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Alignment across Hospital Investments toward Building a Culture of Health in New York State

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ABSTRACT

New York State's Prevention Agenda (NYSPA)—a vision for New York to become the healthiest state—includes evidence-based interventions that emphasize policy, systems, and environmental approaches to health promotion and disease prevention. Although many of these interventions have been incorporated into various New York State (NYS) health care reform initiatives, there has been limited investment in them to date. Aligning existing investments can support healthy communities and accelerate improvement in health outcomes. Community Benefit is one example of community health investment. In 2013, non-profit hospitals in NYS reported $6.04 billion in Community Benefit spending, $188 million of which was dedicated to community health improvement.

This study measured the alignment between Community Benefit activities, Delivery System Reform Incentive Payment (DSRIP) project plans, and the NYSPA. A content analysis was performed on the publicly accessible data regarding health care reform initiatives of all non-profit hospitals in NYS. This data included 2013 Internal Revenue Service (IRS) Form 990 Schedule H's, Hospital Community Service Plans (CSPs), and DSRIP program Domain 3 and 4 project plans.

To contextualize our findings on Community Benefit spending and alignment across community health investments, we conducted stakeholder interviews with administrators at three NYS hospitals. These hospitals were chosen for their high level of alignment in our analysis, as well as diversity in geographic location and size. Hospital size, robust community engagement and involvement of hospital leadership in community health needs assessments and community service planning appear to influence alignment across community health investments. Related to interpreting data on Community Benefit spending, we found that Schedule H data is likely an incomplete picture of all of the activities that a hospital undertakes that may be of benefit to the community. We also found that there was often no specific funding set aside for Community Benefit activities at the beginning of the fiscal year, and that the reporting of this spending was based on retrospective assessments of activities and investments. Without a requirement on minimum contributions for Community Benefit, or public auditing process, there is no incentive for hospitals to fully report this data.

INTRODUCTION

New York State health system reforms support the Triple Aim of better care, better health for all, and lower health care costs. The NYSPA is a framework for state and local collaboration; and for local community health improvement planning and action by local health departments (LHDs), hospitals and other community stakeholders. Since 2013, it has been incorporated into state health care reform initiatives, including the DSRIP and the State Health Innovation Plan. Aligning existing investments in health promotion and disease prevention across initiatives, and increasing use of evidence-based initiatives, can help build healthy communities, accelerate improvement in health outcomes, and promote health equity. To further such alignment, this study assessed the extent to which NYS hospital investments in Community Benefit and population health aligned with evidence-based interventions, as defined by the NYSPA. Through qualitative case studies, it also explored the factors influencing that alignment.

Hospital Community Benefit is one source of investment in community health improvement. Non-profit hospitals are required to demonstrate that they provide benefit to their communities to maintain their tax-exempt status. The Affordable Care Act (ACA) included changes to the federal tax code requiring hospitals seeking tax exemption to conduct community health needs assessments and incorporate community input in the design of their federally-required Community Benefit programs. Through the introduction of Schedule H of tax form 990, the IRS defined seven categories of Community Benefit spending.

1. Financial assistance at cost
2. Unreimbursed Medicaid and other means tested government programs
3. Subsidized health services
4. Community health improvement services
5. Health professional education
6. Research
7. Cash and in-kind contributions, including contributions made by the organization to community groups.

Schedule H also collects information about supplemental categories of Community Benefit activities whose costs are not included in a hospital's total Community Benefit expenditure. For example, community-building expenses are not counted toward a hospital's total Community Benefit investment, but are included as a supplemental category in IRS reporting. Community building activities are defined as those that protect or improve community health and safety, and include activities that address broader determinants of health such as housing and employment.[5]

The Schedule H categories represent a shift in thinking about the role hospitals play in community health from an emphasis on providing health care to those in need, toward addressing the social and environmental determinants of population health locally. Community building expenditures and activities are not included in this report. These expenses are excluded because they do not count toward a hospital's Community Benefit total, and the focus of this report is alignment across community health investments.

NEW YORK STATE POLICY CONTEXT

Two significant initiatives designed to promote the health of NYS residents include the NYSPA and DSRIP. The NYSPA is New York's health improvement plan—a vision for New York to become the nation's healthiest state by addressing five health priorities: prevent chronic diseases; promote a healthy and safe environment; promote healthy women, infants and children; promote mental health and prevent substance abuse; and prevent HIV/AIDS, sexually-transmitted diseases, vaccine-preventable diseases and health care-associated Infections.[1]

Announced in 2014, DSRIP allows NYS to invest $8 billion into transforming the Medicaid delivery system from a fee for service to value-based payment model. It promotes community-level collaboration toward the aim of reducing avoidable hospital use by 25% over five years. NYS has 25 Performing Provider Systems that include health care providers and community-based organizations. DSRIP project plans describe how each PPS will work toward reducing avoidable hospitalizations. PPSs are paid based on their ability to meet milestones associated with the goal of reducing avoidable hospitalizations among Medicaid recipients.

In NYS, there is no minimum Community Benefit requirement, and nonprofit hospitals are exempt from state income and property taxes. The NYS Department of Health (NYS DOH) requires hospitals to submit Schedule H annually, and a Community Needs Assessment and CSP every three years. In November 2015, NYS DOH Commissioner Howard Zucker, MD, JD, issued new guidance to hospitals and LHDs. The Commissioner instructed them to submit one community health improvement plan per county, which should describe the efforts of all participants and the nature of their collaboration. It also specifically stated that, "a hospital's Prevention Agenda efforts should also be reflected in the Community Benefit programs, where applicable, described in its IRS Form 990 Schedule H," and that the "Department's goal is for each hospital to increasingly align its investments in evidence-based interventions related to the *Prevention Agenda.*"[2] NYS DOH also asked hospitals to increase their investments in the Schedule H reported Community Benefit categories of community health improvement and community building and to increasingly align these investments in evidence-based interventions in the NYSPA.[1]

RESEARCH & FINDINGS

To facilitate discussion on strengthening community health improvement efforts across NYS, The New York Academy of Medicine (the Academy) conducted a baseline assessment of the alignment across investments by hospitals and health systems in evidence-based prevention, as defined by the NYSPA. In this report, alignment measures represent the proportion of activities, as described in a hospital's CSP, DSRIP Project Plans in Domains 3 and 4, and IRS Form 990 Schedule H that are evidence-based NYSPA strategies—as compared to "other" strategies. As baseline measures, the data reported are from 2013, at the start of the current 2013–2018 NYSPA. We created confidential hospital and county specific reports that were delivered to hospital CEOs and LHD leaders in March 2017. This report summarizes our statewide findings. In addition, three hospitals with high alignment scores, representing a range of geographies were selected for qualitative case studies. These included interviews with hospital leaders, hospital accounting and business personnel, and Community Benefit managers.

By using multiple data sources from 2013, we attempt to describe the alignment of community health investments at the start of the NYSPA 2013–2018, with the most up to date and publicly available data possible. Still, we acknowledge these data may represent activities and investments occurring in 2012 (as is the case for Schedule H data reported in 2013) and later, as the DSRIP project plans and CSPs reflect future endeavors.

OVERVIEW OF 2013 COMMUNITY BENEFIT SPENDING IN NEW YORK STATE

The Academy has tracked statewide Community Benefit spending since the ACA's inception. It found that nearly $4 billion was spent by nonprofit hospitals in NYS during 2010.[3] In 2012, NYS non-profit hospitals spent $5.48 billion in Community Benefit, an increase of 24 percent from 2010.[4] In 2013, Community Benefit spending increased again, to $6.04 billion. Tables 1 and 2 present 2013 data on overall Community Benefit spending, and the sub-category of community health improvement.

TABLE 1. NYS 2013 SPENDING

ALL VOLUNTARY NON-PROFIT HOSPITALS IN NEW YORK STATE	2013 COMMUNITY BENEFIT DOLLARS	AS % OF TOTAL HOSPITAL EXPENDITURES
TOTAL	$6,038,264,134	11.67%
AVERAGE	$38,460,281	9.74%
MEDIAN	$12,268,753	8.27%
MINIMUM	–$455,683[A]	0.00%
MAXIMUM	$597,022,144	35.03%

The IRS defines community health improvement services as activities or programs subsidized by the organization for the express purpose of community health improvement,[5] documented by a community health needs assessment.

TABLE 2. NYS 2013 COMMUNITY HEALTH IMPROVEMENT SPENDING[B]

ALL VOLUNTARY NON-PROFIT HOSPITALS IN NEW YORK STATE	2013 COMMUNITY HEALTH IMPROVEMENT DOLLARS	AS % OF TOTAL HOSPITAL EXPENDITURES	AS % OF COMMUNITY TOTAL BENEFIT
TOTAL	$187,549,387	0.36%	3.11%
AVERAGE	$1,194,582	0.31%	4.00%
MEDIAN	$118,753	0.09%	1.34%
MINIMUM	$0	0.00%	0.00%
MAXIMUM	$24,049,373	5.96%	42.23%

[A] Negative figures are sometimes the result of a time lag in reimbursement, or carry over in payments from government programs or from the accumulation of small profits in certain categories such as charity care or other subsidized services.

[B] Community building expenditures and activities are not included in the Table 2 figures because they do not count toward a hospital's total Community Benefit investment.

HOW TO READ THE FIGURES IN THIS REPORT

Radar charts, or spider charts, visualize data measured across multiple dimensions and make it easier to compare outcomes across each dimension. In these charts, each axis represents one of the five NYSPA priority areas.

The line graph and percentages represent the degree to which activities described in a hospital's CSP, DSRIP Project Plans in Domains 3 and 4, and IRS Form 990 Schedule H are aligned with the 2013 NYSPA's list of evidence-based interventions.

For example, across all 2013 CSPs in New York State, if 22 activities related to infectious disease prevention were identified and 11 matched evidence-based interventions from the NYSPA, the alignment score is 50%.

A Summary Table at the end of this report includes the alignment scores for each data source and each NYSPA priority area. A more detailed description of this study's methodology concludes the report.

ALIGNMENT OF COMMUNITY INVESTMENTS WITH THE NYS PREVENTION AGENDA

In this section, we report on the alignment of community health investments by hospitals and health systems with evidence-based NYSPA strategies as reflected in 1) the Schedule H forms, and 2) CSPs for all NYS hospitals, and 3) the DSRIP Project Plans of the state's 25 PPSs.

1. Schedule H Reporting

Statewide, activities listed by hospitals in their 2013 Schedule H's ranged between 31%–60% alignment with the evidence-based interventions recommended in the NYSPA, depending on priority area. In each NYSPA category, the alignment scores for individual hospital Schedule H reporting ranged from 0% to 100%.

FIGURE 1. ALL VOLUNTARY NON-PROFIT NEW YORK STATE HOSPITALS SCHEDULE H ALIGNMENT WITH NYSPA

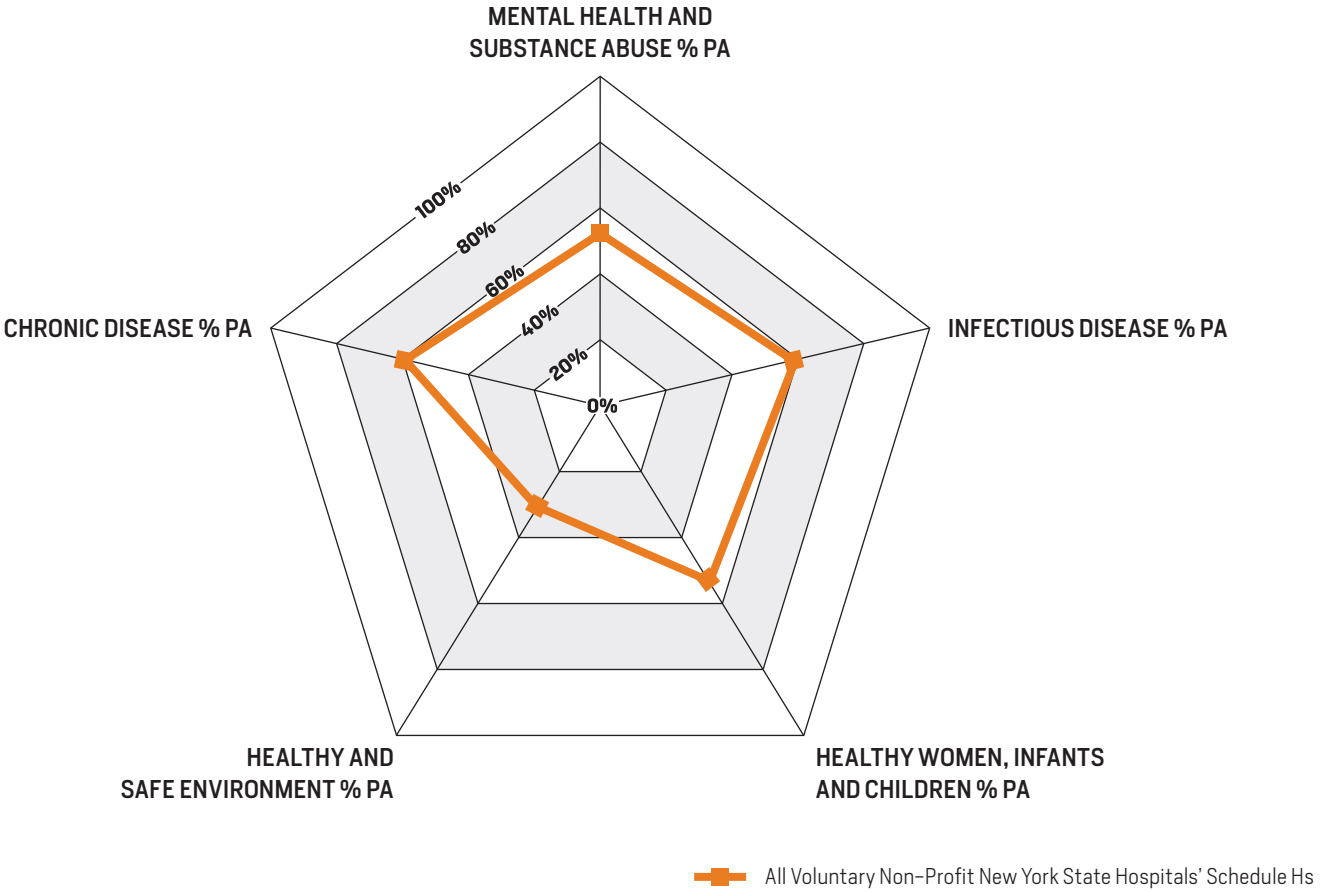


TABLE 3. ALL VOLUNTARY NON-PROFIT NEW YORK STATE HOSPITALS' SCHEDULE H ALIGNMENT WITH THE PREVENTION AGENDA

NYSPA PRIORITY AREA	% OF INTERVENTIONS ALIGNED WITH NYSPA
MENTAL HEALTH AND SUBSTANCE ABUSE	55%
INFECTIOUS DISEASE	60%
HEALTHY WOMEN, INFANTS AND CHILDREN	55%
HEALTHY AND SAFE ENVIRONMENT	31%
CHRONIC DISEASE	60%

2. Community Service Plans

Federal law requires that hospitals develop a publicly accessible Community Health Needs Implementation Strategy, or CSP, every three years.[6] NYS DOH requires hospital CSPs[7] to describe how hospitals will collaborate with LHDs and other partners to address the findings of their federally required Community Health Needs Assessments by working in at least two NYSPA priority areas and addressing one health disparity.

Statewide, activities listed by hospitals in their 2013 CSPs ranged from 48%–71% alignment with the evidence-based interventions recommended in the NYSPA, depending on priority area. In each NYSPA category, the alignment scores for individual hospital CSPs ranged from 0% to 100%.

FIGURE 2. ALL VOLUNTARY NON-PROFIT NEW YORK STATE HOSPITALS' COMMUNITY SERVICE PLAN ALIGNMENT WITH NYSPA

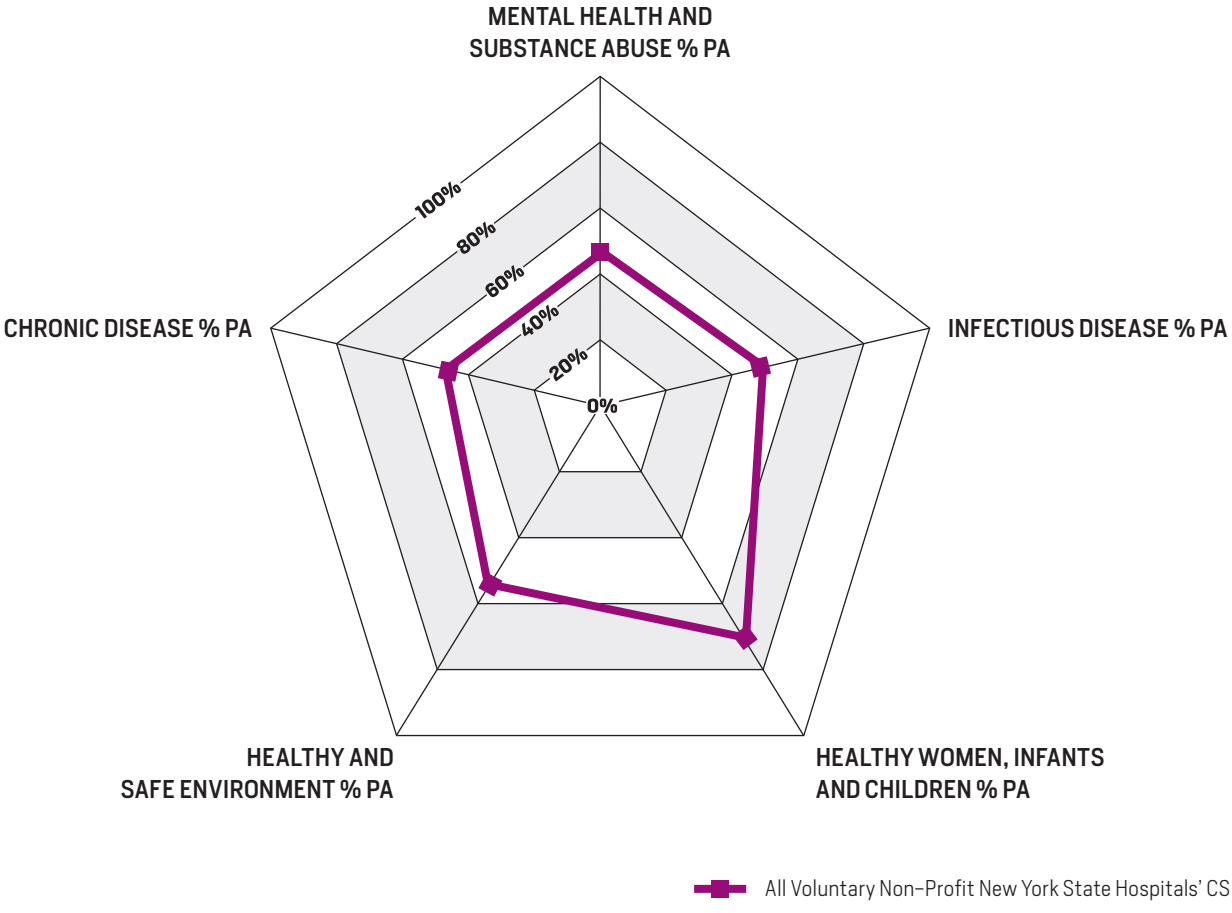


TABLE 4. ALL VOLUNTARY NON-PROFIT NEW YORK STATE HOSPITALS' COMMUNITY SERVICE PLAN ALIGNMENT WITH THE PREVENTION AGENDA

NYSPA PRIORITY AREA	% OF INTERVENTIONS ALIGNED WITH NYSPA
MENTAL HEALTH AND SUBSTANCE ABUSE	48%
INFECTIOUS DISEASE	50%
HEALTHY WOMEN, INFANTS AND CHILDREN	71%
HEALTHY AND SAFE ENVIRONMENT	56%
CHRONIC DISEASE	49%

3. DSRIP Project Plans

DSRIP project plans describe how each PPS will work toward the aim of reducing avoidable hospital use by 25% over five years. PPSs choose from a set of DSRIP Projects, each of which has a specific focus.

- Domain 1 projects address the overall PPS organization.
- Domain 2 projects focus on health care delivery system transformation.
- Domain 3 project plans focus on clinical improvement for behavioral health, asthma, diabetes and cardiovascular disease.
- Domain 4 project plans focus on population health improvement with project categories aligned with the five NYSPA priority areas.

This report only analyzes Domain 3 and 4 project plans because these are the project areas that describe community health improvement and prevention activities, which have the greatest potential to use evidence-based NYSPA strategies.

Statewide, DSRIP Domain 3 and 4 activities planned by PPSs demonstrated between 18% and 82% alignment with the evidence-based interventions recommended in the NYSPA, depending on priority area. In each NYSPA category other than chronic disease prevention, the alignment scores for individual DRSIP project plans ranged from 0% to 100%. Within the chronic disease priority area, alignment between DSRIP project plans and the NYSPA ranges from 43% to 93%.

FIGURE 3. ALL NEW YORK STATE DSRIP PLANS ALIGNMENT WITH NYSPA

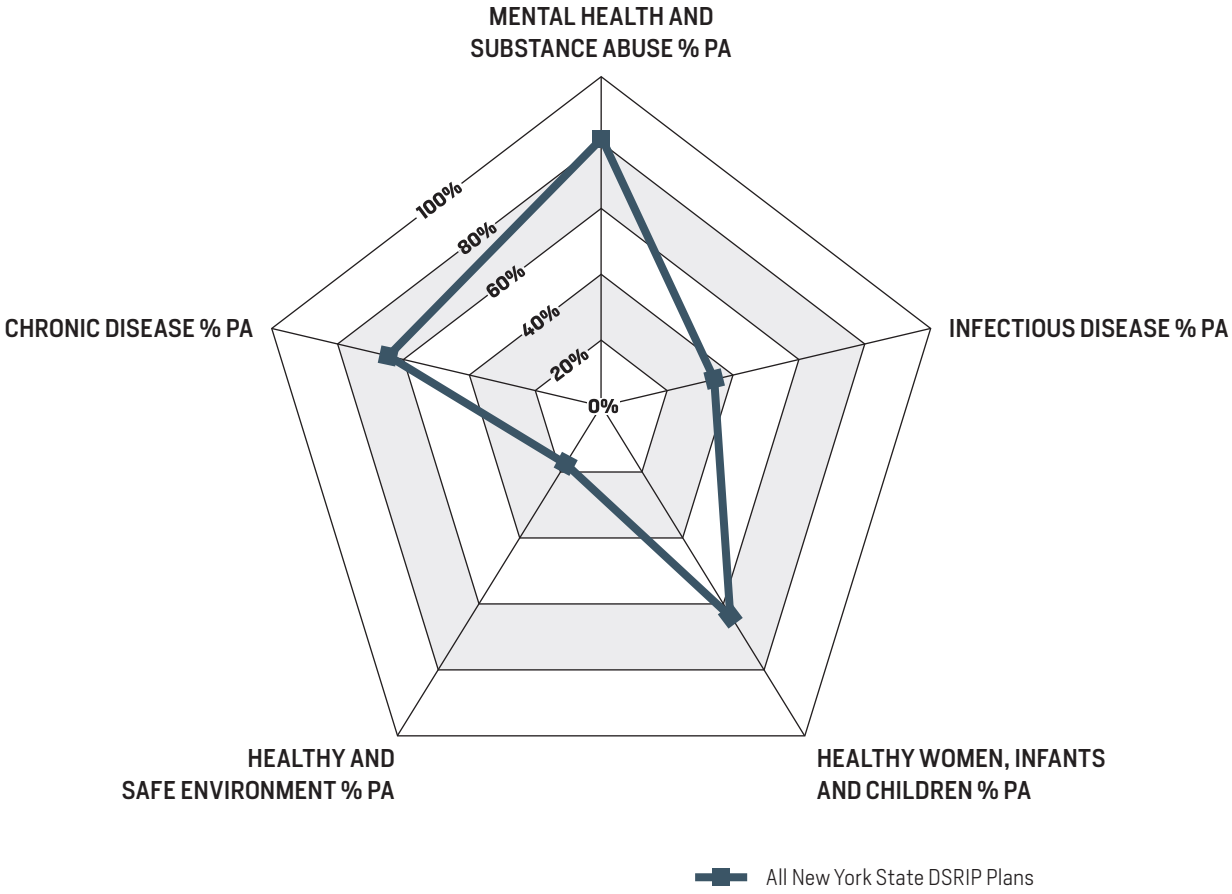


TABLE 5. DOMAIN 3 & 4 PROJECT PLAN ALIGNMENT WITH THE PREVENTION AGENDA

NYSPA PRIORITY AREA	% OF INTERVENTIONS ALIGNED WITH NYSPA
MENTAL HEALTH AND SUBSTANCE ABUSE	82%
INFECTIOUS DISEASE	35%
HEALTHY WOMEN, INFANTS AND CHILDREN	64%
HEALTHY AND SAFE ENVIRONMENT	18%
CHRONIC DISEASE	66%

Summary Chart and Table

Table 6 summarizes statewide alignment scores for each NYSPA priority area as reflected in the Schedule H forms and CSPs for all NYS hospitals, and the DSRIP Project Plans of the state's 25 PPSs. The numbers in parentheses indicate the total count of interventions included in this analysis.

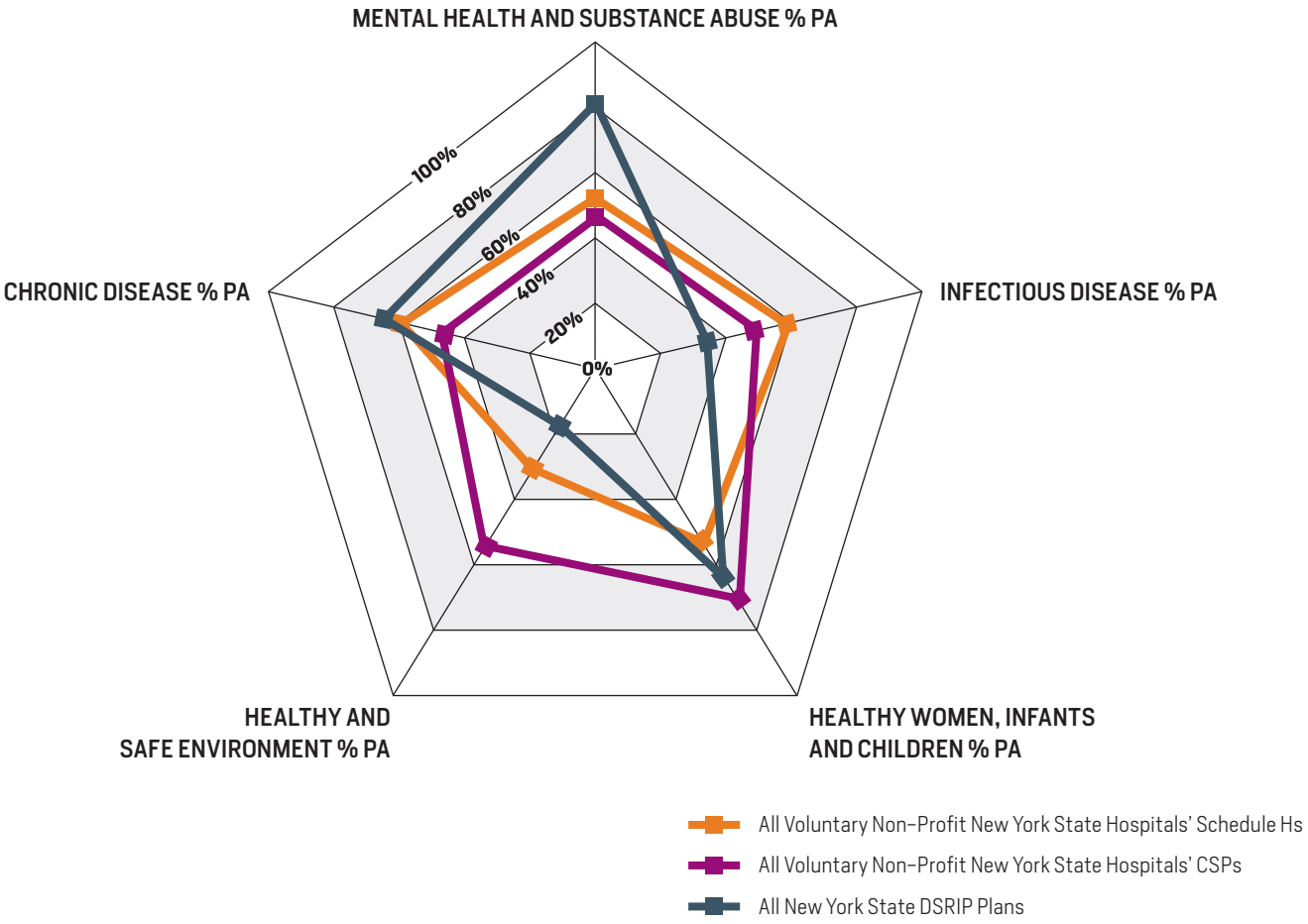
In each NYSPA category, the alignment scores for individual Schedule H reports and hospital CSPs ranged from 0% to 100%. Statewide, DSRIP Domain 3 and 4 activities planned by PPSs ranged from 0% to 100% within each NYSPA priority area, except for chronic disease prevention, where the alignment between DSRIP project plans and the NYSPA ranged from 43% to 93%. This priority area had the highest number of interventions reported. The volume of data on chronic disease prevention activities may increase the precision of the alignment score in this, as compared to the other NYSPA priority areas.

Figure 4 summarizes the alignment of community health investments with the NYSPA among all voluntary non-profit hospitals in NYS.

TABLE 6. SUMMARY OF NYS ALIGNMENT SCORING

	MENTAL HEALTH & SUBSTANCE ABUSE	**INFECTIOUS DISEASE**	**HEALTHY. WOMEN, INFANTS, & CHILDREN**	**HEALTHY & SAFE ENVIRONMENT**	**CHRONIC DISEASE**
COMMUNITY SERVICE PLAN					
STATEWIDE ALIGNMENT WITH PREVENTION AGENDA PRIORITIES	48% (157)	50% (33)	71% (112)	56% (23)	49% (735)
SCHEDULE H					
STATEWIDE ALIGNMENT WITH PREVENTION AGENDA PRIORITIES	55% (81)	60% (49)	55% (180)	31% (61)	60% (508)
DSRIP PPS					
STATEWIDE ALIGNMENT WITH PREVENTION AGENDA PRIORITIES	82% (113)	35% (91)	64% (30)	18% (20)	66% (559)

FIGURE 4. ALL VOLUNTARY NON-PROFIT HOSPITALS IN NEW YORK:
ALIGNMENT OF HEALTH CARE REFORM INITIATIVES WITH NYSPA



CASE STUDIES

To contextualize our findings on Community Benefit spending and alignment across community health investments, we conducted key stakeholder interviews with administrators at three NYS hospitals. These hospitals were chosen for their high level of alignment in our analysis, as well as diversity in geographic location and size. Here we share findings on the factors influencing alignment and insights related to interpreting data on Community Benefit spending.

Factors Influencing Alignment

We found there are several factors that may influence whether or not a hospital's community health investments align with the NYSPA, and across types of documentation.

Hospital size. Within a hospital or health system, different departments and staff may be tasked with completing the Schedule H and drafting the CSP. Thus, the texts describing community health activities that are planned and implemented may not align. At smaller hospitals, the person completing the CSP may be the same person completing the text for the Schedule H, hence there may be a greater chance that the same activities are described in each document, which would make them, appear better aligned in our analysis. In larger health systems, closer collaboration among the staff that prepares CSPs and Schedule H reports could improve clarity and assure more accurate documentation of Community Benefit expenditures.

Engaged hospital and health system leadership. When high–level hospital leaders (such as vice presidents and senior vice presidents) are closely involved in reviewing Schedule H reporting, overseeing community health needs assessments, and CSPs, there is likely to be greater alignment of investments.

Involvement of community members and alignment with LHDs. These three hospitals conducted their community health needs assessments and CSPs jointly with many other stakeholders, including robust community involvement. Many hospitals co–lead community health coalitions with LHDs, and should use these connections in preparing the federally required community health needs assessments and CSPs. To promote alignment across hospital and public health investments, those working to complete community health needs assessments and CSPs may consider engaging LHDs and community coalitions. And, where possible LHDs and hospitals should collaborate on a single community health needs assessment for their county.

Interpreting Community Benefit Data

Community Benefit expenditures are most likely under-reported. Schedule H data is likely an incomplete picture of all of the activities that a hospital undertakes that may be of benefit to the community each year. Any activity that a hospital undertakes that may be a benefit to the community but that has an outside funding source—such as a grant from a foundation—cannot be "counted" on the Schedule H. Also, tracking every activity that would "count" toward Community Benefit seems difficult. Even when robust efforts are made to do so, much of that information is scattered throughout the hospital system.

Community benefit spending is typically not budgeted. In the case studies, we found that except for a staff salary to support a hospital's community health improvement efforts, there was often no specific funding set aside for Community Benefit activities at the beginning of the fiscal year and that the reporting of this spending was based on retrospective assessments of activities and investments. In serving the community, hospitals tend to leverage their own resources (e.g., people, expertise, room/meeting space) rather than use Community Benefit dollars to directly fund activities outside the institution. Reporting for the Schedule H is done via a review of completed activities at intervals throughout the year or at the end of the year. This may be done via a request to various hospital departments who have, in the past, contributed to Community Benefit or who are likely to have related activities, or via a tracking system such as a system-wide database to capture community volunteerism, such as external board membership.

Accuracy of Community Benefit reporting has not been a high priority for hospitals, to date. Rather, interviewees in each hospital emphasized that the priority for the institution is to meet the needs of its community, and not on reporting a complete list of activities and expenditures on schedule H. Without a requirement on minimum contributions for Community Benefit, or public auditing process, there is no incentive for hospitals to fully report this data.

CONCLUSIONS

Aligning the community investments with evidence-based prevention activities can provide important resources to sustain progress toward improving community health and reducing health care costs. NYS hospitals should work to increase alignment across their DSRIP and Community Benefit activities with NYSPA strategies, as well as to improve the reporting of Community Benefit investments. By providing a baseline assessment of statewide alignment of community health investments and the NYSPA, this report aims to enhance collaboration within hospitals in decision making and reporting and among hospitals, LHDs, and community organizations toward:

1. Increasing alignment across hospitals' activities in DSRIP and Community Benefit with the NYSPA priorities of their LHDs and coalitions.
2. Increasing the extent to which hospitals' NYSPA, DSRIP and Community Benefit activities are evidence-based.
3. Improving the accuracy of reporting on all investments in community health.

Factors that may influence the alignment of community health investments with evidence-based NYSPA strategies include hospital size, engagement of a hospital's board of trustees in Community Benefit planning, and the degree to which these activities are proactively planned and budgeted. Still, without a requirement on minimum contributions for Community Benefit, or public auditing process, NYS hospitals have no incentive to fully report this data.

A culture of health is broadly defined as one in which good health and well-being flourish across geographic, demographic and social sectors; in which everyone can make choices that lead to healthy lifestyles and one that guides public and private decision making to foster healthy and equitable communities. While many hospitals have been supporting a variety of community-based prevention and health promotion programs, research demonstrates the value of investing in evidence-based interventions for preventing disease, improving health outcomes and reducing health care costs. The NYSPA's evidence-based interventions emphasize policy, systems and environmental approaches to prevention. Aligning investments in health promotion and disease prevention across all potential elements of state health care reforms can increase the progress towards building healthy communities.

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[6] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

[7] N.Y. Pub. Health Law § 2803-l.

METHODOLOGY

The hospitals included in this study operate in NYS and are classified as non-profit institutions by the IRS. Hospitals classified as public benefit corporations, such as NYC H + H, are not included in this report because they do not have Community Benefit spending and reporting obligations.

The NYSPA's intervention strategies were selected based on support from scientific evidence of their effectiveness. The number of evidence-based prevention interventions included in the codebook for this study totaled 86.

2013 Schedule H Form 990s were obtained via the website Guidestar, which provides non-profit organization financial data. The statewide figures are based on an analysis of 154 Schedule H Forms. The qualitative text in the Schedule H was coded with attention to Part VI, Line 5, titled "Promoting Community Health."

2013 CSP's were obtained from the NYSDOH. In 2014, NYSDOH developed summaries of CSPs submitted by hospitals in November 2013. Reviewers noted priorities, goals and interventions identified in the reports. The number of CSP summaries included in this analysis totaled 134.

DSRIP Project Application Plans were obtained from 2014 public submissions to the Medicaid Redesign Team. The number of Project Application Plans totaled 25. Projects identified as applicable to the NYSPA and selected by at least one PPS were coded. Those projects are:

Domain 3: Clinical Improvement Projects

a. Project 3.b.i: Cardiovascular Health
b. Project 3.c.i & Project 3.c.ii: Diabetes
c. Project 3.d.ii & Project 3.d.iii: Asthma
d. Project 3.e.iii: HIV/AIDS
e. Project 3.f.i: Perinatal Health

Domain 4: Population-wide Projects

f. Projects 4.a.i, ii, iii: Mental Health and Substance Abuse
g. Project 4.b.i: Tobacco Cessation
h. Project 4.b.ii: Preventive Care Management
i. Project 4.c.i & 4.c.ii: HIV and STDs
j. Project 4.d.i: Reduce Premature Births

In this study, a content analysis based on key evidence-based NYSPA strategies was applied to each Form 990 Schedule H, CSP, and DSRIP Project Application Plan. The unit of analysis for the coded data was defined as a NYSPA strategy. Data coding and analysis was conducted using NVivo software. Text extracted from the Form 990 Schedule H, CSP and DSRIP Project Application Plans were categorically coded for the 86 evidence-based NYSPA strategies. Afterwards, alignment of activities with NYSPA was calculated as the proportion of activities that are evidence-based NYSPA strategies—as compared to other strategies described.

The three hospital case studies were selected for high alignment scores, and to represent a mix of hospital sizes based on bed count, and geography. A total of 14 interviews, each lasting about 60 minutes, were conducted and transcribed. These were thematically analyzed to identify factors influencing alignment with the NYSPA and insights related to interpreting data on Community Benefit spending.

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