Factors Impacting Community Benefit Implementation Strategy Plans in Illinois: 
A Qualitative Study

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DISSERTATION

Submitted as partial fulfillment of the requirements for the degree of Doctor of Public Health in
Leadership in the School of Public Health of the University of Illinois at Chicago
Chicago, Illinois. USA
August 2018

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To my witty brother, Brett, in memoriam. Thank you for always being over protective, saving my life, giving me pep talks along the way, and making us recognize that we will never look back on life and wished we worked more.
ACKNOWLEDGEMENTS

I would like to acknowledge the following individuals for their assistance and support over the course of my studies and dissertation process:

To my committee chair, Dr. Christina Welter, who was an outstanding mentor throughout the entire doctoral program and kept challenging me, providing additional insight and moving me along. I will be forever grateful for your kindness and continuous support after losing Brett, and as health issues slowed me down. To each of my committee members, Drs. Kris Risley, Eve Pinsker, and Seweryn, I extend a heartfelt thank you all for your expertise, guidance and most of all, for your support, encouragement, and challenging me. To Bonnie Condon, thanks for jumping on board and providing the hospitals point of view and making this relevant for future community benefit planning processes.

Next, for their friendship, insights, and encouragement, thank you to the members of my 2012 DrPH Cohort. To my wonderful colleagues at the Rhode Island Department of Health, the American Medical Association and Health Care Service Corporation, thanks for continuing to support me through the program.

To all of the hospitals who agreed to speak with me as part of my dissertation process, I extend a warm thank you. Your openness to participating in this process and your honest feedback about the impact of these policies will contribute to enhancing future hospitals experiences in addressing the community needs. Special thanks to Erica Salem and Susannah Camic Tahk, for the assistance with the hospitals and in navigating the IRS data.

Finally and most importantly, I want thank my amazing friends and family. My journey would have not possible without the wonderful support of my dear friends who celebrated every milestone of this program. Thanks to Quinn for being a ray of sunshine over the past three years and being a great excuse to take a break and go on an adventure. Lastly to my brilliant Mom and Dad, thank you for your love and support over these years. Mom, thanks for being my cheerleader and your patience and dedication to helping me finish. Dad, thanks for the endless supply of coffee, delicious meals and recognizing when I needed to take a break and laugh.
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### KEYWORDS (or) ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
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<td>AHA</td>
<td>American Hospital Association</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CHNA</td>
<td>Community Hospital Needs Assessment</td>
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<td>CHIP</td>
<td>Community Health Improvement Plan</td>
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<tr>
<td>GPD</td>
<td>Gross Domestic Product</td>
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<tr>
<td>HHS</td>
<td>US Department of Health and Human Services</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>IRS</td>
<td>Internal Revenue Service</td>
</tr>
<tr>
<td>IRB</td>
<td>Institution Review Board</td>
</tr>
<tr>
<td>IS</td>
<td>Implementation Strategy</td>
</tr>
<tr>
<td>Population</td>
<td>“A cohesive, integrated and comprehensive approach to health care that considers the distribution of health outcomes within a population, the health determinants that influence distribution of care and the policies and interventions that affect and are affected by the determinants” (Institute of Medicine)</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
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SUMMARY

The aim of this study was to identify key factors, including market, community, organizational and leadership, that led to the inclusion of prevention programs in tax exempt hospitals community benefit Implement Strategy (IS) plans. The other aim was to describe the benefits and barriers of the new Affordable Care Act (ACA) requirements as hospitals transitioned their investments towards community health improvements.

This study was framed by recent reforms in the United States, which resulted in overalls throughout to the health care system, including the ACA and Internal Revenue Service (IRS) requirements for tax-exempt hospitals. These required hospitals to conduct Community Health Needs Assessments and develop IS plans every three years to address their broader community needs. This has led to question how hospitals are adjusting to this paradigm shift from typically funding charity care towards investments that improve the overall health of their communities and the factors influencing their inclusion of various programs in their IS plans.

This study utilized a single case study design with embedded units of analysis because it allowed for a greater examination of the factors that influenced tax-exempt hospitals to incorporate prevention programs in their community benefit IS Plans. The case study focused on select Illinois hospitals. Illinois was one of the few states that mandated the public reporting of community benefit IS plans. The methods involved a two-phased approach comprised of: 1. Interviews with hospital stakeholders involved in the planning and decision-making process for the community benefit IS plans; and 2. Content analysis of selected hospitals CHNA, their IS plans and other relevant documents including community benefit meeting notes and reports.
SUMMARY (continued)

Study Findings

Study findings highlighted the various factors influencing the hospitals and underscored the variations in their approaches to the community benefit IS planning process. The study found that hospitals decisions and drivers around which programs to include in their IS plan, particularly those focused around prevention and evidence-based practices, were complex. There was not a single factor or driver impacting how hospitals addressed the requirements. Rather the major themes that emerged from the data on the inclusion of prevention factors into the IS plan were multifaceted. The main themes included:

- A professed need for a clearer guidance and more training for hospitals around prevention and evidence based practices to improve population health
- The need to continue to develop and evolve toolkits and resources to support tax-exempt hospitals by national associations, to provide guidance around best practices, evidence-based programs and implementation tools
- A broad range of approaches, programs and engagement models with the community collaboratives around the IS plans, highlighted the need for additional guidance around community benefit and building activities, particularly if the goals are to shift hospitals towards more community health improvement approaches.
  - Community and public health organizations helped foster collaboration among the hospitals which may have occurred due to limited staffing or resources
- Hospital research centers aided with knowledge of evidence-based practices, the understanding of the social determinants of health and the ability to engage with community members throughout the IS planning process
SUMMARY (continued)

- A validation of senior leadership support, described in other studies, was deemed essential to championing the community benefit activities, fostering organizational buy in and encouraging community partnerships

Recommendations

Based on the study findings and the literature, there are several recommendations for policy, community and public health organizations, national hospital associations, hospital leaders and for future research considerations to improve the community benefit IS plans. The purpose of these recommendations is to expand the knowledge around the community benefit processes and identify opportunities for improvement with the current IRS and state policies and requirements.

Policy Recommendations for the IRS or State Policymakers:

- Include guidance or requirements around involvement and engagement of community and public health organizations in the IS planning process to encourage cross-sector collaboration in support of community health improvement approaches, not just in the CHNA
- Convene and develop a structure or criteria to evaluate the IS plan and programs, inclusive of process and outcome measures, and level of community input, for increased accountability, guidance and a shift towards outcome based community health
- Expansion and clarification around strategies and recommended programs to address the social determinants and evidence-based prevention programs to decrease the ambiguity of hospitals interpretation of the requirements
SUMMARY (continued)

- Establish minimum thresholds for spending allocated towards direct community health improvements services compared to the services focused on hospital internal operations, such as health professional education and Medicaid shortfalls

National Hospital Associations:

- Continue to develop trainings, resource guides and best practices for hospitals in collaboration with public health departments to help them transition from clinically focused community benefit approaches towards prevention activities and ones to address the social determinants of health

Community Organizations, Public Health and Local Collaboratives:

- Increase the training and facilitation support to the hospitals around the IS planning process to bridge new partnerships to address the community needs
- Modify the State’s Community Health Improvement Plan reporting timeline to align to the three-year timelines for the CHNA and IS plans to encourage partnerships between local health departments and hospitals.
- Partner with the hospital associations to offer trainings and co-develop best practice guides to educate hospitals around evidence based prevention programs and how to work with communities on health improvement initiatives

Hospitals and Hospital Leadership

- Training by the hospitals who utilize population health approaches and shifted their community benefit activities to other hospitals to provide recommendations, best practices and strategies
Recommendations for Future Research Studies

- Assess the familiarity, training and utilization of evidence-based public health practices and the social determinants of health by hospitals to identify future training opportunities.
- Assess potential future changes to community benefit spending and programming based on the changes to the individual insurance mandate to see if program funding shifts back to offering more around charity care.
1. BACKGROUND AND PROBLEM STATEMENT

In the United States (US), health care expenditures account for 17.9% of the Gross Domestic Product (GDP) and health care costs have grown faster than many other industries (Sisko et al., 2014). The US also spends more than other developed countries on health care, yet has lower health outcomes than other nations, particularly in the areas of infant mortality, life expectancy and the prevalence of chronic diseases (Squires and Anderson, 2015). In addition to poorer health outcomes, significant racial, ethnic and socioeconomic disparities exist related to access, costs and quality of health care (Braveman et al., 2010). Rising health care expenditures, disparities and challenges related to access and quality of care resulted in national recognition that new approaches were necessary. Reforms included integrating the fragmented health care system, developing new payment models and identifying approaches to address population health.

A major reform that came from the Affordable Care Act (ACA) effecting tax-exempt hospitals required them to quantify the benefits they provide to the community and to address the requirements around prevention services and population health with their community benefit activities. This study proposes to explore what factors influence Illinois tax-exempt hospitals to incorporate prevention programs in their community benefit implementation strategy (IS) plans. The different factors, facilitators and barriers that tax-exempt hospitals have experienced around their community benefit activities for potential population health improvement will be explored through a qualitative case study research design of hospitals in Illinois.

a. BACKGROUND

In 1969, hospitals were granted federal tax-exemption if they provided funding for activities that promoted benefits for their serviced communities (Shortell et al., 2009). The idea
was that the exemption would balance the benefits that hospitals provided in the form of charity care (GAO, 2008). The Congressional Budget Office projected that the value of the federal, state and local tax-exemption status for hospitals was around $12.6 billion in 2006 (CBO, 2006).

In 2007, Senator Grassley of Iowa emphasized to Congress that a review and potential reforms to the tax-exemption status were needed for more transparency and to evaluate the amount of revenue hospitals provided in terms of community benefits (US Senate, Committee on Finance, 2007; Bazzoli et al., 2010). The following year, the Internal Revenue Service (IRS) released reporting IRS Form 990- Schedule H, for tax-exempt hospitals that created community benefit categories, including charity care, unreimbursed costs, subsidized health services, community health improvement services and community benefit operations, research, health profession educations and financial and in-kind contributions (Bazzoli et al., 2010; IRS, 2008).

In 2010, two years following the required IRS reporting form change, additional requirements came out of the ACA for hospitals to assess their community needs and developing IS plans to address the needs (ACA § 9007(a) (amending 26 U.S.C. § 501(r)(4)). This new requirement increased the focus on transparency and accountability and called for hospitals to invest in approaches that addressed their community needs (ACA § 9007(a) (amending 26 U.S.C. § 501(r)(4)). The regulations prescribe hospitals to identify their community needs, and development IS plans and programs to address these needs. Community participation from stakeholders, including public health and members that represent the interest of the hospital service area, was added into the requirements for the needs assessment (IRS, 2013). This ultimately demonstrated a paradigm shift to leverage the capacity of health care and public health to collectively improve the health of communities (Kuehnert, 2012).
This study examines what factors contribute to the inclusion of prevention programs in community benefit IS plans in 13 tax-exempt hospitals in Illinois. This study builds on previous work which characterized how hospital allocated funding towards their community benefit programs and developed their needs assessments. It explores how hospitals developed their IS plans and the factors that led to the inclusion of evidence-based programs aimed at improving population health.

i. The History of Community Benefit Requirements

Since 1969, hospitals have obtained tax-exempt status and benefits under section 501(c)(3) of the Federal Internal Revenue code by providing charity care for individuals unable to pay their hospital expenses (Somerville, 2012). The IRS revised this ruling in 1969 to include a broader community benefit standard which allowed hospitals to provided care back to their service area (Shortell et al., 2009).

In 2006, the tax exemption status for hospitals became a topic of interest. Senator Charles Grassley (R-IA) questioned the level of funding hospitals provided to their community to qualify for the tax-exempt status and the ambiguity around this value (US House of Representatives, Committee on Ways and Means, United States Congress Joint Committee on Taxation, 2006). He investigated the sizeable benefits hospitals received due to the exemption from federal, state income tax, and a variety of local taxes and tax-deductible donations (Rosenbaum and Kindig, 2012). Without clear guidance and requirements, the tax-exempt hospitals were left to determine the variability in funding activities and in what they considered community benefits and how to measure them (GAO, Variation in Standards and Guidance, 2005, Rosenbaum and Kindig, 2012).
As a result of this attention and federal hearings, Congress and IRS changed the tax-exempt hospital requirements and developed a new reporting system, IRS Form 990- Schedule H (Davis, 2011). The purpose was to increase the transparency of hospitals activities and processes and provide a framework for reporting the community benefit expenditures in accordance to five outlined parts (Young et al., 2013; IRS, 2008). IRS Form 990- Schedule H created standardized categories for hospitals to identify their contributions based on community building and benefit, detailed below in Table I (Rosenbaum, 2013).

<table>
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<tr>
<td><strong>Form 990 Schedule H Community Benefit Report Categories</strong></td>
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<td><strong>Part I</strong> – <strong>Financial Assistance and Certain Other Community Benefits at Cost</strong></td>
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<tr>
<td>Financial Assistance at Cost</td>
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<tr>
<td>Medicaid costs</td>
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<tr>
<td>Costs and other means-tested government programs</td>
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<tr>
<td>Community health improvement services</td>
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<tr>
<td>Community health improvement</td>
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<tr>
<td>Health professions education</td>
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<tr>
<td>Subsidized health services</td>
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<tr>
<td>Research</td>
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<tr>
<td>Cash and in-kind donations for communities</td>
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<tr>
<td>Other</td>
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<tr>
<td><strong>Part II</strong> – <strong>Community Building Activities</strong></td>
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<td>Physical improvements and housing</td>
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<tr>
<td>Economic development</td>
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<tr>
<td>Community support</td>
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<tr>
<td>Environmental improvements</td>
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<tr>
<td>Leadership development and training for community members</td>
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<tr>
<td>Coalition building</td>
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<tr>
<td>Community health improvement advocacy</td>
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<tr>
<td>Workforce development</td>
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<td><strong>Part III: Bad Debt, Medicare &amp; Collection Practices</strong></td>
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<tr>
<td>Bad debt expense</td>
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<tr>
<td>Difference between Medicare revenues and costs</td>
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<tr>
<td>Collection Practices</td>
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<tr>
<td><strong>Part IV: Management Companies and Joint Venture</strong></td>
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<td><strong>Part V: Facility Information</strong></td>
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ii. Hospital Community Benefits Requirements after the ACA

The ACA, passed in 2010, drastically transformed healthcare financing, delivery and innovation. It offered opportunities for insurance coverage and provided new revenue sources for hospitals aimed at providing evidence-based quality health services and rewards for better outcomes. Emphasis was on achieving the Triple Aim which called for improving population health and the patient experience of care and reducing per capita costs (Berwick et al., 2008). Also, the ACA required additional changes to the community benefit requirements for tax-exempt hospitals. The revised community benefit requirements aimed to improve community health by encouraging greater investments around prevention, providing care outside the hospital walls and by making quality of health care a key focus ((ACA § 9007(a) (amending 26 U.S.C. § 501(r)(4)); Rosenbaum, 2013).

The new requirements provided more explicit documentation frameworks as part of IRS Form 990- Schedule H and applied to approximately ~2900 nonprofit 501(c)(3) hospitals, which was about 50% of U.S. hospitals (American Hospital Association, 2012). The changes required that hospitals develop and define their financial aid requirements and debt policies, decrease the fees to low income patients, develop and publish their Community Health Needs Assessment (CHNA) and develop an IS plan every three years to address the community needs ((ACA § 9007(a) (amending 26 U.S.C. § 501(r)(4)); Stephens, 2015, Rosenbaum, et al., 2013). These new requirements, along with greater compliance, had the potential to improve population health outcomes by encouraging hospitals to identify their community needs using evidence-based processes and provide more community and population-based interventions.
Schedule H required that hospitals document what they provide to the community compared with the financial value of their tax exemption (Barnett and Somerville, 2012). For the first time, hospitals faced penalties from the IRS for noncompliance with the new requirements (ACA § 9007(a) (amending 26 U.S.C. § 501(r)(4)). The tax-exempt hospitals had to meet the new guidelines by the end of 2013 (Rosenbaum and Kindig, 2012).

The community benefit reporting requirements changed IRS Form 990- Schedule H mandating that hospitals describe and document their community building and benefit activities in two sections. Under Part 1 and 2, Schedule H outlined the eight categories that were considered reportable as part of the IS plan for community benefit activities. The specific categories include “Part 1: Reportable hospital community benefit activities; and Part 2: Community building activities – physical improvements, economic development, community support, environmental improvements, coalition building, community health improvement advocacy, and other (IRS, 2012).”

One of the challenges with the new requirements was the limited details or definitions around the types of activities, the level of expected contributions and how to develop the IS plans (Barnett and Somerville, 2012). Without guidance around funding for the various parts of the IS plans, hospitals could continue to use funding as they had for the past 50 years towards clinical and patient care services rather than towards community health improvement (Barnett and Somerville, 2012). This would result in a missed opportunity given the priority of the ACA around population health and the emphasis on quality programs to improve costs and efficiency. Future reimbursement of prevention programs would likely encourage increased uptake by hospitals to incorporate them in their community benefit IS plans. However due to the newness
of the requirements and the potential impact of the long-term results, gaining an understanding of how certain hospitals incorporated prevention activities into their plans was critical.

### iii. Additional State Provisions to the Community Benefit Requirements

In addition to the federal requirements from the ACA, hospitals had to adjust to other market pressures and state policies around the community benefits. States updated and identified additional provisions around their community benefits to reflect greater details (Nelson, 2015). Between 2013-2016, nine states developed new policies or requirements to encourage more accountability and collaboration around the CHNA and incorporate tighter provisions to IS plans (Woodcock and Nelson 2016). The requirements varied from legislation to legally binding agreements, reporting form changes, evaluation plans and collaboration to other state and local programs or priorities (Nelson et al., 2015). The majority of these state and local changes built on the federal ones. Some states, including Illinois, Minnesota and North Carolina, already required tax-exempt hospitals to conduct a CHNA. However, for several states, it was their hospitals first time conducting a CHNA in 2012 and 2013. Other major provisions were mandatory minimum financial contributions for community benefits and charity care which were implemented in Pennsylvania, Texas, Utah and Illinois (Somerville et al., 2013). In Rhode Island, requirements specified community benefit activities as non-revenue producing community programs, research and education activities, partnerships and health advocacy (Somerville et al., 2013).

One of the provisions of particular interest for this study was related to the hospitals public reporting of the IS plans to address the needs identified from the CHNA. The IS plan guidance was broad and there was no research to date on how the hospitals were developing and
fulfilling the IS plans requirements (Rosenbaum, 2016). It was important to understand how tax-
exempt hospitals were developing their IS plans and how decisions were made to address
community needs. With the emphasis from the ACA on population health improvements, costs
saving and increasing efficiency and coordination, an analysis of the new community benefits
requirements was essential.

iv. Illinois Provisions to the Community Benefit Requirements

Illinois served as an example state because they adopted new standards and requirements
for tax-exempt hospitals between 2006-2014 (Nelson, 2015). Illinois was “one of only five states
that established broad mandatory minimum community benefit requirements, meaning that a
hospital was eligible for tax-exemption only if the value of charity care and certain other
“qualified services or activities” provided equals or exceeds its estimated property tax liability”
(Ill. 35 ILCS 200/15-86(c), 2012, The Hilltop Institute, 2015). The charity care provision
mandated that hospitals provide discounts to uninsured patients based on a specified income
level (Hilltop Institute 2016; Ill. 210 ILCS 89/10, 2012). The Illinois Office of the Attorney
General also developed rules standardizing the language in the financial assistance applications

In addition to the provisions around the minimum benefits and charity care, Illinois was
also one of the ten states to adopt community benefit IS plan reporting requirements to enhance
transparency for their tax-exemption status (Folkemer et al., 2011). The Illinois Community
Benefits Act stated that each tax-exempt hospital develops an annual report of their community
benefit plans and file the plan with the Office of the Attorney General (Hilltop Institute, 2016;
Ill. 210 ILCS 76/20(a)(2), 2003). The plans needed to be made publicly available on the hospital
website, identify the populations served by the hospital and outline the goals and objectives for providing the community benefits (Hilltop Institute 2016; Ill. 210 ILCS 76/15, 2003). The additional requirements for Illinois called for exploration of the IS plans in greater detail, particularly the factors impacting the hospitals and the inclusion of evidence-based programs.

v. Factors Influencing Hospitals Uptake of Evidence-Based Practices

Evidence-based programs are ones that ensure high quality disease prevention research are used to improve the health of the population (National Institute of Health, 2015). The supporting evidence comes from systematic reviews, clinical trials, peer reviewed publications, grey literature and the Community Prevention Services Task Force and the Community Guide. Due to the increased pressure from the federal government and other funding agencies to increase effectiveness and accountability due to recent reforms, the use of evidence-based programs is encouraged and emphasized for in the hospitals setting (Cooney et al., 2007).

A variety of models summarize factors at multiple levels that influence and affect the adoption and implementation of evidence-based programs to improve the population health and those that influence hospital decision-making. While there are several models and frameworks available around these two topics, there are limited ones describing how the adoption of evidence-based programs have been incorporated into hospital settings inclusive of the decision-making processes. For the purpose of this study, the more commonly cited frameworks are used based on the systematic review. These frameworks include the factors that impact the adoption and implementation of evidence-based programs in the public sectors and in hospitals and models that look at the strategies and process that lead to the adoption and integration of these programs into the health care setting (Damschroder et al., 2009; Reschovsky et al., 2015; Powell et al., 2011; Brownson et al., 2012).
Within these frameworks, the adoption and implementation of evidence-based programs are influenced and impacted at multiple levels (Damschroder et al., 2009; Aarons et al., 2011; Brownson et al., 2012). In addition to the various levels in the frameworks, multiple factors impact how evidence-based programs are executed including the larger system/market environment, the organization, interorganizational networks, and the team and clinical leadership (Damschroder et al., 2009; Brownson et al., 2010).

The social-ecological model was also reviewed to think about the factors that influence population health. This model demonstrates the complex factors that impact health and that it is not only shaped by the individual but also at organizational, community and policy levels (McLeroy et al., 1988). Although other factors and frameworks can be considered, the four main factors are hypothesized based on the extensive research around the adoption and implementation of evidence-based practice and hospital decision making include: the market, the hospital organization, the community around the hospital, and the hospital and physician leadership (Brownson et al., 2009; Damschroder et al., 2009).

Market factors affect the extent of how a hospital adopts and incorporates evidence-based practices. The adoption of practices can be caused by regulative pressures at the federal, state or local levels or from market pressures, such as competitive metro areas including the Chicagoland area where there are a surplus of hospitals (Brownson et al. 2009). As a result, the market is an important consideration in relation to how hospitals shift their community benefit practices and incorporate evidence-based prevention practices (Damschroder et al., 2009).

The implementation of evidence-based practices is also impacted by community factors including how hospitals develops partnerships with communities around solving targeted
problems, and the ability to bridge the knowledge gap between the clinical and public health sectors (Glisson and Schoenwald, 2005; Mendel et al., 2008). The area surrounding the hospital is a complex system influenced by the community members and the programs and services addressing the broad determinants of health and the population needs (Trickett, 2009). Hospitals face challenges around their knowledge and ability to find evidence-based programs suitable to their patients (Cooney et al., 2007).

The hospital organizational factors influence the extent to which the hospital uses evidence-based practices. The organizations resources can determine if the hospital has the financial resources needed to adopt and implement the practices (Cooney et al 2007). In addition, making decisions around programs involves the utilizing the best available evidence and using the data and information to facilitate the incorporation of population health strategies and practices in the hospital setting (Brownson et al. 2009).

The perception, uptake and value of the evidence based programs is influence by the hospital and physician leadership (Brownson et al., 2009; Reschovsky et al., 2015). The perceived usefulness by leadership can bias the decision-making process or inclusion of the programs into practice (Brownson et al., 2009; Reschovsky et al., 2015). Hospital leadership consideration of evidence-based practices is also influenced by how it can be imbedded into the existing quality improvement structure within the organizational (Davies and Nutley, 2008; Gnju, 2003; Hoagwood 2003; Mendel et al 2008; Stetler et al, 2008). The leaders ability to champion the adoption of new or current practices is another key component (Davies and Nutley, 2008; Gnju, 2003; Hoagwood 2003; Mendel et al 2008; Stetler et al, 2008).

vi. Early Community Benefit Reporting Challenges
The hospitals faced numerous challenges with the community benefit transition. Recent studies and white papers on hospitals first reporting cycle with the new requirements found that more funding went towards clinical services than community health improvement activities or community building programs (Barnett, 2014). In one national study by Young and colleagues, over 85% of community benefit expenditures were allocated towards patient care services and only around five percent was devoted to community health improvement activities (Young et al., 2013). In addition, community benefit expenditures varied between 1-20% of the hospitals’ organization budget with the majority allocated towards direct patient care benefits (Singh et al., 2015; Young et al., 2013).

Hospitals addressed these requirements in diverse ways due to the lack of specificity in the regulations, the wide range of federal and state provisions and their interpretation of the changes (Young et al., 2013). For instance, hospitals reported that the complex language made it unclear about what activities could be considered as “community benefit” (Rosenbaum et al. 2016). Nine states adopted or implemented supplemental reporting requirements for tax exempt hospitals around charity care and/or community benefits (Nelson et al., 2015).

Another challenge for hospitals in the first reporting cycle was how to engage the broader community members and organizations around the CHNA and IS plans processes (Pennel et al., 2015). There was limited evidence on how tax-exempt hospitals worked with community organizations around the IS plans and incorporated their perspectives and strategies into it. This unknown posed challenged for public health and community organizations on how to coordinate their resources and programming with the hospitals (Rosebaum et al., 2016).
Other challenges hospitals reported faced during this transition period of new reforms were funding shifts, knowledge of population health and evidence-based practices, and lack of staffing to address the changes (Barnett, 2014). The ACA set forth minimal requirements around the IS plans inclusive of community benefit and building details. For community benefit activities, the funding could go towards “financial assistance at cost, losses related to participating in Medicaid, government health programs, health professions education, community benefit operations, research, and a category of services known as “community health improvement” (IRS, 2015). Hospitals could direct funds to support their own hospital operations for health professional education and training or research, such as resident education (Rosenbaum, 2016). Separate from the “community benefit” category, the IRS added Part II “community building,” which included “activities that promote the health of the community it serves” (IRS, 2015; Rosenbaum, 2016). Beyond that, the IRS instructions did not expand the types of evidence or justification needed for hospitals to count programming in this section, leaving it up to interpretation (Rosenbaum, 2016). Some preliminary analysis found that due to the lack of specificity in the requirements, hospitals continued funding or offering existing programs such as health fairs or marketing and categorized these as meeting the new requirements (Rosenbaum et al., 2013; Young et al., 2018). During the first reporting cycle, hospitals ability to redirect federal financial contributions from charity care to community improvement activities was minimal with hospitals allocating less than ~2% of their total revenue to community benefit or building activities (Tahk, 2014).

Other hospital organizational challenges with the new requirements were that the CHNA and IS planning processes were both time and resource intensive. A report from the American Hospital Association stated that hospitals faced staffing challenges based their expertise in
community health, and the social determinants of health to address the needs (American Hospital Association, 2011). While the hospital leadership identified the needs through the CHNA, due to resources constraints, competing priorities and inability to identify effective interventions, many struggled with the implementation (Harvard Law, Center for Health Law and Policy Innovation, 2015).

With any new policies and requirements, such as those proposed around community benefits from the ACA, it is important to explore the factors that influence hospitals to utilize evidence-based practices to ensure the resources are being used effectively. It is necessary to identify the facilitators and barriers that impact these decisions so other hospitals can use this knowledge, support and recommendations to strengthen the quality of programs and activities in the future.

b. PROBLEM STATEMENT AND RESEARCH QUESTIONS

Because IRS Form 990- Schedule H and the Community Benefit requirements were relatively new, little is known about the necessary conditions and factors that drive hospital decision-making to include evidence-based prevention programs in their community IS plans and the facilitators and barriers that influence the processes. This study proposes to explore what factors influence Illinois tax-exempt hospitals to incorporate prevention programs in their community benefit IS plans.

The main research questions for this study are:

1. What factors influence tax-exempt hospitals to incorporate prevention activities into their community benefit IS plans?
2. What *market factors* influence hospitals to incorporate prevention activities into their community benefit IS plans?

3. What *community factors* influence hospitals to incorporate prevention activities into their community benefit IS plans?

4. What *organizational factors* influence hospitals to incorporate prevention activities into their community benefit IS plans?

5. What *hospital and physician leadership* factors influence hospitals to incorporate prevention activities into their community benefit IS plans?

6. What are the *benefits and barriers* for hospitals to address the new requirements and incorporate prevention activities into their IS plans?

7. How have tax-exempt hospitals undertaken prevention activities in their IS plans?

c. **LEADERSHIP IMPLICATIONS AND RELEVANCE**

   i. **Leadership Implications**

   Addressing population health and providing quality community prevention programs are challenges for hospital leadership. Adapting to the new provisions of the ACA, understanding the community needs, and determining the appropriate programs to address, requires balancing several priorities for their organizations, leadership and community organizations. Crucial to this work is understanding the factors that influence the inclusion of prevention programs in order to frame future discussions, training and resources allocated by hospital administrators and community leaders. Effective incorporation of prevention programs that address the community needs includes clarifying the interpretation and expectations that the hospitals have of these new guidelines and prevention in general. Another valuable implication is to understand is how hospitals learned to worked with community partners, such as public health and community organizations. The translated findings can be leveraged for practical solutions and processes to help hospitals and health care systems address their community needs and implement prevention.
strategies to improve health outcomes.

Hospitals are in a position of power to make meaningful community health improvements based on their ability to develop partnerships with community organizations and public health departments to focus on similar initiatives. Considering the resources available, there is a need for hospitals to be strategic in their business decisions and direct funding towards programs that are the highest quality and improve population health. By examining the hospitals approach around there is decision-making processes, the inclusion of evidence-based prevention practices, and community partnerships, there is a need to understand the dynamics impacting these relationships in order to optimize and achieve collective impact. The research suggests that decision-making in hospitals varies greatly across the adoption, initiation and implementation phases due to knowledge, resources, capacity, and state and market factors (Brownson et al., 2009). Greater understanding could enable leaders to prioritize investments and champion evidence-based initiatives to improve population health.

Besides the implications for hospitals, public health department leaders can potentially benefit from a better understanding of organizational and market factors influencing hospitals. This research can highlight strategies for public health organizations on how they frame their work and programs to align with hospitals. Another public health implication is to understand hospitals perspectives around the changes to the community benefit requirements and their organizational adjustments to improve population health. This insight could inform public health on how to serve as better partners and potentially support the hospitals in the future by helping them align with the intended purpose of the ACA and national health care reform efforts.

ii. Relevance and Significance of the Study
The main purpose of this study is to investigate the different factors, facilitators and barriers that tax-exempt hospitals in Illinois have experienced around their community benefit activities for potential population health improvement. It seeks to identify how hospitals viewed prevention and how they have incorporated these strategies and evidence-based programs into their IS plan. The basic understanding of facilitators and barriers could inform other hospitals and generate recommendations for accelerating future practices, processes and programs. The research explored the market, community, organizational and leadership level factors impacting the IS planning process. A deeper understanding around the factors impacting hospitals decisions can contribute to recommendations on how evidence-based prevention programs are incorporated into hospitals future IS plans and the impact on community health outcomes.
II. CONCEPTUAL AND ANALYTICAL FRAMEWORK

a. LITERATURE REVIEW

For the literature review, a systematic approach via PubMed and Google was used to identify and summarize the information pertaining to the research questions, framework and community benefit requirements from grey and peer-reviewed literature. For the grey literature, non-partisan research, advocacy organizations, public health systems and services, and hospital association reports were examined for white papers, technical, project, and focus group reports and national presentations related to preventive services, hospitals community benefit activities and coordination with other agencies in meeting new ACA requirements. When reports were identified, the titles listed in the citations were reviewed for relevance. Additional reports and practice-based research projects were reviewed from the National Coordinating Center for Public Health Services and Systems Research website, the Public Health Services and Systems Research Reference Library and the Hilltop Institute.

There were limited articles on hospitals approaches to population or community health and engagement with the community around the new IRS requirements. Available data on implementing evidence-based programs in hospitals had limited scope around prevention and population health. The research to date was more focused on factors contributing to variations in evidence-based practice in clinical settings, the implementation of these practices in public service sectors and the variation in hospital spending around community benefit activities (Damschroder et al., 2009; Reschovsky et al., 2015; Aarons et al, 2011). Therefore, this review had to expand the focus to include the factors that increased the use of evidence-based programs and practice in the hospital settings and not remain limited to prevention and population health.
This research was important and provided greater context for how hospitals perceive and use evidence based programs and factors that impacted their decision-making.

There are a variety of factors that impact hospital decision-making around the use of evidence based practices and considerations around how organizations adapt, implement and utilize new practices, requirements and interventions (Damschroder et al., 2009; Reschovsky et al., 2015; Aarons et al, 2011). Reschovsky and colleagues developed a conceptual model based on a systematic review focused on factors influencing decision making, including the market environment, network affiliations, the organization and practice site and the physician and care team (Reschovsky et al., 2015). See Figure 1 below. Hospital decisions around the use of evidence-based practices were based on internal and external pressures, which had distinct priorities and could change their relationship with communities. The dynamics that influenced hospitals were complex due to new widespread initiatives at the federal, state and payer level to modify their practice, payment models and functions (Reschovsky et al., 2015). Also, certain network affiliations, including which organizations hospitals partner with that utilize evidence-based practices, the community level characteristics, and communication about these programs influence the decisions to implement them (Reschovsky et al., 2015, Aarons et al., 2011; Glisson and Schoenwald 2005). At the organizational level, some of the sub-factors influencing hospitals decision making included the culture, the infrastructure and resources (Reschovsky et al., 2015, Aarons et al., 2011; Glisson and Schoenwald 2005). At the practice and physician level, leadership, training and perceptions can also influence the use of particular programs (Reschovsky et al., 2015)
For the purpose of this study, multiple frameworks and models were compared and the common factors were considered. All of the frameworks highlighted the multiple levels, phases and players that impact the adoption and implementation of evidence-based programs in the health care setting. To develop the conceptual model and research questions for this study, the most common factors identified in the literature were considered. These included: the 1) *market* – payment and regulatory policies and resources at the state and federal levels 2) the *community* 3) the hospital *organization* and 4) *hospital and physician leadership*. These factors are the more cited ones found in the literature to impact the inclusion of evidence-based practices and hospital decision making. These factors were hypothesized to be relevant to the research questions but not meant to encompass all potential factors that may influence hospitals in their community benefit IS planning processes.

i. **Market, Community, Organizational and Hospital and Physician Leadership Factors**
a. Market

The Market factors included the policies and regulations at the federal, state or local levels that impacted how evidence based practices were advanced or meet resistance (Brownson et al., 2009). The variables that influenced the market environment include but are not limited to various guidelines and incentives towards the use of evidence-based practices and the performance metrics tied to them (Mendel et al., 2008). The various payers and fee schedules also influenced the nature of hospitals practices based on the alignment of incentives and reimbursement rates (Reschovsky et al., 2015). Competing financial resources at the federal and state levels are barriers to the implementation of evidence-based programs (Catalano et al., 2012).

At the broadest level, the market factors have been shown to influence or prohibit evidence-based practices and interventions within the hospital settings (Reschovsky et al., 2015). Research showed that hospitals were sensitive to social and political forces in the market including the ACA, and reimbursement rates standards (Anthony et al., 2014). Health care reform and delivery were changing priorities, funding and decision supports to enhance quality care and improve the health of entire communities (Oostra, 2014).

The ACA provisions increased coverage of preventive services called for education and/or incentives to promote utilization of preventive services and established new performance metrics that rewarded or penalized physicians based on quality and cost (Davis et al., 2011). States that required hospitals to explain the difference in community benefit expenditures showed a drastic difference in spending in their community compared to those who do not report their funding publicly (Rosenbaum et al., 2013). For example, tax-exempt hospitals in Colorado, Wyoming and Vermont spent around 11% of their hospital resources on community benefits
compared to North Dakota with no funding reporting requirements who spent on average 3.75% (Bakken et al., 2014).

Within the market environment, the fiscal resources either supported or hindered hospitals investments in evidence-based programs from the training to implementation (Aarons et al 2011). Both federal and state requirements played a role in hospital practice change including the reimbursement rates, characteristics of payers, level of competition and value-based payment arrangements (Hadley et al., 2014).

b. Community

The community factors have also been shown to impact how the hospital and staff were aware, addressed and collaborated with the community and used evidence-based interventions. The community factors included the community surrounds the hospital and population demographics that influenced the type of programs and the amount that hospitals spent to address their needs (Tahk, 2014). Hospital engagement and orientation with community organizations within their catchment area was also been found to be associated with the inclusion of health prevention programs based on their trust, knowledge of the programs, and infrastructure to support coordination and inclusion (Ginn et al, 2006, Chen et al. 2016).

Many studies showed that hospitals preventive resources varied by geographic location, based on rural and urban environments, and their catchment area (Newhouse et al., 2013). The community location, access and socioeconomic status of the patients that the hospital served impacted how and if the hospital or patients utilized the programs (Tahk, 2014). Also, hospitals have been shown to use funding for community benefit activities based on the demographics and geographic location. For example, if hospitals were in poorer areas, they were likely to provide more charity care than utilizing funding for community programs (Tahk, 2014).
Community stakeholders and coalition preferences had been shown to enhance or impede evidence-based prevention program awareness, adoption and implementation (Spoth et al., 2013). Hospitals that had a strong relationship with community or public health organizations, offered more evidence based prevention programs and supported the implementation of new practices (Damschroder, 2012). Community and public health organizations helped define and developed strategies to address the health issue, besides having a vested interest in the outcomes (Damschroder, 2012). Physician, public health or community organizations and coalitions advocated to the hospitals to address particular needs, provided the evidence to support it and helped accelerate the implementation through training or resources (Brownson et al, 2009). These established relationships supported the sharing of perspectives and inclusion of particular programs of interest.

c. The Hospital Organization

Within the hospital organization, the norms, cultural climate, values and mission were found to encourage or discourage the provision of evidence-based practices (Gershon et al., 2004). The type of the hospital ownership or network affiliation played a role in how new evidence-based practices were determined and operationalized to support clinical decisions (Reschovsky et al., 2015; Reschovsky et al., 2006). Other organizational characteristics that were facilitators or barriers to uptake of programs included knowledge, and training and resources to support new or existing evidence-based practices (Chen, et al. 2016). The clinical infrastructure for the hospital practice including the health information technology and point of care decision support were found to influence the decisions around evidence-based practices (Haynes et al., 1995; Canama et al., 1999; Reschovsky et al., 2015).
Other organizational characteristics of hospitals were important to consider for decision making and to identify the influence around the use of evidence-based prevention programs. These characteristics included the setting, such as large urban or rural, or system type, meaning community-based or academic medical centers, which affected how decisions directions were made (Carroll and Hannan, 1989; D’Aunno et al., 2000). Tax-exempt hospitals distributed the profits in a different way than for profit hospitals by supporting research, underwriting charity care and providing community health improvement programs (Cutler and Morton, 2013; CBO 2006).

Previous studies have showed that the hospitals setting impacted the variation in community benefit programming. Larger hospitals, teaching hospitals and ones located in densely populated urban areas tended to provider more community benefits (Tahk, 2014). Larger hospitals had the capacity to optimize their technology systems to link providers to tools to deliver effective care and to better understand their population health needs (Leavitt Partners, 2016). Also, the size of the hospital impacted the number of individuals within the hospital that are dedicated and trained on population health (Leavitt Partners, 2016).

Organizational characteristics including religious affiliation, community and academic status also effected hospital community benefit activities. Religiously affiliate hospitals were more likely to provide higher beneficial community activity than those without this affiliation (Ferdinand et al., 2014; Ginn and Moseley, 2004). A study from the American Hospital Association found that hospitals knowledge and dissemination of community resources was more common in ones that were part of larger networks, dependent on managed care and in areas with the increased availability of community programs (Proenca et al., 2000).
The hospitals organizational climate affected the use of evidence-based practices, based on their knowledge and skills around the best available evidence, readiness for change and contextual understanding and application (Browson et al., 2009). These variables were fundamental for the organization to use evidence-based practices (Edwards et al. 2000).

The first variable was the knowledge and information of the effective of interventions from various public health resource guides such as the National Prevention Strategy, the Guide to Community Preventive Services and the National Registry of Evidenced-Based Programs and Practices, particularly for the hospital staff (Hausman, 2002; Brownson, 2005). Knowledge of the program often varied based on the leadership, communication and awareness around the differences in definition of evidence based practices (Brownson, 2009). Evidence-based medicine typically included randomized control trials, and rigorous epidemiologic studies, which have taken into account distributional consequences (Sturm, 2002; Mulrow and Lohr, 2001). For public health practitioners that used community level interventions routinely, the evidence was derived from epidemiologic data, program and policy evaluations, qualitative and quantitative data and through a cycle of observation, theory, implementation and evaluation (McQueen et al., 2001). Increased awareness of the different approaches was needed to better share strategies and recommendations across the community, clinical and public health sectors and achieve a shift in the health behaviors (Brownson, et al. 2005; USPSTF, 2014). The benefits included more efficient use of private and public funding, increased access of high quality interventions and a reduction in services that provide minimal value (Hausman, 2002).

The second variable that influenced which evidence-based programs were use practices was the organizational readiness, climate and culture to support and adapt to the change (Maciosek et al., 2001). Intervention decisions were often based on short-term opportunities,
familiar ones, and leadership and competency around new practices (Anderson, 1998; Backer et al. 1995). The hospitals climate receptively of the intervention and the expected capacity for change impacted the use, support and diffusion throughout the organization (Greenhalgh et al., 2004; Klein and Sorra, 1996).

The organization context of the evidence-based intervention considered the community needs, culture and how the programs were viewed and identified (Rychetnik et al., 2004; Allen et al., 2014). For hospitals, shifting from clinical services and screenings to population level interventions was a challenge because the context was less clear and more complex to adapt and implement (Brownson, 2003).

While there were variety of considerations around what that influenced hospitals use of evidence-based practices and decision-making, these variables the most cited in the literature and hypothesized most relevant to this study (Brownson et al, 2009; Damschroder et al 2009). Other factors, not included for this study, highlighted the importance of sharing concepts across sectors and recognizing the contextual differences when thinking about population health. The hospital organizational also had to determine how they worked with their existing values, task and infrastructure to deliver the evidence-based programs (Gershon et al., 2004).

d. Hospital and Physician Leadership

The hospital and physician leadership effected the commitment, involvement and motivation of new practices and their integration evidence-based programs throughout the system (Shortell et al., 2002; Stern and Trajtenberg, 1998). Executive leaders knowledge of population health and evidence-based practices positively influenced the adoption and advancements within the system (Rogers, 2003). Leadership was identified as the driver of
engagement, communication and collaboration to create alignment around population health and how the organizational culture adopted the new practices (Leavitt Partners, 2016).

Hospital leaders, either at the C-Suite level or those charged with the delivery of the community benefit activities, determined use of resources in broader population health initiatives. The long-term success of hospitals approaches to population health included a flexible and adaptive leader who engaged others and created common goals for the organization to shift from costs and utilization to quality and improvement in health outcomes (Leavitt Partners, 2016). Hospital decision-making has been influenced by array of factors including their clinical knowledge, motivations, and their perceptions of evidence-based practice and population health (Stern and Trajtenberg, 1998). Hospital adoption was based on their leaders staying up to date on the best available science, understanding the needs of the population in their catchment area and determining what programs would work within their population and throughout the hospital (Brownson et al. 2009).

Hospital and physician leadership use of evidence-based practices were influenced by the time they used to seek out current literature and programs, their ability to address other competing priorities and to act as change agents and to influence staff within their organization (Damschroder et al., 2009). The leaders championed and drove effective implementation and demonstrated their commitment to quality (Damschroder et al., 2009). However, this required them to be innovative and create the need for a change, engage the hospital staff in the process and determine how to align the existing organizational goals to allocate resources and action across the system (Pettigrew et al., 2001).

The factors impacting the adoption and implementation of evidence-based practices were complex and involved knowing how stakeholders at the various levels interacted and made
decisions to improve population health. The multifaceted dynamics consisted of interacting and unique variables that led to changing the traditional clinical approach.

b. CONCEPTUAL FRAMEWORK

i. Public health frameworks and models

The Institute of Medicine (IOM) stated that in order to address the health problems of the country, the United States needed to focus less on individuals’ treatment and shift to utilize a population health approach (IOM, 2003). Evidence from the Centers for Diseases Control and Prevention (CDC) showed that public health strategies reached and achieved greater health improvements and were cost effective than our current investments (Frieden, 2010). Due to the rising health care expenditures in the US, new approaches were needed to achieve better results and to reflect a broader population perspective (IOM, 2013). Public health approaches included looking beyond clinical interventions and identifying the risk factors to prevent diseases, such as obesity and human papillomavirus and developing multi-pronged approaches (IOM, 2013). The majority of advancements in life expectancy in the US in the last 30 years were from public health initiatives that prevented people from getting diseases including immunizations, sanitation and food safety, and controlling the risk factors, including preventive screenings, smoking, high blood pressure, and high cholesterol (IOM 2013). The main challenges that our country continues to face in the 21st century are from chronic diseases including heart disease, cancer and diabetes that drive 75% of our health care spending and nearly seven of every 10 deaths (CDC, 2013). The majority of these health problems were preventable and required a public health approach and partnering between public health and health care (IOM, 2003, CDC, 2013). Preventive services have been shown not only to benefit the individuals who receive them but
also the communities in which they live, work and play through improvements in overall well-being and productivity (CDC, 2013).

Traditionally, the uptake of preventive services, such as cancer screening, and immunizations, by the clinical sector were due to insurance coverage, or other incentives around quality metrics (Sanghavi and Conway, 2015). Some hospitals were influenced to focus on prevention by public health and community organizations partnering with them to prioritize the community issues, promoting public messaging or developing a community health improvement plans (CDC, 2013). Others pursued prevention as part of their larger goals and efforts around value-based payment reform, or due to state and federal requirements including State Health Improvement Plans and the State Innovation Models (Silow and Carroll, 2013).

With this context in mind, there were challenges that hospitals face in shifting to public health approaches. The majority of the published literature around population approaches comes from the public health discipline rather than clinical or academic research, with more information on the uptake of preventive programs and practices by health departments and community-based organizations rather than by hospitals. From a hospital perspective, there are also challenges to working with community organizations and public health agencies around prevention including time, contracting, coordination and lack of financial incentives (Ginn and Lee, 2006).

In order to shift to a population health approach, it is important to consider that hospitals operated as part of a larger system and decision making around evidence-based prevention practices for their community benefit activities is influenced by a variety of factors. The inclusion, adoption and implementation of evidence-based practices occurs across various levels and settings and with different contextual frames interacting influencing it (Glasgow et
Both the Health Impact Pyramid and the Socio-Ecological frameworks describe how to enhance public health interventions by considering the larger systems that can support it (Spoth et al., 2013). These two frameworks required an examination around the individual, organization, and systems while considering the broader determinants of health and the community setting in which the hospital operates (Trickett, 2009).

ii. Health Impact Pyramid

The former CDC director Dr. Tom Frieden developed the Health Impact Pyramid framework that highlighted the benefits of population health inventions compared to individual ones. The framework aimed to identify strategies and interventions that had the greatest impact and ascending levels with a reduction in impact representing primary, secondary and tertiary care (Figure 2) (Frieden, 2010; Monroe 2011). For example, if hospitals aimed to “Change the context to make the healthy choice the easy choice,” such as tobacco free workplace policies, it would impact a greater percentage of the population with less resources than individual health behavior counseling on tobacco cessation (Frieden, 2010). Clinical and health education interventions played a role in improving population health but Health Impact Pyramid recognized that implementing community and policy change impact a larger population and reinforce behavior changes to maximize the synergies and increase the likelihood of long term improvements in health outcomes (Frieden, 2010).
iii. Socio-ecological Model

For this study, the socio-ecological model was considered to think about the various factors that influenced population health (See Figure 3) (WHO, 2005). This model emphasized the interactions between five levels that contribute to health problems due to a complex relationship at the individual, relationship, community, societal and policy level. The overlap between the levels demonstrated that factors at one level had a dynamic influence on the factors at the other (CDC, 2013).

![Figure 3. The Socio-ecological Model.](image)

While these were just a few of the population health models or frameworks identified in the literature, they both highlighted the importance of involvement, integration and engagement between individuals, health care system, communities, public health and the environment to address complex issues. These frameworks helped shape the conceptual model for this research.
by incorporating key factors and levels that may influence hospital decision-making around population health and their community benefit activities.

iv. Conceptual Framework

The conceptual framework was comprised four major factors, including the market, the community, the hospital organization, and physician and hospital leadership (See Figure 4). The factors described offer an explanation of the internal and external influences that may provide information to answer the research aims. These factors were identified based on the literature surrounding the adoption and implementation of evidence-based research within the health care setting and around hospital decision-making and by a review of public health frameworks. The primary focus for this study were the hospitals. The conceptual framework included the specific factors and the potential influence on the hospital organization around the development of their IS plans.

This conceptual model emphasized the role of external influences on hospital organizations, including the market and the community factors, which includes federal and state policies, and the community where the hospital was located and the potential means that the hospitals adapted their practices (Scott et al., 2000). This study sought to identify the ways in which hospitals incorporate prevention programs into their community benefit activities and understand how internal organization and hospital and physician leadership factors affected this process.
In summary, there were multitude of factors that impact how hospitals identified and implemented new evidence-based practices and the decision drivers. Based on the literature review, there was little information around how hospitals identified and implemented prevention programs and their population health approaches, particularly around meeting their community benefit requirements. There was also a gap in the research around the factors and decision drivers that influenced the inclusion of evidence-based prevention programs by tax-exempt hospitals in community benefit implementation plans. With the shift to focus on prevention and broader population health approaches, tax-exempt hospitals have the opportunity to shift their

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c. SUMMARY

In summary, there were multitude of factors that impact how hospitals identified and implemented new evidence-based practices and the decision drivers. Based on the literature review, there was little information around how hospitals identified and implemented prevention programs and their population health approaches, particularly around meeting their community benefit requirements. There was also a gap in the research around the factors and decision drivers that influenced the inclusion of evidence-based prevention programs by tax-exempt hospitals in community benefit implementation plans. With the shift to focus on prevention and broader population health approaches, tax-exempt hospitals have the opportunity to shift their
programming focus from charity care to determining how to deliver population-based benefits to their communities. As the first reporting cycle demonstrated, tax-exempt hospitals were addressing the needs of their communities differently with various resources and activities (Tahk, 2014). It was essential to determine which factors influence hospitals decisions to focus on prevention to identify any characteristics associated with it (Tahk, 2014).
III. STUDY DESIGN, DATA AND METHODS

a. ANALYTICAL APPROACH

To understand the impacts of the new IRS community benefit requirements on tax-exempt hospitals, this study used a qualitative case study research design. Illinois was selected as a case for this study with a purposeful sampling using select hospitals as embedded units of analysis. Illinois was one of the few states that mandated the public reporting of community benefit IS plans. This study aimed to identify contextual information on the market, community, organizational, and leadership factors that effected how hospitals responded to the community benefit requirements and if they shifted their funding and programs towards more preventive services and activities.

The methods comprised a two-phased approach including: 1. Interviews with hospital stakeholders involved in the planning and decision-making process for the community benefit IS plans; and 2. Content analysis of selected hospitals CHNA, IS plans and other relevant documents including community benefit meeting notes and reports. The case study research design provided an opportunity to investigate a variety of factors that influenced hospitals to include prevention initiatives in their IS plan (Yin, 2009). The study design was an embedded single-case study as depicted in Figure 5 (Yin, 2009). The study aimed to explore the experiences and perspectives of multiple hospitals in Illinois as they adjusted to the new requirements and a case study design with embedded units was an appropriate design for this research. By looking at multiple tax-exempt hospitals as embedded units, this study approach allowed for in-depth examination of this phenomena and identification of strategies for incorporating prevention programs into IS plans that may be useful for tax-exempt hospitals in the future (Yin, 2009).
A qualitative case study research design provided the best methodology necessary for exploration of a new phenomenon while examining the multifaceted dynamics occurring within the hospitals as they addressed these new requirements (Patton 2002; Yin, 2009). The effects of the new community benefit requirements on hospitals were largely unknown and there were not any existing taxonomies describing the status of their IS plans or programs.

This study examined selected hospitals using a stratified purposeful sampling approach, which was relevant for exploring contemporary events, complex phenomena and when the
researchers did not have control over actual behavioral events (Yin, 2009). According to Creswell, a stratified purposive sample was part of a qualitative case study design and was appropriate when exploring a new phenomenon and to capture variations based on qualities of interest (Creswell 2013). The hospitals were in a state of flux after transitioning their traditional community benefit activities to meet the new requirements. The study design aimed to help with the detection, exploration and categorization of the experiences of a variety of hospitals around the development IS plans and the factors that impacted the inclusion of prevention programs.

Yin stated that it was appropriate to use qualitative research to answer the “why” and “how” questions and to uncover the contextual factors that maybe relevant to the study, specifically for this study the hospital setting and an understanding of how the decision-making occurred (Yin, 2009). Therefore, hospital stakeholder interviews allowed for the discovery of experiences, such as organizational processes and social interactions, around how certain activities were incorporated into the IS plans based on the staff and key decision-makers perspectives. According to Patton, these types of organizational dynamics would be difficult to measure quantitatively (Patton, 2002).

The combination of content analysis through semi-structured interviews and document reviews of the IS plans aided in the understanding of the factors impacting hospitals community benefit planning approaches and helped to expand on existing conceptual frameworks (Patton, 2002). The conceptual framework for this study (Figure 4) was comprised of four key factors that based on the literature were associated with the inclusion of evidence-based practices and impacted hospital decision-making. This framework provided context and support for the main research questions of this study. There were no studies or frameworks available to review that
focused on factors influencing the inclusion of prevention programs by hospitals specifically around their community benefit activities.

**ii. Study Setting**

This study took place in Illinois, which is a state in the Midwestern region of the United States. At the time of the study, it had approximately 12.8 million residents and the fifth most populous state, which included Chicago metropolitan area in the northeast with approximately 65% of the states’ residents. There were seven other cities in Illinois with populations over 100,000.

According to the Illinois Health and Hospital Association (IHHA), Illinois hospitals were responsible for maintaining the health and well-being of the 12.8 million residents. In 2016, Illinois had 222 hospitals that had a range of classifications from community hospitals to nationally ranked academic medical centers and specialty hospitals (IHHA, 2016). The hospitals provided health care for private and government payers including Medicare and Medicaid, which accounts for 40% and 16%, respectively, of hospitals’ patient revenue (IHHA, 2016).

**iii. Study Selection**

Illinois was one of a few states that adopted new standards and requirements for tax-exempt hospitals between 2003 through 2014 (Hilltop Institute, 2015). These requirements included establishing mandatory minimum community benefit requirements for tax-exempt hospitals, adopting stricter reporting requirements around filing annual reports with the Attorney General to enhance transparency for their tax-exemption status, and developing and publishing a community benefit implementation plan (Folkemer et al., 2011; Ill. 35 ILCS 5/223(a), 2012). However, the impact of these requirements and how hospitals were addressing the community
needs in their IS plans were largely unknown. These unique requirements for community benefit transparency and reporting set Illinois apart from other states.

The focus of the study utilized a purposeful sampling approach based on diverse group tax-exempt hospitals in Illinois. In 2016, while there were currently 222 hospitals in Illinois. Certain hospitals were excluded from this study because of the state’s Community Benefit Plan laws, including: “government hospitals; hospitals located outside of a metropolitan statistical area, and hospitals with 100 or fewer beds” (IHHA, 2016; Ill. 210 ILCS 76/5, 2003). In 2012, the first year in which the new ACA requirements were enacted, 93 Illinois hospitals filed their IRS Form 990- Schedule H.

iv. Site Selections

The first phase of the hospital selection was based on spending from IRS Form 990-Schedule H. Hospitals spending was identified by looking at the percentage of financial revenue allocated toward community benefit and community building activities, over the total hospital revenue according to 2012 IRS Form 990- Schedule H. The funding percentage allocated towards charity care was excluded. The spending range varied between 0-14.68%. This range was divided into terciles to characterize the hospitals as low, medium and high spenders. Because no previous audits or information was available to determine what or how hospitals were incorporating prevention activities in their community benefit plans, spending was used as a proxy for initial selection purposes.

The second phase used for hospital site selection was the State Plan Index (SPI) quality score of the hospitals community benefit IS plans. The SPI tool was developed by the CDC to evaluate the quality of state’s strategic plans and the relevant action steps around the prevention
of chronic diseases. Because the IRS guidance around community benefit requirements was broad, the quality of the IS plans was expected to vary drastically. Therefore, the SPI tool was used for an initial assessment of the quality of the plans. The tool had nine components, with 60 items and utilized a 5-point Likert type rating, with responses for each item, from 1 = low quality to 5 = high quality and a rating option of “not addressed” (Butterfoss and Dunet, 2005). The tool examined components in plans such as structure, identification/prioritization of issues, clear goals, measurable objectives, and evidence-based strategies (Butterfoss and Dunet, 2005). The rationale to use the SPI tool was that high quality IS plan scores may mean higher quality evidence-based programs and practices, which ultimately contribute to community health improvements (Dunet et al., 2005). This tool was previously used in another study to assess the quality of the CHNA in Texas and the involvement of external community stakeholders (Pennel et al., 2015).

The third phase for site selection was the hospitals demographic information including location, size and teaching status. The hospital location was considered because past research showed hospitals in urban location providing higher funding to community benefits activities (Tahk, 2014). Other characteristics assessed were teaching status and hospital size. Teaching status was considered because previous studies indicated academic medical centers were more likely to be innovative and adopters of evidence-based practices and had more resources to respond to community needs (Cutler and Morton, 2013; Michener et al. 2012). The final demographic characteristic used was hospital size because larger organizations typically had greater resources to commit to support the adoption new approaches (Damanpour, 1991). The categorization of hospitals including the size, location, and teaching status was defined by
Centers for Medicare and Medicaid Services and published by the IHHA. An overview of considerations for site selection were depicted in Table II below.

<table>
<thead>
<tr>
<th>Documents</th>
<th>Content analysis</th>
</tr>
</thead>
</table>
| Phase 1: IRS Form 990-Schedule H for tax year 2012 | 1. Community benefit expenditure (Total amount spent on community benefit activities over the total operating expenses)  
   a. Low spending (0-5%)  
   b. Medium spending (5.01-10%)  
   c. High spending (10-14.68%)  
2. Excluded funding spent on charity care |
| Phase 2: Community Benefit Implementation Strategy Plans and Community Hospital Needs Assessment | 1. State Plan Index tool: topics examined and scored based on the criteria include:  
   a. Organizational structure/ Personnel  
   b. Partner/stakeholder involvement  
   c. Identify/Prioritize Issues  
   d. Identify Assets/ Resources  
   e. Clear Goals/ Measurable Objectives  
   f. Action Plan/ Strategies to Address Issue  
   g. Evidence Based Strategies  
   h. Description of the process  
   i. Evaluation |
| Phase 3: Hospital Demographic Information (IHHA, 2016) | 1. Demographic characteristics of hospitals  
   a. Geographical location (Large urban, other urban, rural)  
   b. Teaching Status (Major teaching, other teaching) |

Although other variables could have been utilized for the site selection, previous studies showed no effect on spending on socioeconomic status of the patient populations, inclusive of income and poverty level, and the level and pattern of community benefit expenditures (Young, 2013). This purposive stratified approach and selection of contrasting hospitals included in this sample potentially added confidence to the findings and might explain the differences in hospital activities (Patton, 2002).
b. DATA SOURCES, DATA COLLECTION & MANAGEMENT

For this study, the main sources of data were collected from qualitative semi-structured interviews, documents, and archival reports and records to help answer the research questions. Measurement tables that aligned with the conceptual framework were used to aid the data collection processes (Appendix 1).

The study was approved by the University of Illinois at Chicago Institutional Review Board in January 2017. The approval included the research protocol, semi-structured interview guides, and consent scripts. The risk to human subjects was expected to be minimal and qualified as an expedited review (Appendix 7).

i. Data Sources and Collection

a. Document review

The documents reviewed for this study were collected in two phases. Phase one included gathering all publicly available community benefit IS plans were from the participating hospitals websites. For phase two, supplementary documents provided by the key stakeholders interviewed were included. At the end of interviews, key stakeholders were asked if they could share additional information including planning documents, meeting minutes or project charters that better inform the study objectives. Patton stated that document reviews provided information about things that may not be observed and helped to elicit new meaning and develop empirical knowledge (Patton, 2009). The purpose for document review were to collect additional data sources and identify contextual information around the IS planning process. Additional documents that were incorporate included:
• Planning documents around the development of implementation plans, including project charters clarifying the review process, roles and responsibilities, timelines, external partners involvement, meeting agendas, and work plans

• Community Hospital Needs Assessments- to identify the community needs, community organizations and members mentioned, and other relevant contextual information

b. Interviews

To gather a deeper understanding of the particular context around the community benefit IS planning and decision-making processes, key stakeholders from the selected hospitals were interviewed (Maxwell, 2013). Semi-structured qualitative interviews were determined the best for eliciting the hospital leadership and staff perspectives and experiences on the community benefit IS plan process (Maxwell, 2013). The semi-structured interviews allowed for a deep exploration of the research questions including key factors from the literature associated with hospitals decisions around the inclusion and implementation of evidence-based practices.

c. Interviews Selection Criteria

Interviews were conducted with key stakeholders who reported active roles in the community benefit planning process and served in leadership, director or manager roles at their hospitals. The stakeholders interviewed were involved in the planning, developed, management or decision making around the community benefit IS planning process (Maxwell, 2013). At the close of interviews, stakeholders were asked if they had recommendations for other individuals within their organization to contact and for their information. This snowball sample technique
was used to identify additional key stakeholders to participate in the study. Interviews were conducted with stakeholders who meet one of more of the following criteria:

- **Hospital Leadership** involved at high level in review or decision-making around the IS plans or community benefit activities. These individuals participated in planning committees, board meetings or workgroups to review the assessment data, finances, programs and outreach strategies. These individuals included Chief Operating Officers, Chief Financial Officers, Chief Nursing Officers, Executive Directors, or Vice President of Strategies.

- **Hospital Directors** involved in the oversight or development implementation of strategies or activities that evolved from the community benefit IS plan. These individuals had a role in prioritizing and directing the program efforts. These individuals included Directors involved in the following roles CHNA Steering Committee Members, Public Relations, Marketing, or External Affairs.

- **Community Benefit Managers/ Coordinators** involved in the day to day operations around community benefit, facilitated, coordinated, or participated in the IS processes. These individuals were charged with the development, execution and staffing around the community benefit activities and included managers and program coordinators of Community Services, Community Benefit, and Community Affairs.

### d. Interview Guide

A semi-structured interview guide aided in the discussion that addressed the various factors of interest that could impacting community benefit IS plans, including the benefits and barriers to the hospitals (Appendix 4). The interview guide was based of the research questions and conceptual framework but allowed for additional questions to be explored based on issues
that arose throughout the interviews.

The interview guide was pilot tested in February 2017 with a hospital stakeholder in a community benefits project leader role at a large health system in Illinois. The pilot interview was excluded from the study sample. The purpose of this pilot test was to assess the guide for flow, clarity, completeness, and length of the interview. The input lead to the inclusion of additional prompts.

e. Interview Procedures

A list of potential stakeholders was identified based on the contact information included on the CHNA and IS plans. These stakeholders were recruited through an introductory email that detailed the overview of the study, the roles in the community benefit process and the voluntary nature of the study (See Appendix 2). If the initial email outreach was unsuccessful, a follow up email and phone call were used. If a hospital stakeholder agreed to participate via email or phone, a consent form was emailed to them for review (See Appendix 3).

All interviews were conducted by telephone. The study’s purpose, objectives, the stakeholders’ role in the IS plan process and informed consent were reviewed at start of each interview. The consent was signed or orally agreed upon prior to the start of the interviews. The consent forms highlighted that no individuals or hospital names would be used in association with this final report. All interviews were recorded via Webex and transcribed verbatim. The interviews lasted between 33 minutes to 58 minutes. Stakeholders were send the copy of the transcriptions to validate their response. Only one confirmed they reviewed the transcript.

f. Summary

The initial intent was to conduct between 18-30 semi-structured interviews with six hospitals (3-5 per hospital). Out of 30 hospitals who were invited to participate in an interview,
13 hospitals responded. A total of 19 key stakeholders interviews were completed. The target to identify six hospitals to participate was made using the selection criteria. However, the approach was revised based on the hospitals interest in participating in the study and the limited number of hospitals stakeholders that worked on community benefit IS plan at each the hospitals. Despite the goals to interview three to five hospital stakeholders per hospital, the majority of the stakeholders indicated that they only had one to two individuals working on community benefits and/or did not recommend other colleagues to participate, limiting the potential depth of the embedded units. As a result, the number of hospitals invited to participate in the study was expanded, utilizing selection criteria previously described.

g. Memos

Memos were generated upon completion of the interviews and after reviewing the IS plans and other documents to capture reflections throughout the data collection, transcriptions and analysis processes. They included contextual insights, observations, themes and noted any biases the researchers felt throughout the study.

The memos were included as part of the analysis for the key informant interviews and were incorporated into ATLAS.ti. Detailed notes were taken during the interviews and used to developed memos following each of the interviews. Memo notes were created in Microsoft Word and used for additional guidance around the interpretation of the interviews. Additional memos were generated by the two researchers as they reviewed and coded the transcripts and noted emerging themes and patterns.

i. Data Management

A table was developed in Microsoft Excel to list all of the various sources of information that were collected. The table was created to track and log all documents, with a detailed
description of it, the source, type, hospital, and date, noted in Table III. The documents and interview transcripts were given a unique id.

The hospital stakeholder interviews were transcribed verbatim and typed into separate word documents. All of the data were coded with a numeric identifier, including the dates and stored on a IBM Thinkpad laptop and MacBook Pro that were password protected. All original data, consent forms and memos were saved and scanned and securely stored electronically for back up. The interviews transcriptions, documents and memos were uploaded into ATLAS.ti 7.5 for backup storage and analysis.

<table>
<thead>
<tr>
<th>Table III: Data Sources and Management Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID Number</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>1.1</td>
</tr>
<tr>
<td>1.2</td>
</tr>
<tr>
<td>1.3</td>
</tr>
<tr>
<td>1.4</td>
</tr>
</tbody>
</table>

c. DATA ANALYSIS PLAN

The data analysis was done in several steps. The analysis for qualitative data and the document review included reviewing and organizing the data by noting major themes and patterns, developing summaries and coding it. After this phase, the data displays were developed to show the relationships and confirm conclusions. Following this initial analysis of all of the data and embedded units, across cross case analysis was completed. Table IV identified the analysis approach for each data source.
Table IV: Data Analysis Approach

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Analysis Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implementation Strategy plans (n=13)</td>
<td>Theme the data (manual review, ATLAS.ti)</td>
</tr>
<tr>
<td></td>
<td>Pattern matching analysis (ATLAS.ti)</td>
</tr>
<tr>
<td>2. Semi-structured Interviews (n=19)</td>
<td>Paired analysis (manual review, second coder)</td>
</tr>
<tr>
<td></td>
<td>Theme the data (manual review, ATLAS.ti, second coder)</td>
</tr>
<tr>
<td></td>
<td>Pattern matching analysis (ATLAS.ti)</td>
</tr>
<tr>
<td>3. Other documents (Annual reports, CHNA, meeting minutes)</td>
<td>Theme the data (manual review, ATLAS.ti)</td>
</tr>
<tr>
<td></td>
<td>Pattern matching analysis (ATLAS.ti)</td>
</tr>
</tbody>
</table>

i. Document Review Analysis

The documents publicly available and those provided by the key stakeholders were manually coded and followed by pattern matching in ATLAS.ti. The initial documents were coded using a codebook that aligned with the research questions (See Appendix 5). The documents reviewed provided additional contextual insight and were analyzed for themes and patterns. The documents were reviewed by both researchers to ensure no key themes were missed and miscoded.

ii. Semi-Structured Interviews Analysis

a. Codebook

The data from the semi-structured interviews were analyzed using varies steps and based on deductive and inductive coding scheme. The first step was to develop an initial codebook with
themes based on the conceptual model and from the literature (See Appendix 5). An inductive coding scheme was used to include emerging codes from the data that were added to the initial code book. Inductive codes were ones that emerge from frequent, dominant or noteworthy themes from the interviews (Strauss and Corbin, 1998). New emerging codes were added after reviewing the transcripts and they were discussed and agreed upon by both researchers. The codebook was updated to reflect these changes based on the priori and deductive codes.

b. Coding protocol

A coding protocol was developed to ensure the reliability of the interview analysis. This included a review of the a priori codes and having two coders review all transcriptions. Prior to reviewing any interviews, the coders agreed that only full sentences would be coded.

c. Inter-Coder Reliability

The second coder was a doctorate level researcher with an experience in qualitative and quantitative research. The primary researcher and the secondary coder both had experience using ATLAS.ti. The two researchers selected three interview transcripts and one IS plan to manually test the codebook and protocol. The purpose was to test the priori codes, determine what was relevant, assess the consistency between the coders and see if the protocol needed to be updated. Refinements were made after based on this test. After this, the researchers manually coded all interviews with the updated codebook. This step was followed by coding the interviews using ATLAS.ti. The researcher reviewed the interviews by the second coder to identify similarities and differences. Where differences were identified, the two discussed the code until agreement was reached. ATLAS.ti did not allow to the calculation of inter-coder reliability.

d. Memos
Another aspect of the protocol was to memo during or after the process and note if context was needed for particular sentences or sections. Memoing was also used if one of the coders identified a potential new code (Miles and Huberman, 1994).

e. Codes and sub-codes

After the first review cycle of the data, the data was categorized into large bucket codes or sub-codes first manually then using ATLAS.ti. This helped identify any relationships, categories or themes within the hospitals. The hospital types were grouped into various categories, i.e. Large academic hospital, rural hospital prior to conducting pattern matching.

iii. Within and Cross-case Analysis

For within and cross-case analysis among the hospitals, a query was run to determine the frequencies among the codes. The results were initially analyzed based on the research questions to examine the patterns. Pattern matching was performed to predict themes among specific variables and to investigate similarities or difference among the hospitals. The frequencies of the codes were also analyzed by using the network views to visually display co-occurrences between the codes and identify opportunities to investigate concepts in more detail.

In addition, a summary table of the findings was developed to show the cross cutting themes among the hospitals based on the major factors of interest and compare them side by side (See Appendix F). This table helped identify the patterns from the key stakeholder interviews and the IS plans and examine the variabilities among them.

d. VALIDITY & RELIABILITY CONSIDERATIONS

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As stated by Yin and Levy, qualitative research should consider the construct, internal and external validity, and the reliability to assess the conclusions being drawn. To assure construct validity, multiple sources of evidence were used including documents, IS plans, IRS Form 990- Schedule H reports, and semi-structured interviews (Yin, 1994; Levy 1988). A second coder helped minimize internal validity concerns by assisting with coding and utilizing codebook and protocols when reviewing the data. Internal validity was lessened by having a detailed process for site selection and a defined codebook. External validity was enhanced by doing a stratified purposeful sample design with the 13 hospitals serving as embedded units to allow for more generalizability (Yin, 1994). To ensure the overall reliability of the study procedures and findings, a formal study protocol was used for replication for data collection for the 13 participating hospitals (Yin, 1994). To ensure internal reliability, all of the documents and interviews were reviewed a minimum of two times. The second researcher aided in coding for review and consistency and confirmed by checking the intercoder reliability. Member checking, inclusive of providing stakeholders with copies of their interview transcripts for review and clarification, helped ensure the accuracy and credibility of the data.
IV. RESULTS

a. OVERVIEW

This chapter first describes the characteristics of the participating hospitals in the study. The study results are presented by the research questions, including emerging themes. The questions were:

1. What factors influenced tax-exempt hospitals to incorporate prevention activities into their community benefit IS plans?

2. What *market factors* influenced tax-exempt hospitals to incorporate prevention activities into their community benefit IS plans?

3. What *community factors* influenced hospitals to incorporate prevention activities into their community benefit IS plans?

4. What *organizational factors* influenced hospitals to incorporate prevention activities into their community benefit IS plans?

5. What *leadership factors* influenced hospitals to address the new requirements and incorporate prevention activities into their community benefit IS plans?

6. What have been the *benefits and barriers* to incorporating prevention activities into their community benefit IS plans? And

7. How have tax-exempt hospitals undertaken prevention activities in their IS plans?

i. Analysis Process
The results were developed using the outlined steps presented in Figure 6. Content and thematic analysis were identified from manual reviews and ATLAS.ti. Data gathered from the IS plans, document reviews and the stakeholder interviews were part of the analysis. Additional details regarding the analysis processes were noted in Chapter 3.

**Semi-Structure Interviews Analysis Steps**

- Conducted semi-structured interviews with hospital stakeholders (n~19)
- Developed transcripts and member checked with hospital stakeholders interviewed (n~19)
- Both researchers manually coded transcripts, assessed consistency, added emergent codes and updated code book
- Both researchers memoed independently on themes, connections and relationships
- Researchers reviewed and discussed codes, themes and memos
- Researchers conducted pattern matching and identified large bucket codes, sub-codes and themes and conducted pattern matching in ATLAS.ti
- Developed network views in ATLAS.ti to identify additional relationships, themes or patterns
- Researchers developed additional memos together for analysis

**Document Review Analysis Steps**

- Review IS plans (n~13), CHNA (n~13) and supplimental documents (~n=2)
- Developed transcripts and member checked with hospital stakeholders interviewed (n~19)
- Both researchers manually coded transcripts, added emergent codes and revised code book
- Both researchers memoed independently on themes, connections and relationships
- Researchers reviewed and discussed codes, themes and memos
- Researchers conducted pattern matching and identified large bucket codes, sub-codes and themes and conducted pattern matching in ATLAS.ti
- Developed network views in ATLAS.ti to identify additional themes or patterns
- Researchers developed additional memos together for analysis
A code book was developed with a priori concepts and tested manually by the two researchers on the first three hospital interview transcripts and one IS plan (See Chapter 3). Through the duration of the analysis, codes emerged and after discussion and consensus between the two researchers, addition codes were added. The codebook was updated to include emerging codes.

b. ANALYSIS RESULTS

i. Characteristics of Study Sample

The state of Illinois was a single case study with 13 selected hospitals participating as embedded units. The hospitals included are described in Table IV. In 2012, 93 hospitals in Illinois submitted their IRS Form 990- Schedule H and met the study sample initial selection criteria (See Figure 6).

One large health system, with nine hospitals, was excluded from the study because the Vice President of Community Outreach served as an advisor for this research. The 84 remaining hospitals were categorized by spending. Spending was based off the IRS Form 990- Schedule H from 2012, the first-year hospitals had to comply with the new IRS requirements. In 2012, of the 93 hospitals that submitted their reports to the IRS, on average 3.09% of their total revenue was allocated to community benefit and building activities, excluding charity care. The range of
spending varied between .01-14.68% Seventy eight percent of hospitals spending fell with the low range of 0-5% (n=73), followed by medium spending within the 5.01-10% (n=15) and high spending 10.01-14.68, (n=6).

After using the community benefit spending for the initial hospital site selection, the hospitals IS plans were evaluated based on the SPI tool. The SPI tool assessed the quality of the IS plans based on an existing scoring criteria developed by the CDC. A 5-point Likert type tool, (1=not addressed; 5=high quality, with an additional “Not Addressed” option for each item), identified the quality of the plan based on nine components (see Chapter 3). The mean score was 2.19 out of 5.0. Of the nine components, the Presentation of Data on Disease Burden was ranged highest (3.1) and the Use of Evidence Based Strategies was one of the lowest (1.21).

A purposeful sample of 30 hospitals were identified to participate based on spend and SPI tool score. Ten low spending hospitals were invited to participate with five having a low SPI score and five having a high SPI score; ten medium spend hospitals were invited to participate with five low SPI scores and five high SPI scores and ten high spend hospitals were invited to participate with five low SPI scores and five high SPI scores. Hospital selection was also based on location (rural and urban) and by teaching category as defined by the Centers for Medicare and Medicaid Services and reported by the Illinois Health and Hospital Association (IHHA, 2017). See Figure 7.

Up to two email invitations were sent to the 30 hospitals introducing the study with a request to participate in a 45-60-minute semi-structured interview. One additional telephone call was made to hospitals if the initial email outreach efforts were unsuccessful. A total of 13 hospitals participated between February 2017 through June 2017, with a 43% hospital response rate. After consent was provided, the interviews were conducted, recorded and then transcribed.
Microsoft Word and Excel and ATLAS.ti were used for organization, analysis and coding the transcriptions among the two researchers.

- Hospitals that submitted their IRS Form 990- Schedule H and had a publicly available IS Plan in 2012
- Hospitals eliminated due to an affiliation with principal investigator research team
- Number of hospitals invited to participate in the research.
- Number of hospitals that participated
- Number of hospital stakeholders interviewed between February - June 2017.

Figure 7: Hospital Embedded Unit Selection

**ii. Characteristics of Participating Hospitals**

Of the 13 participating hospitals, seven fell into the low spend category (.01-5.0%). Eight hospitals were large urban hospitals, four were other urban hospitals and one was a rural hospital. Eight were major teaching hospitals and four had no academic affiliation. Table V provides a description of each of the hospitals that participated in the study.

<table>
<thead>
<tr>
<th>Hospital Site</th>
<th>Percentage of Community Benefit and Community Building Spend</th>
<th>Quality IS Plan Score</th>
<th>Size/Geographic Location</th>
<th>Teaching Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital 1</td>
<td>11.6 %</td>
<td>2.65</td>
<td>Large Urban</td>
<td>Major Teaching</td>
</tr>
<tr>
<td>Hospital 2</td>
<td>14.50 %</td>
<td>2.63</td>
<td>Large Urban</td>
<td>Major Teaching</td>
</tr>
<tr>
<td>Hospital 3</td>
<td>6.11 %</td>
<td>2.26</td>
<td>Large Urban</td>
<td>Major Teaching</td>
</tr>
<tr>
<td>Hospital 4</td>
<td>4.72 %</td>
<td>3.01</td>
<td>Large Urban</td>
<td>Major Teaching</td>
</tr>
</tbody>
</table>

Table V: Hospital Sites by Spend, Quality Score, Size/Geographic Location and Teaching Status
### Definitions:

1. **Community Benefit - Percentage of spend**
   - a. Hospital percentage of spend allocated towards community benefit and building activities, excluding charity care.
   - b. Based on the hospitals 2012 IRS Form 990- Schedule H Form 990

2. **Quality Score of IS Plan**
   - a. Based on 5-point Likert type tool utilizing the State Plan Index

3. **Location**
   - o **Large Urban** - hospitals located in Metropolitan Statistical Areas with greater than one million people
   - o **Other Urban** - hospitals located in Metropolitan Statistical Areas with a total population less than 1,000,000
   - o **Rural** - hospitals not located in a Metropolitan Statistical Area

4. **Teaching Category**
   - o **Major Teaching** - hospitals having 100 or more interns and residents or with a ratio of interns & residents to beds greater than or equal to 0.25.
   - o **Other Teaching** - hospitals with 1 or more interns and residents.

Source for hospital location and teaching categories: Centers for Medicare & Medicaid Services (CMS)

### Characteristics of Hospital Stakeholders Interviewed

Hospital stakeholders were identified based on their contact information in the IS plan or the hospitals website. In addition, a snowball sample technique was used at the conclusion of initial interviews. Stakeholders were asked to identify others within their hospital that would be worthwhile to include to assist with the research study and to share their contact information.

The hospital stakeholders, role and experience were presented in Table VI. The majority of hospital stakeholders interviewed were program managers and coordinators (n=7), followed by directors and divisional directors (n=6), and leadership, including vice presidents, executive
directors and chief executives (n=6). Those in hospital leadership roles, including vice president, executive director and C-Suite, had most years of experience in their organizations (~13 years), followed by directors (~7 years), and managers and program coordinators (~5 years).

<table>
<thead>
<tr>
<th>Hospital Stakeholders n=19</th>
<th>Title/ Role (n)</th>
<th>Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Leadership:</strong> President, Vice President, Executive Directors, Chief Executives</td>
<td>6</td>
<td>13.3</td>
</tr>
<tr>
<td><strong>Directors:</strong> Senior, Division, Regional</td>
<td>6</td>
<td>6.9</td>
</tr>
<tr>
<td><strong>Community Benefit Managers:</strong> Program and Coordinator</td>
<td>7</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>8.28</strong></td>
</tr>
</tbody>
</table>

### iv. Community Benefit Office Location within the Hospital

The hospital stakeholders interviewed were housed in different areas within their organizations (See Table VII). The majority of the stakeholders were located within External Affairs or Community Affairs (n= 8). Only two participants were based in the Government Affairs area and only one stakeholder reported that their position was within the hospital-based research center.
TABLE VII: Location of Community Benefit Offices in Hospitals

<table>
<thead>
<tr>
<th>Hospital Stakeholders n=19</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Affairs/ Community Affairs</td>
<td>8</td>
</tr>
<tr>
<td>Government Affairs</td>
<td>2</td>
</tr>
<tr>
<td>Patient Services</td>
<td>3</td>
</tr>
<tr>
<td>Physician Services</td>
<td>2</td>
</tr>
<tr>
<td>Research Center</td>
<td>1</td>
</tr>
<tr>
<td>Strategy</td>
<td>3</td>
</tr>
</tbody>
</table>

c. RESEARCH QUESTION 1: What factors influenced hospitals to incorporate prevention activities into their community benefit IS plans?

One of the major provisions of the community benefit requirements was that the hospitals through their CHNA and IS plans “not only address the financial and other barriers to care but also the need to prevent illness to ensure adequate nutrition or to address significant health needs from larger social, behavioral and environmental factors that influence health in the community” (Department of the Treasury, 2014). This highlighted that the final IRS rules encouraged hospitals to use community benefit funding in investments that influence health in the broader health of the community.

Two hospital stakeholders mentioned factors that influenced the inclusion of prevention or evidence-based activities in their IS plans. The hospital stakeholders said,

“I think we always try to look at evidence-based programs. When we did the Bronzeville program, they were based off of models that were proven to be effective...Most of the work we are doing, we try to align with those from the start.”
“When we do the CHNA, we definitely try and identify what are the priority health needs and where can we implement preventive services in order to help folks avoid having to deal with getting the disease. Two examples are our Heart Healthy program and the diabetes prevention program that we work on in collaboration with the University.”

The majority of stakeholders could not answer this research question. They talked in general terms of the implementation planning process, spoke more broadly to the factors that impacted their overall IS processes and what influenced the inclusion of various programs including feasibility, leadership, community coalitions and knowledge as defined in greater detail below.

d. RESEARCH QUESTION 2: What market factors influenced hospitals to incorporate prevention activities into their community benefit IS plans?

The market factors explored and derived for this study findings included external state and federal regulations and policies that impact the organization such as Medicaid reimbursement, and payment reform that could impact community needs and planning.

Most hospitals stakeholders identified multiple overlapping market factors that impacted their hospitals ability to address the new community benefit requirements, such as adapting to new payment reform and the inability to address identified community needs such as mental health without available programs. Table VIII below summarized the major market factors themes identified as impacting the community benefit planning processes.
TABLE VIII: Market Themes Impacting Community Benefit Plans

<table>
<thead>
<tr>
<th>Themes</th>
<th># of Hospitals reporting</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement</td>
<td>11</td>
<td>Stakeholder interviews</td>
</tr>
<tr>
<td>Competing federal priorities (e.g. Shift in payment models, readmissions, establishing exchanges)</td>
<td>8</td>
<td>Stakeholder Interviews</td>
</tr>
<tr>
<td>Understanding of the new requirements</td>
<td>7</td>
<td>Stakeholder Interviews</td>
</tr>
<tr>
<td>Lack of Illinois State Budget</td>
<td>6</td>
<td>Stakeholder interviews</td>
</tr>
<tr>
<td>Consolidation</td>
<td>6</td>
<td>Stakeholder Interviews;</td>
</tr>
</tbody>
</table>

i. Market Theme-Reimbursement

Stakeholders spoke to broad range of market factors that their hospital was grappling with including some that challenged their community benefit planning processes. Eleven of the participating hospitals mentioned that reimbursement changes due to Medicaid expansion was a major market challenge for them. With the ACA, reimbursement impacted hospitals by increasing coverage for patients, reductions in charity care spending, and Medicaid eligibility expansions. Due to the Medicaid expansion, hospitals shared that there were more Medicaid payment shortfalls due to the increased coverage and they faced challenges determining how the payment changes impacted them. Other reimbursement changes were that they could no longer count bad debt and Medicare shortfalls in their community benefit reports (CHA, 2015). One hospital stakeholder expressed the market reimbursement challenges and said,

"Probably one of the biggest changes we saw with the ACA is pretty much still doing the same work but our cost of charity care has probably gone down and our cost of uncompensated Medicaid has gone up."

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Two hospitals highlighted that Medicaid funding shifts impacted their ability to allocate appropriate resources and staff to community benefit. Hospital’s legislative and policy staff were pulled into to focus on that instead of identifying programs to address community needs and prevention.

**ii. Market Theme-Competing priorities**

Eight of the hospitals reported that competing federal priorities including the payment shifts from Fee-for-Service to Fee-for-Value, such as becoming an Accountable Care Organization, the focus on lowering readmissions and helping to enroll patients in the insurance exchanges impacted their organizations. Hospital stakeholders stated,

- “There were a ton of system changes that we have had to think through from the old models, like the Fee for Service model. Everybody had that shock and was figuring out how to manage it.”
- “It was a wild time on the federal front and we were in the thick of it while trying to do the implementation plan...We had to get patients on the exchanges and there were several disruptions. One of the biggest challenges during this same time was that Blue Cross canceled their PPO offering which displaced our medically complex patients. This (PPO offering) did not include many full-service specialty hospitals which was a giant challenges for patients and families.”
- “With the ACA, we have trying to capture more of the Medicare population so that is one of the priorities. We are also trying to capture more of private payers but it’s hard because we are one of the few safety net hospitals.”
Although meeting the community benefit requirements was a requirement, they also stated that other federal priorities were higher on their list including the CMS Hospital Readmission Reduction Program. One hospital stakeholder emphasized the hospital was focused on two other priorities and said,

“I know with the new reimbursement model that has been a challenge but a challenge when we’re looking at hospital readmissions and how we are keep people out of the hospital.”

iii. Market Theme—Understanding of the Community Benefits Requirements

Another major market theme that hospital stakeholder stated impacted the community benefit planning process was the vagueness of the regulations. Seven hospitals, from different geographic areas, sizes and teaching categories, mentioned that they struggled with how to interpret the regulations especially during the first cycle.

Several hospitals said they had internal discussions on how to interpret what activities counted as community benefit and clarification around their existing programs since the IRS requirements expanded the types of activities to include ones that address the social, economic and physical environments of health (IRS Form 990- Schedule H). One stakeholder from a large urban hospital stated that they did a consensus process and developed definitions in order to have all of their various hospitals aligned and make sure they were counting programs consistently. When their team could not determine what counted collectively, they brought in finance, legal and used external resource guides from national organizations, such as Catholic Health Association (CHA).

• “We’ve really gone through to make sure what they are counting as community benefit is true community benefit…There were not really any red flags in the collection side. But
then once we start going through the information, we sat down in round table discussions and talk about why I’ve always counted this, and here is where I didn’t. If we are in areas of disagreement, then we write all of those down. We talk to leadership, we compare to the Catholic Health Association guidelines, state guidelines and then we let finance have the final say.”

“Community benefit has a lot of grey areas, so there’s an opportunity to learn more and those resources (from Catholic Health Association, Association for Community Health Improvement), and they should be available to everyone. We procure them and are members of those organizations.”

iv. Market Theme-Readiness to Address the Requirements

Besides having challenges around the ambiguity of the requirements, two hospitals struggled with general readiness and how to comply. Hospital stakeholders said,

“Whether it was the regulation aspects of community benefit or knowing that there was going to be more pressure or expectations around quality or reinforcement..., there were so many things that came through this process. I think everybody was at some point in the spectrum or at the continuum on how to deliver on this”

“The CHNA and IS made community benefits much bigger...It was a scramble on how we could get our arms around it. We were trying to make sure we were hitting deadlines.”

Another hospital stakeholder mentioned the challenges to understanding the requirements and they tried to collaborate with other hospitals. One stakeholder mentioned brainstorming with other hospitals to discuss the ambiguity and that although they normally compete, community benefit was different. The stakeholder said,
“Community benefit is not a competitive part of any health systems...You’re not hesitant to share information because ultimately you know we really do care for the people that we are serving to be able to improve their health outcomes. We should be thinking that we’re all on the same page.”

v. Market Theme - Lack of Illinois State Budget

Another major market factor referenced by six hospitals that impacted overall hospital operations was the lack of a state budget in Illinois. At the time of the stakeholder interviews, Illinois had not passed a budget in approximately two and half years, which meant hospitals were not reimbursed by Medicaid insurance, resulting in reallocation of funding towards other services and hiring freezes (Modern Healthcare, 2017). Hospital stakeholders highlighted the ramifications that this had on their patients, staff, organization, schools of medicine and community partners. Two hospitals mentioned that the state budget impacted their schools of medicine. As a result, one hospital mentioned that they allocated the majority of their community benefit funding to the school of medicine, which qualifies as a community benefit category for “Health Professional Education.” The hospital stakeholder stated, “We have supplied a lot of financial support for the School of Medicine to help keep their doors open. The constant cuts are an issue.”

Another hospital referenced that the state budget impacted the services that their Federally Qualified Health Center (FQHC) usually provided because they were not being reimbursed from Medicaid for prevention services. Consequently, the hospital stakeholder stated, “We funded $16 million increase for the federally qualified health center. We built them a new building as part of our implementation strategy.” This hospital used its community benefit
funding towards subsidizing health services for the FQHC to help keep the facility open and would otherwise have been closed because of the budget crisis.

Several hospitals stated that the lack of state budget affected who they partnered with on various community programs. Hospital stakeholders mentioned their community organizations were closing their doors without state funding or were asking the hospital to completely fund their programs that were previously back by state dollars.

- “The impact of the state budget has affected the organizations that we work with in the sense that some are so dire that we cannot provide all of the funding that they need for them to stay thriving in their community. It’s really unfortunate because some of these organizations serve the most needy groups and closing even a program, if not the whole organization, has a huge impact on the communities.”
- “It could really set back some of our IS plan efforts because when we look at the plans we want to make sure that the organization is at least going to stick around the next couple of years. We don’t want to invest in a program that will be shutting its’ doors.”
- “Because we are in Illinois, we are experiencing financial challenges because we are owed more than $125 million dollars by the state that hasn’t been reimbursed. This conversely is having an impact on what we’re able to fund now in the community. We are having to say no to more requests. That’s not directly ACA but that’s the state of Illinois.”

vi. Market Theme- Limited Funding for Mental Health

Besides not having a state budget, the lack of funding for mental health services and providers also was a common market barrier when hospitals were trying to address one of their
main community needs. In addition to the state budget cuts, between 2009 and 2012, mental health services were cut by approximately $113 million (National Alliance of Mental Illness of Chicago, 2015). Most stakeholders mentioned that due to the defunding at the state level and reimbursement challenges, they did not have locations to send their patients with mental health needs because the agencies were overburdened with patients or the facilities were shutting down. One hospital stakeholder stated the that hospital omitted it as an IS plan priority because they realistically could not fund the services and said,

“The defunding of mental health on federal and state level has really, really impacted our community. We have a behavioral health/mental health group that is one of our affiliates. They are one of the largest providers of mental health services in the community. That has had a real impact on them.”

vii. Market Theme- Consolidation

The ACA increased the rate of consolidation particularly among small and mid-sized hospitals as they struggled to adjust with multiple changes including reimbursement, lowering costs and shifting to fee for value (Dafney, 2014). Consolidation not only impacted the hospitals general operations but also the timing and organization alignment of their CHNA and IS planning processes among the recently merged hospitals. As stated in the requirements, each hospital was required to develop a CHNA and IS plan. One large teaching hospital that recently acquired other smaller hospitals said they had various processes and timelines and stated,

“Those hospitals were already doing community health needs assessments but then had to work to align the processes. Everybody had really great ways that they were doing things and outcomes, but it was all a little bit different. The timelines were a really big
Two hospital stakeholders expressed that they were trying to identify the differences in the plans among their recently acquired hospitals and the programs they offered. One large hospital stakeholder said,

“We identified the variations but felt like we had to make small changes and train the staff at hospitals on how to think of community benefit from a different lens and could not completely overall all of the processes.”

As a result, they decided to first build out a more prescriptive approach to the CHNA and IS process. It was unclear that if the system alignment would improve organizational efficiency overtime and increase or decrease their potential community benefit activities in their relative markets. One hospital stakeholder highlighted that with the merge, additional accountability and reporting to hospital boards was an issue because they now had to get sign off by three boards at the different hospitals and figure out next cycle how they could align them to the larger system and ensure they were more evidenced-based.

The distinct market factors affecting hospitals and their community benefit processes offered insight into the impacts of the requirements within rapidly changing health care environment. With the ACA, several federal policies were transforming the health care landscape in addition to community benefit requirements. It was expected that other market factors would have impacted the community benefit processes and the role that hospitals could play. However, the majority of hospitals did not identify opportunities for alignment around other federal population health initiatives and linking community benefits to other hospital activities. Unique to Illinois was the lack of payment for services due to no state budget and the major cuts in
mental health services. The impact of consolidation was a theme that emerged that would be seen nationally. The market factor themes that emerged highlight the challenges and opportunities for the hospitals to take into account as they adapt to the other political and health care initiatives along with the new community benefit requirements and how they could improve community health.

e. RESEARCH QUESTION 3: What community factors influenced hospitals to incorporate prevention activities into their community benefit IS plans?

The original research questions asked what societal factors impacted the inclusions of programs in the IS plan. However, after piloting the interview with a Project Leader of Community Benefits and the first hospital interview, the research question was changed to clarify that the study was exploring what community factors impacted hospitals. The community factors of interest focused on how the surround community demographics, inclusive of community organizations and public health members were involved and influenced the IS planning process based on their existing relationships with hospitals, knowledge of outside programs and participation in coalitions.

Overall, there was a wide variation reported on the level of involvement with the community organizations and partners in IS planning processes. It should be noted that the IRS requirements stated that hospitals take into account “Input from members of representatives for persons who represent the broad interest of the community served by the hospital facility, including those with special knowledge of or expertise in public health” for the CHNA (IRS 501, Form 990 Schedule H). Generally, all of the hospitals reported requesting input from the community in the development of their CHNA through surveys or focus groups. Some stakeholders mentioned the main reason for inclusion was that it was stated in the requirements.
Other hospitals engaged the community stakeholders beyond the CHNA in decision-making around the IS prioritization and they had an equal voice as the hospital stakeholders. The group that included the community verbalized and recognized the value of their involvement.

Hospitals were considered engaged with the community if there was a committed role in decision making, which includes all phases from defining the issues, identifying resolutions and programs and resources to address the needs (Bassler et al, 2008). Overall, the input and engagement by the community around the IS plans drastically varied. The challenge was that the IRS requirements did not provide much detail around the level of engagement, particularly around the IS plan which meant it was interpreted differently by each hospital.

A logic analysis was used to chart the level of community involvement in the IS plan based on the stakeholder interviews and the IS plans. This followed a similar categorization used by Pennel and colleagues that reported the hospitals involvement and depth of participation by community members and organizations through collaboratives, training and past workgroups around the CHNA (Pennel et al, 2015). Overall hospitals reported more participation and involvement with community partners around their CHNA. All three of the hospitals that reported high involvement were from major teaching hospitals and had existing community steering collaboratives established prior to requirements. See Table IX.

| Table IX: Community Involvement in the IS Plan Process |
|-----------------------------------------------|------------------|-----------------|----------------|
| Level of Involvement                      | Types of Involvement Activities                      | # of Hospitals | Source                        |
| No/ Low involvement                     | • No community stakeholders were involved            | 4              | Stakeholder Interviews; Implementation Strategy Plans |
|                                           | • Community stakeholders were interviewed for the CHNA but were not involved in IS planning |                |                               |


<table>
<thead>
<tr>
<th>Involvement Level</th>
<th>Community Stakeholder Involvement</th>
<th>Number</th>
<th>Stakeholder Interview Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium</td>
<td>• Community stakeholders involved in program identification</td>
<td>6</td>
<td>Stakeholder Interviews; Implementation Strategy Plans</td>
</tr>
<tr>
<td></td>
<td>• Community stakeholders assist with training through various collaboratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Community stakeholders helped identify strategies to address the social determinants of health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>• Community stakeholders involved in decision-making</td>
<td>3</td>
<td>Stakeholder Interviews; Implementation Strategy Plans</td>
</tr>
<tr>
<td></td>
<td>• Community stakeholders are involved in long term partnerships with the hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Community stakeholders help design and implement strategies</td>
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### i. No to Low Involvement - Stakeholder Interview Findings

Four hospitals reported to no to low community engagement for their IS plan. These hospitals referenced that they shared the CHNA data back and IS strategies with the community through forums and conferences to raise awareness but did not include them for programming or activity considerations. One hospital stakeholder said, *“They were involved on the front end. They were not at the Committee meetings to discuss it, or argue about it.”*

Two hospitals stakeholder stated that they involved the community through surveys or focus groups for the CHNA but not beyond it. They both recognized the need to build community steering committees for future CHNA and IS planning. One hospital stakeholder said, *“It’s clear that we cannot do this by ourselves. We have to develop partnerships and that has become very obvious to our internal committee and to the executive team. We are in*
Another hospital stakeholder mentioned that they were working on future involvement and said,

“They were not involved but we are working towards that and defining how we are going to build out our external community benefit team and making sure that our partners also have a seat at the table and can really help us with the next round.”

**ii. No to Low Involvement- IS Plan Findings**

The hospital IS plans were reviewed to determine if the interview findings matched them or if the plans detailed additional involvement. Two of the four hospitals interviewed that reported having no to low community involvement IS plans were found to either not mentioning any community involvement or just restating the CHNA partners but did not explain additional details around the community organizations involvement.

The two hospitals that referenced no to low involvement with community organizations, thanked them and the organization for their participation the IS plans but did not expand beyond that. One hospitals IS plan indicated how the IS priorities were disseminated and noted “Our hospital shares the strategic implementation plan information at its annual Summit, with key stakeholders in attendance.”

The other hospital IS plan with limited involvement stated that the CHNA “took into account from representatives of the community, community members and community organizations.” The remainder of the plans did not mention how community members were involved in the IS prioritization process, but stated the programs were based on the hospital resources and overall alignment with the mission, goals and strategic priorities of the organization.
iii. Medium Involvement- Stakeholder Interview Findings

Among the six hospitals that had medium involvement, stakeholders reported their community organizations assisted hospitals with a variety of activities. The main areas were with program identification, offering trainings and education around how to address the social determinants of health, and facilitation of multi-hospital and public health collaboratives.

a. Program Identification

Some of the hospitals stakeholders stated that the community helped with understanding the needs, determining what programs were available, feasible and balance it with what they were capable of doing during the three-year period. The community organization familiarity with programs helped hospital learn existing efforts that could support their needs and potential collaborative efforts they could leverage. One hospital stakeholder highlighted how community members assisted with their IS plan and said,

“It’s a back and forth of understanding what is happening, learning what is important to the community, existing resources and layering that over the IS planning process. It does inform our decisions and its more sustainable.”

Another hospital stakeholder expressed the positive perceptions of working with the community to learn what was already taking place and said,

“There are maximal benefits from knowing and aligning to other stuff happening. I do not know if we have always been the best at that…I do think it’s one of those things we are constantly getting better at. I do think it informed how we went about our second implementation plan.”
b. Reliance on Existing Programs and Partnerships

Hospitals with medium involvement mainly depended on existing partnerships and knowledge of existing programs for determining which community organizations to engage for input for their IS planning process. One hospital stated they relied on these past partnerships because many of the needs identified extended beyond what the hospital could address alone.

One hospital stakeholder said,

“We had existing relationships with different folks out there in the community, so when it came to develop our CHNA and IS, we went back to those relationships and partnership and asked those folks to help us.”

Other hospitals proposed just repurposed existing programs to fit into the new categories. One hospital stakeholder said their programs were identified by looking at past efforts and said, “We looked at prior programs, budget and history and just kind of resuscitated those.”

c. Hospital Collaboratives

Several hospitals mentioned their active role with community for the IS plan by referencing how they were involved in multi-hospital and public health collaboratives. These hospitals collaboratives included various health departments, community organizations and several hospitals. Three major collaboratives that were referenced were county wide and helped identify common needs and determine coordinated approaches and strategies to addressing the needs using a collective impact framework. The Chicagoland collaborative was developed as a result of the requirements, whereas the other two were existing hospital and public health department collaboratives that supported hospitals in western and southern areas of Illinois.
Hospitals in the Chicagoland area joined these coalitions initially to work on their CHNA, which was led by two public health organizations that recently merged. These collaboratives included representatives from health departments, community organizations across the Cook County area and 25 + hospitals, seven health departments and more than 100 community organizations that came together to develop their CHNA through an interactive prioritization process and identified four main areas to address. The four main areas developed by the Health Impact Collaborative of Cook County included:

1. “Improving social, economic, and structural determinants of health while reducing social and economic inequities.
2. Improving mental health and decreasing substance abuse.
3. Preventing and reducing chronic disease, with a focus on risk factors such as nutrition, physical activity, and tobacco.
4. Increasing access to care and community resources (Health Impact Collaborative of Cook County, 2017).”

Hospital stakeholders highlighted several benefits that they experienced from these collaboratives, including sharing of information between the hospitals, trainings, facilitation, data sharing and coordination. Hospital stakeholders spoke to the value of the collaboratives and said:

- “The sharing has been great. The talent and having these resources means everything, because we would have not been able to individually acquire that or get that or have them available to share that.”
“Nobody has the time to coordinate the meetings and this is a tremendous amount of work in order to have this level of infrastructure to coordinate about 20 something hospitals and seven health departments to move on these issues and to keep it going.”

“They did a beautiful analysis and cross walking of all the community assessments in Chicago and gathered us all in the room together to try to figure out how we can capitalize on our strengths and do more together. I want to say that is a really positive outcome of the ACA to press all of us as hospitals to be more focused in our community work.”

Two large teaching hospitals were familiar of the work with the collaboratives but did not work with them on the CHNA or the IS plans due the various priorities and the resources. One hospital stakeholder stated, “The problem was the areas they were focusing on weren’t our specific health issues in our geographic areas in the south suburbs so it didn’t really apply to us.”

The other hospital focus was on a different population than the other hospitals participating in the collaborative and they had limited resources. This stakeholder said,

“Those partners (in the collaborative) are so much bigger than us and are tied to huge amounts of academic resources. None of them quite serve the most vulnerable or financially challenged populations like we do. It’s really hard to be a player among the players that serve our population. To do that, it’s a huge amount of resources including people from my staff and sending people to all of those meetings.”

d. Social Determinants of Health
The majority of the hospital stakeholders with medium involvement noted that the inclusion of priorities that addressed the social determinants of health were identified by their community partners. The community partners tried to link existing programs to these medical conditions. These community needs and understanding of the social determinants of health were mainly highlighted by the collaboratives that provided a broader perspective on program considerations. Several hospitals reported addressing the social determinants of health and recognized that if they wanted to see improvements in health outcomes, they need to identify the root cause from larger systemic problems.

- “There was a lot rigor around whether or not whether we should tackle the social determinants of health. That’s not something we have done here at the hospital. I think with this second go around, we heard from our committee, our advisory committee, especially our public health department, we had Illinois Department of Public Health and Chicago Department of Public Health, and they were saying, ‘Guys, you’ve got to tackle this. This is the root.’ It was big that we did that. I think that the community really had an influence on that. Without them, I am not sure that as an institution, we were ready to go there. But again, this process helped us move the needle on that. We saw that we have two priorities around the social determinants of health in 2016.”

- “I really want to give credit to the collaborative folks and the public health departments because I think that they had a real focus on social determinants of health and health equity and I think that really did help inform us.”

e. Training and resources

Several hospitals stakeholders mentioned that community organizations and the collaboratives provided training, subject matter expertise, and resources to help guide their IS
plan processes. The training and resources mainly focused around evidence-based practices, how to leverage existing community capacity and bringing in subject matter experts from around the country to discuss how to meet the requirements. One hospital stakeholder noted the benefits of this additional training from the community and said,

“One of the good things is they have speakers on whatever the topic areas is that can bring a different level of expertise that many of us would not have...The talent and having these resources means everything because we would not have been able to individually acquire the knowledge or have those speakers available.”

vi. Medium Involvement- IS Plan Findings

Among the hospitals categorized as having medium involvement with community organizations based on the interviews, some noted their roles in IS plan. One hospital IS plan executive summary stated that they reviewed input from their Community Advisory Committee to select the three priorities to address over the next three years. The plan stated,

“Following the review of input from the Community Advisory Committee, community forums, the community survey, and our hospitals Internal Advisory Team, our Medical Center selected three priorities to address in its implementation strategy over the next three years”

Another hospital’s IS plan stated that with the health department, they organized a task force to review and prioritize the strategies. The majority hospitals did not specify the roles that community partners or public health departments had in their IS plan because it was not required to list their involvement like it was for the CHNA.
vii. **High Involvement - Stakeholder Findings**

The hospitals characterized as having high involvement had their community stakeholders included in the decision-making, the design and implementation strategies and had long term partnerships with them. The three hospitals in this group indicated the importance and inclusion of the community, and their strong existing relationships with the community. The community partners helped with a variety of functions including identify needs, narrowing down priorities, providing guidance around programs to implement or working on formal partnerships with charters around responsibilities on how to execute the strategies and programs. Several stakeholders mentioned that their hospital organization felt this inclusion was valuable to improving community health for the determination of what was important to address:

“We don’t want this at any time to be hospital driven. Yes, we are going to have input. Yes, we’re going to have final say because we’re paying for this and we need to make sure we’re getting the outcomes we’re looking for or we want to see, but we want the programs to be driven by the neighborhood, and established an Advisory Council.”

Another hospital stakeholder mentioned that inclusion of the community reminded them the purpose of the work hospitals and said,

“We always try to keep the focus that this is more about the community and partners that it is not about our hospitals. As long as you keep the community partner as the main focus, I think it makes it easier."

Among the hospitals with high involvement, two mentioned that they had already established external advisory councils that were active throughout the entire community benefit process, from sharing data, resources, voting rights and assisting with program design and
delivery. One hospital stakeholder spoke to the benefit of the inclusion community to weigh into the needs and potential programs and said, “It was very important and intentional for us that our committee had a strong voice and that we incorporated what they thought was important and identified as program needs.”

Another hospital stakeholder spoke to their approach and philosophy around engaging the community and said,

“We pulled together around 15 community stakeholders that have input on it. We poll our community but also sit down with the health departments and FQHC partners to say ‘What do you need? What are your patients and community members coming to you and saying you need?’ so we can get input.”

viii. High Involvement - IS Plan Findings

The high involvement hospitals reported strong existing relationships with the community organizations, including extensive involvement in multiple aspects of the IS planning process. High involvement consisted of inclusion of community organizations and members to help identify, develop and execute the strategies and programs in the IS plan. Of the three hospitals categorized as having high community involvement, their IS plans stated the roles of community organizations and members. All three listed the inclusion of the community:

- “The implementation plan development process involved several iterative steps, overseen by the CHNA Committee and supported by subject matter experts at the hospital. The CHNA Committee was comprised of representatives of public health agencies, organizations that serve communities in Chicago that experience health disparities, and the hospitals patient population, as well as community-focused members of the hospitals
faculty, staff, and leadership.”

• “The current CHNA is part of our continual process to not only understand the health-related needs of the communities we serve, but to work with our community partners and members to develop and implement creative strategies to address them.”

• “Our hospital will continue to work with the External Steering Committee to develop a comprehensive Implementation Plan that addresses each Priority Health Need. Our hospital and its community health partners share a vision of a healthy community and are committed to working together to address significant health needs. We believe that we can most effectively impact the health of our community by working together, recognizing each organizations’ strengths and assets. Successful models and infrastructure are in place and can be leveraged to focus on these and future health needs as our community evolves.”

ix. Emerging Community Theme- Consensus Driven Approach

In addition to the community factors mentioned, one additional theme emerged was having a consensus driven approach with the community around the IS planning process. These hospital organizations felt that providing equal voices to the community members from the beginning was essential to building a realistic IS plan, and helped the hospital be held accountable on the progress throughout the three years.

Only three involved the community organizations in decision making from the CHNA to the IS planning processes. However, these three hospitals had previously established robust community steering committees and emphasized that community members had an equal voice in the process. When asked about the role of the community in the IS planning process, one hospital stakeholder said, “It’s really consensus driven...We really want the committee to have a
voice.” These three hospital stakeholders felt like they benefited inclusion of the community around the priorities and hearing from the populations they serve. Another hospital with high involvement expressed the meaningful participation from the community and said, “There is a decision-making mechanism, a voting procedure of who has the right or to make the final decisions and the advisory council is included in this process.”

In general, hospitals indicated a variety of perspectives and engagement approaches with the community in their IS plan process from communicating the priority needs and strategies to full integrating them for decision making and program delivery. A majority of the hospitals expressed the value of including community partners around the IS planning process and several indicated that they wanted to include them more through partnerships and for future programming in upcoming CHNA and IS cycles.

f. RESEARCH QUESTION 4: What organizational factors influenced hospitals to incorporate prevention activities into their community benefit IS plans?

The organizational factors of interest included the hospital demographic information, teaching status due to potential interest in prevention practices and utilizing new evidence-based approaches, and alignment to other hospital goals, and resources. As identified in Chapter 2, the organizational factors were identified based on the drivers of evidence-based practice in a hospital setting. The hospitals noted more general organizational facilitators that helped with their community benefit processes and provided less detail around which ones were considered in the inclusion criteria of various prevention or evidence-based programs. See Table X.
i. Organizational Theme- Strategic Investment

The strategic investment theme was identified by all hospitals except one and some hospitals reported more than one type of strategic investment their organization supported around community benefits. The overall theme included investment of financial considerations that influenced their community benefit processes. Some hospitals committed their own investments and realized the need to align it to large organizational goals.

a. Strategic Investment - Staffing

The new community benefit requirements shifted hospitals traditional approach of using their funding from charity care towards broader health improvement. One organizational factor explored was if hospitals hired new staff with different skill sets and expertise to support these changes. See Table XI. The majority of hospitals tapped their existing staff but identified the need to train them on community and public health approaches.

| Table X: Organizational Themes Impacting the IS Plan |
|-----------------|-----------------|-----------------|-----------------|
| Theme           | Descriptions                                            | # of Hospitals | Source                      |
| Strategic Investment | • Additional Staff Hired                                 | 2              | Stakeholder interviews      |
|                  | • Committed funding towards training and resources       | 10             | Stakeholder Interviews      |
|                  | • Alignment with other hospitals goals                   | 3              | Stakeholder Interviews      |
| Mission          | • Commitment to community benefit aligned with the hospitals mission | 5              | Stakeholder Interviews; Implementation Strategy Plans |
| Existing Research Center | • Leveraged Existing Internal Research Centers and Subject Matter Experts | 4              | Stakeholder Interviews; Implementation Strategy Plans |
Only two of the hospital stakeholders mentioned that they hired additional staff to help with the community benefit needs. One stakeholder from rural hospital reported adding two new staff nurses to aid with care coordination, which was a high priority area to help reduce readmissions. This hospital stakeholder said, 

“We hired two positions. One that makes phone calls to patients to keep them on their care plan and the other one is a nurse clinical director that works on standardizing our protocols and procedures out in practices.”

Another large hospital system stakeholder stated they hired as a result of the requirements, and said, “We definitely took on additional staff to actually implement programs. We took on more to help us build new programs.” These two hospitals seemed to be the outliers that had the additional resources to hire new staff.

Most hospitals mentioned they were tapping existing subject matter experts or program administrators from other areas within their organization to help. One stakeholder said, 

“A large part of the staffing that I use in the hospital do not report to me. I might coordinate the program as an example, but I work with other programs and departments depending upon the discipline.”

<table>
<thead>
<tr>
<th>Table XI: Organizational Staffing</th>
<th># of Hospitals</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hired additional staff</td>
<td>2</td>
<td>Stakeholder Interviews</td>
</tr>
<tr>
<td>Plan to hire additional staff</td>
<td>1</td>
<td>Stakeholder Interviews</td>
</tr>
<tr>
<td>Did not hire additional staff</td>
<td>10</td>
<td>Stakeholder Interviews</td>
</tr>
</tbody>
</table>
One stakeholder from a large hospital explained that she anticipated they would be adding new staff within the next year because of the CEO commitment to establishing new centers dedicated to community health improvements. The hospital leadership recognized the strategic investments needed around community health policy.

The majority of hospitals stakeholders noted staffing challenges including limited training for existing staff and minimal capacity to work on the community benefit activities to develop partnerships for the actual execution of the IS plan. One hospital stakeholder noted that staffing was a major organizational constraint and said, “*We have people overseeing community benefits but they all wear multiple hats because it’s a small area within the organization. They’re spread thin and do a lot of things.*”

Other hospitals highlighted that although they had community benefit teams established prior to the requirements and that they reviewed and expanded their teams internally. They reflected that with the new requirements, they had to gather a more robust steering committee to incorporate more public health, finance and legal sectors and pay attention to more of the details of the requirements. One hospital stakeholder said,

“*I think the whole goal pressured us to prove this out and the debate around tax-exempt...It opened people’s eyes to say we need to be at the table not and not just write a marketing report. We need finance and really need legal. You need to be thinking through an institutional process and that has majorly shifted.*”

Although the community benefits law went into place in Illinois in 2003, one hospital stakeholder mentioned she was hired back in the mid 1990’s because that’s when Illinois community benefit requirements were put into place. Regardless, her role was established and
continued to transition to meet the new requirements. She said “Community benefits evolved in 1995 because it was required by the Illinois Attorney General and then changed to include the CHNA and IS plan. It’s not so much as the role evolved strategically but based on what was required.”

b. Strategic Investment- Committed Funding to Training and Resources

Another strategic hospital investment that hospital stakeholders highlighted was that their organization committed funding to training and resources to help with these new requirements. Hospital stakeholders identified various types training, guides or resources to help with CHNA and how to identify strategies and programs to include in the IS plan. The training and resources varied from attending national conferences, monthly networking calls, guides and toolkits for planning and reporting, bringing experts on site to train teams, to purchasing national resources and participating in free webinars. See Table XII.

<table>
<thead>
<tr>
<th>Type of Training or Resources</th>
<th># of Hospitals</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended trainings or conferences</td>
<td>2</td>
<td>Stakeholder interviews</td>
</tr>
<tr>
<td>Utilization of National Resources, including guides, webinars and toolkits</td>
<td>8</td>
<td>Stakeholder Interviews</td>
</tr>
<tr>
<td>None utilized/mentioned</td>
<td>2</td>
<td>Stakeholder interviews</td>
</tr>
</tbody>
</table>

c. Strategic Investment -Committed Funding to Training and Resources

1. Attending Trainings or Conferences

Two hospitals stakeholders referenced that they participated in onsite or offsite trainings and conferences which provided details on the requirements, how to develop the IS plans and provided a great opportunity for networking among other hospitals. These hospitals noted that
their organization’s leadership commitment allowed them to attend these trainings. One hospital stakeholders highlighted the value of the training and said, “An organizational facilitator was establishing an infrastructure. We have added a lot of education around the importance of population health and transformation of the community.” Some hospitals stakeholders reflected on the value of the training and education including that it helped their staff buy-in to the community benefit process across the organizations and provided an overview about what changes they needed to make for compliance purposes.

2. Hospital Committed Funding to Training and Resources Utilization of National Resource Guides

The majority of hospital stakeholders noted the financial challenges around attending in-person training but mentioned using resources from some national organizations. The main resources that hospitals tapped for insight and guidance around community benefits include the Catholic Health Association and the Association for Community Health Improvement, run by the American Hospital Association. The resources included toolkits, planning guides, case studies, newsletters legislative updates and regular webinars. One hospital stakeholder spoke to the value of these resources and said,

“Well thankfully, the Catholic Health Association has done a fantastic job providing resources, handbooks and training and all sorts of things that we really needed to disseminate to our team. I try to reference that handbook and hopefully people use it.”

3. No Training or Resources Utilized and/ or Mentioned

Two hospitals stakeholders did not mention any training or resources. One hospital participant expressed that he had to figure out the requirements quickly without additional
support and struggled during the first cycle and said, “The first one, I did not know what I was doing, so I had to learn on the fly.”

d. Strategic Investment - Alignment with Other Hospital Goals

Due to variety of national health care reforms, it was important to investigate if hospitals aligned or leveraged their activities around the CHNA and IS planning with other organizational priorities or goals to address difficult health needs and invest in building out population health efforts. Three hospitals shared their various approaches to leverage the larger hospital system priorities with the CHNA and IS plans.

One stakeholder from a large teaching hospital mentioned that they used the CHNA not only to help set their policy agenda, but also to garner foundational support for a new center focused on community health initiatives. They also looked at the data from the CHNA and recognized the need to narrow their focus and develop a new office to overhaul their existing community program efforts. This hospital stakeholder said,

“We were doing a lot of this but we did not have structure or coordination around it. Some of the big things that came out of it was that we created a new initiative called Healthy Communities to oversee the implementation plan and align and strengthen the myriad of community outreach work that is happening here.”

Another hospital stakeholder expressed that she worked to align the programs in the IS plan to the larger health system strategic plan. The challenge she noted was the lack of staffing, and said,
“I was trying to align the system goals with the priorities that came up because it’s just me. I created a priority of items and things we were doing and how it related to our system...but it was just me leading the charge.”

ii. Mission

Five hospitals identified their commitment to community benefit activities was due to their mission, which helped continue their momentum and for accountability. One hospital stakeholder said,

“Our hospital really does take their mission very seriously, with helping the poor, helping the most needy and vulnerable and they don’t question whether it really needs to happen. It’s more the question of are we doing something we can improve or do we have the funding to support a new effort?”

Another hospital stakeholder emphasized that they had an internal mission board oversee their activities monthly and said,

“It has always been part of our mission to create a community health improvement plan and the work has always been under the mission effectiveness committee. That’s the committee of members that make sure that we are continuing to live our mission.”

In addition to stakeholders referencing the importance of community benefit activities to their hospitals due to their missions, nearly half of the hospitals mentioned their mission in the IS plan. Several hospitals noted that community benefit programs and services were integral to their mission of their hospital and serving the greater community. The IS plans stated:
• “From its inceptions, our hospitals has had an unwavering commitment to service the community, including the uninsured and underprivileged.”

• “The mission of our hospital is to extend the healing ministry of Jesus. Our Community Benefit Program is integral to our mission.”

• “The commitment to provide healthcare, regardless of the ability to pay, reaches back to the founding principles and continues to be integral to our Patients First mission. Our hospital believes that its mission to improve the health of the communities it serves is best accomplished in collaboration with partners both in the community and within the organizations that comprise our system.”

In some IS plans, hospitals noted that particular priority programs were based on the alignment to the mission.

“In addition to developing a plan to conduct the community health needs assessment itself, the recommendations also included refining internal processes at our hospital to assure that the CHNA, and the programs guided by it, are well-integrated into our hospitals efforts to meet its mission.”

Overall, there was much more detail provided in the interviews of the organizational factors impacting their IS plan than was directly written in the plan.

iii. Emerging Organizational Theme- Hospital-Based Research Centers and Internal Subject Matter Experts- Stakeholder Interviews

In reviewing the organizational factors, one emerging theme that aided the IS planning process were the existing research centers and internal subject matter experts at the four large major teaching hospitals that were referenced both by the stakeholders and in the IS plans. The
hospitals with research centers directed their programming towards prevention and broader community initiatives that addressed the social determinants of health. These hospitals were more familiar the complex needs of the populations they served because of their robust research and data system, history and established infrastructure. The funding, infrastructure and common vision within these organizations for multi-pronged approaches to address their needs positioned these hospitals to be more aware and familiar with community health improvement approaches.

One hospital stakeholder stated how the research centers helped and said,

“When it came to the prioritization process, we did work really closely with our College of Medicine and our internal public health center. They helped with additional analysis we wanted to conduct and we relied on them for getting feedback”

Two hospitals stakeholders stated that they felt like they were better positioned to address the new requirements and said,

- “Unlike most organization who never paid any attention to the social determinants of health or community health planning, we have had two internal parts of our organization who have been. One is an epidemiological research-based enterprise who helped with our CHNA...The other one is an entity that provides safety net services in response to the social determinants of health.”

- “The good thing is because of our initiative that we founded 10 years ago, we had already begun the process of being a little more externally focused.”

These hospitals also expressed that the IRS requirements did not change their research centers objectives but helped the hospital system become more focused and aligned around community health improvement investments. One hospital participant stated, “When 2012 came
around, we began getting back to a more formal process and it became more intentional and gave us more discipline around it”

a. Hospital-Based Research Centers and Internal Subject Matter Experts- IS

Plan Findings

In addition to stakeholders referencing the benefits of their internal research centers and their subject matter experts, the IS plans described the benefits of this support. Within the IS plans, two of the hospitals referenced their research centers as a main support to their community benefit process and their focus on public health interventions:

- “In the 1980’s, our hospital also developed the first practice-based research collaborative for pediatrics in the United States. The Research Group now includes over 70 practices in Chicago and its suburbs. In addition to our hospitals CHNA, conducting research, has served as a conduit for both the development of high quality care across the region and for community-focused interventions (such as improved lead screening, improved asthma management, improved obesity screening and treatment, and public health needs assessment).”

- “Our Institute is a public health-focused entity made up of a diverse group of epidemiologists, research assistants and health educators. On a neighborhood by neighborhood basis, they study the prevalence of chronic disease in communities served by our health system. The mission of our hospital is grounded in the belief that in order to serve its neighbors well, it’s important to understand not only patients, but the entire community. The results of our research shapes its’ programs so that better community
engagement, disease prevention and treatment will help to reduce health disparities and bring greater health equality.”

iv. Emerging Organizational Theme: Teaching Status Inclusion of Programs to Address Prevention and Socioeconomic Issues- Stakeholder Interviews

The hospital demographic variables, including the location and size, did not have an impact on the types of programs included the IS plan or was not referenced by the stakeholders as a driver for program considerations. However, major teaching hospitals were more likely to incorporate long lasting impact programs, policies and address socioeconomic issues in their IS plans. The large academic hospitals with established research centered seemed prepared to address the new requirement and had the training and expertise to tap to assist them. One hospital stakeholder stated, “We always try to look at evidence-based programs. When we did the one program, they were based off models that were proven to be effective. We try to align with those programs from the start.”

v. Emerging Organizational Theme: “Backloaded” Existing Programs to Include in the IS Plans

Three hospital organizations stated that because they were short staffed and quickly trying to adjust to the community benefit requirements, they backfilled their IS plans with programs and activities they were currently doing. One hospital stakeholder said his primary goal was to meet the requirements and so they filled in existing activities into the plan. One stakeholder said,

“Probably 80-90% was existing stuff that we fit into these categories. I would say the first time, three years ago, it was 100% backloaded. In other words, we stuff everything we were during into the stuff we said we needed to do.”
This hospital stakeholder recognized that this approach was not ideal and hoped that with future cycles, they would be more prepared and expand their programs. Another hospital stakeholder stated that they continued to focus on clinical programs and continue with ones where they were already involved and said,

“With regards to the implementation strategy plan, we focus on what we do best. Many of these are again, disease conditions and things that we’re currently addressing so we focus on being able to continue doing the clinical element of it.”

g. RESEARCH QUESTION 5: What hospital and physician leadership factors influenced hospitals to incorporate prevention activities into their community benefit IS plans?

Based on the literature review, both hospital and physician leadership were anticipated to influence the inclusion of various programs. However, senior hospital leadership played more of a role in the IS planning process and inclusion of strategies, whereas physicians were not mentioned by the stakeholders. Physicians and clinicians participated in more internal advisory roles or as subject matter experts but were not highlighted by any of the hospitals for championing particular community benefit efforts. See Table XIII.

<table>
<thead>
<tr>
<th>Table XIII: Leadership Themes Impacting in the IS Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme</td>
</tr>
</tbody>
</table>
| Leadership Support | • Championed community benefit process  
• Emphasized community benefit as an organizational priority | 6 | Stakeholder interviews |
| Leadership Communication | • Aligned staff on the purpose  
• Generated organizational buy-in | 4 | Stakeholder Interviews; |
| Leadership promoting Collaboration | • Encouraged participation in public health and hospital collaboratives  
• Partnered with other hospitals to address priority need | 3 | Stakeholder Interviews; |
i. Leadership Support

Several hospitals stakeholders interviewed referenced that their senior leadership, meaning CEO, COO and Presidents, were invested in community benefit activities and it was essential to foster organizational support. Strong senior leadership was crucial in identifying new initiatives, emphasizing the need to invest in partnerships and collaboratives with the community and helping to identify alignment opportunities across the organization. The hospital leadership helped drive that the CHNA and IS plans were a priority for their organization. When asked what factors impacted their community benefit process, one stakeholder said,

“I would have to say, probably the biggest factor for us as far as making this more a priority hospital-wide than it has been in the past is really our President and CEO. I think that he is a visionary guy and he came to think that it’s great that we’re doing all these individual programs and initiatives in the community, but we really need to take that community health needs assessment and just give it more of a priority and make it a blueprint for more impactful, aligned and significant work. As he says, ‘Move the needle’ on some of Chicago’s big issues”

Another hospital stakeholder stated that with their senior leadership help, community benefits became visible throughout the organization and said, “It was a lot easier for the CEO system to communicate that this is the expectation to the President of the hospital.”

Senior leadership communicating the importance of community benefit activities was another major organizational facilitator around the IS planning process. One hospital participant referenced that it was noted as an organizational priority and said, “Senior leadership support
was instrumental. Sometimes it has been a challenge getting community at the clinical leadership level purview, so they (senior leaders) included it as a capitol issue.”

ii. Leadership Communication

Four hospitals emphasized that their senior leadership were crucial to getting other staff and departments involved. Without them, they said it would have been hard to commit and take on more with limited time and resources. One hospital stakeholder shared observations that mentioned that the leadership spearheaded the outreach efforts and said, “I think for us it was really drive from the top. Our CEO took the time to talk with us and to go through it (CHNA). These are busy people, doctors and people doing a lot of good work.”

Another hospital stakeholder commented that they recognized that benefits of the leadership in helping with buy-in and said,

“There really has to be somebody who is in an authority position in their respective area. I have engaged thoroughly with our senior leadership team and I have to say thankfully, our President is very much on board with all of this. He understands the importance of community benefit and does not shy away from stating his expectations to various departments.”

Another hospital referenced that senior leadership helped share why the community benefit requirements were important and aided in the dissemination of the needs and priorities. Without this level of collaboration, the community benefit staff felt uptake in addressing the priorities would have been challenging in large hospitals and said,
“Senior leadership is very important in working with department heads because information needs to be disseminated and everybody needs to work together to really be able to actively report identified community benefit activities. We are such a large health system with thousands of employees and someone had to be able to reach all of them. Some people would otherwise say I have so many other things going on.”

iii. Leadership Collaboration

Three hospitals noted that their senior leaders specified that they should partner with neighboring hospitals either through various collaboratives or on the CHNA. In discussion with hospital stakeholders, different approaches to and perspectives on these partnership emerged, including sharing of CHNA data, identifying mutual priority needs and in some cases working on particular programs together.

One hospital in southern Illinois partnered with their largest competitor who served a similar geographic area. They recognized that it would be a waste of resources to conduct two CHNA that would show almost identical needs. One utilized a data set from a national organization, and their leadership approached the CEO at the neighboring hospital to share the data for their CHNA. This hospital participant commented, “My boss said, ‘Community benefit is an area of non-competition’ That’s his mindset and that helps coming from senior leadership.” The leadership investment and commitment to collaboration early in the community benefit planning process set the stage for the two hospitals staff to recognize that they had overlapping needs, mutual goals and the benefit of a partnership. The hospital participants reflected, “We had top down support and it was kind of a no-brainer that we would partner on community benefit moving forward.” Besides working on the CHNA together, they identified a priority need to
address together. This collaborative included pooling financial resources and working with an community organization and committee to design the program needs and track the impact.

**h. RESEARCH QUESTION 6: What have been the benefits and barriers to incorporating prevention activities into their community benefit IS plans?**

Although the question asked about the benefits and barriers to incorporating prevention into the hospital IS plans, the hospital stakeholders responded to the overall experience to the planning process and addressing the new requirements. About half of the hospitals stakeholders interviewed reflected on multiple benefits of the community benefit requirements recognized through the planning processes. See Table XIV.

<table>
<thead>
<tr>
<th><strong>Table XIV: Hospital Reported Benefits</strong></th>
<th># of Hospitals</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Organizational Commitment to Community Benefits</td>
<td>2</td>
<td>Stakeholder Interviews</td>
</tr>
<tr>
<td>Focus their Community Benefit Programs</td>
<td>2</td>
<td>Stakeholder Interviews</td>
</tr>
<tr>
<td>Value of Engaging the Community</td>
<td>3</td>
<td>Stakeholder interviews</td>
</tr>
<tr>
<td>Hospitals and Public Health Collaboratives</td>
<td>4</td>
<td>Stakeholder interviews</td>
</tr>
</tbody>
</table>

**i. Benefits**

The stakeholders interviewed spoke more broadly to the benefits of the process and learning from their community and hospital partners. One hospital highlighted that the CHNA was not only utilized to meet the requirements but it assisted other departments and staff in organizational planning. The hospital stakeholder felt that it was positive that staff across their organization were coming to them and stated,
“With the ACA and changes over the last few years, we, as a system, are utilizing the numbers (from the CHNA) more than we have before. We get more questions and outreach from other internal stakeholders including senior leaderships and Vice Presidents on what they are working on. They are all utilizing the needs assessment more than they would have otherwise in the past.”

a. Benefits- Increase Organizational Commitment to Community Benefits

Two large urban hospitals mentioned the positive implications of the requirements, including that it helped renew their organization commitment to the community benefits. One hospital stakeholder said,

“It’s been very positive for our hospitals. Our CEO feels the same way. I guess it’s rare that an IRS requirement is being viewed so positively but it really is. We have embraced it. It could have been a report that sits on the shelf but we’re not doing that. It’s really important to us.”

b. Benefits- Focus their Community Benefit Programs

Two stakeholders from major teaching hospitals noted that the CHNA and IS requirements helped them enhance and concentrate their programs in the community. They were doing various efforts throughout the organization but it was disjointed. The community benefit requirements helped them narrow the scope of their efforts, identify gaps, and document all of their existing internal activities to recognize what was going well or where they need to devote more resources or staff too. In general, there seemed to be consensus that it helped them formalize their activities and efforts across their organizations.
• “When 2012 came around, we began getting back to a formal process and it became more intentional. I think it got more discipline. I think that these groups, like the steering committee, community benefit management groups came to the table to more effectively and efficiently gather this information.”

• “It’s pressing all of us as hospitals to be all more focused in our community work.”

• “I am pleased with how we have been able to grow the amount of community benefit and engagement work or refine it and make it certainly as genuine as it can be. It is great to be a part of it because we all want to make a difference. This has certainly been a way to do that and to be better organized around it and I am hopeful we can continue to make an impact.”

c. Benefits- Value of Engaging the Community

Three stakeholders, all from large teaching hospitals, reflected on the value of learning from the community throughout the process about the needs, existing efforts and gathering recommendations. One hospital stakeholder said,

“Outside of being able to talk to community members, we need advice and feedback from external groups so that we can get a better handle on what is being done, what the people need, what else we can do to strengthen the programs that are in place in the community.”

Another hospital stakeholder stated that the community helped with a “honest assessment of what needs were and hoped the hospital could be engaged in the community.” Hospitals also emphasized that the process helped them learn how to include the community and one stakeholder said,
“We learned how to better engage community representatives at the individual and organizational level as well as with policy makers within communities and across neighborhoods.”

d. Benefits-Hospital and Public Health Collaboratives

Four hospitals emphasized that some of the most positive aspects of the community benefit requirements were the public health and hospitals collaboratives that were formed. The hospitals recognized that in order to be responsive to the new requirements, they needed to work at improving health outcomes using a population health approach. Two hospital stakeholders highlighted the value of the Health Impact Collaborative of Chicago and that without the assistance of the Illinois Public Health Institute, they would have never been at the table working with all of their competing hospitals trying to identify what they could address together.

ii. Barriers

With the new requirements, several hospitals felt the burden of adjusting previous community benefit practices and learning how to change their expenditures and program approaches to address their community needs. Many hospital stakeholders shared the barriers, including the inability to address all of the priority needs, shifting their focus from clinical services and the timing and understanding of the requirements. See Table XV.

<table>
<thead>
<tr>
<th>Table XV: Hospital Reported Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of Barriers</td>
</tr>
<tr>
<td>Shifting from clinical care</td>
</tr>
<tr>
<td>Time</td>
</tr>
<tr>
<td>Understanding of the requirements</td>
</tr>
</tbody>
</table>
a. Barriers- Shift from Clinical Care to Community Health

One of the main purposes of the ACA and the community benefit requirements were to reduce costs and improve quality, increase access to care and address the broader community needs. Hospitals stakeholders reported the requirements expanded their services beyond clinical care despite their lack of experience supporting this type of work. One hospital stakeholder said,

“We are used to for years working within the walls of the hospital and this pushing out and upstream and looking at upstream things and social determinates is new. Anybody coming in with that expertise would be very easy to judge groups harshly that are brand new to this. There were financial constraints on things like that too. The smaller the hospital the more challenging it can be.”

b. Barriers-Time

Four hospitals specifically mentioned that the time frames to produce the CHNA and IS were challenging because it was labor intensive. Two stakeholders, both from major teaching hospitals, referenced that the length of time to complete the CHNA was a barrier because three years was a short time period to conduct the assessment, develop and execute the implementation plan.

Another time related barrier was that the CHNA three-year reporting cycles were not aligned with the timing of health departments Community Health Improvement Plans, also known as I-Plans in Illinois. Health departments produced these plans every five years to meet for Local Health Department certification. One hospital stakeholder stated,
“I will say that three years seems really quick. I think health departments are required to do their assessments every five years. I wish we were in sync with the health departments. That’s makes it hard”

Three hospitals stakeholders said they faced barriers coordinating hospital CHNA and IS cycles when they acquired smaller hospitals because the guidance around alignment after consolidation was unclear. One hospital stakeholder said,

“Another challenge was syncing up hospitals timelines when they merged to become part of a larger system. They were unable to align the timing of the CHNA and IS for the system to have them come out at the same time.”

c. Barriers-Understanding of the requirements

Four hospitals expressed challenges understanding and quickly addressing the reporting requirements within the first cycle. A challenge was to what degree were hospitals allocating funding away from charity care and into community benefits and building activities. Other requirements related to barriers referenced were how to interpret the IRS requirements and education and training staff on community health. One hospital stakeholders said,

- “There were some learning curves. It was certainly a learning curve for me. It was an esoteric project. It was something we had to do and we didn’t really understand it. Value-based care was early and we are still in the early part of that. The whole system was changing and stuff was changing slowly.”
- “The first time around, you may have heard, we were trying to figure out what the rules mean, what we were supposed to be doing and even just defining community was a
i. RESEARCH QUESTION 7: How have tax-exempt hospitals undertaken prevention activities in their IS plans?

a. Hospitals Community Benefit -IS Plans Findings

In addition to asking the hospital stakeholders about the inclusion of prevention programs, the IS plans were evaluated. The plans were categorized based on the five levels in the Health Impact Pyramid to determine what level of prevention their activities addressed. As previously mentioned in Chapter 2, the Health Impact Pyramid was a public health model that aims to identify strategies and programs that will have the greatest impact representing primary, secondary and tertiary prevention (Frieden, 2010). The purpose of this evaluation was to determine how hospitals addressed the new requirements and identify if they incorporated strategies in their IS plans that addressed primary prevention or if they continued to target the specific needs of individuals through clinical services or education. The 13 hospitals identified a total of 315 programs to address their community needs. The number of strategies and programs hospitals planned to implement in the three-year cycle based on their IS plans ranged from 5-48, which did not differ based on the hospital size.

Figure 8 below categorized the 13 hospital IS plans using the five levels of the Health Impact Pyramid. The pyramid includes: “1. Counseling and Education; 2. Clinical Interventions; 3. Long Lasting Protective Interventions; 4. Changing the Context to Make Individuals Default Decisions Healthy; and 5. Socioeconomic Factors” (Frieden, 2010).
In evaluating the IS plans, 43% percent were counseling or health education activities, including health fairs, education around diabetes, obesity prevention, nutrition and asthma and counseling services around cancer screening and mental health (n=136, 43.2%). Approximately a quarter of the health needs were being addressed through clinical services, including offering asthma therapy in schools, cancer and diabetes screening and treatment for sexually transmitted infections (STI), (n=88; 27.9%). Hospitals reported 10% activities as long last interventions and another 10% addressed socioeconomic factors (10.2% and 10.8%, respectively). The remainder of the hospitals reported activities focused on “changing the context to make individual default decisions healthy,” through activities like smoke-free policies or advocating for sugar-sweetened beverage taxes (n=25, 7.9%) (Frieden, 2010).

Overall, the strategies in the IS plans primarily consisted of individual education and clinical intervention services that were offered in the hospitals. Some of the hospitals identified that they were continuing existing activities. Although there has been an increased emphasis on addressing
more upstream primary prevention activities and the social determinants of health, only about 30% of the hospitals activities included these types of strategies.

j. SUMMARY

In summary, the study findings confirmed that there are several factors that impact the inclusion of the programs in hospitals IS plans. The study revealed that the transforming health care market impacted hospitals ability to address particular community needs due to competing priorities. Community engagement around the IS varied among the hospitals IS based on their experience and organizational support. The public health and hospital collaboratives were instrumental into helping the hospitals understand the social determinants of health. Furthermore, senior hospital leadership was found to be essential to fostering buy in, and direction to community improvement activities and supporting the participation in hospital and public health collaboratives. Thus, it is an opportune time to build on the factors that have helped hospitals embrace and engage the approach towards community health improvement.
V. DISCUSSION

a. GENERAL DISCUSSION

The introduction of this new requirement and focus around community health improvements into the IS plans represented a major paradigm shift for most hospitals. Up until this time, hospitals focused on access to health care services or various aspects of clinical services and their delivery. These interventions were designed to help individuals and disease populations, but achieved limited public health impact or long-term change.

This study explored the factors that impacted hospital organizations decision-making as it related to the community benefit process, recognizing the market, community, organizational and leadership factors that may affect the inclusion of prevention and evidence based programs. This study utilized data from multiple levels, including the IRS Schedule H -Form 990, the select hospitals IS plans and interviews with 13 hospitals within the state of Illinois.

The study found that that hospital decisions and drivers around which programs to include in their IS plan, particularly those focused around prevention and evidence-based practices, were varied. There was not a single factor or driver impacting how hospitals addressed the requirements. Rather the major themes that emerged from the data on the inclusion of prevention factors into the IS plan were multifaceted. The main themes included:

- A professed need for a clearer guidance and more training for hospitals around prevention and evidence-based practices to improve population health
- The need to continue to develop and evolve toolkits and resources to support tax-exempt hospitals by national associations inclusive of best practices, evidence-based programs and implementation tools
• A broad range of approaches, programming and engagement models with the community and collaboratives around the IS plans, highlighted the need for additional guidance around community benefit and building activities, particularly if the goals are to shift hospitals towards more community health improvement approaches.
  
  o Community and public health organizations helped foster collaboration among the hospitals which may have occurred due to limited staffing or resources

• Hospital research centers aided with knowledge of evidence-based practices, the understanding of the social determinants of health and the ability to engage with community organizations throughout the IS planning process

• A validation of senior leadership support—described in other studies—was deemed essential to championing the community benefit activities, fostering organizational buy in and encouraging community partnerships

i. Key Findings- Factors Impacting the Inclusion of Prevention Programs

The first research question sought to find out about the overall factors that impacted current IS plans inclusion of prevention and evidence-based programs. The findings from the study showed that there was less of an emphasis around the factors that influenced the inclusion of prevention and evidence-based practices in the IS plans as originally expected would shift as a result of the new IRS requirements mainly due to competing market priorities and limited knowledge of them. Another potential reason is that the IRS requirements do not provide detailed instructions around the types of programs to consider in the IS plans. The ACA provided more guidance around the funding categories for community benefit and building. However, hospitals overall showed a significant variation around the programs and activities included in their IS plans and the number of programs they were implementing, with several continuing to
provide ones focused on education and clinical care which were a continuation of existing programming. These findings around the continuation of existing clinical programs were also found by Pennel and colleagues in an examination of the CHNA and IS plans during the first reporting cycle (Pennel et al., 2015).

The stakeholders that mentioned prevention, evidence-based programs and the social determinants of health were from hospitals that already embraced community health improvement strategies driven by their own internal research centers and through existing engagement of community partners. The awareness and readiness of large academic hospitals with research centers of evidence-based practices and prevention programs seemed higher than the other participating hospitals. The ability to utilize subject matter experts from these academic hospitals and address the priority needs was also more common potentially due to the knowledge of prevention programs, established community partnerships, and the resources invested.

The few hospital stakeholders mentioned that they included prevention and social and economic strategies because their hospital and public health collaboratives that helped them recognize why they had to address the root causes of the issues. This suggested that the collaboratives were more likely to help the hospitals focus on broader community health strategies.

Although the findings showed a slight shift in programming towards prevention and the social determinants, more work was needed to help the hospitals with this transition. The lack of emphasis and details around prevention and evidence-based factors from stakeholders and in the IS plans could have been attributed to numerous factors, including: 1. The hospitals stakeholders interviewed were less familiar with the public health categorization of programs, evidence-based
practices and faced challenges in identifying activities to address their needs; 2. The IRS requirements did not indicate where hospitals allocate their funding or that they must address the community needs, which Rosenbaum and colleagues noted was a shortfall because hospital could have devoted their spending to their own operations, including Medicaid reimbursement, research and education (Rosebaum, 2016); 3. The way in which research questions were developed and asked could have led to confusion and additional clarification was perhaps needed; and 4. Hospitals were still transitioning programs from charity care and clinical care and there was not enough guidance or details around these new requirements and how to incorporate prevention programs.

In general, there seemed to be a lack of awareness around evidence-based practices or consideration of prevention programs by the majority of the hospitals. When asked about their definition around prevention and use of evidence-based practice, they generally spoke more broadly to how they were adapting to this new requirement and the process they used when considering the programs. When thinking about the potential disconnect, it may also be that hospitals have traditionally focused on providing clinical care or secondary and tertiary treatment for their patient populations rather than prevention. There may be limited understanding by hospital leadership on these practices and how to work more closely with public health and their communities on how to incorporate them into their IS plans. One potential opportunity is to revise the definitions around community benefits to focus more on prevention and evidence-based programs that have been proven to reach and impact more of the population (Rubin et al., 2015). This change would most likely decrease some of the persistent ambiguity for hospitals and the communities they serve and align with the broader health care reform to focus on population health improvement (Berwick, 2008).
These findings although surprisingly were somewhat similar to other studies and to be expected because for the last 50+ years hospitals focused on providing charity care (Young et al., 2013). The findings highlighted that additional opportunities are needed to help the hospitals understand the prevention programs available to address their needs since the goal of the IRS requirements was to help improve community health. This underscored the potential need to strengthen and clarify the IRS guidance. Also, the study findings highlighted the opportunity for public health departments and community organizations to assist hospitals in the planning processes to enhance and align community health improvement efforts.

ii. Key Findings- Related to Market Factors

Market factors, inclusive of federal, state and local issues were described by stakeholders more than any other factor as impacting the IS plans and their overall hospital operations. The quickly evolving federal and state requirements and implications from the ACA and other market issues challenged hospitals’ ability to address the new community benefit requirements.

Eight hospitals reported that competing market priorities, mainly introduced from the ACA, impacted their capabilities to meet all of the needs identified and requests from their community partners. Some of the competing priorities that hospitals reported undergoing included becoming ACO, focusing on lowering readmission and getting patients enrolled in the insurance exchanges. Community benefit staff were juggling multiple requirements and some were overburdened by having to rapidly adjust their operations. These findings illustrated that community benefit activities could have been considered less of a precedence compared to other federal reforms that hospitals were trying to meet in the evolving health care market.
Medicaid expansion and reimbursement were overarching market themes that nearly every hospital referenced as one of their largest challenges and impacting their community benefit programs. As a result of the ACA health insurance requirements, the number of uninsured individuals was expected and in fact did decline. Because Illinois was a Medicaid expansion state, approximately 650,000 received coverage, resulting in a massive influx of patients and a Medicaid reimbursement shortfall. The staff were prioritizing enrolling patients, which then limited their capacity to simultaneously manage the other community needs. (IHHA, 2017). These findings were in alignment with other national studies. The expectation was that in Medicaid expansion states and with the insurance mandate, hospitals charity care spending would decline and the funding could be allocated to other community benefit activities (Colorado Health Foundation, 2015). However, among the stakeholders, their hospital struggled with Medicaid shortfalls and reimbursement for some of the services they provided. The findings were similar to Ascension Health hospitals that operated in Medicaid expansion sites and saw reductions in charity care but Medicaid shortfalls rise (Kaiser Family Foundation, 2013). Hospitals stakeholders reported that they had to shift the majority of their attention to reimbursement and funding shifts. Due to the recent tax reform and repeal of the individual mandate, it will be interesting to see the potential consequences on hospital revenue and if the pendulum will shift back to having hospitals providing more charity care (Politico, 2017). As stands today, there is likely to be a decline in the number of individuals enroll for insurance and the cost of insurance is projected to increase to make up for these potential shortfalls (Politico, 2017).

One of the other notable market themes that stakeholders expressed were challenges understanding the new requirements. These findings were consistent with ones noted by
Rosenbaum and Pennel and colleagues, which found that the requirements around IS plans and community benefit and building activities lacked detail and could be interpreted differently by the hospitals (Rosenbaum, 2016; Pennel et al., 2015). The various community benefit and building categories on the IRS Schedule H Form 990 required separate categorization and the community building activities required additional justification for the needs the hospitals addressed. This suggested a potential opportunity to clarify the instruction from the IRS and the contributing organizations, such as the CDC, to achieve a common interpretation and provide recommended evidence-based strategies and initiatives that aligned to the various categories.

iii. Key Findings- Utilization of Resources and Training

Some stakeholders reported that they utilized national resources, including those developed by the Catholic Health Association and the American Hospital Association, as guides for categorizing programs and activities and for examples of community benefit and building activities. Overall, the hospitals found a benefit to the guidance from the national nonprofit organizations, such as the Catholic Health Association and the American Hospital Association. Encouraging these associations to avail those resources to hospitals could continue to help strengthen their community benefit IS plans, provide greater clarification and encourage coordination of efforts with public health to meet the community needs. Simultaneously, a recommendation is to provide continued support to the leadership of these associations so that their guides and resources can evolve, remain current and provide the best evidence to guide hospitals.

iv. Key Findings-Related to Community Collaboratives and Partnerships
The benefits of the collaboratives were mentioned extensively by the stakeholders. Included was the value of data sharing, organization and facilitation of collaborative workgroups, and education on prevention and the social determinants of health. Hospital stakeholders all recognized this was a new benefit and most stated that without these collaboratives, they would have struggled to coordinate with public health and community organizations to gain their input to CHNA. Without the collaboratives serving as a convener and neutral facilitator, the hospitals might have continued to work on their community benefit activities in siloes rather than pooling their resources and utilizing a collective impact approach.

The expanded partnerships with community organizations and public health departments were new to most of the hospitals. While the majority of hospitals participated in the collaboratives and worked collectively on the CHNAs, there was a range of involvement and engagement that hospitals had with community partners and public health for the IS plans. Some hospitals included community partners to help identify and implement programs that were feasible and could address the root causes of some of the community health needs. Stakeholders emphasized that they needed to include the community around the CHNA because it was part of the requirements. But there was less emphasis and detail around the community engagement needed for the IS plan. Some hospitals brought the CHNA developed in partnership with collaboratives back to their hospitals and made decisions around the IS plan programs internally. Another potential reason for the lack of community involvement with the IS plans is there is less transparency around them in most states and the IS plan is not required to be publicly available. Illinois is an exception because it requires the hospitals to make the IS plans publicly available. An opportunity exists at the IRS or state level to increase community engagement guidance in the IS plan process and to make the IS plans publicly available nationally. There is also the
opportunity for the hospital and public health collaboratives to continue supporting the hospitals, beyond the CHNA, in the development and implementation of the IS plans. The collaboratives highlighted the importance of helping the hospitals think beyond clinical strategies to ones that could lead to long term community health improvements (Prybil et al., 2014)

v. Key Findings- Related to Hospital Based Research Centers
Hospitals with existing internal research centers were better prepared to address the new community benefit requirements. They had an existing infrastructure in place to collect and analyze data and already had partnerships in place beyond their hospital walls to address the identified needs. These hospitals were more likely to look at how to address the community health issues and develop multipronged approaches with the community to establish programs and policies. For example, one hospital selected a gun violence as a priority. The hospital developed a gun violence prevention policy agenda, established a care coordination model and trained service providers on transitioning youth with violence issues out of the justice system and enhanced evidence-based protocols for the Emergency Department Room to promote interventions and follow up to prevent future violent encounters.

All of the hospitals with existing research centers were from large teaching hospitals with extensive available resources and subject matter experts. These centers utilized public health frameworks to address their community needs. A recommendation is for the partnering of the large teaching hospitals with research centers with smaller hospitals to support evidence-based prevention initiatives and models to address the social determinants of health and their community needs.

vi. Key Findings-Related to Senior Leadership Support
Senior leadership support, from the CEO or VP level, that was vested in addressing community benefits and the changes to meet the requirements, were instrumental in getting the organization staff on board, aligning strategies and gathering sufficient resources. For this study, stakeholders identified senior leadership as important and identified communication, championing, organizational alignment, and promoting partnerships as key leadership qualities crucial to addressing community benefits. Without their leadership backing their community benefit efforts, they would have faced challenges getting internal committees together, corralling organizational alignment, and promoting the value and coordination with the public health and other hospitals collaboratives.

The leadership was also responsible for recognizing overlap in community needs and championing outreach to other hospitals or backing the participation in the hospital and public health collaboratives to collectively work on addressing these needs. One example is the Health Impact Collaborative of Cook County, which is a 25+ hospital and seven public health department collaborative to address community needs. Without leadership encouraging participation in these collaboratives, the hospitals may have remained in their silos, doing clinical services and continued to focus on what happened only within their hospital walls and would not have worked collectively with community partners. The leaders recognized that they should be doing more and knew that they needed to work collaboratively to address the social determinants of health and on prevention and the collaboratives were one way to do this. This presents an opportunity for hospital leadership executives to educate other hospitals leadership about prevention and evidence based practices and the value of aligning with other partners to improve community health.
The significance of strong leadership support as essential to generating organizational alignment and championing new priorities has been identified in other studies (Damschroder et al. 2009). Leadership helped with overall commitment of resources and the recognition that they should be working to improve the health of the broader community. A difference this study was that the stakeholders did not emphasize their leadership commitment to community benefits because of the potential alignment to value-based care reforms. A recent report conducted by the New York State Hospital Foundation found leadership commitment was centered around fulfilling their mission and decreasing overall health care costs (Chen et al., 2016). Value-based care and overall health care cost reduction was not mentioned by these stakeholders.

b. STUDY STRENGTHS & LIMITATIONS

i. Strengths

This study methodology had strengths and limitations. The study examined the community benefit IS planning process from the hospital stakeholder’s perspective. Previous research looked at the CHNA process and the alignment with public health departments, and the financial spending by community benefit and building categories but did not examine broader factors that might influence the IS planning process. Recent studies looked at the roles and perspectives of outside entities including consultants and public health departments stating the opportunities to align their efforts around the CHNA (Pennel et al., 2015). Because this was considered a contemporary phenomenon, there was limited research on this topic. The majority of research around this topic by Tahk, Young et al., Singh et al. and Rosenbaum et al. and others mainly described the hospital spending on programs and activities, trends and changes after the ACA.
The strength of this qualitative case study was that it took into account the spending patterns based on the IRS Schedule H Form 990 reports and the quality of the IS plans for the site selection. Another strength was the ability to triangulate the IS plans with the qualitative findings which focused on the market, organizational, community and leadership factors that played a role in hospitals IS plan decision-making process and the various programs incorporated. The study focused on Illinois as a case and 13 hospitals as embedded units, which allowed for triangulation of IS plan data and the qualitative data from the stakeholder interviews. Although the generalizability of this study was low because it was a case study, the findings identified potential future research and insights, and practice and policy changes in relation to community benefit planning for community organizations, public health and hospitals.

ii. Limitations

However, although the study had strengths, there were also limitations. The site selection data, including the IRS Schedule H Form 990 from 2012 and the accuracy of the hospital reporting and categorization of the funding on this form was unknown and do not account for recent changes in spending. Additional guidance to hospitals around these the funding categories was issued in 2013 and 2014 after the first cycle of CHNA and IS plans were completed after multiple rounds of input and revisions. The guidance provided more details around consistency in reporting which may have meant hospitals shifted their spending patterns in the second reporting cycle due with this information. Efforts were made to address the limitations with the IRS Schedule H Forms 990 from 2012 by using other data sources for the site selection, including the IS plans.

Another limitation was the findings was the study setting was limited to Illinois as a case, the selected 13 hospitals, which aimed to be representative of a range of embedded units based
on criteria and size/geographic location and teaching affiliation. The study was not representative of all tax-exempt hospitals in Illinois and only accounted small percentage of hospitals that met the IRS requirements and resulted in low generalizability and ability to conduct additional statistical analysis.

One of the other limitations was the diversification of hospitals based on their demographic information. Efforts were made to get a representative sample of hospitals throughout the state of Illinois based on the percentage of spend allocated towards community benefit activities, the quality of their implementation plan, their size/ location and teaching status. However, there was a limited response from the small or other urban hospitals, who either did not want to participate or mentioned that they did not have time. The larger urban hospitals allocated more staff to work on community benefit activities, whereas the smaller or other urban hospitals seemed to have either one person dedicated to it or it was added as a new responsibility to their existing role. Consequently, the original approach to focus on hospitals based on spending, quality of the IS plans and location was modified to try to get a sample of various hospitals throughout the state based on their location/size and teaching status. This adjustment allowed for the inclusion of hospitals that would have varying level of resources, and market dynamics.

Within each embedded hospital unit, the study was limited by the ability to engage hospitals stakeholders to participate in the study. The researcher did not have existing past relationships with the hospital staff and therefore, the original outreach approach proved to be more difficult than originally anticipated. In addition, another challenge was reaching a larger representation of hospital staff who were involved in the CHNA and IS planning. It was difficult to interview staff at the various roles at the hospitals, including leadership, administrators and community benefit
managers who may have had crucial roles in decision making. This were fewer staff that were actually involved in the community benefit process than originally expected. Also, the hospital staff that were interviewed either did not refer to additional colleagues for their perspective on the process or if they did, there was no response from that organizational stakeholder names passed along to get their insights. Given these challenges, there were not as many stakeholders interviewed.

Requests were made at the end to the stakeholder interviews for supplemental documents regarding the community benefits process, origins of partnerships, and meeting agendas and minutes. Only two hospitals shared planning documents, which had limited additional content around prioritization, decision-making and program planning besides what was captured through the interviews or the IS plans. It was difficult to determine if other documents would have provided additional insight to research questions or if hospitals did not document their processes well.

The qualitative interviews were self-reported by the hospitals staff around their community benefit processes and it was challenging to gather the full picture of the organizational decision-making processes, particularly when in some instances only one stakeholder from the hospital participated in the study. Another limitation was potential reporting or response bias, that the stakeholders from the hospitals might not have been accurate or truthful in their responses to the semi-structure interview questions.

Similarly, there was a potential for recall bias. Qualitative responses relied on knowledge and recall from the stakeholders related to details about planning processes that occurred one to two years prior based on the CHNA and IS cycle, which might have been challenging (Durand and
Hospitals were undergoing various transitions besides those related to community benefit planning which could have limited their ability to recall specific details. Due to the various timeframes of the community benefit cycles, stakeholders were asked to recall what impacted their planning process which occurred between 1 to 3 years prior. These were longer than ideal recall periods and the historical details might have been limited (Miles and Huberman, 1994; Durand and Chantler, 2014). The triangulation of CHNA and IS plan information aided in addressing the research questions and address the validity of the results.

With respect to the timing and data collection, there was another limitation to note. While hospitals were in the second cycle of their community benefit cycle, new guidance and resources were coming out from the IRS, the American Hospital Association and the Catholic Health Association. As a result, they were learning new details behind the community benefit requirements as the interviews were occurring. The context and knowledge around the ACA, community benefits and prevention initiatives were in a state of transition and the stakeholders were learning to adapt and implement new policies and practices quickly.

With qualitative research, there was always a potential researcher biases and perspectives around the hospitals community benefit processes and around how to determine the significance of the stakeholders comments and in reviewing the IS plans (Miles and Huberman, 1994). To address the biases, direction quotations were used when applicable to support the interpretations. Member checking was completed with the participants by sharing back the transcriptions from their respective interviews.

The main researcher had background in public health and identified the potential topic based perceived disconnect between hospitals with community organizations and public health around
the CHNA and IS plans which was the impetus for the study. As a result, the researcher decided to focus on the hospitals perceptions around the community benefit processes, rather than community organizations or public health departments perspectives. Also, memos were developed after the interviews and reviewed with the second researcher to determine if the findings aligned with results and noted the objective results and separate any potential feelings or biases.

c. IMPLICATIONS

The study was driven by the ACA and the IRS updates to the community benefit requirements that refined hospitals to have a more crucial role in improving community health and address the social determinants of health. These requirements identified an opportunity to determine how hospitals incorporated broader based prevention health strategies into their IS plans and the factors driving their approach. Study findings highlighted the essential factors and underscored the variations in hospitals approaches.

i. Training for Hospitals around Prevention and Population Health

In order for hospitals to adopt and incorporate prevention programs and address their community needs, it is critical that they are educated and trained on these services and approaches. The hospitals need support around these evidenced-based practices focused on community health to expand their capacity and scope. From the findings, it appeared that many hospital stakeholders were unfamiliar of public health or evidence-based prevention practices, which may have limited their ability to identify and incorporate them into the IS plan. Given the significant amount of funding available for community benefits, it may be beneficial to provide them with the training and workforce development programs focused on population health strategies. This also supports recent studies that have noted that in order to attain population
health improvements, more training and workforce programs are needed to help with the integration of public health and health care (IOM, 2012). With the ACA goals to improve population health, there are various opportunities besides just the community benefit programs, for aligning more public health and clinical care training to address common needs and create a more efficient health care system. The study findings highlight that the tax-exempt hospitals might be positioned well to begin training and workforce programs to learn new population health approaches and align efforts with the community.

**ii. Opportunity to Partner with Public Health**

One purpose of this study was to examine the hospitals perspective around the community benefit requirements to inform public health on how they can serve as better partners during this transition. Based the findings around the hospitals current state, they are undergoing major transitions. As hospitals and payers are shifting their approaches to investments in upstream interventions inclusive of prevention, it is an opportune time for public health to work with them to collectively design programs that promote community health improvement.

There are several opportunities for public health practitioners to partner with the hospitals due to their training and experience around prevention, evidence based practices and the social determinants of health. Public health practitioners could work with the hospitals to offer trainings and best practice guides around prevention and evidence-based programs and how to adapt them based on their community needs. Public health may also consider working in in conjunction with the American Hospital Association, Association for Community Health Improvement and the Catholic Hospital Association, who hospitals deferred to for guidance around the new community benefit requirements and resource guides. Public health could also learn and identify the additional provisions that hospitals are undergoing as a result of the ACA and see where
there are opportunities to align the new models of health care deliver and payment with the community benefit efforts.

By partnering with public health on best practices and trainings, hospitals may also learn new approaches on engaging and working collectively with the community. Although sometimes constrained by resources, public health has the ability to identify and implement programs that have been proven to be effective based on proven outcomes, are practical in a community setting and can provide guidance on how to partner on capacity building initiatives. If public health and hospitals can collaborate more around their community benefit efforts, there is a greater potential on improving the health of the communities they serve.

iii. Expand the Role of Community

Even though the IRS requirements called for community and public health input in the CHNA, there is the need to expand their involvement in the IS plans. The level of input by the community organizations needs to be defined in greater detail and throughout the IS planning process to ensure some level of consistency by the hospitals. As identified in the study, hospital stakeholders noted a wide variation in the input and engagement with the community around the IS process. Community members and public health offer valuable perspectives on the programs feasibility and acceptance, as noted by the hospitals with establish community committees. Other studies emphasized the benefits of including the community in assessment and program planning and implementation processes (Shortell et al., 2002). More community involvement offers additional promise around oversight and evaluation around the IS plans and strategies. The findings from this study and others provide a potential opportunity to strengthen the IRS regulations around the community engagement roles.
d. RECOMMENDATIONS

Based on the study findings and the literature, there are several recommendations for policy, community and public health organizations, national hospital associations, hospital leader and for future research considerations to improve the community benefit IS plans. The purpose of these recommendations is to expand the knowledge around the community benefit processes and identify opportunities for improvement with the current IRS and state policies and requirements. These recommendations expand on those identified by Rosenbaum et al., 2013, Rubin, Signh et al., 2015; Young et al., 2018.

i. Policy Recommendations for the IRS or State Policy Makers:

- Develop descriptions, guiding principles and additional directions around for Schedule H Form 990 around the utilization of evidence-based prevention programs to improve community health
- Include guidance or requirements around involvement and engagement of the community and public health in the IS planning process to encourage cross-sector collaboration in support of community health improvement approaches, not just in the CHNA
- Convene and develop a structure or criteria to evaluate the IS plan and programs, inclusive of process and outcome measures, and level of community input, for increased accountability, guidance and a shift towards outcome based community health
- Expansion and clarification around strategies and programs inclusive to address the social determinants and evidence-based prevention programs to decrease the ambiguity of hospitals interpretation of the requirements
• Establish thresholds for spending allocated towards direct community health improvements services compared to the services focused on hospital internal operations, such as health professional education and Medicaid shortfalls

ii. National Hospital Associations:

• Continue to develop trainings, resource guides and best practices for hospitals in collaboration with public health departments and agencies to help them transition from clinically focused community benefit approaches towards activities to address community health improvement and the social determinants of health

iii. Community Organizations, Public Health and Local Collaboratives:

• Expand existing Chicagoland collaboratives across the state to leverage the collective impact framework and identify mutual partnership opportunities, resources and strategies focused on community health improvements

• Extend the role of the collaboratives beyond the CHNA and training to include the assistance with the development, implementation and evaluation of the IS plans inclusive of evidence-based prevention programs and community input

• Increase the training and facilitation support to the hospitals around the IS planning process to bridge new partnerships to address the community needs

• Modify the State’s Community Health Improvement Plan reporting timeline to align to the three-year timelines for the CHNA and IS plans to encourage partnerships between local health departments and hospitals.

• Partner with the hospital associations to offer trainings and co-develop best practice guides to educate hospitals around evidence based prevention programs and how to work with communities on health improvement initiatives

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iv. Hospitals & Hospital Leadership

- Of those hospitals who have familiarity with population health approaches and shifted their community benefit activities, provide recommendations, best practices and strategies
- Identify and mentor other smaller or less resourced hospital leaders around the value of collaboration and coordination through sharing data, partnering with public health and the community, and the importance of championing multi-pronged evidence-based practices approaches for community health improvement

v. Recommendations for Future Research Studies

- Expand the analysis of hospitals spending and the quality of their IS plans across IL and nationally to identify variance based on state reporting requirements
- Assess the familiarity, training and utilization of evidence-based public health practices and the social determinants of health by hospitals to identify future training opportunities
- Identify additional factors and drivers influencing the identification and implementation of evidence-based public health practices by hospitals in the community benefit planning processes to help inform policy moving forward
- Assess potential future changes to community benefit spending and programming based on the new tax reform to see if program funding shifts occur particularly around charity care

e. REVISED CONCEPTUAL FRAMEWORK

This study began with the idea that there were certain factors that impacted hospitals to incorporate prevention and evidence based programs into their IS plans. A conceptual framework
was designed based on a literature review. The findings from this study identified that various factors from the conceptual framework interacted and impacted the hospitals decision making around their IS plans.

An array of modifications were made to the conceptual frameworks because not all of those factors and sub-factors on the original framework influenced the hospitals community benefit IS process and as a result, the conceptual framework was updated and the changes were highlighted. See Figure 9. The following questions were considered when modifying the framework:

a. What a-priori factors and sub-factors were reflected in the findings?
b. What needed to be added based on emergent themes?
c. What factors or sub-factors should be omitted?
d. What modifications should be made to the terminology, particularly of the factors or sub-factors based on the data gathered that would reflect more common language used around the community benefit process?

i. Modification to Market Factors

With the conceptual framework, the market factor terminology needed additional clarification from some hospital stakeholders. The question around market factors was relevant to hospital participants that served in a policy or government affairs position. However, there were a limited number of stakeholders in this role that were interviewed and therefore, more description was needed to clarify the federal, state and local policy and regulations sub-factors that were of interest for this study. Additional probes and clarification was added to the interview guide to provide more detail around the market terminology.
The following market sub-factors were added based on the frequency of stakeholders mentioning the impact on their IS planning process: consolidation, understanding of the new requirements, IL state budget and mental health services. Hospital stakeholder referenced that consolidation impacted the timing and coordination among the newly acquired hospitals. The state budget and lack of mental health services and reimbursement impacted hospitals willingness to address it as part of the IS plan and challenged their ability to partner with previous mental health organizations.

The following market sub-factors were omitted from the conceptual framework, value-based care and practice standards. These two were not referenced by hospitals as reasons for inclusion or alignment of various programs or impacting their decision making around the IS plan. The initial thoughts were that with the growth of ACO and value-based care contracts, hospitals would align their payment programs with various IS programs to improve the social and economic needs of their populations. Perhaps the larger hospitals in Illinois were still moving in the direction for collaboration around these federal requirements and there will be opportunities in the future to align these efforts at the practice and policy levels.

ii. Modifications to Societal/ Community Factors

One of the original research question asked, *What societal factors have influenced hospitals to incorporate prevention activities into their community benefit plans?* The word *societal* appeared too broad to the hospital stakeholders interviewed for the study and the second researcher and additional clarification was added for the interview guides. As a result, the research question changed, the factor was changed to community. Besides the existing sub-factors, new ones emerged which included: public health and hospital collaboratives, previously established relationships, and historical involvement in hospital committee decision making.
These terms described the contextual nature of involvement between community organizations and hospitals.

Besides adding community sub-factors, a few sub-factors, population demographics and community resources, were omitted because they were not mentioned. Availability of community resources was not mentioned as a reason for incorporating various strategies and programs in the IS, besides mental health which was also listed as a major state challenge by nearly every hospital. As a result, mental health services were added to the market factor because the reimbursement and lack of access were due to a variety of state challenges.

The updates to the community factor and sub-factors highlighted how interaction with community organizations might change in relation to the local environment. The modifications also reflected initiatives that occurred at the local and state level including collaboratives between the hospitals, public health and community organizations to improve the health and address the social determinants of health.

### iii. Modifications to Organizational Factors

Within the organization factor, strategic priority, staffing, and knowledge of the social determinant of health were added. Modifications to the sub-factors included changing infrastructure to existing research centers, and modification from type, size and affiliation to size/location and teaching status. The changes to the organizational demographic, meaning size/location and teaching, sub-factors were based on a review of the classification of hospitals defined by CMS.

### iv. Modifications to Hospital and Leadership Factors
Upon review of these questions and the data, the following additions and modifications were made to the conceptual framework, which highlight the range and complexity of factors that interplay in the IS planning process. Under hospital leadership, strategic investment and champion were incorporated as stakeholders emphasized these as key drivers for the their success and getting addition commitment across their organization. Thus, addressing the research question, *What leadership factors have influenced hospitals to incorporate prevention activities into their community benefit plans?*. The sub-factors needed additional detail to clarify what the stakeholders found as key components to achieve the support around their IS planning process.

One main modification to the leadership factor was the change in the heading from physician and hospital leadership to hospital leadership. Based on the interviews, physician leadership was not identified as a key factor but rather the senior hospital leadership support was. Hospitals stakeholders did not mention physicians serving on their internal committees or highlight any particular initiative or program that they introduced or advocated for in the IS plan. In addition, the following sub-factors were omitted from hospital and physician leadership factor in the conceptual framework because they were not aligned with the findings: leadership and knowledge. The sub-factor of leadership seemed duplicative to the general factors of interest. Knowledge was too vague and overlapped with existing sub-factors.
Figure 9: Revised Conceptual Framework

- Changes in training, and resources for hospitals around prevention and evidence-based practices
- Potential changes hospitals prioritization of investments around prevention programs
- Change in role of collaborations to continue to support hospitals in IS planning and implementation process
- Change in IS or state policy to incorporate guidance around the inclusion of the community in the IS planning process, utilization of evidence based practices, and revenue allocated towards the community
VI. CONCLUSION

Although hospitals typically provide clinical and charity care with their community benefit funding, they are starting to make traction by acknowledging the social determinants of health and think beyond their hospital walls. Study findings confirmed the variation in programming and strategies incorporated into hospitals community benefit IS plans and the multitude of factors that have challenged and impacted their processes. While the participating hospitals in this study IS plans were largely disconnected from other federal approaches to achieving population health improvement, there remain opportunities to enhance future cycle efforts by incorporating community building activities into the plans and aligning hospital strategies and assets with those of community organizations and public health. Additional guidance and direction from the IRS or state legislation might be necessary to help hospital shift their programming towards more community benefit and building. The public health and hospital collaborative efforts offer opportunities and examples of approaches on how to continue to educate and advance the investment in upstream prevention programs and incorporate strategies that address the social determinants of health.
CITED LITERATURE


Illinois Public Law, Ill. 210 ILCS 76/5, 2003


APPENDICES

Appendix 1: Study Measurement table

<table>
<thead>
<tr>
<th>Constructs</th>
<th>Sub-constructs to explore</th>
<th>Description and Factors</th>
<th>Data Collection Approach</th>
<th>Possible sub-codes</th>
<th>Analysis</th>
</tr>
</thead>
</table>
| Market environment - Characterized by the politics, size, payers, provider dynamics, reimbursement and payment models. | Politics (State and federal) | This refers to how federal and state politics and policies may influence hospitals spending, innovation, and operating practices around community benefit activities or other emerging issues. | • CHNA  
• Implementation plans,  
• Annual reports  
• Semi-structured interviews | • State regulations  
• Federal regulations (IRS, ACA)  
• Accountability for new requirements  
• Monitoring and reporting  
• Advocacy organizations  
• Complexity | • Theme the data (manual review, ATLAS.ti)  
• Paired analysis (manual review, second coder)  
• Pattern matching analysis (ATLAS.ti)  
• Construct table |
| | Reimbursement- | This refers to how reimbursement is or is not supporting prevention  
• Fee for service  
• Value based payment  
• Payment across and within markets  
• Practice standards | • Financial documents  
• Meeting minutes)  
• Semi-structured interviews | • Medicare physician fee  
• Support of medical education  
• Reimbursement  
• Number of payers (patients and insurers)  
• Practice norms  
• Level of competition | • Theme the data (manual review, ATLAS.ti)  
• Paired analysis (manual review, second coder)  
• Pattern matching analysis (ATLAS.ti)  
• Construct table |
2. What community factors have influenced hospitals decision-making to incorporate prevention activities into their community benefit IS plans?

<table>
<thead>
<tr>
<th>Constructs</th>
<th>Sub-constructs to explore</th>
<th>Description and Factors</th>
<th>Data Collection Approach</th>
<th>Possible sub-codes</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social context – The community in which the hospital operates and serves, the participation, perspectives and involvement of community stakeholders</td>
<td>Community demographics</td>
<td>This refers to those community demographics of the population the hospital serves and how it influence the community benefit strategies around prevention.</td>
<td>• Semi-structured interviews</td>
<td>• Patient population needs</td>
<td>• Theme the data (manual review, ATLAS.ti)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Hospital annual reports</td>
<td>• Insurance status</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• IRS Form 990-Schedule H Form 990</td>
<td>• Poverty level</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Document review</td>
<td>• Racial demographic</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Meeting minutes</td>
<td>• Ethnic demographic make up</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Disparities</td>
<td></td>
</tr>
<tr>
<td>Geographic location</td>
<td>This refers to the geographic location that the hospital serves and how it influences the community benefit strategies around prevention.</td>
<td>• Semi-structured interviews</td>
<td>• Geographic size</td>
<td>• Theme the data (manual review, ATLAS.ti)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Hospital annual reports</td>
<td>• Challenges with access to programs or transportation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• IRS Form 990-Schedule H Form 990</td>
<td>• Rural</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Document review</td>
<td>• Urban</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Transportation</td>
<td></td>
</tr>
</tbody>
</table>
### Relationship with external organizations

This refers to those events, actions and relationships that hospitals have had in the past or present with community or public health partners.

- Semi-structured interviews
- Charters
- Funding reports
- Meeting minutes
- Annual reports
- CHNA implementation plans
- Number of partnerships
- Joint efforts with partners
- Type of program/partnerships (shared training, informal groups)
- Partner staff knowledge and expertise
- Stakeholder involvement

### Availability and resources of external programs or partners

This refers to the availability, capacity and access of external programs or partners to support the community benefit implementation plan.

- Semi-structured interviews
- Annual reports
- CHNA
- Meeting minutes
- Evidence-based practice and programs
- Community programs
- Staffing and funding of partners
- Established or new programs
- Knowledge of community programs

### History

This refers to those events/actions in the hospitals past with the community and other external networks influences the implementation plan and the uptake of prevention programs

- Semi-structured interviews
- Document review
- Annual reports
- Meeting minutes
- Experience, past participation
- Perspectives related to value in partnership, collaboration, activities
- Cohesion
- Shared accountability
- Shared goals
- Communication

### Constructs

<table>
<thead>
<tr>
<th>Constructs</th>
<th>Sub-constructs to explore</th>
<th>Description and Factors</th>
<th>Data Collection Approach</th>
<th>Possible sub-codes</th>
<th>Analysis</th>
</tr>
</thead>
</table>

3. What hospital organizational factors have influenced hospitals decision-making to incorporate prevention activities into their community benefit IS plans?
<table>
<thead>
<tr>
<th>Organizational system/setting - Organizational factors, including organizational type, policies and procedures of the organization, and organizational vision, goals, politics, and culture.</th>
<th>Setting, size and system type</th>
<th>Mission, values, culture</th>
<th>Infrastructure</th>
</tr>
</thead>
</table>
| This refers to the hospitals setting, system, type of leadership, decision making process, innovative practices, hierarchy and approach to community benefit planning and implementation process. | - CHNA  
- Implementation plans,  
- Semi-structured interviews  
- Document review | - Hospital size  
- System type  
- Geographic location  
- Institution type (academic hospital, rural hospital, physician practice, organized delivery system, etc)  
- Governing authority (Board, ownership)  
- Within a larger system  
- Decision making  
- Leadership  
- Innovation | - Document review  
- Hospitals annual reports  
- Semi-structured interviews |
| Setting, size and system type - This refers to the hospitals setting, system, type of leadership, decision making process, innovative practices, hierarchy and approach to community benefit planning and implementation process. | This refers to values and behaviors which describe the hospitals environment and potential approach to working with the community. | This refers to values and behaviors which describe the hospitals environment and potential approach to working with the community. | This refers to use of data systems and information technology that may influence prevention strategies. |
| - CHNA  
- Implementation plans,  
- Semi-structured interviews  
- Document review | - CHNA  
- Implementation plans,  
- Semi-structured interviews  
- Document review  
- IRS Form 990-Schedule H Form 990 spending  
- Annual reports  
- Funding reports | - CHNA  
- Implementation plans,  
- Semi-structured interviews  
- Document review  
- Annual reports  
- Funding reports | - Document review  
- Hospitals annual reports  
- Semi-structured interviews |
| - CHNA  
- Implementation plans,  
- Semi-structured interviews  
- Document review | - Hospital mission  
- Hospitals culture  
- Hospital values  
- Institutional commitment  
- Targeting vulnerable populations  
- Stewardship  
- Long- or short-term approach to addressing the community needs | - Hospital mission  
- Hospitals culture  
- Hospital values  
- Institutional commitment  
- Targeting vulnerable populations  
- Stewardship  
- Long- or short-term approach to addressing the community needs | - EHR use and transition  
- Functionality  
- Data sharing  
- Population health management and measures  
- Population health platform |
| - Hospital size  
- System type  
- Geographic location  
- Institution type (academic hospital, rural hospital, physician practice, organized delivery system, etc)  
- Governing authority (Board, ownership)  
- Within a larger system  
- Decision making  
- Leadership  
- Innovation | - Theme the data (manual review, ATLAS.ti)  
- Paired analysis (manual review, second coder)  
- Pattern matching analysis (ATLAS.ti)  
- Construct table | - Theme the data (manual review, ATLAS.ti)  
- Paired analysis (manual review, second coder)  
- Pattern matching analysis (ATLAS.ti)  
- Construct table | - Theme the data (manual review, ATLAS.ti)  
- Paired analysis (manual review, second coder)  
- Pattern matching analysis (ATLAS.ti)  
- Construct table |
| Priorities | This refers to the hospitals prioritizes EBP and prevention in their organization and in the community benefit plan compared to other competing needs. | • Annual reports  
• Meeting minutes  
• Semi-structured interviews  
• IRS Form 990-Schedule H Form 990 spending | • Healthcare trends (Safety, Quality, Satisfaction, Services)  
• Hospital leadership demands  
• Debt  
• Attracting or retaining patients  
• Reducing readmissions  
• Prioritization process  
• Prevention  
• Upstream population health approaches | • Theme the data (manual review, ATLAS.ti)  
• Paired analysis (manual review, second coder)  
• Pattern matching analysis (ATLAS.ti)  
• Construct table |
| Training and resources | This refers to the training and resources allocated to the community benefit work undertaken by the hospital and the knowledge and skills of staff around prevention program and community benefit activities. | • Semi-structured interviews  
• IRS Form 990-Schedule H Form 990 spending  
• Document review  
• Training reports  
• Meeting minutes  
• Project charters | • Hospital staff dedicated to CB activities  
• Hospital staff type (Full time, PT etc)  
• Institutional training activities/ needs  
• Time committed to planning, implementation and sustainability  
• Level of participation  
• Peer networking | • Theme the data (manual review, ATLAS.ti)  
• Paired analysis (manual review, second coder)  
• Pattern matching analysis (ATLAS.ti)  
• Construct table |
| Facilitators | Identify and describe facilitators to the hospitals approach to prevention and population health and addressing the new requirements. | • Semi-structured interviews  
• Annual reports  
• Meeting minutes | • Understanding of the value to focus on prevention  
• Resources  
• Public health training  
• Leadership support  
• Create healthier communities  
• Social determinants of health | • Theme the data (manual review, ATLAS.ti)  
• Paired analysis (manual review, second coder)  
• Pattern matching analysis (ATLAS.ti)  
• Construct table |
### Barriers
Perceived impediments to community benefit activities or expansion to primary prevention services. Identify the challenges regarding the community benefit changes

- Semi-structured interviews
- Annual reports
- Meeting minutes
- Fiscal constraints
- Loss of staff
- Imposed restrictions on setting work plan,
- Forming partnerships
- Time
- Transition
- Lack of community prevention programs

- Theme the data (manual review, ATLAS.ti)
- Paired analysis (manual review, second coder)
- Pattern matching analysis (ATLAS.ti)
- Construct table

### 1. What hospital leadership factors have influenced hospitals to incorporate prevention activities into their community benefit IS plans?

<table>
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<tr>
<th>Constructs</th>
<th>Sub-constructs to explore</th>
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<th>Analysis</th>
</tr>
</thead>
</table>
| Physician leadership | Knowledge | This refers to the knowledge that physician leaders have around prevention evidence based prevention programs, how to aligns them with hospital systems and standards, or with other state and national initiatives. | • Document review-workplans, training  
• Semi-structured interviews | • Experience level of participants  
• Extend and degree of knowledge about community benefit requirements and prevention programs  
• Skills and training of evidence-based research and implementation in practice  
• Workforce training  
• Learning orientation  
• History of past collaboratives around prevention | • Theme the data (manual review, ATLAS.ti)  
• Paired analysis (manual review, second coder)  
• Pattern matching analysis (ATLAS.ti)  
• Construct table |
### Leadership
This refers to having a vision and motivating others; Making and driving decisions and producing useful change around prevention in the CB plans

- Document review: workplans, training reports
- Semi-structured interviews
- Strategic investment
- Prioritization of prevention
- New approaches to population health
- Innovative practices
- Theme the data (manual review, ATLAS.ti)
- Paired analysis (manual review, second coder)
- Pattern matching analysis (ATLAS.ti)
- Construct table

### Communication
This refers to the physician leadership exchanges ideas and prevention practices that connects with the rest of the team around new practices

- Document review: workplans, training reports
- Semi-structured interviews
- Sharing of information around prevention (associations, committees, etc)
- Understanding of prevention strategies
- Communication distribution
- Theme the data (manual review, ATLAS.ti)
- Paired analysis (manual review, second coder)
- Pattern matching analysis (ATLAS.ti)
- Construct table
Appendix 2: Sample Email Outreach to participate

Subject: Dissertation Project exploring the Community Benefit Implementation Strategy Plan

Hi (Hospital recipient name),

I am a doctoral student at the University of Illinois at Chicago School of Public Health (UIC SPH). I am reaching out to see if you would like to participate in an interview that is part of my dissertation process.

I am interested in learning about how (insert hospital name) developed the community benefit implementation strategy plan. Your input is critical to further understand the organizational challenges and opportunities that hospitals experienced due to the Affordable Care Act requirements and what factors impacted what strategies and programs were included in the implementation plan. I would like to ask you questions about your organizational role and work with others in the development and execution of the community benefit implementation plan.

I anticipate the interview will take no longer between 45 minutes to an hour. It is voluntary and no individual responses will be identified in any of the reports of the findings.

Thank you so much for your consideration of this request.

If you would like to have a discussion before then, please do not hesitate to contact me by phone, at 773 398 8300—or via e-mail, at kheneg3@uic.edu

Sincerely,

Katy A Heneghan, MPH

DrPH Candidate, UIC SPH
Appendix 3: Informed Consent

Person Interviewed: _______________________________________________

Hospital system: __________________________________________________

Position/role: _____________________________________________________

Date ___________ Start time:______ End time: ___________ Tracking number: _____

INFORMED CONSENT LANGUAGE BELOW:

Purpose: Before we get started, I want to review the purpose of today’s discussion. The purpose of this interview is to gather information from hospital staff and leadership who have been involved in the community benefit planning process to learn about your experience in it and the factors that influenced the inclusion of various activities in the implementation plan. This information will help us to know how hospitals are adjusting to the new tax-exempt requirements and developing their implementation plans.

The discussion should take between 30 and 45 minutes. There are no right or wrong answers. If you need to take a break for any reason, please let me know.

Your rights as a participant: I am recording this call to allow us to clarify your answers later, if needed. You can stop the interview or refuse to answer any question at any time. We will not share your individual answers from this discussion with any individual or organization outside the study team. All information will only be shared in the aggregate outside the study team.

Benefits and risks of participation: By participating in this discussion, you will contribute to our understanding of the factors that influence tax-exempt hospitals programs and strategies that are included in their implementation plans. What is learned in this study can further the understanding around hospitals facilitators and barriers to meeting new reporting requirements and provide contextual insight for other hospitals.

What the happen with the information you share today: We will keep what you tell us confidential, and will not release any information that identifies you or your hospital without your prior consent, except as required by law.
Appendix D: Semi-structured Interview Questions

I am interested in learning about your hospital’s Community Benefit Implementation planning process.

1. Before we begin, I would like to learn a little about you. Can you please tell me your role in the hospital? [PROBE: What do you do on a daily basis? How long have you been in this position?]

2. Tell me about your hospital system.
   a. Governance
   b. Hospital System boundaries
   c. Changes

3. What are some of the health care trends your hospital system is trying to address?
   a. What are some of the challenge your hospital is facing?
   b. How has this changed over time?

4. Can you tell me about your specific role regarding the organization’s community benefit implementation plan and process?
   a. Probe/Clarification: Is this your primary responsibility?
      i. How does this role fit in with your other responsibilities?

5. How do you think of prevention? What are some examples you think of about prevention services? (Some examples
   a. Probes/examples: Primary (breastfeeding friendly hospitals, HPV, tobacco free ordinances) secondary (mammography screening, skin cancer screening), tertiary (diabetes management programs

6. What has your (name of hospital) done in the area of prevention in the past for the community?

7. Tell me about the community your hospital serves
   a. Can you tell me about your process around the development of community benefit implementation plans?
      i. How were particular populations identified to target with particular programs?
ii. Who was involved internally in this process?
   1. Do you have a community benefit department of team?
   2. Were consultants used for the assessment or planning processes?

iii. How were programs identified to use to address your community needs?

8. Tell me about the various activities/strategies in your community benefit plan.
   a. How were these selected?

9. How were you involved in the decision-making process around the priorities and strategies to include in your implementation plan?
   a. **Probe/Clarification**: What was your experience in identifying the strategies?
      1. Who was involved? Why? (Council, taskforces formed)
      2. Was there any criteria used/ key factors in the determination?
      3. Were the activities and strategies new or existing efforts?
      4. What were some of the organizational facilitators in selecting these strategies? (Culture, mission, vision, competing priorities, knowledge of programs, infrastructure)
      5. What were some of the organizational challenges with prioritization of these strategies? (Culture, mission, vision, competing priorities, knowledge of programs)
      6. What resources were used to support the planning and decision making efforts? (Staff training, communication planning, leadership investment, infrastructure)
      7. What other resources were needed?
   b. **IF NO**: If you were not involved in decision making or selecting the strategies, what is your understanding around how these are selected?
      a. How were these communicated to you?
      b. Who do you think was involved in this process from your hospital?

**Market environment**

10. What key changes in federal, state or local policies impacted your community benefit implementation plan and the strategies selected?
    a. Prompts: Around prevention and evidence-based practices?
       1. Competing priorities?
       2. Reimbursement?
    b. Did your strategies align with any other federal opportunities/priorities around national reform (ACO, CMS, JCO Triple Aim)?

11. What key changes in federal and state policies and regulations made your community benefit planning process and strategies more difficult?
    a. Prompts: Around prevention and evidence-based practices?
1. Competing priorities?
2. Reimbursement?

Community Context

12. What external associations, organizations or stakeholders were involved in the decision making around the strategies?
   a. Prompts: Community organizations, Agencies Public health departments, Consultants, Regional partnerships, academic institutions, advocacy groups
13. How were these external stakeholders identified?
14. Prompts: History of past partnerships, availability and access of prevention and evidence-based programs?
15. What were these stakeholders and associations roles around your community benefit activities?
   a. Prompts: Collaborative meetings, identifying available programs, implementation of strategies, aid in strategy selection and decision making, Advocate for particular populations
16. What were your experiences in working with these external stakeholders?
   a. Prompts: Benefits? Barriers/ challenges?
   b. How did they contribute to decision making and selecting priorities?
   c. How were they most helpful?
   d. How were they least helpful?

Ending

17. What have you done/will you do differently in selecting your strategies for the implementation plan in the next cycle?
18. Is there anything else about the process you would like to share with me?
19. Is there anyone else in your hospital that you could recommend I speak with?
Appendix 5: Initial Code Book

Approach to Coding:
- Code the whole sentence in which a key word or phrase is found.
- Sentences can be categorized with more than one code
- All codes and all sub-codes will be used for the interviews and document reviewed

Market Environment Context

<table>
<thead>
<tr>
<th>CONSTRUCT</th>
<th>INSTRUCTIONS</th>
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</thead>
</table>
| Politics (Federal & State) - this refers to how the changes in federal and state policy impact hospital approach to community benefit planning and population health | Use for codes mentioning the challenges, barriers, facilitators associated with community benefit provisions, reporting, and addressing population health and new roles based on the state and federal policies. Sub-codes for specific types of politics are necessary, including codes for:  
  - Federal regulations/policies  
  - State regulations/policies  
  - Advocacy  
  - Accountability/reporting  
  Example include: problems with reporting requirements or clarification around the language around implementation plans, population health etc, Alignment opportunities with other national health reform (ACOs, CMS rules), advocacy |
| Reimbursement – this refers to how reimbursement is or is not supporting prevention or upstream population health approaches | Use this collection of codes for all mentions of the reimbursement considerations around evidence-based programs in the implementation plans. Sub-codes for specific types of reimbursement are necessary, including codes for:  
  - Medicare  
  - Medicaid  
  - Competition  
  - Payment models  
  Examples include: medicare physician fee, practice norms, level of competition, reimbursement, payment models, performance measures, data system, CMS rules, |
## Competing priorities

This refers to if the state or regional area have a focus on population health in the community benefit plans or other priorities or investments that may impact the hospital’s approach to population health.

Use this collection of codes for all mentions of state or regional priorities or investments around community benefit plans or other health care issues.

Sub-codes for specific types of competing priorities are necessary, including codes for:

- Debt
- Provider supply
- Accreditation
- Charity care

Examples include: local practice strategies and priorities, debt, provider supply accreditation, JCO, ACO.

## Community context

<table>
<thead>
<tr>
<th>CONSTRUCT</th>
<th>INSTRUCTIONS</th>
</tr>
</thead>
</table>
| **Community demographics** – The population the hospital serves and how it influences the community benefit strategies around prevention | Use this collection of codes for all mentions of how the hospital addresses the particular needs of their community through various strategies and practices. Sub-codes for specific types of community demographics are necessary, including codes for:  
  - Patient population needs  
  - Insurance status/coverage  
  - Poverty level  
  - Racial demographics  
  - Ethnic demographics  
  - Disparities  
  Examples include: priority populations, disparities, community needs, patient population, insurance status, poverty, racial and ethnic demographics, social determinants. |
| **Geographic location** – location that the hospital services and how it influences the community benefit strategies around prevention | Use this collection of codes for all mentions of geographic location being a barrier or facilitator to the prevention programs and evidence based practice in the implementation plan. Sub-codes for specific types of geographic location are necessary, including codes for:  
  - Geographic size/ catchment area |
| **Access to programs** | • Access to programs  
• Rural  
• Urban  
• Transportation  

Examples include: barriers, facilitators, urban and rural setting, transportation challenges, competition in the location, catchment area served, regional partnerships, unique issues |
| **Relationship with external organizations** | Use this code for all mentions of around the perceptions of external partners, networks, and organizations and their involvement in the implementation planning process  
Sub-codes for specific types of relationship with external organizations are necessary, including codes for:  
• Joint partnerships  
• Training  
• Partner staff knowledge/ expertise  
• Stakeholder involvement  
• Level of engagement  
• Communication  

Examples: Valuable partnership, low or no value or relationships, challenges/ barriers associated with external partners, success associated with engaging external partners. Trust, Community decision maker, authentic communication, no to little respect of external organizations, no to little understanding of external organizations roles, understanding of roles of external organizations, Partners knowledge and expertise, workgroup, shared trainings, level of community members involved in the implementation plan |
| **Availability and resources of external programs** | Use this collection of codes for all mentions of the availability, access and resources of external programs focused on prevention and population health  
Sub-codes for specific types of availability and resources of external programs are necessary, including codes for:  
• Access to evidence-based programs and practices  
• Staffing  
• Resources/Funding of partners  
• Established programs  
• Knowledge of community partners  

Examples include: time, resources available, evidence-based programs available, no evidence-based programs available, new
<table>
<thead>
<tr>
<th>Construct</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| **History** - this refers to those events/actions in the hospital's past with the community and other external networks that influences the implementation plan and the uptake of prevention programs | Use this collection of codes for all mentions of historical events and actions with external networks that may have influenced the hospital's efforts around their implementation plans. Sub-codes for specific types of history are necessary, including codes for:  
- Experience  
- Value of partnership  
- Cohesion  
- Shared accountability  
- Mutual goals  
- Communication  
Examples include: No prior collaboration, prior history of collaboration, some trust, sense of loyalty, involved in CHNA, partnership, coordinated, cohesive past workgroup, shared accountability, advocacy, past program support and approaches to prevention, alignment to mutual goals, turnover, shared decision making. |

<table>
<thead>
<tr>
<th>Organizational System/ Setting</th>
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<tr>
<th><strong>CONSTRUCT</strong></th>
<th><strong>INSTRUCTIONS</strong></th>
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</thead>
</table>
| **Setting, Size and System** - this refers to how the hospital setting, type of leadership, decision making process, innovative practices, hierarchy impacts their approach to evidence based practices | Use this collection of codes for all mentions of size of the hospital, system type, institution type, governing author, decision making, leadership and innovative practices which are referenced in connection with a focus on prevention and evidence-based practices for the implementation plan. Sub-codes for specific types of settings, size and system are necessary, including codes for:  
- Hospital size  
- Hospital system type  
- Institution type (Academic)  
- Governing authority  
- Innovation  
Examples include: size, network affiliation, ACO, decision making process, governance, structure, hierarchy, academic medical center, organized delivery system, board, innovative, upstream practices. |
<table>
<thead>
<tr>
<th><strong>Mission, values, culture</strong> - This refers to values and behaviors which describes the hospital's environment and drivers towards evidence-based practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use this collection of codes for all mentions of mission, values, and cultural values and behaviors which are referenced in connection with a focus on prevention and evidence-based practices for the implementation plan.</td>
</tr>
<tr>
<td>Sub-codes for specific types of mission, values and culture are necessary, including codes for:</td>
</tr>
<tr>
<td>- <strong>Mission</strong></td>
</tr>
<tr>
<td>- <strong>Culture</strong></td>
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<tr>
<td>- <strong>Values</strong></td>
</tr>
<tr>
<td>- <strong>Vulnerable populations</strong></td>
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<tr>
<td>- <strong>Stewardship</strong></td>
</tr>
<tr>
<td>Examples include: values to provide quality programs to the community, culture of serving vulnerable populations, mission driven, religious affiliation, alignment to organization values.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Infrastructure</strong> - this refers to use of data systems and information technology that may influence prevention strategies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use this collection of codes for all mentions of new and innovative uses of existing technology to support community benefit strategies around population health and evidence-based practices.</td>
</tr>
<tr>
<td>Sub-codes for specific types of infrastructure are necessary, including codes for:</td>
</tr>
<tr>
<td>- <strong>Electronic Health Record (EHR)/ Electronic Medical Record (EMR)</strong></td>
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<tr>
<td>- <strong>Functionality</strong></td>
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<tr>
<td>- <strong>Data sharing</strong></td>
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<tr>
<td>- <strong>Population health management</strong></td>
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<tr>
<td>- <strong>Population health platform</strong></td>
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<tr>
<td>Examples including: Activating EHR algorithms to generate data pulls and referrals to evidence based programs, flagging patients to utilize prevention programs. Data sharing, population health management, measures, quality improvement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Priorities</strong> this refers to the hospitals prioritizes EBP and prevention in their organization and or a different focus for the organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use this collection of codes for all mentions of how the community benefit implementation plan priorities are determined and how the focus of population health is considered in the hospital compared to other needs.</td>
</tr>
<tr>
<td>Sub-codes for specific types of priorities are necessary, including codes for:</td>
</tr>
<tr>
<td>- <strong>Debt</strong></td>
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<tr>
<td>- <strong>Triple Aim</strong></td>
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<tr>
<td>- <strong>Reducing readmissions</strong></td>
</tr>
<tr>
<td>- <strong>Prioritization process</strong></td>
</tr>
<tr>
<td>- <strong>Prevention</strong></td>
</tr>
<tr>
<td>- <strong>Population health approaches</strong></td>
</tr>
</tbody>
</table>
Examples include: health trends, hospital leadership priorities, focus areas, demands and trends, cost savings, reducing readmissions, economic trends, priority setting process, key factors for consideration, decision making.

**Training and resources** - this refers to the training and resources allocated to the community benefit work, towards prevention health and evidence-based practices.

Use this collection of codes for all mentions of staff, resources, and training used to guide the implementation plan and the training on evidence based practices to support prevention.

Sub-codes for specific types of training and resources are necessary, including codes for:
- **Staff allocated**
- **Institutional training**
- **Time commitment**
- **Level of participation**
- **Knowledge/experience of staff around prevention**
- **Peer networking**

Examples include: Little time, resources, people dedicated to implementation plan, More time, resources, staff, institutional training, activities, time committed, level of participation, peer networking, number of hospital staff, clarifying roles, shift in staffing.

**Benefit** - this refers the facilitators to the hospitals approach to prevention and population health.

Use this collection of codes for all mentions of staff, resources, and training used to guide the implementation plan and the training on evidence based practices to support prevention.

Sub-codes for specific types of benefits are necessary, including codes for:
- **Understanding of prevention**
- **Resources**
- **Public health training**
- **Leadership support**
- **Social determinants of health**

Examples include: Understanding of population health, incorporated into infrastructure and culture, trained staff and resources, leadership support, public health training, dedicated staff to the plan and execution, teamwork, coordination.

**Barriers** - this refers the perceived impediments to community benefit activities and the changes.

Use this collection of codes for all mentions of impediments on focusing on evidence based prevention programs in the implementation plans.

Sub-codes for specific types of barriers are necessary, including codes for:
- **Fiscal constraints**
- **Loss of staff**
- Imposed restrictions
- Forming partnerships
- Time
- Transition
- Lack of prevention programs

Examples include fiscal constraints, lack of reimbursement, loss of staff, change in responsibilities, funding for staff training, expertise, little or no structure to support implementation, support for charity care.

### Physician Leadership

<table>
<thead>
<tr>
<th>Knowledge/ Experience</th>
<th>Use this collection of codes for all mentions of change (i.e., new practices, new resources), related to knowledge management – the capture, management, and use of data.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sub-codes for specific types of knowledge and experience are necessary, including codes for:</td>
</tr>
<tr>
<td></td>
<td>• Experience</td>
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<td></td>
<td>• Knowledge</td>
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<td></td>
<td>• Skills/training</td>
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<td></td>
<td>• Learning orientation</td>
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<td></td>
<td>• History of past prevention efforts</td>
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<td></td>
<td>Examples include: Training around EBP and population health, no/lack of training, Learning orientation, past experience, skills</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Use this collection of codes for all mentions of physician leadership role and ability to drive change and motivate among team, build and maintain successful change (i.e., new practices, new approaches to population health)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sub-codes for specific types of leadership are necessary, including codes for:</td>
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<tr>
<td></td>
<td>• Strategic investment</td>
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<td></td>
<td>• Prioritization of prevention</td>
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<td></td>
<td>• Innovative practices</td>
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<td></td>
<td>• New approaches population health</td>
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<td></td>
<td>Examples include: Buy in, supervision, support, ownership for change, advancing innovative practices, how to align it within the hospital system or other practice standards, offering training to advance knowledge, responsible for implementation</td>
</tr>
</tbody>
</table>
| **Communication** – the means leadership exchanges ideas and connects with the rest of the team around new practices | Use this collection of codes for all mentions of sharing of information, new practices around prevention between the teams or hospital system or related associations working on similar efforts

Sub-codes for specific types of communication are necessary, including codes for:
- **Sharing of prevention information (association, committees etc)**
- **Distribution**

Examples include: sharing of information, barriers, facilitators to sharing new practices, clear understanding of the strategies and practices, no understanding of strategies and practices in the implementation plan |
## Appendix 6: Cross Case Analysis Matrix

<table>
<thead>
<tr>
<th>Factors</th>
<th>Hospitals</th>
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<td>Understanding the New</td>
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<td>Funded training &amp; resources</td>
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<td><strong>Leadership</strong></td>
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<td>Promoted Collaboration</td>
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</table>

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Appendix 7: IRB Approval Letter

Office for the Protection of Research Subjects (OPRS)
Office of the Vice Chancellor for Research (MC 672)
203 Administrative Office Building
1737 West Polk Street
Chicago, Illinois 60612-7227

Exemption Granted

January 9, 2017

Kathleen (Katy) A. Heneghan, MPH
Public Health
65 E. Scott, Apt 8B
Chicago, IL 60610
Phone: (773) 398-8300

RE: Research Protocol # 2017-0022
"An Analysis of Factors Influencing Tax-exempt Hospitals in Illinois to Undertake Prevention Health Activities in their Community Benefit Implementation Plans"

Sponsors: None

This exemption determination does NOT include approval for Dr. Kathleen Cullen Heneghan to conduct human subject research as OPRS records do not indicate she has completed Investigator Training requirements. Please note: If Dr. Kathleen Cullen Heneghan’s role is limited to the analysis of de-identified data, then she will not be key research personnel for this research study and no corrective action is required. If, however, she will interact or intervene with individuals for research purposes or analyze identifiable data then she will be key research personnel, and she will need to be added to this research study via amendment after she has completed UIC Investigator Training requirements:
http://research.uic.edu/compliance/irb/education-training

Dear Ms. Heneghan:

Your Claim of Exemption was reviewed on January 9, 2017 and it was determined that your research protocol meets the criteria for exemption as defined in the U. S. Department of Health and Human Services Regulations for the Protection of Human Subjects [(45 CFR 46.101(b)]. You may now begin your research.

**Exemption Period:** January 9, 2017 – January 9, 2020
**Performance Site:** UIC (Note: Your residence is not an engaged performance site)
**Subject Population:** Adult (18+ years) subjects only
**Number of Subjects:** 300
The specific exemption category under 45 CFR 46.101(b) is:
(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

You are reminded that investigators whose research involving human subjects is determined to be exempt from the federal regulations for the protection of human subjects still have responsibilities for the ethical conduct of the research under state law and UIC policy. Please be aware of the following UIC policies and responsibilities for investigators:

1. **Amendments** You are responsible for reporting any amendments to your research protocol that may affect the determination of the exemption and may result in your research no longer being eligible for the exemption that has been granted.

2. **Record Keeping** You are responsible for maintaining a copy all research related records in a secure location in the event future verification is necessary, at a minimum these documents include: the research protocol, the claim of exemption application, all questionnaires, survey instruments, interview questions and/or data collection instruments associated with this research protocol, recruiting or advertising materials, any consent forms or information sheets given to subjects, or any other pertinent documents.

3. **Final Report** When you have completed work on your research protocol, you should submit a final report to the Office for Protection of Research Subjects (OPRS).

4. **Information for Human Subjects** UIC Policy requires investigators to provide information about the research to subjects and to obtain their permission prior to their participating in the research. The information about the research should be presented to subjects as detailed in the research protocol and application utilizing the approved recruitment and consent process and documents.

Please be sure to use your research protocol number (listed above) on any documents or correspondence with the IRB concerning your research protocol.

We wish you the best as you conduct your research. If you have any questions or need further help, please contact me at (312) 355-2908 or the OPRS office at (312) 996-1711. Please send any correspondence about this protocol to OPRS at 203 AOB, M/C 672.

Sincerely,
Charles W. Hoehe, B.S., C.I.P.
Assistant Director, IRB #7
Office for the Protection of Research Subjects

cc: Paul Brandt-Rauf, Public Health, M/C 923
Christina Welter, Public Health, M/C 923
VITA

Kathleen A. Heneghan

EDUCATION AND TRAINING

2018   Doctor of Public Health (DrPH) in Leadership
       University of Illinois Chicago (UIC) School of Public Health

2009   Master of Public Health (MPH) – Health Behavior, University of Kentucky,
       College of Public Health

2007   Bachelor of Arts (BA) – Communications and Media Studies, Fordham University

PROFESSIONAL EXPERIENCE

2017-Present   Enterprise Network Solutions, Health Care Service Corporation
                Director, Strategic Partnerships (2017-Present)
                • Responsible for the identification, development and management of strategic
                  partnerships that enhance the enterprise commercial insurance business objectives
                Director, Provider Engagement Strategy (2017)
                • Co-developed a five-year enterprise Value Based Care strategic plan for commercial
                  insurance

2013-2016   Improving Health Outcomes, American Medical Association
             Manager, Strategic Collaborations
             • Developed, implemented and advanced a multi-year community engagement
               strategy for the IHO blood pressure initiative project starting from market
               assessment to the execution of health system pilots
             • Manage and co-develop an implementation strategy and business tools
               targeting large employers, commercial insurers and business associations
               for coverage of the evidence-based Diabetes Prevention Program

2009 – 2013  Chronic Disease Prevention and Control, Rhode Island Department of Health
             Program Manager, Comprehensive Cancer Control (2012-2013)
             • Lead a strategic planning process for the development of a new state cancer plan
               with a multidisciplinary team that incorporated evidence-based policy, systems and
               environmental changes initiatives
             • Organized and developed a tailored Survivorship Care Plan for the 11
               Commission on Cancer accredited hospitals in Rhode Island to help them
               achieve the 2015 American College of Surgeon’s Patient Centered Standards
               and to meet the CMS EHR criteria

             Communication Specialist, Initiative for a Healthy Weight (2010-2012)

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• Developed and managed a statewide counter marketing communication campaign to reduce sugar-sweetened beverage consumption and obesity prevention
• Co-developed the first Early Childcare Obesity Strategic Action Guide in coordination with governmental and nonprofit organizations to include policy and systems recommendations

Health Analyst, Healthy Homes and Environment (2009-2010)
• Developed a statewide lead screening report card for physicians to increase screening recommendations
• Implemented the Breathe Easy at Home (BEAH) asthma intervention, including coordination between the housing inspectors, healthcare providers and health information technology specialist

PROFESSIONAL ACTIVITIES

Society Memberships, Committees and Leadership

2018- Present  Chicago Leadership Alliance- Membership and Volunteer Committee Member
2018-Present Chicago Council on Global Affairs, Young Professional Member
2018-Present Health Care Service Corporation, Blue Corps Volunteer Program- Team Ambassador
2017- Present Health Care Service Corporation, Health Equity Committee- Enterprise Network Solutions Representative
2017- Present Health Care Service Corporation, Emerge Millennial Business Group-Career Committee Member
2017-Present American Association of Cancer Educators- Student Member
2017- Present Academy Health, Public Health Systems and Services Research Interest Group –Member
2016-Present American Heart Association, Associate Board of Chicago, Co-Chair
2017-Present Health Care Transformation Task Force, Advanced Payer/Provider Partnership Work Group -Member
2015-2016 Illinois Pathways to Health, Steering Committee -Member
2014-2016 Associations for State and Territorial Health Officers, State Learning Collaborative to Improve Blood Pressure Control-Member
2014-2016 Practical Playbook: Public Health and Primary Care Together- Success Committee Member
2014-2016 Illinois Alliance to Prevent Obesity -Advocacy Committee Member
2014-Present American Heart Association, Illinois Advocacy Committee- Member
2012-2014 University of Illinois at Chicago, DrPH Oversight Committee- Member
2012-2013 University of Illinois at Chicago, Committee on Educational Programs- DrPH representative

2012-2013 National Association of Chronic Disease Directors (NACDD)- Cancer Council, Executive Committee

2012 National Association of Chronic Disease Directors (NACDD)- Cancer Council, Communication Committee Co-Chair

2011-2013 American Heart Association, Rhode Island Advocacy Committee Member

2010-2013 Obesity Prevention in Early Childcare Committee, Co-Chair

2010-2013 Rhode Island Department of Health, On-Call Public Information Officer

2010-2013 Permanent Legislative Commission on Child Care in Rhode Island, Member

2010-2013 Rhode Island Public Health Committee, Advocacy Committee- Member

2010-2013 Rhode Island Department of Health, On-Call Public Information Officer

2010-2013 Permanent Legislative Commission on Child Care in Rhode Island, Member

2008-2009 University of Kentucky Student Public Health Association, Vice President

2007-2009 University of Kentucky, Jumpin’ Jaguars, College of Public Health Coordinator

2005-2007 Fordham University, Student Athletic Advisory Committee, Co-Chair

PUBLICATIONS & REPORTS


AWARDS AND HONORS

2017  Health Care Service Corporation, Spirit Award
2016  American Medical Association, Above and Beyond Award
2013  The Partnership to Reduce Cancer in Rhode Island, Passion Award
2013  American Cancer Society, Cancer Action Network, Outstanding Community Partner in Advocacy
2013  American Heart Association, You’re the Cure on the Hill, Spokesperson Scholarship
2012  Let’s Move! Child Care State Challenge winner
2010  National Institute of Health, Department of Health and Human Services, We Can, Ways to Enhance Children's Activity & Nutrition, Award of Excellence
2007-2009 University of Kentucky, College of Public Health, Academic Master’s Fellowship
2007-2009 University of Kentucky, College of Public Health, Enhancement Master’s Fellowship
2004-2007 Fordham University, Division 1 Volleyball Scholarship