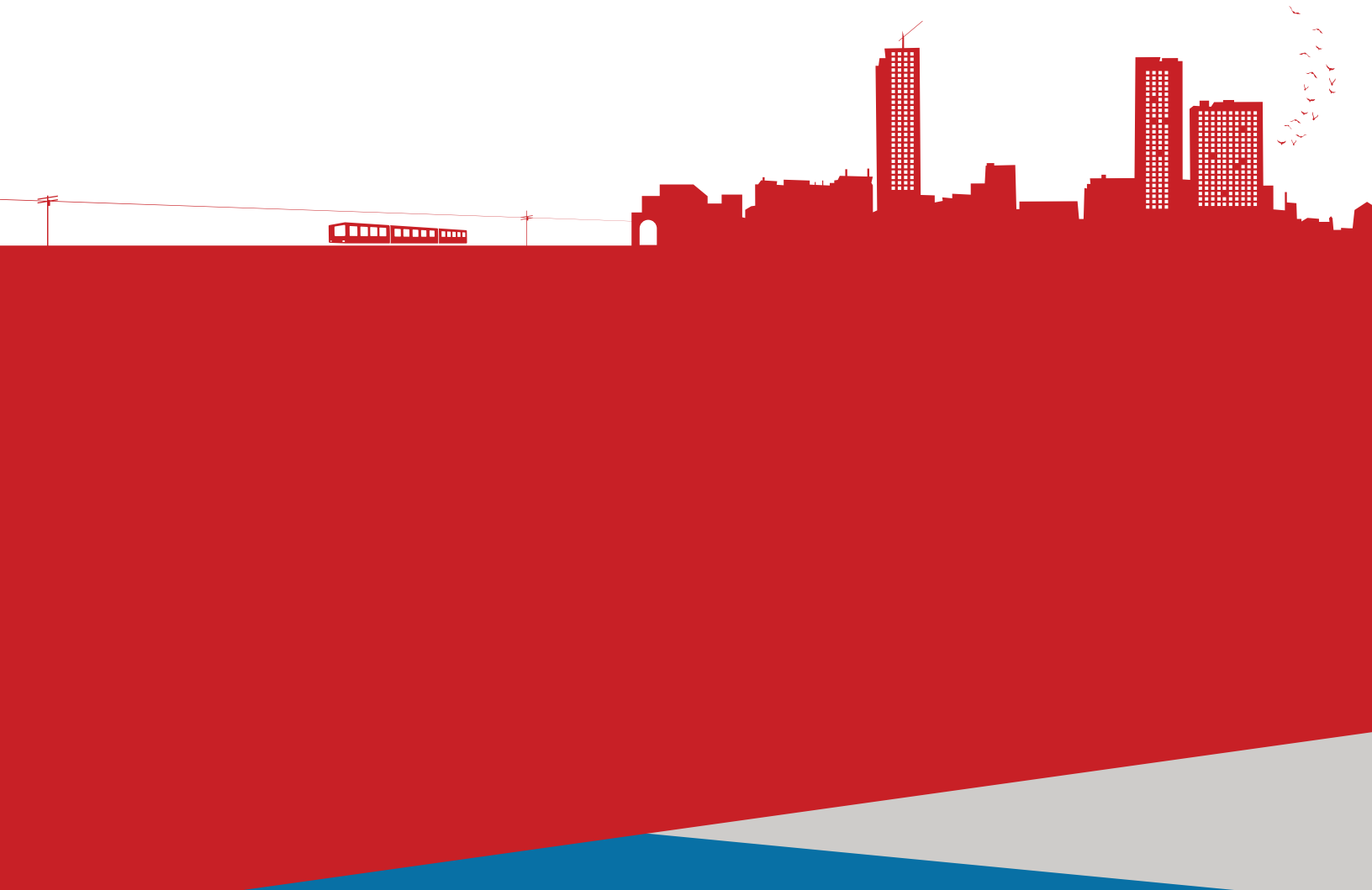


BRIDGES TO HEALTH

INSUFFICIENT DATA

DO CENTRAL VALLEY NOT-FOR-PROFIT HOSPITALS
MEET THEIR COMMUNITY BENEFIT OBLIGATIONS?

Kerry Sakimoto • Bridges to Health Fellow Anthony Galace • Bridges to Health Director

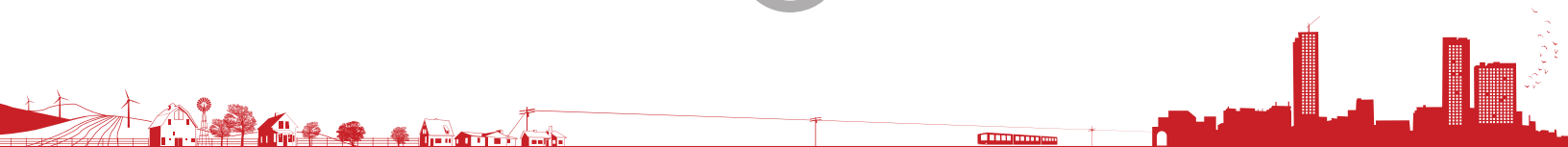


BRIDGES TO HEALTH • MARCH 2016

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ACKNOWLEDGEMENTS

About the Greenlining Institute

Founded in 1993, The Greenlining Institute envisions a nation where communities of color thrive and race is never a barrier to economic opportunity. Because people of color will be the majority of our population by 2044, America will prosper only if communities of color prosper. Greenlining advances economic opportunity and empowerment for people of color through advocacy, community and coalition building, research, and leadership development. We work on a variety of major policy issues, from the economy to environmental policy, civic engagement and many others, because economic opportunity doesn't operate in a vacuum. Rather than seeing these issues as being in separate silos, Greenlining views them as interconnected threads in a web of opportunity.

The Greenlining Institute Bridges to Health Program

Nothing is more essential than our health. Everybody should have access to good health regardless of race or income. Health care must be responsive to the nation's growing communities of color, but health care is not enough. People also need access to the things that lead to good health such as safe neighborhoods, healthy foods, clean environments and decent jobs. Greenlining brings the voices of communities of color into critical decisions that affect all of our lives and health.

Author Biographies

Kerry Sakimoto, Bridges to Health Fellow

Born and raised on Oahu, Kerry will always consider Hawai'i to be his community. He is a recent graduate of Occidental College with a B.A. in politics. During his undergraduate experience, Kerry founds his roots in community organizing and student activism, advocating for greater institutional support for students of color. Interning for the UCLA Downtown Research Center and Asian Americans Advancing Justice, he is interested in pursuing a career in public interest law. As an alumnus of the Public Policy and International Affairs (PPIA) program at the University of California, Berkeley, he is particularly concerned with the intersections of law and policy and the necessity of both to improve the lived experiences of marginalized people. Kerry hopes to actively fight redlining in the health industry, advocating for greater and more effective use of resources to improve the health outcomes of communities of color.

Anthony Galace, Bridges to Health Director

Anthony's passion for advocacy lies at the nexus of public policy, health equity, and racial justice. As the child of Filipino immigrants, his desire to advocate for underserved communities was shaped by his exposure to the struggles his family and other immigrants faced while coming to the United States. His background in health includes direct health care services, health education, and local advocacy. Anthony leads Greenlining's health advocacy efforts to ensure fair and equitable implementation of the Affordable Care Act and access to health care and workforce opportunities for boys and men of color. Additionally, Anthony oversees Greenlining's community benefit advocacy, which focuses on increasing investments towards upstream, preventive health resources to improve community health. Anthony is a native of Chula Vista, California, and a graduate of the University of California Berkeley, with a degree in Integrative Biology.

Acknowledgements

Special Thanks to:

Thank you to the **California Rural Legal Assistance Foundation**, especially **Alejandra Tovar** and **Noe Paramo, Co-Directors of the Sustainable Rural Communities Project**, for their partnership and leadership in helping to facilitate this project.

To **Lauren Valdez, former Bridges to Health Associate**, for her invaluable insights. This project was made possible by the generous support of **The California Endowment**.

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EXECUTIVE SUMMARY

- **Not-for-profit hospitals across California are exempt from paying billions of dollars in taxes annually. In exchange, these hospitals must invest in services and resources that promote health and wellness in the communities they serve.**¹ These investments are known as “community benefit” – health services that address “community needs and priorities through disease prevention and improvement of health status.”² This includes a variety of programs, from charity care to “upstream” efforts to improve community health.
- **Low-income communities and communities of color continue to face long-standing, systemic barriers that result in chronically poor health outcomes.** The social and environmental conditions of the Central Valley present immense potential, and challenges, to achieving health equity. Over two-thirds of Central Valley residents are people of color and one out of every five persons lives in poverty. Not-for-profit hospitals can improve community health by directing community benefit investments beyond hospital walls towards upstream solutions that address the underlying causes of poor health in underserved communities.
- **To determine the extent to which hospital community benefit expenditures effectively address health challenges in the Central Valley, we examined publicly-available records for 11 major not-for-profit hospitals in the Valley.** We analyzed data for the period from 2011 through 2014, comparing annual differences between each individual hospital and contrasting community benefit practices within one given fiscal year, 2012, across individual hospitals.
- **Among the 11 not-for-profit hospitals, we discovered (1) unclear and inconsistent community benefit reporting, (2) underfunding of upstream, preventative health solutions and (3) an absence of meaningful community engagement.** These three findings reflect significant barriers that make it difficult for community benefit spending to successfully address the systemic barriers that restrict communities of color and others from achieving and maintaining good health.
- **Nine out of the 11 not-for-profit Central Valley hospitals relied disproportionately on hospital staff rather than community health advocates and residents in conducting their Community Health Needs Assessment (CHNA).** Approximately two-thirds of focus group participants were employees of a not-for-profit hospital. Community members prioritized the need for upstream, preventative health more than hospital staff, illustrating the importance of uplifting community voices in the CHNA.
- **Not-for-profit hospitals in the Central Valley who reported their community benefit spending invested less than one percent – an average of 0.32 percent – of their 2012 operating budgets on upstream solutions to health for vulnerable populations.** Many of the hospitals studied show decreased upstream community benefit investments year after year, even as expansion of health coverage under the Affordable Care Act decreases the need for charity care
- **Individual hospital community benefit spending varied significantly.** While Dignity Health – Bakersfield Memorial Hospital spent **0.86 percent of its 2012 operating budget** on these targeted upstream investments, Adventist Medical Centers in Hanford, Selma, and Adventist Health – Central Valley General Hospital directed less than **0.001 percent of their 2012 operating budgets towards upstream investments for vulnerable populations.**
- **Data reporting by the hospitals was incomplete, inconsistent, and in some cases did not fulfill legal requirements, making it impossible to fully evaluate the hospitals’ performance.** Some hospitals did not report specific investments directed towards vulnerable populations. In other instances, hospitals did not submit any community benefit information for a given year. Indeed, the most frequently occurring entry in the data tables below is “data not available.”

EXECUTIVE SUMMARY RECOMMENDATIONS

- **Not-for-profit hospitals can do more to promote community health.** These hospitals earn their tax-exempt status by engaging in community benefit activities that improve health and thus they have a responsibility to invest in the most effective, strategic solutions to meet the health needs of their communities. All hospitals in this study serve as anchor institutions in regions that are majority communities of color. Given their ample resources, these hospitals have the capacity to make large gains towards health equity in the Central Valley, but at current rates of investment, they are failing in this responsibility.
- **Not-for-profit hospitals should allocate a larger portion of their total operating expenses towards community benefit, specifically for preventative, upstream solutions beyond hospital walls.** This will result in cost-effective and strategic investments that improve the social and economic factors that most impact health. Furthermore, prioritizing preventative health will improve health outcomes, particularly for low-income residents and communities of color, who experience significant health disparities.
- **Hospitals must make community benefit data and information more accessible, especially to low-income communities and communities of color, whose needs are most often disregarded.** Not-for-profit hospitals must go above and beyond current outreach and dissemination requirements in order to facilitate an inclusive community benefits process that comprehensively assesses community health needs.
- **The needs of communities of color must be a focal point in improving the process by which not-for-profit hospitals address community needs.** Not-for-profit hospitals must adopt a proactive, race-conscious agenda that seeks to address health disparities that disproportionately impact communities of color. This will have a tremendous impact on the success of California and the nation.

INTRODUCTION

A hospital is an indispensable institution that every community needs. As anchor institutions, not-for-profit hospitals can greatly improve the health of their community beyond hospital walls through upstream investments that promote health equity and disease prevention. By prioritizing resources towards the social determinants of health,¹ not-for-profit hospitals will reduce health disparities, and increase opportunities for disadvantaged communities. One means through which they can do this is via the community benefit investments that are required of them to maintain their tax-exempt status (discussed in more detail below).

In previous reports, The Greenlining Institute examined hospital community benefit practices statewideⁱ and in San Franciscoⁱⁱ, finding significant issues centered around transparency, incomplete reporting, and inadequate community input. This report analyzes the role not-for-profit hospital community benefit programs play in achieving health equity in California's Central Valley, a region with a large proportion of people of color and high rates of poverty. These factors increase the potential importance of not-for-profit hospital community benefit efforts. Low-income Americans and communities of color are far more likely to live away from open park spaces, rely on public transportation, miss school or work because of illness, and experience other social and economic inequities that lead to poor health.³

California's Central Valley also has a rich history of diversity and multiculturalism that reflects the potential, and immense challenges, to achieving health equity. Roughly two-thirds of residents are people of color, with Latinos representing 54 percent of the population.⁴ Yet communities of color are more than three times as likely to live in poverty as whites.^{5,6} White residents in the Central Valley have an average income of \$33,515. In comparison, Latinos earn \$18,183, African Americans earn \$23,669, and Asian Americans earn \$24,908.⁷ The average income of communities of color is significantly lower than the \$29,685 statewide average.⁸ These financial constraints negatively impact the opportunities for communities of color to experience good health — whether healthy food is affordable in their community and what environmental conditions they are exposed to because of where they can live. As a result, these underserved communities are far more susceptible to higher rates of diabetes,⁹ heart disease,¹⁰ and are almost three times as likely to experience poor mental health.¹¹

In order to understand the role that community benefit plays in uplifting communities of color in the Central Valley, we explored how not-for-profit hospitals address the needs of underserved communities located in the following six counties: Fresno, Tulare, Kings, Kern, Merced, and Madera. We examined the community benefit practices for the following not-for-profit hospitals:

Kaiser Foundation Hospitals

- Kaiser Foundation Hospital – Fresno

Dignity Health

- Dignity Health Memorial Hospital (Bakersfield)
- Dignity Health Mercy Medical Center (Merced)

Adventist Health

- Adventist Medical Center – Reedley
- Adventist Medical Center – Hanford
- Adventist Medical Center – Selma
- Adventist Health Central Valley General Hospital (Hanford)

Trinity Health

- Saint Agnes Medical Center

Community Medical Centers

- Community Regional Medical Center
- Clovis Community Medical Center
- Fresno Heart and Surgical Hospital

ⁱ Social determinants of health are the environmental and social conditions that affect health outcomes. Examples include education and job opportunities, housing, food markets, social support, and quality of air and water.

ⁱⁱ In 2014, Greenlining followed with a regional analysis of three not-for-profit hospitals in San Francisco. See *Community Benefit and Missed Opportunities: A Case Study of Three San Francisco Hospitals*

WHAT IS COMMUNITY BENEFIT?

Not-for-profit hospitals are required to provide vital health services to address, “community needs and priorities through disease prevention and improvement of health status.” These services are known as “**community benefit**.”¹² In exchange for favorable tax status, not-for-profit hospitals must invest any surplus revenue in addressing the holistic health needs of the communities they serve.¹³ Each year, not-for-profit hospitals receive billions of dollars in state and federal tax subsidies and exemptions, which amounted to nearly \$3.3 billion among California hospitals in 2010.¹⁴

TYPES OF COMMUNITY BENEFIT SPENDING

In order to maintain their tax-exempt status, not-for-profit hospitals are required to annually report all community benefit investments to the state and federal governments. Like all not-for-profit organizations, these hospitals must submit a Form 990 to the Internal Revenue Service, detailing all sources of revenue and expenditures. Additionally, not-for-profit hospitals must report supplemental information via a Schedule H, which details community benefit expenditures and investments. The IRS recognizes the categories listed below as community benefit, although there is wide variation as to how the IRS and not-for-profit hospitals define each category.¹⁵ Hospitals also use their own cost calculation methods to determine the value of the community benefit they provide, which means that each hospital calculates its community benefit spending differently.¹⁶ The following list details the types of investments that are considered community benefit by the IRS:

- **Costs of Providing Financial Assistance (“Charity Care”)** – Hospitals may provide free or discounted health care for low-income uninsured or underinsured patients.
- **Unreimbursed Cost from Medicaid and other Government Assistance Programs (“Short-fall”)** – This constitutes the portion of a hospital’s spending on care for patients covered by Medicaid/Medi-Cal and other government assistance programs that is unreimbursed by the government.
- **Community Health Improvement Services and Community Benefit Operations** – This remains a fairly broad category, which includes the administrative costs of providing community benefit health improvement services.
- **Health Professions Education** – This includes medical residency programs, scholarships, and health education.
- **Subsidized Health Services** – Hospitals provide subsidies for underinsured patients that reduce the cost of care.
- **Research** – In addition to the hospital’s own funds spent on research, research claimed under community benefit may include research funded by grants that the hospital receives from outside sources.
- **Cash and In-Kind Contributions** – This includes grants given to community-based organizations and community clinics.

Upstream Investment

Build affordable housing projects with adequate ventilation to improve the quality of indoor air.

Upstream Investment

Increase programs to clean the air, including public transit and access to zero-emission vehicles.



Downstream Investment

Give charity care to uninsured patients with chronic asthma.

Downstream Investment

Provide emergency treatment for people suffering from asthma attacks.

Not-for-profit hospitals can also include additional information about investments known as **“Community Building Activities,”** which are listed in the Schedule H, Part II. Community building activities are investments in prevention that promote community health by avoiding costly medical treatment.¹⁷ This type of community benefit spending is most closely aligned with upstream solutions — investments outside of the hospital that promote opportunities to maintain good health before ever stepping foot into a hospital. The IRS provides the following examples of community building activities and identifies potential upstream investments in the following areas:¹⁸

- **Physical improvements to infrastructure and housing**
- **Economic development**
- **Community support**
- **Environmental improvements**
- **Leadership development and training for community members**
- **Coalition building**
- **Community health improvement advocacy**
- **Workforce development**
- **Other**

ADVANCING HEALTH EQUITY THROUGH PREVENTATIVE HEALTH

Traditionally, not-for-profit hospitals have directed the vast majority of their community benefit spending towards charity care¹⁹ and financial assistance.^{20,21,22} While charity care and clinical services continue to be important resources, particularly in times of emergencies, this only influences a portion of our health. Doctors cannot be expected to solve problems that only targeted upstream investments can address. Our housing conditions, environmental standards, education and job opportunities, and health behaviors comprise approximately 80 percent of the factors that impact our health.²³

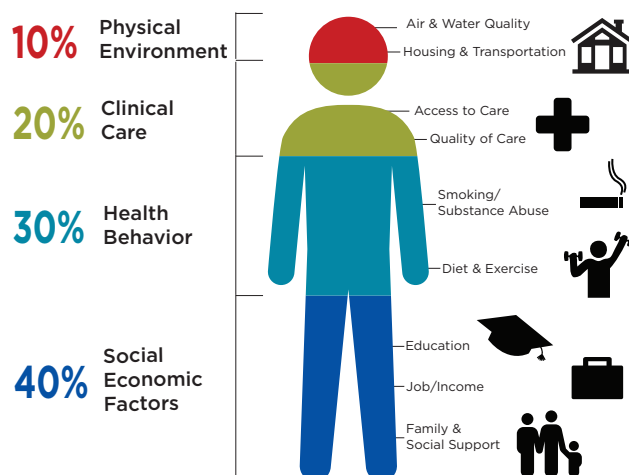


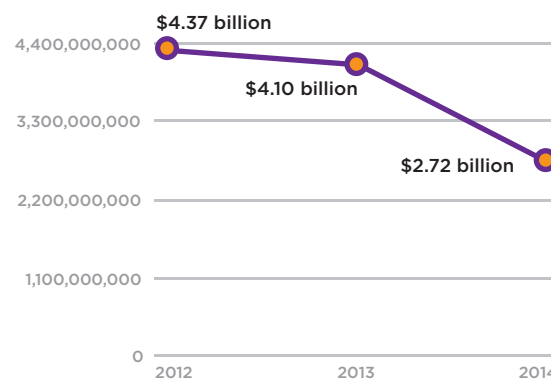
Figure 1: Factors that Influence Health

The 11 not-for-profit Central Valley hospitals studied in this report serve some of the most diverse, yet poorest regions in California — communities that also experience some of the worst health outcomes. People of color make up the majority of Central Valley residents, and these communities are also more than three times as likely to live below the federal poverty level as whites.²⁴ And as a region, Central Valley residents have an average income of \$23,210, over \$6,000 less than the state average and the second lowest in California. Latinos, Asian Americans, and African Americans in the Central Valley have the lowest life expectancies compared to their respective racial and ethnic groups in other regions. African Americans in the Central Valley have the lowest life expectancy in California: 71.4 years, roughly nine years less than the state average of 80.1 years.²⁵

Poor environmental conditions further compound health disparities for communities of color. The regions studied in this report, where communities of color make up the majority, all received an “F” grade for air quality from the American Lung Association²⁶. Elevated levels of pesticide use and pollution have led to significantly higher likelihood of asthma, particularly for residents who live below the poverty line.²⁷

Meanwhile, implementation of the Affordable Care Act (ACA) revolutionized health care in the United States and launched an unprecedented expansion of health coverage, particularly for low-income Americans and communities of color. As illustrated in Figure 2, spending on charity care by not-for-profit hospitals in California declined by roughly \$1.38 billion from 2013 to 2014, the year that Covered California and Medi-Cal expansion took effect.²⁸ These reforms have brought about a rapid decrease in the uninsured rate,²⁹ signaling a unique opportunity for not-for-profit hospitals to invest upstream and target the root causes of poor health, like poverty and environmental conditions, through community-building activities.

Figure 2:
Charity Care Spending For Nonprofit Hospitals



METHODOLOGY

We researched the community benefit spending of 11 Central Valley not-for-profit hospitals affiliated with some of the largest hospital systems in the country. These hospital systems include Kaiser Foundation Hospitals, Dignity Health, Adventist Health, Community Medical Centers, and Trinity Health, all of which operate multibillion-dollar budgets. We relied on publicly available information from the Office of Statewide Health Planning and Development (OSHPD) website. Additionally, we also analyzed available IRS Form 990s for each hospital, obtained through the GuideStar website. Below is a description of the information we utilized for this report:

- **Community Health Needs Assessments (CHNA)** – Every three years, not-for-profit hospitals are required to conduct a CHNA to determine the most pressing health needs of their communities. Hospitals must solicit the input of public health professionals and historically marginalized populations to determine the most pressing community health needs.
- **Community Benefit Plans (CBP)** – Not-for-profit hospitals are required to publish an annual CBP in consultation with the communities they serve. The CBP reports community benefit expenditures of the past year, and outlines the hospital's community benefit implementation plan for in the upcoming year.
- **IRS Form 990, Schedule H** – In order to maintain their favorable tax status, not-for-profit hospitals are required to submit an annual Form 990 to the IRS, which reports total operating expenses, expenditures and other financial details. Schedule Hⁱⁱⁱ is intended to promote transparency and accountability for a hospital's overall community benefit obligations, including charity care, financial assistance, research, and community health improvements.
- **Annual Financial Data, Hospital Pivot Profiles** – OSHPD compiles the annual financial data that hospitals submit each year. Using this tool, available through the Healthcare Information Division, we were able to determine the total operating expenses of some hospitals. Total operating expenses were not available for Kaiser Foundation Hospital – Fresno or Adventist Medical Center – Reedley.

We analyzed the community benefit spending for hospitals in this study from 2011-2014,^{iv} comparing annual differences between hospitals and contrasting community benefit practices within one given fiscal year, 2012, across all hospitals reviewed.

ⁱⁱⁱ The Schedule H requires not-for-profit hospitals to report spending towards the social determinants of health, including a section to report "community building activities."

^{iv} Not for profit hospitals were first required to submit a CBP in 1996, and conduct a CHNA based on ACA guidelines in 2012. The most recently published CBPs detail not-for-profit hospital community benefit activities in 2014.

FINDINGS

LIMITATIONS AND DISCREPANCIES IN DATA TRANSPARENCY

The lack of data and transparency from the not-for-profit hospitals analyzed in this report provided consistent barriers to our research. We discovered missing or unclear data from all 11 hospitals in this study:

- **We were not able to identify Kaiser Foundation Hospital - Fresno's total operating expenses because this facility operates within an integrated hospital system and health plan.** This unique model differentiates Kaiser Foundation Hospitals from all other hospital systems in this study, which prevented us from directly analyzing Kaiser's community benefit footprint compared to other hospitals.
- **Starting in 2013, Adventist Health Hospitals stopped distinguishing their community benefit investments directed towards vulnerable populations from those aimed at the broader community.** This prevented us from determining how, if at all, Adventist Health addressed the needs of low-income residents and communities of color.
- **Adventist Medical Center - Reedley did not disclose its total operating expenses until 2014.** Furthermore, this hospital did not submit a 2011 CBP.
- **Saint Agnes Medical Center did not submit a 2011, 2012 or 2013 CBP.** While we were able to locate community benefit spending data for 2013 referenced in the 2014 CBP, we were not able to obtain data for 2011 or 2012.
- **The Community Medical Center hospitals did not report their community benefit investments directed toward vulnerable populations.** Additionally, this hospital group provided approximated data rather than final expenses.
- **All hospitals, apart from Saint Agnes Medical Center, failed to provide detailed, complete breakdowns of their community benefit investments.** The majority of the hospitals have large portions of claimed community benefit spending unaccounted for in the CBPs.

To fill these gaps in data, we reached out directly to each hospital to solicit additional community benefit information. We sent multiple inquiries by phone and email over the course of several months during the summer and fall of 2015, but received only one response. In another case, we were directed to the hospital's marketing department. However, we did not receive a call back from the marketing department.

SMALL AND INCONSISTENT INVESTMENTS IN VULNERABLE POPULATIONS

We discovered numerous barriers to transparency in the reported community benefit expenditures of every hospital we studied. Although not-for-profit hospitals are required to separate their community benefit spending directed towards vulnerable populations from benefits to the broader community, Adventist Health hospitals omitted this in 2013 and 2014, while the Community Medical Center hospitals also failed to do so for 2014. Additionally, Kaiser Foundation Hospital - Fresno and Adventist Medical Center - Reedley do not disclose their total operating expenses.

In order to compare investments in upstream solutions for vulnerable populations, we analyzed 2012 community benefit data, which was the final year that Adventist Health hospitals disaggregated their spending between vulnerable populations and the broader community. This gave us the largest number of hospitals to compare.

2012 Hospital Comparison: Operating Expenses and Community Benefit Spending Towards Vulnerable Populations

Hospital	Total 2012 Operating Expenses	Total Community Benefit Dollars Towards Upstream Investments for Vulnerable Populations	Percentage of Total Operating Expenses Towards Upstream Investments for Vulnerable Populations
Kaiser Foundation Hospital – Fresno	Data not available	\$1,256,584	Data not available
Dignity Health Mercy Medical Center	\$236,863,394	\$1,102,531	0.47%
Dignity Health Bakersfield Memorial Hospital	\$267,603,710	\$2,180,288	0.81%
Adventist Medical Center – Hanford and Selma	\$211,504,243	\$6,319	0.00%
Adventist Medical Center – Reedley	Data not available	\$0	Data not available
Adventist Central Valley General Hospital	\$86,852,651	\$6,268	0.01%
Saint Agnes Medical Center	\$399,704,289	Data not available	Data not available
Community Medical Centers	\$1,152,444,323	Data not available	Data not available
Total /Average	\$2,354,972,610	\$4,551,990	0.32%

**Because Kaiser Foundation Hospital – Fresno and Adventist Medical Center – Reedley do not disclose their total operating budgets, we were unable to calculate the percent spending dedicated to upstream solutions for vulnerable populations.*

Overall, not-for-profit hospitals in the Central Valley only invested 0.32 percent of their total 2012 operating expenses in upstream solutions for vulnerable populations. Aside from Adventist Medical Center – Reedley and Kaiser Foundation Hospital – Fresno, the nine other hospitals control over \$2.35 billion in operating expenses.

Our analysis also revealed wide discrepancies in the percentage of total operating expenses towards upstream solutions for vulnerable populations. Adventist Medical Centers – Hanford and Selma combined spent less than 0.001 percent of their total operating budgets on upstream investments for vulnerable populations, the lowest in the study.

COMMUNITY INVOLVEMENT

The requirement for a Community Health Needs Assessment stems from recognition that the people who live, work and play in a given community are the foremost experts on that community's health needs. Not-for-profit hospitals are required by law to develop a “method for soliciting the views of the community served by the hospital” and consult community advocates during the development of their community benefit implementation plans.³⁰ Community input is primarily facilitated through the CHNAs. Not-for-profit hospital community benefit spending must be accountable to the health priorities established in the CHNAs.

We found significant variation in the level of community engagement across hospital CHNAs. They differed on: (1) the quality and substance of their community engagement efforts, (2) whom from the community the hospitals engaged, and (3) whether or not the community recommendations received through this process ended up in the implementation strategy.

Hospital Council of Northern and Central California Joint CHNA

In 2013, Kaiser Foundation Hospital – Fresno, Adventist Medical Centers in Hanford, Selma, and Reedley, Adventist Health – Central Valley General Hospital, Saint Agnes Medical Center, and the Community Medical Center hospitals conducted a joint CHNA in consultation with the Hospital Council of Northern and Central California. These hospitals conducted interviews and surveys to assess the health needs of the communities in Fresno, Kings, Madera, and Tulare counties. Two hundred thirty community members were invited to participate in in-person focus groups in addition to an online survey.³¹ The hospitals provided no information as to how the online survey was distributed, which community members were invited to participate in the focus groups, or how they were recruited.

In total, only 84 people participated in the focus groups and survey, and a vast majority of them were hospital employees.³² Although recognizing the need to improve their community outreach strategy, these hospitals did not provide any recommendations or commitments for improving outreach methods and increasing community participation.

The top two health priorities raised by this 84 participant survey clearly related to upstream solutions: addressing poverty and improving access to education.³³ However, none of the implementation strategies of these hospitals directly address poverty or education and it is unclear how these hospitals incorporated community feedback.

Mercy Medical Center – Merced CHNA

Mercy Medical Center conducted the community engagement portion of its CHNA through a private firm, Professional Research Consultants. PRC interviewed 400 individuals through land and cell phone lines. This research method omitted key vulnerable populations such as homeless individuals and those who speak a language other than English or Spanish. Additionally, the survey did not allow the hospital to identify the responses of members from populations which have specific health needs, including LGBTQ community members, pregnant women, undocumented immigrants, and non-white or non-Latino respondents.³⁴ This leaves major gaps in this hospital's understanding of the community it serves.

While Mercy Medical Center – Merced's community engagement survey helped to create a landscape of current health conditions, this hospital missed an opportunity to address these health needs through partnerships with community stakeholders. Several of Mercy Medical Center – Merced's survey questions were geared towards perceived individual health — i.e., “how would you rate your overall health?” — while other questions asked patients to identify their own poor health habits.³⁵ The survey did not ask community participants about potential solutions to community health challenges.

Bakersfield Memorial Hospital CHNA

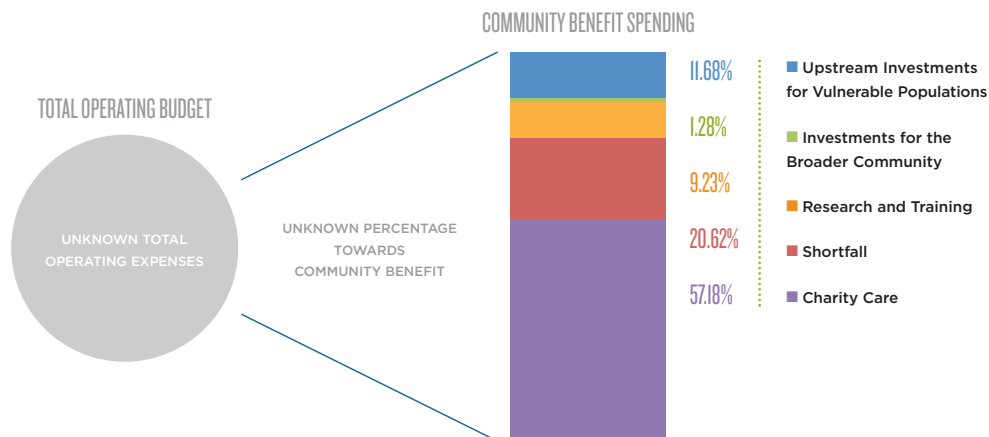
Bakersfield Memorial Hospital also conducted its own CHNA through the Kern Community Benefit Collaborative. This CHNA does not provide any information regarding community engagement other than a list of members on the Community Benefits Steering Committee.³⁶ All members of the steering committee are administrators at not-for-profit hospitals in the area, and it is unclear as to whether or not anyone outside of the hospitals was included in this process.

HOSPITAL PROFILES

KAISER FOUNDATION HOSPITALS

Kaiser Foundation Hospitals operate as an integrated hospital system and health plan, which differentiates this system from the other hospital systems in this study. Therefore, Kaiser Foundation Hospitals submit a consolidated IRS Form 990 for all Kaiser hospitals within and outside of California. Furthermore, Kaiser Foundation Hospitals are exempt from reporting the operating expenses of individual hospitals. Due to these differences, Greenlining is actively exploring ways to better analyze Kaiser's community benefits contributions, and upstream investments overall.

Kaiser Foundation Hospital - Fresno



Profile: 2014 Kaiser Foundation Hospital - Fresno

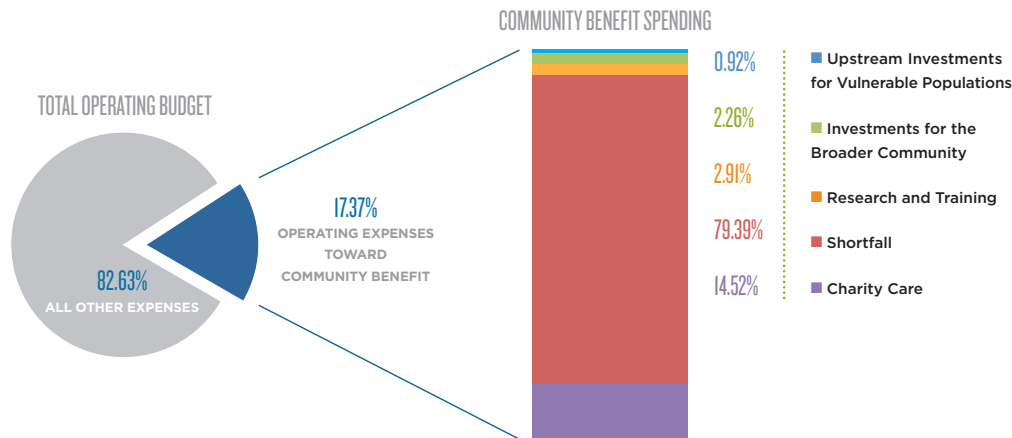
- **Community benefit expenditures for Kaiser Foundation Hospital - Fresno varied up and down from year to year.** Kaiser Foundation Hospital - Fresno decreased its community benefit spending from 2011 to 2012, increased community benefit spending and upstream investments from 2012 to 2013 and reduced them again in 2014. Because this hospital does not disclose its total operating expenses, we were unable to compare total community benefit and upstream investments relative to total operating expenses.
- **While Kaiser Foundation Hospital - Fresno claimed to provide more than \$1.8 million in grants in 2014, this hospital did not provide a full breakdown of grant recipients.** Recipients of over \$600,000 of grant dollars claimed in 2014 were not identified — an improvement over 2012, when Kaiser Foundation Hospital - Fresno did not account for over \$3.6 million of \$4.3 million in claimed community benefit grants.

Year	Percentage of total operating expenses spent on community benefit	Percentage of total operating expenses spent on upstream for vulnerable populations
2011	Data not available	Data not available
2012	Data not available	Data not available
2013	Data not available	Data not available
2014	Data not available	Data not available

DIGNITY HEALTH

Dignity Health's Mercy Medical Center – Merced and Bakersfield Memorial Hospital both operate in areas where roughly two-thirds of the population consists of people of color.^{37,38} In 2014, both hospitals reported an overall decrease in upstream investments for vulnerable populations. Dignity Health was the only hospital system in our study that responded to our request for additional information regarding community benefit spending.

Dignity Health Mercy Medical Center – Merced

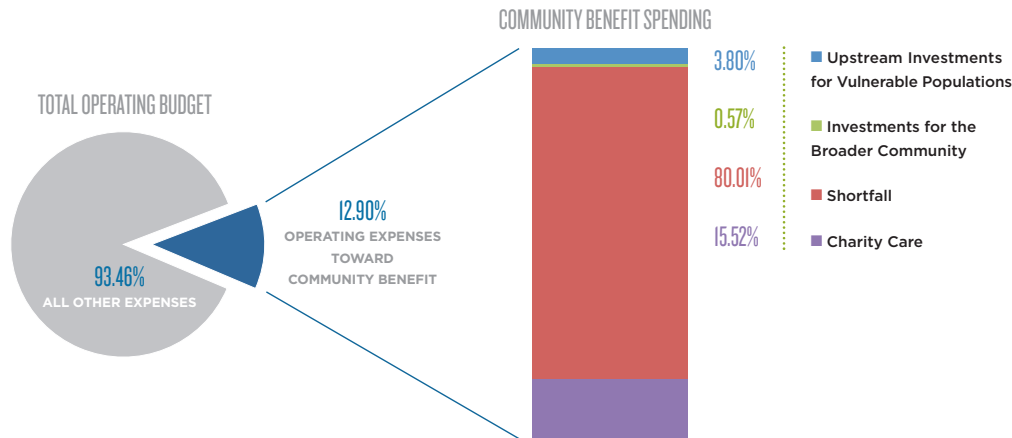


Profile: 2014 Dignity Health Mercy Medical Center – Merced

- **While the percentage of community benefit spending increased from 2011-2014, upstream investments targeting vulnerable populations decreased dramatically.** By 2014, Mercy Medical Center – Merced only invested \$390,296 (0.16 percent of its total operating expenses) in upstream solutions for vulnerable populations, down from \$1.2 million (0.50 percent of total operating expenses) in 2011.
- **Among hospitals in this study, Mercy Medical Center – Merced dedicated the largest portion of its total operating expenses to community benefit.** However, by 2014 this hospital ranked among the lower half of the 11 hospitals in this study with regards to upstream investments for vulnerable populations.

Year	Percentage of total operating expenses spent on community benefit	Percentage of total operating expenses spent on upstream for vulnerable populations
2011	10.12%	0.50%
2012	12.24%	0.47%
2013	13.63%	0.40%
2014	17.37%	0.16%

Dignity Health Memorial Hospital – Bakersfield



Profile: 2014 Dignity Health Memorial Hospital – Bakersfield

- **Bakersfield Memorial Hospital gradually increased its percentage of overall community benefit spending from 2012-2014**, from \$9.8 million (3.67 percent of total operating expenses) in 2012 to \$42 million (12.90 percent of total operating expenses) in 2014.
- **However, Bakersfield Memorial Hospital also decreased the percentage invested in upstream solutions for vulnerable populations from 2011-2014.** In 2011, Bakersfield Memorial Hospital spent \$2.4 million (1.15 percent of total operating expenses) on upstream solutions to health; however, by 2014, this allotment had decreased to \$1.6 million (0.49 percent of total operating expenses).
- **From 2012-2013, Bakersfield Memorial made \$582,773 in total profit from Medi-Cal reimbursements.** That is, this hospital received more funds from federal and state Medi-Cal reimbursements than it spent treating Medi-Cal patients.

Year	Percentage of total operating expenses spent on community benefit	Percentage of total operating expenses spent on upstream for vulnerable populations
2011	6.54%	1.15%
2012	3.67%	0.81%
2013	4.20%	0.52%
2014	12.90%	0.49%

ADVENTIST HEALTH

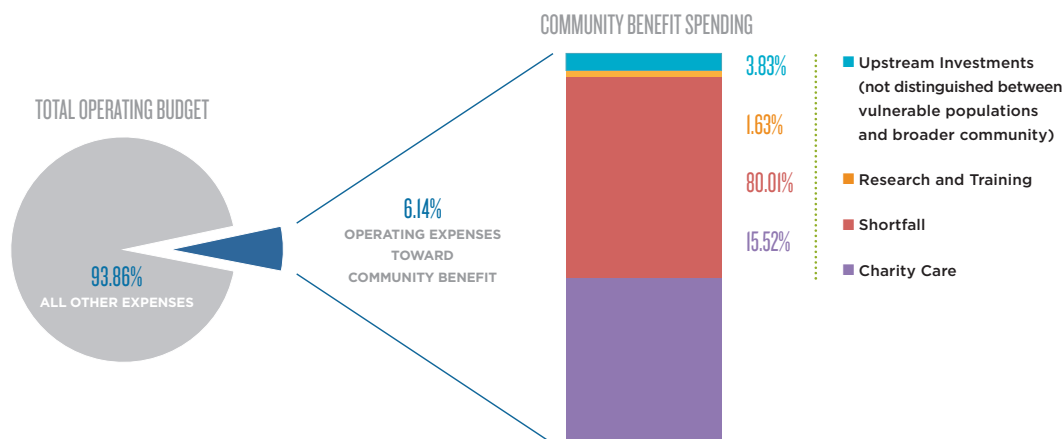
Adventist Health's Central Valley Network consists of four not-for-profit hospitals: Adventist Medical Centers in Hanford, Selma, and Reedley, and Central Valley General Hospital. The data available for the community benefit spending of these hospitals do not live up to expected standards of transparency, particularly regarding upstream, preventative health for vulnerable populations.

By law, not-for-profit hospitals in California must disaggregate investments that benefit vulnerable populations from investments aimed at the broader community.³⁹ However, since 2013, the Adventist hospitals that we studied failed to comply, with no explanation as to why.

Greenlining contacted Adventist Health, hoping to obtain the disaggregated data, and we were consistently directed to the hospital's marketing department. We left multiple messages during the summer and fall of 2015, but received no response.

Adventist Medical Centers – Hanford and Selma

Adventist Medical Centers – Hanford and Selma are roughly 20 miles apart and serve different communities. Since 2011, these two hospitals have reported their aggregate community benefit investments. Although entirely separate facilities, we were unable to determine how each individual hospital contributed to community benefit. This presented significant challenges to assessing their health impact on their respective communities.



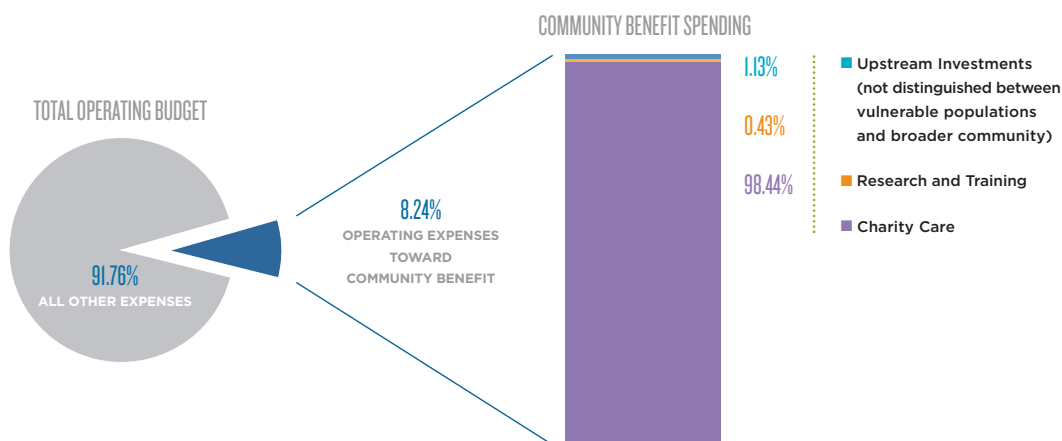
Profile: 2014 Adventist Medical Centers – Hanford and Selma

- **Adventist Medical Centers in Hanford and Selma spent less than 0.001 percent of their 2012 operating expenses on upstream, preventative health for vulnerable populations.** This figure, from the last year these hospitals reported spending on vulnerable populations, translates to a mere \$1,280 of these hospitals' \$207.8 million operating expenses. While Adventist Health hospitals did not report investments aimed at vulnerable populations in 2013 and 2014, total upstream investments overall decreased from 2011-2012.
- **Adventist Medical Centers in Hanford and Selma decreased their community benefit spending from 2012-2014.** In 2012, these hospitals spent a combined \$19.1 million (9.05 percent of total operating expenses) on community benefit overall. However, by 2014, these hospitals reduced their community benefits investments to \$13.2 million (5.80 percent of total operating expenses).

Year	Percentage of total operating expenses spent on community benefit	Percentage of total operating expenses spent on upstream for vulnerable populations
2011	3.89%	0.00%
2012	9.05%	0.00%
2013	6.68%	Data not available
2014	6.14%	Data not available

Adventist Medical Centers - Reedley

The Medical Center in Reedley first began operating under Adventist Health in 2011; that year, it did not submit a CBP. In 2012, this hospital did not dedicate any spending to upstream community benefits. Adventist Medical Center - Reedley did not disclose its total operating expenses until 2014.

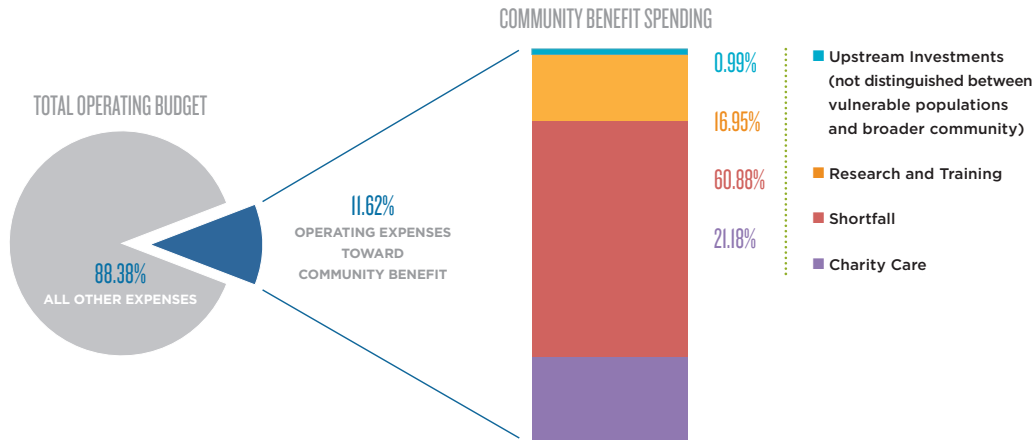


Profile: 2014 Adventist Medical Centers - Reedley

- **Adventist Medical Center - Reedley did not contribute any community benefit dollars to upstream solutions to health in 2012.** While this hospital did contribute \$53,000 towards community health improvement services and community building activities in 2014, Adventist hospitals no longer disaggregated their community benefit spending between vulnerable populations and the broader community. Therefore, we were not able to determine how much went towards serving vulnerable populations.
- **Adventist Medical Center - Reedley provided very little data about its community benefit spending between 2011-2014.** This lack of data makes it effectively impossible for community members or advocates to evaluate this hospital's community benefit commitments.

Year	Percentage of total operating expenses spent on community benefit	Percentage of total operating expenses spent on upstream for vulnerable populations
2011	Data not available	Data not available
2012	Data not available	0.00%
2013	Data not available	Data not available
2014	8.24%	Data not available

Adventist Health Central Valley General Hospital



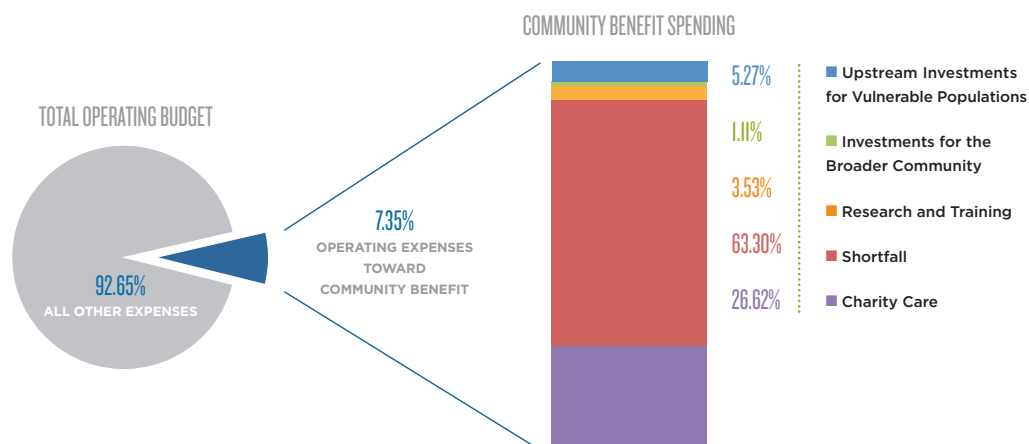
Profile: 2014 Adventist Health Central Valley General Hospital

- From 2011-2014, the total operating expenses of Central Valley General Hospital increased by \$15.3 million, but the percentage spent on community benefit bounced up and down during the same period.
- Central Valley General Hospital decreased spending for upstream investments towards vulnerable populations from 2011-2012, the last year it disaggregated this information. In 2011, this hospital spent only \$17,266 of its \$83.7 million operating expenses (0.02 percent) on upstream investments for vulnerable populations. In 2012, those investments decreased to \$6,268 (0.01 percent of total operating expenses). We were unable to determine what happened to this figure in later years.

Year	Percentage of total operating expenses spent on community benefit	Percentage of total operating expenses spent on upstream for vulnerable populations
2011	10.81%	0.02%
2012	9.92%	0.01%
2013	13.44%	Data not available
2014	11.62%	Data not available

TRINITY HEALTH

Saint Agnes Medical Center



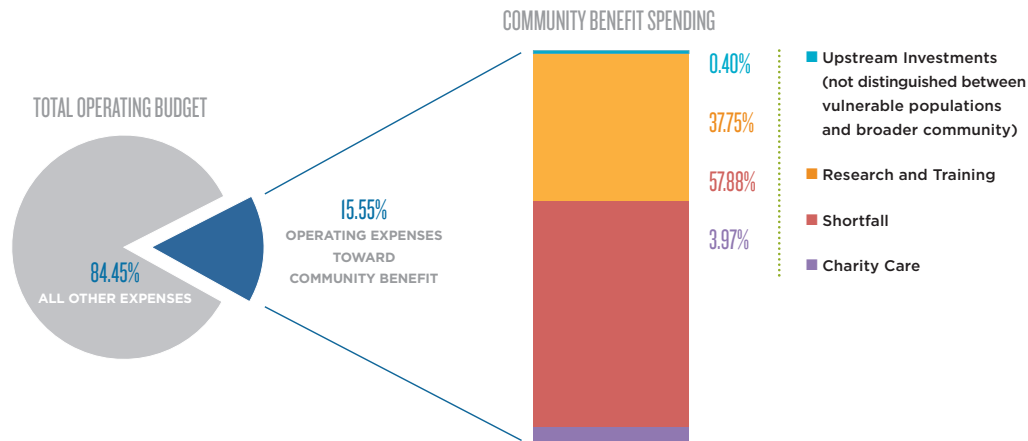
Profile: 2014 Trinity Health Saint Agnes Medical Center

- **Saint Agnes Medical Center allocated 7.50 percent of its 2014 operating expenses to community benefit. However, only 0.39 percent went towards upstream, preventative health solutions for vulnerable populations.** In 2014, Saint Agnes spent roughly \$1.6 million of its over \$400 million operating budget on upstream solutions to address the root causes of poor health for vulnerable communities.
- **No public records exist for Saint Agnes Medical Center's 2011, 2012, and 2013 CBP.** In 2011, Trinity Health submitted a consolidated CBP of all Trinity Health facilities nationwide, making it impossible to distinguish the individual community benefit investments of Saint Agnes Medical Center. Additionally, the hospital did not submit a 2012 or 2013 CBP. We were only able to obtain 2013 community benefit data from the hospital's 2014 CBP.
- **Saint Agnes did not respond to any of our requests for its 2011, 2012, and 2013 community benefit plans, even though we reached out to the hospital roughly every week for three months during the summer and fall of 2015.** Because no public records for 2011 or 2012 community benefit exist, we were unable to compare Saint Agnes Medical Center's community benefit activity for 2012 with the other hospitals in this study.
- **Yet, in the lone CBP Saint Agnes Medical Center released, it is the only hospital to provide a full breakdown of its claimed community benefit spending.** This CBP accounts for all dollars invested towards financial contributions, community building activities, and community health improvement services. No other CPB we obtained contained such complete information.

Year	Percentage of total operating expenses spent on community benefit	Percentage of total operating expenses spent on upstream for vulnerable populations
2011	Data not available	Data not available
2012	Data not available	Data not available
2013	7.34%	0.41%
2014	7.35%	0.39%

COMMUNITY MEDICAL CENTERS

The Community Medical Centers' network consists of three hospitals: Community Regional Medical Center, Clovis Community Medical Center, and Fresno Heart and Surgical Hospital. The largest provider of health care services in the Central Valley, Community Medical Center hospitals file a joint CBP. The Community Medical Center hospital group oversees the largest operating budget of all hospitals in this study, totaling \$1.2 billion in operating expenses in 2014. These extensive resources could translate into significant financial impact from their community benefit dollars.



Profile: 2014 Community Medical Center

- **Community Medical Centers do not disaggregate their community benefit investments directed at vulnerable populations from dollars targeting the broader community,** despite the fact that separating this information is required.
- **While overall community benefit spending increased, upstream investments remained stagnant between 2011-2014. From 2011 to 2014,** Community Medical Center hospitals increased their overall community benefit spending by over \$5.2 million by 2014. However, upstream investments have only increased by \$120,000. We have yet to see substantial improvement in Community Medical Centers' financial support of upstream investments in their communities.

Year	Percentage of total operating expenses spent on community benefit	Percentage of total operating expenses spent on upstream for vulnerable populations
2011	12.26%	Data not available
2012	12.08%	Data not available
2013	12.18%	Data not available
2014	15.55	Data not available

ANALYSIS AND RECOMMENDATIONS

A handful of consistent themes recurred throughout our examination of data from these hospitals: Minimal community engagement, incomplete reporting of data, and small — often tiny — investments in upstream activities that promote health and prevent illness, with even tinier investments aimed at the special health needs of vulnerable populations. In a region beset by high rates of poverty and unemployment and with large numbers of residents whose first language is not English, this represents a major failure.

These hospitals have a responsibility to invest in the most effective, strategic solutions to meet the health needs of their communities. All hospitals in this study serve as anchor institutions in regions that are majority communities of color, with large proportions of low-income residents. Given their ample resources, these hospitals have the capacity to make large gains towards health equity in the Central Valley, but at current rates of investments they are failing to do so.

Not-for-profit hospitals must do a better job of engaging the communities they serve. The tax exemption these hospitals receive is premised on the idea that they operate not to enrich stockholders but to benefit their communities, yet it appears that many of these institutions make no more than a token effort to learn those needs from the community members who know them best.

The sketchy and incomplete reporting of data — including failure by some systems to fulfill the mandate that they specifically report investments in the health of vulnerable populations — should be considered unacceptable. Not-for-profit hospitals can only be held accountable when the communities they serve know how they invest their resources. Too many of the data tables above bear the phrase “data not available,” and the gaps in information among these hospitals raise concerns over the efficacy of the state’s community benefit regulations. California needs greater transparency in order to achieve good health for underserved communities of color as well as for all Californians.

The lack of investment in upstream, health-promoting activities also raises great concerns. Indeed, some hospitals reported no investments at all in community-building activities in their Schedule H, Part II.

Not-for-profit hospitals must refocus their vast resources and attention to improving the social determinants of health in order to address the chronic illnesses and debilitating conditions that disproportionately affect underserved communities of color. In order to combat and reverse the health inequities caused by institutional racism, not-for-profit hospitals must work towards addressing the root causes of health disparities. This should include partnerships with community stakeholders to address the health needs of low-income residents and communities of color. As health care costs skyrocket, community benefit spending geared towards preventative health can benefit more people at a lower cost than simply caring for people after they become ill.⁴⁰ To accomplish this, however, California’s community benefit statutes must be reformed to improve transparency, accountability, and community engagement. The following specific recommendations can help move toward these goals.

For Not-for-Profit Hospitals

- **Not-for-profit hospitals must take seriously their responsibility to solicit community feedback and must include underserved communities in their community benefits decision-making process.** These hospitals must develop a more comprehensive strategy to garner input from the communities they serve. Community members are the best experts on the health needs of the community, particularly for the most vulnerable populations, and hospitals must tap into this expertise — not just to identify problems, but to develop solutions.
- **To promote effective long-term solutions to poor community health, not-for-profit hospitals must increase investments in community building activities and other upstream solutions for vulnerable populations.** Doctors cannot be expected to solve problems that only targeted investments in the community can address.
- **Hospitals must improve their engagement practices to be more culturally competent.** Currently, not-for-profit hospitals are inconsistent and limited at best when it comes to outreaching to the local community. Not-for-profit hospitals must develop comprehensive strategies to increase meaningful participation from community members. For example, hospitals can offer child care services, hold focus groups in locations easily accessible to community members, or otherwise facilitate and incentivize participation. Not-for-profit hospitals must also work to establish trust with community members by forging partnerships with community group and organizations.
- **Not-for-profit hospitals must work collaboratively and across different institutions to uplift the importance of health in all sectors.** The most pressing challenges facing underserved communities require synergistic solutions that combine the efforts of local and state governments, community-based organizations, and other institutions. Not-for-profit hospitals can provide valuable insight and assistance in addressing the social determinants of health through environmental improvements, workforce development, health education, housing, and other factors that require greater allocation of resources.

For Legislators and Regulatory Agencies

- **Legislators must clarify and expand the definition of community benefit to incentivize not-for-profit hospitals to invest in community-building activities and other upstream solutions to health.** This will encourage deeper partnerships between not-for-profit hospitals and community-based organizations, and may require clearer guidelines regarding the Schedule H section of IRS Form 990.
- **State regulatory agencies need the enforcement authority to hold not-for-profit hospitals accountable when they fail to comply with community benefit regulations and reporting standards.** Current not-for-profit tax exemption policies and community benefit legislation do not appear to place meaningful financial penalties on noncompliant not-for-profit hospitals. Legislators should establish tough penalties for noncompliance and require strict enforcement of rules.

For Community Members

- **Community members must build strong partnerships with not-for-profit hospitals, community stakeholders, and local and state officials to improve community benefit standards.** By convening these coalitions, community members can emphasize the importance of strategic upstream investments that address the health needs of underserved communities of color. Furthermore, these community coalitions can also work towards asserting their presence during vital community benefit processes such as the CHNA.
- **Community stakeholders should hold not-for-profit hospitals accountable by directly engaging with them to emphasize the importance of transparent community benefit investments that target the most pressing social determinants of poor health.** Community members have a right to influence how hospitals invest their community benefit funds through the community health needs assessment and implementation process.
- **Community-based organizations and advocates must hold hospitals accountable to the needs of low-income residents and communities of color.** Community advocates should make it a priority to participate in the CHNA and recruit community organizations to engage in the community benefits process. Advocates play an integral role in coalition-building and can work towards educating others on the importance of community benefit.

CONCLUSION

Every community deserves to achieve good health; however, not all communities are afforded this opportunity. As low-income Californians and communities of color continue to confront social and economic barriers, not-for-profit hospitals and other vital anchor institutions must promote health equity. This will require innovative and collaborative partnerships between communities, hospitals, and local and state governments. The Central Valley represents a prime opportunity to build coalitions between not-for-profit hospitals, community advocates and elected officials that can improve health inequities disproportionately burdening communities of color. Barriers to transparency, lack of community involvement, and inadequate upstream investments in health currently prevent community benefit programs in the Central Valley from maximizing their potential. In order to reverse the deeply entrenched barriers caused by institutional racism, not-for-profit hospitals must first recognize inequities in their own practices. By acknowledging and embracing their role in uplifting underserved communities, these hospitals have the potential to lead the effort towards racial and health equity. We hope this report serves as a starting point that fosters dialogue and action with local officials, not-for-profit hospital representatives, and other community members.

REFERENCES

- ¹ Institute for Health and Socio-Economic Policy. (2012). "Benefiting from Charity Care: California Not-for-Profit Hospitals". 1-61.
- ² California Health & Safety Code §127345©
- ³ UCLA Center for Health Policy Research. AskCHIS 2014. Poverty Level compared by Nearby Park or Playground Safe compared by Usual Type of Transportation. Los Angeles, CA: UCLA Health Interview Surveys, 2012. Retrieved from: <http://ask.chis.ucla.edu>.
- ⁴ UCLA Center for Health Policy Research. AskCHIS 2014. Race - Office of Management and Budget & Department of Finance compared by Region. Los Angeles, CA: UCLA Health Interview Surveys, 2014. Retrieved from: <http://ask.chis.ucla.edu>.
- ⁵ UCLA Center for Health Policy Research. AskCHIS 2014. Race - Office of Management and Budget & Department of Finance compared by Poverty Level. Los Angeles, CA: UCLA Health Interview Surveys, 2014. Retrieved from: <http://ask.chis.ucla.edu>.
- ⁶ UCLA Center for Health Policy Research. AskCHIS 2014. Race - Office of Management and Budget & Department of Finance. Los Angeles, CA: UCLA Health Interview Surveys, 2014. Retrieved from: <http://ask.chis.ucla.edu>.
- ⁷ Burd-Sharps, S; Lewis, K. (2011). "A Portrait of California: California Human Development Report 2011". *American Human Development Project of the Social Science Research Council*.
- ⁸ Ibid.
- ⁹ UCLA Center for Health Policy Research. AskCHIS 2014. Race - Office of Management and Budget & Department of Finance compared by Ever Diagnosed with Diabetes. Los Angeles, CA: UCLA Health Interview Surveys, 2014. Retrieved from: <http://ask.chis.ucla.edu>.
- ¹⁰ UCLA Center for Health Policy Research. AskCHIS 2014. Race - Office of Management and Budget & Department of Finance compared by Ever Diagnosed with Heart Disease. Los Angeles, CA: UCLA Health Interview Surveys, 2014. Retrieved from: <http://ask.chis.ucla.edu>.
- ¹¹ UCLA Center for Health Policy Research. AskCHIS 2014. Race - Office of Management and Budget & Department of Finance compared by Number of days in poor mental health during past month. Los Angeles, CA: UCLA Health Interview Surveys, 2014. Retrieved from: <http://ask.chis.ucla.edu>.
- ¹² California Health & Safety Code §127345©
- ¹³ Institute for Health and Socio-Economic Policy. (2012). "Benefiting from Charity Care: California Not-for-Profit Hospitals". 1-61.
- ¹⁴ Ibid.
- ¹⁵ Ibid.
- ¹⁶ Ibid.
- ¹⁷ Barnett, K.; Somerville, M.H. (2012). "Hospital Community Benefits after the ACA: Schedule H and Hospital Community benefit - Opportunities and Challenges for the States." *The Hilltop Institute*.
- ¹⁸ Rosenbaum, Sara et al. (2004). "Encouraging Nonprofit Hospitals to Invest in Community Building: The Role of the IRS 'Safe Harbors.'" *Health Affairs Blog*. Retrieved from: <http://healthaffairs.org/blog/2014/02/11/encouraging-nonprofit-hospitals-to-invest-in-community-building-the-role-of-irs-safe-harbors/>
- ¹⁹ Charity Care is defined as free care that is provided when a patient is not expected to pay or pay only a nominal amount of the charges billed for services. Retrieved from: <https://www.adventisthealth.org/Documents/Financial%20Assistance%20Policies/Financial-Assistance-Policy-PFS-112-COMBINED-2015.pdf>
- ²⁰ Financial assistance policies are hospital programs that will prospectively or retroactively reduce the amount paid by an uninsured or underinsured patient for hospital service charges. Retrieved from: <https://www.adventisthealth.org/Documents/Financial%20Assistance%20Policies/Financial-Assistance-Policy-PFS-112-COMBINED-2015.pdf>
- ²¹ At a minimum, a patient is eligible to apply for charity care or financial assistance when their family income is below 350 percent of the Federal Poverty level and are uninsured or underinsured. Retrieved from: http://www.oshpd.ca.gov/hid/products/hospitals/fairpricing/HSC127400_CharityCarePoliciesSB350.pdf
- ²² Rausa, J.; Fang, S. (2013) "Not-For-Profit Hospitals and Community Benefit: What We Don't Know Can Hurt Us." *The Greenlining Institute*.
- ²³ University of Wisconsin Population Health Institute (UWPHI). (2013). Our Approach. Retrieved from <http://www.countyhealthrankings.org/our-approach>
- ²⁴ UCLA Center for Health Policy Research. AskCHIS 2014. Race - Office of Management and Budget & Department of Finance compared by Poverty Level compared by County. Los Angeles, CA: UCLA Health Interview Surveys, 2014. Retrieved from: <http://ask.chis.ucla.edu>.
- ²⁵ Burd-Sharps, S; Lewis, K. (2011). "A Portrait of California: California Human Development Report 2011." *American Human Development Project of the Social Science Research Council*.
- ²⁶ State of the Air. (2015) Report Card: California. *American Lung Association*. Retrieved from: <http://www.stateoftheair.org/2015/states/california/>.
- ²⁷ Rodriguez, Matthew; Alexeeff, Ph.D., George. (August 2014). California Communities Environmental Health Screening Tool, Version 2.0. *California Environmental Protections Agency - Office of Environmental Health Hazard Assessment*.
- ²⁸ Office of Statewide Health Planning and Development. "2010-2014 Summary Trends - Hospital Quarterly Financial and Utilization Data."
- ²⁹ Kafka, S. (2015). U.S. Uninsured Rate at 11.4% in Second Quarter. Gallup. Retrieved from <http://www.gallup.com/poll/184064/uninsured-rate-second-quarter.aspx>
- ³⁰ California Health & Safety Code 127355(a)
- ³¹ "2013 Community Health Needs Assessment: Fresno, Kings, Madera, and Tulare Counties." *Hospital Council of Northern & Central California*. Retrieved from: http://www.hospitalcouncil.net/sites/main/files/file-attachments/final_2013_chna_fmkt_counties_web.pdf
- ³² Ibid.
- ³³ Ibid.
- ³⁴ 2012 PRC Community Health Needs Assessment Report". *Professional Research Consultants, Inc.* sponsored by *Mercy Medical Center Merced*. Retrieved from: <http://www.dignityhealth.org/cm/media/documents/Mercy-Medical-Center-Merced-NA.pdf>
- ³⁵ Ibid.
- ³⁶ "2012/2013 Healthy Kern Community Health Needs Assessment". *Dignity Health Bakersfield Memorial Hospital*. Retrieved from: <http://www.healthykern.org/content/sites/kern/KERNCHNAFINALREPORT4-3-13.pdf>
- ³⁷ Office of Statewide Health Planning & Development. Healthcare Atlas, Bakersfield Memorial Hospital Facility Details & References. Retrieved from: <http://gis.oshpd.ca.gov/atlas/places/facility/106150722>
- ³⁸ Office of Statewide Health Planning & Development. Healthcare Atlas, Mercy Medical Center - Merced Hospital Facility Details & References. Retrieved from: <http://gis.oshpd.ca.gov/atlas/places/facility/106240942>
- ³⁹ California Health & Safety Code 127355(2)(3)
- ⁴⁰ Barnett, K.; Somerville, M.H. (2012). "Hospital Community Benefits after the ACA: Schedule H and Hospital Community benefit - Opportunities and Challenges for the States." *The Hilltop Institute*.

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