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How Nonprofit Hospitals Can Support Communities and Advance Public Health

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Introduction and summary

Hospitals, critical providers of essential care throughout the pandemic, can serve an influential role in bolstering health equity and population health; and health systems around the nation are increasingly recognizing this responsibility.[1] Nonprofit hospitals have a unique obligation to advance community health. Their tax-free status—saving nonprofit hospitals an average of $11.3 million annually, per hospital—hinges on a need to provide benefit to the community.[2] These hospitals and health systems are well suited to improve population health as trusted clinical care providers and anchor institutions in local communities. However, with scant regulation of what activities qualify as community benefit and little guidance specifying how much hospitals must spend on them, nonprofit hospitals vary greatly in their levels of community engagement and commitments to advancing community health.

Under the Affordable Care Act, nonprofit hospitals must demonstrate that they operate for a charitable purpose by providing "benefits to a class of persons that is broad enough to benefit the community" and serving the public interest.[3] All nonprofit hospitals and health systems are required to engage the community to develop programming to respond to community health needs. While some nonprofit hospitals engage in medical training, research, or facility upgrades to meet the community benefit requirement, others make it a priority to directly address unmet community needs.

Within this flexible framework of serving the community, some nonprofit health systems and hospitals invest in engaging thoughtfully and meaningfully with their communities. As the COVID-19 crisis has made clear, health access and status are inseparable from the environments in which people live, work, and play.[4] Nonclinical factors that influence health, such as social isolation, stress management, and food insecurity, lie at the root of health disparities. With intention and humility, nonprofit hospitals can serve the dual purpose their names and statuses evoke—as providers of high-quality clinical care and as charitable institutions that seek to support their local communities.

This report describes three case studies of health systems taking innovative and intentional approaches to their community benefit programs, as well as best practices for nonprofit hospitals and policy recommendations to support this population health work. Trinity Health, the first of the case studies, has clear systemwide equity and population health priorities and empowers hospitals to identify and respond to more specific community needs. Allina Health, similarly, takes on systemwide programming for common needs yet also encourages health systems to address unique community needs and partner with trusted community organizations. Finally, BJC HealthCare is undergoing strategic planning, prioritizing community co-creation and ethical engagement, and has a deep understanding of its role in community health.

These case studies provide several key lessons for other health systems looking to design equity-focused community benefit:

• Accurately and efficiently assess community needs.

• Co-create programs with community members.

• Join other community organizations in assessment and programming.

• Build commitment and buy-in from the community and within the hospital or health system.

Finally, this report outlines policy actions federal and state governments can take to better support nonprofit hospitals and health systems seeking to meaningfully engage with the community and bolster population health.

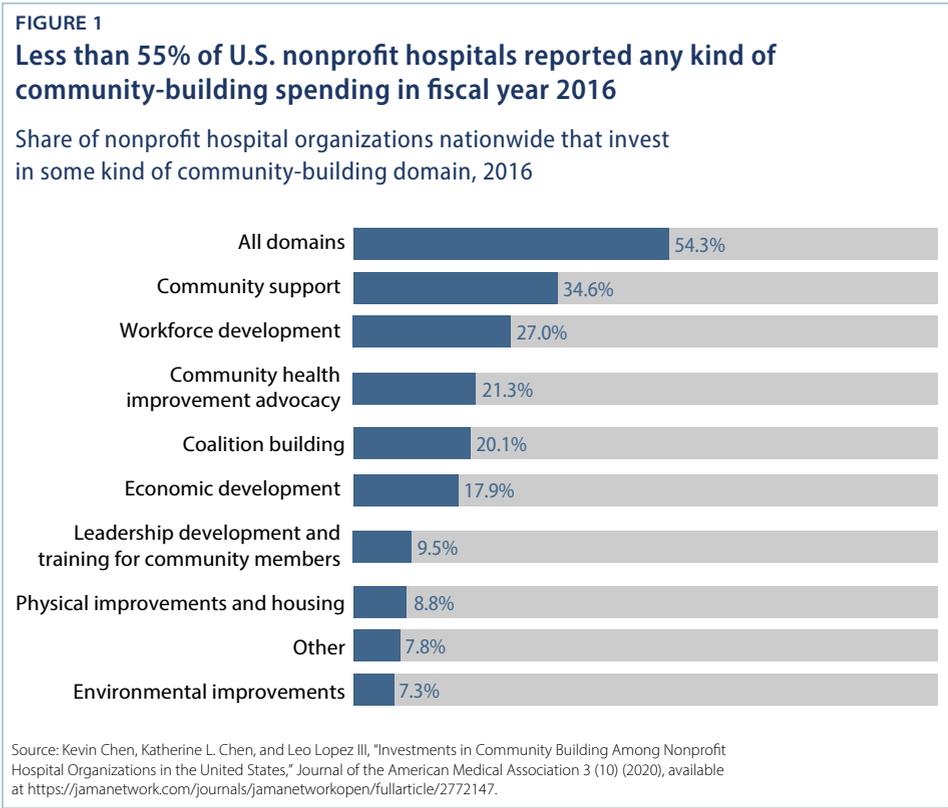# Nonprofit hospitals are uniquely positioned to address community health

Nearly 6 in 10 U.S. hospitals are nonprofit.[5] Under the Affordable Care Act (ACA) and the Internal Revenue Code (IRC), nonprofit hospitals with 501(c)(3) tax-exempt status from the IRS must meet the following four primary requirements:[6] 1) conduct a community health needs assessment (CHNA) and submit an implementation strategy every three years; 2) meet standards for providing community benefit;[7] 3) have an accessible and publicly available financial assistance program; and 4) limit extraordinary collection practices. Notably, some states place additional conditions on hospitals' nonprofit status.[8] The IRS rules do not specify an amount of charity care or community benefit investment required to qualify for nonprofit status.

In recent years, however, some researchers have questioned whether the benefits nonprofit hospitals provide to the community warrant their tax exemption. In fact, of the 10 hospitals with the highest profit margin in 2013, seven were nonprofit.[9] According to one study using 2012 data, the value of nonprofit hospitals' tax exemption as a proportion of total expenses was, on average, greater than their incremental spending on community benefit relative to what for-profit hospitals provide.[10] Furthermore, a study published in *Health Affairs* in 2021 found that, in aggregate, nonprofit hospitals spent 60 percent less than for-profit hospitals on charity care as a share of total expenses.[11] As health care researchers noted in Stat, "In 2017, the top 5% of nonprofit hospitals (by overall net income) were responsible for more than half of the overall earnings of all nonprofit hospitals, but provided only about 20% of overall charity care."[12]

The overall amount of uncompensated care provided by hospitals has decreased in recent years. As coverage rates increased under the ACA, fewer hospital patients were uninsured, reducing the amount of uncompensated care provided by non-profit hospitals. From 2013 to 2017, uncompensated care costs as a share of hospital budgets declined 26 percent in aggregate.[13] States that expanded Medicaid experienced an even more dramatic change, as uncompensated care costs declined 45 percent in expansion states during the same time frame.[14] To some extent,

reduced spending on uncompensated care was offset by increased unreimbursed Medicaid spending. However, hospitals that experienced net gains did not necessarily translate those savings into community-directed spending.[15]

Because hospitals decide how much to spend on community benefit and which programs and activities to fund, hospitals vary widely in their contributions to advancing population health. Nonprofit hospitals must report their spending as community benefit or community building. While the distinction can be murky, the former generally refers to unreimbursed and subsidized health care services and community health improvements, while the latter encompasses activities to build community capacity and address "upstream" social determinants of health.[16] A recent *JAMA* study determined that less than 55 percent of nonprofit hospital organizations report any community building spending, with an overall median of $63,572 in community-building expenditures.[17] (see Figure 1) In 2016, hospital organizations that carried out community-building activities invested in community support and workforce development at the highest rates.

FIGURE 1

Less than 55% of U.S. nonprofit hospitals reported any kind of community-building spending in fiscal year 2016

Share of nonprofit hospital organizations nationwide that invest in some kind of community-building domain, 2016

Domain	Share
All domains	54.3%
Community support	34.6%
Workforce development	27.0%
Community health improvement advocacy	21.3%
Coalition building	20.1%
Economic development	17.9%
Leadership development and training for community members	9.5%
Physical improvements and housing	8.8%
Other	7.8%
Environmental improvements	7.3%

Source: Kevin Chen, Katherine L. Chen, and Leo Lopez III, "Investments in Community Building Among Nonprofit Hospital Organizations in the United States," Journal of the American Medical Association 3 (10) (2020), available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772147.

Health care experts are increasingly calling on nonprofit health systems to address social determinants of health,[18] which the U.S Department of Health and Human Services defines as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[19] Social determinants of health include things such as access to clean water, safe housing, nutrition, and income. While accounting for less than 5 percent of total community benefit spending, U.S. health systems "publicly committed" $2.5 billion toward addressing social determinants from 2017 to 2019, with the vast majority dedicated to housing and employment.[20] Experts suggest that social determinants "can drive as much as 80 percent of health outcomes."[21] According to a 2020 study in *Population Health Management*, greater community-directed community benefit spending is associated with lower potentially preventable hospital readmission rates.[22]

Health inequities have long plagued many Americans, especially those with marginalized or underserved identities.[23] Many health inequities result in health disparities, defined by the Centers for Disease Control and Prevention as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations."[24] Health disparities often occur along racial and ethnic lines. In particular, African American or Black, Hispanic, Asian, and Native Hawaiian or other Pacific Islander Americans, as well as American Indians and Alaska Natives, experience limited access to health care and poorer health outcomes, compared with their white, non-Hispanic counterparts.[25] According to the Kaiser Family Foundation, disparities also "occur across socioeconomic status, age, geography, language, gender, disability status, citizenship status, and sexual identity and orientation."[26]

For example, while 48 percent of white, non-Hispanic Americans with any mental illness received services in 2015, the same was true for only 31 percent of Black and Hispanic Americans and 22 percent of Asian Americans with mental illness.[27] Social determinants of health often underlie health disparities such as inequitable mental health care access. Discrimination, unemployment, community violence, and high incarceration rates in the community are associated with poorer mental health outcomes; and many of these are more common among Black and Hispanic communities due to centuries of systemic racism.[28] For instance, one study published in *The Lancet* found that Black respondents reported poorer mental health if they lived in states with one or more police killings of unarmed Black Americans, with additional police killings resulting in additional poor mental health days.[29] Understanding these insidious social factors is key to meaningfully addressing health inequities and disparities.

Innovative approaches to community benefit

The COVID-19 pandemic and the national reckoning with racial health and economic disparities provides hospitals with an opportunity to reassess how they are serving the health needs of the community and advancing public health. Hospitals can leverage their role as direct care providers—often interfacing with patients when health needs are most acute—to assess health-adjacent social needs and connect patients with resources to address the underlying drivers of poor health. Nonprofit hospitals are uniquely positioned to make significant investments to advance health equity, engage with and meet the needs of local communities, and improve social determinants of health.

The following section describes the experiences of three health systems taking innovative and intentional approaches to their community benefit work, drawing on the authors' interviews in June 2021 with representatives of each health system. Trinity Health takes an intentional, systemic approach, paired with an emphasis on addressing local needs. Allina Health's approach understands its strengths and capacities and uses them to address identified community needs. And BJC HealthCare is currently undergoing strategic planning to develop robust, impactful, and community-minded programs. Critically, all three health systems recognize and emphasize the need to address social determinants of health. As their priorities reflect and experts affirm, clinical care alone cannot fully address health inequities.[30]

Trinity Health: System priorities, local needs

Trinity Health, a health system of 90 hospitals headquartered in Southeast Michigan, has adopted a organizational approach with an emphasis on meeting local needs.[31] The health system sets overarching priorities—for example, screening and addressing social and economic needs, expanding community support services, and improving community conditions—but gives hospitals leeway

to develop programs tailored to their local populations.[32] According to Jaime Dircksen, Trinity Health's vice president for community health and well-being, spending "can be deliberately strategic" to address the system's community support priorities and meet identified needs.[33] Dircksen explained that hospital executives must allow themselves to be guided by local needs:

> For systems that are in multiple communities, you can have a framework but can't set community priorities. Priorities must be set by local communities. That's a very different shift for health system leaders.[34]

While all Trinity Health hospitals follow the shared priorities, the health system's signature program for "social influencers of health" lays the groundwork for individual hospitals to identify community needs and design interventions and policies with community partners to address those needs. For example, as of 2019, 13 of Trinity's hospitals developed projects to address food insecurity.[35] Many of these hospitals took a variety of localized approaches to improving health food access—ranging from farmers market vouchers in Albany, New York, to courses and demonstrations on preparing nutritious, low-cost meals in Hartford, Connecticut, to a food redistribution program in Fresno, California—all in partnership with community-based organizations.[36]

Dircksen identified several challenges to implementing community benefit programs that address community needs. Trinity Health sees its local hospitals as part of the broader community in which they work. The health system has been encouraging hospitals to engage in joint CHNAs, and many of them have successfully partnered with community-based organizations and local health departments in their assessment processes. However, Dircksen said that it can be challenging for local organizations and hospitals to develop joint implementation strategies. Often, hospitals, health departments, and community organizations come together to determine health and social needs, before parting ways to design individual implementation plans. Instead, as Dircksen suggests, continuing to pool resources and collaborate on initiatives would be a more efficient and effective approach.

Dircksen also expressed concerns about the timeline of the CHNA process. While hospitals must conduct CHNAs every three years, public health departments in their service areas conduct their own assessments every five years, and the two cycles rarely overlap. Moreover, according to Dircksen, data lags and the complexity of the issues hospitals take on make it difficult for hospitals and health systems to analyze outcomes and apply lessons learned from the previous cycle.

Trinity Health's community benefit work makes clear the importance of collaboration and information sharing. By prioritizing local needs, the hospitals within Trinity Health's health system take far-reaching community concerns such as food insecurity and customize their initiatives to meet communities where they are and leverage existing capacities.

Allina Health: System resources aligned with community needs

Allina Health, headquartered in southern Minneapolis, frames its community health work as the "sweet spot" where health system resources can meet pressing community needs.[37] In its hospitals' CHNAs, Allina Health has identified issues that cut across different regions in which it works and has developed systemwide initiatives for its entire service area. For example, Allina Health has created Health Powered Kids,[38] an online tool to address childhood obesity; Change to Chill,[39] a web-based platform and in-person program to improve mental wellness for teens; and, most recently, Hello4Health,[40] a program to address social isolation for seniors.

Allina Health was an early leader in addressing social needs in the surrounding population. In 2008, the health system recognized that while Allina Health's health system was known for providing excellent health care in the Twin Cities metro area,[41] many residents in the communities closest to Allina Health were experiencing poor health outcomes.[42] Allina Health began with assessing community needs and engaging stakeholders but soon realized that deeper engagement was necessary. As Ellie Zuehlke, Allina Health's director of community benefit and engagement, described:

> Pretty quickly, residents told us, "Wait a minute. This cannot be about Allina Health improving the health of Allina's backyard. Rather, how can we support community residents—people who live in communities with Allina Health in their backyard?"[43]

So, with a community-driven process, Allina Health worked with local organizations and community members to design the Backyard Initiative, which provided resources to empower local residents to create and operate community health action teams (CHATs) focused on needs identified by South Minneapolis residents.[44] These CHATs offered up to 35 free activities each month, such as exercise classes and peer support programs.[45] The initiative was effective, with more than 95 percent of surveyed residents reporting a greater sense of belonging and 86 percent reporting health-related behavior changes.[46]

At the same time, Allina Health recognizes that unique local problems require individualized solutions.[47] Allina Health attributes much of the success of its local and systemwide initiatives to strong buy-in within the health system and with community members and organizations. As Zuehlke explained, Allina Health thinks strategically to identify where "there is a sweet spot between the needs of the community and what your organization is in a position to respond to."[48]

One example at the nexus of community needs and Allina Health assets is its mental health program, Change to Chill. A CHNA identified the need for increased mental health support for teens, and Allina Health had the resources and capacity to develop programs to address poor mental health.[49] So, Allina Health created Change to Chill, a free online resource for teens that serves Allina Health's entire system, has more than 30,000 unique users, and includes a school partnership program that has reached more than 10,000 students in person.[50] Preliminary evaluations have shown that participants have an increased knowledge of coping techniques and greater confidence in their ability to cope with stress.

Allina Health has also identified several areas in which current federal policy hinders optimal community engagement. Christy Dechaine, the manager of community benefit at Allina Health, echoed Trinity Health's frustration with the CHNA timelines.[51] Dechaine explained that some public health departments are conducting their periodic reviews on nonprofit hospitals' three-year timelines, more often than required, to facilitate coordination. Dechaine added that aligning public health and nonprofit health assessment timelines would not only be more efficient but would also reduce the burden on the community members involved in the process.

Furthermore, Dechaine believes that Allina Health's initiatives could be even more effective with a five-year CHNA and reporting cycle. Pulling together a CHNA that "checks all the boxes" takes a lot of time, effort, and resource investment in activities, such as writing, that take staff time away from addressing the most pressing community issues in need of urgent investment.

Allina Health's understanding of its own strengths and capacities has paved the way for the health system to address community-identified needs without straying from what it does best. Having the humility to let communities lead and invest in organizations that already have trust and connections with the community is key to carrying out effective and meaningful community benefit work.

BJC HealthCare: Strategic planning and community engagement

Recognizing health systems as well-resourced, trusted by the community, and uniquely positioned as clinical care providers, BJC HealthCare—a system that includes 15 hospitals in Missouri and Illinois—has taken steps to make community health a priority. Last year, the health system created a new role, the vice president of community health improvement, and brought on Dr. Jason Purnell, a health equity expert, indicating a commitment to advance population health through community benefit.[52] Purnell sees the value that nonprofit hospitals have in addressing community needs. He explained, "Trust that many people have with their provider can be utilized as a bridge to addressing a broader set of social needs and social determinants."[53]

Prior to hiring Purnell, BJC hospitals had been designing programs to address unmet community needs. For example, three BJC hospitals are in the city of St. Louis, a city with a proportion of African American residents that is four times greater than that of the state, a median income that is 25 percent lower than the state's, and 1 in 4 residents living below the poverty level.[54] Each St. Louis hospital conducted CHNAs, with a rating process to determine the most pressing needs of the community and assess ability to collaborate on addressing these needs. While some St. Louis hospitals developed programs similar to those of others—including for diabetes prevention and education—many hospitals designed targeted implementation plans to meet more specific needs of their service areas and best use their particular capacities.[55] For example, the Rehabilitation Institute of St. Louis, a joint venture between BJC and for-profit Encompass Health, seeks to prevent strokes and brain injuries through education, while St. Louis Children's Hospital focuses on children's asthma, dental health, obesity, and disease prevention.[56]

As Purnell and his team strategically plan for more robust and equity-minded community health improvement activities, he emphasized the importance of co-creating these initiatives with affected community members. In their planning model, community engagement must be diffuse through the entire process. This means that in addition to "episodic" focus groups and CHNAs, building trust and relationships with the community is essential to meaningful and ethical work.[57] Purnell equated the role of community members in that process to trend-spotters in fashion and design who report trends to the companies for which they work: Like trend-spotters, community members would provide on-the-ground intelligence about the most pressing community needs and guide health entities such as BJC to use their resources toward actionable change.

Similarly, a health system must understand its role in community health activity to offer authentic engagement. Health systems are part of a "broader ecosystem" and must clearly and transparently acknowledge the "imbalance of power" between themselves and community groups.[58] Purnell explained further: "Health care organizations are not going to become social service organizations, nor should they."[59] Health care institutions such as BJC bring resources into the community and must know how to lead, convene, and, importantly, follow.

Hospital best practices for population health

As hospitals and health systems increasingly recognize their responsibility to advance community health, they should build these programs using lessons learned from other health systems. These best practices serve as guiding principles to ensure that hospital community benefit programs are effective, aligned with community needs, and using limited resources effectively.

Accurately and efficiently assess community needs

The requirement to conduct a CHNA can be a useful tool to guide targeted interventions and develop programming that meets needs identified by vulnerable community members and groups. Nonprofit hospitals should ensure their CHNA processes adequately engage their communities and assess a wide variety of needs. CHNAs should survey the local population's most pressing needs, include underserved community members, and welcome community input and guidance. As Trinity Health and Allina Health both expressed, conducting CHNAs in conjunction with other health systems and public health entities is key to reducing community burden and most effectively expending resources.

Co-create programs with community members

As Jason Purnell of BJC HealthCare explained, community benefit programs must do more than simply "engage" communities in assessment, development, and implementation.[60] Health systems must humbly co-create these programs with community members. Indeed, Jamie Dircksen of Trinity Health stressed that local communities must set their own priorities and that health systems must trust community organizations and members to determine what is best for their own community.[61]

While community co-creation was a priority for all three systems discussed above, this idea is not universal among health systems. A 2017 study found that few nonprofit hospitals engage community stakeholders and members in meaningful ways

throughout needs assessment and implementation.[62] Community co-creation not only aligns with the purpose of community health improvement; it also increases community buy-in and improves the quality of community benefit programs. According to a 2019 scoping review, "Community members who participate in needs assessments offer unique insights, are more satisfied with the product, and emerge with increased knowledge."[63] Health systems can build opportunities for community empowerment well before implementing community benefit programs: The co-creation process itself can be a powerful community-building exercise.

Join forces with other community organizations

While each health system has its own community benefit requirements, hospitals and health systems should collaborate with other health systems, state and local health departments, and community-based organizations whenever possible. Coordinating initiatives in the same community limits duplication of efforts and can pool together insight and resources to maximize impact.

As Purnell emphasized, health systems are not social service organizations.[64] Health systems and hospitals should have a clear understanding of their role and strengths. Partnering with community-based organizations that have trusted relationships with community members is key. Sometimes a health system's most helpful role is to provide resources or other assets to allow community members and organizations to identify and carry out their own priorities and initiatives. For example, Allina Health's Backyard Initiative was a partnership with a community organization, the Cultural Wellness Center, and its Change to Chill mental wellness program reaches young people through local schools.[65]

Build internal and external buy-in

One of the key distinctions between programs that simply check boxes for IRS community benefit requirements and initiatives that also improve population health is buy-in within the health system and the community. Building trust and relationships with community members and organizations is needed for sincere and effective community engagement.

The three health systems the authors interviewed all had dedicated staff to carry out and report community benefit activity. While that level of human resources may not be available at all hospitals and health systems—particularly at smaller hospitals—as entities whose purpose serves the public interest, nonprofit hospitals have an imperative to address the health of their broader community.

Policies to support nonprofit hospitals' community programs

Because current community benefit standards leave much room for variation between hospitals' programming initiatives, policymakers must step in to offer clarity and incentivize meaningful investments in population health. On state and federal levels, policymakers can address some of the concerns echoed in this report's case studies and set standards for consistent engagement among health systems.

Change CHNA reporting requirements to a five-year cycle

As representatives from both Trinity Health and Allina Health expressed, allowing health systems to conduct CHNAs every five years, instead of the current three-year cycle, would promote synergy between hospital systems and public health while also reducing burden on health systems. The Public Health Accreditation Board requires health departments to complete community health assessments every five years.[66] While health equity experts have been pushing for increased collaboration among health systems, community-based organizations, and local public health departments, the public health and nonprofit health system reporting years do not necessarily line up.[67] Consequently, either health departments conduct assessments more often than necessary to partner with hospitals[68] or the two groups may be conducting potentially redundant assessments of community health at different times, possibly increasing the burden on the community and missing opportunities for coordination.

Conducting new assessments and monitoring metrics every three years take up a lot of resources and human capital. Health systems often prepare for the next CHNA less than two years after beginning to implement the last cycle's activities.[69] In some cases, health systems are required to reassess needs and create new implementation strategies before any real data can be analyzed or measurable health outcomes can be detected. Congress should amend the IRC to allow a five-year CHNA cycle that can be synced to local public health department planning to promote better collaboration and allow for evidence-based decision-

making. More specifically, Congress should add to the statute a recommendation for CHNA consultation and provide flexibility for a fixed period to allow health departments and hospitals to sync assessment cycles.

Clarify tax exemption reporting requirements

A recent Government Accountability Office (GAO) report found that community benefit reporting requirements were unclear to hospital stakeholders.[70] Allina Health representatives concurred with these findings, suggesting that clarity from the IRS on which activities constitute community benefit spending—particularly those aimed at social determinants of health—would be helpful.[71] More guidance on which forms of engagement qualify as community benefit could encourage health systems to invest in population health.

As the GAO noted in its report, the IRS does not define its community benefit standard but instead lists examples of possible activities.[72] As the commissioner of internal revenue testified before Congress in 2005, some of these examples, such as accepting Medicare and Medicaid beneficiaries as patients, are outdated, as most hospitals—both for-profit and nonprofit—consider these standard practices.[73] For example, maintaining an emergency department open to all people, regardless of ability to pay, was previously deemed a community benefit but has been a requirement for all hospitals that operate emergency departments under federal law since 1986.[74]

Yet despite the consensus that addressing social determinants of health is key to advancing population health, the community benefit standard does not explicitly support activities that address unmet social needs.[75] As the GAO recommends, with agreement from the IRS, Congress should clarify which services and activities meet the community benefit standard in the IRC.[76]

Standardize IRS community benefit review and data collection to facilitate program evaluation and information sharing

The community benefit information collected by the IRS is challenging to access, review, and analyze.[77] The tax form used for community benefit reporting relies on narrative text, limiting opportunities for researchers and stakeholders to evaluate

community benefit activity, share best practices, and hold hospitals accountable. While parts of the form request spending amounts for discrete, predetermined categories of community benefit activity, the form solicits data inconsistently and leaves an open-ended narrative section to "provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community."[78] As the GAO suggests, the IRS should consider adding codes to track community benefit reporting and make these data—including data in the narrative section—available to the public, so that they can be accessed by health services researchers and community organizations.[79]

Consider additional standards for community benefit

States have taken a variety of approaches to increase transparency and to support nonprofit hospitals in their community health initiatives.[80] Many of these policies require nonprofit hospitals to meet certain standards beyond what is required federally in order to receive state tax exemption.[81] Several of these policies appear to foster increased community investment: Community benefit reporting requirements are associated with increased spending, as are collaboration requirements between nonprofit hospitals and local health departments.[82]

Many states have implemented policies to hold nonprofit health systems in their states to more rigorous community benefit standards.[83] A 2018 analysis of community benefit spending found that state community benefit policies of any kind—and especially the adoption of multiple policies—are associated with increased community benefit spending.[84] Another study found that the existence of any state law on community benefit is associated with an additional $8.42 per $1,000 of total expenses invested in community benefit, with more than half of the additional spending dedicated to "flexible community benefit spending," including community health improvement and community-building activities.[85]

Several states established minimum standards for community benefit, which provide clarity about expectations for programming or spending levels.[86] For example, Oregon passed legislation in 2019 to create a community benefit spending floor for nonprofit hospitals.[87] Illinois and Utah, meanwhile, require nonprofit hospitals' community benefit spending to meet and exceed, respectively, their property tax liability in the absence of an exemption.[88]

Codify community collaboration standards for needs assessments and implementation plans

The ACA requires nonprofit hospitals to "solicit and take into account input received from persons who represent the broad interests of that community" in their triennial CHNAs.[89] However, California, New Hampshire, New York, and Rhode Island take the federal requirements further to require representation of certain groups—such as community organizations, local governments, or medically underserved community members—in CHNAs.[90] In 2020, Maryland enacted a law that requires hospitals "to conduct their CHNAs *in consultation with community members*" and to submit annual reports on how hospital activities address needs identified in the community.[91] At least three other states—Maine, Massachusetts, and Texas—provide voluntary guidance or encouragement to consult with similar categories of stakeholders.[92] Meanwhile, at least five states have no representation requirement in their CHNA statutory requirements.[93]

Notably, these community involvement requirements only refer to CHNAs and not to implementation plans. Nonprofit hospitals must engage with community members in assessing needs but can design implementation strategies without input from their communities, if they so choose. As expressed by the authors' health system interviewees, initiatives are more ethical and meaningful when co-created with community members. Furthermore, a 2015 study demonstrated that community engagement interventions are associated with improved health outcomes.[94] States that have not yet adopted community engagement requirements should consider doing so for both CHNAs and implementation plans, with the goal of ensuring that members of vulnerable and underserved communities are included.

Require implementation plans to meet community needs

While the ACA requires nonprofit hospitals to adopt an implementation strategy "to meet the community needs identified through the CHNA,"[95] reporting mechanisms rarely hold hospitals accountable to this standard. Several states have implemented policies to address this: Connecticut, Maryland, New Hampshire, and Vermont require hospitals to explicitly tie their implementation plans to their need assessments—a law other states should consider implementing.[96]

States should also consider tying community benefit initiatives to broader equity goals. A 2017 analysis of publicly available CHNAs and implementation plans found that 2 in 3 needs assessments and 1 in 3 implementation plans included one or more health equity term but less than 10 percent of implementation plans included an activity explicitly aimed at health equity.[97] Despite external stakeholders identifying health equity as a need in nearly 80 percent of CHNAs studied,[98] disparities are not even mentioned in federal regulations.[99] For its part, Maryland has been a leader in tying nonprofit hospitals' community work to health disparities: The state explicitly requires nonprofit hospitals to report efforts to "track and reduce disparities in the community."[100]

Conclusion

As anchor institutions in their communities, nonprofit hospitals and health systems are in a unique position to meaningfully improve population health; they have both the resources and legal obligation to serve the public good. Health systems and hospitals should approach community benefit work with humility, collaboration, and buy-in to co-create initiatives with community representatives for lasting, impactful work. Federal and state policymakers have opportunities to guide more nonprofit hospitals to adopt these types of best practices through policies that ensure greater community engagement and channel more resources toward reducing health disparities.

As the featured case studies demonstrate, with some intentional planning and strategic investments, nonprofit hospitals can be key drivers of advancing population health and health equity. Additional support from policymakers and networks of community organizations would further facilitate meaningful community benefit work across the nation.

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Acknowledgments

Endnotes

1   American Hospital Association, "2016 Committee on Research: Next Generation of Community Health" (Washington: 2018), available at https://www.aha.org/guidesreports/2018-03-06-2016-committee-research-next-generation-community-health.

2   Michael Ollove, "Some Nonprofit Hospitals Aren't Earning Their Tax Breaks, Critics Say," The Pew Charitable Trusts, February 7, 2020, available at https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/02/07/some-nonprofit-hospitals-arent-earning-their-tax-breaks-critics-say.

3   Internal Revenue Service, "Charitable Hospitals - General Requirements for Tax-Exemption Under Section 501(c)(3), available at https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3 (last accessed June 2021).

4   Lauren Paremoer and others, "Covid-19 pandemic and the social determinants of health," The BMJ 372 (129) (2021), available at https://www.bmj.com/content/372/bmj.n129.

5   Julia James, "Nonprofit Hospitals' Community Benefit Requirements" (Bethesda, MD: Health Affairs, 2016), available at https://www.healthaffairs.org/do/10.1377/hpb20160225.954803/full/.

6   Internal Revenue Service, "Billing and Collections – Section 501(r)(6)," available at https://www.irs.gov/charities-non-profits/billing-and-collections-section-501r6 (last accessed June 2021).

7   Internal Revenue Service, "Charitable Hospitals."

8   Elinor Higgins and Amy Clary, "How 10 States Keep the 'Community' in Hospitals' Community Health Needs Assessments," National Academy for State Health Policy, April 12, 2019, available at https://www.nashp.org/how-10-states-keep-the-community-in-hospitals-community-health-needs-assessments/.

9   Ge Bai and Gerard F. Anderson, "A More Detailed Understanding of Factors Associated with Hospital Profitability," Health Affairs 35 (5) (2016), available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1193.

10 Bradley Herring and others, "Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits," INQUIRY: The Journal of Health Care Organization, Provision, and Financing 55 (2018): 1–11, available at https://journals.sagepub.com/doi/full/10.1177/0046958017751970.

11 Ge Bai and others, "Analysis Suggests Government and Nonprofit Hospitals' Charity Care Is Not Aligned With Their Favorable Tax Treatment," Health Affairs 40 (4) (2021): 629–636, available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.01627.

12 Ge Bai and David A. Hyman, "Tax exemptions for nonprofit hospitals: It's time taxpayers get their money's worth," Stat, April 5, 2021, available at https://www.statnews.com/2021/04/05/tax-exemptions-nonprofit-hospitals-bad-deal-taxpayers/.

13 Matt Broaddus, "Uncompensated Care Costs Well Down in ACA Medicaid Expansion States," Center for Budget and Policy Priorities, October 21, 2020, available at https://www.cbpp.org/blog/uncompensated-care-costs-well-down-in-aca-medicaid-expansion-states.

14 Ibid.

15 Genevieve P. Kanter and others, "Association of State Medicaid Expansion with Hospital Community Benefit Spending," JAMA Network 3 (5) (2020): e205529, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766544.

16 Kevin Chen, Katherine L. Chen, and Leo Lopez III, "Investments in Community Building Among Nonprofit Hospital Organizations in the United States," JAMA Network 3 (10) (2020): e2021898, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772147; Community Benefit Insight, "Terms and Glossary: Community Building," available at http://www.communitybenefitinsight.org/?page=info.glossary#glossary_3.

17 Chen, Chen, and Lopez, "Investments in Community Building Among Nonprofit Hospital Organizations in the United States."

18 Hannah R. Sullivan, "Hospitals' Obligations to Address Social Determinants of Health," AMA Journal of Ethics 21 (3) (2019): E248–258, available at https://journalofethics.ama-assn.org/article/hospitals-obligations-address-social-determinants-health/2019-03.

19 U.S. Department of Health and Human Services, "Healthy People 2030: Social Determinants of Health," available at https://health.gov/healthypeople/objectives-and-data/social-determinants-health (last accessed July 2021).

20 Leora I. Horowitz and others, "Quantifying Health Systems' Investment in Social Determinants of Health, By Sector, 2017-19," Health Affairs 39 (2) (2020), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01246.

21 Robert Wood Johnson Foundation, "Medicaid's Role in Addressing Social Determinants of Health," February 1, 2019, available at https://www.rwjf.org/en/library/research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html.

22 Krisda H. Chaiyachati, Mingyu Qi, and Rachel M. Werner, "Nonprofit Hospital Community Benefit Spending and Readmission Rates," Population Health Management 23 (1) (2020), available at https://www.liebertpub.com/doi/full/10.1089/pop.2019.0003.

23 Nambi Ndugga and Samantha Artiga, "Disparities in Health and Health Care: 5 Key Questions and Answers" (Oakland, CA: Kaiser Family Foundation, 2021), available at https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.

24 Centers for Disease Control and Prevention, "Adolescent and School Health: Health Disparities," available at https://www.cdc.gov/healthyyouth/disparities/index.htm# (last accessed July 2021).

25 Sofia Carratala and Connor Maxwell, "Health Disparities by Race and Ethnicity" (Washington: Center for American Progress, 2020), available at https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/.

26 Ndugga and Artiga, "Disparities in Health and Health Care."

27 American Psychiatric Association, "Mental Health Facts for Diverse Populations" (Washington: 2017), available at https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts.

28 Margarita Alegría and others, "Social Determinants of Mental Health: Where We Are and Where We Need to Go," *Current Psychiatry Reports* 20 (11) (2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6181118/.

29 Jacob Bor and others, "Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study," *The Lancet* 392 (10144) (2018): 302–310, available at https://pubmed.ncbi.nlm.nih.gov/29937193/.

30 Steven H. Woolf, "Necessary But Not Sufficient: Why Health Care Alone Cannot Improve Population Health and Reduce Disparities," *Annals of Family Medicine* 17 (3) (2019): 196–199, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6827630/.

31 Trinity Health, "Our Communities," available at https://www.trinity-health.org/about-us/our-communities (last accessed June 2021).

32 Trinity Health, "2019 Community Impact Report" (Livonia, MI: 2019), available at https://www.trinity-health.org/assets/documents/chwb-community-impact-report-2019.pdf.

33 Jamie Dircksen, vice president of community health and well-being, Trinity Health, interview with author via phone, June 17, 2021, on file with author.

34 Ibid.

35 Trinity Health, "2019 Community Impact Report."

36 Lisa Eisenhauer, "Trinity Health ministries tackle food insecurity," Catholic Health Association of the United States, April 1, 2020, available at https://www.chausa.org/publications/catholic-health-world/article/april-1-2020/trinity-health-ministries-tackle-food-insecurity.

37 Ellie Zuehlke, director of community benefit and engagement, Allina Health; Christy Dechaine, manager of community benefit, Allina Health; and Susan Nygaard, manager of community health improvement, Allina Health, interviews with author via phone, June 25, 2021, on file with author.

38 Health Powered Kids, "Health Fueled By Fun: Wellness Activities for Kids," available at https://healthpoweredkids.org/ (last accessed July 2021).

39 Change to Chill, "Mindfulness & Stress Relief Resources," available at https://www.changetochill.org/ (last accessed July 2021).

40 Hello4Health, "Making social connections. Building wellness.," available at https://hello4health.org/ (last accessed July 2021).

41 Allina Health, "Allina Health hospitals best in Twin Cities, says U.S. News & World Report," Press release, available at https://www.allinahealth.org/about-us/newsroom/2020/allina-health-hospitals-best-in-twin-cities-says-us-news-and-world-report (last accessed August 2021).

42 County Health Rankings, "2010 County Health Rankings: Analytics Data," available at https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation/national-data-documentation-2010-2019 (last accessed July 2021).

43 Hello4Health, "Making Social Connections."

44 Allina Health, "The Backyard Initiative," available at https://www.allinahealth.org/about-us/community-involvement/initiatives-and-programs/the-backyard-initiative (last accessed July 2021).

45 Allina Health, "The Backyard Initiative model," available at https://www.allinahealth.org/about-us/community-involvement/initiatives-and-programs/the-backyard-initiative/community-health-action-teams (last accessed July 2021).

46 Allina Health, "The Backyard Initiative: A 10-year Community Health Partnership" (Minneapolis: 2018), available at https://www.allinahealth.org/-/media/files/thebackyardinitiativea10yearcommunityhealthpartnership.pdf?la=en&hash=9AC5E8CBF4604114454E043F71347F68.

47 Zuehlke, Dechaine, and Nygaard, Allina Health, interviews with author.

48 Zuehlke, Dechaine, and Nygaard, Allina Health, interviews with author.

49 Change to Chill, "Change to Chill initiative helps teens manage, improve mental well-being," May 28, 2021, available at https://www.changetochill.org/change-to-chill-initiative-helps-teens-manage-improve-mental-well-being/.

50 Allina Health, "Community Health Needs Assessment and Implementation Plan" (Minneapolis: 2019), available at https://www.allinahealth.org/-/media/allina-health/files/about-us/community-involvement/need-assessments/2020-abbott-northwestern-full-report.pdf?la=en&hash=F04496637620A38FC8E0860064D191A7.

51 Ibid.

52 BJC HealthCare, "Jason Purnell to Join BJC as Vice President, Community Health Improvement," July 24, 2020, available at https://www.bjc.org/Newsroom/Article/ArtMID/5522/ArticleID/4521/Jason-Purnell-to-Join-BJC-as-Vice-President-Community-Health-Improvement.

53 Jason Purnell, vice president of community health improvement, BJC HealthCare, interview with author via phone, June 23, 2021, on file with author.

54 Barnes-Jewish Hospital, "2019 Community Health Needs Assessment and Implementation Strategy" (St. Louis: 2019), available at https://www.barnesjewish.org/About-Us/Community-Benefit/Community-Health-Needs-Assessment.

55 Missouri Baptist Medical Center, "2019 Community Health Needs Assessment and Implementation Strategy" (St. Louis: 2019), available at https://missouribaptistmc.thehcn.net/content/sites/bjwc/2019_MBMC_CHNA_w_Implementation_Plan_Updated_12.15.2020.pdf; Barnes-Jewish West County Hospital, "2019 Community Health Needs Assessment and Implementation Strategy" (St. Louis: 2019), available at https://bjwc.thehcn.net/content/sites/bjwc/2019_BJWCH_CHNA_w_Implementation_Plan_Updated_12.09.20.pdf; Christian Hospital, "2019 Community Health Needs Assessment and Implementation Strategy" (St. Louis: 2019), available at https://www.christian-hospital.org/Community/Community-Health-Needs-Assessment?hcn=%2F/tiles/index/display?id=173551066974299613&status=2&alert=1.

56 The Rehabilitation Institute of St. Louis, "2019 Community Health Needs Assessment and Implementation Strategy" (St. Louis: 2019), available at https://encompasshealth.com/-/media/healthsouth/project/healthsouth/locations/rehabinstitutestl-03015900/final-2019-trisl-chna---implementation-plan.pdf?la=en&hash=17B5296FFF6DB1CCB1F26A41AC3F443BD10E47FA; St Louis Children's Hospital, "2019 Community Health Needs Assessment and Implementation Strategy" (St. Louis: 2019), available at https://www.stlouischildrens.org/about-us/community-health-needs-assessment.

57 Purnell, BJC HealthCare, interview with author.

58 Ibid.

59 Ibid.

60 Ibid.

61 Dircksen, Trinity Health, interview with author.

62 Cara L. Pennel and others, "A Mixed-Methods Approach to Understanding Community Participation in Community Health Needs Assessments," *Journal of Public Health Management and Practice* 23 (2) (2017): 112–121, available at https://pubmed.ncbi.nlm.nih.gov/26554464/.

63 Michael D. Rozier, "Nonprofit Hospital Community Benefit in the U.S.: A Scoping Review From 2010 to 2019," *Front Public Health* 8 (72) (2020), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7078328/.

64 Purnell, BJC HealthCare, interview with author.

65 Zuehlke, Dechaine, and Nygaard, Allina Health, interviews with author.

66 Association of State and Territorial Health Officials, "Community-Based Health Needs Assessment Activities: Opportunities for Collaboration Between Public Health Departments and Rural Hospitals" (Arlington, VA: 2017), available at https://www.astho.org/uploadedFiles/Programs/Access/Primary_Care/Scan%20of%20Community-Based%20Health%20Needs%20Assessment%20Activities.pdf.

67 Michael Rozier, Susan Goold, and Simone Singh, "How Should Nonprofit Hospitals' Community Benefit Be More Responsive to Health Disparities?" *AMA Journal of Ethics* 21 (3) (2019): E273–280, available at https://journalofethics.ama-assn.org/article/how-should-nonprofit-hospitals-community-benefit-be-more-responsive-health-disparities/2019-03.

68 Association of State and Territorial Health Officials, "North Carolina Public Health/Hospital Collaborative Members Work to Promote Effective Community Collaboration" (Arlington, VA: 2013), available at https://astho.org/North-Carolina-CHNA-Case-Study/.

69 Ibid.

70 U.S. Government Accountability Office, "Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status" (Washington: 2020), available at https://www.gao.gov/products/gao-20-679?mobile_opt_out=1.

71 Zuehlke, Dechaine, and Nygaard, Allina Health, interviews with author.

72 Ibid.

73 Mark Everson, "The Tax-Exempt Hospital Sector: Hearing Before the Committee on Ways and Means, U.S. House of Representatives," May 26, 2005, available at https://www.govinfo.gov/content/pkg/CHRG-109hhrg26414/pdf/CHRG-109hhrg26414.pdf.

74 Centers of Medicare and Medicaid Services, "Emergency Medical Treatment and Labor Act (EMTALA)," available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA (last accessed June 2021).

75 Centers for Disease Control and Prevention, "NCHHSTP Social Determinants of Health," available at https://www.cdc.gov/nchhstp/socialdeterminants/index.html (last accessed June 2021).

76 U.S. Government Accountability Office, "Tax Administration."

77 Ibid.

78 Internal Revenue Service, "Schedule H (Form 990): Hospitals" (Washington: 2020), available at https://www.irs.gov/pub/irs-pdf/f990sh.pdf.

79 Ibid.

80 The Hilltop Institute, "Community Benefit State Law Profiles Comparison," available at https://www.hilltopinstitute.org/our-work/hospital-community-benefit/hcbp-state-comparison/ (last accessed July 2021).

81 The Hilltop Institute, "What are hospital community benefits?" (Baltimore: 2019), available at https://www.hilltopinstitute.org/wp-content/uploads/publications/WhatAreHCBsTwoPager-Sept2019.pdf.

82 Emily K. Johnson and others, "State Laws and Nonprofit Hospital Community Benefit Spending," *Journal of Public Health Management and Practice* 25 (4) (2018): E9–17, available at https://www.researchgate.net/publication/329299264_State_Laws_and_Nonprofit_Hospital_Community_Benefit_Spending; Tatiane Santos and others, "Can Collaboration Between Nonprofit Hospitals and Local Health Departments Influence Population Health Investments by Nonprofit Hospitals?", *Medical Care* (8) (2021), available at https://www.researchgate.net/publication/351114692_Can_Collaboration_Between_Nonprofit_Hospitals_and_Local_Health_Departments_Influence_Population_Health_Investments_by_Nonprofit_Hospitals.

83 Allie Atkeson and Elinor Higgins, "How States Can Hold Hospitals Accountable for their Community Benefit Expenditures," National Academy for State Health Policy, March 15, 2021, available at https://www.nashp.org/states-can-hold-hospitals-accountable-for-their-community-benefit-expenditures/.

84 Simone R. Singh and others, "State-Level Community Benefit Regulation and Nonprofit Hospitals' Provision of Community Benefits," *Journal of Health Politics, Policy and Law* 43 (2) (2018): 229–269, available at https://pubmed.ncbi.nlm.nih.gov/29630707/.

85 Johnson and others, "State Laws and Nonprofit Community Benefit Spending."

86 Ibid.; Singh and others, "State-Level Community Benefit Regulation and Nonprofit Hospitals' Provision of Community Benefits."

87 H.B. 3076, Oregon Legislature, 2019 regular sess. (July 2, 2019), available at https://olis.oregonlegislature.gov/liz/2019R1/Measures/Overview/HB3076?pubDate=2019-07-02-15-10.

88 Atkeson and Higgins, "How States Can Hold Hospitals Accountable for their Community Benefit Expenditures."

89 Legal Information Institute, "26 CFR § 1.501(r)-3 - Community health needs assessments," available at https://www.law.cornell.edu/cfr/text/26/1.501(r)-3 (last accessed August 2021).

90 Amy Clary, "How States Keep Community at the Center of Hospitals' Community Health Needs Assessments," National Academy for State Health Policy, April 12, 2019, available at https://www.nashp.org/how-states-keep-community-at-the-center-of-hospitals-community-health-needs-assessments/.

91 Anne DeBiasi, Jill Rosenthal, and Allie Atkeson, "States Explore Pivoting Hospital Community Benefit Requirements to Address Disparities Exposed by COVID-19," National Academy for State Health Policy, September 11, 2020, available at https://www.nashp.org/states-explore-pivoting-hospital-community-benefit-requirements-to-address-disparities-exposed-by-covid-19/.

92 Clary, "How States Keep Community at the Center of Hospitals' Community Health Needs Assessments."

93 Ibid.

94 Alison O'Mara-Eves and others, "The effectiveness of community engagement in public health interventions for disadvantaged groups: A meta-analysis," *BMC Public Health* 15 (129) (2015), available at https://www.researchgate.net/publication/273495641_The_effectiveness_of_community_engagement_in_public_health_interventions_for_disadvantaged_groups_A_meta-analysis.

95 Legal Information Institute, "26 CFR § 1.501(r)-3 - Community health needs assessments."

96 DeBiasi, Rosenthal, and Atkeson, "States Explore Pivoting Hospital Community Benefit Requirements to Address Disparities Exposed by COVID-19."

97 Amy Carroll-Scott, "The Role of Nonprofit Hospitals in Identifying and Addressing Health Inequities in Cities," *Health Affairs* 36 (6) (2017), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0033.

98 Ibid.

99 DeBiasi, Rosenthal, and Atkeson, "States Explore Pivoting Hospital Community Benefit Requirements to Address Disparities Exposed by COVID-19."

100 Ibid.

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