Community Benefit - Hindering or Improving Community Health:
Analysis of a Nonprofit Hospital System and the Communities Served
by
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A Dissertation Presented in Partial Fulfillment
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ABSTRACT

In the United States, under the provisions set forth by a policy known as community benefit, nonprofit hospitals receive special tax exemptions from government in exchange for providing a wide range of health care services to the communities in which they are located. In recent years, nonprofit hospitals have claimed billions of dollars as community benefit justifying their tax-exempt status. However, growing criticism by numerous stakeholders has questioned the extent to which the level of community benefit claimed by nonprofit hospitals reflects the exemptions they receive. In addition, a dearth of research exists to understand the relationship between community benefit claims and the impact they have on improving the health of communities.

In an effort to better understand the relationship between community benefit claims, tax status, and community health outcomes this study examines the community benefit policies of a nonprofit healthcare system representing hospitals in California, Nevada, and Arizona. It does so by reviewing materials produced by the system, her hospitals, vested stakeholders, and government that have shaped the development, implementation, and assessment of community benefit policy processes.

Findings of the study suggest that the majority of nonprofit hospital community benefit claims are consumed by shortfalls reported between costs associated with providing care to Medicare and Medicaid patients and the compensation nonprofit hospitals receive from government. Results of the study also demonstrate that community benefit policies do positively impact the health of communities. However, future community benefit policies need to be refined to include measures that capture the magnitude of community health improvement if the relationship between policy and health outcomes is to be fully realized.
DEDICATION

To all those guided by compassion to relieve suffering and the causes that contribute to its presence.
ACKNOWLEDGMENTS

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Chapter 1

INTRODUCTION AND OVERVIEW

Introduction

This study examines the community benefit policy process of a nonprofit healthcare system representing hospitals in California, Nevada, and Arizona. It does so by examining materials produced by hospitals within the system that document the processes hospitals use to develop, implement, and evaluate system and hospital community benefit policy. The materials used for the analysis include system and individual hospital community benefit strategic plans and reports and Internal Revenue Service Form 990 and Schedule H filings. Federal guidelines, state legislation, and healthcare industry reports will also be included to establish the role government and key stakeholders play in shaping nonprofit hospital community benefit policy.

Previous analysis of community benefit policy in the United States has been focused largely on the extent to which the provision of benefits to communities by nonprofit hospitals was reflective of the tax benefits nonprofits receive from local, state, and federal governments (GAO, 2008; IRS, 2012). Included in this work have been a number of discussions regarding how community benefit has been defined, measured, and reported. Research has also compared the amount of uncompensated care, Medicaid services, and various unprofitable services for-profit and nonprofit hospitals provide in order to determine if significant differences exist between nonprofit and for-profit provider types and the benefit they provide to community (CBO, 2006a).

1 Non-profit hospitals traditionally do not pay local sales and property taxes or state and federal corporate income taxes. Non-profit hospitals also enjoy tax-exempt bond financing and may receive charitable contributions that are tax-deductible to the donor (CBO, 2006).
This study seeks to determine the relationship between processes employed to develop community benefit policy and the impact implemented community benefit policies have on community health. To date, there does not exist a study that examines this relationship. This study draws from the policy design literature, the public health literature, the policy analysis literature, and literature that represents the ways in which health has been defined. This work contributes to the public administration, community benefit, and health policy design literature and practice.

Research Questions

Four main questions form the central motivation to conduct this research. They are:

1. To what extent do community benefit policies impact the health of communities?
2. How may social and scientific definitions of health contribute to the process of creating community benefit policies?
3. How does the framing of the populations targeted to receive community benefit policies contribute to improving or hindering community health?
4. How does the tension between remaining fiscally viable and following the mission of nonprofit hospitals influence the implementation of community benefit policy and the subsequent benefits to community they may produce?

Overview of the Dissertation

In order to address the questions raised above, the dissertation will be organized in the following fashion. First, a review of the literature regarding the development of community benefit will begin to inform the audience of concepts central to understanding how community benefit policy came to be, what community benefit has become, and how it
has been studied. Second, a discussion of the literature that has shaped our understanding of health will be joined with literature that has informed the design of public policies.

Next, an examination of the community benefit policies of Dignity Health, a nonprofit health system will be conducted. This step consists of an analysis of (1) the community benefit reports and IRS tax filings of 35 Dignity Health hospitals for fiscal year’s 2010 and 2011, (2) the 2008 through 2012 community benefit reports and strategic plans for hospitals located within states served by Dignity Health hospitals, (3) Community Needs & Assets assessments of representative Dignity Health hospitals and the communities they serve, and (4) other relevant documents that have informed the development of community benefit policy over time.

Results of the analysis will demonstrate the following. First, similarities and differences that may exist among individual hospital’s community benefit plans and the community benefits they claim. Second, the extent to which community benefits are distributed across hospital and community-based initiatives. Third, the effect distributions of community benefit resources have in improving community health based on community need. And fourth, similarities and differences that may exist regarding the amount of resources Dignity Health hospitals commit to improving community health

Taken together, the separate analyses will reflect how Dignity Health hospitals structure their community benefit policies, how community benefit policies are implemented, and how implemented policies impact community health. A discussion of the results of the analysis will tie together the relationship(s) Dignity Health hospitals have on improving or hindering community health in general while addressing the four research questions above specifically.
Significance of the Study

Cost, Quality, and Community

Costs associated with the delivery of health care services in the United States have risen exponentially over the past twenty years (Shi & Singh, 2008). Simultaneously, having consistent access to health services has become a challenge for Americans with millions being uninsured, underinsured, or dependent upon a government-sponsored system that is struggling to meet the needs of those that seek care (Shi & Singh, 2010). The quality of the services that are delivered has also been questioned (Hadley & Cunningham, 2004) and the outcomes that have been measured appear to imply that a substantial gap exists between the resources that are committed to care and the results they produce (Hendryx, Ahern, Lovrich, & McCurdy, 2002).

This paradox between resource allocation and health outcomes has especially affected marginalized communities that live in urban areas (Hargraves & Hadley, 2003; Hurley, Felland, & Lauer, 2007; Lefkowitz, 2007; Manjarrez, Popkin, & Guernsey, 2007). Members of these communities traditionally have been comprised of ethnic and culturally diverse minority populations that struggle to overcome barriers impeding health that include high rates of crime, low levels of educational achievement, and intergenerational poverty (Cattell, 2001; Ibrahim, Thomas, & Fine, 2003; Harris & Kaye, 2004; Glaser, Martz, Harris, & Jacobsen, 2007). Historically, faith-based, nonprofit hospitals have been the primary access points of care for these populations (Raffel & Raffel, 1994). Over time, nonprofit hospitals have done a great deal to respond to the needs of marginalized populations committing billions of dollars to community health improvement (CHW, 2011). However, the resources required to care for the multi-dimensional health and wellness needs of this
demographic are immense and may become even more difficult to sustain or expand in the future (Devers, Brewster, & Casalino, 2004; Barsi, 2008).

**Community Benefit Revenue Rulings and Policy Interpretation**

Since the Internal Revenue Service published its first Revenue Ruling in 1956 and subsequent Rulings in 1969 and 1983 regarding nonprofit status and community benefit, questions have been raised regarding the content of the Rulings and how nonprofit hospitals translate the Rulings into practice. Specific concerns have been voiced with respect to how government (CBO, 2006a; CBO, 2006b; GAO, 2008), health industry stakeholders (AHA, 2006; CHA, 2004), and nonprofit hospitals define community benefit, what methods are most appropriate to account for community benefit expenditures (Pelfrey & Theisen, 1996; Montoya, 1998; Kane & Wubbenhorst, 2000; Clarke, 2008; Trocchio & Hearle, 2007; Salinsky, 2007; Strum Jr., 2007; Levenson, 2008; Shi & Singh, 2008) and the extent to which nonprofits should be allowed to operate in a competitive healthcare environment under the exemptions allowed by their favorable tax status (CBO, 2006b; IRS, 2007; Hearle & Barnett, 2011).

Finding normative community benefit standards among government, industry, and hospitals has been a challenge and efforts continue among stakeholders to reach consensus regarding how community benefit policies should be developed, implemented, and measured (GAO, 2008; Catholic Healthcare West, 2010; St. Joseph’s Hospital, 2010; Folkemer et al., 2011). However, given the breadth and depth of focus that has been placed upon these important areas very little attention has been afforded to understanding how community benefit policies translate into practices that improve the health and well being of communities (Missouri Foundation, 2009).
Assessing Community Need & Producing Outcomes

In developing the programs that deliver health benefits to community, e.g., cancer screening, prenatal health classes, diabetes management seminars, hospitals may conduct community need assessments to determine if the programs they believe may be needed within the communities they serve are indeed those that best meet the needs of individuals and families residing within a hospital’s service area. Hospitals approach the need assessment process in several ways and with varying levels of resources (Barnett, 2009). For example, members of hospital community benefit committees may identify community needs based on information collected from hospital admissions data. Phone and paper surveys distributed throughout a hospital’s service area may also be used to determine need. In some cases, third-party professional or university-based services may be utilized to analyze data and report what they objectively believe community needs are (CHW, 2011). Analysis of state and local health data has also been incorporated into need assessment strategies to understand what preventable and chronic conditions are present within a defined community. These studies may then be paired with hospital programs to adequately address and provide solutions for individual and family needs (Rimsza, Bailey, Russell, & White, 2006).

As well intentioned as these approaches to identifying community need are, it may be argued that the needs of community are assessed and addressed from the hospital’s perspective based on a quantifiable view of health and not one that applies a social-determinant view of health. For example, a perspective that employs a quantifiable view of health may base community benefit policy design decisions on factors that stem from a

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2 The size of a hospital’s service area varies. In many cases, the county in which a hospital is located corresponds to a hospital’s service area. However, in some cases, particularly with hospitals located in high-density urban or low-density rural areas, the size of a hospital’s service area may contract or expand according to patient population and, or service needs.
scientific understanding of what health entails, e.g., economic indicators that can be measured in dollar amounts. Conversely, a social-determinant perspective may inform policy decisions based on factors that measure quality of life, e.g., happiness, resilience to environmental barriers that inhibit health and well being. As such, programs that are delivered into the community based on a scientific, quantifiable perspective may produce positive health returns but may not be achieving the greatest amount of good that they may have had the policy process been informed in concert with a social perspective.

The Framing of Community & Target Populations

In-depth discussion regarding the relationship between community benefit policy development and health outcomes has yet to surface in publications produced by government, hospitals, industry groups, academics, and other vested stakeholders. This observation represents a most perplexing phenomenon for several reasons. First, a great deal of literature has been produced that covers how community benefit should be defined, measured, and reported. However, a dearth of literature has been produced that details how definitions, measurement, and reporting of community benefit policies impact health.

Second, as the name of the policy implies, community benefit serves to benefit the interests of community. Therefore, one could reasonably posit that a fair share of literature has been committed to understanding how community benefit policy impacts the community. However, this is currently not the case. The greatest extent of literature in existence reflects the relationship between community benefit policy and the institutions that develop and implement it. This is not to suggest that this relationship is not important or that contributions made to improve our understanding of this dynamic are not worthy of attention. Rather, this observation serves as a call to stakeholders to create new work that captures the impact community benefit policy has at the community level.
In writing, *Policy Design for Democracy*, Ann Schneider and Helen Ingram (1997) discuss ways in which the defining of target populations informs public policy development processes. Among the pages committed to exploring this subject, Schneider and Ingram investigate the dynamic that forms between those that construct public policy and those who are recipients of policy implementation. Among the authors’ observations, they found that there is a connection between the framing of target populations and policy development processes and that the impact a policy has on policy targets is shaped primarily by the interests of the policy makers and not by the needs of those a policy is designed to benefit.

Placing Schneider and Ingram’s degenerative policy design theory within the context of an analysis of community benefit policy provides an opportunity to test Schneider and Ingram’s theory and the extent to which policy design is motivated by the interests of policymakers and not by the interests of community.

*What is Community?*

Communities have been in existence for a very long time and have been studied empirically for thousands of years. The health of ancient and modern communities has been studied in detail (Rosen, 1958; Manjarrez, Popkin, & Guernsey, 2007) and research has also been conducted to develop policies that can meet the health needs of community in the future (Welton, Kantner, & Katz, 1997).

But, what *is* community? How are they defined and to what extent do policies interact with communities? *The Oxford Dictionary and Thesaurus, Second American Edition* (2002) offers the following:

*Community: n. (pl. –ties) 1a. body of people living in one locale. 1b. locality, including its inhabitants. 2. body of people having religion, profession, etc., in common. 3. [prec. by the] the public.*
The words above provide a distilled explanation of what a community is, what and who makes up community, and that there is a public, or civil component to communities. However, the constitution of communities is difficult to generically simplify and standard definitions can be challenging to apply in a uniform fashion across all communities. Additionally, according to Schneider & Ingram (1997), public policies are context driven and “What may be an excellent design in one context, may well serve poorly in another”. As such, a policy that is instituted in one community may not fit well with a community located in another area. Therefore, one may conclude that communities are unique and the policies that are created within them fare well if they reflect the locality and needs of community and fare poorly if they do not.

This observation provides additional motivation to study community benefit policy and its impact on community health. For example, community benefit guidelines and laws are passed down from higher levels of government and institutional hospital system structures to the local community and individual hospital level. The transformation that occurs from the original intent of the policy into a developed and implemented policy to the outcomes it produces seemingly has to be affected by the ways in which communities and the measures used to capture outcomes are defined. Therefore, the emphasis this dissertation has placed on investigating the relationship between community benefit policy and the health outcomes it produces broadens what steps of the community benefit policy process have been studied previously and contributes new knowledge concerning the interaction between policy, policymakers, and community health.

*Academic Contributions*

A review of the academic literature finds that academicians have generated very few publications directed at unfolding and understanding community benefit policy. One notable
example was the work of John C. David (2009) and the publication of his dissertation, *Not-For-Profit Hospitals in Metro Atlanta: Comparative Analysis of Tax Status and Community Benefit*. Within his analysis, David questioned the preferential tax status of nonprofit hospitals and the extent to which nonprofit hospitals claimed community benefit equaled or exceeded the community benefits provided by for-profit hospitals.

Among his findings, David made three distinct revelations. First, excluding tax rate calculation “components” used to compare and measure differences between nonprofit and for-profit hospitals located in the metropolitan Atlanta service area, nonprofits “provid[ed] a higher percent of net revenue as Community Benefit over the for-profits.” Second, “With federal, state, and local taxes included, the for-profits did much better in Community Benefit provision.” And finally, “A significant amount of federal, state, and property taxes are lost from not-for-profit hospitals, which can be used to provide more Community Benefits.” (p. 3). David’s work was the most recent, and it is believed to be the only objective, comparative analysis of non- and for-profit hospital community benefit policy in the United States to be published within the academic community. David’s research also highlights the opportunity to extend his work beyond a framework that compares non- and for-profit hospitals to include analysis of health outcomes produced via the community benefit policy process.

*Summary*

The significance of conducting research that investigates the relationship between community benefit policy process and the community health outcomes that it may produce were supported in this section by a discussion of five subject areas. First, issues related to cost, access, and quality of care outline the need for research to be conducted whose aim is to provide balanced information that can positively inform health care policy decisions. Second, the evolution and interpretation of community benefit policy suggests that a great
deal of variability exists among stakeholders regarding the extent to which existing
guidelines, reports, and laws shape community benefit policy design. Third, measurement
and assessment techniques employed by nonprofit hospitals to assess and meet community
need appear to be inconsistent among providers and the communities they serve. Fourth, a
degenerative policy theory suggests that the framing of the populations targeted for receipt
of community benefits has been based largely on the impact a policy may have on the
institutions that develop policy instead of being centered on improving the wellness of
communities served by said institutions. And fifth, to date, literature that has been dedicated
to understanding the community benefit policy process has focused on “front end”
segments of the policy process and not on “back end” or outcome/policy effects segments.

Consolidating these five distinct but interrelated subject areas into one distilled idea –
that a great deal of work has been done but opportunities remain, justifies and substantiates
the need for outcomes-focused research to be conducted within the realm of community
benefit. Furthermore, addressing questions relating to the design of community benefit
policy and its effect on health outcomes may inform public administration and related fields
of literature on how to develop best practices that serve the interests of stakeholders as
follows:

*Federal, State, and Local Government:* ensuring the delivery of needed health care services to
communities through a non-governmental institution in lieu of receiving taxes.

*Hospitals:* meeting reporting requirements to maintain tax-exempt status, fulfilling federal and
state community benefit regulations, balancing the needs of the institution with those of
community; i.e., mission to serve marginalized populations.

*Citizens:* improving community health and citizen engagement.
Chapter 2 reviews literature that has informed the development of community benefit policy over the past fifty years. Consideration of literature that has contributed to our understanding of how health has been defined will also be presented within Chapter 2. And, lastly, a discussion of literature that reviews important contributions made by policy theorists will be offered. Familiar theories will be presented first and then followed by discussion of a novel theory that may explain the relationship between the development of community benefit policy and the effect community benefit policies have on improving or hindering community health.

The remaining chapters of the dissertation will be organized in the following fashion. Chapter 3 presents the methodology employed to address the primary, secondary, tertiary, and quaternary questions asked above. A combination of descriptive, quantitative, and qualitative methods will be used to uncover relationships that may exist between the questioned posed, the data that is analyzed, and the impact community benefit policies may have on community health. Chapter 4 reports the findings of the data analysis. Chapter 5 provides an opportunity to reflect upon what knowledge was gained herein and to discuss any conclusions that result from the findings discussed in Chapter 4. Implications for future research will also be voiced within Chapter 5.
Chapter 2

LITERATURE REVIEW: COMMUNITY BENEFIT AND COMMUNITY HEALTH

Introduction

Separate but interwoven interests have produced the body of literature that represents community benefit policy. Government and government-related agencies have been responsible for publishing federal community benefit guidelines, state and local community benefit laws, and reports that address and assess the extent to which community benefit policies have reflected the original intent of its seminal and subsequent guidelines.

Stakeholders representing the health care industry have generated publications that assist nonprofit providers in defining, measuring, and reporting community benefit. Similarly, nonprofit health systems and the hospitals they oversee have also published guidelines, reports, and articles that discuss community benefit, how guidelines may be translated into policy, and ways in which the implementation of community benefit policy can be standardized across the spectrum of nonprofit hospital providers.

Collectively, this group of interests has created a body of work that offers a glimpse into the policy worlds that encompass community benefit and the discussions that are taking place there. As such, the first section of the literature review will present key publications that represent the role each stakeholder has had on shaping the evolution of the community benefit policy development process.

The second half of the review presents literature that describes two streams of thought regarding the ways in which health has been defined over time. These streams, or perspectives – one that was founded under a scientific perspective and one that has developed from a social science view of health, have contributed to our understanding of how conceptions of health have changed over time and how they may continue to evolve in
the future. By comparing and contrasting these two perspectives, one may be able to see contributions each has made to the development of health care policy in general and community benefit policy specifically.

The third and final section of the literature review begins with works that discuss general theories of policy design. Following this, components of Schneider and Ingram’s degenerative policy theory are discussed. Then, aspects of general and the degenerative policy are compared in an effort to demonstrate how said theories may explain the ways in which community benefit policy has developed over time.

**Part 1: Formative Community Benefit Publications**

*Government Regulations & Laws*

A series of changes in the American healthcare environment during the first half of the 20th Century prompted a number of policy responses from government (Raffel & Raffel, 1994; Shortell et. al, 2000; Funigiello, 2005). Among them was the creation of an Internal Revenue Service Revenue Ruling that, for the first time, allowed hospitals the opportunity to qualify as nonprofit tax-exempt institutions. Revenue Ruling 56-185, 1956-1 C.B. 202 (IRS, 1956) sets forth the motivation for its existence with the following statement:

Criteria or tests to be met in determining whether a hospital qualifies for exemption from Federal income tax under section 501 (a) of the Internal Revenue Code of 1954 as an organization described in section 501 (c)(3) thereof.

And:

The only ground upon which a hospital may be held to be exempt under section 501(c)(3) of the Code is that it is organized and operated primarily for the educational, scientific or public charitable purposes.
Revenue Ruling 56-185 also sets forth four “general requirements” that must be followed in addition to “other things” in order for a hospital to receive tax exemption. In their essence, the four criteria are (1) a hospital must be organized as a charitable institution; motivated to serve the needs of community, (2) a hospital must be “operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay”, (3) hospitals must keep an open staff, extending privileges to all qualified physicians located within the community in which the hospital is located, and (4) net earnings “must not inure directly or indirectly to the benefit of any private shareholder or individual”.

Revenue Ruling 69-545, 1969-2 C.B. 117 (IRS, 1969a) was the next guideline delivered by the IRS and established what would become known as the community benefit standard. By modifying Revenue Ruling 56-185 using hypothetical situations regarding the operation of two hospitals, the Ruling outlined for the first time key provisions central to a hospital qualifying as a nonprofit. First, a hospital must operate a full time emergency room and no one is denied treatment regardless of his or her ability to pay. Second, excess revenues minus costs of care delivery are to be distributed back into the operation of the hospital. Forms of redistribution include: facility improvement, medical training, education, and research, and, or improvement in the delivery of care but not directed to individual salaries, bonuses, or shareholder interests. In addition, hospitals are to be overseen by an executive board comprised of members representing the community. And, to continue the guidelines set forth by 56-185, nonprofit hospitals must operate under the auspices of a charitable purpose, i.e., the promotion of health, and hospitals must maintain open access to community physicians to practice medicine.
A third Revenue Ruling published by the Internal Revenue Service in 1969 clarified the relationship between a private medical staff and a nonprofit hospital. Described within the Ruling, 69-631, 1969-2 C.B. 119 (IRS, 1969b), a private medical staff was eligible to receive payments from the federal government for services rendered as provided by the recent institution of Medicare and Medicaid. At question was whether or not government payments to a private medical practice operating within a nonprofit hospital was a violation of standing community benefit regulations. After review, IRS found that this was not a violation based on the fact that funds received for services rendered were allocated directly into hospital operations and not diverted into the private practice.

A fourth guideline, Revenue Ruling 83-157, 1983-2 C.B. 94 (IRS, 1983) provided guidance as it relates to the existence of two or more nonprofit hospitals operating emergency rooms within the same service area. The Ruling states:

A nonprofit hospital that is not required to operate an emergency room where a state or local health planning agency has found that this would unnecessarily duplicate emergency services and facilities that are adequately provided by another medical institution in the community is exempt under section 501(c)(3) of the Code.

Since 1983, the Internal Revenue Service has not published any subsequent Revenue Rulings as they relate to nonprofit hospital tax exemption status, community benefit requirements, or any other guidelines that have modified or added to existing Rulings³.

State Government Law

Currently, across the United States community benefit legislation developed at the state level has been initiated by only 14 states. Variability exists among the legislation that has

³ Revenue Ruling 98-15, 1998-12 I.R.B. did pertain to whether or not nonprofit hospitals could qualify as tax exempt under § 501(c)(3) if they formed limited liability companies with for-profit hospitals. However, for the purposes of this dissertation, the weight of Revenue Ruling 98-15 does not bear heavily on the scope of literature reviewed.
been signed into law with some states’ legislation largely mirroring IRS guidelines while other states have modified federal guidance a great deal to suit the needs of their respective nonprofit healthcare environments. In order to illustrate similarities and differences that exist in the nature and complexity of state level community benefit legislation, statutes from California, Nevada, and Arizona will serve as a representative sample of the 14 states that have community benefit laws. Selecting these three states as examples also coincides with the analysis and discussion of nonprofit hospitals’ community benefit policies since the hospitals under examination are located within these three states.

**California**

Signed into law by Governor Pete Wilson in 1994, Senate Bill 697, Chapter 812, Health and Safety Code Sections 127340-127365 (1994) outlines the requirements private nonprofit hospitals must meet in order to qualify for tax exemption status. Among the six Sections included in SB 697, descriptions of the types of benefits nonprofit hospitals are to provide to community and the reporting requirements hospitals must adhere to in order to fulfill their community benefit obligations are provided. SB 697 gives explicit examples of what counts as community benefit and includes the following: (a) care that is delivered but portions of which are unreimbursed, e.g., charity care, Medi-Cal, Medicare, California Children’s Services Program (b) unreported benefits such as community-based wellness and health promotion classes, (c) medical research and medical education, and (d) outreach clinics serving socioeconomically depressed areas. SB 697 also mandates that a “community benefits plan” must be developed by every nonprofit hospital and that periodic reports must be published for public review.

A definition for community is also present within SB 697. “Community” means the service areas or patient populations for which the hospital provides health care services”. A
community needs assessment measuring community needs, defined as “those requisites for improvement or maintenance of health status in the community” is to be conducted at regular intervals from which an annual community benefits plan should be based. Section 127355 outlines the elements that should be included in a community benefits plan. Examples of these elements include, (a) mechanisms to evaluate the plan’s effectiveness, (b) the inclusion of measurable objectives to be achieved within specific timeframes, and (c) the classification of community benefits into specific categories: medical care services, other benefits for vulnerable populations, other benefits for the broader community, health research, education, and training programs, and nonquantifiable benefits.

In 1998, The California Office of Statewide Health Planning and Development published a report to the legislature titled, Not-for-Profit Community Benefit Legislation (Senate Bill 697) (California, 1998). The report “details the implementation of the bill, summarizes the content of the community benefit plans submitted, and makes recommendations for further evolution of the process”. The general consensus of the findings were positive and an observation made by the Director of the Office, David Werdegar, stated “The bill has been very successful in bringing hospitals and their community partners together in a cooperative effort to build healthier communities”.

Nevada

Contained within the Nevada Revised Statutes, NRS 449.490, Guidance for Filing and Reporting Community Benefit are general guidance for hospitals that provide community benefit services. The statute does not specify if the legislation was written exclusively for nonprofit hospitals and the main theme of the legislation centers on accounting for expenses incurred for service delivery. Under Part 3, subsection (a) a full description of the statute is given. The subsection states:
The expenses that the hospital has incurred for providing community benefits and the in-kind services that the hospital has provided to the community in which it is located. These expenses must be reported as the total amount expended for community benefits and in-kind services and reported as a percentage of the total net revenues of the hospital...”community benefits” includes, without limitation, goods, services and resources provided by a hospital to a community to address the specific needs and concerns of that community, services provided by a hospital to the uninsured and underserved persons in that community, training programs for employees in a community and health care services provided in areas of a community that have a critical shortage of such services, for which the hospital does not receive full reimbursement.

A review of all other current Nevada Revised Statutes does not mention or include any other guidance for nonprofit hospital status qualification or community benefit reporting or measurement standards.

_Arizona_

Within Arizona, two separate statutes define requirements for tax-exempt status and community benefit. The first, under Title 43, Taxation of Income, AZ 43-1201, Organizations Exempt From Tax (AZ, year), states under Part A, “Organizations that are exempt from federal income tax under section 501 of the internal revenue code are exempt from the tax imposed under this title”. AZ 43-201 also provides a list of organizations that are exempt from taxes. Nonprofit hospitals are not explicitly identified on the list. However, under paragraph 4, terms that closely align with previously mentioned IRS Revenue Ruling guidelines are given that suggest nonprofit hospitals would fall into this classification.

Paragraph 4 states:
Corporations organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes or for the prevention of cruelty to children or animals, no part in the net earnings of which inures to the benefit of any private shareholder or individual, and no substantial part of the activities of which is carrying on propaganda or otherwise attempting to influence legislation.

The second statute, under Title 10, Corporations and Associations, AZ 10-11251, provides a series of eight terms and their definitions. Among the terms, four contain the words community benefit and describe what activities and purposes benefits to community should assume. Term seven, “nonprofit health care entity”, explicitly defines the qualifications of a “licensed hospital or community health center” as a nonprofit entity holding tax exempt status and refers back to AZ 43-201, paragraph 4 as the section providing justification for nonprofit hospitals to hold special tax status in Arizona.

*General Accounting Office, 2005*

Following the release of the 1965 Internal Revenue Service Revenue Ruling requiring nonprofit hospitals to provide charity care or other benefits to community in order to qualify for tax-exempt status, variations among nonprofit hospitals in the level of care and benefits they provided to communities was widespread. In their 1965 Ruling, the IRS did not outline a specific threshold of charity care and, or community benefit that had to be met in order to receive tax-exemption from the federal government. As a result, nonprofit hospitals developed their own definitions of community benefit and charity care as well as their own methodologies to capture the resources they dedicated to providing these services.

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4 The eight terms are: assets, community benefit activity, community benefit assets, community benefit organization, community benefit purposes, community health center, nonprofit health care entity, and notice of completion.
Over time, a great deal of criticism was levied against nonprofit hospitals (GAO, 2005). Critics believed that nonprofit hospitals enjoyed a level of exemption from the government in the form of tax “subsidies” that allowed them to operate with a comparative advantage over other providers. In an effort to determine the extent to which nonprofit hospitals complied with the 1965 Revenue Ruling requirement and to address concerns made by other interested parties, the United States Government Accountability Office (GAO), published a report that investigated the ways in which nonprofit, for-profit, and government hospitals defined and measured the charity care and community benefits they were providing. On May 26, 2005 the GAO released, Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits comparing and contrasting the community benefit and charity care practices of these three types of hospitals (GAO, 2005).

In an effort to capture similarities or differences in the amount of charity care that nonprofit, for-profit, and government hospitals provide to their communities GAO compared and contrasted the total amount of unreimbursed care these three hospital types located in five states provided in 2003. Based on their analysis, GAO made three distinct findings. First, government hospitals dedicated “substantially larger shares of their patient operating expenses to uncompensated care than did nonprofit and for-profit hospitals”. Second, nonprofit hospitals claimed a higher share of uncompensated care than for-profit hospitals in four of the five states, “but the difference was small relative to the difference found when making comparisons with the government hospital group”. Third, the distribution of uncompensated care was not even. More specifically, a relatively small number of nonprofit hospitals\(^5\) carried the burden of providing uncompensated care than did other nonprofit hospitals that received the same tax-exempt status.

\(^{5}\) These hospitals were located in urban, high-density service areas.
Additional activities hospitals claim as community benefit besides uncompensated care, e.g., medical education and research, health prevention programs, were unable to be compared at a level that was consistent or reliable among the hospitals examined; leading researchers to posit that variations in what hospitals define and report as community benefit makes it difficult to accurately track and measure claims of benefits to community. Based on this observation, GAO suggested that if consistency in reporting were to be reached, tax law would have to be modified to include more specific criteria for defining, reporting, and measuring activities that hospital’s of all the types contained in the study claim as community benefit.

General Accounting Office, September 2008

In September 2008, The GAO released a second report examining the ways in which hospitals defined, measured, and reported community benefit. Based on insights received from results drawn from their 2005 report, GAO limited the 2008 analysis to include only nonprofit hospitals. Four specific areas of inquiry were pursued. First, interested parties believed that the IRS’s community benefit standard outlined in Revenue Ruling 65 provided a high degree of “latitude” for nonprofit hospitals when they defined what activities they could claim as community benefit. Second, state requirements also varied with respect to tax-exempt status for nonprofit hospitals. Third, definitions of what nonprofit hospitals claim as community benefit vary and this variation may affect the amount of community benefit that is reported. And fourth, differences in how nonprofits measure costs of providing community benefit may affect the amount of community benefits they claim (p. i).

To conduct their analysis, GAO analyzed nonprofit hospitals located in California (166), Indiana (78), Massachusetts (64), and Texas (119). These states were selected based on the consistency and reliability of the data GAO required for their analysis whereas the
remaining 46 states’ data provided only limited and somewhat incomplete information regarding community benefit standards and reporting requirements.

Following their analysis, GAO reported the following results. First, selected hospitals had a shared definition for charity care and other activities that provide benefits to community. However, when defining bad debt and whether or not to include it and Medicaid reimbursement shortfalls as community benefit, consistency was not found. Second, even though hospitals may define community benefit activities similarly, the means by which they measure the cost of providing benefits varies. As a result, the net amount hospitals report as community benefit was inconsistent among the hospitals studied.

Based on the results of their analysis, GAO offered the following observation and recommendation. Since IRS guidance allows a great range of discretion among nonprofit hospitals regarding community benefit reporting, coupled with “the large number of uninsured individuals, and the critical role of hospitals in caring for them, it is important that federal and state policymakers and industry groups continue their discussion addressing the variability in defining and measuring community benefit activities.” (p. 7).

*Congressional Budget Office*

In 2006, the Congressional Budget Office, a nonpartisan policy analysis group published two reports specifically dealing with community benefit. The first, *Nonprofit Hospitals and the Provision of Community Benefits* (CBO, 2006a), sought to determine how much community benefit was being claimed among nonprofit, for-profit, and government hospitals. And, if differences existed regarding the amount of benefit that was being claimed by these institutions, what factors may have contributed to variations in claims. According to the CBO:
The IRS does not specifically require that a hospital provide a certain level of charity care to qualify for tax-exempt status, as long as the hospital provides some benefits to the community. (p. 4).

Therefore, even though substantial levels of community benefit were being claimed each year, did a minimum value exist that could be used as a baseline threshold for all community benefit claims?

For the report, measures of community benefit included uncompensated care (including charity care and bad debt), Medicaid payment shortfalls, and the delivery of unprofitable specialty services\(^6\). Data were initially drawn from all Medicare-certified hospitals in the United States and subsequently limited to a subset of community hospitals for which data on uncompensated care were available. Ownership status, type(s) of specialized services provided, community characteristics, and financial characteristics of hospitals were factors applied within the research methodology. States representing hospitals that met the final selection criteria were California, Florida, Georgia, Indiana, and Texas.

The report generated several findings. One result of the CBO report was that when the aforementioned factors were controlled for, non-profit hospitals provided “between $100 and $700 million more in uncompensated care than would have been provided if they had been for-profits”. This finding, however, was affected by the fact that the difference in uncompensated care provided by non-profit and for-profit hospitals was due in large part to the “fact that non-profit hospitals accounted for a much larger market share of the hospital market than did for-profits”. A second finding was that variation existed by state in the amount of uncompensated care claimed as community benefit. A third result of the CBO analysis showed that nonprofit hospitals had a Medicaid share that was “1.3 percentage

\(^6\) Examples of unprofitable specialty services include: the operation of a Level I trauma service, delivery of high-risk obstetrics services, and the presence of a burn unit.
points lower than for-profit hospitals, a difference that was statistically significant.” (p. 19). In determining if differences existed among the three hospital types with respect to providing specialized services, CBO found that “nonprofit hospitals were significantly more likely than for-profits to provide each of the specialized services examined.” (p. 20).

CBO 2006b

In 2006, the CBO also released, Nonprofit Hospitals and Tax Arbitrage (CBO, 2006b). Motivation to conduct this analysis was based on the notion that because nonprofit hospitals receive special tax-exempt status, they enjoy a competitive advantage against their for-profit counterparts. As has been mentioned previously, nonprofit hospitals do not have to pay federal corporate income taxes, state income taxes, can purchase tax-exempt bonds to finance capital improvements, and individuals that contribute funds to nonprofit hospitals receive a tax deduction for doing so.

Weighing the fiscal advantages nonprofits receive against the benefits they provide to community has left many to question the extent to which nonprofit hospitals effectively are allowed to double-dip as they are (1) not required to meet a minimum threshold of community benefit delivery in order to qualify for tax-exempt status, and (2) the tax advantages they do receive give them a comparative advantage within a highly resource dependent and competitive health care market.

Findings contained within the report appear to support the twofold observation above. According to the Joint Committee on Taxation (JCT), “the exemption from income taxes provided nonprofit hospitals with about $2.5 billion in tax savings in 2002 (the most recent year for which such a calculation can be made), and the use of tax-exempt bonds provided them $1.8 billion—$4.3 billion that substantially reduced their cost of capital.”
Additional information contained within the report determined that nonprofits’ “decisions to finance operating assets with tax-exempt debt are influenced by their ability to earn an untaxed return on their investment assets that is higher than the interest cost they must pay on the tax-exempt debt [and] In addition, the interest income earned by businesses and individuals that purchase the debt issued by for-profit hospitals is subject to federal corporate and individual income taxation, whereas the interest income earned on debt issued by state and local governments on behalf of nonprofit hospitals is generally exempt from those taxes”.

Taken together, the CBO report suggested that preferential tax treatment reduced nonprofit hospitals’ cost of capital “by as much as 2.1 cents per dollar of investment”. And, between years 1991 and 2002, the annual savings nonprofit hospitals received went from $100 billion to $200 billion respectively.

**Internal Revenue Service Reports**

The Internal Revenue Service added its voice to the community benefit policy discussion with the publication in 2007 of the *Hospital Compliance Project Interim Report* in 2007 (IRS, 2007b) and the *IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report* in 2009 (IRS, 2009). The reports were initiated by the Exempt Organizations function of the IRS Tax Exempt and Government entities to “study nonprofit hospitals and community benefit [and] involv[ed] the reporting of types and amounts of potential community benefit expenditures in various areas, including uncompensated care, medical education and training, medical research, and community programs” (IRS, 2007b).

The 2007 report provides a summary of the data received from 487 out of 544 nonprofit hospitals completing a questionnaire developed by the IRS and from IRS Forms
990 filed by the hospitals. A large majority of hospitals (89%) “described themselves as general medical and surgical hospitals”. Early review of the preliminary data showed that uncompensated care made up the largest reported expenditure item and was the most frequently reported type of community benefit” (p. 1). Motivation to conduct the study centered on two central topics. First, to “determine whether and how nonprofit hospitals demonstrate their qualification for exemption as organizations described in section 501(c)(3) under the community benefit standard” and second, to “[identify] how hospitals establish executive compensation and halting abuses by hospitals that pay excessive executive compensation” (p. 3). Additional topics of interest were also investigated including the extent to which hospitals treatment of Medicaid and Medicare patients varied and to review the uncompensated care policies of hospitals surveyed.

A key finding of the study was the determination of the total amount of community benefit claimed by respondents. For the 487 respondents, the “aggregate potential community benefit expenditures by type reported” for all categories totaled $9.3 billion. Uncompensated care comprised 56% of the total ($5.2 billion), medical education and training, 23% ($2.1 billion), medical research, 15% ($1.4 billion), and community programs, 6% ($0.6 billion). Within the community programs category, respondents averaged 3.4% of total revenues committed with 1.4% of this figure dedicated to programs that improved access to care (p. 43).

Aggregate reported community benefit expenditures as a percentage of total revenue for all 487 hospitals was also reported. The mean for all hospitals was 8.8% and the

7 Uncompensated care for the IRS 2007 Interim Report included both bad debt and revenue shortfalls from third-party payers. Charity, or free care was also included in uncompensated care calculations.
following table illustrates the relationship between percentage of total revenue, number of hospitals, and percentage of hospital revenue claimed as community benefit.

Table 1.

Community Benefit as Aggregate Percentage of Total Revenue

<table>
<thead>
<tr>
<th>Aggregate Reported Community Benefit Expenditures As a Percentage of Total Revenue</th>
<th>Number of Hospitals</th>
<th>Percent of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0% to 1.9%</td>
<td>105</td>
<td>21.6%</td>
</tr>
<tr>
<td>2.0% to 4.9%</td>
<td>130</td>
<td>26.7%</td>
</tr>
<tr>
<td>5.0% to 9.9%</td>
<td>112</td>
<td>23.0%</td>
</tr>
<tr>
<td>10.0% to 19.9%</td>
<td>96</td>
<td>19.7%</td>
</tr>
<tr>
<td>20% and over</td>
<td>44</td>
<td>9.0%</td>
</tr>
<tr>
<td>Total</td>
<td>487</td>
<td>100.0%</td>
</tr>
</tbody>
</table>


Results of executive compensation data analysis were not provided in the 2007 Report and were to be included in the final report. Recommendations for future research included determining how nonprofit hospitals calculated reported uncompensated care as these figures varied according to whether or not bad debt, cost-to-charges accounting practices, and other third-party payer reimbursement shortfalls attributed to uncompensated care claims. Lastly, results from future work could inform the continued development of IRS community benefit reporting requirements including revisions made to Form 990 and the newly devised reporting form Schedule H, Hospitals.

As was mentioned above, in 2009 the IRS published, *IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report* (IRS, 2009). The final report included additional analysis of data collected from the questionnaire and Form 990 reports from 487
nonprofit hospitals in 2006. In addition to the information provided by the 2007 interim report, the 2009 document extended its analysis to include differences in community benefit reporting among hospitals according to their location, i.e., high population, other urban and suburban, critical access hospitals, rural non-critical access hospitals and revenue size, e.g., a range from under $24 million up to over $500 million. Hospitals were also categorized based on health insurance coverage and per capita income of the area surrounding the hospital (p. 3). The final report also contained reported variation regarding the extent to which levels of uncompensated care were calculated using bad debt and unreimbursed shortfalls from third-party payers. Analysis and observations regarding executive compensation were also provided in the final report.

Key findings were reported within seven categorical areas: (1) diversity among the fiscal characteristics of hospitals and the demographics of the communities they serve, (2) aggregate level of community benefit provided by hospitals, (3) types of community benefits provided to community, (4) the distribution of community benefit via uncompensated care claims reported by a small proportion of hospitals, (5) reporting of excess revenues (total revenues less expenses) among hospitals, (6) per capita income and insurance coverage levels within hospital service areas, and (7) executive compensation practices.

At the conclusion of their report, the authors provided six key observations and lessons learned to summarize the main themes generated by their analysis. In their essence, the characteristics of hospitals and the demographic features of the communities they served account for the variability of amount and type of community benefits claimed. For example, urban hospitals would be expected to claim more in uncompensated care than rural non-acute hospitals given that a higher percentage of an urban hospital’s patient population consisted of individuals who were more likely to be uninsured or recipients of Medicare,
Medicaid, or state-sponsored insurance. This observation also explained why there was a measurable difference in the aggregate community benefit claims based on percent of total revenue across hospital types. Larger hospitals also reported higher profit margins than rural hospitals and the number of hospitals that reported operating under a deficit fell as revenue size increased.

Summary of Government and Government Agency Reports

Reviewing the literature that has been published by government and government-related agencies revealed the following observations. First, with the IRS Revenue Rulings, qualification guidelines were established that allowed hospitals to differentiate themselves as nonprofit enabling them to qualify for federal tax-exempt privileges. Second, state laws provided additional levels of guidance to nonprofit hospitals even though a great deal of variability with respect to the scope and complexity of the legislation was identified. For example, the depth and breadth of California’s statute was more comprehensive than both Nevada and Arizona. Definitions of community benefit and reporting requirements also varied considerably among the three states’ statutes.

For the CBO, GAO, and IRS reports nearly all conducted comparative research to analyze the extent to which nonprofit hospitals defined community benefit and the methods they employed to measure and account for the benefits they claimed for services provided to community. General conclusions made by these reports suggested that nonprofits hold a comparative advantage over for-profit and government institutions and that among nonprofit hospitals themselves a great deal of variability existed regarding the extent to which individual hospitals claim benefits in relation to the demographic characteristics of the communities they serve.
A positive outcome of all the studies conducted by government and government-related agencies was the development of qualifying criteria and general definitions of what community benefit entails. However, as promising as the results of these initial efforts were these publications noted that a great deal of research needed to be conducted in the future in order for more precise definitions and qualifying criteria to be established – and more importantly, to be incorporated into the design, implementation, and evaluation of hospital driven community benefit policy.

*Industry and Health System Publications*

*Volunteer Hospital Association, Inc. 2002*

In 2002, Volunteer Hospitals of America, Incorporated\(^8\) (VHA) published a concept brief titled, *Community Benefit Planning: Strengthening Commitment to Mission* (VHA, 2002). Building on the voluntary community benefit standards they developed in 1991, the 2002 brief outlined a series of initiatives hospitals could pursue in order to “fulfill both its mission of community service and its charitable, tax-exempt purpose”. The advocacy standards VHA developed aimed to serve the benefit planning processes of member institutions by guiding them through a series of steps that included: mission statement development, fiscal and investment management, educating employees and medical staff, defining clinical priority areas, and developing relationships with other community organizations (p. 3).

Expectations sought by VHA hospital members who completed the planning process included: defining concise hospital community benefit standards, determining community assets, constructing mechanisms for community involvement, creating methods to measure value, and developing a cohesiveness with the community at-large in order to

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\(^8\) At the time the brief was released, VHA was one of the largest national organizations representing nonprofit hospitals and health systems in the United States. VHA provides a wide range of consulting services aimed at improving hospital performance, asset and revenue management, and community benefit planning and strategy development.
ensure long term partnerships with community stakeholders (p. 3). Among the standards that were offered, one specified the importance of the relationship a hospital had with its community. For example, under Standard 3: Be Accountable to the Community, one of the minimum guidelines to be followed was for hospitals to “Invite and respond to community input and involvement in the planning and review of organizational activities.” (p. 5). In light of the motivation to conduct the analysis of community benefit policy development for this dissertation, VHA’s community accountability standard foreshadows a theoretical concept that will be developed in detail in a following section regarding how the framing of target populations may impact the methods nonprofit hospitals undertake to create community benefit policies that may improve community health. Additionally, VHA’s community accountability standard illustrated a unique component of its planning process not seen in other nonprofit hospital industry and advocacy group guidelines.

Contained in the Introduction and Background section of their brief, VHA describes four general areas they recommend be included when developing a community benefit plan. Part C, Target Communities and Populations, describes the significance of accurately defining the community or communities that a hospital intends to serve. Within this subject area, VHA offers the following specific guidance:

Explicitly defining the communities and populations targeted in your community benefit strategy gives your community benefit program boundaries, determines the data collected, and provides direction for choosing which community benefit projects are implemented. It also helps to identify community organizations that should be included in community benefit program planning and implementation. A clear definition of “community” prevents unfocused, ineffective interventions that try to be all things to all people. A community definition identifies target populations
within specific geographic boundaries. Target communities and populations may include: a geopolitical subset (such as a neighborhood, township, census tract), ethnic or economic class group (such as Hispanic, poverty level), gender or age-specific, [and] disease-specific (such as persons with diabetes)(pp. 9-10).

Measuring the impact a community benefit plan has upon targeted population(s) was also included in VHA’s brief. Part 5, Evaluation, provided a general idea of how a hospital could approach evaluating its plan’s impact. VHA recommended that a plan should, “Describe the mechanism and process to evaluate the overall effectiveness of the community benefit plan, including a procedure for soliciting community members’ comments. Show the operational structure that is in place to ensure quality-improvement and continuity.” (p. 11). Detailed recommendations or examples of how a community benefit plan may construct the evaluation phase of its plan were not offered. Additionally, quantitative or qualitative measures used to determine program effectiveness and thresholds that define program success or failure were not included in VHA’s evaluation phase recommendations.

*Catholic Health Association of the United States, VHA, Inc. – June 2004*

In conjunction with the Volunteer Hospital Association the Catholic Health Association of the United States (CHA) published, *Community Benefit Reporting Guidelines & Standard Definitions for the Community Benefit Inventory for Social Accountability* in June 2004 (CHA, 2004). With the input of over twenty-five individuals representing health care organizations across the country, CHA and its two partners sought “to create standardized community benefit categories, definitions, and reporting guidelines in an effort to achieve a national standardized approach for not-for-profit health care organizations.” (CHA, 2004).

In describing the motivation to create a cohesive document that nonprofit health care organizations could use to develop, implement, and monitor their community benefit
plan, CHA’s report offered three observations. First, nonprofit health care organizations, i.e., hospitals, have demonstrated a historical commitment to serving the needs of community. Second, critics of nonprofit hospitals receiving tax exemption status have argued that the lack of a consistent process of determining what community benefits are may detract from hospitals’ ability to justify their special treatment. And third, balancing the fiscal demands of operating a nonprofit hospital while providing meaningful benefits to community has become increasingly difficult. Combined, these three factors formed the need to create a series of guidelines that nonprofit hospitals could employ to overcome potential barriers to community benefit plan development.

Catholic Health Association of the United States – 2008 & 2012

In 2008 and most recently in 2012, the Catholic Health Association of the United States published *A Guide for Planning & Reporting Community Benefit* (CHA, 2008; CHA, 2012). Both the 2008 and 2012 editions built upon previous guidance developed by CHA and its partner, VHA. The 2012 edition, however, represented the most forward-looking, comprehensive collection of community benefit guidelines to be published by any author to date. Contained within the seven chapters of the Guide was a range of topics whose general focus was to provide guidance to community benefit policymakers working at an individual hospital level. Chapter titles include: Getting Started, Understanding What Counts and What Does Not Count, Building a Sustainable Infrastructure, Accounting for Community Benefit, Planning for Community Benefit, Evaluating the Community Benefit Program, and Communications: Telling the Community Benefit Story. Information contained within each chapter provided readers with valuable examples of how one could develop, implement, and measure a hospital’s community benefit policy and programs. A page was also dedicated to discussing how implemented programs could be evaluated based on their impact, e.g., Are
you making a difference? (p. 193). Steps to achieve short-term, intermediate, and long-term results were provided on this single page. However, examples of quantitative or qualitative measure on how to collect, analyze, interpret, and report results were not offered. This observation represents a potential shortcoming of CHA’s Guide in that the Guide does a fantastic job of explaining how to design and implement community benefit programming but fails to include comprehensive steps to determine the relationship between community programs and the extent to which they impact the health of those they are created to benefit.

Defining Community Benefit

Given the examples above of literature that has addressed community benefit policy in general, the next section briefly discusses how community benefit has been defined by government, industry groups, health systems, and within the academic literature. An annotated diversion into this specific area of interest may serve to highlight the perspectives each voice has had with respect to what each considers community benefit to be.

Government

Federal, state, and local governments have provided specific regulations that hospitals must adhere to in order to receive nonprofit status and obtain applicable tax exemptions. In the 1956 IRS Revenue Ruling, a charity care requirement was included that directed hospitals to provide care even to patients who may not have an ability to pay for them. In 1969, the IRS broadened the community benefit definition by allowing the provision of health care to “any broad class of persons as community benefit, including, perhaps, such activities as charity care, health screening, community education about health risks, emergency room services, and basic research.” (CBO, 2006a). A later Revenue Ruling in 1983 further amended the 1956 and 1969 Rulings by determining that a state health agency could decide that the operation of a full time emergency department by a nonprofit
hospital was not necessary in order for a hospital to be classified as a nonprofit entity if operating an emergency department would duplicate services already present within the community where the nonprofit in question was located (Joint Commission, 2006).

**Health Industry Definition**

In a 2007 report published by the Healthcare Financial Management Association (HFMA) titled, *Telling the Story of Community Benefit*, the authors provide and describe ten attributes that should be included in any conceptual or working definition of community benefit. They consist of the following: mission to provide community benefit, use of financial surpluses, accountability, goodwill, provision of charity care, reduction of government burden, provision of essential healthcare services, provision of unprofitable services, education of the public, and serving “other” unmet health needs (HFMA, 2007).

**Health System Definition**

In more recent years, the Catholic Health Association provided its definition of community benefit that a large majority of nonprofit hospitals have followed while developing their community benefit policy. In their publication titled, *Community Benefit Reporting Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability* (CHA, 2004), CHA offers the following:

Community benefit is a planned, managed, organized, and measured approach to a health care organization’s participation in meeting identified community health needs. It implies collaboration with “community” to “benefit” its residents – particularly the poor, minorities, and other under-served groups – by improving health status and quality of life. Community benefits respond to an identified community need and meet at least one of the following criteria: generate a low or negative margin; respond to needs of special populations, such as minorities, frail
elderly, poor persons with disabilities, the chronically mentally ill, and persons with AIDS; the service or programs would likely be discontinued if the decision were made on a purely financial basis. (p. 38).

CHA’s definition also provides a level of continuity among nonprofit hospitals that affords them the ability to count and report all resources and programs that qualify as community benefit. As a result, having a generally agreed upon definition of community benefit, nonprofit hospitals can utilize accounting and reporting practices that follow specific guidelines. This in turn allows nonprofit hospitals operating in various communities the comfort of knowing that the processes they employ to track community benefit are aligned with their nonprofit counterparts operating in other communities.

**Academic Literature Contributions**

To date, the academic literature has not contributed a great deal of insight into the community benefit policy discussion. Aside from John C. David’s Dissertation mentioned above, *Not-For-Profit Hospitals in Metro Atlanta: Comparative Analysis of Tax Status and Community Benefit* (David, 2009) discovery of academic literature that deals specifically with community benefit was less than fruitful. Reasons for the dearth of academic contributions in this policy area are unknown. However, a review of the literature found one definition that shares similar characteristics of those offered by other stakeholders mentioned above. In 1996, Joel Weissman published a paper in the Journal of the American Medical Association titled, *Uncompensated Hospital Care: Will it be There if We Need It?* Within his paper, Weissman defined community benefit as “those programs and services that are generally thought to be provided at low or negative margin and are intended to improve access by disadvantaged groups or to address important health care matters for a defined population.”(p. 824).
Summary

Attempts by government, health industry, health systems, and the academic community to develop a standardized definition of what community benefit entails has produced mixed results. Federal guidelines and state statutes have generated explicit and implicit definitions of community benefit that allow a considerable degree of variability in the ways in which industry, health systems, and individual hospitals may interpret federal and state directives. Industry and health system efforts to produce a standardized, comprehensive definition that meets the needs of all nonprofit hospitals have seemingly produced a degree of interpretive inconsistency that is inherent in federal guidelines and state statutes. However, all nonprofits have yet to adhere to a unified definition of community benefit. And, contributions made by the academic community have been relatively small but demonstrate that the academic perspective has added a degree of value.

One may posit that the development of community benefit policy is rooted in an idea that those willing to forego self-interest in order to serve the needs of community are eligible to receive certain benefits not available to those who do not. Reviewing the body of literature that represents the formative guidance and direction of community benefit from its origins to present day, one may find it difficult to determine just what the central motivations for developing community benefit policy were. Several possible explanations could be made. One may be that due to the evolving nature of America’s health care landscape in the middle of the last century, the development of community benefit policy was a logical response to distinguish between for-profit and nonprofit institutions. Another possibility could be that due to differences in the inherent mission of nonprofit and for-profit hospitals, e.g., nonprofits serve a charitable mission while for-profits serve the interests of shareholders; community benefit policy enabled both institutions to pursue their
independent objectives while (1) providing space for each to fulfill their unique path to providing health care services, and (2) lessening the burden of government to provide care to all those who seek it regardless of their ability to pay for services rendered.

In an effort to uncover a deeper meaning of why community benefit policy came to be and to provide a novel theoretical foundation from which present day community benefit policy may have been constructed a review of the literature pertaining to the origins of our understanding of health is offered in the next section. It is hoped that by embarking on this exercise one may be able to realize that in addition to the practical considerations that were considered when creating community benefit policy, there also may be a historical and theoretical basis to explain how community benefit policy arose and what it may become in the future.

Part 2 - Health: Two Perspectives

From the earliest civilizations cultured in the cradle of Greek philosophy to the complex interrelated global societies found within our present day, conceptualizations of health have evolved from simple beliefs steeped in ancient mysticism to those centered on the complex interactions occurring between man and his technology infused environment. Beliefs of what constitutes health throughout this timeframe appear to have emerged from two distinct paths of thought. The first, a view based on a scientific, rational notion of health suggests that in order for an individual to live a healthy life, he or she must be free of

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9 Science: According to The Pocket Oxford Dictionary and Thesaurus, 2nd American Edition, science is defined as, “the branch of knowledge involving systematized observation and experimentation.” (Jewell, 2002). For the purposes of this paper, the scientific approach to defining health is based on a rational, deductive construction of knowledge based on information gained by performing a series of linear steps that may include: forming a hypothesis, testing a hypothesis, and then analyzing results based on tests or experiments conducted on individuals to determine causation. Disciplines representing scientific approaches to defining health include, but are not limited to: chemistry, physics, human anatomy, economics, and biology.
specific internal agents that cause states of ill health. In the event that an individual should become afflicted with a health compromising entity, a deductive process for identifying the causative menace is initiated followed by a defined course of prescriptive treatment and follow-up. If the same or another agent should afflict the individual in the future, the process is repeated until a state of normalcy is achieved. The second view, one that relies on the idea that one’s health is linked to various social interrelated, and interdependent determinants of health suggests that by understanding how these factors combine to affect health, states of ill-health can be prevented or minimized through the application of a holistic approach to the delivery of health care within a society.

For a majority of the past two thousand years, scientific and social views of health have coexisted in paths parallel to one another. There have been points in time where their paths have touched or briefly crossed but for the most part they have evolved within their own distinct theoretical and applied environments. Joining scientific and social views of health together to form a unifying definition of health remains a challenge for both theorists and practitioners operating within these seemingly disparate fields (Viseltear, 1977; Shi & Singh, 2008). Some may argue that the inherent nature of science and ‘social’ science inhibits these two fields from incorporating one another’s view of health into a singular whole (Field, 1997). However, others believe that as both disciplines have evolved over time their separate spaces of health are beginning to merge into a vision of health that applies contributions from both disciplines into a newly shared existence.

In an effort to better understand how health has evolved from scientific and social foundations into what health may be considered today, the remainder of the first section of the discussion of health will be constructed in the following fashion: First, relevant historical, literary, and practical contributions from both fields will be discussed and compared as
concepts of health emerged from within each discipline. This will be followed by a presentation of ways in which health has been measured from an individual and community perspective to illustrate the extent to which scientific and social approaches to health have manifested themselves from theoretical positions into applied practice. And finally, historical contributions and applied concepts of health will be brought together in a discussion of how each perspective may have shaped the development of community benefit policy.

Early Foundations of Health

The Relationship Between Man and the Heavens

One of the earliest accounts describing health and its differentiation into distinct domains came from Greek mythology. According to Greek texts, Apollo, son of Zeus, had a son, Asclepius. Asclepius was the god of medicine and healing (Dubos, 1965). Asclepius had five daughters who embodied individual, yet interrelated aspects of health: Hygieia (Hygiene), Iaso (Medicine), Aceso (Healing), Agleia/Ægle (Healthy Glow), and Panacea (Universal Remedy, Cure-All). It was believed that each of the daughters possessed inherent qualities that if beckoned, could relieve suffering and, or restore health according to the affliction that befell the beckoner. These appropriated attributes would continue throughout the development of health in western cultures. The idea of maintaining proper hygiene through any number of preventative measures, e.g., eating quality foods, drinking clean water, constructing sewer systems, were pillars of good living in Grecian times and cornerstones of public health today. Developing ‘cure all’ vaccines to prevent infection by *Tuberculosis bacillus* or to treat HIV is seen as a ‘panacea’ that can be universally administered to individuals. What is also interesting and very relevant to this discussion is that among the five aspects of health; hygiene, medicine, and healing were separated. Finding a clear reason why the Greeks made this distinction is most likely not possible. However, if we pair each of
the three aspects to their present day counterpart we may be able to see why the distinctions made by the Greeks have remained with us over the past two thousand years. For example, the evolution of medicine has followed a course of development heavily guided by science. Hygiene, from Greek time to present has been assumed as a social, i.e., public health undertaking. And healing, although tied to both hygiene (social) and medicine (science) appears to have existed within its own space and time. Taken together, it may be suggested that they share a linear relationship with one another. For example, if proper hygiene is not maintained then the services of a medical doctor are required. Once the doctor has performed her duties, healing can then take place. Type 1 diabetes mellitus is a prime example of this phenomenon.

For the early Greeks maintenance of good health was dependent upon one’s relationship with the heavens (Rosen, 1993). If an individual were living according to the proper dictates of gods or goddesses, then they would be able to live a life that was free of affliction. Conversely, if their lives were falling outside of ethereal direction their life and subsequent health would be affected accordingly. Around the 3rd century BC, on the Greek island of Cos, Hippocrates would begin to alter the Asclepius view of health. Hippocrates developed an approach to health that was contingent upon man’s relationship with nature and not with the heavens as contained within the Hippocratic Corpus and summarized by Dubos (1965):

Disease is not caused by demons or capricious deities but rather by natural forces that obey natural laws. Hence, therapeutic procedures can be developed on a rational basis. These procedures include the use of regimens, drugs, and surgical techniques designed to correct the ill effects of natural forces. The well being of man is under the influence of the environment, including in particular air, water, places, and the
various regimens. The understanding of the effect of the environment on man is the fundamental basis of the physician’s art. (p. 322).

In addition to loosening the tie of the relationship between otherworldly entities and health, Hippocrates’ philosophy on health also demonstrated his establishment of a close connection between rationality (science), medicine (regimens, drugs, surgical treatments), and the environment (air, water, places). As with Asclepius’ daughters, Hippocrates' relationships would gradually lose their interconnectivity as each discipline evolved. Hippocrates’ symbiotic space shared by science, medicine, and nature would be slowly disseminated into two spaces – one a fusion of science and medicine and the other a singular space made up of combinations of social and natural elements.

The Relationship Between Man and Body

The application of a scientific method to understanding how man exists became embodied in the discoveries made by the Flemish anatomist Andreas Vesalius in the 16th century. Through his study of human anatomy, Vesalius determined that specific parts of the body, e.g., tissues, limbs, caused specific animations to occur when manipulated. This if/then approach lent itself well to elementary principles of science and upon the publication of De Humani Corporis Fabrica in 1543 (Nuland, 1988) firmly established Vesalius as a pioneer in relating the form of the human body to its function.

Shortly following the landmark efforts of Vesalius another equally gifted and insightful scientist and philosopher appeared. In 1664 René Descartes published L’homme et un traitté de la formation du foetus du mesme authen, or Treatise on Man. Searching for the connection between mind and body, Descartes designed and conducted a series of experiments focused on uncovering how or what caused muscles to expand and contract (Donaldson, 2009). One result of his efforts was the conclusion that man is a machine.
Reading an excerpt from *Treatise on Man* provides a unique view into the deductive logic Descartes applied to reach his conclusion. According to Descartes:

I want you to consider [he concluded] that all these functions in this machine follow naturally from the disposition of its organs alone, just as the movement of a clock or another automat follow from the disposition of its counterweights and wheels; so that to explain its functions it is not necessary to imagine a vegetative or sensitive soul in the machine, or any other principle of movement and life other than its blood and spirits agitated by the fire which burns continually in its heart and which differs in nothing from all the fires in inanimate bodies.

As such, since man was composed of any number of mechanical parts if these mechanized parts became dysfunctional they could be isolated, repaired, and restored to their appropriate operability (Osherson & AmaraSingham, 1981). Descartes’ analysis of the human form solidified Vesalius’ earlier work while severing at last any notion that man’s ability to function was linked in any way to heavenly queuing. Additionally, by peeling back the inner layers of man’s internal world, the notion that health was a function of outward symptoms correlated to an ethereal connection was scientifically proven to be incorrect. This knowing by seeing epistemology began by Vesalius and propelled by Descartes would furthermore establish the application of scientific methodologies as the primary means by which the dynamic relationship between health and human function would be largely considered for the next three hundred years.
For the remainder of the Age of Enlightenment contributions from the social sciences to understand the relationship between man and health were becoming overshadowed by the epistemology of science fathered by Vesalius and Descartes. However, they did not disappear. As western societies began to industrialize during the 1700s and 1800s, agrarian societies began to concentrate their populations in metropolitan areas. Fueled by commerce and coupled with an intense socialization of urban dwellers these metropolitan areas were ripe for culturing and dispersing a wide range of communicable diseases (Fee, 1991). As such, the role public health began to play in combating the prevalence of disease became most important (Afifi & Breslow, 1994). Drawing on the highly innovative efforts Roman cities used to design public health systems around planned architecture, urban centers across the western hemisphere developed their own networks of infrastructure and public health administration whose sole purpose was to serve and protect the public’s health (Rosen, 1993).

In the mid- to late 1880s, with the advent of microscopic techniques to study life at a cellular level, Louis Pasteur, Joseph Lister, Robert Koch and a host of other clinical scientists advanced the scientific basis of disease that for the first time linked microbial agents to disease and antimicrobial agents to treating infected individuals, i.e. germ theory\(^\text{10}\) (Novick, 2005b). Germ theory was then taken out of the laboratory and applied in a social context in various ways including the administration of vaccines to treat communicable diseases and the use of sterile techniques during surgical procedures.

\(^{10}\) Louis Pasteur’s work with fermentation disproved the theory of spontaneous generation, i.e., ‘germs’ lived outside of their ‘hosts’. Robert Koch isolated \textit{Bacillus anthracis} (anthrax), \textit{Tuberculosis bacillus}, and \textit{Vibrio cholerae} and developed Koch’s postulates that outlined the behavior of microorganisms. Joseph Lister recognized the importance of the sterile technique and perfected its use in surgical procedures.
Up until this time, science and society tended to live apart. Scientific philosophers conducting a vast array of experiments would publish many works that expanded human’s knowledge of herself and her relationship with nature. However, for the first time in the modern era, the parallel lines of science and socially oriented concepts of health began to touch. The creation of an industrialized world was the primary mover. A shift from an agricultural to an urban-centric landscape became the catalyst to propel science into the world and the administration of public services became the vehicle to deliver the goods.

This momentous occasion was bolstered by the introduction and application of science-based administrative practices into socially oriented settings. New ways of quantifying the success or failure of public policies were beginning to take hold during this progressive time. Using a rational and objective approach to collecting, accounting, comparing, and analyzing information became the gold standard (Taylor, 1911; Fayol, 1919; Weber, 1924; Lindblom, 1959). Bureaus representing a range of public services, including public health, embraced scientific tenets in an effort to develop, implement, and sustain policies that were responsive to the public’s demand for services. (Van Riper, 1987; Stivers, 2002). Measuring outcomes became a key indicator of the extent to which a program was achieving its expected results. This dichotomy of science and administration would continue to guide the public’s policy processes for years to come and would spill out into the development of quantitative and qualitative research methods used to measure and define states of health and well-being around the middle of the 20th century.

The formalization of medical education also underscored the way in which science was adapting to meet societies’ needs. In 1910, the publication of the Flexner Report in the United States outlined specific measures to educate doctors in a systematic manner. Prior to the Flexner Report, the instruction of American medical school students was developed
from an accumulation of knowledge received from two main sources. The first, scientific 
knowledge gained from American practitioners studying medicine in Europe and brought 
back to the US; and second, from applied knowledge gleaned from medical and surgical 
procedures performed within the context of America’s continental wars (Nuland, 1988).

Building a formalized system of medical education around these two sources was neither 
accidental nor illegitimate. As America and other western societies began to become more 
sophisticated and extend the practice of medicine into the broader spaces of community –
consistent, formalized structures of medical education became obligatory (Flexner, 1910).

The first half of the 20th century would signal a call for an increased role government 
would play in creating and passing legislation that joined government with the supply and
practice of health care (Barr, 2002). In Britain, the National Health Service (NHS) embodied 
this alignment of government with nationally supported health care. And, in the United
States, early attempts to promote government-sponsored health care would begin to sprout.
Britain’s NHS would survive and flourish as a model for delivering government-sponsored
health initiatives while American attempts to provide health services for all of its citizens
would struggle to gain an exclusive foothold and initially be limited to population-specific
policies (Funigiello, 2005). The expansion of government into the delivery of health care
would now inextricably link the delivery of science, i.e., health care, with society.
Government’s role at the federal, state, and local levels would continue to evolve. This
evolution would again change how health care is perceived. Health care was not a stand-
alone product sought solely by individuals but would become mediated by employers,
insurance companies, and most importantly – government (Anderson, 1990).
At about the mid half of the 20th century, social scientists began to fully explore the relationship individuals had between themselves, society and health (IOM, 1988). Anthropologists, archaeologists, and other social scientists had investigated this relationship prior to this time (Good, 1994). However, it would not be until the 1950s that social scientists started to directly challenge the medical model of health and how it defined health in general and individual perceptions of health specifically. Up to this time, the medical, or bio-medical model of health defined health largely in terms of the extent to which science and the application of it through medicinal means could overcome man’s biological shortcomings. Considering the accomplishments of scientists from Vesalius to Lister, having the bio-medical model as the dominant conception of health made sense. Four main assumptions guided the bio-medical model. Elliott Mishler (1981) and later Mildred Blaxter (2004) present and discuss in length each of the assumptions that can be condensed here as: (1) disease was seen as a deviation from normal biological functioning, (2) the doctrine of specific etiology maintained that for every disease there is a cause, (3) the conception of generic diseases posits that diseases were not exclusionary, and (4) the scientific neutrality of medicine assumption suggested that values, either individual or societal can be excluded from the practice of medicine without affecting medicine’s ability to treat and cure disease (Wolinsky, 1980). In writing Approaches to Health and Health Care, Steve Taylor (1997) provides a summary of the bio-medical model that adds to Mishler’s four assumptions. Taylor states that according to the bio-medical model:

Health is the absence of biological abnormality. The human body is likened to a machine to be restored to health through treatments of one sort or another, which arrest, or reverse, the disease process [and] the health of a society is seen as largely
Mishler’s assumptions and Taylor’s definition do not mirror one another exactly. However, they both share a similar approach to defining disease – the result of a biological process leading to a deviation from ‘normal’. Assumptions and portions of the definition also refer us back to examples seen in earlier pages of this paper and how these contributions formed the shape of health until it became firmly rooted in bio-medical soil.

For example, Assumption 1 and the first sentence of Taylor’s definition pair well with the work of Vesalius and Descartes. Assumption 2 and sentence two remind us of the work conducted by Lister, Pasteur, and Koch as well as Descartes’ ‘man as machine’ metaphor. Assumption 3 points to the effect communicable diseases had on industrial societies and the public health response developed to reduce the prevalence of these ambivalent afflictions.

Assumption 4 and the last sentence in Taylor’s definition also follow a similar view of health. That is, health and medicine are value-neutral and “dependent upon the state of medical knowledge and the availability of medical resources”. As such, circumstances existing outside of the agent hosting a disease play no role in determining the diagnosis, treatment, or prognosis of said agent. And, only by means of medical knowledge having been secured in the hands of a highly trained expert and applied in a rational, objective fashion can suffering be confronted and successfully taken away. Within the context of a clinical setting, e.g., hospital, doctor’s office, this assumption and description of the bio-medical model ring true. However, taking assumption 4 and Taylor’s last sentence out of a clinical context and placing it within the context of society, the bio-medical definition of
health begins to change. As a result, it appears that there are limits to the application of a science-based definition of health based on the context in which it is applied.

Positioning health outside of the vacuum of a clinical environment and into society became of primary importance for one sociologist in particular, Talcott Parsons. In writing, Definitions of Health and Illness in the Light of American Values and Social Structures (1958), Parsons engaged in a lengthy discussion whose focus was to draw attention to the strong psycho and somatic relationship he felt existed between mind and body. Parsons believed that these two elements were inseparable and the “interpenetration” of mind with body was so great that drawing a line between them was simply unimaginable. Applying his interest in mental health to his positions, Parsons develops distinctions between the personality and the organism, the role that individuals play within society, and the tasks individuals perform to carry out the “function or functions” necessary to fulfill role requirements. What are most interesting in terms of their application to this paper are Parson’s definitions of health and illness.

According to Parsons:

Health may be defined as the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized. It is thus defined as relative to his “status” in society, i.e., to differentiated type of role and corresponding task structure, e.g., by sex or age, and by level of education which he has attained and the like…Illness, then, is also a socially institutionalized role-type. It is most generally characterized by some imputed generalized disturbance of the capacity of the individual for normally expected task or role-performance, which is not specific to his commitments to any particular task, role, collectivity, norm, or value (pp. 89-90).
Parson’s work provides an interesting comparison to the bio-medical perspective. First, Parsons uses the words ‘capacity’, ‘role’, and ‘socialized’ as determinants for health; not words synonymous with a deviation from biological normalcy. Parsons also introduces external social factors such as sex, age, and educational attainment as factors that relate to one’s health status. The bio-medical model does not provide room for outside influences to affect health. And third, Parsons links an individuals’ health with his ability to carry out social functions and not with his ability to maintain biological functions. The impact Parsons’ work in writing Definitions of Health had on the evolution of socially conceived definitions of health in the years after its publication would be formidable. Granted, tying Parsons to the entirety of key advances in conceptualizations of health after his writings would be a challenge. However, by reviewing many of the texts used for this paper, several authors point to his work as fundamental in affixing social determinants to conceptions of health.

In 1973, Claudine Herzlich published, Health and Illness: A Social Psychological Analysis. Herzlich outlines the dynamic relationship individuals have with society and how these relationships affect one’s perception of health. In an effort to qualify her findings, Herzlich conducted a study analyzing the self-reported health status of eighty upper- and middle-class individuals living in rural regions of France. Motivation for Herzlich to design a study in this fashion was based on her desire to understand “the criteria of the notions of health and illness and their interrelations [and] How are these two concepts related…are they symmetrical…are they mutually exclusive?” The following excerpt from the first page of her book further illustrates the purpose of her inquiry:

If we wish to investigate the social definition of health and illness, we must examine the way the individuals in our society view and experience this pattern of values,
social norms and cultural models, and the way in which the notion of social entities
called “health” and “illness” develops and crystallizes, both logically and
psychologically. (p. 1).

Comparing this statement with assumptions and definitions of the bio-medical model, one
can see the differences that Herzlich wanted to explore. For example, social definitions of
health and wellness are affected by one’s interaction with the world and not based solely on
biological dysfunction. Cultural values and norms seem to play an extensive role in
determining health and health and wellness are social constructions that possess both logical
(rational) and psychological elements.

Among the findings of Herzlich’s work, individuals’ self-perception of health and
illness were most interesting. Regarding health, participants collectively believed that health
could be perceived in a ‘positive’ or ‘negative’ sense with the term “equilibrium” suggesting a
fleeting state of overall health that is ideal but rarely realized. Positive health is “a presence
of which one is fully aware because of one’s feeling of freedom and of bodily and functional
well-being…” (p.53). Health in a negative sense connotes a state of disequilibrium, or illness,
that can exist on various levels and take on many forms, contains a temporal dimension, e.g.,
“chronicity, after-effects”, and varies from person to person. Interestingly, none of the
participants mentioned health to be reliant upon a state of biological functionality. This may
have been due to the questions posed by Herzlich to the study group. However, since the
methods used to collect data were based on open-ended surveys; not seeing biological
factors as catalysts for positive or negative states of health suggests that on an individual,
non-clinical level most folks view health not in terms of how it relates to biological
phenomena but rather how individuals relate to their social environment. Participants also
pointed to a ‘reserve of health’ that inherently manifests itself within individuals.
Conceptions of this reserve were found to vary somewhat among participants but in general, attitude and one’s outlook on life determined the quality and availability of one’s reserve. Herzlich’s findings also extend Parsons’ mind-body dynamic that connected his psychosomatic view of health by viewing perceptions of health from a first-person standpoint. That is, individuals determine their health status by looking at their relationship with the world as opposed to the world looking at the individual, e.g., medicine, to determine what state(s) of health should be (see Figure 2).

Claudine Herzlich’s seminal work would lay the foundation for others to better understand the relationship between individuals, society, and health. For example, A. d’Houtaud and Mark Field investigated the effect social class had on health and Meg Stacey looked at how different cultures viewed gender roles and how this view impacted the development of health concepts within societies (d’Houtaud & Field, 1984; Stacey, 1986). Rory Williams replicated Herzlich’s methodology and applied it to a cohort of elder individuals living in and around Aberdeen, Scotland. Williams’ 1983 publication, *Concepts of Health: An Analysis of Lay Concepts*, sought to test if similarities existed between the ways in which his and Herzlich’s participants thought health to be. Similarities did exist between Herzlich’s Parisians and Williams’ Aberdonians. For example, in both studies health was considered to be the absence of illness and a state of equilibrium was deemed as the ideal state of health. Variations regarding what aspects of living supported one’s ‘reserve of health’ existed between studies; namely, how each group conceptualized strength, weakness, and fatigue and how these dimensions of health affected participants’ ability to maintain a healthy existence. A most interesting observation from Williams’ study was the emphasis that he, and earlier Herzlich, placed on the importance of finding out how lay people, not experts, view health.
Michael Calnan, in writing *Health and Wellness: The Lay Perspective* (1987) pushed the envelope of understanding further regarding how everyday people view health. Dispersed throughout his book, Calnan builds lay definitions of health and illness into a series of models of health seeking behavior that he argues stem from three principle areas: (1) folk culture, (2) sociopolitical values, and (3) perspectives and values of powerful groups “legitimated by society…e.g., the medical profession” (p. 177). Based on an individual’s conception of these three elements and the context within which they find themselves – they will seek various ways to maintain health, manage illness, or prevent illness from occurring. Calnan’s work follows a similar theoretical line as Herzlich and Williams. However, Calnan really zeroed in on the idea of how definitions of health impact the ways in which individual behavior is adjusted to respond to states of positive or negative health. This marked a step forward in understanding that individuals not only define health based on social experiences but that their behavior and attitudes concerning how to maintain health are as importantly impacted by social structures and experiences.

Other disciplines and modes of inquiry weighed in on the ‘health defined’ discussion, with a notable example provided by Michel Foucault’s 1963 publication, *The Birth of the Clinic: An Archaeology of Medical Perception*. Foucault sought to understand how language and a shift in the “gaze” or ways of seeing the world led to the formation of clinics outside of the hospital proper. Foucault attributed the shift to advances in the ways in which knowledge was acquired and subsequently disseminated by practitioners to patients. Through Foucault’s eyes, the historical evolution of scientific inquiry from a practical place to one that was brimming with advances in technology provided room for a new “space” within the health care landscape to become established. According to Foucault:
At the dawn of mankind, prior to every vain belief, every system, medicine in its entirety consisted of an immediate relationship between sickness and that which alleviated it. This relationship was one of instinct and sensibility, rather than of experience; it was established by the individual from himself to himself…the establishment of a corpus of knowledge in the space of the clinic altered this relationship between sickness and healing…[and with the advent of modern medicine, this] meant that the relation between the visible and invisible – which is necessary to all concrete knowledge – changed its structure, revealing through gaze and language what had previously been below and beyond their domain (pp. xiii, 65).

The presence of the clinic not only altered the way in which sickness and healing could be considered but forever changed the dynamics of the doctor-patient relationships that were forged there. For example, when admitted to the hospital patients and their accompanying sickness were insulated from the outside, social world. Physicians would apply the neutral science of medicine to the illness and then once the illness had been healed, the patient would then be released back out into society. In this context, illness precedes the individual. However, with the advent of the clinic, the influence of society on one’s health could not be so easily detached from the individual. Upon entering the clinic, an individual, seen not so much as a ‘patient’ but as a person that was sick, was received by the physician and treated in a way that included a consideration of the relationship between the social space the person was living in, current health status, and future ability to get well once leaving the clinic. The value-free, neutral language used to communicate between physician and patient within the confines of a hospital was motivated to change inside the walls of a clinic in order to facilitate a better understanding of illness and ways to treat it. Therefore, in contrast to a hospital setting, within the ‘space’ of a clinic a person and her social environment were as, if
not more important than her illness. Interactive communication between doctor and patient and the information used to transmit health status on the one hand and ways to effectively remedy illness on the other, drove decision-making – not the one-dimensional dictate of the physician to the patient that had become the norm. As a result of the combined spatial and linguistic changes that took place with the birth of the clinic the membrane that separated healing from sickness became more permeable to the effects of society.

This abridged section of Foucault’s Birth reminds us of the knowing by seeing epistemology introduced earlier in this paper and how it affected the progression of health as it moved from early Greek times into the modern era. As man’s ability to engage more deeply into himself and his world grew, his understanding of what health entails deepened to include elements discovered in both the macro (society) and micro (biologic) realms. Combined, the assimilation of these two avenues of meaning gave birth not only to Foucault’s clinic but also to the ways in which others were defining health.

In two works, Horatio Fabrega Jr., a psychiatrist by training, explored the evolution of health in a way similar to Foucault. In writing, Disease and Social Behavior: An Interdisciplinary Perspective (1974) Fabrega uses language as a foundation upon which to explore the way that the structure of language can shape how one defines and classifies illness. In his fourth chapter, Disease Definitions: Traditional Perspectives, Fabrega begins by discussing the important inclusion of non-neutral words and meanings from society becoming incorporated into the neutral vocabulary of science. Next, Fabrega addresses the meaning of the word disease and how semantic and syntactic functions of the term can be adjusted to alter the meaning of the word based on the context in which it is applied. For example, used as an abstract general term, items can be classified as belonging to a group of “diseases”. However, using a singularizing modifier, referring to disease as “the disease”, or “that disease” takes it out of
the abstract general class and places it into a completely different context (p. 123-124). Using HIV as an example we can see how this abstract-to-categorical change impacts meaning. One could say, (a) “Diseases transmitted by sexual contact include HIV” or (b) “The disease that led to his death was HIV”. This transfer from general to categorical has what Fabrega calls “a narrowing effect”. Within the context of forming a public policy aimed at reducing the transmission of HIV, the language used to conceptualize the problem thus becomes very meaningful.

Following his discussion of word structure, Fabrega proceeds into a lengthy discourse regarding the logical nature of the word disease and its relationship to a series of indicators and how they affect the contextual application of the term. Fabrega writes a few examples of a linear, regression-type formula that illustrate his thoughts and can be represented in the two following examples:

\[ D_1 : X_1, X_2, X_3, X_4, X_5 \]

Or-

\[ D_2 : X_1, X_2, X_4, X_6, X_8 \]

Therefore, Disease one is impacted by the combination of indicators one through five and Disease two is impacted by indicators one, two, four, six, and eight. Based on the impact each indicator has on the designated disease and on one another, individuals will react in various ways to lessen the impact disease has on their ability to maintain health. Space does not allow for further analysis of Fabrega’s discourse here but based on the limited area dedicated to introducing Fabrega’s ideas, one can see that concepts and definitions of health and health-related terms has continued to evolve into a highly complex level of analysis.

Among the topics discussed in, *Evolution of Sickness and Healing* (1997), Fabrega pursues the “evolution of the medical” (p. 185) and the meanings associated with concepts
that resulted from this process. Contained within a subsection of Chapter 7 titled, *Units of Information in the Cultural Evolution of Medicine*, Fabrega describes his assumption, “that the evolutionary process operates in terms of units of genetic and cultural information derived from biological and social systems, respectively, and from any number of a society’s social organizations and institutions”. Borrowing from Richard Dawkins (1982, 1986), Fabrega coins the term “meme”, or “healmeme” more specifically, to describe packets of informational “traits” passed down through time that contain healing responses to sickness. Said healmemes afford individuals and societies the ability to “enact the behaviors associated with sickness and healing” that confronts them throughout their lifetimes. Using the logic of evolutionary psychology, Fabrega believes individuals will engage in social activities that use memes “because reciprocated acts of a similar nature will lead to an enhancement of inclusive fitness”.

Like Fabrega’s discussion of language structure and Foucault’s description of the patient-physician interactions that took place in the clinic; a faint strand of interconnectivity between each of these three concepts begins to appear. Foucault uses a place to describe interpersonal changes; Fabrega in *Disease* uses language and then in *Units* uses packets of language to describe how health information gets transferred from one time to the next. All three of these are deeply embedded within social structures. What this suggests is that social scenarios define health once they have been presented within a social context. The biomedical model is relevant but only within certain, specific contexts. This leads us to conclude that defining health is not limited to determining if its roots stem from a biologic or social history. Rather, the context in which health is being considered matters most. Second, the perspective that is guiding the concepts arranged into definitions of health is important. For example, an individual’s view of his or her health differs tremendously from how a physician
views a patient’s health. And, health considered at the population level possesses characteristics that simply cannot be applied on an individual plane.

This section began by presenting an annotated timeline of key events in the evolution of biological and social definitions of health. Both disciplines have contributed heavily to our understanding of what health entails. Suffice to say, one perspective is not superior to the other. Instead, they can be seen as complimentary positions guiding an evolution of what health was in the past, is today, and may become in the future. A comparison of biological and social concepts and terms used within these two fields may also add to one’s ability to see similarities and differences that exist between these two approaches and how each contributes to our evolving understanding of health. Table 2 illustrates a comparison between these two perspectives.
Table 2.

Concept-Word Comparison Between Biological and Social Perspectives of Health

<table>
<thead>
<tr>
<th>Concept</th>
<th>Biological Perspective</th>
<th>Social Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation</td>
<td>Diagnose, treat, cure</td>
<td>Prevent, preserve, restore</td>
</tr>
<tr>
<td>Idealized Health State</td>
<td>Homeostasis</td>
<td>Equilibrium</td>
</tr>
<tr>
<td>Temporality</td>
<td>Static, finite</td>
<td>Evolutionary process</td>
</tr>
<tr>
<td>Role of Individual</td>
<td>Man as Machine</td>
<td>Man as Person</td>
</tr>
<tr>
<td>Diagnostic Measures</td>
<td>To quantify: EKG, MRI, PET, laboratory tests, objective</td>
<td>To qualify: self-report, observation, subjective</td>
</tr>
<tr>
<td>Relationship with Society</td>
<td>In isolation from</td>
<td>In concert with</td>
</tr>
<tr>
<td>Cause and Effect</td>
<td>Ono-to-one, linear, if-then</td>
<td>Absolute interrelatedness, networks, systems</td>
</tr>
<tr>
<td>Research Design</td>
<td>Deduction, clinical trial</td>
<td>Abduction, ethnography, case study</td>
</tr>
<tr>
<td>Fields of Influence</td>
<td>Biology, Chemistry, Physics</td>
<td>Anthropology, Sociology</td>
</tr>
<tr>
<td>Theoretical Foundations</td>
<td>Positivism</td>
<td>Constructivism, networks</td>
</tr>
<tr>
<td>View of Health</td>
<td>States of health are seen as negative</td>
<td>States of health are seen as positive</td>
</tr>
<tr>
<td>Health and Social Value</td>
<td>Productivity, ability to work</td>
<td>Role performance, contribution</td>
</tr>
<tr>
<td>Illness</td>
<td>Deviation from a measurable norm</td>
<td>Not well, sick, unhappy</td>
</tr>
<tr>
<td>Treatment</td>
<td>Pharmaceuticals, surgery</td>
<td>Therapy, protective measures</td>
</tr>
<tr>
<td>Health Seeking Behavior</td>
<td>Access to services, seeing a doctor, insurance status</td>
<td>Access to services, community well-being</td>
</tr>
<tr>
<td>Public Policy</td>
<td>Research, monetary value</td>
<td>Prevention, societal value</td>
</tr>
<tr>
<td>Medical Education</td>
<td>Science centered, allopathic, naturopath</td>
<td>Society centered, osteopathic, naturopath</td>
</tr>
<tr>
<td>Access to Care</td>
<td>Insurance based, single points of entry, closed access</td>
<td>Need based, multiple points of entry, open access</td>
</tr>
</tbody>
</table>

Note. Concepts and words contained in this table were drawn from multiple sources referenced in the literature review.

The next few pages will be concerned with the ways in which health has been measured. Viewing health in this way allows one to see in a different manner the
relationships between social and biological approaches to health and underscores the importance of viewing each field’s contributions as adding to a holistic understanding of what health entails.

The Measurement of Health

Now that we have briefly discussed the paths the bio-medical and social models of health have followed to define health a brief consideration of how each model has measured health will commence. This annotated presentation aims to demonstrate in another way the differences and similarities that exist between both models of health.

Bio-Medical Measurement

Within the context of a hospital or doctor’s office, health has been measured by any number of tests to determine the extent to which a patient’s condition remains within or deviates from clinically defined ranges of normalcy. Following an external physical examination and sometimes a brief accounting of why the patient presents with the symptoms that he does, a physician may order a series of tests to diagnose disease that may not be readily observed through the physical exam or teased out from within the nuances of the doctor-patient conversation (Jacobs et al., 1996). For example, if a patient is complaining of tightness in the chest a doctor may order an x-ray, analysis of the blood, electrocardiogram, or a treadmill “stress test” to confirm or rule out causes of disease that express themselves symptomatically as chest tightness. Based on the results of the test battery a physician may prescribe any number of treatments, including but not limited to: pharmaceutical drugs, changes in diet, additional follow-up tests to monitor a patients’ future health status, or surgical procedures aimed at reversing or eliminating the cause(s) of the disease that are symptom producing. This process of using a combination of external physical and internal biological tests to validate assumptions made by a doctor in treating a
patient follows the tenets ascribed by the bio-medical model. This process has not undergone a great deal of change since the work of Descartes and others solidified the bio-medical model as one way to determine states of health. Tools and tests used within the process have undergone a great deal of change however. In Descartes’ time, and with the early microbiologists, their analysis of the dark spaces was limited by the technology available to conduct their experiments. As we all know, the resources available to test and measure health today are not what they used to be – a half-century or even one year ago. With the discovery of the fundamental structures that compose every living being (Watson & Crick, 1953) to advances in the diagnostic testing of breast cancer cells (Lambein et al., 2011), the ability and precision with which to quantifiably test and subsequently diagnose disease is unimaginable. One relevant question remains however: Has the ability to develop and apply highly sophisticated bio-medical measures of health improved the quality of life of those to whom it is applied? This question lies outside the intentions of this dissertation but demonstrates a limitation of the bio-medical model in its ability to be the omnipotent source for measuring and preserving health (Engel, 1977; Nuland, 1993). That is, first, everything that contributes to states of health may not be quantifiable, and second, even if you could quantify all factors that affect health, the mechanisms with which to treat or prevent disease from occurring are finite. As disheartening as this realization may be it provides welcome space for socially derived measures of health to contribute to the traditional bio-medical matrices that, even with the best of intentions, can fall short of their desired objectives.

Social Measures of Health

At around the time Claudine Herzlich was conducting her field studies of health, a renaissance of sorts was taking place. Social scientists representing various fields were going out into public spaces and conducting research premised on the idea that if one really
wanted to know what was happening with the health of society, one needed to get as close to the source as possible (Wolinsky, 1980). Carrying forward the voluminous works of French sociologist Émile Durkheim (1895, 1982), this new flock of researchers began to conduct studies relying on interviews and survey instruments as their primary tools to gather information. Designing methodologies around this qualitative approach added to the understanding of the multitude of social dimensions that impact health not readily seen through the static, value-free lens of bio-medical data (Breslow, 1989). In addition to capturing point-in-time information found in a clinical setting, sociologists, medical anthropologists, and others were collecting information that could measure health from a day-to-day perspective over longer periods of time. One result of these efforts was the creation of a wide array of interview and survey instruments that remain in use today. These instruments collect a variety of information that includes self reported health status, subjective well being (Bowling, 2005) (Table 3) and measures to capture participants’ levels of anxiety, depression, or pain (McDowell, 2006) (Table 4).
Table 3.

Survey Instruments: Functional Ability, Health, and Well-Being

<table>
<thead>
<tr>
<th>Measure</th>
<th>Functional Ability</th>
<th>Health</th>
<th>Psychological Well-Being</th>
<th>Social Support &amp; Support/Networks</th>
<th>Subjective Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrument</td>
<td>The Karnofsky</td>
<td>The Sickness Impact Profile</td>
<td>Goldberg’s General Health Questionnaire</td>
<td>Inventory of Socially Supportive Behaviors</td>
<td>The Affect-Balance Scale</td>
</tr>
<tr>
<td>Performance Index</td>
<td>The Barthel Index</td>
<td>The Geriatric Mental State</td>
<td>The Social Network Scale</td>
<td>The Family Relationship Index</td>
<td>Delighted-Terrible Faces (D-T) Scale</td>
</tr>
<tr>
<td>The Quality of Well-Being Scale</td>
<td></td>
<td>The Abbreviated Mental Test Score</td>
<td></td>
<td>Sense of Coherence Scale</td>
<td></td>
</tr>
</tbody>
</table>


Table 4.

Survey Instruments: Anxiety, Depression, and Pain

<table>
<thead>
<tr>
<th>Measure</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrument</td>
<td>The Taylor Manifest Anxiety Scale</td>
<td>The Beck Depression Inventory</td>
<td>The McGill Pain Questionnaire</td>
</tr>
<tr>
<td></td>
<td>The Zung Anxiety Inventory</td>
<td>The Geriatric Depression Scale</td>
<td>The Pain and Distress Scale</td>
</tr>
<tr>
<td></td>
<td>The State-Trait Anxiety Inventory</td>
<td>The Carrol Rating Scale for Depression</td>
<td>The Pain Perception Profile</td>
</tr>
</tbody>
</table>


Data gathered from the application of these instruments and the measures of well being they capture can then be used to identify any number of social factors that may be impacting the participants’ health status. These social factors, or social determinants of
health, have now become synonymous with a large number of studies conducted within the field of public health to determine not only how determinants affect individual health but population health as well and the behaviors that individuals and communities engage in to create environments that are healthy (Fuchs, 1974; Mechanic, 1995; Cowen et al., 1996; Heaney & Israel, 2002; Janz, Champion, & Strecher, 2002; Minkler & Wallerstein, 2002; Montaño & Kasprzyk, 2002).

The collection of data used to protect the public’s health has occurred continuously to some degree since Hippocrates was developing his philosophy of the relationship between health and nature (Novick, 2005b). Over time, as human life has become more sophisticated, measuring health at the population level has become increasingly important (Rosen, 1993). Combating communicable diseases, preventing obesity, or providing clean water in Sub-Saharan Africa are all examples of motivations why the collection of public health information is critical to providing all people with the inherent capacity to lead healthy, vibrant lives.

Commonplace measures of the public’s well being are exemplified by indices that reflect a general snapshot of health and include: birth rate, death rate, morbidity, mortality, risk ratio, and prevalence (Gordis, 2004). Applied within a population context, an urban core for example, numbers tied to these measures may indicate the extent to which public health programs are succeeding. Conclusions drawn from an analysis of this information may then inform policymakers of where a gap or gaps in program development or implementation are (Glanz et al., 2002). And, if available resources can be transfigured to meet the defined needs of the urban area; they can be re-distributed with the hope that their allocation may improve the health and well being of the segment of society that is being observed (Blum, 1981; Novick, 2005a).
Synergy exists between bio-medical, social, and public health measurement techniques. For example, all three approaches seek to uncover information used to create potential solutions to improve health, reduce suffering, or prevent illness from setting in. Second, information that is collected can be analyzed to draw conclusions about the relationship between the dimensions affecting health and the health status of the individual or community being tested. And third, insights gained from the measurement process can be compared against other data to create normal ranges or values of health.

Differences between the three techniques exist as well. A primary difference is the type of information that is collected. Simply stated, biologic material used for measuring health consists of blood, tissues, and fluids composed of a series of fundamental properties essential to life. Social information is composed of information that is more of a phenotype, or expression of physiological processes that usually manifests itself in health-seeking or health-inhibiting behaviors. Second, the context or place where information is being collected plays a significant role in determining the extent to which the factors being tested impact health. For example, biometric tests conducted in Foucault’s clinic may take on a more personal meaning than information that is collected at the population level, e.g., a door-to-door neighborhood survey. And third, how the data are used separates measurement techniques based on the level of analysis being sought. As with contextual considerations, population-based data may be applied to health issues that affect wide swaths of the population whereas point-of-care testing tends to impact health on an intimate, personal level.

The key to understanding how each technique contributes to health is that even though measurement may occur within different contexts and levels of analysis they all serve the interests of those being measured. All too often, one measurement technique is leveraged
at the expense of the others. This may be due to the test(s) being conducted, the level of analysis being observed, or the overall design of the research methodology being implemented (Silverman & Marvasti, 2008). However, if one message can be taken away from this discussion – it is that if one is to truly achieve a holistic sense of the health status of individuals, communities, or even nations, one must be willing to in the very least consider as many of the techniques used to measure health as possible. This way, in the event that policies are developed, implemented, and reviewed for success, the chance that relevant and meaningful indicators of health are included is increased (Kind, Gudex, & Dolan, 1994). The overall effect of this inclusive approach is to design policies that are efficient, effective, and most importantly, improve the health and well-being of those they are intended to serve.

**Summary of Two Perspectives of Health & Their Connection to Community Benefit**

As we have seen in the discussion regarding two perspectives on health, distinctions can be made between these two views. The biomedical model holds unique positions with respect to how perceptions of health stem from an understanding of the human as an object to be studied separate from its environment using quantitative methods of discovery, analysis, and treatment. Conversely, the social approach of health deems that humans and their health condition rest in harmony with her social environment. Methodologies employed to determine health status from a social point of view posit that environmental dimensions that affect health must be considered when addressing an individual’s health and well-being.

The next task is to then place these two perspectives into the context of community benefit policy development to determine the extent to which each perspective may have informed the development and application of community benefit policy. If we extend back
to previous sections of the dissertation and recall the literature that was reviewed regarding the guidelines, statutes, analyses, and reports that were submitted by various stakeholders in the development of community benefit policy and contrast these with biologic and social perspectives on health; we may begin to see the relationship between these two distinct but interrelated bodies of work.

For the literature representing the first section of this review, the majority of the work closely adheres to a bio-medical, scientific perspective of health. Federal guidelines, state statutes, industry reports, health system publications, and academic contributions focused on defining, measuring, and accounting for community benefit in order for nonprofit hospitals to qualify for tax-exempt status. As the literature has suggested, receiving tax-exempt status benefits institutions monetarily with the idea that providing special considerations to nonprofit hospitals afforded them the ability to provide services to the community that were unprofitable, i.e., uncompensated for. And, as we have seen, the largest percentage of community benefit reported by nonprofits in order to maintain their tax-exempt status were based on uncompensated care claims – not community development or other community-based programs. Uncompensated care holds a value or dollar amount that can be quantified. As a result, even though the underlying reasons why uncompensated care claims constitute the highest percentage of reported community benefit, their prominence seemingly justifies a nonprofit hospitals’ receipt of special tax classification. Therefore, this observation could be viewed as representing the primary objective of developing the policy, i.e., protecting the interests of the hospital. And, as such, could be argued to reflect a scientific, quantitative approach to policymaking.

Providing social aspects of community benefit policy thus became the secondary objective of the policy development process. For example, determining need within
communities and then creating policies based on social-demographic characteristics of the community in order to address the health needs present reflects a socially based policymaking orientation. However, this downstream step in the policy process takes place in the implementation phase of the process. And, when comparing the dollar amounts that are committed to upstream activities, i.e., uncompensated care, and the literature that has been dedicated to defining, measuring, and accounting for community benefit claims with dollar amounts that are invested in community based programs and literature published that investigates the impact these investments may have on improving health, a clear distinction between upstream and downstream policy prioritization can be seen.

Therefore, what results is a community benefit policy that is paradoxical in nature promulgating a tension between a bio-medical and social perspective of health. Explanations for this phenomenon have yet to be produced within the literature. However, if we take a closer look at aspects of the policy development process itself, particularly as they relate to community benefit, new insights may be gained that can lay the groundwork for empirical research to be conducted that may provide new insights into why the tension exists and what recommendations can be made that might bring bio-medical and social aspects of community benefit policymaking closer together.

Part 3: Target Populations, Policy Development, and Outcomes

Present within the universe of community benefit, three groups represent the entities that are most affected by community benefit policies. They are: government, hospitals, and communities. As Parts 1 and 2 of the literature review revealed, the majority of the discussion regarding the development of community benefit policies has been focused on the role government has had to produce policy guidelines and the responsibilities placed upon hospitals to carry out the requirements of said policy. Each of the three stakeholder
groups is impacted by community benefit policy development. However, as the name of the policy suggests, community is, or should be, the primary beneficiary of the policy. With good reason and supported by the rising costs, challenges to access, and poor outcomes produced by our current healthcare system; it appears that communities might not be receiving levels of benefit from this policy that they could. Why is this so?

The next section of the literature review tackles this question and hopefully sheds some light on reasons why communities may not be benefitting from existing community benefit policies. To begin, a brief discussion of contemporary policy models takes place to introduce the audience to models that may reflect current community benefit policy development. Then, a novel degenerative policy model created by Anne Larson Schneider and Helen Ingram is introduced that may explain why the tension between a scientific based policy development process appears to overshadow a social, community-based policy approach within the context of community benefit policy development.

Policy Frameworks & Models

For more than a century, research has been conducted within various fields of inquiry to understand how public policies come to be. From political science to public health and public administration models of policy development have been designed and tested in order to attempt to explain the highly complex nature of the relationship between policy development and the effects they have on the public. Health care policy has received a great deal of attention during this time and in recent years has garnered a central position in discussions relating to policy development and its potential effect on delivering care that is accessible, fiscally sustainable, and achieves positive outcomes to individuals and families (Funigiello, 2005).
In an effort to illustrate the work that has been done in the policy development model arena, descriptions of selected models begin this section of the dissertation. This is followed by the presentation of a recent model developed by Anne Schneider and Helen Ingram, a degenerative policy model, which may explain reasons why community benefit has evolved the way it has and the possible impact the design of community benefit policy may have on community health.

*Rational – One Step at a Time*

In an effort to explain the decision making processes of government, Charles Lindblom introduced an idea (1959) that suggested that government policy decisions were reached through the application of a rational, step-wise approach. Known formally as incrementalism, Lindblom raised the idea that the most efficient and effective means with which to make policy decisions rests with the notion that only small changes enacted over relatively long periods of time can result in policies that produce favorable outcomes and that are durable enough to withstand any number of factors that may undermine a policy’s short- and long-term ability to succeed. Lindblom followed up his earlier work in a second publication, *Still Muddling, Not Yet Through* (1979) in which he suggested that critics of his incremental approach to policymaking were off target. In order to address naysayers, Lindblom posited that incrementalism itself was not the problem. Rather, the way in which policies were developed and analyzed was the problem. For example, Lindblom mentioned that a “synoptic” view of incremental policymaking deafens a policy’s impact. Conversely, a policy that reflects a strategic, carefully weighed incremental approach has an opportunity to produce comparatively better outcomes than a policy that does not (p. 518). As a result of employing a sophisticated strategic approach to policymaking, Lindblom argues, “A fast-
moving sequence of small changes can more speedily accomplish a drastic alteration of the status quo than can an only inferior major policy change” (p. 520).

Rationally, Lindblom’s “sequence of small changes” position is sensible. Contextually, however, it might not play out as intended. First, one can agree that a rapid series of small changes can produce effective results. And second, no one benefits from a poor policy decision. However, it may also be argued that quality policy decisions, regardless of their size or pace of implementation, must occur if positive incremental or broad, comprehensive policy change is to become efficient, effective, or both.

Contrasting Lindblom’s incremental policy theory to the development of community benefit policy a case could be made that suggests the evolution of community benefit has followed an incremental approach but at a pace that was not very rapid. To illustrate this observation, consider the following: (1) The length of time that passed between IRS Revenue Rulings, and (2) the length of time that passed between the last Revenue Ruling and the addition of Schedule H to Form 990. As we have seen, the first Revenue Ruling was produced in 1956. The second and third Rulings in 1963 and the most recent Revenue Ruling put forward in 1983. Since 1983, no other Revenue Rulings directly connected to community benefit have been generated. As a result, the changes in the 1963 and 1983 Rulings incrementally amending the original 1956 Ruling took nine and twenty years respectively to happen. Second, in 2007, the IRS released a revised version of Form 990 and added Schedule H – Hospitals in 2008 to be fully implemented beginning in tax year 2009 (IRS, 2009). The revised From 990 was an effort to streamline the reporting process for nonprofits and the addition of Schedule H provided nonprofit hospitals an opportunity to more explicitly demonstrate to the IRS the activities that were being conducted to support individual hospital community benefit activities. Both of these reforms could be considered
as positive and their full impact has yet to be revealed. However, if one contends that the revised 990 and inclusion of Schedule H represent the most recent major overhaul of the nonprofit hospital tax reporting process, the length of time, 1983 through 2007, was substantial. Therefore, taken together the incremental changes that did occur did so at a relatively slow pace.

The Policy Stages Model

In writing, *Politics, Power, & Policy Making: The Case of Health Reform in the 1990s*, authors Mark E. Rushefsky and Kant Patel (1998) place their discussion in the context of health care reform “as a vehicle for understanding the potential and limits of American policy making as we approach the end of the twentieth century” (p. xi). Covering a myriad of topics to support their positions, Rushefsky and Patel define the policy process as a series of “steps or stages” that are followed in order to reach specific ends based on moments of opportunity when policies are most likely to be effectively administered. According to the authors and borrowing heavily from previous work (Cobb & Elder, 1982; Kingdon, 1995; Baumgartner & Jones, 1993), Rushefsky and Patel describe the four steps that make up the policy process: agenda setting, policy formulation and adoption, policy implementation, and policy evaluation (p. 16).

In describing why America has failed to reform her health care system via policy development, Rushefsky and Patel point to three reasons. First, an ideological dilemma was created essentially pitting self-interest versus community interests. Second, the existence of influential interest groups diluted attempts to find consensus among stakeholders. And third, the structure of the US government system prevented opposing parties from setting aside their own positions in order to achieve collective goals (p. 12).
As a result, one may argue that the architecture of the policy process itself was not to blame for a failure to reform health care in America. Rather, factors external to the policy development process effectively diminished the stages of the policy design process from flourishing.

*Institutional Analysis and Development*

According to rational choice theory, models that have been developed to explain the policy making process are based on the notion of “how institutional rules alter the behavior of intendedly rational individuals motivated by material self-interest” (Sabatier, 2007). Elinor Ostrom (2005) has extended this thought much further in the work she and other have done to create the Institutional Analysis and Development Framework (IAD). To simplify her model, Ostrom uses institutions, defined here as “the shared concepts used by humans in repetitive situations organized by rules, norms, and strategies” (Sabatier, 2005, p. 23) to create a multi-layered analysis working at “three levels of specificity…(1) frameworks, (2) theories, and (3) models” to describe what may occur inside policy “action arenas” and the “resulting patterns of interactions and outcomes and the evaluation of these outcomes” that envelops the entire policy making process.

Within the action arena, actors interact with one another under the environmental conditions, e.g., rules, other variables, found within the arena. Actors can be individuals, corporations, or other entities. Predictions of potential outcomes of the policy process can be made and evaluated based on any number of criteria including, but not limited to: economic efficiency, fiscal equivalence, redistributional equity, accountability, conformance to general morality, and adaptability (Sabatier, 2005, pp. 33-34). Rules as well as physical and material factors occurring in the world play a central role in shaping the landscape across the action arena. In particular, “attributes of community” variables play a key role in determining
how a policy may be developed and the potential outcomes a developed policy may have on those that are to be beneficiaries of it. Ostrom notes:

“The attributes of a community that are important in the structure of an action arena include the norms of behavior generally accepted in the community, the level of common understanding that potential participants share about the structure of particular types of action arenas, the extent of homogeneity in the preferences of those living in a community, and the distribution of resources among those affected”

The IAD model that grew out of rational choice theory has been applied in many context areas. Examples include common-pool resource problems, urban government issues, land management, and the development of partnerships among public agencies.

*Agenda Setting, Choices, & Policymaking*

First published in 1984 and again as a second edition in 2003, John W. Kingdon’s, *Agenda’s, Alternatives, and Public Policies* (2003) addressed the ways in which public policy decisions are made. Using agenda setting, policy alternative selection, decision making, and the influence of stakeholders, e.g., the media, interest groups, as key factors that contribute to policies being delivered, Kingdon sought to “determine why some agenda items and alternatives are prominent and others are neglected” (p. xvii) and more specifically, “What makes people in and around government attend, at any given time, to some subjects and not to others?” (p. 1).

Kingdon focused his attention largely on policy decisions occurring at the federal level. He keenly selected health care reform and transportation policy as backdrops for his experimental methodology upon which he could test his theoretical positions. By conducting a series of in-depth interviews among members representing health and transportation interests both inside and outside of government, Kingdon posited that within “the policy
primeval soup” (p. 116) problems are identified, policy choices are presented, alternatives are selected, and policies are enacted based on the presence of opportunities, or windows, made available and acted upon via the interaction of multiple streams of information by stakeholders representing a myriad of interests.

As we have come to learn about the formation of community benefit policy, Kingdon’s framework appears to be a good fit to explain the interaction of interests that have shaped community benefit policy over time. For example, the IRS developed a series of guidelines that nonprofit hospitals translate into policy based on the needs of community. However promising as this observation appears, Kingdon, as well as the literature that forms the large majority of commentary on community benefit policy has revealed; a very important component of the policy making process remains mostly silent in both Kingdon’s analysis and current community benefit policy – the impact the policy process has on improving or hindering the quality of life for whom public policies are directed to serve, the citizenry.

*Punctuated Equilibria*

With the publication of *Agendas and Instability in American Politics* (1993), Frank R. Baumgartner and Bryan D. Jones extended the contributions Kingdon and others made regarding the agenda setting process. New theoretical concepts and methodological approaches to understanding how items are placed on and remain within public policy processes were also developed throughout the book. According to the authors, policy monopolies operating within policy subsystems take action during punctuations of equilibrium to push their agenda items through the policy machinery to achieve the policy outcomes they seek (pp. 3-4). Objectives to be reached are drawn from the images created
by specialist entrepreneurs working in the venue in which a particular issue is being considered (p. 25).

Baumgartner and Jones place their vision of the agenda setting process through the lens of government as institution. The authors test their positions using a novel combination of quantitative and qualitative techniques to analyze levels of media coverage on specific issues, i.e., nuclear energy, pesticide use, smoking, as they pass through the congressional legislative process (p. 57). When considering the knowledge gained from their work in general, the authors determined that both incremental and “bursts” (p. 235) of policy change occur within naturally unstable, not stable policy arenas. And, among the pages dedicated to explaining their observations in more detail, Baumgartner and Jones posited:

Policy subsystems are often institutionalized as “structure-induced equilibria” in which a prevailing policy understanding dominates…[and] During periods when differential intensities of preferences are strong, and when a favorable public image causes a subsystem to be viewed with benevolence rather than hostility, specialists hurry to create institutional structures designed to protect them from later encroachments (p. 238).

Layering this idea onto the community benefit policy subsystem, one can see the words above describe the development and execution of community benefit policy rather well. For example, as the literature has demonstrated, institutional perspectives based on a specialist-scientific view of policy design have dominated the theoretical underpinnings of community benefit. Second, until quite recently, the perception of community benefit policy and its application into society has been positive; nonprofit hospital’s traditional role of serving those in need continues due to their ability to provide benefits to community. As a result, institutional and industry publications that create the policy image of community benefit
highlight the billions of dollars that are committed to providing benefits to community while
downplaying the privileges they receive from their nonprofit status as well as the impact
billions of dollars invested have had on improving community health. Third, institutional
structures that have been put in place, e.g., Form 990 – Schedule H, to improve the
reporting accuracy of community benefit claims, should improve the reporting requirements
nonprofits must adhere to. However, in terms of reporting improvements in community
health, it appears that institutions have yet to incorporate detailed reporting structures that
measure and report community health improvement.

The Market & The Polis

contrasts the differences between a society that follows a market-oriented, individual-centric
model and a model that follows a community interest orientation (p. 33). In doing so, Stone
suggests that creating public policies that adhere to concepts of cooperation that lead to
improving the welfare of communities is possible. However, several factors have to be
considered and multiple points of contact over sustained periods of time need to occur if a
community, or *polis*, model is to be achieved.

One of these factors is balancing the tension that exists between advocates that
support a self-interested market-oriented approach to policymaking and those that support a
community-centric vision for public policy creation. Stone presents the relationship between
these two competing interests in the following:

> It would be as much a mistake to think that the market has no concept of public
> interest as to believe that the polis has no room for self-interest. But there is a world
> of difference between public interest in a market and a polis. In theory, the public
> interest or general welfare in a market society is the net result of all individuals
pursuing their self-interest. In economic theory, given a well-functioning market and a fair initial distribution, whatever happens is by definition the best result for society as a whole. In a market, in short, the empty box of public interest is filled as an afterthought with the side effects of other activities. In the polis, by contrast, people fill the box intentionally, with forethought, planning, and conscious effort (p. 22).

Placing Stone’s description of the differences between self-interest in a market and self-interest in the polis, and contrasting these differences with the tension that exists between nonprofit hospital’s need to meet community benefit reporting requirements and their mission to serve the needs of their communities – one can see that community benefit policy today embodies this tension. For example, a review of the literature revealed that the largest amount of resources committed to community benefit and the claims hospitals report are consumed by uncompensated care shortfalls with the least amount being expended on community-specific programs. Uncompensated care claims are the result of differences between what a hospital charges for services provided and the compensation they receive from third-party payers. One could argue then that this observation represents a market-based policy mechanism operating within current community benefit policy environments. In other words, uncompensated care claims constituting a large portion of community benefit claims are justified because they follow a monetary, market-based philosophy that is measurable against a known quantity, i.e., the dollar, whereas providing resources directly to community in an effort to address factors that may lead to high levels of uncompensated care is of secondary importance because these resources and their subsequent outcomes are difficult, at best, to quantify.

The review of policy models discussed thus far has been presented in a way to provide the reader with a basic understanding of the different ways the policy process has
been dissected and illuminated by various authors. Some have viewed the policy making process as a rational, incremental undertaking that follows a fairly predictable trajectory while others have viewed the policy process as a dynamic, complex task involving a myriad of offsetting interests competing for agenda-setting space.

Pairing the description of the selected models with the literature that discussed the formulation of our understanding of health, a scientific-biomedical perspective and a social perspective, the reader can see that community benefit policy has currently rooted itself firmly within the scientific perspective based on a market-based ideology of policy development. Baumgartner and Jones and Stone speak to this phenomenon in their writings suggesting that the formulation of policy that follows a rational, self-interested rational is not only understandable but seemingly the most efficient and effective means by which policy is created.

However, this observation by no means suggests that this approach actually delivers the intended benefits to society that policies in general and community benefit policy specifically aim to produce. It only points out that developing policy is a most difficult task and when stakeholders attempt to create new or transform existing policy, building policy structures around comprehensible market-science based theories just makes logical sense.

If policy development processes are to shift towards a more community-centered, common interest format new models of theory development need to be discussed. Therefore, in an effort to demonstrate how such a tack may occur, a novel policy model developed by Anne Larson Schneider and Helen Ingram is discussed next.
A Degenerative Policy Model

In writing *Policy Design for Democracy*, Anne Larson Schneider and Helen Ingram (1997, 2007) discuss how the social construction of policy designs impact the ways in which policies are formed and the outcomes they produce. According to the authors:

Much of the public policy in the United States is produced by policy-making systems dominated by divisive social constructions that stigmatize potential target populations and extol the virtues of others. These constructions interact with the political power of the target groups to establish the political agenda, focus the terms of the debate, and determine the characteristics of policy designs (p. 102).

What this perspective boils down to within the space of policy development is that those with power and influence shape policy and reap the greatest benefits while those who do not possess power or influence receive not what they may need but what others believe they are worthy of. Schneider and Ingram term this policy making process as degenerative, speaking directly to the degenerating nature of policy benefits being best at the top and worst as they trickle down to the bottom.

Policies are therefore “socially constructed” based on perceptions of where stakeholders are placed within the policy landscape. If a stakeholder group is deemed to be good they receive maximum benefit. Conversely, if a stakeholder group is considered to be less than, they receive minimum benefit. These “policy target” groups: advantaged, contenders, dependents, and deviants are determined by the influential and the degree of policy benefits they receive are brokered by policy entrepreneurs navigating the muddy waters of the policy process.

Like other policy models, Schneider and Ingram point to the institutional culture of policy-making entities to explain how institutions of all sorts are susceptible to creating
degenerative policies. The authors offer several explanations for why this occurs. At the core of institutional degenerative policymaking lies the notion that competing interests operating within institutions constantly vie for control over the process that leads to either cooperative or antagonistic policy creation. As we have seen, this inherent institutional tension may describe challenges nonprofit hospitals face when developing community benefit policy.

For example, when a nonprofit hospital decides to fund community programs that improve health; authorization to dispense funds may take place within departments that are separate from the departments where community programs are developed and implemented. This separation of interrelated yet distinct interests may prevent a hospital from delivering levels of community programs that are needed not only to meet identified community needs in the short term but also to improve community health in the long term. A community benefit department can justify the need for resources. However, if resource requests are unable to be proven to improve the bottom-line of the balance sheet, requests may be partially funded or not funded at all. Therefore, as a result of the tension that may exist within this scenario an outside observer might conclude that the fiscal survivability of the institution takes precedence over the survivability of the community. Schneider and Ingram offer additional insight as to why this hypothetical example illustrates the impact within-institution tension may have on policy development.

As policies are socially constructed, there inevitably will be winners and losers. As such, determinations of which targets are to receive the most and least benefit need to be made. Historically, nonprofit hospitals have held a special place within the health care environment. They have provided a significant and substantial amount of care to all members of society. And, within recent years as the make-up of health care delivery has shifted into a highly competitive playing field, nonprofit hospitals have worked hard to fulfill
their mission to serve while balancing their need to remain fiscally viable. Paradoxically, however, one could argue that the need to remain competitive in a market-based system while delivering a socially oriented service has shifted nonprofit hospitals away from their historical mission while simultaneously jeopardizing the health of the communities in which they operate. As a result, in order to survive hospitals have insulated themselves within the policies they create, i.e., community benefit, and by default have placed themselves as the primary beneficiaries of policy creation. The losers then become the vulnerable members of community that seek care but are unable to pay for the services they receive. What occurs in the long run is a self-perpetuating cycle of higher and higher levels of uncompensated care claims being filed, community health outcomes that are mismatched against the resources that are committed to providing care, and a continued separation between providers and seekers of care.

Providing a policy solution to the quagmire community benefit policy has found itself in will not be easy. However, if one could examine the community benefit policies of a health care system and its associated hospitals, perhaps new insights could be gained that may lead to recommendations for future policy change. This explorative task will be taken up in the next chapter of the dissertation and following the analysis of the development of community benefit policies of a nonprofit health care system; offerings of policy change will follow in subsequent chapters.

Before we delve into the analytical piece of the dissertation, let us revisit the research questions posed at the beginning.
Research Questions

Four main questions form the central motivation to conduct this research. They are:

1. To what extent does the process of developing community benefit policies impact the health of communities?

2. How may social and scientific definitions of health contribute to the process of creating community benefit policies?

3. How does the framing of the populations targeted to receive community benefit policies contribute to improving or hindering community health?

4. How does the tension between remaining fiscally viable and following the mission of nonprofit hospitals influence the process of developing community benefit policy and the subsequent benefits to community they may produce?
Chapter 3

METHODOLOGY AND METHODS

Background: Community Benefit Policy Analysis and Community Health

In many cases, the relationship between a policy and the outcomes it produces relies on the connections made or not made between a number of dependent, interdependent, and seemingly unrelated conditions and factors. Interacting at different velocities and having various effects on one another these conditions and factors form the generic building blocks and resultant products of the dynamics undertaken to create, implement, and assess public policy. Based on the discussion provided in previous pages, one could surmise that the inherent nature and qualities of community benefit fit this novel description of the policy process.

Mentioned earlier, there has been nearly zero academic research produced investigating the relationship between community benefit policy and community health. Intuitively by name and considering the billions of dollars that are annually dedicated to providing benefits to community by nonprofit hospitals – one is perplexed when a search for theoretical and, or empirical research with community benefit as the centerpiece turns out to be a fruitless effort. Armed with the aim of catalyzing future research within the community benefit universe this study considers relevant partners to the metaphorical elements mentioned above to form an analytical framework that can support knowledge expansion in this area.

For the purposes of this study, the relationship between community benefit policy and community health outcomes is investigated using a mixed methods approach utilizing modified case studies of a nonprofit health system and its member hospitals in concert with a content analysis of community benefit documents. Together, these two methods may
begin to tell the story of a relationship that has yet to be explored within the academic literature. In order to begin to unravel segments of the complex phenomena occurring within the community benefit-community health outcome dynamic, three objectives are sought. The first objective is to describe the environment in which the analysis is conducted. The second objective is to describe the methodological choices the author employs to analyze the data contained within the selected environment. The third objective is to identify for the reader the specific ways in which the data selected for analysis are utilized to answer the research questions.

As a result of achieving the three objectives, it is hoped that the relationships between the contextual environment and the methodological approach used to analyze the data selected for analysis are clearly presented. Following this, a discussion of the results of the analysis commences.

_Selection of the Experimental Environment_

According to a survey conducted by the American Hospital Association in 2011 there were 5,724 registered hospitals operating in the United States. Of those, 2,903 registered as a nongovernmental not-for-profit hospital (AHA, 2013). Within the nongovernmental not-for-profit category many are members of nonprofit hospital systems. These systems may own and, or manage two or more hospitals operating in a single or multiple states. Illustrative examples of nonprofit health care systems include Kaiser Permanente, with 37 hospitals located in Georgia, Hawaii, Maryland, Virginia, Washington D.C., Ohio, Oregon, and Washington; Via Christi Health with 8 hospitals located in Kansas; and North Shore-Long Island Jewish Medical Center located in New York operating 12 hospitals.
The study focuses on Dignity Health, another example of a nonprofit health care system. Founded in 1986 with its corporate headquarters located in San Francisco, California, Dignity Health is the fifth largest hospital provider in the US operating hospitals in California (37), Nevada (4), and Arizona (3). Dignity Health also oversees the delivery of health care services in 17 states and around the globe. Currently, Dignity Health system facilities support 8,400 acute care beds, 800 skilled nursing beds, employ 56,000 staff and 10,000 active physicians, and report 1.6 million patient days annually. And, according to its most recent system-wide community benefit report Dignity Health provided $1.6 billion in Community Benefits and Care of the Poor in FY13 (Dignity, 2013b).

Selection of Dignity Health and its member hospitals for this study is based largely on four key factors: (1) Dignity Health has demonstrated leadership in the development of community benefit policy across its organization and the nonprofit hospital community as a whole, (2) Community Benefit reports published by Dignity Health member hospitals are well-written, easily accessible, and demonstrate a high level of consistency throughout the organization, (3) Community Need/Asset Assessments conducted by Dignity hospitals, combined with the development of the Dignity Health Community Need Index score (CNI) allow stakeholders opportunities to explore the relationship between benefits provided to community and the health outcomes implemented benefits produce, and (4) each of the Community Benefit Reports published by Dignity hospitals is available on the Dignity Health website and include detailed Community Benefit and Economic Value reports and Strategic Plans that respectively contain a number of factors peer health system community benefit publications do not provide.

For example, a review of Kaiser Permanente’s 2011 Community Benefit Report (Kaiser, 2012) found that a great deal of descriptive information was included in the 70 plus
page report, including financial information listing specific categories of resources dedicated
to community benefit activities totaling $1.8 billion for the system as a whole (p. 8).
However, individual community benefit reports by hospital were not included. Additionally,
reviewing the 2011-2012 Community Benefit Report published by the UC-Davis Health
System (UC-Davis, 2012) the author found that community benefit practices were listed in
addition to sub-cATEGORIES of services provided to the community, e.g., unreimbursed care
($137 million), charity care ($53 million), research ($195 million), donations and
sponsorships ($750,000), and education ($77 million), however, detailed financial reports
were not readily available for UC-Davis system hospitals as they were for Dignity Health
hospitals.

Expanding the review of community benefit reports for other nonprofit health
systems yielded similar results as shown above. Some hospitals provided lengthy descriptions
of their community benefit activities, others published facts and figures connecting their
community benefit claims to the benefits they provide, and still others outlined in general
terms the impact their community benefit programs were having on the communities they
served (Samaritan, 2012). But, overall none of the community benefit reports published by
the nonprofit hospitals reviewed combined both general and specific detail about their
respective community benefit programs, resources committed to distinct programs, and the
proposed impact community benefit programs had on communities served. Therefore,
Dignity Health became the contextual environment in which this analysis was to be
conducted.

Selection of Study Methodology

As noted above, the second objective of this section is to describe the methodologies
the author employs to analyze the data. Several methodological options were available.
However, based on the context of the policy to be studied and the nature of the documents utilized for the analysis; a modified case study approach combined with a document content analysis will be employed here. The logic model and literary support for choosing these complimentary methodological approaches follows.

*The Case Study Method*

In publishing the fourth edition of his book, *Case Study Research: Design and Methods*, Robert K. Yin (2009) acknowledged that many methodologies are available to researchers seeking to inquire about relationships that may exist among known variables or to uncover unforeseen relationships that are of interest to stakeholders. Yin highlights the case study methodology to be the preferred method of choice when “how or why questions are being posed, the investigator has little control over events, and the focus [of the study] is on a contemporary phenomenon within a real-life context” (Yin, 2009, p. 2). Yin goes on to provide the reader with a much more detailed definition of what constitutes a case study in the following:

A case study is an empirical inquiry that investigates a contemporary phenomenon in depth within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. The case study inquiry copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and, as another result benefits from the prior development of theoretical propositions to guide data collection and analysis (Yin, 2009, p. 18).
When considering whether or not to incorporate a case study method within a prospective research design, Yin offers four applications that serve as a logical basis for doing so in the following passage:

The most important is to explain the presumed causal links in real-life interventions that are too complex for the survey or experimental strategies, To describe an intervention and the real-life context in which it occurred, To illustrate certain topics within an evaluation, again in a descriptive mode, [and] May be used to enlighten those situations in which the intervention being evaluated has no clear, single set of outcomes (pp. 19-20).

Combining Yin’s case study definition and the four applications he feels are logical motivations for employing the case study methodology with the research questions and contextual environment presented in this study; the case study method is a reasonable and appropriate research framework to apply here. The following five examples drawn from this study’s conceptual framework support the use of this method. First, the extent to which community benefit policies impact community health qualifies as a “how” question. Second, the author has no control over the ways in which community benefit policies have been formulated and community benefit implementation and the outcomes it may produce constitute a real-life situation. Third, there are many more variables, e.g., economic, organizational structure that may contribute to the community benefit policy process that will not be explored in this investigation. Fourth, several sources of data will be utilized in a triangulating fashion to address the research questions posed. And fifth, the scientific and social definitions of health perspectives combined with Schneider and Ingram’s population framing theory form the central theoretical propositions guiding this analysis and subsequent discussion.
As a result of grounding portions of the analysis into Yin’s case study framework the author now possesses an opportunity to explain the presumed causal links that may exist between Dignity Health’s community benefit policy and community health outcomes.

The Content Analysis Method

In writing, Content Analysis: An Introduction to its Methodology, Klaus Krippendorff (2013), provides readers a comprehensive discourse regarding the concepts, components, analytical paths, and evaluative techniques one needs to conduct a thorough content analysis. Included in his treatise are detailed discussions of elements that coalesced to form a current understanding of content analysis. These elements include the historical evolution of content analysis, the logic supporting its use, and the methodological techniques one may use to produce a content analysis that is both reliable and valid. When defining what a content analysis is, Krippendorff offers the following:

Content analysis is a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use…as a research technique, content analysis provides new insights, increases a researcher’s understanding of a particular phenomena, or informs practical actions…Content analysis is a scientific tool. (p. 24).

A similar ‘form determines function logic’ used to determine if a case study methodology is an appropriate tool to use for this analysis is also used to support the choice to apply a content analysis approach. First, the materials reviewed and the data analyzed all come in the form of texts. Examples include: community benefit reports, IRS guidelines, and community need/asset assessments. Given that the data used to address the research questions are derived from texts and not interviews, survey instruments, or limited to numerical data
alone, there is no need to employ quantitative, ethnographic, or other qualitative-based methods at this time.

Second, one could argue that this study is an exploration of an as yet largely unknown policy area. As such, one of the primary goals of this analysis is to follow an abductive path of discovery in order to draw inferential meaning from the text that can not only address the research questions posed but also build a more nuanced analytical framework upon which future analysis of this policy area can be conducted. Third, according to Krippendorff, content analyses are context driven. Therefore, the context (community benefit policy) and the content (texts) used to make connections between context and content should produce “meanings” that help one to understand the nature of the relationship and the effect a (the) relationship may have on the environment in which the relationship exists. These three observations, informed by Krippendorff’s perspective, provide the justification to incorporate content analysis into this project.

*Applying the Content Analysis Method to This Study*

According to Krippendorff, there are several “points of entry” that can be used as starting points for a content analysis and include text-driven, problem-driven, and method-driven analyses (p. 355). Incorporating a problem-driven analysis into this study is a good fit based on the following definition Krippendorff provides for what a problem-driven analysis embodies:

Problem-driven content analyses are motivated by epistemic questions about currently inaccessible phenomena, events, or processes that the analysts believe texts are able to answer. Analysts start from research questions and proceed to find analytical paths from the choice of suitable texts to their answers (p. 355).
With support provided by this definition to use not only a content analysis methodology in general but a problem-based analysis specifically for the purposes of successfully addressing parts of the questions posed in this study; further explanation of how this methodology is applied follows here.

The content analysis begins with a review of the first of two sampling units, IRS Revenue Rulings that pertain specifically to hospital nonprofit status and community benefit (IRS, 1956; IRS, 1969a; IRS, 1969b). A separate word search of each of the three Rulings utilizing a content analysis software program, HyperRESEARCH, is the first step in determining what words were most frequently found within the Rulings. A list of the top fifty words found within each Ruling forms the main recording unit for this sample. The recording unit of fifty words is then reviewed to determine the extent to which scientific and/or social oriented words are present within the Rulings and the significance each of the words plays in their contribution to the Rulings’ text as a whole.

Once this has been completed, a similar search utilizing HyperRESEARCH was applied to 35 Dignity Health hospital Community Benefit Reports for FY12. The 35 hospitals form the second sampling unit. A recording unit made up of the fifty most frequently found words was generated and terms that are closely related to science or social perspectives of health were delineated.

The fifty most frequently found words taken from both sample units will be distilled further into a macro-level codebook. A refined codebook made up of words that demonstrate commonality between both samples was then distilled into a micro-level codebook of ten to twenty words. An illustrative example of how this process adheres to Krippendorff’s component-based analytic process can be seen in the following table.
Table 5.
Relation Between Content Analysis Components and Sampling Units

<table>
<thead>
<tr>
<th>Sampling Unit</th>
<th>Unitizing</th>
<th>Sampling</th>
<th>Recording/Coding</th>
<th>Reducing</th>
<th>Inferring</th>
<th>Narrating</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRS Revenue Rulings</td>
<td>Rulings 1956, 1969a, 1969b</td>
<td>All words for each Ruling</td>
<td>Top 50 most found words</td>
<td>Reduce to 10-20 delineated words</td>
<td>Compare with Reports</td>
<td>Illustrate with word cloud and tables.</td>
</tr>
<tr>
<td>FY12 Dignity Health Community Benefit Reports</td>
<td>Community Benefit Reports FY12</td>
<td>All words for each Report</td>
<td>Top 50 most found words</td>
<td>Reduce to 10-20 delineated words</td>
<td>Compare with Rulings</td>
<td>Connect to research questions.</td>
</tr>
</tbody>
</table>

*Note.* The conceptual framework for this table is drawn from Krippendorff’s (2013) discussion regarding components of a content analysis.

-Words are delineated into social and scientific-based categories.

Selecting the IRS documents for the initial search and as the primary sampling unit is based on the notion that the IRS documents are the founding documents from which all community benefit policies are derived. Selecting 35 Dignity Health hospital Community Benefit Reports as the secondary sampling unit of the search is grounded in the assumption that Dignity Health has based its policies on the IRS documents and that the relationship between the words found within the IRS founding texts and Dignity Health’s policies may be compared in order to draw conclusions regarding the extent to which Dignity Health community benefit policies mirror the textual guidance provided by the IRS Rulings.

Additionally, once these two tasks have been completed it is hoped that the extent to which scientific and/or social terms contributing to the construction of IRS Revenue Rulings and subsequent Dignity Health hospital Community Benefit Reports may be determined. Tables and illustrative figures were then be developed to compare and contrast the similarities and differences that may exist between words that form the historical IRS
Rulings and how they have been translated, i.e., expressed, into current Dignity Health hospital Community Benefit Reports.

There is no need to employ additional coders as the compilation of the codebook lists are developed directly from the documents themselves via the HyperRESEARCH word search utility. It is assumed that if an outside party loaded the IRS and Community Benefit Report documents into the same or similar word search program, the resulting word lists would be identical. In addition, this line of reasoning addresses replicability issues as well on the condition that the same documents used for the initial word search step are employed in future efforts. Concerns regarding sampling validity are also addressed under the author’s assumption that selecting the founding documents and a well-vetted set of secondary documents, i.e., IRS and Dignity Health reports, is based on their temporal connection and present day significance.

Analysis of the Selected Data

The third objective to be reached in this chapter is to describe the ways in which selected data address the research questions. For each of the four research questions presented in this study, information contained within the key texts reviewed provide the data used for analysis. The data selected were drawn from the texts based on the nature of the research question and the judged relevance the data have to each respective question.

To illustrate how this process unfolds, each research question is presented to the reader. This is then followed by a summary of the meaning of the question, what data were drawn from the texts, and how they are used for analysis and interpretation.
Question 1: To what extent do community benefit policies impact the health of communities?

For this question, two separate but interrelated steps were taken. For the first step, summary statistics derived from the analysis of Dignity Health system Consolidated Financial Statements, Community Benefit Reports, and Community Benefit Plans for FY11 and FY12 were reviewed. The sample is the health system as a whole with the unit of analysis being all Dignity Health system hospitals’ aggregate community benefit for FY11 and FY12. This question addresses how Dignity Health system and 35 of her hospitals reported community benefit for FY11 and FY12. Based on data reviewed in this section, one may posit that past reporting reflects a commitment to preserving the financial interests of the hospital more so than improving the health interests of communities.

Part 2 extends ideas presented in Part 1. Namely, that community benefit claim reporting is based on substantiating the fiscal health of individual hospitals rather than the resources hospitals commit to community health improvement. Part 2 also demonstrates variability that exists between individual hospital's community benefit reporting by reporting category. Specific categories reviewed are: Community Health Improvement Services, Health Professions Education, Subsidized Health Services, Research, Unpaid Medicaid, Community-Building Activities, and Community Benefit Operations. To accomplish this, summary statistics derived from an analysis of Dignity Hospital Community Benefit and Economic Value Reports were reviewed. Reporting categories included within each hospital’s community benefit report were compared and contrasted with other system hospitals to demonstrate similarities and differences among hospitals in their reporting of community benefit. The initial sample included 35 hospitals for FY11 and FY12 with the unit of analysis being Dignity hospitals followed by further examination of a second sample consisting of 4 hospitals.
Question 2: How may social and scientific definitions of health contribute to the process of creating community benefit policies?

A content analysis of IRS, Dignity health system, and individual Dignity hospital documents sought to demonstrate the extent to which scientific and social perspectives of health have informed community benefit policy. A search for common terms that reflect both perspectives was undertaken. The search will utilize the components to be included in a content analysis as suggested by Krippendorff (2013, p. 84). These include: unitizing, sampling, recording/coding, reducing, inferring, and narrating. Terms were categorized according to the perspective they reflect and counted for frequency of appearance in documents reviewed. Following this process, a description of the relationship between the terms that are found and the level at which they represent either perspective was possible.

Examples of terms that represent a scientific perspective may include: cost/charge ratio for services, expenses, revenue, and net benefit. Examples of terms that align with a social perspective include those linked to being predictive determinants of health and will include: income, culture, language, education, insurance, and housing. It should be noted here that the word search may reveal terms that vary from the one’s listed above and it will be up to the author’s familiarity with the documents reviewed in concert with the previously discussed literature review to ascertain which words may be used to capture scientific- and socially-based terms.

Question 3: How does the framing of the populations targeted to receive community benefit policies contribute to improving or hindering community health?

Community benefit policies serve the interest of multiple stakeholders. These include: federal, state, and local government, health systems, individual hospitals, and the communities in which hospitals provide services to individuals and families. This question
focuses on the extent to which community benefit policies impact communities in general and marginalized members of community specifically. It is believed that community benefit policies serve the interests of hospitals more so than the interests of community. Furthermore, in conducting community needs assessments hospitals evaluate need based primarily on the hospitals perception of community as opposed to communities defining where needs are and what vehicles may be most effective in addressing community need.

To address this question, an evaluation of Community Needs Assessments (CNA’s) conducted by individual Dignity hospitals and the Community Need Index scores that result from CNA’s was made. Particular focus was directed to the zip codes that demonstrate high and low CNI scores. Comparisons between high and low CNI score zip codes will be paired with a series of health indicators, i.e., determinants of health, to assess the extent to which improvements in community health indicators are occurring over time.

The sample included High and Low CNI scores for selected zip codes located in service areas of Dignity hospitals in at least two states for years, 2009, 2010, and 2011. Examples of factors compared include: observed change over time in social determinants of health indicators for the zip codes, observed Increase/Decrease change in % Revenue/Expense for “Those Living in Poverty” reporting category, and observed increase or decrease in “Persons Served” under Poverty. The unit of analysis for this exercise is selected zip codes for Dignity hospitals located in two or three states for years 2009, 2010, and 2011. It is hoped that by conducting this portion of the analysis, the reader will be able to determine the relationship between CNI score, health outcomes, and resources committed to community health programs within hospital service areas over time and the extent to which this phenomenon is influenced by the ways in which segments of community are viewed.
Question 4: How does the tension between remaining fiscally viable and following the mission of nonprofit hospitals influence the implementation of community benefit policy and the subsequent benefits to community they may produce?

Nonprofit hospitals operate in a resource dependent, highly competitive environment. Historically, the mission of nonprofit hospitals has been to serve all those that seek care regardless of their ability to pay. Over time, balancing fiscal survival with mission fulfillment has become a most challenging proposition for nonprofit hospitals. As a result, a tendency of hospitals has been to shift resources away from community building activities that address underlying causes of ill health into institution-centered activities that protect the financial “health” of hospitals (Raffel & Raffel, 1994).

In an effort to establish the relationship between hospital health and community health, summary statistics gleaned from selected Dignity Health hospital Community Benefit and Economic Value reports were evaluated. Data retrieved from this exercise were compared and contrasted among hospitals in an effort to demonstrate the extent to which resources are being allocated to institution-centered or community-centered activities. Examples of data to be compared may include: levels of investment for “Those Living in Poverty” in “Community Health Improvement Services” per person served over time, levels of investment for “Totals for Community Services” for “Those Living in Poverty” per person served over time, levels of investment for “Benefits for Broader Community” in Community Health Improvement Services” per person served over time, and levels of investment for “Benefits for Broader Community” in “Totals for Community Service” per persons served over time.

These variables are selected because they indicate direct service provision, or services that are provided to community with little or no offsetting revenue. The sample will include
data retrieved from 35 Dignity Health hospitals for FY11 and FY12. The unit of analysis was 35 Dignity Health hospitals.

Limitations of the Study

This study utilizes community benefit reports published within the past four years by Dignity Health system and its respective hospitals. The choice to select Dignity Health as the primary source of data for this analysis has been supported in previous sections. Limiting the analysis to data collected from a representative number of nonprofit hospitals allows the author to make logical associations between community benefit policy and community health outcomes within a health system. However, narrowing the analysis to one health system may inhibit the author to apply findings of this analysis to a wider audience. Subsequent research that includes other nonprofit health systems may provide comparisons among nonprofit hospitals and health systems that can overcome this potential shortcoming.

Chapter Summary

Three primary objectives were sought at the opening of this chapter. The first objective was to describe the contextual environment in which the analysis was conducted. The second, to describe the methodological choices the author employed to analyze the data. And the third, to identify for the reader the specific ways in which the data selected for analysis were utilized to answer the research questions. Additionally, by organizing the chapter in this fashion, the reader has an opportunity to begin to see how the analysis of the data conceptually addresses the research questions presented. In the next chapter, the results of the analysis are offered.
Chapter 4

ANALYSIS OF THE DATA

Background: Community Benefit & National Health Expenditures

The cost of delivering health care in the United States is rising exponentially. Projections from the Centers for Medicare and Medicaid Services estimate national health expenditures to claim 18.3% of Gross Domestic Product (GDP), or $19.2 billion by 2016 (CMS, 2013). This projection combined with health outcomes that consistently fall behind those of peer nations Germany, Canada, France, Australia, and the United Kingdom has raised the level of concern among various stakeholders within the U.S. to heightened levels of awareness and alarm (Davis, et. al., 2007).

Factors that contribute to aggregate U.S. health expenditures include costs associated with providing hospital care, physician and clinical services, dental care, prescription drugs, and the purchase and use of durable medical equipment. Interspersed among these factors are the resources nonprofit hospitals commit to providing benefits to the communities within which they are located. Each year, individual nonprofit hospitals report the resources dedicated to providing a wide range of health programs and services within their service areas as community benefit (Dignity, 2013). The amount each hospital reports as community benefit varies among all nonprofit hospitals. However, in recent years it is not uncommon for individual hospitals to claim over one million dollars or more as community benefit. Determining aggregate community benefit claims for all nonprofit hospitals is difficult to ascertain based on the variety of methods nonprofit hospitals utilize to report annual benefit.

Nonetheless, a general estimate of total community benefit can be made to illustrate the role community benefit claims play in relation to annual national health care
expenditures. Table 6 illustrates the author’s estimate of annual aggregate community benefit claims compared to total hospital care expenditures for years 2008 through 2016.

Table 6.
National Hospital Care Expenditures and Community Benefit Value
For Years 2008 through 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital Care ($ billions)</th>
<th>Community Benefita ($ billions)</th>
<th>Community Benefitb ($ billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>729.3</td>
<td>18.6</td>
<td>25.5</td>
</tr>
<tr>
<td>2009</td>
<td>776.1</td>
<td>19.8</td>
<td>27.2</td>
</tr>
<tr>
<td>2010</td>
<td>814.0</td>
<td>20.8</td>
<td>28.5</td>
</tr>
<tr>
<td>2011</td>
<td>848.9</td>
<td>21.6</td>
<td>29.7</td>
</tr>
<tr>
<td>2012</td>
<td>884.7</td>
<td>22.6</td>
<td>31.0</td>
</tr>
<tr>
<td>2013</td>
<td>920.7</td>
<td>23.5</td>
<td>32.2</td>
</tr>
<tr>
<td>2014</td>
<td>982.7</td>
<td>25.1</td>
<td>34.4</td>
</tr>
<tr>
<td>2015</td>
<td>1,038.3</td>
<td>26.5</td>
<td>36.3</td>
</tr>
<tr>
<td>2016</td>
<td>1,106.6</td>
<td>28.2</td>
<td>38.7</td>
</tr>
</tbody>
</table>

Note. The health spending projections were based on the National Health Expenditures released in January 2012. The projections include impacts from the Affordable Care Act. Adapted from “Table 2 – National Health Expenditure Amounts, and Annual Percent Change by Type of Expenditure: Calendar Years 2006-2021,” by Centers for Medicare and Medicaid Services, National Health Expenditure Projections 2011-2021.

aThe calculation of Community Benefit is based on the number of nonprofit hospitals operating in the United States, approximately 2,903 out of 5,724, or 51% in 2011 (AHA, 2013). This percentage is multiplied by total hospital health care expenditure per year listed above (CMS, 2013). This figure is then multiplied by 5%, representing the guideline established by Texas that estimated the value of community benefit to be roughly 5% of hospital expenditures (Kane, 2006).

bSome sources suggest private nonprofit hospitals maintain 70% of all hospitals operating in the United States (Kane, 2006). Therefore, for comparative purposes figures in this row were calculated applying that estimate.

From the estimates provided in row two above, the rate of growth for community benefit claims between 2008 ($18.6 billion) and 2016 ($28.2 billion) is 51.6 percent while the rate of change for all years is 7.4 percent\textsuperscript{11}. These estimates represent significant and substantial resources claimed by nonprofit hospitals as community benefit. What has been challenging to many is determining the extent to which community benefit expenditures impact the health of communities in which they are committed – especially given the fact

\textsuperscript{11} The rate of growth is determined by calculating percent change, X = \([27.7-18.3]/18.3\] \times 100. The rate of change is calculated by, X = \([27.7-18.3]/18.3\] \times 100/7.
that nonprofit hospitals as a whole receive tax exemptions from federal, state, and local
governments in excess of more than $2 billion per year since 2002 (CBO, 2006). This
sentiment strikes at the heart of this study aids in shaping the following discussion of the
results of the analysis.

The remainder of this chapter contains four distinct but interrelated sections
beginning at the system level, proceeding to analysis focused on individual hospitals,
narrowing further to explore individual community benefit program implementation, and
then broadening back up to a discussion of the relationship between parallels of words used
to form Internal Revenue Service founding documents and Dignity Health system
community benefit policies. Motivation to organize the chapter in this manner stems from
the idea that this approach covers key aspects of community benefit policy translation,
development, and implementation through multiple lenses of analysis.

The first section is a discussion of community benefit at a system level that
introduces the reader to the ways in which Dignity Health reports system-level community
benefit for one fiscal year. The second section illustrates how Dignity Health member
hospitals reported community benefit for two fiscal years. The third section follows four
community benefit programs implemented over a five-year period. And the fourth section
compares and contrasts wording found within Internal Revenue Service Revenue Rulings
with Community Benefit reports for 35 Dignity Health member hospitals.

Each section’s analysis addresses at least one of the research questions at hand.
Discussion of the results gleaned from the analysis is introduced within each section but is
more fully developed in the next chapter.
Section 1: Dignity Health – System Level Community Benefit

Within recent years, Dignity Health has committed a great deal of resources towards community benefit. With and without the inclusion of Medicare shortfalls, the following two tables support this observation.

Table 7.
Total Community Benefit for Dignity Health System
Not Including Medicare: FY08 through FY12

<table>
<thead>
<tr>
<th>Year</th>
<th>Community Benefit ($ thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY08</td>
<td>508,374</td>
</tr>
<tr>
<td>FY09</td>
<td>672,125</td>
</tr>
<tr>
<td>FY10</td>
<td>985,149</td>
</tr>
<tr>
<td>FY11</td>
<td>947,100</td>
</tr>
<tr>
<td>FY12</td>
<td>951,403</td>
</tr>
</tbody>
</table>

Note. Figures were drawn from Dignity Health and Subordinate Corporations: Consolidated Financial Statements, Fiscal Years 2008-2012.
*This table reflects unaudited calculations for “Benefits for the Poor”, i.e., excluding the unpaid cost of Medicare and bad debt.

Table 8.
Total Community Benefit for Dignity Health System
Including Medicare: FY08 through FY12

<table>
<thead>
<tr>
<th>Year</th>
<th>Community Benefit ($ thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY08</td>
<td>966,938</td>
</tr>
<tr>
<td>FY09</td>
<td>1,183,192</td>
</tr>
<tr>
<td>FY10</td>
<td>1,330,769</td>
</tr>
<tr>
<td>FY11</td>
<td>1,400,000</td>
</tr>
<tr>
<td>FY12</td>
<td>1,601,977</td>
</tr>
</tbody>
</table>

Note. Figures were drawn from Dignity Health and Subordinate Corporations: Consolidated Financial Statements, Fiscal Years 2008-2012.
*This table reflects total community benefit claimed for all categories and subcategories including the unpaid cost of Medicare.

Each of the tables above demonstrates aggregate system-level community benefit.

The rate of growth for Table 7 was 87.1% and 66.0% for Table 8 with the rate of change for Table 7 being 29.0% and 21.0% for Table 8. In addition to reporting community benefit in aggregate, Dignity Health reports community benefit categorically. The two main reporting categories are Benefits for the Poor and Benefits for the Broader Community. Based on Community
Needs Assessments, subcategories within each main category account for programs and services that are directed to providing resources that are targeted to benefit the poor directly or the community as a whole. Table 9 illustrates how Dignity Health as a system reported community benefit by category and subcategory for FY12.

Table 9.

Unaudited Summary of Dignity Health System FY12 Community Benefit

<table>
<thead>
<tr>
<th>Persons Served</th>
<th>Total Benefit Expense (thousands)</th>
<th>Direct Offsetting Revenue (thousands)</th>
<th>Net Community Benefit (thousands)</th>
<th>% of Total Expenses Excluding Bad Debt</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits for the Poor:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional Charity Care</td>
<td>108,530</td>
<td>189,101</td>
<td>(721)</td>
<td>188,380</td>
</tr>
<tr>
<td>Unpaid Costs of Medicaid/Medical</td>
<td>1,060,508</td>
<td>2,260,680</td>
<td>(1,689,189)</td>
<td>571,491</td>
</tr>
<tr>
<td>Other Means-Tested Programs</td>
<td>280,517</td>
<td>103,364</td>
<td>(37,297)</td>
<td>66,067</td>
</tr>
<tr>
<td><strong>Community Services:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Services</td>
<td>525,831</td>
<td>55,530</td>
<td>(2,063)</td>
<td>53,467</td>
</tr>
<tr>
<td>Health Professions Education</td>
<td>86</td>
<td>27</td>
<td>-</td>
<td>27</td>
</tr>
<tr>
<td>Subsidized Health Services</td>
<td>193,751</td>
<td>32,386</td>
<td>(4,089)</td>
<td>28,297</td>
</tr>
<tr>
<td>Donations</td>
<td>155,219</td>
<td>33,376</td>
<td>(236)</td>
<td>33,140</td>
</tr>
<tr>
<td>Community Building Activities</td>
<td>12,811</td>
<td>2,961</td>
<td>(1,338)</td>
<td>1,623</td>
</tr>
<tr>
<td>Community Benefit Operations</td>
<td>3,884</td>
<td>8,911</td>
<td>-</td>
<td>8,911</td>
</tr>
<tr>
<td>Total Community Services for the Poor</td>
<td>891,582</td>
<td>133,191</td>
<td>(7,726)</td>
<td>125,465</td>
</tr>
<tr>
<td><strong>Total Benefits for the Poor</strong></td>
<td>2,341,137</td>
<td>2,686,336</td>
<td>(1,734,933)</td>
<td>951,403</td>
</tr>
</tbody>
</table>

Benefits for the Broader Community:

Community Services:
<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Increase/Decrease</th>
<th>Change</th>
<th>Percentage</th>
<th>Change from Previous Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services</td>
<td>585,949</td>
<td>22,546</td>
<td>(5,512)</td>
<td>17,034</td>
<td>0.2%</td>
</tr>
<tr>
<td>Health Professions Education</td>
<td>68,974</td>
<td>78,752</td>
<td>(9,620)</td>
<td>69,132</td>
<td>0.7%</td>
</tr>
<tr>
<td>Subsidized Health Services</td>
<td>9,430</td>
<td>3,182</td>
<td>(972)</td>
<td>2,210</td>
<td>0.0%</td>
</tr>
<tr>
<td>Research</td>
<td>26,281</td>
<td>30,097</td>
<td>(48)</td>
<td>30,049</td>
<td>0.3%</td>
</tr>
<tr>
<td>Donations</td>
<td>165,149</td>
<td>7,611</td>
<td>(27)</td>
<td>7,584</td>
<td>0.1%</td>
</tr>
<tr>
<td>Community Building Activities</td>
<td>38,641</td>
<td>3,146</td>
<td>(8)</td>
<td>3,138</td>
<td>0.0%</td>
</tr>
<tr>
<td>Community Benefit Operations</td>
<td>87</td>
<td>1,469</td>
<td>(23)</td>
<td>1,446</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total Benefits for the Broader Community</strong></td>
<td><strong>894,511</strong></td>
<td><strong>146,803</strong></td>
<td><strong>(16,210)</strong></td>
<td><strong>130,593</strong></td>
<td><strong>1.3%</strong></td>
</tr>
<tr>
<td>Total Community Benefits</td>
<td>3,235,648</td>
<td>2,833,139</td>
<td><strong>(1,751,143)</strong></td>
<td>1,081,996</td>
<td><strong>11.3%</strong></td>
</tr>
<tr>
<td>Unpaid Costs of Medicare</td>
<td>1,116,214</td>
<td>2,604,316</td>
<td><strong>(2,084,335)</strong></td>
<td>519,981</td>
<td><strong>5.4%</strong></td>
</tr>
<tr>
<td><strong>Total Community Benefits Including Unpaid Costs of Medicare</strong></td>
<td><strong>4,351,862</strong></td>
<td><strong>5,437,455</strong></td>
<td><strong>(3,835,478)</strong></td>
<td><strong>1,601,977</strong></td>
<td><strong>16.7%</strong></td>
</tr>
</tbody>
</table>


Reviewing Table 9, several observations may be made. First, within the Benefits for the Poor category, Unpaid Costs of Medicaid consume 6.0% of Total Benefits of the Poor, with the remaining 4.0% largely dedicated to providing Charity Care (2.0%) and resources to fund other Means-Tested Programs (0.7).

Relationships between resources allocated across subcategories included in Total Benefits for the Poor can be seen in Figure 1.
Second, under the Benefits for the Broader Community category the largest commitment of resources is consumed by Health Professions Education (0.7%), leaving the remaining 0.6% to fund other broader community services. Relationships between resources allocated across subcategories under Benefits for the Broader Community can be seen in Figure 2.
Third, if sub categorical totals for Benefits of the Poor and Benefits for the Broader Community are added together, Total Community Benefits equals 11.3% of Total Expenses for the system. And, if Unpaid Costs of Medicaid are added to this figure, Total Community Benefit for Dignity Health system comes to 16.7% as a percentage of total expenses excluding bad debt. If Unpaid Costs of Medicaid and Medicare are subtracted from this number, however, the remaining percentage of total system expenses excluding bad debt equals 5.3% system-wide [(6.0 + 5.4) – (16.7) = 5.3].

Collectively, these four observations suggest that the majority of FY12 Dignity Health system resources claimed as community benefit were committed to funding the...
unpaid costs associated with providing care to Medicaid and Medicare patients. Figure 3 illustrates the relationships between all reporting categories for FY12.

Figure 3.

Dignity Health System: Categorical Community Benefit FY12

Section 2: Dignity Health – Hospital Level Community Benefit

Annually, Dignity Health hospitals submit a Community Benefit Report and Community Benefit Plan for public review. Included in each hospital’s Community Benefit Report and Community Benefit Plan is a description of the hospital’s history, organizational structure and mission statement, discussion of the community benefit planning process, the annual community benefit report including program digests, and the community benefit and economic value report for the fiscal year being reported. The length and complexity of each report varies among hospitals but overall the quality and depth of each hospital’s reports are excellent, simple to follow, and provide for a reader a highly detailed account of each hospital’s annual community benefit policy activities. Additionally, each hospital applies a
similar template when constructing its community benefit reports making it efficient to compare and contrast hospitals with one another for individual and across multiple years.

Annually, Dignity Health publishes their Community Benefit reports on their system website available in a portable document format. For this portion of the analysis, reports for FY11 and FY12 were downloaded by the author and reviewed. Based on the information contained within each report, a series of tables were made to compare and contrast aspects of the Reports that pertain to the research questions posed within this study. Specifically, Question 1: To what extent do community benefit policies impact the health of communities and, Question 4: How does the tension between remaining fiscally viable and following the mission of nonprofit hospitals influence the implementation of community benefit policy and the subsequent benefits to community they may produce? Results of this exercise are reported below.

The first table, Table 10, shows the relationship between reported net community benefit (total benefit expense minus direct offsetting revenue) for 35 reporting hospitals, FY11 and FY12. Percent change for each hospital was also included to demonstrate differences in reported community benefit between FY11 and FY12.
Table 10.

FY11 and FY12 Net Community Benefit Including Percent Change - 35 Dignity Health Hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>2011 $</th>
<th>2012 $</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arroyo Grande Community Hospital</td>
<td>5,350,603</td>
<td>5,229,722</td>
<td>-2.3</td>
</tr>
<tr>
<td>Chandler Regional Medical Center</td>
<td>23,404,657</td>
<td>27,541,560</td>
<td>17.7</td>
</tr>
<tr>
<td>French Hospital Medical Center</td>
<td>8,412,921</td>
<td>6,585,732</td>
<td>-21.7</td>
</tr>
<tr>
<td>Mark Twain – St. Joseph’s Hospital</td>
<td>594,667</td>
<td>3,574,093</td>
<td>501.2</td>
</tr>
<tr>
<td>Mercy Hospital of Folsom</td>
<td>14,896,301</td>
<td>15,554,843</td>
<td>4.4</td>
</tr>
<tr>
<td>Mercy Medical Center - Redding</td>
<td>19,658,891</td>
<td>10,627,415</td>
<td>-45.9</td>
</tr>
<tr>
<td>Northridge Hospital Medical Center</td>
<td>39,381,721</td>
<td>35,627,559</td>
<td>-9.5</td>
</tr>
<tr>
<td>Sequoia Hospital</td>
<td>17,878,567</td>
<td>13,882,182</td>
<td>-22.4</td>
</tr>
<tr>
<td>St. Elizabeth Community Hospital</td>
<td>5,896,550</td>
<td>4,387,682</td>
<td>-25.6</td>
</tr>
<tr>
<td>St. Joseph’s Medical Center</td>
<td>32,267,994</td>
<td>44,397,355</td>
<td>37.6</td>
</tr>
<tr>
<td>St. Joseph’s Behavioral Health</td>
<td>-</td>
<td>651,224</td>
<td>-</td>
</tr>
<tr>
<td>St. Mary Medical Center – Long Beach</td>
<td>30,729,765</td>
<td>9,237,552</td>
<td>-70.0</td>
</tr>
<tr>
<td>St. Rose Dominican Hospital de Lima</td>
<td>11,548,980</td>
<td>52,736,844</td>
<td>356.6</td>
</tr>
<tr>
<td>Bakersfield Memorial Hospital</td>
<td>13,250,006</td>
<td>9,184,535</td>
<td>-30.7</td>
</tr>
<tr>
<td>St. Mary’s Medical Center – San Francisco</td>
<td>30,359,412</td>
<td>27,603,446</td>
<td>-9.1</td>
</tr>
<tr>
<td>Community Hospital of San Bernardino</td>
<td>10,913,442</td>
<td>20,372,715</td>
<td>86.7</td>
</tr>
<tr>
<td>Glendale Memorial Hospital</td>
<td>39,917,089</td>
<td>45,992,685</td>
<td>15.2</td>
</tr>
<tr>
<td>Mercy General Hospital</td>
<td>46,610,711</td>
<td>46,099,208</td>
<td>-1.1</td>
</tr>
<tr>
<td>Mercy Medical Center - Merced</td>
<td>23,683,327</td>
<td>28,983,812</td>
<td>22.4</td>
</tr>
<tr>
<td>Mercy San Juan Medical Center</td>
<td>47,027,091</td>
<td>53,144,357</td>
<td>13.0</td>
</tr>
<tr>
<td>Saint Francis Memorial Hospital</td>
<td>27,378,041</td>
<td>24,988,129</td>
<td>-8.7</td>
</tr>
<tr>
<td>Sierra Nevada Memorial Hospital</td>
<td>5,183,938</td>
<td>2,571,552</td>
<td>-50.4</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>FY11 Net Expense</td>
<td>FY12 Net Expense</td>
<td>Percent Change</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------------------</td>
<td>------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>St. John’s Pleasant Valley Hospital</td>
<td>6,102,417</td>
<td>7,252,275</td>
<td>18.8</td>
</tr>
<tr>
<td>St. Joseph’s Hospital and Medical Center</td>
<td>132,600,045</td>
<td>181,438,125</td>
<td>36.8</td>
</tr>
<tr>
<td>St. Rose Dominican Hospital – San Martin</td>
<td>10,392,328</td>
<td>11,602,533</td>
<td>11.6</td>
</tr>
<tr>
<td>California Hospital Medical Center</td>
<td>52,111,319</td>
<td>98,879,878</td>
<td>89.7</td>
</tr>
<tr>
<td>Dominican Hospital</td>
<td>48,685,414</td>
<td>42,359,446</td>
<td>-13.0</td>
</tr>
<tr>
<td>Marian Regional Medical Center</td>
<td>16,290,496</td>
<td>18,697,517</td>
<td>14.8</td>
</tr>
<tr>
<td>Mercy Gilbert Medical Center</td>
<td>16,680,401</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mercy Hospital - Downtown</td>
<td>15,736,403</td>
<td>18,255,844</td>
<td>16.0</td>
</tr>
<tr>
<td>Mercy Hospital – Bakersfield/Southwest</td>
<td>15,736,403</td>
<td>18,255,844</td>
<td>16.0</td>
</tr>
<tr>
<td>Mercy Medical Center – Mt. Shasta</td>
<td>5,388,484</td>
<td>3,071,664</td>
<td>-43.0</td>
</tr>
<tr>
<td>Methodist Hospital - Sacramento</td>
<td>32,138,753</td>
<td>36,405,763</td>
<td>13.3</td>
</tr>
<tr>
<td>St. Bernardine Medical Center</td>
<td>39,083,898</td>
<td>39,163,575</td>
<td>0.2</td>
</tr>
<tr>
<td>St. John’s Regional Medical Center</td>
<td>23,697,774</td>
<td>27,541,948</td>
<td>16.2</td>
</tr>
<tr>
<td>St. Rose Dominican Hospital - Siena</td>
<td>25,721,065</td>
<td>29,441,377</td>
<td>14.5</td>
</tr>
<tr>
<td>Woodland Healthcare</td>
<td>12,330,270</td>
<td>10,409,046</td>
<td>-15.6</td>
</tr>
</tbody>
</table>

*Note:* Figures included in this table were compiled from Community Benefit and Economic Value reports published by member Dignity Health hospitals for period 7/1/2010 through 6/30/2011 and 7/1/2011 through 6/30/2012. Community Benefit figures listed in the table include category totals for “Benefits for the Poor” and “Benefits for Broader Community” but do not include unpaid costs of Medicare. Figures listed represent Net Benefit, which equals Total Expense minus Offsetting Revenue for all reporting categories. Percent change calculations were made using the formula: \(((y2-y1)/y1)\)*100. Numbers were rounded to the tenth percent.

Results of the comparison between net community benefit reported for FY11 and FY12 showed that 15 hospitals had a negative difference in reported benefit with 20 hospitals demonstrating a positive change. Among the hospitals that had a negative change, St. Mary Medical Center – Long Beach reported the greatest, (-70.0%) while Mercy General Hospital reported the least amount of negative change, (-1.1%).
For the hospitals that demonstrated a positive change, Mark Twain – St. Joseph’s Hospital had the highest gain, (501.2%) while St. Bernardine Medical Center had the least, (0.2%). The average negative and positive gain for all hospitals was (-24.6%) and (65.1%) respectively. Drawing connections between the community benefit reports and reasons for the net decrease or gain in reported community benefit was difficult to ascertain. However, in many of the reports changes in the number of Medicare and Medicaid patients that received services between FY11 and FY12 appear to have made a significant contribution to these differences. Changes in the amount of direct offsetting revenue that was included in hospital reports also appears to have affected net community benefit for this comparative time period. Other possible explanations for the variation in reported benefit could be that the cost of services increased or decreased, reporting techniques improved to capture more quantifiable community benefits that were provided, or that the health care needs of the community changed from one year to the next directly impacting the amount of resources required to provide services within the community.

In an effort to discover specifically what may have caused the changes observed above, additional summary statistics for FY11 and FY12 were collected and compared for the same set of hospitals. The first comparison was made among all hospitals within the Benefits for the Poor reporting category. Table 11 shows these figures for FY11 followed by Table 12 illustrating results for FY12.
### Table 11.

Summary Statistics for Dignity Health Hospitals – FY11

Category: Benefits for the Poor

Subcategory: Net Community Benefit

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Charity Care</th>
<th>Unpaid Medicaid</th>
<th>Community Health Improvement Services</th>
<th>Health Professions Education</th>
<th>Subsidized Health Services</th>
<th>Community Building Activities</th>
<th>Community Benefit Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arroyo Grande Community Hospital</td>
<td>372,709</td>
<td>3,453,110</td>
<td>207,912</td>
<td>5,000</td>
<td>158,108</td>
<td>3,532</td>
<td>50,444</td>
</tr>
<tr>
<td>Chandler Regional Medical Center</td>
<td>2,160,378</td>
<td>14,528,174</td>
<td>531,979</td>
<td>-</td>
<td>1,697,105</td>
<td>-</td>
<td>237,508</td>
</tr>
<tr>
<td>French Hospital Medical Center</td>
<td>1,946,958</td>
<td>4,503,297</td>
<td>301,817</td>
<td>-</td>
<td>302,234</td>
<td>23,416</td>
<td>35,975</td>
</tr>
<tr>
<td>Mark Twain – St. Joseph’s Hospital</td>
<td>94,117</td>
<td>(674,726)</td>
<td>9,109</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>14,560</td>
</tr>
<tr>
<td>Mercy Hospital of Folsom</td>
<td>1,346,344</td>
<td>10,150,873</td>
<td>383,870</td>
<td>-</td>
<td>964,354</td>
<td>6,032</td>
<td>91,225</td>
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<td>Mercy Medical Center - Redding</td>
<td>4,544,585</td>
<td>1,421,643</td>
<td>12,678</td>
<td>-</td>
<td>1,122,508</td>
<td>-</td>
<td>175,674</td>
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<td>Northridge Hospital Medical Center</td>
<td>8,220,142</td>
<td>5,666,140</td>
<td>2,885,999</td>
<td>10,971,607</td>
<td>455,636</td>
<td>1,852</td>
<td>-</td>
</tr>
<tr>
<td>Sequoia Hospital</td>
<td>1,251,097</td>
<td>12,084,621</td>
<td>214,992</td>
<td>-</td>
<td>24,002</td>
<td>1,626</td>
<td>68,810</td>
</tr>
<tr>
<td>St. Elizabeth Community Hospital</td>
<td>1,670,662</td>
<td>1,229,538</td>
<td>4,109</td>
<td>-</td>
<td>622,211</td>
<td>-</td>
<td>63,266</td>
</tr>
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<td>St. Joseph’s Medical Center</td>
<td>4,110,815</td>
<td>14,202,000</td>
<td>3,217,834</td>
<td>-</td>
<td>1,036,091</td>
<td>-</td>
<td>328,782</td>
</tr>
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<td>St. Joseph’s Behavioral Health</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
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<td>St. Mary Medical Center – Long Beach</td>
<td>6,686,063</td>
<td>(2,792,416)</td>
<td>2,194,465</td>
<td>-</td>
<td>3,195,459</td>
<td>-</td>
<td>1,153,444</td>
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<td>3,675,416</td>
<td>4,647,985</td>
<td>260,352</td>
<td>-</td>
<td>178,305</td>
<td>191</td>
<td>366,596</td>
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<td>Bakersfield Memorial Hospital</td>
<td>3,504,965</td>
<td>5,169,011</td>
<td>470,499</td>
<td>-</td>
<td>1,844,300</td>
<td>42,025</td>
<td>73,845</td>
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<td>St. Mary’s Medical Center – San Francisco</td>
<td>1,721,757</td>
<td>15,669,964</td>
<td>596,667</td>
<td>-</td>
<td>160,828</td>
<td>2,675</td>
<td>364,126</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Full Name</td>
<td>Total Beds</td>
<td>Community Beds</td>
<td>Other Beds</td>
<td>NURSING STAFF FTE</td>
<td>Other Staff FTE</td>
<td>All Other FTE</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-----------------------------------</td>
<td>------------</td>
<td>----------------</td>
<td>------------</td>
<td>------------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Community Hospital of San Bernardino</td>
<td>Community Hospital of San Bernardino</td>
<td>3,858,719</td>
<td>946,021</td>
<td>1,370,369</td>
<td>-</td>
<td>-</td>
<td>109,142</td>
</tr>
<tr>
<td>Glendale Memorial Hospital</td>
<td>Glendale Memorial Hospital</td>
<td>7,759,446</td>
<td>29,149,059</td>
<td>13,976</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mercy General Hospital</td>
<td>Mercy General Hospital</td>
<td>4,523,249</td>
<td>33,312,777</td>
<td>1,504,655</td>
<td>-</td>
<td>2,295,103</td>
<td>6,219</td>
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<td>Mercy Medical Center - Merced</td>
<td>3,518,472</td>
<td>9,771,715</td>
<td>51</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>Mercy San Juan Medical Center</td>
<td>Mercy San Juan Medical Center</td>
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<td>2,182,562</td>
<td>-</td>
<td>1,979,785</td>
<td>5,832</td>
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<td>Saint Francis Memorial Hospital</td>
<td>3,620,156</td>
<td>15,498,963</td>
<td>1,752,438</td>
<td>-</td>
<td>283,265</td>
<td>-</td>
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<td>Sierra Nevada Memorial Hospital</td>
<td>Sierra Nevada Memorial Hospital</td>
<td>1,676,906</td>
<td>171,843</td>
<td>189,922</td>
<td>-</td>
<td>2,884</td>
<td>52,393</td>
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<td>St. John's Pleasant Valley Hospital</td>
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<td>530,695</td>
<td>5,394,546</td>
<td>48,153</td>
<td>-</td>
<td>371</td>
<td>-</td>
</tr>
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<td>St. Joseph's Hospital and Medical Center</td>
<td>St. Joseph's Hospital and Medical Center</td>
<td>14,565,187</td>
<td>61,497,986</td>
<td>2,318,407</td>
<td>784,728</td>
<td>89,808</td>
<td>215,827</td>
</tr>
<tr>
<td>St. Rose Dominican Hospital – San Martin</td>
<td>St. Rose Dominican Hospital – San Martin</td>
<td>2,764,707</td>
<td>4,494,322</td>
<td>252,633</td>
<td>20,188</td>
<td>351,907</td>
<td>16,737</td>
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<tr>
<td>California Hospital Medical Center</td>
<td>California Hospital Medical Center</td>
<td>27,960,832</td>
<td>(12,890,061)</td>
<td>15,199,692</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dominican Hospital</td>
<td>Dominican Hospital</td>
<td>6,863,146</td>
<td>32,184,072</td>
<td>846,916</td>
<td>-</td>
<td>1,562,704</td>
<td>504,179</td>
</tr>
<tr>
<td>Marian Regional Medical Center</td>
<td>Marian Regional Medical Center</td>
<td>2,062,138</td>
<td>6,687,141</td>
<td>1,303,725</td>
<td>-</td>
<td>3,128,980</td>
<td>8,608</td>
</tr>
<tr>
<td>Mercy Gilbert Medical Center</td>
<td>Mercy Gilbert Medical Center</td>
<td>1,042,400</td>
<td>11,737,051</td>
<td>268,104</td>
<td>-</td>
<td>1,519,247</td>
<td>-</td>
</tr>
<tr>
<td>Mercy Hospital - Downtown</td>
<td>Mercy Hospital - Downtown</td>
<td>3,596,486</td>
<td>8,224,246</td>
<td>1,090,300</td>
<td>-</td>
<td>406,996</td>
<td>85,162</td>
</tr>
<tr>
<td>Mercy Hospital – Bakersfield/Southwest</td>
<td>Mercy Hospital – Bakersfield/Southwest</td>
<td>3,596,486</td>
<td>8,224,246</td>
<td>1,090,300</td>
<td>-</td>
<td>406,996</td>
<td>85,162</td>
</tr>
<tr>
<td>Mercy Medical Center – Mt. Shasta</td>
<td>Mercy Medical Center – Mt. Shasta</td>
<td>863,173</td>
<td>2,524,835</td>
<td>-</td>
<td>-</td>
<td>264,866</td>
<td>-</td>
</tr>
<tr>
<td>Methodist Hospital - Sacramento</td>
<td>Methodist Hospital - Sacramento</td>
<td>2,266,018</td>
<td>22,721,204</td>
<td>766,895</td>
<td>-</td>
<td>3,867,360</td>
<td>7,729</td>
</tr>
<tr>
<td>St. Bernardine Medical Center</td>
<td>St. Bernardine Medical Center</td>
<td>5,604,945</td>
<td>28,907,306</td>
<td>1,422,209</td>
<td>-</td>
<td>450,162</td>
<td>160,335</td>
</tr>
<tr>
<td>St. John's Regional Medical Center</td>
<td>St. John's Regional Medical Center</td>
<td>2,851,641</td>
<td>19,170,435</td>
<td>459,197</td>
<td>1,587</td>
<td>-</td>
<td>495</td>
</tr>
<tr>
<td>Hospital</td>
<td>Charity Care</td>
<td>Unpaid Medicaid</td>
<td>Community Health Improvement Services</td>
<td>Health Professions Education</td>
<td>Subsidized Health Services</td>
<td>Community Building Activities</td>
<td>Community Benefit Operations</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-------------</td>
<td>----------------</td>
<td>----------------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Arroyo Grande Community Hospital</td>
<td>544,651</td>
<td>3,798,297</td>
<td>163,140</td>
<td>-</td>
<td>-</td>
<td>1,255</td>
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<tr>
<td>Chandler Regional Medical Center</td>
<td>2,939,058</td>
<td>20,702,611</td>
<td>1,448,780</td>
<td>-</td>
<td>638,773</td>
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<td>76,042</td>
</tr>
<tr>
<td>French Hospital Medical Center</td>
<td>661,071</td>
<td>4,195,312</td>
<td>388,300</td>
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<td>140,557</td>
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<td>Mark Twain – St. Joseph’s Hospital</td>
<td>418,145</td>
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<td>5,206</td>
<td>-</td>
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<td>Mercy Hospital of Folsom</td>
<td>1,530,678</td>
<td>10,333,124</td>
<td>276,489</td>
<td>-</td>
<td>957,496</td>
<td>377</td>
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<tr>
<td>Mercy Medical Center - Redding</td>
<td>4,587,221</td>
<td>(6,707,170)</td>
<td>11,296</td>
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<td>-</td>
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<td>Northridge Hospital Medical Center</td>
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<td>9,152,854</td>
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<td>671,569</td>
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<tr>
<td>Sequoia Hospital</td>
<td>1,551,547</td>
<td>6,641,871</td>
<td>256,133</td>
<td>-</td>
<td>21,521</td>
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<td>77,793</td>
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<td>St. Elizabeth Community Hospital</td>
<td>1,735,860</td>
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<td>3,678</td>
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<td>-</td>
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<td>St. Joseph’s Medical Center</td>
<td>5,433,900</td>
<td>27,043,083</td>
<td>2,424,889</td>
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<td>351,740</td>
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<tr>
<td>St. Joseph’s Behavioral Health</td>
<td>61,325</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>366</td>
<td>5,080</td>
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<tr>
<td>St. Mary’s Medical Center – Long Beach</td>
<td>11,281,071</td>
<td>796,130</td>
<td>3,690,095</td>
<td>-</td>
<td>202,110</td>
<td>-</td>
<td>869,855</td>
</tr>
</tbody>
</table>

*Note. All figures used for this table were taken directly from individual Dignity Health system hospital Community Benefit and Economic Value reports published for FY11, reporting period 7/1/2010 through 6/30/2011. Numbers represent dollars.

Table 12.

Summary Statistics for Dignity Health Hospitals – FY12

Category: Benefits for the Poor

Subcategory: Net Community Benefit
<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>ZIP Code</th>
<th>City</th>
<th>State</th>
<th>Type</th>
<th>Street Address</th>
<th>Year</th>
<th>Visits</th>
<th>Appointments</th>
<th>Inpatient Beds</th>
<th>Staff</th>
<th>Charges</th>
<th>Pharmacy</th>
<th>Pediatrics</th>
<th>Emergency</th>
<th>ICU Beds</th>
<th>Cardiovascular</th>
<th>Respiratory</th>
<th>Other</th>
<th>Facilities</th>
<th>Intensive Care</th>
<th>Outpatient</th>
<th>Inpatient Bed Capacity</th>
<th>Length of Stay</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Rose Dominican Hospital de Lima</td>
<td>3,608,253</td>
<td>5,078,762</td>
<td>237,831</td>
<td>5,492</td>
<td>-</td>
<td>197</td>
<td>340,717</td>
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<tr>
<td>Bakersfield Memorial Hospital</td>
<td>4,966,936</td>
<td>(559,664)</td>
<td>502,331</td>
<td>-</td>
<td>2,887,740</td>
<td>22,145</td>
<td>401,910</td>
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<tr>
<td>St. Mary Medical Center – San Francisco</td>
<td>1,649,074</td>
<td>12,512,801</td>
<td>551,182</td>
<td>-</td>
<td>76,551</td>
<td>1,261</td>
<td>544,044</td>
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<tr>
<td>Community Hospital of San Bernardino</td>
<td>4,857,458</td>
<td>9,818,355</td>
<td>1,272,036</td>
<td>-</td>
<td>-</td>
<td>186,359</td>
<td>219,940</td>
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<tr>
<td>Glendale Memorial Hospital</td>
<td>6,705,321</td>
<td>36,729,572</td>
<td>-</td>
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<tr>
<td>Mercy General Hospital</td>
<td>4,253,759</td>
<td>30,490,347</td>
<td>1,711,645</td>
<td>-</td>
<td>2,457,330</td>
<td>4,688</td>
<td>101,022</td>
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<tr>
<td>Mercy Medical Center - Merced</td>
<td>5,800,550</td>
<td>12,448,848</td>
<td>-</td>
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<td>22,009</td>
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<tr>
<td>Mercy San Juan Medical Center</td>
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<td>36,554,284</td>
<td>2,049,064</td>
<td>-</td>
<td>1,852,488</td>
<td>933</td>
<td>92,862</td>
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<td>Saint Francis Memorial Hospital</td>
<td>4,373,498</td>
<td>12,740,022</td>
<td>887,790</td>
<td>-</td>
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<td>-</td>
<td>148,292</td>
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<tr>
<td>Sierra Nevada Memorial Hospital</td>
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<td>152,510</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>53,650</td>
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<td>St. John’s Pleasant Valley Hospital</td>
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<td>-</td>
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<td>39,812</td>
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<td>St. Joseph’s Hospital and Medical Center</td>
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<td>970,141</td>
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<td>St. Rose Dominican Hospital – San Martin</td>
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<td>California Hospital Medical Center</td>
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<td>Dominican Hospital</td>
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<td>-</td>
<td>1,597,125</td>
<td>744,461</td>
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<tr>
<td>Marian Regional Medical Center</td>
<td>3,197,245</td>
<td>9,585,383</td>
<td>1,675,728</td>
<td>-</td>
<td>1,351,940</td>
<td>9,483</td>
<td>218,409</td>
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<tr>
<td>Mercy Gilbert Medical Center</td>
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</tr>
<tr>
<td>Mercy Hospital - Downtown</td>
<td>6,425,821</td>
<td>8,792,874</td>
<td>678,694</td>
<td>-</td>
<td>381,125</td>
<td>52,260</td>
<td>601,025</td>
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</tr>
<tr>
<td>Mercy Hospital – Bakersfield/Southwest</td>
<td>6,425,821</td>
<td>8,792,874</td>
<td>678,694</td>
<td>-</td>
<td>381,125</td>
<td>52,260</td>
<td>601,025</td>
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<tr>
<td>Mercy Medical Center – Mt. Shasta</td>
<td>939,727</td>
<td>581,608</td>
<td>-</td>
<td>496</td>
<td>-</td>
<td>-</td>
<td>20,504</td>
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</tr>
<tr>
<td>Methodist Hospital - Sacramento</td>
<td>3,979,926</td>
<td>26,007,052</td>
<td>961,132</td>
<td>-</td>
<td>2,359,355</td>
<td>581</td>
<td>44,183</td>
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</tr>
<tr>
<td>St. Bernardine Medical Center</td>
<td>7,674,408</td>
<td>26,948,446</td>
<td>1,153,979</td>
<td>-</td>
<td>-</td>
<td>284,694</td>
<td>264,094</td>
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</tr>
</tbody>
</table>


Included in the Benefits for the Poor category is the Unpaid Cost of Medicaid.

Referring back to Figure 3 above, unpaid costs of Medicaid claimed 36% of total community benefit reported for Dignity Health System in FY12. Taking this observation into account and pairing it with differences between unpaid costs of Medicaid between FY11 and FY12 for hospitals that experienced a negative loss or positive gain in overall reported community benefit— one may be able to test the relationship between changes in Medicaid payments and loss or gain of community benefit claims. Table 13 compares the hospitals that demonstrated the highest and lowest decline between years while Table 14 compares the two hospitals that demonstrated the greatest and least gain.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Benefit FY12</th>
<th>Total Benefit FY11</th>
<th>Total Unpaid Cost Medicaid FY12</th>
<th>Total Unpaid Cost Medicaid FY11</th>
<th>Change in Unpaid Cost Medicaid FY12</th>
<th>Change in Unpaid Cost Medicaid FY11</th>
<th>Change in Community Benefit FY12</th>
<th>Change in Community Benefit FY11</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Rose Dominican Hospital - Siena</td>
<td>5,570,606</td>
<td>15,608,699</td>
<td>1,579,898</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>12,259</td>
<td>-</td>
</tr>
<tr>
<td>Woodland Healthcare</td>
<td>1,076,177</td>
<td>6,537,696</td>
<td>175,511</td>
<td>-</td>
<td>49,177</td>
<td>14,472</td>
<td>62,650</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 13.

Comparison of Dignity Hospitals Demonstrating a Decline in Community Benefit for FY11 and FY12: Net Community Benefit to Medicaid

<table>
<thead>
<tr>
<th>Hospital</th>
<th>FY11 Total CB</th>
<th>FY11 Medicaid</th>
<th>FY12 Total CB</th>
<th>FY12 Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Mary Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Long Beach (-70.0)</td>
<td>30,729,765</td>
<td>(2,792,416)</td>
<td>9,237,552</td>
<td>796,130</td>
</tr>
<tr>
<td>Mercy General Hospital</td>
<td>46,610,171</td>
<td>33,312,777</td>
<td>46,099,208</td>
<td>30,490,347</td>
</tr>
</tbody>
</table>

Note: Figures included in this table were compiled from Community Benefit and Economic Value reports published by member Dignity Health hospitals for period 7/1/2010 through 6/30/2011 and 7/1/2011 through 6/30/2012. Community Benefit figures listed in the table includes category totals for Net Community Benefit and Unpaid Costs of Medicaid. Numbers represent dollars.

Reviewing Table 13, one observes that for Mercy General Hospital, the difference between total community benefit and Medicaid is relatively small indicating that the (-1.1%) difference between years may be related to changes in Medicaid compensation. However, if one focuses on St. Mary Medical Center – Long Beach, this connection is more difficult to determine. For example, one observes a 70% decrease in net hospital community benefit between FY11 and FY12. The difference between Medicaid expenses and offsetting Medicaid revenue for FY11 was $101,185,165 (expense) and $103,977,581 (offsetting revenue), resulting in a positive difference of $2,792,416. The difference between Medicaid expenses and offsetting revenue for FY12 was $104,447,593 (expense) and $103,651,463 (offsetting revenue) leaving a net community benefit claim of $796,130.

Therefore, it appears that in FY11 if there was a positive difference between Medicaid expenses and offsetting revenue this should have theoretically lowered total
community benefit claims. Yet, the total community benefit for FY11 was over $20 million higher than FY12 where the difference between Medicaid expenses and offsetting revenue added to the net total of community benefit for FY12 and the number of persons served within this category was relatively the same (61,746 for FY11 and 63,297 for FY12).

Table 14.

Comparison of Dignity Hospitals Demonstrating an Increase in Community Benefit for FY11 and FY12: Net Community Benefit to Medicaid

<table>
<thead>
<tr>
<th>Hospital</th>
<th>FY11 Total CB</th>
<th>FY11 Medicaid</th>
<th>FY12 Total CB</th>
<th>FY12 Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Twain – St. Joseph’s Hospital</td>
<td>(501.2%)</td>
<td>594,667</td>
<td>(674,726)</td>
<td>3,574,093</td>
</tr>
<tr>
<td>St. Bernardine Medical Center</td>
<td>(0.2%)</td>
<td>39,083,898</td>
<td>28,907,306</td>
<td>39,163,575</td>
</tr>
</tbody>
</table>

Note: Figures included in this table were compiled from Community Benefit and Economic Value reports published by member Dignity Health hospitals for period 7/1/2010 through 6/30/2011 and 7/1/2011 through 6/30/2012. Community Benefit figures listed in the table includes category totals for Net Community Benefit and Unpaid Costs of Medicaid. Numbers represent dollars.

Within Table 14, the hospital demonstrating the highest gain in claimed community benefit, Mark Twain – St. Joseph’s Hospital (501.2%) had a net positive Medicaid community benefit total (expenses minus offsetting revenue, $674,726) for FY11 with a negative difference between community benefit expenses and offsetting revenue resulting in a claim of $1,665,373 for FY12. St. Bernardine Medical Center demonstrated a minimal change between net community benefit claimed in FY11 and FY12 (0.2%). This correlation corresponds to the findings seen in Table 13. For example, in Table 14 the hospital experiencing the greatest gain had a positive Medicaid claim in FY11 but a negative
difference in expenses vs. offsetting revenue resulting in a positive difference adding to overall net community benefit.

Comparing the results of Table 13 with Table 14, one can observe that a decline or increase in total community benefit as it relates to reported Medicaid community benefit suggests that the nature of the relationship between net community benefit/Medicaid may be linked to other determinants unforeseen by the analysis conducted thus far and not the extent to which the relationship between changes in reported net community benefit varied compared to changes in reported Medicaid community benefit.

Thus far, the hospital-level discussion has shown that variation exists among Dignity Health hospitals in the amount of community benefit they report as net community benefit and Medicaid community benefit. Tying this reporting variability to health outcomes has yet to be achieved. Therefore, the next step of analysis at the hospital level focuses on the amount of community benefit that has been distributed among the patient populations located within Dignity hospital service areas.

In order to accomplish this task, two sub-categories within the Benefits of the Poor and Benefits for the Broader Community reporting categories were examined and compared among 35 Dignity Health hospitals. The reporting sub-categories are: Community Building Activities and Community Health Improvement Services. Selection of these two sub-categories is based on three criteria. First, unlike other reporting sub-categories, e.g., Medicaid, both sub-categories do not receive offsetting revenue for services provided. Or, stated another way, services provided are not tied to care that is subsidized by a third-party payer, i.e., Medicaid or Medicare. Thus, the services/resources that are provided within these two sub-categories fulfill the nonprofit hospital’s mission to serve underserved or marginalized community members located within each hospital’s service area. Second, the
selected sub-categories also respond directly to the needs of community identified by the Community Needs assessments conducted by Dignity Hospitals (Dignity, 2012a), providing services that target specific populations based on need and not on criteria that may contribute to profitable hospital services. And third, under the reporting sub-categories, Community Building Activities and Community Health Improvement Services, some hospitals report community benefit under the Benefits for the Poor category whereas some hospitals report community benefit under the Benefits for the Broader Community category. Therefore, tables illustrating reporting within both of these reporting sub-categories were developed.

The analysis of the sub-categories begins with presenting reported Community Building Activities and Community Health Improvement Services for 35 Dignity hospitals in FY11 and FY12. Based on a review of this data, four hospitals were selected and compared. To maintain continuity, the four hospitals compared above, St. Mary Medical Center – Long Beach, Mercy General Hospital, Mark Twain – St. Joseph’s Hospital, and St. Bernardine Medical Center were employed. It is hoped that by demonstrating the amount of resources provided to patients within these two sub-categories is completed, one may be able to determine the relationship between Dignity Health community benefit policies via resource allocation and their impact on the health of community.

The following four tables provide summary statistics for 35 Dignity Health hospitals under the Benefits for the Poor and Benefits for the Broader Community for FY11 and FY12 including the sub-categories, Community Building Activities and Community Health Improvement Services. Separate columns are also included that indicate the number of persons served and the amount of resources committed per person served.
Table 15.

Summary Statistics for Dignity Health Hospitals – FY11

Category: Benefits for the Poor – Categorical Investment Per Person Served

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Community Building Activities</th>
<th>Community Persons</th>
<th>Investment Per Person</th>
<th>Community Health Improvement Services</th>
<th>Persons</th>
<th>Investment Per Person</th>
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<td>115</td>
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<td>-</td>
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<td>32</td>
<td>57.88</td>
<td>2,885,999</td>
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<td>134.53</td>
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<td>Sequoia Hospital</td>
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<td>0</td>
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<td>248.55</td>
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<td>Hospital Name</td>
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<td>De BFM</td>
<td>DE BFM</td>
<td>In FTM</td>
<td>In BFM</td>
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<td>-</td>
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<td>15.44</td>
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<td>20.00</td>
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<td>21,641</td>
<td>50.38</td>
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<td>10.97</td>
<td>167,325</td>
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<td>52.44</td>
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</table>
**Note.** All figures used for this table were taken directly from individual Dignity Health system hospital Community Benefit and Economic Value reports published for FY11, reporting period 7/1/2010 through 6/30/2011. Figures represent dollars.

Table 16.

Summary Statistics for Dignity Health Hospitals – FY11

Category: Benefits for the Broader Community

Net Community Benefit

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Community Building Activities</th>
<th>Community Health Improvement Services</th>
<th>Subcategory/Dollars Per Person</th>
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</thead>
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<td>241,582</td>
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<td>4,978</td>
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<td>Methodist Hospital - Sacramento</td>
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<tr>
<td>Hospital</td>
<td>Community Building Activities</td>
<td>Persons</td>
<td>Investment Per Person</td>
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<tr>
<td>Sequoia Hospital</td>
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Note. All figures used for this table were taken directly from individual Dignity Health system hospital Community Benefit and Economic Value reports published for FY11, reporting period 7/1/2010 through 6/30/2011.
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<th>Hospital Name</th>
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<th>Patient Volume</th>
<th>Bil. Cases</th>
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<td>280</td>
<td>0</td>
<td>0</td>
<td>44,449</td>
<td>1,705</td>
<td>26.10</td>
</tr>
<tr>
<td>St. Joseph’s Hospital and Medical Center</td>
<td>104,330</td>
<td>364</td>
<td>286.62</td>
<td>2,575,865</td>
<td>38,529</td>
<td>66.85</td>
</tr>
<tr>
<td>St. Rose Dominican Hospital – San Martin</td>
<td>251</td>
<td>1</td>
<td>251</td>
<td>242,762</td>
<td>1,120</td>
<td>216.75</td>
</tr>
<tr>
<td>California Hospital Medical Center</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>19,850,019</td>
<td>31,127</td>
<td>637.71</td>
</tr>
<tr>
<td>Dominican Hospital</td>
<td>744,461</td>
<td>52</td>
<td>14,316.56</td>
<td>1,573,430</td>
<td>1,969</td>
<td>799.10</td>
</tr>
<tr>
<td>Marian Regional Medical Center</td>
<td>9,483</td>
<td>266</td>
<td>35.65</td>
<td>1,675,728</td>
<td>29,183</td>
<td>57.42</td>
</tr>
<tr>
<td>Mercy Gilbert Medical Center</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mercy Hospital - Downtown</td>
<td>52,260</td>
<td>4,231</td>
<td>12.35</td>
<td>678,694</td>
<td>22,747</td>
<td>29.83</td>
</tr>
<tr>
<td>Mercy Hospital – Bakersfield/Southwest</td>
<td>52,260</td>
<td>4,231</td>
<td>12.35</td>
<td>678,694</td>
<td>22,747</td>
<td>29.83</td>
</tr>
<tr>
<td>Mercy Medical Center – Mt. Shasta</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0</td>
<td>454</td>
<td>*</td>
</tr>
<tr>
<td>Methodist Hospital -</td>
<td>581</td>
<td>0</td>
<td>0</td>
<td>961,132</td>
<td>4,508</td>
<td>213.21</td>
</tr>
</tbody>
</table>
### Table 18: Summary Statistics for Dignity Health Hospitals – FY12

**Category: Benefits for the Broader Community**

**Categorical Investment Per Persons Served**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Community Building Activities</th>
<th>Persons</th>
<th>Community Health Improvement Services Per Person</th>
<th>Community Improvement Services Persons</th>
<th>Community Improvement Services Investment Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arroyo Grande Community Hospital</td>
<td>-</td>
<td>-</td>
<td>123,878</td>
<td>1,399</td>
<td>88.55</td>
</tr>
<tr>
<td>Chandler Regional Medical Center</td>
<td>86,425</td>
<td>750</td>
<td>946,181</td>
<td>20,758</td>
<td>45.58</td>
</tr>
<tr>
<td>French Hospital Medical Center</td>
<td>-</td>
<td>-</td>
<td>204,900</td>
<td>8,105</td>
<td>25.28</td>
</tr>
<tr>
<td>Mark Twain – St. Joseph’s Hospital</td>
<td>274</td>
<td>20</td>
<td>24,608</td>
<td>2,331</td>
<td>10.56</td>
</tr>
<tr>
<td>Mercy Hospital of Folsom</td>
<td>75</td>
<td>0</td>
<td>114,774</td>
<td>1,051</td>
<td>109.20</td>
</tr>
<tr>
<td>Mercy Medical Center - Redding</td>
<td>-</td>
<td>-</td>
<td>33,678</td>
<td>1,716</td>
<td>19.63</td>
</tr>
<tr>
<td>Northridge Hospital Medical Center</td>
<td>327,665</td>
<td>807</td>
<td>1,131,704</td>
<td>14,483</td>
<td>78.14</td>
</tr>
<tr>
<td>Sequoia Hospital</td>
<td>180,650</td>
<td>57</td>
<td>268,605</td>
<td>12,657</td>
<td>21.22</td>
</tr>
<tr>
<td>St. Elizabeth Community Hospital</td>
<td>75</td>
<td>1</td>
<td>55,448</td>
<td>559</td>
<td>99.19</td>
</tr>
<tr>
<td>St. Joseph’s Medical Center</td>
<td>878,275</td>
<td>329</td>
<td>2,397,134</td>
<td>185,456</td>
<td>12.93</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Bed Count</td>
<td>ED Visits</td>
<td>ED ASA</td>
<td>Annual Volume</td>
<td>Patient Days</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>--------</td>
<td>---------------</td>
<td>--------------</td>
</tr>
<tr>
<td>St. Joseph’s Behavioral Health</td>
<td>2,352</td>
<td>12</td>
<td>196</td>
<td>307,389</td>
<td>3,315</td>
</tr>
<tr>
<td>St. Mary Medical Center – Long Beach</td>
<td>261,177</td>
<td>842</td>
<td>310.19</td>
<td>431,634</td>
<td>846</td>
</tr>
<tr>
<td>St. Rose Dominican Hospital de Lima</td>
<td>28,241</td>
<td>8</td>
<td>3,530.13</td>
<td>67,879</td>
<td>81</td>
</tr>
<tr>
<td>Bakersfield Memorial Hospital</td>
<td>31,087</td>
<td>612</td>
<td>50.80</td>
<td>171,531</td>
<td>6,632</td>
</tr>
<tr>
<td>St. Mary’s Medical Center – San Francisco</td>
<td>10,347</td>
<td>58</td>
<td>178.40</td>
<td>451,582</td>
<td>10,862</td>
</tr>
<tr>
<td>Community Hospital of San Bernardino</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>417,107</td>
<td>5,194</td>
</tr>
<tr>
<td>Glendale Memorial Hospital</td>
<td>149,120</td>
<td>0</td>
<td>0</td>
<td>640,274</td>
<td>1,828</td>
</tr>
<tr>
<td>Mercy General Hospital</td>
<td>7,920</td>
<td>0</td>
<td>0</td>
<td>1,392,140</td>
<td>23,201</td>
</tr>
<tr>
<td>Mercy Medical Center - Merced</td>
<td>19,992</td>
<td>188</td>
<td>106.34</td>
<td>723,175</td>
<td>21,463</td>
</tr>
<tr>
<td>Mercy San Juan Medical Center</td>
<td>320</td>
<td>80</td>
<td>4.00</td>
<td>47,783</td>
<td>3,352</td>
</tr>
<tr>
<td>Saint Francis Memorial Hospital</td>
<td>41,880</td>
<td>1</td>
<td>41,880</td>
<td>5,679</td>
<td>177</td>
</tr>
<tr>
<td>Sierra Nevada Memorial Hospital</td>
<td>1,666</td>
<td>6</td>
<td>277.67</td>
<td>72,370</td>
<td>4,914</td>
</tr>
<tr>
<td>St. John’s Pleasant Valley Hospital</td>
<td>3,212</td>
<td>807</td>
<td>3.98</td>
<td>11,142</td>
<td>1,516</td>
</tr>
<tr>
<td>St. Joseph’s Hospital and Medical Center</td>
<td>10,962</td>
<td>1,076</td>
<td>10.19</td>
<td>983,670</td>
<td>47,095</td>
</tr>
<tr>
<td>St. Rose Dominican Hospital – San Martin</td>
<td>34,995</td>
<td>9</td>
<td>3,888.33</td>
<td>84,639</td>
<td>93</td>
</tr>
<tr>
<td>California Hospital Medical Center</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>399,637</td>
<td>3,565</td>
</tr>
<tr>
<td>Dominican Hospital</td>
<td>38,573</td>
<td>0</td>
<td>0</td>
<td>1,394,812</td>
<td>10,344</td>
</tr>
<tr>
<td>Marian Regional Medical Center</td>
<td>2,301</td>
<td>0</td>
<td>0</td>
<td>420,264</td>
<td>20,208</td>
</tr>
<tr>
<td>Mercy Gilbert Medical Center</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mercy Hospital – Downtown</td>
<td>25,148</td>
<td>1,625</td>
<td>15.48</td>
<td>402,327</td>
<td>9,147</td>
</tr>
<tr>
<td>Mercy Hospital –</td>
<td>25,148</td>
<td>1,625</td>
<td>15.48</td>
<td>402,327</td>
<td>9,147</td>
</tr>
</tbody>
</table>
### Bakersfield/Southwest

<table>
<thead>
<tr>
<th>Hospital</th>
<th>FY12</th>
<th>FY11</th>
<th>Total FY11</th>
<th>FY12</th>
<th>FY11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercy Medical Center – Mt. Shasta</td>
<td>186</td>
<td>2</td>
<td>93</td>
<td>52,813</td>
<td>909</td>
</tr>
<tr>
<td>Methodist Hospital - Sacramento</td>
<td>40,075</td>
<td>0</td>
<td>0</td>
<td>14,199</td>
<td>0</td>
</tr>
<tr>
<td>St. Bernardine Medical Center</td>
<td>2,760</td>
<td>52</td>
<td>53.08</td>
<td>67,342</td>
<td>1,478</td>
</tr>
<tr>
<td>St. John's Regional Medical Center</td>
<td>7,348</td>
<td>1,106</td>
<td>6.64</td>
<td>212,328</td>
<td>16,925</td>
</tr>
<tr>
<td>St. Rose Dominican Hospital - Siena</td>
<td>71,659</td>
<td>7</td>
<td>10,237.00</td>
<td>1,845,849</td>
<td>89,209</td>
</tr>
<tr>
<td>Woodland Healthcare</td>
<td>24,479</td>
<td>3,887</td>
<td>6.30</td>
<td>62,651</td>
<td>7,037</td>
</tr>
</tbody>
</table>

*Note.* Figures included in this table were compiled from Community Benefit and Economic Value reports published by member Dignity Health hospitals for FY12, 7/1/2011 through 6/30/2012.

As the four tables above illustrate, a wide range of dollar amounts was allocated within Community Benefit Activities and Community Health Improvement Services for FY11 and FY12 under Benefits for the Poor and Benefits for the Broader Community. Similarly, the amount of resources per person varied widely as well. Viewing aggregate resources committed for all hospitals underscores this observation. For example, one could separate and compare resources committed within one sub-category in order to see the relationship between resource allocation, total persons served, and dollars allocated per person for two consecutive years. Tables 19 and 20 present this relationship for all Dignity hospitals under Benefits for the Poor and Benefits for the Broader Community within the Community Health Improvement Services reporting category.
Table 19.

Community Benefit – Community Health Improvement Services Category

Benefits for the Poor – All Dignity Hospitals – FY11 and FY12

<table>
<thead>
<tr>
<th>Category</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Benefits for the Poor:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Dollars</td>
<td>44,957,634</td>
<td>49,264,764</td>
</tr>
<tr>
<td>Total Persons</td>
<td>435,481</td>
<td>439,502</td>
</tr>
<tr>
<td>Amount Per Person</td>
<td>103.24</td>
<td>112.09</td>
</tr>
</tbody>
</table>

Note: All figures used for this table were compiled from individual Dignity Health system hospital Community Benefit and Economic Value reports, FY11 and FY12. Numbers represent dollars.

Table 20.

Community Benefit – Community Health Improvement Services Category

Benefits for the Broader Community - All Dignity Hospitals – FY11 and FY12

<table>
<thead>
<tr>
<th>Category</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Benefits for the Broader Community:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Dollars</td>
<td>22,522,097</td>
<td>16,383,453</td>
</tr>
<tr>
<td>Total Persons</td>
<td>1,963,655</td>
<td>547,053</td>
</tr>
<tr>
<td>Amount Per Person</td>
<td>11.46</td>
<td>29.94</td>
</tr>
</tbody>
</table>

Note: All figures used for this table were compiled from individual Dignity Health system hospital Community Benefit and Economic Value reports, FY11 and FY12. Numbers represent dollars.

In order to further demonstrate the relationship between total dollars allocated and total dollars allocated per person, comparisons among the four aforementioned hospitals are illustrated in Table 21 and Table 22.
Table 21.

Reported FY11 Community Building Activities and Community Health Improvement Service: Persons Served and Dollars Per Person

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Dollars/Persons Served/Dollars Per Person</th>
<th>FY11 Community Building Activities: Poor</th>
<th>FY11 Community Building Activities: Community</th>
<th>FY11 Community Health Improvement Services: Poor</th>
<th>FY11 Community Health Improvement Services: Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Mary Medical Center – Long Beach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Dollars</td>
<td>-</td>
<td>$229,556</td>
<td>$2,194,465</td>
<td>$1,190,492</td>
<td></td>
</tr>
<tr>
<td>Persons Served</td>
<td>0</td>
<td>0</td>
<td>26,305</td>
<td>14,177</td>
<td></td>
</tr>
<tr>
<td>Dollars Person</td>
<td>-</td>
<td>-</td>
<td>$83.42</td>
<td>$83.97</td>
<td></td>
</tr>
<tr>
<td>Mercy General Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Dollars</td>
<td>$6,219</td>
<td>$15,334</td>
<td>$1,504,655</td>
<td>$1,359,280</td>
<td></td>
</tr>
<tr>
<td>Persons Served</td>
<td>0</td>
<td>0</td>
<td>23,553</td>
<td>16,294</td>
<td></td>
</tr>
<tr>
<td>Dollars Person</td>
<td>-</td>
<td>-</td>
<td>$63.88</td>
<td>$83.42</td>
<td></td>
</tr>
<tr>
<td>Mark Twain – St. Joseph’s Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Dollars</td>
<td>-</td>
<td>$7,415</td>
<td>$9,109</td>
<td>$31,417</td>
<td></td>
</tr>
<tr>
<td>Persons Served</td>
<td>0</td>
<td>204</td>
<td>115</td>
<td>4,978</td>
<td></td>
</tr>
<tr>
<td>Dollars Person</td>
<td>-</td>
<td>$36.34</td>
<td>$79.20</td>
<td>$6.31</td>
<td></td>
</tr>
<tr>
<td>St. Bernardine Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Dollars</td>
<td>$450,162</td>
<td>-</td>
<td>$1,422,209</td>
<td>$47,336</td>
<td></td>
</tr>
<tr>
<td>Persons Served</td>
<td>2,441</td>
<td>0</td>
<td>6,061</td>
<td>372</td>
<td></td>
</tr>
<tr>
<td>Dollars Person</td>
<td>$184.42</td>
<td>-</td>
<td>$234.65</td>
<td>$127.25</td>
<td></td>
</tr>
</tbody>
</table>

Note. All figures used for this table were taken directly from selected Dignity Health system hospital Community Benefit and Economic Value reports published for FY11, reporting period 7/1/2010 through 6/30/2011.

*Total Dollars represents the total amount of resources committed to fund program services.

*Persons represents the total number of persons served.

*Dollars Person represents the amount of total resources consumed per person.
### Table 22.

Reported FY12 Community Building Activities and Community Health Improvement Services for Selected Dignity Hospitals Including Persons Served

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Dollars/Persons Served/Dollars Per Person</th>
<th>FY12 Community Building Activities: Poor</th>
<th>FY12 Community Building Activities: Community</th>
<th>FY12 Community Health Improvement Services: Poor</th>
<th>FY12 Community Health Improvement Services: Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Mary Medical Center – Long Beach</td>
<td></td>
<td>$261,177</td>
<td>$3,690,095</td>
<td>$431,634</td>
<td>$510,21</td>
</tr>
<tr>
<td></td>
<td>Total Dollars</td>
<td>$3,690,095</td>
<td></td>
<td>$431,634</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Persons Served</td>
<td>842</td>
<td>45,261</td>
<td>846</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dollars Person</td>
<td>$310.19</td>
<td>$81.53</td>
<td>$510.21</td>
<td></td>
</tr>
<tr>
<td>Mercy General Hospital</td>
<td></td>
<td>$4,688</td>
<td>$7,920</td>
<td>$1,711,645</td>
<td>$1,392,140</td>
</tr>
<tr>
<td></td>
<td>Total Dollars</td>
<td>$4,688</td>
<td>$7,920</td>
<td>$1,711,645</td>
<td>$1,392,140</td>
</tr>
<tr>
<td></td>
<td>Persons Served</td>
<td>900</td>
<td>21,864</td>
<td>23,201</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dollars Person</td>
<td>$5.21</td>
<td>$81.53</td>
<td>$60.00</td>
<td></td>
</tr>
<tr>
<td>Mark Twain – St. Joseph’s Hospital</td>
<td></td>
<td>$274</td>
<td>$1,200</td>
<td>$24,608</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Dollars</td>
<td>$274</td>
<td>$1,200</td>
<td>$24,608</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Persons Served</td>
<td>0</td>
<td>68</td>
<td>2,331</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dollars Person</td>
<td>$13.70</td>
<td>$17.65</td>
<td>$10.56</td>
<td></td>
</tr>
<tr>
<td>St. Bernardine Medical Center</td>
<td></td>
<td>$284,694</td>
<td>$2,760</td>
<td>$1,053,979</td>
<td>$67,342</td>
</tr>
<tr>
<td></td>
<td>Total Dollars</td>
<td>$284,694</td>
<td>$2,760</td>
<td>$1,053,979</td>
<td>$67,342</td>
</tr>
<tr>
<td></td>
<td>Persons Served</td>
<td>1,475</td>
<td>76</td>
<td>1,478</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dollars Person</td>
<td>$193.01</td>
<td>$138.19</td>
<td>$45.56</td>
<td></td>
</tr>
</tbody>
</table>

Note. Figures included in this table were compiled from Community Benefit and Economic Value reports published by selected Dignity Health hospitals for FY12, 7/1/2011 through 6/30/2012.

aTotal Dollars represents the total amount of resources committed to fund program services.
bPersons represents the total number of persons served.
cDollars Person represents the amount of total resources consumed per person.

For FY11, Table 21 shows that the majority of funds were allocated within Community Health Improvement Services under Benefits for the Poor and Benefits for the Broader Community. Within Community Health Improvement Services, Benefits for the
Poor, St. Mary Medical Center – Long Beach allocated the most funds overall ($2,194,645) with Mark Twain – St. Joseph’s Hospital the least ($9,109). St. Bernardine Medical Center reported the highest dollars per person ($234.65) and St. Mary Medical Center reached the most persons among this group of hospitals (26,305). Within Community Health Improvement Services, Benefits for the Broader Community category, St. Mary Medical Center – Long Beach claimed the top spot in total funds allocated ($1,190,492) with Mark Twain – St. Joseph’s Hospital allocating the least amount ($31,417). Mercy General Hospital reached the most persons (16,294) while St. Bernardine again allocated the most dollars per person ($127.25). Together, Table 20 demonstrates that the hospitals included in this comparison committed a significant amount of resources across both reporting sub-categories.

For FY12, Table 22 shows a similar pattern as seen for FY11. Within Community Health Improvements Services, Benefits for the Poor, St. Mary Medical Center – Long Beach again committed the highest amount of resources ($3,690,095) with Mark Twain – St. Joseph’s Hospital the least ($1,200). St. Mary Medical Center – Long Beach also reached the most persons among this group of hospitals (45,261) as they did in FY11 with Mark Twain – St. Joseph’s Hospital connecting with the fewest (68). And, St. Bernardine Medical Center averaged the highest per dollar amount ($138.19) as they did for FY11. Within the Community Health Improvement Services, Benefits for the Broader Community category, St. Mary Medical Center – Long Beach had the highest dollar per person allocation ($510.21) with Mark Twain – St. Joseph’s Hospital the least amount of dollars per person ($10.56). As with Table 21 for FY11, Table 22 for FY12 demonstrates that a significant amount of resources were committed to serving persons located within each hospital’s service area.
Determining the relationship between variations in resource allocation, numbers served, and dollars committed per person cannot be determined by simply comparing numbers from one year to another, however. These numbers do illustrate that Dignity Health hospitals consistently allocate a great deal of resources to providing needed benefits to community but connecting resource allocation with health outcomes is a relationship that may not be possible to define based on the information contained in the tables above. Therefore, the question that remains is how do resource allocations impact health?

In an effort to delve more deeply into Dignity’s community benefit reports to address this question, another source of data was reviewed. These data came in the form of the Community Need Index (CNI) scores that Dignity Health has calculated for each zip code located within the service areas of each Dignity Hospital. As defined by Dignity Health, CNI scores are the culmination of factors linked to health outcomes. The description below captures the motivation for developing CNI scores and the information that is contained within them that can be used to identify where service needs should be directed. According to Dignity Health (Dignity, 2013):

The Community Need Index Score is an average of five different barrier scores that measure socio-economic indicators of each community. Factors related to income, culture, education, insurance, and housing status are measured to determine CNI scores for zip codes located within hospital service areas. A score of 1, 2, 3, 4, or 5 is assigned to each zip code based on calculations of barriers present within it. A score of 5 indicates highest need while a score of 1 indicates lowest need. Weighted community CNI scores may also be calculated. By comparing CNI scores over a period of time with the resources that have been committed to providing services to the most needy members of Dignity Health’s service
areas one may be able to determine the extent to which resource allocation impacts community health. Therefore, the next section of the hospital-level analysis will review the highest and lowest CNI scores for a select number of hospitals over a four-year period, 2009-2012. The assumption here is that increased levels of resource allocation within targeted zip codes should lower CNI scores over time. If this hypothesis is found to be correct – one may be able to determine the extent to which community benefit policies impact health.

Dignity Health – Hospital-Level Analysis: CNI Scores and Community Programs

For this section of the analysis, 35 Dignity Health hospital Community Benefit Reports were reviewed and CNI scores were compared among all hospitals and their respective service areas for FY09 through FY12. The 35 hospitals were narrowed down to hospitals representing the three main regions where Dignity hospitals are located in California, Nevada, and Arizona. Next, high CNI scores within the service areas of two hospitals, Mercy General Hospital located in Sacramento, California (MGH) and St. Joseph’s Hospital and Medical Center located in Phoenix, Arizona (SJHMC) were compared with all Dignity hospitals located in the Nevada region, the St. Rose Dominican Hospitals (SRDH). Comparing hospitals located across the Dignity system was motivated by the notion that CNI scores may vary among hospital service areas based on the relationship between hospital resource availability and the unique needs of the communities located within each distinct service area. In addition, comparing a different set of hospitals other than the hospitals previously selected for other sections of this analysis was done in order to widen the overall analysis to include as many Dignity hospitals as possible. Table 23 illustrates a change over time comparison between the top two High CNI scores found within the zip code/service areas of this set of hospitals.
Table 23.

Change Over Time in High Community Need Index (CNI) scores by ZIP Code for FY 09, FY10, FY11, and FY12 for Individual Hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>FY09</th>
<th></th>
<th>FY10</th>
<th></th>
<th>FY11</th>
<th></th>
<th>FY12</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High 1</td>
<td>High 2</td>
<td>High 1</td>
<td>High 2</td>
<td>High 1</td>
<td>High 2</td>
<td>High 1</td>
<td>High 2</td>
</tr>
<tr>
<td>MGH</td>
<td>95815</td>
<td>95824</td>
<td>95815</td>
<td>95824</td>
<td>95815</td>
<td>95824</td>
<td>95815</td>
<td>95824</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>SRDH</td>
<td>89122</td>
<td>89119</td>
<td>89122</td>
<td>89119</td>
<td>89110</td>
<td>89119</td>
<td>89110</td>
<td>89119</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4.6</td>
<td>4.6</td>
</tr>
<tr>
<td>SJHMC</td>
<td>85009</td>
<td>85040</td>
<td>85009</td>
<td>85040</td>
<td>Map</td>
<td>Map</td>
<td>85009</td>
<td>85040</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>Only</td>
<td>Only</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

*Note.* Figures used in this table were taken from Community Benefit Reports published by selected hospitals for FY09 through FY12. If more than two zip codes indicated a high score, zip codes were selected in descending order based on highest number of admissions or based on zip code population. Corresponding CNI scores are shown below each zip code. A score of 5 indicates highest need. A score of 1 indicates least need.

aMercy General Hospital, Sacramento, California

bSt. Rose Dominican Hospital Service Area, all Dignity Hospitals located in Nevada

cSt. Joseph’s Hospital and Medical Center, Phoenix, Arizona

For the selected hospitals the top two High CNI scores (5.0, 4.6) remained the same for all years. Based on this observation, the Community Benefit Reports for these hospitals were re-reviewed in an effort to determine if resources increased, decreased, or stayed the same. And, if changes were identified, what was the most likely explanation for CNI scores remaining unchanged for the zip codes selected. Results of this review found that resource allocation did vary over time among this set of hospitals (see Tables 21 and 22). However, more importantly, it was also found that the development and subsequent assignment of CNI scores was a static exercise undertaken in 2009 and has not been updated since that time (Dignity, 2013c). As a result, drawing any relationship between resource allocation, CNI score designation, and changes in CNI scores over time was an optimistic venture but
produced very limited results. Based on the initial findings with respect to resource allocation and High CNI scores, a comparison of resource allocation and Low CNI scores was not conducted.

Up to this point, a series of analytic steps has been undertaken to understand the relationship between Dignity Health community benefit policies and their impact on health. Narrowing the analysis from a system- to a hospital-level perspective has generated some interesting findings. First, the majority of claimed community benefit is consumed by the difference between the costs of delivering care and reimbursement from third-party payers. Second, variation exists among Dignity Health hospitals in the ways in which they report community benefit. Third, even though variation exists Dignity Health hospitals consistently commit significant amounts of resources to addressing community needs. Fourth, although the development of the CNI score provided valuable information regarding the needs of community, the instrument would need to be updated more frequently if a relationship between resource allocation and changes in community health can be made. And fifth, determining the relationship between health outcomes (change in CNI score) and resource allocation (dollars over time) was challenged by the static nature of the CNI instrument.

Collectively, these observations also signify that many of the research questions at hand have been addressed but remain to be answered. For example, Question 3: How does the framing of the populations targeted to receive community benefit policies contribute to improving or hindering community health and, Question 2: How may social and scientific definitions of health contribute to the process of creating community benefit policies?

The results of the analysis contained within the following two sections address each of these questions. Section 3, a review of four community benefit policies and the members of community that they are targeted to benefit pertain to Question 3. The final section,
Section 4, consists of a review of the words contained within IRS Revenue Rulings and Dignity Health Community Benefit Reports address Question 2.

Section 3: Dignity Health – Community Benefit Program-Level Analysis

For the 35 Dignity Health hospitals incorporated into this study, each has created community benefit programs to identify and address specific health needs found within its service area. Programs are developed based on discourse between hospitals and community, information contained within Community Needs Assessments (Rimsza et al., 2006), and data provided by various national, state, and local health care resources (Dignity, 2013a).

The overall goal of each program is to improve the health and well being of individuals and families (Dignity, 2013a). Disease prevention and health promotion form the core dimensions directing the development of many of the programs, underscoring the belief that addressing social determinants of health is a proven approach to decrease the costs of care, improve access to care, and obtain the best health outcomes possible especially among marginalized populations (Anzel, 1970; Rundall, 1994; Ward, 1995; Baxter & Mechanic, 1997; Institute of Medicine, 1997; Taylor, 1997; Aicher, 1998; Pincus, Esther, DeWalt, & Callahan, 1998; Wetzel, Glanz, & Lerman, 2002; Staiti, Hurley, & Katz, 2006; Felland, Hurley, & Kemper, 2008; Mills, 2008; Zedlewski, Chaudry, & Simms, 2008).

Examples of local Dignity Health hospital community benefit programs include cancer-screening initiatives, asthma education programs, weight management classes, youth swimming courses, and chronic disease prevention programs.

A review of community benefit programs developed and implemented by Dignity hospitals found that a majority of the programs target health needs found within marginalized segments of Dignity’s communities. Common characteristics of these communities include large numbers of low-income households, ethnic minorities,
comparatively lower levels of educational attainment, widespread presence of chronic
diseases, higher percentages of individuals and families that pay rent for place of residence,
and health outcomes that tend to be lower as compared to communities located outside of
these marginalized areas\textsuperscript{12}. CNI scores reflect these characteristics in that marginalized
segments of community consistently demonstrate the highest CNI scores among all
communities located within a hospital’s service area (Dignity, 2013c).

In an effort to measure the extent to which the framing of target populations
through implemented community benefit programs impacts community health, community
benefit programs implemented by 35 Dignity hospitals were reviewed and sorted according
to general program characteristics. Programs selected for analysis were narrowed based on
whether or not they met the following subjective criteria: each program needed to be in
existence for at least three years, each program needed to address the needs of marginalized
populations, and selected programs needed to be represented by different hospitals. Rational
for selecting programs based on the author’s subjectivity were grounded within the following
four assumptions.

First, selecting programs that are implemented over several years allows for year-to-
year within-program comparisons to be made. Second, comparing programs from different
hospitals widens the overall analysis and provides opportunities for between-hospital
comparisons. Third, marginalized populations place a heavy burden on community hospital
resources and consistently display health outcomes that are comparatively lower than non-
marginalized communities (Manjarrez, Popkin, & Guernsey, 2007). Analyzing implemented
programs that target this demographic demonstrates the commitment nonprofit hospitals

\textsuperscript{12} Creating demographic profiles of marginalized communities was accomplished by
analyzing a combination of data collected from CNI scores, National and State level data,
and Dignity Health Population Profile information contained within Dignity hospital
Community Benefit Reports.
have demonstrated to carry out their mission to serve all regardless of their ability to pay for services.

And fourth, theorists have proposed that the way in which institutions frame populations targeted to receive services from them correlates to the resources that are committed to service provision. For example, it has been suggested that communities that are deemed as undeserving receive comparatively lower amounts of resource investment than do communities that are deemed more deserving (Schneider & Ingram, 1997). It follows, then, that levels of resources committed to community benefit programs directly influence outcomes that result from resource allocation decisions made by institutions. Therefore, by analyzing community benefit at the program level, one may be able to interpret the target framing/resource allocation dynamic and outcomes that result from this relationship.

Based on the primary review, secondary sorting exercise, and the criteria set forth by the author, the following hospitals and programs selected were: St. Rose Dominican Hospitals – Red Rose Cancer Screening Program, St. Joseph’s Hospital and Medical Center – Asthma Intervention Program, Mercy General – Loaves and Fishes Program, and Chandler Regional Medical Center – First Things First Oral Health Program. In the pages that follow, selected programs are introduced by presenting annotated Program Digests and tables that illustrate data contained within each program that are used to measure program effectiveness. Program effectiveness is determined by the measures set forth by each program.

Finally, a discussion of the results of the analysis for each program is provided and compared with results from other programs. We begin with the first hospital and program, St. Rose Dominican Hospitals – Red Rose Cancer Screening Program.
The Red Rose Program is a cancer-screening program providing diagnostic services to uninsured and underinsured patients residing within the St. Rose Dominican Hospitals service area located in and around Las Vegas, Nevada. The program goal is to provide medical services to vulnerable population(s) and to provide support services to assist with financial hardship and work-related issues to patients. Measuring the success of the program is based on the number of tests provided, number of malignancies detected, and the amount of fiscal resources committed to program implementation. The years selected for analysis are 2010 through 2012. Table 24 provides summary information regarding key aspects of the Red Rose Program.
<table>
<thead>
<tr>
<th>Program Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>St. Rose Dominican Hospitals - Las Vegas, Nevada</td>
</tr>
<tr>
<td>Program</td>
<td>Red Rose Program</td>
</tr>
<tr>
<td>Priority Area</td>
<td>Cancer Screenings</td>
</tr>
<tr>
<td>Program Emphasis</td>
<td>Disproportionate Unmet Health-Related Needs</td>
</tr>
<tr>
<td>Link to CNA and CNI</td>
<td>Uninsured, underinsured, race, culture, ethnic minorities, vulnerable populations, seniors, adults</td>
</tr>
<tr>
<td>Program Description</td>
<td>The RED Rose program will provide free mammography, ultrasound, and/or biopsy for individuals 49 years and younger who are uninsured or underinsured. Support services are also available such as: payment of monthly utilities, transportation cost, groceries, rent, and other incidentals while fighting breast cancer.</td>
</tr>
<tr>
<td>Program Goal</td>
<td>Provide medical services to vulnerable population(s), provide support services to assist with financial hardship and work-related issues</td>
</tr>
<tr>
<td>Measure of Success</td>
<td>Number of tests performed and malignancies detected. Support services provided and dollar value investment made</td>
</tr>
<tr>
<td>Baseline</td>
<td>Assist in eradicating breast cancer. Provide free of charge cancer screenings based on grant funding. Services available in English and Spanish.</td>
</tr>
<tr>
<td>Intervention Strategy for Achieving Goal</td>
<td>Collaborate with community agencies to educate community about the program and its services</td>
</tr>
</tbody>
</table>

*Note.* Contents for this table were excerpted from FY08 through FY12 Community Benefit reports for participating hospitals located within the St. Rose Dominican hospital service area.
Table 25.

St. Rose Dominican Hospital – Red Rose Cancer Screening Program

Program Category, Goals, and Resource Allocation

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammograms</td>
<td>115</td>
<td>↑2008</td>
<td>256</td>
<td>↑2009</td>
<td>280</td>
<td>450</td>
<td>377</td>
<td>375</td>
<td>525</td>
</tr>
<tr>
<td>Ultrasounds</td>
<td>131</td>
<td>-</td>
<td>225</td>
<td>-</td>
<td>286</td>
<td>399</td>
<td>251</td>
<td>276</td>
<td>327</td>
</tr>
<tr>
<td>Breast Biopsies</td>
<td>42</td>
<td>-</td>
<td>63</td>
<td>-</td>
<td>63</td>
<td>65</td>
<td>42</td>
<td>80</td>
<td>68</td>
</tr>
<tr>
<td>Surgical</td>
<td>-</td>
<td>-</td>
<td>45</td>
<td>-</td>
<td>44</td>
<td>+chemo</td>
<td>42</td>
<td>+chemo</td>
<td>49</td>
</tr>
<tr>
<td>Consults</td>
<td>Screenings</td>
<td>-</td>
<td></td>
<td>395</td>
<td>-</td>
<td>453</td>
<td>-</td>
<td>523</td>
<td>-</td>
</tr>
<tr>
<td>Diagnose/Treat</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>6</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Program $</td>
<td>193,971</td>
<td>139,718</td>
<td>491,640</td>
<td>-</td>
<td>491,460</td>
<td>-</td>
<td>472,460</td>
<td>-</td>
<td>422,843</td>
</tr>
</tbody>
</table>

Note. Contents for this table were excerpted from FY08 through FY12 Community Benefit reports for participating hospitals located within the St. Rose Dominican hospital service area.

As Table 25 demonstrates, the number of mammograms, ultrasounds, and breast biopsies increased from 2008 (115, 131, 42) to 2012 (525, 327, 68). Surgical consults, eligibility screenings, and cancer diagnosis and treatment also increased from 2009 (45, 395, 6) to 2012 (49, 668, 17). Within the Hospital Contribution/Program Expense category, resources also rose from 2008 ($193,971) to 2012 ($422,843) with a significant increase between 2008 ($193,971) and 2009 ($491,640).

The effectiveness of breast cancer screening in reducing breast cancer specific mortality has been well researched in the literature (Humphrey, Helfand, Chan & Wolf, 2002). Recommendations for conducting a variety of breast screening techniques and the benefits screening has in reducing mortality among women of various ages has also occurred in recent years (Miller, To, Baines, & Wall, 2002). Controversy regarding the effectiveness of...
conducting screenings for breast cancer remains. However, one could argue that detecting breast cancer early before invasive measures need to be taken or before preventable death occurs is a worthy effort that can benefit the overall health of communities and that resources committed to providing screening services to women are well justified.

The St. Rose Dominican Hospital – Red Rose Cancer Screening Program has demonstrated its ability to provide benefits to the community by increasing the number of breast cancer specific tests it has conducted within a four-year period. The Red Rose Program has also demonstrated that in order to provide increased levels of benefit to the community significant resources need to be paired with increased effort. This observation is supported by a doubling of funds from 2008 ($193,971) to 2012 ($422,843). What is absent from the success measures contained within the Red Rose program is the impact the Program has on improving health in general and reducing mortality specifically. For example, the number of tests performed, number of patients served, and amount of resources committed to program service provision are offered. This provides a reader with information that can be formed into observations regarding program efficiency. However, this does not allow a reader the ability to make observations or connections between policy implementation, resource allocation, and policy effectiveness.

Incorporating mortality and, or other measures of life expectancy and wellness into existing Red Rose Program success measures could provide additional information that may be used to assess program impact. This, in turn could inform future resource allocation decisions to maximize the positive impact this program could have on community health. The second program reviewed is St. Joseph’s Hospital and Medical Center’s Asthma Intervention Program. St. Joseph’s Hospital is located near the urban core of a major metropolitan city, Phoenix, Arizona. As a result, St. Joseph’s receives, assesses, and treats a
number of health conditions not seen in other, non-urban areas including chronic disease conditions such as asthma (Johnson, 2011). A description of the main elements of the Asthma Intervention Program is paired below with a table that provides numerical data representing the program’s evolution between 2007 and 2012. A discussion of the program’s impact on community health then takes place.
<table>
<thead>
<tr>
<th>Program Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program</td>
<td>Asthma Intervention Program</td>
</tr>
<tr>
<td>Hospital</td>
<td>St. Joseph's Hospital and Medical Center – Phoenix, Arizona</td>
</tr>
<tr>
<td>Program Emphasis</td>
<td>Chronic Illness</td>
</tr>
<tr>
<td>Program Emphasis</td>
<td>Disproportionate Unmet Health-Related Needs,</td>
</tr>
<tr>
<td></td>
<td>Primary Prevention, Seamless Continuum of Care,</td>
</tr>
<tr>
<td></td>
<td>Build Community Capacity, Collaborative Governance</td>
</tr>
<tr>
<td>Link to CNA and CNI</td>
<td>Lack of consistent medical care for underinsured or uninsured children with asthma, lack of information regarding the management of asthma, which leads to over-utilization of hospitals. Many families are undocumented and are Spanish speaking only.</td>
</tr>
<tr>
<td>Program Description</td>
<td>Program serves asthmatic children between the ages of 5 and 14 and their caregivers. Educate children and families about asthma. Pair patients with medical home/care facility. Families expected to attend education groups for one year or 6 months if learned skills are met. Families are provided protective asthma supplies.</td>
</tr>
<tr>
<td>Program Goal</td>
<td>Increase referral sources, enroll 80 children, reduce hospitalizations by 90 percent, reduce ER visits by 80 percent, and reduce lost days of school by 80 percent.</td>
</tr>
<tr>
<td>Measure of Success</td>
<td>Compare baseline data from the above-mentioned goals to data from last contact with child.</td>
</tr>
<tr>
<td>Baseline</td>
<td>More than 100,000 children in Maricopa County suffer with asthma.</td>
</tr>
<tr>
<td>Intervention Strategy for Achieving Goal</td>
<td>Coordinate care with asthma educator, provide asthma education and screening, assess progress monthly.</td>
</tr>
</tbody>
</table>

*Note*: Contents for this table were excerpted from FY08 through FY12 Community Benefit reports for St. Joseph’s Hospital and Medical Center.
Table 27.

St. Joseph’s Hospital and Medical Center – Asthma Intervention Program

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>-</td>
<td>-</td>
<td>80+</td>
<td>-</td>
<td>80+</td>
<td>30</td>
<td>80+</td>
<td>437</td>
<td>80+</td>
<td>381</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>↑2008</td>
<td>↑2008</td>
<td>0</td>
<td>0.90</td>
<td>19</td>
<td>0.90</td>
<td>1.00</td>
</tr>
<tr>
<td>ER Visits</td>
<td>47</td>
<td>0</td>
<td>-</td>
<td>↑2008</td>
<td>↑2008</td>
<td>0</td>
<td>0.85</td>
<td>25</td>
<td>0.85</td>
<td>1.00</td>
</tr>
<tr>
<td>School Absences</td>
<td>67</td>
<td>5</td>
<td>-</td>
<td>↑2008</td>
<td>↑2008</td>
<td>6</td>
<td>0.85</td>
<td>26</td>
<td>0.85</td>
<td>0.79</td>
</tr>
<tr>
<td>Symptom Days</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15</td>
<td>0.80</td>
<td>176</td>
<td>0.80</td>
<td>0.95</td>
</tr>
<tr>
<td>Program $</td>
<td>-</td>
<td>-</td>
<td>143,664</td>
<td>143,664</td>
<td>-</td>
<td>-</td>
<td>100,000</td>
<td>-</td>
<td>182,611</td>
<td>-</td>
</tr>
</tbody>
</table>

Note. Contents for this table were excerpted from FY08 through FY12 Community Benefit reports for St. Joseph’s Hospital and Medical Center.

*Program $ include resources allocated to cover program associated costs.

The St. Joseph’s Hospital and Medical Center – Asthma Intervention Program targets uninsured and underinsured asthmatic children between the ages of 5 and 14 and their families to provide necessary health services to educate and assist caregivers and patients with the management of childhood asthma. The necessity of the program is motivated by the high prevalence of asthma found within the St. Joseph’s service area estimated to be more than 100,000 children in 2009 (St. Joseph’s, 2012). The goal of the program, last updated in 2009, has five main components: (1) to increase referrals of families and patients to asthma educators and health care services, (2) to enroll at least 80 children and their families in one calendar year, (3) to reduce hospitalizations related to asthma by 90% from the baseline year, (4) to reduce emergency department visits by 80% from the baseline year, and (5) to reduce lost school days by 80% from the baseline year.

A review of Table 27 shows that the program has been in existence for at least five years beginning in 2007. Baseline figures are offered for Hospitalizations (5), ER Visits (47) and School Absences (67). Improvement in each of the baseline figures provided in 2007
was seen in 2008 with Hospitalizations, ER Visits, and School Absences being (0), (0), and (5) respectively.

A dramatic increase in the number of Hospitalizations, ER Visits, School Absences, and a newly included category, Symptom Days, was seen between years 2010 and 2011. Changes among the categories were also seen between 2011 and 2012 but the figures reported for 2012 were provided as percentages making it difficult to ascertain what factors influenced this observation.

The Asthma Intervention Program Digest also includes annual program goals for each category beginning in 2010 for 2011 and 2012. As it was mentioned above, program effectiveness was determined by the decrease in percent of referrals, hospitalizations, emergency department visits, school absences, and symptom days from year to year. Measuring program effectiveness using change in percent within each category was a challenge, however, due to the fact that in some years (2009) data are missing or are repeated, and in other years (2012) category data are presented as a percent and not as a number. Determining the relationship between resource allocation and program effectiveness over time was also a challenge due to the fact that Hospital Contribution/Program Expense figures were only offered for 2009, 2011, and 2012.

The year that demonstrated the highest gain in referrals (2011, 437) also saw an increase in all other categories, most significantly within Symptom Days (176). This outcome could be expected, as an increase in referrals is likely predictive on increases in other category figures. Measuring the overall effectiveness of the Asthma Intervention Program was inconclusive due to inconsistencies in data reporting over the years reviewed. Furthermore, as stated in Table 26, the baseline number of asthmatic children residing within the service area of St. Joseph’s hospital was 100,000. Comparing this with the highest
number of referrals, 437 in 2011, only 4.3% of all potential patients were referred to the Program.

This is not to suggest that the program was not needed or did not improve the health and well being of the population being targeted, only that a significant need remains and resources committed to program implementation and measurement fall short of well-intended goals.

Analysis of the Loaves and Fishes Program implemented by Mercy General Hospital in Sacramento, California is discussed in the next section. Serving the health care needs of the homeless population, Loaves and Fishes provides preventative and primary care services to a most vulnerable segment of our communities. Program elements and corresponding descriptions will be provided in addition to a table that reflects the relationship between patient visits and resources committed to program delivery. Observations regarding the extent to which Loaves and Fishes impact community health then follows.
Mercy General Hospital – Loaves and Fishes Program

Table 28.

<table>
<thead>
<tr>
<th>Program Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Mercy General Hospital - Sacramento, California</td>
</tr>
<tr>
<td>Program</td>
<td>Loaves and Fishes</td>
</tr>
<tr>
<td>Priority Area</td>
<td>Access to care</td>
</tr>
<tr>
<td>Program Emphasis</td>
<td>Disproportionate Unmet Health-Related Needs, Seamless Continuum of Care, Build Community Capacity, Collaborative Governance</td>
</tr>
<tr>
<td>Link to CNA and CNI</td>
<td>Addresses identified needs of the poor</td>
</tr>
<tr>
<td>Program Description</td>
<td>MercyClinic Loaves &amp; Fishes provides free episodic and urgent health care to homeless people. The Loves and Fishes organizations provides the clinic space and utilities; the County of Sacramento provides physician labor costs, laboratory services, X-ray services and prescriptions; Mercy provides nursing and clerical staff, medical and business supplies and equipment, telephone, housekeeping, security and EKGs.</td>
</tr>
<tr>
<td>Program Goal</td>
<td>Provide healthcare to the homeless population. Maintain ongoing operations to meet the needs of the poor and/or underserved</td>
</tr>
<tr>
<td>Measure of Success</td>
<td>Not Provided in Report</td>
</tr>
<tr>
<td>Baseline</td>
<td>3,089 patient visits</td>
</tr>
<tr>
<td>Intervention Strategy for Achieving Goal</td>
<td>Not Provided in Report</td>
</tr>
</tbody>
</table>

Note. Contents for this table were excerpted from FY08 through FY12 Community Benefit reports for Mercy General Hospital.
Table 29.

Mercy General Hospital – Loaves and Fishes Program

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Visitsa</td>
<td>3,089 Need</td>
<td>2,702 Need</td>
<td>3,823 Need</td>
<td>3,686 Need</td>
</tr>
<tr>
<td>Program $b</td>
<td>191,272 -</td>
<td>173,832 -</td>
<td>271,517 -</td>
<td>259,071 -</td>
</tr>
</tbody>
</table>

Note. Contents for this table were excerpted from FY08 through FY12 Community Benefit Reports for Mercy General Hospital.

*aGoals for outlying years were based on estimated need.

*bHospital Contribution/Program Expense goal estimates were not provided. This was assumed to be tied to the variability of year-to-year need found within the homeless community.

Mercy General Hospital’s Loaves and Fishes Program was reviewed for years 2008 through 2012. As Table 29 demonstrates, patient visits remained relatively consistent from the baseline year to 2012 (3,089 to 3,067). Total Hospital Contribution/Program Expense figures varied somewhat between years with an average for all years being, $241,126 per year. Interestingly, for years 2008 and 2012 the number of patient visits was nearly identical, (3,089 and 3,067) but the difference between resources committed to providing services in these years was over $100,000. Explanation as to why resources allocated to service provision for 2008 and 2012 varied when the number of patient visits was very similar was not provided in the Program Digest. However, given that the Loaves and Fishes program offers a wide range of services that possess varied costs for a demographic whose demand for services also varies considerably from year to year, one could assume that variations among the number and type of services provided/received dictated variation in the figures reported for these years. For example, had the Program Digest included a breakdown of specific services provided, e.g., electrocardiograms (EKG’s), and the costs of providing each test, say $500, differences in costs associated with number of patient visits may have been possible to be made between years.
Loaves and Fishes did not specifically identify program goals other than those that were based on annual need. Unpredictable shifts in the homeless population within Mercy’s service area from year to year most likely contributed to specific program goals for outlying years not being set. Having patient visits and dollar amounts reported in aggregate provided an ability to measure relationships between patient visits and dollars expended for patient visits-total dollars, 2008-2012, ($73.66 per patient per visit). However, determining the extent to which resources allocated improved health could only be considered as having a positive effect but the magnitude of the impact could not be determined at this time based on the information provided in the Digest.

*Chandler Regional Medical Center – First Things First Oral Health Program*

The fourth and final community benefit program reviewed is the First Things First Oral Health Program provided by Chandler Regional Medical Center in Chandler, Arizona. First Things First is a prevention-based oral health program offering education and treatment to expectant mothers and children living in low-income households. The program also establishes oral health best practices for program recipients with input received from dentists, pediatricians, and other local health care partners. A summary of First Things First is provided in Table 30 below followed by Table 31 that illustrates the evolution of program implementation for years 2009-2012.
Table 30.

Chandler Regional Medical Center – First Things First Oral Health Program

<table>
<thead>
<tr>
<th>Program Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Chandler Regional Medical Center - Chandler, Arizona service area</td>
</tr>
<tr>
<td>Program</td>
<td>First Things First Oral Health Program</td>
</tr>
<tr>
<td>Priority Area</td>
<td>Access to care with primary focus on prevention, service to disenfranchised populations, promote health and wellness at the community level.</td>
</tr>
<tr>
<td>Program Emphasis</td>
<td>Service to disenfranchised populations, primary prevention, capacity building, continuum of care, collaboration.</td>
</tr>
<tr>
<td>Link to CNA and CNI</td>
<td>Children in low-income households experience dental cavities at a higher rate and greater severity than their affluent peers.</td>
</tr>
<tr>
<td>Program Description</td>
<td>The program will provide oral health education to expectant women and children 0 – 6 and their families, fluoride varnish treatment to children 0 – 6, and best practice oral health education to dentists, pediatricians, and other local health providers. The program will partner with others to increase access to preventive oral health care for the underserved population in the First Things First service area.</td>
</tr>
<tr>
<td>Program Goal</td>
<td>This is a new program in 2009</td>
</tr>
<tr>
<td>Measure of Success</td>
<td>Total number and percentage of children receiving appropriate and timely oral health visits. Total number and percentage of oral health care providers utilizing a dental home model. Total number and percentage of children with health insurance. Percentage of families with children birth through age five who report they are competent and confident about their ability to support their child’s safety, health, and well-being.</td>
</tr>
<tr>
<td>Baseline</td>
<td>This is a new program in 2009</td>
</tr>
<tr>
<td>Intervention Strategy for Achieving Goal</td>
<td>This is a new program in 2009</td>
</tr>
</tbody>
</table>

*Note. Contents for this table were excerpted from FY08 through FY12 Community Benefit reports for Chandler Regional Medical Center.*
### Table 31.
Chandler Regional Medical Center – First Things First Oral Health Program

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Oral Health Screening</td>
<td>-</td>
<td>1123</td>
<td>4000</td>
<td>3912</td>
<td>3000</td>
<td>4168</td>
</tr>
<tr>
<td>Children - Fluoride Varnish</td>
<td>-</td>
<td>1055</td>
<td>4000</td>
<td>3459</td>
<td>3000</td>
<td>3666</td>
</tr>
<tr>
<td>Oral Health Kits Distributed</td>
<td>-</td>
<td>3252</td>
<td>-</td>
<td>8070</td>
<td>-</td>
<td>7039</td>
</tr>
<tr>
<td>Child/Adult Education</td>
<td>-</td>
<td>4419</td>
<td>6000</td>
<td>15,769</td>
<td>3000</td>
<td>13,277</td>
</tr>
<tr>
<td>Provider Education</td>
<td>-</td>
<td>104</td>
<td>50</td>
<td>283</td>
<td>387</td>
<td>4400</td>
</tr>
<tr>
<td>Child Untreated Dental Decay</td>
<td>-</td>
<td>24%</td>
<td>-</td>
<td>18%</td>
<td>-</td>
<td>19%</td>
</tr>
<tr>
<td>Child Not Seen by Dentist</td>
<td>-</td>
<td>50%</td>
<td>-</td>
<td>55%</td>
<td>-</td>
<td>50%</td>
</tr>
<tr>
<td>Dental Referral</td>
<td>-</td>
<td>234</td>
<td>-</td>
<td>623</td>
<td>-</td>
<td>728</td>
</tr>
<tr>
<td>Referral-Urgent Need</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>23</td>
<td>-</td>
<td>46</td>
</tr>
<tr>
<td>Program $b</td>
<td>-</td>
<td>119,864</td>
<td>86,437</td>
<td>369,000(\text{b})</td>
<td>59,126</td>
<td>470,141(\text{b})</td>
</tr>
</tbody>
</table>

**Note.** Contents for this table were excerpted from FY08 through FY12 Community Benefit reports for Chandler Regional Medical Center.

\(\text{a}\)2009 was the first year the program was introduced.

\(\text{b}\)Individual hospital contribution dollars were matched by First Things First grant awards for 2011 and 2012. Individual hospital contribution and matching grant funds were reported together for these years.

The First Things First program was introduced in 2009 with 2010 being the first year data were reported. Among the first five program categories listed in Table 31, Child Oral Health Screening, Children – Fluoride Varnish, Oral Health Kits Distributed, Child/Adult Education, and Provider Education, all increased the number of services provided between 2010 and 2012 with the exception of Oral Health Kits Distributed (2011 to 2012). Positive change in the Child Untreated Dental Decay was seen between 2010 (24% of the target population) and 2011 (18% of the target population) but fell again slightly in 2012 (19% of
the target population). Within the Child Not Seen By Dentist service category, the percentage of children meeting this criteria rose between 2010 and 2011 (50% to 55%) but then declined back to the 2010 percentage (50%).

Dental Referrals also demonstrated a steady increase in services provided between 2010 and 2012 (234 to 728) as did the number of Referral-Urgent Need cases that were directed toward higher levels of care between 2010 (7) and 2012 (46). Hospital Contribution/Program Expense figures varied between 2010 and 2012. This observation was due to regional grant funds being added to the resources Chandler Regional Medical Center allocated in 2011 and 2012.

Referring back to the description of The First Things First Oral Health Program in Table 30, four measures of success were included in the Digest. These were: (1) Total number and percentage of children receiving appropriate and timely oral health visits, (2) Total number and percentage of oral health care providers utilizing a dental home model, (3) Total number and percentage of children with health insurance, and, (4) Percentage of families with children birth through age five who report they are competent and confident about their ability to support their child’s safety, health, and well-being.

Contrasting the data reported for services provided in Table 31 with the program success measures listed in Table 30, one observes that there is a disconnect between the data reported and the measures that were constructed to evaluate program success. Providing an explanation as to why this inconsistency appears within the First Things First program was an inherently difficult task and would benefit from an explanation provided by a representative of the program.

Data reported do however demonstrate that the program has achieved a certain level of success as many of the program’s services saw increases in services provided within the
years that were reviewed. Unfortunately, determining program success beyond what is reported in Table 31 was not possible at this time. For example, the numbers that were reported in Table 31 are aggregate numbers limited to the number of services/change in percent provided within each category. These figures capture services provided and offer opportunities to evaluate changes between years. However, figures illustrating the relationship between services provided and service area population eligible to receive services could have allowed a stronger comparative analysis to be conducted that could be used to inform categorical and overall program success for all categories and reporting years. In addition, had data reporting followed the original success measures included in the Program Digest, analysis tracking changes in total number and percentage of children and mothers receiving services could have been calculated.

**Summary: Dignity Health – Community Benefit Program-Level Analysis**

The analysis of community benefit policy on a program-level basis sought to measure the extent to which the framing of target populations through implemented community benefit programs impacts community health. Based on the results of the analysis, the following three observations can be made that address and answer this question.

First, assessment of community need through Dignity hospital community needs assessments identified communities targeted to receive services. Specific community benefit programs were created and implemented to address identified needs of populations that could be defined as marginalized. Therefore, even though the targeted populations were defined by Dignity hospitals as being marginalized, or less than, one could argue that motivation to develop and implement community programs was carried out in a positive manner. As a result, communities targeted received services that were intended to and to a certain degree improved health. However, determining the magnitude of the effect was not
possible at this time due to limitations of data published within Program Digests for the programs reviewed.

Second, for all of the programs reviewed, each was committed to providing consistent levels of resources over a period of years to ensure that services were being delivered to the populations served. Although some of the programs committed higher levels of resources than others, i.e., dollars, this may have been a reflection of the costs associated with providing services within the confines of a particular program and not an indication of the intended impact the program sought to make to improve health.

And third, with the exception of the Loaves and Fishes program, all programs included measures of success within Program Digests. Measuring program success was a challenge as reported program data tended to be inconsistent from year to year, program goal criteria changed from dollars allocated to percentage of patients served, and in some cases data were missing. In addition, the programs under consideration did not include consistent measures or data that could be used to examine the relationship between program success and health outcomes.

This was found to be most unfortunate because there are many measures in existence that could be incorporated into community benefit programs in order to equate program success with health outcomes. Examples of these include simple measures of overall health, e.g., mortality and morbidity, or more nuanced indicators of health improvement such as quality adjusted life years (QALY), (Nixon & Ulmann, 2006). The Healthy People 2010 Progress Quotient (Keppel, Pearcy, & Klein, 2004) could also be included as could the recently introduced Global Outcomes Score (GO Score) developed by David Eddy, Joshua Adler, and Macdonald Morris that measures quality of care based on health outcomes by comparing current care levels to target levels of care (2012).
Measuring the relationship between program implementation and health outcomes can be a daunting task but support is available from many sources including guidance from a study conducted by the National Research Council of the National Academies titled, *Improving Health in the United States: The Role of Health Impact Assessment* (2011). Data included in program development, implementation, and measurement would need to be updated to be able to be analyze the relationship between community benefit program and community health. However, based on the quality of work that Dignity hospitals have demonstrated, notwithstanding the exclusion of much needed data required to make these connections, one could imagine that bridging the gap between present observations and future possibilities is very realizable.

In addition to developing measures to determine the impact community benefit programs are having on improving health one could also suggest that the level of resources could be increased to broaden the scope and breadth of services offered. For example, Total System Community Benefit including Medicare for Dignity Health System FY12 was $1,601,977,000 (Dignity, 2013). Of that, 7.8 percent, or $125,465,000 went to Total Benefits for the Poor, where 42.6% was claimed by Community Health Improvement Services ($53,467,000) and 1.2% claimed as Community Building Activities.

Total Benefits for the Broader Community claimed 8.2% ($130,593,000) of Total Dignity Community Benefit, where Community Health Improvement Services represented 13.0% of this amount ($17,034,000) and Community Building Activities 2.4% ($3,138,000).

Furthermore, when comparing the relationship between the percentages of Total System Community Benefit claimed by Community Health Improvement Services and Community Building Activities for Services for the Poor (3.3% and 0.1%) and Services for the Broader Community (1.0% and 0.2%), one can see just how minute the resources
committed to these community benefit areas currently are. Figure 4 visualizes the relationship where the differences between Total Community Benefit and the categories mentioned immediately above are so large they are nearly invisible.
Taken together, each of these observations has addressed and answered the question regarding how analysis of program-level measured the extent to which framing of target populations through implemented community benefit programs impacts community health.
Future improvements based on these observations could be made to form a much stronger connection between community benefit programs and community health outcomes.

The fourth section of the analysis reviews formative and current community benefit documents to specifically address the second research question posed in this study: How may social and scientific definitions of health contribute to the process of creating community benefit policies?

**Section 4: IRS Revenue Rulings & Dignity Health Community Benefit Reports**

Up to this point the investigation into the relationship between community benefit policy and community health has taken the reader through a series of results gleaned from analysis performed within three distinct levels of focus: a nonprofit health care system, a set of individual nonprofit hospitals, and four individual community benefit programs implemented at the community level. Now the study assumes the deepest level of analysis sought – an exploration of the fundamental elements, i.e., words that have been used historically to guide and at present to develop the formation and implementation of nonprofit hospital community benefit policy in the United States.

To briefly review, a modified content analysis methodology was applied to analyze the documents under consideration. A series of analytical steps were followed to draw inferences from the texts based on the words contained within them and the context(s) of their use, i.e., development of community benefit policy and subsequent impact on community health. Founding Internal Revenue Service Revenue Ruling documents 56-185, 69-545, and 69-631 (IRS, 1956; IRS, 1969a; IRS, 1969b) and 35 Dignity Health system hospital community benefit reports for FY12 (Dignity, 2013) were reviewed. Employing a content analysis software program, HyperRESEARCH, primary recording units were constructed representing the top 50 words found within each document. Recording units
were then separated into word categories that reflected social or scientific perspectives of health. The scientific and social word categories formed the primary codebook for each document. Words that were found within each health perspective category for both IRS and Dignity Health community benefit reports were inventoried and collected to form the micro-level codebook that represents words found in all documents representing both scientific and social health perspective categories. Results of each of these steps are provided below.
Table 32.

List of Top 50 Words Most Frequently Found in Selected Documents

<table>
<thead>
<tr>
<th>Document</th>
<th>Top 50 Words/Primary Recording Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRS 56-185</td>
<td>Hospital, charitable, section, public, 501, facilities, income, may, pay, organization, exemption, operated, purposes, community, Code, services, organized, part, benefit, tax, private, charity, shareholder, individual, earnings, patients, corporation, available, physicians, Internal, operations, plan, care, order, rendered, Revenue, formed, members, general, medical, able, exclusively, law, business, taxable, required, area, primarily, financial, held</td>
</tr>
<tr>
<td>IRS 69-545</td>
<td>Hospital, section, 501, code, staff, doctors, medical, operated, benefit, community, organization, exemption, private, under, nonprofit, revenue, care, income, patients, purposes, tax, emergency, purpose, ruling, five, regulations, federal, members, qualify, charitable, organized, public, health, room, available, requirements, generally, space, office, control, cost, privileges, admission, trusts, interest, owners, board, trustees, providing, charity</td>
</tr>
<tr>
<td>IRS 69-631</td>
<td>Organization, hospital, section, medical, 501, services, tax, Code, staff, fees, charitable, exempt, income, Federal, members, program, exemption, private, carry, part, funds, revenue, operated, benefit, duties, purposes, interest, physicians, provides, active, application, 1969, organized, patients, nonprofit, rendered, without, legislation, formed, principal, qualifies, serves, internal, research, district, public, purpose, regulations, exclusively, form</td>
</tr>
<tr>
<td>Dignity Health Community Benefit Reports</td>
<td>Community, health, program, care, hospital, services, Dignity, needs, benefit, county, center, patients, our, assistance, 2012, medical, programs, education, payment, diabetes, patient, assessment, area, need, service, financial, management, provide, goal, disease, support, access, based, prevention, 2013, healthy, primary, report, plan, Mercy, California, chronic, children, board, areas, population, high, information, participants, increase</td>
</tr>
</tbody>
</table>

Note. Words included in this table were extracted from Internal Revenue Service Revenue Rulings 56-185, 69-545, 69-631 and FY12 Dignity Health System Community Benefit Reports for 35 hospitals.

Word clouds were created for each document showing the top 50 words. The word clouds also capture the frequency of the words used based on the size of the words in relation to other words. For example, in Figure 5 the word *hospital* is the biggest because it was mentioned the most (23 times) and the word *held* is among the smallest because it was mentioned the least (2 times). Word clouds for each document are presented in the figures below. Inferential meaning based on the relationship(s) among words within each word.
cloud suggest that the size/frequency of the largest words represent the core meaning of each document analyzed.

Figure 5.

Word Cloud for IRS 56-185

extent corporation purposes care income charity community any shareholder individual other organized hospital Internal will patients pay some operations tax section merely public part which earnings may available such physicians exempt operated benefit 501 all must those private organization plan Code use under however exemption services facilities who charitable

For Figure 5, hospital (23), charitable (14) section (12), public (12), 501 (11), facilities (10), income (9), pay (8), organization (8), and exemption (8) make up the top ten words found within IRS Revenue Ruling 56-185.
Figure 6.

Word Cloud for IRS 69-545

purposes been care income community Any other organized

hospital health Patients than see members staff space tax

section room doctors Medical nonprofit public Federal purpose Ruling control

available Revenue requirements have operated benefit 501 emergency all those
private Regulations organization qualify Code their under exemption five

generally office charitable

For Figure 6, hospital (48), section (23), 501 (22), code (14), staff (13), doctors (13), medical (13), operated (12), benefit (12), and community (12) make up the words that are mentioned the most often in Revenue Ruling 69-545.

Figure 7.

Word Cloud for IRS 69-631

these purposes apos income carry organized hospital patients principal

than qualifies members staff tax see section Rev medical nonprofit

part funds rendered Rul Federal interest this Revenue exempt physicians without

active operated provides benefit duties 501 fees private

organization 1969 Code legislation their

application formed under program exemption services charitable
For Figure 7, representing IRS Revenue Ruling 69-631, organization (16), hospital (9), section (8), medical (8), 501 (8), services (6), tax (6), code (6), staff (5), and fees (5) are the words most mentioned in this document.

Figure 8.

Word Cloud for FY12 Dignity Health Community Benefit Reports

Figure 8 represents the 50 words most frequently found within FY12 Dignity Health community benefit reports for 35 reporting hospitals. The top ten words found within these documents were, community (7954), health (7867), program (3500), care (3239), hospital (2642), services (2540), Dignity (1894), needs (1890), benefit (1791), and county (1471).

Based on the literature review contained in Chapter 2, the top 50 words included in the recording units for each document were then separated into categories representing scientific or social perspectives of health defined. Words that did not fit either perspective were reported in an “other” category. Words that were the same for each recording unit were not duplicated within word categories. Table 33 illustrates this categorization.
### Table 33.

Recording Units Separated into Scientific, Social, or Other Category

<table>
<thead>
<tr>
<th>Document</th>
<th>Scientific</th>
<th>Social</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRS 56-185</td>
<td>Hospital, income, pay, exemption, private, shareholder, individual, earnings, code, corporation, physicians, internal, operations, plan, revenue, medical, law, business, taxable, financial</td>
<td>Charitable, public, 501, community, benefit, charity, patients, care</td>
<td>Facilities, may, organization, operated, purposes, services, organized, part, available, order, rendered, formed, members, general, able, exclusively, required, area, primarily, held</td>
</tr>
<tr>
<td>IRS 69-545</td>
<td>Hospital, code, doctors, medical, operated, organization, exemption, private, revenue, income, tax, emergency, regulations, organized, requirements, office, control, cost, privileges, admission, trusts, interest, owners, board, trustees</td>
<td>Charitable, 501, benefit, community, nonprofit, care, patients, federal, qualify, charitable, public, health, charity</td>
<td>Section, staff, under, purposes, purpose, ruling, five, members, room, available, generally, space, providing</td>
</tr>
<tr>
<td>IRS 69-631</td>
<td>Organization, hospital, medical, tax, code, fees, exempt, income, exemption, private, funds, revenue, operated, duties, purposes, interest, physicians, application, organized, internal, research, regulations</td>
<td>501, charitable, federal, benefit, patients, nonprofit, legislation, qualifies, serves, district, public</td>
<td>Section, services, staff, members, program, carry, part, provides, active, 1969, rendered, without, formed, principal, purpose, exclusively, form</td>
</tr>
<tr>
<td>Dignity Health Community Benefit Reports</td>
<td>Hospital, medical, payment, diabetes, assessment, financial, management, goal, disease, report, plan, board, high, information, increase</td>
<td>Community, health, care, needs, benefit, county, patients, assistance, education, patient, need, support, access, prevention, healthy, primary, chronic, children, population, participants</td>
<td>Program, services, Dignity, center, our, 2012, programs, area, service, provide, based, 2013, Mercy, California, areas</td>
</tr>
</tbody>
</table>

*Note.* Words contained within this table were drawn from IRS Revenue Rulings 56-185, 69-545, 69-631, and FY12 Community Benefit Reports from 35 Dignity Health system hospitals.

Reviewing Table 33, one finds that among the IRS documents several words were similar within the scientific and social categories. Within the scientific category the words hospital, exemption, private, code, doctors/physicians, revenue, and tax/taxable were found
in all IRS documents. For the social category, IRS documents shared charitable, public, 501, benefit, charity/charitable, and patients. When comparing the IRS documents with the Dignity Health community benefit reports, however, few words separated into the scientific and social categories were similar among all four documents. Table 34 illustrates this finding.

Table 34.

<table>
<thead>
<tr>
<th>Category/Micro-Level Codebook</th>
<th>Scientific</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Words</td>
<td>Hospital, medical</td>
<td>Benefit, patients</td>
</tr>
</tbody>
</table>

*Note.* Information contained within this table was extracted from Table 33.

This section began with a review of guiding IRS documents and Dignity Health community benefit reports for FY12. The selection of these documents using a modified content analysis methodology sought to discern the relationship between documents that were created to guide policy development and the impact the words included in these founding documents may have had on influencing current community benefit report policies. As we have seen, commonalities exist within the IRS documents and Dignity Health community benefit report texts. However, overlap among all documents was not observed to a great degree. Inferences drawn regarding the meaning of the documents reviewed and how they affect policy creation must be limited at present. This conclusion stems from the notion that scientific and social definitions of health are present within community benefit policy documents but the magnitude of the influence founding documents have on the development of current community benefit policy creation cannot be determined based on the steps of discovery taken within this study.
The results do demonstrate, however, that word selection in the creation of policy matters and that even though words from one source of documents might not present themselves with great presence in another set of related documents, this does not indicate that their connection to one another is not felt. The limited results of this analysis could also be the result of a limitation in number and type of documents reviewed. For example, the Catholic Health Association of the United States has published *A Guide for Planning & Reporting Community Benefit* (CHA, 2012) that contains guidance for the development of nonprofit hospital community benefit policy development. Future studies utilizing a textual content analysis methodology might be well served if this literature was included alongside the literature chosen for this analysis.

The following chapter explores the results found above in more detail paying particular attention to the ways in which the analysis addressed and answered the research questions posed at the outset of this study. One can imagine that additional insights may be made between the results and the discussion of community benefit, literature reviewed, and choice of methodology found within the chapters above.
Chapter 5

RESULTS, IMPLICATIONS, AND DISCUSSION

Introduction and Overview

The analysis began with a discussion comparing and contrasting national health expenditures with estimates of community benefit expenditures for years 2008 through 2016 (see Table 6). Highlighting the relationship between these two components of the U.S. health care system served three purposes: First, to demonstrate the significant and substantial amount of resources each component has contributed historically and may contribute to future health expenditures; Second, to demonstrate the rate of growth over time of national health expenditures and community benefit; and Third, to provide the reader with a national, macro-level view of community benefit prior to narrowing the discussion to increasingly lower levels of concentration.

Following the introduction, four phases of analysis were initiated. Each phase focused on specific features of the community benefit policy environment. The features selected were a nonprofit health system, individual hospitals within a nonprofit hospital system, implemented community benefit programs, and words used to develop community benefit policies. The selection of these components and the analysis that occurred among them were based on one central idea: The exploratory nature of the study motivated the inclusion of key aspects of community benefit policy into the analysis in order to provide the reader an ability to (1) appreciate the complex nature of the community benefit landscape (2) in order to make connections between community benefit policy and community health outcomes that could (3) lead to recommendations on how to improve existing community benefit policy development, implementation, and measurement. In addition, by beginning the analysis at a system level and narrowing down to concluding with an analysis of words
used to inform policy creation the reader would be provided with a head to toe understanding of the community benefit policy environment. As a result of constructing the analysis in this fashion it was hoped that meaningful contributions to the understanding of community benefit could be made and that a firm foundation upon which to build future research would be constructed.

The remainder of the chapter is organized into three sections. The first section addresses each of the research questions and how the results of the analyses spoke to each question. The second section discusses the implications the study may have on researchers, policymakers, and the field of public administration. The third and final section provides the author an opportunity to offer concluding observations and suggestions for future undertakings.

Let us now begin with section one – a discussion of the analysis and research questions.

**Answering the Research Questions**

*Question 1: Community Benefit Policy and Community Health*

The first research question asked how community benefit policies impact the health of communities. In particular, it questioned the relationship between the extent to which resources claimed as community benefit hinder or improve community health. The first three phases of the analysis addressed this question.

*System-Level Analysis*

A review of system level community benefit for Dignity Health revealed that between 2008 and 2012 reported community benefit almost doubled (see Tables 7 and 8). A further breakdown of categorical community benefit claims for FY12 demonstrated that the majority of claims were tied to the unpaid costs of Medicare and Medicaid where categories
directly tied to community-based health improvement programs garnered relatively minuscule resource allocations (see Table 9 and Figure 3). Based on these two observations, one may infer that current system-level community benefit policy is concerned most with subsidizing the uncompensated costs of delivering care and least with providing resources that address community health improvement. Subsidizing uncompensated costs of care does comply with one of the assumptions of community benefit, i.e., relieving government’s burden. However, what one can glean from this finding is that current community benefit policy serves the fiscal interests of the hospital more than the health and well being of community.

Hospital-Level Analysis

Phase 2 focused on analyses of individual system hospital community benefit policy. More specifically, the second phase sought to compare and contrast similarities and differences among 35 Dignity Health hospital community benefit claims for FY11 and FY12. The analysis produced several significant observations. First, among all hospitals for FY11 and FY12 a wide range of increase or decrease in total community benefit claims was observed. For example, a percent change decrease of 70% and an increase of 501% were observed among all hospitals between FY11 and FY12 (see Table 10).

Second, when comparing two hospitals demonstrating a decline in community benefit claims between FY11 and FY12 each reported similar differences between Medicaid expenditures and Medicaid offsetting revenue for FY11 and FY12 (see Table 13). However, the hospital that demonstrated the largest decrease from FY11 and FY12 (-70%), reported $30,729,765 in total community benefit for FY11 with $9,237,552 reported for FY12 while the hospital with the smallest decline (-1.1%) claimed nearly identical amounts for total community benefit from FY11 to FY12.
This observation suggests that even though Medicaid uncompensated care claims represent a significant amount of total community benefit for all hospitals, individual hospital community benefit reporting varies considerably even when differences between Medicaid expenses and Medicaid reimbursements are nearly identical.

In an effort to further identify the relationship between community benefit claims and health outcomes, direct, community-based allocations for the poor and the broader community were compared and contrasted for all hospitals. Achieving this objective was sought by calculating the community benefit investment per person within the Benefits for the Poor and Benefits for the Broader Community categories for FY11 and FY12. Findings from the analysis determined that the amount of investment per person for both categories, FY11 and FY12 varied considerably among all hospitals (please see Tables 15 through 18). Possible explanation for the variance in resource allocation may have been attributed to the relationship between the type and complexity of the services provided and the numbers of persons served by each program within the categories examined. However, the results did demonstrate that even though differences in investment per person existed and the resources available to fund community based programs varied, Dignity Health hospitals demonstrated consistent levels of resources commitments to implement community-based programs for FY11 and FY12 (please see Tables 19 through 22).

What the data did not demonstrate was the actual impact resource allocation had on improving individual and, or community health. In an effort to determine the extent to which resource allocation impacted community health an additional set of data was reviewed.

Data analyzed to seek out this relationship were sought from a community-based hospital service area index created by Dignity Health. Introduced in Chapter 3, the
Community Need Index, or CNI, was a tool developed by Dignity Health to measure community characteristics based on a set of five measures used to capture community need profiles among all of Dignity Health hospital’s service areas. Employing the CNI to determine health outcomes was motivated by the notion that by determining changes in CNI scores with changes in resources allocated within high and low CNI service areas one could surmise the extent to which resource allocations improved or hindered community health over time.

What the analysis found was that the value of the CNI/resource allocation/health outcome relationship was hampered by the fact that the CNI instrument was a static, not an active measurement tool. In other words, CNI indexes were created in 2009 but had not been updated since that time (see Table 22). This was found to be a most unfortunate finding given that changes in resource allocation within hospital service areas could be calculated over time but changes in CNI scores could not. Nonetheless, the result of the analysis suggests that even though determinations between resource allocation and community health could not be determined at this time, a mechanism that could make this connection in future investigations is in place and could be updated to measure resource allocation/health outcome relationships.

Program-Level Analysis

The third phase, an analysis of implemented community benefit programs offered yet another means with which the study attempted to make connections between community benefit policy and community health outcomes. Selecting individual programs as focal points for analysis was centered on the idea that if higher-level system and individual hospital analyses were unable to form a relationship between policy and policy effects perhaps analysis at a local, community level would yield more promising results.
Four community benefit programs provided by Dignity Health hospitals located in California, Nevada, and Arizona were selected among 35 hospitals according to a set of criteria set forth by the author (Chapter 3). Discovery from the analysis revealed the following four findings. First, community need assessments conducted by hospitals produced programs that addressed needs within communities particularly among the most vulnerable. This finding was observed in the Program Digests provided by each program that described the priority area of the program, the emphasis on specific segments of community that the program was intended to benefit, and how the program linked to community need assessments and Community Need Index scores.

Second, significant amounts of resources were allocated to fund community programs. The amount of resources committed to fund individual programs varied depending on the type and amount of services provided. For example, the St. Rose Dominican Hospital Red Rose Cancer Screening Program dedicated over $450 million per year from 2009 to 2012 while Mercy General Hospital’s Loaves to Fishes Program providing health care services to the homeless averaged $250,000 per year over the same time period.

Third, program success measures were included in three of the four programs. Variation in the type of program success measures included in each of the programs existed. In one case, St. Joseph’s Hospital and Medical Center’s Asthma Intervention Program, the measures changed from increasing the overall number of patients served to increasing the percentage of patients served. Reasons for the shift in program success measures were not possible to determine for the Asthma Intervention Program making it difficult to capture the extent to which the Asthma Intervention Program was programmatically successful or not.

More importantly, among all of the programs analyzed, none included health outcome measures in their Program Digests. Therefore, making inferential determinations
between program development, resource allocation, and program success, i.e., improving the health of those served by implemented programs was not possible.

And fourth, the inherent qualities of each program offered the study a rich and comprehensive examination of community-based programs implemented across a nonprofit health system. However, the program-specific attributes made it difficult to compare and contrast programs system wide in order to assess which programs were providing the highest levels of community benefit that produced the greatest positive shift in improving community health.

Question 2: Social and Scientific Definitions of Health and Community Benefit

The second question asked what contributions social and scientific definitions of health had on the creation of community benefit policies. Guided by the literature review conducted in Chapter 2, the fourth phase of the analysis, an examination of the relationship between historical words found within guiding IRS documents and present-day words found within Dignity Health system community benefit reports sought to answer this question.

Results of the content analysis yielded the following observations. First, among the IRS guidelines reviewed the 50 most frequently used words within individual IRS documents were observed with similar frequency among all of the IRS documents. Second, within the IRS documents words that reflected a scientific perspective of health were the majority of all words found while words that reflected a social perspective of health were found most often within Dignity Health community benefit reports. Third, when comparing IRS guidelines with Dignity Health community benefit reports only two words that represented a scientific perspective of health were shared between the two sets of documents – hospital and medical. And fourth, shared words representing a social perspective of health were found among all documents but were limited to two, benefit and patients.
Based on the findings of the analysis, inferences could be made that support the notion that both scientific and social perspectives of health contributed to the process of creating community benefit policies. For example, the IRS documents contain several examples of words that reflect scientific and social perspectives of health. Similarly, words found within Dignity community benefit reports also demonstrate the inclusion of both scientific and social perspectives of health. And, when comparing both sets of documents, words that are representative of both perspectives were found among all documents reviewed. However, the magnitude of the influence historical IRS guidelines has had on shaping current community benefit policy development remains to be seen. Additional steps in future research studies would need to be undertaken in order to determine the extent of which historic and present-day texts connect and if they do connect to what degree do connections shape policy creation.

Question 3: Framing of Target Populations

In general, the third question sought to determine the relationship between how the framing of target populations impacts community health outcomes. The question evolved following a discussion in Chapter 2 of traditional policy models and a degenerative policy model developed by Anne Larson Schneider and Helen Ingram. In particular, the question sought to test Schneider and Ingram’s idea that negatively constructed members of society will receive lower levels of resources than more deserving segments of society. By measuring the amount of resources committed to community-based programs and by measuring the health outcomes of implemented community benefit programs, the study sought to ascertain whether or not Schneider and Ingram’s degenerative policy theory was present within current community benefit policy reviewed here. Two phases of the analysis addressed this question and produced a number of relevant and meaningful findings.
Hospital-Level Community Benefit

Results produced by the analysis of Dignity Health hospital community benefit found that for FY11 and FY12 Dignity hospitals committed significant levels of resources to programs targeted to benefit the health of individuals residing within her service areas. A comparison among 35 Dignity hospitals of differences between net community benefit for FY11 and FY12 including the percent increase or decrease in net community benefit reported between FY11 and FY12 illustrated two prominent findings. First, for all hospitals, changes in reported net community benefit (total benefit expense minus offsetting revenue) varied considerably between FY11 and FY12 (see Table 10). This observation was consistent for hospitals demonstrating a positive or negative change in reported community benefit. The analysis was not able to discern what influenced variance in reported community benefit. However, the observation was made that changes in costs associated with providing care coupled with changes in the amount of Medicaid reimbursement used to offset costs may have contributed to variability in the amount of net community benefit claims seen between FY11 and FY12.

Second, a comparison of two community benefit reporting sub-categories, Community Building Activities and Community Health Improvement Services contained within Benefits for the Poor and Benefits for the Broader Community found that among all 35 hospitals, variability existed in the amount of resources committed in FY11 and FY12 within each sub-category (see Table 15 through Table 18). Narrowing the analysis further to a comparison between total resources committed per person served within the Benefits for the Poor category found that between FY11 and FY12 resource commitment, total persons served, and amount per person was consistent (see Table 19). However, the amount of resources allocated, total number of persons served, and amount per person decreased
within the Benefits for the Broader Community sub-category between FY11 and FY12 (see Table 20).

Analysis was refined further by selecting a sub-set of four hospitals, St. Mary Medical Center – Long Beach, Mercy General Hospital, Mark Twain – St. Joseph’s Hospital, and St. Bernardine Medical Center to determine the relationship between community benefit claims, number of persons served, and amount of resources allocated per person served within Community Building Activities and Community Health Improvement Services, FY11 and FY12. Discussion of the results found within two of the hospitals, St. Mary Medical Center – Long Beach and St. Bernardine Medical Center will serve to highlight the results garnered from this level of the analysis.

St. Mary Medical Center – Long Beach did not report Community Building Activities for the Poor FY11 or FY12. In addition, data were missing within the Community Building Activities for the Broader Community category in FY11. Comparable data were available for FY11 and FY12 within the Community Health Improvement Services for the Poor category. Reported total dollars committed to Community Health Improvement Services for the Poor showed differences between resources for FY11 ($2,194,645) and FY12 ($3,690,095). Number of persons served also grew, 26,205 (FY11) and 45,261 (FY12) resulting in a similar average of resources allocated per person for each year $83.42 and $81.53 respectively (see Table 21 and Table 22).

A more dramatic difference between resource commitment, number of persons served, and amount of resources committed per person was observed within St. Mary’s FY11 and FY12 Community Health Improvement Services for the Broader Community category. In FY11, $1,190,492 was claimed with 14,177 persons served leading to an $83.97
per person average allocation. However, in FY12 $431,634 was claimed, 846 persons were served, resulting in a $510.21 average allocation per person.

For St. Bernardine Medical Center, differences between resource claims and number of persons served changed within Community Building Activities for the Poor and Community Health Improvement Services for the Poor categories between FY11 and FY12 highlighting the effect changes in resource claims and persons served had on the average amount of resources allocated per person. Within Community Building Activities for the Poor St. Bernardine claimed $450,162 in total resources, 2,441 persons served, resulting in an average allocation per person of $184.42 in FY11. In FY12, St. Bernardine claimed $284,694 in resources with 1,475 persons served, leading to a $193.01 per person allocation. Therefore, even though changes in resource claims were noted, the number of persons served decreased by nearly half in FY12 resulting in a very similar per person allocation for FY11 and FY12.

The hospital-level analysis demonstrated that for all hospitals resources were consistently being committed to fund community-based programs. Variation in the amount of resources claimed, persons served, and average allocation per person was found across all hospitals. Differences among the amount of resources claimed, persons served, and average allocation per person were also observed within two reporting sub-categories among a sample of four hospitals. Therefore, one could infer from these results that marginalized, or negatively constructed communities located within Dignity hospitals are positively viewed within the community benefit policies that produce implemented community-based programs. However, the results did not offer any connection between resource commitment, persons served, and average allocation per person and health outcomes. And, even though consistent amounts of resources were being committed within marginalized communities the
findings were not such as to suggest the extent to which levels of resources committed were either hindering or improving health.

An attempt to address this apparent disconnect between resource allocation and community health outcomes was made by comparing resources committed within Dignity hospital service areas with CNI scores that corresponded to zip codes located within Dignity hospital services areas. The author surmised that by measuring the relationship between committed resources and changes in CNI scores over time one could abductively infer the effect resource allocation had on improving health. For example, if a positive change in resources were observed this would likely change CNI scores from higher scores, 5 indicating most need, to lower scores, i.e., 4, 3, 2, or 1. Conversely, if resources were found to decline over time a corresponding negative change in CNI scores would most likely occur, e.g., from 1, 2, or 3 to 4 and 5.

Unfortunately, analysis between resource allocation and changes in CNI scores were not possible beyond identification of zip codes that represented changes in High CNI scores among three Dignity Health hospital service areas (scores of 4 or 5). This discovery came when the author realized during the analysis that the CNI scoring instrument was a static measure developed in 2009 and had not been updated since that time (see Table 23). This finding was most disappointing for several reasons but most importantly signified that the study was unable to make a connection between resource allocation and health outcomes within the hospital-level analysis. This finding did, however, propel the study to seek out yet another level of analysis that might yield more promising results.

**Hospital Program Analysis**

Building upon the analysis conducted from a hospital perspective, a review of community-based programs directed to meet the inherent needs of communities located
within Dignity Health hospital services areas was conducted. As we have seen, the hospital level analysis produced results that demonstrated relationships that existed between resource allocation, persons served, and resources committed on a per person basis. However, connections were not made between resource allocation and health outcomes. As such, the study sought to make this connection by examining implemented community-based programs whose focus was to improve community health and well-being.

As was mentioned in a previous section, community health information acquired through community need assessments and assignment of CNI scores shaped the development and subsequent implementation of community-based programs. Specific programs created to address the inherent health care needs of vulnerable populations including cancer patients, the homeless, low-income children with oral health needs, and uninsured and underinsured children with asthma were found within Dignity hospital service areas. Consistent levels of resources were also made available to fund programs in addition to the inclusion of limited factors used to measure program success.

Determining if Dignity’s community benefit categories were degenerative in nature rested on the notion that if Dignity viewed vulnerable members of community negatively, community benefit programs would reflect this view in the form of levels of resources committed to funding programs, if the programs actually met the needs of program recipients, and the extent to which programs improved community health. For example, a negative view would imply low levels of resources committed to programs that may not reach members of the community that need them the most and the health outcomes achieved from program implementation would reflect minor, if any, positive change in community health.
Results gleaned from the analysis of Dignity Health hospital community benefit Program Digests showed that it is likely that Dignity hospitals view vulnerable populations negatively but not in the way society would view murderers or child abusers as negative and undeserving but negative in their inability to effectively change their health status without the assistance of intra-community resources. For example, nearly all of the recipients of community benefit programs are underinsured or uninsured. Insurance status does not make them bad people unworthy of institutional support. Rather, when seeking health care services insurance status plays a key role in determining the positive or negative impact uninsured and underinsured patients have on a hospital’s bottom line. Therefore, Dignity hospitals view vulnerable patients and what ails them from a mission-based perspective positively but from a fiscal-based/insurance perspective, negatively. Support for this position was seen by the commitment of Dignity hospitals to effectively capture the needs of community that informed resource allocation and implementation of community-based programs. And, had outcome measures for determining before and after policy effects from program implementation been incorporated into Program Digests, one could have measured the impact said programs had on improving community health.

This observation, positing that nonprofit hospitals view vulnerable populations in a positive and negative light based not on their need for services but on their ability to pay for services presents an opportunity to explore the fourth research question and the results of the analysis that were developed to answer it.

**Question 4: Nonprofit Hospital Fiscal Viability and Hospital Mission**

The fourth question sought to understand the relationship between a nonprofit hospital’s ability to remain fiscally viable while fulfilling its mission to serve all those that receive care. Specifically, how does the tension between these opposing forces influence the
implementation of community benefit policy and the health outcomes they may produce. All four phases of the analysis contributed to answering this question. However, the majority of the discussion will center on results produced by system- and hospital-level analyses.

Recalling Table 6, the contribution national community benefit claims has had and is estimated to have in the future on national health care expenditures is significant. The exponential growth in community benefit claims by Dignity Health system and its member hospitals parallels national estimates. Currently, and in future years Dignity Health system will claim billions of dollars in community benefit. Distribution of community benefit claims among benefit claim categories showed that the largest percentage of community benefit claims are captured by resources used to bridge the gap between costs associated with providing care and reimbursements provided by Medicare and Medicaid (68% of total claims FY12). The remaining 32% of community benefit claims are scattered across a number of programs ranging from research, health professions education, community building activities, and community benefit operations.

Comparing all system-level community benefit claim categories, the least amount of resources was dedicated to providing services that are unprofitable, do not receive offsetting revenue, and are aimed specifically at the community level to address community health care needs in order to promote positive health and well being (see Figure 1 and Figure 2). Therefore, based on the results of the ways in which Dignity Health reports system-level community benefit, community benefit claims serve the interests of subsidizing a structurally flawed health care system instead of providing services under the name in which the tax exemption is given. In other words, Dignity Health meets the requirements defined by government, industry, and nonprofit hospital criteria for community benefit but one could argue based on review of one nonprofit health care system – a more appropriate term for the
policies that allow nonprofits to receive special tax exempt status is health care system benefit.

In addition, IRS Rulings, industry guidelines, and hospital policies do not adhere to defined explicit thresholds that measure the level of benefit nonprofit hospitals are required to reach in order to maintain tax exempt status. The literature review did reveal that some states, e.g., Texas, have established percentages of net hospital expenditures, 5%, that must be met in order to fulfill state community benefit obligations. However, at the federal level, in most states, and among current nonprofit hospital community benefit policies, threshold levels are implied and vary considerably across the community benefit landscape.

A positive development has been an effort to improve the reporting of community benefit via changes made in IRS Form 990 and the addition of Schedule H. The long-term effect of the evolution in community benefit remains to be seen as revised IRS reporting criteria have only been recently enacted. Nonetheless, capturing the true monetary value of community benefit claims may enlighten stakeholders to the significant and substantial role this policy has on not only providing justification for an institution to possess rival tax exemptions but to demonstrate the impact community benefit policy has on improving the health of individuals and families.

Comparative analysis of individual Dignity hospitals and the benefits they provide to community demonstrated that for the resources that were allocated to providing direct community health services discernable impacts were made. However, as compared to resources claimed by other main community benefit reporting categories the resources allocated at a community level were quite minimal (see Figure 2, Figure 3). This observation was further supported when comparing percentages of system total net community benefit with Services for the Poor and its sub-categories, Community Health Improvement Services.
(3.3% of total) and Community Building Activities (0.1% of total) and Services for the Broader Community and its sub-categories, Community Health Improvement Services (1.0% of total) and Community Building Activities (0.2% of total). And, the ability to measure the magnitude of health outcome impact as an effect of resource allocation was greatly hindered by the absence of health outcome measures within community benefit program designs.

Summary

Within this chapter, a discussion of the results of the analyses was aided by examining the extent to which each research question was addressed and answered by the methodology developed and the analyses undertaken here. Each of the research questions was addressed and answered by single or multiple phases of the analysis and as a result several central findings representative of the study as a whole were found.

First, structural factors lying outside the community benefit policy environment have greatly shaped current community benefit policy. One example is a greatly improved body of federal, state, and industry literature that provides explicit guidance on what constitutes community benefit and how to report it but rather inconsistent guidance on what benchmarks must be explicitly met in order for nonprofit hospitals to receive their unique tax-exempt status.

Second, the overwhelming majority of community benefit claims are consumed by uncompensated care with comparatively little resources being claimed by allocations dedicated to the development, implementation, and measurement of community health programs.

Third, the impact community benefit policies have on improving community health is difficult at best to ascertain due to an absence of measures included within community
benefit programs that capture the relationship between need assessment, program design, resource allocation, and health outcomes.

Fourth, Dignity Health’s community benefit policies are not degenerative in nature. The study suggests that insurance status creates an inherently negative perception of community not the hospitals that work diligently and consistently to provide services for those in need.

Fifth, the health system employed to provide the author with a canvass upon which to build the study, Dignity Health, has demonstrated a strong commitment to developing sound, transparent community benefit policies across her network of hospitals. Dignity Health represents the gold standard of producing and openly sharing her community benefit reports with the broader community. And, even though the study revealed areas in which recommendations for future improvement to Dignity Health community benefit policies could be made, review of Dignity Health documents suggests that Dignity Health will continue to be a leader in developing forward thinking strategies to build upon the innovative policies they have created thus far.

And lastly, the results of the study demonstrated that community benefit is a complex, dynamic policy that possesses a great deal of nuanced information that can be understood on a broad level, but continued analysis of community benefit policy must be undertaken in order to expand upon the achievements of this study to reach deeper levels of understanding. For, as one can suggest with ease implications for researchers, community benefit stakeholders, and public administration based on the findings contained within this study are possible.
Implications

The observations presented above suggest that stakeholders vested in exploring community benefit policy in the future have many opportunities to investigate numerous dimensions of the policy and the role it plays in the delivery and receipt of health care in the United States. Researchers, community benefit policymakers, and the field of public administration may all gain from developing future studies that delve into understanding all or parts of this policy environment.

Implications for Researchers

The exploratory nature of this study motivated the use of modified case study and content analysis procedures to form inferential relationships between elements of community benefit policy. Specifically, the study sought to determine the extent to which community benefit policies hinder or improve community health. The selection of a single health system and four levels of analysis: system, hospital, program, and text/words, as a framework upon which to design and execute the study provided a degree of depth and breadth capable of addressing and answering the research questions at hand. However, future studies do not need to place such limitations on subsequent designs in order to improve on the work established here. One could imagine the contributions a comparative analysis among several health systems could have on broadening knowledge on this topic. For example, identification of best practices or more explicit measures of community health outcomes could be developed if information distilled from multiple health systems was collected. Second, if future efforts were expanded to include all nonprofit hospitals in the United States, quantitative methodologies could be used separately or in conjunction with qualitative approaches in order to build strong conceptual frameworks to test a wide range of new hypotheses.
Implications for Policymakers

Policymakers representing various interests and operating at multiple levels of influence have already grappled with developing health care policies that serve the interests of community while balancing the needs of the institutions upon which they are prosecuted (Longest Jr., 1988; Lambrew, Ricketts III, & Morrissey, 1993; Chapel, Stange, Gordon, & Miller, 1998; Chassin & Galvin, 1998; Bovbjerg, Marsteller, & Ullman, 2000; Mitchell & Shortell, 2000; Weil, 2001; Gabel, 2004; Bazzoli, Lindrooth, Kang, & Hasnian-Wynia, 2006; Blumenthal, 2006; Draper & Ginsburg, 2007). Community benefit is no exception. As the study infers, many valuable policy developments have been made since the founding of community benefit over fifty years ago but a great deal of work remains if certain effects of policy implementation – community health outcomes are to be well understood. Recent changes to national health policies including the recent passage of the Patient Protection and Affordable Care Act (ACA, 2010), may impact the way in which community benefit policy evolves. Particularly, the inclusion of the individual mandate in the ACA might place an even higher burden on nonprofit hospitals to provide services to the community at levels they are not currently capable of (Principe, Adams, Maynard, & Becker, 2012). As a result, nonprofits may be extremely motivated to explore innovative and novel paths to policy building that provide hospitals an ability to successfully navigate uncertainties that lay ahead.

The study also underscores the notion that nonprofit hospitals will most certainly continue to be scrutinized by stakeholders who are critical of current tax-exemptions enjoyed by nonprofit hospitals. Therefore, efforts by policymakers to include benchmarks and measures that capture the impact community benefit policies have on the communities in which they are located must be pursued – especially as it pertains to the relationship between community benefit/resource claims and community health outcomes. If these
components of community benefit fail to be incorporated into future policies one could suggest that levels of criticism are likely to continue or increase.

**Implications for Community Benefit Policymakers**

Individuals who are tasked with creating community benefit policy face numerous challenges including balancing a hospital’s mission to serve community while maintaining a bottom line that is strong enough to withstand the weathering inflicted by numerous elements present within the nonprofit hospital community benefit environment. As this study has demonstrated with the assistance of a review of Dignity Health system’s community benefit policies a most worthy effort has been undertaken by Dignity Health to develop community benefit policies that meet the myriad of environmental, institutional, and community challenges that face her hospitals. However, a recommendation to include health outcome measures is strongly suggested in the future development of community benefit policy in order to not only create a connection between community benefit policy and the outcomes it produces but more importantly to, through the effective allocation of limited resources, improve the lives of individuals and families residing within the communities in which Dignity Health hospitals and other nonprofit hospitals exist.

**Implications for Public Administration**

The field of public administration is expanding rapidly into new fields of knowledge (Denhardt & Vinzant Denhardt, 2000; Vigoda, 2002). The nonprofit sector, nanotechnology, systems/complexity theory, and health care are now all being represented through the research that is being conducted within the field (Clark, 2000; Glaser, Flentje, Bryan, & Jacob, 2004; Keast, Mandell, Brown, & Woolcock, 2004; Collard, 2006; Glaser, Martz, Harris, & Jacobsen, 2007). Building upon the traditional avenues explored by public administration including law, finance, organizational theory, state and local government, and
the recent work of others operating in parallel areas there appears to be no limit to the contributions public administration research and practice can have on enlightening audiences on an expansive range of meaningful and relevant topics. This study suggests that community benefit policy is worthy of consideration by the field and by working with other researchers focused on community benefit policy (Somerville, Nelson, & Mueller, 2013) community benefit appears to be a natural candidate for serious consideration in the future.

Conclusion

This study has explored a great deal of territory covering the evolution of health care in the United States, the ways in which our understanding of scientific- and socially-constructed perspectives of health have developed over time, and how these two areas have influenced the development of community benefit policy creation, implementation, and measurement. Based on the insights gained from the paths explored above a series of questions were constructed to understand what community benefit policy is and how community benefit policy impacts the health of community. A methodological framework built upon the literature review and observations made by the author regarding the history of community benefit policy creation was employed to test the research questions and to identify the relationship between community benefit and community health. The results of the exploratory analysis, guided by an examination of four levels of data collection interpreted through the use of modified case study and content analysis approaches revealed a number of findings. The findings suggest that community benefit policy does impact community health but in order to fully determine the extent that it does, community benefit policies created in the future will need to be enhanced to include measures that capture the magnitude of community benefit policy effects on community health.
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