENTS?**

_____

_____

_____

_____

What is the approximate yearly income of this household? _____

In order to help keep us informed, it would be helpful to have your name and address. Providing your phone number would help if we need to contact you about your responses. Thank you!

Name: _____    Phone: _____

Street/Box: _____    County: _____

Town: _____    Zip: _____

**This survey is entirely confidential. No personal information will be shared with others without your express permission.**

Thank you for your time! We hope that with this information we can improve healthcare access for all Maine families.

Please return this survey to: **Consumers for Affordable Health Care Foundation, P.O. Box 2490, Augusta, ME 04338-2490.**

What is Consumers for Affordable Health Care Foundation?

CAHC Foundation is an independent nonprofit organization whose mission is to empower and inform consumers that their voice will be heard in shaping healthcare policy and programs. For more information contact us at (207) 622-7083.

**SAMPLE**

## 4.   Responding to Calls for Assistance

Healthcare or other advocacy or community organizations often receive calls from people who are experiencing problems with the healthcare system. These calls can come from people who don't have insurance and want information about where they can get health care, or from those who have received bills they can't pay, or from people who may have received inadequate care because their local hospitals did not have an interpreter. These calls seeking help and information are an opportunity to do one-to-one outreach and to learn about individual problems and experiences. Keeping track of these calls and the problems you hear will allow you to see trends and issues that may indicate systemic problems that could be addressed through community benefits. Keeping track of callers and their issues will also allow you to contact them about changes that may benefit them such as changes in eligibility for a particular program.

By their nature, advocacy organizations try to help people with their immediate problems. But in order to engage callers, the organization should:

- Develop protocols for asking questions. The basic questionnaire on the preceding pages will be the type of survey you will want to use. Do what you can to make sure you have sufficient time to talk through the survey with the caller.

- Document and analyze the information you gather from your pool of callers. Look for trends.

- Involve callers in dealing with their problems. This will serve to educate callers about the shortcomings of the health system and decrease their isolation by supporting them in self-advocacy.

- Formally invite callers to get involved with efforts to make changes that will affect them or resolve their problems.

- Involve callers in institutional or policy follow-up, whether or not there are solutions to their immediate problems. Can an institution, for example, a hospital, be approached to change a harmful policy? Can a regulator be urged to craft a regulatory solution? Is legislation necessary or possible? Should the media be made aware of the problem? Are there other people in the community that might be facing the same problem that should be contacted?

- Keep callers informed of changes that may affect them.

Of course, running a system like the one described above can be complicated and may require tremendous resources. Some groups have established hotlines or helplines, and can modify existing practices in line with the suggestions above.[47] Others may not have the resources to engage in record keeping and systematic analysis. Instead they may want to focus on one-to-one outreach techniques, engaging the caller and supporting his/her participation.

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47. For more information on establishing helplines, contact Health Care For All at (617) 350-7279.

## 5.    Convening Community Forums

Community forums and "speak-outs" also help organizations identify potential partic-ipants in a campaign while learning of additional unmet needs. Working with local community groups and agencies, such as senior groups, tenants' groups, day care cen-ters, and neighborhood associations, local people can be recruited to attend and speak about their healthcare experiences and needs. This approach can be used by commu-nity groups or conducted collaboratively with an institution.

The **Lynn Health Task Force,** an established group with membership of nearly one hun-dred grassroots activists, community groups, and social service agencies, initiated a community benefits effort in Lynn, Massachusetts, a racially diverse working-class city of ninety thousand with many unmet health needs. As required under the community benefits guidelines issued by the Massachusetts Attorney General, the local hospital had filed a community benefits report. The Task Force found the report inadequate and responded by filing a rebuttal and initiating its own campaign. After gathering information, the Task Force then organized a community meeting, or "speak-out," on community health needs, attended by seventy people. The Task Force's work plan for this speak-out can be found on the following page.

## Sample Community Meeting Work Plan: The Lynn Health Task Force Community "Speak-Out"

**1. Group decides on target participants:** The Lynn Health Task Force targets participation from community members, agencies, city officials, and hospital officials. It uses its own membership list and knowledge of its planning group to identify individual activists and representatives of legal services, senior groups, unions, a community kitchen, the community health center, and the Visiting Nurses Association (VNA).

**2. Publicity:** a) Mailing and phone calls made to members, churches, agencies, city officials, hospital leaders; b) flyers posted in public places; c) articles in the local newspapers.

**3. Location, time, logistics:** Meeting held on a weekday evening in a downtown location near public transportation. Childcare offered. Transportation provided through a senior service organization. Refreshments provided.

**4. Organization of the meeting:** An experienced facilitator from the VNA who leads an open "brainstorming" discussion about health needs of the community. The results were recorded on butcher-block paper, put on walls around the room. Activity: Participants were asked to "vote" on their top three priorities by going up and putting stickers on the butcher-block paper. Needs were prioritized by the number of "votes."

**5. Issues identified:** More primary care providers, free care, transportation, information on programs, mental health, HIV, teen pregnancy, substance abuse, hospital interpreter services, and domestic violence counselors.

**6. Follow-up:** All meeting participants invited to become part of the Task Force. Newspaper articles published about the meeting and the needs identified. The Task Force put together a report using this information and the results of the telephone poll, and then asked for a meeting with the hospital. Members divided up responsibility for further investigation of each major issue.

**7. Results:** Membership/leadership expansion: New members joined the Task Force, resulting in renewal and expansion of its role as a leader in the eyes of community members and both hospital and city officials. Community education: Heightened community understanding of unmet health needs. New resources and enhanced community role: When the hospital went up for sale shortly after the speak-out, the Task Force played a role in choosing the new owner and negotiating resources for community-identified health issues, as well as institutionalizing community participation in hospital governance.

**SAMPLE**

## 6. Conducting Community Needs Assessments

Community needs assessments involve gathering existing data and information from community and public health sources, conducting surveys, and doing focus groups and interviews. Less formal assessments can be done using many of the individual outreach techniques described in this section, including household meetings, interviews, community forums, and questionnaires targeted to underserved people. The needs assessment may be conducted by a community coalition or in collaboration with a health institution. If a needs assessment is being used to expand participation, the people being surveyed must also be invited into the process and given opportunities to develop their leadership.

## 7. Utilizing Community-Based Research

As described previously, the process of gaining community participation is in part an information-gathering process, largely focused on community need. However, there is often additional information that must be gathered to craft an effective campaign. This information usually concerns the local health delivery system and any regulatory oversight that might apply to a particular situation or issue. (See Section III for more on important research tasks.) In many instances having community members directly participate in gathering information about the health system can be an important part of the leadership development process.

> Members of the **Brockton Interfaith Community (BIC)** conducted "research actions" as part of their campaign. Grassroots leaders met with the CEOs of two hospitals, with the health center director, and with the commissioner of the state agency that regulated free care. They also sought information and organized meetings on public programs and financing mechanisms with advocates, academics, and public officials. As BIC leaders became local experts on their healthcare system and its power relations, they were further developing their leadership skills, involving more people, expanding their allies, and preparing themselves for negotiations with hospital officials.

As illustrated here, community groups may also draw on expertise from community-based healthcare organizations and from academics who track the many changes taking place in the healthcare system. These sources are helpful to understanding both the big picture of what's happening as well as specific issues. Community-based providers may know the history of a given health institution and how it operates, especially when it comes to underserved populations. In addition, local health centers and social service agencies are likely to have conducted needs assessments of low-income neighborhoods as part of their ongoing planning efforts.

## Putting It Together

Although your group will never really be finished doing outreach, putting the information you have gathered into some accessible form to be shared with your group and its new members is a critical step. A formal report, or at a minimum a less formal tabulation of the information your group has gathered, will be necessary. It will be important for new members to see that the time and energy they took to answer a questionnaire or participate in a community speak-out actually will be used to further the work. Your group should do the best it can to analyze and prioritize the health needs and issues that can be identified in the "raw data." In the Lynn Speak-Out (page 52) there is a description of a simple group exercise to use to "group prioritize." Once prioritized, this information can be the basis for the next steps. For example, it will help your group shape its agenda, issue a report on health needs, or form the basis of a letter to a hospital or institution to begin a community benefits dialogue. Even though your health assessment won't be formal or scientific, the broader and more diverse your group, the more weight the assessment will carry.

## C.   Creating an Outreach Work Plan

As you can see, you will likely need to use several methods in your outreach efforts. Your choice of approach will depend on your organization and the relationships you already have. Your group has identified constituencies it wants to reach out to and thought about the various methods of outreach. At this point a work plan might be helpful.

## ✔ GROUP EXERCISE: Outreach Work Plan

In the spaces below, write down the names of the constituencies you listed on page 37 and fill in the chart for each. Doing this planning in a group setting will ensure that you make use of all the relationships and knowledge that individuals in your group may have. It will also increase the number of people to volunteer to do the work!

| Constituency | Contact | Initiation | Method of Contact | Date by Which Contact Should Occur |
|---|---|---|---|---|
| **Homeless** | Campaign to End Homelessness– Jim Smith | Julie knows Jim and will call and invite to next meeting | Telephone call | Two weeks prior to meeting |
| **Children with disabilities** | [Name(s)] | Rob | Questionnaires distributed at Head Start (call to see if Family Voices has chapter here) | [Date] |
| | | | | |
| | | | | |
| | | | | |

**EXERCISE II-2**

## D.  Membership Development

### 1.  From Action Comes Ownership

Once your group has sparked the interest of new people and organizations, it needs to involve them in many different types of activities and at many levels of your group's work. The goal of involving people is "leadership development" or more specifically:

- to build relationships and confidence and decrease isolation

- to share responsibility and power

- to demystify public health data, the local health system, and health policy jargon

- to familiarize new leaders with the potential participants (institutions, regulators, media, legislators, etc.) so they can see/experience power dynamics, relationships, personalities, and styles

- to have people working together comfortably and engaging in effective group problem solving

- to build commitment and ownership

- to strengthen the work with the experience and knowledge of each participant

Some opportunities to involve new members include:

- leadership and decisionmaking roles within your coalition

- representing the coalition in negotiations and meetings with institutions

- representing the coalition in dealings with the press

- representing the coalition in regulatory proceedings

- conducting and organizing new trainings and forums and continuous outreach efforts

### 2.  Providing Support

If your group builds a proper support system, new members engaging in these activities will gain confidence and knowledge. Proper supports could include pairing new members with well-established members to do research and engaging in activities to build experience. Additionally, by providing practice sessions, such as mock negotiations, you will enable new members to become skilled at tasks such as public speaking and negotiation.

## 3.  Building on What You Hear

The recruitment and involvement of new members make up a dynamic and long-term process. Engaging in continued outreach will ensure a growing base of support and create a solid foundation, built layer by layer, for your group. The keys to success are:

- active listening;
- keeping your outreach going by periodically revisiting some of the planning techniques and exercises found in this manual, such as "Who in Your Community Has Unmet Health Care Needs?" (page 37), "Putting It Together" (page 54), or the Outreach Work Plan (page 55), as new members join your group and bring new information and relationships;
- paying attention to integrating new members, keeping them active, and sharing information and power.

Following up on information gained from new members or from ongoing monitoring will help to sustain your group. Building on what you hear will keep your group grounded and ensure that its goals are current. Developing a reputation for your group as an active listener will increase your group's credibility with the community at large. Great diversity and depth within your group will ensure your credibility with regulators, industry leaders, and the press, who will view your group as truly representative of the community and a pipeline of information.

## E.  Building Strong Community Organizations

Unless your group is long established, it will be necessary to create some structures for decisionmaking and communication. Because community benefits are ultimately about resource allocation, clear processes for choosing priorities, setting goals, and choosing tactics are essential. Clarifying the ground rules early will help your group avoid later conflict or competition for community benefit resources among constituencies that may have different needs and priorities. Establishing and utilizing these internal processes will ensure that all participants will feel respected and will support the group's efforts.

The following are important questions for groups involved in a *community-driven effort* to improve community benefits.

**1.** What are the mission and principles of the group or the campaign?

"To identify populations in the state with barriers to accessing appropriate health care, to advocate for adequate and appropriate services and to empower these populations to be active participants in their own health care."
—New Hampshire Minority Health Coalition

**2.** Who is the membership? Are individuals and organizations able to be members? Are hospital staff able to join? Are organizations or government agencies doing business with the health institution allowed to be members? If yes, what level of interconnection is acceptable and how will conflicts of interest be avoided?

**3.** Will it be a priority to develop leadership and group ownership especially among those most affected by the issues? How will new members be recruited and integrated into the group? What are the group's policies about integration? What is its position about giving people authority within the group?

In Hartford, Connecticut, healthcare advocates endeavored to reach out to parents and develop leaders within communities while working to improve health services for area children. The **Building Parent Power (BPP)** organization was formed. Community outreach took the form of eight monthly workshop sessions that would train parents to participate in healthcare decisionmaking. Participants came from a range of racial and cultural backgrounds and learned valuable advocacy skills while becoming more unified as a group. During the training, when an issue emerged involving the possible loss of Blue Cross/Blue Shield's assets from a proposed merger, parents felt confident enough about their knowledge and skills to testify at public hearings, sponsor community forums, engage in local outreach, and write articles for local media.

**4.** How will decisions be made? How will leadership be chosen? Will some or all decisions be delegated to designated individuals or to group decisionmaking?

### Levels of Involvement in the Decisionmaking Process



©1997, Interaction Associates, LLC
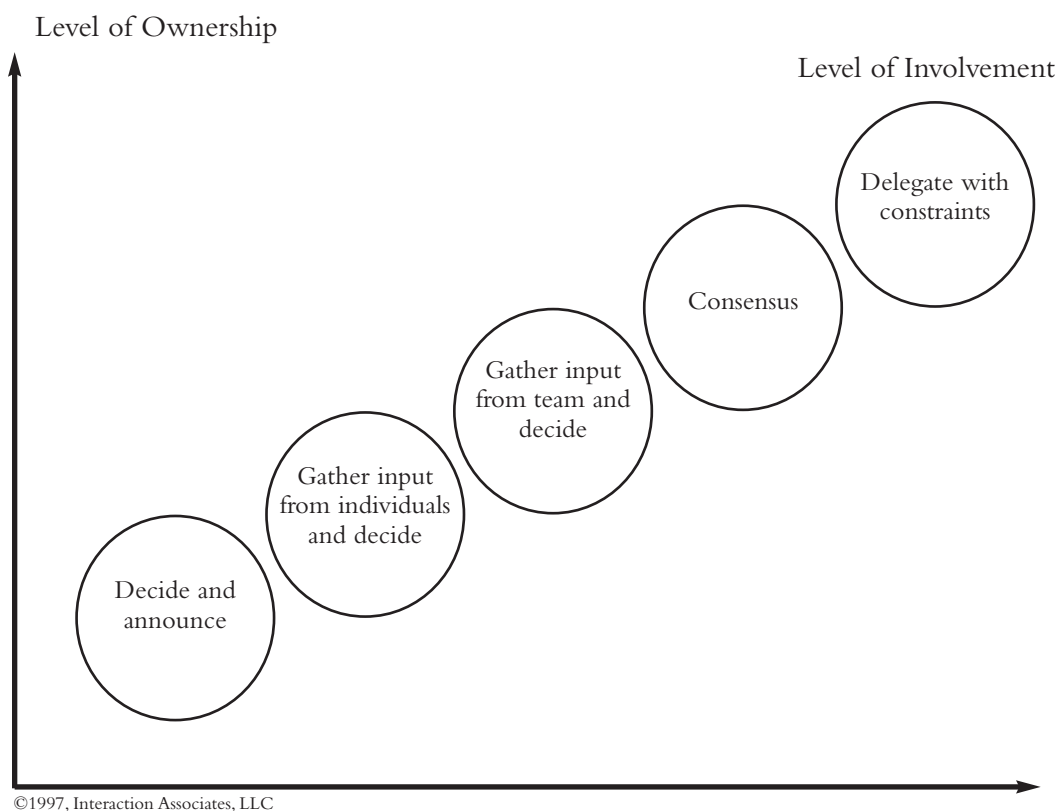
**5.** How will the group communicate with its own members and with the outside world, including other community groups who may not be members, but are interested in the campaign?

- group e-mails?

- broadcast faxes?

- newsletters?

- phone trees?

**6.** What resources are necessary to carry out the action plan? Where will these be obtained?

- in-kind contributions?

- donations from membership?

- grant support?

Community representatives participating in an institutional effort to improve community benefits will also have to address the same questions. This is particularly important if the representative does not come from a broad-based and diverse coalition. The community leader in this situation must be proactive and structure ways to ensure that he or she is being accurate and true to the interests of the underserved segments of the community. Some of the outreach tools described in this manual can help a representative accomplish this goal. Community representatives in institutional processes have another specific duty. That duty requires them to advocate for a commitment by the institution to reach beyond its familiar circle of collaborators and involve new and diverse people, particularly disenfranchised populations, in its efforts.[48]

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48. A more in-depth analysis on organizational development can be found in "Handles for Organizing a Healthy Community," published by The Access Project.

# Crafting a Strategic Approach

**IN THIS SECTION**

Along with the strategies you will need to build and sustain a coalition (internal strategies) there are also a number of important external strategies to employ when dealing with institutions, the press, legislators, regulators, and even allies. This section discusses some key elements of strategic thinking and approach.

## A.  Seeing and Creating Opportunities

Opportunities to bring community benefits issues to the public eye can come in many different forms. Examples are listed below; see the Resource Materials Section of this manual for a chart that provides more information for community benefits campaigns on each of the examples used in this section.

## An External Event:
## Health Institution Restructuring

Today's ever changing healthcare marketplace is the scene of countless restructurings. Healthcare institutions are engaging in mergers, consolidations, joint ventures, and conversions from nonprofit to for-profit status. These changes often require some type of regulatory oversight that gives community leaders a public forum to raise important issues and exercise influence. In addition, community members may be motivated to mobilize and organize coalitions to represent their interests and negoti–ate with the institutions involved in the restructuring. In many cases, these coalitions have won valuable community benefits from the healthcare institution involved in the transaction.

Community members mobilized when St. Vincent Healthcare System, a nonprofit hospital in Massachusetts, went up for sale. They formed the **Central Massachusetts Community Health Coalition (CMHC)** and voiced their concerns through letters to local newspapers and regulators. As a result of their vocal positions and the depth and numbers in their coalition, CMHC was able to play a successful role in the sale negotiation process. When OrNda Healthcorp (who was later purchased by Tenet Healthcare (Tenet)) emerged as the likely buyer, CMHC participated in the negotiations process. As a result of the work of the coalition, Tenet was required to create a task force that identifies and works to resolve community health needs. The task force will focus on community benefits and other essentials such as interpreter services and accessibility for the disabled. CMHC members play a significant role on the task force.

The **Pajaro Valley Coalition to Save Community Health Care** formed as a result of the proposed sale of Watsonville Community Hospital to Community Health Systems (CHS). Watsonville is the only hospital located within its service area in California. The closest hospital is located 14 miles away in Santa Cruz. Watsonville serves a community of 100,000 that is predominantly farm labor. Thirty-six percent of the population lives at or below the federal poverty line. Watsonville is over a hundred years old and had always been a nonprofit hospital. In the fall of 1997, CHS, a for-profit hospital chain based in Tennessee, offered $71.6 million to purchase Watsonville. By the end of January, 1998, when Watsonville and CHS signed a Letter of Intent, CHS had reduced its purchase price to $58.6 million.

The Coalition represented more than 16 organizations, whose members included seniors, healthcare workers, farm workers, children's advocates, and policymakers. The Coalition formulated a set of Principles, including that the medically indigent receive free and/or low-cost medical care at the hospital, no matter who owns it. The Coalition believed all of these Principles should govern any proposed deal, and they were the standard by which they would measure any final agreement. In June, 1998, Watsonville and CSH sought the Attorney General's required approval of the sale. In August, the Attorney General held the first public hearing on the sale. Key criticisms at the hearing focused on the over $11 million drop in the sales price, CHS's vague indigent care and emergency room commitments, and Watsonville's proposed use of the sales proceeds.

The Attorney General approved the transaction in September, 1998. As a result of the Coalition's efforts, CHS agreed to "target" the current annual charity-care expenditure, although it did not agree to a specified amount. CHS also agreed to annually increase that expenditure by a percentage equal to the regional Consumer Price Index, if necessary. CHS also agreed to extend an indigent care contract with the County of Santa Cruz, although CHS's performance under this agreement was not a condition of the Attorney General's approval.

## A Community-Created Event:
## a) Community Examines Hospital Books, Issues Report

Often there will not be an external event, but community leaders can still successfully raise public attention around financial issues. For example, communities can commission researchers to analyze the finances of area hospitals. Reports that detail both that local hospitals have significant surpluses and that significant health needs exist in a given community can galvanize a public reaction and uncover community health crises.

Communities in Maine, Massachusetts, and Oregon have taken the initiative in studying the benefits hospitals derive from tax-exempt status in comparison to benefits the same hospitals have provided to their communities in return. With the assistance of hospital finance experts, members of these communities have studied publicly available documents and records such as audited financial statements, property assessments, and IRS filings over a period of years. From these documents, they were able to analyze the hospital's operating, financing, and investing activities. They were also able to value the hospitals' charity-care provision and tax exemptions. Study findings have been the beginning point for community benefits negotiations with these same institutions. The analyses often reveal spending priorities that do not coincide with documented community health need (e.g., high levels of capital spending in well-served communities and relatively low provision of free care or capital spending in underserved areas). Some reports document the estimated value of the institution's tax exemption in relationship to costs of free care. These reports have garnered public and media attention stimulating stronger community efforts to establish a dialogue that can influence the design of community benefits.

After publishing a report which analyzed the finances of the acute care hospitals in Portland, Bangor, and Lewiston, Maine, the **Maine People's Alliance** organized separate meetings with executives from the four hospitals in Portland and Lewiston. In Portland, 10–12 community members met with the hospital executives, and in Lewiston, 15–20 community members attended the meetings. Maine People's Alliance identifies two successes arising from these meetings. First, Mercy Hospital in Portland agreed to open a free dental clinic and credited the community meetings with inspiring the idea. Second, when the state's largest psychiatric hospital went bankrupt and up for sale, community members organized a successful campaign to have a nonprofit, as opposed to for-profit, corporation purchase the hospital and to have community members sit on the new Board of Directors. They attribute this victory, in part, to the relationships built and developed in their initial meetings with the hospital executives and to their greater understanding of how hospitals function in the community.

## b) Linking Neighborhoods and Constituencies for Power

Statewide organizations can accomplish several goals by engaging in efforts to link neighborhoods and constituencies to promote systemwide or institutional policy changes. Not only will they build larger and broader membership, they will also foster stronger consumer involvement in health issues and link local groups together. The local groups also benefit by becoming involved in efforts to influence health resource allocation and policy at the local and the state level.

The **Illinois Campaign for Better Health Care** conducted a series of participatory training sessions about health issues, community needs and solutions. Participants included representatives from neighborhood-based organizations, many of whom were not directly involved in healthcare issues, but were directly engaged with community residents on a day-to-day basis. The sessions gave organizations the opportunity to learn about local health needs. It also helped to develop relationships among participants. The group then initiated discussions with a local religious hospital to improve and expand specific community benefits.

## An Issue Focus:
## Challenging Institutional Behavior

Community efforts can originate from pressing community needs that require a response. Questionable institutional practices or even health status statistics regarding preventable health problems such as rising infant mortality, asthma, or violent teen deaths can be used to illustrate health system deficiencies. Raising issues of community benefit this way is particularly poignant if this information is categorized by neighborhood or ethnic group, or a disproportionate percentage of poor health status falls in one area or on one group, potentially revealing discriminatory practices.

The **Idaho Community Action Network (ICAN),** a grassroots membership organization, created a free-care campaign for St. Luke's Hospital in Boise based on the hospital's collection policies. ICAN first engaged in a door-to-door outreach effort to identify new members interested in health access. At a training session to discuss community benefits, many insured members who had used one of the local hospitals were satisfied with the quality of care they received and, given their satisfaction, were not clear about the relevance of community benefits. A new member at the training then spoke movingly about her experience with illness and the added stress of having a lien placed on her house because she could not pay her bill. Motivated by her story, the group decided to pursue the issue of free care and hospital collection practices.

ICAN continued its door-to-door outreach efforts and was able to find individuals with debt collection problems. The group used records from the county assessor's office to identify more individuals against whom the hospital had placed liens. These people were then contacted and personal visits set up. Many joined the effort to negotiate stronger hospital free-care policies and debt relief for those now subject to liens. ICAN also looked into St. Luke's federal 990 tax form, which provided financial information and details on free care. Additional research also showed that the collection agency used by the hospital is actually a subsidiary of the hospital.

ICAN continues to press forward with demands for improved free-care policies, a set percentage of hospital revenues dedicated to free care, debt forgiveness for low-income residents, expanded primary care access, and community involvement in a needs assessment that will help shape more community benefits.

## An Institution-Initiated Effort:
## Ensuring the Community's Leadership

Healthcare institutions themselves may initiate collaboration with the community to design and set priorities for community benefits. The impetus for this might arise from external factors, such as state regulations or voluntary industry guidelines, or internal factors, such as hospital leadership renewing its commitment to community service.

In 1996, in response to concerns raised by Service Employees International Union 1199 and **Washington Citizen Action** about the increasingly competitive and price-sensitive health system, the Seattle-King County Department of Public Health began to investigate whether there was a decrease in the level of community benefits provided by area hospitals, health plans, and other providers of health services. The Department of Public Health convened over 30 representatives from area hospitals, health plans, community-based providers, consumer advocacy organizations, labor, and business. After a year of discussion and analysis about community health needs, the group recommended specific actions that collaborating community partners could take to address specific health issues in the community. Relying on hard data and the insights of steering committee members, the report, issued in 1997, called for a community benefits focus on healthcare problems for particular vulnerable populations. The specific priorities for a coordinated community benefits program in 1998–1999 include childhood asthma, diabetes among African Americans, and breast and cervical cancer screenings among Vietnamese women.

The Steering Committee developed action plans that rely on a commitment to collaboration and coordinated financial support, as well as use of data to evaluate effectiveness. In one example of the approach used, a successful Asthma Outreach Program at a children's clinic is to have its capacity expanded through additional medical provider staff, outreach workers and medical assistant clerical support. This element of the community benefits program will be evaluated based on the provision of services to additional patients. Start-up funding will also be provided for replication of this successful model in a region of the county that is experiencing a high rate of avoidable asthma hospitalizations. Assistance will also be provided to develop data systems to enhance evaluation of this program and to improve retention. In future years, the collaborating organizations in the King County Health Action Plan expect to increase participation and broaden efforts.

The experience of the community groups that participated in development of the Action Plan was a mixed one that has left participants cautiously optimistic. The process facilitated participation from community-based providers and advocates, rather than from community residents. The proposed programs are culturally appropriate, community-based and address genuine community need. However, the consensus-driven decisionmaking process left issues about the broader community benefits obligations of health institutions unaddressed. Sustained community attention will be required to ensure that the Action Plan efforts continue and develop the capacity to deepen community participation and broaden community benefits beyond specific programs to a stronger community voice in overall resource allocation.

In the neighboring towns of Cambridge and Somerville in Massachusetts, teenage pregnancy, domestic violence, substance abuse, and HIV are common problems. Since the early 1990s, the **Cambridge Health Alliance,** a public authority that represents Cambridge City Hospital, the Cambridge Department of Public Health, and Somerville Hospital, has worked energetically with its community to address many of these problems. When the Health Alliance decided to open a new neighborhood health center at 119 Winsdor Street, it actively sought the input of neighborhood residents and held nearly 30 community meetings to identify community health needs and concerns. As a result of these meetings, the Health Alliance and the neighborhood developed a community advisory committee that represents varied interests of the community. The community advisory committee continues to work with the health center manager and medical director to identify priority healthcare needs.

Among the programs offered at the new Windsor Street Community and Health Center are a seven-chair dental clinic; a Latino Mental Health program staffed by bilingual and bicultural psychiatrists, psychologists, social workers, and community workers; a WIC program; and a play area for young children. Co-located at the Windsor Street Community and Health Center are six community-based programs, which include Cambridge Head Start Day Care, the Community Arts Center, Inc., Community Learning Center, Computer Center, Recreational Activities Program (RAP), and Work Force Unemployment Prevention Program. The Health Alliance also made a commitment to increase the number of neighborhood residents on staff at all levels of the health center and agreed to develop training programs to increase employment opportunities.

## A New Law or Regulation: Community Benefits Laws

Currently, 14 states have laws, regulations, or guidelines specifically governing community benefits. In other states, a community benefits requirement might be a component of another law such as conversion or certificate–of–need laws. Many of these laws contain public process provisions which include input from community members and public hearings. As a result, community members have used these laws as tools to organize coalitions and successfully negotiate with local healthcare institutions.

The 1996 Massachusetts community benefits guidelines were sparked by a community campaign led by Boston's Commissioner of Health and Hospitals, Judith Kurland, and the **Boston Health Access Project (BHAP)** of Health Care For All. Kurland commissioned a study documenting the rich cash reserves of Boston's numerous teaching hospitals, which contrasted sharply with the unmet needs of Boston's residents. BHAP recruited a diverse group of grassroots activists and leaders who publicly challenged the hospital's right to tax-exempt status, given their record. BHAP sought support from the Attorney General, who subsequently issued the guidelines, mandating all Massachusetts hospitals to allocate resources to community benefits and to engage the community in determining needs and designing responses.

The Boston Health Access Project then hired a Latina organizer to mobilize residents of one neighborhood in Boston to implement the guidelines with three Boston hospitals that served that area. The Jamaica Plain Community Benefits Group was formed, composed of grassroots community members, many of whom were Latino residents who had had little voice in the City's political establishment. The group organized a speak-out, prioritized a set of issues to bring to the hospitals, formulated programs to address the issues, and negotiated with the hospitals. Along with another active community group, Tree of Life, the community won community benefits resources for a neighbor-to-neighbor outreach and community building initiative and for a program in the schools to address the high rate of chronic asthma among children.

## B.  Recognizing Dual and Shifting Roles

Advocates and community leaders often find themselves in a particular type of role in any given effort or campaign to create change. It is often an outsider's role, the vocal critic knocking at the door of the "back room" where all the decisions are made. Your community benefits campaign may begin in this manner. But at various points in your work there may come a time when the role of your group will change. There is a tremendous difference between remaining a vocal critic on the outside and being part of a process while seated at the decisionmaking table. In the context of community benefits, a highly critical outsider's approach may not be the only option. At various stages of your work and your group's evolving relationship with the institution, a different tone and tact may be necessary, depending on your goals and the situation. For many groups and coalitions engaged in community benefit work, intermittent shifting from outsider to collaborator/decisionmaker has been necessary. In fact, you may find different segments of your group are playing different roles at the same time. In these instances, groups have had to fluctuate from engaging in more reactive analysis and critique to being in a position to set and achieve an agenda.

Increased responsibility and accountability come with "sitting at the table." The community leader in this new position is representing and exercising power on behalf of the community. That leader has a responsibility to proactively reach out to as much of the community as possible, to remain connected, and to actively listen. The community leader engaged in an institutional community benefits process must set the example of broad and diverse community engagement, setting the standard for the institution to follow.

## C.   Getting Clear on the Goals

In playing these dual roles, and in order to plan strategies, a critical first step in any campaign is to set clear goals in at least five areas. Your goals may change over time, but it is important to discern them at this early stage.

### 1.   Policy Goals

Setting some specific "external" or policy goals is necessary before choosing the style and tone of your communication with people and institutions outside your coalition. In order to set policy goals you will need to have a grounded understanding of health needs and barriers in your community. You will also need to have a sense of the types of institutions operating in your community and which of these your group believes should be responsible for community benefits.

The exercises and sections in this workbook that will help you clarify your policy goals are: "What Does It Take to Be Healthy?" (page 4), "Evaluating Community Benefits Activity" (page 5), and "The Argument for Institutional Responsibility" (page 13). Additionally, the information you have gathered and processed in your outreach efforts will be invaluable. If your policy goals are legislative, look at the Key Elements section (page 23) to identify issues you will want to consider.

### 2.   Organization and Coalition Building Goals

Not only will you want to consider policy goals such as increasing access to health care, you may want to consider "internal" goals for building your organization or coalition. For example, is it a priority to engage in outreach to new constituencies, increase participation and leadership by less active coalition members, or expand your work to a new geographic area?

In order to define goals for building an organization and to understand the importance of organizing and the integration of people into your group, see Section II.

### 3.   Short-Term and Long-Term Goals

It is important to differentiate between short-term goals (e.g., funding for the local clinic that is about to close) and long-term goals (e.g., building a strong and continuing working relationship with an institution or group of institutions). As your group chooses tactics, it will need to think about how these choices affect your organization's credibility, reputation, and short-term and long-term goals.

## 4. Policy Arenas

Your group will also need to choose the policy arenas you seek to affect, at least on an interim basis. In the context of community benefits, there are three policymaking arenas or levels to consider: **institutional, communitywide, and statewide.** Is it the free-care policy of the local hospital your group wants to change? Or is that the first step in a larger statewide strategy to pass a law? Part of this decisionmaking will require an examination of the mission (and structure) of your group, and of the separate organizations that may be part of your group. Is your group neighborhood-focused and less likely to take on a statewide agenda? Or is it constituency-focused and more willing? Is your group willing to seek out resources to engage in a broader campaign? Of course, if you begin with a narrower focus, you may later decide to expand.

Whatever type of goal you are focused on, it is important to engage in a group process to clearly lay out coalitional or campaign goals. With broad and diverse participation and information, your group is more likely to craft an effective strategy that takes into account all the subtle elements that exist in your community. In addition, exploring the goals you want to achieve as a group is necessary in order to ensure that the tactics and tone the group ultimately use are supported by its members. For example, if your group was working with a willing institution, a more cooperative tone might be in order. Members of your group may believe that this type of approach is a "sell-out" or soft. Clear group-determined goals, particularly long-term goals, may help to persuade them that tactic will ultimately yield the best results. A documented group process will also serve as a reminder that goals and tactics were democratically chosen.

✓ **GROUP EXERCISE: What Will Your Goals Be?**[49]

Groups will need to revisit a strategic planning process periodically, since coalitional or group goals will change or be modified over time as new developments occur and relationships change.

The following simple worksheet will help your group ensure that it has identified its goals in each of the eight areas:

| Goals | Short-Term | Long-Term |
|---|---|---|
| **Policy** (External) | | |
| **Community-Building** (Internal) | | |
| **Arena** (Community institution or statewide?) | | |
| **Approach** (External event? Community-created event? Other?) | | |
| **Strengths** (including allies) | | |
| **Weaknesses** (including opponents) | | |
| **Opportunities** | | |
| **Threats** | | |

**EXERCISE III-1**

49. Based on an exercise in "A Community Health Agenda for Somerville: Update 1997: Part II."

# D. Considering the Circumstances

Circumstances play an important role in determining goals and strategy.

**Consider the following three scenarios.** What might be the long-term and short-term goals for the coalition in each scenario? How might tone differ in each case? How might tactics such as media strategy, letter writing, demonstrations, and organizing differ?

> **Scenario 1:**   A small urban hospital is well known for its commitment to and strong relationship with an established, diverse, and broad-based multi-issue community coalition. The hospital initiates a new community benefits effort. It invites the community coalition to be part of a community benefits committee.
>
> **Scenario 2:**   Four neighborhood groups band together for the first time and write to the CEO of the local nonprofit hospital. They ask for a meeting to discuss community health needs and their concerns about the lack of communication between the hospital and the community and the paucity of information available about the hospital's free-care and community benefits policies. The hospital agrees to meet with them.
>
> **Scenario 3:**   A local nonprofit hospital is being sold to a large for-profit hospital chain with a notoriously bad record on free care and community benefits. The local hospital has a lukewarm reputation on free care and community benefits. Neither buyer nor seller will agree to meet with an ad hoc coalition made up of two small advocacy organizations. However, the attorney general, with authority to approve or disapprove the deal, pushes the seller to meet with the coalition and hammer out some agreement.

Short- and long-term goals probably will differ for the community coalitions in each scenario for various reasons. For example, each coalition is at a different stage of development, ranging from well established to fledgling. The fledgling coalition may have to devote more significant resources to organizing and outreach, with more modest (yet very important!) policy objectives. Moreover, new or ad hoc coalitions likely will not have the same perceived power as well-established groups, perhaps causing them to temper their policy goals.

The manner in which community benefits issues come to the fore also affects strategy and goals. For example, the level of cooperation and openness will be greater from the institutional initiator in scenario 2 than in scenario 3, where there may be outright hostility. Also timing and timelines will differ. The coalition in scenario 1 probably can take a slower and more deliberate approach than the ad hoc group facing regulatory deadlines in scenario 3. Despite these differences, some guidelines for strategy emerge from these examples:

## 1.   Know the History

**Understand whether there is a history of good or bad communication between the institution and the community.** How does the institution itself describe its relationship with the community? Would institutional executives be shocked or pleased by the way that they are viewed by the community? If your perception of the level and quality of communication is very different from that of the institution, answering these questions will give you some clues about how forthright to be and how best to present the issue of concern to your group.

**Understand history and relations from other perspectives.** How is the institution viewed by "essential community providers" (e.g., safety-net providers such as health clinics)? By constituency groups representing the uninsured? By the media? By other competing institutions? By unions and healthcare workers? What is the general public perception of this institution? Answering these questions will help you identify perceptual barriers you may need to overcome in order to be effective. For example, people often view nonprofit children's hospitals as charitable because they serve children. But assume the local children's hospital does not have good free-care policies, or does not provide sufficient interpreter services. Understanding the perception barriers will help you craft an effective public message.

**Understand the history of the mission of the hospital or institution.** If it is a nonprofit, does it engage in fundraising? Do their annual reports and fundraising efforts espouse "charity" as a core element of the institution's mission? Has its mission changed at any time in the past? Who are its major donors? If it is a for-profit or large chain, how does the institution behave in other communities? Getting this type of information may allow you to use the institution's own words and claims as tools.[50] For example, if a large hospital chain has provided certain benefits and resources to another community where it owns an institution, it is easy to argue to a regulator and the media that your community deserves the same. Additionally, comparing lofty mission statements to actual practices can also be effective.

> **Roger Williams Hospital in Rhode Island** originally was incorporated in 1904 "for the purpose of establishing and maintaining a hospital and of rendering medical and surgical aid to those in need thereof, and especially for the purpose of assisting such poor and unfortunate persons as are in need of medical and surgical treatment and are unable to apply therefore . . ."

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50. Information about the healthcare institution's mission can be found in its articles of incorporation which can be requested from the secretary of state's office or department of corporations. The mission statement may also be available on the institution's Web site.

**Understand the structure and finances of the institution.** Gaining a sense of the financial condition of the institution and how its money flows may reveal new issues and opportunities. Does the hospital make all of its resources available to the community to address unmet needs, or are these resources hidden and untapped? What is its corporate structure? For example, does this structure include a foundation with a strong charitable mission, which, however, is used for fundraising? Are there substantial assets in one or more subsidiary corporations? If the institution is nonprofit, are some or all of its subsidiaries for-profit? Is it engaged in a partnership with an HMO or other hospital with a better community benefits record? Such information will allow you to see additional leverage points and issues that will interest the media, regulators, and legislators. For example, a nonprofit institution that claims it is doing all that it can for community benefit, may have tremendous assets that are untapped for such uses. A local nonprofit institution may be allied with a for-profit that is draining charitable resources from the community.

**Understand the institution's current community benefits activity.** Was the community involved in shaping this activity? Will the institution provide your group information about its activities? Look at the key elements on page 23: Do the institution's community benefits activities include any of the elements outlined in that section that your group deems critical? Are they addressing unmet needs of the underserved? Look back at the true community benefits examples on page 5. Do the institution's activities meet the criteria your group identified in those exercises? Answering these questions will help you begin to craft an overall approach to the institution and a media strategy as well. If your state has a community benefits law, check to see whether an annual report is required. Also check with the attorney general's office; most have a charitable trust department that will be helpful to you. You should also consult the institution's 990 Forms.[51]

## 2.  Gain an Institutional Perspective

In scenario 2, no relationship exists between the institution and community; although the institution is willing to meet with the community, a delicate and balanced approach is necessary. A balanced approach should include being a critical outside voice as well as engaging in efforts to build trust and relationship, and efforts to gain an understanding of the institution's perspective.

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51. Financial and corporate structure information can be found in the institution's Form 990 filings with the Internal Revenue Service. Under new IRS regulations, tax-exempt organizations must provide requesters with copies of their exemption applications and their three most recent 990s. Organizations may make these documents available on their Web sites. Organizations that do not comply with these new requirements are subject to penalties of $20 per day of violation to a maximum of $10,000. See 64 Fed. Reg. 17,279 (1999). Many of the financial documents are very complicated to read and it is advisable to consult with financial experts such as university professors.

Understanding history will help you gain perspective, but there are other important questions to answer: Is the local healthcare industry changing around the institution? Is the institution facing fierce competition or is it the fierce competition that is confronting other institutions? As for community benefits, how does this institution rank against other local entities? What reasons might the institution have for working with your group? Does your group see common interests that the institution may not? Answering these questions will help you to make an informed guess as to how committed the institution might be to any given community benefits process. The answers also will help reveal potential allies and other targets. For example, if the institution you're focusing on is a "Goliath" in your community, smaller and/or public institutions feeling squeezed by its presence may be very happy to work with your group to ensure that "Goliath's" resources address unmet community needs.

Also determine who are the institution's leaders, including the board of directors. Consider meeting with them one-on-one. What kind of background and life experiences do these leaders have? Keep in mind the relative inexperience of some institutional executives in dealing with constituency and community leaders (as opposed to business and civic leaders). What do you think they might expect upon meeting you or members of your coalition? What stereotypes might be at play on both sides? How might your definition of "community" and "community leaders" be different than theirs? How do you want the coalition to be perceived? Additionally, who within the leadership do you or members of your group have a relationship with? Where (or who) are the potential points for influence?

## 3. Find Your Allies

Allies, such as the attorney general in scenario 3, can also be important to create leverage for or give greater weight to the community. Situations like scenario 3 are probably not the norm. It is more likely that you will have to seek out allies.

Allies may or may not be part of your coalition, depending on how much your interests align. In the area of community benefits and depending on the types of institutions your group focuses on, you may find unusual allies. For instance, a financially strapped public hospital may be a strong ally in scenarios 2 and 3. In other instances, hospitals in general may be strong allies if your group chooses to focus on HMOs. There is, of course, a long list of traditional allies such as labor unions, neighborhood providers, nurses, constituency groups, and ethnic neighborhood groups. The key is to think broadly.

✔ **GROUP EXERCISE: Allies List**

| Potential Ally | Contact Person | Common Interest? (allies) | Conflicting Interest? (opponents) | Inside/ Outside Coalition | Person to Initiate Contact and Deadline |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
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**EXERCISE III-2**

# E.  Communities and Institutions: First-Meeting Challenges

Your group has organized, trained, and researched. You have identified or created an opportunity to raise the community benefits issue. The institution(s) agrees to meet with you. Now what? First-meeting challenges won't be part of every campaign. Look back at the three scenarios on page 72; the coalition in scenario 1 will not have to pay as much attention to the flow, content, and credibility issues involved in a first meeting. However, if your situation and circumstances more closely resemble scenario 2 or 3, you will need to put some energy and thought toward that first meeting, even if you have dealt with the institution before.

By answering many of the questions concerning history and perspective, you have the information you need to begin planning for the meeting. Think about the following items as you plan.

**1.** Draft an agenda: You want to eliminate surprise to the extent possible. You also want representatives of the institution (as well as the representatives from your group) to be prepared. Prior to the meeting, the agenda should be shared and discussed with whoever is coordinating the meeting on behalf of the institution. It should include goals for the meeting, a list of attendees, and time frames for discussion. Perhaps most importantly, it should include time to discuss next steps.

**2.** Consider the attendees: Who will represent your group? And from the representatives, who will be the point person? Looking at the agenda, what would be the appropriate roles for each attendee? And who will be present from the institution? How many people overall? We recommend you seek an institutional representative with decisionmaking authority or substantial influence to meet with.

**3.** Keep a record: Make sure that agreements, next steps, assigned tasks, and other important information are written down. The minutes to the meeting can be shared with the institution to ensure that the process continues to build upon the work that has been done and the agreements that have been reached.

**4.** Prepare adequately: Is there any documentation or paper that you want to present or that you want from the institution before the meeting. Is your group clear on the goals? Is your group clear on things NOT to say?

Your coalition/group should be clear on what it *hopes* to accomplish and what *can* be accomplished in this first meeting. Coalition goals for a first meeting might include:

- establish credibility
- show strength by revealing depth and diversity of coalition
- show expertise by revealing knowledge that you and your members bring to the table
- show cooperation
- ease fear, break down stereotypes that may exist

It is unlikely that you will begin hammering out a community benefit plan in this first meeting (although not impossible!). While topics for discussion will vary, consider the following potential first meeting topics:

- introductions of organizations and individuals

- highlight common ground and shared interests and concerns

- discussion of unmet health needs of underserved

- discussion of the particular health needs your group has identified and how you did it

- sharing of specific information, e.g., what the institution's free-care policy is

- defining a process for working together

- defining goals for working together

- setting general timelines and deadlines

- agreeing on evaluation

- other?

## F.   The Very Bare Necessities of Negotiation

Not every situation will require negotiation, but there may come an intimidating time when your coalition will engage in negotiation with an institution or group of institutions. This may evolve over time into a more collaborative decisionmaking process, but the following are some techniques we should think about. Despite the formality of the word "negotiation," each one of us negotiates every day. For example, we negotiate with our family and with our coworkers, and supervisors. In reality, negotiation can be described simply as a situation where both sides have positions but are willing to compromise to reach agreement. In fact, it may be helpful to have an explicit discussion in your group about the ways in which people have gained negotiation experience in their own lives. We don't intend to summarize the many written works on the art of negotiation. Instead, we hope to provide you with the minimum: basic concepts and a worksheet to use to ensure that your coalition or group representatives have the necessary information to engage in effective negotiations.

Those who represent and negotiate on behalf of the campaign must be given decisionmaking power. One could imagine the logistical nightmare of trying to get group approval for even the slightest change in negotiated terms. The group should give the representatives a range of decisionmaking authority, with clear parameters and a bottom line.

## Understanding Both Sides

Understanding the institutional perspective becomes especially important in a negotiation phase. In particular, it is important to understand how issues you raise may be received by the institution. For example, consider the following list of issues or demands a community coalition might be concerned about in the sale of a local hospital to a for-profit buyer:

**1.** Admit, treat, and seek Medicaid enrollment for all uninsured patients.

**2.** Keep the emergency room open indefinitely.

**3.** Have clear notice, visible to the public, stating the institution's policy for treatment of the uninsured.

**4.** Produce and distribute pamphlets on policies for uninsured patients.

**5.** Continue or increase current level of financial support for outpatient clinics.

**6.** Provide shuttle services that will pick up all low-income or underserved patients requesting rides to and from the hospital and between the hospital campuses and satellite facilities.

**7.** Provide translation services for every language represented in the institution's population.

**8.** Create a program to provide prescription drugs to the members of the community who are uninsured or whose insurance does not cover prescription drugs and cannot afford to pay for them.

**9.** Furnish statistical information regarding admission and treatment for the uninsured as well as other basic primary care services.

**10.** Establish a Community Advisory Board with community members who live in communities served by the institution.

**11.** Preserve as many jobs as possible to maintain services and quality patient care.

**12.** Use endowment or foundation money to be used for community services or other community benefits in line with donor intent.

**13.** Continue operation of HIV/AIDS programs for as long as five years.

**14.** Continue maternity-care services, including midwife services, and continue to provide transportation vouchers to disadvantaged pregnant mothers.

How realistic is this list? What are the odds that the for-profit buyer will agree to the outlined terms—for example, the demand to keep the emergency room open indefinitely? It may intend to do so, but it may not want to commit and tie its hands. Is there another way to present the issue that may be more viable from the institution's perspective and yet achieve important community goals? Often you will be able to reach only partial agreement on a term. If this is the case, one solution might be to create an opportunity for reconsideration at some later date. In other words, if you can't reach agreement in the short term, try to make sure that there will be a community process at the point that the issue again becomes relevant.

## For Example:

**Original demand:** Keep the emergency room open indefinitely.

**Modified demand:** Keep the emergency room open for a term of five years. At the end of the five-year term, and at any point thereafter that the institution proposes to discontinue ER service to the community, the institution shall provide at least one public hearing 90 days prior to any decision. The institution shall also accept written comment from the public for the 90-day period. Prior to the public hearing, the institution shall issue a report detailing how the critical services provided by the ER will continue to be available to the community.

**Original demand:** Provide shuttle service that will pick up all low-income or underserved patients requesting rides to and from the hospital and between the hospital campuses and satellite facilities.

**Modified demand:** Provide shuttle service between the hospital and its satellite facilities. Work with other local agencies that provide transportation on an areawide basis to do a transportation-needs assessment and plan. The plan should coordinate and expand existing services for low-income or underserved patients and set minimum standards for minimum response times. Provide funding to hire a consultant to design the plan.

In the preceding examples, it may be that the negotiation can only carry the coalition a certain distance toward its goals. If a compromise term is acceptable to the institution, this may be the point where your group needs to turn away from the institution and focus on broader change to achieve the underlying goal. In the emergency room example, perhaps a legislative remedy would be appropriate. Such a remedy might include legislative changes requiring licensed acute-care hospitals to provide emergency services. What seems like a setback in your community benefits work might become the basis of a legislative campaign.

✔ **GROUP EXERCISE: Gimme, Gimme**[52]

The following exercise can be used as an icebreaker to start off a training session on negotiations for your group. It makes the point that we negotiate things every day: What movie do you want to go to? This yard sale item is too high—can you sell it for less? Will you do your homework after school or after dinner?

**Step 1:** Choose one person who has something that is really nice: a leather jacket, a delicious cookie, a nice pen.

**Step 2:** Select someone else to try to get the item from that person. Give him/her about five minutes to try to get it. (Maybe do this twice with another pair of people; vary the power dynamics by having a white male try to get something from a Latina woman, or a Latina woman try to get it from a Latino male.)

**Step 3:** After they've tried—and they may or may not succeed—talk about the "tactics" the person used to try to get the item. (Did he/she beg? Reason? Threaten? Name drop? Enlist help?) Write these down on a big sheet of paper.

**Step 4:** Also talk about ways the person in step 1 tried to avoid giving the item to the other person. Did he/she just stonewall? Sidestep? Pass the buck?

All of the brainstormed items on your lists are just what can happen in negotiations.

**EXERCISE III-3**

52. Based on an exercise developed by Health Care For All, Massachusetts.

# Is Community Benefits an Important Issue for My Community?

After looking over this workbook, you may still be unsure if pursuing community benefits is right for your community. To begin to answer this question it is helpful to think about the big picture and to take a broad look at the health system as it is today.

# A. Money Facts

- Our nation spends approximately 13–14 percent of our gross domestic product (GDP) on health care. The GDP is the market value of all goods and services produced in the United States in a year. In terms of dollars, that 13–14 percent equaled **$1.035 trillion in 1996** and **$1.1 trillion in 1997.**[53]

- Just to get a sense of perspective, the country with the next highest level of per capita expenditure level is Switzerland. While we spend about four thousand dollars annually per person on health care, the Swiss spend about half of that, or twenty-five hundred dollars per person.[54] In short, the United States has by far the most expensive health system in the world.

- We, the people, pay a HUGE share of that $1.1 trillion. First, obvious public spending such as for Medicaid, Medicare, and public health facilities accounts for 46 percent of total health expenditures. (This number does not include out-of-pocket or insurance premiums that we might pay as well.)[55] There are additional hidden public costs, such as tax "subsidies" offered to employers who provide insurance to their employees. Employer payroll deductions used by employers to pay health insurance premiums are not taxable, in effect, this exclusion creates a tax subsidy for employment-based insurance. This "program" costs the public tax revenues of $76 billion annually.[56]

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53. National Center for Health Statistics, *Fastats A to Z* (last modified March 22, 1999), *http://www.cdc.gov/nchswww/fastats;* John K. Iglehart, "The American Health Care System—Expenditures," 340 *New Eng. J. Med.* 70 (January 7, 1999).

54. Marcia Angell, M.D., "The American Health Care System Revisited—A New Series" (editorial), 340 *New Eng. J. Med.* 48 (January 7, 1999).

55. See Fastats, note 53.

56. See Iglehart, note 53.

**Figure 1** **Where does the money come from? WE pay the majority via taxes and our own pockets.**

## The Healthcare Pie
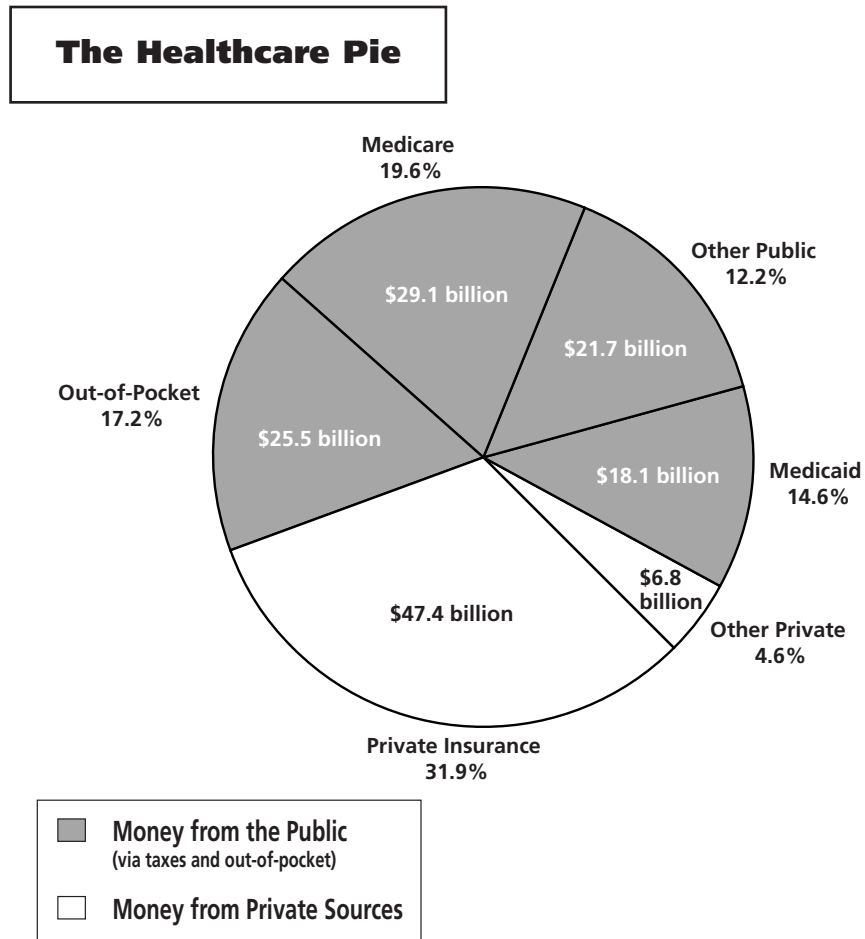


Based on data from "The Nation's Health Dollar, 1997: Where It Came From," Health Care Financing Administration [Office of the Actuary, National Health Statistics Group], *http://www.hcfa.gov/stats/nhe-oact/tables/chart.htm,* last modified October 29, 1998.

## B. What Kind of Access and Quality Are We Really Getting for Our Money?

Even though a lot of money is flowing in today's health system, the impact of these tremendous resources is not what you might expect. Moreover, the health system is not accountable to the major payer (the public at large). Look at the following statistics pulled from a recent article in the *New England Journal of Medicine*.[57]

### HEALTHCARE ACCESS

- The percentage of Americans without health insurance increased from 14.2 percent in 1995 to 16.1 percent in 1997. This brought the actual number of uninsured to around 43.4 million in 1997. It is also estimated that about 71.5 million people were without insurance for some portion of 1997. Incidentally, most of these people are employed.

- These figures do not include the significant number of people who are underinsured. Those who are underinsured have insurance with high deductibles or large out-of-pocket costs, or have insurance that does not cover necessary medical treatment. The result is that underinsured people often have to choose between going untreated or having to pay extremely high costs. For example:

  one in eight insured families without elderly members spends about 10 percent of its income on out-of-pocket healthcare costs.

  for insured families with members who are 65 or older, 50 percent of income goes to out-of-pocket healthcare costs.

  insured people with the most serious health problems spend about twenty-one thousand dollars a year for premiums and out-of-pocket payments.

- Approximately 15 percent of our nation's children were uninsured in 1996. In that same year, some eight hundred thousand children went to the emergency room for all their care.

- Hospital closings and service losses nationwide have had a disproportionate impact on minorities and lower-income neighborhoods, severely curtailing accessibility in these communities.[58]

### HEALTHCARE QUALITY

We have the most advanced health technology in the world, but does that translate to better quality?

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57. Robert Kuttner, "The American Health Care System—Health Insurance Coverage," 340 *New Eng. J. Med.* 163 (January 14, 1999).

58. See Alan Sager et al., *Before It's Too Late: Why Hospital Closings Are a Problem, Not a Solution* (June 2, 1997, 2nd ed.), p. 8; Julio Mateo, Jr. and Jaime Rossi, *White Knights or Trojan Horses? A Policy and Legal Framework for Evaluating Hospital Consolidations in California* (Consumers Union West Coast Regional Office, April 1999).

- The quality of care for minorities and the uninsured is often inferior.[59] In fact, race and sex have been found to independently influence how physicians manage chest pain.[60]

- The rise of managed care and competition have caused providers to blend business decisions with medical decisions about how much and what kind of medical services should be available to patients. Where should the line be drawn?

- Nurses and physician assistants are doing jobs that doctors once performed; nurses' aides and assistants are performing jobs that used to belong to nurses—all in the name of lowering cost. How does this affect quality of care? How does it impact on the increase in medical mistakes?

- The number of specialty hospitals, specialty physicians, and specialty treatments continues to rise and the line between insurers and providers continues to blur. Are we moving toward more coordinated health services, or are we moving toward a more fragmented system?

## C. So Where Does the Money Go? Prescription Drugs as a Case Study

It may be helpful to examine one of the many segments of the healthcare marketplace to understand why access and quality have not increased even though we are spending so much money. A few facts about the pharmaceutical industry reveal some of the reasons why exorbitant health spending doesn't seem to relate to the access and quality we have.

- Drug companies and pharmaceuticals represent the fastest growing segment of the healthcare industry.[61] It was projected that drug companies would spend an estimated $1.3 billion dollars on consumer advertising in 1998.[62] We have all seen the ads for Claritin, Viagra, and other brand-name drugs. This level of spending (projected to be a 50 percent increase over previous years) follows an advertising increase of 42 percent between 1996 and 1997.[63] The Food and Drug Administration loosened the restrictions for advertising drugs on television in August 1997. Since that time, there has been a marked increase in the number of commercials advertising prescription drugs. These new drugs are almost exclusively high-cost brand-name drugs, which often are out of reach for the poor and uninsured. Doctors

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59. See Karen Scott Collins et al., *U.S. Minority Health: A Chartbook* (The Commonwealth Fund, May 14, 1999).

60. Kevin A. Schulman et al., "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization" (special article), 340 *New Eng. J. Med.* 618 (February 25, 1999).

61. Katharine Levit et al., "National Health Expenditures in 1997: More Slow Growth," 17 *Health Affairs* 99,101 (November/December 1998); Iglehart, note 53.

62. Levit at 105.

63. American Healthline, *Trends & Timelines—Direct-to-Consumer Ads: FDA Rules Create Ad Bonanza* (August 8, 1998).

charge that such advertising distorts the traditional doctor–patient relation-ship by inducing patients to want drugs that they do not need;[64] in fact, a recent survey found that the primary source of information for clients who requested drugs was not a physician or other provider, but direct-to-consumer ads such as television and magazine advertisements.[65]

● Nationwide healthcare expenditures for research and development of new technology have increased from 42 percent to 52 percent over the last decade, largely because of increased research and development spending by drug companies. At the same time the number of uninsured continues to grow, but resources for this issue remain stagnant.[66]

● Even with all the money flowing, the drug industry continues to resist changes to the Medicare program that would add drug coverage and allow the federal government the purchasing power to buy discounted drugs.[67]

● Meanwhile, over nineteen million elderly people or about half of all Medicare enrollees have no drug coverage. Our elderly spend more for drugs (34 percent of all health expenditures by the elderly) than for either hospital or physician care.[68]

● For those who do have drug coverage (either through Medi-gap insurance, Medicaid, or an employer-sponsored plan), benefits available to the enrollee decrease as the price of drugs continues to rise.[69]

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64. Ibid.

65. Ibid.

66. Ibid.

67. See Iglehart, note 53 above.

68. See Kuttner, note 57, above.

69. Ibid.

**Figure 2**  **Where does the money go? The majority goes for caring for us when we are sick.**

## The Healthcare Pie

Physician Services
19.9%

$29.6 billion

Hospital Care
34.0%

$50.5 billion

Nursing Homes
7.6%

$11.3 billion

$10.7 billion

Prescription Drugs
7.2%

$39.6 billion

$6.8 billion

Admin. and Net Cost
4.6%
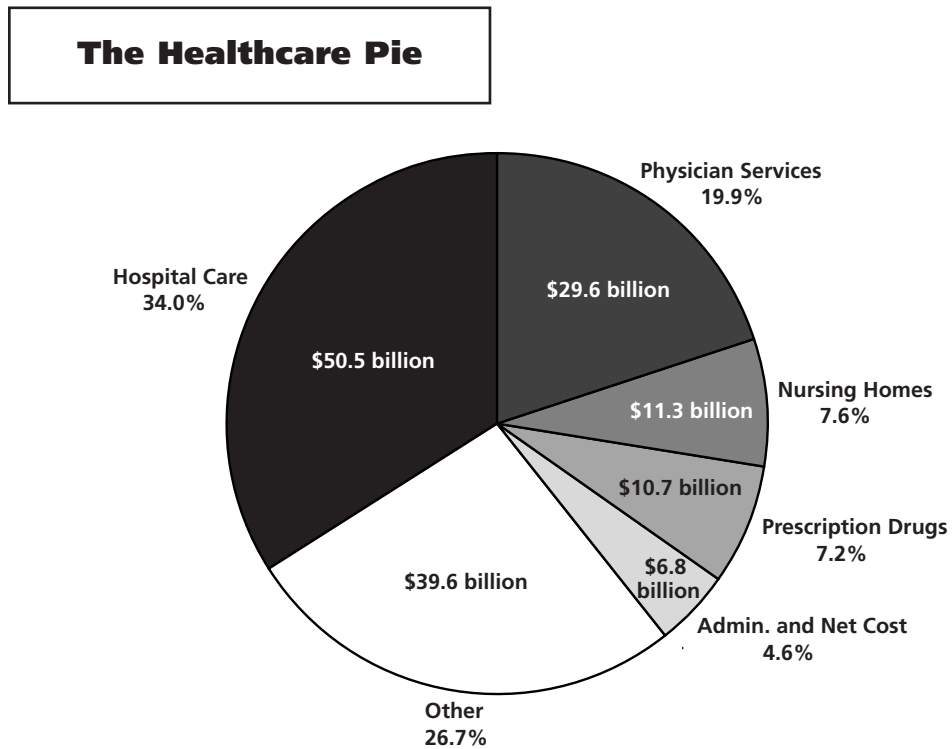
Other
26.7%

**"Other" includes:**
**dental services**
**other professional services**
**home health**
**durable medical products**
**over-the-counter medicines & sundries**
**public health**
**research**
**construction**

*Source:* Data from "The Nation's Health Dollar 1997: Where It Went," Health Care Financing Administration [Office of the Actuary, National Health Statistics Group], http://www.hcfa.gov/stats/nhe–oact/tables/chart.htm, last modified October 29, 1998.

*Note:* Some costs or expenses are not included in this chart such as drug company advertising and research and development and benefits such as Women, Infants, and Children programs.

CONCLUSION

CONCLUSION

Now, take a look back at your list of what it takes to be healthy on page 4. Your list might look something like this:

> ❑ **prevention**
>
> ❑ **language and culturally appropriate care**
>
> ❑ **good food and proper nutrition**
>
> ❑ **good communication between doctors and patients**
>
> ❑ **clean environment**
>
> ❑ **less crime**
>
> ❑ **peace of mind**
>
> ❑ **exercise**
>
> ❑ **outreach and education**

## D. The Mismatch

There is a mismatch between the amount of money we spend and the access and quality we as a society receive. There is also a mismatch between what we need to be healthy and how resources are allocated. Compare the "good health list" with the statistics in the healthcare pie on the previous page. Is our health system addressing the issues that we believe make us healthy?

**Figure 3** **The Healthcare System We Need Versus Today's Healthcare System**
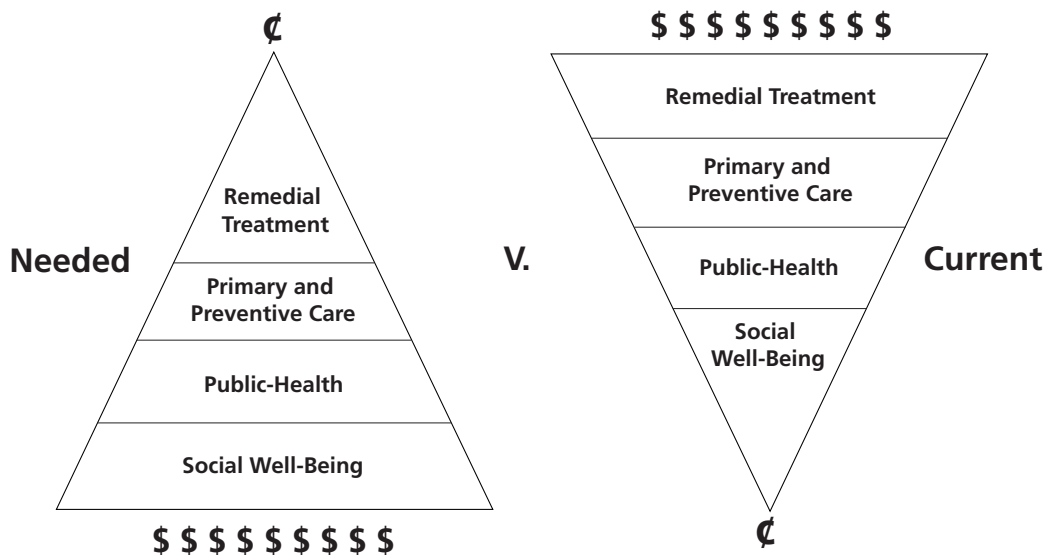


*Source:* Community Catalyst, Boston at Risk 2000, *Six Principles for a New Health Care System: A Blueprint for Action* (October 1994).

**90**

**The Access Project**

It is important to highlight these disconnects as your group considers the importance of community benefits work. As we noted at the beginning of this workbook, community involvement in healthcare decisionmaking is critical to protect free care and other safety net services as health care continues to change. But perhaps more importantly, community benefits can also be an effective step for your group to bring about deeper change and address the discrepancy between what is needed for good health and the way that health dollars are actually spent. Community leaders may be the missing consumer voice that demands quality and shapes the content of care. Community leaders can work to influence where hospitals are located and the services they provide. Consumers should monitor the changing role of the doctor in today's managed care world. Communities need to reevaluate the role of and establish relationships with local health institutions to improve the delivery of care to our communities. In the long term, your group may seek a broader role for grassroots leaders in governing local institutions, setting priorities, and in the allocation of health dollars overall.

After reading this workbook, you will hopefully agree that organizing around community benefits issues can improve health care in your community by:

- creating communication and dialogue between grassroots leaders and institutional and other health resource decisionmakers to ensure collaboration around identifying problems, crafting solutions, and selecting priorities;

- increasing access to appropriate and respectful health care for those most in need in our communities;

- making more efficient use of existing resources to keep people, especially vulnerable populations, healthy;

- increasing participation by diverse institutions as well as more traditional community benefits providers in community benefits processes and community dialogue;

- involving everyone (industry, government, and the people) in changing the dynamics and making a health system that really is about keeping us healthy!

We hope that this workbook has been a helpful resource in your community's efforts to improve your local health system.

CONCLUSION

# RESOURCE MATERIALS

The information in this section is supplemental to the materials found in the preceding pages of the manual and can be used for reference. As you begin to design your own community benefits campaign, these fact sheets and tables will be useful.

# A. Community Benefits Laws, Regulations, and Guidelines*

| State | Citation | Governs |
|---|---|---|
| California | Cal. Health & Safety Code § 127340, *et seq.* | Private nonprofit acute–care hospitals |
| Connecticut | Public Act. No. 00-57 2000 Substitute House Bill No. 5292 | Hospitals and managed care organizations |
| Georgia | Ga. Code Ann. §§ 14-3-305, 31-7-90.1 | Nonprofit hospitals operated by hospital authorities (a public body) |
| Idaho | 1999 Idaho Sess. Laws 126 Idaho Code § 63-602D | Tax exempt nonprofit hospitals |
| Indiana | Ind. Code § 16-21-9-1, *et seq.* | Nonprofit hospitals |
| Massachusetts | Attorney General's Community Benefit Guidelines for Nonprofit Acute Care Hospitals, June 1994 (reissued January 2000); Attorney General's Community Benefit Guidelines for Health Maintenance Organizations, February 1996 (reissued January 2000). | Nonprofit acute care hospitals; HMOs |
| Minnesota | Minn. Stat. § 144.698 Minn. Stat. § 62Q.07 | Acute care institutions and outpatient surgical centers, health insurers, including HMOs |
| New Hampshire | 1999 N.H. Laws 0924 N.H. Rev. Stat. § 7.32-c, *et seq.* | Healthcare charitable trusts (nonprofit hospitals, insurers [BCBS is excluded], and HMOs) |
| New York | N.Y. Pub. Health Law § 2803-1 | Nonprofit general hospitals |
| Pennsylvania | 10 Pa. Cons. Stat. § 371, *et seq.* | Institutions of purely public charity |
| Rhode Island | R.I. Gen. Laws § 23-17-43 | Hospitals (statewide community standard for provision of charity care) |
| Texas | Tex. Health & Safety Code Ann. § 311.042, *et seq.* | Nonprofit hospitals |
| Utah | Nonprofit Hospital and Nursing Home Charitable Property Tax Exemption Standards (December 18, 1990), Utah State Tax Commission | Nonprofit hospitals and nursing homes |
| West Virginia | W.Va. Code State R. tit. 110, § 24.1 | Tax exemption of nonprofit hospitals |

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* As of the printing of this manual, 14 states had passed laws, regulations, or guidelines that related to community benefits.

## B. Handling the Tough Questions

If your group takes on a community benefits effort, there may be critics. Institutions, legislators, regulators, providers, the media, and other people within your community may be openly critical of your efforts. You may get tough questions about why institutions should provide community benefits at all. This section of the workbook anticipates these tough questions and provides you with "sound bites," or quick answers, as well as more detailed explanations helpful to community leaders speaking publicly. It may also be potentially useful for the sympathetic institutional insider, legislator, or regulator who wants to champion community benefits within an institution or from a regulatory or legislative framework.

### 1. Question: For-profit healthcare institutions pay taxes; why should they also provide community benefits?

*Quick Answer:* Health care is different from other for-profit industries because it is so basic and essential for all people: Hospitals are required to treat people in emergency situations regardless of ability to pay.[70] Community benefits applies this "social good" view of health care to nonemergency situations because we believe that all people should have basic access to "health" care (as well as sick care). Besides, other for-profit corporations have recognized their obligations as corporate citizens in our communities. Banks, classic bottom-line institutions, have a 50-state community obligation, so why shouldn't healthcare institutions?[71]

*Further Discussion:* For-profit healthcare institutions should also have a community interest obligation to the public because they increasingly are dominant players in local healthcare markets. Their strong position in local markets is creating an uneven playing field. While they have great resources, for-profits service a smaller percent of the at-risk population. The effect is either to increase responsibility of public and nonprofit institutions or to leave more people unserved. From a public policy perspective it makes sense to require for-profit institutions to provide free care and community benefits to the communities they serve. However, there may be a different standard for community obligation between tax-exempt nonprofits and tax-paying for-profits.

Additionally, many for-profit institutions were once nonprofit. In many of these cases, state regulators and legislators have required that these converted institutions provide community benefits at the same levels as did their predecessor nonprofits as a condition for approving the conversion. These conditions have been required through legislation, as a condition of regulatory approval of the transaction. They also have been obtained via private agreement between the community, the institution, and sometimes the regulator. Community activism and vigilance are what have led regulators and legislators to impose these conditions on for-profit healthcare institutions. However, it is important to note that community benefits commitments can be gained in

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70. 42 United States Code § 1395dd.

71. See page 15 for a discussion of the Community Reinvestment Act (12 U.S.C. § 2901, *et. seq.*) which requires banks to demonstrate that they are serving their communities, not just their customers.

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policymaking arenas other than the legislative. Private agreements have the potential to be very effective over the long term, and conversion transactions are tremendous opportunities for advancing community benefits because community and regulatory leverage is so strong. Many for-profits see community benefits in this context as a cost of getting the deal done.

### 2. Question: We're a nonprofit hospital, and we already provide more free care and treat more Medicaid patients than any other hospital in the community. We can't afford to do any more.

*Quick Answer:* Collaborating with community leaders in a community benefit process does not necessarily cost more for the institution. In fact, in the long run it could cost less, if health status among indigent patients is improved and patients seek care before they become severely ill, when care is more expensive. For example, shifting resources into preventative programs may be less costly than treating very sick people in the emergency room. It's not just a question of how much free care your institution is providing, but a question of what type of care and the process by which community benefit priorities are chosen. Institutional partnership with the community can result in greater and more sustainable community health improvement with the same amount of resources.

*Further Discussion:* A community benefits program should be based on priorities determined through a collaborative institution-community planning process. Such a process takes advantage of institutional healthcare knowledge and the expertise and experiences of community leaders to solve community problems. Good communication will ensure that all the assets of the community can be dedicated to improving health status. Institutions providing more resources than other hospitals and health institutions in the area to solve community health problems can work together to create a model for collaboration and to set a standard for results.

### 3. Question: We already make charitable donations to a number of causes. Isn't that enough?

*Quick Answer:* Are these donations made to charities that target priority community health needs? How are these charities chosen?

*Further Discussion:* It depends. The charities to which an institution makes donations may not serve the community's needs and concerns. While it is admirable to make charitable donations, community benefits should be determined through a process that involves the community. For example, your institution might not be meeting community needs if your community has a very large teen pregnancy problem, and you sponsor a road race in another city that supports breast cancer research.

#### 4. Question: Our employees participate in many community activities — mentoring programs, domestic abuse counseling, donations to the United Way. Aren't these community benefits?

*Quick Answer:* All the institution did was hire good people! Plus, individual generosity does not equal an institutional commitment to community benefits.

*Further Discussion:* Employee volunteer activities could be considered a community benefit if the employees are given paid time off to participate in activities that address community-identified health needs or if such activities are considered to be a part of their jobs. Otherwise it is inappropriate to claim the volunteer work or charitable giving of employees as an institutional community benefit.

#### 5. Question: We're a teaching institution that trains doctors, conducts research, and develops state of the art medical technology — all of which work to make sick people better faster: that is a community benefit.

*Quick Answer:* If you are wealthy and/or fully insured, you benefit from highly trained specialists and cutting edge technology. However, such "benefits" are unlikely to reach those most in need. An uninsured or underinsured person or family likely has trouble getting even the most basic care. Research and technological developments are of "benefit" to society. But the definition of community benefit is more specific than the claim that merely operating and existing is of benefit to the community and therefore a community benefit.

*Further Discussion:* Is the focus of the teaching institution in sync with the needs of the community? For example, some teaching institutions will train more specialists than internists, even though their surrounding community may have a shortage of primary care physicians. Does the institution pay attention to cultivating doctors and medical students who are committed to the local community? Or does it train physicians who then take their knowledge elsewhere? Does the institution cultivate medical students who reflect the cultural diversity of the community? If the institution is a hospital, what is its community benefit activity outside of medical education?

#### 6. Question: Community benefits are for hospitals; we're an insurer and we don't provide care.

*Quick Answer:* The growing and unmet health needs that exist in our communities are serious. In today's health system, where over 85 percent of the enrolled workforce is in managed care,[72] we should not be relying solely on hospital resources to fulfill these needs. In order to solve the complex problems in health care, all the players need to participate, and insurers and HMOs are definitely players in today's health system.

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72. Department of Health and Human Services, *Highlights National Expenditures, 1997* (last modified October 30, 1998) *http://www.hcfa.gove/stats/nhe-oact/hilites.htm.*

*Further Discussion:* Insurers and HMOs often possess tremendous financial resources and power in our communities. They are changing the incentives and dynamics in local health care delivery systems. As the health system evolves and the lines between insurers and providers continue to be blurred (is an HMO an insurer or a provider or both?), traditional ideas about community benefits must also change. In fact, shifts in the industry are the genesis for changes in the way policymakers and community leaders are viewing community benefits. Community benefits are no longer the sole province of nonprofit hospitals. Whether non-profit or for-profit, there are many other types of institutions that can and should be held responsible for community benefits obligations.

### 7. Question: As the state's largest insurer, the "community" we serve encompasses the entire state. How can we provide community benefits to such a vast constituency?

*Quick Answer:* You don't need to provide community benefits to everyone. You should choose a vulnerable group and work with that group to identify its priority issues. For example, you could target the elderly and provide prescription drugs or discounts on drugs for those whose insurance does not cover prescription drugs.

*Further Discussion:* It is better to choose a discrete group for several reasons. You will be able to identify and convene members of that group so that you can get a grounded sense of its priority issues. You will also be able to consult directly with them on the best way to address any issue, given the particular circumstances faced by people in that group. Third, targeting resources will make it easier to understand the effect of community benefits programming and more likely that problems within the program will be identified and solved through consumer feedback.

### 8. Question: We're considered "the insurer of last resort." Isn't that a community benefit?

*Quick Answer:* It is a legitimate piece of a community benefit effort, but after passage of the federal Health Insurance Portability and Accountability Act (HIPAA, also known as "Kennedy-Kassebaum") and the various state laws that followed it, the need for an "insurer of last resort" has been overshadowed by other pressing health needs.[73] Moreover, insurers and HMOs are best positioned to respond to the lack of preventative care for indigent patients, transitional insurance coverage for welfare-to-work families, and well-child programs.

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73. HIPAA mandates that insurers offer and renew policies without regard to the health of the individual, the members of the group, or their dependents. It also changes preexisting condition law so that a person does not lose coverage for a preexisting condition just because he or she changes to a new policy. For more information, see *State and Federal Insurance Reforms for Individuals and Small Groups* (States of Health, September 1997), available from Community Catalyst.

*Further Discussion:* The rationale here is the same as it is for question 6. All stake-holders in the health care system, including consumers, insurers, and hospitals, need to participate and collaborate in problem solving and evaluation in order to improve delivery of health care. Keep in mind that "insurer-of-last-resort" status is an incomplete and inadequate measure to address unmet health needs especially for the over forty-four million uninsured people who can't afford what is often expensive nongroup health insurance.

### 9. Question: We know the problems in the community; we don't need to consult with the community. Besides, our board consists almost entirely of community leaders.

*Quick Answer:* Would you launch a new product without doing market research? Your board consists of community/civic leaders, but can and should they speak for the uninsured and underserved members of the community who should be the focus of any community benefits effort?

*Further Discussion:* Institutional executives, administrators, and board members who make decisions about health care resources are often outstanding civic and business leaders. In their decisionmaking they may take "community" into account, but if they are unfamiliar or isolated from vulnerable populations, then their idea of community is not complete. The very people meant to benefit from "community benefits" are not represented in the decisionmaking and resource allocation process.

Currently over forty-four million people are uninsured in this country. An even larger and growing number of people are at risk for poor health status because of a complex mix of factors such as lack of transportation, education, or interpreters or complex enrollment procedures, discriminatory treatment, and cultural differ-ences.[74] Identifying the exact mix of barriers and issues that particular people face in trying to access quality health care requires feedback from the very people that face those barriers every day. People who live the situation bring invaluable infor-mation not only about the barriers, but about solutions that fit their particular cir-cumstances and existing community infrastructure and resources. They should be involved as partners who are recognized for the important insights they bring to the table about community health needs and possible solutions. Institutions ready to dedicate dollars to a community benefit program should think of such a process in terms of market research and as a means to increase the effectiveness and effi-ciency of their community benefits products.

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74. See Robert Kuttner, "The American Health Care System: Health Insurance Coverage," *New England Journal of Medicine* 340 (January 14, 1999).

### 10. Question: We provide health care. That's a community benefit.

*Quick Answer:* While we provide care to those who have insurance, there remain over forty-four million people without insurance. No matter what, we pay for their care. Community benefits are efforts to shift institutional resources into tailored strategies to improve the health of the uninsured and vulnerable. We can either pay to keep people healthy or we can pay for sick people and their care.

*Further Discussion:* There is an overwhelming need for improvement in the way that uninsured and vulnerable populations access health care. The support, expertise, and cooperation of all healthcare institutions is needed.

### 11. Question: We have a fiduciary responsibility to run a financially viable institution, and keeping this institution viable is critical to the community.

*Quick Answer:* We don't think we have to threaten or harm the financial health of any institution in order to make the community healthier. Institutions should not view community benefits efforts as a threat to their financial stability, particularly before any discussions have taken place. The community position is not black and white. We want to look at the issues and work together to craft solutions that will work for our institutions and for us as consumers over the long term. We all have to balance the checkbook!

*Further Discussion:* The financial viability of the healthcare institution is important to the community. And the support of the community is critical to its long-term viability. A commitment to collaboration and community benefits planning does not necessarily require allocating more resources. Perhaps the institution is spending resources in an ineffective or untargeted way. For example, one community benefits campaign identified the use of outreach workers as an important tool to improve access to primary care in the community. The community may prioritize a part-time outreach worker over some other program currently offered by the institution. The end result can be a simple shifting of resources.

On the other hand institutions may claim they are suffering financially, when in fact they are not. (See page 63 for examples of community groups working to define the financial capacity of local hospitals.)

### 12. Question: Community benefits are not enough to solve the very serious problems that plague our health system. We should focus on other issues.

*Quick Answer:* In a situation that is so complex with problems so large, is there any better place to begin than by building dialogue among the various players and participants? Besides that, unreimbursed care and other services are the only available option for over forty-four million uninsured people. Isn't that enough of a reason?

*Further Discussion:* Though not a panacea for all community health woes, improving community benefits can establish important building blocks to healthier individuals and communities. When people hear the term community benefits, they probably think of health services for traditionally disenfranchised populations. But, the concept transcends the service component. Ideally, community benefits also means strengthening strained or disconnected institution–community relations. It means strong communities engaging in collaborative problem-solving with institutions to achieve both short-term goals (e.g., better free-care policies and removing all of the health access barriers described earlier) and long-term goals (e.g., expansion of coverage and other systemic health reforms). Of course, this is the ideal. But, communities that engage in community benefits campaigns are likely to see health institutions that have become more familiar with the needs of vulnerable populations as well as more open to community participation. Both this familiarity and openness are necessary ingredients to ensure that any reform actually translates into greater access and better quality health care.

## C. Free-Care Safety Net Fact Sheet[75]

### WHAT IS FREE CARE?

Free care is care provided by a hospital for which it does not expect to be paid.[76] Hospitals may provide free care to people who show they cannot afford to pay for their care. Some hospitals also provide services at a discount to patients who are able to pay some, but not all, of the cost of their care. These discounted services are also considered free care. Most hospitals require that in order to be eligible for free care, a patient's income must be under a certain defined level.

### ARE HOSPITALS OBLIGATED TO PROVIDE FREE SERVICES?

There are laws and legal obligations that require hospitals to provide free services to those in need. However, these laws are often quite vague and limited. Although they do provide a base for valuable community care, they often lack specific requirements as to how or how much free care hospitals must provide.

For example, nonprofit hospitals are classified as charities and receive tax exemptions, and therefore have some obligation to provide services and other benefits to the community. Often this obligation is met in part by providing some amount of free or reduced-cost care. Additionally, some state laws require hospitals, nonprofit or for-profit, to provide services to those who can't afford to pay. And hospitals with emergency rooms are obligated under federal law to provide at least emergency services to those in crisis regardless of their ability to pay.

Despite the critical importance of free care to the more than forty-two million uninsured people in this country, there are no standard federal free-care requirements and few clear state standards. Since there are so few standards, each hospital creates its own free-care policy. Because the laws do not require hospitals to provide certain levels, free care is different from hospital to hospital and access to health care for the uninsured varies from community to community.

### IS IT EASY TO GET FREE CARE?

Despite the fact that free care is an important foundation of our healthcare safety net, it can sometimes be difficult to obtain. Since individual hospitals create their own free-care policies, problems can arise. For example:

● There may not be a standard process within a hospital. The hospital may give free care on a discretionary basis and make decisions on a case-by-case basis.

● Those in need of services may not even know that the hospital provides free care. Information about free care may not be given at the time of service. The hospital may not post signs or provide pamphlets explaining its free-care policy. If there are signs or pamphlets, they may be written in a language the patient does not understand or may explain the policy in a very complicated or intimidating way.

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75. Additional copies of this Fact Sheet can be obtained by contacting The Access Project.

76. An overwhelming majority of states consider free care to be a community benefit. At least one state, Massachusetts, excludes it as a community benefit because there is a separate financing mechanism for free care.

- The application itself may be difficult to read, complicated to complete, or written in a language the patient does not understand.

- The application process may be disrespectful, long, and complicated, and patients may receive bills in the meantime.

- Only certain services may be provided free. Patients could still be left with large bills even after receiving free care. For example, room and board may be covered but laboratory and doctor services often are not.

- Eligibility levels may be set excessively low. People who own a home or a car may be disqualified from receiving free care.

- Free-care patients may get different treatment or receive different priority from insured patients.

## HOW DOES THIS CONFUSION AFFECT THE UNINSURED?

For people who are already in ill health, the effect can be devastating.

- Uninsured people may be intimidated or confused by the application process and therefore decide not to get the care they need, or delay getting it, making them sicker.

- Uninsured patients may try to pay hospital bills instead of getting needed medications, paying rent, or buying food.

- Patients unable to pay may be subject to stressful harassment from bill collectors.

- Because of unclear eligibility requirements, people who are actually eligible for free care may be denied free services.

## WHAT SHOULD A GOOD FREE-CARE POLICY INCLUDE?

**1.** A written, board-approved policy that sets a clear and consistent standard for free-care eligibility.

**2.** Notice to the community that free care is available, including appropriate notice during the admitting process, notices throughout the hospital, and outreach to free-care–eligible populations in the community.

**3.** A simple and language-appropriate application including an explanation of the time frame and process for approval, the hospital and patient responsibility, if any, and all options available to the patient, including sliding scale fees or discounted fees based on ability to pay. The application should clearly state what the patient can expect and it should guarantee that the patient will not be billed until a free-care determination has been made.

**4.** A respectful and quick approval process including open communication between patient and institution.

**5.** Comprehensive health services including prescription drugs, laboratory services, doctor and specialist services, and X-rays.

**HOW CAN COMMUNITY LEADERS TAKE FIRST STEPS TOWARD IMPROVING FREE CARE?**

Community groups should learn about the free-care policies at their local hospitals. Community leaders should find out whether there are free-care laws or regulations in their state and what these laws require. An important first step would be to request the policy and an application directly from the hospital. The hospital response and the materials you receive will reveal a great deal about the fairness and effectiveness of the policy. Interviewing free-care patients is also important to understanding how the free-care process might be improved. Clinic providers and other primary care providers in the community will also provide valuable information and a slightly different perspective about unmet healthcare needs and the relationship of local hospitals to the community. The task is to identify problems as well as what is working.

**WHAT ARE THE OPPORTUNITIES COMMUNITY LEADERS CAN USE TO RAISE THESE ISSUES?**

The first step is to approach the hospital. Some institutions will be willing to discuss free care with community leaders and advocates and make changes to improve free-care policy. There are also many changes that are occurring today in the healthcare marketplace, such as mergers and nonprofit to for-profit conversions, new laws and regulations addressing hospital community benefits obligations, and the development of Medicaid managed-care networks. Many of these changes present opportunities for community groups to negotiate for more free care and better policies.

## Holding Hospitals Accountable for Free Care in Your Community

In addition to looking at a hospital's free-care policy (i.e., how that hospital decides what free care to provide), there is also the question of how much free care the hospital provides, and whether that is sufficient.

Determining how much free care hospitals actually provide can be complicated but, it is important to understand in order to ensure that the community is being fully served. There are certain key concepts to understand when determining how much free care a hospital is providing and how much it should be providing.

**FREE CARE, BAD DEBT, AND UNCOMPENSATED CARE**

**Key Definitions:**

- **Free Care:** These are free services hospitals provide to patients who show that they cannot afford to pay for their care. Hospitals do not expect to be paid for these services.

- **Bad Debt:** These are the services hospitals provide for which they expect payment, but never receive it. Bad debt usually arises out of insurance companies or individual patients not paying bills.

● **Uncompensated Care:** These are the services that hospitals provide but for which they do not receive full payment. The term includes free care and many categories of "unpaid care" including bills that insurance companies and individuals don't pay. "Uncompensated care" may also include the difference between what the hospital receives for treating Medicare and Medicaid patients and what it usually receives for privately insured patients. Hospitals lump all these shortfalls together and call them uncompensated care.

## WHAT IS THE DIFFERENCE BETWEEN BAD DEBT AND FREE CARE?

In reality, it may be difficult to see the difference between free care and bad debt from these very general definitions. The following two examples should help illustrate the difference.

● **Bad Debt:** An insured woman takes her baby to the emergency room with a high fever. The baby is treated and released. Because she didn't get prior approval before going to the ER, her insurance company denies coverage and will not pay the hospital for the services. The hospital sends her the bill, but she does not pay it. The hospital assumes the loss.

● **Free Care:** An uninsured, single, twenty-five-year-old woman goes to the hospital with a broken arm. She applies for and receives free care because her income of six thousand dollars per year is below the eligibility level defined by the hospital or state.

## WHY ARE THESE DIFFERENCES IMPORTANT TO THE COMMUNITY?

In order to hold a hospital accountable for providing free care, it's important to get an accurate assessment of the free services it provides. Hospitals may talk about free care and uncompensated care as if they were the same. Since uncompensated care includes free care, bad debt, and often the Medicare and Medicaid "shortfall," it is not an accurate assessment of how much free care the hospital is really providing to the community.

## WHY IS IT IMPORTANT TO EXCLUDE BAD DEBT WHEN CALCULATING FREE CARE?

Not all services classified as bad debt are provided to those who are unable to pay. For example, when insurance companies refuse to pay the hospital bills of policy holders, it increases a hospital's bad debt and benefits only the insurance companies. In these cases, patients are not receiving free care because they, or their employers, are paying insurance premiums. All industries have bad debt; it is simply a cost of doing business.

## COSTS AND CHARGES
### Key Definitions:

● **Cost:** This is the actual amount of money a hospital spends to provide each service.

● **Charge:** This is the full list price of a given hospital service. Many HMOs and insurance companies negotiate price discounts and do not actually pay full charges.

## WHY IS IT IMPORTANT TO UNDERSTAND THE DIFFERENCE BETWEEN COSTS AND CHARGES?

When citing the amount of free care that they provide to the community, hospitals will often base calculations on the price that they charge instead of the actual cost of providing the service. In such instances, it can appear that the hospital is providing more free care than it actually does. Communities should ask hospitals to provide free-care calculations based on cost, not charges. If no cost-based information is available, using one-half of charges is a good approximation.

Even for uninsured and underinsured individuals who are not eligible for free care, the distinction between cost and charge is very important. Often, the uninsured and underinsured patient will pay the full retail price for a service while an insurance company can negotiate a discount. Thus, people with middle incomes who are uninsured or underinsured but are not eligible for free care end up paying the most for their healthcare.

Strong free-care policies together with appropriate accounting from your local hospital will ensure that eligible free-care recipients are not denied free care and that all available resources are dedicated to caring for those most vulnerable in our communities.

## KEY QUESTIONS TO ASK ABOUT A HOSPITAL'S FREE-CARE POLICY

**1.** Is there a written policy available that sets clear standards for free-care eligibility?

**2.** Are the hospital's policies regarding free care widely available and easy to understand?

**3.** What are the exact free-care eligibility requirements? What is included in income calculations? For example, must people mortgage their home before they are eligible for free care?

**4.** Is there a partial free-care or sliding scale system based on a person's ability to pay?

**5.** What services are covered under the free-care policy—doctors' services? lab work? prescription drugs? Is every available effort made to provide comprehensive services as free care, and not just emergency care? Does the hospital have an on-site pharmacy and staff physicians who could provide free services?

**6.** Does the free-care application process put patients at ease? Is it a daunting or intimidating process? Are applicants treated with respect?

**7.** When is free-care eligibility determined—before or after services are provided? Are patients billed while they wait for an eligibility decision?

**8.** Is the measurement of "overall free care provided" based on the actual cost of goods and services provided, or is it based on the much higher price normally charged to an insured patient? Is the hospital counting bad debt as free care?

## D. Organizing Opportunities and Helpful Terms

| Organizing Opportunity | Regulatory Oversight | Relevant Laws | Important Information |
|---|---|---|---|
| Health Institution Restructuring (see page 62 for example) | Commissioner of Health; Commissioner of Insurance; Commissioner of Corporations; Attorney General | Conversion legislation; Certificate of need laws; Licensing and certificate of authority laws; Nonprofit corporation code; Corporation code | Articles of incorporation or bylaws; Corporation's financial statements for the past five years; Form A (for insurers and HMOs) |
| Community Examines Hospital Books, Issues Report (see page 63 for example) | Attorney General | Nonprofit corporation code; Tax code | Articles of incorporation or bylaws; Audited financial statements; Property assessments; IRS filings |
| Linking Neighborhoods and Constituencies for Power (see page 64 for example) | N/A | N/A | After groups have met and connected, they can determine the institution or issue to target and the corresponding important information. |
| Challenging Institutional Behavior (see page 65 for example) | Commissioner of Public Health;County or City Commissioners (if a public hospital) | Certificate of need laws; Licensing laws; Hill-Burton (if any requirements continue to exist); State free care requirements (may stand alone or may be found in other laws such as hospital regulations or conversion laws. Some hospitals may be required to perform a certain level of free care based on an earlier agreement). | For closing of services: Certificate of need application (if required in your state); For collection policies you should consult:<br>• Institution's financial records for the past five years<br>• Financial records of nearby hospitals for comparison purposes<br>• Records at the local assessor's office to see who has had a lien placed against them by the institution. If there are many people with liens, it is an indication that the institution has poor collection practice. |
| Ensuring the Community's Leadership (see page 65 for example) | Department of Public Health; Department of Insurance; Attorney General | Although an institution may begin a community benefits effort on its own initiative, it is more likely that the impetus could come from any of the following sources:<br>• Conversion legislation<br>• Certificate of need laws<br>• Licensing and certificate of authority law<br>• Nonprofit corporation code<br>• Corporation code | • Articles of incorporation or bylaws<br>• Audited financial statements<br>• Property assessments<br>• IRS filings<br>• Financial records of nearby hospitals for comparison purposes |
| Community Benefit Laws (see page 67 for example) | Commissioner of Health; Commissioner of Insurance; Attorney General | Community Benefits Law; Certificate of Need Law; Conversion Law; Tax Law | Community Health Needs Assessment; Community Benefits Plan |

The grid on the previous page is designed to provide you with the necessary information to begin a community benefits campaign based on a number of "organizing opportunities." After the opportunity, it lists the regulators involved, relevant laws, and other important information. A list of Helpful Terms explaining many of the terms in this grid follows. Each organizing opportunity corresponds to an example in the workbook as noted.

## Helpful Terms

### REGULATORS

- **Attorney general.** Nonprofit institutions are made up of charitable assets, and each state's attorney general is responsible for monitoring charitable assets and ensuring that they are devoted to their original intended purpose. The attorney general must make sure the nonprofit charitable assets of the hospital, HMO, or insurer continue to be devoted to their original purposes (i.e., health care of the community).

- **Commissioner of corporations.** The commissioner of corporations must approve the articles of incorporation and bylaws of any new corporation (whether nonprofit or for-profit). However, in most states, the commissioner automatically approves articles of incorporation and bylaws as long as they are filed on time.

- **Commissioner of health.** The state commissioner of health is often charged with licensing hospitals and granting certificates of need, and as a result, is often required to approve transactions involving healthcare entities (mergers, conversions, sales).

- **Commissioner of insurance.** The state commissioner of insurance regulates insurers and HMOs by granting licenses ("certificates of authority"), and thus approves transactions involving HMOs and insurers.

### RELEVANT LAWS

Community leaders who are beginning a community benefits campaign need to find avenues for public process (e.g., public hearings, public notification of transactions, and availability of documents for public inspection). Certain laws that are pertinent to the healthcare industry contain these provisions. Below is a list and description of laws that may contain public process provisions. Because laws vary from state to state, it is important that you become familiar with your state's laws.

- **Certificate of need laws.** These laws require hospitals to obtain a certificate or permit from the state department of health prior to making a significant expenditure or change to the hospital, such as a new heart transplant service or a change in ownership. Some states refer to certificate of need as determination of need. Many certificate of need laws require public hearings. When the department of health is determining whether to grant a certificate of need, it should consider whether the hospital provides, or plans to provide, community benefits. Unfortunately, not every state has a certificate

of need law (35 states currently have certificate of need laws), and they vary from state to state. As a result, you should determine whether your state has a certificate of need law and, if so, what it governs.

● **Conversion legislation.** Twenty-six states have passed laws that specifically govern the conversion of nonprofit hospitals, HMOs, or insurers to for-profit. Although a few states have passed laws that collectively govern the conversion of nonprofit hospitals, HMOs, and insurers, most laws only govern the conversion of one type of healthcare entity (i.e., just hospitals). If your state has a conversion law, you should determine what it governs. While some of these laws specifically require an annual community benefits program, most do require public notice, hearings, and access to documents.

● **Corporation code.** Each state has a series of laws that govern how for-profit corporations operate; these laws are called the corporation code. In transactions that involve for-profit hospitals, HMOs, or insurers, the corporation code should be consulted. The corporation code will also tell you which transactions have public process provisions.

● **Insurance code.** Laws governing insurance companies and HMOs are found in the insurance code. It will contain provisions regarding mergers, acquisitions, and sales. The insurance code will also tell you which transactions have public process provisions.

● **Licensing laws, certificates of authority.** In all but one state,[77] hospitals must be licensed by the state department of health in order to function as a hospital. Similarly, HMOs and insurers must be licensed by the state department of insurance in order to conduct business. A license for an HMO or insurer is called a certificate of authority. New licenses are needed when there is a change in ownership, and licenses must often be renewed every few years. When granting licenses, the department of health or the department of insurance should consider whether the hospital, HMO, or insurer provides, or plans to provide, community benefits. Although no state currently requires community benefits as a condition of receiving a license, community benefits requirements could also potentially be placed in hospital, HMO, or insurer licensing laws. Licensing laws are currently very weak in terms of public process. While licensing applications will probably be considered public records (although this may vary from state to state), to our knowledge there are few, if any, public hearing requirements.

● **Nonprofit corporation code.** Each state has a series of laws that govern how nonprofit corporations operate; these laws are called the nonprofit corporation code. The nonprofit corporation code will also tell you which transactions have public process provisions.

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77. Ohio is the only state that does not require hospitals to receive a license.

● **Tax code.** Each state also has a series of laws and regulations that explain its tax system. These laws should have sections explaining tax exemption and what corporations must do in order to receive it. Community benefits requirements are sometimes located in the tax code.

## NECESSARY DOCUMENTATION

● **Articles of incorporation and bylaws.** Every corporation must file articles of incorporation and bylaws when it becomes incorporated. In the case of nonprofit corporations, these documents will state the corporation's charitable purpose. These documents may be requested from the secretary of state's office in your state.

● **Financial statements for the past five years.** This information will allow you to determine what level of community benefits the corporation should be providing. These documents are public records, and as such, may be requested from the corporation.

● **Form A.** Insurers and HMOs that are engaged in a merger, sale, or conversion from nonprofit to for-profit file an application with the commissioner of insurance. Many states refer to this document as a Form A. It is important because it explains the terms of the transaction and provides background information on the companies involved in the transaction. It may also discuss community benefits. The Form A is a public record and may be requested from the commissioner of insurance after it is filed.

● **Form 990.** Tax-exempt organizations must file annual 990 forms with the Internal Revenue Service. These forms provide some basic information about how the institution is spending its money and are a good place to begin studying institutional finances. The 990 forms may contain information about the board of directors and the institution's community-giving practices. They also may help you to understand the institution's corporate structure. However, the documents are difficult to read, and it is advisable to consult with financial experts whenever possible. Under new IRS regulations, tax-exempt organizations must provide copies of their exemption applications and their three most recent 990s to anyone who requests this information. Organizations may make these documents available on their Web sites. Organizations that do not comply with these new requirements are subject to penalties of $20 per day of violation to a maximum of $10,000. See 64 Fed. Reg. 17, 279 (1999).

● **Internal hospital credit and collection policies.** You should learn and understand the hospital's internal policies regarding debt collection, including eligibility requirements for free care and sliding scale fees and information on how the hospital bills. For a better understanding of these policies, see page 102, "Free-Care Safety Net Fact Sheet."

## E. Model Act*

## The Healthcare Institution Responsibility Act

**DIGEST**

**100.**   **Legislative Findings; Intent**

**100.1**   The legislature finds that access to healthcare services is of vital concern to the people of this state.

**100.2**   The legislature further finds that healthcare services providers play an important role in providing essential healthcare services in the communities they serve. In addition, insurers have become a dominant force affecting the provision of health care based on their ability to control reimbursement rates and make pur-chasing decisions on behalf of large patient populations. The legislature therefore also finds that insurers play an important role in providing essential healthcare services in the communities they serve.

**100.3**   Notwithstanding public and private efforts to increase access to health care, the people of this state continue to have tremendous unmet health needs. Studies suggest that as many as [number] or [percent] of the state's residents are unin-sured or underinsured.

**100.4**   The legislature further concludes that licensing privileges conveyed by this state to health care institutions for the right to conduct intrastate business should be accompanied by concomitant obligations to address unmet health care needs. These obligations should be clearly delineated.

**100.5**   The state has a substantial interest in assuring that the unmet health needs of its residents are addressed. Healthcare institutions can help address these needs by providing community benefits to the uninsured and underinsured members of their communities.

**100.6**   Community benefits should become a recognized and accepted obligation of all healthcare institutions in this state. Accordingly, every healthcare services provider that receives a license under section [cross reference with the health care services provider licensing section of the code] and every insurer that receives a certificate of authority under section [cross reference with the insur-ance certificate of authority section of the code] must provide community ben-efits in a manner set forth in this Act.

**101**   Definitions

**101.1**   As used in this Act, the following terms have the following meanings:

**a.**   "Administration" means the [state] Insurance Administration.

**b.**   "Bad debt" means the unpaid accounts of any individual who has received medical care or is financially responsible for the cost of care rendered to another, where such individual has the ability to pay, and has refused to pay.

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* A commentary to this Model Act is available from Community Catalyst.

c.  "Community" means the geographic service area(s) and patient population(s) that the healthcare institution serves.

d.  "Community benefits" means the unreimbursed goods, services, and resources provided by healthcare institutions that address community-identified health needs and concerns, particularly of those who are uninsured or underserved. Community benefits include but are not limited to the following:

1.  Free care;

2.  Public education and other programs relating to preventive medicine or the public health of the community;

3.  Health or disease screening programs;

4.  Free or below-cost prescription drugs;

5.  Transportation services;

6.  Poison control centers;

7.  Donated medical supplies and equipment;

8.  Unreimbursed costs of providing services to persons participating in any government-subsidized healthcare program;

9.  Free or below-cost blood banking services;

10. Free or below-cost assistance, material, equipment, and training to EMS and ambulance services;

11. The costs to implement a basic enrollment program that provides a package of primary-care services to uninsured members of the community; and

12. Health research, education, and training programs, provided that they are related to identified community health needs.

e.  "Department" means the [state] Department of Health.

f.  "Free Care" means care provided by a healthcare services provider to patients unable to pay and for which the provider has no expectation of payment from the patient or from any third-party payer, and as further defined in §106 of this Act.

g.  "Healthcare Institution" means healthcare services providers and insurers jointly, as defined by this Act.

h.  "Healthcare Services Provider" has the meaning stated in section [ ] of the [state health code].

**i.** "Insurer" means an entity [under state code section] that pays for or arranges for the purchase of healthcare services provided by acute healthcare services providers. The term "insurer" shall not include [the state Medicaid program], other governmental programs of public assistance and their beneficiaries or recipients, and the workers compensation program established pursuant to [state code section or chapter].

**j.** "Person" means any individual, partnership, corporation, association, joint venture, insurance company, or other organization.

**102.** **Community Benefits; Basic Requirements**

**102.1** Each healthcare services provider that receives a license from this state shall provide community benefits to the community or communities it serves.

**102.2** Each insurer that receives a certificate of authority from this state shall provide community benefits to the community or communities it serves.

**102.3** Within 18 months from the day this Act is signed into law, each healthcare institution shall develop in collaboration with the community:

**a.** An organizational mission statement that identifies the institution's commitment to developing, adopting, and implementing a community benefits program;

**b.** A description of the process for approval of the mission statement by the healthcare institution's governing board;

**c.** A declaration that senior management of the healthcare institution will be responsible for oversight and implementation of the community benefits plan;

**d.** A community health assessment that evaluates the health needs and resources of the community it serves;

**e.** A community benefits plan designed to achieve the following outcomes:

**1.** increase access to healthcare for members of the target community or communities;

**2.** address critical healthcare needs of members of the target community or communities; and

**3.** foster measurable improvements in health for members of the target community or communities.

**103.** **The Community Health Assessment**

**103.1** Prior to adopting a community benefits plan every healthcare institution subject to this Act shall identify and prioritize the health needs of the community it serves. It shall also identify health resources within the community. As part of the assessment, the healthcare institution shall solicit comment from and meet with community groups, local government officials, health related organizations, and healthcare providers, with particular attention given to those persons who are themselves underserved and those who work with underserved populations.

**103.2** The Department shall compile available public health data, including statistics on the state's unmet healthcare needs. In preparing its community health assessment, a healthcare institution shall use available public health data.

**103.3** Healthcare institutions are encouraged to collaborate with other healthcare institutions in conducting community health assessments and may make use of existing studies and plans in completing their own community health assessments.

**103.4** Prior to finalizing the community health assessment, each health care institution shall make available to the public a copy of the community health assessment for review and comment.

**103.5** Once finalized, the community health assessment shall be updated at least every three years.

**104.    The Community Benefits Plan**

**104.1** Every healthcare institution shall adopt, annually, a plan for providing community benefits.

**104.2** The community benefits plan shall be drafted with input from the community as provided for in Section 103.1 of this Act.

**104.3** The community benefits plan shall include, at a minimum:

**a.** a list of the services the healthcare institution intends to provide in the following year to address community health needs identified in the community health assessment. The list of services shall be categorized under:

   **1.** Free care;

   **2.** Other services for vulnerable populations;

   **3.** Health research, education, and training programs;

   **4.** Community benefits that address public health needs; and

   **5.** Nonquantifiable services, such as local governance and preferential hiring policies that benefit those who are uninsured or underserved.

**b.** a description of the target community or communities that the plan is intended to benefit;

**c.** an estimate of the economic value of the community benefits that the healthcare entity intends to provide under the plan;

**d.** a report summarizing the process used to elicit community participation in the community health assessment and community benefits plan design, and ongoing implementation and oversight;

**e.** a list of individuals, organizations, and government officials consulted during development of the plan and a description of any provisions made for the promotion of ongoing participation by community members in the implementation of the plan;

**f.** a statement identifying the healthcare needs of the communities that were considered in developing the plan;

**g.** a statement describing the intended impact on health outcomes attributable to the plan, including short- and long-term measurable goals and objectives;

**h.** mechanisms to evaluate the plan's effectiveness, including a method for soliciting comments by community members; and

**i.** the name and title of the person who shall be responsible for implementing the community benefits plan.

**104.4** Each healthcare services provider shall submit its community benefits plan to the Department prior to implementation.

**104.5** Each healthcare services provider shall make its community benefits plan available to the public for review and comment prior to implementation.

**104.6** Each insurer shall submit its community benefits plan to the Administration prior to implementation.

**104.7** Each insurer shall make its community benefits plan available to the public for review and comment prior to implementation.

**105.** **Annual Report**

**105.1** Within 120 days of the end of the healthcare services provider's fiscal year, each healthcare services provider shall submit to the Department an annual report detailing its community benefits efforts in the preceding calendar year. The annual report shall include:

**a.** the healthcare services provider's mission statement;

**b.** the amounts and types of community benefits provided, listed in categories provided in §104.3(a), provided on a form to be developed by the Department;

**c.** a statement of the healthcare services provider's impact on health outcomes attributable to the plan, including a description of the healthcare services provider's progress toward meeting its short- and long-term goals and objectives;

**d.** an evaluation of the plan's effectiveness, including a description of the method by which community members' comments have been solicited; and

**e.** the healthcare services provider's audited financial statement.

**105.2** Each healthcare services provider shall prepare a statement announcing that its annual community benefits report is available to the public. The statement shall be posted in prominent locations throughout the healthcare services provider's facility, including the emergency room waiting area, the admissions waiting area, and the business office. The statement shall also be included in any written material that discusses the admissions or free-care criteria of the healthcare services provider. A copy of the report shall be given free of charge to anyone who requests it.

**105.3**   Information provided in accordance with §105.1(b) shall be calculated in accordance with generally accepted accounting standards. This information shall be calculated for each individual healthcare services provider within a system and not on an aggregate basis, though both calculations may be submitted. Each healthcare services provider shall also file a calculation of its cost-to-charge ratio with its annual report.

**105.4**   Within 120 days of the end of the insurer's fiscal year, each insurer shall submit to the Administration an annual report detailing its community benefits efforts in the preceding calendar year. The annual report shall include:

    **a.**   the insurer's mission statement;

    **b.**   the amounts and types of community benefits provided, listed in categories provided in §104.3(a), provided on a form to be developed by the Administration;

    **c.**   a statement of the insurer's impact on health outcomes attributable to the plan, including a description of the insurer's progress toward meeting its short- and long-term goals and objectives;

    **d.**   an evaluation of the plan's effectiveness, including a description of the method by which community members' comments have been solicited; and

    **e.**   the insurer's audited financial statement.

**105.5**   Each insurer shall prepare a statement announcing that its annual community benefits report is available to the public. The statement shall be posted in the insurer's business offices. The statement shall also be mailed to each subscriber. A copy of the report shall be given free of charge to anyone who requests it.

**105.6**   Information provided in accordance with §105.4(b) shall be calculated in accordance with generally accepted accounting standards. This information shall be calculated for each individual insurer within a system and not on an aggregate basis, though both calculations may be submitted. Each insurer shall also file a calculation of its cost-to-charge ratio with its annual report.

**105.7**   Any person who disagrees with a community benefits report may file a dissenting report with the Department or with the Administration, as appropriate. Dissenting reports shall be filed within 60 days of the filing of the community benefits report and shall become public records.

**106.   Free Care**

**106.1**   Every healthcare services provider that provides free care in full or partial fulfillment of its community benefits obligation shall develop a written notice describing its free-care program and explaining how to apply for free care. The notice shall be in appropriate languages and conspicuously posted throughout the healthcare services provider facility, including the general waiting area, the emergency room waiting area, and the business office.

**106.2** Every healthcare services provider that provides free care in full or partial fulfill-ment of its community benefits obligation shall report the value of such care, provided that the value of such care does not include any bad debt costs.

### 107.    Subsidized Care; Sliding Scale Fees

**107.1** In determining sliding scale fees or other payment schedules for uninsured per-sons, healthcare services providers should base such fees on the income of the uninsured person.

**107.2** Where the sliding scale fee is below actual costs, the healthcare services provider may include the difference in its community benefits computation.

### 108.    Monitoring and Enforcement of Healthcare Services Provider Community Benefits

**108.1** The Department shall assess a penalty of not less than $1000/day against any healthcare services provider that fails to file a community benefits plan or a timely annual community benefits report.

**108.2** The Department shall revoke or decline to renew the license of any healthcare services provider that fails to provide community benefits as required by this Act. The Department may issue a provisional license for a period of up to one year to any healthcare services provider that has had its license revoked or non-renewed.

**108.3** Before taking any punitive action, the Department must hold an adjudicative hearing, giving the affected parties at least 14 days notice. Any person who filed a dissenting report has standing to testify at the hearing. Any punitive measures taken by the Department following the hearing shall be considered final action for purposes of appeal.

**108.4** Any final action by the Department shall be subject to judicial review by the state superior court at the initiation of any person who participated in the adju-dicative hearing.

**108.5** The Department shall submit a report to the Legislature on September 1 of each year that contains the following:

   **a.**  The name of each healthcare services provider, if any, that did not file a community benefits report in the preceding year;

   **b.**  The name of each person who filed a dissenting report, and the substance of the complaint;

   **c.**  A list of the most common activities performed by healthcare services providers in fulfillment of their community benefits obligation;

   **d.**  The dollar value of the community benefits activities performed by health-care services providers, expressed in both aggregate and individual terms; and

   **e.**  The amount of net patient revenue for each healthcare services provider.

**108.6** The report referred to in section 108.5 of this Act shall be available to the public.

**108.7** The Department shall promulgate rules and regulations necessary to effectuate this Act.

### 109. Monitoring and Enforcement of Insurer Community Benefits

**109.1** The Administration shall assess a penalty of not less than $1000/day against any insurer that fails to file a community benefits plan or a timely annual community benefits report.

**109.2** The Administration shall revoke or decline to renew the certificate of authority of any insurer that fails to provide community benefits as required by this Act. The Administration may issue a provisional certificate of authority for a period of up to one year to any insurer that has had its certificate of authority revoked or nonrenewed.

**109.3** Before taking any punitive action, the Administration must hold an adjudicative hearing, giving the affected parties at least 14 days notice. Any person who filed a dissenting report has standing to testify at the hearing. Any punitive measures taken by the Administration following the hearing shall be considered final action for purposes of appeal.

**109.4** Any final action by the Administration shall be subject to judicial review by the state superior court at the initiation of any person who participated in the adjudicative hearing.

**109.5** The Administration shall submit a report to the Legislature on September 1 of each year that contains the following:

**a.** The name of each insurer, if any, that did not file a community benefits report in the preceding year;

**b.** The name of each person who filed a dissenting report, and the substance of the complaint;

**c.** A list of the most common activities performed by insurers in fulfillment of their community benefits obligation;

**d.** The dollar value of the community benefits performed by insurers, expressed in both aggregate and individual terms; and

**e** .The amount of net premium revenue for each insurer.

**109.6** The report referred to in section 109.5 of this Act shall be available to the public.

**109.7** The Administration shall promulgate rules and regulations necessary to effectuate this Act

## F. Excerpts from the Catholic Health Association Social Accountability Budget

## Calculation of Ratio of Patient Costs to Charges

| PERIOD OF ANALYSIS | BUDGET 1990 |
|---|---|
| **I. Adjusted Total Operating Expenses** | |
| A. Total operating expenses | $38,500,000★ |
| B. Less: adjustments | |
| 1. Cost for nonbilled services | 700,000 |
| 2. Medicare program costs | 19,500,000 |
| 3. Education/research expenses | 1,000,000 |
| 4. Fund-raising expenses/other | 425,000 |
| Total adjustments | 21,625,000 |
| Adjusted total operating expenses | $16,875,000 |
| | |
| **II. Adjusted Total Patient Charges** | |
| A. Total patient service revenue | $50,000,000 |
| B. Less: adjustments | |
| 1. Medicare program charges | 26,000,000 |
| 2. Other charges | 0 |
| Total adjustments | 26,000,000 |
| Adjusted total patient revenue | $24,000,000 |
| | |
| **III. Ratio Calculation** | |
| A. Adjusted total operating expenses | $16,875,000 |
| B. Adjusted total patient revenue | $24,000,000 |
| Calculated ratio = A/B = (applied to total patient charges) | 70.31% |

★ Some have argued that this figure should be increased by 4 to 5 percent to account for financial needs not included in operating expense number, such as working capital, preservation of purchasing power of capital invested in plant, plant expansion, and contingencies. This is certainly a defensible addition to the formula, although you should be explicit in explaining that a "plus factor" for these financial needs has been included.

*Source:* Excerpted with permission from the Catholic Health Association Social Accountability Budget.

## Unpaid Costs of Public Programs*

| PERIOD OF ANALYSIS | BUDGET 1990 | | | |
|---|---|---|---|---|
| | | | | Broader Community Benefits |
| | Benefits for the Poor | | | |
| | Medicaid | All Other | Total | Medicare |
| **Patient volumes** | | | | |
| Inpatient cases (discharges) | 500 | 240 | 740 | 2,360 |
| Inpatient days | 2,000 | 1,200 | 3,200 | 20,000 |
| Outpatient visits | 6,000 | 4,000 | 10,000 | 40,000 |
| **Charges** | | | | |
| Inpatient | $1,600,000 | $960,000 | $2,560,000 | 20,000,000 |
| Outpatient | 720,000 | 480,000 | 1,200,000 | 6,000,000 |
| Total | $2,320,000 | $1,440,000 | $3,760,000 | $26,000,000 |
| **Reimbursement and other support** | | | | |
| Inpatient | 800,000 | 540,000 | 1,340,000 | 13,500,000 |
| Outpatient | 360,000 | 240,000 | 600,000 | 4,500,000 |
| Total | $1,160,000 | $ 780,000 | $1,940,000 | $18,000,000 |
| **Estimated expenses** | | | | |
| Ratio of costs to charges | 70.31% | 70.31% | — | N/A |
| Total expenses | $1,631,250 | $1,012,500 | $2,643,750 | $19,500,000★ |
| Unsponsored expenses | $ 471,250 | $ 232,500 | $ 703,750 | $ 1,500,000 |

★ From Medicare cost report or from other cost accounting information as appropriate, such as overall ratio of costs to charges.

*Source:* Excerpted with permission from the Catholic Health Association Social Accountability Budget.

## Summary Analysis of All Nonbilled Services/Costs*

| PERIOD OF ANALYSIS | BUDGET 1990 | | |
|---|---|---|---|
| | Services and Programs for | | |
| | The Poor | The General Community | The Total Community |
| Number of services and activities | 12 | 8 | 20 |
| Units of service (patients served) | 800 | 600 | 1,400 |
| Encounters | 1,600 | 1,200 | 2,800 |
| Total community benefit expense | $400,000 | $300,000 | $700,000 |
| Identifiable funding for nonbilled services | $100,000 | $ 50,000 | $150,000 |
| Unsponsored community benefit expenses | $300,000 | $250,000 | $550,000 |

★ *Source:* Excerpted with permission from the Catholic Health Association Social Accountability Budget.

## Estimated Costs of Fund-Raising*

| PERIOD OF ANALYSIS | BUDGET 1990 | |
|---|---|---|
| 1. Apportionment of contributions | | |
|    a. Charitable activities | $ 500,000 | 50.0% |
|    b. Other community benefits | 300,000 | 30.0% |
|    c. All other contributions | 200,000 | 20.0% |
|    Total contributions | $1,000,000 | 100.0% |
| 2. Calculation of fund-raising expenses for community benefits and charity | $250,000 | |
|    Total fund-raising expenses | | |
|    Percentage allocation of expenses | | |
|      Benefits for the poor | | 50.0% |
|      Benefits for the broader community | | 30.0% |
|    Allocation of expenses | | |
|      Benefits for the poor | $125,000 | |
|      Benefits for the broader community | $ 75,000 | |

★ *Source:* Excerpted with permission from the Catholic Health Association Social Accountability Budget.

## G. Other Helpful Materials Available on Community Benefits

The Access Project, Fact Sheet: Defending Community Benefits in a Changing Health Care World (February 1999).

The Access Project, How Many Uninsured? A Resource Guide for Community Estimates (June, 1999).

Kevin Barnett, The Future of Community Benefit Programming (1997). The Public Health Institute, Berkeley, CA. (510) 644-9300.

The Catholic Health Association of the United States, Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint, (1989).

Coalition for Nonprofit Health Care, Redefining the Community Benefit Standard: State Law Approaches to Ensuring the Social Accountability of Nonprofit Health Care Organizations (July 1999).

Community Catalyst, "Boston at Risk 2000: Facilitator Manual" and "Boston at Risk 2000: Six Principles for a New Health Care System: A Blueprint for Action" (October, 1994)

Community Catalyst, Health Care Institution Model Act and Commentary (December 1999).

Community Catalyst, Community Benefits in a Changing Health Care Market, States of Health, Vol. 7, No. 5 (July 1997).

Community Catalyst, Compendium of State Community Benefits Laws, Regulations and Guidelines (November 1999).

Alan Sager et. al, Before It's Too Late. Why Hospital Closings Are a Problem, Not a Solution (June 2, 1997, 2nd ed.). Available by request at asager@bu.edu.

Mark Schlesinger and Bradford Gray, A Broader Vision for Managed Care, Part I: Measuring the Benefit to Communities, *Health Affairs* (May/June 1998) 152-168.

Mark Schlesinger et. al, A Broader Vision for Managed Care, Part II: A Typology of Community Benefits, *Health Affairs* (September/October 1998) 26-49.

## Contact Information for Groups Cited in Community Benefits Manual

**Boston Health Access Project**
c/o Health Care For All
30 Winter Street, 10th Floor
Boston, MA 02108
(617) 350-7279
Fax: (617) 451-5838

**Brockton Interfaith Community**
65 West Elm Street
Brockton, MA 02401
(508) 587-9550
Fax: (508) 587-9550

**Building Parent Power**
13 Enfield Street
Hartford, CT 06112
(860) 527-6569
Fax: (860) 527-6534

**Cambridge Health Alliance**
1493 Cambridge Street
Cambridge, MA 02139
(617) 665-1002
Fax: (617) 665-1003

**Central Massachusetts Community Health Coalition**
360 West Boylston Street
West Boylston, MA 01583
(508) 852-5539
Fax: (508) 852-5425

**Community Catalyst**
30 Winter Street, 10th Floor
Boston, MA 02108
(617) 338-6035
Fax: (617) 451-5838

**Health Care For All**
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Boston, MA 02108
(617) 350-7279
Fax: (617) 451-5838

**Health Law Advocates**
30 Winter Street, 9th Floor
Boston, MA 02108
(617) 338-5241
Fax: (617) 338-5242

**Idaho Community Action Network**
1311 West Jefferson Street
Boise, ID 83702
(208) 385-9146
Fax: (208) 336-0339

**Illinois Campaign for Better Health Care**
44 E. Main Street, #414
Champaign, IL 61820
(217) 352-5600
Fax: (217) 352-5688

**Local 1199, Northwest, SEIU**
221 First Avenue West, Suite 212
Seattle, WA 98119
(206) 283-1199
Fax: (206) 283-3459

CONTACTS

**Lynn Health Task Force**
c/o Neighborhood Legal Services
37 Friend Street
Lynn, MA 01902
(781) 599-7730
Fax: (781) 595-2002

**Maine Consumers for
Affordable Health Care**
P.O. Box 2490
One Weston Court, level one
Augusta, ME 04338-2490
(207) 622-7045
Fax: (207) 622-7077

**Maine People's Alliance**
27 State Street, Suite 44
Bangor, ME 04401-5113
(207) 990-0672
Fax: (207) 990-0772

**New Hampshire Minority
Health Coalition**
P. O. Box 3992
1415 Elm Street, 2nd Floor
Manchester, NH 03105
(603) 627-7703
Fax: (603) 627-7703

**Neponset Valley Community
Health Coalition**
Norwood Town Hall
P.O. Box 40
Norwood, MA 02062
(781) 762-1240
Fax: (781) 762-9180

**Northwest Federation of Community
Organizations**
1905 South Jackson Street
Seattle, WA 98144
(206) 568-5400
Fax: (206) 568-5444

**Oregon Health Action Campaign**
3896 Beverly Avenue NE, #J-6
Salem, OR 97305
(503) 581-6830
Fax: (503) 370-7630

**Pajaro Valley Coalition To Save
Community Health Care**
204 East Beach Street
Watsonville, CA 95076
(831) 763-3401
Fax: (831) 728-8266

**Universal Health Care Action
Network—Ohio**
1015 E. Main St., Room 302
Columbus, Ohio 43205
(614) 253-4340
Fax: (614) 253-4339

**Washington Citizen Action**
100 South King Street
Seattle, WA 98104
(206) 389-0050
Fax: (206) 389-0049

## About the Authors

The Access Project would like to thank the authors, Natalie Seto and Bess Karger Weiskopf, for developing this manual. In their work at Community Catalyst, they have garnered broad experience and provided counsel to many communities on issues related to healthcare restructuring and community benefits through two national projects: *The Community Benefit Initiative* and *The Community Health Assets Project.* These projects provide policy, legal, strategic, and other technical support to community coalitions, regulators, legislators, and the media nationwide.

Natalie A. Seto was the director of *The Community Benefit Initiative, The Community Health Assets Project,* and *The New England Action in Health Law Project.* Ms. Seto is also an author of many papers, publications, and community training tools relating to healthcare restructurings and community benefits. Previously, Ms. Seto worked at Health Care For All, a Massachusetts consumer rights organization, where she helped to develop consumer leadership and community-based coalitions. Ms. Seto has an undergraduate degree from Miami University and a J.D. from Boston College School of Law.

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Ms. Seto and Ms. Weiskopf previously collaborated and authored "Protecting Health, Preserving Assets: A Comprehensive Study of Laws Governing Conversion, Mergers, and Acquisitions Among Health Care Entities," published in *Clearinghouse Review.*

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# Feedback on Community Benefits:
# An Opportunity for Action and Healthcare Change

**TELL US WHAT YOU THINK ABOUT THIS WORKBOOK.**

Please comment on:

- whether this manual was too simple or complex
- whether you found the information useful and well presented
- what other information you would like to have about community benefits
- any other thoughts you have about how we can improve the publication

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Thank you!

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