

# UC Berkeley

## UC Berkeley Electronic Theses and Dissertations

### Title

Partnerships for Community Benefit: Exploring Non-Profit Health Systems as Corporate Citizens in the Communities They Serve.

### Permalink

<https://escholarship.org/uc/item/2cb9j1k8>

### Author

Jackson, Reginald W.

### Publication Date

2012

Peer reviewed|Thesis/dissertation

**Partnerships for Community Benefit: Exploring Non-Profit Health  
Systems as Corporate Citizens in the Communities They Serve**

**By**

**Reginauld Jackson**

**A dissertation submitted in partial satisfaction of the  
requirements for the degree of**

**Doctor of Public Health**

**in the**

**Graduate Division**

**of the**

**University of California, Berkeley**

**Committee in charge:**

**Professor Stephen M. Shortell, Chair**

**Kevin Barnett**

**Thomas Rundall**

**David Vogel**

**Fall 2012**



## **Abstract**

### **Partnerships for Community Benefit: Exploring Non-Profit Health Systems as Corporate Citizens in the Communities They Serve**

**by**

**Reginauld Jackson**

**Doctor of Public Health**

**University of California, Berkeley**

**Professor Stephen M. Shortell, Chair**

The introduction of the IRS Form 990 Schedule H and the 2010 Patient Protection and Affordable and Care Act (ACA) has challenged not-for-profit (NFP) health systems and hospitals to reassess the charitable practices that afford them tax-exemption. Many NFP health systems have been prompted to reexamine their roles, contributions, and impact in the communities they serve. These organizations have begun to explore alternative means to plan and strategically provide community benefit. As the regulatory landscape changes, the decision-making of leadership around community engagement may call for more transparent community engagement and efficient strategies that target specified needs. This will ultimately affect the goals and types of partnerships that are formed with various community stakeholders.

This research examines how large not-for-profit health care delivery systems establish partnerships aimed to improve community health. It is an exploratory project that examines the types of partnerships that these organizations engage in at system and hospital levels to affect the social and environmental conditions of their communities. Case studies were built around three different types of partnerships implemented by NFP health systems and hospitals through their projects and programs with community stakeholders. Each case study analyzed what took place before and while NFP health providers implemented partnerships directed toward community health. Through cross-case analysis, the degree to which principles of community-based public health and corporate social responsibility factor into the form, structure, and purposes of those partnerships were assessed.

Based on qualitative and quantitative data, four key characteristics were found to be consistent across the three partnership strategies examined. The findings emphasize the importance of purposeful strategic planning that is aligned with an organization's mission and responsive to its market environments. They also highlight the value of stakeholder engagement that is flexible, empowered, and sustained. I explore the implications of these findings in the context of the evolving policy and market landscapes shaped by new requirements of the IRS and the ACA.

*Dedicated to Ana Helena Jackson*

*In loving honor of my mother Elaine Jackson and my daughter Ariya Jackson*

*In memory of my father, Walter S. Jackson*

*With hard work we finally crossed the finish line*

## Acknowledgements

With Gratitude to God

I would also like to acknowledge and thank:

My wife and best friend, Ana Helena Jackson

My supportive and inspirational  
family, friends, and mentors:

Elaine and Ariya Jackson,  
Shelley and Anika Jackson,  
Gerry Battley, Virginia Bennett, and Lena Kirby,  
Howard and Barbara Traylor  
Rahn Gatewood, JD and Jim Meyers, DrPH

My thesis chair, Stephen Shortell and my advisors  
Kevin Barnett, Thomas Rundall, and David Vogel  
for providing invaluable guidance and support

Also a handful of local public health and healthcare leaders including:  
Sandra Dratler, Abby Rincón, Elize Brown, Jean Nudelman,  
Eileen Barsi, Pablo Bravo, and Susan Vickers  
for helping me along this journey

## Contents

Figures & Tables	p. iv
Chapter 1 Introduction	p. 1
Chapter 2 Organizational Decision-Making and Stakeholder Engagement for Community Impact: A Not-For-Profit Hospital Perspective	p. 22
Chapter 3 Community Benefit: The California Picture	p. 39
Chapter 4 Methodology	p. 55
Chapter 5 Case 1: Community Partnerships	p. 62
Chapter 6 Case 2: Community Investments	p. 79
Chapter 7 Case 3: Grant-Making	p. 101
Chapter 8 Multi-Case Analysis and Ladder of Partner Participation	p. 122
Chapter 9 Conclusion: A Review of Key Points and Next Steps	p. 139
Works Cited	p. 147
Appendices	p. 155

# Figures & Tables

## Figures

### Chapter 1

- 1.1 Research Outline
- 1.2 Relationships Between Research Questions
- 1.3 Risk-Opportunity Continuum and Spectrum of Corporate Social Responsibility
- 1.4 Frameworks and Actions to Investigate NFP Health Systems as Corporate Citizens partnering to impact social/environmental conditions
- 1.5 Proposed Ladder of Partnership Participation
- 1.6 Conceptualization of Sustainable Development
- 1.7 Ladder of Community Participation
- 1.8 Hypothetical Ladder of Partnership Participation
- 1.9 Research Outline (revisited)
- 1.10 The Role of Partnerships from Different Perspectives

### Chapter 2

- 2.1 Strategic Planning for Community Benefit
- 2.2 Impact of Socially Responsible Principles and Stakeholder Engagement on Strategic Planning for Community Benefit
- 2.3 Market Failure and Zones of Opportunity/Disaster

### Chapter 3

- 3.1 Spectrum of Health System Community Benefit
- 3.2 Spectrum of Health System Community Benefit and Community Building Activities
- 3.3 Community Benefit Planning and Programming Process
- 3.4 Community Benefit Planning and Programming Process (revisited)
- 3.5 Spectrum of Health System Community Health Impact and Socially Responsible Activities

### Chapter 4

- 4.1 Application of Conceptual Frameworks to NFP Health System Strategies and Purposes
- 4.2 Research Design

### Chapter 5

- 5.1 Network of Overlapping Partnership Environments
- 5.2 Advantages and Challenges to Community Partnerships Model

### Chapter 6

- 6.1 Advantages and Challenges to Community Investments Model



## Chapter 7

### 7.1 Advantages and Challenges to Grant-Making Model

## Chapter 8

### 8.1 Organizational Hierarchy of Power

### 8.2 Correlation Between Power-Sharing and Managerial Discretion

### 8.3 Individual Relationship Scores by Case Study

### 8.4 Composite Relationship Variable Scores for All Case Studies

### 8.5 Composite Relationship Scores by Case Study

### 8.6 Ladder of Partnership Participation with Case Study Relationship Scores

### 8.7 Updated Ladder of Partnership Participation

### 8.8 Spectrum of Health System Community Benefit and Ladder of Partnership Participation

### 8.9 Relationship Between Degree of Stakeholder Engagement and Organizational Risk

### 8.10 Spectrum of Corporate Social Responsibility and Ladder of Partnership Participation

## Tables

## Chapter 2

### 2.1 Variables That Define Degrees of Freedom

### 2.2 Programs That May Account for Community Benefit Activity

## Chapter 5

### 5.1 Case Department Community Partners

## Chapter 6

### 6.1 Financial Ratios Used to Assess Borrowers

## Chapter 7

### 7.1 Case Department Grant Support

### 7.2 Case Department Safety Net Provider Partners

## Chapter 8

### 8.1 Promising Practices to Resolve Resource Constraints that Threaten Community Benefit Partnerships' Ability to Achieve Shared Goals

### 8.2 Case Studies' Partnership Design and Objectives

### 8.3 Key Business Drivers

### 8.4 Practices to Take Into Account Sensitive Stakeholder Relationships

### 8.5 Key Relationship Components

# **Partnerships for Community Benefit: Exploring Non-Profit Health Systems as Corporate Citizens in the Communities They Serve.**

**“...to make a difference in the lives of those served by this large health system.” – Richard L. Clark, President & CEO Healthcare Financial Management Association**

## **Introduction**

Since 1969, health systems and hospitals seeking exemption from federal taxation have had to demonstrate a provision of a charitable public good for communities as a whole. Exemption is based on the principle that “government’s loss of tax revenue is offset by its relief from financial burdens that it would otherwise have to meet with appropriations from public funds, and by the benefits resulting from the promotion of general welfare.” (GAO, 2008). Health systems and hospitals that have not met this standard have had their tax-exemption status challenged and in some cases revoked (New York Times, 1986; Singer, 1997). Of those organizations that have chosen to maintain tax-exempt status, they have dedicated resources toward the promotion of health and well-being in the communities they serve.

In order to achieve this, many not-for-profit (NFP) health systems and hospitals partner with community and other organizations to implement service programs and perform other activities that will benefit the community; particularly community-building activities. A partnership in this context is any type of collaboration that consists of organizations working together to improve health, social, or environmental conditions (Mitchell, 2000). Partnerships that NFP health systems and hospitals engage in to provide this form of community benefit may target: economic development, environmental improvements, physical conditions, or social support amongst others. Examples of these partnerships include, but are not limited to: neighborhood improvement and revitalization projects; funding or investing in small business development; hospital representation in community coalitions; providing community-based clinical services; training community health workers; internal and external programs to reduce environmental hazards; projects to improve the built environment; and workforce volunteer programs.

There have been considerable differences in how NFP health systems and hospitals have defined and provided community benefit to gain tax-exempt status. Until recently defining these practices has been largely left to the discretion of these institutions. Most hospitals use federal guidelines as parameters for their activities. In 2007, Congress began considering reforms to the community benefit standard in order to establish more consistent definitions, measures, and transparency (US Senate, Committee on Finance, 2007). Later that year a redesigned tax-exemption Internal Revenue Service (IRS) Form 990 Schedule H was released with regulators citing a need to “keep pace with changes in the law and with the increasing size, diversity, and complexity of the exempt sector” (IRS, 2007). The introduction of the revised IRS Form 990 calls for NFP hospitals to report on conventional community benefit provision, as well as their community health improvement and building efforts. This represents a shift in policy that is calling for increased transparency in NFP health systems’ community benefit practices.

See Appendices A through C for a review of the evolution of community benefit and recent laws calling for increased transparency in business practices.

The underlying question that NFP health systems' leaders must ask themselves in light of the new reporting standard is what role their organization should assume in the communities they serve. As NFP organizations, these institutions must balance the demands of their mission-driven services in light of these new regulations as well as the market based demands of sustaining an operable business. The question of how to best serve as stewards of community resources, given the tremendous resource constraints most businesses face with the current economic environment, is one that most NFP health systems and hospitals have continued to address. In practice, this primarily involves determining how to optimally balance organizations' community engagement decision-making and strategies with their impact on the institutions' relationships with stakeholders. With this in mind, NFP health systems and hospitals will have to strategically examine the partnerships that they engage in with different stakeholders to achieve social and environmental impact.

### Proposal

This thesis introduces my investigation into the relationships that not-for-profit health systems initiate as corporate citizens in their communities. My project aims to conduct exploratory research into the types of partnerships that these systems engage in at system and hospital levels to affect the social and environmental conditions of their communities.

Not-for-profit health systems and hospitals have a significant impact on the social and environmental conditions of their communities, aside from customary community benefit obligations such as charity care or assuming bad debt. This research advances the current community benefit discussion by focusing on partnerships and their effect on social and environmental conditions that cut across other fields of interest namely, community partnerships, corporate citizenship, and sustainable development. I will build three case studies around the different types of partnerships implemented by these organizations through their projects and programs with community stakeholders and other organizations. Through cross-case analysis, I will assess the degree to which principles of community-based public health and corporate social responsibility factor into the form, structure, and purposes of those partnerships.

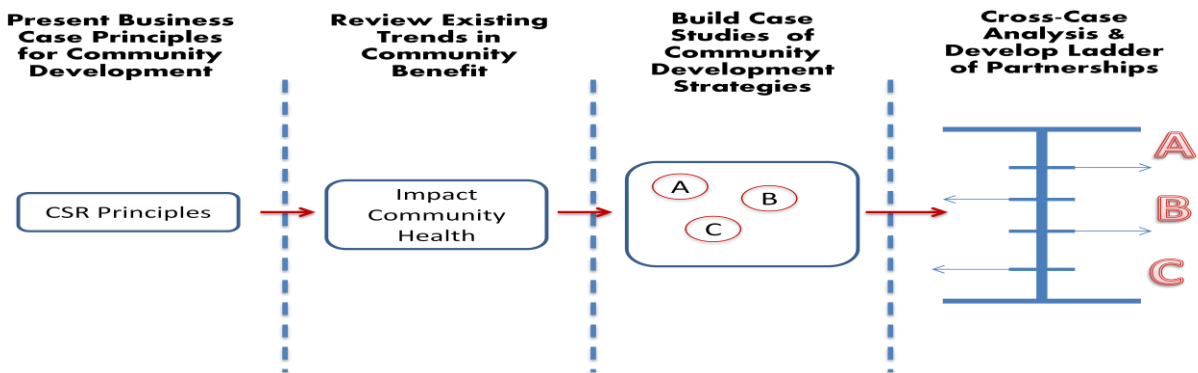


Figure 1.1

It is my hope that this research will inform discussions regarding: how organizations can strategically achieve social and environmental impact; what constitutes community benefit for NFP healthcare providers; and identifying key components for organizations to consider when implementing partnerships with environmental/social impact goals.

### Significance

The introduction of Schedule H to the Internal Revenue Code Form 990 in 2008 brought with it a formal examination of which practices are being reported as community benefit for not-for-profit health systems and hospitals that have been granted tax-exempt status. Schedule H has now called for NFP health systems and hospitals to rigorously assess and report their community benefit practices, including the impact that these efforts have on the conditions of the communities they serve. Currently there is no uniform agreement regarding what constitutes acceptable community benefit. This has blurred the distinction on criteria traditionally used to distinguish NFP hospitals from their for-profit (FP) counterparts. It follows that the findings from Schedule H reporting will significantly impact what community benefit practices should and should not count as appropriate for tax-exempt status. Of equal significance as the Schedule H reporting requirements are the conditions under which they were introduced. In defining the calculation of community development activities' expenditures, it is argued that the IRS has marginalized the value of these efforts. Early versions of Schedule H did not include costs associated with community development in the numerator of calculating community benefit but were included in the denominator. This would lead to a diminished percentage of community development activities expenses that could be reported for community benefit (Gray, 2010). In 2011, the IRS added language to Schedule H that allows hospitals to include some community development activities in their calculation of community benefit costs (IRS, 2011). However, which community building activities can be charged as community benefit costs dependent on their link to the improved health of populations and communities remains to be seen. The direction that community benefit practices take as a result of this policy crossroads will influence NFP health providers' strategies to affect community conditions and ultimately their ability to meet tax-exempt status requirements.

The 2010 Patient Protection and Affordable Care Act (ACA) has also contributed additional requirements on NFP health systems and hospitals regarding their community benefit practices. Many of the changes expected with health care reform have considerable implications on these institutions' decision-making towards strategic planning and forming partnerships. It is expected that the Affordable Care Act will call for increased coverage of previously uninsured residents, a shift in reimbursement structures that will incentivize preventive care, and – as it directly pertains to community benefit – specify requirements for community health needs assessments and community stakeholder engagement. All of these standards may prompt modifications in how community benefit is delivered. NFP hospitals that once accounted for charity care and some preventive services and programs as community benefit may have to explore alternative practices as the pool of uninsured will decrease and their preventive services will be ultimately subsidized. Additionally, decision-making around community

engagement may call for new community engagement strategies for NFP hospitals. They will be required to transparently engage and document local stakeholders for identifying and addressing community needs in accordance with the ACA. This will affect the goals and types of partnerships that are formed with other health providers, clinics, and community stakeholders.

#### Fit Within Current Discussions

The uncertainty surrounding what constitutes tax-exempt qualifying community benefit presents an opportunity for NFP health systems and hospitals across the country to make the case for which activities are most important and meaningful. Of particular interest is Part II of Schedule H which allows for reporting on community development activities but not the costs associated with them. At the heart of this section is the question of how NFP health providers contribute to the social and environmental health conditions of the communities they serve. Managing resources set aside by organizations to be contributed to the sustainable development of their local, regional, or global communities is an issue of liability that cuts across considerable businesses NFP and FP alike (for a discussion of profit-distribution structures' and their liabilities see Appendix D). This conversation extends into exploring best practices for organizations to engage and partner with community stakeholders to achieve positive social and environmental impact. Organizations' efforts to achieve social and environmental impact in communities will be defined as investment in sustainable development. Impact in this context is defined as affecting the social and environmental determinants of well-being and quality of life. The rationale and strategies for engaging in these community partnerships can inform an array of organizational managers across a multitude of sectors looking to achieve optimal results from their stakeholder engagement practices.

#### **Problem Statement**

There are limited established management models, guidelines, or best practices that not-for-profit health system leaders can use to inform how new partnerships with community-based or private organizations should be developed.

Organizations across a multitude of sectors are exploring ways to better channel their resources toward developing the communities in which they operate. These institutions can use guidance when determining how involved they will be in partnerships, prior to engaging in them, when they want to be deliberate in improving community conditions. I want to know how NFP health systems approach improving community conditions through the partnerships they form with other organizations working in and with those communities. It is important to explore this because the issue of how organizations can better engage in and serve communities is arising across diverse fields from organizational governance, corporate social responsibility, tax-exemption of not-for-profit organizations, and the provision of community benefit by NFP health systems.

## **Study Purpose**

The purpose of this research is to begin to fill the gap in our knowledge of implementing health system and hospital partnerships with community-based public and private organizations to produce community benefit.

## **Goals & Rationale of Research**

This research explores how three specific NFP health systems and hospitals approach the improvement of community conditions through the partnerships they form with other organizations that work with those communities. I have chosen these NFP institutions as the sites for my case studies because they fit criteria of being corporate citizens that affect their communities socially and environmentally. “Corporate citizenship activities readily available to NFP health systems include: participating in community development banking, making financial investments in a community, making site selections decisions that advantage underserved neighborhoods, training and using underutilized workers; and practicing outright philanthropy in a community” (Longest, 2002). NFP health systems have also been found to be more likely to go beyond the minimal requirements for community benefit, offering richer examples of practices to explore (Schlesinger, 2004). Given their similarities, NFP health systems can provide a paradigm for FP businesses looking to operate as corporate citizens as their system-wide approaches to comprehensive social and environmental impact are similar. In addition, the introduction of Schedule H has presented an opportunity to broaden the discussion regarding the provision of community benefit. Documentation of NFP health systems’ community building efforts within a defined framework as corporate citizens can help to inform this discussion.

## **Research Objectives**

### **1. Contribute to an expanded definition of community benefit.**

NFP organizations with access to considerable financial and personnel resources, in particular, play significant roles in improving the conditions of the communities they serve. In addition to the provision of social programs that stem from their missions, these resource-rich NFP’s are businesses that may: serve as employers, affect the built environment, leave environmental footprints, affect local policy, or invest in community improvement activities. The contributions that these organizations make to their communities are not limited to conventional community benefit practices, they are also achieved through the many other interactions NFP’s have with communities and the organizations that affect them. My proposed case studies will illustrate these practices as they are performed for the purpose of providing community benefit.

### **2. Introduce a typology of health system – community-based/private organization partnerships**

My research will draw from corporate social responsibility (CSR) literature to identify key resource allocation decisions of NFP health care organizations. A CSR framework will be integrated with my new model of partnership types that is grounded in principles of a community-based public health (CBPH) framework. These principles propose the balances of trust, power, and accountability within partnerships necessary for

institutions to effectively engage in community development efforts. Together, these two frameworks will: 1) guide my exploration of the resource allocation, power, trust, and accountability dynamics that exist between organizations and their partners to achieve social and environmental impact and 2) will also inform my proposed Ladder of Partnership Participation. Exploration of these partnership types may help organizations' decision-makers to be more strategic in how they approach their partnerships oriented toward achieving social and environmental impact.

3. Present case studies of partnership types

My proposed research will develop a typology of 3 types of partnerships that occur between organizations and communities. I will apply this typology to existing partnerships through three case studies from local San Francisco Bay Area health systems. Qualitative and quantitative data was collected from interviews, document reviews, and surveys. The findings from analysis of this data will: serve to demonstrate promising practices for organizations to improve local community health as corporate citizens; provide insight into how CSR concepts are reflected in NFP healthcare system practices; explore the boundaries of community benefit requirements for NFP hospitals and health systems; and validate the applicability of a new partnership typology to the NFP organizational setting.

4. Identify forms, structures, and purposes of each partnership examined

I expect organization-community partnerships with different goals to consist of varying forms, structures, and purposes relative to what the partners intend to achieve. I will identify these for each case study.

5. Analyze case studies to:

- a. assess degrees of power-sharing, trust, and accountability
- b. identify decision-making practices raised by resource constraints within NFP health systems prior to engaging in these partnerships.

I believe that there are best practices for organizations to engage with communities by implementing partnerships that take into consideration the sensitive power, trust, and accountability dynamics that typically exist between these types of partners. I am particularly interested in how trust, power, and accountability considerations are factored into organizations' decisions to implement different partnerships with community stakeholders.

6. Synthesize what is learned in objectives 1-5 to identify promising practices in stakeholder engagement, power-sharing, trust building, accountability, and resource constraint resolution for each type of partnership.

I propose that corporate social responsibility and community-based public health frameworks, when combined, can provide useful perspectives into implementing purposeful partnerships in communities that balance financial, social, and economic concerns. Identifying key resource allocation principles and integrating them into

different types of organizational-stakeholder partnerships will illuminate promising practices to be strategic and deliberate about having a social and environmental impact.

## Research Questions

### Primary Question:

How do large not-for-profit health care delivery systems establish partnerships with public and private organizations aimed to improve community health?

### Secondary Questions:

- What are the forms, structures, and purposes of these partnerships?
- In what ways do trust, power-sharing, and accountability vary by different types of partnerships?
- For each type of partnership, what are the best practices for dealing with issues raised by resource constraints that threaten the ability of the partnership to achieve shared goals?

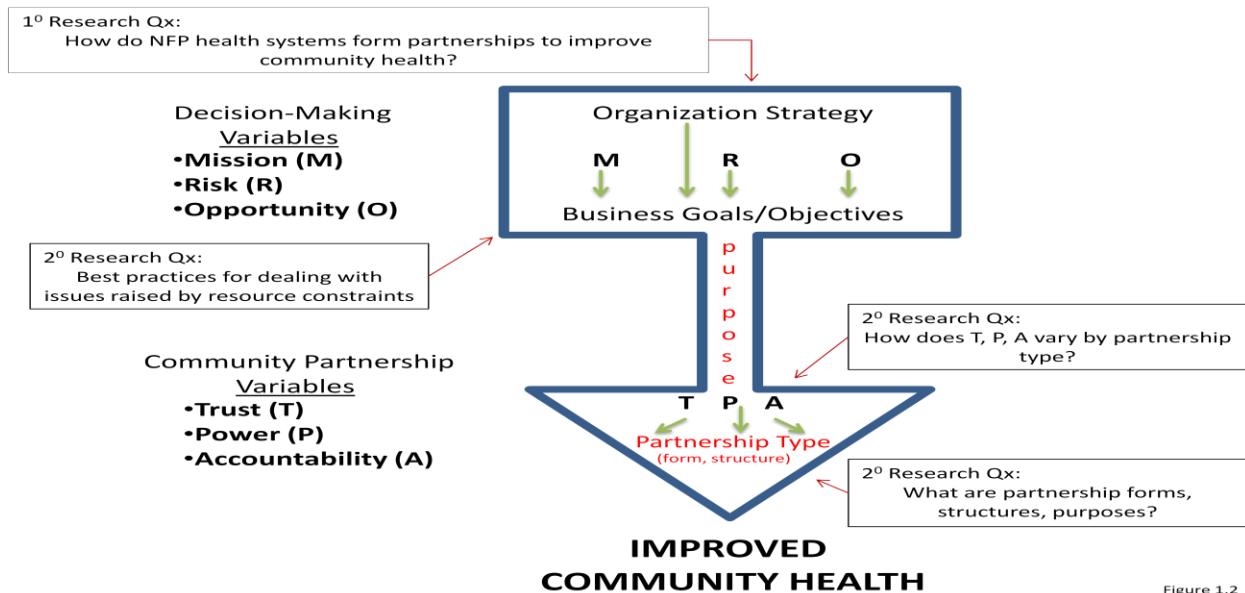


Figure 1.2

This research will be exploratory and inform the community benefit discussion. I will analyze what takes place before and while NFP health providers implement partnerships directed toward improved community health. My research will compare these practices against what is suggested in corporate citizenship and community partnership literature and models. I hope to illuminate community/sustainable development examples and how organizations choose to do them to improve community health.

## Conceptual Frameworks

### Risk-Opportunity Continuum for Organizations

The contributions of NFP health systems and hospitals to communities are often isolated within the realm of community benefit. A corporate social responsibility framework suggests that



there are other ways that institutions contribute to the sustainable development of these communities. I will investigate not-for-profit healthcare systems through the lens of corporate citizenship as informed by existing corporate social responsibility literature. This field predicts that organizations looking to make an impact on local conditions will take their own economic, as well as, various stakeholders' social and environmental considerations into account. These considerations are expected to influence where an organization's decisions fall along a risk-opportunity continuum; where managers take action from protecting their organization against external risk by using core assets to improve their underlying business context (SustainAbility, 2004).

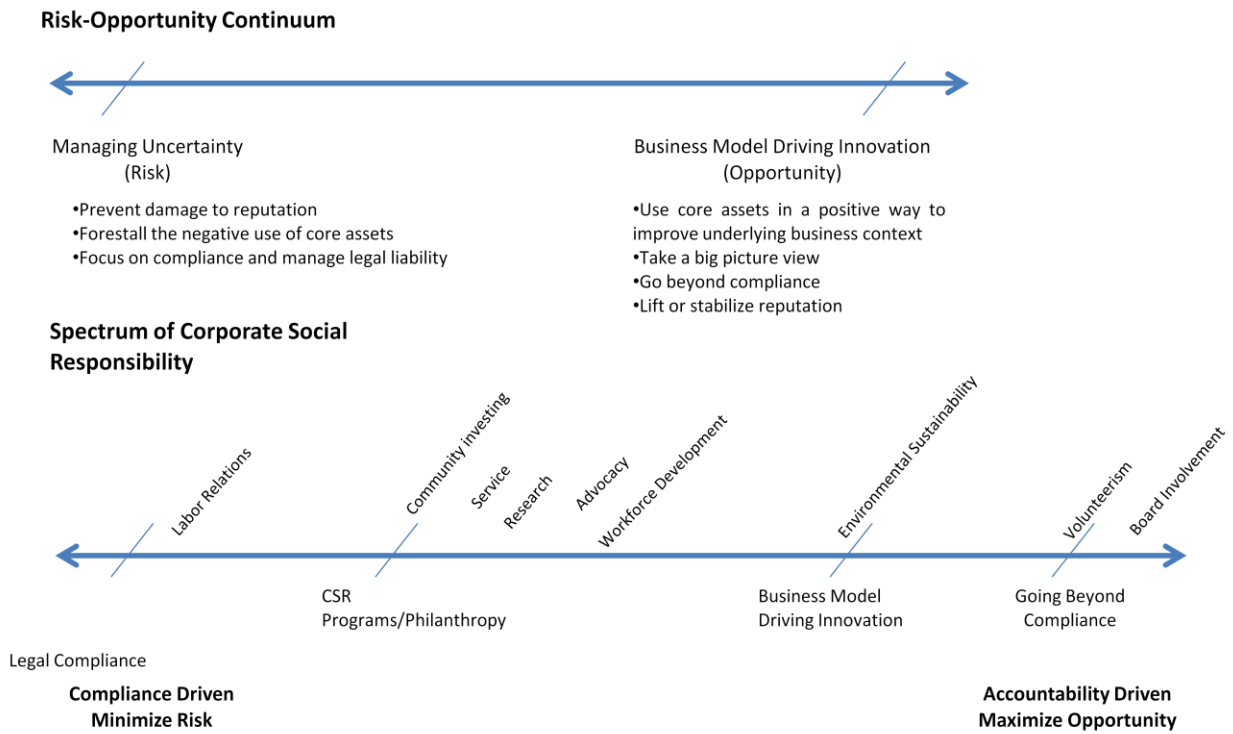


Figure 1.3

Figure 1.3 above illustrates the risk-opportunity continuum described and then shows where businesses' actions fall relative to that range of socially responsible activities (Mackness, 2008). The factors involved in managerial decision-making illustrated in this literature will guide my identification of key principles investigated in each case study.

This project will also draw from principles of community-based public health that propose levels of trust, balances of power, and levels of accountability necessary for institutions to effectively engage in community development efforts. CBPH is a community participatory action approach that promotes the inclusion of and partnering with stakeholders including residents and organizations. It is grounded in the assumption that stakeholders are more likely to participate and outcomes achieved if they participate in defining the local agenda (Casey, 2007). Figure 1.4 illustrates how these frameworks will be applied to review NFP hospital's partnerships to provide community benefit.

**Frameworks and actions to investigate NFP health systems as corporate citizens partnering to impact social/environmental conditions**

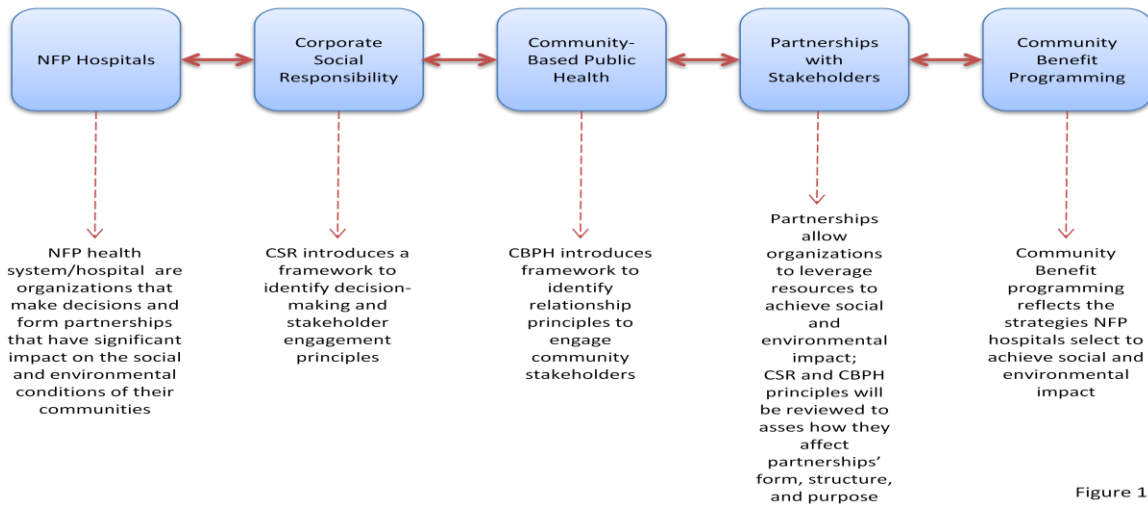


Figure 1.4

**A CBPH-based Model for Organizations**

In 2006, The Ladder of Community Participation was published to serve as a model to depict different typologies of institutional-stakeholder partnerships that take CBPH principles into account (Morgan, 2006). I have worked with the architects of this model and other professional practitioners to adapt a version suitable for large, resource-rich NFP health systems and hospitals. This proposed Ladder of Partnership Participation aims to illustrate the degree to which trust, power-sharing, and accountability vary by different partnerships between organizations and stakeholders (see figure 1.5). It is proposed that CBPH principles are more integrated into organization-community partnerships as they are located higher up the Ladder.

***Proposed Ladder of Partnership Participation***

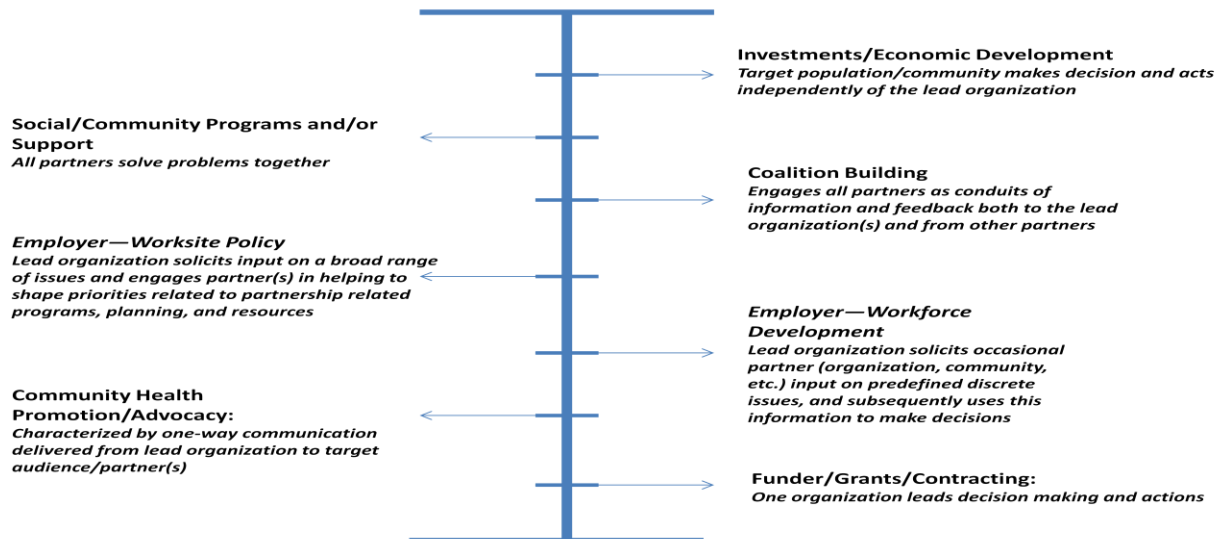


Figure 1.5

(For an illustration and discussion of the intersection of the Risk-Opportunity Continuum and Ladder of Partnership Participation models see Appendix E.)

## **Organizations**

### Organizations and Community Health

As institutions realize the challenges that have arisen in the nation's financial, housing, and health care markets, it is becoming apparent that complex social problems call for dynamic responses coordinated across multiple sectors (Peloza, 2009). There has been a concentrated effort by organizations, for-profit and not-for-profit alike, to seek ways to offset the systematic underinvestment in disadvantaged communities that has led to unhealthy physical and social environments (Jones, 2000). Both FP and NFP organizations grapple with these issues as their efforts to have a positive impact on communities are often met with mixed results. Having an impact on the health of a community calls for managing complicated issues across an array of socio-political contexts. Community health problems can stem from violence, the built environment, and unemployment, for example, all of which are rooted in shortcomings at individual, communal, and systematic levels. Population health issues such as the prevalence of chronic diseases, health disparities, or healthy behaviors also follow this pattern as they often result from multiple breakdowns across a continuum of social levels. Unchecked, these social ills will worsen and compound upon themselves, making the task of ultimately untangling them difficult. In light of these circumstances, organizations have looked at how to establish healthy and functional relationships in the communities they are located in and/or serve. They have achieved this by infusing financial, knowledge, and labor-related resources into rebuilding these areas' infrastructures. (For a brief history of the scholarly examination of organizations' relationships with communities see Appendix F.)

### Organizations and Corporate Social Responsibility

Corporate social responsibility describes the field through which academics and managers explore why and how organizations interact with communities. In its broadest categories, CSR typically includes issues related to: business ethics, community investment, environment, governance, human rights, the marketplace, and the workplace (Business for Social Responsibility, 2003). Despite discussion and investigation into CSR for the last 50 years, there is still no set agreed upon definition of the term. This is due in part to the range of theories and applications of CSR that have grown from the different conditions, cultures, and purposes under which these organizations operate. To provide a general idea of the term's implications, CSR will be defined as "the social responsibility of business [to] encompass the economic, legal, ethical, and discretionary expectations that society has of [that] organization at a given point in time" (Carroll, 1970). As it relates to social and environmental impact, CSR is "a discretionary allocation of corporate resources toward improving social welfare that serves as a means of enhancing relationships with key stakeholders" (Barnett, 2007). It implies that, other than shareholders, companies are also responsible to other stakeholders including: workers, suppliers, environmentalists, and communities (Doh, 2006).

The field of corporate social responsibility has consequentially developed to account for the implications of which roles businesses should assume in society. A review of the theories that

developed in the field of CSR has suggested that four groupings of theories categorized these interactions (Garriga, 2004). These theories have been categorized as: instrumental, political, integrative, and ethical. This work has concluded that:

...most of [the] current CSR theories are focused on four main aspects: (1) meeting objectives that produce long-term profits, (2) using business power in a responsible way, (3) integrating social demands and (4) contributing to a good society by doing what is ethically correct.

(Garriga, 2004)

Each of these perspectives presents essential considerations that should be taken into account when creating a framework for resource allocation decisions for organizations interacting with communities. The literature shows that business will operate to maximize shareholder (and in some instances stakeholder) value; they operate within the context of society and their presence affects the communities in which they operate; they respond to demands from society; and finally business practices can be implemented by means that can improve the conditions of the communities they work in or serve. These theories take into account an underlying assumption that the communities in which organizations are located are critical support structures for those businesses and are essential to those businesses' sustainability. This has been referred to as the enlightened self-interest model, proposed by Wallich and McGowan in 1970 who suggest that it is in the "long-term interests [of] stakeholders to be socially minded" which strengthens the environment to which organizations belong (Lee, 2008).

The research described in this study furthers the proposition that components of these four dimensions are integrated in characterizing the interactions between organizations and their communities. I draw from different aspects of these CSR theories, specifically those regarding corporate citizenship, social and environmental impact, and community relations. Organizations' social and environmental impact on their communities has been demonstrated through philanthropic donations, workforce development, green building, and other avenues that are grounded in differing degrees of these dimensions. These suggest that businesses have power in society and a responsibility to their local communities and their conditions. This responsibility entails responsiveness to communities' evolving sets of values and needs.

#### Organizations and Sustainable Development

"Any meaningful accountability framework that takes sustainable development as its starting point will need to address centrally how decisions are made, and by whom, or in other words questions of governance." Simon Zadek, 2007

Simon Zadek defines the practice of organizations' efforts to invest in communities as sustainable development. Sustainable development, similar to community development for NFP health systems, is accomplished within the constraints of organizational resource capacities to achieve social and/or environmental impact. This can be visualized in the format of three interlocking spheres of:

- Economic: the creation of material wealth (including financial income and assets of the company)
- Social: the quality of people’s lives, particularly equity between people and communities
- Environmental: protection and conservation of the natural environment

(Zadek, 2007)

### Conceptualization of Sustainable Development

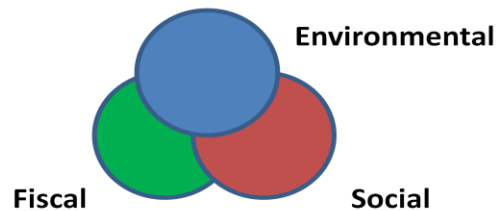


Figure 1.6

Conceptually, sustainable development is a balance of interdependent economic, social, and environmental effects as Figure 1.6 illustrates. Managing this balance fosters a “business approach that creates long-term shareholder value by embracing opportunities and managing risks that come from economic, environmental, and social developments” (Dow Jones Sustainability Index, 2003). This perspective implies that there is a trade-off that occurs between these different forms of “capital” for an organization. The extent to which managers engage in sustainable development will be influenced by factors such as organizational policies, cultures, values, and business drivers amongst others. (For a discussion of CSR in practice see Appendix G.)

### Proposed CSR Theoretical Model

In discussing the arguments for social responsibility, Keith Davis introduced the idea of businesses being citizens in their community as managers that adhere to the same socio-cultural norms as the rest of society (Davis, 1973). Theories that have accepted this framing of the relationship between organizations and communities offer the basis for my argument that CSR is an appropriate framework for examining organizations as corporate citizens. A review of the literature has shown that three commonalities exist amongst models of corporate citizenship, these include: responsibility toward local community, partnerships, and consideration for the environment (Garriga, 2004). It follows that a framework drawing from these components of CSR theory can begin to inform how these organizations engage with partners to affect community conditions.

My research applies a theoretical model of corporate social responsibility that balances the financial and other resource constraints of an organization against their intended social and environmental impact. The essential components of this framework are the elements of managerial decision-making that balance the aforementioned constraints against a desired impact. This includes internal and external factors that affect an organization’s degrees of freedom and impact.

## **Community-Based Public Health & Community Partnerships**

### CBPH is important for achieving community impact (social & environmental)

Community-based public health is a participatory action approach that focuses on improving a community's social and environmental conditions that affect its health. It is an approach grounded in principles of community-based participatory action which promotes the inclusion of and partnering (on equal grounds) with community stakeholders including residents, and organizations. These principles of participatory action are grounded in core concepts of participation, trust, power relations, accountability, and responsiveness, they include:

1. Facilitation of collaborative, equitable partnerships in all phases that attend to social inequalities.
2. Emphasis of public health problems of local relevance and ecological perspectives that recognize and attend to multiple determinants of health and disease.
3. Long-term commitment to sustainability.

(Israel, 2008)

CBPH is employed as an inclusive strategy mostly touted by health departments to work with local residents, community organizations, policy makers, businesses, and health providers toward reducing health disparities and improving the living conditions and well-being of their shared communities (Rattray, 2002). Partners in these endeavors may also involve organized communities, researchers, schools, elected officials, advocacy organizations and media outlets. The strategy is grounded in the assumption that communities or stakeholders are more likely to participate and outcomes be achieved if they participate in defining their own local agenda (Casey, 2007). Community participation is defined as "the social process of taking part (voluntarily) in formal or informal activities, programs and/or discussions to bring about a planned change or improvement in community life, services and/or resources" (Bracht, 1990). It has been shown that choosing a mission which reflects the needs of the external community, is supported by the community, and is realistic about the resources necessary to achieve the associated goals is also critical to the success of the partnership (Mitchell, 2000). This has been shown to be true for community development initiatives in particular as well. "NFP health systems are looking to develop meaningful partnerships with stakeholders to affect local social and environmental conditions through community benefit" (Barnett, 2004).

These initiatives are sustainable only when the intended beneficiaries are allowed to shape and take responsibility for them; imposing them from the outside rarely works. They require participation and consent, especially by citizens, intended beneficiaries, and the various expressions of civil society and the "third" sector, including nongovernmental organizations and community-based organizations. Community partners contribute: "unique strengths and shared responsibilities" to enhance understanding and effectiveness of a given phenomenon, effort, or impact; the social and cultural dynamics of the community; and access to integrating knowledge gained with action to improve the health and well-being of community members (Israel, 2008). "A sense of ownership is a precondition of development" (Stern, 2004). A more balanced sharing of power between providers and communities has long been considered an

effective means of engaging stakeholders. Power, within this context, is informed by definitions from pluralist, political-economic, and hegemonic theories that suggest competing agendas and contention due to oppression (Dahl, 1961; Polsby, 1963; Gramsci, 1971). Block emphasizes just this kind of paradigm shift as being important to the development of partnerships, shifting away from hierarchal, patriarchal power with its top-down, high control orientation to shared power and authority; and from dependency to interdependence in relationships (Block, 1987). (For a discussion of the business value of partnerships, see Appendix H.)

## **Partnerships**

### Partnerships Defined

Partnerships are collaborative efforts by which conditions to improve performance or outcomes are created. A partnership is defined as “a collaborative relationship between entities to work toward shared objectives through a mutually agreed division of labor” (Axelrod, 2004). Partnerships are particularly valuable where financial resources are limited or diminishing (i.e. unstable economies); they offer institutions channels through which multiple perspectives and capacities can be integrated into unique solutions. For organizations looking to improve their impact in the arena of partnerships it is difficult for them to measure and report the impact that is made through their endeavors. Questions remain around how to use partnerships strategically during planning and how to improve the efficiency of their functioning during their formation. (See Appendix I for a review of partnership theory.)

### Partnership Stages and Measurement

Paul Florin, et. al suggests a developmental model of partnerships that consists of 5 stages (Florin, 1993). This research will focus primarily on 3 of these stages which entail a partnership’s establishment of structure, planning for action, and implementation. These stages define the parameters of my investigation into how partnerships take shape. This specifically entails illuminating how roles and procedures are clarified, goals and objectives set, and how resources and responsibilities are allocated.

Evaluation of partnerships can occur from 3 different perspectives. Robert Kiltgaard states that evaluation in this field assesses: the benefits and costs for a specific partner; evaluating partnerships as a whole; and evaluating the enabling environment (Kiltgaard, 2004). For the purposes of this research, all 3 of these levels were drawn from as they inform the measurement of factors such as sustainability, trust, transaction costs in interacting, incentives, and contextual conditions or settings, among others, that guided my investigation.

### Typologies of Partnerships (Forms and Structures)

Partnerships take a multitude of forms including but not limited to: alliances, basic contractual agreements, campaigns, consortia, coalitions, collaborations, or joint ventures. They can be aimed toward pooling financial, labor, and information resources in order to address issues that require solutions derived from multiple perspectives. The operational links and interactions between partners define the structures of these partnerships. Effective partnerships are clear

and specific with their structures as it is an essential foundation for inter-organizational or inter-community partnerships (Zuckerman, 1995; Mays, 1997).

#### Application of Partnerships (Purpose)

There is a considerable amount of research dedicated to the effectiveness of partnerships between organizations and groups. Partnerships between public and private organizations in the field of health care and public health have been of particular interest. Health care organizations explore partnerships for the purposes of efficiently delivering services, reducing costs, and increasing their impact on target populations. It has also been noted that public private partnerships improve the corporate image of private organizations. These partnerships, at times, serve as a means of diffusing public pressure for private companies to engage in their communities (Auty, 1999).

#### Partnership Characteristics

A review of the community coalition literature by Granner and Sharpe presents categories of partnership functions that loosely follow the 5 stages of coalition development suggested by Florin (Granner, 2003). A summary of measures or scales characterizing partnerships were then identified, consisting of: member characteristics and perceptions, organizational or group characteristics and climate, organizational or group processes, and impacts and outcomes. This research particularly draws from measures and scales that relate to trust, communication, transparency, accountabilities of partners, and levels of participation in decision-making.

#### The Call for Partnerships

There has been an increasing recognition that the determinants of good health are very broad and the health agenda is so large that no single sector or organization can tackle it alone. Emerging health problems require a range of responses beyond the capacity of either the public or private sectors working independently, and therefore bridges had to be built between them (Harrison, 1996). Some specific health threats are so formidable that single sectors are unlikely to have the necessary resources (political, technical and scientific) to address them (Buse, 2001). With this in mind, health policy experts have stated that improvements in population health status are likely to come from “a complex, diverse, integrated, and dynamic enterprise...whose primary goal is improving and protecting the health of the public” (Studnicki, 2002). “With the shift from hospital to community-based care, there will be increasing numbers of partnerships that bring together health care businesses, volunteer-run community programs, and in some cases state and local governmental groups to change patterns of access, lower cost, improve outcomes, and influence health care policy” (Hinton-Walker, 1998). It is widely agreed that addressing health outcomes at a population level will require a multi-stakeholder approach that employs the capabilities of a multiple partners.

For partnerships seeking to affect health conditions for entire populations, thoughtful investment into their forms and structures are necessary for sustainable development. Characteristics of collaborative partnerships that are essential to the successful development of relationships are highlighted as: Truth, Accountability, Respect, Growth, Empowerment, and Trust (Weaver, 1997). It is suggested that these elements are essential to achieving and



sustaining the impact of the goals of partnerships; this is a primary concern for NFP and FP organizations seeking to improve community conditions. It is suggested that partnership forms that facilitate inclusive relationships with stakeholders affected by these conditions will most likely lead to sustainable community development. These relationships should have degrees of trust, power-sharing, and accountability in them in order to achieve sustainable development in communities. I believe that a framework intended to explore organizations' managerial discretion when engaging in sustainable development activities should account for these elements of inclusiveness.

**Partnership Framework – Ladder of Community Participation**

An adaptation of Sherry Arnstein's Ladder of Citizen Participation model, called the Ladder of Community Participation, has been developed for public health planners and program managers with the intent to form partnerships with community stakeholders (Morgan, 2006). (See Appendix J for background on the Ladder of Citizen Participation.) Similar to its predecessor, this model cites community engagement strategies that range from health department-based initiation of action to community-based initiation of action. Each of the seven strategies is briefly described below (with its citizen predecessor listed in parenthesis as a reference):

*Ladder of Community Participation (Morgan, 2006)*

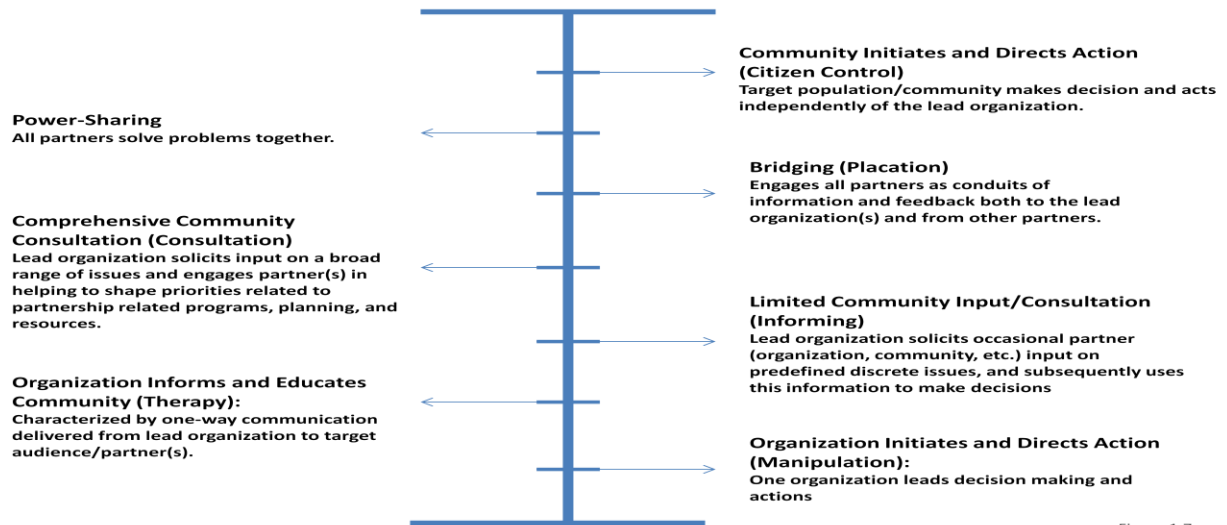


Figure 1.7

**Revision of the Ladder of Community Participation for Organizations**

While this typology of community partnerships provided by the Ladder of Community Participation is strictly oriented toward community engagement, its CBPH principles are ones that are relevant to partnerships that occur between organizations that seek to improve community health. The Ladder of Community Participation is often used at the level of an organization or department looking to be strategic in how it engages the community it serves. The creation of this tool has been discussed with its developers, local community partnerships experts, county health department directors, and community organizers (See Appendix Q for interview instrument). This study's preliminary research has indicated that application of a

revised framework for partnerships may be useful in framing the relationships that exist between organizations whose intent is to have a positive impact on the communities they serve. Many practitioners in the field have expressed that the relationships described in the Ladder of Community Participation are applicable to inter-organizational relationships geared toward community health improvement. These partnership typologies may prove to help organizations be more strategic in how they approach their partnerships oriented toward community health improvement.

Strategic partnerships facilitate the evaluation of projects if organizations are clear and direct on their goals and expected outcomes. This also helps to determine if disadvantaged populations with unmet health needs are adequately taken into consideration during the decision making, planning stages of partnerships and the policies they develop. The Ladder of Community Participation has inherent weaknesses that are transferable to its application in typing organizational partnerships. Partnerships are fluid in nature and are often very cyclical in their structure and performance. Different components of various Ladder strategies may be at work any given time, this makes it difficult to explicitly state which type of partnership is in operation. This is a significant weakness of the framework, especially if it is intended to be used for strategic or evaluative purposes. A possible next step to address these shortcomings would be to develop an adopted framework that is customized to the strategic and operational tendencies of organizations, particularly when they enter partnerships with one another. A typology of partnerships developed specifically for these relationships which considers their nuanced relationships may better fit as a framework to evaluate them. This is a process worth further investigation and may contribute to how partnerships geared toward community health improvement are planned and evaluated.

The criteria cited in Part II of Schedule H has informed the types of partnerships included in Figure 1.8 that would take place between NFP health systems and other stakeholders. These are partnerships aimed toward the improvement of community infrastructures. They generally target: economic development, community support, environmental improvements, coalition building, community health advocacy, and workforce development.

**Hypothetical Ladder of Partnership Participation**  
(possible examples in parenthesis)



Figure 1.8

The Ladder of Partnership Participation can begin the development of a framework for NFP health systems and hospitals to organize and approach their community development work as corporate citizens. I hypothesize that more CBPH principles are taken into account as an organization progresses up the ladder. It has been suggested that organizations should strive to foster relationships with their partners over time that will naturally evolve to be more inclusive in a similar manner (Zadek, 2007). Insights of CSR should be integrated, where appropriate, with these principles of CBPH to illuminate how best practices of community benefit are accomplished. One of the goals of my research will be to explore how managerial discretion is affected by CBPH principles in determining whether an organization will pursue social or environmental impact that only adheres to legal compliance or pursues more risky investments.

Currently, it is difficult to determine if there are approaches for organizations that work with partners to achieve social and environmental impact that are more effective than others. It is important to assess different forms, structures, purposes (community benefit, community development purposes) under different conditions on the ladder. This research provides a baseline point of reference for exploration of this issue with an assessment of best practices. The identification of principles taken into account within different partnerships informs future research to potentially compare effectiveness across partnerships.

In the future, a fully developed model can guide decision-making about how to proactively engage communities to achieve specific social, environmental, and economic outcomes that will improve community conditions. Organizations are in need of a tool that will fare well in uncertain circumstances of social and environmental impact where social acceptability criteria constantly evolve and vary by region or demographics (Zadek, 2007).

## **Gaps in Literature**

Questions that have arisen about the engagement of community stakeholders to achieve sustainable development cut across many fields. Of particular interest are how to determine which managerial discretion-related factors should be taken into account prior to and during the engagement of community partnerships with stakeholders. There is an expressed need, in the literature and in practice, to understand relationships between organizations and their stakeholders; specifically how they can be optimized to achieve sustainable social and environmental impact.

My research illuminates how decisions about community and sustainable development are made by NFP health systems. Taking into account studies regarding interorganizational linkages, strategic planning, and community benefit, there is little research examining nonprofit healthcare systems as corporate citizens and the partnerships they engage for the purpose of community development. This is salient because – while components of this process has been researched within the fields of community benefit, organizations and sustainable development, and community partnerships – there has been limited investigation into the intersection of these fields, all of which can potentially inform each other.

NFP health providers are practical laboratories for the best practices of corporate citizenship. Yet while there has been some discussion about these institutions in this light, it has not been thoroughly explored (Longest, 1998, 2006; Prybil, 2004). While the community partnership literature has explored which forms, structures, and goals of these partnerships are optimal, there has not been any formal exploration into how and why the often resource-rich organizations involved in these partnerships determine the roles that they will play (Barnett, 1997). However, there has been considerable research into why NFP health providers can do this work and examples are given with best practices (Barnett, 2004).

It is my belief that the examination of exemplary community benefit practices can be a model for the cost effective practice of CSR and inform the corporate citizenship discussion. FP organizations can learn from best practices of community benefit where sustainable development is a priority yet financial constraints and limited resources are restrictive reality. It is my hope that this work establishes a foundation from which research investigating organizations' managerial decision-making and implementation of partnerships for sustainable development can develop.

This research will contribute to the discussion by beginning to address these questions. The "Theory of Decision-Making" section presents key principles driving the business case for investing in the development of communities. The next section, "Community Benefit: The CA Picture" reviews a sample of existing trends of NFP health systems and hospitals' community benefit practices. Then, three case studies investigating different forms of health system or hospital-stakeholder partnerships are presented. These cases examine the realm of decisions and relationships driving these partnerships in the context of the decision-making and stakeholder engagement principles presented earlier. Finally, the relationships constituting the

partnerships will be assessed to measure the degrees of community-based public health principles present in each.

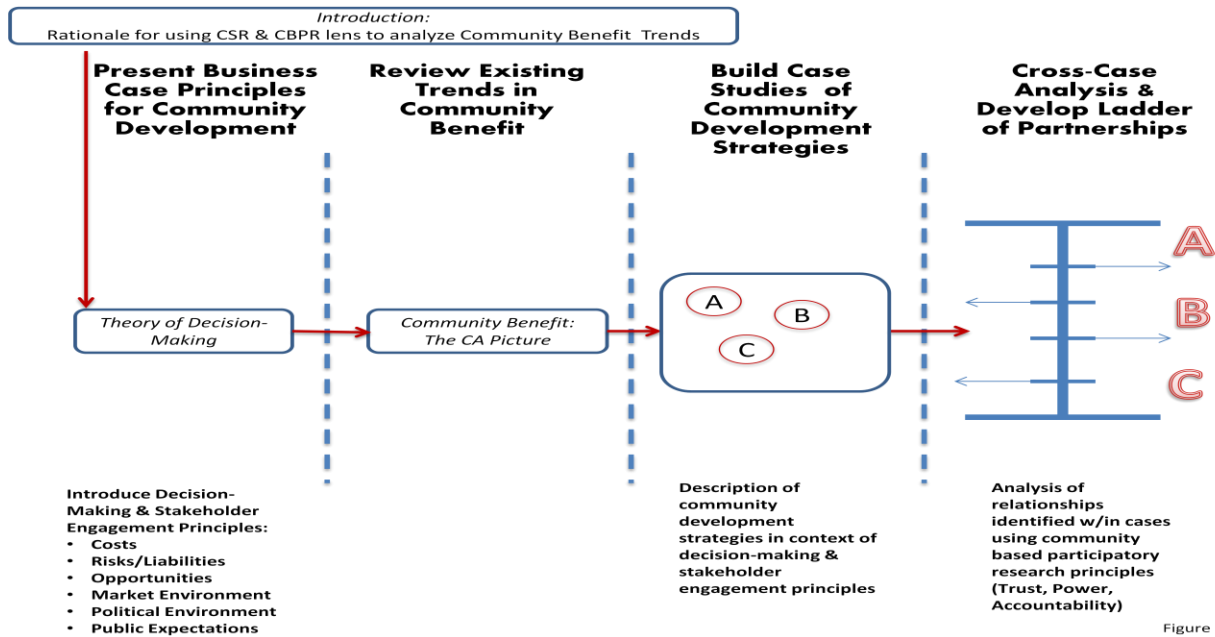


Figure 1.9

## Implications

NFP healthcare systems target an array of operational, social, or environmental issues that challenge the health of the communities they serve. Considering the resources available to these institutions and the implications of their application, there is a need for not-for-profit health systems to be strategic and explicit with their community directed partnerships. Understanding and optimizing these relationships is becoming increasingly important for organizations looking to work in resource deficient communities that exhibit poor outcomes and disparities. As the Accountability and Care Act continues to take shape, NFP health systems have an increased stake in the management of individuals' health outcomes in these communities. Exploring these partnerships can also inform the discussion introduced by Schedule H regarding what social- or environmental-oriented activities constitute community benefit. Finally, a better understanding of how to apply CSR principles to organization-community relationships is timely. The practice of corporate social responsibility is beginning to become integrated into the business decisions for organizations looking to increase shareholder value through stakeholder relations.

**The role of partnerships from different perspectives**

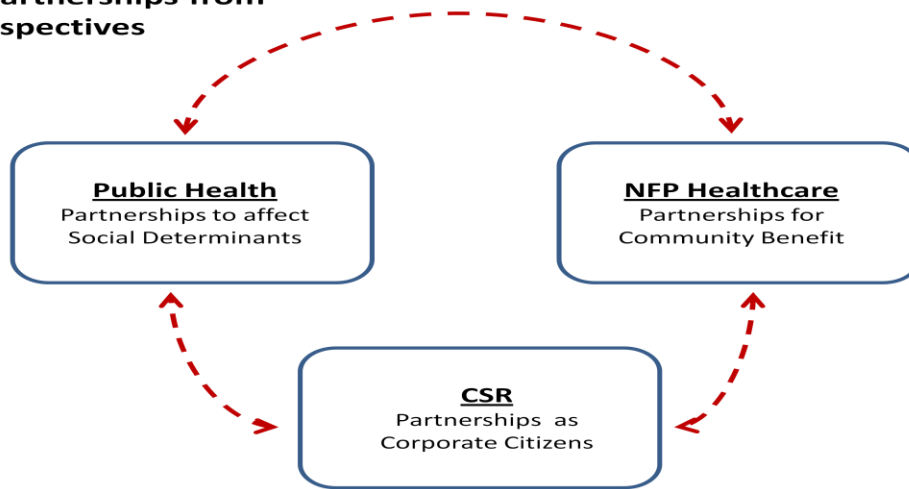


Figure 1.10

This research expands on previous studies by developing a typology of partnerships that occur between nonprofit healthcare providers and the communities they serve. Next steps following this project will include developing case studies around other types of partnership not captured here. The findings that stem from this work will aim to generate hypotheses regarding the interplay between stakeholder relationships and organizational decision-making prior to engaging in partnerships to achieve social and environmental impact. This research will also propose the levels of power, trust, and accountability associated with those partnerships. Once proximal measures of partnership effectiveness can be identified, it is my hope that empirical research can be conducted to test the nature of the relationships I propose in this study. Finally, the Ladder of Partnership Participation also expects to be of use to NFP and FP managers (possibly with mission integration or strategic CSR responsibilities) seeking to model relationships after best practices for partnering with community stakeholders.

# Organizational Decision-Making and Stakeholder Engagement for Community Impact: A Not-For-Profit Hospital Perspective

## Introduction

This chapter reviews frameworks set forth by the current corporate social responsibility literature as they pertain to businesses' decision-making and stakeholder engagement. It is necessary to outline these principles as considerations weighed by managers responsible for community benefit planning and programming within NFP health systems and hospitals. These perspectives provide the context and terminology that will be used for discussing community benefits planning and practice in future sections of this research. As briefly reviewed earlier, the goal of community benefit programs are to invest in the sustainable development of communities by improving social and environmental conditions. The frameworks here are introduced to address this study's research objective of applying corporate responsibility frameworks to understand businesses' balance of economic, environmental, and social concerns. A specific question this section addresses: to what extent does California's current community benefit landscape align with behavior explained by CSR-related principles of decision-making and stakeholder engagement?

Recent discussions of CSR have led to "nuanced arguments regarding corporate social performance, sustainability, stakeholder theory, green marketing, citizenship theory, and business ethics, among others." (Cheney, 2007). My review will draw from many of these perspectives – primarily discussions about environmental sustainability, stakeholder theory, and citizenship theory. It is my intent to present an overview of business' decision-making principles as they pertain to responsiveness to social or environmental needs. Attention will be given to the different implications these decisions have for non-profit organizations. Next, this section will discuss how these decision-making principles apply to NFP health systems and hospitals by influencing their decision-making and engagement of partners while working toward sustainable development. Finally, these dynamics will be discussed within the context of what is observed in current community benefit management practices found in selected California NFP health systems and hospitals.

The premise underlying the field of corporate social responsibility dictates that businesses that make an effort to achieve social good must balance their endeavors against the cost of business operations. It is from this baseline that considerations of what type of action to take, how much impact can be achieved, and which partners to engage will develop. The ideal alignment of these activities results in socially responsible practices that "make sense." Corporations that are socially responsible will be defined from the perspective of being responsive to society's evolving and dynamic set of values and needs (Seeger, 2007). Doing "what makes sense" occurs when financial benefits overlap with the benefits of sustainable development (Porter, 2002). The literature related to corporate social responsibility has produced an evolving cache of issues define the environment in which decisions about "what makes sense" occur. Areas of CSR that best characterize these issues as they pertain to leaders' and managers' community benefit strategies include corporate citizenship, stakeholder engagement, and environmental

sustainability. The implications suggested by these particular frameworks shape the lens through which any decision-maker is likely to engage in discussions of achieving social or environmental impact.

In his book The Civil Corporation, Simon Zadek uses corporate citizenship to define the behavior of businesses acting responsibly within the circumstances of the fiscal markets and social communities in which they operate. Corporate citizenship describes a business' actions as they pertain to community development to be "understood in terms of its viable options and what it makes of them." (Zadek, 2007). Zadek goes on to explain, "internal and external factors together create spectrum of possibilities at any given point in time – that define a corporation's practical scope for making choices between viable choices." (Zadek, 2007). These conditions illustrate the comprehensive environment which contextualizes operational decisions managers consider while investing in sustainable development. In addition to this perspective that illustrates a business's operational environment, stakeholder engagement research provides insight into an organization's interactions with agents that are a part of that setting. Research that investigates the stakeholder engagement of corporations has established a framework for interpreting managers' rationale for partnering with other agencies and individuals involved in or affected by that business' operations (Jones, 1995; Hillman, 2001; Pelozo, 2009; Rivoli, 2011). This framework also explores when partnerships are necessary, the risks and opportunities associated with the cultivation of these relationships, and the various forms of engagement that may develop. Finally, issues raised in the sustainability literature are pertinent to both of the aforementioned topics of decision-making and stakeholder engagement. Sustainability research has framed discussions regarding the reasoning for organizations to monitor and improve their environmental performance. The purpose of this discourse has essentially been concerned with how organizations can limit their environmental footprint, reduce operational costs, and gain competitive advantages. This dialogue also raises issues around organization's internal capacity to implement new technologies, accepting high accountability standards, and meeting the demand of various stakeholders including community members, employees, suppliers, and shareholders. In the following pages, principles derived from these three perspectives will establish this research's basis of interpreting organizations' socially responsible decision-making and partnership patterns.

## **Background**

NFP health systems and hospitals tend to engage in the provision of programs ranging from relatively minimal investment of resources such as posting health education signs to significant contributions of resources to long-term, multi-faceted regional initiatives. Examples of these practices include: sponsoring health fairs, launching health awareness education campaigns, supporting community organizing efforts, lobbying as advocates, implementing green initiatives, or coordinating care with public health and service providers. These same practices can also be interpreted as means of self-promotion, marketing, improving public relations, liability management, extending service lines, and strategic positioning within a competitive environment. The primary question these procedures raise is whether an organization is purposefully being socially or environmentally responsible as opposed to just implementing smart business practices. The general response is that, at times, it is both. NFP health systems



and hospitals maintain dual obligations – managing business operations and meeting criteria for tax-exemption. As a result, these institutions are subject to criticisms that they manage community benefit programs to meet needs driven by financial interests as opposed to the needs of their community. In order to operate as a business, these institutions have responsibilities to pursue revenue-driven or self-promoting avenues in order to meet regulatory requirements, protect against liability, or seek competitive advantages. In other instances such as going green, many businesses are pursuing means of improving their cost-efficiency while also strategically marketing themselves. The purpose of this chapter is not to debate the merits of these potential contradictions, because despite their intent, some institutions have shown that there are principles of high performance in these areas that are effective. These principles inform decision-making about achieving social and environmental impact.

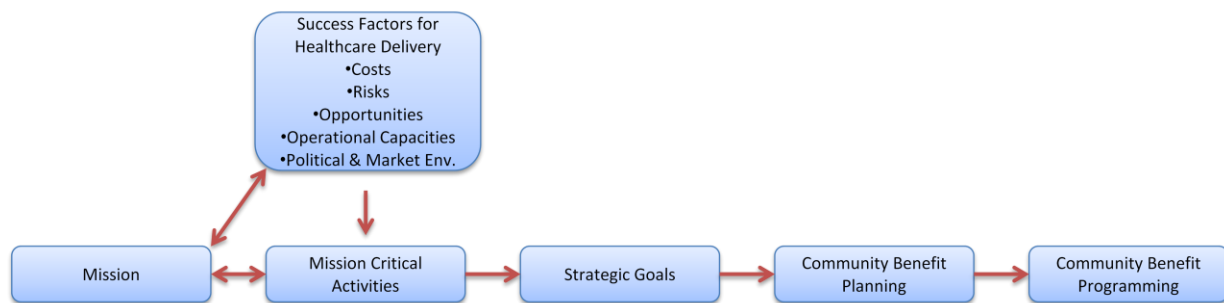
Leadership and management within organizations are charged with the responsibility of making decisions that will advance their operations, profitability and business value. In the case of nonprofits, this also includes advancing the mission of an organization. The parameters of these decision-making responsibilities are defined by a range of variables including: costs, market demands/public expectations, risks due to liabilities, opportunities to gain advantages, corporate strategies, political environment, quality of services, and operational efficiency amongst others. The most prominent factors of these considerations are generally ones that have a direct or immediate impact on operating within the local, regional, or national markets. For hospitals in particular, this wide range of factors can take the form of: payer-mixes in specified locales; purchasing new equipment or facility renovations; conservative or liberal leaning political leaders; competition for physicians, insurance plan prices, state regulations, or affluent patients; lobbying for reimbursement rates; or the incidence of chronic diseases, violence, or unemployment. All of these variables define the parameters in which organizations make decisions regarding their current allotment of resources and future strategic planning.

For NFP health systems and hospitals, the context of a mission-driven orientation directly influences how decisions are made and how stakeholders are engaged. The missions of these organizations are intended to formalize responsible and socially aware business practices, which distinguishes them from their for-profit counterparts. While the aforementioned principles drawn from the CSR literature apply to both FP and NFP organizations, it is the explicit commitment to populations, communities, or causes through mission-driven efforts that distinguish the two. Both engage stakeholders in order to sustain their practices. However, the constituencies of stakeholders differ. FP organizations are profit-driven for the purposes of creating business value for shareholders. By contrast, NFP organizations work to generate profits that provide an operating margin that is applied towards sustaining business operations and furthering their mission. Both types of organizations also rely on and must respond to the market, political, and social environments in which they operate. For both organization types, this necessity calls for active engagement of stakeholders and raises the question of how to best undertake this endeavor within the constraints of operating an organization.

## Decision-Making

Organizations will take into account key considerations when determining the viability of management strategies directed toward being socially responsible. The principal considerations discussed here include: costs; risk of liabilities; opportunities to gain advantages; market demands; public expectations; political environment; and operational capacity strengths and weaknesses. In the case of NFP organizations, mission-orientation is equally as important. The figure below has been adopted and revised from an illustration of the relationships between these considerations as they pertain to strategic planning (Ginter, 2002). Each of these variables will be briefly described and discussed in the context of CSR issues relevant to NFP health systems and hospitals.

### Strategic Planning for Community Benefit



Adopted & revised from Ginter et. al, 2002.

Figure 2.1

### Commitment to Mission

Managerial decision-making as it relates to sustainable development has been discussed extensively as a business strategy that does not explicitly or measurably create value for an organization. Those developing strategies for these purposes often assume a “societal perspective [which] argues that things beyond, but including, economics are important goods for a wide variety of stakeholders, many of whom contribute to the wealth creation potential of firms (e.g. employees, customers, suppliers, communities – in addition to investors)” (Rivoli, 2011). Leadership within organizations that invest in sustainable development strategies often do so with expectations of indirect positive return or impact. On other occasions, there is a direct relationship between adopting socially responsible practices that will improve efficiencies or limit liabilities.

FP and NFP organizations alike face these uncertainties when investing in the development of their communities. However, they notably differ given the stakeholders to whom they are accountable and the scope of regulations governing their socially responsible practices. Attention must be given to the mission-driven governance of NFP organizations – this key distinction guides NFP organizations’ community-oriented decisions and practices. While their FP counterparts primarily operate with a fiduciary duty to shareholders; NFP organizations’

obligations lie with their community to operate as sustainable businesses that will provide services and benefits. NFP companies' regulatory and operational environments are significantly influenced by this legal obligation. The CSR literature characterizes these activities as normal business practices, with any positive social effects portrayed as additional benefits. In contrast, mission-driven NFP organizations are expected to "go beyond" undertaking solely profitable activities. This often leads to the engagement of practices that are intended to provide added social benefits at the cost of sacrificing financial returns. However, it is important to note that many socially responsible activities in both NFP and FP spheres have shown profitable returns to the organizations implementing them. Mission-orientated strategies distinguish NFP's objective to "keep to the mission of the organization" from FP's intent to "be committed to being socially responsible." This distinction explains the differences in the occurrence of and justifications for investing in activities intended to improve social or environmental conditions. FP businesses engage in these types of practices given their competencies and opportunities to differentiate themselves from competition. Also, they generally do so if the costs affiliated with them are modest (Vogel, 2005). By comparison, NFP organizations are expected to develop community development strategies, invest resources into these communities, and engage community stakeholders as core components of their critical business activities.

#### Leadership & Management Strategy

Corporate strategies are developed by leadership with the intent to support operations or secure opportunities that may increase business value for their organization. This can be accomplished by increasing profits by way of improving revenues, recognition, and reputation; or similarly by reducing financial losses and liabilities. To achieve this, leadership that adopt sustainable development strategies do so in order to "create long-term shareholder value by embracing opportunities and managing risks deriving from economic, environmental, and social developments." (Zadek, 2007; Sustainability Asset Management, 2000). The adoption of sustainable development practices is thought of as a management strategy meant to establish positive relationships with stakeholders and achieve operational efficiencies. It also reflects that leaders acknowledge an organization's intimate relationships with stakeholders and its environment. The sustainability literature highlights these interdependencies which exist between businesses, society, and their environment. Hart argues that organizations should be aware of their responsibility for the impact of their activities on the environment (Hart, 1997).

In order to be sustainable, an organization's activities must be affordable in the long run and have a long-term positive impact on society or the environment. Sustainability literature offers a perspective that explains the rationale of managers seeking an intersection between the pursuits of strategies that yield positive social impact while simultaneously being driven to reduce costs. This perspective manifests itself by way of innovations and new technologies, the reduction of operational costs, and crafting responses to regulations that present competitive advantages and influence practice and outcomes in the field. These strategies also reflect a sense of social responsibility that can achieve the secondary effect of attracting prospective employees, partners, and customers. This assertion can be taken into account when considering mission-driven organizations such as NFP health systems and hospitals that may

enjoy strong employee commitment and lower turnover as a result of their reputation (Vogel, 2005). (For a discussion of the relationship sustainability strategies and reducing business risks, see Appendix K).

Zadek states that, “a corporation’s approach to addressing any challenge or opportunity including those embodied in any vision of sustainable development, depends on how it deals with investments and risks” (Zadek, 2007). In addition to considering costs, it is also important for business leaders to take precautions in reducing risks related to uncertainties. Risks emerge from uncertain financial returns or outcomes as well as unforeseen public expectations or changing regulatory requirements. Uncertainties might affect an organization’s profitability, reputation, competitive advantage, or market share. An organization’s potential liabilities shape its decisions regarding which community development initiatives to adopt and potential partnerships to form. Decisions by management represent purposeful efforts to limit or reduce adverse publicity, fines, or susceptibility to unfavorable regulations. Organizational leadership that employs these strategies can be viewed as reducing liabilities or creating opportunities to gain competitive advantages by differentiating themselves from their competition.

Corporate citizenship literature indicates that, depending on capacity and market position, it is in some organization’s interests to elect sustainable development strategies as dimensions of an organization’s broader efforts. Additionally, the adoption of socially responsible policies and practices is a management strategy that should be held to the same criterion of practicality as would any other dimension of a business model. It has been argued that adoption of these practices is justified when they align with an organization’s operational competencies and strategic planning (Vogel, 2005). In order to be effective, businesses should “do what makes sense” as well as engage with the appropriate stakeholders affected by their business practices. In the context of risks and opportunities, being socially responsible should be based on promoting an organization’s strengths in order to mitigate potential effects of its weaknesses (Lougee, 2008).

Attentiveness to an organization’s strengths and weaknesses is a key element that influences its managers’ effectiveness in directing sustainable development activities. Prior to adopting socially responsible practices and relationships, Zadek suggests that businesses take account of their internal capacities and external factors (Zadek, 2007). Internal competencies include: formal, explicit policies and processes; organizational cultures and values; and patterns of leadership. External factors include business drivers such as: direct, short-term market pressures; and longer-term strategic challenges and opportunities (Zadek, 2007).

**Variables that define degrees of freedom**

Internal Competencies:	Formal, explicit policies and processes	Organizational cultures and values	Patterns of leadership
External Factors:	Direct, short-term market pressures	Long-term strategic challenges	Long-term strategic opportunities

Table 2.1

These variables determine the maneuverability an organization has to take action. He defines this maneuverability as the degrees of freedom which outline the parameters of what a company should do to be socially or environmentally responsible given its present capabilities. These degrees are affected by two sets of factors:

1. General Factors: including technical opportunities, competitor strategies and public pressure
2. Company-specific Factors: including availability of finance, the quality of leadership and overall corporate competencies

(Zadek, 2007)

Corporate citizenship literature dictates that organizations be viewed in the context of their internal or external factors in addition to the viable options to act responsibly that are available to them. As discussed above, managers' choices to "do what makes sense" concerning sustainable development is determined within the constraints of leadership patterns, cost and risk management strategies, and internal capacities. It is also influenced by the market context in which a firm operates including competitors, regulations, and public expectations. Companies' develop strategies intended to shape these external factors in order to improve their position within the market context as well as increase their abovementioned degrees of freedom.

### Market Environment

An organization's market environment limits managers' decisions when choosing between viable options to explore opportunities and take risks while remaining profitable. The ability to be successful within the marketplace is contingent upon an organization's ability to secure market share by differentiating itself through reputation, products, or efficiency of service. Porter and Kramer have illustrated this environment as consisting of, "the availability of skilled and motivated employees; the efficiency of the local infrastructure, including roads and telecommunications; the size and sophistication of the local market; [and] the extent of governmental regulations" (Porter, 2002). The competitive landscape and market demands of services, products, and accreditation shape what organizations deem as necessary actions to take. To be viable as a business, organizations must be responsive to the landscape shaped by these conditions in order to meet market demands. These demands are driven by pressure from consumers, workers, investor, and other stakeholders; often these groups are the primary drivers for assuming socially responsible practices as well. Being socially responsible can serve as a vehicle for organizations to differentiate themselves within the marketplace on the grounds of cost-efficiency, connectivity to stakeholders, and reputation (Vogel, 2005). However, it must be noted that competitive markets do not tend to promote the responsible or ethical behavior of its participants. This is a relevant concern in the social responsibility discussion given the tendency of organizations to demonstrate herd effects that would skew toward less responsible actions that are less costly.

In order to set forth sustainable development initiatives, management must identify opportunities where social or environmental benefits can be achieved within the limits of what is economically viable for its market. Zadek summarizes this point, saying that “the critical issue is more often the need for a company to satisfy current market conditions while simultaneously investing in...opportunities that are consistent with sustainable development and competitive needs” (Zadek, 2007). This overlap of social and economic benefit has been referred to as the “Zone of Opportunity” where organizations can be profitable and provide social benefits (Karani, 2011). Similar to Porter and Kramer’s assertions mentioned earlier, this zone defines where organizations can “do what makes sense”. The fact that the public’s interests are not inherently met due to imperfect markets creates many opportunities for organizations to invest in sustainable development. Health systems and hospitals consistently face these challenges as the healthcare industry is immersed in imperfect markets. This is mainly due to asymmetry of information, market power, and externalities that are not accounted for in cost or the provision of care (i.e. preventive services are not stressed in the current system yet the related downstream costs are borne by all). In some cases these opportunities are profitable, in many others they are not in the fiscal interests of an organization.

### Political Environment

In addition to meeting the demands of the market in which an organization operates, decision-makers must also be cognizant of their political environment. Organizations are embedded in their communities and are directly affected by its formal and informal expectations. The standards and expectations set forth by regulations as well as political attitudes and relationships directly impact leadership patterns within organizations. Relationships between organizations also exist at a delicate equilibrium – which is maintained to foster stability within a given market. Management’s decisions are influenced by needs to be in compliance with current regulations and to anticipate imminent policies that may affect business practices. Companies tend to be attentive to their political environment as it can directly affect their reputation as well. It is in managers’ interests to maintain positive reputations and relationships within this political economy while running a large organization because “public opinion and politicians can have major effects on corporate values.” (Lougee, 2008). Moreover, the need to be responsive to one’s political environment is complicated by the evolving nature of society. The sustainability literature makes note of this dynamic in citing the importance of organizations’ recognition of their interdependence with external actors and calls for the adjustment of internal capabilities in response to rapidly changing markets (Hart, 2010; Teece,1997). Additionally, Rivoli et. al have discussed the time dynamic of socially responsible practices, pointing out that societal expectations of businesses do change over time (Rivoli, 2011). This may be due to changes in regulatory environments, relationships with stakeholders, or public expectations. Over the last decade alone, systematic and informal public expectations about which activities businesses should invest in have changed due to financial scandals, strained economies, and increased legislative scrutiny. This dynamic is pertinent to businesses and sustainable development as public expectations of socially and environmentally responsible practices have risen as well over this period.

## **Stakeholder Engagement**

To stay informed of issues to which they may need to be responsive, organizations may rely on their relationships with the various stakeholders affected by their practices. This helps businesses to understand the direction in which expectations are shifting. Organizations' stakeholders consist of: capital suppliers (shareholders), employees, other resource suppliers, customers, community residents, and the natural environment (Hillman, 2001). Interactions with stakeholders allow managers to exert influence on public expectations and shape the markets in which they take place. These dynamics lead to corporations maintaining relations with their communities in a manner that increases their capacity to manage strategically, effectively, and competitively. Edward Freeman established the concept of stakeholder theory which "maintains that corporate performance should be evaluated in terms of its ability to satisfy not only its shareholders, but also other important corporate constituencies such as customers, employees, suppliers, local communities, and society at large." (Lougee, 2008). This rationale established an expanded scope of accountability and relationships with constituents, other than stockholders, with whom business managers should be attentive and responsive.

In order for socially responsible initiatives to be effective as a strategy, it is proposed that their objectives must be aligned with both internal organizational capacities and relationships with stakeholders (Peloza, 2009). Engaging relationships with stakeholders is a central component of corporate responsibility. Corporate responsibility has been defined as a strategic approach to management that understands the centrality of stakeholders and nature to the long-term success of the firm and builds on that understanding (Rivoli, 2011). Stakeholder theory establishes the argument for developing interactions with stakeholders in the community as an essential management priority. The literature states that these relationships should be established in such a way that shareholder and stakeholder interests converge. This is achieved by aligning internal capacities and strategies with external relationships to produce outcomes that provide social and economic gains (Porter, 2002).

Engaging stakeholders serves the purpose of providing venues through which organizations can establish ties with external agents affected by its business practices. Relationships and lines of communication with stakeholders provide businesses with gauges of community need and public expectations. For businesses' strategies intended to achieve lasting sustainable development objectives, it is argued that an organization has to engage its stakeholders (Zadek, 2007). Understanding needs and expectations are necessary components for any sustainable development strategy. The responsible actions organizations decide to take that are informed by the engagement of its stakeholders result in what is referred to as negotiated boundaries of accountability. Zadek calls these negotiated boundaries "the real boundaries of responsibility of any organization...set through negotiation with those stakeholders who can penalize a business for 'getting it wrong' and equally those that can reward it for getting it right" (Zadek, 2007). The subsequent stance that organizations adopt regarding sustainable development is a direct result of these negotiated boundaries. (For a discussion of the negotiated boundaries organizations and their relationships with stakeholders see Appendix L.)

The value of stakeholder engagement is realized in the increased capacity to identify areas of sustainable development that offer the greatest strategic values to businesses (Porter, 2006). By fostering relationships with stakeholders, organizations can add value through improving communication and shared understanding. The sustainability literature has indicated that those businesses that perceive their interconnectedness to society and the environment become innovative in working with stakeholders to develop products that reduce risks and cut costs. Sharma et. al found that organizations with greater stakeholder integration capabilities had more proactive environmental strategies and incorporated elements of product stewardship (Sharma, 1998). Hart identifies product stewardship as an essential component of sustainability and states that it should be achieved through the external stakeholders in the product development and planning process (Hart 1995). It is supposed that a firm's efforts are then better situated in the context of what the community wants, therefore garnering more buy in from the community and ultimately making them more sustainable. It also indicates that the organization is willing to listen, partner, and engage with their community which can provide a boost to their reputation with stakeholders. It has been suggested that this can lead to: increased product acceptance; improved service delivery; development of distinctive competencies; reduced unfavorable litigation and publicity; and favorable regulatory policies (Harrison, 1996). The benefit of engagement strategies can be realized through establishing strong relationships with an organization's community and stakeholders, reducing the likelihood of liabilities, and maximizing the impact of sustainable development efforts.

### **Community Benefit Programs**

The community benefits programming of NFP hospitals are intended to operationalize strategies that support sustainable development in communities. As businesses that are obligated to invest in the health of communities at-large, NFP health systems and hospitals abide by the decision-making and stakeholder engagement principles discussed above. Those principles frame managers' decisions that direct socially responsible activities and sustainable development. Upon reviewing a selection of community benefit reports submitted by California NFP health systems and hospitals to the state's regulatory oversight body, there is justification for examining community benefit practices through the lens of CSR frameworks. It can be shown that patterns of community benefit planning and programming reflect many of the decision-making and stakeholder engagement principles explained by corporate social responsibility literature. The analysis in the next chapter of this research will discuss the incidence and content of community benefit programming found throughout California. Here, a brief cross-section of community benefit programming will be presented to illustrate how patterns of management strategies and practices might be influenced by socially responsible decision-making and stakeholder engagement principles.

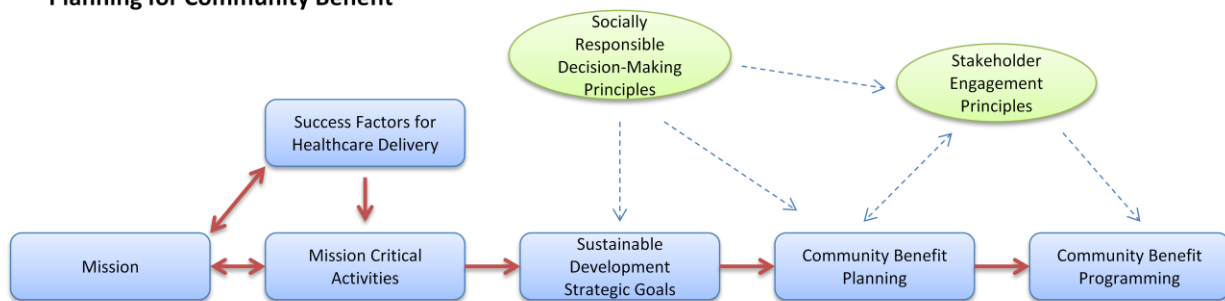
In order to plan community benefit programs, NFP health systems and hospitals are required to formally assess the social and health-related conditions of the communities they serve. This is accomplished through conducting community needs assessments, surveying and interviewing local stakeholders, assessing hospital utilization data, and collecting other statistics on disease incidence, employment, crime, poverty, and violence. This process is coupled with the strategic planning of NFP health systems which establishes priorities and goals for departments that will



support business operations and development. The strategic planning of organizations is essential to the viability of NFP health systems and is a primary driver in shaping the direction of an organization’s activity, including its community benefits programming. Conversely, all departments within a NFP hospital are expected to carry forth activities that support its mission. This is consistent with corporate citizenship literature suggesting that there are multitudes of ways that these institutions contribute to the development of their communities through various departments. This is important to note because the contribution of NFP health systems and hospitals to communities is often isolated to the realm of understanding their community benefit efforts. However, within mission-driven NFP organizations, all departments are directed by their mission critical activities as well as that organization’s strategic goals.

Ginter et al. describe strategic goals as outputs of a firm’s mission, vision, and values – providing specific direction for the objectives and goals of departments within an organization (Ginter, 2002). Taking this process into account, the activities of community benefit departments are extensions of NFP health system’s and hospitals’ overall strategic and operational goals. The figure below depicts how community benefit planning is directed by the strategic goals of an organization. It goes on to further illustrate how the formation of strategic sustainable development goals directs community benefit planning and can be influenced by socially responsible decision-making principles. Finally, the figure demonstrates how stakeholder engagement principles affect relationships that are formed to facilitate community benefit planning and programming.

**Impact of Socially Responsible Principles & Stakeholder Engagement on Strategic Planning for Community Benefit**



Adopted & revised from Ginter et. al, 2002.

Figure 2.2

The remainder of this section will review how the decision-making and stakeholder engagement principles discussed earlier can be applied to examine community benefit planning and programming. The decision-making principles discussed in the context of corporate citizenship affect the shape of strategic goals targeting sustainable development. Stakeholder engagement shapes the planning and programming of community benefit departments. I will briefly review the dual obligations of community benefit departments to mission and business strategy; how strategic goals and planning of community benefit departments are influenced by

operational capacities and market or political environments; and lastly how stakeholder engagement principles affect community benefit planning and programming.

Community benefit planning must align with the direction set forth by an organization's strategic goals; and do so by providing benefits to society that meets state and federal criteria. The unit goals of community benefit departments are guided by the directional strategies of an organization's strategic goals.

Citing Karlewski, Ginter et al explain that "strategic goals relate specifically to mission-critical activities and provide specific direction. They are broad enough to allow considerable discretion for unit managers in formulating their objectives for individual units...They provide direction and decision makers are free to exercise initiative in building working relationships and alliances, negotiate cost-sharing arrangement where possible, develop approaches to access the most up-to-date information systems, and to participate in managed care contracts"

(Ginter, 2002)

This illustrates the framework of organizational strategy within which community benefit department managers plan programming and partnerships that will satisfy the organization's goals.

The key factor that distinguishes sustainable development strategies from other strategic plans is their attention to achieving a positive impact on social and environmental conditions. From the perspective of sustaining business operations, the provision of community benefit serves as a critical activity required for the maintenance of tax-exemption and an avenue of contribution to the community. The significance of using CSR principles as a reference point for the examination of community benefit planning is its stress of departments' competing obligations to meet strategic goals and social needs. It also explains why strategies embracing this approach can lend themselves to viable business operations. The literature exploring corporate citizenship states that sustainable development has the strongest case for "firms that have made CSR part of their strategy for attracting and retaining customers, employees, and investors" (Vogel, 2005). This is certainly true for NFP health systems and hospitals, which are established on the mission of serving their communities and have the maintenance of their tax-exempt status as a core component of their critical business operations. The content community benefit programs, in particular, are wedded to the strategic goals of their organization and guided by the decision-making principles that generated them. This dynamic justifies their assessment from the dual perspectives of their provision to achieve social or environmental impact as well as directly supporting business activities.

The linkage between community benefit programming, mission, and strategic goals results in activity that: accounts for charity care to patients that cannot pay; extends hospitals' lines of service delivery into the community through screenings and mobile clinics; serves as public relations or marketing vehicles to promote business in order to secure market share or competitive advantages; or reduces the cost-impact of un- and underinsured patients seeking

care by directing them to lower cost settings. Programs dedicated to serving these functions generally fall into the following categories:

**Programs that may account for community benefit activity**

Supportive services for youth, families, homeless	Patient medical treatment case management/medical care coordination	Workforce development	Health service provision	Patient outreach and screenings	Improving healthy food environments
Sponsor/administer mobile health and dental clinics	ER patient referrals to clinics for medical homes	Hospital facility expansion	Community-based rotations for medical residents	Support of county public health or economic initiatives	Charity Care

Table 2.2

Some programs in this realm help improve a health system or hospital’s competitive position within the market as well as demonstrating an investment in the sustainability of a community’s healthy development. A selection of community benefit activities that support the provision of preventive services and health education or promotion in the community setting also alleviates the burden of uncompensated care provided within hospitals that drain resources. These activities reduce the fiscal and legal liabilities and risks associated with the treatment of uninsured patients who may become sicker and more expensive to care for as inpatients if their illnesses go unchecked. Funding the development of clinical information technology infrastructures also serves the purpose of investing in the sustainability of communities and at the same time increases the propensity for those clinics to serve as medical homes. This reduces the potential cost burden for hospital of patients that would otherwise seek expensive care in their emergency rooms. Hospitals may also invest in medical workforce preparation and training in the community through partnerships with high schools, community colleges, and allied health programs. This strategy supports the economic development of a community and also raises the profile of hospitals’ reputations as well as the breadth their immediate recruiting pool. In some cases, facility renovations and new equipment that may be necessary to accommodate increased patient loads also serve the purpose of attracting higher quality physicians and insured patients. While all of the above examples demonstrate programs that align with both mission and organizational strategy, it is difficult to objectively discern whether these priorities drive program content equally.

Many of community benefit programs stem from strategies and plans designed to meet the mission and strategic goals of NFP health systems. The dual obligation to mission and business operations strategy affects the internal competencies of an organization in addition to its external market and stakeholder pressures. In order to adequately carry out socially responsible strategies intended to invest in the sustainable development of communities, particular organizational competencies are necessary. Competencies are any skills, information, performance measures, or corporate cultures that facilitate an organization’s ability to meet its mission and strategic goals. Most of the community benefit programs

described reflect unique competencies that fall in the above categories which give management and staff the capacity to effectively invest in the sustainable development of communities.

Skills that facilitate the planning and programming of sustainable development activities include:

- proficiency with aligning departmental plans and programming with broader organizational goals;
- abilities to form and maintain relationships with stakeholders and other partners;
- possessing an understanding of the relationship between the social determinants of health and the applicability of upstream interventions;
- capacities for grant-making and funded project oversight;
- knowledge of health service delivery capacities;
- knowledge of community assets including social services.

Information-based competencies include technologies that can track, measure, and index community needs like:

- poverty-levels;
- violence;
- employment;
- availability of housing;
- rates of uninsured individuals.

Competencies that measure performance primarily consist of:

- systems to monitor and report community benefit activities or
- systems to monitor and report environmental performance

These are intended to assure that programs are in compliance with state and federal regulations.

Finally, most NFP health systems and hospitals adamantly adhere to maintaining corporate cultures that support a commitment to their mission. Specific organizational competencies that extend from this commitment include:

- managerial discretion;
- developing understandings of current community conditions and optimal responses to meet their needs;
- supporting the provision of adequate staff and department size to manage meaningful community benefit programs.

Large departments with more staff and resources are reflective of purposeful investment in community benefit by organizational leadership. Units with these competencies have the capacity to be more attentive to their investments into community relative to their smaller counterparts that dedicate fewer resources to projects.

Another set of variables influencing how socially responsible goals of community benefit departments take shape are the external market and political pressures their organizations face. The key consideration that NFP health system leadership and managers must take into account regarding the competitive market is the demand for healthcare services and how to meet that demand. The task of operating in competitive markets intersects with the competencies of staff and leadership to identify Zones of Opportunity. As discussed earlier, here “the interests of private companies and of society are aligned together; there is an opportunity to make choices that lead to improving both profits and social welfare. There is potential for a firm to behave “more responsibly” and simultaneously increase its profits” (Karani, 2011). While the provision of services and programs that invest in community health warrant significant interventions; these activities often exist in a space where there is a divergence between profits and public interests (Karani, 2011). Since the delivery of healthcare occurs in an imperfect market and therefore the public’s needs for many health and social services are not met. Given that NFP health systems and hospitals have competing market-driven and mission-driven pressures. It at times calls for these businesses to make decisions that are in the Zone of Disaster, where activities are not profitable (Karani, 2011). In Karani’s Zone of Disaster, organizations’ profits decline in markets where the public’s interest can still be improved. It follows that, given operational and strategic pressures to remain viable, community benefit programs tend to only fall in the Zone of Opportunity where it is profitable or aligned with business interests to provide a social good.

**Market Failure & Zones of Opportunity/Disaster**

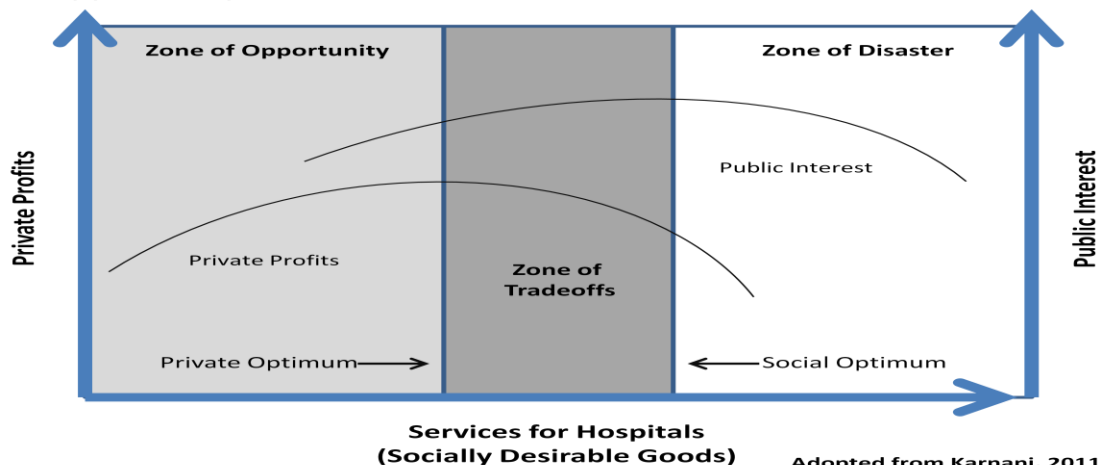


Figure 2.3

In terms of being responsive to political markets, leadership and management must also account for trends in public health issues and public expectations for health service delivery. This leads to considering strategies that will target obesity-incidence reduction, violence prevention, increasing cultural competency, and encouraging healthy lifestyle behaviors. Responsiveness to political markets also calls for engagement in the federal and state regulation landscape that determines what should be counted as community benefit in justifying tax-exemption, how community benefit programming should be monitored, and what

practices are expected of NFP health systems and hospitals. The CSR literature indicates that businesses engage in these discussions as well as implement innovative practices that can move policy and regulations forward, potentially becoming a requirement for all practitioners (Rivoli, 2011). NFP health systems employing this strategy seek to differentiate themselves as leaders and innovator in their field as it pertains to investing in their communities. This also serves the strategic purpose of building reputations and allowing organizations to participate in setting the direction of what expectations to which they may be accountable.

As corporate citizens, NFP health systems and hospitals have an immediate stake in engaging with communities through developing relationships and partnerships. This is necessary in order to identify arising local needs and to negotiate the boundaries of their accountability to stakeholders within those communities. Engagement serves as an avenue of communication that enables management to determine which stakeholders they will engage and the extent to which they will partner. It also aids community benefit department managers and staff with staying abreast of evolving community conditions and expectations. Given the requirement of community benefit planning to be grounded in needs identified by community health assessments, stakeholder engagement provides value by contextualizing health data. Feedback from stakeholders validates and adds narratives to findings from needs assessments.

The ability of community benefit departments to engage stakeholders is significantly influenced by two competencies.

- The first is the size, staff, and resources available to community benefit department; this affects the breadth and depth to which a department can create, maintain, and monitor partnerships with stakeholders.
- The second is the stance of the organization's corporate culture toward the importance of engaging community stakeholders. The nature of this competency has an immediate impact on the value and prioritization of community stakeholders and shapes the types of partnerships formed with those groups.

Outcomes stemming from the interplay of these variables affect the legitimacy and reputation that a NFP hospital has in regards to its presence and investments in the community the communities it serves. This has direct impact on how a health system or hospital is perceived by the community.

It follows that NFP health systems and hospitals have an interest in managing the public expectations of their investment in the community. Community engagement can help leadership and management within NFP hospitals to predict public expectations and consequently influence those expectations through their relationships with stakeholders. These organizations have an incentive to control what is expected of them and by creating and maintaining a positive public perception of their community investment activities. This can be achieved by leadership and managers choosing to address community conditions that are most closely aligned with their internal strategic goals and existing competencies. This approach allows leadership within these organizations to contain public expectations of their investments

within the realm of the hospital's strategic goals. As suggested in the corporate citizenship literature, this might explain why there is a prevalence of community benefit programming that is closely associated with relieving cost burdens or liabilities borne by hospitals and fall within the Zone of Opportunity. As a consequence, community benefit programming that solely target community identified needs and may only exist in the Zone of Disaster are less likely to occur. This too is consistent with discussions within the CSR literature which suggests that investments in sustainable development should promote an organization's strengths in order to mitigate potential effects of its weaknesses (Lougee, 2008).

## **Discussion**

Corporate social responsibility literature provides a framework that captures key considerations that are taken into account when deciding how to invest in the sustainable development of communities. This chapter was meant to highlight important considerations in this realm for organizations that have emerged from the CSR dialogue. The principles drawn from these discussions help clarify the processes that determine which socially responsible practices and policies make sense for an organization to adopt. These considerations are applicable to the assessment of NFP health systems' planning and practice of community benefit related activities. Health systems plan their community benefit activities in the context of strategic goals and resource constraints, as well as the market and political environments in which they operate. The current regulatory atmosphere surrounding community benefit particularly brings these dynamics to light as health systems respond to new requirements and expectations stemming from Schedule H reporting and the Patient Protection and Affordable Care Act.

The application of a CSR-informed perspective of health system's community benefit related decisions introduces the consideration of organizations' mission, risks, and opportunities under a unified theme. CSR frameworks also help to explain how market and political pressures shape the context in which health system leadership make decisions. The interplay and prioritization of these factors varies for different NFP health system which results in an assortment of community benefit strategies and programs. The next chapter will review the patterns and composition of community benefit programs that serve the same communities in California to demonstrate this phenomenon. The review presented in this chapter prepares the discussion in the following chapter in three ways. First, it establishes a basis for the shape of community benefit practices that stem from the decision-making principles outlined in this section. It also provides a framework of how the decision-making of health system leadership affects the planning, distribution, and reporting of community benefit related activities. Finally, the CSR perspectives discussed above introduce cause for additional dialogue about the behavior of NFP health systems in this space. Part of that discussion should include whether these institutions are not incentivized to pursue responsible community benefit planning and programming given their competitive environments. The relative incidence of programs that satisfy the minimal state and federal legal liabilities compared to those that go beyond to address upstream social determinants of health would inform that conversation. Also of interest are the types of community benefit programs that tend to define the parameters of health systems' zones of opportunities or disaster and where tradeoffs can occur.

## Community Benefit: The California Picture

### Introduction

This chapter will address this study's research questions that inform the dialogue of how large NFP health systems and hospitals work with partners and community stakeholders to achieve positive social and environmental impact. The findings of this section will specifically address how large NFP health systems and hospitals establish partnerships aimed toward providing community benefit; and what are the forms and goals of these partnerships. It is the intent of this chapter to provide an overview of current community benefit practices in California and provide context for the research questions addressed in this study. An assessment of current community benefit programming will provide an overview of strategies from which examples of unique programs can be identified. These practices will then inform further investigation through the development of case studies of promising practices.

NFP health systems and hospitals that implement community benefit programs California provide a wealth of diverse practices from which to sample for the purposes of this research. The volume of programs offers insights into strategies that seek to improve health in the state's socio-economic, demographic, and political environment.

California passed its own community benefit legislation in 1994 with Senate Bill 697. SB 697 requires NFP hospitals to assess community needs, develop plans for programming to address those needs, and submit an annual report to the Office of Statewide Health Planning and Development (OSHPD). In the annual reports, NFP hospitals are expected to address a number of issues in the assessment of health needs, as well as in the planning, design, and implementation of programs intended to address those needs. An analysis of these reports provides insights into current practices of NFP hospitals and health systems, and the manner in which these institutions work with partners and community stakeholders to achieve positive social and environmental impact.

Current national discussions regarding community benefit practices have called for a closer look at how NFP health systems and hospitals serve their communities in manners deserving of their tax-exempt status. Recent public and policy dialogue, as well as a growing number of media articles questioning the charitable practices of selected NFP hospitals, has contributed to actions at the federal level to increase public oversight of these activities. The IRS is refining an expanded set of reporting requirements for NFP hospitals with a revised Form 990, Schedule H. These new requirements, as well as section 501r of the Patient Protection and Affordable Care Act intend to increase the transparency of NFP hospital community benefit practices. They also create pressure for NFP leaders to be more strategic in how they address unmet health needs.

This chapter examines California NFP hospitals' practices reported in their annual SB 697 reports to provide a statewide context and structure for an in depth analysis of the health system partnerships that are the focus of this research. The review of community benefit programming in California used for this research consists of a sample (n = 49) of community



benefit reports submitted to OSHPD in 2010 from NFP hospitals and health systems primarily serving the eight largest metropolitan areas within the state (total NFP hospital n = 225) for the year 2009. Reports were reviewed to assess their content, program descriptions, and whether SB 697 criteria were met. Specific criteria used in the review included:

- Community-oriented language in mission and/or vision statements<sup>1</sup>;
- How communities were assessed;
- Process and criteria used in setting priorities;
- Oversight or management structures and functions;
- Identification of populations served;
- Specific activities or services provided;
- Measurable objectives;
- Funding allotted to the program (for a complete list of specific screens see Appendix M).

In regard to meeting the criteria of California Senate Bill 697 a minority of those hospitals reviewed provide explicit language demonstrating a commitment to the underserved. The degree or type of community involvement in conducting needs assessments was often not addressed. It was often unclear how priorities were set, and in many cases, there was discontinuity between identified community benefit programs and the identified community priorities.

Most programs are either hospital-directed (managed by hospital staff, located in hospital facilities) funded projects, or involve participation in an assortment of regional coalitions. A majority of programs consist of healthcare services, while a small, but growing number of preventive services or primary prevention activities also exist. Hospitals tend to work with local community based organizations, local not-for-profit agencies, and in some cases other hospitals. A mixture of larger system goals and priorities in addition to identified local community needs appear to drive programming content.

The state of community benefit practices in California is a reflection of: state and federal regulations, the health needs of specific regions, available resources, and individual health systems and hospitals strategic plans and operational objectives. Generally, community benefit programming is tightly aligned with the objectives of health systems and hospitals to extend or curtail the need for healthcare provision within their facilities. The findings of this review suggest that opportunities exist to be more strategic in community benefit planning to meet the demand of increasing community needs across the state. As health reform redefines what will count as community benefit, hospitals can look to re-examine their existing programming and explore possibilities that may leverage their resources more efficiently.

---

<sup>1</sup> SB 697 defines “mission statement” to mean a hospital’s primary objectives for operation as adopted by its governing body (CA SB 697, 1994)

## Background

### Community Benefit Defined

Community benefit has been characterized by the practice of providing services intended to improve community health, the health of individuals, and increase access to health care, advance medical or health care knowledge, or relieve government burden (CHA, 2008). Community benefit has been explicitly defined as:

...a planned, managed, organized, and measured approach to a health care organization's participation in meeting identified community health needs. It implies collaboration with a "community" to "benefit" its residents – particularly the poor, minorities, and other underserved groups – by improving health status and quality of life.

(CHA, 2004)

Today's practice of community benefit generally falls within the categories of charity care, government-sponsored healthcare, and community benefit services. The activities that fall in these categories may take place within and outside of hospital settings, with emergency room-based and inpatient services constituting the majority of traditional community benefit expenditures (Barnett, 2004).



Figure 3.1

Community benefit services, however, consist of activities that primarily entail NFP health systems and hospitals engaging in relationships with their community stakeholders. These activities may include: community health improvements, health professions education, subsidized health services, research, financial and in-kind contributions, community-building activities, and community benefit operations (CHA, 2008). Regardless of setting, community benefit provided by NFP health providers is generally interpreted as having a positive impact on the conditions that affect the health needs of a community at-large. However, this legal construct has never been formatively defined, which has left these NFP health systems and hospitals considerable leeway in interpreting how their practices fit within the parameters of community benefit (for discussions of the evolution and legal constructs of community benefit see Appendices A and B). This has created lasting ambiguity around the true value of benefit provided to communities by NFP health institutions as well as the justification of them being exempt from taxation (Stevens, 1989).

### The Current Debate & Community Benefit Reporting

The political environment that has developed as a result of financial scandals at the turn of the millennium has led to increased scrutiny into the financial practices of FP and NFP organizations. One of the immediate results was the passing of the Sarbanes-Oxley Act in 2002, which called for more rigorous financial accounting and auditing practices for businesses (for a discussion of Sarbanes-Oxley Act, see Appendix C). It was from the same vein of this political platform that legislators began to further the debate of justifying NFP organizations' tax-exempt status. Senator Charles Grassley of Iowa has been a prominent figure in holding NFP health systems to task to prove that their provision of benefit to their communities deserves exemption from federal, local, and state taxation. This stricter attention to community benefit practices is grounded in the ongoing debate regarding whether there is a true difference in the impact that NFP and FP health providers have on their communities (Stevens, 1989; Clark, 1980). The argument is specifically made that NFP health systems do not differ from their FP counterparts in the provision of indigent care. However, it has been found that NFP health systems are more likely than FP's to be significantly more involved in other, diverse forms of community benefit (Ginn, 2004; Schlesinger, 2004).

### Schedule H

The question of what activities and programs should be acceptable means of community benefit has stemmed from the reporting requirements presented by Schedule H. In 2008, the General Accounting Office (GAO) reported that there were variations in the activities that NFP hospitals define as community benefit that resulted in differences in the amount of benefits reported (GAO, 2008). The evolution of community benefit has led NFP health systems and hospitals to generally account for and report their practices under the categories of charity care, bad debt, acceptance of the publicly insured, and community at-large benefit. The Schedule H of Form 990 has moved community benefit policy toward a more structured assessment of NFP health systems' and hospitals' practices. The schedule has six parts including:

- Part I: Charity Care and Certain Other Community Benefits
- Part II: Community Building Activities
- Part III: Bad Debt, Medicare, and Collection Practices
- Part IV: Management Companies and Joint Ventures
- Part V: Facility Information
- Part VI: Supplemental Information

Hospitals filing in 2010 reported the complete schedule for the 2009 tax year (Salinsky, 2009). Parts II and III of Schedule H were added to the schedule to collect information from hospitals on commonly disputed forms of community benefit. "Hospital representatives have argued that a wider range of activities should be recognized as providing benefit to the community served, including the cost associated with building community assets" (Salinsky, 2009). Of particular interest to this research is Part II, the Community Building section, which allows hospitals to illustrate their community/sustainable development activities. Part II of the schedule allows reporting on activities "intended to improve community infrastructure [i.e.

physical improvements and housing development], economic development, community support, environmental improvements, coalition building, community health advocacy, workforce development, and other activities” (Salinsky, 2009).

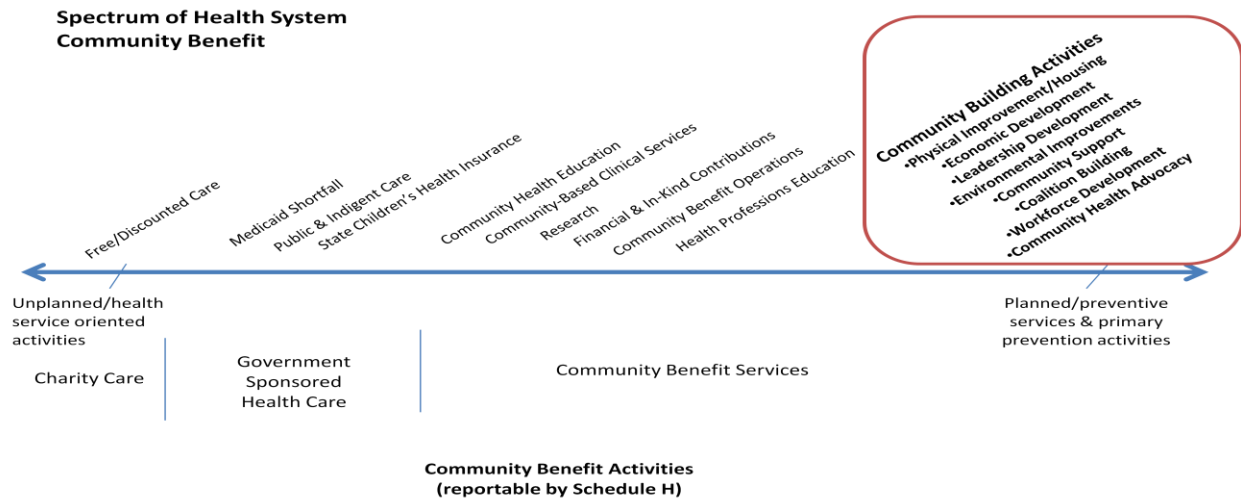


Figure 3.2

The justification of reporting the activities highlighted above (see Figure 3.2) has been contested because they may not address a particular community need. This has been a prerequisite for most practices reported under the community benefit standard. Conversely, community development practices are found at the core of NFP health systems and hospitals that assume roles of corporate citizens in the communities they serve. Hospitals’ increased recognition of the relationship between social determinants and community health has elevated the importance of community building activities. These practices are touted as necessary for work in communities to develop and implement programs that maintain and improve community health (CDC Expert Panel, 2011).

### Stewardship & Community Development

Many NFP health systems and hospitals fulfill their charitable mission through legacies of providing goodwill to the public. Optimizing the use of resources afforded to these institutions by means of tax-exempt status has defined the NFP health organizations’ practice of stewardship (Magill, 2004). Within healthcare organizations, stewardship has been defined as the equitable, cost-effective, and appropriate use of limited resources and talents to benefit all members of the community (Botelho, 1998). Stewardship in health care has been suggested to be embedded in an ethical obligation to honor the trust that communities invest in these institutions (Dean, 2007). The role of stewarding community resources ranges from meeting legal requirements specified by IRS Ruling 69-545 to going beyond the charitable care also provided by FP providers and tending to the health of entire communities (Barnett, 1997).

Inherent in what has been generally defined as community benefit is the role NFP health organizations should assume in their communities to address health needs. These institutions are businesses that have an impact on the social and environmental conditions of their

communities through a variety of avenues. From this perspective, it has been argued that the traditional and incentivized roles of health organizations for community development, given their true capacity, are too limited (Longest, 2005). Many NFP health systems and hospitals have the ability to: influence a range of community infrastructures; affect locally accepted business practices; contribute to the development of the local workforce; and impact environmental conditions – all of which can further their missions of providing goodwill to the public. Concretely defining parameters around what it means to provide community benefit will consequentially affect how NFP health systems and hospitals embody these roles and affect the conditions of their communities. Given the reimbursement environment for NFP health organizations, there is currently little incentive to go beyond minimal community benefit programming provision (Shortell, 2009). Policy that may arise from Schedule H reporting will therefore significantly encourage or dissuade providers’ activities outside of the hospital. This will in turn affect their strategies to address the unmet health needs of communities, and their root causes, through community benefit.

Redefining Community Benefit

Under the sections of Schedule H dedicated to Community Health Improvement Services and Community Building Activities, NFP health systems will report their efforts to affect the social and environmental conditions of their communities. Health systems across the country are encouraging their member hospitals to be more proactive in defining their community benefit. This includes the explicit definition of planning, identification, measurement, evaluation, and communication of their programs through rigorous and consistent methods of data collection and analysis (Sandrick, 2006).

**Community Benefit Planning & Programming Process**



Figure 3.3

As noted earlier, many not-for-profit health providers’ engagements with communities occur through different partnerships across various dimensions of the organization. The improved illumination and description of these roles assumed by NFP healthcare providers in their community will significantly facilitate their community benefit reporting.

Why California is a Unique State

California has the largest population in the United States and is the third largest geographically, making it a uniquely expansive and distinct region. The state has a considerable mixture of rural, urban, and suburban settings which serve as the backdrop for very diverse social, economic, and cultural demographics. This combination of factors results in a wide array of various social, economic, and environmental conditions throughout the state. These conditions

in turn produce a considerable range of community needs. In response to these needs, an assortment of non-governmental organizations (NGO's) have taken root within the state to organize, advocate for rights, and provide needed services to a litany of California's populations and communities. The state's NGO population itself is varied and represents communities or provides services that are different than what may be seen in other parts of the country.

It follows that many communities within California also have a long history with activism, empowerment, and partnerships to improve conditions, particularly those of underserved areas. This has led to the cultivation of many mature relationships between communities, NGO's, and other institutions working to improve the social and environmental conditions of California. Over the years, these circumstances have presented the state's NFP hospitals with a substantial selection of opportunities to form partnerships for the purpose of addressing a variety of community needs and conditions.

California houses over 30 health systems in California, with some of the largest NFP health systems in the country headquartered there. Furthermore, there are approximately 225 not-for-profit hospitals throughout the state that assume responsibility for delivering care and services to most of California communities and their populations. Additionally, it is one of the few states with state legislation aimed toward directly regulating their community benefit practices. The culmination of these characteristics gives the state a unique profile regarding its not-for-profit health care delivery network. These circumstances have been conducive to making the state a national leader in healthcare policy, practice, and delivery. Many systems have to employ creative and customized strategies to address the diverse needs presented throughout the state. In many cases, California health systems allow their hospitals to internally adopt flexible and tailored strategies to engage local communities for impact that may not be achievable elsewhere. This results in customized practices and partnerships that still fit into the broader policies, strategies, and objectives of a system as whole. These types of occurrences provide a wider array of community or stakeholder engagement strategies and partnerships from which this research can sample.

For the purposes of assessing the landscape of California's NFP community benefit practices, a selection of NFP hospitals that primarily serve the state's eight largest metropolitan services areas were reviewed. The sample consisted of hospitals that belong to large health systems as well as individual facilities that were affiliated with networks from other states. Hospitals that serve rural and large metropolitan areas were selected. These settings present notable issues to hospitals from sprawling geographic areas that are barriers to access in and of themselves to concentrated pockets of poverty, disease, and need that are often found in urban communities. Combined, these hospitals serve a diversity of communities and populations that face a wide array of issues. These may include any combination of: lack of access to health and social services; considerable health and economic disparities; immigration; violence; and unemployment.

### California NFP hospital requirements

California's Senate Bill 697 was added to the Health and Safety Code in 1994 with the intent to clarify the intent of community benefit and establish definitive parameters around its measurable provision by not-for-profit hospitals. The legislation calls for all NFP hospitals to perform a community needs assessment, conduct a community benefits plan in accordance with the assessment, and submit annual updates of that plan. Moreover, each NFP hospital's mission is required to reflect a commitment to their social obligation to provide community benefits in the public's interest (CA SB 697, 1994). This responsibility guides the expectation of these institutions to identify needs and document their relative community benefit activities. CA SB 697 defines community needs as essentials for "improvement or maintenance of health status in the community." Community is codified as the "service areas or patient populations for which the hospital provides health care services."

The mandatory community needs assessment is defined as "the process by which the hospital identifies, for its primary service area as determined by the hospital, unmet community needs" (CA SB 697, 1994). The community needs identification process is prescribed as follows:

...either alone, in conjunction with other health care providers, or through other organizational arrangements, a community needs assessment evaluating the health needs of the community serviced by the hospital, that includes, but is not limited to, a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangement. The community needs assessment shall be updated at least once every three years.

(CA SB 697, 1994)

The state of California specifically defines community benefit as a hospital's "activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status." It calls for the provision of programming that is intended to provide services and additional benefit to definable populations that have expressed need for those services. Finally, hospitals are responsible for the development of a community benefits plan. "Community benefits plan" means a written document prepared for annual submission to [OSHPD] that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken in order to address identified community needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community" (CA SB 697). For the purposes of holding these hospitals accountable for this process, they are expected to annually submit a detailed community benefits plan to OSHPD documenting their intended activities and progress against the previous year's goals. This allows for an objective evaluation of the hospitals' performance and provides an opportunity to assess their program planning and need identification process. Figure 3.4 illustrates the components of the community benefit planning and programming process that are expected to be reported.

**Community Benefit Planning & Programming Process**

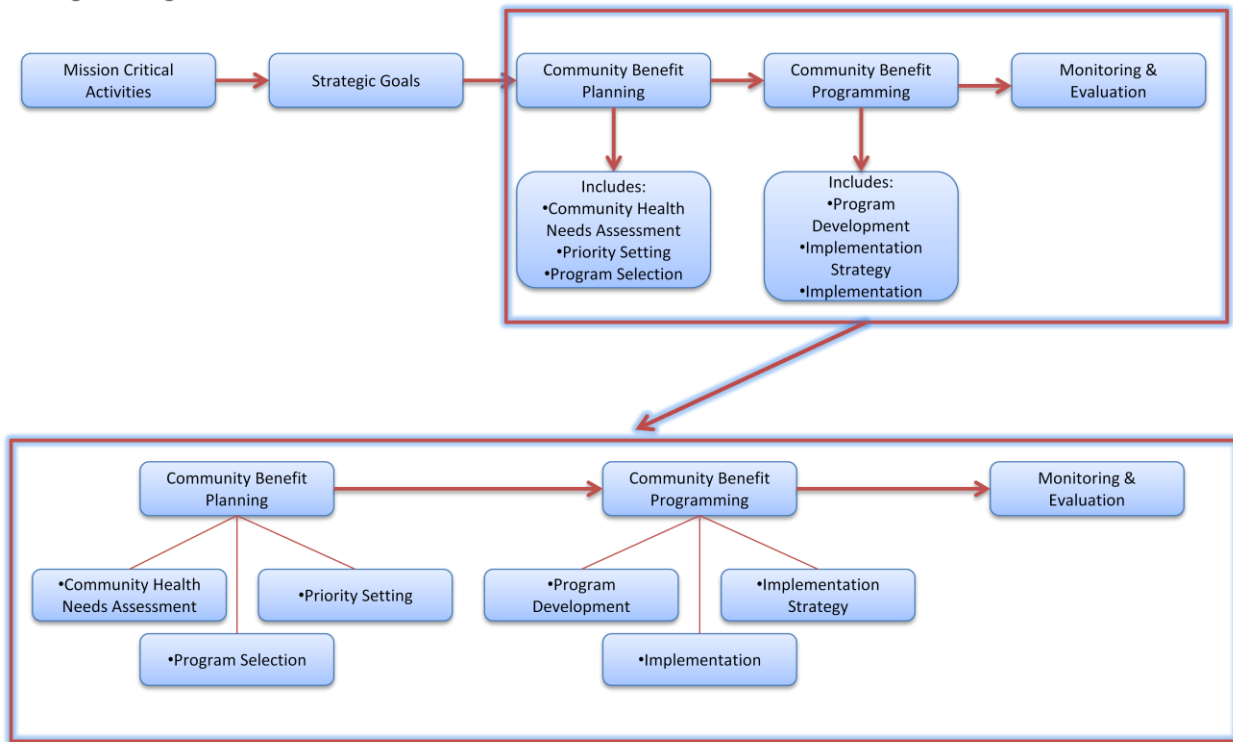


Figure 3.4

It is from this vantage point that the following sections will appraise a sample of California’s NFP hospitals’ community benefit programming for the year 2009.

Accordance with CA SB 697 obligations

California Senate Bill 697 requires that NFP hospitals maintain mission statements demonstrating a commitment to their obligation to provide community benefit in the public interest. These hospitals are also responsible for the consultation of affected stakeholders, the administration of community needs assessments, and development of community benefits plans. This requirement calls for hospitals to report processes for community consultation in “the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangement” (CA SB 697). Finally, they are required to annually submit these community benefits plan to OSHPD within 5 months of the fiscal year end which in turn makes the reports available to the general public (CA SB 697).

To assess the content of community benefit reports reviewed for this research, five sets of criteria were developed to determine the degree to which CA SB 697 requirements are being met. The following screens were applied to each hospital’s community benefit report:



1. Identify commitments to benefiting a community
  - a. Does mission statement contain language declaring a commitment to improve health in community?
  - b. Does report contain other documentation (vision, objectives, etc.) containing language declaring a commitment to improving health status in community?
  
2. Community Needs Assessments (CNA)
  - a. How did they define their community (e.g. primary/geographic service area)?
  - b. Did they identify specific communities with disproportionate unmet health needs?
  
3. Community Benefit Program Plan Development
  - a. Are there explicit criteria documented for setting priorities?
  - b. Is there any description of a priority setting process
  - c. Match of CNA priorities with community benefit programs
  
4. Community Stakeholder Representation/Participation
  - a. Community needs assessment
  - b. Program planning
  
5. Quality of Programming/Thoroughness of Report
  - a. Progress measures?

Findings for this assessment from these screens are provided in the table below.

*Commitments to Community Benefit*

Screen	Yes	%	No	%
Hospitals contained language in mission demonstrating commitment to underserved populations (1a)	9	18%	40	82%
Showed other documentation demonstrating commitment to underserved population (1b)	12	24%	37	76%
Hospitals identified a specific geographic service area (2a)	46	94%	3	6%
Hospitals identified communities with disproportionate unmet needs (2b)	38	78%	11	22%

*Community Needs Assessments and Community Benefit Planning*

Screen	Yes	%	No	%
Hospitals documented criteria for priority setting (3a)	22	45%	27	55%
Hospitals described a priority setting process (3b)	29	59%	20	41%
Hospitals described a process to solicit community input in CNA (4a)	38	78%	11	22%
Hospitals had no language describing a process to solicit government official input in CNA (4a)	47	96%	2	4%
Hospitals indicated that their community benefit plan was developed in consultation with their respective community (4b)	14	29%	35	71%
Hospitals listed the community groups consulted during development of community benefit plan (4b)	10	20%	39	80%

Screen	Strong	%	Moderate	%	Weak	%
Hospitals had linkages between priorities and community benefit programming (3c)	32	65%	7	14%	10	20%

Screen	All Major Programs	%	Some Major Programs	%	No Major Programs	%
Hospital reports had measurable objectives (5a)	22	45%	6	12%	21	43%

Table 3.1

**Assessment of CA Community Benefit Programs**

A content review of the community benefit reports from over 50 NFP hospitals in California revealed consistent programming strategies dedicated to individual, population, or community health outcomes. Within this sample, community benefit activities primarily consist of: funding community based organizations (CBO's) programs; administering hospital-based programs; providing direct health services, health education, and promotion; funding community clinics and health centers; training physician residents; and participation in coalitions and consortiums oriented toward health care issues.

Examples of community benefit programming in California include:

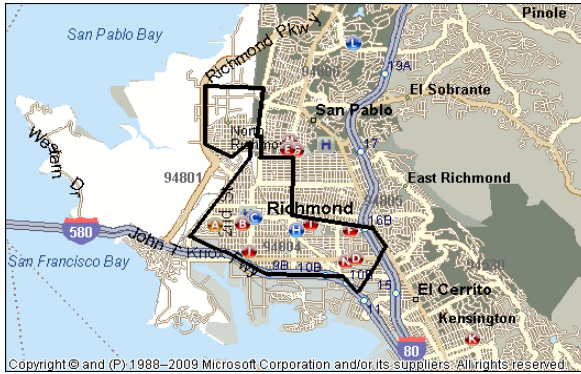
Program Type	Examples
Hospital Funded CBO Program	youth support, family support, homeless support, food environment, physical activity, job training, health service provision
Hospital-Based/Run Program	youth support, family support, case management, care coordination, internships
Direct Health Services & Health Education/Promotion	mobile clinics, health fairs, screenings, immunizations, patient outreach, farmer's markets, volunteerism, hospital facilities expansion/renovation
Medical Residency Training & Placement	community residency rotations, family practice residencies
Funding Community Clinics & Health Centers	infrastructure support, technical assistance, emergency loan pools, clinical guideline implementation, electronic medical records
Participation in Advocacy & Service Provision Coalitions/Consortiums	healthy food access, obesity prevention, community empowerment, green purchasing, land use, climate and air quality

Table 3.2

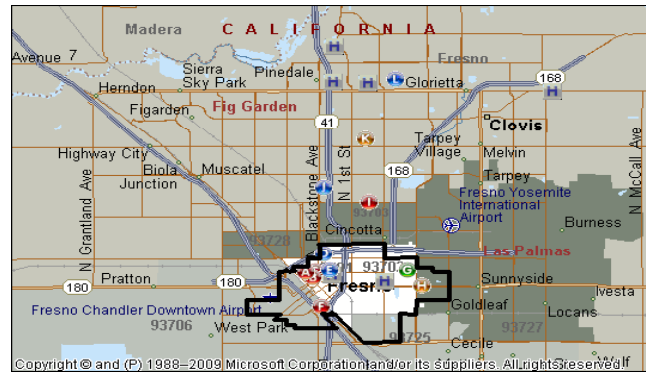
The geographic distribution of these programs tended to vary by region with more rural settings having a less concentrated presence of community benefit programs than urban ones. Further research might determine whether there is a correlation between programming and the concentrations of need in the communities that these hospitals serve.



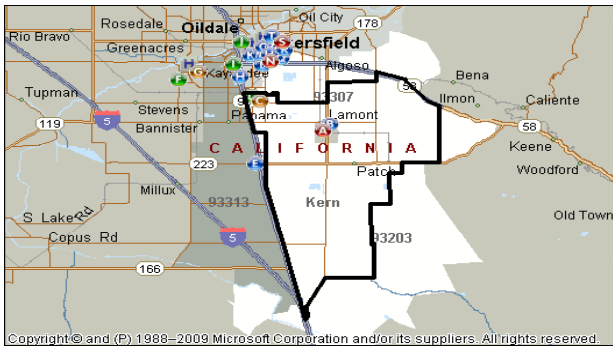
Richmond Local Health Access Map



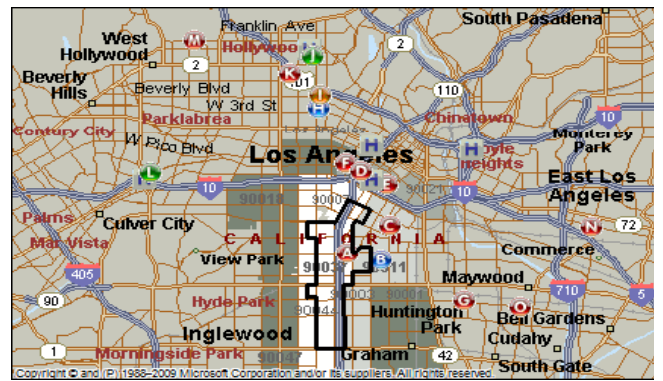
Fresno Local Health Access Map



South Kern Local Health Access Map



South Figueroa Local Health Access Map



Partners for community benefit programs in California typically consist of:

- neighborhood centers,
- community clinics,
- community clinic consortia,
- other hospitals,
- schools/school districts,
- faith-based organizations,
- county public health departments,
- CBO programs targeting select populations or providing specific services,
- local shelters (homeless, battered women, etc.)

These partnerships typically take the forms of funding or in-kind donation models. There are also instances of investing, sharing practices, and community development projects. The objectives and goals of community benefit programs are generally geared toward the following outcomes:

- youth development
- violence prevention
- family support; healthy behaviors
- healthcare access
- chronic disease management
- gang intervention
- improving food & health environment
- mental health services
- job training/skills training
- domestic violence
- health education/promotion

## Promising Community Benefit Models

The forms and goals of most community benefit programming throughout California are homogeneously structured and defined. Most programs work with a similar pool of local, regional, and state level partners. This mimetic pattern of programming may be expected from competing hospitals and systems that are required to comply with the same state and federal regulations (DiMaggio, 1983). It is also likely a result of these organizations' operations within the same market environments that present the same demographics demands for services, resource constraints, and costs of care.

Despite the general uniformity of community benefit programming in California, there are a handful of examples that are unique in their approach to improving communities' social and environmental conditions. These programs tend to target different stakeholders, engage with those partners in a manner different than what is typically observed, or have defined outcomes that fall upstream of those identified by the general population of community benefit programs. When taking into account principles of community-based participatory action and corporate social responsibility, these program work actively to engage community partners to achieve significant and purposeful impact on the communities they serve. The case studies that follow will highlight a sample of three strategies that effectively coordinate the strategic decision-making of the organization with its partnerships with community stakeholders. These characteristics make this subsample of programs unique candidates to assess in regard to their decision-making and community engagement models.

## Corporate Citizenship

This review of current community benefit programming has indicated that many systems have begun to implement programs that go beyond community benefit activity that is solely grounded in medical services (see figure 3.5).

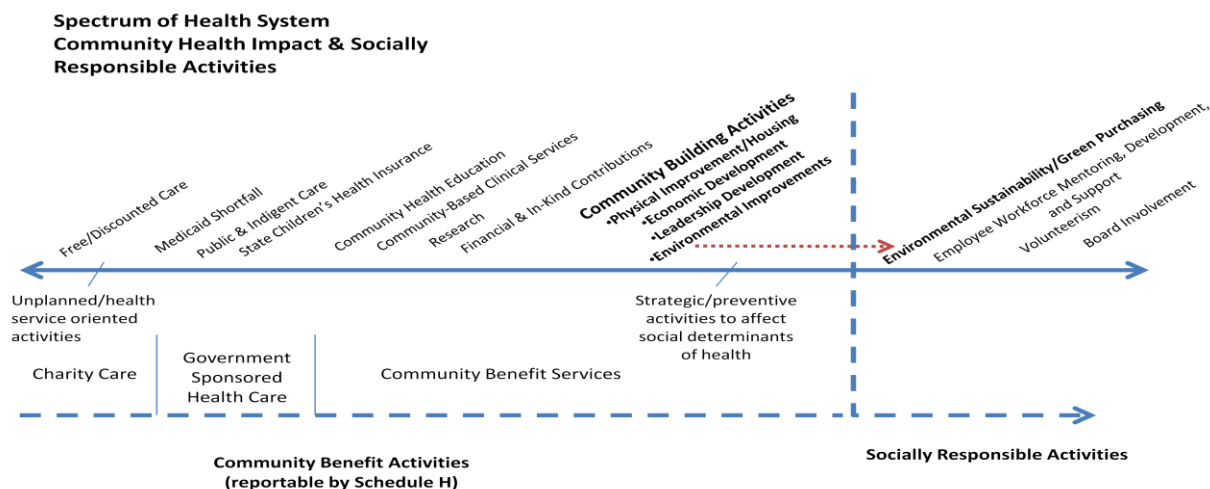


Figure 3.5

Some worth noting in California include: micro-financing, volunteerism, environmental sustainability including green purchasing and improving the built environment, and investments

to increase access to healthy foods in food deserts. Examples can be found nationally as well, these include healthy communities programs, sponsorship of 1<sup>st</sup> time home ownership programs, diversity workforce development, facility site selection, partnerships with vocational schools, and numerous neighborhood revitalization projects. These trends suggest that a growing number of NFP health systems recognize the link between community building and population health. These types of projects also signify that NFP health systems and hospitals recognize the significant roles they play in their communities aside from the provision of healthcare. Many of these programs are oriented toward sustainable development and community building. They demonstrate these systems' commitment to socially responsible activities as corporate citizens in their communities. Another momentous example of health systems that are electing to go beyond healthcare to benefit their communities is the Healthier Hospital Initiative. As a project that began in 2010, health systems have established a nationwide coalition of NFP and FP hospitals that are committed to the provision of promising environmental sustainability practices for the healthcare sector. (See Appendix N for a discussion of the background and significance of hospitals' environmental sustainability initiatives and policy advocacy.)

## **Discussion**

This overview of community benefit planning, programming, and reporting trends in California establishes the context for the investigation of NFP health systems' decision-making and community stakeholder engagement. It has examined a sample of NFP hospitals' reports and assessed their performance against CA SB 697 criteria. It was found that there is not complete compliance to the law's requirements on behalf of many of the state's NFP hospitals. It has also indicated that many opportunities remain for hospitals to strategically target pockets of their communities with the most need.

### Decision-making

- A majority had no documentation of their prioritization process for community needs.
- Less than half of the hospitals reviewed listed measurable objectives for their programs in their reports. Of the remaining hospitals, a significant number had no measurable objectives listed at all.

### Stakeholder Engagement

- No indication of how stakeholder input was solicited, which stakeholder groups were consulted, or if their community benefit plan was done in consultation with community stakeholders.
- Furthermore, a significant majority had no mission-related language that indicates a commitment to populations that demonstrate the most need in their communities.

While required to define a process for the identification of priority community needs, many of the community benefit reports were not clear in regards to the decision-making for that procedure. There was similar ambiguity in regards to how stakeholders were engaged and whether hospitals' programs achieved any impact. Taking into consideration the federal requirements being called for by Form 990 and the ACA, many hospitals currently do not

sufficiently report their processes to target community needs and engage stakeholders. At face value, it appears that the requirements called for by CA SB 697 have not been completely effective in insuring the adherence to community benefit guidelines by many institutions. These findings suggest that there are opportunities for many hospitals to be strategic and transparent about their decision-making and partnerships to achieve impact in the communities they serve. Alternatively, it is possible that many hospitals do not have the resources to adequately report their priority setting, stakeholder engagement, or program measurement. If this is the case, the argument can be made that valuable lessons can be learned from those that are able to effectively meet these criteria given limited resources. It is also possible that the state agency responsible for oversight of NFP hospitals' activities is under-capacity. This might result in the inadvertent creation of leeway for health systems to relax their commitment to meet the law's requirements given their own resource constraints.

Clear frameworks for strategic decision-making and stakeholder engagement can potentially address many of the issues raised by this assessment. Analysis of the content and geographic distribution of programs in relation to concentrated areas of high need indicate that opportunities exist to strategically leverage resources to achieve impact in targeted communities. This can be accomplished through partnerships with various stakeholders to leverage the capital and applicable competencies that exist in these areas. Strategic investments through these means can meet both the health systems' business objectives and unmet needs of the communities they serve. This is specifically pertinent in California given the political and market environments that are readily embracing and preparing for the changes called for by the Affordable Care Act. If the state's landscape changes such that the number of uninsured decreases and current community benefit services are subsidized by federal support; charity care and provision of health services will account for fewer community benefit dollars. Beginning to understand how to strategically invest in other practices other than medical services that support develop community's health can inform the practices of those health providers that can improve in this area.

# Methods

## Overview

This exploratory research examines how NFP health systems and hospitals partner with communities. This includes an introduction to the intersections of community benefit, corporate social responsibility, sustainable development, and community partnerships; a literature review of these topics; three case studies examining NFP health systems and hospital partnerships oriented toward community development; a review of the research findings – including lessons learned, implications, and possible applications. Each case study will assess one example of an exemplary partnership of a given type as defined in the proposed Ladder of Partnership Participation.

Case studies that consisted of interviews, document analysis, and surveys were selected to illuminate how NFP health systems and hospitals approach partnerships with the purpose to affect social and environmental conditions. The case studies specifically explored the trust, power, and accountability balances between partners during the implementation of the partnerships.

## CSR & Partnership Frameworks

The risk-opportunity continuum and Ladder of Partnership Participation discussed in the introduction were employed as frameworks to guide the investigation of decision-making considerations made by managers prior to and during the initiation of partnership strategies with stakeholders. The Ladder of Partnership Participation was adapted from a similar model used by the Contra Costa County Department of Public Health. Simultaneously, I worked with staff from the Public Health Institute’s Partnership for the Public’s Health to frame a typology of organization-community partnerships adapted from their models of community based public health (CBPH). Figure 4.1 illustrates how these frameworks were applied to examine the interaction between NFP health system partnership strategies and their purpose(s).

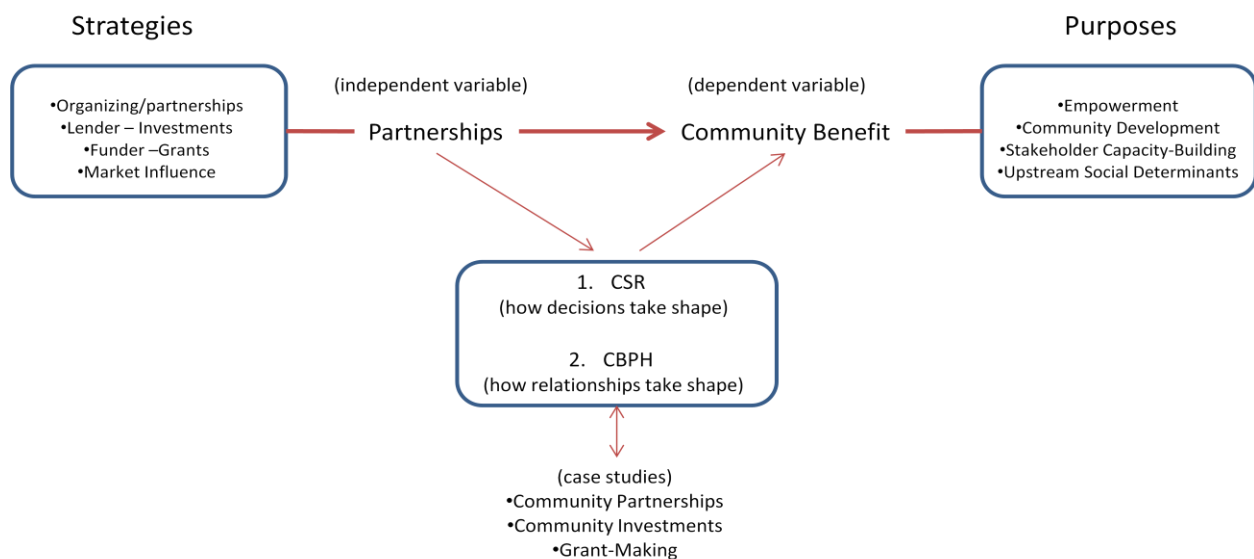


Figure 4.1



## Research Questions

### Primary Question:

How do large not-for-profit health care delivery systems establish partnerships with public and private organizations aimed to improve community health?

### Secondary Questions:

- What are the forms, structures, and purposes of these partnerships?
- In what ways do trust, power-sharing, and accountability vary by different types of partnerships?
- For each type of partnership, what are the best practices for dealing with issues raised by resource constraints that threaten the ability of the partnership to achieve shared goals?

## Research Design

This study employed an embedded multiple-case study design that examined NFP health systems in the context of their community/sustainable development efforts, with units of analysis consisting of partnerships between systems or hospitals and external organizations. Figure 4.2 illustrates the research design of this study.

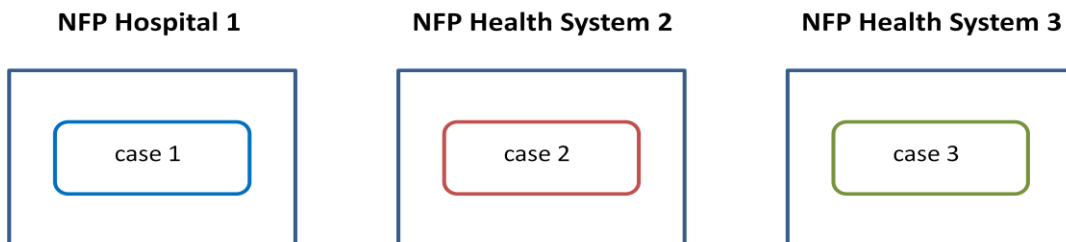


Figure 4.2

Partnership implementation was assessed through mixed methods analysis. Background information was collected on California community benefit programs that included their target populations, objectives, geographic distribution, and funding allocation. Interviews were conducted and surveys were administered to NFP health system leadership and management to gain a sense of their decision-making as it pertained partnerships with stakeholders and investment in communities. The intent was to establish an overview of practice in the field and to support that with a deeper investigation into the decision-making and partnership models that brought a select group of community benefit activities to fruition.

### Community Benefit Programs

A review of California's NFP hospitals' community benefit reports was conducted to develop a baseline representation of California's nonprofit hospitals' community benefit reporting for the year 2010. The purpose of this process was to better understand the landscape of current hospital practices aimed at providing community benefit programming. It was also meant to facilitate a discussion about the impact of CA CB 697 policies on reporting and practices,

particularly community development activities. In August of 2010, a list of all hospitals that submitted community benefit reports in 2010 for programming provided in 2009 was obtained from the Office of Statewide Health Planning and Development. Only NFP hospitals located within the 5 largest combined statistical areas in California were included in the review. Children's hospitals and regional public hospitals located in these areas were excluded from the analysis.

Hospitals from the largest 5 combined statistical areas in California were selected. These include:

1. Los Angeles-Long Beach-Riverside
2. San Jose-San Francisco-Oakland
3. San Diego-Carlsbad-San Marcos
4. Sacramento-Arden-Yuba City
5. Fresno-Madera
6. Bakersfield
7. Stockton
8. Modesto
9. Salinas
10. Merced

(United States Census Bureau, 2012)

The study sample included 49 NFP hospitals that are associated with 8 health systems that operate within California. No hospitals that met the inclusion criteria were excluded from the analysis.

## **Case Studies**

### Case Selection & Criteria

Drawing from the pool of health systems serving the largest Californian metropolitan areas, I used a purposive selection strategy to choose three local NFP health systems and hospitals for analysis. Consideration of partnerships was restricted to interactions between NFP health systems and stakeholders that involved support beyond financial contributions. They must also have included exchanges of other resources or expertise. The pool of sites from which to sample was limited to Bay Area NFP health systems. Here, I was able to gain access to key decision-makers, managers, and leaders within the organization and their partners for: in-depth interviews, document analysis, and administration of surveys.

Within the selected sites, potential partnerships were determined by how they were created, maintained, and used to achieve shared goals within the following categories:

- Investing and Economic Development
- Diversity Recruiting/Workforce Environment
- Environmental Improvement
- Physical Improvements
- Provision of Community Health Workers
- Grant-Making/Funder Model

These categories were drawn from the community building activities as prescribed by Schedule H which include: expenditures for physical improvements, economic development, support-system enhancements, and environmental improvements focused on various types of hazards

and pollution, leadership development for community members, coalition building and advocacy related to health, and workforce enhancement (Gray, 2009).

Community benefit practitioners from local health care systems were referenced to further identify promising practices that fit into each of the above categories. Promising practices were self-defined by community benefit practitioners and health system leaders that I spoke with prior to and during my field work. Potential cases that were identified are outlined below:

#### Potential Cases-

- a) Investing
- b) Grant Making
- c) Workforce Development
- d) Environmental Contracting – Green Building
- e) Environmental Contracting – Biodegradable Products Supplier
- f) Advocacy
- g) Environmental Partnering – Built Environment
- h) Partnering with Clinics
- i) Partnering with Local Community Organizations

To meet age and adherence to uniform community benefit laws criterion, the prospective cases must have: consisted of matured partnerships with stakeholders that had been established for at least 5 years; were primarily located within the state of California; and must have met the majority of California’s community benefit reporting requirements. The final partnerships from which to build case studies were selected because key decision-makers reported them as strategically important to the missions of their organizations and the cultivation of relationships with stakeholders. Three partnerships were identified within local community benefit departments that met these criteria and were willing to grant access to their programs for evaluation.

### **Data Collection Methodology**

#### Constructs Measured in Each Case Study

The constructs examined in this study were mission, risk, opportunity, trust, power, and accountability. The preliminary selection of constructs to explore in this study was informed by: professional experience; literature reviews; and previous interviews with local public health practitioners, community benefit directors, and other community health representatives (see Appendix O for a list of constructs). Granner and Sharpe conducted a literature review of community partnerships revealing key constructs and scales used to measure them (Granner, 2004). A database summarizing these constructs and scales can be found in Appendix P. The survey instrument used was developed in consultation with the CDC Partnership evaluation tool, as well as other power, trust, and accountability psychometric scales. It also adopted scales from previous tools used to examine various components of partnership mobilization, capacity, and leadership.

## Interview Guide & Scales

See Appendix Q for interview instrument and Appendix R for partnership evaluation survey.

## Methods of Data Collection

This exploratory research employed qualitative and quantitative methods. Data was collected between the fall of 2010 through the summer of 2011 at two NFP health systems and one hospital in the Bay Area. Leadership, management, and staff were interviewed and surveyed to understand how decisions were made, including what factors were taken into account. I also sought to understand how partnerships were formed and maintained, as well as what factors influenced this process. There were three means of data collection used in this research.

Two qualitative data collection methods included:

1. Key Informant interviews: 32 one-hour interviews with NFP health system representatives at various levels of the organization including leadership and community benefit professionals. Interviews were also conducted with representatives of their partner or contracted organizations.
2. Archival review of performance reports, grants, meeting agendas, attendance rosters and minutes, and institutional mission integration policies. Performance reports, grants, progress reports, meeting agendas, and mission integration policies were examined to understand the goals of each partnership, and whether partnership and contractual goals were achieved.

Quantitative data collection methods included:

3. Surveys: 21 questionnaires that included validated psychometric scales to measure trust, power, accountability, and organizational values were administered to interviewees, board members, and select staff at each site.

In-person interviews began in December of 2010 and were completed in September of 2011. They were administered to the directors and staff of select community benefit programs to gain a sense of how decisions were made to engage in partnerships with stakeholders and how those partnerships would take shape.

Surveys were administered to respondents and their community partners to assess levels of trust, power-sharing, and accountability within each partnership. The survey used to measure these variables was accompanied by a cover letter that explained the purpose of the study. Participants were informed that their responses would be kept confidential and only viewed by the researcher. Participants who completed the survey contacted the researcher to be picked up personally or returned it by mail in a sealed envelope. All respondents were ensured that collected data would be aggregated for analysis so that individual responses could not be identified.

## Analysis

All key informant interviews were transcribed and coded upon completion. Transcripts were coded by themes suggested in CSR and CBPH literature as relative to partnership implementation. They were also coded by one emergent theme, mission, that arose during the interviews. A code key informed by theories and frameworks of decision-making, stakeholder engagement, and participatory action was created to search for themes in each interview transcript. The key served as a summary of important themes and phrases that were interpreted to reference constructs identified from CSR and CBPH literature. A primary rater coded each transcribed interview and an experienced second rater also independently coded a sample of the interviews. The raters used the code key to identify references to each construct in the transcripts of the interviews. As interviews were conducted, the interview guide and code key were refined per additional feedback from informants. Over the course of the analysis, there were four instances of coding discrepancies between raters. Discrepancies were resolved by the following process. First, both raters revisited the text of the original interview transcript to gain a sense of the code's implication in the context of the response. Next the code and the definition of its corresponding construct were reviewed. Finally, the raters shared their interpretation of sections that were coded differently and came to agreement on a final categorization.

A database was created to log all quotes from interviews that were coded by decision-making and relationship constructs. Quotes were entered into an excel spreadsheet that served to track and organize each quote by the construct(s) they referenced. Separate worksheets were created for each case and quotes were recorded in the order of respondents for each case. Comments that best summarized the common intent expressed by respondents in regards to each construct were selected for inclusion in the body of each case study.

Once coding was completed, factors from each case were identified that influenced decision-making and implementation that could be linked directly to study evidence found in archival review. Analysis of data was performed by triangulating the presence of partnership selection considerations from interviews, archival document analysis, and surveys. The Ladder of Partnership Participation was built from community participatory action and general partnership theory to develop a classification of partnerships that was better suited to evaluate not-for-profit healthcare providers' partnerships; specifically those intended to deliver services or improve environmental and social conditions as a community benefit. I used a multiple-case study approach to examine the partnerships of three NFP healthcare systems in the Bay Area. Upon developing the typology, I explored the strengths and weaknesses of these categorizations as criteria for evaluating the effectiveness of the partnerships engaged in by these systems. In addition, for each type of partnership, I identified promising practices to resolve issues raised by resource constraints that threaten the ability of the partnership to achieve shared goals.

It was my intent to test the applicability of the partnership typology used for community-based public health strategies to the NFP organizational setting. I compared hypothesized levels of trust, power-sharing, and accountability in partnerships as defined in the Ladder of Partnership

Participation with informant insights, archival analysis, and survey results. Analysis was performed to assess the degree of variability of measured constructs across partnership types. The finalized Ladder was a normative model and therefore no partnership strategy was determined to be inherently exceptional in comparison to another.

#### Threats to Validity & Methods to Offset Them

This exploratory research was not intended to be used for causal inference or to make generalizable claims about all partnerships. The number of sites studied was small and the selection process was nonrandom. Organizations may have had an incentive to report greater levels of trust, power-sharing, or accountability and thus could have over-estimated the effectiveness of the process and outcomes of partnerships. Extensive use of direct quotations from multiple informants with varying viewpoints of the partnerships in which they participate increased assurance in the data collected. Interview respondents were contacted to verify their comments and other local community benefit practitioners reviewed the study's findings for validity.

## Case 1

### Overview

This section presents case evidence to illustrate a NFP hospital system's community benefit strategy that incorporates the application of community organizing principles in its partnerships with local stakeholders. The intent of this strategy is to develop the capacity of local stakeholders to take preventive measures that will improve the health of the communities it serves. Within the department, one director supervises the activities of 6 core interrelated community benefit programs.

The case department directs a majority of its services and programming toward the underserved populations and communities in its region. The health system operates in a county where one in five households have an annual income less than \$30,000 and approximately 10,000 families live under 100% of the Federal Poverty Level (U.S. Census, 2005). In recent years, job growth has decreased and unemployment has increased to over 10% (case department #1, personal communication, January 2011). In addition, underserved and isolated populations in the county have reported lower rates of health insurance and access or utilization of public programs.

These dynamics present significant challenges, specifically to families and individuals who are subject to economic, cultural, and physical barriers when seeking services. Poverty and cultural barriers contribute to the creation of disenfranchised communities that are challenged to empower themselves for the improvement of their immediate conditions and behaviors. These circumstances are compounded by a diffuse and often under-resourced public infrastructure that is equally challenged with reaching and delivering services to these isolated populations.

In the face of their own constraints, local agencies and stakeholders in this region have become adept at working together to leverage resources to fill in gaps of services and care. Concentrated efforts are made to share information, collaborate on county-wide initiatives, and pool support of programs meant to improve communities' and individuals' health. The underlying goal of these partnerships is to invest in efforts that will produce sustained and healthier outcomes throughout the county.

The community benefit department for this health system was selected because of the strong community organizing approaches that it integrates into community outreach, community program planning, and local stakeholder relationships. This case will explore how the community benefit department of a NFP health system responds to these community and infrastructure challenges through the use of community organizing as a core component of its operational strategies. The programs and staff in this department actively engage in partnerships with the intent to empower communities and connect underserved populations to services they need. The extent to which these practices are embraced has been nationally recognized and is unique to the field of community benefit. The following sections identify and examine the decision-making and relationships that are formed to drive this type of community benefit strategy. For this particular strategy of community partnership, the decision-making

variables of mission, risk, and opportunity will be described in the context of how they relate to the trust, power, and accountability dynamics of relationships between partners.

The following section will provide further details on the organization, strategies, decision-making, and partners of this department. The chapter will then describe the decision-making and relationship measures that informed the data collection process of the case study. Next, the results of the data collection will be shared followed by a discussion of these findings in the context of informing community benefit practice.

## **Background**

The case department is situated within a regional mission-driven NFP hospital network in northern California that is part of a multi-state health system. The health system operates two full-scale hospital facilities and is the second largest employer in the county. The county itself is largely rural and depends on agriculture as a driver of the local economy; with manufacturing, health, and education services being the significant industries in the area. Many areas in the county are federally classified as Medically Underserved Populations due to low-income populations and Primary Care Health Professional Shortage Areas (case department #1, personal communication, January 2011). The hospitals affiliated with the community benefit department being explored in this case serve a broad spectrum of populations hailing from the suburban and rural communities. California OSHPD reports indicate that 62% of the patients the health system serves are Hispanic, 16% are seasonal agricultural workers, and 42% of all encounters were for homeless patients (case department #1, personal communication, January 2011). The department's programs are aligned with this data, as they target populations with disproportionately unmet health needs including: "recent immigrants, migrant seasonal agricultural workers, day laborers, homeless, working poor, and uninsured or underinsured children, adolescents, and adults" (case department #1, personal communication, January 2011).

Six core programs and clinics constitute the make-up of the case department, each with a manager and a staff ranging from five to ten team members. All of the programs in the department are housed in one facility, separate from the hospital campuses, and many of their outreach and service delivery activities are planned in conjunction with one another or other hospital departments – few program activities are done in isolation. The programs within the department actively partner with local public agencies that include: schools; churches; non-profit agencies and hospitals; the county department of public health as well as other county and city officials; and various resident and community groups.

The department specifically seeks to "[integrate] actions through strategic elements that address the political, social, behavioral and physiological determinants of health" (case department #1, personal communication, January 2011). The department achieves this through the application of community organizing and partnership strategies intended to build capacity to address social determinants in the community; as well as meets the department's and broader organization's strategic goals. As discussed above, the department, its programs, and staff prioritize the improvement of social and health conditions of communities through



the strategic application of community organizing and partnerships. These are essential components of the community benefit strategy and are institutionalized through formal policies guiding the department's governance. The programs and staff are explicitly charged to work with residents and other agencies to empower communities to: access health and social services; participate in municipal decisions that affect them; and build their capacity to take ownership of their collective well being.

All actions taken on behalf of the organization are expected to be consistent with the system's mission, values, and commitment to serving vulnerable populations. The health system's policies institutionalize its commitment to community benefit investments and hold it accountable to focus on disadvantaged populations despite rising healthcare costs. Approximately 60% of the system's patients are below the Federal Poverty Level and it has reported spending over \$40 million on the provision of charity care and subsidies to other state and local care delivery programs (case department #1, personal communication, January 2011). The system annually invests approximately 10% of its net income into programs or projects intended to increase access to healthcare, community services, and foster partnerships with other funders and stakeholders. 1.5% of the system's operating budget directly supports community benefit department activities and programs. Since this is viewed as mission-driven work, this has amounted to more than \$2 million dollars a year in the past despite significant resource constraints due to the economy.

As a NFP hospital provider in this region, the health system faces particular challenges to delivering care to the underserved and isolated populations throughout the county. Like its counterparts, the health system faces key issues of rising costs, uncompensated utilization, developing implications of healthcare reform, increased health needs in the community, and reduced public services and safety net capacities to meet those needs. In addition, the county's infrastructure and demographics give rise to high incidents of socially, culturally, and geographically isolated populations with limited access to resources. The confluence of these factors places a strain on the system because of need for and use of services provided by hospitals.

### Strategies

Community empowerment and leveraging partnerships are the key strategies that factor into all programming and relationships that emerge from the department. Any outreach or community engagement through the department actively applies principles of empowerment, capacity-building, and collaboration. Operationally, these strategies are an extension of the core principles adopted to guide the department. These principles are intended to operationalize the mission and values of the organization and call for emphasis on: disproportionate unmet health-related needs; primary prevention; collaborative governance; the development of a seamless continuum of care; and building community capacity.

Programs within the department are strategically-oriented to address the social, behavioral, and physiological determinants of health. Whenever possible, each program works in concert with one another dependent on which services are needed or populations are served.

Community empowerment and coalition building are central components to all of the department’s activities. Program activities are designed to build capacity that can encourage residents, especially vulnerable populations, to become more engaged in working with one another and other stakeholders to manage individual’s and community’s health. The department applies community organizing as a strategy because of the large numbers of vulnerable populations that are largely uninsured and lack access to many health and social services. Given the largely rural and expansive geographic nature of the county, a centralized infrastructure to provide these services is limited. Additionally, given the economic downturn in recent years, there are limited public financial resources available to deliver care and services to isolated populations spread throughout the county.

Key decision-makers involved in the process of community benefit planning, programming, and implementation are comprised of staff from the aforementioned departments and committees. In addition, executive leadership from the office of the organization’s strategic planning works closely with their counterparts in mission integration to assure that organizational and community benefit goals are aligned. Decisions regarding partnerships, community engagement, and daily operations are determined by the department’s managers and staff. At this level, staff members are explicitly expected to seek out and foster relationships with community stakeholders for the purposes of achieving the community benefit department’s goals. The parameters in which these decisions are made are determined at the committee and executive leadership levels of the organization.

In a county where there is a burdened infrastructure to deliver services to the populace, partnering is encouraged and takes place amongst most public agencies and stakeholders. The case community benefit department serves as a conduit between the system, other agencies, stakeholders, and communities by working with them as partners to specifically develop sustainable solutions to issues facing underserved communities. Staff and leadership at the department and system level actively collaborate and form partnerships with stakeholders throughout the county. These partners consist of an array of various stakeholders, service providers, and advocacy agencies as depicted in Table 5.1.

Other NFP hospitals	Neighborhood Groups	Housing development organizations
County department of health services	County senior services	Law enforcement
Homeless service agencies	Maternal and child health agencies	City and Municipal leadership
Health education and promotion agencies	Violence prevention agencies	City parks and recreation
Community clinics	Families, children, and seniors	Public works departments
County public school systems	Farmer’s markets	Chambers of commerce
Public transit	Agricultural workers	Local and statewide foundations and philanthropies

Table 5.1

At the system level, these partnerships assume a variety of forms as resources and capacities vary amongst the stakeholders engaged with working with underserved communities. Partnerships take place in the form of networks, joint ventures, community initiatives, sponsorships, shared advocacy, or endorsements. Through the approval for provision of resources and staff time to support these collaborations, the system establishes a framework that guides staff activities in the community benefit department. At the department level, community benefit program teams engage in partnerships that are less formal in structure and consist of direct relationships with stakeholder and residents and emphasize information sharing and resource sharing. Informal relationships are important to the department's organizing strategy as they allow staff to be responsive to marginalized populations and emergent needs in the community. Given the limited resources available to most stakeholders providing services to marginalized populations in the county, many partnerships are structured to share accountability, resources, or fiscal burden.

The community benefit department's programs, projects, and partnerships prioritize the delivery of services and empowerment of underserved and isolated populations throughout the county. Barriers to this strategy include cultural and geographic isolation of marginalized communities such as recent immigrants, home-bound seniors, and youth. Many residents do not access health or social services because of language, cultural, transportation, or childcare barriers. These dynamics lead to communities that are disconnected from the community-based support available to them and foster downstream predicaments ranging from physical illness and food insecurity to violence, social isolation, or depression. It is due to the prevalence of these circumstances and conditions that the case department has adopted a community organizing strategy to engage partners to address the social determinants of health.

## **Findings**

### **Roles of Mission, Risk, and Opportunity**

The community benefit guiding principles that institutionalize the mission of the organization are the primary drivers of the department's use of limited resources, populations served, and partners for collaboration. The policies that stem from them serve as initial screens for which community needs are targeted and how they will be met. The mission establishes the foundation of guidance regarding: partnership purpose; partner and population selection; the roles representatives of the organization assume in partnerships; and establishing credibility amongst peer agencies.

The community benefit department first considers partner selection when engaging in partnerships. Whether at the system or department level, appropriate partners are determined on the grounds of fit with the mission of the health system. An executive described part of the process of forming collaborations by taking those considerations into account,

*"...I think in terms of deciding or determining what partnerships were a good fit, it needed to be aligned with the mission and vision of our organization; social justice kinds of principles." [System Executive Leader #1]*

Once staff from the department is engaged with other stakeholders as partners, the system's mission serves as a beacon for purpose and provides clarity to their roles. One organizer in the department describes their work in the community as aligned in this way,

*"...and the good thing about what we do is very much congruent with the values of the [founding ministry] because their vocation was to go out in the community, bring people together, help them understand the issues, bring the resources for the partners to help them resolve...so it makes it very clear for us." [Community Benefit Department Staff Organizer]*

The principles that guide the community benefit department's community organizing and partnership strategy are operationalized extensions of the health system's founding ministry. The department's roles and commitment to partnerships are clear to its staff as well as its partners – this establishes a sense of credibility amongst peers.

Many of the local stakeholders with an operational focus on meeting the needs of underserved populations throughout this county rely on the political currency of shared values amongst partners. Being a mission-driven organization facilitates the case department's ability to maintain sustained relationships with local stakeholders doing similar work because of their shared commitment. One longstanding partner with the department noted the operational value of demonstrating a strong commitment to vulnerable populations,

*"I mean people that you contract with this kind of work, you need some mission behind it, you know, no matter what agency it is, there has to be commitment to people. Caring about people, and if that is missing, it's not going to work" [Community Stakeholder Partner]*

The importance of shared values is magnified in a market where nonprofit service providers may significantly rely on limited state funds, subsidies, or philanthropic grants. Agencies that work with marginalized communities do so in an erratic market where the availability of these funds can be minimal or inconsistent. Proven commitment to working with these populations serves as political currency that provides more stability than funding streams. Commitment to these values also plays an important role to justify the allocation of costly and limited resources. When asked why partnerships are necessary to provide services to marginalized communities one official responded,

*"Our mission and vision of our hospital is what really drives this, because it costs a lot of money to do it, but we feel through the mission and vision of [our founding ministry] it is the right thing to do, which is I think initially what drives the majority of these collaborations because all of the populations that we are serving are underserved" [System Department Director]*

The system's commitment to the improvement of the health, social, and environmental conditions of marginalized populations sustains its consistent engagement in with populations

that have a negative impact on the system's bottom line. The use of community organizing and partnerships as strategies allows the community benefit department to reduce liabilities for the health system. It offsets the system's cost of care and risk assumed through the provision of services and care to vulnerable populations.

Reaching these vulnerable populations and helping them to develop healthier lifestyles and health seeking behaviors while connecting them with needed services is very costly. Leadership within the system reiterated the significance of costs associated with carrying out the health system's mission by supporting programs for underserved populations.

*"So serving the vulnerable, where we...what can we do together that we couldn't do on our own kind of thing, is kind of the premise." [System Executive Leader #1]*

Strategically working through partnerships is necessary to increase the likelihood of effectiveness and offset the inherent risks of serving marginalized populations. Using partnerships and community organizing as strategies to achieve community impact both embodies the organization's mission imperative and eases the department's challenges of operating within resource constraints. With the system committing 1.5% of its operating budget to community benefit activities, limited staff and budget are spread across its programs. In addition, the department is challenged with engaging hidden or isolated populations with high health risks that infrequently access services. Forming partnerships with local stakeholders and residents spreads the burden of outreach and service delivery and helps to offset the costs of the health system doing this work unilaterally.

Many community benefit program manager's discussed the value of empowering residents to learn healthy behaviors and connecting them to preventive services in the community. This was contrasted with the alternative scenario where the health system assumes liabilities associated with people receiving inpatient care in their facilities,

*"...we try and hook them up the best we can with any services that we have in the county or through their insurance company...whatever we can do for the bottom line for the health system. It is very expensive to have an emergency room visit [so being able to provide care outside of the hospital setting] is really beneficial to the entire health system." [Community Benefit Department Manager #2]*

*"...if it's a major diagnosis, obviously they are going to end up in the emergency room and probably get a huge bill that they probably will not be able to pay. And the hospital will obviously get no money for doing the services and as far as depending on what they are coming in for, for example if you have a upper respiratory infection it could be a simple call but it could turn into pneumonia and turn into a hospitalization, the little thing that the person could have gotten when we aren't here... if we don't get it, it could turn into something major" [Community Benefit Department Program Staffer]*

*"[The] advantage to [reaching residents in their communities] for the health system is because we help them through their bottom line, to keep that frequent flyer out of the emergency room and the hospital" [Community Benefit Department Program Manager #2]*

*"...we were able to report that we deferred I think it was 78 emergency room visits or acute care visits" [Community Benefit Department Program Manager #2]*

All of the community benefit department's staff are aware of the preventable downstream health and cost effects that their programs impact. This is an example of significant leveraging of resources given the relatively small staff and limited resources at their disposal. This is a dynamic that is not lost on the department,

*"...we don't have very many people, so really thinking strategically knowing that we have these core initiatives around obesity prevention, around prevention and around oral health so how like in the bigger picture, and we are violence prevention program, so in the bigger picture, how is that going to help us meet our strategic goals and initiatives?" [Community Benefit Department Program Manager #1]*

The department is able to optimize its limited staff and resources to satisfy the mission and goals of its organization by applying two important tactics. First, programs and staff strategically link their efforts to core system initiatives and priorities so that their activities are oriented toward specific populations and health outcomes. Second, the department actively partners with local stakeholders that are committed to working with vulnerable populations which offsets the risks associated with investing resources into these communities alone.

In addition to serving as a buffer from risks for the health system, the case department's strategy to partner with stakeholders presents opportunities to increase effectiveness and create business value for the larger organization. Partnerships and organizing help the department to: leverage stakeholder and community resources to achieve health impact and to identify means to develop less costly means of providing care to the public. An essential component of the department's ability to recognize and act on these opportunities in the community is the degree of managerial discretion granted to staff by department directors and system leadership. When describing how partnerships are formed in the community, a program manager explained,

*"...if something does come up I can kind of go, oh, you know, I think this is a need and they will go okay, that is all right, let's try that, and that is my biggest thing is that this organization is very flexible in the way that they kind of let us make our own decisions" [Community Benefit Department Program Manager #3]*

The integrated and coordinated structure of the department gives the staff the information and knowledge necessary to identify needs and opportunities in marginalized communities as they arise. Attention to the strategic goals of the system plays an important role in the identification

of activities that may impact selected health outcomes. A staff member described how the system's goals are considered as follows,

*"So the hospital has a strategic plan for our community benefits department and the strategic plan...and then they relook at it. So somebody outside of me is looking at our community, [and] what are the highest needs in these areas..[partners addressing these needs] is who we collaborate with, other agencies who are working with the same populations to get the patients to the services that they need." [System Department Director]*

Programs' staffs are enabled to make decisions about engaging stakeholders and residents to achieve the strategic goals of the department and system. This stems from trust in the staffs' capacity to act as ambassadors of the system's mission and to do so within the confines of what is fiscally or politically feasible for the department and health system.

By working closely with their partners, small service provider agencies throughout the county can informally coordinate referrals, service provision, and program activities in the community. The case department representatives are active partners in this network and are able to leverage the connectivity to increase the impact of their services and outreach within vulnerable communities.

*"...we serve by leveraging the strengths of these individual non-profits. You know, what could we do together, again, better, and with greater impact to the community that we couldn't do on our own? And certainly when you bring outside resources that leverage your own resources spent engaging the populations so it kind of doubles and triples it." [System Executive Leader #1]*

*"So we don't look at other [programs or activities] as competition at all. We really look at it as, how do we enhance each other?" [Community Benefit Department Program Manager #1]*

*"Our program cannot do it all on our own and I rely on those other organizations just like when we are out doing a health education on nutrition and something comes up around parenting, I am going to call in one of my partners to come in and say that is not our specialty, we don't do parent ed., but I know somebody at [another agency in the county] and get that [referral to them]." [Community Benefit Department Program Manager #3]*

The department leverages its connections with partners to facilitate residents' access to services in the county. Many populations with limited access to health and social services due to isolation or other barriers need these types of coordinated networks to increase their awareness and usage of local assistance. Leveraging resources through partnerships also presents the department with opportunities to pool resources and collaborate to deliver larger scale initiatives with a wider reach. This approach amplifies what could be achieved by one

organization because of additional access to partners' funds and resources, grant monies, and populations.

As one of the only large institutions in the county to engage directly with community building efforts with the underserved, the department's work also creates business value. The department's core competency of community organizing distinguishes the health system from its counterparts as sought after partner for initiatives that engage marginalized communities. As a health provider, this fortifies the organization's commitment to underserved communities and enables it to consistently work in lockstep with its stakeholder partners.

### Roles of Trust, Power, and Accountability

Due to its commitment to community organizing and partnerships strategies, the case department is immersed within a network of overlapping partnership environments. The community benefit department works at the intersection of three distinct relationships that must be balanced and coordinated in order to carry out its programs and activities. Figure 5.1 illustrates the interaction of these relationships.

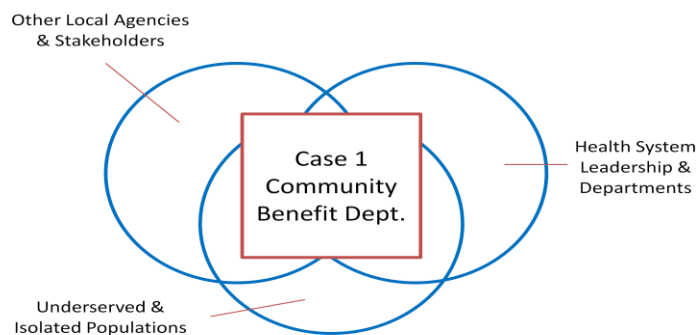


Figure 5.1

The first consists of the relationships between the community benefit program directors and staff and other governing bodies or departments throughout the system that are essential for strategic coordination of outreach and care delivery. The second set of relationships exists at the inter-organizational level and takes place within partnerships between the community benefit department and other local agencies or stakeholders. The last sets of relationships the case department must manage are partnerships that take place with resident groups from the underserved and isolated populations they serve.

In order to achieve significant impact in the community given limited resources, staff in the case department actively partner with stakeholders throughout the county to enhance their impact with vulnerable populations. These partnerships occur in a county where there are intimate and long-standing connections between agencies. It follows that relationships are key tool to achieve impact and sustainable solutions. In this context, relationships are necessary to establish networks to stay informed about emergent needs or problems in the community, what services or programs are available to those communities, and to facilitate agencies' capacity to take action together.



For the case department's strategies of community organizing and partnering, the establishment of trust is essential at the onset of partnerships and must be maintained over time. As a part of a well-established organization, leadership and staff of the community benefit department have long histories of partnerships with stakeholders throughout the county. This includes relationships with public and private agencies as partners and relationships with communities as organizers and residents themselves. These experiences have led to an approach to partners that values open communication and transparency about intentions.

*"I think that communication is essential. Having everybody put out on the table what their self-interest is, trying to, having that honesty, that you are able to talk about the good and the bad, and to also work to evolve what you are" [System Executive Leader #2]*

*"And a lot of what we do is keeping those channels open, either easing them open or kicking them open, whatever need may be, but one of the things that we bring...we are immersed in dialog as a practice and as a philosophy...that is one of the things we bring to partnerships" [Community Benefit Department Director]*

Leadership and staff representing the case department stress the importance of maintaining communication and keeping partners informed about their intent and current activities. This practice manifests the trust that staff sees as essential for engaging in partnerships that serve the department's purpose of aiding and empowering marginalized communities. By engaging in dialogue between partners, shared understanding and agreements can be reached.

*"I think respect and trust have to be a part of it. Shared mission and vision and goals, you know being on the same page. I mean it is okay to see things from different points of views. But if you're trying to collaborate and have the best outcome possible, there's going to have to be agreements. And if there's not shared understanding, making sure people have all the information to make an informed decision, stay at the table and dialogue about it you know." [System Executive Leader #1]*

Taking this approach has fostered the development of relationships where partners learn to find common ground and understand each other's perspectives and agendas. Stakeholders in the community believe that this has led to achieving sustained effectiveness in the community. The value that trust plays in relationships between the health system and other stakeholders in the county is reflected in the respect local stakeholders have for the system's commitment to the community.

*"...the fact that they reached out to people from different sectors within our organization, to me speaks to the trust they have in us as an organization to be able to be at a community planning table and to have the communities interest and needs as our priority and reason for being there" [Community Benefit Department Director]*

The department and its staff are recognized for their close ties with the community and their partners trust this connection by looking to the health system as credible conveners with marginalized communities. This is a dynamic that was acknowledged by partners of the organization on more than one occasion in speaking to the importance of trust between partners and within the community.

Trust and transparency also serve significant purposes for engaging resident stakeholders as partners. Trust is particularly valuable to the department's community outreach strategies given the history of these communities not traditionally receiving consistently attentive, direct, and tailored support from hospitals. Leadership and staff within the case department are sensitive to this dynamic and seek to directly engage isolated and vulnerable populations.

*"...the folks in the community feel isolated and alone and unsupported and then they don't trust you because when they needed you, you weren't there... if you are at least willing to try and you are not arrogant about it and you're not saying, "we have the answer, we will solve the problem for you"... [instead saying] let's give this a try, and if that doesn't work, we'll figure out why it didn't work and we'll try something else...I think that transparency builds trust and it builds a sense of partnership and not [receivership from a provider]." [Community Benefit Department Director]*

As a department that focuses its outreach through community organizing strategies, trust is an essential component of resident engagement. It is an element that allows partners to find common ground and pursue agreed upon goals. Especially inherent to the strategy of organizing is the value of sharing power and authority with involved stakeholders as equal partners. The community benefit department is unique in that it extends its definition of stakeholders to include residents of underserved communities. They characterize these groups as equal and valuable partners in their service and outreach efforts who will ultimately take ownership of improving the health of their own communities.

*"...I think still our ultimate goal is how do engage other people in it, so that eventually we can move out of it. I mean our community organizers, the whole output [metric] for that is eventually we need to move out of those communities and those communities need to then take on issues themselves" [System Executive Leader #2]*

Community partnering and organizing is a part of the case department's broader goals of achieving sustained community health for vulnerable populations. This is reflected in the department's strategy to empower residents to improve the conditions in their community and to advocate for other agencies in the county to recognize them as equal partners with valuable assets. In speaking to the principles of the department, one director from the case department expressed the importance of encouraging partners to assume inclusionary approaches that engage marginalized communities. In sharing an account of challenging partners about engaging residents, the director reflected,

*“[I asked why] it’s not open to [the residents’] participation and so I said you know this is something that I want to continue talking about because we are just beginning the efforts and it’s a slow process so there is plenty of time. But I need you to know that is not congruent with our philosophy and the way we do things and so I will continue to advocate for opening up and leveling at the highest levels of the playing field and at some point, if that doesn’t happen, then we’ll have to think about, does it feel, can we do this with integrity” [Community Benefit Department Director]*

*“...joining with other agencies in building a partnership, [we consider] how do we help to influence others in doing partnerships the way that we do it. So, how do we begin to influence developing democratic processes within the partnerships, how do we begin to shift the conversations from service delivery to empowerment, and authentic collaboration with the people who are being served” [Community Benefit Department Director]*

Shared power is a principle that the department and its staff exercise at the inter-agency level as well as at the community level with residents. The department integrates its objectives for these partnerships by advocating for comprehensive community engagement that involves all stakeholders, including residents, addressing community needs. The purpose of empowering populations to address their own health and social needs is to achieve greater sustained impact in their communities. One organizer explained why it is important for the leadership of organizations to recognize residents’ input on a level equal with their own,

*“I think that is what we identify definitely when it comes to partnership with the community, you need somebody that is more inclusive, somebody that is less directive, somebody that is really looking to create partnerships that are equal and not partnership in which one person has got most of the cards and then you have everybody else...[the] type of style we use that is more relationship building that has to do with building community that is asset based so it’s not based on what we want and what you got to give us, it’s more like this is what we want, let’s work together. That is key.” [Community Benefit Department Staff Organizer]*

*“...so that you allow the community to make decisions, even though you might have the authority to make the decision, handing that decision to the community,” [Community Benefit Department Staff Organizer]*

A necessary element of this strategy is the encouragement of leadership and staff from partnering organizations to recognize the merits of community empowerment. The community organizing strategy is hinged upon the belief that a community has to take ownership of addressing its needs in order to achieve sustained impact. Therefore, partnerships geared toward community improvements must embody a paradigm shift that consists of relationships that are inclusive of residents as stakeholders.

As partnerships take shape, stakeholders are expected to take responsibility for the purpose of their collaboration and their roles in those efforts are important. This is a core element of the case department's partnering strategy. Partners are expected to be clear in their intent as well as what they will contribute to the partnership. A director in the department expressed the necessity of this at the onset of building partnerships. Once stakeholders have convened and agreed to work as partners, the primary question becomes,

*"...what does each organization bring to the table and what is the scope of work for that organization?" [System Executive Leader #1]*

This clarifies what the relationships, expectations, and responsibilities will be between organizations in the participating in the partnership. In order to achieve this there must be agreement upon what the goals for the partnership as well as what role each partner will assume in achieving those goals.

*"Each person that comes around the table has their own self-interests as to why they're around the table. And how do we engage ourselves in the ultimate objective of the community at-large who needs something or who wants something. And so a lot of times, it's not us identifying the need, it's more the community coming to us and saying what they feel their need is" [System Executive Leader #2]*

Furthermore, partners are not only accountable to each other, they are responsible for their duty to the communities they are serving. The department takes into consideration what services and benefits will be made available to the underserved and isolated communities they are tasked with serving.

*"...make sure there is a voice for those of us who serve the uninsured. Because our hospitals serve everyone, so we need to partner with those organizations that serve all members of our community." [System Executive Leader #1]*

*"We want to make sure that if we send the patients somewhere it is someplace where it is safe, and again there is so much resources in the community that one person can't always know it all" [Community Benefit Department Program Staffer]*

As active partners in the community, department staff and leadership hold themselves to a standard of being advocates for the interests and empowerment of marginalized communities. This perspective is formally instructed by the principles of the department and exemplified in the role staff assumes in the partnerships to achieve community health.

## **Discussion**

Community organizing and empowerment is a community benefit strategy that calls for stakeholder partnerships in order to be effective. For the case department to apply this strategy, an organizational infrastructure has evolved that institutionalizes and enables the application of community empowerment and partnership principles. This case has

demonstrated the decision-making and relationships of a community benefit department that effectively navigates the challenges these dynamics present. The reward of these efforts has been an increased capacity to leverage the resources of other community stakeholders and residents to have a significant impact on communities' health despite constraints. This strategy has also led to the investment in empowered stakeholders that have increased capacity to achieve positive impact on their communities.

### Decision-Making

This case study highlights and defines the organizational characteristics and decision-making of a community benefit strategy that foster sustained partnerships with community stakeholders. The organization and department are structured to coordinate programs that actively share information and planning amongst one another. This facilitates opportunities to identify needs and allows for the discretion to act on emergent issues in communities the system serves. The organization's mission, principles, and policies influence partner selection and direct the objectives of partnerships formed through the strategy. The mission also orients the department toward the leverage of its resources to serve vulnerable populations. The use of partnerships as a strategy to serve vulnerable populations reduces risks by spreading the burden of outreach and service delivery. It is also the primary means through which the department establishes connections to stakeholder groups to organize and empower disadvantaged communities. Finally, community organizing and partnerships present significant opportunities to achieve greater impact on the health of communities because it engages multiple stakeholders to work toward aligned goals.

### Relationships

This case department directly engages community residents and stakeholders through partnerships. It relies on relationships that are significantly affected by variables of trust, power-sharing, and accountability. For organizations in this particular county to form partnerships that leverage resources and coordinate services, formal and informal agreements of mutual engagement are essential. It is generally accepted that a system of networks and partnerships in the community that are seen as hierarchies puts stakeholders' credibility, reputation, and impact at risk. Therefore, while organizations may approach partnerships with different agendas, the development and maintenance of functional relationships are critical. To achieve this partners are expected to maintain lines of communication amongst themselves, share power and authority, and take ownership of the purpose of their partnerships.

### How Decision-Making Affects Relationships

The decision-making that directs this community benefit strategy distinctly affects the department's stakeholder relationships within partnerships. The mission-driven orientation of the organization and its demonstrated commitment to underserved populations generates trust and credibility amongst other non-profit agencies serving similar populations throughout the county. The health system's mission imperative also calls for partnerships that help the case department to serve populations it could not reach alone. Moreover, community partnership formation is a valuable strategy to distribute the risks associated with outreach and care delivery to underserved communities. Leadership accepts the extra degree of risk,

uncertainty, and surrendered control associated with the community partnership and organizing model that would not be assumed in the absence of this strategy. Finally, the empowerment of communities is formally recognized as a strategic goal of the department. As a result, decision-makers facilitate the managerial discretion and maneuverability necessary to promote community organizing principles and encourage power-sharing and responsiveness to community-identified needs.

### Lessons Learned

The relationships and strategies necessary to build sustainable partnerships in communities require conscious decisions to engage their stakeholders. The community benefit strategy reviewed in this case study reflects an organization's formal and informal commitments to community stakeholder partnerships intended to impact community health. To apply this strategy as a tool, decision-makers within the health system incorporate unique values and practices that foster relationship building in the community and flexible responses to uncertain political and market environments. The case department's policies and culture are driven by the objective to empower communities and connect underserved populations to services that address community needs. The community partnership strategy provides a practical avenue to pool and leverage financial resources and competencies that are available in the community. This has proven to be a necessary tool that has low costs but yields high impact in a community with overburdened public and not-for-profit infrastructures that have significant resource constraints.

This case study demonstrates organization and department infrastructures that are established to facilitate partnerships and empowerment through policies, guidelines, and incentives that encourage active community engagement. Two important considerations about how partnerships are fostered and their consequent value can be drawn from how this strategy is implemented. The lessons learned from this strategy include: 1) stakeholder partnerships are necessary to the promotion of empowerment in communities; and 2) organizations that seek to build community capacity should encourage balanced and equitable relationships that recognize and share power with stakeholders and residents.

1. The promotion of community empowerment through stakeholder partnerships and community organizing requires:
  - a. The development of long-term relationships with a multitude of community stakeholders and residents. Ongoing engagement with representatives from other health systems, public agencies, not-for-profit organizations, and resident groups is necessary to the maintenance of a local network that is responsive to evolving community needs. The establishment of long-term relationships also helps to offset local hierarchies which can pose risks to the success of a partnership.
  - b. Leadership that allows department staff the discretion to seek creative opportunities and solutions for community needs. Increased managerial discretion allows staff the flexibility needed to operate in the community to

pursue and create opportunities that are in the interests of the health system's mission.

2. The leadership of organizations that seek to implement community-based partnership strategies should be prepared to promote equitable relationships and encourage power-sharing amongst stakeholders.
  - a. Department managers and staff are empowered by their leadership to foster and engage in relationships and roles that empower other community stakeholders and residents.
  - b. Leadership has to recognize the value of the assets that communities possess. In addition, resident stakeholders must be acknowledged and empowered as equals in community partnerships.
  - c. Engagement in empowered community partnerships with stakeholders and residents calls for adjusted expectations with timeframes to accomplish projects' objectives. Leadership should account for the due process necessary for community empowerment, capacity building, and joint definition of goals. These steps are time intensive do not progress along the controlled timetables of typical business projects.

The case department has found a delicate balance with the demands of strong community relationships within the constraints of mission-driven organizational objectives and limited resources. The department's competencies to build stakeholder partnerships and to work closely with underserved populations make it an invaluable asset to local organizations and residents alike. These capacities differentiate the health system from its competitors as a trusted community facilitator. Over time, these values and practices can be transferred to other local stakeholders and resident groups to build the community infrastructure's capacity to engage in more empowered and sustained partnerships. Figure 5.1 below summarizes key strengths and limitations of the community partnership strategy observed in this case.

#### **Case 1: Advantages and Challenges to Community Partnerships Model**

##### **Key Program Strategy Strengths**

- Department is a small and receives little funding yet leverages it to achieve significant impact at a high financial and social ROI for the system.
- Flexibility of program managers and staff to use discretion in community to form relationships with local stakeholders and identify needs and emergent opportunities for community impact.
- Mature and effective relationships with important community-based stakeholders makes the brand the health system as a reputable community organizer within the region.
- Capacity building invests in the assets of communities and achieves sustainable ownership of health, social, and environmental conditions.

##### **Key Program Strategy Limitation**

- Increased risk because of more uncertainty and lack of control by opening up processes to more stakeholders including resident stakeholders who may not even have an agenda.
- The process of stakeholder engagement necessary for community building requires time and personnel commitments beyond what may be budgeted or meets federal reporting standards
- Community building is a significant time investment and capacity building occurs over time, it is difficult to achieve the immediate impact sought to satisfy short-term strategic goals

Figure 5.2

## Case 2

### Overview

This case study examines the decision-making and relationships that guide partnerships formed through the community investments program of a large NFP health system. The investment program highlighted here primarily provides below market interest rate financing to organizations working to improve communities' health. Daily management and administration of the program is performed by one investment director who reports to the system's broader investments and grants governance committees.

In any given year, the program manages upwards of 70 loans totaling more than 70 million dollars. The vast majority of loans are disbursed to organizations within the vicinity of the system's service areas in California and neighboring states; or those of its religious sponsors. The program's investments are typically made in community clinics, community development banks, credit unions and loan funds, non-profit housing developers, and human and social service agencies (case department #2, personal communication, November 2010).

The case program is one component of the community benefit department's mission-oriented strategies to invest in the social good of communities. The program's investments and partnerships aim to offset the underinvestment of resources in disadvantaged communities and populations. Targeted community needs include: increased access to jobs, affordable housing, increased food access, and provision of education and healthcare for people who are economically poor or underserved. The community investment program specifically supports smaller non-profit organizations that address these needs at a local or national level. Financial investment of this kind is valuable because participants in the program are not typically attractive borrowers to traditional lenders and have difficulty securing loans.

The application of community investments is a unique strategy relative to other community benefit programs sponsored by NFP health systems in California. Internally, this strategy presents the challenge of balancing the duty of fiscally responsible investing with achieving the social good of the organization's mission. Investments in organizations that serve communities meet the organizations criteria to develop healthy communities but simultaneously introduce significant uncertainties as a lender. The pool of borrowers this strategy supports present difficulties to an investor that needs to assess risks of financial stability and operational performance. Many of the borrowers the program partners with do not have consistent revenue streams and heavily rely on external funding sources at times. In addition, rigorous and consistent metrics of social impact are not available. As a result, it is difficult to determine investments' performance in regards to improved housing, jobs, or health care provision in a community.

This case will explore how the community investment program of a large NFP health system responds to these challenges by financially investing in the development of community infrastructures and service delivery. It will illustrate the decision-making that managers and leadership contend with to balance the demands of fiscally responsible investing with the



decision to invest in risky partners. The following sections identify and examine the decision-making and relationships that are formed to drive this type of community benefit strategy. For this strategy, the decision-making variables of mission, risk, and opportunity will be described in the context of how they relate to the trust, power, and accountability dynamics of relationships necessary to enable borrowers to enhance the social good of communities.

The following will provide further details on the organization, strategies, decision-makers, and partners of this program. It will then describe the decision-making and relationship measures that informed the data collection process of the case study. Next, the results of the data collection will be shared and a discussion of these findings in the context of informing community benefit practice will conclude this case.

### **Background**

The community investment program is physically situated in the national headquarters of a large mission-driven NFP multi-state health system. The health system, one of the largest in the nation, operates over 40 hospitals throughout California and its neighboring states. Given this large region, the health system is responsible for delivering care and services to a diverse cross-section of communities and populations across a range of socio-economic settings. Throughout the system, community benefit programming is formally directed by policy to prioritize the support of communities that have high rates of unmet health needs or high-risk populations. Programming is also required to actively collaborate through partnerships to address the needs that contribute to poverty and social or health vulnerabilities.

The program that will be explored in this case is a component of the system's larger community health department. Management of the investments program is coupled with the system-wide grant program and is supervised by the staff of one director. While all grantees awarded through the grant program are distributed funds through the system's local hospitals, loans made through the community investment program are financed directly through the system's headquarters.

The program works closely with other NFP health systems locally and nationally as a partner in various alliances and joint ventures to invest in vulnerable infrastructures necessary for healthy communities. This engages the health system as a participant in large community investment projects such as: creating emergency fund pools for community clinic assistance; funding statewide healthy food initiatives; or supporting housing developments in marginalized communities. The primary focus of this case study will be the local level partnerships formed directly with community-based stakeholders that provide services that enable healthy communities. The community investments program defines a healthy community as one that has access to: health services; community development financing; affordable housing; economic development; and other forms of institutional change for low-income populations (case department #2, personal communication, November 2010). The program achieves this by strategically financing below market interest rate loans to local borrowers in support of their efforts to: empower low-income people, specifically in marginalized communities, to manage

and own enterprises; introduce employment and management opportunities; and re-invest in decaying urban areas or revitalized rural areas.

The community investments program began twenty years ago as a means of support to communities that had been historically underserved by traditional capital markets. These areas had demonstrated needs for affordable houses, job training, social service provision, and community health clinics. The program was intended to support local non-profit agencies addressing the social good of underserved communities. The system formally defines social good as “improved access to jobs, housing, food, education, and health care for the people of a low-income/minority community.”(case department #2, personal communication, November 2010). It follows that, the program focuses on: affordable housing for low income families, seniors and persons with special needs; increased employment opportunities for unemployed and underemployed persons particularly for women and persons of color; and working with non-profit organizations that demonstrate a commitment to a community-based agenda and safeguarding the environment (case department #2, personal communication, November 2010). Upon its introduction, the content and direction of the case program signaled a paradigm shift away from the system’s history of charitable, non-strategic contributions to vulnerable communities. Instead, the program was designed to specifically finance below market rate investments in communities that had demonstrated need and had a history of lack of access to capital.

### Strategy

The community investments program falls under the system’s community health department which also houses oversight of all of the system’s community benefit programs and initiatives. The director of the program reports to the Vice-President of community health and all investments are reviewed by a sub-committee responsible for community economic initiatives. The sub-committee reviews loan applicants, determines loan amounts and interest rates, and makes loan approval recommendations to the system’s investment committee. The investment committee has approval authority for community investments. Annual allocation of investments for the program is set by the Board of Directors and the signature of the system’s Chief Financial Officer is required for all community investments.

The intent of the program is to channel financial resources to non-profit organizations, community development financial institutions, and other projects that promote social good. The allocation of investments consists of projects financed for: working capital, facility, or healthcare related needs; equity or capital for low-income housing developments, and intermediary community development financial institution (CDFI) fund pools that are disbursed to community development projects in underserved communities. It is expected that the director comprehensively evaluate the social and financial status of prospective borrowers. The health system prescribes that three sets of screens be applied to all of the program’s loan applicants. They include social, financial, and other considerations. The program’s social criteria stipulate investments are:

- made to non-profit organizations that target resources to low-income communities
- invest in the revitalization of urban or rural areas
- empower low-income people to create, manage and own enterprises
- demonstrate a commitment to healthy communities and/or safeguard the environment when linked to the health status of the community

Financial consideration of borrowers consists of:

- assessment of the project’s risk potential, marketing/business plan, and other sources of funding,
- cash flow needs,
- available collateral,
- ability to repay,
- level of management expertise,
- adequacy of financial systems
- organizational record of achievement

Other financial ratios used to assess borrowers include those listed in Table 6.1:

Operating Margin	Excess Margin	Operating EBIDA Margin	Days Cash on Hand	Cash-to-Debt Ratio
Cushion Ratio	Debt-Service Ratio	Debt-to-Capitalization Ratio	Capital Spending Ratio	

Table 6.1

These screens examine the security of the loan and take into account: sources of repayment, whether the organization provides a critical service, the quality of the borrower’s revenue stream, their breakeven financial performance, and history of managing expenses. Characteristics of the borrower are also reviewed such as longevity, the strength of their management team and executive leadership, as well as reputation within the community.

Additional considerations to be taken include:

- overall diversity within the community investment portfolio (types of investments),
- geographical distribution of service areas,
- type of investor (CDFI’s),
- leveraging potential of investment
- and relationship with potential borrower

(case department #2, personal communication, November 2010)

It is accepted that “these investments may lack preferred investment characteristics such as market rates of return, or medium to high liquidity; however, preservation of invested capital will be expected.” (case department #2, personal communication, November 2010). Despite the challenges of unstable markets faced by this program, it is expected to function without compromising investment performance. It should be noted that the blended rate of return of

the community investment portfolio has consistently outperformed its benchmark of the Consumer Price Index over rolling three-year periods.

The community investments program is allotted 5% of the system's investable assets. However, the Board of Directors typically approves more than this amount depending on how its complete investments portfolio is performing. Since the program began, over \$120 million have been invested in over 140 organizations. In any given year, the program manages upwards of 70 loans totaling more than 70 million dollars. Over 85% of these funds are invested in the form of direct loans while up to 15% occurs in the form of providing guarantees for borrowers with other loans.

While the community investments program has been an effective community benefit strategy for the health system to channel funds into underserved areas, it presents some challenges to system leadership and staff. The distribution of loans to non-profit agencies that work to improve community conditions is risky for an investor in two ways. First, there are challenges to assign monetary value to the performance and outcomes of the investments made. Second, the pool of borrowers often relies on a considerable amount of "soft-money" to support their operations and generate little, if any, revenue. There are risks associated with these agencies' ability to achieve their goals or pay back the capital borrowed. These characteristics make it difficult to assess the true risk of an investment with this niche of borrowers. Additionally, the structure of the program itself puts forth the need to balance the fiduciary duties of rigorous financial investing with the pursuit of the social good as prescribed by the mission of the organization. Given the limited staff and resources dedicated to the program, the system's capacity to identify and pursue opportunities for investments and partnerships is restricted. Finally, in the context of the current recession and Congressional budget cuts, there have been significant reductions in funds that have traditionally supplemented the efforts of this program. Some agencies have been burdened with additional demands, as is the case with safety net health centers and clinics. Others have fewer resources available to them, as is the case with communities that rely on community development block grants that have reduced 25% in recent years (Fessler, 2012). All of these activities have placed additional burdens on the targeted communities and partners of the case program and limit the health system's capacity to leverage resources in these areas.

The program primarily disburses loans to community based non-profit organizations and CDFI's that serve low-income and underserved communities. The program also partners with other health systems and philanthropic foundations to pool their investments as emergency resources non-profit health providers that may lack capital. Partnerships formed through the community investments program are primarily contractual agreements. Over the course of its history, there have also been instances of informal arrangements that consisted of sharing governance and technical expertise.

Structures of contractual agreements with partners fall under the following six investment types:

1. Direct Loans
  - a. Secured/unsecured loans between health system and borrower
2. Intermediary Investments
  - a. Loans between health system and non-profit organization that loans to other non-profit organizations (i.e. community development banks, credit unions, etc.)
3. Lines of Credit
  - a. Promise between health system and non-profit organization to make a direct loan
4. Guarantees
  - a. Contractual promise with a third party to make good on a loan in the event of a default by a borrower. This type is reserved for agencies affiliated with the sponsoring ministries of the health system
5. Linked Deposits
  - a. Below market rate deposit by the health system into a community development financial institution to make small business and affordable housing loans
6. Equity Capital
  - a. Stock purchase in community development banks or other alternative economic enterprises

(case department #2, personal communication, November 2010)

Prior to finance approval through the program, all prospective borrowers disclose their financial documents to be reviewed by the community investments director. Direct loan borrowers are monitored in the way of site visits by community investments staff and the submission of accountability reports every six months. The reports are intended to allow borrowers to demonstrate the progress of their efforts in the communities they serve. Loans disbursed by the community investment program are allotted terms up to a maximum of five years.

The non-profit agencies and CDFI's that receive funds from the community investment program are expected to promote the advancement of social good in underserved communities. The purpose of the program is to leverage its investments into the strategic application of resources and expertise into marginalized communities. The investment strategy of the case program is aligned with the community revitalization practices of housing, community, and economic development agencies throughout the country. These practices apply coordinated responses to the needs of underserved communities that arise at the intersection of housing, social service, education, employment, safety, and healthcare access deficiencies. While the blueprint for community development has improved in recent decades, there is still significant underinvestment in the revitalization of poor and underserved these communities. The community investments program is intended to direct the health system's resources towards addressing these shortcomings.

## Findings

### Roles of Mission, Risk, and Opportunity

The community investments strategy requires that leadership balance the mission of social good provision with the fiduciary and governance responsibilities of a financial lender. The health system's organizational frameworks and standards specifically call for collaborative partnerships to improve the health status of individuals and build the capacity of community assets (case department #2, personal communication, November 2010). At the same time, the case program's loan structures and borrowers introduce risks to the system in the form of liabilities of repayment, foregone interest, and uncertain impact. This presents the program's decision-makers with a three-tiered challenge of: 1) addressing innumerable community needs; 2) through financially fragile partners; and 3) within the limited resources of the program. A long-standing board member summarized the challenge of investing in underserved communities,

*"[Taking into account] society and the opportunities to help, there is always far more to do than there are resources to do it. Even scripture says the poor you will always have with you. So you know, we are not going to be able to do all of that and you do have to balance the good of the organization with the good that one can do beyond the organizations primary work and so there is always that wonderful tension. " [System Board Member]*

The health system's leadership accepts that their mission and guiding principles prompt the health system to act as an institution that assumes a role in marginalized communities that goes beyond healthcare delivery. The principles are applied as frameworks to justify and guide decision-making that lead to investments in the social good of underserved communities. However, as a NFP health provider, the mission also prompts the organization's primary function to provide health care to its communities. The health system must be fiscally responsible to preserve operations as a business that performs this function. To remain viable, it is understood that these obligations must take precedence regarding resource allocation and therefore impose constraints onto community benefit activities. The weakened national economy and uncertain financial markets have similarly imposed further restraints on health system activities that do not directly support healthcare operations. The architects of the community investments program reconcile the tensions presented here through the incorporation of a broader definition of health that aligns with its strategic goals. By taking the social determinants of health into consideration, leadership justifies the investment of significant resources into improving the conditions of underserved communities as a business priority. System officials explained the rationale of how a community investment strategy aligns with both the mission and business operations of a health system.

*"I also think, and I believe it is a part of our mission – it's a part of our vision to invest in the community and investing in acute care facilities for the health of the community is not the only way to invest. Because truly...acute care is probably about ten percent of a community's healthcare needs. So the ninety percent that isn't there is a part of our vision,*

*to say that's health care in the community in a different way" [Community Benefit Department Director]*

*"I think it all comes down to a clear sense of what's our mission as an organization....to play a role in preventing illness in the first place. Through primary care and preventive care but also from going further upstream to say we have some resources toward the development of affordable housing, toward the development of grocery stores in food deserts of our communities, toward addressing all of those other components of health that are so fundamental. And be willing to put your resources where your mouth is.." [System Executive Leader #1]*

This line of thinking establishes an explicit connection between community development and the health of individuals the system serves as patients. Without this caveat of ideology, the provision of below-market interest rate loans to initiatives that do not directly support core business lines of the health system might become vulnerable to competing resource demands. Instead, the case program is widely supported and its funding is neither compromised nor threatened. The purpose of the community investments program aligns with the mission and strategic priorities of the health system. As a result, the resources that are dedicated to the program are preserved because they support the objectives of a competitive health system that delivers services to high need populations.

The mission of the health system helps decision-makers to recognize the importance of the social determinants of health to maintain a healthy community. It also directs leadership to recognize the necessity of partnerships to impact the health of marginalized communities. When asked about the role of partnerships, one executive stated that the system's mission can only be fulfilled through the partnerships it forms in the communities it serves.

*"[Our] mission gets expressed in one of three ways: compassionate, affordable, high quality health care services which is a given; and then partnering with others in the community to improve the quality of life; and then advocating on behalf of brothers and sisters who are poor and disenfranchised. It's the latter two ways in which the mission gets expressed that we can only do our work if we do it in partnership with other people" [System Executive Leader #2]*

In addition, the mission of the health system serves as a screen for the selection of partners.

*"[The] first criteria is whether or not the organization has a common sense of purpose, mission, and reason for existing because there are some organizations which we just don't have anything in common with so whether or not there is a like mindedness between the organizations makes a big difference on whether or not we work with them" [System Executive Leader #2]*

The health system's mission calls for partnerships with community stakeholders to realize its objective of going beyond the hospital setting to improve conditions of underserved

communities. In order to achieve this, the health system invests in partners with common purpose that typically have difficulty securing financial support elsewhere. The common goals of the partners also help to reduce the risk of the investment as they are indicators to the system that its borrowers have a significant stake in the outcome of the partnership as well. This approach helps to insure that the relationship will provide impact that is a win-win for both partners.

The borrowers the case program selects as partners are aligned with its mission and achieve its strategic goals of developing underserved communities. However, since most of the program's loan recipients do not generate revenue and rely on limited public and grant funding, their financial instability poses risks to the program and health system. Investments in risky borrowers through below-interest rate loans present challenges of governance for decision-makers who are allotted limited resources within the health system. In order to be a responsible financial lender there must be clarity on the system's risk tolerances it will accept because of its mission imperatives. By financing risky borrowers as a means of mission fulfillment, the system must acknowledge the liabilities it may take on. A committee member explained,

*"...if your committee and your governance structure is very clear about these are expectations for volatility, this is the reason we've chosen to participate in this asset class...it guides your approach and it guides your organization through the tough times. Because you can go back to that governing document or whatever and say, we expected this, we knew. Like for example, if you set it up and you say the priority is the mission and we understand that from time to time we may experience losses, the first time you get that loss and half of the committee members don't remember it, you go back and say this is the commitment we made. If you say the expectation is financial return and we'll structure things so that we'll be repaid and we're going to minimize loss, you might make a different set of decisions" [Community Investments Committee Member #2]*

In addition to clarifying oversight, decision-makers must prioritize efforts to structure the loans in ways that will preserve capital the system has dedicated to community development. Depending on the structure of a loan, the health system may assume increased risk due to loans that are continually extended or only receive interest payments. This can potentially result in instances where the program's risk tolerances do not accurately reflect the content of its portfolio. The director and investments committees are mindful of these liabilities and actively manage the program's investments within the restraints of the program risk tolerances. In keeping with the rigorous fiduciary duty of a lender, the system benchmarks the program's stability and performance against market indexes as a measure to insure that the integrity of the program's funding is not jeopardized.

*"The aim or the benchmark for the program is to equal the CPI over a rolling three years. And the point there is to ensure that the capital is maintained." [System Executive Leader #1]*



The risks of unpaid loans present significant liabilities to the health system and the viability of the case program. The potential of taking on too much financial risk cautions the health system's decision-makers to be careful about loan terms, amounts, and structures and governance of the overall program. This is in the best interests of the system as well as the borrowers. Program representatives consistently point out the significance of not overburdening borrowers that provide important services to underserved communities. If a community stakeholder participating in the case program is not strong enough to manage debt, its performance or survival could be put at risk. The impact of this is characterized as a lose-lose to the system and the community,

*"The community ends up losing an organization that's providing services. We would lose our investment. So it's a lose-lose." [Community Investments Committee Member #1]*

The immediate risk to the community posed by this strategy is the potential of overburdening partners with repayment obligations that stress their capacity to function as an effective community stakeholder. A partner that must scale back its programming or ultimately closes because of loan burdens will become a lost community asset. To prevent this, the program's director and sub-committee adjust interest rates or repayment terms to accommodate the capacity of borrowers. This purposeful governance helps to protect the system's financial investment and their partners' operational capacity. Rigorous oversight of the program also offsets risks to the program's effectiveness because of limited staff capacity.

*"I think the biggest risk is that we don't maybe have the resources to do as much due diligence as you might want to on organizations like these ...in order to really understand, you know, all the different aspects of assessing risk, it's a lot of work.. so I am guessing that we could be doing more in-depth analysis if we had more resources and I think to really know the credits, that would be helpful" [Community Investments Committee Member #2]*

Limited staff restricts the program's capacity to assess its partners in a manner consistent with traditional lenders. Given the volume of borrowers and demands of thoroughly evaluating their respective risks, an understaffed program risks the chance of overlooking indicators of potential investment performance. While the case program has a long track record of success despite limited resources, these risks present the potential to disrupt the viability and effectiveness of the program. The oversight structure of the case program minimizes these risks as investments are thoroughly screened and monitored by its director and a series of committees.

The partnerships formed through the community investments strategy also buffer the health system from risks associated with limited resources. By partnering with borrowers and other investors, the system leverages financial, administrative, and expert resources it may lack internally. It also presents the system with chances to match partners' competencies with

specific community needs. These opportunities and their potential impact on community development are primary considerations for the program decision-makers. These partnerships present avenues to amplify the impact of the program's invested dollars on social and environmental conditions. An example of this is realized in the program's provision of pre-development financing to housing developers in underserved communities. The program's director explained the rationale for leveraging the system's resources to enable a borrower to secure more funding from traditional lenders.

*“Pre-development that means planning, getting all of the permits in line and ready for development. Traditional lenders know how much of a risk that is because you have nothing on the ground. Traditional lenders like to come in when you have the land, you have the project all lined up, all the permits, and you're ready to put the stakes in the ground and you want to go for it. So we provide a lot of the non-profit pre-development financing...you're allowing them to use your funds to get all of the everything in place then all of a sudden the traditional lending takes place. The project might be thirty-three million dollars; you might have provided just a five hundred thousand dollar pre-development loan. What's the impact? Okay – thirty-six units of affordable housing, thirty-three million dollars in development – for five hundred thousand pre-development. That's leveraging” [Community Investments Committee Member #1]*

The program's role in these partnerships also positions the health system as a valuable and recognized community asset. When asked about the relevance of the program to the organization's goals, an executive explained that the value of the program is realized in its immediate benefit to the community at-large.

*“[It gives us the] ability to leverage our resources to achieve a greater social good than certainly we could do on our own. And that social good being for the end user, the resident, the client, as well as for the non-profit in the community, that's the biggest benefit. And then right along with that is the reputation of being a real community partner who respects other organizations in the community and collaborates with them and works to help them achieve their successes... reputation is a big business driver, a very big business driver.” [System Executive Leader #1]*

The health system benefits from its community investments for reasons ranging from the realization of its mission objectives to the elevation of the system's status as an institution committed to improving people's social and physical environments. The strategy also moderates the impact of harmful upstream determinants on poor downstream health outcomes which can potentially lead to uncompensated care or costly ER visits. These returns of societal impact and augmented political capital are recognized as the value the case program creates in place of the foregone interest from its below-market rate loans. The community

investments strategy essentially exchanges interest rate returns for improved health conditions in underserved communities. The program director explained the importance of the opportunity to make a significant impact in underserved communities when justifying the investments strategy,

*“So that’s a major reason why we’re doing this. It’s not to get a return on our investment. I think we could do a lot better job of looking for returns. We could definitely do a better job of investing in the community. But I think, because of the business that we’re in, what better return on investment could we get if we improved the health of some of these individuals. I mean if you want to drive down the cost of healthcare and end the misuse of health services, what better way than to improve it. Improve the individual.” [Community Investments Committee Member #1]*

While the system foregoes interest it could receive from traditional investments, the leadership considers its returns in terms of elevated reputation and improved health conditions for underserved communities to be just as valuable if not more. This perspective was shared by a key decision-maker when discussing the value of the social return on community investments,

*“So when you look at the huge macro picture of it, I think these kinds of investments have a financial return, which is probably bigger than the real financial return, as well as the social good, common good return.” [Community Benefit Department Director]*

The health system uses this strategy to generate sustained capacity building of local stakeholder organizations, residents, and the community as a whole. The gains from community development financing leverage enough resources to have wide reaching impact that is left with the community once the system’s involvement has stopped. This perspective also factors into the recalibration of the assessing the liabilities of their community investments. The risk is not perceived to be as high when the program’s financing is viewed through the aforementioned societal lenses as opposed to a strictly financial approach. In the case program’s decision-makers’ view, the potential for downstream impact on community and individuals’ health that comes from their investments is invaluable.

#### Roles of Trust, Power, and Accountability

The community investments program optimizes the potential of its partnerships through the close relationships it has with its borrowers. The process of creating these relationships begins with the health system establishing open lines of communication with its partners and requires substantial levels of trust at the onset of their partnerships. From the system’s perspective, the process of trust-building requires setting aside its internal interests for the sake of developing a shared sense of community need with its partners.

*“...you’re always balancing what is the good of the community not what’s good for me. Because good for me might be a little bit different than the whole community. And if you’re not there to listen to the other half of the community, you might not get the whole picture. And vice-versa, the community might be this is what we need in terms of healthcare. Whatever it happens to be. And I think there’s enough things that jointly one would say is connected with health in the community” [Community Benefit Department Director]*

The health system adopts a stance on community engagement that calls for coming to a common definition of the social good of the community with its partners. Engaging in these two-way relationships is an integral component to the system being able to work as a part of the community and not as an outsider. Program representatives understand the delicate importance of preserving trust with its community stakeholders. Given that collectively communities can have long memories, the maintenance of trust is important for long-term strategic plans and sustainability. The system’s leadership acknowledges the value of the political capital that stems from being perceived as a trusted community asset.

The program’s strategy is grounded in the belief that stakeholder organizations that work in and with underserved communities have the appropriate expertise to address social good in those areas. This belief calls for trust in partners’ experience and effectiveness in these communities. Thorough review of borrowers’ financial, managerial, and social performance helps the program’s decision-makers to establish this trust. However, there must also be communication with these partners about the implications of being a borrower and to discuss what can’t be captured in financial statements. These steps are taken to establish clarity around performance, expectations, and how the lender and borrower should relate to one another as partners. The importance of being attentive to the program’s relationships with partners is elevated once investments are made and financial control of the project is handed over to borrowers. Representatives of the program cited the role that open communication and trust plays in shaping their relationships with borrowers once the loan is disbursed,

*“...the relationship has to be for you to “be there” when things are going wrong so you can at least be aware and see if you can help in any way. So, you’re an investor, but you also want to be there for the individual. You want to have a tight relationship. Versus a non-existent kind of I’m just going to watch over you. But I think the success is really the trust. And allowing the individuals to do what they need to do without putting any additional blocks on what they need to do.” [Community Investments Committee Member #1]*

Trust in the expertise and effectiveness of the borrower to make an impact on the community is particularly important,

*“Once you go forward with an investment, you gotta hand over the trust. You gotta say okay I trust you. I’m going to make this investment in you, I trust you. And you hope that they’re not going to prove you wrong basically. I mean just like your trust with a bank.” [Community Investments Committee Member #1]*

Leadership within the health system recognizes that the success of their community investments is dependent on the capacity of the program to build and maintain strong relationships with its borrowers. One executive noted the importance of having the right person for the job and the internal capacity to facilitate administration of the loans.

*“I think you need people on staff that can get out into the community to cultivate the relationships with the not-for-profit partners. And generate the applications and the deals. I think being able to analyze those deals and the financials and infrastructure of the not-for-profit, are certainly a key to our program. What gets very little recognition is the fact that our in-house attorneys and paralegals review all of the legal documents that have to be executed in this transaction. There’s a lot of infrastructure that we can bring to bear on the program that helps it to be as successful as it is” [System Executive Leader #1]*

The program’s representatives cite a strong correlation between the cultivation of meaningful relationships with borrowers and productive projects. Essential components of this process are program staff that excel at relating to stakeholders and are sensitive to understanding local community dynamics. In addition, the capacity of the program to ease the burden of the financing process serves to build trust with borrowers.

Initially the health system takes the lead in framing the parameters for establishing trust with its borrowers. Once the investment is disbursed, control of the financed capital is relinquished to the partner. Relative to other community benefit strategies, community investments presents a unique shift in power dynamics between the health system and its partners over the course of a partnership. Before a loan is financed, the health system assumes full control of how resources will be distributed and applied. The program reviews and assesses borrowers’ performance and determines loan structures, interest rates, and amounts to be financed. However, once the funds are transferred, the loan recipient directs the application and use of resources. The program director cited the importance of power-sharing and handing over complete control of a project to a borrower. It was noted that after the project is financed the partners’ relationship changes.

*“...it’s a different relationship. You know, you have expectation of them. They do not have expectations of you. Once they receive our dollar, they have no more expectation. They don’t make...they can’t make any other requirements from us. It’s all one-sided.*

*So you can either be a good lender or a good investor or a bad investor. Good investor meaning I'm willing to go along with an organization to a certain point. A bad investor is I'm going to be on you until you pay me back" [Community Investments Committee Member #1]*

Much of the power-sharing that is required to effectively implement the community investments strategy is grounded in the trust discussed earlier. The program's decision to empower their borrower is justified by trust in their expertise and capacities to deliver social good. The program looks to give its borrowers the freedom to exercise their expertise in the community.

*"...the success is you gotta have trust on your borrower to begin with. Or trust gets developed. You gotta give them the opportunity to do their thing. And unless they prove you wrong you gotta let them do what they need to do." [Community Investments Committee Member #1]*

*"And you step back and you let them do their thing. Versus, what are you doing? Why did you decide on that piece of lumber versus this piece of lumber? Why those windows or why do you have to do this? You can't. You gotta let the organizations do what they need to do. " [Community Investments Committee Member #1]*

The decision to relinquish control of how resources are applied to addressing community needs is inherent to the process of developing shared goals and then financing partners to carry out the work. Some aspects of this process are counterintuitive to how a healthcare provider traditionally views care provision.

*"You don't have control, and I think in a health care space there is a high degree of interest in being in controlled position and that is why a lot of health care providers don't partner to the same extent as [we do]because I think the control element is really important so you are risking an uncertain outcome because you can't control what the outcome will be and you are hoping the outcome will be positive because you are engaging with someone who has shared vision, shared objectives and shared philosophy of you know meeting the needs of the community." [System Executive Leader #2]*

The viability of the community investments strategy is strongly tied to the health system's trust and empowerment of its partners to apply their expertise in addressing community needs. This approach leads the health system to assume a role amongst other stakeholders that is balanced as opposed to hierarchal. The necessity to take this position within partnerships is magnified in the context of the limited resources of the program. Sharing power with partners helps to offset resource constraints of the health system. The system compensates for staff and expertise it may not have internally and leverages those resources through its partners by

relinquishing control of the capital used for community investments. The willingness to surrender control of a project is essential to this strategy whether it occurs in relation to borrowers or with other community investors. The director of the program shared an example of how the system partners with other investors to finance a borrower,

*“Even though we’re equal, one of us has to take the lead. Because you put a strain on the non-profit having to deal with two or three or four...[lenders]. So you have to choose a lead. To us, it’s to our benefit not to be the lead. We don’t have the staffing, the capacity, so we’re always looking to partner with somebody who can take the lead. Who has the experience or is good enough to take the lead. So we’re not afraid to give up the leadership capacity as long as they do what they’re supposed to do.” [Community Investments Committee Member #1]*

To fully realize the potential value of partnerships to the community investments strategy, the program tempers its direct involvement in order to optimize leveraged resources. In light of the program’s resource constraints, the system maximizes return on investment by allowing its partners to assume control of projects. The community investments strategy is rooted in the belief that empowered partners will take advantage of unobstructed opportunities to apply their competencies and maximize the impact of their investment.

The empowerment of partners is also rooted in the expectation that borrowers will effectively apply the investment dollars to achieve significant impact in underserved communities. These expectations are reflected in the structures of the loan contracts agreed to between the health system and its borrowers. The contractual agreement establishes the parameters of accountability regarding use of funds and conditions of repayment. These terms establish formal guidelines of the partnership in addition to the system’s legal expectations of the borrower. As discussed earlier, health system decision-makers are very mindful of their responsibility as a lender to not burden their partners with loans and terms that may hinder the borrower’s ability to perform.

*“...it would be very inappropriate to enter into an investment lending situation with a not-for-profit that we could tell from the very beginning would not be able to service that debt and handle it well. Because that would contribute to its ultimate greater difficulty or downfall.” [System Executive Leader #1]*

The system holds itself accountable as a responsible investor to not overburden its borrowers which could lead to the disastrous loss of services in their communities. However, once the loan is disbursed, expectations within the partnership shift to the borrower. The program director described this shift,

*“...once you have set the structure...[and] I’m going to make an investment at this amount at this rate for this term. Once that’s done, then the relationship changes,*

*that's where the individual needs to take those dollars and make them work. Your expectation as an investor is that they are really going to proceed with the project"*  
[Community Investments Committee Member #1]

Expectations of the borrower and lender evolve along with the shift in power that occurs once a project is financed. The borrower is held accountable for performing the agreed upon tasks and repaying the loan under the contract's terms.

Despite the framework of change and formal guidelines set by the community investments strategy, the program faces certain difficulties in linking the impact of their investments to community health outcomes. The combination of a lack of accurate social or environmental impact measures with the overwhelming need in underserved communities makes it difficult to accurately determine the impact of a borrower's performance. It is therefore difficult to hold borrowers accountable for their performance in the context of improving the social good. For the health system, this presents challenges with determining direct correlations between the impact of their investments and improved community health.

*"One of the things that's missing from this framework is tracking or seeing the benefit as far as improving the health of the community. That is a very difficult one. So you take a community like Richmond and you go in and you build several low-income affordable quality housing. And you might impact the lives of say one hundred individuals. But there's so much more needed in the community that really that is just a drop of water. So it would be really difficult to measure I guess the impact that you're having. I think that's the trade-off that's hard to measure."* [Community Investments Committee Member #1]

The community investments strategy is hinged upon a theory of change that empowers and builds the capacity of community stakeholders to affect social determinants of health. It is expected that these efforts will have a sustainable impact on the community health of marginalized areas. The program's decision-makers accept that by partnering with these stakeholders it will be difficult to ascertain their impact given the complex issues they are addressing in challenging environments.

## **Discussion**

The investments strategy presents the system with opportunities to leverage the capital of other organizations and the expertise of local stakeholders to improve communities' social and environmental conditions. This case study illustrates decision-making that accounts for the unique risk management and tolerances necessary to partner with borrowers that provide services to underserved communities. To achieve this, the system's leadership contends with the challenge to balance the objectives of their mission with the fiduciary duties of a responsible lender and steward of resources. The program's key responses to these challenges are to: meticulously screen borrowers; provide below market interest rate financing; and



empower stakeholders to exercise their own expertise to impact in their communities. The primary goal of the strategy is to invest in social determinants that affect communities' sustainable development and health. This is accomplished by building communities' capacity for governance, access to leveraged funds, and provision of needed services.

### Decision-Making

The provision of loan investments as a community benefit program is a mission-guided strategy that allows the health system to go beyond its primary work as a healthcare provider and improve underserved community conditions. As it is currently structured, it is not a strategy that has strong links to other business drivers of the health system aside from the improvement of conditions in disadvantaged communities. The strategy is recognized as a means that generates political goodwill and elevates the system's reputation. The investments also serve as a means of partnering with other stakeholders to leverage resources, distribute risk, and increase impact.

The decision-making that drives investments primarily consist of diligent risk management and risk tolerances that account for the unique profiles and objectives of their borrowers. The chief liabilities taken into account by the case program's director and committees are financial stability, uncertain impact, potential burdens to borrower, and the risk of lost services to the community. Leadership readily acknowledges its commitment to mission-based principles that enhances the value of the social return on investment to the communities they serve. This leads the system to recognize its investments as significant opportunities that exchange traditional interest returns for improved health conditions in community.

### Relationships

This strategy calls for complete shifts in power and accountability dynamics from the onset of an investment with a partner to its conclusion. The health system assumes complete control of the partnership in determining which borrowers are financed and on which terms. The system considers itself partially at fault for the community services or care that would be lost if borrowers cannot meet the obligations placed on them. Once the loan is disbursed, the borrower assumes full control of how those funds are spent and is solely accountable for whether the intended impact is achieved. Trust is the most important relationship variable that must be established between the program and its partners beforehand to facilitate this process. Once a project is financed, the investment program completely hands control over to its borrowers to apply the resources appropriately and to repay the loans.

The relationships that stem from the community investments strategy are intended to empower borrowers to exercise their expertise in communities and with populations of which they have an intimate understanding. Leadership throughout the system supports the investments program because it is viewed as an investment in committed people – it is also recognized that the system's representatives must demonstrate a genuine commitment to the borrowers as well. Decision-makers accept that in order to fully leverage the competencies it does not have internally; the organization must relinquish the control and power of a project to

its partners. Given the limited staff and resources of the program this is an acceptable proposition.

#### How Decision-Making Affects Relationships

The primary business factors that affect the investment program's relationships with borrowers are the health system's mission and its terms and conditions for loan finance. The organization's mission-directed objectives lead to investments with borrowers that have riskier financial and performance profiles than a traditional lender would consider. The mission also establishes partner selection criteria that call for alignment between the health system and borrowers' values and objectives.

The life-cycle of an individual investment naturally shifts the degrees of power and accountability from lender to borrower once a project has been financed. The structure of the program's investments fosters increased freedom for the borrowers to apply funds as they see fit. These characteristics highlight the program's intent to create conditions that empower borrowers with increased discretion and minimize the burdens of repayment. The program's decision-makers foster open communication and joint definition of goals to stabilize the partnership and facilitate success. These measures are taken in addition to risk assessments and screens of borrowers' profiles to stay informed about uncertainties that may arise over the course of the loan.

#### Lessons Learned

Efforts to strategize the revitalization of communities are "motivated partly by the re-recognition that all well-functioning communities need many ingredients to thrive including jobs, good schools, safe streets, and the like" (Erickson, 2009). Over the last twenty years, community development networks have been very successful with the revitalization of communities across the nation. However, many underserved neighborhoods still lack access to community development networks and matured community development corporations. This leaves a void created by an absence of agencies that can secure and allocate resources needed for community development projects. This case study highlights an investments strategy that creates opportunities for community stakeholders to address the needs that stem from these gaps in resources and services.

NFP hospitals have a significant stake in the establishment and longevity of healthy communities and the provision of below market rate loans present a valuable tool that directs resources toward those communities' emergent needs. The capital provided by this strategy contributes necessary community resources that have an immediate impact on how housing, education, and employment landscapes of communities are reshaped. The program also allows the system to meet its charitable obligations as a steward of community resources in a manner that other lenders would not traditionally support. That unique distinction of the community investments strategy addresses an unmet and critical need for underserved communities. The provision of loans that support critical services for underserved communities that might not be funded otherwise distinguishes this model from other partnership strategies.

The implementation of this strategy is based on two key considerations: the first consideration is how to manage risk and the second is how to manage relationships with borrowers.

1. The formation of partnerships and empowerment of local stakeholders are essential. They allow the case program to leverage its limited resources and amplify the impact of its dollars beyond what either partner, the system or borrower, could achieve alone.
  - a. In some instances, the capital allows borrowers to accomplish pre-development projects that traditional lenders would rate as too risky to finance. However, once those projects are completed, borrowers can then exponentially leverage their initial capital into larger commitments from other investors.
2. Compared to traditional financing models, there are considerable liabilities associated with the finance of capital to local stakeholders with risky profiles. To address this, the leadership has decided to adopt a screening framework that contextualizes its risk in respect to other social criteria that achieve the mission of the organization.
  - a. The program's decision-makers contend that these types of investments present less risk than their counterparts in traditional markets because of their ability to monitor performance signals more clearly and ahead of time. One key decision-maker explained that risk is a part of any investment and one should be just as willing to take a chance on their own community if they are willing to do so in the stock market. Under these terms, the high risk of the investments is offset by the high reward of the social returns that have greater value.

Despite the effectiveness of the program to channel resources to non-traditional borrowers and achieve impact through community development, the investments strategy does present some issues to its decision-makers. As a financial lender, the limits of the program's infrastructure and resources to rigorously assess portfolio risk are noteworthy concerns.

1. Assessment of the program's structure and policies to review its apparent and hidden risk tolerances; specifically oversight and loan finance and repayment terms.
  - a. Presently, there is limited staff responsible for the assessment of the program's potential applicants and oversight of any active accounts. There are potential risks embedded in this arrangement given the volume of borrowers and net amount the program manages annually. These limitations restrict the extent of in-depth analysis that can be performed to determine the credit implications of financing borrowers. This is of particular concern with the assessment of smaller agencies like human service providers or community organizations. The totality of these matters present difficulties to the assessment of the true risk present in the community investment's portfolio.
  - b. The program's policies and structures that guide the strategy allow for adjustments to borrowers' interest rates and terms of repayment. While this lets the program customize its partnerships with borrowers dependent on their circumstances, it alters expectations for the loans' classification and

performance. From the standpoint of fiduciary responsibility, stricter guidelines might call for the decision-makers to explicitly define the parameter of the program. Examples include: circumstances under which principal is repaid over time and how long extensions of interest rate-only payment periods can occur. Resolving this issue could help the decision-makers to clearly delineate how the program values social returns on investments from its borrowers relative to the value of their financial returns.

The community investments strategy has led to projects that have revitalized numerous communities. An example of this is the creation of mixed-use residences where residents have walkable access to healthy foods from local markets in their buildings within neighborhoods with adequate lighting and access to public transportation routes. Partnerships that support and lead to these types of outcomes improve environments that shape many social determinants of health for disadvantaged communities. This begins with the support of local stakeholders that, while risky, are significantly engaged in these communities. It is held that the program's riskiest investments which finance smaller amounts to more fragile borrowers achieve the most significant impact in their communities when they are successful.

The balance of the health system's mission against the risks and costs of investing in community development is a central decision-making criterion for the case program. A community investment strategy presents risks due to borrowers that may be challenged to repay their loans, the assumption of foregone interest, and investment impact that is difficult to measure. These risks are offset by opportunities to channel resources that can be immediately applied to address the needs and revitalization of communities. In addition, the program's reputation is elevated because of its recognized commitment to partnering with community stakeholders that have nowhere else to turn. This generates business value in the form of positive political capital for the system in its communities. It also has a demonstrable impact on how community development takes hold in underserved areas. It is for these reasons that the community investments strategy offers a distinct advantage relative to other funding mechanisms in that it immediately channels resources into disadvantaged communities. Figure 6.1 summarizes other advantages and challenges to community investments as a NFP health system strategy.

## **Case 2: Advantages and Challenges to Community Investments Model**

### **Key Program Strategy Strengths**

- Offers direct impact on community conditions as opposed to traditional capital market investments that provide a trickle down dynamic to community impact at best.
- Borrowers are given the freedom to do what they see as necessary in the communities in which they operate.
- Capital can be invested into projects on an ongoing basis as returned capital can be re-invested into a community.
- The partnerships the health system offers build the governance capacity of community stakeholders through improved management and experience. This positions communities which seek financing to have increased access and improved chances to secure and leverage additional capital resources.

### **Key Program Strategy Limitations**

- Limited staff to provide screening and oversight of loans
- Risk assessment through past and forecasted performance is difficult
- Risk assessment and accountability are difficult due to the lack of available metrics to gauge performance toward impact of social determinants
- The strategy also presents the challenge of making strategic linkages between the goals of the organization and the intended impact of the program's investments.
- System programs do not replace existing charitable endeavors at the hospital level but there is room for more strategic alignment of these efforts.
- Revolving loan issues

Figure 6.1

## Case 3

### Overview

This case study examines the decision-making and relationships that define the partnerships administered through the regional community benefit department of a large NFP integrated health system with community clinics. The health system's regional grants strategically fund and provide technical assistance to safety net partners in support of the quality improvement of their care delivery management. These partnerships aim to improve community health outcomes by enhancing the clinical and operational capacity of these safety net providers. The case department dedicates a team of its staff to manage and facilitate all levels of the health system's interactions with safety net partners in its region.

The health system's strategic partnership with northern California community clinics at the center of this case study was established to share a chronic disease management program and its supporting systems. The program had effectively reduced cardio-vascular related morbidity in at-risk populations within the health system's membership. The introduction of the program into community clinic settings was intended to achieve similar results with the health outcomes of medically underserved and vulnerable populations.

The disproportionately poor health status of vulnerable populations presents challenges to safety net providers given their limited resources. These patients are more likely to seek health care when it is an emergency and do not consistently seek follow-up care. This increases the burden on public providers to manage the health of their patients. The community clinics taking part in the partnership serve from 5,000 to 65,000 patients with approximately 80% of coverage coming from Medi-Cal or self-pay sources (CCHE, 2008). In the wake of healthcare reform, enrollment in Medi-Cal by California residents is expected to increase by 1.7 million (Long, 2010). Reliance on public funds for operating revenue to deliver care to a rapidly growing population poses considerable resource constraints on northern California community clinics. These limitations affect safety net providers' capacities to implement the adequate population and disease management systems necessary to improve quality of care and health outcomes. The concentration of these populations in the safety net setting is the basis of the argument for improving community clinics' quality of care. It is believed that this can have a significant impact on the improvement of health outcomes of these groups.

The grant-making by the case department is part of a strategy to intentionally support and enhance northern California community clinics' capacity to meet the demands of the safety net's patient populations. The health system's regional funding represents a unique community benefit strategy because its grants are purposefully paired with the contribution of population management expertise and promising clinical practices. This differentiates the health system from other funders that lack care delivery experience, population management tools, and the technical proficiency of an integrated healthcare system. It also distinguishes the community benefit department's funding strategy from those of other NFP health systems because of its direct knowledge of and experience with the clinical information management of its own health system members.

This case explores how a regional community benefit department of a NFP integrated health system manages its partnerships with community clinics as a grant-maker and technical advisor. It describes the decision-making of leadership and managers within the health system that directs resources and expertise towards the support of community clinic partners' efforts to improve health outcomes. The case study illustrates the role that relationships between clinicians and staff in the health system and clinics play in shaping the evolution of the partnership. The following sections identify and examine the decision-making and relationships that are formed to drive this type of community benefit strategy. For this grant-making strategy, the decision-making variables of mission, risk, and opportunity will be described in the context of how they relate to the trust, power, and accountability dynamics of the relationships between the regional department and community clinics.

The following will provide further details on the organization, strategies, decision-makers, and partners of this program. It will then describe the decision-making and relationship measures that informed the data collection process of the case study. Next, the results of the data collection will be shared and a discussion of these findings in the context of informing community benefit practice will conclude this case.

## **Background**

The case community benefit department is located in the regional offices of the health system which are within immediate proximity of the organization's national headquarters. The health system is a nationally recognized provider that operates in multiple regions across the country and throughout all of California. As an integrated system, it is comprised of three separate entities which consists of the system's own physicians, health plan, and hospital facilities. While each operates exclusively, they share responsibility for the organization's governance and decision-making. Within the region, the NFP health system operates 20 hospitals, in 15 different rural and urban markets, and provides health care to over 3 million members.

The regional community benefit department strategically contributes approximately \$20 million a year in grants to various stakeholders and initiatives across northern California intended to improve community health conditions. Most funded activities pertain to the improvement of healthy living environments or enhancement of safety net providers' capacities. Within the organization, the case community benefit department coordinates the engagement of its safety net partnerships with physicians at the system, regional, and facility levels. Its staff's daily ongoing responsibilities call for them to: arrange technical assistance and trainings for grantees; monitor and evaluate the progress of funded projects; negotiate project changes and renewals, develop new relationships and partnerships with clinics; and serve as a health system liaison for community clinic partners.

The current relationships between all levels of the health system and safety net are well established because they began as informal partnerships nearly twenty years ago. A formal partnership between the system and community clinics throughout the state was codified in 2003 (BTW, 2007). There is a separation of responsibilities and roles in partnerships across

national, regional, and local levels as well as between administrative and clinical leaders. At the local level, direct engagement takes place between hospital community benefit department staff, hospital physicians, and partner clinics in their vicinity. Regionally, the case department acts on behalf of the system in partnerships with clinics, clinic networks, and clinic consortia.

The case study’s partnership began between the region and community clinics in 2007 with the intent to improve the clinics’ capacities to develop population and chronic disease management systems for high risk patients. Grant-making and technical assistance channeled through the case department strategically targets the enhancement of care management and information technology in the community clinic setting. Support for these two areas was meant to apply the organization’s unique resources to reinforce management infrastructures. These resources help community clinics overcome challenges to improve health outcomes that include low medication adherence and high incidence of adverse events in risky patient populations. Efforts to address these issues involve assistance for systems to: implement clinical guidelines for applying evidence-based medicine; establish baseline metrics for the health status of patient populations; and improve clinics’ capacity to manage population health panels. Grants are awarded to provide capital support for program and purposes listed in Table 7.1:

Specific clinical program	Medical directors
Clinic infrastructure reinforcement	Electronic health records
Regional clinic networks	Patient registries
State clinic associations	Maintain and establish ongoing enrollment of patients at clinic sites
Clinic physician training	Quality improvement (IT support, management systems and processes, annual meetings, etc.)

Table 7.1

Funding for core operational support is channeled through regional clinic networks to their members. Simultaneously, competitive grants are awarded to networks and individual sites for specific programmatic support. Grants from the regional department tend to be larger than those that are distributed from local facilities and tend to have multi-year commitments.

The funds disbursed by the regional community benefit department are intentionally aligned with the mission and strategic priorities of the larger health system. The regional partnerships with community clinics are an extension of the health system’s commitment to improve the health of individuals and their communities. Through its engagement with community clinic stakeholders, the health system is able to disseminate its internal resources and practices into pockets of underserved communities it does not traditionally reach. To date the partnership has evolved to include engagement with dozens of clinic sites. In contrast to the health system’s member base that has some form of commercial coverage, clinics that participate in the partnership may serve populations where 98% of their patients are below 200% of the Federal Poverty Level (FPL), are uninsured, or rely on public insurance. The partnership allows the health system to leverage its resources towards the application of its care management



programs to over 11,000 patients in the safety net. As a result, community clinics in northern California that have implemented the shared program and systems have seen a 60% decrease in chronic conditions for patients following the regimen (case department #3, personal communication, April 2011).

The grant-making strategy to reinforce the clinical and operational capacity of community clinics is administered in an evolving context of challenges that are taken into account by the case department. Given that the health system is an insurer, a number of its members are likely to receive care as health plan members or safety net patients over their lifetime. Therefore, the system is invested as a significant community stakeholder in many of the challenges to improve and maintain the health of individuals in the community at-large. Aside from the difficulties the partnership has encountered with improving health outcomes in the safety net patient population, other obstacles are present. The Affordable Care Act is expected to expand enrollment eligibility and change reimbursement schedules. This may elevate the role of community clinics as health providers and population health managers. Determining the appropriate role to support partner clinics in preparation for these impending changes is a key consideration for the case department's decision-makers. These considerations must also take into account the potential shift in clinics' status from grantees to competitors in the provider market. In addition, the recent economic downturn has resulted in significant reductions in the amount of capital available for funding to grantees. In the last year, the system experienced a 45% decrease in its community benefit grants and donations. Resource constraints have increased the value of the system's other, non-financial, contributions and expertise as a partner with community clinics in the safety net. Determining the appropriate role as a grant-maker and a partner will be essential to the success of the partnership with community clinics.

### Strategy

The key components of the case department's grant-making strategy entail the provision of care management practices and information technology systems. The intent of all programming supported by the case department extends from the mission of the organization to improve the health of the system's members and the communities in which they live. In practice, the strategy is implemented through monetary grant awards to clinic stakeholder that is coupled with clinical and management expertise. Expertise is provided in the form of shared clinical guidelines and practices to: implement evidence-based medicine; ensure adequate patient follow-up to monitor adherence; and establish processes to measure performance. Funding also supports the acquisition of information systems to monitor clinics' on-site management of patients, track treatment of high-risk patients, and monitor patients' health outcomes.

The case community benefit department reports directly to the regional External and Community Affairs office and also works very closely with leadership in system's national Community Benefit office. The physical proximity of these three offices has resulted in intimate and immediate interaction between decision-makers that set the direction of the regional community benefit strategy. The decision-making that directs community clinic engagement is primarily coordinated amongst leadership from the case department, the national community

benefit office, and representatives of system’s physician group. Actual fund amounts per grant are set by a contribution committee composed of members from throughout the health system.

The regional safety net partnerships are managed by a team that consists of the director, a group lead, managers, and staff who are responsible for regular oversight with clinic, network, and association grantees. The parameters of partner engagement are consensually defined through dialogue amongst leadership at the national, regional, and local levels. The structures of the partnerships are formalized in the contracts of the grant awards disbursed to community clinic stakeholders. The case department staff facilitates support for clinics within the explicit boundaries of those contracts. The department coordinates the provision of funds, clinical expertise, and technical assistance to the grantees through means that are less formal in structure. Additional support to partners not explicitly defined in the grant is drawn from departments, offices, and physicians throughout the health system.

The regional department’s partnerships with safety net providers include essential services providers listed in Table 7.2:

Free clinics	Regional community clinic networks, coalitions, and consortia
Public hospitals	Statewide safety net associations
Federally Qualified Health Centers (FQHC’s)	<b>School-based clinics</b>
FQHC look-alike agencies	<b>Private specialists</b>
County health systems	<b>Food, housing, job training providers</b>

Table 7.2

In recent years, the department has expanded its catchment of grantees to include other essential service providers to communities such as: private specialists, school-based clinics, or food, housing, and employment training providers. In order to partner with a potential safety net site, department staff evaluates clinics with the following criteria:

- Operation within the proximity of a health system hospital where significant combined market share can be achieved;
- Strength of clinic’s reputation and leadership;
- Performance in the community served (local level physicians and community benefit staff are also consulted for a sense of the clinics’ role in the community);
- Partnerships are reviewed in the context of their strategic value to the health system to meet goals informed by community needs assessment and strategic priorities.

The case department faces the challenge of strategically investing in the capacity building of its partner community clinic stakeholders. A significant component of the partnerships entail coming to shared understanding around quality of care management and the limitations of care

delivery based on reimbursement structures. Translation of practices can also pose difficulties to the partnership. While the system has been effective with achieving success through its own care delivery processes for its members, these systems do not always translate into the safety net care setting. This has resulted in the need for facilitating on-going dialogue between the managers and physicians of all partners to develop innovative solutions. The regional community benefit department itself has limited resources due to the competing demands of care delivery and community health initiatives. This imposes resource constraints on decision-makers within the department and calls for creativity around priority setting, leveraging internal and external resources, and developing closer relationships with its partner stakeholders.

## **Findings**

### **Roles of Mission, Risk, and Opportunity**

The grant-making strategy of this case study's community benefit department is directed by the health system's commitment to its health plan members and their communities. The mission of the organization explicitly guides decision-makers' engagement and oversight of their partnership with safety net clinics. The strategic grant-making the department makes towards community clinics allows the health system to have an impact on the greater community beyond just its own members. One project manager contextualized the role of partnerships to achieve the organization's mission by reflecting,

*"We're here to improve the health of our member and the members of the communities where we have a presence. So these partnerships are really meant...to have an impact on overall community health." [Community Benefit Department Project Manager #2]*

As a NFP health system that primarily provides care to members of its own health plan, partnerships are necessary to meet the mission's directive to impact the larger community. The health system's mission orients its decision-makers toward identifying partnerships that will help expand their impact on the health of communities beyond health plan members. The mission also provides guidance for partner selection as they seek to work with other agencies with a similar commitment to improving health conditions in their communities.

*"We're here to make people's lives better...isn't that also what our partners are all about? We're not-for-profit [and] they're not-for-profits, we're not doing it for shareholders, and we're not doing it for quarterly bonuses from Wall Street type stuff. People don't get into this because they want to become crazy rich. They often come into it because of a sense of mission, because of a sense of service" [Community Benefit Department Project Manager #2]*

Shared sense of mission and service is a critical consideration for decision-makers within the health system when selecting clinics to fund as partners. The significance of shared values is recognized in the discussions and agreements made between the health system and its partner

clinics. One manager explained the value of shared goals as a precursor to establishing openness and clarity of intent amongst partners,

*“So I think the ability to share a vision and not be kind of obtuse about it is good.”*  
*[System Executive Leader #1]*

Shared mission establishes recognition of the inherent priorities and goals of the health system and its partner clinics to improve the health conditions of their communities.

To account for the risks a funder assumes as a grant-maker, the case department staff reviews clinics’ background, fiscal stability, performance, leadership, and fit with identified community needs. Decision-makers within the department primarily evaluate future partners within the constraints of these potential liabilities. The system’s strategic goals and other resource constraints also pose limitations on the type of support the regional department will provide to its partner clinics. A manager responsible for assessing potential partners explained that the capacities of their organization impose immediate constraints on what partnerships are formed.

*“...it's really dependent on [our health system] capacity, and what [our health system] does and doesn't have available, and [our health system]'s goals and priorities.”*  
*[Community Benefit Department Project Manager #1]*

The system’s decision-makers who manage partnerships with safety net clinics balance investments in other initiatives as well as the time, financial, and political constraints of the case department itself. When asked about the limitations to partnering with clinics, a key leader described their team balances their available resources against the needs of their partners and the community.

*“We’re not given hundreds of millions of dollars every year to this. There’s a need, you could certainly do that. So I think we have to balance our own, or look for some kind of a balance within our other strategic priorities, which absolutely include commitments to community prevention, community based prevention...So there’s an internal balance that we have to do. The trade offs are time and money...Political capital... [as a group, we have to identify what issues are important and] there’s a risk if we don’t...”*  
*[Community Benefit Department Director]*

The availability of resources has an impact on the effectiveness and sustainability of partnerships formed with safety net clinics. Prior to engaging in partnerships, decision-makers within the department forecast their role over the lifespan of the project and what can be accomplished. One manager explained the key risks that are considered at this stage,

*“Most of that is about sustainability. Can we initiate an engagement and see it through? Do we have the people? Do we have the internal resources? If we share an idea or a clinical approach and they implement it badly and it doesn’t work and they say, that’s what [our health system funder] does, we’re concerned about that.” [System Executive Leader #2]*

Staff takes into account that the prospective success of the partnership not only affects the ability of the clinics to deliver care, but also the reputation of the health system. It is understood that the health system must have adequate administrative, clinical, and resources to substantially contribute to effective partnerships. The provision of funds and shared practices can introduce liabilities to the organization if there is improper implementation or other unintended consequences.

In regards to the health system, its partnerships with clinics are aligned with its efforts to offset risks to its own operations that are associated with an unstable safety net.

*“We need them to keep doing what they’re doing so that people don’t inappropriately flood and use resources such as hospital ERs, which is not a good place for people to receive care. And it crowds out the services. So there is some mutual interest here of course.” [Community Benefit Department Director]*

The support of improved functionality and quality of care provided by community clinics reduces the health system’s liabilities associated with the costly utilization patterns of underserved populations. In addition, safety net clinics with sub-optimal operational and clinical practices can threaten the health of current and non-health plan members. Decision-makers within the health system apply a population health perspective which accounts for the impact of individuals on the collective health of their respective communities. A project manager explained the concern for the health of plan members and non-members alike and how shared clinical practices present opportunities to reduce risks for the health system,

*“The health of the community is impacted by all the constituents and all the community population, so you can't just deal with one without affecting another” [Community Benefit Department Project Manager #1]*

*“The hugest risk is community wellness. And you can't have good population health if you're only looking at one segment of the population. The other segment will impact. And the financial impact is huge, too.” [Community Benefit Department Project Manager #1]*

*“...[through this partnership,] they're [going to] have better clinical practices. And when we have patients going back and forth or patients going to [our health system’s]*

*hospitals who are then followed up at a clinic, that this is [going to] be better care [at the clinic], and they have better techniques or techniques that are more similar to [our health system]'s." [Community Benefit Department Project Manager #1]*

The health maintenance of non-members poses risks to the health system because this population affects the health of the system's own members. In addition, the interchangeability of members and non-members within a community as health plan members heightens the importance of the health system investing in the management of care in settings outside of the system.

The strategy to fund safety net clinics presents the health system with opportunities to offset these risks as well as to achieve its strategic goals and objectives. To identify opportunities for partnerships key decision-makers first determine the appropriate role for the health system to assume. Given the complexities of the safety net's challenges to deliver quality care to underserved populations, the department must be strategic in regards to the how to support the management of specific issues. The formation of partnerships with community clinics is a strategic response to community needs that allows the health system to leverage its resources.

These partnerships present opportunities to improve the health of populations beyond just the members of the health system's health plan. Leaders within the health system recognize their limited capacity to reach individuals that do not receive care in their settings. The partnerships formed by the case department allow the system to leverage its resources and amplify the effects of their operational and clinical practices.

*"...by itself [our health system] couldn't have a huge impact in the community because as a health plan we look after our members. Now, a lot of times a very large percentage of the communities are members. We do have a big impact that way, but to sort of have an impact on the broader community, I don't think they're actually is much [we] can do on [our] own...I think that was realized early on you have to have these relationships if you want to sort of move the dial if you will in the community at large and often times these people have forged the relationships with people in the community, they have the expertise, they have the cultural competency, whatever you want to say that really much, much amplifies the resources that we give." [Community Benefit Department Project Manager #2]*

The provision of funds to implement shared clinical and operational practices in community clinic settings gives the health system opportunities to transfer the impact of its models of delivery to a wider audience. Through partnerships with the clinics, the case department

leverages the internal resources of the system to achieve significant impact in the larger community.

The determination of how the department will support the clinics is influenced by the strategic goals of the health system. One representative explained that the rationale for funding clinics must align with the priorities of the health system,

*“It’s[the] bottom line...what is supported is [going to] be about [our health system] goals, priorities, and the business case, period.” [Community Benefit Department Project Manager #1]*

The provision of operational and clinical support to community clinics specifically meets the system’s goals to establish strong ties to the safety net and improve the quality of care in their settings. It is also acknowledged that partnerships with the clinics present opportunities for the department to differentiate itself from other NFP health systems in the region.

*“...If you took let’s say a organization that thinks a little more ambulatory, I don’t think necessarily that they think about caring for patients over a spectrum of long life cycle of chronic disease. So there’s a lot of reasons why [our health system] in terms of what values it embodies in which it would think of it all as emblematic of what its vision would be in terms of working with the safety net.” [Community Benefit Department Program Lead]*

*“It’s a strategic advantage. It’s not necessary. It’s not a requirement. It’s not a mandate. It’s a differentiation I think actually for us, both among givers as well as among other hospital systems. I see it’s really different than what I’ve observed from [other] hospitals that just don’t seem to have as identified or shared interest with the community health centers and the clinics.” [Community Benefit Department Director]*

The health system and clinics have similarities in care delivery structures that require efficient management of patients within specific financial constraints. The health system’s expertise with patients from similar communities and similar operational incentives as the clinics facilitates the organization’s intent to position itself as a leader in providing efficient care to large populations. The partnerships present opportunities to have a broader influence on the practices that take place in the safety net than its competitors. A clinical leader within the system illustrated the appeal of partnerships with the health system to clinics,

*“So I think change from a population perspective is easier if you are in control of the significant portion of the population. And then by nature of that dominance or market share that, at the very least, you account for that many patients. But because of the position you hold in terms of influencing healthcare delivery, there’s probably a bit more affinity, particularly in the safety net, towards looking at a model of care that seems to be successful in the large portion of the population.” [System Executive Leader #1]*

The health system’s success with managing the health of large populations makes it an attractive partner after which to model. This presents opportunities for the health system’s practices to permeate throughout the communities it serves and increases the proportion of its influence in other settings. Decision-makers view this as a means to increase the market-share of the health systems practices and influence. It also helps to brand the system as an invested stakeholder in the community.

#### Roles of Trust, Power, and Accountability

The grant making strategy of the case department stems from leadership’s intent to establish itself as a trusted stakeholder that invests in the long-term sustainability of the safety net. To achieve this, administrative staff and physicians cultivate ongoing relationships throughout the safety net community. It is through continuous communication that the case department establishes trust and shared understanding with its clinic partners. When asked what was most important to sustainable and successful partnerships, the department director responded,

*“Trust, which you can only build over years... I think a long period of time in doing what you say you’re [going to] do and showing that you respect and you honor your commitments. If you can’t do what you say you’re [going to] do, telling them why beforehand. As much transparency as possible....” [Community Benefit Department Director]*

The director stressed the importance of transparent intent and proven commitment for building trust within long-term partnerships. Key leaders regard trust, transparency, and communication as critical to the initiation of formal partnerships in the grant-making strategy. Their decisions are also influenced by pre-existing relationships, performance history, and future goals. A key decision-maker involved in the early formation of the case strategy explained the significance of familiarity to a partnership,

*“I think there’s an aspect of previous work together so that there’s some confidence in each other’s capacity to work on a particular project that comes to a successful fruition. There’s a willingness to kind of share an aspiration so I think with these early adopters if you will, I think I was pretty transparent to people. I said, you know, what I really want*



*to see is to see if we can achieve a population outcome that is a demonstration of successful translation of a model that we've done at [our health system]. I don't think you can say that very well to folks that you haven't worked with and that you have reticence in terms of sharing a vision like that." [System Executive Leader #1]*

Trust between partners emerges through open communication and familiarity with one another's performance during past projects and partnerships. It is also grounded in a shared faith to achieve improved health outcomes with target populations. The importance of clear communication and understanding is highlighted in the instance of shared clinical practices between each partner's physicians. Clear communication and shared understanding of objectives between these two groups clarifies the context, benefits, and challenges of the clinical aspect of the partnership. One hospital physician summarized the role of communication between hospital and clinic physicians,

*"I think understanding the context, understanding the organizational intent helps to guide what the engagement will actually look like – what would be in scope, what would not be in scope..., I think [my counterparts] are more enthusiastic when they really understand the why" [System Executive Leader #2]*

As the partnerships for this strategy are built around sharing of clinical practices, system physicians are necessary to garner the buy-in of their counterparts in the safety net.

Decision-makers within the case department cite clarity of intent and shared understanding of goals as essential conditions for engaging partners.

*"...part of it is just understanding, especially with major partners, what's their strategic plan. What's their work plan for the next three to five years? What parts of that could we help them with, whether it's through a grant or consultation..." [Community Benefit Department Program Lead]*

It is understood that trust amongst partners must be nurtured over time and that a long-term approach to building successful partnerships must be adopted. This long-term approach involves clear and honest communication of organizations' objectives and shared commitment to the partnership over an agreed period of time. A clinical leader compared the outlook of this process to that of chronic disease management,

*"...and like the management of chronic conditions it's what you do in the long haul. It doesn't do any good to manage the blood pressures perfectly for six months. It's*

*actually better, although this wouldn't be the goal, to manage it kind of well for 15 years ...but if you can take the longer view in clinical care and in these relationships you're going to be a lot more successful" [System Executive Leader #2]*

It is held that trust in the process of building a partnership over time is just as important as developing trust with the partners themselves.

The process of communication with the clinic's leadership and physicians is necessary for the department's internal decision-making about the role they will assume in a given partnership. Decision-makers determine the case department's role with a project dependent on how trust evolves over the course of a partnership. A project manager explained,

*"So we strategize, all right, what can we do with the safety net institute this year? What are they asking for and what can we do? What are the consortia asking for lately? How much of that could we do? And when there's an established relationship that's functional it's much easier for us to talk someone through, here's what we can do. Here's what I'm not so sure we're[going to] be able to do. Because they've grown to trust and have seen us make contributions when we can. But if it's a new organization coming to us you have to build the relationship first." [Community Benefit Department Program Lead]*

Communication and trust with clinic partners helps decision-makers within the department to identify opportunities for the future direction of their partnerships. Staff within the case department explained that trust within a partnership allows for discussions that are clear and forthright. In these instances, communication takes the shape of on-going discussions where each partner can share clinical and operational experiences as well as identify future opportunities. A physician within one health system's hospitals described the process of communication with clinic stakeholder partners,

*"As they're evolving, we're evolving. We're able to share then the results of our experiences. Really, we're not telling them what to do. We're sharing with them what we have found successful, and they get to decide whether or not that sort of— whether those sorts of things as we believe led to our success would likely lead them to similar successes" [Hospital Physician]*

Communication and transparency between organizations allows for trust to evolve within the partnerships over time. The evolution of these relationships increases decision-makers' confidence in their partner's intentions and performance over the course of their partnerships.

Just as trust evolves over the course of the relationships cultivated through the grant-making strategy, so does the degree of power-sharing that exists between the case department and its community clinic grantees. The purpose of each clinic partnership is unilaterally determined by the system's leadership. As a funder, the case department determines: which partners will receive grants; award amounts, and the clinical or operational support that will be received. These terms are not decided within the partnership but are informed by the organization's strategic goals and capacity to provide resources given its resource constraints. This creates an imbalance in ownership of the partnership process that is recognized by decision-makers within the health system. One respondent described power-sharing within a funder-grantee partnership,

*"And I don't know that there are very many partners that really see power sharing in the equation because we are so big because we have so many resources... some struggle more than others, but these are especially hard to find. So it doesn't feel as much give and take." [Community Benefit Department Program Lead]*

Since the department's partnerships with community clinic stakeholders are built around a grant program, it is accepted that the funder has final authority in regards to the scope of work and allocation of funds. This is necessary condition to optimize the unique supplemental expertise that the health system offers. These provisions increase the value of the partnership because the clinics gain access to customized applications of the system's operational and clinical guidelines. This in turn increases the likelihood of clinics' willingness to accept less control over the direction of the partnership.

The case department's provision of grant dollars and unique resources allows it to define the conditions for optimal application of their support. This may occur in spite of any of the clinic partners' requests or expressed needs that are not well aligned with what the health system has determined it will support. One manager explained that decision-makers must take into account which of the clinics' expressed needs can and will be met given the resources available within the system.

*"That's part of what makes [us] unique in this field, is the fact that we do have all these other resources, and we say to the extent that we can and to the extent that they're useful to you, yes. Please contact us for these different things...it's figuring out what they ask really is on our part and can we fulfill." [Community Benefit Department Project Manager #2]*

At the onset of a partnership, decision-makers with oversight of the case department are responsible for the determination of which of the health system's clinical or operational resources best compliment the needs of a given clinic stakeholder. The role assumed by the health system is also affected by leadership's perceived opportunities to support the safety net in a manner that differentiates the health system from other partners of the safety net. These considerations shape the role that the case department assumes with each clinic partner. One key leader explained how the health system's objective to support the safety-net over the long-term helps to offsets this power imbalance,

*"And I think they now trust us enough to know that we're in it for the long haul. They may not always like what they get...but they do realize that there is value to the resources that we provide and sustain every time." [Community Benefit Department Director]*

The initial imbalance in power is also offset with a mutual understanding that the health system and clinic are implementing the new clinical and operational improvements together. A common framing of this aspect of the partnership by the department staff is found in the question of "how can we best work together given what we can work on with our partners?" A clinical representative illustrated this point in the context of implementing the shared guidelines,

*"So the power relationship is undeniable but the certain aspect of that but I think it really can be downplayed by the fact that we should emphasize what is the mutual learning in terms of what's happening in implementation of a program." [System Executive Leader #1]*

There is an emphasis on mutual learning and long-term investment that counteract the power imbalance that exists between partners. As the relationships with community clinic stakeholders evolve, it is felt that the power shifts to a peer-to-peer interaction. A prominent representative of the department reflected on the nature of the interaction between the system and clinics when the partnerships are successful,

*"...so the successful relationships involve getting to much more of a peer, peer relationship. Now we're still going to be better resourced than they are, but they have lots of things that we don't or least they have skills that are more developed around... Maybe it's not true that they have a more diverse but they certainly have certain types of patients, socioeconomic class of patients that we don't. And so there's a lot that we can learn about the way they do things that are helpful in the long-term in our thinking*

*about our processes..., what can we do together? And I think part of the relationship to sustain over many years you have to get to that.” [System Executive Leader #2]*

Given evolution of a long-term partnership where there is mutual learning and commitment, it is expected that power-sharing finds more balance between partners as the partnership evolves. As each partner increasingly recognizes value in the assets brought to projects by their counterpart, power-sharing increases and facilitates the sustainability of the partnership.

The power of the department is also exerted in the defined scope of work that is expected of its clinic stakeholder partners. Given the health system’s experience with implementing clinical guidelines and using its operational tools, leadership within the organization strive to set reasonable expectations of its partners applying these practices for the first time. A manager discussed the process of working with partners to craft projects that will successfully secure grant support and achieve objectives that will improve the clinics’ quality care.

*“[It] is about scaling back what they think they have to put in a proposal. [Our health system] does understand what it takes to increase one health outcome. They get the complexities, how much time, how many years it takes to do that. And so grantees don't need to put 5,000 things into a proposal. They need to do two and do it really well.” [Community Benefit Department Project Manager #1]*

To insure the success of their projects, each partnership consists of terms that define the expectations of each participating organization. As a funder, the case department is obligated to hold its community clinic partners accountable to the implementation of their agreed commitments.

Accountability is also an important component of the long-term relationship that evolves between the case department and its community clinic partners. The health system’s grant-making strategy to invest in the safety net is hinged upon the organization’s own invested stake in the communities it serves. The case department director explained the health system’s role in maintaining the health of communities as a decision driver for working with the safety net.

*“We are a part of the safety net, but the way that we provide, the way that we shore it up is not only by just taking everybody and destabilizing the safety net, but it’s by a portfolio of approaches that includes a very explicit support of the very infrastructure and capacity building, and pushing them along a trajectory of increased integration, and increased quality.” [Community Benefit Department Director]*

Accountability in the context of the grant-making strategy for the case department is grounded in the shared stake the health system and community clinic stakeholders have in the health of their shared populations. Shared accountability as a community stakeholder is an obligation that decision-makers feel distinguishes their work from that of other funders or health systems that support community clinics.

*“And it's very different than other foundations because the other foundations don't have that commitment to entire wellness that [our health system] does because we share the same people...” [Community Benefit Department Project Manager #1]*

*“So it has enabled us to say we have a shared strategic interest, which is the health of the population, their ability to choose where they get care, and their ability to get extremely good high quality care irrespective of where they enter. We are a provider in the community.” [Community Benefit Department Director]*

Leadership within the health system believes that it is responsible for the health of its patients whether they receive direct care in their own settings or that of the safety net. As a health plan, the health system has population health concerns that can be optimally addressed through coordinated efforts with safety net providers.

## **Discussion**

The grant-making strategy presented here was selected because of the breadth and comprehensiveness of the financial and specialized support it offers. The strategy is grounded in the health system's unique organizational structure and care delivery model that manages clinical information and population health outcomes. The operational and clinical competencies the case department shares through its partnerships are intended to improve health outcomes in the larger community beyond its own member population. The population health perspective that the health system has adopted leads it to identify itself as accountable for the collective health of communities. This stems from leadership's recognition of the system's accountability for the health and environment of individuals whether they receive care in their settings or not.

As a funder, the case department determines the objectives, terms, and resources committed to the partnerships it forms with community clinic stakeholders to impact population health. The relationships formed with these stakeholders are important to the health system's process to identify opportunities and sustain effective partnerships. Familiarity and trust are important to the formation of these partnerships. Once they have been established, transparency and clarity of intent over the course of the partnership are necessary for its longevity.

### Decision-Making

Decisions that determine the objectives and resources devoted to partnerships for this strategy are consensually determined amongst the system's operational and clinical decision-makers. Leadership within the health system hold themselves accountable to contributions that improve the health and well-being of the communities where their facilities are located. This is a mission-driven perspective that manifests itself through its strategic goal to strengthen the safety net. This is primarily achieved through the formation of partnerships with community clinic stakeholders aimed to improve their capacity to deliver care and manage patient populations. The objectives and strategic goals of the health system also drive partner selection and purpose of partnerships.

These partnerships take shape in the context of the resources and competencies that are available to the case community benefit department as well as its commitments to other community prevention initiatives. The principal liabilities that are taken into account during decision making include the potential impact of partnerships, the stability of the organization, and the reputation of the health system. The unique provision of operational and clinical expertise presents opportunities for the health system to leverage its resources for increased community impact. The partnerships also present opportunities to distinguish the system from foundations and other health systems that do not share population health management issues with the safety net as providers. It positions the health system to brand and differentiate itself as an invested stakeholder and expand its influence on the health care practices and outcomes in its market and the community at-large. Lastly, leaders within the health system recognize the value of philanthropic partnerships with clinic stakeholders. Given their shared populations and the looming effects of the Affordable Care Act, the political capital and goodwill generated through the support of the safety net can help to distinguish the health system as a preferred partner in the future.

### Relationships

The grant-making strategy the case department employs relies on sustained and clear communication with community clinic stakeholders to achieve its objectives. Those dynamics emerge from trust and shared commitment between partners and are essential to the establishment of effective projects. Relationships are maintained between staff and physicians at the system and local levels of the health system and community clinic stakeholders. Strong communication and trust between each partner's physicians at the local level is especially important to foster the shared clinical practices that are the cornerstone of each partnership. A long-term approach to build relationships within the partnerships is fostered to increase their prospects of longevity and effectiveness. Commitment to the partnership is grounded in both parties' invested stake and accountability for the health of shared populations. The health system acknowledges the power and control that it holds in the partnerships as a funder that must meet its own objectives and strategic goals. However, the department's demonstrated

long-term commitment to the safety net is viewed to offset many initial power imbalances as each collaborator shares more ownership of the partnership over time.

#### How Decision-Making Affects Relationships

The health system's mission informs the strategic goals of the organization which directly influence the objectives of the department's partnerships, partner selection, and what resources will be given to a project. Business considerations such as availability of resources, potential to leverage existing resources and expertise, and existing market share also affect which areas and clinic stakeholders are viable candidates for partnerships. These conditions create non-negotiable boundaries of what the health system will fund and support.

The strategic partnerships reviewed above are a result of relationships that are intentionally formed within the safety net by the case department to identify needs and opportunities. Trust and open channels of communication are purposefully fostered to increase the probability of an effective working relationship with stakeholders. The degrees of power and accountability shared within each partnership are unilaterally determined by decision-makers within the health system. As a funder, the case department furnishes grant applications with objectives aligned with the system's strategic goals and controls what resources and expertise are assigned to a partnership.

#### Lessons Learned

The grant-making strategy examined in this case study reflects a unique partnership model that directly targets stakeholders whose improved services align with the objectives of the funding organization. It also stands apart from the traditional funder model because of the specialized technical assistance and expertise the health system offers as a clinical provider. It is a sustainable model that can be justified because it is aligned with the organizations operational competencies and its strategic planning.

The intended impact of the partnership is one that is mutually beneficial to both partners' strategic goals. For safety net stakeholders, it enhances their capacity to improve their clinical operations, increase access to care and high quality services, improve revenue streams, capture lost efficiencies, and increase their capacity to adopt other reforms such as the implementation of electronic health records. The health system benefits from strengthened safety net networks that apply similar technology and management platforms as its own. This can position each partner as preferred collaborators as the healthcare landscape evolves. In the near term, the improved capacity of safety net stakeholders in areas where the system has significant market share can ultimately buffer the organization from the downstream costs of an unhealthy community. The partnership is an ideal example of a management strategy that is



intended to reduce liabilities and create opportunities to gain competitive advantages and differentiate the health system from its competition. The following three considerations can be drawn from the grant-making strategy reviewed in this case study.

1. Business Drivers:

- a. The strategy examined in this case calls for a community benefit department to balance the strategic goals and resource constraints of a large NFP health system with the emergent needs of communities and clinic stakeholders in their region. The partnerships formed by this grant-making model are strategic responses to these issues. On one hand, they leverage the strengths of the system's core competencies to further penetrate its market. On the other, these partnerships present opportunities to forge stronger relationships with clinic stakeholders. This in turn is acknowledged as potentially advantageous in light of the implications of health care reforms. Purposeful investment in community clinic's infrastructures and practices reduce the liabilities associated with an unstable safety net. Most notable of these risks is the potential increase in patients with public coverage that seek care in the health system's own facilities. The partnerships aim to increase the number of prepared community clinics should there be a need for coordination of patient care with the safety net. They also extend the penetration of the health system's business and care delivery models further into the communities where it has a presence. As more clinics adopt these models, the health system may gain advantages over its competitors as an insurer and provider.

2. Resources and strategic goals influence relationship variables:

- a. Since the partnerships are an extension of core operational strategies, the health system exerts significant control over their objectives and participants to reduce uncertainties of implementation and outcomes. The strategic goals, core competencies, and resource constraints of health system ultimately determine the degrees of power and accountability that are assumed within its partnerships with clinic stakeholders. As the market and political environments evolve in the wake of health care reforms, it is understood that the relationship dynamics with safety net partners may change accordingly.

3. Trust facilitates longevity of partnerships:

- a. The effective relationships with clinic stakeholders by the case department's staff are grounded in familiarity and open communication. This is particularly relevant at the local level of the partnership, where clinicians from both settings must come to an understanding of how the shared practices can be translated to help improve care delivery in the safety net.

The grant-making strategy reviewed in this case illustrates a distinctive funder model that couples specialized technical assistance with evolving business relationships community

stakeholders. This unique blend of shared business, clinical, and population health objectives amongst partners distinguishes this strategy from other community benefit models. It reflects a broad alignment of ideas and goals between partners and fosters clinical and operational improvements in health care delivered to their shared populations. Figure 7.1 summarizes the strengths and challenges of the grant-making model.

### **Case 3: Advantages and Challenges to Grant-Making Model**

#### **Key Program Strategy Strength**

- Capacity to offer clinical and operational resources for population health management allows department to leverage expertise for significant impact in communities.
- Can form unique partnerships with community clinic stakeholders that differentiates the health system's contributions from that of its competitors.
- Investment in development of safety net infrastructure extends penetration of health system's practices into marketplace and potentially offsets future risks.
- Matured relationships with safety net around shared practices and operations may be strategically advantageous as healthcare landscape evolves.

#### **Key Program Strategy Limitation**

- Can only form partnerships with community clinic stakeholders in defined service areas of health system's hospitals.
- Grants are limited to scope of issues defined by the health system's goals which may not address clinics' or communities' immediate needs.
- Difficult to determine health outcomes that result from partnerships because population health management interventions are primarily measured by intermediary process outcomes.
- Limitations of many clinic stakeholders' resources and capacities diminish the department's pool of prospective partnerships and areas of impact.

Figure 7.1

## Multi-Case Analysis and Ladder of Partner Participation

The case studies examined in this research present three community benefit strategies that incorporate unique stakeholder partnerships to achieve community health impact. The study selected practices from California NFP health systems with hospitals that demonstrated robust capacities to report processes that identify community needs and engage community stakeholders. Analysis of the decision-making and relationships that comprise these community benefit strategies provides insight into how health systems can effectively engage stakeholders to improve communities' social and environmental conditions. This research highlights these strategies' coordination of strategic decision-making with community stakeholder engagement and partnerships. The review of these community benefit strategies helps address this study's secondary research questions:

- What are the forms, structures, and purposes of these partnerships?
- In what ways do trust, power-sharing, and accountability vary by different types of partnerships?
- For each type of partnership, what are the best practices for resolving the issues raised by resource constraints that threaten the ability of the partnership to achieve shared goals?

An examination of the literature found that there is a limited pool of management models, guidelines, or best practices to inform how new partnerships with community-based or private organizations should be developed. One objectives of this research is to contribute a useful model of decision-making for partnerships within the context of NFP health systems.

### **Key Findings from Partnerships**

The partnerships observed in these case studies present NFP health systems with opportunities to reinforce and expand upon their community benefit strategies. The objectives of most community benefit partnerships are determined by the strategic direction and available resources of the larger health system. NFP health systems' strategic direction tends to be defined by the organization's mission, political and market environments, and its resource constraints. Partners are selected based on their: mission alignment with the system; unique resource, service, or knowledge competencies; and capacity to address identified community needs.

Partnerships with community stakeholders help to achieve health systems' strategic objectives to improve conditions within communities. They achieve this through leveraged resources and competencies that amplify social and environmental impact. Given the limited resources, staff, and competencies many community benefit departments confront, partnerships augment departments' capacity to reach wider populations and provide increased services despite significant constraints. Table 8.1 summarizes some of the practices identified in this research used by community benefit departments to compensate for their resource constraints.

**Promising Practices to Resolve Resource Constraints that Threaten Community Benefit Partnerships’ Ability to Achieve Shared Goals**

<ul style="list-style-type: none"> <li>•Strategic leverage of partners’ competencies to achieve greater community impact and outreach</li> </ul>	<ul style="list-style-type: none"> <li>•Contributions to partnerships are restricted to organization’s core competencies and strengths</li> </ul>	<ul style="list-style-type: none"> <li>•Mission alignment and shared liabilities are used as criterion to guide purposeful partnerships with stakeholders</li> </ul>
<ul style="list-style-type: none"> <li>•Small department staff is charged with the engagement of many community stakeholder partners</li> </ul>	<ul style="list-style-type: none"> <li>•Invest seed funds for projects that is used to secure larger future financing</li> </ul>	<ul style="list-style-type: none"> <li>•Cross-purpose use of community benefit with organization’s other departments/functions</li> </ul>

Table 8.1

Upon reviewing the strategies in this research at a macro level, the following was a common finding: partnerships provide health systems with means to leverage limited resources; which allows them to meet the needs and demands created by imperfect healthcare, economic, and social service markets. Secondary findings indicated that the pooled resources of partnerships allowed for:

- reduced duplication of services
- informal stakeholder networks that share information about emergent community needs
- strengthened stakeholder relationships that help identify and incubate opportunities to strategically act in communities
- increased awareness of evolving landscapes and priorities of communities and their stakeholders
- increased capacity of community stakeholders to affect community health

Common obstacles faced by partnerships include additional costs and time commitments as well as sacrifices of control within a partnership’s project.

Many outcomes achieved through these partnerships are intermediary in nature and are expected to result in improved community health outcomes. Given the limitations of the data collected for the case studies, it is not possible to establish proven correlations between many partnerships’ activities and the impact they have on communities’ social and environmental conditions.

The case studies demonstrate the array of local community partners that community benefit departments engage. These stakeholders address a breadth of community needs and contribute a wide range of competencies. They also present health systems with immediate avenues to identify both emergent community needs as well as opportunities to address those needs. A variety of different strategies are applied to engage community partners. The strategies reviewed here were: community empowerment, community development investing, and grant-making with supplemental technical assistance to build the capacity of stakeholders. Table 8.2 summarizes the forms, structures, purposes of those strategies.

**Case Studies’ Partnership Design & Objectives**

	<b>Community Partnering</b>	<b>Community Investing</b>	<b>Grant-Making</b>
<b>Forms</b>	Networks, Joint Ventures, Initiatives, Sponsorships, Endorsements, Coalitions, Collaborations, Advocacy Groups	Below-Market Interest Rate Financing, Governance Support	Grant Support, Technical Assistance
<b>Structures</b>	Informal Cooperative Groups, Contractual Agreements	Shared Ownership, Joint Investment Pools, Contractual Agreements	Contractual Agreements, Informal Cooperative Groups
<b>Purpose</b>	Community Empowerment	Community Development	Stakeholder Capacity Building, Quality Improvement

Table 8.2

**Key Findings from Review of Decision-Making Variables**

Trends in community benefit planning and programming are sufficiently understood in the context of decision-making principles and frameworks furnished by corporate social responsibility literature. The patterns observed in the strategies this research examined are consistent with those of organizations that seek to balance economic, social, and environmental effects. The application of CSR frameworks and principles distinguishes three key attributes of community benefit practices; they are:

- Mission-Driven: Socially responsible strategies align with the competencies and goals of health system
- Markets: Market and political environment shape parameters of community benefit strategies
- Management: Distribution of managerial discretion within health systems influences how partnerships take shape and degrees of power, trust and accountability that exist within stakeholder relationships

Socially responsible strategies should align with competencies and goals of health system

The missions of the NFP health systems examined here set parameters for the strategic goals that call for the use of the partnerships and orient their objectives. Within one health system, the values of the organization explicitly call for community partnerships. The case community benefit partnerships are intentional about which stakeholders are engaged to pursue the health systems’ objectives. The grant-maker and investments strategies present rigorous screening processes for partner selection. The community partnering strategy is equally intentional about its inclusionary stance for resident stakeholders. The strategies also leverage organizational competencies to achieve the objectives of the larger health system and create business value. The empowerment goals of the community partnerships case study are aligned with the department’s strong capacity for community organizing. The department’s staff is recognized for its valuable connection to underserved communities; this augments the health system’s reputation as an invested community stakeholder. The funding and technical assistance illustrated in the grant-maker case study stem from that health system’s unique attributes that combine clinical and population health management to deliver care to at-risk populations. This subsequently presents the health system with advantages that distinguish it from its competitors. The objectives of the community benefit strategies are direct extensions of their health systems’ values and strategic goals. Improvement of community conditions are sought

through each strategy and are explicitly associated with their organization's goals: community empowerment (organizing and partnering case); improving the social good (investments case); and stabilizing the safety net (grant-maker case).

#### Market and political environment shape parameters of community benefit strategies

NFP health systems' responses to their market environment can be understood in terms of risks, opportunities, and tradeoffs. Markets' demands, costs, and regulations shape each health system's strategic goals and objectives. The community benefit departments' programs are extensions of these objectives. They also take shape within resource constraints defined by their organizations' strategies to remain profitable and competitive within their respective markets. The following summarizes the relationship between risks, opportunities, and tradeoffs and the community benefit strategies examined in this research.

- a) Limit risks: The strategies reviewed in the case studies aimed to improve the capacity of communities and their stakeholders to create better health outcomes. This objective indirectly reduces avoidable health outcomes as well as the need for costly care in inappropriate settings. Community benefit goals to build healthy communities through empowerment, improved housing, increased employment, or enhanced medical care alternatives are thought to help limit risks to their health systems.
- b) Create opportunities: 1) Strategies to partner with various stakeholders present community benefit departments with opportunities to offset their resource constraints of limited staff, competencies, and dollars. 2) Partnerships introduce opportunities to identify community needs and leverage partners' resources to achieve greater social or environmental impact. 3) The partnership types differentiate health systems from their competitors because of the competencies they bring into the community. Community organizing, community financing, and population health management are unique resources that each health system offers communities through their community benefit strategies. 4) Furthermore, in the instance of the grant-maker example, a health system leverages its unique resources to influence stakeholders through means that can create advantageous market opportunities in the future.
- c) Make tradeoffs: The community benefit programming reviewed in chapter three demonstrated trends within NFP health systems' programming to "do what makes sense" in regards to community benefit. Most programs consist of traditional forms of community benefit services such as charity care, health education, or basic community-based clinical services. The strategies identified in this research exemplify intentional efforts to go beyond compliance and invest in upstream social determinants of health that have an impact on social and environmental conditions of communities. For these community building activities, what makes sense falls in the Zone of Tradeoffs where short-term profitability is often foregone for public good. The investments strategy crystallizes this in the instance of their commitment to below-market rate finances where they trade off more profitable returns for community impact.

The political environments of relationships and regulations in a local community influence decision-makers' strategies because expectations evolve over time. Public expectations, political attitudes, and regulations influence the acceptability of what and how issues are addressed through community benefit departments' partnerships. The hierarchies and relationships amongst stakeholders within a given market also reach new points of equilibrium as the political environment changes.

As public expectations and market landscapes evolve, so do the community benefit strategies and relationships crafted in response to them. The strategy to develop the infrastructures of clinic stakeholders in anticipation of healthcare reform highlights the impact a system's political environment has on its partnerships. In many instances, the political attitudes that surround one issue prompt different responses amongst health systems. A notable example is found in the varied response to and advocacy for the provision of care and services to undocumented citizens. Each of the strategies reviewed above have employed approaches to this sensitive topic based on what leadership considered appropriate for its political relationships. On one hand there are examples of direct engagement with these populations to facilitate access to healthy foods, health care, or economic opportunities. On the other hand, indirect efforts are made through funding and support of third parties where those populations receive services. Important business drivers that affect the considerations listed above are summarized in table 8.3.

**Key Business Drivers**

Control Costs & Profitability	Market Position & Differentiation	Influence Market (Future Demands & Regulations)
Satisfy Mission	Reputation	Stability of Health System

Table 8.3

Managerial discretion influences how strategies take shape

A notable dynamic to surface over the course of this research was the discretion community benefit directors and staffs can assume with the implementation of strategies and partnerships. The range of freedom these managers assume affects the content and relationships within partnerships. Managerial discretion in this regard is determined by a health system's policies and the risk tolerances for uncertainties of its leadership. These factors affect the distribution of power and control within a health system. Figure 8.1 illustrates where the locus of control can vary within an organization.



Figure 8.1

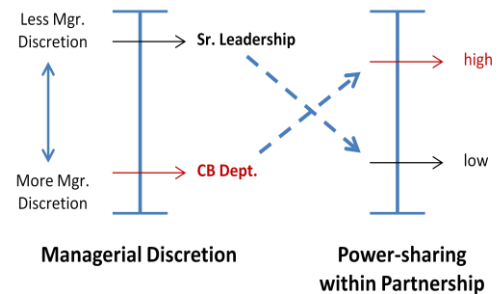


Figure 8.2

The variability of control over the direction and content of a strategy within an organization can affect how the partnerships formed by its departments manifest. Community benefit managers and staff directly interact with local stakeholders and do so within the pre-established parameters of flexibility and discretion conferred upon them by the systems' leadership. The range of managerial discretion allowed within a health system can influence the content and relationships within its partnerships. It also has downstream effects in regards to how power is shared within those partnerships. This influences how freely relationships with stakeholders are formed and develop over time. Figure 8.2 demonstrates how power-sharing within a relationship could potentially correlate with where the locus of discretion falls within an organization.

In all of the strategies reviewed, a degree of control is forsaken as a risk to achieve impact in the communities they serve. However, differences arise dependent upon how much freedom a director or staff is granted to act on behalf of their health system. Considerable leeway is given to managers and staff that lead the community partnerships and organizing model. The expectation to form community relationships is formalized by policy and their work culture promotes active stakeholder engagement. The director of the community investments program exercises a significant amount of discretion in the screening, selection, and oversight of borrowers; the same holds true in regards to how terms of finance are established. In both of these instances, the partners engaged through these strategies achieve a unique level of shared control over the direction and outcome of the partnership. On the other hand, senior leadership and directors responsible for oversight of the grant-related partnerships establish the objectives and content of their partnerships with safety net stakeholders. As a result it is acknowledged that a power imbalance exists within the partnerships that stem from this strategy. Future research may further investigate whether measurements of trust, power, and accountability within community partnership are affected by the degree of managerial discretion within an organization.



### Key Findings from Review of Relationship Variables

Formal parameters dictate how community benefit department staff engages local stakeholders and are established prior to partnerships. Community engagement is essential to each of the strategies reviewed; it helps the case departments and their respective systems maintain connectivity to the evolution of community issues and stakeholder activities. Parameters for engagement are formed by the policies, strategic goals, and objectives of the health system. It is within these boundaries that informal relationships evolve between representatives of agencies engaged in a particular partnership. Informal relationships are unique assets and allow individuals to exercise greater discretion to align interests, ideas, and opportunities with their partners.

Trust, power, and accountability dynamics that comprise formal and informal relationships between local stakeholders take shape dependent on the objective of the partnership and familiarity of its partners. It is observed that these dynamics are influenced by the maturation of stakeholders' relationships and expectations in shared communities. Levels of trust, power, and accountability also change over a partnership's lifetime. The nature of the case departments' relationships with their stakeholders are consistently aligned with the purpose of their partnerships. Decision-makers responsible for the implementation of the strategies reviewed in this research reported the importance of taking these dynamics into account over the course of a partnership. Table 8.4 summarizes each strategy's response to unique relationship dynamics with its stakeholder partners.

#### Practices to Take Into Account Sensitive Stakeholder Relationships

Case Strategy	Unique Relationship Dynamic	Strategy's Response to Potential Issues
Community Organizing	Empowerment needs shared power	Attentiveness to not establishing hierarchies amongst partners
Community Investments	Borrowers' freedom to apply expertise	Hand over control of investment dollars and their application once loan is disbursed
Grant-Making	Inherent power imbalance	Acknowledge power imbalance and encourage shared learning perspective within its stakeholder partnerships

Table 8.4

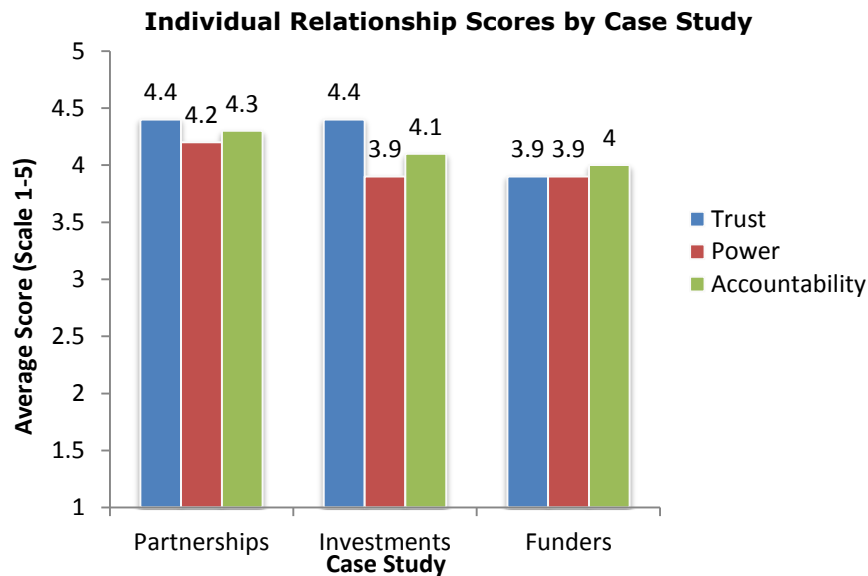
Within each case study, the importance of sharing power varied, trust was consistently held in high regard, and accountability was generally consistent and formalized through contract agreements. The most frequently cited component to the implementation of a partnership was trust. Open communication and transparency help partners to reach shared understanding about the purpose of their partnerships. Upon implementation of a partnership, ongoing accessibility to partners is important to help work through any problems that may arise. The open door policy is essential to departments' strategies that are accountable for the protection of their financial investments. It also holds true for health systems that operate in close-knit communities where relationships with stakeholders provide significant political currency. Table 8.5 summarizes components of stakeholder relationships that were cited as important to the partnership strategies highlighted in this research.

**Key Relationship Components**

Shared Goals & Understanding	Reliability	Long-Term Commitment
Open & Ongoing Communication	Reputation	Stability of Partner

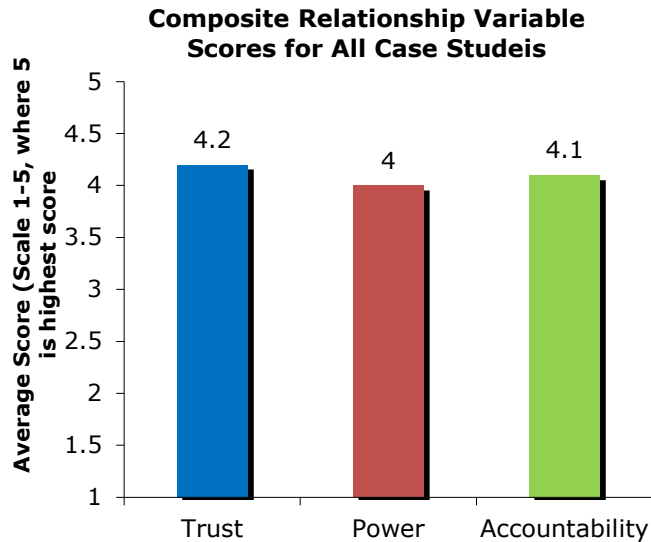
Table 8.5

A pilot questionnaire was administered to 21 respondents (Partnerships n=10; response rate: 100%, Investments n=8; response rate: 80%, Funders n=3; response rate: 37.5%). Data collected from the respondents interviewed for the case studies was used to further examine the relative degrees of power, trust and accountability that emerge in each strategy’s partnerships (see appendix 5 for questionnaire). Respondents were asked about the relationship dynamics of their stakeholder relationships during the planning and implementation of their partnerships. The relationships in each strategy were scored using a five point scale where “5” was the highest score possible. The average scores for each relationship variable in each case study are shown in figure 8.3. The community partnerships strategy reported the highest scores across the relationships variables and the funder model reported the lowest scores.



**Figure 8.3**

The average composite relationship score for each variable is illustrated in figure 8.4. The composite score combines the power, trust, and accountability averages from each case study to provide a score for each case variable.



**Figure 8.4**

The individual and composite measurements of the relationship variables indicate that all three were highly rated on a five point scale. This suggests that power, trust, and accountability are considered important to the respondents' partnerships. Figure 8.4 indicates that all of the relationship variables were scored closely on average.

The following additional trends were seen for each variable:

Trust:

- The trust scores for the partnerships and investments strategies were the highest of all measured variables.
- The lowest trust score is seen with the funder model, which was the only partnership strategy where it scored lower than the other two variables.
- The composite trust score is slightly higher than what was reported for power or accountability.

Power:

- Power scored highest in the community partnerships model.
- Power scored lowest across all cases out of all of the relationship variables measured.
- There is little variability with power scores across cases.

Accountability:

- Accountability scores highest in the community partnerships model.
- The funder model was the only case where accountability scored higher than either power or trust.
- There is little variability with accountability scores across cases.

Interpretation of this data is limited in scope given the small sample of respondents surveyed, nevertheless some findings help inform what was found through review of the case studies. The high rating of trust across cases supports patterns observed in this research's interviews that suggest the importance of open communication and transparency in each partnership

strategy. The survey’s trust scale responses indicate that those characteristics are held as necessary to the planning and implementation of partnerships. It also points out the importance of building and fostering ongoing relationships with partners. The consistency of accountability scores across the strategies supports the observation that shared commitment and sense of responsibility for improved outcomes in shared communities are essential to effective partnerships. However, in regards to accountability, a small number of respondents across cases expressed interest in changes to how their partnerships operate; but most indicated that they were satisfied with partnership structures. The composite power scores indicate that most partners involved in partnerships reported more control over their projects than expected. Almost all respondents acknowledge the need for partners and their competencies to make projects work. Many respondents reported less control over budget and influence of goals which may explain power scores that were slightly lower than the other two variables.

The average composite relationship score for each case study is illustrated in figure 8.5. The composite score combines the trust, power, and accountability averages to provide the following relationship scores for each case study.

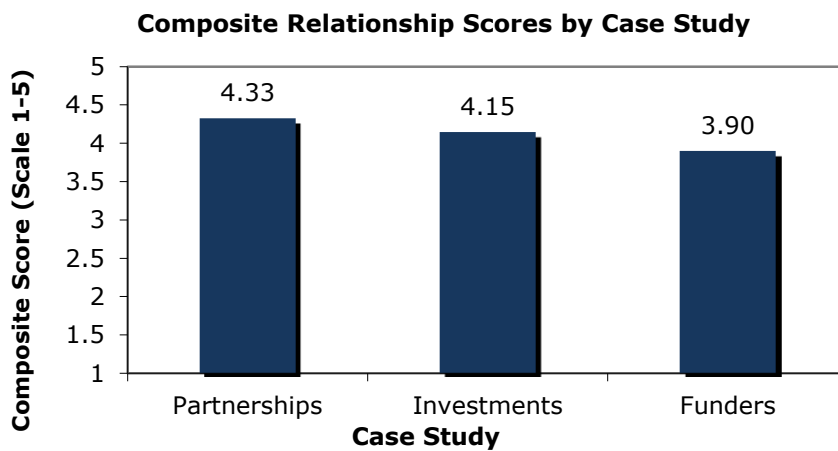


Figure 8.5

The following trends were seen:

Community Partnerships:

- The partnerships case study had relatively higher relationship scores which are indicative of higher reported levels of trust, power, and accountability across agencies participating in the strategy’s partnerships. This was expected because decision-makers for this strategy purposefully promote power-sharing and relationship development with a multitude of community stakeholders.

Community Investments:

- Expected investments to score highest because of the complete control borrowers are given once the loan is disbursed, this was not the case.

Grant-Making:

- The grant-making strategy has lowest relationship scores, but this model is less dependent on interaction prior to partnership. There were also no partner responses to

include in the analysis. The funder model's relationship score was higher than expected, and may be due to the consistent level of interaction amongst partners due to the technical assistance and strategic planning that occurs within the partnership. There are multiple levels of the relationship and the health system and safety net stakeholders are increasing their coordination in light of impending changes due to health care reform.

### Ladder of Partnership Participation

The results from the composite relationship score calculations were used to populate the Ladder of Partnership Participation framework introduced earlier. It is proposed that each relationship score reflects the degree of community based public health principles practiced within that partnership with stakeholders. The concept of the Ladder intends to frame the types of strategic partnerships organizations establish with stakeholders relative to how they interact with those partners. Figure 8.6 illustrates how each partnership strategy, based on their relationship scores, fit in relation to each other onto the Ladder's framework.

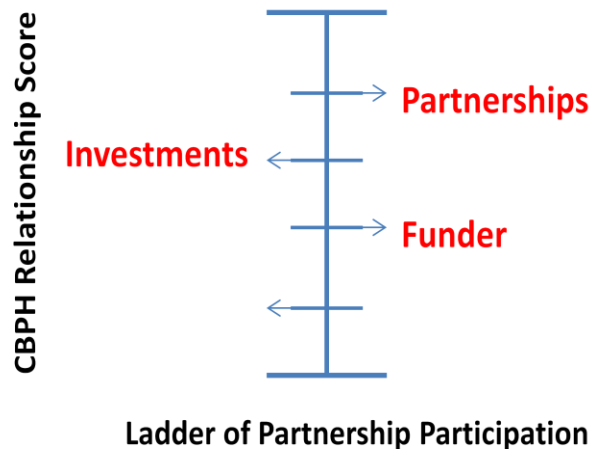


Figure 8.6

The Ladder of Partnership Participation was updated upon review of the scores for each partnership strategy. It is informed by the revised placements of inter-organizational partnership types. Figure 8.7 illustrates the framework's revisions which are bolded in red.

**Updated Ladder of Partnership Participation**

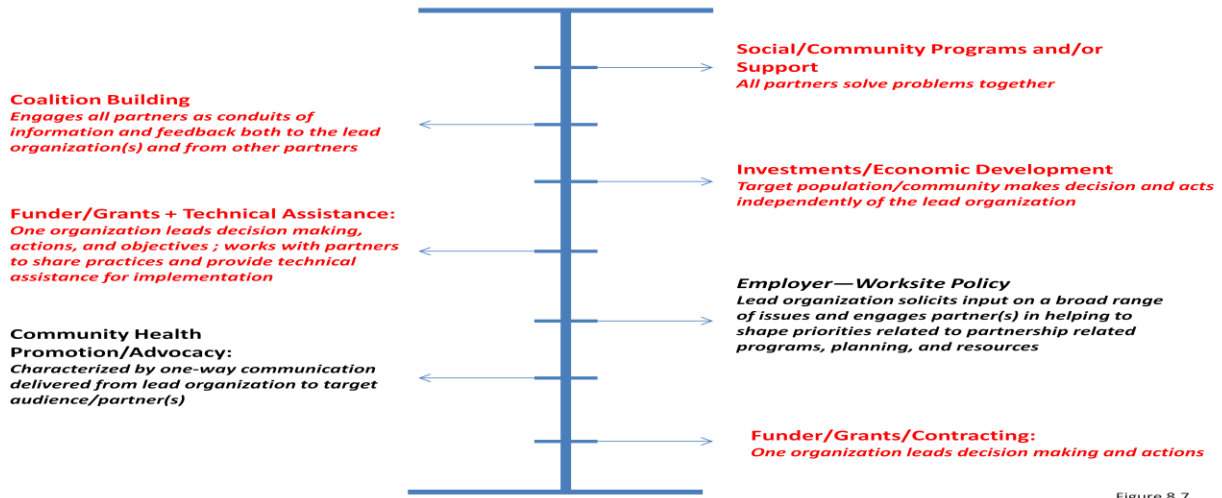


Figure 8.7

Figure 8.7 illustrates the adjustments to the proposed Ladder framework that was informed by the relationship scores for each partnership strategy. The Ladder framework captures the associations between the strategic objectives of NFP health systems’ decision-makers and the partnerships they form to improve community health. The framework serves as a conceptual guideline of how decision-makers categorize the array of potential partnership forms and stakeholder relationships geared toward community health improvement. These partnership typologies may prove to help organizations be strategic about their approaches to inter-organizational partnerships that are oriented toward improved social and environmental conditions.

Figure 8.8 demonstrates how the proposed Ladder of Partnership Participation can be integrated into the aforementioned spectrum of health system community benefit. The combination of these two frameworks creates a model that illustrates partnership forms in the context of their application to achieve community health impact. The model demonstrates how a range of partnership strategies can be intentionally applied across the spectrum of community benefit services.



Figure 8.8

This spectrum presents a similar risk-opportunity continuum for decision-makers as the one described in the introduction of this research (See Figure 1.3). The order of activities in the framework illustrates the relative risk NFP health systems assume with the implementation of community benefit programs. Increased risk is assumed by leadership for programs that are captured toward the community building activities end of the spectrum.

With this model, managers should view stakeholder engagement as a variable function of risk where the need for more substantive engagement increases as a health system assumes increased risk to execute a community benefit program. Figure 8.9 demonstrates the relationship between degrees of stakeholder engagement and the risk presented over the range of community benefit activities.

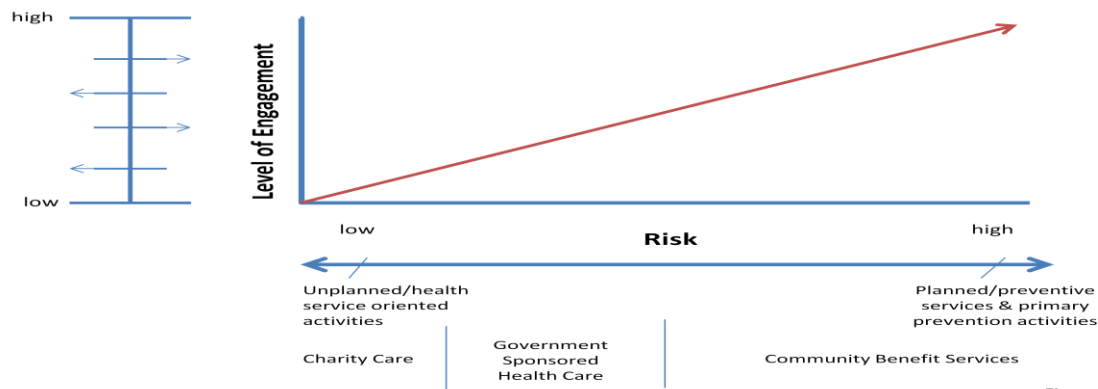


Figure 8.9

Community building activities represent greater opportunities to achieve broad and significant social and environmental impact. In addition, activities towards that end of the spectrum call for increased application of relationship principles when working with community stakeholders. Conversely, most community building activities tend to present more uncertainty in regards to control and outcome for decision-makers in comparison to what is required to provide more traditional services. Therefore this framework indicates that increased opportunity is associated with increased risk.

The integrated model points out that there are appropriate partnership types and relationship dynamics which are conducive to the achievement of specific outcomes. The level of risk tolerance places an organization on the Spectrum of Community Benefit Activities and its relationship dynamic with stakeholders places its partnerships somewhere on the Ladder of Partnership Participation. The merged frameworks aim to demonstrate that there are appropriate partnerships for a system’s current programming as well as for their strategic objectives and goals.

This allows decision-makers to take into account their organization’s risk tolerances and determine where their community benefit activities occur on a spectrum of alternatives. It also helps to orient managers towards stakeholder engagement and relationships that fit their department’s objectives. This combined framework can help leadership, directors, and staff to

strategically select the appropriate programs, stakeholder relationships, and partnership types to best achieve their intended impact on social and environmental conditions.

**Future Research and Other Applications**

The model proposed above is preliminary and exploratory, its implications and potential use are based on initial findings and would be better informed by further investigation. In practice, this framework can be the starting point for future research and used by managers in their assessment of strategically planning partnerships. The data calculated for the relationship scores that populated the Ladder of Partnership Participation presented here was based on a small sample size. A next step in this process would entail a more robust surveying of NFP health systems and their partners to further develop the framework. Also, as additional partnership types are identified, the Ladder of Partnership Participation can be further populated. Future research can inform which forms and structures across a broader range of partnership types tend to be best suited for the strategic goals and objectives of a given organization. The development of different NFP health system partnership typologies to achieve social or environmental impact could potentially move the field forward to better understand the interaction between levels of impact, stakeholder relationships, and scope of influence within partnership.

In regards to alternative applications of the model, the Spectrum of Corporate Social Responsibility can be merged with the Ladder in a manner similar to Community Benefit Spectrum. Figure 8.10 illustrates how that model might take shape.

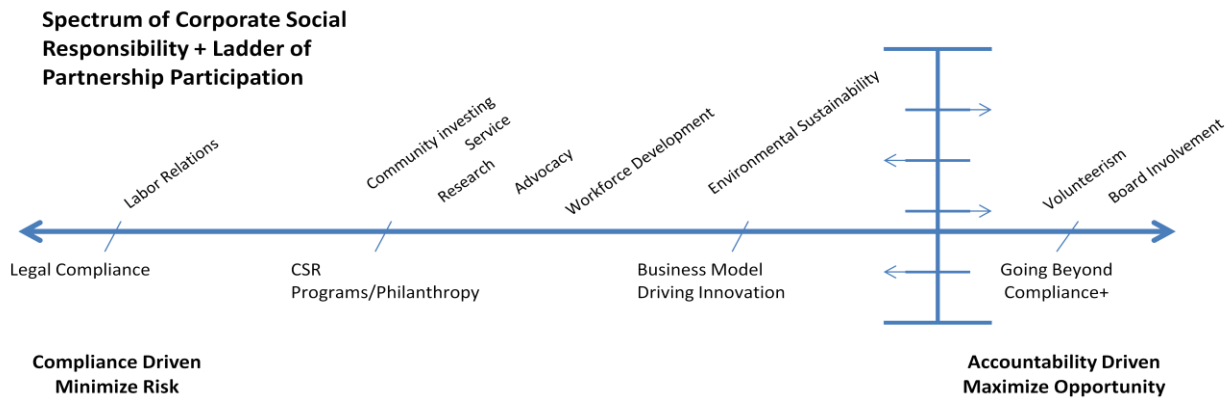


Figure 8.10

The utilization of this model in for-profit settings offers managers insight into the strategic engagement of stakeholders for partnerships that are intended to achieve social or environmental impact. The implications are similar to those discussed above for NFP managers. Decision-makers in these settings must also keep in mind the strategic objectives, profitability, and market and political environments when considering how to effectively engage stakeholders.



## **Discussion**

The key findings drawn from the partnerships, decision-making variables, and relationship variables discussed in this research provide overarching insights into conditions that influence NFP health systems' community benefit strategies. This research observed that strategic decisions that direct community benefit partnerships are influenced by trust and power-sharing between partners, shared mission, NFP health systems' strategic goals, and potential opportunities to leverage resources for increased impact. The lessons realized from the review of this collection of strategic partnerships are captured under three categories. They include:

- Conditions that facilitate the alignment of interests and goals;
- Conditions that determine control within and direction of partnerships;
- Issues that arise because of resource constraints.

### Factors that facilitate alignment of interests and goals

Trust is important across all partnership forms regardless of the strategy that is implemented. For NFP health system managers and staff that engage stakeholders, trust is valued in the form of transparency and open communication about each partner's purpose for involvement. Also of importance is shared understanding of the partnership's goals and each partner's intentions as a participant in the partnership. Since there are formal contractual agreements and informal expectations of shared commitment to communities, accountability does not prominently factor into decision-making prior to partnerships. However, it does significantly factor into the implementation of partnerships as partners are expected to meet their contractual and community obligations. Prior to the engagement of stakeholders within a partnership, decision-makers take into account the potential of shared missions and organizational goals with partners. These considerations serve as approximations of a shared sense of accountability to improved community conditions. They are also indicative of shared business drivers and incentives to reduce similar risks and liabilities. This indicates a shared commitment to the effectiveness of a partnership.

### Factors that determine direction and control of partnerships

The strategic goals and objectives of NFP health systems that are determined by leadership establish the parameters within which community issues and needs are defined. These parameters in turn determine how needs will be addressed as well as which resources will be applied to address them. In effect, the leadership of NFP health systems exercises significant control over which issues and needs their organization will consider and the terms on which their organizations will respond. These pre-determined conditions directly influence an organization's partner selection, partnership types, and partnership objectives. Consequently, they also dictate the power and other relationship dynamics that manifest within a partnership with stakeholders.

Typically, the executive leadership within organizations are not receptive to joint partnership goal definition with local stakeholders but are more agreeable to doing so with organizations that yield equal power, resources, and similar goals. These partners are most likely to be other health systems or large foundations with similar business drivers and risk tolerances. It should be noted that the partnership and investments strategies reviewed in this research

demonstrate a willingness on the part of their systems' leadership to move in the direction of joint definition at local level with their strategies.

#### Issues and responses to resource constraints

Many community benefit managers and staff are consistently challenged with the execution of their operations within limited resources. It is common for community benefit departments to be understaffed and under-resourced; this imposes sizable resource constraints to their efforts to improve community health. Two distinct instances of resource constraints and their impact are worth noting:

1. As health systems' costs escalate and their budgets continue to shrink, many tend to multi-purpose their departments, strategies, staffing, and spending. Community benefit programs and charges can be subject to this practice as evidenced by their frequent combination with a hospital's marketing or community relations departments. This often results in the reduction of community benefit to a reporting function of one manager or director who is under-prepared to optimize a program's potential in a given region.
2. The resource constraints of health systems and hospitals' partners also impact the functionality of community benefit departments. The recent economic downturn has dried up funding sources and other available resources for traditional community partners including non-profits and clinics. This has created a void that adds pressure to community benefit departments to address more need for services and care as there are fewer partners to spread the burdens of delivery.

Solutions to resource constraints can be found in strategies by NFP health systems that enhance the value and purpose of community benefit to their health system. This is accomplished through the application of community benefit based strategies to actively reduce the potential for downstream costs due to mismanaged care or missed prevention opportunities. Resource constraints have spurred the ingenuity of NFP health system decision-makers to leverage their community benefit dollars for greater impact and financial resources through partnerships. This includes the provision of seed money that secures a foundation to be financed for greater support later. Community benefit departments often leverage the competencies of local stakeholders and partners that have better access to vulnerable populations or unique cultural skills and other capacities. These community relationships are also leveraged to serve as vehicles that can navigate sensitive political and market environments which can help health systems to offset future liabilities and constraints.

#### **Conclusion**

The three case studies presented in this research focus on community benefit strategies that demonstrate linkages between decision-making and stakeholder engagement. The key findings of this study indicate that opportunities exist for health systems to strategically improve the health and conditions of communities through partnerships with stakeholders.

Strategic engagement of stakeholders entails the insurance that these partners and partnership objectives are aligned with the system's mission. Internally health system decision-makers should be sure that their direct contributions to partnerships stem from their organization's core competencies and strengths. The use of partnerships should also be an intentional strategy to leverage relationships, competencies, and capacities the organization does not possess. Relationships with stakeholders are necessary to NFP health systems' strategies to extend their reach into communities and improve their capacity to increase the availability of health and social services. The type relationships and partnerships formed with stakeholders are influenced by the parameters of each health system's mission, business objectives, and political environment.

The interactions of these principles imply that different partnership forms and structures can be strategically applied to community benefit programming and increase the likelihood of achieved strategic impact. Decision-makers within organizations that work closely with community stakeholders should keep this in mind, as there can partnerships that are likely to be more conducive and better structured to achieve desired outcomes.

## Conclusion: A Review of Key Points and Next Steps

In recent years, the health policy landscape has devoted increased attention to the charitable practices undertaken by NFP health systems' to meet their responsibilities as tax exempt institutions. Awareness of the current and potential roles of these institutions in communities they serve has been elevated by these discussions. Key components of the community benefit discourse ask: what services and activities constitute acceptable community benefit; which stakeholders should be engaged; and in what manner to engage those stakeholders to identify and address community needs.

The IRS began to establish initial parameters that address those questions with the introduction of the Form 990 Schedule H. This dissertation set out to inform the discussion through an examination of alternative approaches taken by NFP health systems and hospitals to partner with community stakeholders to address unmet health-related needs. The primary and secondary research questions include:

### Primary Question:

How do large not-for-profit health care delivery systems establish partnerships with public and private organizations aimed to improve community health?

### Secondary Questions:

- What are the forms, structures, and purposes of these partnerships?
- In what ways do trust, power-sharing, and accountability vary by different types of partnerships?
- For each type of partnership, what are the best practices for dealing with issues raised by resource constraints that threaten the ability of the partnership to achieve shared goals?

This research examines how organizations form partnerships and channel their resources toward the improvement of the social and environmental conditions in communities in which they operate. The issue of how organizations partner to invest in their local communities spans across both not-for-profit and for-profit sectors. Of particular interest is how to manage and leverage limited resources to sustainably improve the health of their communities. The findings from this research are intended to illuminate ways in which large NFP health systems optimize their resources and engage stakeholders as partners to improve community conditions.

This study also examines large NFP health systems as corporate citizens in their local communities examining community building strategies that go beyond traditional health promotion services and activities. The corporate citizen perspective on NFP health systems frames considerations of how key business drivers are balanced in the process to achieve social good. This perspective clarifies the decisions made by organization leaders to improve social and environmental conditions while maintaining their economic vitality as businesses.

My research applies theoretical frameworks provided by the corporate social responsibility as well as community-based public health to frame the decisions and partnerships formed by NFP health systems and hospitals. These frameworks highlight the intersections between organizational decision-making and stakeholder engagement that are necessary to improve community health. The CSR literature introduces organizational strategy, risks, and opportunities in the context of their impact on the choices businesses make in order to invest in the sustainable development of communities. The CBPH literature introduces the relationship variables of trust, power, and accountability that are essential to partnerships with community stakeholders. Finally, the Ladder of Partnership Participation model was introduced to illustrate different types of partnerships that take shape between as a consequence of these decisions and relationships.

### **Summary of Key Findings**

The three case studies presented highlight community building strategies that capture the movement of health systems beyond traditional community benefit practices. The strategic partnerships that these organizations form to improve community conditions were the central focus of each case study. The review of these partnerships was meant to provide insight into the interactions between the strategic decision-making of NFP health systems and their relationships with community-based partners. Key findings from the case studies that can inform decision-makers' partnership strategies are summarized below:

- 1) An organization's mission and strategic goals are significant determinants of its partnerships and supported activities.
  - Partnerships are strategies intended to achieve an organization's goals which are extensions of its mission. The missions of the NFP health systems examined here set parameters for the strategic goals that call for the use of the partnerships and orient their objectives. Partner and partnership alignment allows organizations to leverage their competencies and limited resources to achieve impact that meets their broader organizational goals. Alignment also increases the likelihood of working with partners that will hold themselves accountable to the achievement of similar goals and impact in shared communities. Decision-makers should strategically select partners and objectives that are aligned with the intended direction of the organization.
- 2) Organizations are significantly influenced by their market environment and resource constraints
  - NFP health systems make decisions in response to risks and opportunities presented to them by their market and political environments. It is important that decision-makers assess risks and costs to their organization against the benefits of community impact. Risks typically consist of rising healthcare costs, avoidable health outcomes, and increased demand for costly care in inappropriate settings. Other risks are imposed by market constraints such as reimbursement limitations that can lead systems to cuts to staff necessary to effective community benefit programs. Many opportunities distinguish health systems from their competitors and leverage their unique competencies to

create advantageous market positioning. Projects that present a balance of risk and opportunities fall in the Zone of Tradeoffs which can entail the sacrifice of short-term profitability for the public's good.

- Community benefit departments confront limited resources, staff, and competencies. Partnerships allow health systems to meet needs and demands created by imperfect healthcare, economic, and social service markets. They augment departments' capacity to identify needs, reach wider populations, and provide increased services despite significant constraints.
- 3) Sustained stakeholder engagement requires flexibility and a commitment to create an environment of trust among partners' leadership, managers, and staff.
- Trust facilitates the implementation and maintenance of community stakeholder partnerships. Open communication and transparency, in particular, help partners to reach shared understanding about the purpose of their partnerships. The maintenance of ongoing relationships and accessibility with partners is important to help work through any problems that may arise.
  - The range of managerial discretion allowed within an organization can affect how relationships with stakeholders are formed and develop over time. It can specifically influence how trust develops and power is shared between stakeholders within those partnerships.
  - Partnership structures can evolve as their purpose and political environments evolve and they should change to remain strategically viable
- 4) Sustained community partnerships must involve: 1) empowered stakeholders and 2) decision-makers that acknowledge the long-term time commitments necessary for these relationships.
- Partnerships with community stakeholders have sensitive power dynamics. It is important that leadership within organizations recognize the value of stakeholder empowerment to the sustainability of their community-based partnerships. There should also be recognition of the ongoing time commitments necessary to engage decision-making processes grounded in stakeholder-empowered partnerships – particularly for community building activities. Often, these processes and their outcomes do not coincide with traditional business cycles. Organizational leadership should be aware of tradeoffs that call for relinquished control over partnership timeframes and objectives for the sake of sustainable and shared community outcomes.

### **Current Landscape Revisited and Implications**

This research was prompted by the limited management models, guidelines, or best practices available to NFP health system leaders that could inform how partnerships with community-based or private organizations should be developed. The purpose is to: 1) inform discussions

about how organizations strategically achieve social and environmental impact and 2) to highlight key considerations their leadership might take into account with the implementation of partnerships to achieve these goals. New requirements called for by the Affordable Care Act and developing IRS reporting standards elevate the importance of community partnerships and demonstrable community benefit. As the current policy landscape evolves, increased scrutiny of NFP health system's community benefit practices will prompt decision-makers to closely examine their strategies and the nature of their partnership with stakeholders to achieve community benefit. Leadership will also have to address whether they are being intentional enough about the improvement of social and environmental conditions that affect communities' health. As businesses, they will also have to address questions about the risk and tradeoffs they are willing to assume to achieve community benefit in the absence of accurate community impact measures.

The health systems reviewed in this study demonstrate recognition of the links between community building and population health. Their partnerships reflect an intentional investment in the improvement of community infrastructures for underserved populations. In order to sustain community-based initiatives, formal and informal relationships must be built amongst stakeholders. The groundwork necessary to create and maintain these community ties is an essential ingredient for conditions that allow partnerships to improve community conditions. With this in mind, NFP health system management should assess their community benefit partnerships and practices to account for the necessity of this invaluable process. In the same vein, federal and state agencies should consider the inclusion of coalition-building activities that can be accounted for as community benefit.

Health system leaders and federal policy-makers can also consider other alternatives to broadly encourage more forms of community investment through market and regulatory influences:

1. The evolution of accepted environmentally sustainable practices by NFP health systems has shown that it is possible for this particular market to gradually adopt new practices over time. Leading healthcare systems that have voluntarily coordinated universal adoption of environmentally friendly policies and requirements have been able to raise the standard of accepted practices within the market over time (Practice Greenhealth, 2010). This suggests that there may be opportunities for market leaders or legislators to pursue policies that incentivize the evolution toward community benefit practices that invest more broadly in the health and development of communities.
2. Another option would consider the provision of tax credits for for-profit health systems and hospitals to engage in specific community-building projects with their NFP counterparts and other community stakeholders. Under this model, FP hospitals would receive similar considerations for eligibility as those that receive indigent care compensation adjustments through disproportionate share (DSH) designations. Any DSH-type legislation that encourages FP health system's community building investment would have to be combined with stricter regulations and penalties for NFP health systems that do not explicitly meet state or federal community benefit criteria. Parallel

policies of this nature would have to be enacted to disincentive NFP health systems that might curtail their community benefit practices in light of this proposal.

These scenarios represent examples of how adoption of community building strategies can be potentially expanded to a wider audience of NFP and FP practitioners. The null alternative would allow current NFP health systems' and hospitals' practices to stand as is in regards to their stakeholder engagement and community benefit objectives. Currently, the majority of required community benefit processes called for by federal and state regulations leave planning and programming in the complete control of hospitals. This is compounded by the absence of any criteria or guidelines that call for stakeholder engagement once a hospital completes a community health needs assessment. This process is not substantially addressed by the current Schedule H. All of these processes can be conducted in the absence of significant community engagement (IRS, 2011). However, the trajectory of policies and political expectations in the court of federal and public opinion may make that position increasingly difficult to defend over the next few years. The recent trends and content of community benefit practices suggest that there are opportunities for NFP health systems to employ strategies that demonstrably improve the social and environmental conditions – specifically for underserved populations. For federal regulators to take further steps to correct this, it has been suggested that they explicitly require community input and demonstrable evidence of that engagement. This can be reinforced with stricter oversight at the state level that coincides with higher financial penalties for violators. Alternatively as Schedule H increases the transparency of community benefit activities for public review, non-regulatory actions can be taken locally by stakeholders to use the data as a tool to hold NFP hospitals accountable to local community conditions.

### **Remaining Questions and Future Research**

While this research intended to provide insights into the decision-making and conditions that surround NFP health systems' community benefit strategies, many questions about these practices remain. Given the current state of federal and state regulations that guide community benefit practice, the question is raised as to whether there are disincentives for NFP health systems to pursue responsible community benefit planning and programming. Pressures to perform in competitive markets within current regulatory parameters might compel many NFP health systems to commit a minimal amount of staff and resources toward community benefit. These conditions prompt further questions of whether many profit-driven NFP health systems use community benefit programming primarily as a tax-exempted means to brand their organization and seek out competitive advantages in their local markets. As these circumstances persist, regulators and stakeholders will continue to examine incidences of health systems' use of community benefit programming as avenues to market or increase demand for their premium services.

This research has examined the trends and elements of decision-making and relationships that influence selected community benefit strategies of California NFP health systems. These strategies were observed from a unique perspective enlightened by the fields of corporate social responsibility and community-based public health. From this basis, there are numerous



opportunities for this work to be built upon by future research that pertain to policies, practice, and data collection.

The findings from this research indicate that there is a use for further assessment of the potential for bolstered oversight of community benefit reporting by NFP health systems and hospitals in California. A cost-benefit analysis can evaluate the potential support for additional oversight. This might include the need for additional resources and include the development of efficient reporting mechanisms that offer up to date data that can be used by the public.

The community-building strategies introduced in this research offer insights into the decision-making of the leadership and management of NFP health systems. A consistent theme that occurred over the course of this research was the unique trade-offs NFP health systems assume to achieve mission-driven objectives. Business leaders and academicians will continue to investigate the business value and effectiveness of socially responsible strategies. Consequentially, there is a place for future research to advance perspectives that observe NFP organizations and health systems through the lens of corporate citizenship. This is particularly relevant to NFP health systems as mission-driven organizations that take into consideration projects that do not always lend themselves to rigorous methods to determine returns on investments. Follow-up studies may help to determine if there are ways to better align competencies or limit liabilities that are associated with many socially responsible strategies.

Future inquiries that examines the correlation between the decision-making and relationship variables identified in this study and measures of partnership performance is also a sensible progression of this research. While the core of this research provided a qualitative analysis of variables that influence partnership strategies; the next step would be to investigate those variables' associations with intermediary measures of partnership and population health outcomes. A variation of this type of research might also look at developing more precise measures of community health impact that can be measured against the risks and liabilities assumed by health systems and other stakeholders. Finally, there are opportunities to for more extensive data collection to further develop and refine the Ladder of Partnerships framework this research introduced. These types of analysis may help policy-makers, leaders, and practitioners to assess the benefits of various partnership strategies and impact on community health.

### **Next steps for NFP Health Systems and Community Benefit Practice**

In addition to policy changes, the evolution of community benefit practices will also be a result of trends that are encouraged and accepted in the market and political environments of healthcare. As leadership of NFP health systems tackle questions about the strategic use of their resources for community benefit, they should also consider what roles their organizations should assume in their local communities. There is a place for health systems to embrace larger roles as corporate citizens that promote socially responsible projects in their communities and not limit their scope of activity to defined community benefit practices. NFP health system leadership should acknowledge their responsibility to be mindful of their capacity to be powerful agents of change in local and regional communities. These organizations should be

attentive of their potential and optimize opportunities to behave sensibly and responsibly as corporate citizens. This includes resisting opportunities to exploit inefficiencies in local healthcare market, pursuing investments that can close gaps in local safety net infrastructures, and investing in patient and community empowerment to create healthy communities.

Guidelines for the provision of community benefit encourage NFP health systems to embrace socially responsible practices. This makes these organizations capable examples of strategic corporate citizens. Many opportunities exist for NFP health systems to be more purposeful with their practice of socially responsible endeavors. The evolution of community benefit guidelines and accepted standards of corporate citizenship should focus on the examination of NFP health systems and hospitals as large employers, political actors, food and product purchasers, and environmental stewards.

NFP health systems should take into account which practices will provide substantive social benefits to their community yet allow the organization to remain profitable. When organizations “do what makes sense” their financial benefits overlap with the benefits of sustainable community development. From this vantage point, decision-makers can account for the urgent issues that challenge many health systems and underserved communities. For health systems, these can include pressing issues such as costs of care, accessibility to care in appropriate settings, regional coordination of health services, or food and product standards in hospitals. Communities, on the other hand, face health disparities, food deserts, unemployment, education, and housing.

Health system leadership can respond to these challenges through the application of strategies that: pool resources to leverage their impact; advocate for health access and healthy communities; or invest in community development that improves the physical infrastructure of communities. The strategic coordination of health services within a defined region is a potential response that pools the resources of health systems in a shared market. Institutions that provide care to low-income patient populations can partner and pool their resources regionally to strategically leverage their resources and offset the constraints of capitated payment models. Alternatively, hospitals that operate in affluent areas could co-invest in regions of higher need and health disparities with other providers that serve those populations more frequently.

NFP health systems can also collectively influence the markets in which they operate to create healthier conditions for the communities they serve. Hospitals across the country have leveraged their pooled purchasing power to affect the behavior of vendors to raise medical product standards that are used in their facilities (HSCA, 2011). Similar approaches can be taken to target the improvement of the local built environment that includes the walkability and lighting of neighborhoods and traffic routes to increase accessibility to grocery stores, business centers, and other essential services. Health systems’ advocacy strategies and programming can also be aligned through the advocacy for healthy eating in communities or investments in the creation of usable community gardens. What all of these ideas have in common is the fact that they represent responsible and prudent business strategies for health

care providers that intend to limit liabilities and maximize their community health impact. The maturation of the national community benefit discussion will influence hospitals to look closely at what type of partnerships they form with community stakeholders and how those partnerships will take shape. These developments raise the significance of the findings from this research and will spur NFP health systems to thoughtfully examine their community benefit strategies and partnerships.

The current health care landscape is rapidly evolving and NFP health systems are adjusting to these changes. There is increased momentum amongst various community stakeholders to connect the dots between community development, regional planning, and community health. More institutions across a growing number of fields are beginning to discuss how they can partner to coordinate their efforts to improve the social and environmental conditions of the communities in which they operate. Federal and state level regulators and public stakeholders have begun to highlight the need for transparency of NFP health systems' planning, actions, and impact. This has called for clearer definitions of health disparities, increased calls for evidence of community stakeholder engagement, and more acute demonstrations of community health impact. Technologies and collaborative strategies are now available that will enable health systems to map economic and health data with geographic information software (GIS) to create platforms that can align diverse data. These tools will increase transparency for the public and serve as tools for decision-makers that intend to be more strategic about their investment of resources to impact community health. As the convergence of these developments continues, there will be greater demand for health providers to increase their capacity to target where true needs occur in underserved communities.

Whichever direction health systems pursue will have to include purposeful and strategic allocation of limited resources meant to provide community benefit. Effective and sustained partnerships with community stakeholders will be necessary and essential components to the establishment of socially responsible strategies that will improve the conditions and health of local communities. The decision-making and relationships highlighted in this research offer insights that can be used by executives and managers that will have to navigate circumstances that necessitate different types of partnerships. The strategy models and frameworks discussed here can assist managers' that engage in community building strategies with various stakeholders. NFP health systems and communities will continue to develop and refine their understandings of each other. Clear decision-making, deliberate strategies, and strong stakeholder relationships will help each to achieve the sustainable improvements they seek in their shared communities.

## Works Cited

- Arnstein S. (1969). "A Ladder of Citizen Participation." *Journal of the American Institute of Planners* 35 (4): 216-224.
- Auty R. (1999). "Global public-private partnerships: part I – a new development in health?" *Bulletin of the World Health Organization*, 2000. Remarks made at parallel session number 7. 1 at: *Third Global Forum for Health Research, June 8, 1999 Geneva*.
- Axelrod R. (2004). "Theoretical Foundations of Partnership." In Liebenthal A, Feinstein O, Ingram G (eds.), *Evaluation & Development: The Partnership Dimension* New Brunswick: Transaction Publishers.
- Barnett K. (2004). "Advancing the State of the Art in Community Benefit: A User's Guide to Excellence and Accountability." *Public Health Institute* November.
- Barnett K. (2007). "The Future of Community Benefit Programming." *The Public Health Institute and the Western Consortium for Public Health* June.
- Barnett K. (2009). "Beyond the Numerical Tally: Quality and Stewardship in Community Benefit." *Public Health Institute* February.
- Barnett M. (2007). "Stakeholder Influence Capacity and The Variability of Financial Returns to Corporate Social Responsibility." *Academy of Management Review* 32 (3): 794-816.
- Blagescu M, Young J. (2005). "Partnerships and Accountability: Current thinking and approaches among agencies supporting Civil Society Organisations." *Overseas Development Institute*. London.
- Block P. (1987). *The Empowered Manager: Positive Political Skills at Work*. San Francisco: Jossey-Bass Inc.
- Botelho R. (1998). "Negotiating Partnerships in Healthcare: Contexts and Methods." In Suchman A, Botelho R, Hinton-Walker P (eds.), *Partnerships in Healthcare: Transforming Relational Process* Rochester: University of Rochester Press.
- Bowen H. (1953). *The Social Responsibilities of the Businessman*. New York: Harper & Row.
- Bracht N. (ed.) (1990). *Health Promotion at the Community Level*. Newbury Park: Sage Publications.
- Buse K, Waxman A. (2001). "Public-private health partnerships: a strategy for WHO." *Bulletin of the World Health Organization* 79 (8): 748-754.

Business for Social Responsibility (2003). "Overview of Corporate Social Responsibility." October <http://bsr.org/CSSResources/IssueBriefDetail.cfm?DocumentID=48809> (accessed 3/22/2009).

Carroll A. (1979). "A Three-Dimensional Conceptual Model of Corporate Performance." *Academy of Management Review* 4 (4): 497-505.

Casey M, Prentice B, Williamson J, Boyle K. (2007). "Strategies for Building Community-Public Health Partnerships." *Public Health Institute, Partnership for the Public's Health* December.

Casson M. (1998). "The Economics of Leadership." In Jones I, Pollitt M. (eds.), *The Role of Business Ethics in Economic Performance* London: Macmillian Press.

Catholic Health Association (2008). *A Guide for Planning and Reporting Community Benefit*. St. Louis: Catholic Health Association of the United States.

Catholic Health Association. (2004). "Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventor for Social Accountability." *Catholic Health Association of the United States, VHA Inc., and Lyon Software* St. Louis.

Clark R. (1980). "Does the Nonprofit Form Fit the Hospital Industry?" *Harvard Law Review* 93 (7): 1416-1489.

Clarke R. (2008). "The essence of community benefit." *Healthcare Financial Management* March: 140.

Cornwall A, Lucas H, Pasteur K. (2000). "Accountability through Participation: Developing Workable Partnership Models in the Health Sector." *IDS Bulletin* 31 (1): 1-13.

Dahl R. (1961). *Who Governs? Democracy and Power in an American City*. New Haven: Yale University Press.

Davis K. (1973). "The Case for and against Business Assumption of Social Responsibilities." *Academy of Management Review* 16 (2): 312-322.

Dean L, Proctor D. (2007). "'Honoring the Trust' Through Community Benefit." *Health Progress* 88 (1): 6-8.

Doh J, Guay T. (2006). "Corporate Social Responsibility, Public Policy, and NGO Activism in Europe and the United States: An Institutional-Stakeholder Perspective." *Journal of Management Studies* 43 (1): 47-73.

Dow Jones Sustainability Index (2003). "Corporate Sustainability." [http://www.sustainability-index.com/07\\_html/sustainability/corpsustainability.html](http://www.sustainability-index.com/07_html/sustainability/corpsustainability.html) (accessed 4/2/2010).

Emerson J. (2003). "The Blended Value Proposition: Integrating Social and Financial Returns." *California Management Review* 45 (4): 35-51.

Energy Information Administration (2003). Commercial Buildings Energy Consumption Survey (CBECS) Database. (<http://www.eia.gov/consumption/commercial/>) accessed 12/1/2010.

Erickson D. (2009). *The Housing Revolution. Networks and Neighborhoods*. Washington DC: The Urban Institute Press.

Fessler P. (2012). Shrinking Community Grants Put Cities In A Crunch. *National Public Radio*. Retrieved March 3, 2012, from <http://m.npr.org/news/front/147751971?singlePage=true>.

Florin P, Mitchell R, Stevenson J. (1993). "Identifying training and technical assistance needs in community coalitions: a developmental approach." *Health Education Research* 8 (3): 417-432.

Friedman F. (1970). "The Social Responsibility is to Increase Profits." *New York Times Magazine* September 13: 32-33.

Friedman M. (1962). *Capitalism and Freedom*. Chicago: University of Chicago Press.

Garriga E, Mele D. (2004). "Corporate Social Responsibility Theories: Mapping the Territory." *Journal of Business Ethics* 53: 51-71.

Ginn G, Moseley C. (2004). "Community Health Orientation, Community-based Quality Improvement, and Health Promotion Services in Hospitals." *Journal of Healthcare Management* 49 (5): 293-306.

Global Health and Safety Initiative (2009). *The Eco-Health Footprint Guide: Measuring Your Organization's Impact on Public Health and the Environment (Version 1.2)*.

Goodman R, Wandersman A, Chinman M, Imm P, Morrissey E. (1996). "An Ecological Assessment of Community-Based Interventions for Prevention and Health Promotion: Approaches to Measuring Community Coalitions." *American Journal of Community Psychology* 24 (1): 33-61.

Gramsci A. (1971). In Hare Q, Nowell-Smith J, (eds.) *Selections from Prison Notebooks of Antonio Gramsci*. New York: International Publishers.

Granner M, Sharpe P. (2003). "An Inventory of Measurement Tools for Evaluating Community Coalition Characteristics and Functioning." *Prevention Research Center, Norman J. Arnold School of Public Health, University of South Carolina* April.

Granner M, Sharpe P. (2003). "Evaluating community coalition characteristics and functioning: a summary of measurements tools." *Health Education Research* 19 (5): 514-532.

Gray B, Palmer A. (2010). "Does it all add up?" *Trustee* 63:22-26.

Gray B, Schlesinger M. (2009). "Charitable Expectations of Nonprofit Hospitals: Lessons from Maryland." *Health Affairs* 28 (5): w809-w821.

Harrison J, St. John C. (1996). "Managing and partnering with external stakeholders." *Academy of Management Executive* 10 (2): 46-60.

Healthcare Supply Chain Association. (2011). HSCA Group Purchasing Industry Endorse Landmark Environmental Tool from Practice Greenhealth to Help Guide Selection and Procurement of Environmentally Preferable Products for Hospitals [Press Release].

Retrieved from

[http://www.supplychainassociation.org/resource/resmgr/press\\_releases\\_2011/hsca\\_endorses\\_pgh\\_questionna.doc?](http://www.supplychainassociation.org/resource/resmgr/press_releases_2011/hsca_endorses_pgh_questionna.doc?)

Hillman A, Keim G. (2001). "Shareholder Value, Stakeholder Management, and Social Issues: What's the Bottom Line?" *Strategic Management Journal* 22 (2): 125-139.

Hinton-Walker P. (1998). "Community Partnerships: Building Collaborative Models for Care." In Suchman A, Botelho R, Hinton-Walker P (eds.), *Partnerships in Healthcare: Transforming Relational Process* Rochester: University of Rochester Press.

Israel B, Schulz A, Parker E, Becker A, Allen A, Guzman J. (2008). "Critical Issues in Developing and Following Community Based Participatory Research Principles." In Minkler M, Wallerstein N. (eds.), *Community-Based Participatory Research for Health* San Francisco: Jossey Bass Publishers.

Jones C. (2000). "Levels of racism: a theoretical framework and a gardener's tale." *American Journal of Public Health* 90 (8): 1212-1215.

Jones T. (1995). "Instrumental Stakeholder Theory: A Synthesis of Ethics and Economics." *Academy of Management Review* 20 (2): 404-437.

Karnani A. (2011). "Doing Well by Doing Good: The Grand Illusion." *California Management Review* 53 (2): 69-86.

Kiltgaard R. (2004). "Evaluation, of, for, and through Partnerships." In Liebenthal A, Feinstein O, Ingram G (eds.), *Evaluation & Development: The Partnership Dimension* New Brunswick: Transaction Publishers.

Lasker R, Weiss E, Miller R. (2001). "Partnership Synergy: A Practical Framework for Studying and Strengthening the Collaborative Advantage." *The Milbank Quarterly* 79 (2): 179-205.

Lee, M. (2008). "A review of the theories of corporate social responsibility: Its evolutionary path and road ahead." *International Journal of Management Reviews* 10 (1): 53-73.

Long P, Gruber J. (2010). "Projecting the impact of the affordable care act on California." *Health Affairs* 30: 63-70.

Longest B, Lin C. (2005). "Can Nonprofit Hospitals Do Both Well and Good?" *Health Care Management Review* 30 (1): 62-68.

Longest B. (1998). "The Civic Roles of Healthcare Organizations." *Healthcare Forum Journal* 41 (5): 40-42.

Longest B. (2002). "Nonprofit Health Systems: A Promising New Class of Corporate Citizen." *Inquiry* 39: 334-340.

Longest B. (2006). "The community development potential of large health services organizations." *Community Development Journal* 41 (1): 89-103.

Mackness, J. (2008). CSR Frameworks. Powerpoint lecture presented in Cheit Hall room 110 on the U.C. Berkeley Haas School of Business campus.

Magill G, Prybil L. (2004). "Stewardship and Integrity in Health Care: A Role for Organizational Ethics." *Journal of Business Ethics* 50: 225-238.

Mayer R, Davis J, Shoorman D. (1995). "An Integrative Model of Organizational Trust." *Academy of Management Review* 20 (3): 709-734.

Mays G, et al. (1998). "Managed Care, Public Health, and Privatization: A Typology of Interorganizational Arrangements." In Halverson P, Kaluzny A, McLaughlin C. (eds.), *Managed Care and Public Health* Gaithersburg, MD: Aspen Publishers.

Mitchell S, Shortell, S. (2000). "The Governance and Management of Effective Community Health Partnership: A Typology for Research, Policy, and Practice." *The Milbank Quarterly* 78 (2): 241-289.



Morgan M, Lifshay J. (2006). "Community Engagement in Public Health." *Contra Costa Health Services, Public Health Division* March.

New Economics Foundation (1998). "Participation Works! 21 Techniques of Community Participation for the 21<sup>st</sup> Century." *New Economics Foundation* London. [www.neweconomics.org](http://www.neweconomics.org).

New York Times (1986). "Blue Cross Tax Status Is Challenged." *New York Times* July 4 <http://www.nytimes.com/1986/07/04/us/blue-cross-tax-status-is-challenged.html?&pagewanted=all> accessed (3/10/2010).

Paustenbach D. (2002). "The US EPA science advisory board evaluation (2001) of the EPA dioxin reassessment." *Regulatory Toxicology and Pharmacology* 36: 211-216.

Pelozo J, Falkenberg L. (2009). "The Role of Collaboration in Achieving Corporate Social Responsibility Objectives." *California Management Review* 51 (3): 95-113.

Pelozo J, Falkenberg L. (2009). "The Role of Collaboration in Achieving Corporate Social Responsibility Objectives." *California Management Review* 51 (3): 95-113.

Polsby N. (1963). *Community Power and Political Theory*. New Haven: Yale University Press.

Press D, Mazmanian D. (2000). "Understanding the Transition to a Sustainable Economy." In Vig N, Kraft M. (eds.), *Environmental Policy 4<sup>th</sup> Edition*: CQ Inc.

Pretty J, Guijt I, Thompson J, Scoones I. (1995). *Participatory Learning and Action: A Trainer's Guide* London: International Institute for Environment and Development.

Rattray T, Brunner W, Freestone J. (2002). "The New Spectrum of Prevention: A Model for Public Health Practice." *Contra Costa Health Services, Public Health Division* April.

Rivoli P, Waddock S. (2011): "First They Ignore You: The Time-Context Dynamic and Corporate Responsibility." *California Management Review* 53 (2): 87-104.

Salinsky E. (2009). "Schedule H: New Community Benefit Reporting Requirements for Hospitals." *National Policy Health Forum*. Issue Brief no. 67. April 21.

Sandrick K. (2006). "Defining & Measuring Community Benefit." *Trustee* October: 66-74.

Schlesinger M, Gray B, Bradley E. (1996). "Charity and Community: The Role of Nonprofit Ownership in a Managed Care System." *Journal of Health Politics, Policy and Law* 21 (4): 698-750.

Schlesinger M, Gray B, Gusamo M. (2004). "A Broader Vision for Managed Care, Part 3: The Scope and Determinants of Community Benefits." *Health Affairs* 23 (3): 210-221.

Schlesinger M, Gray B. (1998). "A Broader Vision for Managed Care, Part 1: Measuring The Benefit To Communities." *Health Affairs* 17 (3): 152-168.

Schlesinger M, Gray B. (2006). "How Nonprofits Matter In American Medicine, And What To Do About It." *Health Affairs* 25: w287-303.

Seeger M, Hipfel S. (2007). "Legal Versus Ethical Arguments. Contexts for Corporate Social Responsibility" In May S, Cheney G, Roper J (eds.), *The Debate over Corporate Social Responsibility* New York, NY: Oxford University Press

Shortell S, et al. (2002). "Evaluating Partnerships for Community Health Improvement: Tracking the Footprints." *Journal of Health Politics, Policy, and Law* 27 (1): 50-91.

Shortell S, Washington P, Baxter R. (2009). "The Contribution of Hospitals and Health Care Systems to Community Health." *Annual Review of Public Health* 30: 373-383.

Singer L. (1997). "The Conversion Conundrum: The State and Federal Response to Hospitals' Changes in Charitable Status." *American Journal of Law & Medicine* 23 (2-3): 221-250.

Stern E. (2004). "Evaluating Partnerships." In Liebenthal A, Feinstein O, Ingram G (eds.), *Evaluation & Development: The Partnership Dimension* New Brunswick: Transaction Publishers.

Stevens R. (1982). "'A Poor Sort of Memory': Voluntary Hospitals and Government before the Depression." *The Milbank Memorial Fund Quarterly. Health and Society.* 60 (4): 551-584.

Stevens R. (1989). *In Sickness and In Wealth* New York: Basic Books.

Studnicki J, Murphy F, Malvey D, Costello R, Luther S, Werner D. (2002). "Toward a population health delivery system: First steps in performance measurement." *Health Care Management Review* 27 (1): 76-95.

United States Government Accountability Office. (2008). "Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements." GAO-08-880, September.

US Census Bureau (2012). "Table 2. Annual Estimates of the Population of Combined Statistical Areas: April 1, 2010 to July 1, 2011" (CSV). *2011 Population Estimates – US Census Bureau, Population Division* April 2012. Retrieved August 10, 2012.

US Census Fact Figure (2005) Anon. County, 2005 American Community Survey Data Profile Highlights.

US Internal Revenue Service (1983). *Revenue Ruling 83-157, C.B. 94* <http://www.irs.gov/pub/irs-tege/rr83-157.pdf> (allows hospital without emergency room to qualify under community benefit standard if it can show that need for service in community was met).

US Internal Revenue Service. (1969). *Revenue Ruling 69-545, C.B. 117* <http://www.irs.gov/pub/irs-tege/rr69-545.pdf> (adopting the community benefit standard over charity care standard).

US Internal Revenue Service. (2007). "Form 990 Redesign for Tax Year 2008 Background Paper." *Internal Revenue Service* December.

US Internal Revenue Service. (2011). *2011 Form 990, Schedule H instructions*, <http://www.irs.gov/pub/irs-pdf/i990sh.pdf> (revisions to cost accounting for community building activities).

US Senate Committee on Finance – Minority Staff, (2007). "Tax-Exempt Hospitals: Discussion Draft." July 19 <http://grassley.senate.gov/releases/2007/07182007.pdf> (accessed 3/14/2010).

Vogel D. (2005). *The Market for Virtue: The Potential and Limits of Corporate Social Responsibilities*. Washington, DC: Brookings Institution Press.

Wallerstein N. (1999). "Power between evaluator and community: research relationships within New Mexico's healthier communities." *Social Sciences & Medicine* 49: 39-53.

Wallich H, McGowan J. (1970). "Stockholder interest and the corporation's role in social policy." In Baumol W (ed.), *A New Rationale for Corporate Social Policy* New York: Committee for Economic Development.

Weaver R, Farrell J. (1997). *Managers as Facilitators* San Francisco: Barrett-Koehler, Inc.

Zadek S. (2007). *The Civil Corporation*. London: Earthscan Publications.

Zhang I. (2007). "Economic consequences of the Sarbanes-Oxley Act of 2002." *Journal of Accounting & Economics* 44:74-115.

Zuckerman H, Kaluzny A, Ricketts T. (1995). "Strategic Alliances: A Worldwide Phenomenon Comes to Health Care." In Kaluzny A, Zuckerman H, Ricketts T. (eds.), *Partners for the Dance: Forming Strategic Alliances in Health Care* Ann Arbor, MI: Health Administration Press.

## Appendices

### *Appendix A:*

#### ***The Evolution of Community Benefit***

“Private charitable and religious hospitals were the most prominent type of hospital in the early twentieth century” (Stevens, 1989). These “voluntary” institutions provided care and tended to the sick in society regardless of their ability to pay. Due to their altruistic orientation toward the health of whole communities; these institutions were granted “charitable immunity” on the grounds that their acts of benevolence to serve the poor and meet communities’ needs were a public good (Stevens, 1982). It was on the grounds of claiming the goodwill of charitable care that these institutions attained protection from legal liability and taxation. Over the course of the 20<sup>th</sup> century, these institutions sought to continue distinguishing themselves as unique from government and proprietary organizations due to these social commitments. The voluntary status of these institutions was adamantly defended as a means to continue receiving government funding without the challenges to autonomy that typically accompanied it (Stevens, 1989). Essentially, the persistence of maintaining NFP status by these organizations has been the result of political and economic motivations that were justified on the basis of providing social and community goodwill. The provision of a charitable public good for communities as a whole served to be the foundation of the formal community benefit criterion that would be developed in later years.

### *Appendix B:*

#### ***IRS Rulings 69-545 & 83-157***

The community benefit standard for NFP hospitals was formally articulated with the adoption of IRS Ruling 69-545 in 1969. Prior to 1969, tax exempt status was granted on the grounds of claiming the goodwill of charitable care. This ruling provided a framework by which the 501 (c)3 charitable status for hospitals would be determined including: a full time operating emergency room where no one needing emergency care is denied treatment; an open medical staff; use of surplus funds to improve patient care, facilities, medical training, education, and research; having a board of trustees consisting of independent civic leaders; and did not discriminate against patients covered by public programs (IRS Revenue Ruling, 69-545, Schlesinger, 1996). In 1983, IRS Ruling 83-157 further reinforced a vague conceptual framework of community benefit that did not hold NFP health providers to any consistent norm of measuring community benefit (Barnett, 1997). The lack of clarity stemming from these rulings has led to the uncertainty that revolves around which practices do and do not count as community benefit. This has also led to blurring the roles that NFP health systems and hospitals play in their communities that would be consistent with these practices. With the introduction of Schedule H, these are the two issues that legislators, policymakers, and NFP health provider managers are wrestling with today.

*Appendix C:*

***Sarbanes-Oxley Act of 2002***

The securities legislation resulting in the Sarbanes-Oxley Act (SOX) was prompted by the collapse of the Houston based energy company Enron in 2001. SOX called for reform to corporate governance, accounting, and auditing practices. The Act established the Public Company Accounting Oversight Board (PCAOB) and put forth regulations intended to increase the transparency, accuracy, and reliability of corporate financial reporting. The purpose of this legislation was to create strict guidelines for governing and accounting for the internal activities of organizations (Zhang, 2007).

*Appendix D:*

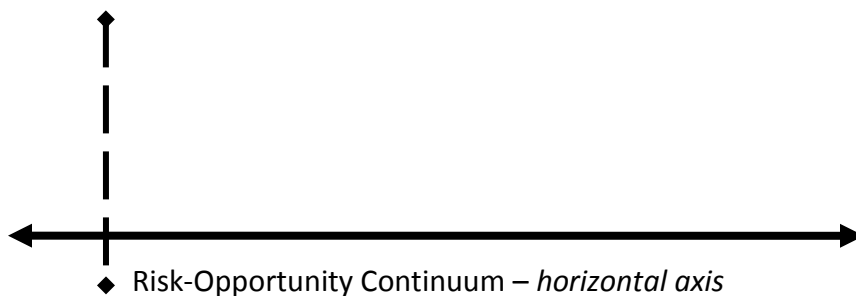
***NFP & FP Governance***

Organizations fall under two different profit-distribution structures where an institution is either held accountable to shareholders (FP), or stakeholders affected by the provision of its program and/or services (NFP). Shareholders are defined as any person or group that have purchased shares or stock in an organization and have rights to earnings attained by that firm. Stakeholders are persons or groups that are affected by the business practices, programs, or services provided by an organization. Accountability to shareholders or stakeholders is reflected in the sharing of benefit, profits, or stock in the business which is issued to either one of these two groups. These dynamics of liability provide parameters around the operational and programmatic priorities of these institutions. They also influence leadership and managerial discretion within these organizations when determining their responsibilities to society.

*Appendix E:*

***Illustration of Hypothetical Ladder of Partnership Participation***

Partnerships Typologies (Ladder of Partnership Participation)– *vertical axis*



Attention to the intersection between the Ladder of Partnership Participation and the Risk-Opportunity Continuum offers organizational managers guidance with establishing partnerships with stakeholders.

I hypothesize that more CBPH principles (power, trust, and accountability) are taken into account as an organization progresses up the Ladder. I do not propose that any partnership

type is inherently more effective than another. However, there may be forms, structures, and purposes that are more appropriate for partnerships with certain stakeholders looking to achieve certain goals.

The Risk-Opportunity Continuum contextualizes resource allocation decisions taken into account by managers given their constraints. I propose that an organization's decision-making, partners, and goals differ dependent on the action an organization finds necessary to protect itself against external risks or to improve its market position.

*Appendix F:*

### ***Organizations' Relationships with Communities***

Scholarly examination of the relationships between organizations and communities often begins with Howard Bowen's Social Responsibility of the Businessman (Bowen, 1953). Bowen explores the roles of organizations in society and introduces formalized concepts of businesses interactions with society. He refers to social responsibility of businessmen as an obligation to "make decisions...that are desirable in terms of the values of society" [sic] (Bowen, 1953). He asks, "...are businessmen by virtue of their strategic position and their considerable decision-making power, obligated to consider social consequences when making their private decisions? If so, do they have social responsibilities that transcend obligations to owners or stockholders?" (Bowen, 1953). Grounded in the ethical issues inherent in economic practices, this work establishes the obligations of businesses to society from moral, managerial, and legal perspectives. In 1962, Milton Friedman challenged businesses' responsibility to society, stating that the only social responsibility of managers was to "make as much money for their stakeholders as possible" (Friedman, 1962). From the perspective of absolute capitalism, Friedman said that social responsibility "is a fundamentally a subversive doctrine in a free society" (Friedman, 1970). These two perspectives offered the polar extremes between which the responsibilities of business to society were considered.

*Appendix G:*

### **CSR in Practice**

*"Corporate Citizenship is about business taking greater account of its social and environmental – as well as its financial – footprints." -- Simon Zadek, The Civil Corporation.*

For FP organizations corporate social responsibility is best understood as one piece to businesses' strategies to manage risks (Vogel, 2004). Typically, the drivers of CSR are investors, employees, consumers, and other stakeholders. It can be considered a response to non-market, public pressures by managers within organizations. As communities are stakeholders for organizations, managers have an immediate interest in engaging with communities to address local needs in order to sustain their business. Practicing CSR as a corporate citizen has been discussed as means for firms to manage intangible risks, such as the interests of stakeholders and how they impact the legal compliance of those organizations (Zadek, 2007). Domestically, these practices have generally been used to address policies related to community relations, environmental practices, and investing in diversity amongst others (Vogel, 2004). Rewards of corporate social responsibility have been anecdotally suggested to include

workforce recruitment and retention, employee morale, and company recognition in the communities they serve—essentially elements of social reputation. The value of these elements to an organization, combined with their financial value of the social reputation that comes with it has been referred to as the blended value proposition (Emerson, 2003).

However, CSR is typically only practiced if costs are low and can be done within the constraints of resources that companies are willing to spend on this strategy (Vogel, 2004). Managers looking to be socially responsible must examine whether their organization is doing what it can do given its range of external options and internal competencies; these determine an organization's degrees of freedom (Zadek, 2007). Internal factors that affect these decisions are: policies and processes; culture and values; and patterns of leadership. External factors include: business drivers and market pressures. These drivers consist of the financial considerations that managers must take into account prior to engaging in sustainable development activities. This includes impacts on financial, labor, product and service costs, markets, and whether they will have good or bad impact on short or long term gains. Of note is the implied intent of corporate citizenship having value as potential strategy to move organizations from short-term transaction towards (riskier) relationships with stakeholders that can foster sustainable economic, social, and environmental impact. "Corporate citizenship's key contributions to business strategy are the relationship building with stakeholders it encourages; offers businesses new sources of information that are not available through financial markets and other commonly used channels, and is driven by social and environmental aims" (Zadek, 2007). Since financial markets, for the most part, are not aligned with the value of these interactions, firms are hard pressed to invest adequate resources into developing practices to achieve these ends. This is similar to the conundrum of going beyond legal compliance of community benefit that managers of NFP health organizations face in justifying their community development programs.

#### *Appendix H:*

##### ***Business Value of Partnerships & CBPH***

Partnerships present opportunities to develop relationships with the community and trust in the organization. This is particularly relevant for NFP health systems and hospitals looking to maintain legitimacy in communities they serve. This interaction has been historically strained because of the imbalanced power dynamics that can exist between resource-rich organizations and disadvantaged communities and is currently still difficult to manage. NFP health systems in particular are looking for ways to be more strategic and deliberate with how they initiate partnerships with the communities they seek to improve. They must foster partnerships that include the various community stakeholders that stand to benefit from their community development practices (Magill, 2004). Research suggests that the most-cost effective and sustainable approach to community health improvement is achieved through broad engagement of diverse stakeholders and strategic leveraging of available resources (Barnett, 2009). For businesses in general, these participatory approaches offer strategic benefits of increasing the effectiveness of sustainable development. "It is important that organizations build a sense of shared values with key stakeholders" (Zadek, 2007). Partnerships give organizations access to information, knowledge, trends and other assets that are only available

from the community and not the financial markets or other traditional sources of information. Partnerships grounded in CBPH may be particularly valuable because it specifically focuses on health outcomes and community conditions. These are outcomes that can provide measureable data about the performance of a partnership. Taking into account the static nature of community conditions, CBPH also offers valuable insight into current criterion of social acceptability for business practices. These criteria are constantly changing or vary by region or demographics and building equitable partnerships in the context of these risky environments with unstable bases of legitimacy helps businesses to manage their liabilities (Zadek, 2007). The value of trust gained from partnerships with stakeholders to business is also important. The most important link between business ethics and financial performance is the impact of a culture of trust on the reduced need to police business relationships (Casson, 1998). It has even been suggested that companies that are able to build trust and integrity into their community relations lowers the cost of establishing and maintaining business operations (Jones, 1995).

*Appendix I:*

### ***Partnership Theory***

Theories of partnerships essentially fall under two categorizations, rational choice and social or collective choice. Rational choice theories consider transaction costs, principal-agent theory, and theory of teams amongst others. Social or collective choice theories include but are not limited to game theory, organizational theory, examination of social networks, and diffusion of innovations.

The iterated prisoner's dilemma model is commonly cited for offering a conceptual understanding of how partnerships function. The model, based in game theory, demonstrates the roles of players (donor and recipient), the choices they have, and the consequences or their actions in terms of payoff if players do or do not cooperate.

The prisoner's dilemma presents two key theoretical components of partnerships – trust and accountability. In the context of organizational transactions that involve risk, trust is defined as “the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party” (Mayer, 1995). Accountability is defined as being held responsible by others who have a stake in what is being done (Blagescu, 2005; Cornwall, 2000).



*Appendix J:*

**Original Framework – Ladder of Citizen Participation**

Sherry Arnstein originally published “A Ladder of Citizen Participation” in 1969 to illustrate various levels of citizen participation relative to different distributions of power between the powerful and the powerless (Arnstein, 1969). It cites 8 levels of participation that range from what is termed (citizen) manipulation to complete citizen control.

- Citizen Control
  - *Target population/community makes decision and acts independently of the lead organization.*
- Power-Sharing
  - *All partners solve problems together.*
- Placation
  - *Engages all partners as conduits of information and feedback both to the lead organization(s) and from other partners.*
- Consultation
  - *Lead organization solicits input on a broad range of issues and engages partner(s) in helping to shape priorities related to partnership related programs, planning, and resources.*
- Informing
  - *Lead organization solicits occasional partner (organization, community, etc.) input on predefined discrete issues, and subsequently uses this information to make decisions*
- Therapy:
  - *Characterized by one-way communication delivered from lead organization to target audience/partner(s).*
- Manipulation:
  - *One organization leads decision making and actions*

(Arnstein, 1969)

There are now several decades of experience in evolving and implementing ‘participatory’ approaches to development practice and research. This has been particularly focused on how best to bring people who have traditionally been marginalized from decision-making in institutions that deeply affect their lives...the objective of such approaches has been to push the activity in question up the ‘ladder of citizen participation’, moving it beyond functional or consultative participation towards a degree of involvement by multiple stakeholder groups that allows effective change to occur beyond rhetorical engagement (Zadek, 2007). While there have been a number of attempts to operationalize these ladders, yet it has been difficult to determine if they have been tested or used for research (*Participation Works! From the New Economic Foundation, 1998*; Zadek 2007; IIED Model Participatory; Learning & Action: A Trainers Guide by Pretty, 1995)

*Appendix K:*

***Strategies for Sustainability & Business Risks***

Organizations develop these strategies to protect or increase their profits and reduce the risks of their losses. These factors define the primary constraints within which corporate strategies are developed. The cost of business transactions stems from the investments of financial, labor, time, and political capital associated with an organization's activities. The intended use and availability of these resources often shapes the decision-making of leadership and managers within organizations. The impacts of financial costs on an organization's profits are primary considerations taken into account when determining a course of action. More specifically, financial costs' impact on achieving immediate goals or profits has been cited as the most prevalent constraint for managers (Vogel, 2005). This is consistent with the notion of managers' objective to create and maximize their business' value. Value maximization provides the primary criteria for determining what trade-offs to make during decision-making.

*Appendix L:*

***Negotiated Boundaries & Stakeholder Relationships***

In order to negotiate boundaries of accountability with stakeholders, organizations must determine which stance of engagement is most appropriate for their internal capacities and intentions in the community. The CSR literature recognizes that there are a multitude of forms of engagement available to organizations intending to work with stakeholders. Attention to the process of engagement is significant because organizations must strategically decide which stakeholders to form relationships with and how those relationships will be formed to achieve their intended impact. Regardless of partner, the nature of the relationship an organization forms is particularly important. Jones states that, "firms that contract with their stakeholders on the basis of mutual trust and cooperation will have a competitive advantage over firms that do not" (Jones, 1995). Stakeholder engagement literature reflects other discussions of community based participatory action in stressing that meaningful relationships must be established. Meaningful relationships with stakeholders for the purpose of this review consist of: communication, trust, respecting values, accountability, and acknowledgement of power differentials (Israel, 2008). Discussions of relationships between organizations and their stakeholders are particularly mindful of the power dynamic that exists between the two. The ability of management within organizations to establish relationships with external partners is often determined by internal organizational strategies, agendas, as well as the level of decision-making discretion of the individual manager. The interplay of these variables directly impact the extent of power-sharing that takes place between representatives of an organization and the stakeholder being engaged. It is important to recognize the role of power in the interchange between organizations and stakeholders. The value of stakeholder engagement is realized in the ability of stakeholders to penalize organizations for "getting it wrong". However, when there are power imbalances, communities are often at a disadvantage in not being able to mobilize because they lack access to information, leverage, and concentrated political capital. These barriers to taking collective action often prevent stakeholders from significantly penalizing organizations for not honoring negotiated boundaries.

The types of relationships formed between organizations and stakeholders, and what constitutes them, shape the type of engagement that takes place between the two. A continuum of corporate involvement has been illustrated in the CSR literature to describe various types of relationships organizations establish with community stakeholders. In depicting the continuum, Pelozo says the following:

At the one end, relationships where firms make traditional donations are labeled philanthropic. He argues that in the transactional stage, greater business benefits can accrue when the firm focuses on donations around specific activities (e.g., a percentage of every sale). At the other end of the spectrum are integrative relationships that are characterized by shared employees and activities, a relationship that approximates a joint venture.

(Pelozo, 2009)

Organizations that adhere to this framework strategically choose their partners and how those partners are engaged; this increases the likelihood of the desired benefits being obtained (Jones, 1995). Additionally, it is suggested that organizations institutionalize relationships and responsiveness into the model of how companies engage their stakeholders (Rivoli, 2011). This responsiveness to stakeholders should emphasize “organizational processes and structures that react to the social needs and values of a wide range of individuals and groups who have an interest in the organization” (Seeger, 2007). These views promote equitable relationships between organizations and stakeholders and encourage the representation of the needs, interests, and perspectives of stakeholders in organizational decisions.

*Appendix M:*

***California Community Benefit Report Review Criterion:  
Protocol for OSHPD Community Benefit Report Review***

- 1. What are the components of the hospital mission, vision statements, or objectives that reflect elements of a commitment to improving health in the community?**
  - a. Look for presence/absence of language that addresses:
    - i. Is the term community there?
    - ii. The “community context” is it mentioned/alluded to?
    - iii. Commitment to community as a whole
    - iv. Identification of vulnerable populations
  
- 2. Community assessment**
  - a. Identify any “red flag” issues
  - b. How did they define their community (e.g., primary service area)?
  - c. What criteria did they use to define their community (e.g., volume of service)?
  - d. Did they identify specific communities with disproportionate unmet health needs?
  - e. Is the BHC community identified as one of their communities?
  - f. Is there an “assets” component to the assessment?

- g. What analytic methods and data sources were used in the assessment?
  - i. Is there anything missing in quantitative/qualitative sources (i.e. baseline county data? Is the process for how community input was gained explained? Is it reliable?)?

### 3. Setting priorities

- a. What are the priorities identified in the assessment?
  - i. Who was involved in the decision-making for setting priorities?
- b. What evidence is provided of community engagement in setting priorities?
- c. What criteria and process was used in setting priorities?
  - i. Is it explicit criteria or general guidelines?
- d. Is there an actual connection between priorities that were set and community benefit programs that were put in place?

### 4. Oversight and management

- a. What body (if any) is identified with oversight responsibility for community benefit?
- b. If a body is identified, what is the composition?
- c. If there is no oversight body, who sets priorities and makes decisions?
- d. Who is responsible for management of programs – is there a key contact?

### 5. List all major programs and provide brief descriptions of key elements for each.

For the subset of these programs that relate to the BHC site's outcomes:

- a. Population served?
- b. What geographic region is the population coming from?
- c. What are the specific activities/services provided?
- d. What are measurable objectives?
- e. What outcomes have been achieved to date?
- f. What might be envisioned next steps/strategies to take to the next level?
- g. What funding has been allotted to the program?
- h. What is the time horizon of the program?

*Appendix N:*

#### ***Background and Significance of NFP Hospitals and Environmental Sustainability***

##### ***Background***

Through the mid-1990s, health systems and hospitals' general posture toward environmental sustainability did not differ significantly from that of other major service and production industries. Health care organizations at this time worked to be compliant with federal environmental protection regulations, purchased products through the Environmental Protection Agency's Energy Star program, and in some instances participated in socially responsible environmental investment portfolios (Press, 2000).

In 1994, an Environmental Protection Agency (EPA) interim report on the risks posed by dioxins brought attention to the potential health effects of the carcinogen. The report specifically cited that medical waste incinerators were the leading source of releasing this toxic air pollutant (Paustenbach, 2002). This spurred a response from a handful of hospitals to assess their operations and evaluate any contribution of dioxins to their local environments.

In 1996 the Health Care Without Harm (HCWH) coalition began in an effort to redefine the health care sector's understanding of the relationship between their practices, the environment, and health. The HCWH coalition's earliest efforts targeted the reduction of medical waste incinerators in the US and the removal of medical products that use mercury. To date, a significant number of medical waste incinerators have been closed and mercury based products have been completely eradicated in the United States. In the 15 years since, this attention to hospitals' adverse impact on the environment has evolved into a healthcare sector-wide campaign to monitor and improve the environmental sustainability of healthcare facilities.

### *Significance*

The environmental footprint of United States health care sector is considerable given the industry's vast resource consumption and waste production as a result of the physical construction and daily operations of over 5,000 hospitals. Environmental footprints were introduced as a measure to conceptualize the environmental impact of any activity that consumes or makes demands of the planet's natural resources (i.e. ecological, carbon, land use). Operationally, they offer a high-level assessment of an organization's environmental impact. Health systems and hospitals have notably high energy and water consumption, unique toxic profiles, and produce considerable amounts of waste. These institutions affect their environment through their: operations; affect on the built environment; supply chain; and transportation (Eco-Health Footprint GHSI 2010). This results in hospitals having a significant impact on the environmental conditions of their communities; they are the second most energy intensive buildings in the United States (EIA, 2003). The comprehensive influence that these institutions have on the environmental conditions, policies, and practices in communities they serve warrant specific attention towards how they are addressing their environmental impact.

### *Appendix O:*

#### **Potential Constructs**

Governance (Managerial Discretion)/Within Organization Prior to Partnership [Decision-making of managers that are confronted with an array of options and have the capability and thus obligation to use their discretion in a responsible manner (Barnett, 1997)]:

1. What are the Opportunities
2. What are the Risks/Returns
3. What is the Investment
4. What are the Trade-offs
  - a. Forms of capital considered (economic, social, environmental)

5. Degrees of Freedom (*What is the Capacity of the Organization?*)
  - a. Policies/processes
  - b. Culture/Values
    - i. i.e. value interests of community, regardless of community being actual partner
  - c. Patterns of Leadership
  - d. Business Drivers
  - e. Market Pressures
6. Degrees of Effect (*How much Impact can be made?*)
  - a. Importance of issue
  - b. Urgent vs. Long Term
  - c. Size of issue
7. Transaction Costs
8. Information/Knowledge
9. Social Reputation

Within Partnership:

1. Trust
2. Accountability
3. Power Balance
4. Involvement of Leadership
5. Community Control/Involvement

*Appendix P:*

***Preliminary Partnership Scales Literature Review (Granner & Sharpe, 2004)***

Title on List	Page # in <u>Inventory of Measurement Tools</u>	Author(s)	Year Published	Validated?	# items
Community representation	2	Rogers	1993	no	1
Level of participation	3	Prestby	1990	no	
Member and board participation	3	Taylor-Powell	1998	no	2
Member and board participation	3	Taylor-Powell	1998	no	2
Member and board participation	3	Taylor-Powell	1998	no	2
Involvement in the organization	4	Giamartino and Wandersman	1983	yes	3
Member participation	5	Hays	2000	yes	10
Member participation	5	Hays	2000	yes	10
Member participation	5	Hays	2000	yes	10
Member participation	5	Hays	2000	yes	10
Role clarity	5	Rogers	1993	no	4

Role clarity	5	Rogers	1993	no	4
Role clarity	5	Rogers	1993	no	4
Role clarity	5	Rogers	1993	no	4
Operational understanding	5	Rogers	1993	yes	5
Operational understanding	5	Rogers	1993	yes	5
Sense of Community	6	McMillan	1995	yes	5
Sense of Community	6	McMillan	1995	yes	5
Sense of Community	6	McMillan	1995	yes	5
Member satisfaction	7	Kegler	1998	no	1
Member satisfaction	7	Butterfoss	1996	no	2
Satisfaction level	8	McMillan	1995	yes	4
Satisfaction with coalition	8	Rogers	1993	yes	5
Commitment	9	Kumpfer	1993	yes	3
Commitment	9	Kumpfer	1993	yes	3
Leadership effectiveness	12	Taylor-Powell	1998	no	5
Leadership effectiveness	12	Hays	2000	yes	6
Leadership	12	Kegler	1998	yes	6
Formality of coalition structure	14	Gottlieb	1993	no	6
Partnership relations	17	Cook	1994	no	n/a
Group relationships	17	Taylor-Powell	1998	no	n/a
Satisfaction with group	17	Taylor-Powell	1998	no	4
Communication	18	Kegler	1998	yes	4
Member communication	18	Rogers	1993	yes	5
Involvement/inclusion	19	McMillan	1995	yes	5
Cooperation and networking subscale	22	Cook	1994	yes	2
Cooperation and networking subscale	22	Cook	1994	yes	2
Internal collaborative functioning	22	Taylor-Powell	1998	no	12
Internal collaborative functioning	22	Taylor-Powell	1998	no	12
Internal collaborative functioning	22	Taylor-Powell	1998	no	12
Group functioning	23	Taylor-Powell	1998	no	26
Group functioning	23	Taylor-Powell	1998	no	26
Group functioning	23	Taylor-Powell	1998	no	26
Coalition Checklist	23	Brown/Minkler	1984/97	no	12
Coalition Checklist	23	Brown/Minkler	1984/97	no	12
Coalition Checklist	23	Brown/Minkler	1984/97	no	12
Coalition Checklist	23	Brown/Minkler	1984/97	no	12

*Appendix Q:*

***Ladder of Community Participation Interview Guide***

Hello, thank you for taking the time to speak with me. I am a student from a Qualitative Research Methods course in the School of Information and have chosen to develop a project that will explore the various relationships between communities and organizations looking to work with those communities.

I would like to spend about 15 or 20 minutes asking you about your experiences with and thoughts about these types of partnerships. I am going to ask a few open ended questions about your background

If you don't have any questions, I'd like to ask, if it's alright if we begin? Please feel free to ask me any questions at any time.

Would you mind if I recorded our conversation?

1. In what capacity have you worked with community stakeholders and the different organizations that work with them?
2. Community Capacity: What capacities do communities need to be prepared to work in these relationships?
  - a. Are there good examples?
  - b. Bad examples?
3. What are the essential components of a healthy or successful partnership in this area?
  - a. What kinds of relationships exist?
  - b. Does power play a role? Trust?
  - c. Can you think of any examples?
4. What has called for the need for partnerships?
  - a. Can you cite of any examples?
  - b. What was done before the partnerships were established?
5. When are partnerships with organizations appropriate or necessary?
  - a. Are there times when they are more useful?
  - b. Are there times when they are less useful?
6. What is the role of power? Trust? Accountability?
  - a. What role do they play in establishing/implementing partnerships?
  - b. How are these dynamics managed?
  - c. Are they evaluated? Measured?
7. What works?
  - a. What types of partnerships work b/w communities and organizations?
  - b. Examples?
  - c. What types of partnerships don't work b/w communities and organizations?
  - d. What was the same about these?
  - e. What was different?
8. Any other general thoughts about these relationships that you'd like to share?

*Thank You.*





13. We feel that *our partners* negotiate joint expectations fairly. 1 2 3 4 5
14. Our partnerships' direction is often dominated by one or a few individuals. 1 2 3 4 5
15. We intend to speak openly in our negotiations with *our partners*. 1 2 3 4 5
16. My partners have access to information not available to me and this information convinces me that the partner is right. 1 2 3 4 5
17. How much influence would you say that your organization has on *defining the overall goals* of its partnerships?
- None
  - A little
  - Moderate
  - A lot
18. How much influence would you say that your organization has on *ways to measure the effect* of its partnerships?
- None
  - A little
  - Moderate
  - A lot
19. How much influence would you say that your organization has on *designing project activities* related to its partnerships?
- None
  - A little
  - Moderate
  - A lot
20. How much influence would you say that your organization has on *developing the budgets of its partnerships' projects*?
- None
  - A little
  - Moderate
  - A lot

What type of input does your organization typically have in the following areas? [CHECK ONE ANSWER FOR EACH QUESTION]

21. What type of input does your organization typically have in setting the budget for its partnership's programs? [CHECK ONE ONLY]
- no role
  - advice only
  - develop
  - recommend
  - approve
  - does not apply



**Part II – Implementation**

Mutual Benefit (there is balance in the relationship; I do things to help them, and they do things to help me)

- 31. Importance: How important is this component for your partnerships? 12345
- 32. Occurrence: Please indicate how mutually beneficial your partnerships are (as a whole)? 12345

Good/Clear Communication (shares information; promotes clear understanding)

- 33. Importance: How important is this component for your partnerships? 12345
- 34. Occurrence: Please indicate the level of clear communication that your partners (as a whole) provide. 12345

Responsible (can be counted on)

- 35. Importance: How important is this component for your partnerships? 12345
- 36. Occurrence: Please indicate how responsible you feel your partners are (as a whole). 12345

37. How much influence would you say that your organization has on *deciding how partnership activities are conducted?*

- a. None
- b. A little
- c. Moderate
- d. A lot

38. How much influence would you say that your organization has on *how the project's budget is spent?*

- a. None
- b. A little
- c. Moderate
- d. A lot

Please circle the number to the right of each statement that most closely describes the opinion of members of your organization toward its partners.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1	2	3	4	5

- 39. I feel that I have a voice in what my partnerships decide. 1 2 3 4 5
- 40. In our opinion, our partners are reliable. 1 2 3 4 5
- 41. Partners have information you need to do your work effectively. 1 2 3 4 5
- 42. Partners have the expertise to make good decisions about the work. 1 2 3 4 5
- 43. Partnerships have a feeling of cohesiveness and team spirit. 1 2 3 4 5
- 44. I feel a sense of pride in what our partnerships accomplish. 1 2 3 4 5

- |   |           |
|---|-----------|
| 45. We think that <i>our partners</i> meet their negotiated obligations to our department.                | 1 2 3 4 5 |
| 46. I am satisfied with how our partnerships operate.   | 1 2 3 4 5 |
| 47. We think that people in <i>our partnerships</i> succeed by stepping on other people.                  | 1 2 3 4 5 |
| 48. We think that <i>our partners</i> take advantage of our problems.                                     | 1 2 3 4 5 |
| 49. We feel that <i>our partners</i> will keep their word.  | 1 2 3 4 5 |
| 50. I would like to change how the partnerships operate.  | 1 2 3 4 5 |
| 51. We feel that <i>our partners</i> try to get out of their commitments.                                 | 1 2 3 4 5 |
| 52. The partnerships use their staffing resources effectively.  | 1 2 3 4 5 |
| 53. We feel we can depend on <i>our partners</i> to move our joint projects forward.                      | 1 2 3 4 5 |
| 54. We think that <i>our partners</i> are dependable.   | 1 2 3 4 5 |
| 55. Our partners work together effectively as a group.  | 1 2 3 4 5 |
| 56. We worry about <i>our partners'</i> commitment to agreed upon goals.                                  | 1 2 3 4 5 |
| 57. Member organizations in the partnerships contribute complementary resources (staff, time, financial). | 1 2 3 4 5 |
| 58. We intend to work openly with <i>our partnerships</i> because they will not take advantage of us.     | 1 2 3 4 5 |

Please rate communication within the partnerships over the past 12 months on the following scales (**circle one for each pair of adjectives**).

- |                 |   |   |   |  |               |
|-----------------|---|---|---|--|---------------|
| 59. Poor        |   |   |   |  | Good          |
| 1               | 2 | 3 | 4 |  | 5             |
| 60. Frequent    |   |   |   |  | Infrequent    |
| 1               | 2 | 3 | 4 |  | 5             |
| 61. Informative |   |   |   |  | Uninformative |
| 1               | 2 | 3 | 4 |  | 5             |
| 62. Comfortable |   |   |   |  | Awkward       |
| 1               | 2 | 3 | 4 |  | 5             |
| 63. Effective   |   |   |   |  | Ineffective   |
| 1               | 2 | 3 | 4 |  | 5             |