In Sickness and in Wealth: Hospitals, Community Benefits, and the Affordable Care Act

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Abstract

The new community benefit guidelines for non-profit hospitals enacted by the 2010 Patient Protection and Affordable Care Act (ACA) present major opportunities for the public health and planning fields alike. Given that social determinants—the economic and social conditions that affect our health—play a disproportionate role in shaping health outcomes, hospitals are in a unique position to broadly impact population health and community development by investing their benefit dollars in preventative and more meaningful activities. By updating the community benefit standard to include periodic health needs assessments with input from diverse community representatives; requiring an implementation strategy that outlines how hospitals will address identified health needs; and redesigning IRS Form 990 to include Schedule H to better capture hospitals' spending, the new guidelines have the potential to transform how hospitals allocate their community benefit resources.

Massachusetts is one of several states that had implemented similar guidelines in line with the new ACA provisions. As such, this thesis focuses on Massachusetts General Hospital (MGH) as a case study to better understand the impact of the Attorney General's Voluntary Guidelines on its community benefit program, and, by extension, the health of MGH's three target communities: Charlestown, Chelsea, and Revere.

The case study unveiled various findings, including the importance of community engagement and capacity building; the strength of the coalition model; and the integral role of collaboration in fostering successful and sustainable programs. Given the research conducted, this thesis outlines recommendations for more nuanced and well-defined community benefit guidelines. Its discussion concludes with further research considerations and an argument for the inclusion of "health in all policies," given the countless and inter-related factors that shape our health outcomes.

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Introduction

Purpose

Hospitals have long been important institutions in communities, and many, from their founding, have made it their mission to care for their (often poor) patients and the neighborhoods in which they are located. Particularly in older cities, where hospitals remain anchor urban institutions—organizations that are tied to the communities in which they are located and tend not to move—the need for community development has grown over time as surrounding neighborhoods have increasingly transitioned to low-income and/or migrant families. Given the poor state of health in many communities across the country, in addition to mounting environmental issues and growing disinvestment, hospitals have an even greater imperative to reflect their missions by caring for those in need. By accounting for the social determinants of health, which are the economic and social conditions that influence our health, hospitals have the opportunity to not only address and help prevent major health issues, but also to invest in strategies that will create healthier neighborhoods and healthier residents.

In the 1990s, Massachusetts joined other states in requiring or strongly suggesting that hospitals provide community benefits. Massachusetts' Voluntary Guidelines issued by the Attorney General recommend that hospitals develop community benefit plans and conduct community health needs assessments (CHNAs) every three years. A community health needs assessment is "a process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community" ("Definitions of Community Health Assessments (CHA) and Community Health Improvement Plans (CHIPs)," n.d.).

On a national level, however, what form those benefits could and should take has been left largely up for interpretation by hospitals on an individual basis. With the passage of the 2010 Patient Protection and Affordable Care Act (ACA), all non-profit hospitals in the U.S. are now required to abide by outlined provisions and provide community benefits or face steep penalties. These national provisions have created a major opportunity as community benefits and CHNAs have the potential to serve as an impetus for community development and revitalization in cities across the country.

At this critical period of policy implementation, it is appropriate to ask how past efforts to implement community benefit programs have fared, what policies worked or failed, and what processes were most effective. Beginning to understand
the effects of the new provisions is also critical to improving upon them. Using the case study of Massachusetts General Hospital (MGH), a non-profit, teaching hospital in Boston, I will analyze the relationship between the hospital and communities at the establishment and over the course of the implementation of state community benefit laws and guidelines.

The impetus for the Attorney General’s office to issue Voluntary Guidelines was spurred by the fact that the majority of hospitals in Massachusetts are non-profit, and also by the perception that most, if not all, were doing well economically, but not adequately investing in their communities (Bird, 2006). The most prominent reason, which pushed the Attorney General and other advocates to create formal language around community benefits in the state, was the “growing gap between the institutional wealth of downtown hospitals and the neighborhoods’ unmet health needs” (Knox, 1993). Although many hospitals in Boston, including MGH, pride themselves on meeting the needs of the poor and vulnerable, the Attorney General Guidelines served as a catalyst for more formalized and systematic responses to the needs of the communities these hospitals serve.

My research will investigate the nature of the Guidelines and their procedural efficacy in attaining the imagined outcomes of meaningful community benefits and impact. I will analyze the procedural efficacy through the lens of the CHNAs and implementation strategies; this will help me understand the role community engagement and participation play in the assessments, strategic plan creation, and implementation, and how the framework of these processes inform this engagement. This analysis will aid in illuminating the nature of the relationship between hospitals and their surrounding neighborhoods, as well as the hospital’s sense of responsibility in being a leader in community development. The strategic plans and programs implemented over the course of the existence of the state guidelines will highlight the forms of community benefits developed, and their pursuant impacts on the health of the community, particularly the social determinants. Because the Affordable Care Act’s community benefit provisions are being implemented on the national level, lessons learned and innovations generated on the state level could serve as prescriptions and lead to recommendations for how national community benefit guidelines can or should evolve to be most effective.
Research Questions

I will answer the following questions in my thesis:

1. What has been the relationship between hospitals and the communities they serve before and after the implementation of state community benefit guidelines?
2. How have the state guidelines, particularly around the community health needs assessment and the strategic plan components, and the process through which they were implemented, been effective (or not) in creating meaningful community benefit programs and health outcomes?
3. How did the framework of these processes inform the role of and approach to community engagement, participation, and capacity building?
4. What have the impacts of the strategic plans and programs implemented been on community health and addressing the social determinants of health?

Methodology

Case Study Selection

In this thesis, I will use the case study as my research method, particularly given the exploratory nature of my thesis (Yin, 2002). I am focusing on one hospital, Massachusetts General Hospital, as an embedded unit of analysis within the case of Massachusetts state policy on community benefit programs. Because I am attempting to understand the effect of state and national guidelines on a hospital’s community benefit program, a single case study adequately serves this purpose. Massachusetts is an appropriate state example because of its longstanding history of community benefit guidelines dating back to the early 1990s.

Although many other hospitals in the Boston area, like Boston Medical Center and Boston Children’s Hospital, took up the Voluntary Guidelines as swiftly as MGH did, MGH’s approach stood out. The creation of the Center for Community Health Improvement (CCHI) to house the community benefit program and the consistent rhetoric and action around improving its communities’ health and wellbeing highlight the hospital’s commitment.

Within the MGH case, I am further looking at the hospital’s three target communities of Charlestown, Chelsea, and Revere. Because the ACA is a new legislation, research on the community benefit provisions is still emerging; thus, my initial examination of a specific geographic location will be supported by a review of
practice by other hospitals, which will be useful in understanding how these
guidelines or ideals have manifested themselves across various cities and states.

In addition, I am relying on the use of triangulation to support the validity of
my observations and findings. Specifically, I’m utilizing MGH’s community health
needs assessment reports; interviews with staff at MGH’s Center for Community
Health Improvement as well as local organizational leaders in the hospital’s
communities; conversations with other agencies involved in relevant work; and
supplementary literature and case studies.

The selection of MGH as the main case study was based on several factors:
the accessibility of its CHNAs, reports, and staff; the period of time over which the
hospital has had a community benefit program; and the types of communities it
serves. MGH has been creating community benefit plans over the course of nearly
20 years, works with predominantly lower income communities and also
communities of color, and has relevant hospital and community stakeholders who
willingly participated in the research.

Data Collection

My research methods primarily relied on document review of community
benefit reports, comprised of community health needs assessments and
implementation strategies. Gaining access to as many community benefit and
strategic plans over the years would have been particularly helpful in identifying
trends. However, this information was catalogued in a variety of different formats
and exists in various locations, making it particularly difficult to not only find but also
access. Conversations about the earlier period and information gleaned from
MGH’s website, as well as the 2012 community benefit reports’ allusions to previous
assessments and plans aided in filling in some of the resultant gaps in information.
Reviewing both the outlined framework through which the communities and MGH
conduct these processes and the role of community engagement was also valuable
in understanding and analyzing outcomes and impacts.

Furthermore, interviews with leadership at CCHI in addition to conversations
with local organizations and city officials in the target communities allowed for a
more nuanced understanding of the process, relationships, community engagement
and capacity, and other critical observations. Beyond the MGH case, I interviewed
persons at Community Catalyst in Boston, which is an organization that focuses on
advocacy around the health care system. I also spoke with individuals at the New
York State Department of Health and NYU School of Medicine when I was still
exploring additional cases in other locales with similar state guidelines.
Health Impact Pyramid

For the purposes of this thesis, I’m interested in evaluating programs using the Health Impact Pyramid in order to gauge what tier the programs correspond to, and what level of impact programs might have in a community according to this model. Since the ACA wants to move the U.S. toward a preventative model of healthcare, a community benefit program that attacks poor health outcomes at the root is a perfect way for hospitals to be proactive, not reactive with regard to health. The Health Impact Pyramid, as discussed in A Framework for Public Health Action: The Health Impact Pyramid, demonstrates the types of interventions possible, the corresponding level of impact as well as the level of individual effort needed (Frieden, 2010). At the base of the 5-tier pyramid exists socioeconomic determinants of health, which has the greatest potential impact, affects a larger swath of the population, and requires the least individual effort. At the top of the pyramid sits counseling and education and clinical interventions (Frieden, 2010).

![Health Impact Pyramid Diagram](image-url)

Figure 1: Health Impact Pyramid (Frieden, 2010)
Context

Public Health and Planning: A Shared Genesis

In *Confronting the Challenges in Reconnecting Urban Planning and Public Health*, Jason Corburn outlines the shared genesis of the public health and planning fields and highlights the challenges and opportunities for reconnecting them once more. As stated in his piece, public health and planning "evolved together as a consequence of late-19th-century efforts to reduce the harmful effects of rapid industrialization and urbanization, particularly infectious diseases" (Corburn, 2004). The housing conditions of the poor in overcrowded and poorly ventilated tenements, coupled with a lack of proper sanitation regulations led to many outbreaks of deadly diseases like cholera and typhoid (Corburn, 2004). In attempting to stymie the spread of disease and improve overall conditions for the poor and for cities, campaigns around creating sewer systems and erecting better quality housing emerged, involving reformers from health, planning, and civil engineering backgrounds.

Over time, however, both fields went their separate ways; public health increasingly focused on germ theory and the "'hosts of disease" rather than the environment, which led to the entrenchment of the biomedical model of disease. This standard "attributes morbidity and mortality to molecular-level pathogens brought about by individual lifestyles, behaviors, hereditary biology, or genetics" (Corburn, 2004). City planning focused on zoning and land use, and later relied on urban renewal to revitalize ailing urban cores.

The Current State of Health

The U.S. is experiencing major health epidemics: almost 36% of adults over the age of 20 are obese (National Center for Health Statistics, 2013); more than 50% of Americans live with at least one chronic disease like diabetes (Nolte & McKee, 2008); and due to health disparities, there is a 33 year difference "between the longest living and shortest living groups in the U.S."(Murray et al., 2006). Particularly in regard to disparities, it is important to ensure access to quality affordable health care to treat these poor health outcomes. However, to truly deal with community health, our society must begin to seriously focus on preventative health and make it a priority. Indeed, "studies indicate that behavior and environment account for roughly 70% of our health outcomes. Genetics account for 20% and medical care, 10%" (Cohen, 2011). Nevertheless, only 4% of the nation’s health expenditures are focused on prevention (Cohen, 2011).
Addressing the environment, lack of resources, and other social determinants are critical approaches to the prevention of poor health outcomes. The World Health Organization defines social determinants of health as

The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world (World Health Organization, 2008).

Where you live, whether or not you have a job, the type of job you may have, how safe your neighborhood is, and your proximity to grocery stores all contribute to the status of your health.

The color of your skin is also a determining factor. In his book, *Toward the Healthy City*, Corburn highlights a statement that Adam Karpati, the former Executive Deputy Commissioner of the New York City Department of Health and Mental Hygiene, made regarding the “concentration of health disparities in poor, African-American and Latino neighborhoods:” (Corburn, 2009)

They are due primarily to differences in the social, economic, and physical conditions in which poor people live and the health behavior patterns that arise in these settings. “Health disparities” are more than “health-care disparities”...one lesson from the health data is that disparities exist for almost every condition. This observation suggests that, regardless of the specific issue, poor health shares common root causes. It is important to remember, then, that strategies aimed at particular issues need to be complemented by attention to those root causes of poor health: poverty, discrimination, poor housing, and other social inequities. Fundamentally, eliminating health disparities is about social justice, which is the underlying philosophy of public health (Corburn, 2009).

He goes on to say that “in the New York City area, the predominantly poor, minority neighborhoods of the South Bronx, Harlem, and Central Brooklyn have rates of diabetes, asthma, mental illness, and HIV/AIDS that are nearly double that of the rest of the city” (Karparti et al., 2004).
This shared understanding of the linkages between the built environment and health, and the role of both the public health and planning fields in addressing poor health outcomes, particularly those influenced by social determinants, is at the core of how community benefits can become critical instruments for social justice and create healthier neighborhoods in a more holistic sense, particularly in disadvantaged communities of color.

**Anchor Institutions**

In recognizing that one’s zip code is a major determinant of one’s health outcomes, placed based strategies for tackling disinvestment, unemployment, and other issues become especially imperative. Anchor institutions, like hospitals and universities, are organizations that are tied to the communities in which they are located; once established, they tend not to move (The Democracy Collaborative, n.d.). Thus, they are important resources and can influence the wellbeing of a neighborhood. Literature on anchor institutions has primarily focused on relationships between universities and their communities, and in recent years, more focus has shifted to the role of hospitals as anchors.

Despite the clear opportunities for community engagement, relationships between major anchor institutions and communities have often been characterized by tension and competition. The tension between universities and their surrounding communities is a well-known example. Martin et al. highlight the history of tension and non-cooperation that has encompassed the relationships between universities and the communities in which they are located in their article on innovative community-university partnerships (Martin et al., 2005). These tensions include community hostility toward universities, which were often isolated in rural areas, followed by universities’ response to increasing urbanization by creating higher walls and retreating within themselves in reaction to unfolding deterioration and distress around them. However, both universities and communities began to realize that in order to address the many social issues that both faced, creating a collaborative and synergistic relationship would be valuable and beneficial to all involved (Martin et al., 2005).

Similarly, Maurrasse underscores how these institutions can and should create partnerships, particularly centered on social justice (Maurrasse, 2001). The Road Half Traveled: University Engagement at a Crossroads expounds on Maurrasse’s work with universities as partners; presents three major roles that universities can play as anchors (facilitator, leader, or convener); and discusses how to “realize” the anchor mission and develop policies to support community university partnerships (Hodges & Dubb, 2012). For the authors, successful
partnerships must be rooted in “comprehensive community building” (Hodges & Dubb, 2012).

Like many universities, hospitals' missions are also rooted in service. Indeed, the first hospitals were created expressly to serve the poor and indigent. Hospitals based on religious values and its calls to help the suffering also flourished. Today, Catholic hospitals and health institutions constitute the largest group of health care providers in the U.S., with over 600 hospitals and 1,400 other facilities (CHA “About,” n.d.). Lutherans and Methodists are examples of other Christian denominations that have also started hospitals.

Despite the common service- and people-oriented mission, however, many hospitals have often been content to hide in their proverbial ivory towers and instead focus on making themselves the best institutions for their patients. The position of hospitals as economic drivers tethered to their respective communities is a resource that should be leveraged by communities and propelled by hospital leadership, especially given the makeup of many of the neighborhoods in which hospitals are located. In “high poverty” cities around the U.S., hospitals were the largest employers in 8 of the 26 major cities with populations over 250,000 (Zuckerman, 2013). Although offering employment is a critical asset to these communities, hospitals have an obligation to build on their role as neighborhood employers and also be at the forefront of embracing a true anchor mission that aligns with their own mission.

Literature related to the history and role of hospitals, including Reinventing the American Hospital, is also pertinent. In this article, the authors stress the need for hospitals to reinvent themselves in order to keep pace with the societal and market forces in order to be a part of the true health reform that the United States desperately needs. One of the important ways in which a hospital is able to adjust when it comes to public health is in gathering information and data about not only the patients it serves but also the members of the community at large. Indeed, the authors state, “Taking a broad, population-based view of the continuum of care is essential to the hospital’s ability to reconfigure resources” (Shortell et al., 1995). Such a needs assessment will allow the hospital to make fundamental changes, like adjust the number of personnel available at the hospital, while also supporting larger service and program modifications based on the assessment results. The article also stresses the necessity for primary data collection to inform any potential changes, underscoring the need for a collaborative relationship with the community in conducting a needs assessment, a central tenet of the ACA provisions.

In Re-examining the Role of the Community Hospital in a Competitive Environment, Sigmond argues that community hospitals, defined as “one[s] which
[are] concerned about the health of the people in [their] community” have the opportunity to once again lead reform on issues that were once central principles, like cost-effectiveness and comprehensive personal care (Sigmond, 1985). With a history of caring for underprivileged populations that dates back to the 18th and 19th centuries, community hospitals have generally responded to the needs of communities, economically, socially, and health-wise. If the pressure for community hospitals to become what Sigmond calls “commercial ventures” is not abated, it is clear that the underprivileged communities are the ones who will lose (Sigmond, 1985). As such, the author argues for incentives to help mitigate such pressure, which include toughening up the tax-exemption criteria. Sigmond states, “The threat of losing federal income tax exemption, especially if combined with state and local tax exemption, can be a powerful incentive for some hospitals to meet high standards of community service” (Sigmond, 1985). Indeed, the author sees this as the strongest incentive that rewards community hospitals; and by creating incentives for community hospitals to not abandon their mission he foresees the strengthening of the community fabric that comes along with such incentives. Many state-level guidelines around community benefits attempt this through both explicit community benefit guidelines and penalties for non-compliance (U.S. Government Accountability Office, 2008).

As a whole, anchors need to understand that their health as organizations is tied to the health of communities. In the long run, there is also the economic argument that underscores the need for anchors to think seriously about investing in their surrounding community; attracting and maintaining talent is one major motive.

**Community Benefits**

One avenue through which hospitals began to more intentionally carry out the service mission is via community benefits. In 1946, the federal government passed the Hospital Survey and Construction (Hill-Burton) Act, which was the beginning of formalized requirements for hospitals to provide community benefits (The Hilltop Institute, 2011). As part of the law, hospitals could receive federal grants and loans for capital upgrades, and in exchange they agreed to provide a “reasonable volume” of free or reduced care to patients who needed it (HRSA, n.d.). Because there was not a specific set of guidelines or oversight to help inform the nature of charity care, however, the lack of cooperation was prevalent. Even so, it was due to this provision of charity care that the IRS conferred the tax-exempt status onto non-profit hospitals (The Hilltop Institute, 2013).
After the ushering in of Medicare and Medicaid in 1965, which helped cover the costs of those who were unable to pay their hospital bills, the IRS shifted their standards for what they believed constituted charity care (The Hilltop Institute, 2011). In 1969, the IRS created the “community benefit standard,” which required non-profit hospitals to provide benefits to the community as whole, not just poor patients, in order to maintain their tax-exempt status (The Hilltop Institute, 2013). Hospitals could demonstrate this community benefit through five factors the IRS outlined in this ruling, including by operating an emergency room open to all members of the community regardless of their ability to pay and using surplus revenues for activities such as research and education (U.S. Government Accountability Office, 2008). The Hilltop Institute defines hospital community benefits as “initiatives and activities undertaken by non-profit hospitals to improve health in the communities they serve.”

Collectively, hospitals’ tax benefits are worth $12.6 billion a year, and tax exemptions are estimated to be nearly $21 billion, demonstrating both the scale of their exemption and also the potential impact of community benefit investments (Trust for America’s Health, 2013) (Somerville, 2012). In addition to receiving billions in tax exemptions and tax benefits, non-profit hospitals have also experienced new heights of financial success in recent years; a 2008 Wall Street Journal article noted that there were more profitable non-profit hospitals (77%) compared to for-profit institutions (61%) (Carreyrou & Martinez, 2008). Moreover, the “combined net income of the 50 largest not-for-profit hospitals increased more than eight-fold to $4.27 billion between 2001 and 2006” (Zuckerman, 2013).

The National and Local Landscape

Although the general concept of hospitals providing community benefits has been around for some time, the amount spent by individual institutions and the interpretations of what activities count toward benefits has largely varied. Provision of Community Benefits by Tax-Exempt U.S. Hospitals, a 2013 article published in the New England Journal of Medicine, demonstrated that hospitals spent an average of 7.5% of their operating expenses on community benefits in 2009 (Young et al., 2013). However, for individual hospitals, that number fluctuated from less than 1% to over 20%, demonstrating the varied commitment to community benefits (Young et al., 2013). The added guidance from the new provisions around community benefits will be especially important in helping to address this variation and its effects on how these programs are handled and address community health.

Prior to this time period, it was even more difficult to truly assess how much hospitals spent on community benefits given the variation in how different hospitals
defined community benefit (U.S. Government Accountability Office, 2008). The Government Accountability Office’s report on non-profit hospitals published in September of 2008 states that consensus existed on charity [free and reduced cost] care, the unreimbursed cost of means-tested government programs, and other activities that benefit the community as examples of community benefit, but this was not the case for other elements, like bad debt and the unreimbursed cost of Medicare. In 2006, Massachusetts non-profit hospitals spent an average of 2.6% of their operating expenses on charity care. 3.6% was spent on bad debt and 5.4% on the unreimbursed cost of Medicare, two contentious forms of community benefit (U.S. Government Accountability Office, 2008).

In Massachusetts, both for-profit and non-profit hospitals must provide charity care as a condition of hospital licensure (The Hilltop Institute, n.d.-c). In addition, the Attorney General issued Voluntary Guidelines on community benefits for non-profit hospitals. Community Benefits Guidelines for Non-Profit Acute Care Hospitals were originally issued in 1994 and subsequently revised in 2008. The Guidelines recommend that all non-profit hospitals develop a community benefit plan. The Guidelines also advise the non-profit hospitals to conduct a community health needs assessment once every three years, very similar to the ACA guidelines. Although voluntary, many hospitals in the Boston area have complied and have conducted CHNAs over the last two decades, including Brigham and Women’s Hospital, Boston Children’s Hospital, Massachusetts General Hospital, and Boston Medical Center. Leslie Aldrich at CCHI stated that despite the fact that the Guidelines were voluntary, the institution recognized that there was still an unspoken obligation to comply, and MGH understood that it was in the best interests for the patients and community at large to do so (L. Aldrich interview). MGH also acknowledged that it had to set an example by taking up these Guidelines in a sincere manner. This commitment and its subsequent work places MGH in a laudable position compared to the vast and varied national landscape of benefit programs and hospitals’ fulfillment of their service-oriented missions.

Like Massachusetts, other states across the U.S. have taken the lead on community benefit guidelines and requirements given the lack of strong guidance from the IRS. According to the Hilltop Institute’s January 2011 Issue Brief, in the absence of federal specificity, state and local governments, which separately confer significant tax exemptions (e.g., property tax, state and local income tax, and state and local sales tax), have taken various courses of action to clarify community benefit standards and their application to nonprofit hospitals for purposes of evaluating whether hospitals are entitled to exemption from various state and local taxes (Folkemer et al., 2011).
Of the 15 states requiring hospitals to provide community benefits, only 4 of them have explicit penalties for failure to comply; the rest do not specify any penalties. In addition, the majority of states do not have a minimum quantity of community benefits that need to be provided to comply with the requirements (U.S. Government Accountability Office, 2008). As one can see, the community benefit
landscape across the U.S. as a whole is convoluted, and in many cases, is not adequately enforced.

The need for oversight and penalties for hospitals that do not comply with health related laws are particularly imperative given the injustices that can occur. In the state of New York, many hospitals that have been mishandling the state’s uncompensated care program, the Indigent Care Pool (ICP) program. In February of 2012, the Community Service Society (CSS) published a report that assessed the financial assistance programs of 201 hospitals, and found that in regard to their assistance materials “the majority [66%] of New York Hospitals violate the HFAL [Hospital Financial Assistance Law], fail to comply with the [Department of Health’s] HFAL guidance, or otherwise impose additional barriers to financial assistance” (Benjamin, Slagle, & Tracy, 2012). Instead of adequately providing financial assistance to those who qualified, Stony Brook Hospital, for example, failed to notify and provide financial assistance to needy patients, and instead categorized patients who couldn’t pay their bills as bad debt. Moreover, “New York Hospitals report patient bad debts in order to enhance their ICP distribution payments...” further allowing some hospitals to continue abusing the ICP program (Benjamin et al., 2012). Hospitals that do provide the most financial assistance “often receive the least amount of funding from the ICP program on a per application basis” (Benjamin et al., 2012).

By categorizing patient’s lack of payment as bad debt, Stony Brook Hospital, SUNY Downstate Hospital, Massena Memorial Hospital and others are able to send collection agencies after patients or place liens on their homes to ensure payment. In 2008, Stony Brook reported 680 liens; SUNY Downstate placed 1,053 liens; and Massena had the highest number with 5 liens per hospital bed, totaling 249. The report also rightfully highlights the harmful effects of such practices, like damaging personal credit and preventing home sales, not to mention the injustice of wrongfully denying patients existing financial assistance and further punishing them for their inability to pay (Benjamin et al., 2012).

As mentioned previously, there is contention among hospitals as to whether bad debt should count as a form of community benefits. If hospitals are mistreating financial assistance funds while also racking up large percentages of bad debt, this presents major issues with regard to further misrepresentation of hospital community benefits and the need for accountability. Further, CSS’ report is a reminder that enacting a law does not ensure compliance.
The Patient Protection and Affordable Care Act

Community benefits are now getting renewed and more scrutinized attention with the new provisions passed under the 2010 Patient Protection and Affordable Care Act. These provisions include a new IRS form, Schedule H (Form 990), which is meant to “increase transparency and objectively categorize non-profit hospitals’ community benefit activities” (Nelson, Somerville, Mueller, & Boddie-Willis, 2013). As it stands, the form has two sections for reporting community benefits: Part I - Financial Assistance and Certain other Community Benefits at Cost; and Part II - Community Building Activities (IRS, 2013). Part I encapsulates “reporting of financial assistance policies, the availability of community benefit reports, and the cost of financial assistance and other community benefit activities and programs.” Part II reflects activities not listed in Part I that “protect or improve the community’s health or safety.” Areas that fall under Part II’s Community Building Activities per the IRS’ guidelines are:

- Physical improvements and housing
- Economic development
- Community support
- Environmental improvements
- Leadership development and training for community members
- Coalition building
- Community health improvement advocacy
- Workforce development (IRS, 2013)

The list above reflects the importance of initiatives that go beyond medical care and address social determinants of health. Such activities not only aid in improving community health, but they also have the potential of playing an essential role in community and economic development. However, as it stands, only the activities listed in Part I are deemed community benefit, although the IRS has expressed that “some community building activities [those listed in Part II] may also meet the definition of community benefit [Part I],” and would be counted as such. In order to meet the requirements of Part I, a community building activity must:

1. Be carried out or supported for the purpose of improving community health or safety
2. Be subsidized by the organization
3. Not generate an inpatient or outpatient bill
4. Not be provided primarily for marketing purposes
5. Not be more beneficial to the organization than the community
6. Not be required for licensure or accreditation
7. Not be restricted to individuals affiliated with the organizations
8. Meet at least one community benefit object, including improving access to health services, enhancing public health, advancing generalizable knowledge, and the relief of government burden

9. Respond to a demonstrated community need (Barnett & Somerville, 2012)

In creating a separate section for community building activities, the IRS has created confusion in terms of how these activities count toward community benefits and also “limited community benefits to those activities that had traditionally been understood as directly promoting, or improving, individual or community health” (Zuckerman, 2013).

Another major standard in the new provisions is that hospitals must conduct community health needs assessments at least once every three years. Prior to conducting the health needs assessment, however, a hospital must define the community it serves. A definition that relies solely on a geographically defined area is considered “minimally adequate.” Rather the definition is expected to reflect “hospital best practices and public literature recommending a community definition that embraces ‘areas of the greatest need’ such as federally designated medically underserved areas, medically underserved populations, and health professional shortage areas.” Furthermore, the IRS will reject any definitions that do not include minority, low-income or medically underserved populations, as the community definition is “purposefully designed to advance health equity” (Somerville, Nelson, Mueller, & Boddie-Willis, 2013).

Once the hospital has defined its community, it must seek input from across a diverse spectrum of this community for the assessment as well as adopt an implementation strategy to address the needs highlighted by the CHNA. If hospitals do not comply with the outlined requirements, they will be charged a tax penalty of $50,000 and could also lose their tax-exempt status (The Hilltop Institute, 2011).
| Community Health Needs Assessment | Each non-profit hospital facility must conduct a CHNA once every 3 years. The assessment must include input from “persons who represent the broad interests” of the community. The report must also detail a “prioritized description of all identified needs along with...the process and criteria used in prioritizing such health needs.” The assessment must be made widely available to the public (Zuckerman, 2013). |
| Implementation Strategy/Community Benefit Plan | Hospitals must adopt an implementation strategy to meet the needs identified in the CHNA. The implementation strategy must discuss how a hospital plans to meet identified needs or why it has chosen not to meet certain needs. The implementation strategy must also receive approval from the hospital's governing body (Nelson et al., 2013). |
| IRS Form 990 Schedule H | This form must be filled out as part of the community benefit reporting requirements. Schedule H is meant to increase transparency and categorize a hospital's community benefit and community building activities. |
| Minimum Community Benefit Requirement | Currently, federal law does not specify a minimum amount of benefits that hospitals have to provide. Rather, the IRS uses a “facts and circumstances” test (Nelson et al., 2013). |
| Penalties | Non-profit hospitals that do not comply face a $50,000 fee and risk losing their tax-exempt status (The Hilltop Institute, 2011). |

The above serves as background and context for why planners, health officials, and advocates, as well as others concerned with the wellbeing of communities, should be working in conjunction given the call for a preventative model of health and given the major role social factors play in influencing health outcomes. At the same time, these stakeholders should also be leveraging the role of hospitals as anchors and the corresponding resources they can provide. Community benefit programs in particular comprise an enormous opportunity for both health and wealth generation.
Case Study: Massachusetts General Hospital

Case Study Aim

The purpose of this case study is to gain deeper insight into the nature of a non-profit hospital’s community benefit program. By studying Massachusetts General Hospital, I aim to have a better understanding of its approach to community benefits—namely, how it has been shaped by the state Attorney General’s Guidelines; how successful it has been in engaging with its communities around their health; and how effective the strategic plans have been in addressing identified health issues, social determinants, and also creating meaningful impact in MGH’s three target communities.

Brief History of Hospital

Massachusetts General Hospital was officially incorporated in 1811 and opened its doors in 1821 in Boston, MA through the efforts of Reverend John Bartlett, John Collins Warren, and James Jackson. MGH was the third general hospital to be constructed in the U.S., and followed in the steps of Pennsylvania Hospital and New York Hospital (MGH “A Narrative History of Mass General,” n.d.). Since the 19th century, MGH has become one of the foremost medical institutions, currently ranked the second best hospital in the nation by the 2013-14 U.S. News & World Report (Leonard, 2013). In addition, it “conducts the largest hospital-based research program in the United States,” with an annual research budget of more than $750 million (MGH “Hospital Overview,” n.d.). The hospital’s mission is the following:

Guided by the needs of our patients and their families, we aim to deliver the very best health care in a safe, compassionate environment; to advance that care through innovative research and education; and to improve the health and well being of the diverse communities we serve (MGH “Hospital Overview,” n.d.).

MGH’s main campus is located on Fruit Street in Boston, but the hospital also has six health care centers in other parts of the city and neighboring towns. Despite its presence in many locales, MGH serves three “target” communities: Charlestown, Chelsea, and Revere. The hospital has had health care centers in all

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1 General hospitals are those that are equipped to deal with varying types of disease and injury.
three for over 40 years, and given the low-income status of the areas, decided that geography was a straightforward way to define its jurisdictions and serve the communities most in need (L. Aldrich interview). In addition, MGH’s reach extends to other neighborhoods like East Boston, and the towns of Everett and Winthrop.

Pre-Attorney General Guidelines (before 1994)

As part of its commitment to its communities, MGH’s community benefits largely took the form of outreach, education, and caring for the sick poor, which constituted the foundation of the hospital. Two specific examples to highlight include MGH’s relationship with Boston Healthcare for the Homeless Program (BHCHP) and the hospital’s partnership with the Timilty Middle School in Boston. In 1985, BHCHP opened a clinic in MGH’s medical walk-in unit (CCHI Brochure, n.d.). Since then, BHCHP and MGH continue to provide primary care at facilities and on the streets of the city, and address the health-related issues faced by the homeless population. In 1989, MGH formed a business and education partnership with the Timilty Middle School in Roxbury, and through a Science Connection Program, provides science fair mentoring, summer internships (SummerWorks), and teacher professional development, among other elements (“MGH/James P. Timilty Middle School Partnership,” n.d.). Both programs are still in existence today.
Despite the work MGH was involved in prior to 1994, the hospital's community benefit program was not formalized in any manner. Furthermore, as a hospital with thousands of employees and many departments, outside of increasing access to care for vulnerable patients through health centers, most of this type of work was done was on an individual, not comprehensive, basis (L. Aldrich interview).


When the Attorney General enacted its Voluntary Guidelines around community benefits in 1994, MGH immediately took heed and created the Center for Community Health Improvement (CCHI) and hired Joan Quinlan, Executive Director, to develop the hospital’s first health needs assessments and implementation plans. CCHI’s guiding principles include:

- A commitment to the underserved and to reducing health care disparities
- A broad definition of health, inclusive of social determinants
- Building on community strengths and assets
- Community-based participatory research evaluation (CCHI “About,” n.d.)

The center’s approach involves assessing health needs in a collaborative manner, identifying priorities, and finally, determining which evidence-based programs will most successfully meet the community’s needs (CCHI “About,” n.d.).

From the beginning of this process, Leslie Aldrich, Associate Director of CCHI, remarked that Quinlan’s foresight allowed her to not only “check the boxes” to meet the requirements and guidelines, but also to truly engage with communities to help address health needs. From the beginning, Quinlan spoke with local leaders and stakeholders, and from these conversations, molded the first health needs assessments. During the process and those proceeding, each community has identified the priorities they believe are most essential to improving their health and wellbeing.

Revere

Revere, with a population of over 51,000, is a town well known for the country’s first public beach. In addition to the beach and other outdoor spaces, residents regard access to public transportation, food access, and the diversity of the town as assets. Traditionally an Italian community, Revere has seen an influx of immigrants, particularly Latinos, over the course of the last twenty years. A decade ago, the community also became home to many low-income families in search of more affordable housing. Despite the noted assets, many families in Revere are
struggling financially – 15% of residents live below the poverty line (Revere CHNA, 2012).

Revere Community Health Needs Assessments Over Time

With the CCHI created in 1995, the first community health needs assessment was conducted in 1996. The CHNA uncovered a high rate of substance abuse. Specifically, it had “40% more alcohol and other drug related hospital discharges and twice the mortality rate from substance abuse related illnesses than in the state” (Revere CHNA, 2012). As a result, the community along with MGH and other stakeholders, including the police and schools, made the decision to create the Revere CARES (Community, Action, Resources, and Education to Sustain a Healthier Community) Coalition, an organization tasked to begin tackling the problem of substance abuse among youth (Revere CHNA, 2012).

Today, the coalition has over 200 members, including local government officials, schools, businesses, and community organizations. According to Rosina “Kitty” Bowman, Director of Revere CARES, MGH studied best practices around substance abuse, and a coalition model made the most sense given the need to bring the community together in order to work effectively on such a pervasive issue (R. Bowman interview). As it stands, the coalition’s staff is funded by MGH and Bowman plays the dual roles of partner for the hospital as well as a facilitator for the community in her position as director. The Revere CARES model is one of the vehicles through which MGH promotes a healthier environment in the community (in addition to community and patient centered navigation to help reduce barriers to care, and youth development) (L. Aldrich interview). Revere CARES coalition follows the Strategic Prevention Framework, which “uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span” (SAMHSA, n.d.). The five steps are:

1. Assess their prevention needs based on epidemiological data
2. Build their prevention capacity
3. Develop a strategic plan
4. Implement effective community prevention programs, policies and practices
5. Evaluate their efforts for outcomes

As part of this process, the coalition then needed to identify the risk and protective factors, which involved using public health data in addition to going out into the community and speaking with residents and other stakeholders. Through this process, Bowman stated that the “group developed a common language, a common understanding of what the problem was, and a common vision” (R. Bowman interview).
Their strategic plan outlined the following priorities:

- Advocate for public policy changes and enforcement efforts
- Conduct community awareness campaigns about the harms of substance abuse
- Implement science-based prevention and early intervention programs for youth
- Build a healthier community by collaborating with others (Revere CHNA, 2012)

According to Bowman, the strategic plan continues to guide the coalition’s work based on what it is ready to do and what the greatest need is (R. Bowman interview). To continue its work, Revere CARES applied for a Drug Free Communities grant in 1998. In 2007, the coalition implemented a norms/social marketing campaign and also established a Food and Fitness taskforce to address obesity among youth (Revere CHNA, 2012). In 2010, Revere became a Mass in Motion community, which allowed it to tap into resources like a workplace wellness program and grants to “build policies, systems and environments that promoted wellness and healthy living” (HHS “Mass in Motion History,” 2014). Given the work of the coalition and other community organizations, Revere has already seen positive changes, especially around the decrease in the use of gateway drugs and binge drinking (R. Bowman interview).

The community’s most recent assessment in 2012 had strong engagement, with more than 900 residents and stakeholders participating in the process via quality of life surveys, community forums, and focus groups. CCHI trained the assessment committee to conduct the information gathering process, which involved the qualitative data above, as well as quantitative data from the Behavioral Risk Factor Surveillance System (BRFSS), state and local public health data, and MGH patient data, among other sources. In addition to management, MGH also played a role in convening and facilitating the conversations held throughout the assessment process with residents, local organizations, and other stakeholders. Given the presence and work of Revere CARES and MGH over many years, the community has a strong foundation of trust, and the coalition and hospital are known for effectively managing cross-collaborations among relevant stakeholders, including the city (Revere CHNA, 2012). In addition to ensuring that as many voices are brought to the table during the assessments, one of Bowman and MGH’s other goals is to use these processes as a way of building capacity in the community (R. Bowman interview).

One major way that the coalition has created the infrastructure for capacity building has been through strengthening its partnership with the city. Revere
CARES won the grant that created the position “manager of Healthy Initiatives,” in the city’s department of health, which Cate Blackford currently holds. For a number of years, the city has had limited capacity at the municipal level to deal with public health issues, and Revere CARES recognized that in order for its work to be sustainable over the long term, the city needed to take ownership of it (C. Blackford interview). In helping to build capacity in the city, Revere CARES set the stage for this to occur through the initiatives it is a part of, including the Healthy Eating/Active Living program and the work around substance abuse. In partnership, the city and the coalition work with and build capacity among both passionate residents and organization members. Capacity building happens around specific skills, like leadership and project management, and in broader facets. Blackford’s goal is that if the staff were to disappear, the work would still be a priority because they’ve helped to lay the foundation in the community (C. Blackford). In addition, she believes the increased success they have experienced thus far around the health initiatives can be attributed to the city and coalition’s commitment to growing capacity.

In June of 2012, after seven months of the assessment process, the assessment committee established community health priorities, and decided to continue focusing on substance abuse and the effects it has on the quality of life, and also added healthy relationships and public safety as new areas on which to concentrate (Revere CHNA, 2012). As part of the strategic plan for substance abuse, the coalition will focus on “reducing marijuana and prescription drug misuse; building capacity to address the needs of the recovery community; bringing strategies to prevent fatal and non-fatal opioid overdoses to other local communities in order to take a regional approach; and addressing substance abuse related violence.” In terms of healthy living, the programs will focus on work in schools through student engagement, healthier meals, and increasing knowledge regarding nutrition and physical activity (Revere CHNA, 2012).

Despite the work that is still necessary to move Revere toward a healthier future, one of the transformations Bowman was most proud of after the most recent assessment was that the city saw itself on the verge of making a change in terms of how it allowed outside perception to affect healthy lifestyles and the opportunities for community improvement. For a long time, Bowman noted that the Revere community often allowed outsiders’ opinions on safety in particular mold their own opinions on the type of community Revere truly was. This change in “how a community sees itself makes a dramatic difference in how it functions” and occurred in part because of all of the work that’s been done toward acknowledging and confronting Revere’s issues as well as celebrating the town’s assets (R. Bowman interview).
Chelsea

Chelsea is a town adjacent to Boston with a population of 35,000. Known for its diversity, Chelsea is a gateway city for many immigrant communities; indeed, 46% of residents are foreign-born and hail from more than 24 countries. With a poverty rate twice as high as the rest of the state, standing at over 24%, the effects of a financial crisis and receivership in 1991 are still being felt. Even so, residents see themselves as resilient and welcoming; their leadership as strong, committed, and engaged; and their town as walkable and affordable (Chelsea CHNA, 2012).

Chelsea Community Health Needs Assessments Over Time

The results of the 1996 CHNA led to family violence as one of the health priorities highlighted. In response to this, the community and MGH turned to the Police Action Counseling Team (PACT), which was a program developed at Yale that was adapted for Chelsea’s needs (L. Aldrich interview). In this iteration, Chelsea police partnered with social workers at MGH’s community location and were on call to intervene whenever children witnessed violence, no matter the day or hour (Chelsea CHNA, 2012).

Soon after, a Director of Community Health position was created at MGH Chelsea and more programs were implemented over the years to address other priorities. Those programs include the creation of a health center at Chelsea High School; the Visiting Moms program, which serves high-risk immigrant and refugee new mothers; and Healthy Chelsea, a coalition addressing obesity through healthy food access (Chelsea CHNA, 2012).

In the most recent assessment conducted in 2012, the community and MGH reached new levels of engagement, benefiting from the input of 1,100 residents throughout the process. The report cites that this most recent assessment was built upon a foundation of “extensive coalition building, community engagement, and successful outcomes over the past 15 years” (Chelsea CHNA, 2012). In a conversation with Chelsea’s City Manager, Jay Ash, he confirmed that this level of engagement was an anomaly in Chelsea, and the visioning process that was part of the assessment was a result of MGH’s “extraordinary effort” (J. Ash interview). In addition, MGH’s credibility and facilitative leadership was valuable in getting local leaders and stakeholders to agree to join the community assessment committee and take their role seriously (J. Ash interview). To ensure the committee members’ involvement and underscore his own commitment to the project, Ash also played an important role and personally contacted every member to emphasize the need for his or her participation in this process (Chelsea CHNA, 2012).
The diversity of voices from both the committee members and others involved throughout the assessment process was also lauded as “the first time such a diverse group in Chelsea had assembled around common goals.” Once on board, the committee members’ suggestions around community engagement (i.e. hosting a Chelsea Community Forum and focus groups) helped to further the commitment to engaging a broader segment of the population (Chelsea CHNA, 2012). Ash again praised MGH and noted that it “went to extraordinary lengths to reach out to every segment of the population.” He also noted that others have promised such engagement in the past but didn’t have the resources to follow through; MGH made seeing this come to fruition a priority (J. Ash interview).

From October 2011 through May 2012, meetings, data collection, and analysis led to the establishment of the assessment’s priorities. Priorities were chosen given the following criteria: community need; potential for impact; community interest, will, and readiness; and an assessment of the need for additional resources (Chelsea CHNA, 2012). Using this criteria, the assessment committee identified the top ten health concerns, with the first three being 1) drug abuse, addiction, overdose, and alcohol; 2) violence and public safety; and 3) poor diet/inactivity/obesity/hunger and malnutrition. After a lengthy discussion, committee members decided to prioritize only one of the above issues with the reasoning that measurable impact could be made if all resources and efforts were spent on dealing with one issue. As such, the prioritized issue became “substance abuse and the effects it has on quality of life with a focus on crime and safety” (Chelsea CHNA, 2012).

In addressing programs and strategies to implement and tackle this issue, the assessment report acknowledged the Health Impact Pyramid and also that several strategies are needed to touch on various tiers of the pyramid to create the largest impact; the report calls strategies that accomplish this goal and impact various health outcomes “cross-cutting” (Chelsea CHNA, 2012). Some “cross-cutting strategies” highlighted include the broken-window approach, which “decrease[s] substance abuse and increase[s] perception [of] public safety in certain high risk neighborhoods.” Collaboration is another strategy and involves a “comprehensive model to coordinate community-based services, track progress and measure results while simultaneously changing the way community-based organizations work together.” Policy development is also highlighted as a way to “advocate and support state and local policy changes that positively impact substance abuse intervention and treatment efforts” (Chelsea CHNA, 2012). Ash has been very satisfied with the pursuant implementation strategy and noted that the Healthy Chelsea campaign begun in 2009 is now a “force” in the neighborhood. In
addition, after this most recent assessment, MGH committed to funding a staff person as part of the drug initiative.

Charlestown

Charlestown is a Boston neighborhood geographically separated from the rest of the city on a peninsula. It is only 1.4 square miles and has a population of over 16,000. It is well known for its historic landmarks – namely, the Bunker Hill Monument and the U.S.S. Constitution in the Navy Yard. The residents also praise its sense of community, diversity, tradition and culture, and its availability of services. Traditionally a working class, Irish-Catholic neighborhood, Charlestown is now home to a 23.5% minority population. It is also a neighborhood with stark income disparities – Charlestown has the highest median income in Boston at $76,898, but 17% of the population lives below the poverty line (Charlestown CHNA, 2012).

Charlestown Community Health Needs Assessments Over Time

Although MGH began conducting CHNAs in Charlestown at the same time as the other communities, MGH had less involvement in the community until an existing coalition, Charlestown Substance Abuse Coalition (CSAC), reached out to MGH in 2004 as a result of startling trends regarding substance abuse (Charlestown Substance Abuse Coalition, n.d.). The community was responding to an alarming landscape: during this time period in Charlestown, the rate of drug-related deaths was 50% higher compared to Boston as a whole, and drug-related hospitalizations were more than twice that of Boston. Indeed, Aldrich mentioned that during this timeframe the community lacked readiness to address this issue and was somewhat in denial about the magnitude (L. Aldrich interview). A Drug Free Communities Proposal that CSAC put together acknowledged that two factors hindered their progress on addressing the drug issues: 1) the community lacked widespread readiness to change; and 2) competing priorities existed among those involved. Reaching out to MGH signaled the community’s readiness to again tackle substance abuse (Charlestown Substance Abuse Coalition, n.d.)

To support CSAC and its work, MGH provided a variety of resources, including a coalition coordinator and support in structuring a process to engage and mobilize the community to address youth substance abuse (Charlestown Substance Abuse Coalition, n.d.). The coalition also worked with organizations across the city and state, and engaged in building capacity among local residents and parents through leadership roles, for example (Charlestown CHNA, 2012). Through this renewed partnership and an assessment conducted in 2005, the committee directed key informant interviews, focus groups, and administered surveys (Charlestown Substance Abuse Coalition, n.d.).
The results of the data collection highlighted how visible drug use was, the fact that it was seen as “normal,” and the role of media in glorifying drug use. The assessment as well as other data also allowed the coalition to determine which drugs they wanted to focus on, namely heroin, prescription drugs, and alcohol. The assessment also led to the development of fourteen risk and protective factors that the coalition would use in targeting youth substance abuse. Goals and the pursuant strategies to tackle this issue are highlighted in the grant proposal, and strategies include increasing awareness around the extent and impact of youth drug use, existing treatment options, and the importance of involving parents. CSAC also developed a working group called Changing Community Attitudes to “develop appropriate content and dissemination strategies to reach youth, parents and other community members with campaign messages and materials” (Charlestown Substance Abuse Coalition, n.d.).

In looking at the most recent assessment in 2012, 800 people participated, echoing Chelsea and Revere’s strong engagement. To meet the varying needs and accommodate the diverse stakeholders, materials were printed in both English and Spanish, translators were present, and meetings served dinner and had on-site babysitters available for parents. Given the conversations initiated and the data gathered, the community identified substance abuse and the effects it has on quality of life as its health priority. The other priorities chosen were cancer prevention/healthy living; access to care with an emphasis on autistic youth; and educational opportunities for all residents. In order to tackle the many priorities centered on creating a healthier neighborhood, the assessment committee decided to create the Charlestown Collaborative. The Collaborative is meant to address the priorities listed above, and its main mission is to “increase successful outcomes for all of Charlestown’s youth and their families.” Within the Collaborative, subcommittees were created to address each specific priority (Charlestown CHNA, 2012).

The strategies for substance abuse, designated a tier I priority, included social marketing around drug abuse, developing a drug prevention curriculum for middle school students, and supporting the creation of a drug court (Charlestown CHNA, 2012). Cancer prevention/healthy living and education were designated tier II priorities. Strategies included exploring access to affordable, healthy foods, and exploring ideas for how to further engage parents around the quality of their children’s educations, respectively.

The Charlestown report explicitly mentioned several issues that fall under social determinants that came up in the assessment—including housing and air quality—which the assessment committee and MGH concluded that they would not address due to one of the following factors: other community organizations were
already working on them, the community wasn’t ready to address the issue, and/or resources are limited.

**Learning from the Target Communities**

Although the coalition model present in Charlestown, Chelsea, and Revere is just one tool that the communities and MGH have used to address health issues, it has played a critical role in bringing together community stakeholders, organizations, and in some cases, the municipal government to tackle concerns highlighted by the community health needs assessments. In addition, the periodic assessments have been able to create an infrastructure through which MGH and its local partners can engage and build capacity both among residents and other stakeholders interested in taking on more active roles in their neighborhoods, and also among local organizations to help sustain and embed the various initiatives around community health. The cross-collaboration and capacity building exemplify two significant strategies that hospitals need to embrace to not only help ensure more meaningfully positive health outcomes but also secure the sustainability of programs.

**Post Passage of the ACA Provisions (2010)**

Given the national provisions highlighted in the ACA around community benefits, MGH made the decision to formalize their CHNA process and adopted the MAPP: Mobilizing for Action through Planning and Partnerships model developed by the Centers for Disease Control for the 2012 health assessments (MGH CHNA, 2012). MAPP is a “community-driven, strategic planning process for improving health,” and calls for involving a diverse spectrum of the community and using various sources of data, which echoes language in the ACA provisions (MGH CHNA, 2012). Aldrich also noted that the model helped MGH streamline its CHNA process, which had been traditionally in the hands of the individual community coalitions and their reflected needs; The model also “infused” more community engagement and new dialogue into different conversations (L. Aldrich interview). Another adjustment included the timeframe to carry out the assessments, which called for a shorter process timeline compared to the one historically followed by the communities. Beyond these formalities, however, MGH has not made any other drastic changes given the similarities of the national provisions to Massachusetts’ Voluntary Guidelines.
Spending

In fiscal year 2012, MGH spent $100,290,756 on community benefits, representing 5.2% of total operating expenses (CCHI Brochure, n.d.) ("Hospital and HMO Annual Reports," 2012). This figure does not include MGH's spending on free care, Medicaid or Medicare, which totaled $303,256,000, representing another 15.6% of operating expenses. The chart below breaks down the spending by benefit type (CCHI Brochure, n.d.).

### MGH Community Benefit Spending FY2012

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<tr>
<th>Community Benefit Program Expense</th>
<th>$7,386,721</th>
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<tbody>
<tr>
<td>Grants for Community Health Centers in East Boston, South Boston, Mattapan and North End</td>
<td>$4,598,971</td>
</tr>
<tr>
<td>Subsidies to MGH Health Centers</td>
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<tr>
<td>Corporate Contribution from MGH/MGPO</td>
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<td>Determination of Need Spending</td>
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<td><strong>Other Resources</strong></td>
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<td>Doctor Free Care</td>
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<td>Hospital Health Safety Net Care</td>
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<tr>
<td><strong>TOTAL per AG Guidelines</strong></td>
<td>$100,290,756</td>
</tr>
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</table>

#### Additional Information

- **Cost of services in excess of reimbursement**
  - Free Care: $48,537,000
  - Medicaid: $104,377,000
  - Medicare: $150,342,000
  - **TOTAL ADDITIONAL**: $303,356,000
Evaluating Strategies and Programs

CCHI System for Evaluation

As mentioned previously, CCHI’s work is guided by the principles of evidence-based and culturally appropriate initiatives in addition to community based participatory evaluation (MGH CCHI “About,” n.d.) Danelle Marable is the director of evaluation and is supported by a team of three other evaluators who work alongside the programs and coalitions in the communities to evaluate the status and progress of both work done in priority areas and specific initiatives. Each program and coalition in all three communities had previously been assigned an evaluator, but CCHI has recently moved to a system whereby evaluators are now focused on a priority area (e.g. substance abuse prevention) and all programs connected to that priority. To aid them in this work, the team relies on a central database called Efforts to Outcomes, which is a case management system customized to MGH’s needs. In addition, the team uses “the techniques of Community Based Participatory Research” to support their evaluation work (MGH CCHI “About Us - Staff,” n.d.). Community based participatory research (CBPR) in public health “focuses on social, structural, and physical environmental inequities through active involvement of community members, organizational representatives, and researchers in all aspects of the research process. Partners contribute their expertise and share decision making and ownership of the research (Israel et al., 2001). It is seen as “a transformative research paradigm that bridges the gap between science and practice through community and social action to increase health equity” (Wallerstein & Duran, 2010).

In line with the principles of CBPR, the assessment committees from each community are part of the evaluation team and work with evaluators to design the goals, objectives, and outcomes that should be undertaken during various timeframes as a result of the issues that each community highlights via the CHNAs. The contents of the strategic planning is then reviewed by subcommittees, which also “discuss the infrastructure needed” to accomplished the proposed goals (MGH CHNA, 2012).

As part of evaluation and reporting, evaluators complete mid-year reports, as well as end of the year reports, which the Massachusetts Attorney General Guidelines require. CCHI has also created priority groups, which brings together CCHI staff across the different communities to share the work they are doing around similar issues; the groups report to one another four times a year (L. Aldrich interview).
In terms of planning, the evaluation team structures the goals, objectives, and strategies to fall under short-term, intermediate, or long-term time frames. Short-term strategies and outcomes are more process-oriented (e.g. holding events, reaching out to certain numbers of people, and creating a new position), and are meant to be accomplished in about a year (L. Aldrich interview). Intermediate/long-term goals are based on a three to five year timeline. Aldrich noted that even though goals are supposed to be assessed every three years, they understand that it is not likely they will see long-term outcomes in that period of time (given the fact that these changes take so long); to see a change in norms or behavior takes closer to five or more years. She also mentioned that CCHI uses Healthy People 2020 as a guide. Healthy People 2020 "provides science-based, 10-year national objectives for improving the health of all Americans" (Healthy People 2020 “About Healthy People,” n.d.) CCHI adopted several of Healthy People 2020’s goals for the priorities that are similar to those in the target communities, and revised them to fit CCHI’s five-year timeline (L. Aldrich interview).

**CCHI Goals, Objectives, and Strategies**

All of the priorities highlighted by the communities are large-scale issues and time is needed to truly assess how successful each will be in reaching desired outcomes and goals. On the Priority Area page within the CCHI section on MGH’s website, the following message is displayed:

We know that social and economic factors in communities are significant determinants of health status and health behaviors, accounting for 70% of morbidity and mortality. Together with our community partners, we are focusing on the social determinants of health and how they affect health outcomes, and working to develop strategies to prevent and treat illnesses. We are making substantial progress in six core areas listed below (MGH CCHI “Priority Areas,” n.d.)

CCHI outlines the following six priorities:

1. Substance Abuse Prevention
2. Violence Prevention and Public Safety
3. Obesity/Hunger Paradox – Healthy Eating/Active Living
4. Youth Development/Education
5. Cancer Prevention and Early Detection
6. Access to Care for Vulnerable Populations
The above priorities were compiled based on the communities’ needs assessments and will be CCHI’s focus for at least three years (i.e. 2012-2015). The following charts highlight each priority’s goals in addition to the objectives and strategies in place to reach them (MGH CHNA, 2012).
### Priority 1: Substance Abuse Prevention

<table>
<thead>
<tr>
<th>CCHI Objectives</th>
<th>Community &amp; Hospital Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Reduce substance abuse to protect the health, safety, and quality of life for all, especially children (HP 2020).</td>
<td></td>
</tr>
</tbody>
</table>
**By 2015, a 5% change for the following:**  
Decrease current use of alcohol and tobacco among youth and adults. (YRBS, BRFSS)  
Decrease the percent of youth and adults engaged in binge drinking. (YRBS, BRFSS)  
Decrease the percent of current marijuana usage among youth. (YRBS) |  
Increase the percent of youth who perceive great risk associated with substance abuse. (YRBS)  
Decrease opioid overdoses and deaths. (BSAS) |

**Primarily through community coalitions and with patients provide:**  
Education: Evidenced-based prevention curricula in schools, Youth Asset Development Model.  
Early childhood home visiting: To build resiliency, increase protective and decrease risk factors for children and families.  
Parent engagement: Parent Coffees and on-line parent conversations.  
Social marketing/Communication Policies: To address alcohol, tobacco, prescription drug and Narcan availability and distribution.  
Safety/Law Enforcement: Underage drinking/alcohol sales, public usage, disturbances. Explore Broken-Window Approach: Collaborate with community organizations/police to reduce drug activity in neighborhoods and increase perception of safety. |  
Community-based Interventions: Comprehensive models to coordinate community-based services to youth, track progress and measure results (ex. Harlem Children’s Zone).  
Community Health Workers to connect persons with addiction and their families to treatment and other services.  
**Clinical Interventions:**  
Universal evidence based screening and brief intervention (SBI) in primary and specialty care (OB).  
Embed abuse services within adult med.
## Priority 2: Violence Prevention and Public Safety

<table>
<thead>
<tr>
<th>CCHI Objectives</th>
<th>Community &amp; Hospital Strategies</th>
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</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Prevent unintentional injuries and violence, and reduce their consequences (HP 2020) and help individuals to be and feel safe and secure in their homes and communities.</td>
<td><strong>Community &amp; Hospital Strategies</strong></td>
</tr>
<tr>
<td>By 2015, a 5% change for the following:</td>
<td><strong>Primarily through community coalitions and with patients provide:</strong></td>
</tr>
<tr>
<td>Increase the feelings of safety in one’s community. (Community Survey/Focus Groups)</td>
<td>Early childhood home visiting: To build resiliency, increase protective and decrease risk factors for children and families.</td>
</tr>
<tr>
<td>Increase connectedness to neighbors and the community. (Community Survey, BRFSS)</td>
<td>Education and School Based Programming: Evidence based curricula; community resource guide.</td>
</tr>
<tr>
<td>Increase identification of victims and referrals to services. (Program Data)</td>
<td>Parent engagement: Parent coffees to build connectedness and skills.</td>
</tr>
<tr>
<td>Decrease percent of youth who have been threatened or injured or experienced dating violence. (YRBS)</td>
<td>Social marketing/Communication</td>
</tr>
<tr>
<td></td>
<td>Physical Environment: Improve the built environment to increase safety and physical activity (lighting, sidewalk, and park improvements, etc.).</td>
</tr>
<tr>
<td></td>
<td>Safety/Law Enforcement: Police enforcement/presence around underage drinking/alcohol and drug sales, public usage, disturbances, etc. “Broken Window” approach with “drug houses” in Chelsea.</td>
</tr>
<tr>
<td></td>
<td>Clinical Interventions:</td>
</tr>
<tr>
<td></td>
<td>Navigation: Through HAVEN, MGH’s domestic violence program and violence intervention Advocacy Program (VIAP), a program for victims of community violence in the MGH Emergency Dept.</td>
</tr>
<tr>
<td></td>
<td>Universal evidence based violence/domestic violence screening and brief intervention (SBI) in primary and specialty care and within the worksite.</td>
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</tbody>
</table>
### Priority 3: Obesity/Hunger Paradox – Healthy Eating/Active Living

<table>
<thead>
<tr>
<th>CCHI Objectives</th>
<th>Community &amp; Hospital Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Promote and improve health, fitness and quality of life and reduce chronic disease risk through the consumption of healthful diets and daily physical activity and achievement and maintenance of healthy body weights (HP 2020).</td>
<td><strong>Physically Environment:</strong> Farmers markets/mobile food pantries. Improve the built environment to increase safety and physical activity (ex. lighting, sidewalks, bike lanes, clean parks, walking trails).</td>
</tr>
<tr>
<td><strong>By 2015, a 5% change for the following:</strong></td>
<td><strong>Clinical Interventions:</strong> Universal evidence based screening and brief intervention (SBI) in primary and specialty care (OB) for nutrition, physical activity, and hunger.</td>
</tr>
<tr>
<td>Healthy Eating: Increase the amount of nutritious food and decrease access to sweetened beverages inside of school. (School Data)</td>
<td>Routine collection of BMI in Primary Care.</td>
</tr>
<tr>
<td>Increase consumption of fruits and vegetables by adults and youth. (YRBS/BRFSS)</td>
<td>Prescriptions for healthy eating and physical activity from physicians.</td>
</tr>
<tr>
<td>Active Living: Increase the percent of youth and adults who meet federal physical activity guidelines (Youth: 1 hour per day 5+ days a week/Adults: 30 minutes a day 5+ days a week). (YRBS/BRFSS)</td>
<td></td>
</tr>
<tr>
<td>Increase access to food resources, especially for those that screen positive for hunger. (MGH)</td>
<td></td>
</tr>
<tr>
<td>Change the built environment to enhance access to physical activity. (Community Data)</td>
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</tbody>
</table>
**Priority 4: Youth Development/Education**

<table>
<thead>
<tr>
<th>Goal: Improve the healthy development, health, safety and wellbeing of adolescents and young adults (HP 2020).</th>
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</thead>
<tbody>
<tr>
<td><strong>CCHI Objectives</strong></td>
</tr>
<tr>
<td>By 2015, a 5% change for the following:</td>
</tr>
<tr>
<td>Increase leadership opportunities for youth. (CCHI Program Data)</td>
</tr>
<tr>
<td>Increase youth assets. (CCHI &amp; School Data)</td>
</tr>
<tr>
<td>Increase the percent of youth who participate in extracurricular and out of school activities. (YRBS &amp; CCHI Program Data)</td>
</tr>
<tr>
<td>Increase youth participation in MGH CCHI programming and interventions. (CCHI Program Data)</td>
</tr>
<tr>
<td>Increase educational achievement for youth participating in CCHI programs. (CCHI Program and DOE Data)</td>
</tr>
<tr>
<td><strong>Community &amp; Hospital Strategies</strong></td>
</tr>
<tr>
<td>Peer Leadership Groups in schools: Empower students to engage in efforts that positively impact their schools and communities.</td>
</tr>
<tr>
<td>Youth Asset Development: With schools, help build youth internal and external assets helping youth develop resilience and strengths that are necessary to prevent problems.</td>
</tr>
<tr>
<td>Mental Health/Social Support: Continue to provide medical and mental health services at the Revere and Chelsea school-based health clinics.</td>
</tr>
<tr>
<td>STEM-Youth Scholars Program: Expose youth to topics and careers in Science, Technology, Engineering, and Math as pathway out of poverty.</td>
</tr>
<tr>
<td>Bicentennial Scholars: Intense college coaching and SAT preparation for STEM participants as well as continued support in postsecondary education.</td>
</tr>
<tr>
<td>Clinical Interventions: Youth Mentoring by MGH Employees.</td>
</tr>
<tr>
<td>CCHI Objectives</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td><em>By 2015:</em> Navigate 60% of MGH vulnerable patients (as defined by TopCare) to breast, colon or cervical cancer screening appointments. (MGH Patient Data) Navigate 3900 patients for breast cancer screening and follow-up at Manhattan, Geiger, Neponset and Mid-Upper Cape Health Centers. Navigate 1800 MGH patients to breast and cervical follow-up appointments.</td>
</tr>
<tr>
<td><em>Goal:</em> Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer (HP 2020) with a focus on prevention and early detection.</td>
</tr>
<tr>
<td><em>Launch smoking prevention for youth and smoking cessation in all three communities.</em> Increase the number of smoke free housing units in Chelsea and Revere. Healthy Living Objectives for Charlestown, Chelsea and Revere – See Healthy Living Logic Model.</td>
</tr>
<tr>
<td><em>Patient Navigation:</em> For breast, cervical and colorectal screening and abnormal follow-up reduce barriers to screening. Social Marketing: Healthy living campaign with a focus on smoking. Policies: Healthier food options at schools, stores and restaurants; increase physical activity time in schools; smoke free housing in Chelsea and Revere.</td>
</tr>
<tr>
<td><em>Physical Environment:</em> To promote healthy living – farmers markets; increase physical activity by improving lighting, sidewalks, bike lanes, walking trails, etc. <em>Clinical Interventions:</em> TopCare Screening: Reminders, education, letters, phone calls and navigation to encourage individual screening. Smoking Prevention/Cessation</td>
</tr>
</tbody>
</table>
Priority 6: Access to Care for Vulnerable Populations

<table>
<thead>
<tr>
<th>CCHI Objectives</th>
<th>Community &amp; Hospital Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease barriers to care and increase cultural competence by expanding language capacity, navigation and outreach. (MGH Data; CCHI program data)</td>
<td>Community health workers/interpreters and navigators.</td>
</tr>
<tr>
<td>Increase number of health care providers interested in community health to increase cultural competence. (COPC Elective)</td>
<td>Continue support for Senior HealthWISE Boston Health Care for the Homeless Program at MGH and the MGH Chelsea Refugee and Immigrant Health Program.</td>
</tr>
<tr>
<td>Possible Clinical Strategies: Promote Community Oriented Primary Care course for medical, pediatric and meds/peds residents.</td>
<td>Work with Partners Population Health Management to incorporate needs of vulnerable patients and populations in care redesign and high-risk patient management.</td>
</tr>
<tr>
<td></td>
<td>Work with Primary Care and the health centers to implement the medical home and adapt to the needs of vulnerable patients.</td>
</tr>
</tbody>
</table>

Although the community has refined the above priorities and pursuant strategies, CCHI states that it will further prioritize "strategies that impact multiple areas...and/or cut across multiple communities" (MGH CHNA, 2012). Some of the cross-cutting strategies include education/mentorship and safety/law enforcement.

Program Evaluation and the Health Impact Pyramid

As mentioned in the Methodology section, I will be evaluating the strategies that the priorities outline to reach their objectives by using the Health Impact Pyramid developed by Thomas Frieden, MD, MPH (Frieden, 2010). The pyramid is a useful tool as it helps assess the level of impact of programs given the nature of the intervention. Programs addressing the social determinants of health fall at the bottom of the pyramid, have the greatest population impact, and require the least individual effort. Interventions at the top tier fall under counseling and education.
and have the least population-wide impact and also require the most individual effort.

I will be using the pyramid to highlight and evaluate several of the community and hospital strategies for three priorities: 1) substance abuse prevention, 2) violence prevention and public safety, and 3) obesity/healthy living. These three priorities were highlighted as the top concerns in each community (MGH CHNA, 2012).

**Strategy Examples by Pyramid Tier**

**Tier 5: Counseling and Education**

Offering community health workers that connect people with addiction and their families to treatment and other services as a strategy for substance abuse prevention falls under the *counseling and education* tier. In *A Framework for Public Health Action: The Health Impact Pyramid*, Frieden states that counseling and education is "generally the least effective type of intervention," because of the difficulty in producing individual behavioral change. He goes on to say "The need to urge behavioral change is symptomatic of failure to establish contexts in which healthy choices are default actions." However, he does acknowledge that these types of interventions are sometimes the only option and "when applied consistently and repeatedly" may have an impact (Frieden, 2010).

The strategy involving early childhood home visiting in order to build resiliency and decrease risk factors for children and families also falls under this fifth tier.
Tier 4: Clinical Interventions

An example of a clinical intervention is the strategy under violence prevention and public safety, which involves universal evidence-based violence/domestic violence screening and brief interventions. Regarding this tier, Frieden states, "although evidence-based clinical care can reduce disability and prolong life, the aggregate impact of these interventions is limited by lack of access, erratic and unpredictable adherence, and imperfect effectiveness" (Frieden, 2010). This problem of irregularity is further exacerbated by lack of health insurance.
Tier 2: Changing the Context to Make Individuals’ Default Decisions Healthy

The strategy involving policies around healthier food options at schools, stores and restaurants; increasing physical activity time in schools; and banning trans fat falls under the second tier, changing the context to make individuals’ default decisions healthy. According to Frieden, this tier is categorized by the fact that individuals would have to expend considerable energy to not benefit from them. In the case of the three target communities, this means that children who are served healthier food options will by default be able to make healthier food decisions. Similarly, adding more structured time for children to play in schools makes it difficult for them not to participate in physical activity.

Changing the physical environment through the availability of more healthy food at farmers markets and through mobile food pantries, as well as improving the built environment to increase both safety and physical activity via enhanced lighting and more sidewalks are also examples of changing the context.
**Tier 3: Long-Lasting Protective Interventions**

Although not exemplified in any of the strategies under the three priorities selected above, examples that fall under this tier include immunizations and colonoscopies. These interventions are meant to be one-time or infrequent (Frieden, 2010). Similar to clinical interventions and counseling and education, these interventions are less effective than changing the context and addressing socioeconomic factors because they involve reaching out to people on an individual basis. However, when these interventions occur, they do result in long-term health benefits.

**Tier 1: Socioeconomic Factors**

As mentioned in previous sections, addressing socioeconomic factors, or the social determinants of health, result in the largest health impact on populations because these factors address the root of poor health outcomes, which include poverty, unemployment, substandard housing, and other environmental factors. Strategies that deal with these issues tend to require more creative thinking to create an impact. Although not explicit in the above three strategies, MGH’s priority on Youth Development/Education has several strategies that fall under this section,
and the hospital has other key programs, like workforce development, that create opportunities to improve socioeconomic conditions for communities. The Review of Practice section in this thesis has further examples of more comprehensive work being done by hospitals and hospital systems to get at root causes of poor health through initiatives like housing rehabilitation and economic development.

Progress

The strategies and programs that MGH and local stakeholders have put in place have yielded positive results over the last decade and also more recently.

Some statistics include the following:

- Revere saw the following changes occur in a decade: drinking rates among high school students dropped from 59% in 1999 to 40% in 2011 (MGH CHNA, 2012); from 2001-2009 among high school students, the ease in obtaining alcohol fell from 83% to 69%; for marijuana, it decreased from 83% to 67% (MGH CCHI “Substance Abuse Prevention & Intervention,” n.d.).
- In 2010, Revere CARES Coalition received the Community Anti-Drug Coalitions of America Got Outcomes Coalition of the Year Award for achieving measurable reductions in teen substance abuse (MGH CHNA, 2012).
- In Charlestown, calls to Emergency Medical Services for heroin overdoses decreased by 62% from 2003 to 2010 (MGH CHNA, 2012); drug related deaths decreased 78% between 2003 and 2008 (MGH CCHI “Substance Abuse Prevention & Intervention,” n.d.).
- In Chelsea, patients were screened for food insecurity in 2013 as part of the Food for Families program; of the more than 3,000 patients screened, 18% were running low on money for food and/or needed food assistance; of the 18%, 135 families received in-depth consultations to assess need (MGH CCHI “Food for Families,” n.d.).
- In 2013, the Chelsea Board of health passed a ban on trans fat with the support of the Healthy Chelsea Coalition (MGH CCHI “Healthy Chelsea,” n.d.).

Discussion

Evidence-Based Programs

Creating evidence-based programs are critical, particularly around securing funding and lending legitimacy to programs. Even so, Terry Kennedy, Executive Director of Charlestown’s Kennedy Center remarked that they are entering into “new territory” around these implementation strategies and “[they] are creating the evidence.” This new territory refers to the innovative or less orthodox ways of
tackling poor health compared to more traditional methods. This may be a risk, and progress or outcomes may not always fit into neat criteria, but entering into this new territory has the potential to be extremely valuable. Aldrich also called their three to five year goals “lofty” given how ambitious they are for the length of time during which they plan on achieving them. Nonetheless, CCHI and its target communities continue striving toward accomplishing their set goals (L. Aldrich interview).

**The Health Impact Pyramid**

Despite the varying levels of impact of the different tiers, it is important to note that although addressing social determinants of health is the most effective way to create healthier communities, the other types of interventions still play an important role, and ideally health care institutions and programs should “attempt to implement measures at each level of intervention to maximize synergy and the likelihood of long-term success” (Frieden, 2010).

Frieden makes explicit that social and economic change requires fundamental societal transformation, which in turn relies on political will and commitment. The role of time is also an important factor, and the evidence to support the efficacy of more transformative programs may not be as apparent or tangible. Interventions closer to the top of the pyramid tend to be less contentious, and thus easier to implement (Frieden, 2010). Despite the politics involved and will needed to make fundamental changes to issues that affect our health, Frieden believes (and I echo) that health care institutions are in a position to lead and push these larger changes forward, both by setting examples in the way they expend community benefit dollars and also by leveraging their economic and political clout; it’s an imperative in the face of so many distressed and unhealthy communities across the country.
Review of Practice

Catholic Health Association of the United States

As mentioned previously, religious hospitals make up a large portion of health care institutions in the U.S. Catholic hospitals are modeled after Jesus’ mission of love and healing, and his particular regard for the poor and marginalized of society (CHA“About,” n.d.) (Catholic Health Association of the United States, 2012). Catholic Health Association of the United States (CHA) was established in 1915 after Catholic health ministry leaders wanted to maintain their mission and identity in the face of technological advances in the health care delivery field. CHA includes 600 hospitals, as well as over 1,400 long-term care and other health facilities present in every state in the nation (CHA “About,” n.d.). Providing just and compassionate care for all is integral to CHA’s mission and those values have greatly contributed to their work in advocating for “systemic planning and standardized public reporting of community benefit,” in addition to making them leaders in this space for over 20 years (Catholic Health Association of the United States, 2012). Indeed, IRS adapted the changes in Schedule H from the work that CHA had been doing around rigorous accounting for community benefits (Zuckerman, 2013).

One of the major tools CHA provides is a publication entitled A Guide for Planning and Reporting Community Benefit. The newly revised 2012 edition includes guidance on the new ACA guidelines in addition to a framework for a “more strategic approach to planning, delivering and reporting on community benefit programs” (Catholic Health Association of the United States, 2012). For CHA, providing community benefits should be a reflection of a non-profit hospital’s mission, not just regulations that must be followed.

Another resource is Healing Communities and the Environment, which was jointly published with Health Care Without Harm, “a coalition of more than 470 health-related organizations in 52 countries working to transform the health care sector, without compromising patient safety or care, so that it is ecologically sustainable and no longer a source of harm to public health” (Lipke, Matheny, & Trochchio, 2013). The document is meant to highlight that improving environmental health improves community health; one of its suggestions is to include environmental factors in the health assessment process and consider how tackling these factors could aid in addressing highlighted priorities. Given the impact that the environment has on health and the mismatch in healthcare spending, this document plays an important role in further educating health care leaders about social determinants of health and the opportunities that exist with community benefits to address them.
Overall, non-profit hospitals and health care leaders should be looking to the work of CHA for guidance as they embark on creating or revising their community benefit programs to not only comply with IRS guidelines but also to better serve their communities.

**Bon Secours Baltimore Hospital**

Bon Secours Baltimore Hospital (BSBH) is situated in South West Baltimore, which has an overwhelmingly minority population (76% of residents are black). The median household income of $28,514 is much lower than the state median of over $72,000 (U.S. Census “State & County QuickFacts: Maryland,” n.d.). The community also struggles with a high unemployment rate (24.3%) and most of it falls under the designation of being a food desert. The hospital recognizes its role as an anchor institution with a longstanding history in the community, and works to fulfill the mission of the Bon Secours Health System by “being ‘good help’ to all in need” (Bon Secours CHNA, n.d.). In the 1990s, Bon Secours delved into community development “in earnest,” and has since been a shining example of the resources and change that a non-profit hospital is capable of (Zuckerman, 2013).
Since 1995, Bon Secours has rehabilitated and constructed over 650 units of rental housing in the area, creating much needed affordable housing and simultaneously combating large swaths of vacancies that had come to characterize the neighborhood. Their work has also included converting more than 640 vacant lots into green spaces and removing 133 tons of waste from the community (Zuckerman, 2013).

In the most recent 2012 CHNA, Bon Secours identified community health needs in two categories: community engagement recommendations and primary care assessment recommendations (Bon Secours CHNA, n.d.). The community engagement recommendations are categorized as Healthy People, Healthy Economy, and Healthy Environment, reflecting the multi-faceted ways that its communities are affected.

**Community Engagement Recommendations**

<table>
<thead>
<tr>
<th><strong>Healthy People</strong></th>
<th>Food and Nutrition: Improve residents' access to healthy food and nutrition education and promote urban agriculture by:</th>
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<tbody>
<tr>
<td></td>
<td>• Encouraging the development and use of open spaces, community gardens and urban agriculture, and the transformation of vacant lots</td>
</tr>
<tr>
<td></td>
<td>• Encouraging the availability and affordability of healthful food choices in homes, schools, offices, stores, Farmer’s Markets and other vendors.</td>
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<tr>
<td></td>
<td>Physical and Mental Health: Improve the health status of residents, with a particular focus on substance abuse, infant mortality, chronic illnesses and mental health by:</td>
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<tr>
<td></td>
<td>• Reaching out to, educating and providing services to at-risk and stigmatized populations</td>
</tr>
<tr>
<td></td>
<td>• Using improved assessment, screening and prevention tools and strategies</td>
</tr>
<tr>
<td></td>
<td>• Encouraging physical activity, recreation and other prevention-related tools</td>
</tr>
<tr>
<td></td>
<td>• Increasing the programming, facilities and personnel dedicated to the prevention and treatment of alcohol and drug addiction.</td>
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<tr>
<th><strong>Healthy Economy</strong></th>
<th>Jobs: Create jobs and prepare residents for these jobs, by:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Providing job readiness programs and ongoing adult education</td>
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<tr>
<td></td>
<td>• In addition, participate in the creation of jobs in areas in which we have the most expertise and influence. By creating connections to opportunities in the growing health care field, namely, we can help both our industry and our community.</td>
</tr>
</tbody>
</table>

|                     | Housing: Improve the housing market to retain and attract homeowners |

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Healthy Environment

Through economic, physical and marketing strategies by:

- Supporting the creation and preservation of strong, stable blocks
- Attracting new homeowners through the creation of new and diverse homeownership opportunities
- Helping existing homeowners maintain and improve their investment.

Transportation: Support and promote efforts to improve the public transit systems in our communities and make West Baltimore more bicycle and pedestrian-friendly by:

- Advocating for more and better forms of public transportation as well as alternative forms of transit.
- Encouraging our own employees to carpool, bike to work, use public transportation and other modes of transportation, by building a culture that facilitates such a shift and by offering incentives.

Reduce the risks from hazardous materials, such as pest management by:

- Reducing and/or eliminating hazards, pesticides and other toxic chemicals inside our facilities.

Reduce energy and water usage in homes and buildings:

- With energy-efficient repairs and renovations, and
- By adopting Baltimore Green Building high efficiency standards.

Encourage the use of community open spaces, gardens and urban agriculture, and the transformation of vacant lots with:

- Tree-planting
- Other measures that will increase the number of public green spaces community members can go that are safe and well maintained.

Reduce the risks from hazardous materials in West Baltimore buildings using such strategies as:

- Integrated Pest Management
- Brownfield site-redevelopment or Healthcare without Harm and Maryland Hospitals for a Healthy Environment.

Increase energy and water conservation of all West Baltimore residents, businesses, government agencies and others with a public education campaign.
As demonstrated in the chart above and in the continuing work of Bon Secours, the recommendations acknowledge the major role of social determinants of health and the fact that hospitals can effect greater change in health outcomes by not just providing health care, but also creating jobs, improving the housing market, and creating healthier environments. Their present day work also includes family and women’s services, financial services, and a focus on local and minority procurement (Zuckerman, 2013). It is also important to note that Bon Secours further recognizes that it too must change its own internal culture to support its work in creating healthier communities. Developing more energy-efficient and environmentally sound practices within its own healthcare facilities is one major example.

Despite the positive work being done, the leadership does recognize the obstacles they have faced, including sustaining community involvement and momentum in the work they do. For example, the coalition ReachOut that was created to kick start Bon Secours’ community development efforts in 1995 has faced a steady decline of involvement—over the years, numbers have dropped from an average of 90 people at each meeting to a turnout of barely 30 (Zuckerman, 2013).

These examples underscore the realities many institutions face, and also stress the need for steady, continuous work to revitalize disinvested areas. George Kleb, the Executive Director of Housing and Community Development is aware that much work has been done, but they “still have a long way to go” (Zuckerman, 2013).

St. Joseph Health – Sonoma County

Based in Sonoma County and the Northern Region of California, St. Joseph Health (SJH) also has a Catholic tradition and has been healing communities since the early 20th century. Its guiding principles include dignity, service, excellence, and justice. As a reflection of justice, St. Joseph “advocate[s] for systems and structures that are attuned to the needs of the vulnerable and disadvantaged, and that promote a sense of community among all persons” (St. Joseph Health “About Us,” n.d.). Two anchor hospitals fall under St. Joseph Health: Santa Rosa Memorial Hospital and Petaluma Valley, which primarily serve Sonoma County, a more white and well-off area compared to the rest of CA. Given the fact that St. Joseph Health operates on a county-wide system, it relies on Dignity Health and Thompson Reuters’ Community Need Index (CNI) (St. Joseph Health Santa Rosa CHNA, 2011). CNI allows SJH to identify the health disparity severities by zip code. These zip codes reflect the communities of undocumented immigrants, agriculture/day workers, and other low-income families (St. Joseph Health Petaluma Valley, n.d.). The most recent CHNAs identify issues like childhood obesity and nutrition; youth alcohol, tobacco, and other drug use; and children’s oral health.
In addition to initiatives around identified community health needs, SJH is also tackling a broader issue through its Health Communities outreach – capacity building (Zuckerman, 2013). St. Joseph describes its work in the following manner:

A Healthy Community creates opportunities for each resident to meet his/her potential physically, mentally, socially, emotionally and spiritually, building on the strengths of its people and systems to improve the quality of life and creating a sense of hope. Area Healthy Communities activities build community capacity and empowerment individually and collectively, through community organizing, leadership development, partnership and coalition building (“Sonoma County Healthy Communities,” n.d.).

One of the avenues through which capacity is built is through Neighborhood Care Staff, which is comprised of community organizers who mentor community leaders in neighborhoods with un-met health needs (Zuckerman, 2013). Agents of Change Training in our Neighborhood (ACTION) is a grassroots leadership development program created in 2002 that works with local residents, community groups, and organizations (“Sonoma County Healthy Communities,” n.d.). They offer training to organizations on community organizing and work alongside residents and others to help them make the changes they want to see in their neighborhoods. This program has led to the development of healthier school menus, the creation of community gardens, and other beautification efforts in communities (Zuckerman, 2013). By building the capacity to empower communities, SJH is also equipping residents and organizations with the tools to advocate for their own needs (which becomes particularly important in a process like the community health needs assessments), as well as effect the changes they want to see in their neighborhoods.

Due to the large population of agriculture and day workers, St. Joseph Health System has also been involved in the development of MiVIA, a personal health record program that was launched in 2003 (“About MiVIA,” n.d.). The electronic health record allows migrant and day workers to store and have access to all of their critical health information that they can use regardless of their location. This is a critical tool for a population that “suffer[s] disproportionately from undiagnosed and/or unattended chronic medical conditions due to lack of continuity of care resulting from a transient lifestyle” (“About MiVIA,” n.d.). Members of MiVIA are given a photo identification card, which lists their emergency contacts, medications and allergies, as well as existing medical conditions. Most recently, other populations, like the homeless, have been given the opportunity to enroll in the program. The added benefits of MiVIA include members taking more of a priority in caring for themselves and also having better access to health care screenings via referrals (Helseth, 2010).
Further Examples

The following chart highlights other examples from *Hospitals Building Healthier Communities*’ “Emerging Trends and Best Practices from Across the Nation (Zuckerman, 2013):”

| Sustainability Practices | Cleveland Clinic and University Hospitals (Cleveland, OH): Evergreen Cooperatives  
Kaiser Permanente (Oakland, CA): Healthier Hospitals Initiative, California Freshworks Fund |
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<tbody>
<tr>
<td>Local Hiring</td>
<td>Wrangell Medical Center (Wrangell, AK): Rural Health Careers Initiative</td>
</tr>
</tbody>
</table>
| Housing Development      | Nationwide Children’s Hospital (Columbus, OH): “Healthy Neighborhoods, Healthy Families”  
St. Joseph’s Hospital Health Center (Syracuse, NY) |
| Community Investment     | Rhode Island Hospital, St. Joseph’s Hospital, and Women & Infant’s Hospital (Providence, RI): South Providence Development Corporation  
Baystate Health (Springfield, MA): Wellspring Initiative |

The above cases exemplify hospitals and systems that not only went beyond complying with mandated guidelines but have also taken up the anchor mission and have made the wellbeing of their communities a priority to be addressed on a daily basis.
Findings and Recommendations

Findings

The following findings are based off of the case study and demonstrate that a health care institution requires more than just good intentions to work with a community and address health in a more holistic manner. Certain conditions are important and/or play a large role in creating trust; developing an effective and sustainable process and set of initiatives; empowering communities; and ultimately transforming them. The following conditions aided in creating a better process for MGH:

- Existing capacity as well as capacity building
- Coalitions and other partnerships
- Leadership support
- The use of varied data sources
- Meaningful community engagement

The MAPP Process and the Importance of Capacity

Although MGH had been conducting its health assessments in a similar fashion to the ACA provisions, the MAPP framework formalized the process. Given the tenets of the framework, namely creating a community-driven assessment and involving a diverse set of stakeholders, it is a strong model for other hospitals to adopt to not only ensure they meet the IRS guidelines, but also to ensure that the community health needs assessments truly succeed in accomplishing their purpose. Despite its efficacy, Aldrich noted that using the process was time consuming and labor intensive, but worthwhile nonetheless (L. Aldrich interview). It is clear that in order to conduct the process effectively, ample capacity is needed to conduct the various forms of data collection and analyses as well as reach out and involve as many voices as possible, particularly those usually ignored, in addition to facilitating meetings and conversations. The responsibility of this capacity can theoretically land on either the health care institution or the community. CCHI and the communities benefit from a health care institution that has the funds and manpower to take on the assessment and do so successfully within the new ACA timeline of a year.

This also highlights how critical capacity is to being able to adequately comply with the IRS provisions. Hospitals that aren’t as well-funded or don’t have as many resources to dedicate to such a process will do what they can to comply, but it may not be the work necessary to make the kinds of change that a community benefit program is expected to. As Jessica Curtis of Community Catalyst put it,
community benefits are inherently local, so even with national guidelines, what the hospital chooses to do in regard to community benefits centers around existing relationships and local capacity (J. Curtis interview).

The other side of the capacity issue is the community’s and community-based organizations’ (CBOs) capacity to work alongside the hospitals in this process. Curtis notes the pressure that communities often receive from hospitals, and the type of support needed to be actively engaged in the process and also engaged with the hospital in a manner that ensures the community and CBOs are gaining from the experience; currently there is no investment in CBO capacity on a large-scale to handle this (J. Curtis interview). Presently, Community Catalyst is working on pilot programs (most recently in the Bronx) to develop training materials and a curriculum around this type of capacity building. Capacity building around managing and leveraging these types of relationships is important because in a scenario where a community leans on the hospital to provide the capacity needed, it may very well create an imbalance whereby the hospital may take advantage of this dynamic or default to control the process and subsequent outcomes. Thus, capacity to adopt the provisions should be developed on both ends of the partnership and leveraged in a balanced manner whenever possible.

The importance of developing this capacity along with community engagement for both hospital and community is highlighted in Hospitals Building Healthier Communities. In the Integrating an Anchor Institution Mission chapter, Zuckerman stresses that “hospitals should recognize that community engagement and building community capacity are long-term investments that are integral to successful implementation of an anchor institution mission” (Zuckerman, 2013).

In the cases of Charlestown, Chelsea, and Revere, such capacity was important in relation to developing the assessment committee as well as leading the assessment and implementation process. In addition, residents and other stakeholders need to be made aware of and engaged in the process; community meetings and focus groups need to be facilitated; public health data need to be accessed and interpreted; priorities and strategies need to be negotiated given the health issues highlighted and the resources available; partnerships need to be established or solidified to carry out the work; and programs need to be evaluated. Thus, a variety of roles exist and must be filled by capable and qualified individuals for the process to run smoothly and be successful.

**The Strength of the Coalition Model**

The coalition model that exists in all three communities emerges as a principal tool in successfully addressing identified health issues. The model creates the space for a variety of different stakeholders to come together and work around
the same goals to accomplish outcomes. In addition, the variety of stakeholders and organizations involved each bring a specific viewpoint and level of expertise that further strengthens the work being done. Examples of relevant partners in addition to health care institutions include school superintendents, the police, boys and girls’ clubs, religious institutions, community based organizations, and neighborhood developers.

Even so, Aldrich stated that most hospitals don’t engage in coalition work like MGH does. Many hospitals join coalitions as partners, while MGH is essentially the “back bone” for the coalitions in the three communities. One major benefit to this role is that the hospital is able to provide community benefit funding to pay for staff rather than rely on volunteers. This allows MGH and the coalitions to continually engage with the community without the constant pressure of looking for funding to be sustainable and continue their work. In addition, Aldrich noted that coalitions allow MGH to look at population-based goals in changing community norms (L. Aldrich interview).

In a 2008 article published by the Robert Wood Johnson Foundation entitled “Allies Against Asthma,” the benefits of coalitions is one of the five themes highlighted. Although it pertains to a specific public health issue, the gains are useful nonetheless. One major benefit emphasized is the following: the “power of coalitions is that they often address multiple levels of a complex problem from different sectors simultaneously.” The diversity of the coalition members in the communities of Chelsea, Charlestown, and Revere underscore this point. Jay Ash, City Manager of Chelsea, also noted that the city relies on partners for much of the work they do. In addition to tackling issues on a variety of levels, coalitions also play a big role in larger policy changes around health. Dr. James Krieger is quoted in the article saying that “changing policy necessarily requires advocacy, and advocacy requires a coalition of forces...” At its base, collaborations underscore the fact that stakeholders, like hospitals, public health leaders, and community organizations, are all working toward the same outcomes and everyone benefits in the long-term by investing in these partnerships (Robert Wood Johnson Foundation, 2008).

Throughout all three communities, MGH also recognizes the need to partner with organizations and other stakeholders, recognizing that “no one institution can improve community health alone” (L. Aldrich interview). Depending on the priorities or issues, MGH is invited to collaborate with different partners or move to create new partnerships to help advance the work. Often the makeup of existing coalitions, like Revere CARES, generally expands and evolves in order to address new interests and priorities (L. Aldrich interview).
Hospital Leadership Support

Aldrich at CCHI noted that having the backing of the hospital’s leadership is key and has certainly contributed to the success of this work. Aldrich goes on to say that Dr. Peter Slavin, President of MGH, has been a true advocate for this endeavor and believes in the work the Center for Community Health Improvement is doing, and also believes that community health is part of the DNA of the hospital. In 2007, MGH, under Slavin’s leadership, changed the mission statement of the hospital to incorporate “to improve the health and wellbeing of diverse communities we serve,” which was a momentous occasion. Not having the support of leadership makes the work more of an encumbrance than an opportunity to help create transformative change given the resources and support necessary to address and complete the work (L. Aldrich interview).

Hospitals Building Healthier Communities also touches on the importance of creating an environment that supports ongoing initiatives, not just short-term programs, and this requires an internal infrastructure. The report goes on to note that a true understanding of a hospitals’ mission is needed, especially by leadership who must recognize that this work is not stretching the mission or moving outside of “its scope of responsibility,” but rather underscoring the very mission most hospitals tout, which is to serve the less fortunate (Zuckerman, 2013).

The Use of Varied Data Sources during CHNA Process

In the context of these health assessments, a variety of data sources, including public health and other quantitative data, were used to support the qualitative information that the community highlighted through their personal experiences, surveys, and meetings. This also allowed MGH to expose and call attention to health issues that served as a cause for concern but may not have been as readily apparent in the community. For example, in Charlestown, the public health data unearthed a problem with Hepatitis C. CCHI presented this information to the community as another issue to consider (Charlestown CHNA, 2012).

The use of varied data sources also allowed for a much more participatory process whereby the knowledge and lived experiences of the residents of the community carried just as much importance and weight as quantitative, “scientific” data. This is significant, as the process helps to empower the community and also builds trust among MGH and relevant stakeholders, since the hospital has made it clear that it values community knowledge and is not merely dictating the process, and by extension, the programs.
Community Engagement

In creating the space for varied sources of information to mold the community health needs assessments, MGH also concurrently underscores the importance of community engagement, a critical aspect of a community health needs assessment as demonstrated in the case study above. In this context, community engagement centers on active community participation, as the new guidelines explicitly state that the CHNA must “take into account input from persons who represent the broad interests of the community served by the hospital facility...” (Catholic Health Association of the United States, 2012).

Community Catalyst further emphasizes the role of community engagement in a document entitled Community Engagement in CHNAs: Preliminary Responses from Current Practitioners. One takeaway from the responses and review of a sample of CHNAs includes the point that “the community tends to reaffirm trends and issues that come out through public health data, though they tend to frame barriers to care and other problems as socioeconomic issues, e.g. poverty, lack of insurance coverage, rather than a strict public health frame” (“Community Engagement in CHNAs: Preliminary Responses from Current Practitioners,” 2011).

The various avenues of engagement used to collect residents’ opinions, hopes, fears, and experiences also ensure that many voices from a diversity of backgrounds would be captured and taken into account throughout the process. Aldrich also noted “unless it [the decision on which issues to prioritize] comes from the community then it’s not going to be successful; it needs to be born from the community in order to move forward” (L. Aldrich interview). Thus, strong community engagement ensures that a broad segment of the population’s interests are being addressed while also lending validity to the public health data gathered and the subsequent programs established.

The Impact of Attorney General Guidelines on ACA Compliance

According to Leslie Aldrich, the Attorney General’s Voluntary Guidelines helped MGH tremendously “because [MGH] took it [the guidelines] seriously and wanted to do it in a collaborative manner.” Leslie went on to say that MGH has had coalitions in place, which allowed them to conduct community health needs assessments more easily, as well as an evaluation team in place to track and measure outcomes. If MGH had not had the experience going through the community benefit provisions for the state, Aldrich noted that it would not have been prepared to undertake the ACA provisions. She is confident MGH’s model will help them achieve measurable outcomes and change population health as they have been able to create the necessary capacity to support this work and the community benefit program (L. Aldrich interview).
MGH Reflection

MGH stands in large contrast to many hospitals that have not taken up the community benefit standard in earnest across the country. As the findings demonstrate, the hospital and CCHI have been able to develop an assessment and implementation strategy process along with its community partners that should be recognized for its level of engagement and capacity development. In addition, the hospital relies on evidence-based strategies to address prioritized health needs and uses a community based participatory research approach to evaluate outcomes. Even so, in referencing the Health Impact Pyramid, many strategies fall higher on the pyramid and have less population impact compared to strategies that could address social determinants of health. On a strategic level, it makes sense that the hospital and community are focusing on issues that can be tackled given existing resources and capacity, but it is not necessarily the “deeper-rooted” work.

MGH is in a great position to build on its successes and community work since it is apparent that the institution wholly understands the influence of social determinants. CCHI’s guiding principles incorporate a broader definition of health that includes social determinants; the community health needs assessment reports reference Dr. Frieden and the Health Impact Pyramid; and most recent Charlestown report mentions the need to address issues like housing and air quality. As such, MGH should push their work further by strategizing with its communities and partners on programs that more directly address social determinants, in addition to sustaining the programs that have proven to be successful, even if they do not have as large of an influence on the population as a whole. In this way, MGH will maximize its impact on both the populations it serves and on the environment in which they live.

Recommendations

Recognizing Community Building Activities as Community Benefit

As mentioned previously, the new Schedule H form has a section for reporting “Financial Assistance and Certain other Community Benefits at Cost” (Part I) and “Community Building Activities” (Part II). The latter section allows hospitals to list activities that are broader than health care delivery, and reflect social and environmental factors. Although health care institutions have the opportunity to report all activities they believe fall under community benefits generally, the IRS standards need further clarification as to the influence and importance of Part II in complying with its standards. Only some activities listed in Part II of Schedule H are deemed to be community benefits for the purposes of compliance, and can
therefore technically be listed in Part I instead. Part I appears to be the more weighted section in terms of fully satisfying the tax-exemption criteria (Nelson et al., 2013). Even so, the IRS should be pushing beyond this and broadening what counts as community benefit to include the suggestions and more under “community building activities,” given the fact that these initiatives tend to get at the core of addressing social determinants. The implementation strategies that reflect communities’ needs should be used as an important opportunity to develop programs that have a greater population impact and simultaneously highlight the importance of “community building activities” for more transformative health changes.

**Prioritizing Community Benefit Types**

Compliance for tax-exemption is comprised of seven community benefit types: unreimbursed costs for means-tested government programs; charity care; subsidized health services; community health improvement; health-professions education; cash or in-kind contributions to community groups; and research. However, even if some hospitals may spend a large percentage on community benefits overall, the breakdown of resources allocated to the different elements that constitute the benefits can be largely skewed to “health-professions education” and “research,” for example, rather than toward “community health improvement.” In the case of the 2013 *Provision of Community Benefits* study, an average of 45.3% of resources were allocated to “unreimbursed costs for means-tested government programs,” which are those that are based on financial need (Medicaid being the main example) (Young et al., 2013).
Thus, although not all of the benefit types will receive resources equally, shifting more of the allocation toward other benefit types that have the potential to make greater impact on population health, like "community health improvement," would be much more impactful. In Dr. Young’s study, an average of 5.3% of expenditures fell under the "community health improvement" category in 2009 (Young et al., 2013). Given the ACA’s major goal of enrolling the millions who previously had no health coverage, one would also expect the resources spent on charity care and other unreimbursed costs to decrease, theoretically freeing up resources that can be invested in other areas. This shift will take some time to manifest itself, and states with more robust Medicaid programs, for example, may have hospitals that already spend less on free care; thus, it is important to take a comprehensive look at a hospital’s allocation of resources when evaluating community benefit spending.

MGH and other hospitals should take the opportunity to reassess where their financial resources are going and the level of impact those benefit types have for the greater population. I argue that raising the level of resources going toward "community health improvement" as well as "in-kind contributions to community groups" (if spent effectively) has the potential to transform the health and wellbeing of the population.
of residents, and in turn will lead to a more proactive model of healthcare in which the focus is on fostering health. Hospitals that are heavily dependent on “means-tested government programs” to make the case for their community benefit compliance and don’t re-strategize accordingly may be in greater danger of losing their tax-exempt status.

**Enforcing Penalties for Non-Compliance**

If hospitals cannot adequately demonstrate the value of their community benefits, they will be charged a tax penalty of $50,000 and may lose their tax-exempt status. Given the fact that compliance is based on the IRS’ “facts and circumstances test,” discretion will determine compliance, still making it unclear as to when penalties may be exacted. This gray area creates the space for non-profit hospitals that aren’t interested in taking the ACA provisions seriously to continue reaping the benefits of tax-exemption without adequately investing in their communities.

In Massachusetts, the penalty lies in the original licensure requirement, which requires hospitals to maintain or increase the percentage of free care they offer. If for-profit or non-profit hospitals do not comply, the state will not issue a license to “establish or maintain an acute care hospital” (The Hilltop Institute, n.d.-c). Because the more comprehensive guidelines around community benefits are voluntary for non-profit hospitals, there are no penalties involved for hospitals that choose not to adopt the provisions.

Of the hospitals with detailed community benefit requirements, several of them also have explicit penalties for non-compliance (U.S. Government Accountability Office, 2008). For example, non-profit hospitals in Texas must provide community benefits as a condition of tax exemption. Hospitals must abide by one of four community benefit standards, three of which have a minimum level of requirement (The Hilltop Institute, n.d.-d). Failure to comply in reporting the community benefits plan results in a $1,000 (or less) per diem penalty for each day of non-compliance. If the hospital does not comply within the established time frame, the “Commissioner of Health may request that the Attorney General institute and conduct a suit in the name of the state to recover civil penalties” (U.S. Government Accountability Office, 2008).

In 2011, the Illinois Department of Revenue denied three hospitals their property tax exemption because of their failure to provide adequate charity care. Illinois requires non-profit hospitals to provide free care or other “health services to low-income or underserved individuals” in order to receive property and sales tax exemptions (The Hilltop Institute, n.d.-b). The new cases, which include Decatur Memorial and Edward Hospitals, were bolstered by a 2010 Supreme Court ruling,
which stated that the revenue department “was correct in withdrawing Provena
Covenant Medical Center’s property tax exemption in 2004” (Bergen, Kathy, 2011). In 2002, Provena indicated that it provided $38 million in free care and community benefits, but in fact only 302 patients benefited from free care that year.

As evidenced by the cases in Illinois and the majority of New York Hospitals not complying and abusing the funds from the ICP program mentioned previously, it is naïve to assume that given the new national guidelines all hospitals will maintain or increase their benefits to comply; as such, actions like the one taken by the Illinois revenue department are necessary to signal to all non-profit hospitals that the IRS and government are serious in demanding that they pay their dues and truly adhere to the charitable missions so many tout.

Establishing A Fixed Percentage of Expenses for Community Benefits

As it stands, the IRS does not require hospitals to meet a specific quantity in order to satisfy the community benefit requirements. Instead, the IRS uses a “facts and circumstances test,” which considers all relevant conditions in order to decide whether or not a hospital indeed meets the requirements (Nelson et al., 2013). The IRS should establish a percentage that they expect hospitals to spend as part of their compliance with the community benefit provisions. I argue that non-profit hospitals should meet a minimum threshold of 5% of operating expenses. Of the five states that have minimum requirements, (The Hilltop Institute, n.d.-a), Pennsylvania and Texas have compliance options that specify a 5% standard (The Hilltop Institute, n.d.-d). In addition, experts have noted that prior to 1969, the IRS unofficially used 5% of operating expenses as its benchmark to assess whether hospitals would qualify for tax exemption (Bakken & Kindig, 2012).

Given the large variability in the allocation of operating expenses toward community benefits, a fixed percentage will make clear how much health care institutions are returning to communities in exchange for the many tax breaks they enjoy on a local, state, and national level. It also allows for more explicit penalties if hospitals do not meet the threshold.

It should be noted that because of nationwide variability of non-profit hospitals’ finances, the IRS has recognized that a “quantitative requirement for tax exemption could have disproportionate effects on hospitals, and some hospitals ‘could have a very difficult time meeting quantitative tests that key off of charity care or other community benefit expenditure levels’” (Mills, Elizabeth, Peregrine, Michael, & DeJong, Ralph, 2009). Thus, more research would be beneficial to understand any adverse effects of a baseline percentage for community benefits.
**Democratizing the Form 990 Schedule H**

Schedule H is the new IRS form that is meant to collect more financial data from hospitals and also to help objectively categorize community benefit activities (Nelson et al., 2013). Given the more stringent reporting requirements that exist, Schedule H in particular is a very important resource for researchers, other hospitals, and just as importantly, communities. By accessing hospitals' Schedule H forms, communities would have the opportunity to rely on their own understanding of the level of commitment that community health care institutions demonstrate to serving them. As part of the new IRS guidelines, hospitals are expected to make their community health needs assessments “widely available to the public,” but that is not the case for the Schedule H forms they file (IRS, 2013). In reality, the forms are often difficult to access and their unattainability relegates the community to depend more heavily on the information voluntarily released and distributed by the hospitals to shape their understanding and knowledge of the community benefit activities.

Young et al., for example, obtained all of the data for the 1,800 hospitals they studied from GuideStar, a company that “obtains, digitizes, and sells data that organizations report on Form 990 and related schedules.” The authors were in a position to pay for data, but, as we know, most communities don’t have that luxury or access to partners that could aid in obtaining such information on their behalf. As such, it is important that the tax document is made readily available by both the hospitals that file them and the IRS who collects them, since doing so would create greater transparency around the community benefit program and aid communities in advocating for their health and wellbeing.
Moving Forward

Areas of Further Study

Comprehensive Assessment and Efficacy of Benefit Programs

Given that this thesis focuses on the community benefit program of one hospital, more research is needed to look at hospitals across the country comprehensively to identify larger trends in addition to more generalizable best practices. The ACA guidelines are only several years old, so a study of the first round of community health needs assessments and implementation strategies would serve to begin to highlight potential points on which hospitals might need guidance or facets of the regulations that need further clarification. In addition, a comprehensive look at all of the Form 990 Schedule H documents filed by each non-profit would be very expedient from a comparative point of view.

In the future, a comprehensive look and assessment of the effectiveness of community benefit programs in creating initiatives that actually have an impact will also be valuable. Certainly some time will need to pass in order to be able to see the realized successes or failures clearly, as well as the impact on health and communities. Comparing hospitals' impacts to the benchmarks outlined by Healthy People 2020’s four cross-cutting foundation health measures, which include social determinants of health and disparities, would allow for a better understanding of advances in community health on a national level (Healthy People 2020 “About Healthy People,” n.d.).

Accounting for the Uninsured

Despite the fact that more than 9 million people have been newly insured under the Affordable Care Act (Carman & Eibner, 2014), millions still don’t have insurance, including an estimated 11.5 million undocumented immigrants that live in the U.S. (Hoefer, Michael et al., 2012). Because the undocumented population does not qualify for any federal coverage, including Medicare or (nonemergency) Medicaid, a large gap exists between this population and options for receiving adequate (or any) care, which can undermine the work that many health institutions undertake in communities (“Immigrants and the Affordable Care Act (ACA),” 2014). Understanding how to care for the undocumented immigrant population on a more localized level will be important in developing tailored solutions to address their health issues, and is imperative in order to ensure that advances in community health can have measurable impacts on the lives of all.
Charity Care

Hospitals provide charity care—free or reduced care—to patients who are unable to afford the care they’ve received. A mandate that calls for insurance for all would theoretically reduce the amount of people dependent on charity care programs. Despite the surge in the insured population in the U.S., however, nearly 16 percent are still without insurance (Carman & Eibner, 2014). Many individuals still find the health insurance options unaffordable; others have chosen to opt out of having health insurance; and others still do not qualify given their undocumented status or because, as legal residents, they have been in the U.S. for less than five years. The understanding is that demand for charity care programs may not actually decline, but instead shift to serving a different population. As such, it will be necessary to re-evaluate both what should be done with some of the resources that may no longer be needed for charity care and also how charity care should evolve going forward (Chazin, Friedenzohn, & Somers, 2010).

A report entitled The Future of U.S. Charity Care Programs: Implications of Health Reform, was published in 2010 but highlights various issues that still need to be considered. A major concern going forward is that providers may be reluctant to continue participating in charity care programs given that they can receive higher reimbursements elsewhere. Another consideration is what eligibility guidelines for patients may be logical given the new and existing health care options. Most relevant to this thesis is a third issue that involves understanding how an evolving charity care program impacts hospitals’ community benefit spending (Chazin et al., 2010).

Health in All Policies

In thinking about the number of factors that affect our health, hospitals should be leading the charge with the idea of “health in all policies.” Hospitals have an opportunity to do more than just comply with state and federal regulations. They should also think creatively about how to tackle health issues at the root. Given the World Health Organization’s most recent report stating that 1 in 8 deaths globally can be attributed to air pollution (7 million people died in 2012), it is clear that we must move past an individual-based and reactive response to health care (“7 million premature deaths annually linked to air pollution,” 2014). We, as a nation, and as a global community must push for health in all policies, particularly as this underscores how our health is impacted far more greatly by external forces and environments, not just individual choices and genetics.
In 2013, the American Public Health Association, the Public Health Institute, and the California Department of Health published Health In All Policies: A Guide for State and Local Governments. The Public Health Institute site describes the concept in the following manner: “Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. The goal of Health in All Policies is “to ensure that all decision-makers are informed about the health, equity, and sustainability consequences of various policy options during the policy development process” (Rudolph, Linda et al., 2013). The report outlines “windows of opportunity” through which new partnerships can be created to support healthy policies with government agencies. Several examples of opportunities include guidance and best practices: “incorporate strategies that promote community health into comprehensive land use and transportation plans,” permitting and licensing: “streamline permitting processes for farmer’s markets to provide healthy food in underserved residential neighborhoods,” and purchasing: procurement and contracts: “establish policies supporting contracting with veteran-, minority-, or women-owned businesses” (Rudolph, Linda et al., 2013).

In addition, collaboration across a variety of sectors is undergirded by establishing what the report calls an “environmental frame,” which asserts the impact of our environments (home, work, etc.) on health, and appeals to values around “fairness, efficiency, [and] opportunity...” The report emphasizes “if environments matter for health, then our society, and the government agencies that serve it, should consider health outcomes in the decisions that shape those environments” (Rudolph, Linda et al., 2013). This environmental frame is necessary in order to begin to earnestly address health issues and make changes via policy implementation, and the ACA’s community benefit provisions serve as a significant starting point in institutionalizing it.
## Appendix

### List of Interviewees

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<tr>
<th>Name of Interviewee</th>
<th>Position and Organization</th>
<th>Date of Interview</th>
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<tbody>
<tr>
<td>Leslie Aldrich</td>
<td>Associate Director, MGH Center for Community Health Improvement</td>
<td>January 8, 2014</td>
</tr>
<tr>
<td>Jay Ash</td>
<td>City Manager, Chelsea, Massachusetts</td>
<td>March 21, 2014</td>
</tr>
<tr>
<td>Cate Blackford</td>
<td>Manager of Healthy Initiatives, Department of Health, Revere, Massachusetts</td>
<td>April 1, 2014</td>
</tr>
<tr>
<td>Rosina Kitty Bowman</td>
<td>Director, Revere CARES Coalition</td>
<td>February 28, 2014</td>
</tr>
<tr>
<td>Michele Craig</td>
<td>Outreach and Training Coordinator, Hospital Accountability Project, Community Catalyst</td>
<td>January 9, 2014</td>
</tr>
<tr>
<td>Linda Cummings</td>
<td>Director, Essential Hospitals Institute; Vice President of Research, America's Essential Hospitals</td>
<td>February 10, 2014</td>
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<tr>
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