Telling Our Story:

New Hampshire's Community Benefits

November 21, 2002

Office of Health Planning and Medicaid
New Hampshire Department of Health and Human Services

In Partnership with:

Office of the Attorney General
Division of Charitable Trusts
Community Health Institute

Funding Provided by the Endowment for Health

The New Hampshire Health Care Plan

In 1995, the Legislature directed the Department of Health and Human Services (DHHS) to prepare "a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety and well-being of the citizens of New Hampshire" (RSA 126A). The DHHS Office of Planning and Research responded by creating a statewide Health Care Planning Process that involved more than 1000 New Hampshire residents in 7 community councils, 22 focus groups, 18 town meetings, and 4 symposia.

This planning effort culminated in the issuance of the October 1998 report, ***The New Hampshire Health Care System: Guidelines for Change***. The report set forth 27 recommendations designed to improve the State's ability to: monitor and manage the rapidly evolving health care system; increase communities involvement in and direction of the health care system; enhance the ability of the market to perform effectively; and assure that New Hampshire citizens have access to needed health care. *The Guidelines for Change* established the direction and goals of the State Health Care Plan. ***Telling Our Story: New Hampshire's Community Benefits*** is another in the series of reports that constitute the New Hampshire Health Plan (see the following page for a complete listing of the reports issued to date and how to obtain copies).

Beginning in the fall of 1998, the Department of Health and Human Services began taking steps to implement the recommendations contained in the *Guidelines for Change*. One of the first action steps completed was the statewide 1999 Household Insurance Coverage and Access Survey (recommendation 2) that established a baseline estimate of New Hampshire's uninsured (see *Health Insurance Coverage in New Hampshire*). That study was updated in 2001 with funding from the Health Resources Services Administration (HRSA). The 2001 work also included a survey of NH employers and focus groups of consumers and employers. The data, issue briefs, and report that resulted from the survey can be found on the Department's web site:

http://www.dhhs.state.nh.us/dhhs/HPR/Library/Program+Report

Another major step in the implementation of the *Guidelines for Change* - the analysis of New Hampshire's health care market - began in the spring of 1999. The DHHS, Office of Health Planning and Medicaid, partnered with the New Hampshire Department of Insurance and the Attorney General's Office to begin the joint monitoring of the health care market (Recommendation 1) and to develop a data system that provided information on the performance of the market (Recommendation 15). *Strengthening the Safety Net: The Financial Status of NH's Community Health Centers* and *The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis* represented the first reports to be released (Fall/Winter 2000) from the New Hampshire health care market analysis.

The New Hampshire Legislature passed SB 69 - known as NH's community benefits statute - in 1999. The recommendation (27) in the *Guidelines for Change* that appeared in the section "Partnering with Communities" under the discussion of the importance of communities to the health care system had called for: "Develop[ment] of operational standards for community benefits (with representatives from communities, non-profit providers, and representatives from the NH Insurance Department and the Office of the Attorney General) that reflect community values." Beginning in early 2000, the DHHS and the Attorney General's Office conducted a series of workshops on the purpose and expectations for compliance for the new community benefits legislation. This analysis of the content of the reports filed in the first year of the implementation of SB 69 - with the AG's Office, Division of Charitable Trusts - demonstrates that significant progress has been made towards achieving that recommendation and provides legislators with information they might need to revise SB 69.

New Hampshire Health Care Plan Reports

The Elements of an Ideal Health Care Delivery System

An Inventory of Health Status Indicators

New Hampshire's Health Status Goals

Health Planning, Values and Preferences

The State, Communities, and Individuals: Roles and Responsibilities in New Hampshire's Health Care System

The New Hampshire Network Survey Report

Creating a Healthier New Hampshire: A Consumer Report on Proposed Changes to New Hampshire's Health Care System

The New Hampshire Health Care System: Guidelines for Change

Health Insurance Coverage in New Hampshire

Strengthening the Safety Net: The Financial Status of NH's Community Health Centers

The Health of NH's Community Hospital System: A Financial and Economic Analysis

Assessing Child Health: A Starting Point for Communities

Regional Health Profiles

The 2002 Health Insurance Coverage Survey

Office of Health Planning and Medicaid
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301
www.dhhs.state.nh.us/dhhs/hpr
603-271-5254

Community Benefit Plans

Information on SB 69 and links to some of the community benefit plans filed with the Office of the Attorney General, Division of Charitable Trusts can be found at:

Office of the Attorney General
Division of Charitable Trusts
33 Capitol Street
Concord, NH 03301
www.state.nh.us/nhdoj/CHARITABLE/char.html
603-271-3591

PREFACE

The Office of the Attorney General, the New Hampshire Department of Health and Human Services and the Community Health Institute, wish to acknowledge the financial support that the New Hampshire Endowment for Health provided that made the analysis of the community benefit plans and the statewide conference to announce the results of that analysis possible. The interest and enthusiasm for this project that Dr. James Squires, President and Mary Vallier-Kaplan, MHSA, Program Director of the Endowment for Health provided was invaluable.

Kevin Barnett, Dr. PH, Public Health Institute, Christine Shannon, MS, Administrator, DHHS, Office of Health Planning and Medicaid, Bruce Spitz, Spitz Consulting Group LLC, Jonathan Stewart, MA, MHA, Executive Director, Community Health Institute, Michael DeLucia, JD, Senior Assistant Attorney General and Director of Charitable Trusts, and Terry Knowles, MPA, Registrar, Charitable Trusts, prepared this report.

John Bonds, Planning Coordinator, DHHS Office of Health Planning and Medicaid and Jim Zibailo, (former) Research Analyst, DHHS OHPM, contributed to this report by organizing and categorizing the extensive amount of information contained in the community benefit plans - without them the analysis would not have been possible. Ryan P. Shannon, a summer intern from the University of New Hampshire, prepared the preliminary information that was used to highlight possible exemplary practices for further review. Kimberly Firth, Health Planning and Policy Analyst, DHHS OHPM, provided the communications expertise necessary to assemble this report.

Amy Cullum, MA, MPH, Senior Consultant and Susan Friedrich, MBA, Managing Director from the Community Health Institute (CHI) conducted the interviews with the health care charitable trusts and developed the case studies on exemplary practices that are included as part of this report. Many thanks to: Laura Zickell, Monadnock Community Hospital; Hilary Douglass, Frisbie Memorial Hospital; Norreen Biehl, Wentworth Douglass Hospital; David Lash, Exeter Health Resources, Inc.; Ann Peters, Lamprey Health Care, Inc.; Kathy Crompton, SeaCare Health Services, Inc.; Pamela Puleo, Concord Hospital; Thomas Link and Jane Shapiro, Cheshire Medical Center; Tom Clairmont, Lakes Region General Hospital; and Margaret Franckhauser, Community Health and Hospice for their time, valuable insight and contributions to the Community Benefits Exemplary Practices section of this report. Sharon Kramer-Gabay, CHI, provided the organizational skills required to deliver the report on time and hold the statewide conference associated with its release.

A special thank you is in order to the Health District Council members, who both attended and presented at the series of meetings that were held on community benefits. Their thoughts and comments were helpful to the reports' authors.

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Background

New Hampshire's community benefit legislation was established in 1999 … "to ensure that the health care charitable trusts provide the communities they serve with benefits in keeping with the charitable purposes for which the trusts were established and in recognition of the advantages the trusts enjoy." Furthermore, public access to the community benefit plans was seen as a means to assure … "appropriate use of the resources of health care charitable trusts."

Health care providers and communities have been very interested in both the process and outcome of this legislation. In 2000 and 2001, the Attorney General's Office (AG), the Department of Health and Human Services (DHHS) and the Community Health Institute (CHI) held statewide workshops for Health Care Charitable Trusts (HCCTs). The purpose of the workshops was to clarify the intent of the legislation, to discuss how it would be implemented, and to set forth the AG's expectations for submission of the required reports known as community benefit plans. One of the themes that emerged from these sessions was a strong desire by the AG's Office to use the first 2-3 years of implementation to learn what worked best.

The HCCTs were not the only ones interested in the community benefits process. New Hampshire has seven District Health Councils that allow community participation in the DHHS' health care planning process. [1] The members of the District Councils have reviewed and considered the community benefits process in order to learn about the process and to be able to bring innovative practices into their communities.

The availability of community benefits plans has also sparked considerable interest among community members, advocacy groups, foundations, legislators and health care charitable trusts. Based on the frequent requests that come to the AG, these plans are seen as essential for evaluating the performance of individual providers, as well as the health of communities.

In 2001, the New Hampshire Endowment for Health provided funding to the Community Health Institute, the Attorney General's Office Division of Charitable Trusts and the DHHS Office of Health Planning and Medicaid to analyze the first year's experience with the community benefits process, address the system/infrastructure issues and disseminate information to the public. This report is the product of the Endowment for Health's grant.

It is important to note that no other state has a community benefits statute that involves all health care charitable trusts. Most restrict their attention to non-profit hospitals or to very large non-profit providers. Little evidence exists that other states are attempting to learn from and refine a process that helps communities to influence their non-profit health care charitable trusts. Most states with community benefit legislation have done very little to study or use the information contained in the plans. Perhaps the most significant way New Hampshire differs from the other states that have community benefits legislation is the active collaboration between the Attorney General's Office and the Department of Health and Human Services, [2] and between the DHHS and the community-based District Councils.

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[1] The legislative review statement that was included in Chapter 312:3 called for the legislature to further consider and amend the statute based on the results of the statewide health planning process and the initial reports filed in compliance with the act.

[2] During the implementation of the community benefits statute, the Endowment for Health also funded the *Empowering Communities with Data* project, a collaborative effort between the DHHS and the UNH Health Policy and Practice Institute. A second grant was announced in the Fall of 2002 that would, among other things, provide a data analyst to work directly with communities. While making data available at the community level

Report Purpose

The purpose of this report is to increase public access, awareness, and understanding of the information contained in the community benefit plans submitted by the health care charitable trusts to the Attorney General's Office. There were three major objectives of the project that resulted in this report:

1. Analyze community benefit plans to identify linkages between priority health needs that were determined through local needs assessment and community engagement processes and the programs developed to address those needs.

2. Analyze community benefit plans to identify exemplary practices in different components of the planning and implementation process, conduct interviews and prepare case studies of notable examples.

3. Hold a statewide conference for public release of the community benefits report that would allow for sharing among the health care charitable trusts.

Findings from this study and the statewide conference could be used by the legislature in any revisions or "look-backs" to SB 69. The project partners can take advantage of the opportunity - both in the review of the plans and in the conversations that will ensue with the charitable trusts - to identify areas for improvement in local practices and the state reporting process. A set of recommendations will provide the basis for the development of a revised reporting form and options to streamline the process (see IV. Discussion and Recommendations section).

Outline of the Report

This report begins with information on New Hampshire's legislation and how NH fits within the national context of community benefit efforts. The methodology section describes the sources of information and methods of analysis that were used in order to assess the linkages between health-related needs and the services/activities associated with them and to identify exemplary practices. Limits to the study are also included in the methodology section. A summary of the findings of the analysis follows the methodology section. Finally, this report concludes with a discussion of the findings and recommendations for action to improve the community benefits process and increase the utility of the information contained in the community benefits plans. The Appendices contain samples of forms used in the analysis and the complete exemplary practices case studies.

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can have a number of uses, charitable trusts will benefit when they conduct the community needs assessments required by the statute.

I. INTRODUCTION

History of Community Benefits in New Hampshire

During the past twenty years of dwindling sources of revenue, federal and state policymakers have begun to raise questions regarding the correlation between the tax-exempt status of nonprofit hospitals and the benefits, if any, received by the community in exchange for this tax advantage. In the early 1980s, Texas was the first state in the country to examine this issue in detail and to subsequently enact a law requiring non-profit hospitals to file a "community benefits" report with the state on an annual basis. Many other states, including New Hampshire, have enacted similar laws during the ensuing years.

In the 1999 session of the New Hampshire Legislature, Senator Katherine Wheeler, Senator James Squires, and Representatives Emerton, Copenhaver, and Fuller Clark sponsored Senate Bill 69, an act relative to health care charitable trusts and community benefits. Governor Shaheen signed the bill into law on July 16, 1999. The legislation requires each health care charitable trust to develop a community benefits plan within 90 days of the start of its fiscal year. Each health care charitable trust is required to:

- submit its community benefits plan to the Director of Charitable Trusts on an annual basis;
- provide notice to the public of the availability and process for obtaining a copy of its community benefits plan; and
- prominently display such notice in its lobby, waiting rooms, or other area of public access.

The effective date of the law for health care charitable trusts with a total value of fund balances of at least $1,000,000 was January 1, 2000; health care charitable trusts with a total value of fund balances of at least $100,000 had to comply effective January 1, 2001. Any health care charitable trust with a total value of fund balances of less than $100,000 is exempt from the provisions of this law.

This law also requires that the health care charitable trust prepare a community needs assessment (RSA 7:32-f) and seek input from the public during all phases of the process, including the development of the community benefits plan (RSA 7:32-e IV and VI).

The Role of the Director of Charitable Trusts

The legislation amended RSA Chapter 7, Director of Charitable Trusts, and added a new section to the existing statute: 7:32-c to 7:32-l. Jurisdiction for the administration and enforcement of the law is under the supervisory authority of the Attorney General, Director of Charitable Trusts. The law requires that within 90 days of the start of its fiscal year every health care charitable trust shall develop a community benefits plan. Every health care charitable trust must submit its community benefits plan to the Director of Charitable Trusts on an annual basis no later than 90 days after the start of the trust's fiscal year. Failure to meet this deadline may result in a fine of not more than $1,000, plus attorney's fees and costs for each violation.

An extension of time for filing the community benefits plan may be granted by the Director upon application made by the health care charitable trust and for good cause shown. This section of the law was amended during the 2001 legislative session.

The Director of Charitable Trusts may grant an exemption from the provisions of RSA 7:32-c to 7:32-l to those health care charitable trusts for which compliance would be a financial or administrative burden. An exemption, if granted, is valid for a period of three years from the date of issuance, unless the Director of Charitable Trusts revokes it, and written notice of such revocation is provided to the health care charitable trust. The Director of Charitable Trusts has granted a very limited number of exemptions.

Since its enactment compliance with the law has been excellent and many commendable plans have been filed.

(See APPENDIX A for a copy of SB 69, NH's Community Benefit Legislation).

New Hampshire in a National Context

Legislative History

The concept of community benefit emerged as a public issue in 1969 with the issuance of an IRS Ruling (69-545), which expanded the definition of charity beyond a "relief of poverty" focus to services/activities for any group of individuals that are large enough to constitute benefit to the general community. This new interpretation of charity offered the potential for more comprehensive approaches to health improvement. At the same time, it raised concerns among some that it would reduce emphasis on free medical care and dilute services for low-income populations. Despite an early court challenge, the community benefit interpretation of charity was upheld, and was reaffirmed in 1983 with another IRS Ruling (83-157).

As noted earlier, public interest in the charitable obligations of tax-exempt health care organizations grew in the early 1980s, as federal domestic spending declined and states reduced allocations to local jurisdictions. As cities and counties began to search for new sources of revenue to strengthen their local health and social safety net, their attention shifted to non-profit hospitals. Local officials began to demand tangible returns for revenues lost through property tax exemptions.

A number of lawsuits made their way into the courts. The highest profile case was the Utah State Tax Commission v. Intermountain Health Care in 1985. After considerable debate, Utah's State Tax Commission issued a set of formal guidelines in December 1990 (UT State Tax Commission) that included explicit standards for the volume of charity care provided by non-profit hospitals and nursing homes.

Since 1990, a total of 11 states have established statutes that are intended to increase the accountability of non-profit hospitals. In addition, the Office of the Massachusetts Attorney General issued a set of Voluntary Guidelines for Nonprofit Hospitals (Office of the AG, MA) in 1994, and parallel Voluntary Guidelines for Health Maintenance Organizations (HMOs) (Office of the AG, MA) in 1996.

Three of the 11 states with formal statutes (i.e., Utah, Texas' SB 427, 1993, and Pennsylvania's Institutions of Public Charity Act, 1997) include minimum financial thresholds for charity care and related community benefit activities. The other eight states emphasize local accountability by requiring public reporting of health planning processes (e.g., needs assessments, community outreach and engagement) and the documentation of services/activities that address priority unmet health needs. Nine of the 11 statutes focus exclusively on nonprofit hospitals. Only Utah's legal statute and New Hampshire's legislative statute apply more broadly to other health care charitable trusts (HCCTs): Utah to Nursing Homes, and New Hampshire to all HCCTs. In addition, as noted above, Massachusetts' Voluntary Guidelines apply to both non-profit hospitals and HMOs.

The specific circumstances associated with the development of community benefit statutes are unique in each state, but two common themes emerge. In states such as Texas, Utah, and Idaho, impetus for state action was generated by legal challenges to individual non-profit hospitals. Pennsylvania's statute followed two decades of individual legal actions, most against urban hospitals, to increase services to proximal low-income communities. The emergence of a more prescriptive statute in three of these four states can be attributed, at least in part, to the adversarial environment created by the legal challenges.

California's statute (SB 697, 1995) was developed by in cooperation with legislators and hospital stakeholders in the year following the passage of SB 427 in Texas. California sought a more cooperative approach to avoid the development of legislation that focused primarily on the imposition of financial thresholds for charity medical care. Representatives of California hospitals made the case that the legislation should encourage broad engagement, emphasize local accountability, and allow for flexible responses to local circumstances. This more cooperative approach to development has yielded similar statutes in New York (Section 2803-1, Chapter 922, 1990), Indiana (Burns Ind. Ann., 1994) Massachusetts (Voluntary Guidelines), New Hampshire (SB 69, 2000), and most recently in Maryland (HB 15, 2001).

Implementation Issues

Common themes have also emerged in the implementation of statutes. In most cases, state agencies have not been provided with public funding to carry out oversight responsibilities. Agency administrators in some states have re-deployed existing staff to manage the filing process and respond to inquiries, but most lack the resources to conduct systematic analyses and/or facilitate the implementation process. In essence, the role of most state agencies is limited to serving as "libraries" for community benefit reports that are submitted on an annual basis.[3]

There are a few exceptions. The Texas Department of Health (TDH) conducts an annual review of the financial data submitted by hospitals to verify that they have met minimal requirements. Information is also gleaned from an annual survey disseminated in cooperation with the American Hospital Association and the Texas Hospital Association (Annual Survey of Hospitals). In 2001, an additional component was added to the survey that focused on charity care policies. Findings from this inquiry have not been published to date.

The California Office of Statewide Health Planning conducted a qualitative review and published a report of findings in January of 1998 (CA Health and Welfare Agency). Internal funds were also leveraged to support a series of workshops and site visits to increase public awareness and enhance the implementation process. The California legislature provided some funding to increase staff support for further analysis and facilitation the following year, but terminated that support in 2000.

In Massachusetts, the Office of the Attorney General has conducted qualitative reviews of reports and provided feedback to hospitals. In 1999, they published a compendium of "Best Practices" (Office of the AG, MA, 1999) and held a public conference to share findings. In the last few years, State representatives have worked with health care stakeholders, consumer advocates, and others to develop reporting guidelines that increase the specificity and uniformity of information. In addition, the AG's office secured funding from the W.K. Kellogg Foundation and leveraged funds from life insurance settlements to develop a searchable web site to post community benefit reports. The new web site has been activated, and FY 2001/2002 reports using the new guidelines are available for review.

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[3] In New Hampshire, the Attorney General's Office and the Department of Health and Human Services have been engaged since the passage of the statute in informing communities, meeting with governing boards, reading the filed materials and offering commentary.

Finally, in New Hampshire, the passage of SB 69 coincided with the health care planning process initiated by the Department of Health and Human Services (NH DHHS). One of the documents that have been produced as part of this public, community-based effort - the *Guidelines for Change* (NH DHHS, 1998) - contains 27 recommendations for the improvement of the health care delivery system in New Hampshire. Recommendation 27 specifically called for the development of operational standards for community benefits that reflected community values. This initiative enabled the DHHS to conduct a number of analyses and co-sponsor public forums with the NH Office of the Attorney General to enhance the implementation of the community benefit statute (see above **Background** section).

Recent Trends

In the last two years, two general trends have emerged at the national level that hold significant implications for the implementation of community benefit statutes. First, the number of uninsured and underinsured people has increased. It should be noted that there is no evidence to date that any community benefit statute has produced a measurable increase in the volume of charity care provided or reduced the number of uninsured in any single state. Rising costs, increasing competition, and downward pressure upon reimbursement, have combined to undermine the ability of HCCTs to have an impact upon this systemic problem.

The second general trend is an increase in fiscal constraints upon state budgets. The combination of the recent economic downturn, losses in stock market investments, and uncertainties associated with international events (and their impact on federal domestic spending, energy costs, and international trade) will force states to find new sources of revenue in the coming years. In this context, it is likely that pressure upon HCCTs will increase.

While there is some indication that hospitals have become more engaged with a variety of stakeholders in local communities, no systematic analysis has been conducted to determine the net impact of HCCT investments in community health improvement. Assessing the impact of community health improvement activities and isolating key contributing factors is a difficult task even in the best of circumstances.

The most significant work to date in the development of a typology for classification of community benefit activities has been carried out by the Catholic Health Association of the United States (CHA) in collaboration with Voluntary Health Association (VHA), Inc. Their work resulted in the publication of the Social Accountability Budget (SAB) in 1989 (Catholic Health Association) and the dissemination of a software package that facilitates uniform documentation and reporting by hospitals. Unfortunately, variations in the level of competence among users of the SAB, and inconsistencies in the accounting methodologies used to calculate the value of activities, prevent comparative analysis of HCCT performance in this area.

A recent study in California (Barnett, 2002) identified a number of common themes among a set of 24 community benefit program activities selected as exemplary practices. One of the most important themes identified was the clear targeting of programs to serve populations and communities with disproportionate unmet health needs. This is a core issue that goes back to a major concern raised with the issuance of IRS Ruling 69-545 in 1969. In an era of growing budgetary constraints, it has become increasingly important to ensure that charitable resources are strategically allocated to serve those most in need. The need to clearly target services and activities to serve specific populations with disproportionate unmet needs is an emerging standard in the field, and a number of national health care trade associations have indicated their support of this concept (Barnett, 2002).

In the next phase of SB 69 implementation, New Hampshire state agencies and HCCTs are in a unique position to provide leadership for the rest of the nation. The broad application of SB 69 to all HCCTs encourages a collaborative approach to identify and address unmet health needs in local communities. Lessons from state experience, and research in states such as Massachusetts and California, provide insights into the value of uniform guidelines for reporting and attention to key elements of the community benefit planning process. Ongoing cooperation among state agencies mobilizes complementary expertise to foster thoughtful and comprehensive approaches to oversight and management. Local structures such as the District Health Councils, provide an excellent platform for ongoing local dialogue. Finally, the combination of a public effort to support statewide health planning and private funding from The Endowment for Health will help to develop a state infrastructure to promote broad engagement and ongoing enhancement of efforts to address unmet health needs in local communities.

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II. METHODOLOGY

Areas of Inquiry

There were four primary areas of focus for the inquiry. The first area of inquiry focused on the identification of sources of data and information used by Health Care Charitable Trusts (HCCTs) to identify unmet needs. Examples of sources include, but are not limited to, secondary epidemiological and demographic data, telephone surveys, key informant interviews, focus groups, and community forums. The purpose was to analyze the process and determine to what degree the end product comprised a comprehensive and meaningful analysis of community needs.

The second area of inquiry was an assessment of linkages between health needs, identified in the assessment and community engagement process, with the services/activities supported by the HCCTs. The inquiry included a focus on the identification of populations targeted for services/activities.

Third, the analysis examined key components of the community benefit planning and implementation process to identify exemplary practices. The purpose of this area of focus was to provide examples of organizational behavior that might be replicated by other HCCTs.

The final area of focus for the inquiry examined alternative approaches to refine and improve the current community benefit legislation and HCCT practices in the field.

Sources of Information

There were three sources of information for this inquiry. The primary source of information was the community benefit reports submitted by HCCTs to the Office of the New Hampshire Attorney General, Division of Charitable Trusts, for fiscal year 2000/2001. There were 75 community benefit plans submitted to the NH Office of the Attorney General for the first round (FY 00-01), including 24 from non-profit hospitals and 51 from other forms of HCCTs (e.g., Community Mental Health Centers, Community Health Centers, nursing homes, Visiting Nurse Associations, specialty treatment centers).

Additional information was obtained by the NH Department of Health and Human Services (DHHS), Office of Health Planning and Medicaid (OHPM) during a series of District Health Council meetings around the state between Fall 2001 and Spring 2002. Preliminary findings from the reports were supplemented by telephone calls and site visits during Fall 2002 to select and document exemplary practices.

Methods of Analysis

Community Needs, Targeted Populations and Services/Activities Provided

The first step in the analysis was to categorize and group identified needs, methods to secure data/information, and services/activities reported by the HCCT (see APPENDIX B). Services/activities were listed as “justified” if they identified the source(s) of data/information that support the focus; “not justified” if no information was provided.

The plans were divided equally among three reviewers, who completed the tables for their group of HCCT plans. DHHS Office of Health Planning and Medicaid staff consolidated reviewer findings into a single table. These findings were then re-structured by content category (e.g., primary care, health education) geographic region, and whether identified needs were addressed or not addressed. The content categories used are a simplified adaptation of the Community Benefit Inventory for Social Accountability (CBISA), which is the most common framework used by non-profit hospitals across the country. This adaptation of the CBISA accommodates New Hampshire's community benefit legislation and the first year pattern of documentation. (A listing of content categories is provided as APPENDIX C.)

Interested parties who requested information from the community benefit plans questioned whether there was any regional variation in the services/activities developed to address needs. In addition, once the reviewers completed the tables discussed above, they found it difficult to summarize or tally the large amount of information contained in the plans in a meaningful way. As a result, they chose to divide the state into the regions that were used to describe the findings of the 1999 NH Health Insurance Coverage and Access Survey (NH DHHS).[4] (A map showing these regions is included in APPENDIX D.) These six regions - the North Country, Central Western, Central Eastern, Southwest, South Central, and the Seacoast - represented a reasonable way to look at the state that people could identify with, and at the same time, provided a way to simplify a complex, time-consuming task.

A second major area of focus for analysis was to determine whether specific target populations were identified as the focus of services/activities. In the review of plans, services/activities were placed in one of four categories; Low Income populations (LI), Vulnerable Populations (VP), Other Populations (OP), or Community-At-Large (CAL). The targeted populations were important because the legislation explicitly identified that services to Vulnerable Populations be considered as a community benefit. However, the legislation did not restrict the definition of community benefits as only those services provided to Vulnerable Populations. Indeed, the fact that the legislation identified support of public health programs (that are often aimed at the entire population) as community benefits indicates that the community-at-large was a suitable target population.

The legislation identifies vulnerable populations as any group of people "that are at risk of not receiving health care services due to medical, financial or other barriers." In order to keep with the customary usage of the term, we separated these populations into those that were low income (LI) and therefore faced difficulty paying for their health care services, and the vulnerable population (VP) whose medical or demographic characteristics created potential barriers to care (e.g., seniors, physically or mentally disabled populations, and immigrants). Other populations (OP) include, but are not limited to women, children and adolescents. Services/activities were placed in the LI, VP, or OP category if there was any indication of a focus on these populations. If there was no indication, services/activities were placed in the CAL category.

Exemplary Practices

The identification of exemplary practices among NH HCCTs was a three-stage process. The first stage involved a review of the community benefit plans to extract information that described relevant functions of the HCCT and addressed specific components of the community benefit process. In the second stage, DHHS OHPM staff conducted a series of District Health Council meetings where Council members who filed community benefit plans provided briefings on their needs assessment

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[4] These 6 regions were based on the 24 geographic areas called hospital service areas (HSAs) developed by the NH Health Services Planning and Review to capture the patterns of medical care usage across the various regions of New Hampshire. These hospital service areas were then grouped together to develop the 6 regions.

process, the findings, the contents of their plans, and lessons learned from the process. Finally, the third stage involved a series of site visits to validate preliminary findings.

First Stage Analysis

The first step in the identification of exemplary practices was to identify key components of the HCCT community benefit process. Initially, the categories were based on a conceptual framework first articulated in the 1997 monograph "The Future of Community Benefit" (Barnett, 1997). Key components of the community benefits process include:

- HCCT organizational mission statement;
- governance and decision making;
- operations and management;
- policies and procedures;
- community assessment process;
- program planning and implementation; and
- program monitoring.

Areas of focus under governance/decision making included the composition of the board, criteria for board membership, community benefit-related structures (e.g., community benefit subcommittee), and community benefit functions and roles for board members. Areas of focus under operations and management included staffing commitment and level, department and location of function, links to senior leadership, and the cost of plan preparation.

Under community assessment, areas of focus included how the community was defined, primary and secondary data collection processes, the identification of community assets, and the major health concerns that were identified. Under program planning, areas of focus included the composition and scope of community stakeholders, the form of engagement, the description of the planning process, the priority setting process, links between services/activities and major health concerns, and the role(s) and contributions of the HCCT (a copy of the Exemplary Practices framework is provided as APPENDIX E).

For the first level of review, DHHS/OHPM contracted with a University of New Hampshire intern to review plans and transfer relevant information from each plan to a matrix. The intern worked under the supervision of the DHHS/OHPM Administrator and the external consultant who developed the matrix. In order to validate the first level information compilation, the external consultant selected and reviewed a random group of complete plans to compare against the information documented in the matrices.

The second level review involved a separate analysis of the findings by three reviewers and a ranking of practices in each category based on the information available. Two of the reviewers consolidated the components and focused primarily on the needs assessment process, the community engagement process, selection of priority areas of focus and the activities and services that were provided or being developed. The reviewers ranked the HCCTs. DHHS staff then consolidated the separate rankings, and preliminary selections were made for further inquiry.

Second Stage Analysis:
District Health Council Meetings

The District Council meetings that were held by the DHHS OHPM during the Fall of 2001 and the Spring of 2002 supplied additional information that was used to compliment that which was obtained in the community benefit plans. A total of twenty-one meetings were held which allowed representatives of many of the HCCTs who filed plans the first year to answer questions that were posed to them on their needs assessment, community engagement and priority-setting processes, and the activities and services they were providing as a result. [5]

Third Stage Analysis:
Site Visit Process

Health Care Charitable Trusts or regional collaboratives of HCCT's identified as potential exemplary practices were contacted for additional information through a process of telephone interviews and site visits. Prior to the interview process, site visit staff reviewed the community benefit plans submitted by each organization from the subject community and received a briefing from the study team involved in selecting the exemplary practice sites. Site visit staff worked with the identified community benefits contact persons in advance to identify and schedule individual or group interviews as appropriate. A semi-structured interview was used wherein the interviews were guided by an interview protocol, but specific question sub-sets were varied through a free-flowing exchange of information to:

- discern key points in the process;
- probe for more in-depth discussion of program highlights identified in the document reviews;
- understand lessons learned; and
- gather input on recommendations for improving the community benefits process in New Hampshire.

(A copy of the complete set of interview questions used at the site visits is included as APPENDIX F)

Information from the document reviews and interviews was then abstracted and summarized to produce case studies for each study community that are included in Tab 5 Exemplary Practices Case Studies.

Limits of the Inquiry

The primary sources of information for this study are the 75 community benefit plans submitted to the Attorney General's Office, Division of Charitable Trusts in the first year of the SB 69 implementation. It is important to note that not all NH HCCTs are covered in this analysis. Only HCCTs with one million dollars or more in their fund balance were required to submit community benefit plans in the first year. In subsequent years, HCCTs with one hundred thousand dollars or more in their fund balance are required to submit community benefit plans.

Since key information for this study is drawn from reports submitted in the first year of statute implementation, a few caveats are in order. Some HCCTs may have misinterpreted instructions from the State, resulting in the submittal of incorrect or incomplete information. Others may have inadvertently left out information that was requested. Still others included information that was not

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[5] Not every HCCT that filed the first year participated in the District Councils. Since 3-4 HCCTs were able to present at each meeting, many were represented. The questions used in the exemplary practice interviews were not part of the community benefit reporting form, therefore, the decision was made not to lose this rich source of information and to use it to complement what could be found in the plans.

requested and/or relevant to intent of the statute. [6] It would be anticipated that these problems would be less prevalent in subsequent years as the HCCTs learn and improve their processes and the State revises the reporting requirements.

The strength and weakness of the data drawn from community benefit plans is that it relies on the perceptions and actions of individual HCCTs. The statute currently gives HCCTs the flexibility to determine how they conduct needs assessments, how they engage their communities, and how they develop their plans. The intent was to give HCCTs and their communities' flexibility to accommodate the diversity of circumstances in local communities. The State did not provide uniform definitions of need, require that HCCTs employ specific methodological approaches, nor did it instruct the HCCTs on how they were to interpret the information, prioritize those needs, and respond to them. All of those decisions were left to the HCCTs.

As a result, HCCTs could have defined needs differently, relied on different data sets, employed different analytical approaches, interpreted the data differently or developed different responses to similar needs. Some uniformity in approach emerged, however, in regions where HCCTs pooled funding and expertise to conduct a common needs assessment. This approach also offered the potential for a coordinated approach to priority setting and the development of services/activities to address unmet health needs.

HCCTs were given considerable flexibility in terms of how they defined the services they provided and how they valued those services. For example, if the individual writing the plan adopted a narrow interpretation of the scope of reportable services, their plan may have understated the extent to which the HCCT engaged its community in the process or provided charitable services. It would also be possible for two HCCTs with identical roles in a collaborative project to report significantly different contributions because they used different accounting methodologies.

The function(s) of the HCCT also played a critical role in how they prepared and presented a community benefits plan. For example, State data could indicate that childhood obesity in one town was four times higher than any other town in New Hampshire. However, it is unlikely that a nursing home would address that problem in its community benefits plan. The nursing home's failure to mention childhood obesity would not indicate that the problem had been addressed, nor would it mean that the nursing home had been in any way derelict in the process.

Substantive engagement of community residents in the planning process creates the potential for the implementation of well-designed services/activities. Well-designed in this case means that the services made optimal use of local assets and were strongly supported by a wide spectrum of interests. There are many obstacles, however, to broadly representative and meaningful community engagement. Community action is voluntary. There is no guarantee that local residents will respond to requests for input and/or ongoing engagement, or that they will cooperate in the manner anticipated by the HCCT if they choose to participate. Further, the process is always idiosyncratic – specific to that place and time and the people who attended. This means that a hospital or Community Health Center or Visiting Nurse Association could advertise on radio and in the local papers (as several did) about their community benefits meetings and only one or two people would attend. In this instance, good faith actions by the HCCT did not produce the kind of response hoped for in the legislation.

Finally, because the HCCTs defined their communities, those involved in the community aspect of the process might not reflect the sentiment of the residents in the local town (e.g., a nursing home could

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[6] This was particularly true when documents designed for other purposes, such as reporting requirements, were submitted. Many times they included dozens of objectives making it nearly impossible to determine the "needs" and how they were identified.

define its community as its owner, employees and its elderly patients – where many of the patients might be much wealthier or poorer and less healthy and coherent than the elderly residents that lived in the nearby communities). In most cases, there are both obvious and practical reasons why outreach efforts do not result in meaningful engagement. It is anticipated that the quality of these processes will improve with experience.

The lack of uniform definitions and methodology, the differences in roles and perceptions of HCCTs and the nature of community involvement means that the community benefit plans cannot be added together to provide a comprehensive picture of health needs and services in New Hampshire. In other words, the fact that a hospital and a CHC provided charitable care in a community does not mean that all the charitable services needed in that community have been met. Nor can we say, that because a nursing home identified affordable independent housing as a need that it had not addressed, that some other agency was not working to meet that need. A comprehensive assessment of community needs requires a comprehensive approach that includes all of the residents within an area and relies on uniform definitions and methodology – something that is clearly beyond the scope or the intended use of the community benefits plans. That being said, the community benefit plans do give the State a picture of community generated or a "ground up" view of needs - something that is valued in NH and is a central component of the DHHS's health care planning process.

III. FINDINGS

Needs and Services

This project examined the nature of the community needs HCCTs addressed and the services they provided. In 2001, New Hampshire HCCTs identified 422 health needs. These needs were grouped into seven categories:

> *Access:* This category includes free and/or or subsidized medical services provided to low income or uninsured individuals, or subsidies made to providers (e.g., a hospital's support of a Community Health Center) that care for the poor and uninsured. Examples of services include, but are not limited to, primary and specialty care, dental services, and pharmaceuticals.
>
> *Health Care Support Services:* Transportation services, outreach efforts to increase public awareness of available services, and service enhancements (e.g., expanding hours of care, child care, translation services, hospice services) are included in this category.
>
> *Prevention and Health Education:* This included clinical and community-based prevention services and health education services for individuals and groups.
>
> *Medical Research:* This included both clinical research (e.g., the NH/Dartmouth Hitchcock Psychiatric Research Center) and community research (Northern New England Cardiovascular Disease study).
>
> *Graduate Medical Education (GME) and Provider Training.*
>
> *Health-Related Activities:* Activities outside of medical service delivery are included in this category. Examples include, but are not limited to, exercise programs, skills training (e.g., early literacy programs, parenting training and job-shadowing for youth), and basic support such as subsidized housing and food for vulnerable populations.
>
> *Community Development:* This category includes economic development (e.g., neighborhood revitalization) and general support for community groups (for non-health services, such as donation of space, funds and/or equipment to community organizations, contributions to community foundations, and participation in community planning and development activities).

Table 1 shows that the most frequently identified need was for *Prevention and Health Education* services (screenings, nutrition counseling, domestic violence prevention, etc.). The second most frequent set of needs the HCCTs identified was effectively shared by *Access* related services (87) and *Community Development* activities (86). However, when the needs are disaggregated by those linked to services and those that are not being addressed, a different picture emerges.

HCCT service programs and activities were developed in response to 301 of the 422 identified needs. The programs are identified in the community benefits plans. Service programs that addressed *Prevention and Health Education* needs were the most frequently offered, followed closely by service programs for *Access* and *Health Care Support* needs. Nearly three fourths of the services provided (219 of the 301 needs) addressed these three categories. It is important to note that this represents the **number** of programs identified in the community benefit plans. However, those programs may vary significantly in terms of **resource allocation**. For example, a hospital may have spent $500 to train teenagers as baby sitters and $3,000,000 on charity care. The baby-sitting training and the charity care are each counted as one service. These activities are not weighted by the resources allocated to them because the HCCTs used different methods for valuing those services. Thus, even though charitable care and financial support represented 8 percent of the HCCTs' service programs they may have accounted for the lion's share of the resources the HCCTs allocated to their communities (e.g., in 2001, New Hampshire's 24 non-profit hospitals provided $41 million in charity care).

The charitable trusts did not develop service programs for 121 identified needs. Seventy percent of the needs not addressed were for *Health-Related* activities and *Community Development*; needs viewed as peripheral to the central mission of most health care providers. The same picture emerges when we only examine the proportion of needs addressed within categories. For example, two thirds of the *Health-Related* needs and *Community Development* needs were not addressed; that is, HCCTS did not provide services for 85 of the 126 *Health-Related* and *Community Development* needs identified. Whereas only 20 percent of *Access, Health Care Support Services, Prevention and Health Education, Medical Research and Education* needs were not addressed.

Table 1 Summary Totals of Links Between Identified Needs and Services/Activities

Type of Need	**Identified Needs**	**Addressed by Services**	**Not Addressed**
Access	87	76	11
HC Support Services	57	51	6
Prevention/Health Ed.	110	92	18
Medical Research	3	3	0
GME/Provider Training	9	8	1
Health-Related Activities	70	32	38
Community Development	86	39	47
Totals	422	301	121

When a HCCT community benefit plan indicated that a need was not being addressed, it was difficult and at times impossible, to determine what that meant. This confusion rests with the variety of reasons that a HCCT might have for identifying a need and not developing or providing any services to respond to that need. For example:

1. A HCCT could be a member of a regional consortium that allocated service responsibility among its members. For example, a Community Health Center in the consortium might have assumed full responsibility for operating a subsidized prenatal care program while the hospital assumed responsibility for poor diabetic patients. This did not mean that the CHC was indifferent to the diabetic patients or that the hospital would not care for the poor pregnant women. It simply meant that the needs were recognized and allocated within the community.

2. A HCCT may not address identified needs that are viewed outside of their organizational mission and scope of expertise. For example, while a needs assessment may have identified prenatal care as a priority, a local nursing home is unlikely to have assumed responsibility to address this particular need.

3. One or more HCCTs may not address an identified need that is being addressed by another non-profit organization that is not defined as a HCCT. For example a non-profit housing agency could be building low cost independent living units for elderly

residents. As a result, the local hospital that identified this need could redirect its focus to another area of need within the community.

4. A HCCT might be providing the services to address an identified need but failed to list them in the plan.

For these reasons, we cannot conclude that the absence of services/activities reported by any individual HCCT to address an identified need in a local community means that the need is not being addressed. Because of the ambiguity surrounding the identified needs not addressed, the study was focused primarily on linkages between identified needs and services/activities.

Table 2 Number of Service Programs by Need

Type of Need	Number of Service Programs
1. Access	
A. Charity Care/Financial Support	22
B. Primary Care	13
C. Specialty Care	6
D. Respite Care	4
E. Dental Care	17
F. Pharmaceuticals	12
G. Other	2
Total	**76**
2. Health Care Support Services	
A. Transportation	11
B. Outreach	9
C. Service Improvements	31
Total	**51**
3. Prevention/Health Education	
A. Prevention Services	34
B. Community Health Education	53
C. Other	5
Total	**92**
4. Medical Research	**3**
5. GME/Provider Training	**8**
6. Health-Related Activities	
A. Basic Support	10
C. Skills Training	6
D. Other	16
Total	**32**
7. Community Development	
A. Physical/Economic Development	2
B. General Support/Collaboration	21
C. Other	16
Total	**39**
Total for All Categories	**301**

Table 2 provides a more detailed description of the kinds of services that were listed as community benefits. *Prevention and Health Education* were the most common services identified - with community health education (conferences and symposia, developing inventories of services available for individuals suffering from specific illnesses, etc.) representing more than half of those services. Services developed in response to the needs for access to care were ranked second. *Access* represented one fourth of all of the needs addressed, but charity and financial subsidies for those unable to pay for their care represented only 8 percent of all the services and 30 percent of the *Access* services (it is important to note, however, that charity care alone is probably much more significant as a percentage of HCCT community benefit expenditures). HCCTs indicated that they were more likely to report separate programs for subsidizing the providers of care (e.g., when a hospital subsidized a Community Health Center or dental clinic) than the patient. Direct provider subsidies represented 70 percent of the *Access* activities, with the most frequent subsidies provided for dental care, primary care and pharmaceuticals. In fact, the subsidies to providers and community health education were the most prevalent forms of services that community benefits assumed. For those services identified as *Health Care Support* services, 21 HCCTs identified 31 efforts to improve the amount or quality of existing services. This included expansion of their hours of operation, interpreter services, support groups and childcare services.

Services and HCCTS

The primary sources of information for this study were the 75 community benefit plans submitted by Health Care Charitable Trusts. Twenty-four (24) of those plans were submitted by hospitals, and the other 51 by other HCCTs such as nursing homes, Community Mental Health Centers, Community Health Centers, Visiting Nurse Associations, and a variety of specialty care centers.

In the analysis of linkages between identified needs and services/activities, however, only 70 community benefit plans were used. Two hospitals and three other HCCTs did not provide needs assessment data or identify priority unmet needs in their plans. Table 3 displays a summary breakout of the 70 HCCTs by region as follows:

Table 3 HCCTs by Region

Type of HCCT	**Number of HCCTs**						
	North Country	**Central Western**	**South Central**	**Central Eastern**	**Southwest**	**Seacoast**	**Totals**
Hospitals	4	4	3	4	4	3	**22**
Other HCCTs	2	4	10	8	8	16	**48**
Totals	**6**	**8**	**13**	**12**	**12**	**19**	**70**

The hospitals are listed separately (see Table 4) because they differ significantly from nearly all other health care providers in terms of: 1) the financial resources they use; 2) the range of the services they provide; 3) the number of patients they care for; 4) the number of individuals they employ; and 5) their role in the local economic life of the community. These differences are so pronounced that if hospitals are grouped with other non-profits, the hospitals would overshadow any differences that might and - in fact - do exist (See Table 4 below). For example, while hospitals represented less than one third of the HCCTs reviewed, they were responsible for providing more than one half of all the community benefits, 62 percent of the services for *Access* and *Preventive and Health Education* needs and more than 68 percent of the charity and financial support services. Whereas, non-hospital HCCTs were responsible for most of the *Health Care Support Services, Health-Related Services* and *Community Development* services.

Table 4 Services and HCCTs

Types of Needs	Service Programs by Hospitals	Service Programs by All Other HCCTs	Totals
1. Access	47	29	76
2. Health Care Support Services	24	27	51
3. Prevention/Health Education	57	35	92
4. Medical Research	3	0	3
5. GME/Provider Training	2	6	8
6. Health-Related Activities	15	17	32
7. Community Development	13	26	39
Totals all categories	**161**	**140**	**301**

Services and Regions

The regional distribution of service programs (shown in Table 5) suggests that more service programs exist in the South West region of the state. A word of caution may be in order here. One possible explanation could be that the longstanding regional cooperation in the Keene area's *Council for a Healthier Community* (see case study in APPENDIX G Exemplary Practices) may have produced a more clearly **articulated** set of community benefits (but not necessarily a greater amount of services) than in the other regions within the state. HCCTs in the South West region of New Hampshire may have allocated services among a larger number of clearly identified services programs than any other region, but the amount of services and resources spent on those services may have been much greater in the Seacoast and the South Central regions of the state.

Table 5 Service Programs by Region

Types of Needs	Service Programs and Activities						
	North	C. West	C. South	C. East	S. West	Seacoast	Totals
1. Access	8	12	13	13	16	14	76
2. Health Support	9	6	10	3	13	10	51
3. Prevent/Health Ed.	24	15	7	11	27	8	92
4. Medical Research	0	3	0	0	0	0	3
5. GME/Training	0	2	0	1	5	0	8
6. Health-Related	3	6	3	4	10	6	32
7. Community Dev.	4	12	0	10	7	6	39
Totals all categories	**48**	**56**	**33**	**42**	**78**	**44**	**301**

Services and Targeted Populations

Forty percent of the services/activities supported by HCCTs were focused on the community-at-large or did not identify a target population. There was no way to determine if this was due to the nature of the reporting form, which did not ask for a specific **population** to be identified, or truly reflected the approach the charitable trust chose to take. The New Hampshire legislation clearly indicates that public health services are community benefits. Many public health initiatives are directed at all residents within a geographic region.

There are very few surprises when services are considered in terms of the populations the HCCTs are intended to serve (see Table 6). Nearly half of the services for the community-at-large were for *Access* and *Preventive and Health Education* services. Twenty-percent of the services were for *Community Development*. A similar pattern emerged for the vulnerable populations. In contrast, most of the services for the low income population are for *Access* and *Health Care Support* - services that would be needed by individuals who would be unable to pay for all of the care they needed or received. When viewed together, 52% of the services under *Access* are directed towards the low income and vulnerable populations. Half of the services for groups that fell within the category of other populations (e.g., women, men and adolescents) were for *Prevention And Health Education.*

Table 6 Program Targeting of Services/Activities

SERVICES/ACTIVITIES	**POPULATIONS TARGETED**				
	Community At Large	**Low Income**	**Vulnerable Population**	**Other Populations**	**Totals**
1. Access	29	22	18	7	**76**
2. Health Care Support Services	20	7	19	5	**51**
3. Prevention/Health Education	35	5	28	24	**92**
4. Medical Research	3	0	0	0	**3**
5. GME/Provider Training	4	0	2	2	**8**
6. Health-Related Activities	6	5	17	4	**32**
7. Community Development	24	0	15	0	**39**
Totals all categories	**121**	**39**	**99**	**42**	**301**

Community-At-Large: All residents within a geographic region.
Low Income: Individuals unable to pay all or most of their care.
Vulnerable Populations: Elderly, disabled, mentally ill.
Other Populations: Women, men, adolescents.

Community Benefits Exemplary Practices: Lessons Learned

As previously described, interviews were conducted with representatives of Health Care Charitable Trusts from seven New Hampshire communities. Case studies of the community benefit processes in these communities are found in Tab 5 Exemplary Practices Case Studies. The case studies discuss alternative approaches taken by New Hampshire HCCT's to key aspects of the community benefit process including specific lessons learned and recommendations for improving New Hampshire's community benefit program. The findings from the aggregate lessons learned from the exemplary practice interviews indicated that successes were often based on the four areas discussed below.

1. Broad and inclusive participation that was demonstrated by:

- a history of collaboration in the community;
- solicitation of broad-based community input;
- involvement of community advocacy groups;
- participation of HCCT board members on task forces and advisory committees; and
- the presence of a community benefits “champion” - usually an energetic HCCT or community leader - who brought people together to create a community improvement agenda.

2. Organization and procedures that promoted:

- a collaborative team approach that ensured shared and equal participation among the partners;
- rules of engagement that defined how participants could exercise their votes, what their obligations were and that respected agenda items and time schedules;
- a commitment to develop and implement a plan;
- recognition that the process was as important as the product;
- the provision of needed administrative support needed to make the process work;
- shared costs and perspective in the needs assessment process; and
- development of systems for accurate tracking of community benefits.

3. Prioritizing of needs that were:

- realistic and practical;
- built on consensus of the participants;
- focused on needs that require a community response; and
- based on common indicators and benchmarks of community health.

4. Prioritizing of services/activities that:

- remained true to the missions of participating organizations, (that is, members were encouraged to “do what they can” within their mission and resources);
- increased awareness within a community; and
- created broad recognition and general ownership of the community benefit plan.

IV. DISCUSSION AND RECOMMENDATIONS

Discussion

This preliminary inquiry provides some insight into the scope of efforts supported by a subset of New Hampshire's HCCTs (those who had fund balances of more than $1 million which included 24 non-profit hospitals) [7] and their relative responsiveness to local dynamics as it relates to health care. The initial filing of community benefit plans displayed an array of needs and services emphasizing the local perspective. The analysis found most of the services were targeted for the community-at-large and vulnerable populations.

This review of the community benefit plans revealed that most of the community services and activities provided by the HCCTs are for prevention and health education, access and health-related services. Hospitals supported the largest share of services and activities among the first year filers, despite representing less than one third of the HCCTs. They were responsible for more than half of all the services and activities and more than 60 percent of the access, prevention and health education services.

The Central Role of the "Community" Assigned by SB 69

SB 69 emphasizes the "community" focus and imposes specific requirements for community engagement on HCCTs. The community benefits law calls attention to the eminent role that the community must play in determining the behavior and performance of its HCCTs stating:

> *Each community is unique and its particular health care problems and needs should be examined and the community benefits provided by health care charitable trusts which serve it should be directed toward addressing the issues and concerns of that community. Community involvement in the development of community benefits plans is necessary to make the health care charitable trusts more responsive to the true needs of the community.*

Because community engagement and direction is central to the law, it must remain central to the process and the reports generated must therefore describe the method(s) utilized by the HCCT to interact with the community. The State may have a role in fostering and improving the community engagement process by providing baseline information on the health status of communities; formatting the community benefits plans in order for local citizens to read and understand the nature of their HCCTs services and activities; and by helping communities share their experiences in this process.

Linkages Between Community Needs and Services/Activities

The findings of this study suggested that approximately 70% of the **identified** health care needs were being addressed by the HCCTs that filed community benefit plans with the Attorney General's Office in the first year of the implementation of SB 69. While this may indicate that a gap exists between identified needs and services/activities, SB 69 contains no language mandating HCCTs to address **all** health needs identified in local needs assessments. It is not the intent of SB 69, nor is it a reasonable expectation, to meet every unmet health need in local communities. Both the size and the organizational mission of different HCCTs impose practical limits on their ability to support a broad

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[7] HCCTs with fund balances of greater than $100,000 were required to file in the second year of SB 69 implementation and are not included in this study.

range of activities. [8] It is, however, important to insure that charitable assets are leveraged to make optimal use of their resources and internal expertise and to build on existing local community assets to address those identified unmet needs in an effective and sustainable manner. To the extent that HCCTs and other community stakeholders can effectively address unmet needs in specific areas, they ease the government burden and can help the State determine how to focus resources to address remaining unmet needs.

Alternatively, it should also be noted that there are numerous important services/activities supported by New Hampshire's HCCTs not identified in the community needs assessments. Many of these services/activities were in place before the passage of SB 69 and are being publicly documented for the first time. This observation does not necessarily mean there was no need for the service/activity and that the HCCT should cease it and devote resources elsewhere. In fact, had a certain service/activity not existed, the health need addressed by the HCCT might well have shown up in the community needs assessment. For example, a need for prenatal services for uninsured pregnant women might not show up due to the fact that the local Community Health Center served that population and, therefore, has addressed the need.

Documentation of Community Benefit Plans

The Attorney General's Office created a reporting form designed to give HCCTs some flexibility to identify and present how they conducted their needs assessments, designed and implemented their plans, engaged their communities, cooperated with other HCCTs and estimated the economic value of their services and activities. This flexibility of reporting made it difficult to assess the effectiveness of the process with any degree of consistency. In order to make the information contained in the community benefit plans more useful to local citizens, government representatives, and state administrators, the data needs to be presented in a more uniform fashion. Uniform definitions of terms and accounting methodologies are needed in order for state administrators to evaluate the quality of local processes and determine the value of resources allocated to address health needs. However, any such effort to increase uniformity would have to be balanced with the need to preserve the communities' flexibility to determine where to focus their resources and that did not impose an additional administrative burden on the HCCTs.

HCCTs identified as engaging in exemplary practices called for clearer guidelines on definitions and methodology and help in determining what counts as a community benefit in the case studies (see APPENDIX G). Case study interviewees also called for assistance in efforts to evaluate the impact of services/activities in the community. Most HCCTs lack the internal expertise to evaluate the aggregate impact of community health improvement initiatives. External assistance is needed from state agencies, philanthropies and academic institutions to build local capacity in this area.

Recommendations

Findings from this report suggest that the community benefits process can be improved and several recommendations for changing the process are listed below. However, no matter what changes result from this report, all stakeholders should not lose sight of the fact that communities are at the center of the community benefits process. Communities must be engaged in the needs assessment, the design of a HCCT's community benefits plan, as well as the approval, implementation, and evaluation of the

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[8] For example, 75% of the identified needs not being addressed were in the categories of *Health-Related Activities* and *Community Development*.

plan. Therefore, any changes intended to streamline the system (e.g., lengthening the time between needs assessments from 3 to 5 years) should not be used to streamline or diminish community engagement. Each year, community members must have the opportunity to participate in the development of HCCTs community benefits plans. In implementing changes, the Attorney General's Office can assist communities by redesigning the community benefit plan reporting form so resulting information can easily be understood and utilized by members of the community for the improvement of the health care system.

The following recommendations were developed based upon input resulting from the HCCT case study interviews, the District Health Council discussions, comments received by the Director of Charitable Trusts, and the findings of this analysis.

1. The Attorney General's Office and the Department of Health and Human Services, together with representatives from the HCCTs, should convene a workgroup to revise the reporting form. The revised form should include essential data elements and be designed to emphasize and promote a standard and uniform way to record the information.

The use of standard definitions for needs assessments, services and community engagement would permit a more accurate assessment of HCCT performance. It would streamline the Attorney General's procedure for collecting and quantifying data and enable HCCTs to monitor their performance for annual reporting. More importantly, it should reduce the burden on the HCCTs by decreasing the time and resources required to write the reports. The form should be designed to permit electronic filing in the future. Every HCCT subject to SB 69 should - at a minimum - be required to submit the reporting form with all the required information completed.

This workgroup should establish guidelines or standards that answer the main question posed by many of the HCCTs - what counts and how do we count it? If the HCCTs used standardized methodology for estimating the value of services, the financial commitments of the HCCTs may be reported in a more accurate manner. Further, the services provided would be presented in a manner that permits a quantifiable comparison to the resources allocated to those programs. The AG's Office should then answer a basic question raised in the report; namely, does charity care consume most of the resources allocated to community benefits? Once the assessment methodology for measuring impact is established, the AG's Office and the DHHS will be better able to determine whether the community benefits provided are having the desired impact and whether or not other approaches might be more constructive.

2. The DHHS should provide baseline epidemiological data that all communities can easily use in preparing their needs assessments.

This recommendation has the potential to reduce the financial burden of preparing community needs assessments on the HCCTs and provide more consistency and uniformity across these assessments.[9] The DHHS will be able to develop a more comprehensive understanding of community needs in New Hampshire. The *Empowering Communities with Data* project, a collaborative project between the DHHS and the Health Policy and Practice Institute at the University of New Hampshire, funded by the Endowment for Health, could serve as the basis for this recommendation.

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[9] The Office of Health Planning and Medicaid and the Office of Community and Public Health, received numerous requests for data that the HCCTs needed for their community needs assessments, particularly for an updated *Primary Care Access Data Set* or the *Regional Health Profiles.* Many of the HCCTs that filed in the second year used the *Regional Profiles* in their needs assessments.

3. The legislature should lengthen the time between needs assessments from 3 to 5 years.

If possible, the community benefits process should minimize the financial burden it imposes on HCCTs. Data collected by the Attorney General's Office reveals that tens of thousands of dollars have been expended on the community needs assessment process. The policy question that arises is whether or not this is the best use of scarce health care dollars. In addition, the increase to five years represents a reasonable increase in time since it is difficult to measure changes in the health of populations over short time periods, especially in a state like New Hampshire where small numbers make it difficult to show statistically significant change. However, the HCCTs should continue meeting with community members - at least on an annual basis - to solicit their input on services and to report progress on addressing identified needs to the community.

Collaboration among HCCTs should continue to be encouraged if it makes the community benefits process more effective and less costly. Collaboration, however, does not eliminate the need for each HCCT to report the individual nature of the services they are providing, the value of those services, and how their community was involved in the process.

4. The Attorney General's Office and the DHHS should continue to hold regional and statewide meetings with the HCCTs.

The District Health Councils are an existing mechanism for convening regional meetings on the issue of health care in New Hampshire. The AG's Office and the DHHS should continue using the District Council process as a forum for discussing these recommendations. There are other resources, such as the Foundation for Healthy Communities' community benefits group, which may also be utilized.

These meetings will provide an opportunity to:

- discuss and revise implementation issues;
- share exemplary practices;
- offer technical assistance; and
- provide guidance on evaluating the impact and effectiveness of community benefit services/activities.

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APPENDIX A
NH's COMMUNITY BENEFIT STATUTE SB 69

Provided Under Separate Cover

APPENDIX B

COMMUNITY NEEDS, TARGETED POPULATIONS, SERVICES/ACTIVITIES PROVIDED MATRIX

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APPENDIX C

CONTENT CATEGORY LISTING

Community Benefit Content Categories

1. **Access**

    A. Charity Care / Financial support for medical services
    B. Primary Care
    C. Specialty Care
    D. Respite Care
    E. Dental Care
    F. Pharmaceuticals
    G. Other

2. **Health Care Support Services**

    A. Transportation
    B. Outreach / Information (e.g., available HCCT services)
    C. Service Improvements

3. **Prevention / Health Education**

    A. Prevention Services
    B. Community Health Education
    C. Other

4. **Medical Research**

    A. Clinical
    B. Community-Based

5. **GME / Provider Training**

6. **Health-Related Activities**

    A. Basic Support
    B. Prevention Activities
    C. Skills Training
    D. Other

7. **Community Development**

    A. Physical / Economic Development
    B. General Support / Collaboration
    C. Other

APPENDIX D

MAP OF NH REGIONS USED IN STUDY

Provided Under Separate Cover

APPENDIX E

EXEMPLARY PRACTICES FRAMEWORK

Matrix Provided Under Separate Cover

Community Benefit Exemplary Practices

New Hampshire Health Care Charitable Trusts
Categories and Criteria for Selection

I. Mission Statement

A. **Explicit language indicating charitable intent**
(e.g., serve regardless of ability to pay, uninsured, low income communities)

B. **Review / revision process**
(i.e., description of inclusive process to enhance organizational mission)

Note: Select 4-5 examples from reports that capture flavor of different approaches that all clearly reflect charitable intent and diversity of HCCTs. No calls or site visits needed.

II. Governance / Decision making

A. **Board composition**
(i.e., reflects diversity of community beyond providers and opinion makers)

B. **Criteria for board membership**
(i.e., criteria that reflect charitable intent; not simply health care experience)

C. **CB-related structures**
(e.g., board sub-committee, community advisory committee, task force)

D. **CB functions / roles**
(i.e., clear indication of role of board or structure in planning & decision making)

Note: Narrow down to 2 examples that describe alternative approaches endorsed by the state. Would require calls to clarify info and to notify intent to publish with name.

III. Community Assessment

A. **Defined community**
(i.e., information reflects an effort to describe geographic community and populations in comprehensive manner and ID pockets of unmet health needs.)

B. **Secondary data collection**
(e.g., quality of data, evidence that has sought out variety of sources)

C. **Primary data collection**
(e.g., quality of data, effort to solicit information from diverse community stakeholders)

D. **Assets information collection**
(i.e., identification of formal and informal groups and activities that can serve as entry points for CB contributions.)

Note: Narrow down to 2 examples; significant potential for overlap with section IV (community engagement) examples selected. Would involve both calls and site visits to validate information.

IV. Community Engagement

A. **Form of outreach**
(i.e., evidence that multiple methods used to solicit input and participation by diverse community stakeholders)

B. **Composition of stakeholders**
(e.g., service-based community organizations, faith community, community residents, business, schools, coalitions)

C. **Form of engagement**
(i.e., evidence of engagement in assessment, plg., decision making, and implementation).

Note: Narrow down to 2 examples (potential overlap with III.); requires calls & site visits.

V. Program Planning

A. **Priority Setting**
(i.e., explicit criteria cited for use in the selection of programs)

Note: Other elements of program planning (e.g., role of community stakeholders, links to major health concerns) covered in other aspects of exemplary practice documentation and needs assessment inquiry. Narrow down to 2 examples (if we can find them) that reflect an effort to use explicit and objective criteria; would require follow up calls to clarify info and to notify intent to publish with name.

VI. Documentation

A. **Program targeting**
(i.e., evidence of effort to clearly focus services and activities in communities and/or on populations with disproportionate unmet health needs.)

B. **Accounting methodology**
(i.e., use of explicit methodology for calculation of financial value in different categories.)

Note: Narrow down to 2-3 examples of program targeting to highlight different approaches (i.e., populations and their characteristics), and 1 accounting methodology (if we can find one) that moves in a direction the state would support. Program targeting could be documented without calls; accounting methodology might need a call to clarify and validate.

VII. Program Monitoring

A. **Program objectives**
(i.e., clear delineation of objectives within specified time periods).

B. **Monitoring strategy**
(i.e., clear description of methods and indicators to be used to document the impact of program activities and responsible stakeholders).

Note: Possible overlap with III and IV. Identify 1-2 examples; may only have a good example of program objectives, or the selection of indicators. Would require calls to clarify and validate.

VIII. Organizational Infrastructure

A. **Management / staffing**
(e.g., appointment of dedicated staff, identified linkages with senior leadership).

B. **Policies**
(e.g., integration of CB programming with organizational strategic planning, institution of policies to increase accountability, involvement, enhance quality)

Note: Select 1-2 examples. Would require calls to clarify and validate.

APPENDIX F

EXEMPLARY PRACTICES SITE VISIT QUESTIONS

Exemplary Practices
Site Visit Questions

1. Are community benefits viewed as an important aspect of your organization?
2. Who in the organization is responsible for community benefits?
3. What is their position and role within the executive administration of the organization?
    a. Management / staffing: Was staff dedicated to this process? How were they linked to senior leadership?
    b. Was the community benefits programming integrated with organizational strategic planning, institution of policies to increase accountability, involvement, enhance quality?

4. How is the organization's board involved in the community benefits process?
5. Needs Assessment. Review the community benefits plan and ask the organization to expand on any of the following issues:

    a. How it defined their community (in terms of geography, needs that were addressed and populations served).
    b. How it defined need.
    c. The availability, nature and use of secondary data
    d. The availability, nature and use of primary data

6. How was the community engaged in the collection of information:

    a. Surveys: How were surveys structured, analyzed and used?
    b. Community Forums (meetings open to the public and structured to encourage and allow public comments): When and where did a community forum occur? How was participation solicited? How many individuals attended? Who represented the organization? How were comments recorded?
    c. Focus Groups (a small selected group of individuals asked to consider specific questions): How were participants selected? How many individuals were in a group? How often did it meet? Who developed the questions and the format for the group? What were they asked?
    d. How were websites or the media used to encourage community engagement?
    e. Were comments invited from individuals who were not employed by, board members of or contractors to the organization? Who was asked to comment? Who selected these individuals?
    f. Were coalitions created (i.e., non-legally binding alliances)? What was the nature of the coalition? Who was involved?
    g. Were partnerships created (i.e., legally binding alliances)? What was the nature of the partnership? Who was involved?

7. How was the community involved in:

    a. Analyzing the data? Who were the participants in this process (e.g., the charitable trust, other service-based community organizations, faith community, community residents, business, schools, coalitions, others- please specify)?
    b. Prioritizing needs? What needs were identified? What criteria was used to rank them? How were the specific needs ranked? Who were the participants? What ability did the participants have to review, comment, modify, approve or reject the ranking?

   c. Developing the plan? Who were the participants? What ability did the participants have to review, comment, modify, approve or reject the plan?
   d. Designating specific services and activities as community benefits? Who were the participants? What ability did the participants have to review, comment, modify, approve or reject the specific services and activities?
   e. Implementing the plan? Who were the participants? What ability did the participants have to review, comment, modify, approve or reject the implementation process?
   f. Evaluation of the plan? Who were the participants? What ability did the participants have to review, comment, modify, approve or reject the evaluation plan?

8. Community Benefits

   a. What services were designated as community benefits?
   b. Who made the designation?
   c. Were any national or state guidelines used to assist this process? Which ones?
   d. How were the benefits linked to community need?
   e. Which population would benefit the most from these services?
   f. What timeline was established for delivering each of the services or activities (e.g., immediately, six months, etc.)?
   g. What unit of service was used to measure activity (e.g., inpatient days of charity care, the cost of the service, etc.)?
   h. What was the financial commitment that the organization made to the community benefits process and to the community benefit services and activities? What accounting methodology was used to calculate the financial value for each of the services?
   i. What specific methods and indicators were to be used to document the services and activities provided by the organization and the impact those services were having on the community and stakeholders?

9. Assessment of Community Benefits process.

   a. Was this process useful for your organization? In what ways?
   b. Was the process detrimental? In what ways?
   c. Were any of the outcomes from the needs assessments and the community engagement process unanticipated? What were they?
   d. Did you request information or assistance from the AG's Office during this process? What did you request? Did you get the information and assistance you requested? If not, what happened?
   e. Did you request information from any other State agency or department? Which agency? What was the request? Did you receive what you asked for? If not, what happened?
   f. Were you able to use existing federal or state data files or reports in this process? Which ones? Were they useful? In what way? What were their limitations?
   g. How would you improve the process?