Governance and Management of Community Benefit

How Can Hospitals Be Positioned to Address New Challenges?

Not-for-profit hospitals face scrutiny by many stakeholders of their tax-exempt status and community benefit activities. In earlier times, the nature of services hospitals delivered was assumed adequate to merit tax exemption. Today, questions are being raised regarding hospital tax-exempt status that require institutions to provide concrete evidence and hard data.

BY CONNIE J. EVASHWICK, Sc.D., FACHE, & KANAK GAUTAM, Ph.D.

From top, Dr. Evashwick is a professor in the departments of Health Management and Policy, and Community Health; and Dr. Gautam is associate professor, Department of Health Management and Policy, both at Saint Louis University's School of Public Health, St. Louis.

This article reviews the current climate of accountability facing tax-exempt hospitals. It also focuses on two areas of internal organization that position a hospital to report with accuracy and transparency to external audiences. The first relates to good governance practices that can encourage community-oriented activities. The second relates to changes in operations and strategic management of community benefit activities. Results of a preliminary survey on management issues conducted by the Saint Louis University School of Public Health help illustrate required changes in managing community benefit activities today.

TAX-EXEMPTION AND CURRENT SCRUTINY OF NOT-FOR-PROFIT HOSPITALS

According to the Internal Revenue Code 501(c)(3), a tax-exempt organization operates exclusively for one of several purposes – religious, charitable, scientific, public safety, literary or educational purposes, and has no net earnings directed to private benefit. In the past, not-for-profit hospitals qualified for tax-exemption under Revenue Ruling 69-545, enacted in 1969, which states that hospital care amounts to "promoting health" – a charitable purpose under 501(c)(3). Some ambiguity remained, e.g., Ruling 69-545 also established a community benefit standard for determining tax-exemption consisting of criteria such as operating an open emergency room, having an open medical staff and providing teaching and research activities. Yet, none of these criteria alone was sufficient or necessary – authorities evaluated all facts and circumstances in determining tax-exemption on a case-by-case basis. Despite this lack of clarity, significantly less challenge of hospitals' tax-exempt status existed in the past compared to today.

Today, not-for-profit hospitals face unprecedented scrutiny of their tax-exempt status from Congress, state governments, the Internal Revenue Service (IRS), unions, the media and others. Economic and political trends have provoked the questioning. With increased budget deficits, governments are debating taxing all organizations.

Not-for-profit hospitals have their roots as community-based organizations. During the past three decades, however, many independent hospitals have joined health systems out of financial necessity. Large health systems are regarded by many as big businesses that should pay taxes. Observers comment on the lack of operating difference between for-profit and tax-exempt hospitals. Further, regulators are concerned regarding instances of promoting "private benefit" such as excessive CEO pay or hospital-physician joint ventures. The IRS has introduced a revised Form 990 for objective reporting and better evaluation of community benefit activities of not-for-profit hospitals. Form 990s are accessible to the public online. The availability of this information may lead to further questions about reported executive compensation, charity care, billing practices, and balance among various types of community benefit activities.

Facing a higher bar in demonstrating tax-exemption, tax-exempt hospitals cannot adopt a "business as usual" approach. The not-for-profit field is beginning to articulate "good governance"

practices that hospitals and other health care organizations are expected, if not required, to follow.[1,2] Hospitals need to institute appropriate governance practices that promote a culture supporting "community benefit" and rejecting "private benefit." Further, in response to increased demand for transparency and measurement regarding community benefit activities, hospitals must make appropriate strategic and operational changes in the management of community benefit programs.

CHA has made major contributions to the field of community benefit by articulating important aspects of governance, structure, data gathering, and evidence-based planning and evaluation. *The Guide for Planning and Reporting Community Benefit*,[3] as well as previous publications and ongoing conferences, has laid a foundation for solid community benefit activity that can be followed by all types of health care organizations. CHA also recognizes "best practices" and provides numerous opportunities for those in the field to share experiences with one another. Given the current climate, however, it is timely for hospitals in particular to reassess their governance, structure and operations to ensure their organization is optimally poised to deliver evidence-based community benefit programming that indeed responds to the needs of the local community.

Governing to Promoting Community Benefit

Governance in the not-for-profit sector refers to actions of a volunteer board of directors in establishing and monitoring the organization's long-term direction. Boards have a fiduciary responsibility to hold hospital assets in trust and ensure their utilization for the community. An informed and proactive board can establish goals, sanction resources and hold management accountable for community benefit outcomes while framing policies to prevent "private benefit" activity.

The promotion of good governance is termed a "pillar" of the IRS enforcement program for tax-exempt organizations. The rationale is that a well-governed organization will be compliant with conditions of tax-exemption while poor governance may lead to non-compliance. Nine practices of good governance for promoting community benefit practices are described here:

1. Trustee recruitment. As per IRS's 2007 Guidelines on Good Governance Practices for tax-exempt organizations, governing boards should have trustees actively engaged in the organization's operations and passionate about its programs.[4] The guidelines emphasize recruiting trustees who are knowledgeable about and committed to the community. In many hospitals, the

Hospitals need to institute appropriate governance practices that promote a culture supporting community benefit and rejecting "private benefit." Further, in response to increased demand for transparency and measurement regarding community benefit activities, hospitals must make appropriate strategic and operational changes in the management of community benefit programs.

majority of not-for-profit hospital trustees belong to business organizations and often do not show interest in the not-for-profit goals, preferring to advocate "efficient" practices and programs. As Stephen Shortell comments on trustees of the 1990s who focused on mergers rather than patient care: "The system needs leaders who understand that the enterprise begins and ends with the patient. . . . The system needs leaders who understand that integration is not about acquisitions, mergers, ownership of health plans or physician practices . . . but rather is about coordinating care for patients across providers, activities, and settings over time."[5] Selecting trustees with mission-oriented values and experience can promote more mission-oriented hospital activity.

2. Trustee orientation and education. Further, trustees need thorough orientation and continuing education regarding tax-exempt organization, their community benefit mandate, and avoidance of "private benefit." Many trustees do not understand the complexities of health care, nor the culture, legalities and obligations of not-for-profits. Additionally, management may fail to provide adequate education about trustee powers, leading to passive boards. The IRS guidelines on good governance practices include ensuring that directors fully understand their roles and responsibilities, including mission, code of ethics, due diligence, duty of loyalty, transparency, fundraising policy, financial audits and compensation practices.[6] Trustees should be well-educated about how health care operates, the tax-exempt mandate, and their own powers in order to be confident enough to promote community interests.

3. Board independence. One of the requirements of the Community Benefit Standard under Revenue Ruling 69-545 is that board control

Excessive executive compensation reduces the credibility of tax-exempt hospitals. To avoid such cases, a compensation philosophy statement is needed that articulates the organization's long-term policy on executive compensation, supports the organization's charitable purposes and mandates a process that qualifies for the legal protection under IRS guidelines.

should be vested in "independent civic leaders." The IRS defines a "community board" as one with a majority of board members who are independent persons representative of the community. The IRS does not define "independent community members," but excludes practicing physicians, officers and hospital department heads. The key requirement for independence is the lack of a financial or personal relationship with the organization or management. The reasoning is that board members having such relationships find it difficult to render objective decisions.

Independent directors are less likely to be passive and more likely to have an attitude of "constructive skepticism" in dealing with management.[7] Boards of not-for-profit hospitals can be dominated by the CEO and preoccupied with finance and strategy. Active, independent trustees are needed to advance community interests.

4. Board committee on community benefit. Given limited meeting time, much board business is transacted in committees. Tax-exempt hospital boards need a standing committee on community benefit to oversee community benefit activities. The community benefit committee should include regular board members, along with a majority representation of community stakeholders knowledgeable about the community. The committee should promote program priorities based on community needs. It should participate in developing the hospital's community benefit plan in coordination with the community benefit director, and forward the plan to the whole board for approval. The community benefit committee should monitor progress toward planned community benefit goals and receive periodic progress reports. Such a committee can ensure that community benefit activities remain high on the board's agenda and visible on a regular basis.

5. CEO accountability to the board. The IRS emphasizes "accountability" as essential for tax-exempt organizations. As the highest executive, the CEO must be accountable to the board for community benefit activities. Accountability can be established by having the board include explicit criteria related to improving community health status in the CEO's performance review. This will ensure that CEOs personally work for the betterment of the community and allocate sufficient resources for community benefit initiatives. Another step that has been taken by several Catholic hospitals is to link CEO compensation to community health goals. Most executive compensation plans in tax-exempt hospitals do not align CEO compensation with community health outcomes. This is a missed opportunity in light of concerns about "excessive executive compensation." Linking executive compensation with community health goals can demonstrate organizational commitment to community needs.

6. Excessive compensation. According to the IRS, tax-exempt organizations that pay more than reasonable compensation for services rendered can be accused of providing "private benefit." Excessive executive compensation reduces the credibility of tax-exempt hospitals. To avoid such cases, a compensation philosophy statement is needed that articulates the organization's long-term policy on executive compensation, supports the organization's charitable purposes and mandates a process that qualifies for the legal protection under IRS guidelines. Trustees on the compensation committee, together with lawyers and consultants, must be independent to avoid being influenced by management. Compensation arrangements should be comparable to similar organizations and jobs. Further, organizations should have supporting documentation for high profile items such as loans, incentive plans and discretionary awards.

7. Conflict of interest policies. Conflict of interest focuses on whether a director has a financial or other relationship relative to a particular transaction or arrangement that requires the individual to be excluded from the deliberations and/or decisions of a body. According to Revenue Ruling 69-545, the board should adopt written and specific "independence" standards with respect to relationships or interests of directors and periodically review potential opportunities for conflict of interest.

8. Composition of audit, compensation and nomination committees. Audit, compensation and nomination committees should be controlled by independent trustees. Audit committees are charged with oversight of financial

reporting and disclosure, including monitoring internal control processes and overseeing external auditors. To ensure the integrity and accuracy of financial information critical for evaluating the hospital's performance audit committee members should not have a financial or other relationship with management. Similarly, the compensation committee must not be influenced by management in setting CEO pay. The nominating committee appoints trustees to sensitive committees such as audit and compensation committees, and the appointment of trustees to these committees must be transparent and acceptable to the community as representing its interests.

9. Board communication. Boards must also communicate their actions in pursuit of public benefit. Boards, especially independent directors, have credibility because they are perceived as "independent outsiders" and "community representatives." Alegent Health's board publishes its conflict of interest statements, displays photographs of its board members on its website, and posts the charters of each board committee. Baptist Health South Florida in Miami publishes its board policies on major issues of external scrutiny, including policies governing loans to officers; board member travel and reimbursement information; and information on executive air travel, meals and business entertainment expenses. As legal fiduciaries of the community, boards need to communicate their governance activities to reassure the community that its interests are protected.

STRATEGIC AND OPERATIONAL CHANGES IN COMMUNITY BENEFIT MANAGEMENT

In addition to good governance practices, adaptive changes at strategic and operational levels are required for managing the community benefit function in a demanding environment. Recently, Saint Louis University's School of Public Health conducted an online survey of managers in charge of the community benefit function in hospitals and health systems. Preliminary survey results are used to highlight eight organizational structures and processes essential for today's community benefit programs to operate effectively.

1. Strategic approach for community benefit programs. Core principles developed by "Advancing the State of Art in Community Benefit,"[8] a national community benefit demonstration project consisting of 70 hospitals, provide a strategic road map for the future that is applicable to most hospitals. Core principles include:

- emphasis on disproportionate unmet health-related needs, or focusing programs on the most vulnerable populations.
- emphasis on primary prevention, or increasing program activities addressing underlying cause of persistent health problems for improving health status and quality of life.
- building a seamless continuum of care, or developing evidence-based links between community health improvement activities and clinical service delivery.
- building community capacity, or working with the community to build the capacity of community assets.
- emphasis on collaborative governance, or engaging diverse community stakeholders in the design and evaluation of programs, thereby enabling sharing of resources and skills.

These principles can guide both fledgling and established community benefit programs because they are value-driven and consistent with mission. They emphasize prioritizing community needs, building community partnerships, sharing resources and not duplicating programming — useful guides for creating community benefit programs with limited resources that have measurable impact. Goals and specific, measurable objectives reflecting the core principles should be articulated in a hospital's annual community benefit plan so that priorities and activities are known to board, staff and community alike.

2. Training. When those involved with the community benefit activities of their hospitals were asked what topics they would most like to have additional training in, the top three choices were related to program evaluation. When asked what educational programs they preferred most regarding community benefit reporting, the top three choices were constructing community dashboards, determining what counts as community benefit and understanding new IRS reporting requirements. Community benefit managers and staff also reported needing training with new tools related to health promotion, communication, finance and information systems.

Yet, when asked if their organization was planning training sessions regarding the new IRS reporting requirements, 26.8 percent reported their hospital was not planning educational programs even though inappropriate reporting may result in the organization being audited. Until now, training resources allocated by a hospital for community benefit have been scarce; this has hardly been a priority given other more pressing needs. Immediately, adequate budgets and time-off should be provided for training, including for boards, senior managers

Tax-exempt hospitals are being challenged to demonstrate their contributions to the community as never before. They must organize community benefit activities, comply with enhanced reporting requirements and prevent any suggestion of providing "private benefit."

and staff involved in programming and reporting.

For the first time, CHA's Community Benefit 101 seminar in fall 2007 had nearly as many accountants and lawyers as staff from mission and community outreach departments.

3. Expertise of community benefit staff. Just as departments of health care marketing and informatics began to require formal education in these disciplines once they evolved to become core hospital functions, community benefit staff need formal education in the disciplines related to community benefit. Community benefit staff are likely to have specialized backgrounds in social work, nursing, health education or ministry, none of which emphasizes the range of skills and knowledge required to plan and evaluate sophisticated community-based programming. To upgrade staff skills, a multi-disciplinary educational program is needed that encompasses public health, epidemiology, program evaluation and statistics. There have been early discussions about a university certificate in community benefit.

To facilitate recruitment and training, hospitals should, at a minimum, delineate the knowledge, skills and competencies they expect of the person in charge of community benefit. In the recent survey of those involved in community benefit activities for their organizations, 61 percent of respondents said they would like to obtain a certificate in community benefit from an accredited university. Their response supports demand for sophisticated training to match the new demands of their jobs.

4. Coordination. When staff from finance, accounting, mission and marketing become involved in community benefit activities, coordination and teamwork presents a challenge. Our survey inquired about which hospital department managed the community benefit function and which reported community benefit information. In 66 percent of the cases, the "managing department" differed from the "reporting department." "Managing departments" were titled some variation of community benefit, mission, or community outreach, while "reporting departments" tended to be finance or accounting. Separation between management and reporting can create problems. The revised Form 990 requires financial reporting on charity care along with non-financial information on subjects like community building and health professions education, which staff in finance may have little knowledge. Improved coordination is essential in order to have all involved understand the goals of community benefit, the activities engaged in by the hospital, and the data required for reporting to various stakeholder audiences. Only when all on the team collaborate will the program and the information come together.

5. Staffing. Survey respondents were asked if their organizations were planning any changes due to the new IRS community benefit reporting requirements. Surprisingly, only 5 percent responded that they had added staff. Community benefit activities are expanding in most hospitals, and so are staffing needs. Examination of staffing increases reported by hospitals participating in Advancing the State of the Art in Community Benefit revealed that full-time employees were added in five areas related to community benefit activities: reporting, health promotion, community partnering, external communication and liaison with board committee. The increased activity load on community benefit directors combined with the need to differentiate community benefit activities from those of other departments may result in some activities suffering from inadequate staffing. This is particularly true in smaller, under-resourced hospitals. Well-analyzed, thoughtful plans for community benefit activities with measurable outcomes consistent with the hospital's mission are needed to justify enhanced staffing.

6. Structuring. The survey found that those responsible for community benefit are based in a variety of departments, including marketing, mission, public relations and community outreach. Given the clarity of IRS requirements, the community benefit program should be in a unit distinct from marketing. The budget should be separate, not incorporated into the budget of other activities.

In the past, community benefit staff partnered with other departments to engage in activities such as health screenings or wellness programs. With the need for increased precision in reporting, departmental autonomy and a separate dedicated budget are required. Internal collaboration can still occur, but community benefit should be its own department, division or unit, however small. It should be listed in the phone directory; and the person responsible should have a title and

office known to community members, physicians and staff throughout the hospital. Finally, the community benefit program should be accountable to a senior administrator, who has access to the governing board.

7. Reporting and information systems. The new IRS Schedule H requires rigor in accounting and reporting. An information system specifically for community benefit may be helpful, such as the Community Benefits Inventory for Social Accountability, the information system developed by joint action of CHA and VHA Inc. In the recent survey of those interested in community benefit, the single greatest response to the question, "What have you done in response to the new Schedule H?" was "purchase a new or upgraded information system." Educating the accounting staff and reviewing existing reporting processes and procedures is timely. Both those planning programs and those filling out IRS forms need to understand each other's respective tasks so that the integrity of the intent is maintained: to enhance the health of the community and be able to report accurately how this was accomplished. Reports should also be tailored for multiple stakeholders. Information about community benefit should go to the board, community partners, hospital staff, physicians and the lay community in general. Having an efficient method for preparing and disseminating this information is essential to achieve the transparency and solicit the broad input that is at the heart of improving community health.

8. External communication. In our survey, one-fourth of the subjects were not reporting their activities to members of the community, and about one-third were not reporting activities to groups designated as community partners. Hospitals need to be proactive in telling their stories to the community and explaining the rationale and impact of activities before being asked. Although marketing costs cannot be counted as community benefit, communication specialists from the public relations or marketing department can be engaged to match the message to the audience. For example, local governments may prefer the story told in a detailed, factual manner; community members may prefer the story with pictures; physicians may prefer an educational session.[9]

Also, hospitals need a web-based communication strategy. For example, Lucille Packard Children's Hospital in Palo Alto, Calif., publishes a community benefit report on its website, including detailed descriptions of programs. Advocate Health in Chicago relates on its website that $296 million in community benefits was provided in 2006 and provides personal stories. A number of hospitals prepare and circulate full-size reports that rival their annual report for color and format. These can be vivid reminders of what tax-exempt organizations contribute to their communities.

Conclusion

Tax-exempt hospitals are being challenged to demonstrate their contributions to the community as never before. They must respond by organizing community benefit activities, complying with enhanced reporting requirements and preventing any suggestion of providing "private benefit." Strengthening governance practices is imperative for balancing the finance-orientation of boards with mission-orientation that promotes community benefit activities. Additionally, with limited resources and increased pressure for community benefit programming, adopting a strategic approach, specifying measurable goals and objectives, enhancing staff, offering training for those at all levels of the hospital, and structuring authorities and reporting in a systematic way are needed to make community benefit activities more effective in present and future environments. ■

Comment on this article at www.chausa.org/hp.

NOTES

1. Panel on the Nonprofit Sector, *Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations*, Panel on the Nonprofit Sector, 2007.
2. Lawrence Prybil et al., *Governance in Nonprofit Community Health Systems: An Initial Report on CEO Perspectives* (Chicago: Grant Thornton LLP, 2008): 3.
3. Catholic Health Association, *A Guide for Planning and Reporting Community Benefit,* 2006. More information can be found at www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/Resources/TheGuide/.
4. Cinda Becker, "IRS Affirms Board Accountability: Not For Profits Are Warned Not to Take Rules Lightly," *Modern Healthcare* 37, no. 7 (2007): 10.
5. Stephen Shortell, "A Time for Concerted Action," *Frontiers of Health Service Management* 18, no. 11 (2003): 33-36.
6. Becker, 10.
7. Michael Peregrine and Bernadette Brocollo, "Independence and the Non-Profit Board: A General Counsel's Guide," *Journal of Health Law* 39, no. 4 (2006): 497-526.
8. Kevin Barnett et al., *Advancing the State of Art in Community Benefit,* Public Health Institute, November 2004. More information is available at www.phi.org/pdf-library/ASACB.pdf.
9. Patricia Cahill, "Telling The Community Benefit Story," *Health Progress* 86, no. 4 (2005): 44-47.