



EXPLORING HOSPITAL INVESTMENTS IN COMMUNITY DEVELOPMENT

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Key Findings

- From 2012 to 2016, nonprofit hospitals in the United States spent an average of \$67.9 billion annually on community benefits. Of these expenditures, 6.9 percent (\$4.7 billion) were directed toward community health improvement and cash and in-kind contributions to community groups, the two subcategories of community benefits spending with the greatest potential overlap with the community development sector.
- Separate from community benefits spending, 59.1 percent of nonprofit hospitals reported community building expenditures, which support activities that enhance communities' capacity to address nonmedical impediments to health. Averaging \$474.0 million annually, these expenditures represent hospitals' most direct investments in community development.
- Annual per capita community building expenditures varied widely across states, from \$0.03 in Rhode Island to \$8.43 in Delaware.
- Compared with other nonprofit hospitals, hospitals in rural areas and high-poverty counties less frequently reported spending on community building activities.
- Nonprofit hospitals engage in a broad range of initiatives that address both individual patients' social needs and community conditions. Many of these efforts involve partnerships with the community development sector.

Introduction

In recent years, growing attention has been paid to the nonmedical factors that affect individual and population health. Wide disparities in life expectancy can be identified across neighborhoods within the same city, highlighting the critical role of place and community context.¹ Among modifiable factors, social and environmental circumstances are thought to account for roughly half of the variation in health outcomes, more than twice the portion accounted for by clinical care. Furthermore, behavioral factors, which are profoundly influenced by community contexts, account for an additional 30 percent of health outcomes (Park, Roubal, Jovaag, Gennuso, and Catlin, 2015; Remington, Catlin, and Gennuso, 2015). As nonprofit hospitals pursue their mission to promote health and well-being, it is clear that many opportunities for high-impact interventions exist outside the traditional clinical setting.

¹ See National Center for Health Statistics, *Life Expectancy at Birth for U.S. States and Census Tracts, 2010–2015*, available at www.cdc.gov/nchs/data-visualization/life-expectancy/.

Recently, the COVID-19 crisis has illuminated the direct threat that deeply entrenched racial and economic disparities present to public health. In several large cities where data are available, infection, hospitalization, and mortality rates have correlated strongly with the share of neighborhood residents who are low-income or Black or Hispanic (Benitez, Courtemanche, and Yelowitz, 2020). Many have pointed to underlying health disparities linked to poverty, systemic racism, and inadequate housing as important contributing factors (Perry, Harshbarger, and Romer, 2020; Ray, 2020; Hooper, Napoles, and Perez-Stable, 2020), highlighting the importance of these root causes of ill health.

At the same time that the COVID-19 pandemic has brought to light the imperative of investing in patients' and communities' social health needs, it has been profoundly disruptive to the health-care sector. The American Hospital Association (2020) estimated the total financial impact of costly COVID-19 hospitalizations, foregone nonemergency services, increased demand for personal protective equipment,

and additional supports for hospital staff at \$202.6 billion in the first four months of the pandemic. Health-care systems vary dramatically in their ability to absorb these costs, with smaller independent hospitals, hospitals serving rural areas, and critical access hospitals² in the most financially precarious positions (Khullar, Bond, and Schpero, 2020). Last, on the consumer side of the equation, pandemic-related job losses have resulted in massive increases in the number of uninsured adults (Dorn, 2020), and the extent to which individuals are able to regain insurance in the near term is dependent on public policy responses and the pace of economic recovery.

In this report, we examine how much nonprofit hospitals reported spending on community development-related activities from 2012 to 2016. Although hospitals were facing much different financial circumstances during this period, our analysis provides important insight into spending priorities and can help identify gaps in funding and focal areas. We define community development-related investments primarily as expenditures reported under the community building category in hospitals' tax filings, although we also briefly examine hospitals' mandatory community benefits expenditures for additional context. This quantitative landscape analysis is followed by a qualitative examination of the types of community development-related activities in which hospitals described participating, focusing on the three states of the Third Federal Reserve District (Delaware, New Jersey, and Pennsylvania).

Although community building accounts for a relatively small share of hospital expenditures, it is the focus of our analysis for two reasons: Compared with community benefits, this is a relatively understudied area of hospital spending, and many of the activities included in this category (such as investments in housing stability, job quality, and neighborhood context) have long been focal areas of the community development sector. Although community development organizations may be well positioned to partner with hospitals

² Critical access hospitals are small, rural hospitals that are identified as the only providers of emergency and other essential health-care services in their regions. For more information, see www.ruralhealthinfo.org/topics/critical-access-hospitals.

to address community health needs, they may not have sufficient information about hospitals' typical investments in these activities. Our hope is that this report can provide both baseline information on this spending and concrete examples to help inform conversations between hospitals and community partners.

Background on Hospital Community Benefits Requirements

Nonprofit hospitals justify their tax-exempt status through the community benefits they provide beyond standard medical services (Rubin, 2013). According to the most recent estimates, there are over 2,900 private nonprofit community hospitals, accounting for just under half of all hospitals in the United States.³ Since 2009, the IRS has required nonprofit hospitals to report expenditures on community benefits activities on Schedule H of Form 990 (Rubin, Singh, and Jacobson, 2013).

The Patient Protection and Affordable Care Act (ACA), which was signed into law in 2010, mandates that hospitals complete a community health needs assessment (CHNA) and accompanying community health implementation plan (CHIP) every three years (Bakken, Kindig, and Boufford, 2014). These documents are designed to provide a strategic framework and benchmarking tool to guide hospitals in meeting the health needs of their surrounding communities.⁴ Since 2012, narrative descriptions of hospitals' approach to CHNA/CHIP development as well as other activities undertaken to address community health needs have also been reported by hospitals on Schedule H.

In much of the existing literature, the term "community benefits" is used to refer specifically to expenditures that hospitals are required to report in Part I of Section H, which are summarized and reported to Congress annually by the IRS. Part I community benefits expenditures are divided

³ American Hospital Association, *Fast Facts on U.S. Hospitals, 2020*, available at www.aha.org/statistics/fast-facts-us-hospitals. Other hospitals include those owned by for-profit investors and those operated by state, local, or federal governments, as well as psychiatric hospitals.

⁴ For more information, see the IRS guidance regarding CHNAs: www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3.

into seven subcategories: financial assistance, government-sponsored means-tested health care, subsidized health services, community health improvement services, research, health professions education, and cash and in-kind contributions (See Text Box 1 for definitions). Historically, the majority of community benefits expenditures have fallen into the patient care subcategories, particularly charity care and unreimbursed care, with relatively smaller shares allocated to nonclinical subcategories, such as community health improvement (Young, Chou, Alexander, Lee, and Raver, 2013). Prior research suggests that, in aggregate, hospitals' Part I community benefits expenditures exceed the estimated value of their tax exemption (Young, Chou, Alexander, Lee, and Raver, 2013; Rosenbaum, Kindig, Bao, Byrnes, and O'Laughlin, 2015). However, there is no minimum requirement for hospitals to maintain this tax-exempt status, which leads to great variation in spending across organizations, states, and regions (Singh, Bakken, Kindig, and Young, 2016).



Text Box 1. Definitions of Form 990 Schedule H, Part I Community Benefits Expenditures Subcategories

- **Financial Assistance (Charity Care):** Includes free or discounted care provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or some of the services.
- **Government-Sponsored Means-Tested Health Care (Unreimbursed Care):** Includes unpaid costs of public programs for low-income persons, such as Medicaid. The shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries.
- **Subsidized Health Services:** Clinical services provided despite a financial loss to the hospital. A service meets an identified community need if it is reasonable to conclude that if the organization no longer offered the service, it would be undersupplied in the community.
- **Community Health Improvement Services:** Activities and programs subsidized by the tax-exempt hospital, carried out or supported for the express purpose of improving health.
- **Research:** Studies and investigations designed to increase general knowledge and which are made public. For example, research can include behavioral or sociological studies related to health, delivery of care, disease prevention, or studies related to changes in the health-care delivery system.
- **Health Professions Education:** Educational programs that result in a degree, certificate, or training necessary to be licensed to practice as a health professional, as required by state law, or continuing education necessary to retain state license or certification by a board in the individual's health profession specialty.
- **Cash and In-Kind Contributions:** Includes funds and in-kind goods and services donated to nonhospital affiliated individuals or to community groups and other not-for-profit organizations for a community benefit purpose.

Source: Language from Internal Revenue Service, 2016 Instructions for Schedule H (Form 990), available at www.irs.gov/pub/irs-prior/i990sh--2016.pdf, and Bakken and Kindig, (2014).

Separately, on Part II of Schedule H, hospitals can report expenses in the optional, supplemental category of community building, which will be explored in depth in this report. Community building expenditures are used for activities that enhance communities' capacity to address both individual health needs and upstream social determinants of health, which are nonmedical factors that affect individual and community well-being, such as housing, community context, economic status, education, and food access (Artiga and Hinton, 2018) (See Text Box 2 for definitions). The separate reporting of these supplemental expenditures from Part I community benefits leads to considerable confusion about whether and under what circumstances this spending can be counted toward hospitals' fulfillment of their community benefits obligations (Rosenbaum, Byrnes, Rothenberg, and Gunsalus, 2016). In 2011, the IRS revised the instructions for Schedule H to allow some community building activities to be counted as community benefits if the hospital can demonstrate evidence-based results in improving health. However, the IRS has provided little guidance as to the standard of evidence required and how it would be assessed, limiting the effectiveness of this change for incentivizing further hospital investment in community building activities (Rosenbaum and Choucair, 2016; Rozier, Goold, and Singh, 2019).

Despite this ambiguity, many hospitals recognize the value and potential impact of investing in efforts to improve health at the community scale (Hostetter and Klein, 2016). Through the framework established by the CHNA and CHIP requirements, hospitals have the tools and a strategic approach to track and address community health (Bakken and Kindig, 2014). Furthermore, as anchor institutions, hospitals may be particularly well positioned to invest in communities, as they are often among the largest employers and purchasers in their areas. There is considerable overlap between community building activities and the work of the community development sector, pointing to clear opportunities for knowledge sharing and collaboration. However, despite cross-sector interest in these activities (Hilt, 2019), compared with core community benefits, few analyses have focused on community building (Bakken, Kindig, and Boufford, 2014; Singh, Bakken, Kindig, and Young, 2016).

Text Box 2. Definitions of Form 990 Schedule H, Part II Community Building Activities Subcategories

- **Physical Improvements and Housing:** Includes housing rehabilitation for vulnerable populations, removing harmful building materials (e.g., lead abatement), neighborhood improvement and revitalization, housing for vulnerable populations upon inpatient discharge, housing for seniors, and parks and playgrounds.
- **Economic Development:** Activities such as assisting in small business development and creating employment opportunities in areas with high unemployment.
- **Community Support:** Includes childcare, mentoring programs, neighborhood support groups, violence prevention, disaster readiness and public health emergency preparedness, and community disease surveillance (beyond what is required by accrediting bodies or government entities).
- **Environmental Improvements:** Activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, the safe removal or treatment of waste, and other activities to protect the community from environmental hazards.
- **Leadership Development and Training:** Includes training in conflict resolution; civic, cultural, or language skills; and medical interpreter skills for community residents.
- **Coalition Building:** Participation in community coalitions to address health and safety issues.
- **Community Health Improvement Advocacy:** Efforts to support policies and programs to safeguard or improve public health, access to health-care services, housing, the environment, and transportation.
- **Workforce Development:** Activities such as recruiting physicians and other health professionals to underserved areas and collaboration with educational institutions to train and recruit health professionals needed in the community.
- **Other:** Community building activities not described in the subcategories above.

Source: Language from Internal Revenue Service, 2016 Instructions for Schedule H (Form 990), available at www.irs.gov/pub/irs-prior/i990sh--2016.pdf.

Data

To explore community benefits and community building activities undertaken by nonprofit hospitals, we utilized data from IRS Form 990 Schedule H made available via the Community Benefits Insight (CBI) web tool.⁵ We extracted expenditures data covering tax years 2012–2016 for all hospitals in the United States⁶ using the CBI application programming interface (API), which enables users to query the CBI database. For hospitals in Third District states (Delaware, New Jersey, and Pennsylvania) that reported community building expenditures, narrative descriptions of community benefits activities for tax years 2014–2016 were drawn from each hospital’s CBI profile.⁷ Where necessary, supplementary narrative data from other sections of hospital tax filings and related published materials were reviewed. See the appendix for a fuller discussion of the data sets and methods used in this report.

Although the CBI data set is the most comprehensive publicly available source of information on hospital community benefits activities, there are several limitations to the data and analysis. One immediate challenge is the lag in public availability of Form 990 data. At the time of analysis, the most recent year of hospital tax data available for all institutions was 2016.⁸ To compensate for year-to-year variations in expenditures, we combine data from tax years 2012 to 2016. As a result, our analysis may not fully capture more recent trends and activities.

Consistent with prior analyses (Singh, Young, Lee, Song, and Alexander, 2015; Young, Chou, Alexander, Lee, and Raver, 2013), we define hospital locations as the county in which the facility⁹ is located,

⁵ Available at www.communitybenefitinsight.org/.

⁶ The CBI data set does not include information on hospitals in Puerto Rico or any U.S. territories.

⁷ Filings from earlier years were less descriptive of community benefits and community building activities.

⁸ Depending on the organization’s fiscal year, tax year 2016 may include partial year information from 2017.

⁹ The CBI data set includes short-term acute hospitals, children’s hospitals, and critical access hospitals. Outpatient service providers that are affiliated with hospitals are not counted as separate facilities.



although we acknowledge that patients may cross county boundaries to find their nearest or preferred hospital and that some hospitals may define their communities using smaller geographies (e.g., cities, zip codes) or larger, multicounty regions. For multiple facility hospital systems that file consolidated Forms 990 but have locations in different counties, we allocate reported spending based on each facility’s share of the system’s overall bed count.¹⁰ Although the CHNA process encourages hospitals to be responsive to the community needs surrounding each facility, we acknowledge that this may not result in proportional allocation of funding. Additionally, a substantial number of independent hospitals merged with other hospitals or health-care systems during the study period. We treat these as single facilities in years in which they filed Forms 990 individually and as part of multiple facility systems in years in which they joined consolidated filings.

Last, like many administrative data sets, Form 990 data can be subject to data entry error, as evidenced by instances where reported values are inconsistent

¹⁰ Leider et al. (2017) employ a similar approach, allocating community benefits expenditures based on each facility’s share of the system’s total operating costs.

with IRS guidance.¹¹ A related challenge arises from ambiguity in how different activities are accounted for and classified, particularly in the community building subcategories. Although the IRS provides detailed guidance in its Schedule H instructions, the diversity of activities that could fall under these subcategories leaves considerable room for interpretation. Despite these limitations, we believe our analysis provides a useful baseline for those seeking to better understand hospitals' community-oriented activities.

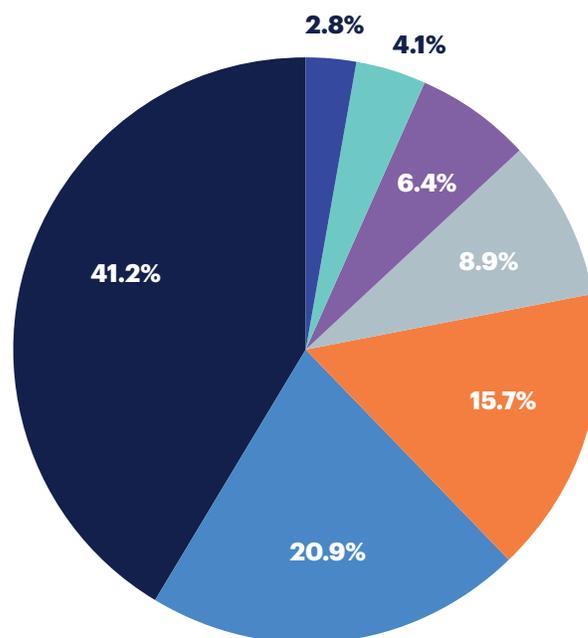
Hospital Community Benefits and Community Building Expenditures

To provide context for our analysis of community building spending, we begin this section with a brief examination of Part I community benefits expenditures. This is followed by a fuller discussion of Part II community building expenditures and how these expenditures vary across hospital characteristics and geographic areas. We analyze both community benefits and community building expenditures at the national level, with a deeper dive into community building spending in the states and regions of the Third Federal Reserve District.

Overview of Total Community Benefits Spending

From 2012 to 2016, hospitals reported over \$339 billion¹² in community benefits expenditures, averaging roughly \$67.9 billion annually. Over half of this spending was in the patient care subcategories of unreimbursed care (41.2 percent) and charity care (20.9 percent) (**Figure 1**). The next-largest spending subcategory was health professionals education (15.7 percent), which was primarily driven by teaching hospitals.¹³ A relatively small share of expenditures went toward the subcategories with the greatest potential overlap with the community development sector: community health improvement services (4.1 percent) and

FIGURE 1: AGGREGATE COMMUNITY BENEFITS SPENDING BY SUBCATEGORY, 2012–2016



- Unreimbursed Care
- Charity Care
- Health Professionals Education
- Subsidized Health Services
- Research
- Community Health Improvement Services
- Cash and In-Kind Contributions

Source: Authors' calculations using 2012–2016 IRS Form 990 data accessed via Community Benefits Insight.

¹¹ For example, some hospitals report negative values in certain expenditure subcategories, although IRS instructions indicate that the minimum value for these fields should be \$0. These are recoded to \$0 in our analysis.

¹² All dollar figures reported in 2016 dollars.

¹³ Identified by a flag in the CBI data set denoting membership in the Council of Teaching Hospitals.

FIGURE 2: AVERAGE ANNUAL COMMUNITY BENEFITS SPENDING BY HOSPITAL SIZE, 2012–2016



Source: Authors' calculations using 2012–2016 IRS Form 990 data accessed via Community Benefits Insight.

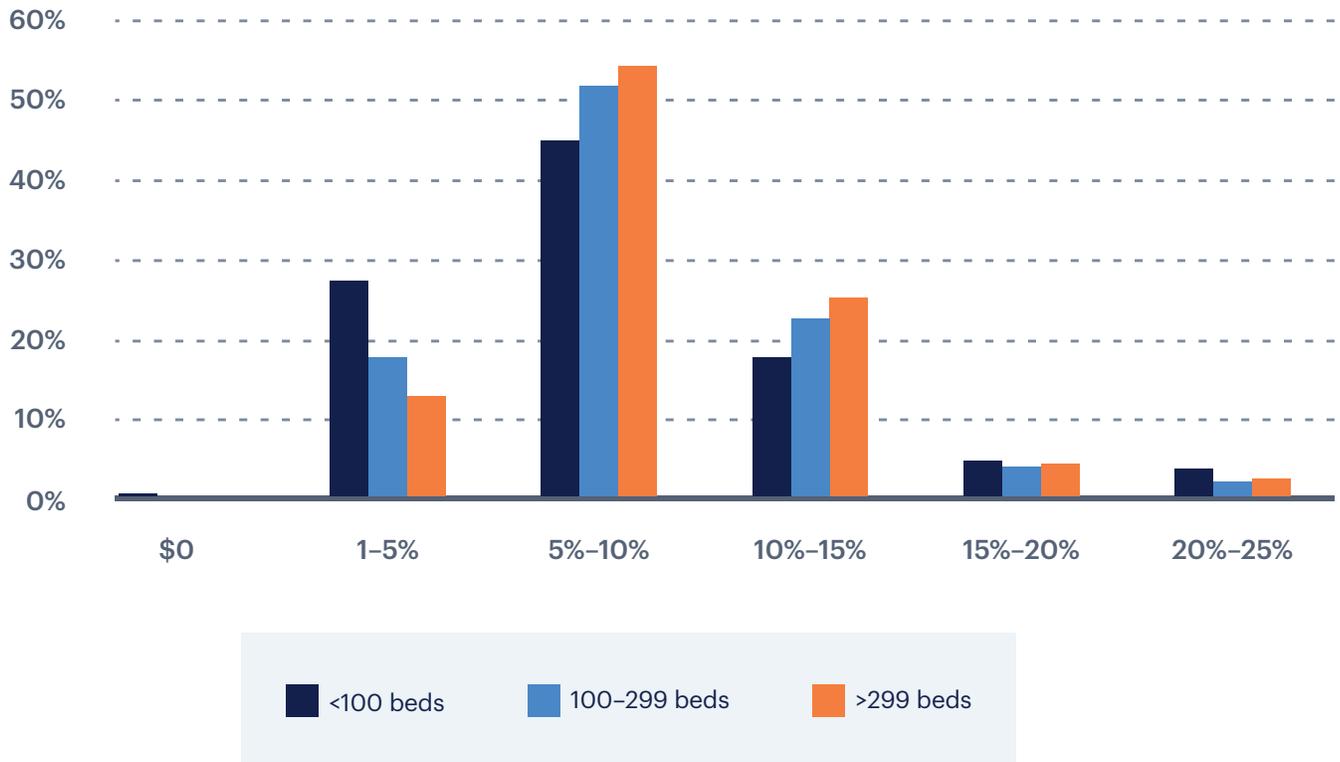
cash and in-kind contributions (2.8 percent). These expenditures typically support medically oriented health promotion programs (e.g., immunizations, community-based clinics, health fairs) but may offer opportunities for collaboration with community stakeholders. Despite accounting for a small share of overall community benefits, in aggregate these expenditures were substantial, averaging \$4.7 billion annually.

We examine average annual community benefits spending by hospital size, as defined by bed

count (**Figure 2**), and find that spending increased with hospital size; over half of small hospitals spent less than \$5 million and over half of large hospitals spent over \$20 million on community benefits activities. Smaller hospitals likely have fewer resources to allocate to community benefits activities, serve fewer patients annually, and may serve less populated areas.

For a comparison that takes into account variation in hospital budgets, we examine average annual community benefits spending as a percentage of

FIGURE 3: AVERAGE ANNUAL COMMUNITY BENEFITS SPENDING AS A PERCENTAGE OF TOTAL EXPENDITURES BY HOSPITAL SIZE, 2012–2016



Source: Authors' calculations using 2012–2016 IRS Form 990 data accessed via Community Benefits Insight.

total expenditures (Figure 3).¹⁴ While differences between large and small hospitals remain after adjusting for total expenditures, they appear much less dramatic: The majority of hospitals in each size category allocated between 5 and 15 percent of total expenditures to community benefits activities.

Overview of Community Building Spending

Our primary analysis focuses on community building expenditures to examine how much

hospitals allocate to efforts to address upstream and nonmedical factors that influence health. We start by exploring community building expenditures at the national level and then turn our attention to the states of the Third Federal Reserve District.

Unlike the community benefits expenditures discussed in the prior section, hospitals are not required to engage in community building activities, although the majority (59.1 percent) did report expenditures in this area during the study period. Still, community building spending was low in comparison with community benefits spending, averaging \$474.0 million annually during the study period, or 0.7 percent of what was spent

¹⁴ Total expenditures are the hospital's total operating expenses, including all expenses associated with operating the tax-exempt hospital. This does not include uncollected debts or income taxes. Hospitals report total operating expenses on the IRS Form 990.

TABLE 1: OVERVIEW OF AVERAGE ANNUAL COMMUNITY BUILDING SPENDING BY HOSPITAL AND LOCATION CHARACTERISTICS, 2012–2016

	Share Reporting Spending >\$0	Number Reporting Spending >\$0	Aggregate Spending (Millions)	Spending per Hospital*
Total	59.1%	1,766	\$474.0	\$268,348
Hospital Size				
<100 Beds	52.7%	693	\$60.0	\$86,641
100–299 Beds	63.2%	613	\$201.6	\$328,919
>299 Beds	65.7%	461	\$212.4	\$460,882
Context				
Urban	61.4%	1,205	\$412.9	\$342,625
Rural	54.8%	561	\$61.1	\$108,918
Reporter Type				
Single Facility	53.0%	1,040	\$338.5	\$325,264
Multiple Facility	71.0%	726	\$135.5	\$186,708
County Poverty Quintiles[†]				
1 (Lowest)	61.2%	396	\$72.5	\$183,120
2	61.3%	379	\$98.5	\$260,226
3	60.2%	407	\$97.2	\$238,984
4	55.0%	367	\$158.1	\$430,207
5 (Highest)	57.7%	218	\$47.7	\$219,159

* For hospitals in years where community building expenditures >\$0.

Note: Number of hospitals in each category may not sum to 1,766 because of rounding.

[†] Poverty quintiles defined using the share of individuals for whom poverty status is determined with incomes below the federal poverty level. Upper thresholds for each quintile are as follows: (1) 10.8 percent, (2) 14.1 percent, (3) 17.2 percent, (4) 21.2 percent, (5) 53.9 percent.

Sources: Authors' calculations using 2012–2016 IRS Form 990 data accessed via Community Benefits Insight and U.S. Census Bureau 2012–2016 American Community Survey estimates.

on community benefits activities. **Table 1** breaks out community building spending by hospital and location characteristics. As with community benefits, larger hospitals more frequently reported spending on community building activities and reported more spending on average. Compared

with their rural counterparts, a higher percentage of hospitals in urban locations reported community building expenditures and reported much higher average annual spending per facility. This is in part attributable to the generally smaller size of rural hospitals.

TABLE 2: OVERVIEW OF AVERAGE ANNUAL HOSPITAL COMMUNITY BUILDING SPENDING BY SUBCATEGORY, 2012-2016

	Share Reporting Spending >\$0	Aggregate Spending (Millions)	Share of Aggregate Community Building Spending
Community Support	39.6%	\$103.5	21.8%
Workforce Development	31.9%	\$126.6	26.7%
Coalition Building	27.8%	\$28.2	5.9%
Community Health Improvement Advocacy	26.1%	\$92.3	19.4%
Economic Development	21.7%	\$37.0	7.8%
Leadership Development and Training	15.0%	\$7.6	1.6%
Physical Improvements and Housing	12.6%	\$39.3	8.3%
Environmental Improvements	10.5%	\$8.5	1.8%
Other	10.1%	\$31.8	6.7%

Source: Authors' calculations using 2012–2016 IRS Form 990 data accessed via Community Benefits Insight.

Hospitals were defined as single or multiple facility reporters. As described previously, multiple facility reporters are hospitals with multiple locations that jointly report their community benefits and community building expenditures in consolidated Forms 990. Hospital mergers accelerated in the years following the passage of the ACA (Creswell and Abelson, 2013), leading to an increase in the number of multiple facility reporters. Following a merger, smaller, formerly standalone hospitals may retain the same name but report expenditures under a larger umbrella health system. Multiple facility hospitals more frequently reported community building expenditures than single facilities; however, average spending per facility was substantially higher among single facility reporters.¹⁵

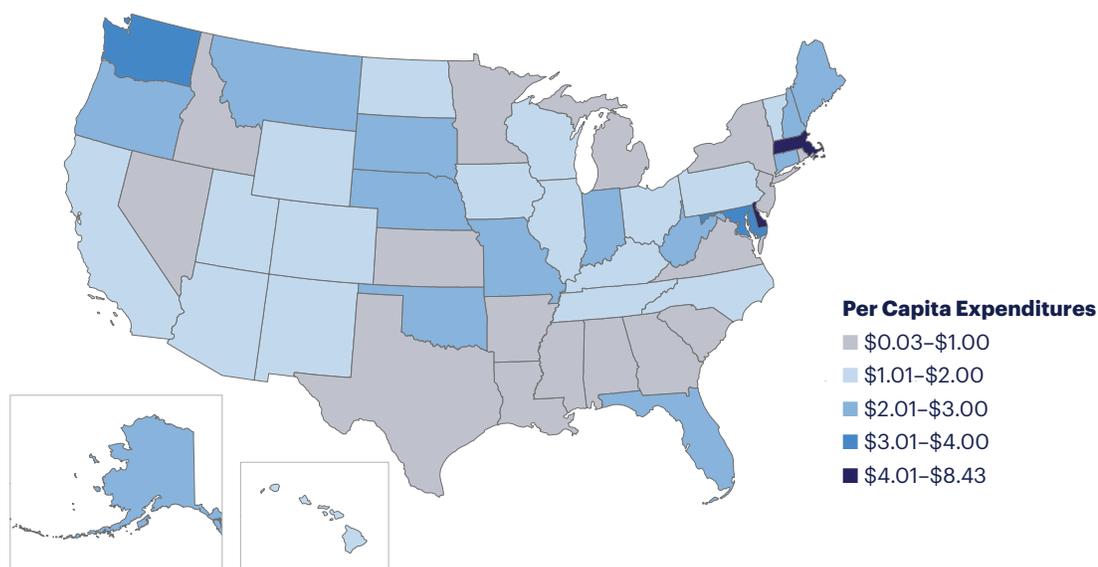
Hospitals located in higher-poverty counties less frequently reported community building

expenditures than those in medium- and low-poverty counties. However, hospitals in the second-highest poverty quintile reported much higher average spending per facility and the highest annual aggregate spending. By contrast, aggregate community building spending in the highest poverty quintile was substantially lower than that of the other four quintiles, in large part because there were fewer hospitals overall located in these counties.

The most commonly reported subcategory of community building expenditures was community support (39.6 percent), followed by workforce development (31.9 percent). More than two-thirds of aggregate community building spending was reported in the subcategories of workforce development, community support, and community health improvement advocacy (**Table 2**). Less than one-fifth of aggregate spending was allocated toward the more place-based subcategories of physical improvements and housing, economic development, and environmental improvements.

¹⁵ Some analyses report average spending per reporter, which aggregates expenditures for multiple facility reporters. In our analysis, we allocate expenditures for multiple facility reporters to their constituent hospitals based on their share of the system's bed count, resulting in a lower estimate.

FIGURE 4: AVERAGE ANNUAL PER CAPITA COMMUNITY BUILDING SPENDING BY STATE



Sources: Authors' calculations using 2012–2016 IRS Form 990 data accessed via Community Benefits Insight and U.S. Census Bureau 2012–2016 American Community Survey estimates.

TABLE 3: MSAs WITH THE 10 HIGHEST AND 10 LOWEST AVERAGE ANNUAL PER CAPITA COMMUNITY BUILDING SPENDING (100 LARGEST MSAs), 2012–2016¹⁶

Ten Highest		Ten Lowest	
Orlando-Kissimmee-Sanford, FL	\$8.58	Salt Lake City, UT	\$0.08
Tulsa, OK	\$6.40	Colorado Springs, CO	\$0.07
Seattle-Tacoma-Bellevue, WA	\$5.73	Provo-Orem, UT	\$0.07
Boston-Cambridge-Newton, MA-NH	\$5.46	Spokane-Spokane Valley, WA	\$0.07
Stockton-Lodi, CA	\$5.15	Greensboro-High Point, NC	\$0.06
New Haven-Milford, CT	\$4.57	Ogden-Clearfield, UT	\$0.04
Baltimore-Columbia-Towson, MD	\$4.05	Durham-Chapel Hill, NC	\$0.02
Hartford-West Hartford-East Hartford, CT	\$3.76	El Paso, TX	\$0.00
Lancaster, PA	\$3.68	McAllen-Edinburg-Mission, TX	\$0.00
Memphis, TN-MS-AR	\$3.61	Palm Bay-Melbourne-Titusville, FL	\$0.00

Sources: Authors' calculations using 2012–2016 IRS Form 990 data accessed via Community Benefits Insight and U.S. Census Bureau 2012–2016 American Community Survey estimates.

¹⁶ The Lakeland-Winter Haven MSA reported the highest per capita spending (\$20.75) among the 100 largest MSAs. However, the underlying spending was largely attributable to one hospital that reported lease payments to the local municipality for use of publicly owned medical facilities under the subcategory of community support. These expenditures may be more appropriately categorized as an operating expense. Accordingly, this MSA is excluded from Table 3. For more information, see www.communitybenefitinsight.org/?page=search.view.hospital&id=538&year=2016.

TABLE 4: NONMETROPOLITAN PORTIONS OF STATES WITH THE 10 HIGHEST AND 10 LOWEST AVERAGE ANNUAL PER CAPITA COMMUNITY BUILDING SPENDING, 2012–2016

Ten Highest		Ten Lowest	
Colorado	\$9.18	Florida	\$0.23
Utah	\$8.79	Hawaii	\$0.21
Oregon	\$8.17	Arizona	\$0.19
New Hampshire	\$5.26	Tennessee	\$0.16
West Virginia	\$5.12	Connecticut	\$0.14
Nebraska	\$4.65	Alabama	\$0.09
South Dakota	\$4.26	Wyoming	\$0.09
North Dakota	\$2.60	Washington	\$0.02
Maryland	\$2.51	Massachusetts	\$0.02
Maine	\$2.45	Texas	\$0.01

Sources: Authors' calculations using 2012–2016 IRS Form 990 accessed via Community Benefits Insight and U.S. Census Bureau 2012–2016 American Community Survey estimates.

Note: Nonmetropolitan areas consist of all counties in a state that are not part of an MSA. These are not necessarily contiguous areas. Three states (Delaware, New Jersey, and Rhode Island) do not have nonmetropolitan counties.

We examine average annual per capita community building expenditures at the state level and find that it ranged widely, from \$0.03 in Rhode Island to \$8.43 in Delaware (**Figure 4**).¹⁷ This variation reflects differences in both the amount of spending per hospital as well as the number of nonprofit hospitals in a given state. Nationally, annual community building spending per capita was \$1.49, similar to the \$1.57 recorded in an analysis of 2009 Form 990 data (Singh, Bakken, Kindig, and Young, 2016). Southern states generally had lower per capita spending, while the Northwest, the upper Midwest, and New England had generally higher per capita spending.

Wide variation in community building spending was visible across metropolitan statistical areas (MSAs) as well.¹⁸ **Table 3** shows the MSAs among the 100

largest in the United States with the 10 highest and 10 lowest average annual per capita community building expenditures during the study period. Although there is a notable diversity in MSA size and regions across the two lists, northeastern MSAs are more represented among those with the highest per capita spending and western MSAs more among those with the lowest. Notably, Washington and Florida include MSAs on both ends of the spectrum.

We analyze community building per capita expenditures in nonmetropolitan portions of states to observe patterns for predominantly rural communities and to compare with metropolitan areas.¹⁹ **Table 4** presents the nonmetropolitan areas with the 10 highest and 10 lowest average annual per capita expenditures. Nonmetropolitan portions of states in the West had the highest per capita expenditures, although states in New

¹⁷ See the online data appendix to this report for community building spending in each state, available at <https://philadelphiafed.org/community-development/publications/special-reports/exploring-hospital-investments-in-community-development>.

¹⁸ See the online data appendix to this report for community building spending in each MSA.

¹⁹ See the online data appendix to this report for community building spending in each nonmetropolitan portion of states.

TABLE 5: AVERAGE ANNUAL SPENDING BY COMMUNITY BUILDING SUBCATEGORY, THIRD DISTRICT STATES, 2012–2016

	Share Reporting Spending >\$0	Aggregate Spending (Thousands)
Delaware		
Community Building	62.9%	\$7,877.5
Coalition Building	34.3%	\$43.8
Community Health Improvement Advocacy	22.9%	\$629.7
Community Support	28.6%	\$62.6
Economic Development	31.4%	\$1,481.5
Environmental Improvements	0.0%	\$0.0
Leadership Development and Training	25.7%	\$72.5
Physical Improvements and Housing	5.7%	\$3.2
Workforce Development	60.0%	\$5,568.1
Other	5.7%	\$16.2
New Jersey		
Community Building	40.5%	\$8,521.0
Coalition Building	21.1%	\$372.8
Community Health Improvement Advocacy	21.4%	\$286.9
Community Support	34.4%	\$2,559.7
Economic Development	12.9%	\$98.2
Environmental Improvements	11.9%	\$237.4
Leadership Development and Training	4.4%	\$291.5
Physical Improvements and Housing	7.8%	\$656.7
Workforce Development	21.8%	\$2,513.0
Other	7.5%	\$1,504.7
Pennsylvania		
Community Building	45.9%	\$17,424.7
Coalition Building	11.5%	\$1,041.4
Community Health Improvement Advocacy	15.4%	\$4,244.0
Community Support	28.1%	\$4,278.8
Economic Development	7.2%	\$1,045.4
Environmental Improvements	1.6%	\$628.1
Leadership Development and Training	5.2%	\$225.7
Physical Improvements and Housing	4.9%	\$726.3
Workforce Development	17.4%	\$2,921.3
Other	5.9%	\$2,396.3

Source: Authors' calculations using 2012–2016 IRS Form 990 data accessed via Community Benefits Insight.

Note: The three highest subcategory values are highlighted in each column.

England and the Midwest were represented as well. Nonmetropolitan areas with low spending spanned all regions. Notably, the range in per capita spending across nonmetropolitan areas was similar to that of larger MSAs. However, unlike MSAs, nonmetropolitan counties are not necessarily contiguous, cohesive regions, suggesting there may still be significant gaps in local community building spending even where overall per capita spending is relatively high.

Third District Spotlight

In **Table 5**, we take a deeper dive into community building expenditures in Third District states.²⁰ Despite its much smaller population, annual aggregate community building spending in Delaware (\$7.9 million) approached that of New Jersey (\$8.5 million), and its per capita spending was the highest nationally. The share of Delaware hospitals reporting any community building spending (62.9 percent) was the highest among Third District states and exceeded the overall national share. As the most populated state with the largest number of hospitals among the three, Pennsylvania had the highest aggregate annual expenditures (\$17.4 million), although fewer than half of hospitals in the state (45.9 percent) reported any community building spending. An even smaller share of hospitals in New Jersey (40.5 percent) reported any community building spending. In all three states, workforce development was one of the most frequently reported spending subcategories, although the share of hospitals reporting community building expenditures and annual aggregate expenditures were substantially higher in Delaware. Spending in the subcategories of community support and community health improvement advocacy was also common across the three states.

Figure 5 illustrates the variation in per capita community building spending across MSAs and nonmetropolitan portions of Third District states. MSAs in Delaware had the highest average annual per capita spending in the Third District and were

among the highest in the nation. In New Jersey, the highest per capita spending was in the Vineland-Bridgeton MSA, while the remaining areas had much lower per capita spending, including zero community building expenditures reported in the Ocean City MSA. The highest per capita spending in Pennsylvania was reported in the Lancaster MSA. Throughout Pennsylvania, per capita spending was higher in the eastern and western areas of the state and lower across central Pennsylvania and nonmetropolitan areas.

Alignment of Hospital and Community Development Activities

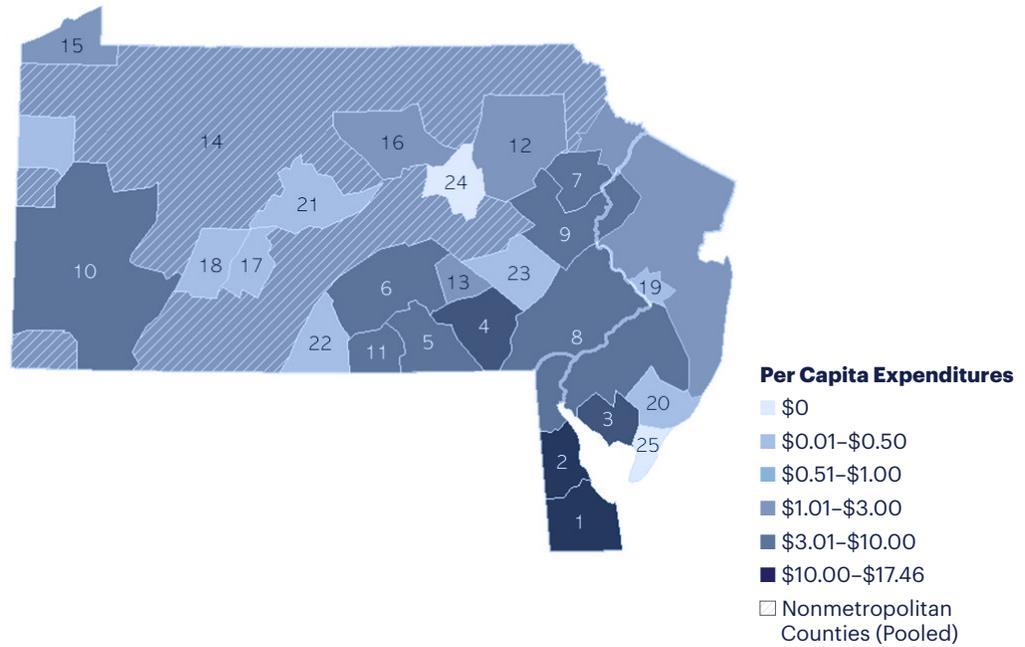
In addition to expenditures data, Schedule H of IRS form 990 asks hospitals to provide a narrative overview of the activities undertaken as part of their community benefits requirements. Although these accounts vary in their comprehensiveness, they provide valuable insights for community partners interested in pursuing collaborative community development activities with hospitals in the future. Using qualitative methods, we combed through these narratives to identify concrete examples of programs, practices, and partnerships that may inform potential collaborations between health-care systems and community development stakeholders.

Our qualitative analysis is limited to hospitals serving the states of the Third District. We further narrowed this list to hospitals that spent at least \$100,000 in a given year in community building to identify those with substantial investments in these activities. (For more information on the qualitative data set and analytical methods, see the appendix.) We omit interventions that pertain primarily to hospital-based clinical practices, improvements to hospital facilities, and standard health education or screening efforts. Instead, to home in on areas of alignment between sectors, we focus on interventions that respond to patients' and communities' broader contexts.

We categorize relevant activities based on the underlying social determinant of health addressed, using the classification system developed for the Kaiser Family Foundation by Artiga and Hinton (2018)

²⁰ These estimates include counties in New Jersey and Pennsylvania that fall outside of the Third Federal Reserve District.

FIGURE 5: METROPOLITAN STATISTICAL AREAS IN THIRD DISTRICT STATES AND NONMETROPOLITAN PORTION OF PENNSYLVANIA BY AVERAGE ANNUAL PER CAPITA COMMUNITY BUILDING SPENDING, 2012–2016



1. Salisbury, MD-DE	\$17.46	14. Nonmetropolitan PA	\$0.74
2. Dover, DE	\$12.34	15. Erie, PA	\$0.68
3. Vineland-Bridgeton, NJ	\$8.30	16. Williamsport, PA	\$0.52
4. Lancaster, PA	\$3.68	17. Altoona PA	\$0.43
5. York-Hanover, PA	\$2.63	18. Johnstown, PA	\$0.41
6. Harrisburg-Carlisle, PA	\$2.26	19. Trenton, NJ	\$0.32
7. East Stroudsburg, PA	\$1.62	20. Atlantic City-Hammonton, NJ	\$0.18
8. Philadelphia-Camden Wilmington, PA-NJ-DE-MD	\$1.52	21. State College, PA	\$0.07
9. Allentown-Bethlehem-Easton, PA-NJ	\$1.16	22. Chambersburg-Waynesboro, PA	\$0.06
10. Pittsburgh, PA	\$1.13	23. Reading, PA	\$0.03
11. Gettysburg, PA	\$1.04	24. Bloomsburg-Berwick, PA	\$0.00
12. Scranton–Wilkes-Barre–Hazleton, PA	\$0.93	25. Ocean City, NJ	\$0.00
13. Lebanon, PA	\$0.83		

Sources: Authors' calculations using 2012–2016 IRS Form 990 data accessed via Community Benefits Insight and U.S. Census Bureau 2012–2016 American Community Survey estimates.

TABLE 6: OVERVIEW OF SOCIAL DETERMINANTS OF HEALTH

Community and Social Context	Economic Stability	Education	Food	Health-Care System	Neighborhood and Physical Environment
Social integration	Employment	Literacy	Hunger	Health coverage	Housing
Support systems	Income	Language	Access to healthy options	Provider availability	Transportation
Community engagement	Expenses	Early childhood education		Provider linguistic and cultural competency	Safety
Discrimination	Debt	Vocational training			Environmental hazards
Stress	Medical bills	Higher education		Quality of care	Parks and playgrounds
	Support				Walkability
			Zip code/ geography		

Health Outcomes: Mortality, morbidity, life expectancy, health-care expenditures, health status, functional limitations

Adapted from Artiga and Hinton (2018), *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*

and depicted in **Table 6**.²¹ Within each of these six categories, we create subcategories to classify the specific interventions identified in our analysis; for example, under “Food,” providing an onsite food pantry and supporting fresh produce deliveries to vulnerable community members are grouped under “providing direct assistance for food-insecure households.” **Tables 7** through **12** summarize the findings of our qualitative analysis. To differentiate interventions that mitigate individuals’ nonmedical health risks from those with a broader community focus, we distinguish between patient-based (e.g., housing a homeless individual who frequently uses the emergency department) and community-based (e.g., increasing the supply of affordable housing in the community) activities. To be considered a community-based intervention, the beneficiaries must be a geographically or culturally defined group that is not exclusive to the patients of a particular hospital. As a result of different hospitals’ approaches

to implementation, some interventions could fall into both categories (e.g., providing onsite legal aid services to low-income patients versus funding community-based legal aid organizations).

Although we use the framework of social determinants to guide our analysis, we acknowledge that there is considerable debate among public health and health-care practitioners as to the proper use of this term (Castrucci and Auerbach, 2019; Alderwick and Gottlieb, 2019). To impact social determinants, hospitals’ activities would have to address systemic, upstream causes of poor health and health disparities, such as poverty, discrimination, educational inequality, air and water quality, and other factors (Frieden, 2010). Many of the interventions outlined in this section focus on midstream and downstream social health risks, which are also important for addressing the immediate needs of the patients and communities. Although patient-based interventions generally address downstream health risks, community-based interventions range from midstream

²¹ For our analysis, we adapt the qualitative coding methodology of Horwitz, Chang, Arcilla, and Knickman (2020).

TABLE 7: COMMUNITY AND SOCIAL CONTEXT INTERVENTIONS

Overview of Intervention	Patient-Based?	Community-Based?
Community Capacity Building		
Providing grant capital to community organizations		✓
Providing in-kind support to community organizations		✓
Community Programs		
Supporting violence prevention initiatives	✓	✓
Supporting local arts and culture programming		✓

(e.g., supporting community-based food banks and food distribution services) to upstream (e.g., expanding access to healthy, affordable food retail options in the community).

Community and Social Context

Although community context interacts with health in numerous and complex ways, collective efficacy and social supports are associated with better self-rated health and improved access to health resources (Healthy People, 2020). Hospital interventions included in this theme enhanced the ability of local actors to address community needs. While reported activities are not directly attributed to subcategories of community building, many of these interventions align with the “community support,” “coalition building,” and “leadership development” subcategories.

While it was common for hospitals to report financial contributions to partner organizations, some have formalized this process by establishing dedicated grantmaking programs or funds focused on addressing patients’ and communities’ nonmedical needs. Additionally, several hospitals described providing in-kind support to community partners, including free or discounted use of meeting or office facilities, equipment donations, and administrative support for community initiatives or programming.

“This successful summer program partnership has resulted in Wellspring-Ephrata

community hospital and Ephrata Public Library collaborating with other community partners to develop a community hub at the library. This hub will serve as a resource center for residents desiring connections with community and social service organizations located in Lancaster city, approximately 16 miles away.” (2016 Form 990, Schedule H, Part VI)

Hospital efforts to support community-based approaches to addressing social isolation and collective efficacy were less common, typically focusing instead on initiatives such as arts and culture programming. However, the COVID-19 crisis is expected to have a significant negative impact on the mental well-being of medically and economically vulnerable households (Choi, 2020), further elevating the importance of these initiatives in the near future.

Economic Stability

Health indicators such as life expectancy, infant mortality, and chronic illness are strongly correlated with socioeconomic status, with the lowest-income households experiencing the most adverse outcomes (Braveman, Cubbin, Egerter, Williams, and Pamuk, 2010; Chetty et al., 2016). Hospitals’ major presence in local economies enables them to play a meaningful role in promoting access to opportunity. Interventions included in the economic stability theme leveraged hospitals’ positions as major employers,

TABLE 8: ECONOMIC STABILITY INTERVENTIONS

Overview of Intervention	Patient-Based?	Community-Based?
Financial Security		
Supporting financial counseling and financial literacy programming	✓	✓
Job Access and Training		
Collaborating on career pipeline models		✓
Providing youth summer employment opportunities		✓
Providing on-the-job training programs		✓
Prioritizing local hiring		✓
Local Economic Development		
Engaging with local economic development initiatives		✓
Implementing supplier diversity initiatives		✓
Facilitating tech transfer for local business development		✓
Supporting Resource Access		
Establishing/investing in resource access sites		✓
Implementing onsite medical-legal partnerships	✓	

purchasers, and innovation centers. These activities align most closely with the community building subcategories of “economic development” and “workforce development.”

“A key component in the organization’s economic development strategy is supplier diversity, which is an integral part of [University of Pittsburgh Medical Center’s] overall supply chain management strategy. Designed to ensure that certified minority, women-owned, or disadvantaged business enterprises are provided with maximum opportunities to participate as partners and suppliers of goods and services, UPMC’s supplier diversity program encourages development of these firms to make them competitive in the outside market.” (2016 Form 990, Schedule H, Part VI)

For many adults, steady, high-quality employment is a prerequisite to good health (Robert Wood Johnson Foundation, 2013). As employers, hospitals offer a wide array of entry-level and midskill job opportunities. Several reported efforts to prioritize hiring from their surrounding communities, ranging from participating in local job fairs and providing job search assistance (e.g., reviewing resumes, conducting mock interviews) to more extensive engagement with the workforce development system. A number of hospitals noted their participation in “career pathways” programs, which enable participants to build skills while working and attaining progressively more advanced credentials. This model enables hospitals to both equip underemployed community members with in-demand skills and to facilitate upward mobility for incumbent workers.



“Temple University Hospital is committed to building local workforce and improving skills sets needed to deliver quality health care... About half the students are union members and half from the general community, including laid-off workers and welfare recipients. Career pathways include nursing, behavioral health, allied health, childcare, health IT...Also, through our community health worker program, we work in partnership with TU Center for Social Policy, District Council 1199c Training and Upgrading Fund, and Philadelphia Workforce

Development Corporation to develop job skills for unemployed individuals living in our community...” (2016 Form 990, Part III)

A handful of hospitals reported engaging in youth-focused initiatives, including participating in summer youth employment programs, providing stipends for summer courses, or partnering with the workforce development system on postsecondary training initiatives.

“[University of Pittsburgh Medical Center] collaborates with Urban Innovation21, providing sponsored internship training experiences for Pittsburgh Promise students. UPMC also works with the city’s Learn and Earn program to offer exploratory career experiences to local youth from at-risk areas.” (2015 Form 990, Schedule H, Part VI)

Social safety net programs that provide regular income and help defray living expenses are also critical for stabilizing the most economically vulnerable households. To assist eligible individuals in securing these supports, some health-care systems have invested in onsite or community-based resource access points.

“Christiana Care has partnered with Delaware’s Community Legal Aid Society, Inc. (CLASI) to provide free, civil legal services to low-income patients, adults and children... Some of the matters addressed through this program are safe housing, prevention of subsidized and public housing evictions, assistance obtaining or preserving income maintenance and government benefits, access to social services, appropriate educational services, health insurance, and access to health care. CLASI attorneys are located onsite at the Wilmington hospital and are integrated into health-care teams.” (2016 Form 990, Schedule H, Part V, Section C)

TABLE 9: EDUCATION INTERVENTIONS

Overview of Intervention	Patient-Based?	Community-Based?
Community Programs		
Providing financial or in-kind support for early childhood education and daycare		✓
Investing in literacy and English language programs	✓	✓
K-12 Education		
Supporting school-based wraparound services		✓
Providing financial support for local schools		✓
Vocational Programs		
Providing opportunities for health-care career exposure		✓
Expanding access to postsecondary health-care education		✓

Education

There is strong evidence that education contributes to better health outcomes, both directly and through improvements in social and economic outcomes (Hout, 2012; Lleras-Muney, 2005). Hospitals’ education-related interventions spanned pre-K through postsecondary training and the adult education system. These interventions line up with the community building subcategories of “community support” and “workforce development.”

Several hospitals reported providing subsidized preschool and daycare services. In addition to helping meet the needs of working parents, high-quality early childhood education is strongly linked to better health and economic outcomes later in life (Heckman, Pinto, and Savelyev, 2013). Many of these programs were operated onsite, with free or discounted facility use. Some were integrated into other community-based programs that offered wrap-around services to vulnerable children and families.

“IMPACT (Innovative Model for Preschool and Community Teaming), a collaboration

between [Inspira Medical Center] and the Vineland Board of Education, provides health and social services, preschool programs and literacy programs, targeting the needs of the low-income residents in Cumberland County.” (2016 Form 990, Schedule O)

Hospital engagement with K–12 systems took several different forms. Some of these interventions were direct financial contributions, most commonly payments in lieu of taxes designated for public school districts.²² Others made contributions to local charter school networks or sponsored afterschool and extracurricular activities. Health-care career exposure and exploration were also common avenues of engagement, including programs such as job shadowing, mentoring, and work-based learning programs.²³

²² In some instances, these funds were earmarked for school-based health services, which are discussed under the health-care system theme.

²³ Unlike programs included under the economic stability theme, these opportunities were generally unpaid.

TABLE 10: FOOD INTERVENTIONS

Overview of Intervention	Patient-Based?	Community-Based?
Food Security		
Providing direct assistance for food insecure households	✓	✓
Providing financial and in-kind support for community food programs		✓
Participating in coalitions to address food insecurity and hunger		✓
Food Environment		
Advocating for improved nutritional standards in educational settings		✓
Supporting the establishment and maintenance of community gardens		✓
Expanding healthy food retail options		✓

“Another program focused on high school students is the Abraham Lincoln High School/health-care pathway program. The ambulatory care services department at [Fox Chase Cancer Center] works with about 20 high school students that are considered high risk students from economically disadvantaged families. The staff teaches them nursing assistant skills in their classroom and then the students spend time at Fox Chase where they work with clinic assistants to allow them to apply the knowledge learned in the classroom to the workplace. The goal of the program is to equip the students with work ready skills and decrease the high school dropout rate.” (2016 Form 990, Schedule H, Part VI)

Food

Recognizing the importance of access to healthy foods for physical and mental well-being (Gundersen and Ziliak, 2015), several hospitals outlined strategies to address food insecurity and the dearth of healthy food options in many low-income communities. Interventions in this theme mostly pertained to the “community support,” “coalition building,” and “community health improvement advocacy” subcategories of community building.

The most commonly reported strategies were patient-based interventions to provide direct assistance for food insecure households, such as assisting with Supplemental Nutrition Assistance Program (SNAP) enrollment, providing vouchers for fresh fruits and vegetables, offering subsidized meal or grocery delivery services, and supporting onsite food pantries.

“Through a partnership with the Benefits Data Trust, a nonprofit that assists individuals obtain government benefits such as food stamps and WIC, [Children’s Hospital of Philadelphia] is trying to address household food insecurity in primary care clinics. Families with children under 5 years of age are screened by providers for household food insecurity.” (2014 Form 990, Schedule H, Part VI)

Some hospitals pursued strategies to increase healthy food access at the community level. These included efforts to expand healthy food retail options in underserved areas, such as establishing farmers’ markets and increasing the availability of fruits and vegetables in corner stores. Others invested in the capacity of local food banks, community gardens, and urban farms to improve their ability to meet community needs.

TABLE 11: HEALTH-CARE SYSTEM INTERVENTIONS

Overview of Intervention	Patient-Based?	Community-Based?
Access to Care		
Assistance with transportation to/from health-care appointments	✓	
Funding, staffing, and supporting school-based health or wellness centers	✓	
Providing onsite clinical care in homeless shelters and transitional housing settings	✓	
Community Outreach		
Supporting peer-based outreach to underserved communities		✓
Supporting community-based health insurance enrollment efforts	✓	✓

“[St. Mary Medical Center] is one of the lead member agencies in the Hunger and Nutrition Coalition (HNC). This group met monthly to develop a plan to address food insecurity in our community, which is currently 8.8 percent in Bucks County. The end result was to hold a weekly “pop-up” food market in two of the poorest areas in our county... SMMC colleagues helped with food distribution through the donation of a refrigerated food truck, bar code inventory system, and also by distributing food, sample tasting, and recipes to qualified patrons of the food market.” (2016 Form 990, Schedule H, Part VI)

“Through a community partnership grant, Wellspan-York Hospital has helped York Fresh Farms build a cold storage room to keep its harvest of locally grown food on its two urban farms fresh and readily accessible to underserved community members.” (2016 Form 990, Schedule H, Part VI)

Health-Care System

While hospitals influence many aspects of this social determinant, in keeping with the emphasis of this report, we focus on interventions that addressed community-based, nonmedical impediments to health-care access or utilization. These activities aligned with the community building subcategories

of “community support,” “leadership development,” and “community health improvement advocacy.”

Lack of affordable or reliable transportation presents a major barrier to health-care access for many low-income patients (Syed, Gerber, and Sharo, 2013), particularly those in rural and exurban communities where public transit options are limited. To address this, some hospitals brought clinical services into community settings through programs such as school-based health centers. Others coordinated transportation to medical appointments or from emergency care for vulnerable patients.

To disseminate important health information and facilitate access to services, some hospitals implemented peer-based outreach strategies that leveraged existing community networks and social capital.

“Through collaboration with a large number of faith-based communities, St. Francis Medical Center-Trenton Faith Community Nursing Initiative has provided health screenings and education to a variety of faith-based communities within the city of Trenton. We are also looking to assist these communities with identifying and training congregants to be faith community nurses in addition to developing health ministries within the congregation.” (2016 Form 990, Schedule H, Part VI)

TABLE 12: NEIGHBORHOOD AND PHYSICAL ENVIRONMENT INTERVENTIONS

Overview of Intervention	Patient-Based?	Community-Based?
Neighborhood Quality of Life		
Supporting public spaces such as parks and playgrounds		✓
Supporting street cleaning and greening services for surrounding neighborhoods		✓
Supporting efforts to improve walkability		✓
Participating in federal place-based initiatives		✓
Supporting the acquisition and rehabilitation of abandoned properties		✓
Environmental Conditions		
Investing in healthy homes initiatives	✓	
Providing leadership and advocacy for improved local air quality		✓
Housing Security		
Engagement with local housing and homelessness coalitions		✓
Supporting emergency and long-term responses to homelessness	✓	✓
Supporting the provision of affordable housing		✓

Several outreach efforts focused on barriers to care that are more prevalent in Hispanic and Latino communities, including language accessibility and addressing the impact of immigration status on insurance access (Ortega, Rodriguez, and Bustamante, 2015).

“One example of [Gettysburg Hospital’s] commitment may be found in the ongoing relationship that has been developed between our bilingual Latino health educator and Latinos residing and working in Adams County...extending beyond just the need to improve access to health care, the Latino health educator has become an integral voice in local immigration dialogues. In addition, she has, in partnership with community organizations, instituted education and outreach initiatives that connect Adams County Latinos with available resources...” (2016 Form 990, Schedule H, Part VI)

Neighborhood and Physical Environment

Housing and neighborhood conditions are increasingly recognized as having profound impacts on residents’ health and well-being (Edmonds, Braveman, Arkin, and Jutte, 2015; Taylor L., 2018). The community development sector’s extensive experience with place-based initiatives makes it an invaluable partner for hospitals looking to address these social determinants. The community building subcategories that are most closely related to these activities are “physical improvements and housing,” “environmental improvements,” “coalition building,” and “community health improvement advocacy.”

To increase the availability of safe and inviting spaces for outdoor activities, several hospitals described partnering on efforts to establish and maintain parks, playgrounds, and walkable infrastructure in their surrounding community.

“In addition to providing ongoing support and participation, [Beebe Medical Center] has been an active partner in the Walkable Bikeable Delaware campaign, working to gain funding and build out healthy infrastructure and environment for residents across [Sussex County].” (2014 Form 990, Schedule H, Part V)

“Cooper has partnered with Camden city, Camden County, and community groups on the construction of three new neighborhoods parks. Cooper has taken the responsibility for the ongoing maintenance and upkeep of the three parks.” (2016 Form 990, Schedule O)

As anchor institutions, hospitals are natural participants in federal place-based programs designed to promote comprehensive community development. For example, Cooper Hospital in Camden, New Jersey reported playing an active role in planning and implementing the Camden Promise Neighborhood, which has continued to be active beyond its initial federal funding period.²⁴

Improving the housing security of vulnerable community members was another common focus area for hospitals. The enormous expense of addressing medical conditions that arise from chronic homelessness is well documented (Culhane, 2008), and there is considerable evidence that low-barrier housing programs can be a cost-effective response (Ly and Latimer, 2015; Woodhall-Melnik and Dunn, 2016). However, even episodic homelessness or residential instability is associated with poor health outcomes (Taylor L., 2018), emphasizing the need for preventative measures as well.

“[Saint Mary Medical Center] partnered with local nonprofit organizations...to improve access to eviction prevention resources and housing and case management services for homeless or those at risk of becoming homeless: (a) provided grant support to local nonprofit organizations serving the homeless and those experiencing a housing crisis including funds for emergency shelter housing, transitional and permanent

supportive housing, (b) supported establishment of new [Bucks County] central intake center to assist with identification of the most vulnerable in need of housing..., (c) provided grant support for diversion case management for low-income families experiencing a housing crisis to prevent homelessness.” (2014 Form 990, Schedule H, Part V)

“[Inspira Medical Center] is working in collaboration with the M25 “housing first” initiative. The M25 Initiative is a nonprofit in Cumberland County, New Jersey created for the sole purpose of equipping and empowering local church and faith-based organizations to engage in an innovative housing first program to end homelessness in the community...The organization believes that this initiative has the potential to reduce costs by revealing more beneficial and cost-effective ways for vulnerable individuals to engage with public services.” (2016 Form 990, Schedule H, Part V)

Other housing-related interventions focused on neighborhood stabilization. For example, in addition to its involvement with the Camden Promise Neighborhood, Cooper Hospital reported partnering with Habitat for Humanity and St. Joseph’s Carpenter Society to acquire and rehabilitate vacant properties and build new affordable homes in the Cooper Plaza neighborhood of Camden.

Some hospitals viewed addressing health and safety hazards in the home as critical to alleviating the underlying causes of ill health. Many chronic physical and mental health conditions can be triggered or exacerbated by deteriorated housing (Krieger and Higgins, 2002; Taylor L., 2018). Hospitals leveraged their resources and medical expertise to help patients identify home-based hazards and connect them to local partners for assistance.

“The UPMC Pinnacle Lead Poisoning Prevention & Education Program (LPPEP) is a nonprofit, self-supporting, non-grant-funded

²⁴ For more information, see www.centerffs.org/promise-neighborhood/home.

program that passionately cares about the children in south central PA... When a child is diagnosed with an elevated [blood] lead level (EBL) by their physician, physician assistant, or nurse practitioner, the LPPEP will contact the parent to discuss the lead elevation and make an appointment for an environmental lead investigation...If the lead risk assessor does a home visit and recognizes any of the above, they are provided expert education, as well as referrals to assist them to correct these unhealthy home issues.” (2016 Form 990, Schedule H, Part VI)

Discussion and Implications for Practice

Nationwide, community building spending by nonprofit hospitals averaged \$474.0 million annually from 2012 to 2016, with expenditures per capita varying widely across states and metro areas. Although there is considerable variation by geography and hospital characteristics, we find that community building spending is typically lower in rural areas and the highest-poverty counties, in part because these areas have fewer hospitals but also because average per-hospital expenditures are lower than in urban areas and lower-poverty counties. Our analysis identifies gaps in community building investments but also points to opportunities for expanding collaboration with the community development sector.

Hospitals invested considerably less in community building than in core community benefits, which averaged \$67.9 billion in spending annually during the same period. Furthermore, a relatively small share of these community benefits expenditures (6.9 percent) was allocated to activities with a public health focus. There are several potential reasons why hospitals may be reluctant to invest in nonmedical interventions that address social health determinants. Hospitals may not have the in-house expertise to identify high-impact community interventions or may point to the difficulty of attributing population-level health outcomes to individual hospital initiatives. Additionally, some view these activities as outside their scope of work (Rubin, Singh, and Jacobson, 2013; Powell

et al., 2018). Hospitals may also struggle to tie utilization outcomes such as decreasing emergency department visits to upstream interventions, particularly those that yield results on extended time horizons (Hostetter and Klein, 2016). Smaller hospitals and those that disproportionately serve low-income or uninsured patients face considerable financial constraints, and a growing number of hospitals will have to navigate difficult tradeoffs as a result of the COVID-19 pandemic (Khullar, Bond, and Schpero, 2020; Kelleher, Hacke, and Steinitz, 2020).

Despite these challenges, it is clear from our analysis and prior work that hospitals have begun to implement initiatives addressing nonmedical and upstream determinants of health (Taylor et al., 2015; Horwitz, Chang, Arcilla, and Knickman, 2020; Artiga and Hinton, 2018). Some examples of upstream interventions identified in our review addressed the availability of and access to social supports, early childhood education, neighborhood amenities, housing insecurity, and access to employment opportunities. Many of these efforts address needs that are increasingly salient in the time of COVID-19.

To sustain this work through financially challenging times for both health-care providers and community partners, hospitals will need to act creatively and strategically to align resources and initiatives (Kelleher, Hacke, and Steinitz, 2020). Even prior to the emergence of COVID-19, there were calls for greater intraregional coordination of community benefits and community building activities among public health stakeholders (Powell et al., 2018; Corrigan, Fisher, and Heiser, 2015). Multisector collaborations bridging health care, public health, and community-based organizations can improve local coordination, reduce duplication of efforts, and increase funding available for high-impact, upstream interventions (Corrigan, Fisher, and Heiser, 2015; Spencer and Freda, 2016). Particularly important for resource-constrained hospitals and communities with fewer health-care providers, these types of collaborations could help attract additional philanthropic and Community Reinvestment Act-motivated capital to their regions (Kuehl, 2019; Sobel Blum, 2014). Beyond better coordination of funds, hospitals may also have the opportunity to reassess

their real estate holdings and explore opportunities to leverage excess property for community benefit (Kelleher, Hacke, and Steinitz, 2020).²⁵

For the community development sector, hospital community benefits and community building spending represent another potential resource for supporting ongoing work that contributes to community health and well-being. For hospitals, partnering with the community development sector enables them to leverage existing knowledge and resources in the community in order to maximize their impact on the social determinants of health.

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²⁵ For example, in late 2019, the New Jersey Housing and Mortgage Finance Agency rolled out a program to assist health-care systems in developing affordable housing on or in hospital-owned land or buildings (Abrams, 2019).

A selection of guides, case studies, and reports on many of the strategies and focus areas described in this report.

- **American Hospital Association:** Housing and the Role of Hospitals
- **Build Healthy Places Network, Prosperity Now and the Financial Health Network:** Fostering Healthy Neighborhoods
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Appendix: Methodology

Quantitative Analysis of Hospital Community Benefits and Community Building Spending

The purpose of this analysis is to observe patterns in hospital community benefits and community building spending across states, counties, and types of hospitals, and to identify models or opportunities for hospitals to collaborate more closely with the community development sector.

Data

The quantitative analyses of hospital community benefits expenditures use fiscal year 2012–2016 data for nonprofit hospitals from IRS Form 990 retrieved using the Community Benefits Insight (CBI) API.²⁶ The number of hospital facilities included in the analysis each year ranges from 2,820 to 3,034. CBI data are merged with 2012–2016 American Community Survey

(ACS) data in order to include county-level population and poverty rates of the hospitals' locations.

Analysis

Unless otherwise specified, expenditure figures are reported as annual averages across the 2012–2016 period. This adjustment is made to account for the variability of spending at the hospital level over time, particularly in substate geographies. Hospitals are classified into the following categories for analysis of community benefits and community building expenditures:

- **Facility Type:** Multiple facility reporters are health-care systems that encompass more than one hospital and that file joint Forms 990, reporting aggregate expenditures for all hospitals in the system. Single facility reporters are standalone hospitals that file individual Forms 990. For multiple facility reporters, reported spending is allocated at the hospital level by each hospital's share of the system's overall bed count.
- **Geography:** Hospital spending is summarized at the state, metropolitan statistical area (MSA),²⁷ or nonmetropolitan portion of state using state and county Federal Information Processing Standards (FIPS) codes. Urban/rural location is defined using the urban location flag included in the CBI data. Per capita spending is calculated using state and county population data from the 2012–2016 ACS.
- **Size:** Hospitals are grouped by bed count at the facility level.
- **County poverty quintiles:** Using ACS data, poverty quintiles²⁸ are calculated for all counties in the United States and then merged at the facility level using state and county FIPS codes.

²⁷ MSA definitions are delineated in OMB Bulletin 15-01.

²⁸ Based on ACS Table S1701: Poverty Status in the Past 12 Months.

²⁶ Available at www.communitybenefitinsight.org/.

All dollar figures are reported in 2016 dollars. Expenditures reported from 2012 to 2015 are adjusted for inflation using the Bureau of Economic Analysis annual implicit price deflators for personal consumption expenditures.

Limitations

Hospital discretion in interpreting and reporting community benefits and community building expenditures may result in inconsistencies across organizations. Additionally, there is some potential overlap between community building and community benefits activities. Hospitals are incentivized to report activities as community benefits rather than community building when an activity meets the criteria for both, since community building activities are not counted toward overall community benefits expenditures. Although this could mean that we are underestimating the amount of community building spending, the lack of a minimum community benefits expenditure standard and the ambiguity associated with reclassifying community building activities as community benefits mitigates this concern (Rosenbaum and Choucair, 2016).

Qualitative Analysis of Community Development-Related Activities

To deepen our understanding of the types of community development-related activities in which hospitals were engaged during the study period, we conduct an exploratory analysis of narrative responses provided alongside community benefits expenditure data on Schedule H of Form 990.

Data

The qualitative data set includes information extracted from tax filings for nonprofit hospitals in Third District states (Delaware, New Jersey, and Pennsylvania) that reported total community building expenditures of \$100,000 or more in tax year 2014, 2015, or 2016. Only filings from tax years in which this spending threshold was met are included in the data set. Where hospitals provided virtually identical narrative responses across multiple years, only responses for the most recent tax year are retained. The final

data set included 79 distinct filings from 42 different hospitals. Like the expenditures data, narrative responses are primarily drawn from Schedule H of Form 990,²⁹ compiled from the Community Benefits Insight hospital search tool. Where a hospital's Schedule H responses indicate that additional details could be found in supplementary materials, such as Form 990 Schedule O and community benefits statements published on hospitals' websites, these materials are added to the data set (total of four additions for three different hospitals). Although materials such as CHNAs and CHIPs are commonly referenced, these documents are outside the scope of this analysis.

Analysis

The compiled data set and supplementary materials were imported into MAXQDA, a qualitative data analysis software. Using this software, we code the narrative responses to identify activities corresponding to each category in the social determinants of health framework outlined by Artiga and Hinton (2018) (see code list that follows). We exclude activities related to clinical care, medical research, or improvements to hospital buildings or facilities. Additionally, we exclude health-related services that focused on individual behavior change and did not indicate a sustained community partnership, even if these services were occasionally integrated into a community context (e.g., providing cardiovascular health screenings at a community event). Occasionally, hospitals provide descriptions of services that are available within the community but not directly undertaken or financially supported by the organization. We do not code these activities.

To ensure consistent use of codes, a subset of files (12) were coded independently by both members of the research team and analyzed for intercoder agreement. Where the use of codes differed substantially, we discussed divergent cases, clarified definitions, and recoded the affected data.

²⁹ Specifically, Part V Sections B and C and Part VI. In some instances, Part IV of the core Form 990 also included pertinent information and was added to the data set.

Topical Codes

- **Community and Social Context:** Encompasses activities that promote community cohesion, build the capacity of community actors, or connect community members to resources.
- **Economic Stability:** Encompasses activities that stimulate local economic demand, contribute to economic mobility, or promote household financial security.
 - **Subcode: Financial Health:** Used to identify interventions to address individual or community financial distress beyond immediate medical expenses (e.g., financial counseling).
- **Education:** Encompasses hospital involvement with early childhood and K–12 education and efforts to expand access to postsecondary opportunities for nontraditional or underrepresented students.
 - **Subcode: Vocational/Job Training:** Identifies public-facing activities related to health-care career exposure and education that are not directly associated with employment opportunities.
- **Food:** Encompasses activities that address individual or community food insecurity and increase the accessibility of healthy and affordable food in underserved communities.
- **Health-Care System:** Encompasses efforts to address community-level barriers to health-care utilization, such as extending access to clinical care into community contexts (schools, emergency shelters, etc.) and conducting targeted engagement to underserved populations.
- **Neighborhood and Physical Environment:** Encompasses investments in community facilities, infrastructure, or initiatives that facilitate healthier living or mitigate environmental health hazards.
 - **Subcode: Housing:** Identifies interventions that address housing insecurity, housing quality, and the availability of affordable housing.



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