

WHAT ROLE DO CHARITABLE, NONPROFIT HOSPITALS HAVE IN
COMMUNITY BUILDING ACTIVITIES POST-2010 *PATIENT PROTECTION AND
AFFORDABLE CARE ACT* REFORMS? LEADERSHIP PERSPECTIVES FROM AN
EXPLORATORY, INTRINSIC CASE STUDY OF PERSISTENT POVERTY LEAVER
COUNTIES IN RURAL NEW MEXICO

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ABSTRACT

Mark Joseph Woodring: What role do charitable, nonprofit hospitals have in community building activities post-2010 *Patient Protection and Affordable Care Act* reforms? Leadership perspectives from an exploratory, intrinsic case study of persistent poverty leaver counties in rural New Mexico

(Under the direction of Sandra Greene)

Strengthening the community benefit practices of charitable, nonprofit community hospitals remains an urgent healthcare policy issue. Current literature suggests the comparative difference between nonprofit and for-profit hospitals continues to shrink, and policymakers may ask the nonprofit hospital industry to make tax concessions post-Patient Protection and Affordable Care Act (ACA) accordingly. This dissertation examines the perceived community benefit of charitable, nonprofit hospitals in two rural New Mexico persistent poverty counties through an exploratory, intrinsic case study. Community building activities are defined as tax-exemptible community benefit provided by the hospital. The hospital community building programs that are reported on *IRS Form 990 Schedule H: Part II* may be the last legitimate, distinguishable difference between the operating outcomes of nonprofit and for-profit community hospitals. Key informant interview data did not reveal major differences between the views of the nonprofit hospital CEOs and other local leaders on how a nonprofit, charitable hospital can best benefit a county. There was strong agreement between both groups of leaders that more transparency of the nonprofit hospital tax exemptions would be welcomed by the public. Better understanding the current, diverse perspectives of key local constituencies on the

inherent value of a charitable, nonprofit hospital can help frame future discussions and decisions by healthcare boards, hospital administrators, community leaders, policymakers and taxpayers.

For my mom, in memoriam.
Let us run with perseverance the race marked out for us.

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I would like to acknowledge the support of my dissertation chair and committee members as we conclude this exciting project. I have learned more than you can imagine on this journey, and I am looking forward to new roads I have yet to travel. Some of those planned paths bear resemblance to Arlo Guthrie's *City of New Orleans*, penned by Steve Goodman. The steel rails *still* ain't heard the news.

I also give thanks for the blessings of family and friends, and for places like Farmington (Iowa), and Aurora (Nebraska); Keokuk and Kahoka; the Hamilton Cardinals and the Solon Spartans; little towns from Murray to Memphis, Missouri; Logan, Harlan, and Atlantic, Iowa, and all the bitty places like them, for giving their kids a chance. Jenna and Ashlyn—this is where your daddy's from. Kari—thanks for being so loving and gracious to allow me the time away from home to show them through this project.

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PREFACE

“Living conditions of poor people—such as housing, nutrition, and employment...are a result of economic and political realities that cannot be changed without fundamental and highly unlikely system changes.”¹

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KEY DISSERTATION TERMS & CONCEPTS:

Persistent Poverty County - As defined by the United States Department of Agriculture (USDA), a county that has three consecutive U.S. decennial censuses with poverty rates $>20\%$.²

Leaver County – A persistent poverty county where the most recent U.S. decennial census reported a poverty rate $<20\%$.³

Deeper County – A persistent poverty county with a reported poverty rate that worsens each decennial census for at least three consecutive censuses.

IRS Form 990 – A federal reporting requirement for tax-exempt organizations.^{4 5}

Schedule H – An additional IRS Form 990 federal reporting requirement for tax-exempt hospitals.⁶

Schedule H: Part II – A specific section of IRS Form 990 Schedule H that discloses community building activities funded by tax-exempt hospitals.⁷

Community Building Programs – According to IRS Form 990 Schedule H Part II, these programs include physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, and workforce development investments made by the tax-exempt hospital.⁸

Community Benefit - nonprofit hospitals are required to provide and report measurable charitable benefit to their communities in exchange for tax-exempt status.⁹

ACA - *2010 Patient Protection and Affordable Care Act* legislation that outlines various U.S. healthcare reforms.¹⁰

Exploratory Case Study – “The exploratory case study investigates distinct phenomena characterized by a lack of detailed preliminary research”.^{11 12 13}

Intrinsic Case Study – “An intrinsic case study is the study of a case (e.g., person, specific group, occupation, department, organization) where the case itself is of primary interest in the exploration. The exploration is driven by a desire to know more about the uniqueness of the case”.^{14 15 16}

PILOTs – “In recent years, local government revenue pressures have led to heightened interest in Payments in Lieu of Taxes (PILOTs), which are payments made voluntarily by tax-exempt nonprofits as a substitute for property taxes.”¹⁷ PILOTs are also “Federal payments to local governments that help offset losses in property taxes due to non-taxable Federal lands within their boundaries.”¹⁸

CHAPTER I: INTRODUCTION

Background

Projected health outcomes of a population may be socially determined by street address or zip code.^{19 20 21 22} With the number of “persistent poverty” zip codes measured by the U.S. Department of Agriculture (USDA) in 2000 increasing 12% after the 2010 census,^{23 24 25 26} key policymakers continue to fervently articulate the adverse impact poverty has on health in America.^{27 28 29 30} Despite grim, recessionary statistics of the past decade,^{31 32 33 34 35} some persistent poverty counties have actually steadily reduced poverty levels to <20% in 2010 according to secondary, USDA data review¹. Socioeconomic analyses refer to these counties as “leavers”³⁶, which could serve as inspiration for leaders in high poverty communities to judiciously research.^{37 38}

Statement of the Issue

The 2010 Patient Protection and Affordable Care Act (ACA) is expected to expand health insurance coverage to many uninsured populations in the U.S. If reforms are successful, a reduction in the level of charity care provided by hospitals will be realized. Early indications from ACA reform efforts already suggest charitable, financial support provided by hospitals are in fact decreasing,^{39 40 41 42} which further narrows a comparative gap between the strategic objectives of for-profit and nonprofit hospitals.^{43 44}
^{45 46 47} While the profits generated from for-profit hospitals ultimately benefit stock

¹As defined by the USDA, persistent poverty counties have three consecutive U.S. decennial censuses with poverty rates >20%. Raw data were obtained for this project from Tim Parker at the USDA Economic Research Service.

shareholders, these for-profit facilities also market “millions of dollars invested in medical technology, building upgrades, improving healthcare and creating jobs, and investing in community sponsored activities, donations, and volunteer hours” to the public.⁴⁸ It is not clear if a distinguishing difference can be made between the value society derives from tax-exempt hospitals and other for-profit health systems post-ACA⁴⁹, so hospital leaders should expect the IRS to continue scrutinizing the charity provided by nonprofit hospitals.⁵⁰

This study sought to gain a better understanding of the community development role charitable, nonprofit hospitals have in persistent poverty counties, and assessed current leadership support for hospital community building activities⁵¹ since passage of the ACA. To justify hospital tax-exempt status, such social capacity building may be the last legitimate, distinguishable difference between the operating outcomes of nonprofit and for-profit community hospitals.^{52 53 54 55 56} My fifteen years of executive experience at the highest levels of nonprofit health system administration and governance, and subsequent completion of a thorough literature review (Chapter Two), has led me to what nonprofit hospitals are doing to contribute to the tax base and local economy, both fiscally and socially. Thus, my research question is the following: What role do charitable, nonprofit hospitals have in community building activities post-2010 *Patient Protection and Affordable Care Act* reforms, particularly in persistent poverty counties?

Many of the hospital community building approaches listed on *IRS Tax Form 990 “Schedule H: Part Two”*⁵⁷, such as leadership training, workforce development, and environmental improvements, have been shown to successfully reduce poverty over time^{58 59 60 61 62 63 64 65 66 67 68 69}. Hospitals in persistent poverty counties may be more willing

to consider supporting alternate healthcare delivery systems to dually support local health and economic improvement efforts. Unfortunately, current Schedule H data are inconclusive—and often not available—for recent community building activities by hospitals in persistent poverty “leaver” counties. Without key informant interviews to find out what nonprofit hospitals are doing, “it is impossible to know what is not being reported”.⁷⁰

Significance of The Issue

Nonprofit hospitals should continue to be interested in providing charitable support to the community post-ACA for various reasons. First, the ACA is not expected to provide universal coverage. Nearly 30 million patients could remain uninsured after all reforms take affect⁷¹. In addition, health systems that discharge high percentages of patients that live in poverty may experience indirect, adverse financial consequences given reimbursement methodologies.^{72 73 74 75 76} These payment changes could compromise comprehensive, high-quality healthcare delivery and negate future hospital community benefit, particularly in persistent poverty counties.

Lastly, the idea of “community benefit” remains a fluid concept.^{77 78} In October 2012, the Robert Wood Johnson Foundation and the University of Maryland Baltimore County (UMBC) Hilltop Institute released a series of issue briefs related to the new IRS charitable expectations of nonprofit hospitals^{79 80 81}. These briefs built on previous legal research and community benefit commentary^{82 83 84 85 86}, and offered guidance to nonprofit hospital boards and executive leadership for greater accountability of ensuring benefit is broadly supporting local needs beyond charity care^{87 88}. One such perspective includes community building activities.

Community building activities of healthcare organizations is not a new concept,²
89 90 91 92 93 94 95 96 97 98 but changing hospital tax-exemption requirements to include these
local community building efforts could infuse billions of dollars currently spent on
marketing and administrative expenses, capital equipment, and competitive acute
programs and facility construction, into upstream community health strategies to
strengthen the local social economy and support new population health initiatives.

Such policy would be similar to John Quirk’s suggested approach of taxing
nonprofit hospitals like normal businesses⁹⁹, but would use the income generated for
community building initiatives instead of solely for uninsured care. Driving a reported
\$12 billion annually of foregone charitable tax-exempted payments to community health
investments would be significant “community benefit” payments in lieu of taxes³, and
would ease the concerns of nonprofit advocates that limiting exemptions would hurt
public health¹⁰⁰. Increasing community building investments by hospitals could also
potentially slow the growth of other hospital-related spending, and unlock economic
potential of marginalized patient populations. While some nonprofit hospitals are truly
struggling to survive operationally and remain viable enterprises, others are “struggling”

²Consider the community benefit definition of Community Medical Center in Toms River, NJ. This health system decided to look “outside the hospital walls” to address challenges facing their service area in “nutrition, housing, social support, environment and education needs.” Community Medical Center first embarked down on this path in 1987, and was highlighted in the Journal of Health Administration Education in the summer of 1994.

³According to a Hilltop Institute June 2012 Brief, “the value of tax exemption accruing to the approximately 2,900 nonprofit hospitals in the United States has been variously estimated from \$8.5 billion to \$21 billion, including the value of federal and state taxes avoided, eligibility for tax-deductible donations, and access to lower-cost capital financing from issuance of tax-free bonds. The Joint Committee on Taxation estimated aggregate financial benefits from federal, state, and local tax preferences afforded to nonprofit hospitals and their supporting organizations in 2012 at \$12.6 billion. Recent “Prevention and Public Health Fund” in the ACA legislation was supported by the American Public Health Association, calling for \$18.75 billion in new funding for local public health programs, but over \$6 billion was cut to fund Medicare physician payments. The fund was further reduced after the FY2013 sequestration.

to keep up with neighboring “competition”, acquiring the latest medical technology, providing deluxe accommodations¹⁰¹ and growing “market share”. In 2004, the Federal Trade Commission and U.S. Department of Justice reported competition amongst hospitals and providers may adversely impact community benefit.¹⁰²

With large federal budget deficits projected into the foreseeable future, policymakers may ask the hospital industry to make further revenue concessions post-ACA—but without compromising patient safety initiatives or quality of care. Ultimately if sufficient data are not captured on *IRS Tax Form 990 “Schedule H: Part Two”* related to community building activities, policymakers may perceive justification to extract more revenue from nonprofit hospitals—especially as approaches to simultaneously reduce hospital operating costs while improving public health exist.¹⁰³

Purpose & Specific Aims

In *Health Services Research* Cordes claims, “In persistent poverty counties the delivery issue is that of overcoming economic deprivation and its impact on health status and access to care. Researchers must be attuned to such differences when analyzing health status and health needs, prescribing models of delivery, and analyzing health policy.”¹⁰⁴ The key purpose of this study is to better understand the specific community building philosophies of charitable, nonprofit hospitals and their county leaders located in economically improving, rural New Mexico persistent poverty “leaver” counties.

Specifically this research addresses the following:

1. Since recent passage of the ACA, what perceived role exists for these charitable, nonprofit hospitals to meet the needs of the county *outside* of the traditional care setting?

2. How engaged are these charitable nonprofit hospitals with the various community building activities listed on *IRS Tax Form 990 "Schedule H: Part Two"*?
3. How would local leaders and hospital CEOs feel about their hospital making payments in lieu of taxes into a local, public charitable trust or foundation to invest more organizational resources into specific community building activities to improve the overall health of the county?¹⁰⁵

The research aims were the following:

1. To analyze current expectations of local leaders on how a charitable, tax-exempt nonprofit hospital can best benefit the county;
2. To evaluate specific community benefit applications post-ACA, as some hospitals report through *IRS Tax Form 990 "Schedule H: Part Two"*;
3. To assess the willingness of nonprofit hospital leaders to support alternative public health funding mechanisms that increase local community building activities—particularly those that could infuse new social capital into persistent poverty counties and economies;

Considerable amounts of literature are available that evaluates the specific impact hospitals have on affecting the overall conditions in a county, especially those serving smaller, rural populations. However, distortions and misconceptions of the current evidence exist given the variable assumptions that are made to produce the evaluation data and the influence of those who use it¹⁰⁶. The project purpose and aims will be successfully met by bridging a post-ACA gap in the voluminous literature on nonprofit hospital community benefit and forging new ground on potential public health funding considerations by county leaders.

Importance of the knowledge to be gained

This project primarily impacts one area of health policy—definition of charitable community benefit. Some believe more public accountability and clearer transparency of charitable, nonprofit hospital tax exemptions is needed. Charitable, nonprofit hospitals may have potential to lead a new generation out of poverty, and expand access to the American dream by transforming poor, local economies through healthy community building. Nonprofit hospital tax-exempt proceeds could go into a locally controlled, public healthcare charitable trust. A foundation governance structure with “FQHC-like user board composition”¹⁰⁷ could provide public trust over fund distributions and ensure “accountability and local flexibility in responding to community needs”.^{108 109} Similar foundations are often created after nonprofit hospitals are purchased by for-profit systems¹¹⁰. This approach also allows hospital boards to remain committed to—and more narrowly focused on—quality and other core competencies inside of the institution. However, an incremental step may need to occur prior to seeing more of this public health funding mechanism taking place—posting the value of a charitable, nonprofit hospital’s tax exemptions online each year. The willingness of nonprofit hospital leaders to do so is not known.

CHAPTER II: REVIEW OF THE LITERATURE

My literature review focused on the economic impacts of hospitals and community benefit practices of nonprofit hospitals. While “almost every state has analyzed the impact of health care on its economy to some degree”^{111 112}, empirical evidence from published peer-reviewed literature suggests elements of uncertainty are present in these analyses given the variable assumptions that must be made.^{113 114 115 116} Nonprofit hospitals may not be benefiting a county any more than a for-profit hospital, and perhaps less.

Literature Review Methodology:

In order to develop a clearer understanding of what role charitable, nonprofit hospitals specifically have in community building activities post-ACA reforms, research was conducted on what is currently known about the overall impact of a hospital on its surrounding county. When considering this impact, there are a number of community forces that must be reviewed. My work experience suggests at least four focused schools of thought should be considered—local job creation, care and access, conceptual county attractiveness and benefit, and other local investments made by the hospital. This thorough literature review process is necessary to lead to a better understanding of a nonprofit hospital’s role in a county.

Because persistent poverty counties require three concurrent US decennial censuses for designation, the literature review initially sought examples from the past three US decennial censuses, dating back to 1990. *Google Scholar* is an emerging research engine and was primarily utilized to locate current hospital impact thematic literature. The efficient snowball method was then utilized after acceptable works for the review were identified.¹¹⁷

GOOGLE SCHOLAR SEARCH STRATEGY

Hospital impact search was limited to English	
Concept	Key words and search terms
Hospital economic impact	“Hospital Economic Impact” <i>[exact phrase]</i> Publication date of 1990 to 2012 First 200 articles reviewed
AND	
Hospital community benefit	“Hospital Community Benefit” <i>[exact phrase]</i> Publication date of 1990 to 2012
AND	
Hospital closure	“Rural Hospital Survival” <i>[exact phrase]</i> (With at least “closing”, “economic” or “impact”) Publication date of 1990 to 2012
AND	
Hospital community development activity	“Hospital Partnership Investment” “Community Development” <i>[exact phrase]</i> Journal: Health Affairs Publication date of 1990 to 2012

Inclusion Criteria:

Only peer-reviewed material was considered for the literature review. All methods of study (qualitative, quantitative, case study, etc.) were acceptable. Additional criteria were established by theme per table below:

Article Inclusion Process	
Concept	INCLUSION CRITERIA
Hospital economic impact	Authors specifically discussed the economic or retail impact of a hospital.
Hospital community benefit	Authors specifically discussed the community benefit impact or process of a hospital.
Hospital closure	Authors specifically discussed the economic impact of hospital closure.
Hospital community development activity	Authors specifically tied the idea of a hospital or health entity investing with a micro-financial institution, foundation or healthy community development corporation.

Exclusion Criteria:

Thematic literature not related to research in the United States was excluded.

Search Results:

Hospital Economic Impact: This search resulted in 600 hits on Google Scholar. The first 200 articles returned were reviewed, resulting in 8 articles meeting the inclusion criteria (one was a duplicate). Additional research was performed using “Related Articles” and “Cited By” hyperlinks of seven of the articles, to the point of saturation where no new knowledge was gained by the researcher.

Hospital Community Benefit: This search resulted in 96 hits on Google Scholar. After twenty-five successful reviews, and further utilizing “Related Articles” and “Cited By” hyperlinks of these articles, it was determined the level of saturation was reached for this theme.

Hospital Closure: This search resulted in 40 hits on Google Scholar. Further analysis determined 9 of these articles met the inclusion criteria, and “snowball” searches

continued to further address issues related to the economic impact of hospital closure on its service area.

Hospital Community Development: This search resulted in 140 hits on Google Scholar, whereas only 5 met the inclusion criteria. Similar to the other themes, additional material was found utilizing “Related Articles”.

Of the four literature review searches, the first two returned a plethora of material and published literature. The latter two searches resulted in less quantity of material and articles to review, but were instrumental in obtaining a more complete review of potential impacts of hospitals on a county.

Additional Search Strategies:

While reviewing the returned search results from the aforementioned strategy, further investigation occurred with articles that perfectly matched the search concept and inclusion criteria. Embedded hyperlinks (i.e. “Related Articles” and “Cited By”) in the literature allowed new or related search results to quickly surface, which led to accumulating additional literature to previously uncovered search material. These additional articles were accessed through Google Scholar, PubMed, and the Internet. This “snowball” effect was very successful in obtaining additional high quality, peer reviewed research for the literature review. In totality, when considering the various impacts a hospital has on its surrounding community, these themes have been outlined for further review and analysis. Some of the articles may fit into more than one theme, as there is some overlap of these concepts.

Part 1: Estimating Hospital Economic Impact

Healthcare Economic Multiplier Models Should Be Considered Cautiously

Intuitively, a hospital's presence (whether for-profit or nonprofit) will drive economic activity. Hospitals hire workers and many purchase supplies from local vendors⁴. The healthcare industry can help support the creation of additional jobs and consumption.^{118 119} Local hospitals will often collaborate with trade groups and associations to calculate employment multipliers and forecast the economic impact of local health care spending. These constituencies will often tout economic benefit studies to the public utilizing forms of input-output methodology.^{120 121 122 123 124 125 126 127 128 5} Of these types of economic studies and reports, literature review did not find published quantitative evidence that refutes the positive economic effect a hospital (whether for-profit or nonprofit) has on a community. This may give credence to the idea that multiplier-types of economic impact analyses can be used by special interest groups as "rent-seeking" devices.^{129 6} Refinements of hospital economic multiplier approaches have been suggested.^{130 131}

⁴The Kansas City Star reported "A Healthy Building Business" on November 6, 2012, citing over \$1 billion spent in the metropolitan area over the past five years which acted as a "safety net" for local construction companies that had seen a significant slowing in work from other industries during the recession. HCA, a for-profit health system, accounts for nearly 30% of the hospital inpatient beds in the region and completed numerous facility-related projects.

⁵"This report is a tool hospitals can use as they work with local elected officials and in their community relations efforts. Nationwide, hospital care is the largest component of the health care sector, which itself is a growing segment of the U.S. economy. In 2008, the health care sector represented 16.2% of Gross Domestic Product (GDP)—a measure of economic output—or approximately \$2.34 trillion. Hospitals accounted for \$725 billion of that total." Courtesy of the Georgia Hospital Association

⁶"Given data limitations, measurement error, and methodological weaknesses, some degree of humility is advisable in estimating income multipliers and community economic impact" write Woller and Parson.

Part 2: Estimating Economic Impact of Hospital Closure

Some Hospital Closures May Negatively Affect the Economy

Some struggling hospitals remain open, despite inefficiencies and low volume, through subsidies.^{132 133 1347} Various opportunity costs are considered when bailouts come to fruition⁸. However, some hospitals may ultimately close. Misconceptions about the economic impact of hospital closure exist, leading small town mayors to conclude their towns largely suffered a “poor economy” following a hospital closing, when in reality this perception was not backed up by statistical evidence¹³⁵⁹. This may be a result of significant hospital advocacy on how vital hospitals are to local economies and job creation. Healthcare leaders are trusted sources of information and knowledge, and must be aware of the impact their language has on community leaders. Evidence does not suggest massive, bloodletting economic collapse related to hospital closure in a community.

The economic effect of a hospital closing in a community has been studied, and generally past evidence has shown there is no statistical difference in the local economy pre- and post-closure, though findings are not conclusive as contradictory evidence has been presented as well.^{136 137 138} Explanations for why there are “no significant short-

⁷Ricketts states, “Rural hospitals have been able to survive, even thrive, because the Medicare payment policies that were discriminatory to rural hospitals have been blunted by Congress, and, more important, there has always been a real justification for the location and mission of hospitals in rural places.”

⁸Ricketts further writes, “One of the key arguments in support of the continued subvention of rural hospitals by government and the removal of differential reimbursement rates for rural hospitals is their contribution to overall rural economies.”

⁹The negative economic effects resulting from the hospital closure was mentioned at least once by 63.4% of survey respondents, more than any other survey response. However, I concur with the authors that “whether accurate or not, the perceptions of mayors are important in their own right. Their ideas represent the thinking of knowledgeable community leaders and are the impetus for behaviors.”

term or long-term economic differences between counties that lose their hospitals and the ones that retain their hospitals”¹³⁹ include “resilient” local economies, as well as the suggestion that the downward spirals many hospitals face before actually shutting their doors to the service area (i.e. reducing staff, cutting programs and services, delaying capital improvements, etc.) occur pre-closure. “Clearly, rural hospitals that are in full operation are major economic engines of these communities. However, once the point of closure has been reached, the economic impact is severely diminished.”¹⁴⁰

Recently, it has been suggested “hospital closures have a negative direct effect on the economic health of the county only if the hospital is the only hospital in the community”, noting, “counties losing the only hospital in the county experience a long term decrease in real per capita income (PCI) of roughly \$703 (approximately 4%), and increases in unemployment rate of 1.6%.”¹⁴¹ However, evidence suggests “closures in communities with alternative sources of hospital care had no long-term economic impact” after a 24-month decrease of per capita income.¹⁴²

Part 3: “Community Benefits” of Hospitals

The Value of Tax-Exempt Status Continually Questioned

One of the more contentious, debatable policy themes of a hospital’s impact is related to defining the “value of community benefit”.¹⁴³ Debates over tax-exempt status for certain businesses date as far back as the Tariff Act of 1894, with more specific focus on charitable, religious and educational organizations through the years. The Hill Burton Act of 1946 further entwined federal funding of hospitals in exchange for providing charity care to the community. This quasi-arrangement was strengthened by the IRS in 1956 through a mandate that nonprofit hospitals provide charity care in exchange for tax-

exempt status. In 1965, the adoption of Medicare allowed an evolution of mandated charity care services to providing “community benefit”, as Medicare recipients receive significant financial discounted healthcare services at hospitals. Today, nonprofit hospitals are still required to provide and report measurable charitable benefit to their communities in exchange for tax-exempt status¹⁴⁴.

While relief from taxation helps nonprofit hospitals with thin operating margins financially stay afloat¹⁴⁵, “policymakers at all levels of government” have questioned “whether not-for-profit hospitals provide a benefit to the public and if this benefit is commensurate with the value of the tax exemption they receive”^{146 147}. The following quote further illustrates the discrepant issue: “I think the community benefit [of PRMC] speaks for itself”, comments one charitable, nonprofit hospital board chair. “The 3,000 people who are employed, the 500,000 people inpatient and outpatient who are treated at the hospital, that’s the community benefit we’re talking about.”¹⁴⁸ Clearly this is not the community benefit policymakers are talking about, as for-profit hospitals provide employment and care treatment benefits to the community, too. The evolving expectations of nonprofit hospitals to act “charitably” is well reported, and some suggest the value of foregone tax receipts should at least equal the value of uncompensated care provided by the hospital.^{149 150} Application of a set standard has been, and remains, inconsistent amongst hospitals.^{151 152 10} Even with the new Schedule H established in 2010, no specific definition of community benefit has yet been offered by the IRS as they have only begun collecting this new information¹⁵³. As mentioned previously, the macro economic impact of local, nonprofit hospital workers is not a defining, distinguishable

¹⁰Modern Healthcare reported in their research some hospitals still include unpaid medical bills as community benefit even though Schedule H instructions ask they do not. (December 19, 2011)

difference compared to for-profit hospital workers, but it is one regularly referenced by nonprofit hospital leaders, nonprofit hospital advocacy groups, and community leaders alike to describe the importance of having a hospital.

Some believe community benefit standards “should include and encourage community-building activities, as they are already favored under the Code, and they directly address social determinants of health, which is critical to improving population health and addressing growing health disparities.”¹⁵⁴ A case can be made for defining community benefits broadly, and for hospitals to increase collaborations and partnerships with community organizations.¹⁵⁵

“Society stands to benefit greatly if nonprofit health systems practice corporate citizenship broadly and vigorously,” states Longest in *Inquiry*.¹⁵⁶ Two previous AHA studies further illustrate hospital strategies that have benefited their communities through economic development, creating career ladders for staffing and education, and investment in nursing homes and long term care. Their organizational successes may be associated with improvement in community poverty rates over time (Appendix F1 and F2). Nonprofit hospitals building critical county infrastructure and strengthening core community assets through philanthropic investments can positively benefit patients, though some hospital leaders believe such a view is outside of their professional scope.¹⁵⁷

Part 4: Literature Summary

Ultimately, hospital economic impact literature leads to societal questions as to what kind of healthcare do we want in our communities, how much subsidy will it require, who will pay for it and how?¹⁵⁸ I believe it can be difficult for healthcare leaders and non-economists to ascertain the construct validity of published quantitative

approaches and economic models regarding health economics and hospital closure. Current findings do result in serious industry and policy reflection on the potential economic affects a hospital has on a community. Despite conflicting evidence, the economic and social importance of small rural hospitals on their communities has significant face validity.

A recent economic analysis to measure the effects of a hospital closure in 1999 found “because hospitals do not close at random, county economic environments influence closure and vice versa.”¹⁵⁹ Empty, closed hospitals that were later occupied by new health entities such as nursing homes also seemed to minimize any negative economic effect of the hospital closing on the community.¹⁶⁰ Put succinctly and perhaps best, “future economic consequences of the local health care sector will vary by community.”^{161 162 11} These potential consequences depend upon local leadership.

Attempts at reaching consensus on how to best improve community health will likely be met with conflicting perspectives and priorities between a significant number of key stakeholders at local, state, and national levels. To understand how nonprofit hospitals can best benefit rural, persistent poverty “leaver” counties post-ACA, it is clear researchers and policymakers must acutely appreciate the unique nuances of each county. Perhaps “the best anyone can do is to understand deeply the specific problems that afflict the poor and to try to identify the most effective ways to intervene.”¹⁶³ Literature review suggests a detailed understanding of hospital community development in persistent

¹¹Christiansen and Faulkner write, “The actual impact on community income of a rural hospital’s closure would depend greatly on the community’s response to that event. At one extreme, the closure could result in out-migration of hospital employees, loss of the community physician, and a graduate decline in the attractiveness of the community as a living environment...nonetheless, one could construct an equally plausible scenario resulting in an entirely different outcome...of maintaining the economic and social structure of the community.”

poverty, rural New Mexico counties will require a qualitative case study research approach, listening to key leaders describe the local conditions, challenges, and opportunities economic deprivation brings.

Discussion of the Literature

What We Do *Not* Know

Current hospital economic impact studies do not focus on the development potential of the poor in persistent poverty counties. This type of development focus could distinguish nonprofit hospitals from for-profit hospitals. Only 6% of reported community benefit dollars of nonprofit hospitals are routinely invested in community social programs (compared to 71% of community benefit dollars spent on uncompensated care)¹⁶⁴, and often these community programmatic investments are not community-minded “evidenced-based” strategies but instead are hospital “public-relations minded” strategies.¹⁶⁵ Other evidence suggests only 2.2% of hospital spending is related to community health programs.¹⁶⁶ The local economic impact of increasing community building activities by nonprofit hospitals was not revealed through literature review.

Additionally, I found published works from literature review are often rural in nature, which sometimes reflects poverty but not at the level being discussed in my project. Studying hospitals in rural, persistent poverty counties has not currently been done to my knowledge¹². “Very little is known about the health care safety net in small towns, especially in towns where there is no publicly subsidized safety-net health care,”

¹²Though Cordes does discuss healthcare in persistent poverty counties, measured then as “Per capita family income in the lowest quintile of all U.S. counties in 1950, 1959, 1969, and 1979” which included 242 counties, in The Changing Rural Environment and the Relationship between Health Services and Rural Development. (HSR: Health Services Research 23:6 February 1989) While he describes poverty as part of a “generic” rural policy agenda, he does take the opportunity to share the need for considering regionalism and alternate healthcare delivery systems, specifically to better serve high poverty areas.

state Taylor, et al. in *Journal of Rural Health*.¹⁶⁷ To my knowledge, healthcare economists have not yet published what potential role these “leaver” hospitals may have had in improving their local persistent poverty economies¹³. Additionally, little empirical review or evidence of what has helped these persistent poverty leaver counties reduce poverty has been cited since 2010. For researchers and policymakers interested in learning how to have lasting positive change and impact in high poverty areas, “leavers” could make unique, key learning labs.

IRS Tax Form 990 “Schedule H: Part Two” currently offers little evidence of reported community building activities by nonprofit hospitals in persistent poverty counties, and few of the hospitals identified for potential study submitted *IRS Tax Form 990* for their healthcare organizations. The hospitals in the case studies proposed for qualitative analysis may be a glaring example of continued flaws in the *IRS Form 990 “Schedule H”* reporting expectations of nonprofit hospitals. Information is either “rolled up” into the corporate health system’s *IRS Form 990* where specific community detail is not reported thoroughly, or sections like “*Schedule H: Part Two*” are simply left blank (Appendix A2 and A3). Also county-owned or government-sponsored hospitals are not obligated to file *Form 990* reports with the IRS.

Despite new disclosure opportunities for hospitals, there will continue to be many unanswered questions regarding the community benefits provided by nonprofit hospitals in the marketplace. This dissertation project is not suggesting community building activities by hospitals are not occurring. These activities simply may not be widely

¹³Or may not have had. According to secondary data review, some persistent poverty counties successfully, continuously reduced poverty to <20% over the last few decades without the presence of a nonprofit or for-profit hospital. The reduction is also not a result of sizeable population change.

reported by nonprofit hospitals via *Form 990s*. However, the IRS may take the viewpoint if the work is not documented, it was not done. Given the political realities of the new Schedule H reporting, strengthening the community benefit practices of charitable, nonprofit community hospitals remains an urgent healthcare policy issue. This limited case study can provide a perspective of two hospital community building philosophies that do not fund these activities according to Form 990.

Limitations

I used *Google Scholar* as my primary search engine for the literature review. This technology is still quite new, particularly for social science research. *Google Scholar* does not lend itself well for systematic literature reviews because of incomplete recall.¹⁶⁸ Additional searches using PubMed and the Internet helped supplement the initial findings and generate supporting literature. Literature review themes focused on nonprofit hospital community benefit, hospital community building and development, hospital economic impact, and hospital closure. But notwithstanding systematic deficiencies in the literature review process, the peer-reviewed articles and thoroughly compiled secondary data reveal a significant body of knowledge for further study.

CHAPTER III: RESEARCH DESIGN & METHODOLOGY

Study Design

It is not known how charitable, nonprofit hospitals located in persistent poverty leaver counties are investing in community building activities. A qualitative research design was chosen to better understand the current roles and local expectations of such activities. Because time and resource constraints limited access to studying all leaver counties together, an exploratory^{169 170}, intrinsic^{171 172} case study approach was chosen for the project. A qualitative case study¹⁷³ research method utilizing key informant interviews with hospital CEOs and community leaders in two persistent poverty counties is an effective way to learn more about each hospital's role in community development. Studying the economic impact of such development would require quantitative methods and is outside of the scope of this study. However, the case study chosen consisted of two rural New Mexico counties that quantitatively experienced continual, historical improvements in overall poverty rates according to secondary data review.

Both counties were selected from the preliminary list of leaver counties identified in the Appendix. Interestingly, secondary data review of all persistent poverty counties in New Mexico identified only two deviant cases of continual improvement in county poverty rates since the 1980 U.S. census, to where poverty levels today are now reportedly less than 20%. These were the two counties chosen for the case study. The Institute for Healthcare Improvement (IHI) similarly conducted follow-up qualitative research based on methodology identifying quantitative outlier county performance.¹⁷⁴

The study qualitatively analyzed descriptive views of these leaders by comparing and contrasting the language used in each of the two different counties. Working with the small subset of the potential sites in New Mexico allowed the study to achieve a deeper understanding of issues related to the project aims, and provided great insight for more narrowly focused follow-up studies for future work. Hospitals in persistent poverty counties are under-represented in the literature, yet these hospitals may be more likely to consider alternate delivery approaches outside of the traditional acute care setting. They are also at heightened risk of closure given a poor payor mix and today's challenging operating environment for sole county hospitals.

Phase One: Methods for Selection of Hospitals and Leaver Counties (October 2013)

I corresponded and met with staff from the UNC Center for Work, Poverty, and Opportunity to discuss various issues related to hospitals operating in high poverty communities, at which time the idea of researching hospitals in "persistent poverty" counties was suggested by the Center. This led to further analysis and secondary quantitative data review of all USDA persistent poverty counties nationwide (Appendix) being conducted. I prepared a list of counties that have experienced a continual decrease in poverty rates over the past thirty years to where they no longer meet the definition of persistent poverty ("leavers"), and a list of counties that have experienced a continual worsening in poverty rates over the past thirty years ("deeper"), and reviewed them thoroughly. Of all the possible site selections for case study, New Mexico and Louisiana were the only states with multiple leaver counties. Given the uncertainty of how Hurricane Katrina may have confounded the population data in Louisiana, I strongly considered the New Mexico counties for the study. Additionally, it was of intrinsic

interest that New Mexico also had a persistent poverty deeper county—something different appeared to be going on in one impoverished part of the state that was not occurring in another. Therefore, an exploratory, intrinsic case study of the two leaver counties was selected—Taos County, New Mexico, and Rio Arriba, New Mexico. Taos County ranks 18 of 32 on current County Health Rankings, while Rio Arriba County currently ranks 31 of 32. According to AHA Annual Hospital Guides, over the past decade New Mexico hospitals located in leaver counties experienced significantly higher growth in labor expenditures than the hospital in Sierra County, New Mexico (the deeper county). The current uniqueness of these two leaver counties support the definitions of an intrinsic case study¹⁷⁵. Criteria and methodology for the initial 21-county potential inclusion is outlined in the Appendix.

IRB & Confidentiality Issues

An IRB application was completed and submitted in January 2014 after successfully defending the dissertation proposal. Truman Medical Center and the University of Missouri – Kansas City both expressed in writing I did not need to involve the IRB or Privacy Boards in Kansas City for my project. I received an IRB approval with exemption for continuing review from UNC IRB for my project on March 3, 2014 (Appendix).

Preliminary Participation (March 2014)

I made initial contact with the two hospital CEOs in the two counties proposed for study through a brief introductory letter approved by the University of North Carolina IRB. I followed up with each of them via E-mail and telephone two weeks later to

formally ask them to participate in the project¹⁴. Networking with leaders at the New Mexico Hospital Association, and relying upon networking with other healthcare industry leaders at the American Hospital Association to help enlist their participation (as initially planned) was not necessary. I found both CEOs to be very responsive and supportive of meeting with me. I believe my willingness to travel to their hospitals was a key factor in garnering their support, and allowed me to generate incredibly rich data I likely would not have received through a phone interview.¹⁵

Once I garnered their support, I reached out to ten other local, civic leaders throughout the county engaged in various community health, development, and education leadership roles to participate as well. To get a wider county health perspective outside of the hospital walls (similar to community health needs assessment approaches), which lessens potential influence or bias of the hospital CEOs, hospital board trustees were excluded from the study. Participants included: an assistant school superintendent; a retired dean of a large college of liberal arts who completed graduate work at NYU in nonprofit leadership that currently leads a nonprofit youth development agency; a former prosecutor that is the current county economic development executive; two county public health leaders (one was the divisional physician leader for the state health department, and the other a public health director); a county government executive; two regional chamber of commerce board presidents (one of which earned a law degree and previously worked for the U.S. Department of Housing and Urban Development, and the other a

¹⁴One CEO immediately E-mailed me back after receipt of my letter and was incredibly supportive of my project!

¹⁵I received a personal hospital tour, insights on the impact drug and substance abuse has on families of the staff, and very candid replies, nonverbal cues, and smiles to my questions.

longtime native to the area who was incredibly welcoming and a tremendous resource on the history of the region); a United Way Executive Director; and a Community Foundation Executive Director. All participants were specifically chosen for their direct professional relationship to various community building activities listed on *IRS Form 990 Schedule H: Part Two*.

Phase Two: Methods for Qualitative Study (May and June 2014)

Key Informant Interviews

An interview guide was developed and included early ice breaker questions related to the leader and their respective role in the county to help them feel more comfortable answering questions. Most questions asked were open-ended, allowing participants flexibility in how they chose to answer each particular question. To strengthen content validity of the study, central questions from the interview were derived from the literature review, Schedule H, and my work experience in healthcare administration. All of the interviews were “semi-structured”¹⁷⁶ in nature whereas after completion of the structured question, I was able to follow up with participants on various topical trajectories. This provided for a more open and natural dialogue to occur.

Sample and Sampling of Participants

Specific county leadership *roles* were identified prior to soliciting interview participation. The specific *people* working those roles were identified through the Internet and were mailed a letter asking for their voluntary participation. Networking with other leaders ensured participation in each county leadership category. Key criterion for interview selection was, *first*, was the participant perceived to be in an active

leadership role within the county; and *second*, did the leader have professional experience related to the community building theme? Again, hospital trustees were not considered.

Study Table 1: Participant Criteria

County Leadership Role	Community Building Activity Theme
County Executive	Economic Development/Environmental Improvements
Economic Development Official	Economic Development/Physical Improvements
Education Administrator	Workforce Development/Leadership Development
Chamber President	Coalition Building/Workforce Development
Public Health Executive	Community Health Improvements
United Way/Community Foundation	Community Support
Executive Director	

I followed up with each leader (or their assistant) by phone to schedule an interview. In three cases, the leader (or their assistant) expressed they had not seen the initial letter but agreed to kindly consider the request. After resending the introductory letter via email, the interview requests were granted. Getting the right leader in the public health offices scheduled for interview required persistence and networking. Neither school superintendent initially solicited for interview expressed an interest in participating. Through persistence and networking, alternate educational administrators were identified and contacted for successful participation.

The following table summarizes the county leaders interviewed. This is a purposeful, small sample of “leaders” in the county, disproportionately stratified to ensure certain hospital community building concepts are represented from the literature. The case study results are not statistically generalizeable to the county itself or to other counties with similar leaders.

Study Table 2: Participants

County Leadership Role	Male	Female	Taos County	Rio Arriba County
Hospital CEO	X	X	X	X
County Executive	X		X	
Economic Development Official	X			X
Education Administrator	X	X	X	X
Chamber President	XX		X	X
Public Health Executive	X	X	X	X
United Way/Community Foundation Executive Director		XX	X	X

Data Collection

Key informant interviews gave me an opportunity to collect a wide variety of focused opinions from local leaders that offered in-depth insight to the study aims. A majority of the research took place in New Mexico, and the working hypothesis developed as new knowledge was gained. The interview guide was pre-tested with local hospital and community leaders, and the UCLA Center for Health Policy Research Guide for Key Informant Interviews was followed. I conducted seven face-to-face interviews with participants in their workplace offices, and five telephone interviews with participants that were unavailable during my trip to New Mexico, for a total of twelve interviews. After receiving permission from each leader, the key informant interviews were audio recorded. I transcribed all interviews within 24-hours of the interview. Interviews ranged in duration from 25 minutes to over two hours, with most interviews being completed within 45 minutes. Notes were taken in all interviews, and were used to verify and match against the final transcripts to ensure accuracy. Recordings of the interviews were then destroyed.

Data Analysis

I approached the qualitative data analysis without pre-determined codes, themes or ideas. This is a traditional social science data analysis approach.¹⁷⁷ Transcripts of the entire interviews were read thoroughly and carefully to get a general sense of what was being said and conveyed by the leaders. Notes were made on the transcripts as various impressions and questions began to mentally emerge from reading the text. Seven key questions from the interview were then selected to specifically identify any emerging themes related to the key study aims under investigation. These questions were questions 5, 7, 8, 9, 10, 12, and 13 (Appendix B).

The material from these questions was then organized by study aim. Sentences, paragraphs, or interview segments were again analyzed. Interview material from the hospital CEOs was grouped and analyzed separately from other leader interview material. Group topics that related to one another were combined into a larger, macro-level theme. The final reported themes did generally reflect past literature.¹⁷⁸ Some of these final codes also offer a surprising, unique perspective on theoretical community benefit practices by nonprofit hospitals that have not yet been published to my knowledge.¹⁷⁹

Study Limitations

Qualitative research is subject to personal researcher bias. The key informant interviews sought to better understand the issues from various leadership perspectives and are reported objectively as possible. However, there are some career experiential biases inherent with the analysis process. My work and life experience working in the hospital administration field likely led to some (even if marginal) unintended temporal bias, though I believe a researcher independent of health administration would yield

similar key interviewee responses and subsequent analysis. Reliability of the data is very high, though replicability in conducting this study again with the same leadership subjects and getting consistent responses would be limited as the key informants and their responses could change depending on their current financial and political environment or job status. For example, one CEO resigned for a new position a few months after our interview. Local conditions could also change over time, thereby potentially affecting future overall themes and outcomes. This study only reflects a snapshot in time.

Resources to improve inter-rater reliability of the transcribed themes are limited. As a dissertation project, I was solely responsible for transcription and coding of key informant interviews. I worked in conjunction with my chair and UNC Health Library resources to ensure a strong qualitative analytic process. External validity—the ability to generalize study findings to other leaver county hospital settings, or other nonprofit hospitals in general—is also limited. The research may only be a partial leadership reflection of the specific counties included in the study. Additionally, the hospital service areas do not necessarily coincide with county boundaries, which may have colored interviewees’ responses. However, “the goal of qualitative work is not to generalize across a population.”¹⁸⁰ Additionally, Yin suggests a difference between statistical generalization and analytical generalization, where perhaps findings of the case study offer new insights or hypotheses warranting further research or introspection.¹⁸¹ The research is important for board governance, and may help provide opportunities for further dialogue within various counties or hospital service areas, persistent poverty or otherwise, and with many different types of other community leaders not represented here.

Lastly, as Cordes suggested, the defining healthcare delivery issue in persistent poverty communities is helping patient populations overcome economic deprivation, and using USDA persistent poverty statistics was necessary to identify locations to evaluate potential poverty trends in charitable, nonprofit hospital markets; however, poverty is also a term that is very difficult to measure and quantify. The reliance upon one indicator that is based on U.S. Census Bureau data may not fully describe the economic status of a community.^{182 183 184} The study does not infer any causality between past community building efforts by the hospitals and the improvements in county poverty rates since 1980. Of possible interest to agricultural economists, the quantitative improvement in poverty rates assumed from the “leaver” counties does not necessarily match the qualitative data obtained from the informant responses.¹⁶ Percentage improvements on paper may be purely subjective to the naked eye or personal perception of participants. Nonetheless, the continual improvements in historical poverty rates by the group are striking and may warrant further research by agricultural economists and policymakers.

¹⁶Leaders interviewed for the study described the leaver counties as, “fundamentally a poor county with not so great health outcomes”, “very, very poor”, “having the challenge of providing a set of services without a large tax base”, “multi-generations of poverty and many social challenges”; “many working poor”; “a county with crumbling infrastructure based on a longstanding aversion to business development in areas that could only be described as a slum, udder squalor, with roofs collapsing and broken windows” and “its such a big, big mess, I wouldn’t even know where to begin to fix it.”

CHAPTER IV: STUDY FINDINGS

RESEARCH AIM NUMBER ONE:

To analyze current expectations of local leaders on how a charitable, tax-exempt nonprofit hospital can best benefit the county.

KEY FINDING:

- **The hospital CEOs and other community leaders described the role of their local nonprofit hospital in the exact same themes, none of which appear distinguishable from for-profit hospitals.**

Participants were specifically asked, “How does the hospital best benefit the county?”, and then later in a follow-up question, to describe from their perspective the impact on the county if the hospital closed. These questions were intended to evoke responses from two distinct, but related value paradigms: first, concretely, the hospital exists today, so how does it best benefit the county?; and secondly, abstractly, if the hospital were to close, what is the key benefit the county would miss most?

As expected, the hospital CEOs described the hospital best benefiting the county in three main categories: 1) As a large employer and economic engine; 2) As a source for emergency care; and 3) As a beacon to make the county more attractive for population and industrial growth. These themes support the view of previous literature. However, what I found surprising is the exact, flawless consistency between their thematic responses and other county leaders, especially given the difference between the groups of

individuals interviewed. I theorize on why this might be the case in Discussion Chapter

Five. Some of the example quotes from the leaders include:

“The hospital is extremely important for accidents that occur here, and it provides a great economic impact as well. The hospital provides many of the higher paying jobs in the county. There is no way a company would come here without the hospital.”

“Generally speaking the hospital is recognized as one of the largest employers in the community so we try to do any and all advocacy on their behalf that we can.”

“The hospital plays a vital role providing higher paying jobs and is one of the largest employers in the region.”

“From an economic development standpoint, hospitals are critical. They are a “leakage stopper” preventing the exodus of our hard-earned dollars here being spent in other communities.”

“The hospital is a lifeline for the citizens of this community and county. The nearest hospital is probably, with new technology and roads, probably a 25 minute drive at a high rate of speed, but if you are having a life and death emergency its too far. Additionally, if they had to go be hospitalized elsewhere they have to pay for gas to get there and back, and hotel, and pay for food, and they are already pretty poor.”

“It’s a huge employer!”

“I think about all the level of services and all of the people who use the emergency room for primary care, which is huge here.”

“Hospitals are the epicenter of the community, and having a hospital reduces the need for community members having to travel longer distances which can be a barrier to health, so that’s how it benefits the community in the most obvious way. It benefits the community by providing good quality healthcare locally. And of course, economically it helps with jobs and brining tax dollars in and having a lot of healthcare workers and administrators so in that perspective it’s a good thing. Finally it raises the appearance of the community so it’s a draw for people who want to live here.”

As a hospital administrator, I also found striking the perceived benefits of the charitable, nonprofit hospitals described by county and hospital leaders do not seem to have defining, distinguishable characteristics or differences compared to the benefits that

could be similarly depicted for a for-profit hospital. Additionally, the leaders did not create any new expectation or role beyond the nonprofit hospital's current scope of perceived local benefit—from their standpoint, hospitals should remain a viable operating entity employing hundreds of workers with high paying jobs, provide essential emergency care, and any perceived role in economic development was through mere presence of the hospital. There was wide agreement between the two categories of leaders that the hospital helps attract and/or retain new businesses, retirees, and workers, all of which were perceived as essential to the local economy. No perceived role of the hospital actively leading work “outside of the traditional walls” was mentioned by the leaders.

RESEARCH AIM NUMBER TWO:

To evaluate community benefit applications post-ACA, as some hospitals report through *IRS Tax Form 990 “Schedule H: Part Two”*.

KEY FINDINGS:

- Interviews with the hospital CEOs and diverse groups of community leaders confirm the publicly available *Schedule H Part Two* data, which revealed little to no direct investments are made by the hospitals into community building activities. No defined community building financing strategies by the hospitals exist.
- The hospital CEOs were not able to definitively provide the annual tax-exempt value of their respective organizations. Additionally, their answers reflected the idea of an employment multiplier effect that benefits the county

in lieu of taxes, which again does not appear to be a distinguishable characteristic compared to for-profit hospitals.

- **No case study participant disagreed with the idea of posting the exemption value online to provide more tax-exempt transparency of the nonprofit hospitals.**

In addition to completing Schedule H, the ACA requires a high level of dialogue and engagement between the hospitals and the service population through strong community needs assessment planning. Questions 9 and 10 of the interview guide focus on these concepts.

“In the Affordable Care Act there is a provision for nonprofits to maintain tax-exempt status with the IRS to work with a local coalition on community benefit based on data,” commented one community leader.

Through the course of my interviews with the hospital CEOs and leaders in both counties, it was clear that collaborative approaches were indeed in place to meet the community health needs assessment requirements of the ACA. While both counties had similar versions of a “community health council” comprised of hospital, civic, and public health leaders, it was clear from study participant feedback that the health council in Rio Arriba County was locally perceived as the stronger of the two. The health council is an “incredibly strong”, “powerhouse organization” that works collaboratively to “formulate policy, secure funding for projects identified through the needs assessment, and develop alternate upstream payment strategies.” (See Appendix of RACHC bylaws).

Also, the community health council has closely integrated with planning efforts of county officials and has engaged in local public policy debates.

“Elections here are not based on patronage, they are based on promoting good policy. Politics here have a very strong family base, and functions like extended family. To get elected you need to have good health policy, and the local health council candidate forums are perceived as very important!” commented one county leader.

Despite some health improvement successes of the councils, both “suffer from the same challenge of lack of resources.” On one hand, “the council in it of itself doesn’t need much funding. Essentially all of the council leadership time is volunteer.” On the other hand, funding for council initiatives is needed through foundations, grants and other sources to pursue the planned policy goals of the council, some of which go unmet without necessary resources to implement, according to the leaders.

As a hospital administrator, I understand difficult choices get made that focus on funding “acute care” needs and equipment versus investing resources on more “upstream”, public health and prevention efforts. I also understand nonprofit hospitals must provide proof of “community benefit” to demonstrate continued eligibility for tax-exempt status. Question number 8 of the interview guide probed deeper into the tax-status of the charitable hospitals, which gets to the heart of the need for these hospitals to complete Schedule H. Can local leaders quantitatively speak to the economic value of the exemption, I wondered?

When the CEOs and county leaders were asked if they could guess the approximate annual dollar of the hospital’s tax exemptions (which could be a potential funding source for council programming efforts), no one offered a definitive reply—most simply acknowledged they had no idea.

“Boy, I don’t know. I would just be guessing! I don’t really know.”

“I’ve never had to do that calculation.”

“I don’t know, but the hospital is very supportive of the community.”

“Oh, I have no idea...sorry! I would not even begin to know how to guess that. Yeah, I don’t know that one.”

“I have no idea, and couldn’t begin to imagine.”

Three responses, however, did yield similar perspectives on the question. Two of these next three answers were from the hospital CEOs. These quotes relied upon speculative, theoretical economic multiplier language, and do not suggest a differentiating difference between the local economic impact of a nonprofit hospital and a for-profit hospital:

“It really comes to that whole dollar turn. The economics of the dollar turns three times by the time we pay somebody and they rent and buy houses, pay taxes, and buy goods and services. We essentially employ 400 people, so its huge just from that.”

“I wouldn’t be able to tell you what those are, but if I could elaborate on the impact of the tax base. If you look at 300 employees, and understanding our economic leakage, even if we only capture 50% of the leakage, the taxes that each worker pays back into the gross revenue into the municipality—you are looking at a very significant base.”

“I’m not sure, to be honest with you. Probably lots! Hospital salaries last year were \$22 million dollars, so most of the people making that money live in town, so that is spent in town buying groceries, buying gas, paying their home taxes.”

One participant asked in reply to my question on the value of the exemption, *“Did you get online and look at the community benefits survey to find the answer?”*, which I found to be a very informed, logical assumption on part of the leader asking the question. However, as hospital insiders know, that data or “answer” is not publicly available on Schedule H or the IRS Form 990 anywhere. So I simply asked all study participants a

follow-up question later in the interview (Question 13) to describe how they would feel about the hospital publicly posting the value of their annual tax exemptions online each year (perhaps through that community benefit report). Not one leader in the study, hospital CEO or otherwise, disagreed with doing so. In fact, some assumed this was already being done, while others felt more transparency of the hospital industry would certainly be a good thing:

“Yes, I’m always in favor of any nonprofit having full transparency.”

“I would assume that they already do that. I mean, that’s part of the public process of a nonprofit hospital organization having to do that.”

“Sure, that’s all in the study and goes on your 990’s and your community assessment anyway, so I don’t have a real problem with that.”

“I’d be fine with it, more transparency from the hospital would help and would be beneficial.”

“I would assume they would already. If I would look, it would be there.”

Two non-hospital leaders deferred and simply stated they had no strong opinion on the matter, and a third offered a riveting, balanced perspective of the issue:

“It would be a two-edged sword. I get paid by a county that relies on taxes to have revenues to provide services. We cannot necessarily impose MORE taxes, because that would have an adverse economic affect, but to the extent we are not receiving taxes means there is a lot of work that needs to be done that we cannot get to...here specifically our drug problem and our mental health issues go unmet because of lack of resources. So it would be a two-edged sword.”

This case study demonstrates overwhelming support exists from county and hospital leaders for publicly reporting the value of the hospital tax exemptions. The third study aim explores if local leadership support exists for nonprofit hospital “PILOTS”(payments in lieu of taxes) in these counties that could be specifically invested in community building activities or other unfunded public health needs of the county,

such as substance abuse or mental health programs mentioned by the county executive. When asked about the hospital's current efforts in the various community building activities listed in *Schedule H: Part II* (Question 10), no participant mentioned specific hospital financial support in any areas listed or described.

RESEARCH AIM NUMBER THREE:

To assess the willingness of nonprofit hospital leaders to support alternate public health funding mechanisms that increase local community building activities—particularly those that could infuse new social capital into high poverty populations and economies.

KEY FINDING:

- **While considerable conceptual optimism was expressed of contributing nonprofit hospital PILOTS into community building activities through a locally controlled, public health foundation, the leaders working in the healthcare industry were pessimistic if such an approach would be financially viable for nonprofit hospitals.**

During the background portion of the interviews, some study participants shared the growing challenges leaders faced in the counties—substance abuse, gangs, and poor graduation rates to name a few. They also said serious difficulties exist in the counties raising funds to provide essential community services with a shrinking tax base. So when I asked participants later in the interview to describe how they would feel if the hospital would be willing to make payments into a public fund or trust to invest in community building activities in lieu of paying taxes to tackle the aforementioned, the concept was met with considerable *conceptual optimism*. Their quotes included:

“That would be incredibly huge! Incredibly beneficial! They just don’t have enough money here to help, and they don’t have lots of ways to raise it.”

“If its directly invested into the local community, and targeted to the indigent population, I’m for it!”

“Most definitely! I would be very supportive. For example, more funding could be available for literacy programs. So many development delays start with reading.”

“It would be nice if they would authorize some of those funding streams to the work of other nonprofits.”

“Yes, if they did that type of work in close collaboration with other entities.”

The importance of how such a fund should be structured, with the hospital working as a true collaborator on such an initiative, was further emphasized by many of the participants, as seen by the following quotes:

“We would not want the hospital to run it, but their involvement and leadership would be very important. Hospitals in general tend to bully...the 500 pound gorilla in the room.”

“Maybe the hospital funds are connected to a larger community endowment or some kind of locally created social Robert Wood Johnson Foundation type of organization, where if you had something like that they are looking at other social problems; healthcare is one of them so hospitals are PART of the solution.”

“What tends to happen is you have a lot of well intended individual efforts in rural communities, and their effectiveness is only the sum of the component parts. If it worked collectively together we would get more impact per dollar and it would be beneficial to the community for a more systematic approach.”

“To really help to the folks on the street that need the help, we need to earn their trust first.”¹⁷

Based on this research, I am optimistic that the two hospitals in this case study would be examples of positive collaboration with such a theoretical population health fund. But because of fiscal realities post-ACA and possible perceived scope creep of the

¹⁷This viewpoint is supported by research conducted by Duflo and Banerjee in *Poor Economics*.

hospital reported by participants, an *economically pessimistic* view emerged from the healthcare-related leaders when they circumspectly discussed this alternative public health funding approach:

“If we can get our fiscal house in order, then I think philosophically, morally, ethically, the hospital will do as much of that funding as we can afford, its just right now we’re holding our own just getting from day to day.”

“My sense is hospitals are suffering in general, and my sense is they are pulling back and really focusing on what their core missions are, so I’m not sure they have extra dollars to be doing extra things. Hospitals are struggling with the cost of healthcare going up, the cost of salaries continue to go up, healthcare providers at all levels are very expensive, so hospitals are struggling to keep the lights on in many cases.”

“Hospitals cost a lot of money to run, and if we did that I don’t know if we could necessarily stay open. If hospitals were to do things like that I don’t think most would survive. The other thing is, I don’t necessarily trust the money would be spent in the best manner that would be most effective.¹⁸ People have good ideas and they take off like a dart, but they don’t research to see if its evidence-based. Unless there was a way to manage how the money was spent, I probably wouldn’t feel like that would be a good thing to do.”

“You know, part of me sort of hesitates when people go well, we should take this thing, and try to make it do all these other things. So this hospital over here should go and fix all of these problems through housing or community building initiatives. Hospitals in my world—in the medical model—they deal with sick people, and I really think that there is a lot hospitals can still do to improve the quality of care inside the walls”¹⁹.

Lastly, some of the leaders discussed various operational issues on this type of public health funding approach, such as timing of hospital cost report settlements (what if the hospital gives away the PILOT and later has a negative settlement?), not wanting

¹⁸An example was later offered of two fulltime employees managing seven pregnant women who were abusing drugs, and “if you were to ask me as a taxpayer do you want your taxes to go to case manage pregnant women who are in jail who are drug users without a different outcome, I’d say no thank you.”

¹⁹This viewpoint is similar to one from the Public Health Institute’s “Best Practices for Community Health Needs Assessment and Implementation Strategy Development” by Kevin Barrett, DrPH, likening a hospital’s limited set of preventative health interventions to the difficulty of “asking to make a kangaroo an elephant” (page 68).

community groups to have to feel like they are competing against each other for funds (can this be done in a way that does not to disrupt the cooperation that already exists?), and working with diverse constituencies on a common definition of success (should one or two coalitions or initiatives be funded or five or six ineffective or underfunded ones?) . More study is needed to further explore these issues.

Key Findings Summary:

- 1) The hospital CEOs and other county leaders described the role of their local nonprofit hospital in the exact same themes, and the benefits they described seem indistinguishable from the benefits provided by for-profit hospitals;
- 2) Publicly available *Schedule H: Part Two* data had revealed little to no direct investments are made by the hospitals into community building activities. Interviews with the respective hospital CEOs and diverse groups of community leaders confirm this.
- 3) The hospital CEOs were not able to definitively provide the annual tax-exempt value of their respective organizations. Additionally, their answers reflected the idea of an employment multiplier effect that benefits the county in lieu of taxes, which again is not distinguishable from for-profit hospitals.
- 4) No case study participant disagreed with the idea of more tax-exempt transparency of the nonprofit hospitals by posting the exemption value online; and
- 5) While considerable conceptual optimism of contributing nonprofit hospital PILOTS into community building activities through a locally controlled, public health foundation was expressed by many of the case study participants, the leaders working in the healthcare industry were pessimistic if such an approach would be financially viable for nonprofit hospitals.

CHAPTER V: DISCUSSION

Study Aim One:

Similar to my literature review findings, many participants in my study discussed the hospital in the context of the largest employer in town, the economic impact of the hospital workforce “dollar turn”, and the profound effect the hospital has on making the county more attractive for people and businesses to relocate to. But none of these are distinguishing differences between nonprofit hospitals and for-profit hospitals, which provide direct tax support into a network of local, county, state, and federal levies and related economic infrastructure. Ironically, one participant in my study mistakenly referred to the local charitable, nonprofit hospital as “a large, for-profit” entity—twice.

The lack of difference between the thematic analysis of the hospital CEOs and the other county leaders, on one hand, could stem from the messaging power of the hospitals, hospital advocacy groups and trade associations. If these groups tout the “economic impact” studies enough times, eventually this message takes hold (whether evidence-based or not). A few county leaders hedged on fully answering some interview questions and referred me to the hospital leadership for more information. Another stated they would do whatever the hospital asked them to do. That makes for a powerful platform for hospital leadership to be speaking from. Some of the leaders expressed concern on the negative impact on the economy if the hospital closed (“well without it I don’t think the town would be sustainable” and “it would be bloodletting...massive”). There is

political benefit, or power, or both, in having communities think this way. It is not necessarily in the interests of the hospital or hospital CEO to correct such viewpoints with balanced analysis.

On the other hand, making sure hospital interests and other local interests are aligned with a unified message could be an example of close collaboration between the leadership groups. This case study may demonstrate collaborative leadership in tight-knit counties with leaders possessing a strong desire and regard for both the hospital and county to be successful. Evidence suggests thriving counties can have thriving hospitals.

As I reflect on the interviews, I can hear echoes from both of these possible perspectives throughout my visits. The participants were all very engaged with the activities of the local hospitals. It is clear the hospitals are viewed as very important to the county and that the leaders would not want to lose them. Ultimately, I did find the participants' refraining from describing a key benefit of the hospital as supporting the poor, uninsured, or underserved a little disheartening. Has the charitable purpose of nonprofit hospitals eroded beyond community leadership recognition?

More targeted case study research is needed to learn about the perceived benefits and current expectations of county leadership groups with for-profit county hospitals, particularly in persistent poverty "leaver" counties. A list of such hospitals is available in the Appendix. I speculate little difference would be found between the perceived "best benefit" of any of these for-profit hospitals and the findings of the two nonprofit hospitals in New Mexico.

Study Aim Two:

In my study, Hospital CEOs were no better at answering the question, “What would you guess to be the approximate dollar value of the hospital’s annual tax exemptions?” than other community leaders. Not surprising to me or the dissertation committee, no participant was able to offer a concrete dollar figure to this question. The strongest answer by one of the CEOs essentially matched the answer of another community leader by describing the economic impact the employed hospital workers “dollar turn” had on the local economy and tax base. In defense of the CEOs, if I was asked in an interview to provide the value of the tax exemptions of the hospitals I have led, I would not be able to quantify a specific number either. This is for various reasons—and I believe one important reason is that currently there is no market competitive advantage to either know this figure or to disclose it. This is the paradox facing many nonprofit hospital CEOs—compete like a for-profit business, act like a for-profit business, but maintain the tax benefits of a nonprofit organization. Spending increasingly scarce organizational resources on nonreimbursable community building programs is not only unprofitable, it ultimately becomes uncompetitive in practice if other nonprofit hospitals do not agree to follow suit. However, public disclosure of all hospital tax-exempt value in theory could level the playing field.

Previous research shows an interesting phenomenon occurred once all Medicare-participating hospitals began publicly reporting clinical quality metrics and patient satisfaction scores—clinical quality and patient satisfaction efforts in hospitals improved.^{185 186} Community benefit expenditures reported by nonprofit hospitals “range wildly, and these wild swings could not be explained by the underlying level of

community poverty, profitability, or lack of health insurance among community residents.”¹⁸⁷ It has been suggested only state law that has mandated additional transparency of nonprofit hospitals can explain drastic differences in community benefit expenditures reported.¹⁸⁸

Public reporting of nonprofit hospital tax exemptions leads to at least two theories: One, as explored through literature review, effective community building and development can lead those in poverty to healthier, stronger economies. Second, I believe many markets would begin to experience what I coin a “backdoor bundling” of healthcare services through more effective tax-exemption public reporting. Capital investments, administrative overhead and other hospital related spending would shift towards funding the greater health of the population.

In regards to “bundled payments”²⁰, as used in the traditional sense, one hospital CEO stated, “I think we all get it, I think we are all comfortable with it, the payment systems just haven’t moved with the concepts fast enough”. The notion of offering bundled payments to healthcare providers has been discussed for decades, and remains incredibly complicated to successfully achieve for many various, divergent reasons²¹. However, nonprofit health systems do not need to wait for the payment concept to catch up. A more pragmatic view of bundling might be limiting the operating margin of nonprofit health systems by posting the value of their tax exemption online, and asking

²⁰More information on bundled payment reimbursement methods are available at <http://innovation.cms.gov/initiatives/bundled-payments/>

²¹Another hospital CEO in the study commented, “There is the world we are living in now where we have fee-for-service, and they say we are going to transition to capitation, and I still don’t see how its going to happen for us. There have been no negotiations with payors or anything as to receiving a lump sum of money to manage these folks. Bundled payments? Lets see if they make it happen. I don’t hold my breath.”

those exempted dollars to be spent on healthy community building activities. This would limit the amount of hospital working capital available to be spent in ways that exploit volume-based reimbursement methods and other nonprofit competitive tendencies.

It is clear through this second study aim a possible next step could be to engage nonprofit hospital CFOs, Healthcare Financial Management Association leadership, and other scholars to discuss how a universally accepted, consensus nonprofit tax exempt value could be constructed, applied and publicly reported for nonprofit hospitals, especially given the plethora of work that already goes into existing community benefit surveys and reports, Medicare Cost reports, and annual financial statements (Appendix Financial Analysis of Case Study Hospitals). Estimates for this value have already been completed by various studies, which in many cases demonstrate some nonprofit hospitals fail to provide quantifiable benefit commensurate with the exemption. Conceptually, posting the value online each year could make community benefit reporting of nonprofit hospitals much simpler and more transparent to their respective communities, and provide policymakers a clearer “exemption test”.¹⁸⁹

More research is needed on this issue of tax-exempt transparency—other leaders may disagree with the leaders in this study. But I believe if nonprofit hospital tax-exempt transparency increases, funding for community building activities, community health initiatives and other public health programs would correspondingly increase as well. While hospitals in some markets may struggle over time to replace aging plant, equipment and facilities with such an approach, additional policy considerations could help alleviate this concern (much like the 1946 Hill-Burton Act that provided federal loans and grants for hospital construction).

Study Aim Three:

While philosophically the hospital CEOs were conceptually supportive of efforts to financially support more community building and public health efforts, the stated fiscal realities of their organizational operations resulted in less investments in these activities than they would otherwise prefer. (However, both hospitals had large billboards along the highway advertising the excellent orthopedic work that could be performed at their facilities, which were both very modern and recently expanded.)

Many participants—including the hospital CEOs—were receptive to the idea of a public foundation to oversee nonprofit hospital PILOTS, under certain conditions. The following table summarizes overarching, guiding principles that could be utilized to create a successful public health foundation framework. This framework provides key considerations to help overcome possible leadership resistance to the idea of charitable, nonprofit hospitals establishing a public health foundation funded by their tax-exemptions, based on the key findings of the case study.

Study Table 3: Guiding Leadership Principles for a Public Health Foundation

Leadership Principle	Participant Rationale
Invest tax-exempted proceeds in a cooperative, independent health endowment fund not controlled by the hospital.	It is important for the hospital to be a key participant in the process, but not to have total control of the process. It is also important that the proceeds do not supplant other local resources.
Funds should be locally administered and directly invested into the local community according to county health needs assessment.	Buy-in of the public foundation would be dependent upon decisions being made by local decision-makers in a collaborative fashion.
Target the most pressing needs of local indigent populations.	Nonprofit “charitable purpose” implies helping those in need, according to one county leader interviewed.
Invest funds in evidenced-based programs where ROI can be effectively studied.	According to the interviews, leaders may be more willing to participate knowing the funds are being effectively administered with an established definition of success.
To build trust, include the population groups that are targeted to receive the funds on the advisory board that manages the endowment.	Similar to community-based participative research and FQHC governance models, programs will be more effective if the impacted populations are included in planning and decision-making of the policies intended to help them.

Discussion Summary – A Call to Action:

Findings in this case study support the notion that nonprofit hospital leaders and boards should give strong consideration to how they are legitimately different from for-profit hospitals post-ACA¹⁹⁰, especially as growing evidence suggests for-profit hospitals also provide community benefit services¹⁹¹. Ethically, “as part of the fundamental mission of healthcare organizations”¹⁹², hospital leaders and trustees of nonprofit hospitals must dually fulfill moral and legal fiduciary responsibilities that “transcend compliance”¹⁹³. It is clear hospital and community leaders still readily believe their local hospitals benefit the community¹⁹⁴—and in all the ways described by the leaders above in this study, they do—but hospitals may have more work to do in regards to a more transparent “benefit” process and distinction with other for-profit hospitals.

With more resources being committed upstream and less operating income available for the acute care environment, local discussions amongst trustees and hospital leaders could ensue on how much can a hospital now afford to pay for specialists, administrators, marketing campaigns, lobbyists, and duplicative equipment in the marketplace. I believe publicly reporting the annual tax-exemptions of charitable, nonprofit hospitals will further shift the community paradigm and care continuum to funding outside of the institution—to where hospital leaders today often state they strive their organizations to be. Publicly reporting hospital tax-exemptions could allow leaders to successfully look more holistically at community health in a fee-for-service reimbursement model. The bundling of hospital services would just occur backwards from the traditional viewpoint of bundled payment. This upstream infusion of capital could also have a profound, dual effect on strengthening poor economies and slowing the healthcare cost curve.

“Our social economy,” stated one study participant, *“is hurting. And if we understand economic development, our local economy is indicative of how healthy our social economy is. Our social economy is dependent upon our nonprofits, and on us as individuals, which exist between the private sector and government. This social economy is essentially the wheel—the hub if you will—that turns everything around.”*

“It is incredibly important,” stated another participant, *“to understand the dynamics of the community and how it works together with the divergent interests in cultures. Creating cross-cultural conversation that benefits the whole*

community, lifting up the community in any way we can, and investing in social service programs can have positive impact and can create change.”

Lastly, data from the key informant interviews concurred with assessments outlined in the literature—poverty has a negative impact on health. So if the evidence is clear, the question in my mind as a healthcare administrator then becomes, “Will healthcare organizations choose to take an active role in reducing the ill-health effects of poverty by combating it with sustained community building activities?” Intuitively, without a defined, strategically funded community building approach, it seems unlikely the historical statistical decreases in poverty in these two counties can be explained by direct, purposeful efforts by the nonprofit hospital organizations studied. Perhaps this poverty leaver data represented a statistical fluke.²² We know the qualitative assessments gathered did not necessarily correlate with statistical “improvement” in these counties, according to the leaders.

Regardless, I believe provider passivity on these issues today may jeopardize a hospital’s tax-exempt status in the future. Getting charitable, nonprofit hospitals more committed to investing in “upstream” population health can provide significant community benefit. Posting the annual value of charitable, nonprofit hospital tax exemptions online can hold nonprofit hospitals accountable to that commitment. However, such commitment will require a plan for change on how these hospitals operate in a post-ACA environment. Creating more dialogue and research on tax-exempt transparency for nonprofit hospitals is the central focus of Chapter VI.

²²Recall footnote on page 19 that mentioned the existence of leaver counties that did not have a hospital located in the county. Continual poverty rate improvements in leaver counties may be a result of many other complicated, confounding factors needing further study.

CHAPTER VI: PLAN FOR CHANGE

The intended audiences for these results are hospital CEOs, health system governing boards and hospital trustees, hospital association leaders, policymakers and taxpayers. Hospital CEOs will act rationally based on their marketplace and environment, and after considering the perspectives of the various leaders in my study I offer this plan to change behavior: charitable, nonprofit hospitals will begin to publicly post the value of their tax-exemptions online each year to stimulate new healthy community building initiatives and socially strengthen local economies. Achieving this policy goal may require mandated action from Congress or the IRS. Minimally, a multi-step grassroots process utilizing strategic social network theory and analysis is needed.

Dissemination Strategy

A successful grassroots plan for change will require at a minimum eight interwoven dissemination initiatives to communicate the potential value of posting nonprofit hospital tax exemptions online.

My first goal is to disseminate research findings by submitting and publishing my study in a peer-reviewed scientific and practice-oriented journal, such as *Applied Economic Perspectives and Policy* (<http://www.aaea.org/publications/aepp>).²³ “The use of case studies is of growing interest to agricultural economists,” states Harling.¹⁹⁵ I

²³If rejected, alternative submission possibilities could include *Inquiry; Journal of Health Politics, Policy, and Law; Journal of Healthcare for the Poor and Underserved; or Population Health Management*.

believe this step is critical in creating credibility with key stakeholders as nonprofit hospital leaders renew dialogue on community benefit post-ACA. Scholastic support of the study findings demonstrate the ideas conceptually are valid and warrant further review and consideration by the nonprofit hospital industry, academic researchers and various policymakers.

The second dissemination strategy is to write a one-to-two page opinion essay in *Trustee* magazine, ACHE magazine *HH&N*, or *Health Executive* magazine that references the published study, which will broadly outline potential considerations the findings have on hospital governance and community health needs assessments. This forum provides an outlet for a wider, larger intended audience.

The third objective involves my current employer, Truman Medical Centers (TMC), which is a public hospital and health system that provides over \$130 million of uncompensated care per year (at cost). While our hospital accounts for less than 10% of all the hospital licensed beds in the Kansas City metropolitan market, TMC provides over 34% of all charity care in the region. TMC is the “safety-net provider” for Kansas City.

Post-ACA, public hospitals like TMC will be “competing” with other hospitals in the market as more uninsured patients gain coverage. On first blush, our leadership team may not see value in posting our annual tax exemptions online each year. The level of uncompensated care delivered at TMC far and away exceeds our exemption value. But I believe including this figure as part of our community benefit reporting will put TMC on the offensive. Local newspaper reporters may investigate what the value is at the other nonprofit charitable hospitals, and look to TMC as the proactive leader in the field.

Additionally, my direct boss—TMC’s President and Chief Executive Officer—is in favor of the community benefit PILOT concept. As the former Chief Marketing Officer for Heartland

Health who was responsible for compiling and reporting community benefit reports, and as the former President Pro Tem of the Missouri State Senate, our CEO has been a staunch advocate for increasing transparency of community benefits provided by nonprofit hospitals. Kansas City area nonprofit health systems have thrived with rich commercial payor mixes, largely because of the presence of a safety net provider like TMC providing a substantial amount of charity care.

I will also work with our CEO to obtain the conceptual endorsement of America's Essential Hospitals, the national association that promotes effective policy of safety net hospitals across the country. If other public hospitals begin to publish the value of their tax exemptions each year, a small wave of support can begin in many communities across the country. These hospitals are likely the most willing to participate as they really have the least risk in doing so. I believe there is almost an instinctive herd mentality with hospitals of not wanting to be amongst the last to do anything. Hospitals can be very faddish (consider TQM, Toyota, Lean, Centers of Excellence, Quality, Safety, EMR, Wellness, and Population Health to name a few). These first steps create entry level ripples to hopefully make a larger wave. Public posting of the exemption can benefit sole county community hospitals as well as the safety net hospitals. Charitable, nonprofit hospitals in multi-hospital markets bear the most risk in doing so, and likely will be the most resistant.

Fourth, I will offer to meet with Senator Charles Grassley of Iowa, and with Representative Paul Ryan of Wisconsin, and their respective health policy teams to suggest the concept of public posting of the exemptions. I will write an introductory letter to their office, and submit a copy of the published article with the letter. As a native Iowan and past chair of a new FQHC network in Southeast Iowa, I worked with our senators to establish this new network. We would not have been successful without Senator Grassley's support. As a former hospital

CEO in Iowa, I am also familiar with his thinking on hospital community benefit issues and I anticipate a strong willingness from him to consider the matter further. Representative Ryan currently chairs the House Budget Committee and is actively studying the War on Poverty. He and his health policy team may be receptive to budget neutral ways to support poverty reduction efforts.

Fifth, I will meet with Iowa Hospital Association President Kirk Norris, Wisconsin Hospital Association Steve Brenton, and Missouri Hospital Association president (and former CMS deputy administrator) Herb Kuhn to outline the published study and enlisted support of our nation's public hospitals. I will ask if they will visit with their hospital board leadership to consider creating a workgroup to further study the issue for further association recommendations. I have met and worked with all three of these gentlemen, and they are incredibly proactive hospital association leaders, lead incredibly proactive hospital associations, and like to create the future by defining it.¹⁹⁶

My sixth step is to submit the project for presentation at regional or national audiences, including professional association meetings, hospital associations, symposiums, or APHA annual conference to further engage health leaders and policymakers on the various concepts and opportunities presented in this study. I would anticipate conceptual receptiveness from public health leaders and advocates.

The seventh initiative is to visit with Mr. Richard Wittrup, retired CEO of Brigham and Women's Hospital in Boston, who currently runs the healthcare blog Health Care Anew (www.healthcareanew.blogspot.com). Mr. Wittrup grew up in Harlan where I served as CEO, and I sought his advice and counsel on various healthcare leadership issues. He, too, is a CEO very supportive of transparency, reform and need for change. His blogs are springboards for

various health policy discussions in the industry, and social media can be a very effective channel for networking and information distribution.

Finally, to keep the momentum moving forward, more research is needed. Chapter V outlines various opportunities for follow-up research and collaborative work to continue with other groups. I will also explore opportunities with various foundations and think tanks to participate in that research as I remain very interested in policy development that strengthens the safety net, improves public health, and has potential to revitalize poor economies.

Potential Benefits of the Study

In conclusion, multiple benefits can result from this work. Clarifying nonprofit hospital community benefit requirements and how they are actualized can be very useful to help address unanswered questions of how for-profit and nonprofit hospitals operationally differ post-ACA. Interview findings result in common themes that, when presented and disseminated, can act as a catalyst for renewed community benefit discussions between healthcare leaders, hospital boards, and policymakers as ACA health reforms continue. This study identifies very strong “needs assessment planning” dialogue occurring between key community constituencies and hospital leaders to improve local health, but not necessarily dialogue to support new financial investment or development of those needs in local counties by the hospitals. Better understanding the current, diverse perspectives of key community constituencies on how a nonprofit hospital can strengthen poor, local economies and impoverished populations can help frame these future discussions and decisions by hospital boards, administrators, community leaders and policymakers.

APPENDIX A1: IRS SCHEDULE H (FORM 990: PART II)

Please contact author for copy or download from [irs.gov](https://www.irs.gov) as the text is too small and light.

APPENDIX A2: 2011 IRS SCHEDULE H (FORM 990: PART II) FOR PRESBYTERIAN
HEALTH (NM)

Please contact author for copy or download from guidestar.org as the text is too small and light.

APPENDIX A3: 2011 IRS SCHEDULE H (FORM 990: PART II) FOR TAOS HEALTH
SYSTEM (NM)

Please contact author for copy or download from guidestar.org as the text is too small and light.

APPENDIX B: KEY INFORMANT INTERVIEW GUIDE

Hi, thank you again for your time and agreeing to participate in this interview. As you know, I'm Mark Woodring, and this interview is a part of my dissertation project at the UNC School of Global Public Health.

The information you have provided thus far has been very helpful in getting me to better understand the local dynamics of overall health and the economy here in _____. This interview gives us the opportunity to specifically talk about [insert hospital] and the impact it has here on the community and economy.

I am conducting a series of identical interviews with other key community leaders here in _____, and upon completion I will be compiling your feedback, along with feedback from personal interviews I've had with other community leaders in New Mexico. This will help me better understand the effect hospitals have in their local communities.

If OK, we'll go ahead and get started? With your permission, may I tape record our conversation? I will be taking notes, but I plan to transcribe our interview, and would be happy to get you a copy once complete. There are 3 main sections to the interview, and each should last approximately 10-15 minutes per section. The first section is related to general background information on you and the community:

SECTION ONE

- 1) Please tell me a little about yourself and your role in the county.
 - ➔ Are you originally from here?
 - ➔ How long have you lived here?
- 2) How would you describe this county?
- 3) Describe what conditions are necessary to reduce poverty in the county.
- 4) Describe the impact poverty has on the overall health of the county, if any?

The second section of our interview is focused more exclusively on your perspective of the hospital here in [_____] County:

- 5) Describe how the hospital benefits the community, if at all?
 - ➔ What is the most significant benefit?
- 6) Describe how the hospital can affect the economic conditions of the county, if at all?
 - ➔ How can it affect the economy most?

- 7) Describe the impact on the community if the hospital closed?
- 8) What would you guess is the approximate annual dollar value of the hospital's tax-exemptions?
- 9) What role does the hospital have in meeting the needs of the poor *outside* of the care setting here in your local community?
 - ➔ Does the hospital specifically meet the needs of the poor in some way outside of the hospital walls?

The last section of our interview is related to other community benefits the hospital may provide the county. I'm going to name various community building activities. Please describe the hospital's efforts in any or all of these activities:

- 10) Housing investments or physical improvements; county economic development efforts; environmental improvements; leadership development and training of community members; community health improvements; county workforce development efforts.
- 11) Do you have any thoughts or ideas on how the hospital could be encouraged to financially support more of the community building activities described in this section?
- 12) How would you feel about the hospital making payments in lieu of taxes into a local, public charitable trust or foundation to help invest more resources into these specific community building activities listed in this section?
- 13) How would you feel about the hospital publicly reporting the value of their nonprofit tax exemptions online each year?

CONCLUDING COMMENT & QUESTION:

- 14) Is there anything else you would like to share regarding how [insert hospital] benefits the community or the poor here in the county?

APPENDIX C: CASE STUDY SELECTION METHODS

After consultation with the UNC Center for Work, Poverty, and Opportunity, “persistent poverty” was determined to be the most appropriate indicator to measure changes in poverty rates over time. First, the definition is consistent, and the U.S. Census process offers a reputable poverty measurement method. This terminology describes U.S. counties that have had 20% or more of their population in reported poverty for three consecutive censuses.

Second, when describing the intent of the study to the Center’s staff, discussion ensued on measures of success and needing a “tipping point”—at what level of poverty does a county go from “high” poverty to “average”, “moderate” or “low” poverty? In the absence of formal, uniform “poverty rating system”, intuitively breaking below the 20% threshold would—at a minimum—no longer allow a county to be considered as one in “persistent poverty”, at least by USDA definition. This could be considered a sign of progress in the right direction.

Census data were then obtained through the United States Department of Agriculture (USDA) on poverty rates for all counties in the U.S. from 1980-2000 censuses. Poverty data for the most current decade was obtained directly from the U.S. Census Bureau, and all data were cross-checked by information provided by U.S. Representative Clyburn’s office (Rep. Clyburn had proposed in 2009 a “10-20-30 Amendment” requesting 10% of appropriated funds to go to a specific list of counties that have had 20% or more of their population in poverty for 30 years). When reviewing the 2000 Census data, counties that reported poverty rates below 20% were removed from the list. By definition, they could not meet USDA “persistent poverty” criteria.

Data were then extrapolated from the subset—adding new 2010 U.S. Census poverty rates greater than 20% resulted in a significant number of “new” persistent poverty counties emerging from the previous decade (from over 350 in 2000 to over 475 in 2010). However, of primary interest to the study was the number of counties that did NOT meet persistent poverty criteria in 2010, but DID meet the criteria in 2000. I later learned these counties are called “leavers”. 28 counties that were considered persistent poverty in 2000 no longer meet the criteria based on 2010 U.S. Census data (approximately 6% of the previous total), though this is not to suggest poverty has been eradicated in these communities.

Further removing the counties with no hospital or a for-profit hospital, 18 counties remain with a sole community, non-profit hospital. Concerned about the impact and potential migration of those affected by Hurricane Katrina in 2003, a “Katrina Rule” was employed where counties were removed from contention that experienced a population decrease in 2010 greater than 5% of U.S. Census 2000 measured population. Surprisingly, this did not impact the Louisiana parishes, but did remove remaining North and South Dakota counties, as well as one each in Texas and Arkansas. This left ten communities for potential study.

The data were then analyzed to obtain persistent poverty counties that had continual trends of worsening poverty rates over the past 30 years. I coined these counties “deeper”. While most persistent poverty counties experience fluctuating rates, surprisingly there are only 26 counties (5% of the total) that experienced continual worsening trends of reported poverty decade by decade. After removing the counties with no hospital or for-profit hospitals, 16 counties

remained in this group. However, 5 of the counties were in very large, multi-hospital counties that would almost lend themselves to a separate, and more economically complex, study (Philadelphia, PA; St. Louis, MO; Richmond, VA; College Station, TX; and Athens, GA). A 6th large multi-hospital community, Albany, GA, recently had its health systems merge, and for the sake of the study was too similar to those counties being removed due to population size and the presence of multiple competing hospitals, so it was removed as well leaving 11 more potential communities for further comparative review. Was there a state that had both leavers and deepers?

Lists of both leaver and deeper counties were analyzed. In 2001, Jim Collins released *Good to Great*, where commonalities of successful Fortune 500 companies were researched and identified by their sustained, superior performance compared to similar companies that did not “make the leap”.²⁴ Leadership, amongst other factors, was a key determinant in a company improving from “Good” to “Great” (as measured by cumulative stock returns).²⁵ Learning more about the current community building practices of hospitals in these two rural, New Mexico leaver counties that “made the leap” is of intrinsic interest to me, and is the focus of my dissertation project.

²⁴ Collins, Jim. *Good to Great*.

²⁵ *Ibid*

**APPENDIX D1: NONPROFIT HOSPITALS IN PERSISTENT POVERTY “LEAVER” AND
“DEEPER” COUNTIES PER DEVIANT SAMPLE METHODOLOGY**

CITY	STATE	POPULATION	HOSPITAL
Napoleanville	LA	686	Assumption Community Hospital
Union	MS	2,147	Laird Hospital
Centreville	AL	2,466	Bibb County Medical Center
Wilburton	OK	2,972	Latimer County General Hospital
Jonesboro	LA	3,662	Jackson Parish Hospital
Taos	NM	4,700	Holy Cross Hospital
Breaux Bridge	LA	8,139	St. Martin Hospital
Espanola	NM	10,495	Espanola Hospital
Dillingham	AK	2,481	Kanakanak Hospital
Hammond	LA	20,019	North Oaks Medical Center
Eufaula	AL	13,908	Medical Center Barbour
Warren	AR	6,219	Bradley County Medical Center
Fitzgerald	GA	9,053	Dorminy Medical Center
Cordele	GA	11,608	Crisp Regional Hospital
Claxton	GA	2,276	Evans Memorial Hospital Washington Country Regional Medical Center
Sandersville	GA	6,097	
Truth or Consequences	NM	6,475	Sierra Vista Hospital
Henderson	NC	16,095	Maria Parham Medical Center
Darlington	SC	6,289	McLeod Medical Center
Los Banos	CA	35,972	Memorial Los Banos
Grundy	VA	8,061	Buchanan General Hospital

APPENDIX D2: FOR PROFIT HOSPITALS IN PERSISTENT POVERTY PER DEVIANT
SAMPLE METHODOLOGY THAT WERE NOT CONSIDERED FOR STUDY AT THIS
TIME

CITY	STATE	POPULATION	HOSPITAL
Stiglar	OK	2,731	<u>Hascall</u> Co. Community Hospital
Franklin	VA	8,582	South Hampton Memorial Hosp.
Jourdanton	TX	4,285	South Texas Regional Med Ctr
Newton	MS	3,699	Pioneer Community Hospital
Plymouth	NC	3,878	Plymouth Hospital
Palatka	FL	10,558	Putnam Community Med Center
Hartsville	SC	7,764	Carolina Pines Regional Hospital
Millen	GA	3,037	Optim Medical Center – Jenkins

**APPENDIX E: COUNTY HEALTH AND PAYROLL DATA OF PRELIMINARY CASE
STUDY CANDIDATES**

County Health Rank*	County	City	State	Hospital	2000 Payroll	2012 Payroll	% Change	Change per FTE
39 of 64	Assumption Parish	Napoleanville	LA	Assumption Community Hospital	N/A	N/A	N/A	N/A
14 of 82	Newton County	Union	MS	Laird Hospital	N/A	N/A	N/A	N/A
58 of 67	Bibb County	Centerville	AL	Bibb County Medical Center	\$ 3,829,000	\$ 6,801,000	77.6%	63.8%
63 of 77	Latimer County	Wilburton	OK	Latimer County General Hospital	N/A	N/A	N/A	N/A
16 of 64	Jackson Parish	Jonesboro	LA	Jackson Parish Hospital	N/A	N/A	N/A	N/A
23 of 32	Taos County	Taos	NM	Holy Cross Hospital	\$ 6,333,000	\$ 22,945,000	262.3%	117.0%
38 of 64	St. Martin Parish	Breaux Bridge	LA	St. Martin Hospital	N/A	N/A	N/A	N/A
32 of 32	Rio Arriba County	Espanola	NM	Espanola Hospital	\$ 9,191,000	\$ 22,291,000	142.5%	156.0%
7 of 23	Dillingham Census Area	Dillingham	AK	Kanakanak Hospital	N/A	N/A	N/A	N/A
48 of 64	Tangipahoa	Hammond	LA	North Oaks Medical Center	N/A	\$128,640,000	N/A	N/A
31 of 67	Barbour County	Eufaula	AL	Medical Center Barbour	0	0	0	0
36 of 75	Bradley County	Warren	GA	Bradley County Medical Center	\$ 4,914,000	\$ 7,600,000	54.7%	48.7%
134 of 156	Ben Hill County	Fitzgerald	GA	Dorminy Medical Center	\$ 7,674,000	\$ 10,821,000	41.0%	82.0%
145 of 156	Crisp County	Cordele	GA	Crisp Regional Hospital	N/A	N/A	N/A	N/A
127 of 156	Evans County	Claxton	GA	Evans Memorial Hospital	\$ 4,379,000	\$ 10,960,000	150.3%	95.6%
139 of 156	Washington County	Sandersville	GA	Washington Country Regional Medical Center	N/A	N/A	N/A	N/A
29 of 32	Sierra County	Truth or Consequences	NM	Sierra Vista Hospital	\$ 3,454,000	\$ 6,448,000	86.7%	50.7%
93 of 100	Vance County	Henderson	NC	Maria Parham Medical Center	\$ 16,339,000	\$ 29,768,000	82.2%	52.6%
35 of 46	Darlington County	Darlington	SC	McLeod Medical Center	N/A	N/A	N/A	N/A
38 of 56	Merced County	Los Banos	CA	Memorial Los Banos	N/A	N/A	N/A	N/A
N/A	Buchanan County	Grundy	VA	Buchanan General Hospital	N/A	N/A	N/A	N/A

*www.countyhealthrankings.org accessed November 8, 2012. Payroll data supplied by the 2000-2001 and 2012 AHA Guides.

Table Analysis:

Having previously met established research selection criteria outlined in the Appendix, the study table reports publicly released information from Guidestar and the American Hospital Association Guide on nonprofit hospitals located in persistent poverty counties. In the counties that have had continuously improving poverty rates (green list), with one exception, hospital wages increased more than 100% since 2000. However, in the counties that experienced worsening poverty rates (red list), the hospital wages failed to reach this doubling multiplier in all cases but one.

The results are not definitive, and complete data sets are not available. I am not suggesting causation from these figures, but the tendency towards higher hospital labor multipliers perhaps is associated with a reduction in community poverty levels in this cohort. Further quantitative study would be required as the true economic impact reflected here is not known, and these initial findings are not generalizable to all hospitals located in persistent poverty.

Finally, regardless of the poverty rates or labor inputs, all of these counties remain amongst the poorest of health according to *County Health Rankings*—though perhaps as a whole, those highlighted in green seem to have slightly higher comparative health rankings than those in red. But if the overall goal of a hospital is to “improve the health of the public”, clearly more efforts must be made in all of these communities.

APPENDIX F1: AHA CASE STUDY 1

By comparing overall poverty levels of then and now, it is interesting to note that 9 of 10 hospitals in the study experienced a reduction in their poverty rate, perhaps explained in part as a result of their respective hospital strategies. However, only one county (Jasper) was designated as persistent poverty by the USDA. In fact, this county was specifically added to the study after the original selection criteria did not adequately reflect all of the geographic considerations of the US hospital market.

Place of Study	County	County Poverty % Level Time of Study (1990 Census)	County Poverty % Current Level (2010 Census)
Bolivar, MO	Polk	20.3	14
Lindsay, OK	Garvin	19.7	15.8
Iron County, MI	Iron	17.1	12.7
Park Rapids, MN	Hubbard	17.2	11.7
Ridgeland, SC	Jasper	25.3	21.5
Lexington, NE	Dawson	10.6	14.2
Colville, WA	Stevens	17.2	15.1
Onawa, IA	Monona	14.8	11.5
Wheatland, WY	Platte	15.7	10.3
Seymour, TX	Baylor	23.7	17.3

The Strategies and Environments of America's Small, Rural Hospitals

AHA Hospital Research & Educational Trust funded by The Pew Charitable Trusts (1992)

<http://www2.census.gov/prod2/popscan/cph-1-100.pdf>

<http://quickfacts.census.gov> (2006-2010)

APPENDIX F2: AHA CASE STUDY 2

In the following table, very similar trends to the previous AHA case study exist---reduced poverty rates over the long-term were realized after hospital strategic plans were executed. In this example, only two of the counties were designated as persistent poverty (Greene and McKinley). However, the improvements are striking, causing me to wonder if the hospital, as a key cornerstone of the community, could claim some ownership of the improved statistic.

Place of Study	County	County Poverty % Level Time of Study (1990 Census)	County Poverty % Level Current (2010 Census)
Greene County, AL	Greene	45.6	28.4
Pend Oreille County, WA	Pend Oreille	20.2	18.3
Tioga County, PA	Tioga	14.6	15.8
Hampton, IA	Franklin	11.3	10.6
McKinley County, NM	McKinley	43.5	28.4
Pendleton County, WV (no hospital)	Pendleton	17	15.1

"Working from Within: Integrating Rural Health Care"

American Hospital Association (1993)

APPENDIX G: NONPROFIT HOSPITAL CASE STUDY CANDIDATE COMPARISON

Non-profit, persistent poverty hospital case study potentials vs. other for-profit hospitals		
	Non-profit Hospitals Studied	For-profit Hospitals
Accept Medicare contractual adjustments?	YES	YES
Accept Medicaid contractual adjustments?	YES	YES
Provide Charity Care?	YES	YES
Compliant with EMTALA?	YES	YES
Participate with HCAPS?	YES	YES
Amongst largest employers in town?	YES	YES
File IRS Form 990 with completed Schedule H?	Most NO	NO
Pay Taxes?	NO	YES

APPENDIX H1: COUNTY HEALTH RANKINGS REPORT FOR RIO ARRIBA COUNTY, NM

Please contact author for copy or download from countyhealthrankings.org. Appendix page is illegible and the text is too small and light.

APPENDIX H2: COUNTY HEALTH RANKINGS REPORT FOR TAOS COUNTY, NM

Please contact author for copy or download from countyhealthrankings.org. Appendix page is illegible and the text is too small and light.

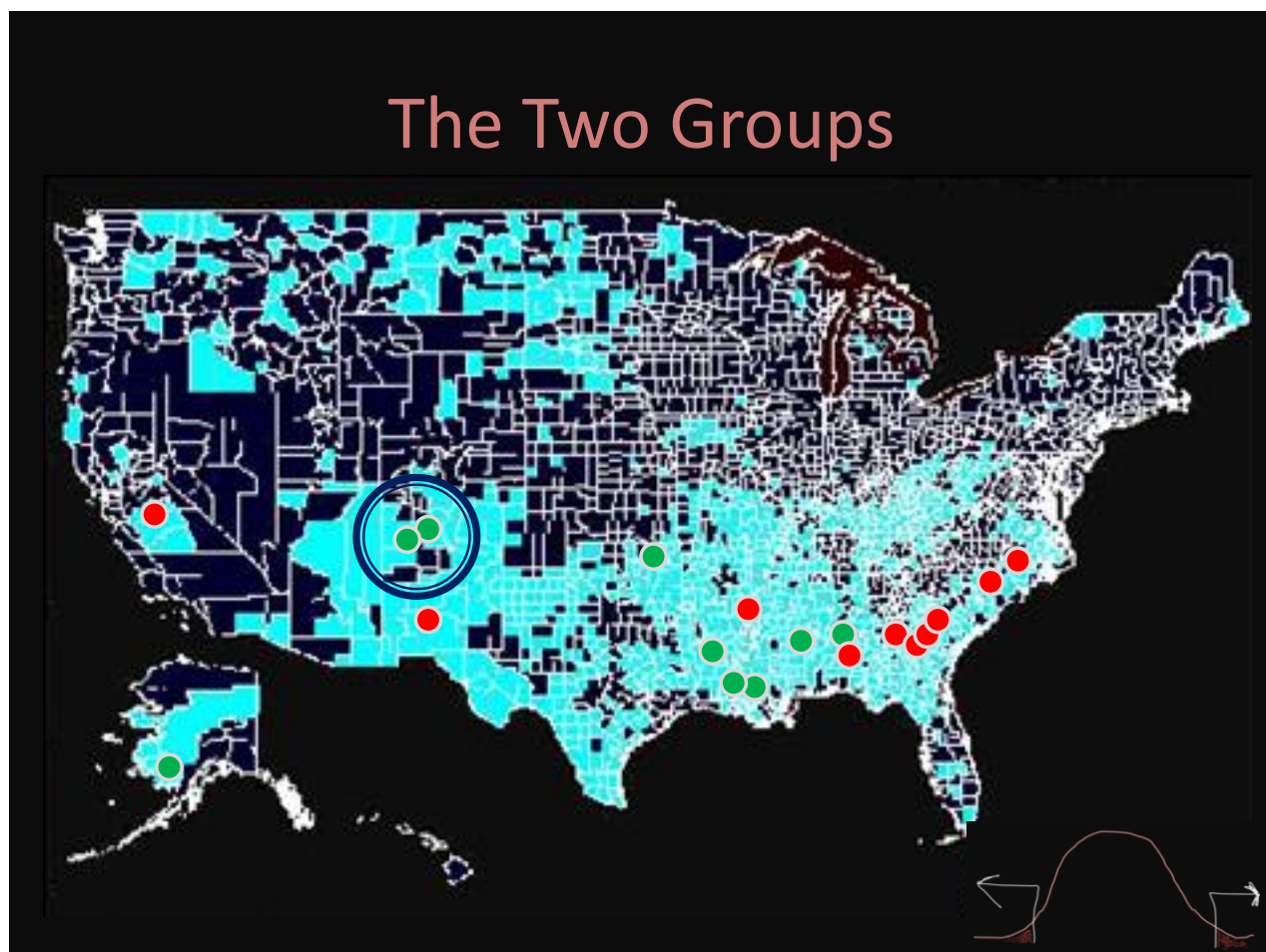
APPENDIX I: UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL NOTICE OF IRB
EXEMPTION

Please contact author for copy. Appendix page is illegible and the text is too small and light.

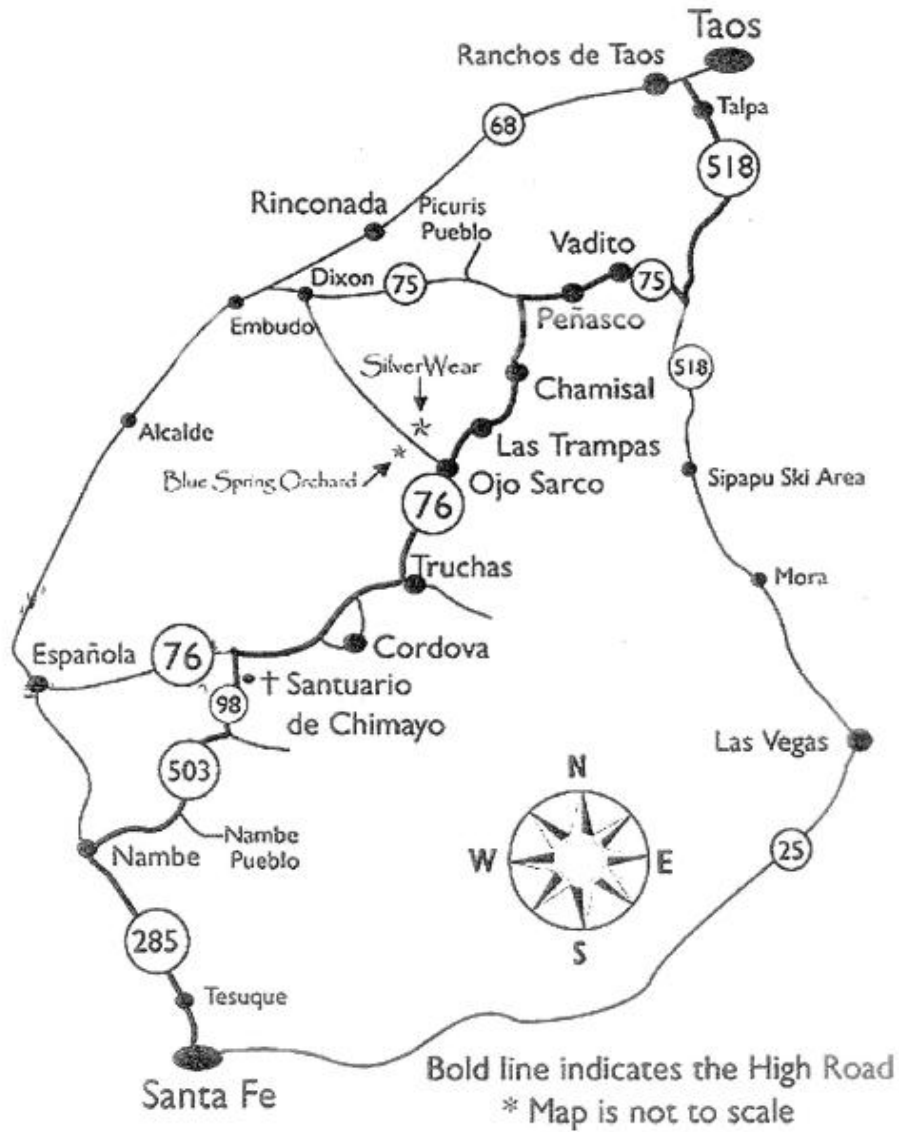
APPENDIX J: INTRODUCTORY LETTERS TO KEY STUDY PARTICIPANTS

Please contact author for copies. Appendix pages are illegible and the text is too small and light.

APPENDIX K: MAP OF CHARITABLE, NONPROFIT HOSPITALS LOCATED IN “LEAVER” AND “DEEPER” COUNTIES



APPENDIX L: MAP OF HOSPITAL LOCAL SERVICE AREA



APPENDIX M: HOLY CROSS HOSPITAL AND EXPANOLA HOSPITAL FINANCIAL DATA & ANALYSIS

Financial information was obtained through the American Hospital Directory (AHD) for sole, exclusive educational purposes of this dissertation. Upon review, four key areas of emphasis stood out in relation to this dissertation project which could lead to further follow-up quantitative study:

- Does the value of uncompensated care from the Medicare Cost Report (Worksheet S10) exceed the estimated tax-exempt value of the hospitals?
- The financial operating margin of the hospitals suggests these organizations may have difficulty paying an exemption tax (PILOT) if all other hospital spending was held constant. More study is needed on the estimated value of the exemption, the projected balance (if any) after uncompensated care was applied to the value, and what potential organizational spending reductions could take place to achieve the PILOT goal.
- Interestingly, the hospital with a stronger financial operating margin (Espanola Hospital) consistently operates with zero (0) days cash on hand. More study is needed to determine if these surplus funds are funneled to its corporate health system partner bank account in Albuquerque. If so, further study would be needed to determine how that decision impacts the local banks and local investment decisions. Would this practice be detrimental to local community development in Rio Arriba County?
- Lastly, it is incredibly challenging to crosswalk cost report data back to published IRS 990's, and the figures do not always necessarily match. For example, audited total assets in 2011 for Taos Holy Cross Hospital is listed as \$45,458,028 in the IRS 990, and was \$44,942,198 according to the settled cost report for the same time period. Discrepancies occur throughout the statements. With Espanola Hospital's IRS 990 rolling up to the Presbyterian Health System statements, crosswalking the public data is currently not possible.

Financial reports were downloaded from ahd.com on October 21, 2014 for: Holy Cross Hospital, Taos, NM 87571, CMS Certification Number 320013; and Espanola Hospital, Espanola, NM 87532, CMS Certification Number 320011. Please contact author or AHD for copies of the reports as the text is too small and light for publication.

APPENDIX N: RIO ARRIBA COUNTY HEALTH COUNCIL BYLAWS & MEMBERSHIP
LIST

Please contact author for copy or download from rachc.org as the text is too small and light.

WORKS CITED

- ¹ Patrick, D.; Stein, J.; Porta, M.; Porter, C.; Ricketts, T. Poverty, Health Services, and Health Status in Rural America. *The Milbank Quarterly*, Vol 66, No 1 (1988), pp 105-136.
- ² <http://www.ers.usda.gov/data-products/chart-gallery/detail.aspx?chartId=38238#.VCGGG5S8BBo> Accessed September 23, 2014.
- ³ <http://arec.oregonstate.edu/jaeger/poverty/FAQpoverty1.pdf> Accessed December 27, 2012.
- ⁴ <http://www.guidestar.org/rxa/news/articles/2001-older/understanding-the-irs-form-990.aspx> Accessed September 23, 2014.
- ⁵ <http://www.irs.gov/uac/Form-990,-Return-of-Organization-Exempt-From-Income-Tax-> Accessed September 23, 2014.
- ⁶ <http://www.irs.gov/pub/irs-dft/f990sh--dft.pdf> Accessed September 23, 2014.
- ⁷ <http://www.irs.gov/pub/irs-pdf/f990sh.pdf> Accessed September 23, 2014.
- ⁸ <http://www.irs.gov/pub/irs-pdf/f990sh.pdf> Accessed September 23, 2014.
- ⁹ King, Jackson, et al. Form 990 Disclosure requirements challenge hospitals, provide opportunities. *The Health Lawyer*. Volume 21, Number 3. February 2009.
- ¹⁰ <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf> Accessed September 23, 2014.
- ¹¹ <http://srmo.sagepub.com/view/encyc-of-case-study-research/n139.xml> Accessed September 23, 2014.
- ¹² Baxter and Jack. *Qualitative Case Study Methodology: study design and implementation for novice researchers*. The qualitative report. Vol 13, no 4. Dec 2008. Page 548.
- ¹³ Yin, R.K. *Case study research: design and methods* (3rd ed.) Thousand Oaks, CA: Sage. 2003.
- ¹⁴ <http://srmo.sagepub.com/view/encyc-of-case-study-research/n183.xml?rskey=GD7VN1&row=1> Accessed September 23, 2014.
- ¹⁵ Baxter and Jack. *Qualitative Case Study Methodology: study design and implementation for novice researchers*. The qualitative report. Vol 13, no 4. Dec 2008. Page 550.
- ¹⁶ Stake, R.E. *The art of case study research*. Thousand Oaks, CA: Sage. 1995

¹⁷ <http://www.lincolnst.edu/subcenters/significant-features-property-tax/upload/sources/ContentPages/documents/PILOTs%20PFR%20final.pdf> Accessed September 23, 2014.

¹⁸ <http://www.doi.gov/pilt/index.cfm> Accessed September 23, 2014.

¹⁹ <http://www.americashealthrankings.org/AboutUs/IntroductionandPurpose.aspx> Accessed September 23, 2014.

²⁰ <http://www.countyhealthrankings.org/about-project/team> Accessed September 23, 2014.

²¹ LaVeist, Pollack, et. al. Place Not Race: Health Aff October 2011 vol. 30 no. 10 1880-1887

²² <http://www.nber.org/mtopublic> Accessed January 18, 2013.

²³ <http://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/geography-of-poverty.aspx> Accessed December 3, 2012.

²⁴ http://hac.nonprofitsoapbox.com/storage/research_notes/rn_poverty.pdf Accessed December 3, 2012.

²⁵ http://www.rooflines.org/2819/persistent_poverty_in_rural_america/ Accessed December 3, 2012.

²⁶ <http://arec.oregonstate.edu/jaeager/poverty/FAQpoverty1.pdf> Accessed December 27, 2012.

²⁷ http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2011/HUDNO.11-254 Accessed January 18, 2013.

²⁸ Berwick, Dr. Don. Former CMS Administrator. “The Moral Test”. Comments made in a speech at the National Forum for the Institute for Healthcare Improvement. December 11, 2011.

²⁹ APHA Annual Meeting Opening Session Keynote Address. Sir Michael Marmot. November 4, 2013. Boston, MA.

³⁰ <http://budget.house.gov/hearingschedule/> The War On Poverty Progress Report. U.S. House of Representatives Committee on the Budget Hearings. July 31, 2013; January 28, 2014; April 30, 2014; June 10, 2014; July 9, 2014; Accessed August 28, 2014.

³¹ <http://www.businessweek.com/ap/financialnews/D9PNRJ1G2.htm> Accessed January 18, 2013.

³² http://hac.nonprofitsoapbox.com/storage/research_notes/rn_poverty.pdf Accessed December 3, 2012.

³³ http://www.sdaho.org/index.php?option=com_content&task=view&id=708&Itemid=662 Accessed January 18, 2013.

- ³⁴ <http://www.aha.org/content/00-10/10june-econimpact.pdf> Accessed January 18, 2013.
- ³⁵ <http://www.cbpp.org/cms/index.cfm?fa=view&id=3700> Accessed December 3, 2012.
- ³⁶ <http://arec.oregonstate.edu/jaeger/poverty/FAQpoverty1.pdf> Accessed December 27, 2012.
- ³⁷ Raynor, Ahmed, and Henderson. Are “great” companies just lucky? Harvard Business Review.
- ³⁸ Poor Economics. Banerjee and Duflo. Public Affairs, April 2011. Page 15.
- ³⁹ http://www.aspe.hhs.gov/health/reports/2014/UncompensatedCare/ib_UncompensatedCare.pdf Accessed September 30, 2014.
- ⁴⁰ Goodnough, Abby. Hospitals Look to Health Law, Cutting Charity. The New York Times. May 25, 2014.
- ⁴¹ Draper, Electa. Medicaid expansion reducing hospital losses from uninsured, study says. The Denver Post. Posted 6/3/2014. Accessed 6/19/2014.
- ⁴² <http://www.kansascity.com/news/business/health-care/article2146988.html> Accessed 9/18/14.
- ⁴³ Young, G.; Desai, K. Nonprofit Hospital Conversions and Community Benefits: New Evidence from Three States. 1999.
- ⁴⁴ Colias, M. Is this charity? AG, hospitals debate. Crain’s Chicago Business. October 2, 2006.
- ⁴⁵ <http://www.chicagobusiness.com/article/20120228/NEWS03/120229801> Accessed September 23, 2014.
- ⁴⁶ Gray and Schlesinger. The accountability of nonprofit hospitals: lessons from maryland’s community benefit reporting requirements. Inquiry 46: 122-139 (summer 2009).
- ⁴⁷ Schlesinger and Gray. How nonprofits matter in American medicine, and what to do about it. Health Affairs, 25, no. 4 (2006). W287-W303.
- ⁴⁸ Advertisement. Lafayette Regional Health Center. HCA Midwest Health System. The Buckner Clarion. May 8, 2014
- ⁴⁹ Byrd, James D. and Landry, Amy. Distinguishing community benefits: tax exemption versus organizational legitimacy. Journal of Healthcare Management. January-February 2012, Volume 57.
- ⁵⁰ [http://www.irs.gov/Charities-&-Nonprofits/Charitable-Organizations/New-Requirements-for-501\(c\)\(3\)-Hospitals-Under-the-Affordable-Care-Act](http://www.irs.gov/Charities-&-Nonprofits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act)

- ⁵¹ <http://www.irs.gov/pub/irs-dft/f990sh--dft.pdf> Page 2. Accessed October 20, 2013.
- ⁵² Byrd, James D. and Landry, Amy. Distinguishing community benefits: tax exemption versus organizational legitimacy. *Journal of Healthcare Management*. January-February 2012, Volume 57.
- ⁵³ http://www.rwjf.org/en/blogs/new-public-health/2012/10/new_hospital_communi.html Accessed January 20, 2013.
- ⁵⁴ Young, G.; Desai, K. Nonprofit Hospital Conversions and Community Benefits: New Evidence from Three States. 1999.
- ⁵⁵ Lawrence Singer MHSA, JD (2008): Leveraging Tax-Exempt Status of hospitals. *Journal of legal medicine*. 29:1, 41-64.
- ⁵⁶ “Show Me the Money: The Implications of Schedule H”. Salinsky/National Health Policy Forum Issue Brief No 831, April 2009
- ⁵⁷ <http://www.irs.gov/pub/irs-dft/f990sh--dft.pdf> Page 2. Accessed October 20, 2013.
- ⁵⁸ Nyangaga, Julius; Smutylo, Terry, et al. Research that matters: outcome mapping for linking knowledge to poverty-reduction actions. *Development in Practice*. Nov 2010, Vol. 20, Issue 8. P 972-984.
- ⁵⁹ Cunningham and Jones. Poverty Reduction Strategies for New Orleans, LA. Rockefeller Center at Dartmouth College. July 2008.
- ⁶⁰ James A. Richardson Jr. & Jonathan K. London (2007): Strategies and Lessons for Reducing Persistent Rural Poverty: A Social Justice Approach to Funding Rural Community Transformation, *Community Development*, 38:1, 92-107
- ⁶¹ Jung, et al. Public Expenditure and Poverty Reduction in the Southern United States. Southern Agricultural Economics Association Annual Meeting. Atlanta, GA. January 31 to February 3, 2009.
- ⁶² Partridge and Rickman. Persistent Rural Poverty: Is it Simply Remoteness and Scale? *Review of Agricultural Economics*. Vol 29, No 3. Pg 430-436.
- ⁶³ Blalock, et al. They Get You Out of Courage: Persistent Deep Poverty Among Former Welfare Reliant Women. *Family Relations* 2004. 53, 127-137.
- ⁶⁴ Brown and Warner. Persistent Low-Income Nonmetropolitan areas in the US: Some conceptual challenges for development policy. *Policy Studies Journal*, Vol 19, No 2. Spring 1991. 22-41.

⁶⁵ Dismantling Persistent Poverty in the Southeastern United States. The University of Georgia Carl Vinson Institute of Government. Report to Senator Zell Miller.

⁶⁶ Isabel Sawhill, Senior Fellow and Cabot Family Chair, Economic Studies, The Brookings Institution. Before the Ways and Means Committee Income Security and Family Support Subcommittee, United States House of Representatives “Solutions to Poverty” April 26, 2007

⁶⁷ Parrott, Sharon. Reducing Poverty: Four Key Policy Areas that Need More Policy and Foundation Attention. August 2008 Center on Budget and Policy Priorities. Prepared for the Charles Stewart Mott Foundation “Defining Poverty Reduction Strategies” Project.

⁶⁸ www.afterschoolalliance.org Afterschool Programs: Helping Kids Succeed in Rural America. Issue Brief 4. September 2007.

⁶⁹ Gibbs, Nancy. To Fight Poverty, Invest in Girls. Time. February 14, 2011.

⁷⁰ Gray and Schlesinger. The accountability of nonprofit hospitals: lessons from maryland’s community benefit reporting requirements. Inquiry 46: page 127 (summer 2009).

⁷¹ http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf Accessed November 5, 2013.

⁷² <http://capsules.kaiserhealthnews.org/index.php/2013/11/safety-net-hospitals-lose-more-under-medicare-quality-based-payments-analysis-finds/> Accessed November 20, 2013

⁷³ <http://www.healthcarefinancenews.com/news/commonwealth-fund-safety-net-hospitals-face-disproportionate-impact-reimbursements?topic=05,29,19,21> Accessed 12/20/2012.

⁷⁴ http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/1647_Berenson_higher_readmissions_at_safety_net_hosps_ib.pdf Accessed 12/20/2012.

⁷⁵ Berwick, Nolan, and Whittington. The Triple Aim: Care, Health, and Cost. Health Aff May 2008 vol. 27 no. 3 759-769.

⁷⁶ <https://www.aamc.org/advocacy/washhigh/highlights2012/304250/medpacdiscussesreadmissionpaymentreductionprogram.html> Accessed January 18, 2013.

⁷⁷ Lawrence Singer MHSA, JD (2008): Leveraging Tax-Exempt Status of hospitals. Journal of legal medicine. 29:1, 41-64.

⁷⁸ Folkemer, D, et al. Hospital Community Benefits after the ACA: The Emerging Federal Framework. The Hilltop Institute Issue Brief, January 2011.

⁷⁹ Health Policy Snapshot, “What’s New With Community Benefit?” Robert Wood Johnson Foundation. October 2012.

- ⁸⁰ Barnett, K., and Somerville, M. Hospital Community Benefits after the ACA: Schedule H and Hospital Community Benefit—Opportunities and Challenges for the States. The Hilltop Institute Issue Brief, Oct. 2012.
- ⁸¹ Somerville, M., et al. Hospital Community Benefits after the ACA: Community Building and the Root Causes of Poor Health. The Hilltop Institute Issue Brief, October 2012.
- ⁸² Leveraging Tax-Exempt Status of Hospitals”; Singer, L.; Journal of Legal Medicine (2008)
- ⁸³ Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make Any Difference?”; Wood, K. Rev. Litig. (2001)
- ⁸⁴ Are We Getting Our Money’s Worth? Charity Care, Community Benefits, and Tax Exemption at Nonprofit Hospitals”; Hanson, J.; Loyola Consumer Law Review (2004)
- ⁸⁵ Caring for the Uninsured: Are Not-for-profit hospitals Doing Their Share?”; Lisa Kinney Helvin; Yale Journal of Health Policy, Law and Ethics (2008).
- ⁸⁶ The Community Benefit Standard for Nonprofit Hospitals: Which community, and for whose benefit?”; C.M. McGregor, Journal of Contemporary Health Law Policy (2007).
- ⁸⁷ Lawrence Singer MHSA, JD (2008): Leveraging Tax-Exempt Status of hospitals. Journal of legal medicine. 29:1, 41-64.
- ⁸⁸ Somerville, M., et al. Hospital Community Benefits after the ACA: Partnerships for Community Health Improvement. The Hilltop Institute Issue Brief, February 2012. Page 3.
- ⁸⁹ Doeksen, GA. A healthy health sector is crucial for community economic development. Journal of Rural Health. Vol 14, No 1. Winter 1998.
- ⁹⁰ <http://www.kansascity.com/2012/07/16/3707113/mobile-market-to-bring-fresh-food.html> Accessed September 23, 2014.
- ⁹¹ http://harlanonline.com/display_ads/WellnessCenter.pdf page 39. Accessed September 23, 2014.
- ⁹² Stewart, Wojcik, Felix, and Slayton. Enhancing Rural Economic Development: Crafting a healthcare revolving loan fund. Journal of healthcare for the poor and underserved VOL 13, No 4. Nov 2002.
- ⁹³ Hutson, M. Power, politics, and community development. Community Development. 2012.
- ⁹⁴ Torres, GW and Barnett, K. Hospitals as community builders. Health Forum Journal. Nov/Dec 2002.

- ⁹⁵ Kovner, Anthony. The hospital community benefit standards program and health reform. *Hospital & Health Services Administration*. 39:2 Summer 1994.
- ⁹⁶ Braunstein, S. and Lavizzo-Mourey, R. How the health and community development sectors are combining forces to improve health and well-being. *Health Affairs*, 30, no. 11 (2011): 2042-2051.
- ⁹⁷ Jutte, D., et al. Bringing researchers and community developers together to revitalize a public housing project and improve health. *Health Affairs*, 30, no. 11 (2011): 2072-2078.
- ⁹⁸ Community Development and Health. *Health Policy Brief*, November 10, 2011. *Health Affairs*.
- ⁹⁹ Singer, L. Leveraging tax-exempt status of hospitals. *Journal of legal medicine* 29:1, page 58. 2008.
- ¹⁰⁰ Salinsky, E. What have you done for me lately? Assessing community hospital benefit. *National Health Policy Forum Issue Brief* April 19, 2007 page 15.
- ¹⁰¹ <http://www.nytimes.com/2013/09/22/sunday-review/is-this-a-hospital-or-a-hotel.html> Accessed September 23, 2014.
- ¹⁰² Columbo, J. The role of tax exemption in a competitive health care market. *Journal of Health Politics, Policy, and Law*. Vol 31, No. 3. June 2006. Pages 624 and 635.
- ¹⁰³ Chen, MD, Pauline. What we can learn from Third-world health care. *Doctor and Patient* July 26, 2012. *New York Times*. <http://well.blogs.nytimes.com/2012/07/26/what-we-can-learn-from-third-world-health-care/> Accessed September 24, 2012.
- ¹⁰⁴ Cordes, S. The Changing Rural Environment and the Relationship between Health Services and Rural Development. *Health Services Research* 23:6 February 1989.
- ¹⁰⁵ Benjamin, G. Putting the public in public health: new approaches. *Health Affairs*, 25, no. 4 (2006): 1040-1043.
- ¹⁰⁶ Schlesinger and Gray. How nonprofits matter in American medicine, and what to do about it. *Health Affairs*, 25, no. 4 (2006). W288.
- ¹⁰⁷ bphc.hrsa.gov/about/requirements/requirements/slides.pptx Slide 52. Accessed November 5, 2013.
- ¹⁰⁸ Schlesinger and Gray. How nonprofits matter in American medicine, and what to do about it. *Health Affairs*, 25, no. 4 (2006). W294.
- ¹⁰⁹ Benjamin, G. Putting the public in public health: new approaches. *Health Affairs*, 25, no. 4 (2006): 1040-1043.

- ¹¹⁰ <http://hcfgkc.org/about/history> Accessed September 23, 2014.
- ¹¹¹ Ona and Davis. Economic Impact of the CAH program on Kentucky's communities. 2011. J Rural Health. Page 22.
- ¹¹² American Hospital Association. Beyond Health Care: The Economic Contributions of Hospitals. 2006.
- ¹¹³ Cordes, Van der Sluis, et al. "Rural Hospitals and the Local Economy: A needed extension and refinement of existing empirical research. Spring 1999. Journal of Rural Health. Page 190
- ¹¹⁴ Christianson and Faulkner. The contribution of rural hospitals to local economies. Inquiry 18:46-60. 1981. Page 58
- ¹¹⁵ McDermott, RE; Cornia, GC; Parson, RJ. The economic impact of hospitals in rural communities. J Rural Health. 7(2) p 117-133. 1991.
- ¹¹⁶ Vaughn, M, Hilsenrath, P, and Ludke, R. The contribution of hospitals to a local economy: a case study in Iowa and Illinois. Health Care Manage Rev, 1994, 19(3), 34-40.
- ¹¹⁷ <http://www.indstate.edu/polisci/grad/appendix1.htm> Accessed September 23, 2014.
- ¹¹⁸ Doeksen, GA. A healthy health sector is crucial for community economic development. Journal of Rural Health. Vol 14, No 1. Winter 1998. Page 68
- ¹¹⁹ Brooks, L., Whitacre, B. Critical Access Hospitals and Retail Activity: an Empirical analysis. 2010. Journal Rural Health.
- ¹²⁰ Doeksen, G. The business of caring: The economic impact of mississippi's hospitals on the state's economy. Prepared for the Mississippi Hospital Association. February 2004.
- ¹²¹ http://www.ihaonline.org/imis15/IHAOnline/Information/Economic_Impact_Report/IHAOnline/Information/Economic_Impact_Report.aspx?hkey=bc05795b-c56c-4fdd-a465-12f9278fc0a2 Accessed September 23, 2014.
- ¹²² Doeksen, G. Economic importance of the healthcare sector in a rural economy. International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy. June 2003.
- ¹²³ Berry, et. al. Measuring the impact of the healthcare sector on a local economy: Tallahatchie County, MS. Mississippi Department of Health and Mississippi Office of Rural Health. September 2001.
- ¹²⁴ Richardson, J. Hospitals and the Louisiana Economy 2011. Prepared for the Louisiana Hospital Association. www.lhaonline.org Accessed September 23, 2014.

- ¹²⁵ 2009 Hospital Economic Impact Report. Georgia Hospital Association analysis based on American Hospital Association's 2006—"Beyond Health Care: The Economic Contributions of Hospitals"
- ¹²⁶ Rotarius, T, and Trujillo, A. The economic impact of several hospitals on their community. *The Health DCare Manager*. Vol 22, Number 4, pp 318-330.
- ¹²⁷ Doeksen, The Economic Impact of the Health Sector on Summers County, West Virginia. National Association of Counties Project. Federal Office of Rural Health Policy, 2008.
- ¹²⁸ <http://www.gpb.org/news/2012/05/28/ga-hospitals-add-38b-to-economy> Accessed November 21, 2012.
- ¹²⁹ Woller, G.; Parson, R. Assessing the community economic impact of microfinance institutions. Romney Institute of Public Management.
- ¹³⁰ Cordes, Van der Sluis, et al. "Rural Hospitals and the Local Economy: A needed extension and refinement of existing empirical research. Spring 1999. *Journal of Rural Health*.
- ¹³¹ Ona and Davis. Economic Impact of the CAH program on Kentucky's communities. 2011. *J Rural Health*.
- ¹³² Capps, Dranove, Lindrooth. Hospital closure and economic efficiency. *Journal of health econ*.
- ¹³³ Brooks, L., Whitacre, B. Critical Access Hospitals and Retail Activity: an Empirical analysis. 2010.
- ¹³⁴ Ricketts, T. Rural Communities and Rural Hospitals: Editorial. *J of Rural Health*. Spring 1999.
- ¹³⁵ Hart, Gary; Pirani, Michael; Rosenblatt, Roger. Causes and Consequences of Rural Small Hospital Closures from the Perspective of Mayors. *Journal of Rural Health*. July 1991.
- ¹³⁶ Ona, L.; Hudoyo, A.; Freshwater, D. Economic Impact of Hospital Closure on Rural Communities in three southern states: a quasi-experimental approach. *Journal of Regional analysis and policy*. Vol 37, No. 2. P155-164.
- ¹³⁷ Pearson, D. and Tajalli, H. The Impact of rural hospital closure on the economic health of the local communities. *Texas Journal of Rural Health*. 21 (3) pp 46-51.
- ¹³⁸ Doeksen, G.; Altobelli, J. The Economic Impact of Rural Hospital Closure: A Community Simulation. U.N.D. Rural Health Research Center (North Dakota) 1990.

- ¹³⁹ Pearson, D. and Tajalli, H. The Impact of rural hospital closure on the economic health of the local communities. *Texas Journal of Rural Health*. 21 (3) pp 46-51.
- ¹⁴⁰ Pearson, D. and Tajalli, H. The Impact of rural hospital closure on the economic health of the local communities. *Texas Journal of Rural Health*. 21 (3) pp 46-51.
- ¹⁴¹ Holmes, G.M.; Slifkin, R.T.; Randolph, R.K.; Poley. The effect of rural hospital closures on community economic health *Health Serv Res*. 2006.
- ¹⁴² Holmes, G.M.; Slifkin, R.T.; Randolph, R.K.; Poley. The effect of rural hospital closures on community economic health *Health Serv Res*. 2006.
- ¹⁴³ Noble, Hyams and Kane. Charitable Hospital Accountability. *Journal of Law, Medicine and Ethics*, 26. 1998. 116-137
- ¹⁴⁴ King, Jackson, et al. Form 990 Disclosure requirements challenge hospitals, provide opportunities. *The Health Lawyer*. Volume 21, Number 3. February 2009.
- ¹⁴⁵ Byrd, James D. and Landry, Amy. Distinguishing community benefits: tax exemption versus organizational legitimacy. *Journal of Healthcare Management*. January-February 2012, Volume 57.
- ¹⁴⁶ Salensky, E. What Have You Done for Me Lately? Assessing hospital community benefit. Issue Brief, George Washington University. 2007.
- ¹⁴⁷ <http://www.modernhealthcare.com/article/20120711/NEWS/307119985> Accessed September 23, 2014.
- ¹⁴⁸ Inside Maryland hospital CEO pay. August 11, 2013.
<http://www.delmarvanow.com/article/20130812/WIC01/308110024> Accessed September 23, 2014.
- ¹⁴⁹ Lawrence Singer MHSA, JD (2008): Leveraging Tax-Exempt Status of hospitals. *Journal of legal medicine*. 29:1, 41-64.
- ¹⁵⁰ Byrd, James D. and Landry, Amy. Distinguishing community benefits: tax exemption versus organizational legitimacy. *Journal of Healthcare Management*. January-February 2012, Volume 57.
- ¹⁵¹ Colias, M. Is this charity? AG, hospitals debate. *Crain's Chicago Business*. October 2, 2006.
- ¹⁵² Carlson, J. Not-for-profits in no hurry to voluntarily file Schedule H information to the IRS. *Modern Healthcare*. May 4, 2009.

¹⁵³ “Show Me the Money: The Implications of Schedule H” by Salinsky/National Health Policy Forum Issue Brief No 831, April 21, 2009

¹⁵⁴ Courtney, Bobby. Indiana Health Law Review. 2010-2011.

¹⁵⁵ Bilton, M. Seeing community benefit broadly. Everybody wins when hospitals collaborate with others to serve their communities. Health Progress Vol 86, No. 4. Page 39. 2005.

¹⁵⁶ Beaufort B. Longest Jr. (2002) Nonprofit Health Systems: A Promising New Class of Corporate Citizen. Inquiry: December 2002, Vol. 39, No. 4, pp. 334-340.

¹⁵⁷ Longest, B. Community Development Potential of Large Health Care Organizations. Community Development. 2005. Pages 93-95.

¹⁵⁸ Cordes, S. The Changing Rural Environment and the Relationship between Health Services and Rural Development. HSR: Health Services Research 23:6 February 1989. Page 778.

¹⁵⁹ Probst, Samuels, Hussey, Berry and Ricketts. Economic Impact of Hospital Closure on small rural counties: 1984-1988. J of Rural Health. Fall 1999.

¹⁶⁰ Probst, Samuels, Hussey, Berry and Ricketts. Economic Impact of Hospital Closure on small rural counties: 1984-1988. J of Rural Health. Fall 1999.

¹⁶¹ Cordes, Van der Sluis, et al. “Rural Hospitals and the Local Economy: A needed extension and refinement of existing empirical research. Spring 1999. Journal of Rural Health. Page 190.

¹⁶² Christianson and Faulkner. The contribution of rural hospitals to local economies. Inquiry 18:46-60. 1981. Page 58

¹⁶³ Poor Economics. Banerjee and Duflo. Public Affairs, April 2011.

¹⁶⁴ Magill, G. and Prybil, L. Board oversight of community benefit: an ethical imperative. Kennedy Institute of Ethics Journal. March 2011, page 44.

¹⁶⁵ Barnett, K. Best practices for community health needs assessment and implementation strategy development. Public Health Institute, February 2012. Pages 115 and 107.

¹⁶⁶ Rosenbaum, S., et al. Hospital Community Benefit Expenditures: Looking Behind The Numbers. Health Affairs Blog, June 11, 2013. 12:46 pm.

¹⁶⁷ Taylor, Blewett, et al. “Small Town Health Care Safety Nets: Report on a Pilot Study”. J of Rural Health Spring 2003.

¹⁶⁸ <http://www.systematicreviewsjournal.com/content/2/1/115> Accessed October 7, 2014.

¹⁶⁹Baxter and Jack. Qualitative Case Study Methodology: study design and implementation for novice researchers. The qualitative report. Vol 13, no 4. Dec 2008. Page 548.

¹⁷⁰ Yin, R.K. Case study research: design and methods (3rd ed.) Thousand Oaks, CA: Sage. 2003.

¹⁷¹Baxter and Jack. Qualitative Case Study Methodology: study design and implementation for novice researchers. The qualitative report. Vol 13, no 4. Dec 2008. Page 550.

¹⁷² Stake, R.E. The art of case study research. Thousand Oaks, CA: Sage. 1995.

¹⁷³ Creswell, J. Research Design, 3rd Edition. Chapter One, "The Selection of a Research Design". Page 13. Sage Publications. 2009.

¹⁷⁴ Institute for Healthcare Improvement 90-day R&D Project Final Summary Report: Counties of Interest: Achieving Better-or-Worse-Than-Expected Health Outcomes. Cambridge, MA. January 2011.

¹⁷⁵ An Overview of Case Study. Dr. Kenneth Harling. Learning workshop "Case studies: their future role in agricultural and resource economics" held at the annual meeting of the American agricultural economics association, Long Beach, CA. July 27, 2002.
www.farmfoundation.org/news/articlefiles/1028-1_harling.pdf Accessed June 19, 2013.

¹⁷⁶ <http://www.qualres.org/HomeSemi-3629.html> Accessed September 23, 2014.

¹⁷⁷ Creswell, J. Research Design. 3rd Edition. Page 187.

¹⁷⁸ Ibid. Page 186.

¹⁷⁹ Ibid. Page 187.

¹⁸⁰ Taylor-Powell, E. and Renner, M. "Program Development & Evaluation: Analyzing Qualitative Data". University of Wisconsin-Extension Cooperative Extension. Madison, Wisconsin. 2003. Page 9.

¹⁸¹ Yin, R.K. Case study research: design and methods (3rd ed.) Thousand Oaks, CA: Sage. 2003.

¹⁸² NYC Center for Economic Opportunity. Policy Affects Poverty: The CEO Policy Measure 2005-2009. March 2011. Michael R. Bloomberg, Mayor.

¹⁸³ Joan R. Rodgers and John L. Rodgers. Chronic Poverty in the United States. The Journal of Human Resources, Vol. 28, No. 1 (Winter, 1993), pp. 25-54. The University of Wisconsin Press.

¹⁸⁴ Blank, Rebecca. Presidential Address: How to improve poverty measurement in the United States. *Journal of Policy Analysis and Management*, Vol. 27, No. 2, 233–254 (2008)

¹⁸⁵ <http://rds.epi-ucsf.org/ticr/syllabus/courses/15/2009/05/21/Lecture/assignment/QualityImprovementReading.pdf> Accessed July 17, 2014.

¹⁸⁶ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1713194/> Accessed July 17, 2014.

¹⁸⁷ Rosenbaum, S., et al. Hospital Community Benefit Expenditures: Looking Beyond the Numbers.

¹⁸⁸ Ibid.

¹⁸⁹ Columbo, J. The role of tax exemption in a competitive health care market. *Journal of Health Politics, Policy, and Law*. Vol 31, No. 3. June 2006. Page 636.

¹⁹⁰ Byrd, James D. and Landry, Amy. Distinguishing community benefits: tax exemption versus organizational legitimacy. *Journal of Healthcare Management*. January-February 2012, Volume 57.

¹⁹¹ Magill, G. and Prybil, L. Board oversight of community benefit: an ethical imperative. *Kennedy Institute of Ethics Journal*. March 2011, page 30.

¹⁹² Magill, G. and Prybil, L. Board oversight of community benefit: an ethical imperative. *Kennedy Institute of Ethics Journal*. March 2011, page 26.

¹⁹³ Magill, G. and Prybil, L. Board oversight of community benefit: an ethical imperative. *Kennedy Institute of Ethics Journal*. March 2011, page 25.

¹⁹⁴ Kovner, A. Community Benefit Standards and Reform. *Hospital and Health Services Administration*. 39:2. Summer 1994.

¹⁹⁵ An Overview of Case Study. Dr. Kenneth Harling. Learning workshop “Case studies: their future role in agricultural and resource economics” held at the annual meeting of the American agricultural economics. Page 1.

¹⁹⁶ http://www.goodreads.com/author/quotes/12008.Peter_F_Drucker Accessed July 17, 2014.