Nonprofit Hospital Spending

Exploring the Impact Beyond Hospital Walls

Veronica Viceñas
UCLA Health Policy & Management
Field Studies Consulting Report
Fall 2017

Preceptor
Anthony Galace, Health Policy Director
The Greenlining Institute

TABLE OF CONTENTS

EXECUTIVE SUMMARY 2

BACKGROUND 3

- **Context on Nonprofit Hospitals** 3

LITERATURE REVIEW 4

- **Prioritizing Low-Income Communities of Color** 5
- **Measuring the impact of investments** 5
- **Limitations** 6

ANALYSIS OF COMMUNITY HEALTH NEEDS ASSESSMENT 7

- **Sutter Health, CHNA** 7
- **Kaiser Permanente, CHNA** 8
- **Variation in Assessment of Priority Needs** 8
- **Prioritized Investments** 9

NON-COMMUNITY BENEFIT UPSTREAM INVESTMENTS 9

- **Supplier Diversity** 10
- **Employment Opportunities in Health Care** 10

RECOMMENDATIONS 11

- **Stakeholder Involvement** 12
- **Criteria for Funding Allocation, Upstream Investments** 13
- **Minimum Funding Requirements** 13

CONCLUSION 14

APPENDICES 15

REFERENCES 20

EXECUTIVE SUMMARY

Background
The Greenlining Institute aims to redefine the role of nonprofit hospitals through their Community Benefit dollars and have them contribute to the larger effort of reducing health disparities, particularly for low income communities of color. Community Benefits are required by all nonprofit hospitals as a condition for receiving tax-exemptions; the extent of where and how much they fund depends largely on the hospitals themselves. Although health inequity is closely linked to economic inequity, nonprofit hospitals have historically focused their Community Benefit funding on individual behavior change to improve health.

Objective and Approach
The objective of this report is to provide the Greenlining Institute with information on current nonprofit hospital spending in Alameda County and identify strategies to magnify the impact of their investments on low-income communities in the county. To understand the trends of Community Benefit investments in Alameda County, I analyzed both Kaiser Permanente and Sutter Health's Community Health Needs Assessment (CHNA). In my analysis, I focused specifically on the CHNA stakeholder involvement and the hospitals' priority funding areas. To develop the recommendations, I conducted a literature review of scholarly research on the impact of social determinants of health and measures for effective preventative health.

Recommendations
The recommendations specifically call for nonprofit hospitals to shift investments and maximize the impact of Community Benefit dollars by focusing on the social determinants of health. Specifically, I recommend the following:

1. Increase community stakeholder involvement in the CHNA process. Specific increase of community-based organizations that hold an intersectional lens to health will provide insight to social determinants outside of a medical or treatment perspective.

2. Develop criteria that requires nonprofit hospitals to invest their Community Benefit dollars specifically on interventions or programs that address social determinants.

3. Establish a minimum amount of Community Benefit funding to be allocated specifically to social determinants. Currently, no minimum requirement exists, resulting in varying degrees of financial investments.

The implementation of these recommendations relies on state and federal policies to hold nonprofit hospitals accountable.

BACKGROUND

The Greenlining Institute (GLI) is a policy, research and advocacy organization rooted in racial and economic justice. Greenlining is a response to redlining, a racially discriminatory practice that explicitly disinvested in communities of color.[i] GLI's nationwide work touches on several policy issues including but not limited to environmental, economic and health equity. Recognizing the interconnectedness of these issues, the GLI aims to impact the health and wellbeing of communities of color through nonprofit hospital dollars. Consequently, the GLI envisions nonprofit hospitals playing a greater role in reducing racial health disparities and improving community health through their Community Benefit dollars.

Context on Nonprofit Hospitals

Nonprofit hospitals receive tax exemptions in the form of millions of dollars each year. In exchange for these tax exemptions, they are required to provide Community Benefits (CB) that will improve the community's health. To determine where to allocate their funding or CBs, nonprofit hospitals conduct a Community Health Needs Assessment (CHNA). Those involved in the CHNA process largely determine where the CB dollars will be invested. There are no guidelines that specify exactly who should be involved in the CHNA process. Additionally, there is no minimum funding requirement for nonprofit hospital's CBs.

LITERATURE REVIEW

Health inequity is closely linked to social inequity. According to the Alameda County Public Health Department (2008) "health, disease and death are not randomly distributed…illness concentrates among low-income people and people of color residing in certain geographical spaces." [ii] Extensive literature has documented the relationship between health outcomes and social determinants of health (SDOH). Examples of SDOH are employment opportunities, quality of education, access to healthy and affordable foods, housing security and other factors that are associated with poverty. Poverty in and of itself is not experienced at random. In Alameda County and across the nation, there is a racial narrative that underlies present racial inequity. Redlining is a perfect example of a systemic policy that actively sought to deny people of color wealth building opportunities while advancing those of Whites.[iii] Recognizing the racial history of the country and current forms of systemic racism help nonprofit hospitals understand the importance of undoing the disadvantages that people of color in Alameda County have faced. The adverse impact of these disadvantages is thoroughly documented by the Alameda County Public Health Department's *Life and Death from Unnatural Causes: Health and Social Inequity in Alameda County* (2008). The report includes a map of Alameda County that shows a correlation between the regions with the highest unemployment rates, the highest poverty rates and mortality rates (Appendix A, B, C). The report also documents generations of poverty in the same regions.

Prioritizing Low-Income Communities of Color

Nonprofit hospitals in Alameda County should prioritize investments that build economic opportunities, offer housing security, improve educational opportunities and create a healthier living environment for communities of color. According to Beyers, M., et al (2008), "low-income people and people of color are more likely burdened by poor environments, which often include substandard housing, poor schools, and pollution." [iv] People living in poverty are particularly vulnerable to illness and tend to have greater comorbidity. The film documentary, *Unnatural Causes: Is Inequality Making Us Sick?*, shed light on the relationship between health and the distribution of resources. Those with the least resources are more likely to live shorter, unhealthier lives than their counterparts. In addition, the film demonstrated that individual behaviors are influenced by people's environment and their access to (or lack thereof) resources, adding to the importance of investing in environmental changes rather than narrowly focusing on changing individual behaviors.

Measuring the impact of investments

The impact of investments in SDOH are difficult to measure due to the following reasons, 1) sometimes positive health outcomes are the result of various favorable factors, making it difficult to accurately measure the influence of cumulative impact [v] 2) this is further compounded by the lack of patient information sharing across entities, a challenge to tracking and documentation, and 3) the benefits of some investments take place over a long period of time, requiring greater funding to measure.

Nonprofit hospitals can help mitigate these challenges by working in partnership with their county public health departments and community based organizations. These entities form part of a health system that supports the health and wellbeing of their community. By working in partnership together, nonprofit hospitals can use their medical data to understand some of the specific causes of comorbidity, readmission rates, mortality, etc. This information can be used in conjunction to public health department and CBO data to identify specific strategies to tackle health disparities. An example of this strategy involves identifying neighborhood "hot spots." [vi] Hot spots are areas with high hospital readmission rates and high rates of comorbidity. This information is used to identify the type of resources needed in a region. A cross departmental partnership and the close monitoring of a specific region facilitates evaluation of investments.

Limitations

First, it is difficult to demand a minimum percentage of dollars to be directed to social determinants of health when there is not a policy mechanism of enforcement. To help enforce implementation of a minimum spending requirement a special "penalty" tax could be applied to nonprofit hospitals that fail to invest a minimum percentage.

Second, it is difficult to measure the impact of investments made to the social determinants of health. Prevention efforts are more difficult to measure than treatment efforts largely because they generally take a longer time to actualize. For instance, economic security is a determinant of health, however it is difficult to capture the impact of employment opportunities on community health because the effects are not as

immediate. In addition, it is difficult to accurately determine whether a positive health outcome is due to a single factor, or the combination of multiple factors.

Furthermore, the lack of interdepartmental collaboration between hospitals, community based organizations and public health departments create a challenging environment for tracking and measuring an impact. Sharing of information across these entities is crucial to capturing the impact of the Community Benefit dollars. It is also important for program evaluation—a component that is necessary to secure greater sources of funding. Sharing of patient information (in a secure manner) across these entities would not only support the evaluation and funding of program effectiveness, but would also help garner greater funding to areas that are too frequently overlooked in healthcare.

ANALYSIS OF COMMUNITY HEALTH NEEDS ASSESSMENT

Sutter Health, CHNA

Sutter Health's 2013 CHNA process enlisted the help of hospital representatives and community members for key interviews and focus groups that formed their primary data[vii]. Their secondary data source was in the form of health outcomes based on geographic area. From this information, SH identified nine health needs in Alameda County. Of the nine community needs identified in Alameda County, SH planned to address only three[viii]:

1. Lack of access to mental health services/treatment
2. Limited access to quality primary health care services
3. Lack of access to basic needs: food, housing, jobs

Kaiser Permanente, CHNA

Kaiser Permanente's CHNA report on Alameda County involved a range of community stakeholders. KP primarily collaborated with various hospital partners and used public health data from county health departments (Alameda, Berkeley). Lastly, KP gathered input from a range of members in the community that included health department representatives, some nonprofit agencies and residents living in underserved areas[ix]. In the CHNA, KP provides a list of stakeholders involved in their process, including their meeting data, and the stakeholder's expertise. From this data, KP utilized a set of metrics that identified 10 health needs and listed them in order of priority. Healthy eating and active living was prioritized as the number one concern[x].

Variation in Assessment of Priority Needs

Difference between KP and SH is evident in their process, approach and in the allocation of CB investments. Although both nonprofit hospitals provide services to Alameda County, they identified dissimilar areas of community health needs. Subsequently, the areas of investments were not entirely aligned between the two hospitals even though they served the same geographic area (Appendix D, E). SH designated and ranked their top three community health needs as: 1) Lack of access to mental health services/treatment, 2) Safety as a health issue, and 3) Limited access to quality primary health care services. On the other hand, KP ranked their three major priority areas (Table 1) slightly differently between their primary services areas in Alameda County: Fremont, Oakland, and San Leandro.

Table 1: Kaiser Permanente Service Areas, Top three priority needs[xi]

Fremont	Oakland	San Leandro
1. Obesity, Diabetes, Healthy Eating/Active Living 2. Mental Health 3. Economic Security	1. Obesity, Diabetes, Healthy Eating/Active Living 2. Violence/Injury Prevention 3. Economic Security	1. Obesity, Diabetes, Healthy Eating/Active Living 2. Mental Health 3. Economic Security

Prioritized Investments

Investments between both hospital systems, KP and SH, were largely focused on downstream activities. Downstream investments do not address root cause issues; instead they focus on the reactionary. For instance, KP listed "Obesity, Diabetes, Healthy Eating/Active Living" as their number one priority throughout Alameda County. In this case, emphasis and investment was placed in increasing healthy eating and physical activity among children and adolescents in Alameda County[xii]. Similarly, SH focused its efforts on bolstering mental health services and treatment rather than attempting to address the root causes of mental health issues[xiii]. Investments in these areas will not address the fundamental causes of health issues.

NON-COMMUNITY BENEFIT UPSTREAM INVESTMENTS

As tax-exempt charitable organizations, it is important to ask whether hospitals are doing enough for the communities they serve. Beyond the CB component, nonprofit

hospitals can leverage their financial and employment capacity to better serve communities of color.

Supplier Diversity

Hospital systems are contributing to community in ways that are not necessarily captured through their CB data. A perfect example of these kind of investments is Kaiser's Supplier Diversity efforts. Supplier Diversity is a way of ensuring that diverse-owned businesses are supported[xiv]. As a large nonprofit organization, KP has a tremendous amount of purchasing power. They have the financial capacity to bring substantial changes to the business they purchase from. KP recognizes the magnitude of their impact and therefore institutionalized supplier diversity throughout their nationwide hospitals. In California, KP invested $745,374,379 in 2013 and $845,798,222 in 2014 through KP's Supplier Diversity[xv]. This kind of investment adds to the progress and growth of communities of color and represents a large financial investment in Alameda County.

Employment Opportunities in Health Care

Health care is a fast growing and expanding field with a large potential of employment opportunities. In fact, KP is one of the largest employers in the Bay Area. With such growth, an organization's commitment to Diversity and Inclusion should be at the forefront. This means that employment opportunities should be extended to people of color, especially in Alameda County. These institutions service large numbers of

people of color and should explore how to increase representation of people of color among their employees.

California is growing in terms of diversity and people of color are becoming the majority. This rising majority needs providers that represent their needs and values. Cultural competency cannot be taught and it is necessary that hospitals make investments to increase diversity among its employees to better serve their patients. In addition to employment opportunities, nonprofit hospitals should invest in education pipelines for youth of color that lead to careers in health. Investments in early childhood education programs, in internships that support educational and professional growth, and investments in scholarships or grants that specifically support people of color are all important. For instance, Kaiser's KP Launch program is an internship program designed specifically for underserved young people who are pursuing careers in health[xvi]. Although KP Launch is supplemented through CB, it is an example of the kind of work that should be recognized as a high priority for SH and other nonprofit hospitals alike. These kinds of investments support employment opportunities for people of color who are highly underrepresented in one of the fastest growing industries.

RECOMMENDATIONS

The ACA encouraged CB to be more equitably distributed to upstream health interventions by nonprofit hospitals. It introduced a requirement that forced hospitals to analyze the needs of the communities they serve, and identify areas to strategically allocate those funds. Despite the advancements made by this law, more mandates are necessary to redefine how CHNAs are conducted, which stakeholders participate, and

ultimately how the CBs are distributed. Low income communities of color are disproportionately impacted by a range of conditions and should be of utmost priority for nonprofit hospital' upstream investments. Policies should create the parameters by which investments are made, to create a container that benefits communities of color in Alameda County and beyond.

Stakeholder Involvement

As far as the CHNA, additional policy should address the matter of community representation throughout the CHNA process. It is concerning that there is an overrepresentation of hospital staff and representatives in the CHNA process. The overrepresentation may be indicative of the strong focus on downstream activities, such as chronic disease management. To best address health issues and change health outcomes, nonprofit hospitals should include a broad range of perspectives that mirror the communities in their service areas. Many of the organizations that currently participate in the CHNA are involved in the health sector in some way or another. However, it is necessary to include organizations from the environmental, energy, housing and the economic development sectors; all of which have a focus beyond direct medical and health care. In addition to providing a cross sectoral perspective on community health, stakeholders in these sectors hold information that will have a macro level impact on the everyday lives of community members. Therefore, the recommendation is that nonprofit hospitals consult community-based organizations carry throughout the CHNA process, particularly those that carry an intersectional lens to health.

Criteria for Funding Allocation, Upstream Investments

Nonprofit hospitals should allocate their investments directly into the upstream to address root cause issues. To ensure accountability of investments in this area, a policy must provide guidelines by which nonprofit hospitals make their investments. This policy serves as a mechanism for enforcement and will drive nonprofit hospital monies towards areas that will generate maximum impact. Therefore, the recommendation is to implement a policy that requires CB to be allocated directly towards upstream investments.

Minimum Funding Requirements

Lastly, it is important to note that nonprofit hospitals do not have a minimum dollar amount or percent of total operating expenses requirement for how much they spend towards CB. The lack of a requirement gives nonprofit hospitals free range to allocate as much or as little as they want even though the reason they hold a tax-exempt status is due to their charitable mission. Is it reasonable to receive billions of dollars in tax breaks and only allocate 2 percent of funds towards CB investments?[xvii] There must be a value placed on how a hospital is deemed a charitable organization that qualifies them for tax exemptions or nonprofit status. To eliminate variation in spending, nonprofit hospitals should be required to allocate a minimum percentage directly on activities that address root cause issues. The recommendation is that all nonprofit hospitals be required to be transparent about their total operating expenses

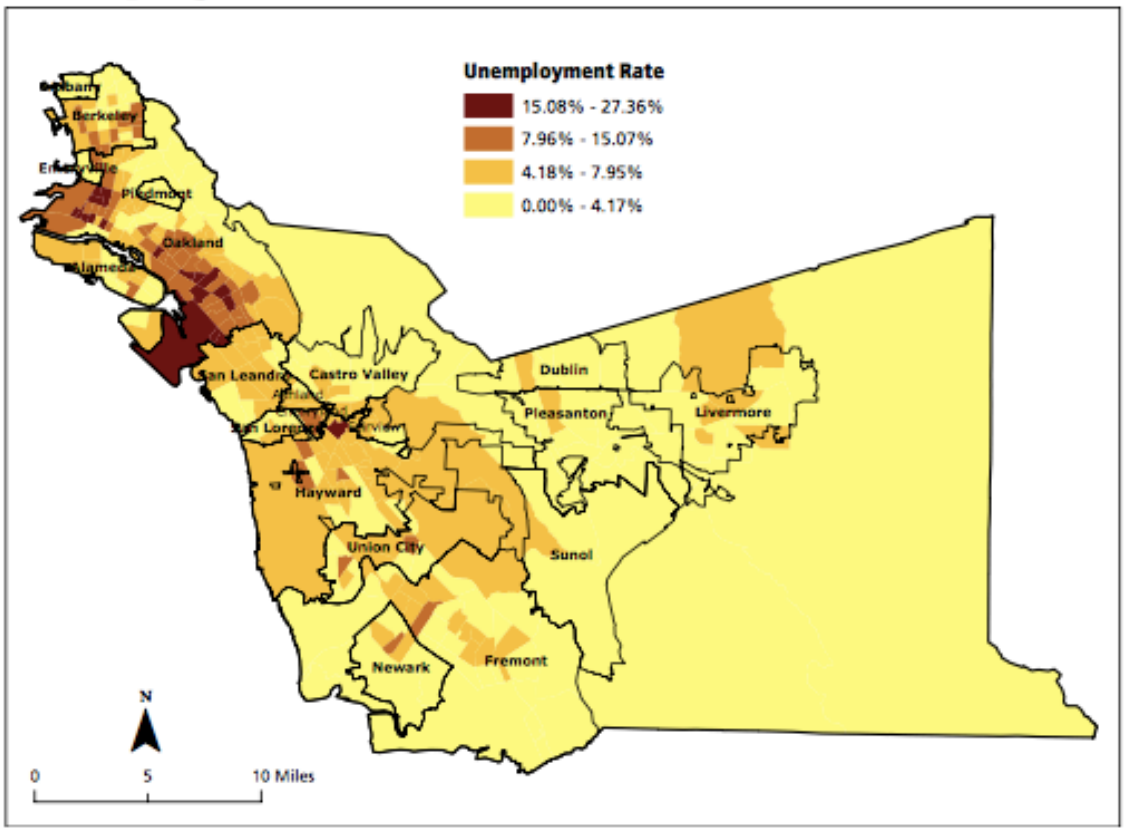
(Appendix F) and allocate 10% of their total operating expenses towards community building and upstream activities[xviii].

CONCLUSION

As an organization that carries an intersectional lens on health, The Greenlining Institute must lead the effort to actualize policies that will redirect nonprofit hospital funding away from the reactive and towards prevention. The impact of CB dollars will be maximized once nonprofit hospitals expand the scope of their financial investments to address the social determinants of health.

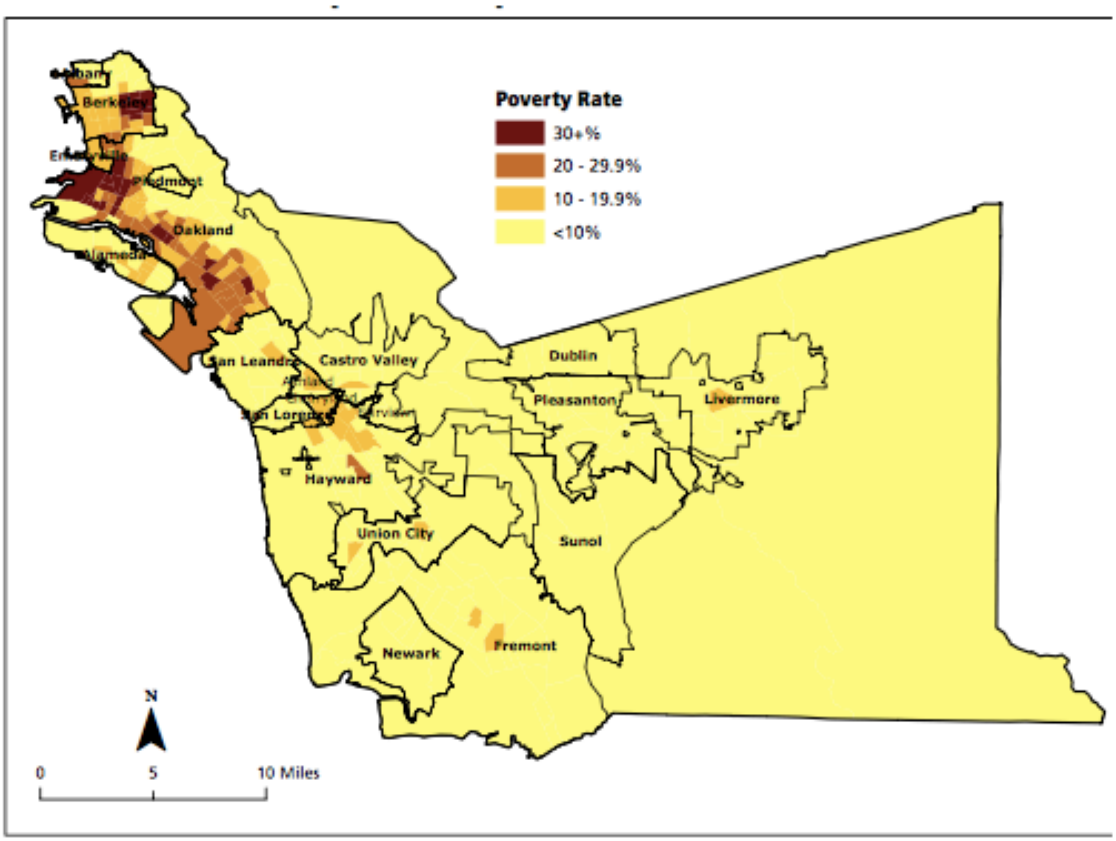
APPENDICES

Appendix A: Unemployment Rate, Alameda County (2000)



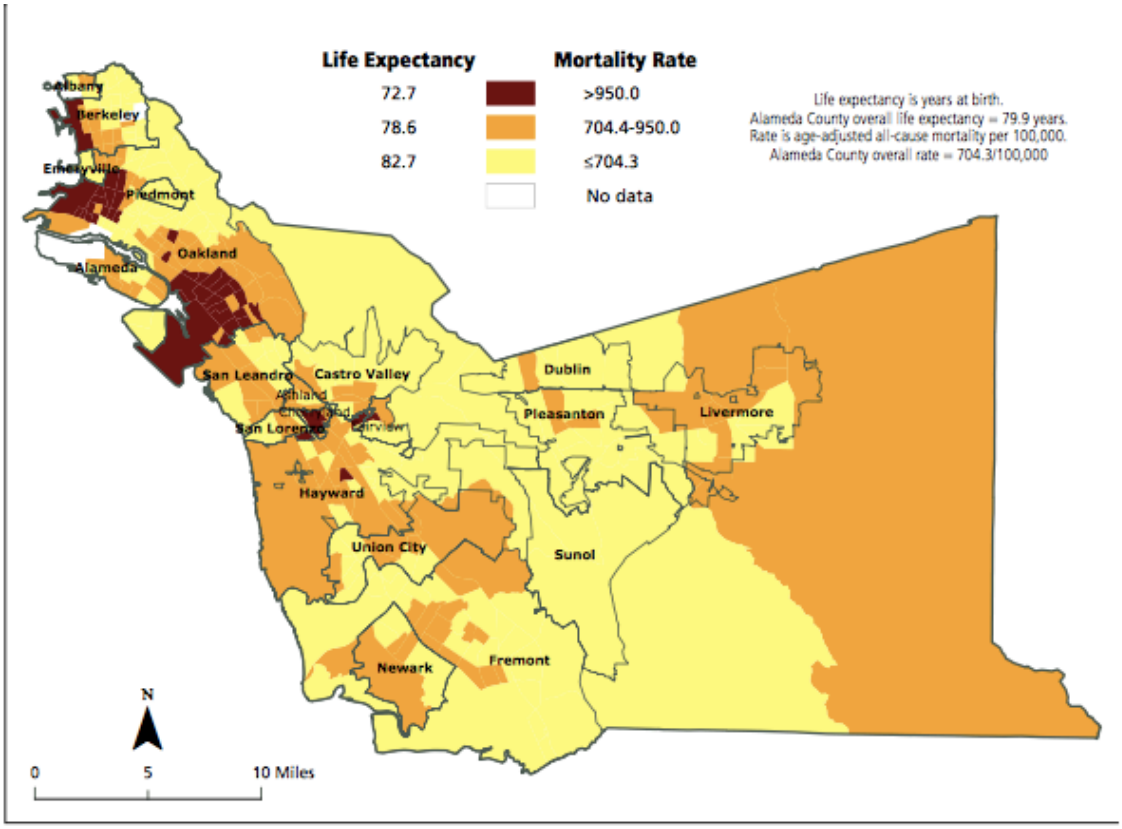
Source: Census 2000.

Appendix B: Neighborhood Poverty Rate, Alameda County (2000)



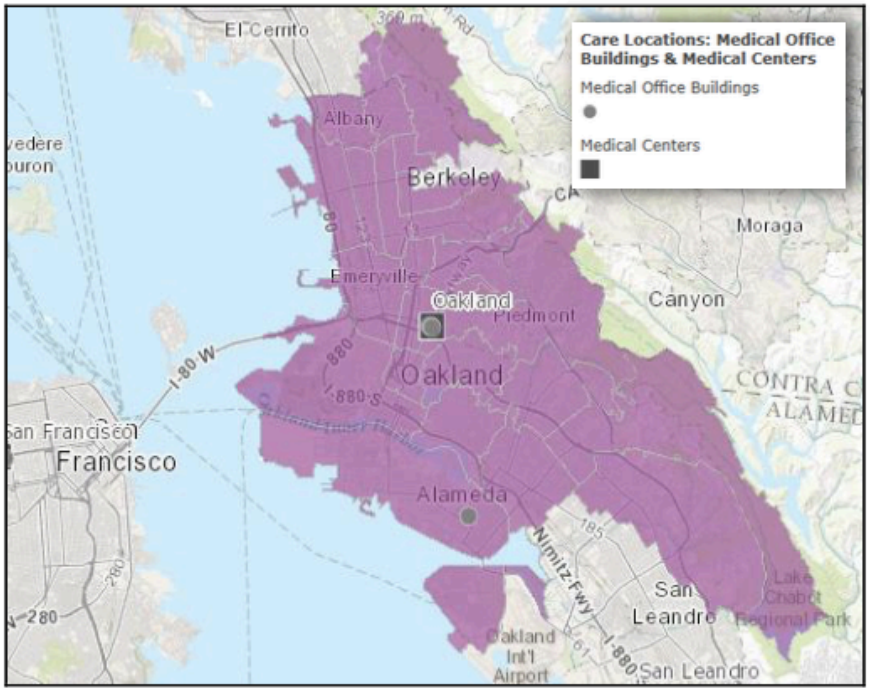
Source: Census 2000.

Appendix C: Mortality Rate, Alameda County (2001-2005)

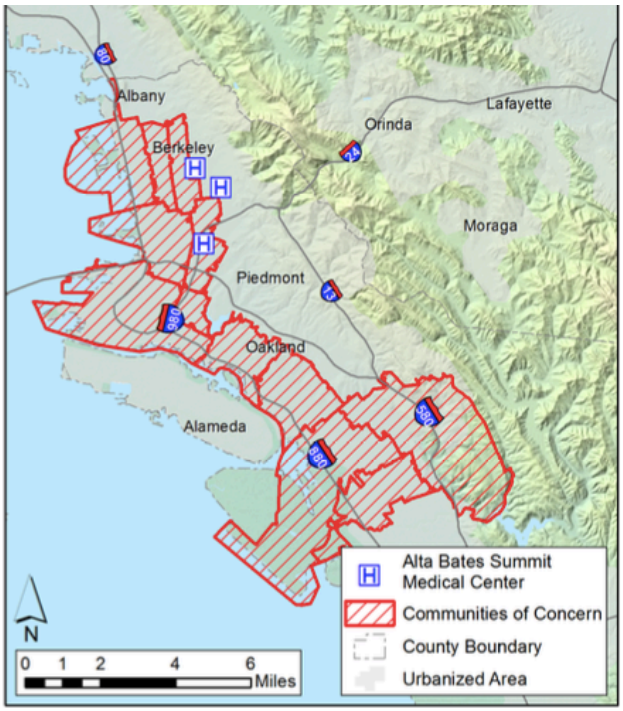


Source: CAPE, with data from vital statistics 2001-2005.

Appendix D: Kaiser Permanente Service Area



Appendix E: Sutter Health Alta Bates Service Area



Appendix F: Kaiser Permanente Bay Area Community Benefits (Total Operating Expenses not publicly displayed)

Kaiser Hospital	Total Operating Expenses	Total Community Benefit	Shortfall	Charity Care	Upstream for Vulnerable Populations	Broader Community
Fremont	NA	$7,778,140	$2,897,333	$2,808,658	$1,266,616	$194,351
Hayward	NA	NA	NA	NA	NA	NA
Oakland	NA	$35,856,473	$10,433,801	$4,425,631	$7,533,457	$477,461
Total	NA	$43,634,613	$13,331,134	$7,234,289	$8,800,073	$671,812

REFERENCES

[i] The Greenlining Institute (2017). *Issues and Impact*. Retrieved from: http://greenlining.org

[ii] Beyers, M., et al. (2008). *Life and Death from Unnatural Causes: Health and Social Inequity in Alameda County*. Alameda County Public Health Department: Community Assessment, Planning, Education and Evaluation (CAPE) Unit. Retrieved from: http://www.acphd.org/media/53628/unnatcs2008.pdf

[iii] Beyers, M., et al. (2008). *Life and Death from Unnatural Causes: Health and Social Inequity in Alameda County*. Alameda County Public Health Department: Community Assessment, Planning, Education and Evaluation (CAPE) Unit. Retrieved from: http://www.acphd.org/media/53628/unnatcs2008.pdf

[iv] Beyers, M., et al. (2008). *Life and Death from Unnatural Causes: Health and Social Inequity in Alameda County*. Alameda County Public Health Department: Community Assessment, Planning, Education and Evaluation (CAPE) Unit. Retrieved from: http://www.acphd.org/media/53628/unnatcs2008.pdf

[v] Anderson, L. M., et al. (2005). *Evidence-based public health policy and practice: Promises and limits*. American Journal of Preventive Medicine*, 28*(5), 226-230.

[vi] Butler, S.M., Grabinsky, J., and Masi, D. (2015). *Hospitals as Hubs to Create Healthy Communities: Lessons from Washington Adventist Hospital*. The Brookings Institute. Retrieved from: https://www.brookings.edu/research/hospitals-as-hubs-to-create-healthy-communities-lessons-from-washington-adventist-hospital/

[vii] Sutter Health. (2015). *Sutter Health Alta Bates Summit Medical Center: 2015 Community Benefit Plan Update.* Retrieved from: https://www.oshpd.ca.gov/HID/CommunityBenefit/Letters_2015/Alta_Bates_Summit_Medical_Center_Summit_Campus_Community_Benefits_Report_2015.pdf

[viii] Derias-Tyehimba, Liz (2017). *Alta Bates Summit Medical Center Community Benefit Analysis Memorandum*. The Greenlining Institute.

[ix] Kaiser Permanente. (2016). *Kaiser Permanente: 2016 Community Health Needs Assessment*. Retrieved from: https://share.kaiserpermanente.org/wp-content/uploads/2016/12/2016-KFH-Oakl-Rich-CHNA_Final_Remediated.pdf

[x] Derias-Tyehimba, Liz. (2017). *2016 Kaiser Permanente Community Health Needs Assessment Memo*. The Greenlining Institute.

[xi] Kaiser Permanente. (2016). *Kaiser Permanente: 2016 Community Health Needs Assessment*. Retrieved from: https://share.kaiserpermanente.org/wp-content/uploads/2016/12/2016-KFH-Oakl-Rich-CHNA_Final_Remediated.pdf

[xii] Kaiser Permanente. (2016). *Kaiser Permanente: 2016 Community Health Needs Assessment*. Retrieved from: https://share.kaiserpermanente.org/wp-content/uploads/2016/12/2016-KFH-Oakl-Rich-CHNA_Final_Remediated.pdf

[xiii] Community Health Insights. (2016). *Alta Bates Summit Medical Center Service Area*. Retrieved from: http://www.altabatessummit.org/CHNA/absmc-2016-chna.pdf

[xiv] Kaiser Permanente. (2016). *Kaiser Permanente Supplier Diversity*. Retrieved from: http://supplierdiversity.kp.org

[xv] Kaiser Permanente. (2014). *Kaiser Permanente Insurance Company: California Supplier Diversity Summary Report.*

[xvi] Kaiser Permanente. (2017). *KP Launch: Diversifying the Future of Health Care*. Retrieved from: https://share.kaiserpermanente.org/article/ncal-launch/

[xvii] Rosenbaum, S., Rieke, A., Byrnes, M. (2013). *Hospital Community Benefit Expenditures: Looking Behind The Numbers*. Health Affairs Blog. Retrieved from: http://healthaffairs.org/blog/2013/06/11/hospital-community-benefit-expenditures-looking-behind-the-numbers/

[xviii] Young, G. J., et al. (2013). *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*. The New England Journal of Medicine. Retrieved from: http://www.nejm.org/doi/full/10.1056/NEJMsa1210239#t=article