FY23
Data Companion

For use with HAN Data Collection

FY23 Data Companion

This guide is not meant to be read cover-to-cover but should serve as a reference for the Healthcare Anchor Network's (HAN) FY23 data collection cycle. This Data Companion aims to bring together definitions, how-to information, changes from previous years, and any other supporting information that may be helpful to walk users through the data collection process. Each item in the table of contents can be clicked to navigate to the information you need.

This guide is designed to be used specifically for FY23 data collection. It should not be used with data collection periods for other fiscal years.

Table of Contents

- Table of Contents
- Data Collection Process
- Data Collection Overview
  - Who is collecting this data?
  - What data are we collecting?
  - Why are we collecting this data?
  - How do HAN members benefit from submitting data?
  - How will the data be used?
  - How can I access the platform?
- Metrics Principles
  - Selected Anchor Strategies
  - Required vs. Optional Indicators
  - Principles and Polarities
- Changes for FY23 Collection
  - Changes to Hiring Metrics
  - Changes to Procurement & Construction Metrics
  - Changes to Sustainability Metrics
- System Characteristics/the "Getting Started" sheet
  - G1.0 Revenue Bracket
    - G1.1a Recent mergers/acquisitions
    - G1.1b Nature of mergers/acquisitions
  - G2.0 Ownership Structure
  - G3.0 501c3 Status
  - G4.0 Number of acute care facilities
    - G4.0a Rural

G4.0b Suburban
G4.0c Urban
G5.0 Number of unique patients
G6.# Focus of Service
G6.1 Academic medical center
G6.2 Freestanding pediatric hospital
G6.3 Non-Catholic Faith-based system
G6.4 Catholic healthcare system
G6.5 Safety-net system
G6.6 Specialty healthcare system
G6.7 None of the above/Community health system
Hiring Indicators
List of Characteristics
H1.# Number of Employees
H2.# Employees At the Director Level or Above
H3.# Employees At the Senior Executive Level or Above
H4.# Employees Earning At or Above the Local Living Wage (Wage Alone)
H5.# Employees Earning At or Above the Local Living Wage (Wage + Select Benefits)
H6.# Employees Earning At or Above the Local Living Wage (Wage + Select Benefits + Retirement)
H7.# Retained Employees
H8.# Total New Hires
H9.# Total New Hires into Quality Jobs
H10.# Impact Hires
H10.0a Intentional, Outside-In, Pathways, Programs and Partnerships
H10.0b Rationale or methodology statement for defining economically disadvantaged geographies
Economically Disadvantaged
Stable Schedule
Stable Hours
H11.# Wage Gains
H12.# | H13.# | H14.# | H15.# Employees Receiving Tuition Reimbursement or Cost Advancement
For 2- or 4-year degrees, or post-Bacc certificates
For sub-Bacc certificates
For “Other Career Advancement Programs”
H16.# Resources for Anchor Mission Hiring & Workforce Development
H16.0 Total FTE Dedicated to Anchor Mission Hiring & Workforce Development Activities
H16.01 Job Descriptions for Roles Related to Anchor Mission Hiring & Workforce Development Activities
H16.1 Total Budget Dedicated to Anchor Mission Hiring & Workforce Development Activities

Procurement Indicators

- P0.2c List of Data Enrichment Vendors
- P1.0 Tier 1 Total Spend
  - P1.0a Exclusion Categories for Total Spend
- P1.1 Tier 1 Addressable Procurement Spend
  - P1.1a Exclusion Categories for Addressable Procurement Spend
- P1.2 Tier 1 Local Procurement Spend
  - 1.2a Neighborhood Procurement Spend
  - 1.2b Regional Procurement Spend
- P1.3 or P1.4 | Tier 1 Diverse Procurement Spend
  - Metrics appended with ".41" ask for the count of unique businesses that represent the dollar amount entered for that given metric. These counts are optional for FY23
- P1.6 Tier 1 Diverse & Local Procurement Spend
- P1.7 | P1.8 Tier 1 Employee-Owned Procurement Spend
- P2.0 Tier 1 Total Construction Spend
- P2.2 Tier 1 Local Construction Spend
  - 2.2a Regional Construction Spend
  - 2.2b Neighborhood Construction Spend
- P2.3 or P2.4 | Tier 1 Diverse Construction Spend
  - Metrics appended with ".41" ask for the count of unique businesses that represent the dollar amount entered for that given metric. These counts are optional for FY23
- P2.6 Tier 1 Diverse & Local Construction Spend
- P2.7 | P2.8 Tier 1 Employee-Owned Construction Spend
- P3.2 Tier 2 Local Procurement Spend
  - 3.2a Regional Procurement Spend
  - 3.2b Neighborhood Procurement Spend
- P3.3 | P3.4 | P3.5 Tier 2 Diverse Procurement Spend
- P3.6 Tier 2 Diverse & Local Procurement Spend
- P3.7 | P3.8 Tier 2 Employee-Owned Procurement Spend
- P4.2 Tier 2 Local Construction Spend
  - 4.2a Regional Construction Spend
  - 4.2b Neighborhood Construction Spend
- P4.3 | P4.4 | P4.5 Tier 2 Diverse Construction Spend
- P4.6 Tier 2 Diverse & Local Construction Spend
- P4.7 | P4.8 Tier 2 Employee-Owned Construction Spend
- P7.# Resources for Anchor Mission Purchasing
- P7.0 Total FTE Dedicated to Anchor Mission Purchasing Activities
- P7.01 Job Descriptions for Roles Related to Anchor Mission Purchasing

 ONLY USE WITH FY23 DATA COLLECTION

P7.1 Total Budget Dedicated to Anchor Mission Hiring & Workforce Development Activities

The total budget expressed in dollars allocated to anchor mission purchasing activities. The budget should be reflective of the salary and fringe benefits of the FTE reported in P7.0 and any administrative overhead.

P8.0# Total Impact Hires by Vendors

P9.0# Workforce and Budget Allocation to Impact Purchasing

Sustainability Indicators

S1.# Percentage of Energy Usage from Renewable Energy Sources

S2.# Sevoflurane, Isoflurane, Desflurane, and Nitrous Oxide Use

S3.# Percent Alternative Fuel Vehicles Purchased/Leased

S4.# Number of Product Types Transitioned from Disposable to Reusable Products

Single-use/Disposable

Reusable

S5.# Number of Product Lines Free of Both PVC and DEHP

S6.# Percentage of Spend on Furnishings and Furniture Free of All Five Target Chemicals

S7.# Percentage of Spend on Sustainable Food

Place-based Investment Indicators

I0.2a SRI or ESG Investment Policy

I0.2b Place-Based Investment Objective

I0.2c ESG/SRI Options in Employee Retirement Accounts

I0.3 Total Investable Assets

I0.3a/b Allocation to Place-Based Investments

I0.4a/b Dollars of Place-based Investment Deployed

I0.5 Dollars Invested in Geographically Targeted Mutual Funds

I0.6a Cash & Cash Equivalents in High Impact Banks and Credit Unions

I0.7a/b Affordable Housing Units

I0.7c Permanent Jobs At or Above the Local Living Wage

I0.8a/b/c Workforce and Budget Allocation to Place-Based Investment

I0.9, a-i Total Dollars Deployed for Currently Active Project/Investments

I#.#, Individual Project Details

I#.1 Short Project Description

I#.11a Project Start Date

I#.11b Project Term

I#.11c Interest Rate

I#.12 Dollars Deployed to the Project During the Most Recently Completed Fiscal Year

I#.2 Category Areas

I#.3a Associated Grant Activity

Appendix A: Exclusions for Total and Addressable Spend

Appendix B: Local Living Wage

ONLY USE WITH FY23 DATA COLLECTION

- How are we defining a living wage?
- Is the MIT Living Wage calculator too broad in its definition of “basic needs”?
- Why do we use the threshold at the county/MSA-level and for “2 Adults Both Working, 1 Child”?

Appendix C: Impact Hires
- How are impact hires defined?

Appendix D: Classifying Diverse Spend
- Self-Certified/(“Self-identified”) and Third-Party Certified
- Classifying Diverse Spend Example:
- Classifying Tier 2 Diverse Spend Example:

Appendix E: Local Spend
- What is the difference between regional and neighborhood?
  - Catchment Area
- What is ‘local’?
  - Regional
  - Neighborhood
- Why don’t we count every business? Don’t they all create jobs and help the local economy?
  - Local Multipliers & Tax Base
  - Stabilizing Economic Activity
  - Jobs & Employment
  - Individual Wealth Building
  - Other Anchor Strategies Principles

 ONLY USE WITH FY23 DATA COLLECTION

Data Collection Process

In the Fall of each calendar year, the data collection timeline is announced at the Q4 Building the Evidence Base meeting. The table below shows a general outline of the steps in the data collection process, including milestones and recommended roles to ensure data accuracy.

Step	Time Period/ (Deadline)	Responsible Party	Notes & Milestones
Phase I: Data Collection Preparation			
Submit your Data Team Contacts	Fall of each calendar year	HAN Executive Lead and/or HAN Project Manager Lead	This is shared with HAN staff so we know who should have edit and read access to your data submission. It also tells us the appropriate subject matter experts to contact should we have questions about your data submission. *Should we not receive a roster from your Executive or Project Management Lead by the deadline, HAN will opt-in the Executive and/or Project Management Lead as the primary data collection contact.*
Phase II: Data Submission			
Submit your Data via your shared Unique Submission folder.	January through March 31/last Friday in Quarter I	HAN Data Team Contacts	Submissions are only accepted through your shared file in Office365. ***Emailed files, copies of the original file or reuploaded files cannot be accepted for submission.***
Phase III: Data Review			
A member of the HAN team will provide additional details specific to your organization's data submission. Members are provided up to 3 weeks to make corrections	April 1 through June	HAN Internal Staff	HAN reviews data internally and provides your organization's data team with a list of questions we have about your data. This list will have fields that allow your organization to respond and correct as appropriate. For any data points where the time to reconcile exceeds the available time needed to report out to the network, individual members may be afforded the ability to correct "parked" data for upload later in the calendar year.
Phase IV: Report Outs			
HAN Dashboard released and PDF reports emailed	July - September	HAN Internal Staff	HAN provides static PDF report outs, dashboard demonstrations, and presentations to the network during this time.

Data Collection Overview

Who is collecting this data?

Founded in 2017, The Healthcare Anchor Network (HAN) catalyzes health systems to leverage their hiring, purchasing, investing, and other key assets to build inclusive local economies that sustain healthy communities. Through this anchor mission approach, health systems fully activate their unique platform as a leading community institution in partnership with others to meaningfully address economic and racial inequities in community conditions that create poor health.

HAN supports health systems in implementing the anchor mission by raising the bar for best-in-class practices, accelerating adoption among individual organizations through an action-oriented framework, and fostering unique sector collaborations to scale social impact. Today, over 70 health systems participate in HAN, representing more than 1,000 hospitals and employing more than 2 million people.

As part of participation in HAN, health system members are expected to collect and submit the required anchor strategies' core set of indicators on an annual basis.

What data are we collecting?

Since 2018, HAN has worked in collaboration with its members to standardize nearly 50 indicators for the areas of Human Resources, Supply Chain, Treasury, and Sustainability. That process prioritized the following four goals:

- Be limited and concise, but well-defined and flexible
- Embed equity
- Leverage the knowledge of our members and of work done to date
- Reflect current work and drive positive future behavior

Why are we collecting this data?

One of the critical shifts–or a systemic change in the healthcare sector that needs to occur to normalize this anchor mission approach–identified early on by HAN and its members is the need to build a compelling evidence base for this work. Members of HAN's Building the Evidence Base (BEB) Initiative Group have identified a framework for evaluation and metrics collection that seeks to create an understanding of the connections between program level activities within health systems (e.g., inclusive, local hiring) and health and economic outcomes in their communities (e.g., health disparity measures). As part of achieving that shift, HAN has prioritized collecting and standardizing data on program level activities for the first time in the healthcare sector.

Collecting this data will help enable systems to track their progress in creating more equitable and healthy communities through the adoption of anchor strategies. The data collection process, including specific metrics being collected, has been directly shaped by member input and will continue to evolve in accordance with HAN goals.

We recognize that not all institutions may join HAN with the mechanisms fully in place to track this data, but we expect members to collect the indicators that can be gathered and work in good faith toward building the necessary processes and infrastructure to collect the required indicators in the future.

How do HAN members benefit from submitting data?

Members use these metrics to establish baselines and set internal goals contextualized by the overarching landscape of healthcare anchor systems throughout the United States.

Additionally, members that submit data are able to benchmark unique metrics online through the HAN Dashboard. Many of the metrics are uniquely collected by HAN. Members also benefit from understanding the collective impact of this work–leading to increased accountability and commitment to the anchor approach and the communities in which this work is carried out.

How will the data be used?

HAN will compile metrics submitted by each health system into the HAN Dashboard platform. The HAN Dashboard is a password-controlled platform that will allow members to visualize their own data and compare it with the **aggregate values** of all members that submit data. **No data from any health system will be individually identifiable to another HAN member.** The permitted uses of the data collected in this process is further described in the data sharing agreement executed by each HAN member and the Healthcare Anchor Network.

How can I access the platform?

Once the required metrics are uploaded to the platform for a new member system, the Lead Contact(s) for that system are provided with individual login information. The Lead Contact determines extension of access to the dashboard to other members of the same system.

Access to the dashboard is contingent on submitting required metrics, and the ability to benchmark against the Network aggregate data is on a metric-by-metric basis (you are able to see the HAN median/average for a particular metric if your system has submitted data for that metric).

Metrics Principles

Selected Anchor Strategies

HAN currently collects and analyzes indicators from within the three main pillars of the Anchor Mission approach: Hiring, Procurement, and Investment. Thus, some degree of involvement of the Human Resources, Supply Chain, Facilities, and Treasury departments is necessary to collect the appropriate data. For Procurement, members of Finance and central data/information systems departments may also be necessary to extract the correct data. For members that have signed the Impact Purchasing Commitment, a Sustainability/sustainability purchasing representative will be needed.

Other evolving anchor strategy areas, such as Anchor Philanthropy, Policy Advocacy, or Community Engagement, may have their own set of indicators in the future, as the Network's work and goals continue to evolve.

Required vs. Optional Indicators

Indicators are divided between required and optional. As the name suggests, submitting required indicators is expected of all HAN members. Optional indicators greatly enrich the picture of the progress of your institution's anchor mission. **Members that sign leadership agreements with HAN often have additional required indicators**. The icons below are located next to the title of each metric throughout this document. The icons below show the indicator is required. If an icon next to an indicator is grey, parts of that indicator are required for all members (for example, members are expected to submit breakdowns by race, ethnicity, and gender for H4.0 Number of Employees Earning At or Above the Local Living Wage (Wages Only), but not Barriers to Employment (those employees earning at or above the local living wage who have one or more disabilities, are justice-involved individuals, etc.).

Icon	Required of…
ALL	**…all** HAN member systems.
IWC	…HAN member systems that are active signatories of the Impact Workforce Commitment.
IPC	…HAN member systems that are active signatories of the Impact Purchasing Commitment. *(Grayscale icons indicate these metrics may be required depending on the specific goals your organization chose as a part of your leadership commitment). If you have questions about what metrics are a part of your commitment, please email data@anchornetwork.org)*
G	…HAN members that wish to qualify for the Gartner® Healthcare Supply Chain Top 25. Members must submit **all metrics in the Procurement & Construction metric set with this icon** in order to count as having submitted data to HAN. For more information including specifics about weighting, please email data@anchornetwork.org.

Principles and Polarities

Creating common metrics for a network of health systems of different sizes and contexts requires some degree of flexibility and ability to navigate tensions that naturally emerge. For that end, the process of setting core indicators seeks to observe the following principles and balance the following polarities:

The core set of indicators ought to…

1. Be limited and concise so that they focus on the key activities of HAN;
2. Embed equity considerations via the breakdowns of indicators (race/ethnicity, gender, income);
3. Leverage the knowledge that our members, partner organizations, and work done to date;
4. Balance *flexibility* (which makes data appropriate for different contexts) with *strict definitions* (which make data comparisons meaningful);
5. Celebrate current achievements but drive positive future behavior by being aspirational

Changes for FY23 Collection

In the spirit of continuous improvement, a number of changes are made to the Data Collection process for each cycle. These changes can materialize in the schedule for data collection, the way data are submitted, or changes to definitions. Changes may also add *clarity* to a metric definition (compared to a substantive change to a metric). This section outlines the details of those changes.

Changes to Hiring Metrics

- **Changes to metric numbers.** Due to the newly added metrics for the Impact Workforce Commitment, metric numbers for all hiring metrics have been updated for clarity purposes.
- **Addition of new metrics:**
  - H2.# Employees At the Director Level or Above
  - H3.# Employees At the Senior Executive Level or Above
  - H8.# Total New Hires
  - H9.# Total New Hires into Quality Jobs

Changes to Procurement & Construction Metrics

- **Addition of number of vendors for Minority-, Women-, and Veteran- and Small businesses:** There are now line-items to submit the number of vendors representing the spend in each category.
- **Request to confirm reported dollars are not double-counted across diverse categories.**

Changes to Sustainability Metrics

- **Removal of "Required" status for non-IPC HAN members for FY23.** For FY23, HAN is only collecting sustainability metrics from currently active IPC signatories.
- **New criteria for submitting "sustainable food" purchasing.** Since the launch of the Impact Purchasing Commitment (IPC), Practice Greenhealth has released an update to their Healthy Food in Health Care Standard including their Food Purchasing Criteria. **IPC participants will continue to reference the former criteria in reporting on "sustainable" food purchasing.** For those IPC participants that also report metrics

through the Practice Greenhealth Environmental Excellence Awards application they will need to report in alignment with the updated Food Purchasing Criteria. To learn more about the updated criteria go here.

System Characteristics/the "Getting Started" sheet

Submitting these characteristics allows you to benchmark against several of the criteria below in the HAN Dashboard.

G1.0 Revenue Bracket

Total gross revenues of your healthcare system: Less than $5B, $5-9.999B, $10B or More

G1.1a Recent mergers/acquisitions

Is this data reflective of any mergers or acquisitions that have occurred since the previous HAN Data Collection cycle? (Not applicable for first time submitters)

G1.1b Nature of mergers/acquisitions

If this data is reflective of recent mergers or acquisitions, please describe the nature of the aforementioned merger(s) and/or acquisition(s).

G2.0 Ownership Structure

Only select Public if the data for which you are submitting is governed by a public entity such as a local, state, or federal agency or department.

G3.0 501c3 Status

By default, Public entities in G2.0 should select "Government" for this metric. Healthcare systems that have an affirmed 501c3 status should select "Non-profit".

G4.0 Number of acute care facilities

The total number of in-service hospitals in your system. Do not include inoperable facilities (under construction, recently constructed, or otherwise out of service) or hospitals reflective of a recent merger (unless the data you are submitting reflects those additional hospitals).

G4.0a Rural

Please indicate the number of acute care facilities located in Rural areas in your system.

G4.0b Suburban

Please indicate the number of acute care facilities located in Suburban areas in your system.

G4.0c Urban

Please indicate the total number of acute care facilities located in Urban areas in your system.

G5.0 Number of unique patients

The total number of unique patients served by your system.

G6.# Focus of Service

These characteristics should describe your focus of service. You may select Yes for more than one, except in the case of "None of the Above".

G6.1 Academic medical center

Regardless of your system's accreditation status, please select yes if your healthcare system is all of the following (adapted from the Joint Commission International standards for accreditation as an Academic Medical Center):

- organizationally or administratively integrated with a medical school,
- **the principal site** for the education of **both** medical students (undergraduates) **and** postgraduate medical specialty trainees (for example, residents or interns)
- is currently conducting medical research with approval and oversight by an Institutional Review Board (IRB) or research ethics committee

G6.2 Freestanding pediatric hospital

Select yes if your data are representative **only** of children's hospital system operations. Systems that serve a broader population but operate one or more children's hospitals should not select yes.

G6.3 Non-Catholic Faith-based system

Select yes if your system is faith-based, but is not Catholic.

G6.4 Catholic healthcare system

Select yes if your healthcare system has an active Catholic affiliation.

G6.5 Safety-net system

Select yes if your system's healthcare delivery is predominantly accessed by patients that are uninsured, use Medicaid or other government assistance, or other types of vulnerable patients.

G6.6 Specialty healthcare system

Select yes if your system has a specific focus not otherwise specified ("Sibley Women's Hospital").

G6.7 None of the above/Community health system

Select yes here if you cannot select Yes to any other categories.

Hiring Indicators

List of Characteristics

The list below is **NOT** a list of metrics, but rather a list of characteristics designed to provide guidance to those seeking source data from other departments (IT, Analytics, etc.) for the purposes of completing HAN's Hiring metrics. This list is not designed to be exhaustive. Obtaining these characteristics will allow you to calculate nearly all of the hiring metrics requested for the FY23 data collection cycle.

For every employee that was employed *at any time between the first day of FY23 and the first day of FY24.*

- Start date of employment
- End date of employment
- Wage/Salary rate on Day 1 of FY22
- Wage/Salary rate on Day 1 of FY23
- Job Title and/or Position Classification as of Day 1 of FY22
- Job Title and/or Position Classification as of Day 1 of FY23
- Whether the employee received a mostly unchanging schedule at least 2 weeks prior to work dates throughout FY21
- Whether the employee works at least the minimum number of hours necessary to receive fringe benefits throughout FY22
- Receives/d Health Insurance Benefits throughout FY22
- Receives/d Retirement benefits throughout FY22
- Receives/d Paid Leave benefits throughout FY22
- Race
- Ethnicity
- Gender
- Received Pre-Paid and/or Reimbursement for Tuition
- Whether tuition benefits went toward a 2-year degree or higher credential, a post-Baccalaureate certificate, a sub-baccalaureate certificate, or another professional development program.
- Whether the employee was hired through an Impact Hiring program or practice/intentional hiring program or practice
- Zip code of employee's residence
- County location of employee's primary worksite
- Disability status
- Arrest/criminal conviction status

H1.# Number of Employees

As of Day 1 of the reference year for which you are submitting data (typically the most recently completed fiscal year), the total headcount of part-time and full-time employees at your healthcare system that are **not physicians, medical students, trainees, interns, and per-diem**[1], **non-permanent, or contracted positions.** This is a calculated field and is based on the sums across race, ethnicity, and gender identity. For HAN reporting purposes, each employee must be counted once in race, once in ethnicity, and once in gender. Example: If an employee selected "White" as Race/Ethnicity and "Female" as gender/sex, and nothing else, that employee would be counted once as White, once as Ethnicity Unknown, and once as Female.

Categories of Race H#.1a-g

HAN collects employee headcounts for eight distinct categories of race across seven metrics. These categories are based partly on Census categories. Any category of race that is appended with "Alone" describes employees that identify only as the category in question. Race and Ethnicity are treated as distinct concepts in HAN data. The seven metrics are American Indian/Alaksan Native Alone, Asian Alone, Black or African American Alone, Native Hawaiian or Pacific Islander Alone, White Alone, More Than One Race OR Another Race Not Already Specified.

Categories of Ethnicity H#.2a-c

HAN collects employee headcounts for two distinct categories of ethnicity. These categories are based partly on Census categories. The categories of ethnicity are Hispanic or Latinx, and Not Hispanic or Latinx. The typical description of "Latino" describing persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture has been amended as "Latinx" to remove any gender indicator for this metric.

Categories of Gender H#.3a-e

HAN collects employee headcounts for five categories of gender across four metrics. These categories aim to collect information about persons of non-binary genders. The four metrics are Male, Female, Transgender, and More than One Gender OR Another Gender Not Already Specified.

Categories of Barriers to Employment H#.5, #.6, #.7

HAN collects employee headcounts for two distinct categories under "Barriers to Employment". These include "With Arrest(s) or Criminal Conviction(s)" and "With Disability(ies)". An additional category, "With Other Barriers to Employment" is also captured. We encourage systems to report information about those with other types of barriers to employment as defined by the health system.

---

[1] In the wake of the COVID-19 pandemic and the resulting shifts in operations, members have shared that certain per-diem or temporary employees are being converted to regular non-temporary employees in the same position. If a per-diem position was converted to a regular (non-temporary) position between the first day and last day of the fiscal year, that employee should be included in the reported headcount.

ONLY USE WITH FY23 DATA COLLECTION

H2.# Employees At the Director Level or Above IWC[2]

As of Day 1 of the reference year for which you are submitting data (typically the most recently completed fiscal year), the total headcount of employees at your healthcare system that are **not *practicing* physicians/physicians without a leadership role/appointment, medical students, trainees, interns, and per-diem[3], non-permanent, or contracted positions that are in Director-level positions or higher.**

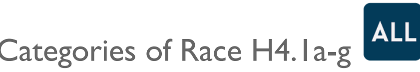
Categories of Race H2.1a-g
Categories of Ethnicity H2.2a-c
Categories of Gender H2.3a-e
Categories of Barriers to Employment H2.5 | H2.6 | H2.7

H3.# Employees At the Senior Executive Level or Above

As of Day 1 of the reference year for which you are submitting data (typically the most recently completed fiscal year), the total headcount of employees at your healthcare system that are **not *practicing* physicians/physicians without a leadership role/appointment, medical students, trainees, interns, and per-diem[4], non-permanent, or contracted positions that are in Senior Executive ("C-suite") positions.**

Categories of Race H3.1a-g
Categories of Ethnicity H3.2a-c
Categories of Gender H3.3a-e
Categories of Barriers to Employment H3.5 | H3.6 | H3.7

H4.# Employees Earning At or Above the Local Living Wage (Wage Alone) ALL


Categories of Race H4.1a-g ALL

Categories of Ethnicity H4.2a-c ALL

Categories of Gender H4.3a-e ALL

Categories of Barriers to Employment H4.5 | H4.6 | H4.7 IWC

---

[2] Members that have signed the Impact Workforce Commitment can choose either H2 or H3 to report.
[3] In the wake of the COVID-19 pandemic and the resulting shifts in operations, members have shared that certain per-diem or temporary employees are being converted to regular non-temporary employees in the same position. If a per-diem position was converted to a regular (non-temporary) position between the first day and last day of the fiscal year, that employee should be included in the reported headcount.
[4] In the wake of the COVID-19 pandemic and the resulting shifts in operations, members have shared that certain per-diem or temporary employees are being converted to regular non-temporary employees in the same position. If a per-diem position was converted to a regular (non-temporary) position between the first day and last day of the fiscal year, that employee should be included in the reported headcount.

As of Day 1 of the reference year for which you are submitting data (typically the most recently completed fiscal year), the headcount of part-time and full-time employees at your healthcare system that are not physicians, medical students, trainees, interns, per-diem employees, and non-permanent/contracted positions that earn at or above the Local Living Wage based on MIT's Local Living Wage Calculator based on the gross pay rate (plus bonuses and overtime) alone. The Local Living Wage threshold used should be based on the geographic location where the employee spends most of their working time (primary worksite), should assume that the employee is from a 2-Adult Household (Both Working) With 1 Child (regardless of the employee's actual family structure). For fully remote employees, the geography used with the MIT Living Wage calculator should match the employee's residence. Please see Appendix B: Local Living Wage for a history and rationale for using MIT's Local Living Wage calculator.

Using the MIT Living Wage Calculator

Step 1: Go to the MIT Living Wage Calculator at http://livingwage.mit.edu/.

Step 2: Select the state, then metropolitan statistical area or county[5] of the group of employees (based on work location) for whom you are trying to find the Living Wage threshold.

Step 3: Look for the Living Wage value under the column "2 Adults (Both Working) 1 Child". This is the hourly rate threshold to determine the number of employees that earn at or above the Local Living Wage. *To annualize this rate, multiply it by 2080 hours.*

Step 4: Using the data collection worksheet, report only the total count of employees earning at or above the local living wage across all hospitals in your system. HAN does not request the numbers for each geography.

H5.# Employees Earning At or Above the Local Living Wage (Wage + Select Benefits)

Categories of Race (H5.1a-g), Ethnicity (H5.2a-c), and Gender (H5.3a-e)
Categories of Barriers to Employment H5.5 | H5.6 | H5.7

As of Day 1 of the reference year for which you are submitting data (typically the most recently completed fiscal year), the headcount of part-time and full-time employees at your healthcare system that are not physicians, medical students, trainees, interns, per-diem employees, and non-permanent/contracted positions that earn at or above the Local Living Wage based on MIT's Local Living Wage Calculator when including both the employee's gross pay rate (plus bonuses and overtime) and Select Benefits.

Select Benefits specifically include healthcare insurance, childcare supplements, housing supplements, and transportation benefits. Other benefits may be included if they:

- directly and immediately affect a household budget, and
- where it can be reasonably assumed that the removal (or lack) of the benefit would result in an even or a net increase in a household's expenses.

For example, student loan supplements (paid either directly to the employee or on behalf of the employee) immediately lower a typical household monthly expense. It can be reasonably assumed that the removal of this benefit would increase the expenses of a household.

---

[5] If the worker location is in a county that is located in a metropolitan statistical area, use the MSA as the geography for determining the Living Wage threshold. Otherwise, use the county.

Inversely, retirement benefits are not immediately realized in a household budget and therefore should not be included in this indicator. Retirement is included in H23.# Employees Earning At or Above the Local Living Wage (Wage + Select Benefits + Retirement)

H6.# Employees Earning At or Above the Local Living Wage (Wage + Select Benefits + Retirement)

Categories of Race (H6.1a-g), Ethnicity (H6.2a-c), and Gender (H6.3a-e)
Categories of Barriers to Employment H6.5 | H6.6 | H6.7

As of Day 1 of the reference year for which you are submitting data (typically the most recently completed fiscal year), the headcount of part-time and full-time employees at your healthcare system that are not physicians, medical students, trainees, interns, per-diem employees, and non-permanent/contracted positions that earn at or above the Local Living Wage based on MIT's Local Living Wage Calculator when including the employee's gross pay rate (plus bonuses and overtime), Select Benefits, and qualifying Retirement benefits.

Retirement should be included ONLY if all employees are eligible to receive employer contributions to retirement regardless whether the employee contributes.

H7.# Retained Employees

Categories of Race (H7.1a-g), Ethnicity (H7.2a-c), and Gender (H7.3a-e)

Categories of Barriers to Employment H7.5 | H7.6 | H7.7 IWC

As of *the last day* of the reference year for which you are submitting data (typically the most recently completed fiscal year), the headcount of part-time and full-time employees at your healthcare system that are not physicians, medical students, trainees, interns, per-diem employees and non-permanent/contracted positions ***who were also employed on Day 1 of the fiscal year.*** This count excludes anyone that was not an employee on Day 1 of the reference year.

H8.# Total New Hires

Categories of Race (H8.1a-g), Ethnicity (H8.2a-c), and Gender (H8.3a-e)
Categories of Barriers to Employment H8.5 | H8.6 | H8.7

As of *the last day* of the reference year for which you are submitting data (typically the most recently completed fiscal year), the headcount of part-time and full-time employees at your healthcare system that are not physicians, medical students, trainees, interns, per-diem employees and non-permanent/contracted positions ***who were hired within the start and end of the fiscal year.***

H9.# Total New Hires into Quality Jobs IWC

Categories of Race (H9.1a-g), Ethnicity (H9.2a-c), and Gender (H9.3a-e)
Categories of Barriers to Employment H9.5 | H9.6 | H9.7

As of *the last day* of the reference year for which you are submitting data (typically the most recently completed fiscal year), the headcount of part-time and full-time employees at your healthcare system that are not physicians, medical students, trainees, interns, per-diem employees and non-permanent/contracted positions ***who were hired within the start and end of the fiscal year into roles that meet the minimum standards set out in the Quality Job definition.***

H10.# Impact Hires IWC

*If your system does not have an Intentional, Outside-In Pathway, Program, or Partnership in place to source hires that match the Impact Hire definition, you do **not** need to report this indicator.*

Categories of Race (H10.1a-g), Ethnicity (H10.2a-c), and Gender (H10.3a-e)
Categories of Barriers to Employment H10.5 | H10.6 | H10.7

The headcount of part-time and full-time employees at your healthcare system that are not physicians, medical students, trainees, interns, per-diem employees and non-permanent/contracted positions that meet all of the following criteria:

1) They were hired through an intentional outside-in pathway or program or partnership that is built with a community organization or education partner and which has a focus on place. Individuals must either:

- Reside, at the time of hire, in targeted economically disadvantaged zip codes or more granular geographic areas (e.g., Area Deprivation Index zones, Census block or tract) that your organization serves
  OR:
- Enter the institution through a partnership with a community-based, workforce or educational organization that has an **explicitly stated** focus on reaching communities within economically disadvantaged geographies that your organization serves.

2) They were hired on or after the first day of the fiscal year and were still employed as of the last day of the fiscal year.

3) The position in which the person was hired is a Quality Job. A Quality Job:

  - includes employer-paid/subsidized health insurance.
  - includes paid leave.
  - includes employer-funded retirement benefits (e.g., employer contributions to 401(k)).
  - pays at or above the MIT Local Living Wage for a 2-Adults (Both Working) 1 Child household in the employee's primary worksite.
  - provides a stable schedule and stable hours.
  - has either an established career pathway or earning growth opportunities.
  - requires less than a Bachelor's degree

H10.0a Intentional, Outside-In, Pathways, Programs and Partnerships

Pathways, programs and partnerships with community organizations and/or education providers (and which may be accompanied by internal hiring policy and process changes) that prepare local residents of economically disadvantaged geographic areas who are experiencing barriers to employment for jobs at the healthcare institution through training, skills development, and support services. ***The pathway, program or practice should be novel relative to typical operations related to hiring and recruitment.***

Intentional Outside-in Pathways, Programs & Partnerships: What could this look like?		
Job category of focus	***Partner Organization***	***Pathway Program***
Jobs with the lowest barriers to entry	Community-based organization (Goodwill)	Kaiser Permanente Southern California works in partnership with Goodwill to connect people with barriers to employment, including veterans, youth, uniquely abled, homeless, and recently incarcerated people, to jobs with low barriers to entry, such as food and nutrition services and environmental services. Goodwill helps people to prepare for the hiring process through employment readiness workshops and soft-skills training.
Jobs that require short-term certification(s) and less than an associate's degree	Community-based training organization (New Bridge)	University Hospitals partners with New Bridge as a short-term training provider to implement a Patient Care Nursing Assistant training program and Medical Assistant pathway, which prepare residents of Cleveland's Greater University Circle for employment.
Jobs that require an associate's degree	Education provider (Colby Sawyer College)	Dartmouth Health partners with Colby-Sawyer College to implement a Pharmacy Technician apprenticeship. Participants earn an hourly training wage and college credits towards an Associate of Science in Health Science, and upon completion of the program, are transitioned into full-time roles.

H10.0b Rationale or methodology statement for defining economically disadvantaged geographies

A short written rationale or methodology statement describing what constitutes economic disadvantage for your organization's Impact Hire strategy. Optionally, list the economically disadvantaged areas of focus for your organization's impact hiring strategy (e.g., anchor mission zip codes).

Economically Disadvantaged

Currently, healthcare systems should use their internal definition for determining economically disadvantaged geographies. You may define such areas based on your Community Health Needs Assessment (CHNA), or any other criteria that is aligned with your institution's anchor mission approach. Most commonly, these are zip codes identified using CHNA-derived data. *For the purposes of reporting Impact Hires, hires via partnership(s) with a community organization(s) that have a focus on reaching communities within economically disadvantaged geographies that your health system serves can be reported if your health system does not have economically-disadvantaged geographies that it targets for hiring.*

Stable Schedule[6]

The work schedule is provided to the employee no less than two weeks prior to the work dates. For example, an employee reporting to work on October 27 knew their work schedule for October 27 no later than October 13.

Stable Hours

The minimum number of hours worked necessary to provide employer-sponsored health insurance, paid leave, and a retirement plan.

H11.# Wage Gains

Wage gains should be reflective only of the cohort of retained employees at the beginning of the reference year and **should be inclusive of gains from all sources (promotions, compression adjustments, cost of living, and merit increases).** Here's an example of how to calculate wage gains:

1. Pull a list of all employees as of the first day of the immediately following fiscal year (for FY23, this would be all employees on Day 1 of FY24; this removes anyone separated during FY23).
2. Remove employees that are physicians, medical students, trainees, interns, per-diem employees and non-permanent, or contracted positions (removes higher-wage positions and non-permanent positions).
3. Remove any employees that were hired after day 1 of FY23.

After following these steps, you should have the correct cohort to calculate wage gains. For those employees left:

[7]Average their wages on the first day of the immediately following FY (End Wages)

Average their wages on the first day of the FY (Beginning Wages)

Calculate using the following formula:

- (End Wages minus Beginning Wages) Divided by Beginning Wages

H12.# | H13.# | H14.# | H15.# Employees Receiving Tuition Reimbursement or Cost Advancement

The total number of employees either part-time or full-time who have received tuition assistance either in the form of pre-payment to the education provider or as reimbursement to the employee during the reference year.

For 2- or 4-year degrees, or post-Bacc certificates

These employees used tuition benefits to work towards a program of study typically designed to be completed over 2 or more years of instruction or provide a degree at the baccalaureate level or above (2-year Associate's or higher). Certificates from regionally or nationally accredited institutions at the baccalaureate or higher level (for example, an employee enrolled in a Master's certificate program at a university) should also be included in this count. **An**

[6] This practice is in line with the recommendations from the Center for Law and Social Policy (CLASP) as well as precedents set by Oregon law and New York City, San Francisco, and Seattle ordinances.
[7] To annualize hourly wages, multiply the hourly wage rate by 2080.

employee enrolled in a 12-week course on Business Analytics from Udacity or Codecademy or a certificate in Public Speaking from LinkedIn Learning would NOT be included in this count.

For sub-Bacc certificates

These employees are using tuition benefits to work towards a program of study of any length from regionally or nationally accredited institutions where entry to the certificate program does not require a Bachelor's degree. **An employee enrolled in a 12-week course on Business Analytics from Udacity or Codecademy or a certificate in Public Speaking from LinkedIn Learning would NOT be included in this count.**

For "Other Career Advancement Programs"

These employees are using tuition benefits to work towards a program of study typically designed for less than 2-years of instruction and are not provided through a regionally or nationally accredited institution. For example, an employee enrolled in a 12-week course on Business Analytics from Udacity or Codecademy or a certificate in Public Speaking from LinkedIn Learning would be included in this count.

H16.# Resources for Anchor Mission Hiring & Workforce Development

These indicators should only be reported if your institution has formally allocated staff time to specifically support implementation of anchor mission strategies related to inclusive, local hiring and internal workforce development.

H16.0 Total FTE Dedicated to Anchor Mission Hiring & Workforce Development Activities

This indicator should only be reported if your institution has formally allocated staff time to specifically support implementation of anchor mission strategies related to impact hiring. Total FTE at your health system dedicated to implementing an impact hiring strategy, which could include roles such as workforce development coordinators, recruiters for impact hires (or a % of recruiter's time to interfacing with impact hire partnerships), career coaches, and supervisors who support impact hires in developing career paths.

Example: 1 Workforce Development Coordinator, 1 Career Coach, and 20% support from a recruiter who interfaces with impact hire partnerships equals 2.2 FTE.

H16.01 Job Descriptions for Roles Related to Anchor Mission Hiring & Workforce Development Activities

Please copy and paste or upload job descriptions inclusive of the roles you determined were related to Anchor Mission Hiring & Workforce Development Activities in H16.0.

H16.1 Total Budget Dedicated to Anchor Mission Hiring & Workforce Development Activities

The total budget expressed in dollars allocated to anchor mission hiring and workforce development activities. The budget should be reflective of the salary and fringe benefits of the FTE reported in H16.0 and any administrative overhead.

Procurement Indicators

P0.2c List of Data Enrichment Vendors

Please share which Data Enrichment Vendor(s) your system uses to certify vendors as diverse, small, etc., if applicable. Examples include Supplier Gateway, Supplier.io, Tealbook, and Viva.

P1.0 Tier 1 Total Spend

The summed dollar amount of all **operating, capital, AND construction expenses** incurred during the fiscal year with direct vendors to your health system, **minus the expense categories listed below**:

- Compensation
  - Salaries and wages (including overtime and bonuses)
  - Resident and board member compensation
  - Fringe benefits
  - Medical director fees
- Government Transfer Payments
  - All other taxes
  - Hospital and tax assessment
- Financial Accounting Concepts
  - Bad debt
  - Depreciation and amortization
  - Interest payments

P1.0a Exclusion Categories for Total Spend

Please indicate which of the categories are ***not included*** in your reported data for P1.0 Tier 1 Total Spend.

P1.1 Tier 1 Addressable Procurement Spend

P1.0 Tier 1 Total Spend (above) **minus the expense categories listed below. Construction expenses should not be included in this count, as outlined in the category list below.**

- Construction expenses
- Construction-related capital expenses
- Compensation
  - Salaries and wages (including overtime and bonuses)
  - Residents and board member compensation
  - Fringe benefits
  - Medical director fees
- Government Transfer Payments
  - All other taxes

ONLY USE WITH FY23 DATA COLLECTION

- Hospital and tax assessment
- Financial Accounting Concepts
    - Bad debt
    - Depreciation and amortization
    - Interest Payments
- Purchasing Categories
    - Claims costs
    - Utilities
    - Sponsorships
    - Prime pharmaceutical distributor
    - Retail pharmacy
    - Spend with non-profits (including hospitals)
    - Blood, OPO (Organ procurement organization)
    - **Optional Exclusions[8]:**
        - Independent physician groups - **Optional**
        - Building leases - **Optional**
        - Business employee expenses (e.g. miles, meals, and expenses) - **Optional**

P1.1a Exclusion Categories for Addressable Procurement Spend

Please indicate which purchasing categories are ***not included*** in your reported data for P1.1 Tier 1 Addressable Procurement Spend.

P1.2 Tier 1 Local Procurement Spend [9]

1.2a Neighborhood Procurement Spend

The subset of P1.1 addressable procurement spend that was spent during the fiscal year with vendors that meet ALL of the following criteria:

- Vendor's headquarters location must be located in your health system's catchment area.
- Vendor must have at least one business location in targeted economically disadvantaged zip codes as defined by your health system.
- Vendor cannot be a publicly traded company. HAN provides a list of publicly traded companies and their Tax Identification Numbers (i.e., TIN or EIN) in the Data Collection Sheet.

1.2b Regional Procurement Spend

The subset of P1.1 addressable procurement spend that was spent during the fiscal year with vendors that meet ALL of the following criteria:

[8] If your system has an intentional strategy to increase spend with diverse-owned businesses in these categories, they may be reported in spend with diverse-owned businesses.
[9] IPC signatories may report *either* Neighborhood alone, Regional alone, or both.

ONLY USE WITH FY23 DATA COLLECTION

- Vendor's headquarters location must be located in your health system's catchment area.
- Vendor must have at least one business location in your system's catchment area.
- Vendor cannot be a publicly traded company. HAN provides a list of publicly traded companies and their Tax Identification Numbers (i.e., TIN or EIN) in the Data Collection Sheet.

Below is a breakdown of the differences between neighborhood and regional spend:

Local Spend Definition Components	Regional Procurement Spend	Neighborhood Procurement Spend
Headquarters Location	Headquarters must be located in your catchment area.	
Operating Location	At least one business location must be in your ***catchment area.***	At least one business location must be in an ***economically disadvantaged zip code or similar geographic concept (e.g., Area Deprivation Index)*** targeted by your system.
Publicly Traded Status	Business cannot be publicly traded.[10]	

For more information and a detailed rationale of collecting local spend, see Appendix E: Local Spend.

P1.3 or P1.4 | Tier 1 Diverse Procurement Spend

The subset of P1.1 addressable procurement spend that was spent during the fiscal year with vendors that are either third-party certified or self-certified/self-identified as a diverse vendor. For more information, please refer to Appendix D: Classifying Diverse Spend.

> G Only P1.3a Third Party Certified Spend with Minority-Owned Businesses & P1.3b Spend with Women-Owned Businesses qualify for Gartner. Other subsets of this metric are required for HAN members, but do not count towards Gartner qualification. Self-certified/self-identified data does not count toward Gartner qualification.

[10] HAN provides a list of publicly-traded companies and their tax identification numbers in the Data Collection Sheet.

Metrics appended with ".41" ask for the count of unique businesses that represent the dollar amount entered for that given metric. These counts are optional for FY23

P1.6 Tier 1 Diverse & Local Procurement Spend

The subset of P1.1 addressable procurement spend that was spent during the fiscal year with vendors that are Local (either Regional OR Neighborhood) **AND** Diverse. This is **NOT** a sum of Diverse and Local. For more information, please refer to Appendix D: Classifying Diverse Spend.

P1.7 | P1.8 Tier 1 Employee-Owned Procurement Spend [11]

The subset of P1.1 addressable procurement spend that was spent during the fiscal year with vendors that are at least 30% owned (or eligible to be owned) by its employees through an Employee Stock Ownership Plan (ESOP), employee-owned cooperative, or other qualified plan. HAN provides a list of companies certified as employee-owned and their Tax Identification Numbers (TIN) in the Data Collection Worksheet.

P2.0 Tier 1 Total Construction Spend

The dollar amount of all construction expenses, construction-related capital, and non-construction expenses related to construction projects (such as architectural design services, landscaping services specifically for a construction project, etc.) with direct vendors to your health system incurred during the fiscal year.

P2.2 Tier 1 Local Construction Spend

2.2a Regional Construction Spend

The subset of P2.0 Tier 1 Total Construction Spend that was spent during the fiscal year with vendors that meet ALL of the following criteria:

- Vendor's headquarters location must be located in your health system's catchment area.
- Vendor must have at least one business location in your system's catchment area.
- Vendor cannot be a publicly traded company. HAN provides a list of publicly traded companies and their Tax Identification Numbers (i.e., TIN or EIN) in the Data Collection Sheet.

2.2b Neighborhood Construction Spend

The subset of P2.0 Tier 1 Total Construction Spend that was spent during the fiscal year with vendors that meet ALL of the following criteria:

- Vendor's headquarters location must be located in your health system's catchment area.
- Vendor must have at least one business location in targeted economically disadvantaged zip codes as defined by your health system.

[11] HAN provides a list of certified Employee-owned companies as a resource in your submission file. Any companies listed would count as third-party certified. Impact Purchasing Commitment signatories should submit third-party certified data.

- Vendor cannot be a publicly traded company. HAN provides a list of publicly-traded companies and their Tax Identification Numbers (i.e., EIN or TIN)

Below is a breakdown of the differences between neighborhood and regional construction spend:

Local Spend Definition Components	Regional Procurement Spend	Neighborhood Procurement Spend
Headquarters Location	Headquarters must be located in your catchment area.	
Operating Location	At least one business location must be in your ***catchment area.***	At least one business location must be in an ***economically disadvantaged zip code or similar geographic concept (e.g., Area Deprivation Index)*** targeted by your system.
Publicly Traded Status	Business cannot be publicly traded.	

For more information and a detailed rationale of collecting local spend, see Appendix E: Local Spend.

P2.3 or P2.4 | Tier 1 Diverse Construction Spend

The subset of P2.0 Tier 1 Total Construction Spend that was spent during the fiscal year with vendors that are either third-party certified or self-certified/self-identified as a diverse vendor. For more information, please refer to Appendix D: Classifying Diverse Spend.

> G Only P1.3a Third Party Certified Spend with Minority-Owned Businesses & P1.3b Spend with Women-Owned Businesses qualify for Gartner. Other subsets of this metric are required for HAN members, but do not count towards Gartner qualification. Self-certified/self-identified data does not count toward Gartner qualification.

Metrics appended with ".41" ask for the count of unique businesses that represent the dollar amount entered for that given metric. These counts are optional for FY23

P2.6 Tier 1 Diverse & Local Construction Spend

The subset of P2.0 Tier 1 Total Construction Spend that was spent during the fiscal year with vendors that are Local (either Regional OR Neighborhood) **AND** Diverse. For more information, please refer to Appendix D: Classifying Diverse Spend.

P2.7 | P2.8 Tier I Employee-Owned Construction Spend

The subset of P2.0 Tier I Total Construction Spend that was spent during the fiscal year with vendors that are at least 30% owned (or eligible to be owned) by its employees through an Employee Stock Ownership Plan (ESOP), employee-owned cooperative, or other qualified plan. HAN provides a list of companies certified as employee-owned and their Tax Identification Numbers (TIN) in the Data Collection Worksheet.

P3.2 Tier 2 Local Procurement Spend

3.2a Regional Procurement Spend

The dollar amount of operating expenses and capital non-construction related expenses that was spent during the fiscal year with vendors that are suppliers to your health system's direct vendors (may or may not be subcontractors). These vendors must meet ALL of the following criteria:

- Vendor's headquarters location must be located in your health system's catchment area.
- Vendor must have at least one business location in your system's catchment area.
- Vendor cannot be a publicly traded company. HAN provides a list of publicly traded companies and their Tax Identification Numbers (i.e., TIN or EIN) in the Data Collection Sheet.

3.2b Neighborhood Procurement Spend

The dollar amount of operating expenses and capital non-construction related expenses that was spent during the fiscal year with vendors that are suppliers to your health system's direct vendors (may or may not be subcontractors). These vendors must meet ALL of the following criteria:

- Vendor's headquarters location must be located in your health system's catchment area.
- Vendor must have at least one business location in targeted economically disadvantaged zip codes as defined by your health system.
- Vendor cannot be a publicly traded company. HAN provides a list of publicly traded companies and their Tax Identification Numbers (i.e., TIN or EIN) in the Data Collection Sheet.

Below is a breakdown of the differences between neighborhood and regional construction spend:

Local Spend Definition Components	Regional Procurement Spend	Neighborhood Procurement Spend
Headquarters Location	Headquarters must be located in your catchment area.	
Operating Location	At least one business location must be in your ***catchment area.***	At least one business location must be in an ***economically disadvantaged zip code or similar geographic concept (e.g., Area Deprivation Index)*** targeted by your system.

ONLY USE WITH FY23 DATA COLLECTION

Publicly Traded Status	Business cannot be publicly traded.

For more information and a detailed rationale of collecting local spend, see Appendix E: Local Spend.

P3.3 | P3.4 | P3.5 Tier 2 Diverse Procurement Spend

The dollar amount of operating expenses and capital non-construction related expenses that was spent during the fiscal year with vendors that are suppliers to your health system's direct vendors (may or may not be subcontractors). These vendors may either be third-party certified or Self-certified/self-identified as a diverse vendor. For more information, please refer to Appendix D: Classifying Diverse Spend.

P3.6 Tier 2 Diverse & Local Procurement Spend

The dollar amount of operating expenses and capital non-construction related expenses that was spent during the fiscal year with vendors that are suppliers to your health system's direct vendors (may or may not be subcontractors). These vendors must be Local (either Regional OR Neighborhood) **AND** Diverse. For more information, please refer to Appendix D: Classifying Diverse Spend.

P3.7 | P3.8 Tier 2 Employee-Owned Procurement Spend

The dollar amount of operating expenses and capital non-construction related expenses that was spent during the fiscal year with vendors that are suppliers to your health system's direct vendors (may or may not be subcontractors). These vendors must be at least 30% owned (or eligible to be owned) by its employees through an Employee Stock Ownership Plan (ESOP), employee-owned cooperative, or other qualified plan. HAN provides a list of companies certified as employee-owned and their Tax Identification Numbers (TIN) in the Data Collection Worksheet.

P4.2 Tier 2 Local Construction Spend

4.2a Regional Construction Spend

The dollar amount of construction expenses and non-construction expenses related to construction projects (such as architectural design services, landscaping services specifically for a construction project, etc.) that was spent during the fiscal year with vendors that are suppliers to your health system's direct vendors (may or may not be subcontractors). These vendors must meet ALL of the following criteria:

- Vendor's headquarters location must be located in your health system's catchment area.
- Vendor must have at least one business location in your system's catchment area.
- Vendor cannot be a publicly traded company. HAN provides a list of publicly traded companies and their Tax Identification Numbers (i.e., TIN or EIN) in the Data Collection Sheet.

4.2b Neighborhood Construction Spend

The dollar amount of construction expenses and non-construction expenses related to construction projects (such as architectural design services, landscaping services specifically for a construction project, etc.) that was spent during the

fiscal year with vendors that are suppliers to your health system's direct vendors (may or may not be subcontractors). These vendors must meet ALL of the following criteria:

- Vendor's headquarters location must be located in your health system's catchment area.
- Vendor must have at least one business location in targeted economically disadvantaged zip codes as defined by your health system.
- Vendor cannot be a publicly traded company. HAN provides a list of publicly traded companies and their Tax Identification Numbers (i.e., TIN or EIN) in the Data Collection Sheet.

Below is a breakdown of the differences between neighborhood and regional construction spend:

Local Spend Definition Components	Regional Procurement Spend	Neighborhood Procurement Spend
Headquarters Location	Headquarters must be located in your catchment area.	
Operating Location	At least one business location must be in your ***catchment area.***	At least one business location must be in an ***economically disadvantaged zip code or similar geographic concept (e.g., Area Deprivation Index)*** targeted by your system.
Publicly Traded Status	Business cannot be publicly traded.	

For more information and a detailed rationale of collecting local spend, see Appendix E: Local Spend.

P4.3 | P4.4 | P4.5 Tier 2 Diverse Construction Spend

The dollar amount of construction expenses and non-construction expenses related to construction projects (such as architectural design services, landscaping services specifically for a construction project, etc.) that was spent during the fiscal year with vendors that are suppliers to your health system's direct vendors (may or may not be subcontractors). These vendors may either be third-party certified or self-certified/self-identified as a diverse vendor. For more information, please refer to Appendix D: Classifying Diverse Spend.

P4.6 Tier 2 Diverse & Local Construction Spend

The dollar amount of construction expenses and non-construction expenses related to construction projects (such as architectural design services, landscaping services specifically for a construction project, etc.) that was spent during the fiscal year with vendors that are suppliers to your health system's direct vendors (may or may not be subcontractors). These vendors must be Local (either Regional OR Neighborhood) **AND** Diverse. For more information, please refer to Appendix D: Classifying Diverse Spend.

P4.7 | P4.8 Tier 2 Employee-Owned Construction Spend

The dollar amount of construction expenses and non-construction expenses related to construction projects (such as architectural design services, landscaping services specifically for a construction project, etc.) that was spent during the

fiscal year with vendors that are suppliers to your health system's direct vendors (may or may not be subcontractors). These vendors must be at least 30% owned (or eligible to be owned) by its employees through an Employee Stock Ownership Plan (ESOP), employee-owned cooperative, or other qualified plan. HAN provides a list of companies certified as employee-owned and their Tax Identification Numbers (TIN) in the Data Collection Worksheet.

P7.# Resources for Anchor Mission Purchasing

P7.0 Total FTE Dedicated to Anchor Mission Purchasing Activities

This indicator should only be reported if your institution has formally allocated staff time to specifically support implementation of anchor mission strategies related to purchasing and procurement. Total FTE at your health system dedicated to impact purchasing. The total dollar amount allocated to management of impact purchasing activities in your health system.

Example: 1 Director of Supplier Diversity + 5% support from Community Health + 10% support from Sustainability + 5% support from Facility Maintenance = 1.2 FTE.

P7.01 Job Descriptions for Roles Related to Anchor Mission Purchasing

Please copy and paste or upload job descriptions inclusive of the roles you determined were related to Anchor Mission Purchasing Activities in P7.0.

P7.1 Total Budget Dedicated to Anchor Mission Hiring & Workforce Development Activities

The total budget expressed in dollars allocated to anchor mission purchasing activities. The budget should be reflective of the salary and fringe benefits of the FTE reported in P7.0 and any administrative overhead.

P8.0# Total Impact Hires by Vendors

The total headcount of impact hires from Vendors. The headcount can come from both direct (Tier 1) vendors as well as Tier 2 vendors (vendors that are suppliers to your health system's direct/Tier 1 vendors). A hire can only count as an Impact Hire if the Vendor has made a commitment to your system's intentional pathways, programs, and partnerships that targets your system's economically disadvantaged zip codes.

P9.0# Workforce and Budget Allocation to Impact Purchasing

This indicator should only be reported if your institution has formally allocated staff time to specifically support implementation of anchor mission strategies related to impact purchasing. Total FTE at your health system dedicated to implementing an impact purchasing strategy, which includes supplier diversity, sustainability, community wealth building and local purchasing strategies.

Example: 1 Director of Supplier Diversity and 5% support from Community Health, 10% support from Sustainability, and 5% support from Facilities equals 1.2 FTE.

Sustainability Indicators IPC

Only for members that are signatories of the Impact Purchasing Commitment. Non-IPC HAN members should not complete this section. Each metric in this section is only required per your healthcare system's selected goals.

S1.# Percentage of Energy Usage from Renewable Energy Sources

Renewable electricity includes electricity produced from solar, wind, geothermal, biogas, biomass, and low-impact small hydroelectric sources (certified as Low-Impact Small Hydroelectric by the Low Impact Hydropower Institute). Electricity produced from biogas/biomass sources (via anaerobic digesters) typically qualifies as a renewable electricity source according to the Energy Information Administration (EIA). Paying attention to the fuel source and fuel generation is critical in qualifying the renewable energy attributes towards renewable electricity (e.g. methane turning into electricity through an electric generator from landfill or dairy farm source). The key distinction is that renewable energy may come from various sources that are zero or low-carbon and in some cases not be considered renewable electricity (e.g. a renewable natural gas RNG project that supplies thermal applications via existing natural gas lines or CNG vehicles).

According to EPA's Green Power Program: Much of the confusion about renewable electricity use claims, including solar power use claims, is because our electricity grid does not distinguish where the electricity was generated and delivered.1 Electrons produced by a solar panel are no different than electrons produced by a coal-fired power plant or any other electricity generating technology. The indistinguishability of these electrons coupled with the inability to direct where electrons flow within the grid resulted in the U.S. electricity market establishing a separate accounting framework that tracks the generation, sale, and ultimate "use" of renewable electricity. Renewable electricity generators, therefore, produce two distinct market commodities: 1) electricity and 2) RECs. These commodities can be used and/or sold separately or together. The REC instrument embodies the environmental attributes of the underlying electricity generated from a renewable resource

Facilities cannot claim renewable energy from their utility grid mix and must own/retire the associated RECs for any onsite/offsite renewable energy generation.

S1.1 Total kWh from conventional electricity

S1.2a Total kWh from solar/photovoltaic energy sources

S1.2b Total energy usage in kWh from geothermal sources

S1.2c Total energy usage in kWh from Biomass sources

S1.2d Total energy usage in kWh from Bio-gas sources

S1.2e Total kWh from Low-Impact Hydropower sources

S1.2f Total kWh from Wind sources

S1.2g Total kWh from purchased mixed-source RECs

This metric should not include single-source RECs. Single source REC's should be reported in S1.2a-f.

S2.# Sevoflurane, Isoflurane, Desflurane, and Nitrous Oxide Use IPC

Inhaled anesthetic gases include desflurane, isoflurane, sevoflurane, and nitrous oxide. While primarily used in the operating room and ambulatory surgical centers, they may also be used in other settings like dental clinics, interventional radiology, labor and delivery, and emergency departments.

S3.# Percent Alternative Fuel Vehicles Purchased/Leased

The total count of passenger and courier vehicles, shuttles, vans, buses, light-, medium-, and heavy-duty trucks used to move patients, employees, and materials around health system facilities. The count should include both vehicles purchased in the calendar or fiscal year (per member preference) and those leased in the calendar or fiscal year (per member preference).

The count should not include ambulances and helicopters.

Alternative Fuel Vehicles (AFVs) are those defined by Section 301 of the Energy Policy Act of 1992, as amended (42 U.S.C. 13211), and otherwise includes:

- Electric vehicles
- Hybrid electric vehicles
- Plug-in hybrid electric vehicles
- Dedicated alternative fuel vehicles
- Dual fueled alternative fuel vehicles
- Qualified fuel cell motor vehicles
- Advanced lean burn technology motor vehicles
- Low greenhouse gas vehicles
- Compressed natural gas powered vehicles
- Self-propelled vehicles such as bicycles
- Any other alternative fuel vehicles defined by statute.

The EPA SmartWay program helps suppliers adopt advanced, fuel-efficient technologies and operational practices in the freight supply chain, which save fuel, lower costs, and reduce adverse environmental impacts, especially in low-income communities near ports, highway, air, and rail infrastructure.

S4.# Number of Product Types Transitioned from Disposable to Reusable Products

For each product category, indicate whether your system has transitioned from using single-use versions of these product categories to versions specifically labeled as reusable at least 75% of the time.

Single-use/Disposable

According to the Food and Drug Administration a single-use device, also referred to as a disposable device, is intended for use on one patient during a single procedure. It is not intended to be reprocessed (i.e., cleaned and disinfected or sterilized) and used on another patient. It is typically disposed of in either the solid waste or regulated medical waste stream.

Reusable

Reusable medical devices are devices that health care providers can reprocess and reuse on multiple patients. These devices are designed and labeled for multiple uses and are reprocessed by thorough cleaning followed by high-level disinfection or sterilization between patients. They are made of materials that can withstand repeated reprocessing, including manual brushing and the use of chemicals.

S5.# Number of Product Lines Free of Both PVC and DEHP

For each product line, indicate whether your system purchases PVC- and DEHP-free versions of these products.

Polyvinyl chloride (PVC), or vinyl, is a synthetic thermoplastic material made by polymerizing vinyl chloride. The properties of the material depend on the additives, including plasticizers. The plasticizers used most often in PVC medical devices is DEHP, or di(2-ethylhexyl)phthalate, which acts as a softener as unplasticized PVC is hard and brittle at room temperature.

S6.# Percentage of Spend on Furnishings and Furniture Free of All Five Target Chemicals

The total dollar amount spent during the calendar or fiscal year (per member preference) on furniture and furnishings products that meet the Healthy Interiors Criteria.

The total dollar amount spent during the fiscal year on furniture and furnishings products that do not meet the Healthy Interiors Criteria.

For each product type listed, indicate whether that product was purchased during the calendar or fiscal year (per member preference), regardless of whether or not the products met the Healthy Interiors Criteria.

The Healthy Interiors criteria eliminates the use of formaldehyde, per and poly-fluorinated compounds (PFAS), polyvinyl chloride (PVC), antimicrobials, and flame retardants from furniture and furnishings.

This includes seating (chairs, stools, sofas, benches, etc.), work surfaces (tables, desks, etc.), beds (including mattresses), storage units (cabinets, filing cabinets, dressers, drawers, etc.), shelving (bookshelves, built-in shelves, etc.), panels and partitions, cubicle curtains, and window coverings.

S7.# Percentage of Spend on Sustainable Food

The total dollar amount spent during the calendar or fiscal year (per member preference) on all food items regardless of sustainability status.

The total dollar amount spent during the calendar or fiscal year (per member preference) on all food items that are in line with Practice Greenhealth's healthier food purchasing standards **AND** carry at least one of the certifications or label claims reported as "sustainable".

Please note that, for the purposes of this specific IPC provision, we are tracking sustainable food, not local food (Practice Greenhealth has separate definitions for both categories). Thus, as long as a food product has at least one of the label claims and/or third-party certifications from the list linked above, it can be counted towards the sustainable food goal.

Please note that since the launch of the Impact Purchasing Commitment (IPC), Practice Greenhealth has released an update to their Healthy Food in Health Care Standard including their Food Purchasing Criteria. **IPC participants will continue to reference the former criteria in reporting on "sustainable" food purchasing.** For those IPC participants that also report metrics through the Practice Greenhealth Environmental Excellence Awards application they will need to report in alignment with the updated Food Purchasing Criteria. To learn more about the updated criteria go here.

Place-based Investment Indicators

10.2a SRI or ESG Investment Policy

At any point since day 1 of your most recently completed fiscal year, did your health system's investment policy have additional Socially Responsible Investing (SRI) or Environmental, Social, & Governance (ESG) language, screens, frameworks included in your organization's investment policy?

> SRI is any investment strategy where, in addition to financial returns, social impact is a criteria for investment and/or a consideration in evaluating performance.
>
> ESG is any investment strategy where, in addition to financial returns, environmental impact, social impact, and/or corporate governance issues (business ethics, anti-competitive practices, corruption, tax and accounting transparency) are criterion for investing and/or a consideration in evaluating performance.

10.2b Place-Based Investment Objective

10.2b should be reported as of day 1 of the most recently completed fiscal year.

Place-based investing is defined as an impact investment approach that targets both social and financial returns.

Specifically, place-based investments combine positive social, economic and environmental impacts *in specific communities and geographies of need (i.e., underfunded and/or underserved populations)*, while at least preserving principal or achieving a modest financial return (i.e., one that is less than market rate for that asset class). The purpose of place-based investments is to address gaps in the marketplace by adding affordable and flexible capital for community projects.

In a place-based investment, at least the principal of the investment should be preserved for the investing institution. Place-based investments are reflected on the balance sheet rather than within an organization's operating budget.

Though grant dollars are a valuable asset that health systems should also leverage to address community needs, for the purposes of HAN reporting, **grant dollars and similar expenses should not be categorized as place-based investments**. To illustrate:

HAN member system provides a local community development organization a $250,000 grant and a $1,000,000 7-year loan at a 2% interest rate to construct affordable housing. The $1 million loan counts as place-based investment. The $250,000 grant does not but ***should be reported*** *in the section asking for additional project information further below.*

Is it a place-based investment?

To determine if your health system has made a place-based investment, use the following shorthand test. For the project in question, does the investment:

1. Preserve the principal or generate a financial return that is below market rate for that asset type?
2. Address a community priority or social need in a high need community or for a high need population that you serve?
3. Not focus on healthcare access or services for your own organization?
4. Not benefit exclusively your own employees, patients or plan members?

If you can answer "yes" to all four questions, it most likely counts towards this portion of data collection.

At this time, grants and philanthropic activity that are not done in alignment with a place-based investment are not captured in HAN data collection.

Additionally, geographically-targeted mutual funds do NOT count as place-based investments and should not be reported in 10.3a/b Allocation to Place-Based Investments. Please report these investments in 10.5 Geographically Targeted Mutual Funds. Deposits (such as cash or cash equivalents) should not be reported in 10.3a/b Allocation to Place-Based Investments. Instead, please report these dollars in 10.6a Cash & Cash Equivalents in High Impact Banks and Credit Unions.

10.2c ESG/SRI Options in Employee Retirement Accounts

As of day 1 of the most recently completed fiscal year, did your health system provide ESG/SRI fund options in employee retirement accounts?

Only indicate "Yes" if the following are true:

- Options are made available to employees in a self-directed or partially-self directed retirement plan.
- You would characterize the ESG/SRI status and availability of these options as "widely publicized" to employees.
- The take up rate of these options (based on whether contributions are made, not on the amount of contributions/proportion of portfolio), is at least 10% of your employee base eligible for retirement contributions.

10.3 Total Investable Assets

As of day 1 of the most recently completed fiscal year (opening balance), the total long-term reserves or unrestricted investment funds/pools. Pensions and other restricted assets should be excluded from this total.

10.3a/b Allocation to Place-Based Investments

As of day 1 of the most recently completed fiscal year (opening balance), the total dollar amount that has been formally budgeted, carved out, or set aside for your health system's place-based investments.

10.4a/b Dollars of Place-based Investment Deployed

As of the last day of the most recently completed fiscal year, the dollars allocated to place-based investment, the total amount that has been transferred to the project's management firm, the underwriters of the project, or the managers of the specific investment vehicle. Legally obligated dollars that have not been transferred can also count as deployed.

10.5 Dollars Invested in Geographically Targeted Mutual Funds

Geographically targeted investments that impact liquidity in the secondary market but do not directly result in the origination of new projects. Examples include CCM Community Impact Bond Fund and RBC Access Capital Mutual Fund. While they generate more social impact than traditional investments, these types of investment products do not provide the same additionality of resources to address community needs and HAN tracks them separately.

I0.6a Cash & Cash Equivalents in *High Impact* Banks and Credit Unions

The number of dollars held in high impact community banks or credit unions. **This does not include CDFIs.** The reported amount should only reflect cash or cash equivalents (like savings and certificates of deposit), not debt or equity investment vehicles. A community bank or credit union is 'high impact' if it received a 3-star rating from BankLocal. Systems may use any bank located in any part of their catchment area that received a 3-star rating.

BankLocal has created a scoring system that provides a broad measure of how banks contribute to the health of their local economies. A bank that receives three stars is considered 'High Local Impact'.

Example: ProMedica places a $100,000 annual deposit in the Toledo Urban Credit Union, an important black-owned credit union serving low- and moderate-income neighborhoods within Toledo.

I0.7a/b Affordable Housing Units

The total number of housing units created and/or maintained by your place-based investments where rent/mortgage payments are less than 30% of the gross income of *low-to-moderate income families (families' whose total income is less than 120% of Median Family Income for the area).*

This definition reflects HUD's classification of affordability as well as its income limits for several housing programs.[12]

Housing units need to have covenants that protect their affordability for at least 30 years in order to be counted towards this indicator. You may include housing units that are not yet operational but are currently being developed or that have had their tax credits authorized.

I0.7c Permanent Jobs At or Above the Local Living Wage

Creation of permanent part- or full-time jobs as a result of your place-based investments. These jobs must pay a rate at or above the MIT Local Living Wage for a 2-Adult (Both Working) 1-Child Household for the job location.

I0.8a/b/c Workforce and Budget Allocation to Place-Based Investment

This indicator should only be reported if your institution has formally allocated staff time to specifically support implementation of anchor mission strategies related to place-based investing. (a) Total FTE at your health system that are responsible for initiating, completing, and monitoring place-based investments. (b) The total dollar amount allocated to management of place-based investment activities in your health system. (c) Upload of job descriptions for roles included in your FTE count in metric I0.8a.

Example: 1 Director of Impact Investing + 5% support from Legal +10% support from Community Health + 5% support from Real Estate = 1.2 FTE.

[12] https://www.huduser.gov/portal/datasets/il.html

I0.9, a-i Total Dollars Deployed for Currently Active Project/Investments

For each category, enter the total dollars deployed to place-based investments that support each given category as of the last day of the most recently completed fiscal year.

- Only include projects that are currently active. This means that your system is actively invested in the project and the 'work' of the project has not concluded. For example,
  - If your investment supported the ongoing maintenance of an affordable housing development where construction was completed two years ago, and that maintenance work is supported by your investment dollars in the most recently completed fiscal year, this counts as an active project.
  - if your investment supported only the construction of this project, and the construction completed two years ago, this is not an active project.
- While we encourage categorizing the entirety of one project to a single category, you may categorize each dollar. This means that within a project, you are able to split the dollars across different categories related to that project. For example, if you deployed $1M to an affordable housing development that also has a renewable energy component (solar panels), you do not have to dedicate the full $1M to either a single category, you can split a portion of it between the two relevant categories as you deem appropriate).

I#.#, Individual Project Details

For investment indicators I(#.#), enter information only about place-based investment projects that were initiated ("legally committed") at any point during the most recently completed fiscal year.

I#.1 Short Project Description

A 3-4 sentence description of the project. It's okay if the entirety of the description does not display in the cell.

I#.11a Project Start Date

The month and calendar year when dollars were initially committed and/or transferred to the project's managers, underwriters, or financial intermediaries. *Must have occurred in the most recently completed fiscal year.*

I#.11b Project Term

The time horizon of the loan. For example, "10 years".

I#.11c Interest Rate

The amount charged over and above the principal amount to the borrower. For example, "2.0%".

I#.12 Dollars Deployed to the Project During the Most Recently Completed Fiscal Year

The dollar amount of investment obligations to the project's management firm, its underwriters, financial intermediaries, or managers of the specific investment vehicle. Legally committed dollars that have not yet been transferred can also be reported here.

I#.2 Category Areas

For each category, indicate whether or not the specific project supports the activity in question. Unlike the categories for metric I0.9, these are yes/no, not dollar amounts. Select "yes" for as many choices as appropriate.

I#.3a Associated Grant Activity

Are grant dollars leveraged in conjunction with this project? (Y/N)

I#.3b Grant Dollar Amount

The total amount of grant dollars awarded **in conjunction with** the place-based investment.

Appendix A: Exclusions for Total and Addressable Spend

In calculating the percentage of their total spend annually that is diverse, health systems have often excluded different purchasing categories to create an "addressable spend" denominator. This variance makes it difficult to meaningfully benchmark between institutions. To address this problem, HAN has sought to create a shared definition regarding spend exclusions for the healthcare sector.

From 2018-2020, HAN provided an initial list of exclusions. With the launch of the HAN Impact Purchasing Commitment in 2021, the HAN team revisited the list of exclusions in partnership with members in order to further define the current exclusion areas and add new ones as appropriate, thereby bringing additional clarity and comparability to this metric across the healthcare sector, while keeping as much spend in the denominator as possible and accounting for reasonable exclusions:

- Spend that is not truly procurement (e.g., taxes, compensation);
- Spend that is highly regulated (e.g., blood and organ procurement);
- Spend with outsized impact (e.g., prime pharmaceutical distributor); and
- Spend that is resource intensive to track (e.g., building leases).

The exclusions outlined below were made as a result of group consensus and factored in the expertise of those who are active with other national initiatives (e.g., Billion Dollar Roundtable, federal requirements) and have mature supplier diversity programs to achieve as much alignment as possible, while still having the exclusions reflect unique aspects of the healthcare sector.

Category	Definition
All other taxes	A contribution to state or federal revenue, levied by the government.
Bad debt	Loans or outstanding balances owed to the health system that are no longer deemed recoverable and must be written off.
Blood, OPOs (Organ Procurement Organizations)	Blood and organs donated, recovered, preserved, and distributed. OPOs are federally designated to serve specific areas of the country via Donation Service Areas.
(Optional) Building leases	A legal contract used by landlords and tenants to formally agree on the rental terms of commercial buildings that are used for office, industrial, or retail purposes. *We acknowledge that some systems have a specific strategy in this category for diverse and/or local spend and may include it in the denominator. Overall the spend in this category is not significant enough to impact comparability.*
(Optional) Business employee expenses	Reimbursement of expenses incurred by health system employees, such as miles, meals, and the like.

ONLY USE WITH FY23 DATA COLLECTION

	We acknowledge that some systems have a specific strategy in this category for diverse and/or local spend and may include it in the denominator. Overall the spend in this category is not significant enough to impact comparability.
Claims costs	Costs incurred as a result of insurance processes and adjusting claims (e.g., court costs, fees). Vendors that provide processing or supportive functions to satisfy insurance claims may be included in data submission.
Depreciation and amortization	Two methods of calculating the value for business assets over time. Amortization is the practice of spreading an intangible asset's cost over that asset's useful life. Depreciation is the expensing of a fixed asset over its useful life.
Fringe benefits	Fringe benefits are perks that employers give to their employees above and beyond any financial compensation. Examples of common fringe benefits include life, disability, and health insurance, tuition and education assistance, as well as retirement benefits.
Hospital and tax assessment	This is a provider assessment in which hospitals are evaluated to determine the taxes which will be contributed towards the state's share of Medicaid. For instance, Health System A, based in New York, would undergo an assessment to determine how much would be collected by the state of New York to fund Medicaid services.
(Optional) Independent physician groups	A business entity organized and owned by a network of independent physician practices for the purpose of reducing overhead or pursuing business ventures such as contracts with employers, accountable care organizations (ACO) and/or managed care organizations (MCOs). *We acknowledge that some systems have a specific strategy in this category for diverse and/or local spend and may include it in the denominator. Overall the spend in this category is not significant enough to impact comparability.*
Interest payments	The monetary charge for borrowing money, typically expressed as an annual percentage rate (APR). Interest is the amount of money a lender or financial institution receives for lending out money.
Medical director fees	A type of professional fee, this category refers to the fees paid to be a director of a department.
Prime pharmaceutical distributor	These distributors purchase prescription medicines and other medical products directly from pharmaceutical manufacturers for storage in warehouses and distribution centers across the country. State and federally licensed pharmacies, hospitals and healthcare providers place orders with distributors for the medicines and products they need, and distributors process and deliver the orders daily.

Residents and board member compensation	Compensation provided to residents and board members of the health system.
Retail pharmacy	A retail pharmacy is one that is onsite and embedded within a health system, rather than separate.
Salaries and wages (including overtime and bonuses)	The regular payment by an employer to an employee for employment that is expressed either monthly or annually, but is paid most commonly on a monthly basis. A salaried employee is paid a fixed amount of money each month.
Spend with non-profits (including hospitals)	Spend with an organization that is designated as a nonprofit, and therefore has been given tax-exempt status (501(c)3) by the Internal Revenue Service (IRS). This includes spend with nonprofit hospitals.
Sponsorships	This includes funds directed towards community relations, scholarships, real estate taxes, and/or fundraising.
Utilities	Spend that is done with companies providing basic amenities, such as water, sewage services, electricity, dams, and natural gas.

Appendix B: Local Living Wage

Pursuing an anchor mission entails leveraging your anchor institution's economic assets to create resilient, equitable communities. Alongside patients and community residents, health systems' employees are a key population that HAN members can positively impact via its anchor strategies. Many HAN members have created special commitments to ensure the health and well-being of their employees, such as Rush University Medical Center, which defines their employees as their "first community".

As the Social Determinants of Health (SDoH) body of research shows, income and the overall economic situation of a family are key factors in determining health outcomes, and thus, remunerating employees with a living wage is indissociable from the anchor mission.

While wages are primarily driven by market factors (overall business cycles, recessions, talent supply/demand dynamics), considerable thought should be given to the lowest wage employees, who face barriers to productivity (increased sickness of self and family members and thus, increased absenteeism, for example) at higher rates than their higher-wage counterparts.

How are we defining a living wage?

HAN Staff, together with the Building the Evidence Base initiative group, have decided to use a living wage definition that:

- Eases the data collection burden on HAN members;
- Standardizes the living wage calculation across the Network to preserve the relevance of the indicator and member-to-Network comparisons and;

- Creates an indicator that both celebrates the current achievements and incentivizes members to continue to advance in their anchor mission journey.

Thus, HAN selected the MIT Living Wage Calculator. The MIT Living Wage calculator is a widely-used tool from a credible institution that provides hourly living wage values that take into account the cost of living and household composition (family size). It has wide geographic coverage (entire United States) at the metropolitan and county level.

The calculator estimates basic monthly expenses around the country, including "food, childcare, health insurance, housing, transportation, and other basic necessities." Also accounting for taxes, the calculator provides an hourly wage for a family to meet its "basic needs, while also maintaining self-sufficiency."

Is the MIT Living Wage calculator too broad in its definition of "basic needs"?

It is important to note that the MIT Living Wage Calculator is fairly conservative in its estimates, as it does not include money for entertainment, restaurant meals, vacations, and other leisure activities, and thus "is perhaps better defined as a minimum subsistence wage for persons living in the United States."

Why do we use the threshold at the county/MSA-level and for "2 Adults Both Working, 1 Child"?

Given that health systems have limited information on the household income and family size of its employees and that individually calculating the living wage for every employee would increase the data collection burden significantly, HAN staff and the Building the Evidence Base initiative group have determined that the following set of assumptions ease the data collection burden on health systems while still providing meaningful data for analysis and benchmarking:

- The living wage threshold to be used should be representative of the MSA or county level;
- The living wage threshold to be used should be representative of a household with two working adults and one child. This assumption is based on the fact that the average family size is 3.23 and 64.8% of all households are family households (where the householder does not live alone and is related to at least one other person living in the household)[13].

While these assumptions will not hold true for every employee in your healthcare system, it yields local living wage values that are both aspirational and reflective of current achievements in terms of the anchor mission. They also reflect the standard composition of U.S. households in a satisfactory manner and create a common, fairly accurate definition for the entire Network.

[13] Data source: United States Census Bureau 2019 American Community Survey 1-Year Estimates. Data accessed on Sep 27, 2021.

Appendix C: Impact Hires

Pursuing an anchor mission entails leveraging your institution's economic assets to create resilient, equitable communities. Alongside patients and community residents, health systems' employees are a key population that HAN members can positively impact via its anchor strategies. Many HAN members have created special commitments to ensure the health and well-being of their employees, such as Rush University Medical Center, which defines their employees as their "first community."

As the Social Determinants of Health (SDoH) body of research shows, income and overall economic well-being of a family are key factors in determining health outcomes, and, thus, providing quality jobs with comprehensive benefits, stable scheduling, and growth opportunities is indissociable from the anchor mission.

How are impact hires defined?

HAN staff, in consultation with partner organizations and the Building the Evidence Base initiative group, have decided to prioritize three aspects when defining impact hires: a) job quality, b) intentionality, and c) equity.

With these three aspects in mind, the definition of impact hires borrowed heavily from the work of the National Fund for Workforce Solution's CareerSTAT, Aspen Institute's Job Quality, and the leadership of current HAN members. Hires defined as Impact are part-time and full-time employees at your healthcare system that are not physicians, medical students, trainees, interns, per-diem employees and non-permanent/contracted positions and **must meet all of the following conditions**:

1) They were hired through an intentional pathway, program or partnership that is built with a community organization or education partner and which has a focus on place. Individuals must either:
   - Reside, at the time of hire, in targeted economically disadvantaged zip codes or more granular geographic areas (e.g., Area Deprivation Index zones, Census block or tract) that your organization serves
     OR:
   - Enter the institution through a partnership with a community-based, workforce or educational organization that has an explicitly stated focus on reaching communities within economically disadvantaged geographies that your organization serves.
2) They were hired on or after the first day of the fiscal year and were still employed as of the last day of the fiscal year.
3) The position in which the person was hired:
   - includes employer-paid/subsidized health insurance.
   - includes paid leave.
   - includes employer-funded retirement benefits (e.g., employer contributions to 401(k)).
   - pays at or above the MIT Local Living Wage threshold for a 2-Adult (Both Working), 1 Child Household in the employee's primary worksite.
   - provides a stable schedule and stable hours.
   - has either an established career pathway or earning growth opportunities.
   - requires less than a Bachelor's degree

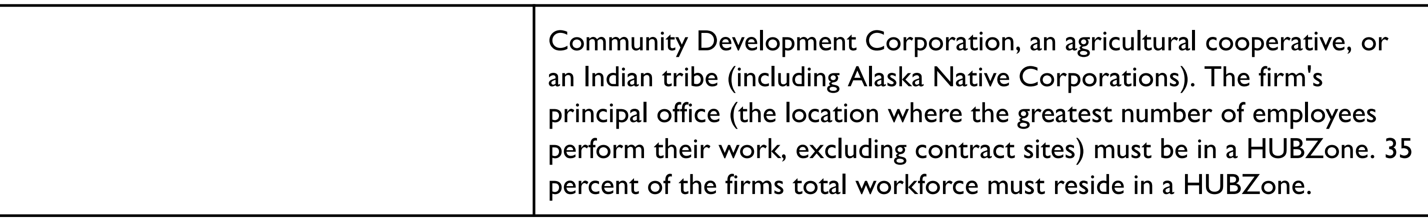
Other considerations related to Impact Hires:

- Your institution must have an ***intentional*** approach to hiring individuals from targeted zip codes/economically disadvantaged areas. Individuals hired that ***happen*** to reside in economically disadvantaged areas but were not hired through an intentional program would not count as impact hires.
- This indicator is not to be understood as a measure that applies to all of your workforce, but rather as an indicator that counts hires from intentional, established hiring programs.
- Your institution ought to report the number of individuals hired, even if both are hired for the same position. Impact Hires captures the number of persons in certain positions (explained above), not the count of positions or occupations.

Appendix D: Classifying Diverse Spend

A vendor or business is considered "Diverse" if the vendor is designated as minority-owned, woman(en)-owned, LGBTQ-owned, veteran-owned, a DBE business, or a HUB business per SBA's guidelines, outlined below:

Certification	Definition
Minority-Owned Business Enterprise (MBE)	Minority-Owned Business Enterprise is a designation for businesses that are at least 51 percent owned, operated and controlled by one or more people who are African-American, Hispanic, Asian American or Native American. MBE can be certified by local, state or federal agencies. National certification is also offered through the National Minority Supplier Development Council (NMSDC).
Women-Owned Business Enterprise (WBE)	Women's Business Enterprise is a national certification for women-owned businesses. The Women's Business Enterprise National Council (WBENC) oversees the certification that is widely accepted by corporate and nonprofit organizations as well as local, state and federal agencies.
Veteran-Owned Business Enterprise (VBE)	At least 51 percent of the business must be directly and unconditionally owned by one or more veteran(s) or service-disabled veteran(s). The veteran owner(s) must have full control over the day-to-day management, decision-making, and strategic policy of the business.
Small Business Enterprise (SBE)	Indicates whether a business concern is eligible for assistance from the SBA. Indicates whether the business is small, usually certified by a federal, state or local government agency or organization as having met all of the government standards that award eligibility.
Disadvantaged Business Enterprise (DBE)	Disadvantaged Business Enterprise-certified businesses meet government standard eligibilities as women, minority, disabled and other disadvantaged businesses as a result of economic disadvantages with respect to education, employment, residence or business location or social disadvantage and lack of business training. The business must be at least 51 percent owned by one or more people who are socially and economically disadvantaged. Certification requirements are met through a federal, state or local government agencies.
LGBT Business Enterprise (LGBTBE)	Indicates whether a business is at least 51 percent owned, operated, managed, and controlled by LGBT person(s) who are either U.S. citizens or lawful permanent residents. Exercises independence from any non-LGBT business enterprise.
Historically Under-Utilized Business Zones (HUBZone)	Historically Under-Utilized Business is a federal designation for a small business at least 51 percent owned and controlled by U.S. citizens, or a



	Community Development Corporation, an agricultural cooperative, or an Indian tribe (including Alaska Native Corporations). The firm's principal office (the location where the greatest number of employees perform their work, excluding contract sites) must be in a HUBZone. 35 percent of the firms total workforce must reside in a HUBZone.

Consistent with Federal Government reporting standards, a vendor should be classified in only ONE diverse category, regardless of whether that vendor meets multiple diverse criteria. In other words, don't double count this spend among the diverse categories (minority-, women-, veteran, and other-diverse). If a vendor is both minority-owned and of another ownership category, most HAN members have historically opted to report this vendor as "minority-owned". Your institution should decide how it will count spend in these and other instances in which a vendor represents multiple diverse categories. Vendor categories by ownership-structure and location (employee-owned, regional, or neighborhood vendors) are not exclusive. Dollars spent with these vendors may be entered in both their geographic ("local") metric as well as their diverse metric.

Self-Certified/("Self-identified") and Third-Party Certified

Reporting of spend with vendors that are certified diverse by a third-party is required for all Impact Purchasing Commitment signatories. Spend with businesses not certified as diverse by a third-party certifier cannot be reported as third-party certified nor counted towards the diverse spend goal of the Impact Purchasing Commitment. This includes vendors that have self-identified their ownership status.

Members that are not Impact Purchasing Commitment signatories may opt to submit either spend with vendors that are certified as diverse by a third-party, spend with vendors that self-certify as diverse, or both.

A vendor is third-party certified if it has obtained a certification from a third-party certifier. HAN does not prescribe which certifiers may be used. However, third-party certifiers must have a review process and not allow businesses to self-certify. For example, a SAM certification from the Small Business Administration is NOT considered an acceptable certification for IPC purposes, but the 8(a) program is acceptable.

Some examples of certifiers could include:

- National Minority Supplier Development Council (NMSDC)
- Small Business Administration
- Women's Business Enterprise National Council (WBENC)
- National Veteran Business Development Council (NVBDC)
- U.S. Department of Veteran Affairs
- or a state/local government agency.

Classifying Diverse Spend Example:

In the past year, I spent $1,000 with Vendor A, which is a minority-owned, women-owned, and employee-owned business.

Metric Title	Data Entry (Correct)	Data Entry (Incorrect)
Tier 1 Total Diverse Procurement Spend	$1,000	$1,000
Tier 1 Minority-Owned Procurement Spend	$1,000	$500
Tier 1 Women-Owned Procurement Spend		$500
Tier 1 Employee-Owned Procurement Spend	$1,000	$1,000

Classifying Tier 2 Diverse Spend Example:

Tier 2 Diverse spend should only be counted when the related Tier 1 Vendor is NOT a Diverse vendor.

Example 1: In the past year, I contracted with Vendor B (a Tier 1, non-Diverse vendor) to spend $1,000. Vendor B needs to spend $100 with Vendor C (a Minority-owned vendor) in order to fulfill the $1,000 contract.

Example 2: In the past year, I contracted with Vendor D (a Tier 1, Minority-Owned Business) to spend $1,000. Vendor D needs to spend $100 with Vendor E (also a Minority-owned vendor) in order to fulfill the $1,000 contract.

Metric Title	Example 1	Example 2
Tier 1 Total Diverse Procurement Spend		$1,000
Tier 1 Minority-Owned Procurement Spend		$1,000
Tier 1 Women-Owned Procurement Spend		
Tier 1 Employee-Owned Procurement Spend		
Tier 2 Total Diverse Procurement Spend	$100	
Tier 2 Minority-Owned Procurement Spend	$100	
Tier 2 Women-Owned Procurement Spend		
Tier 2 Employee-Owned Procurement Spend		

Appendix E: Local Spend

Pursuing an anchor mission entails leveraging your anchor institution's economic assets to create resilient, equitable communities. Health systems can creatively leverage their supply chains to address the upstream social, economic, and environmental conditions that have the greatest impact on the health of local residents. In doing so, they can create family-supporting local jobs and build community wealth, particularly in the most disadvantaged areas within their footprint.

Procuring goods and services locally has a multiplier effect that can increase local economic activity beyond that one purchase. Dollars spent on local businesses will recirculate in the community in the form of salaries paid to the business' employees, additional tax revenue collected and spent by the municipality, and additional spending or investment made by the local business itself as a result of your institution's contract. For a local business, a procurement contract from an anchor institution can be a significant source of income, and collectively, anchor institutions can contribute to stabilizing a local economy against the fluctuations of global markets.

As Social Determinants of Health (SDoH) research shows, income and the overall economic situation of a family are key factors in determining health outcomes. Thus, intentional local purchases of goods and services, in particular those that support historically marginalized groups and equitable conditions, are indissociable from the anchor mission.

What is the difference between regional and neighborhood?

Because the Healthcare Anchor Network is such a diverse group of health systems in terms of scale, our metrics need to be relevant for small and large health systems alike. With that in mind, the Building the Evidence Base initiative group created two indicators to measure the local procurement efforts of our members: regional spend and neighborhood spend. Members can choose to submit one or the other during the yearly data collection cycles.

Regional spend is defined as any spend (procurement or construction) with locally owned businesses within your institution's entire catchment area.

Catchment Area

The area serviced by your health system. Catchment area should be determined by your system's core business (the provision of healthcare), not by supply chain activities.

Neighborhood spend is defined as any spend (procurement or construction) with locally owned businesses within zip codes focused on by your anchor mission efforts. These zip codes must be considered economically disadvantaged by your institution. Several systems have chosen to align their economically disadvantaged zip codes with data resulting from their Community Health Needs Assessment.

What is 'local'?

We define local in terms of 'regional' and 'neighborhood'. In each case, to qualify as local, the business/vendor must meet all of the following criteria:

Regional

- Vendor's headquarters location must be located in your health system's catchment area.
- Vendor must have at least one business location in your system's catchment area.

- Vendor cannot be a publicly traded company. HAN provides a list of publicly traded companies and their Tax Identification Numbers (i.e., TIN or EIN) in the Data Collection Sheet.

Neighborhood

- Vendor's headquarters location must be located in your health system's catchment area.
- Vendor must have at least one business location in targeted economically disadvantaged zip codes as defined by your health system.
- Vendor cannot be a publicly traded company. HAN provides a list of publicly traded companies and their Tax Identification Numbers (i.e., TIN or EIN) in the Data Collection Sheet.

Below is a breakdown of neighborhood versus regional spend:

Local Spend Definition Components	Regional Procurement Spend	Neighborhood Procurement Spend
Headquarters Location	Headquarters must be located in your catchment area.	
Operating Location	At least one business location must be in your ***catchment area.***	At least one business location must be in an ***economically disadvantaged zip code or similar geographic concept (e.g., Area Deprivation Index)*** targeted by your system.
Publicly Traded Status	Business cannot be publicly traded.[14]	

Franchises, if owned and operated by local residents, are considered local businesses.

Why don't we count every business? Don't they all create jobs and help the local economy?

While traditional economic development approaches that focus on business attraction can bring jobs to a local community, the impact is often blunted by the amount of public subsidies provided per job created. Moreover, with such companies, wealth that would otherwise stay circulating within the local economy is extracted to enrich absentee owners and shareholders. In general, research shows that homegrown, local businesses, which are owned by local residents, tend to generate significantly higher economic benefits than publicly-traded companies or large corporations. Democratically owned businesses (such as cooperatives and ESOPs) have an additional wealth building aspect.

However, while the regional and neighborhood spend indicators are strictly limited to locally owned businesses, the Healthcare Anchor Network (HAN) will track quality job creation fostered by its members through contracting with large businesses as a separate indicator (a separate document will also be crafted to articulate such definition).

[14] HAN provides a list of publicly traded companies and their tax identification numbers in the Data Collection Sheet.

Below we have a compilation of studies that illustrate the distinctions between the economic impacts of regular and locally owned businesses:

Local Multipliers & Tax Base

It is true that a large business relocating to a community may increase local economic activity via its employment and operations, as the media hits and spotlights are keen to highlight. However, often such businesses receive large public subsidies and tax breaks as incentives to create jobs in a community. According to multiple studies from Good Jobs First, these incentives can reach as much as $400,000 per job or higher.12 Such subsidies can drain local revenues, weaken the tax base, and impoverish social services, offsetting gains from additional employment.[15]

Another commonly overlooked factor is that small, local businesses have a significantly greater local multiplier effect than large corporations. With some variation in the figures and context, several studies show that the dollars spent on a small, locally owned business recirculate back on the local economy at rates approximately **twice as high** as with national chains or large corporations.[16]

In addition, a study in Massachusetts showed that locally owned businesses generate more public revenue than they cost to service, while the opposite is true for big-box retailers, shopping centers, or fast-food restaurants[17], not to mention that large, community-hopping corporations often require significant amounts of tax incentives from local governments.

Stabilizing Economic Activity

Compared to their large-scale counterparts, small businesses have a greater counter-cyclical effect on the economy, by creating and retaining more jobs during economic downturns. A study published in the American Economic Review shows that large companies are quicker to shed jobs during a recession or times of high unemployment while taking

---

[15] "How Corporate Welfare Hurts You - The American Prospect." Accessed June 25, 2020. https://prospect.org/economy/corporate-welfare-hurts/.
[16] "Indie Impact Study Series: A National Comparative Survey with American Booksellers Association" Summer 2012. Accessed June 25, 2020.
http://nebula.wsimg.com/09d4a3747498c7e97b42657484cae80d?AccessKeyId=8E410A17553441C49302&disposition=0&alloworigin=1.
"Independent BC: Small Business and the British Columbia Economy." February 2013. Accessed June 25, 2020.
https://ccednet-rcdec.ca/sites/ccednet-rcdec.ca/files/ccednet/pdfs/independant_bc_small_and_the_british_colombia_economy.pdf.
Amar Patel and Garret Martin. "Going Local: Quantifying the Economic Impacts of Buying from Locally Owned Businesses in Portland, Maine." Maine Center for Economic Policy. December 2011. Accessed June 25, 2020.
https://www.mecep.org/wp-content/uploads/2011/12/MECEP_Report_-_Buying_Local-12-5-2011.pdf.
"Thinking Outside the Box: A Report on Independent Merchants and the New Orleans Economy." The Urban Conservancy and Civic Economics. September 2009. Accessed June 25, 2020.
http://www.independentwestand.org/wp-content/uploads/ThinkingOutsidetheBox_1.pdf.

[17] Richard K Gsottschneider. "Understanding the Tax Base Consequences of Local Economic Development Programs." Fall 1998. Accessed June 25, 2020.
https://ccednet-rcdec.ca/sites/ccednet-rcdec.ca/files/ccednet/pdfs/understanding_the_tax_base_consequences_of_local_economic_development_programs.pdf.

ONLY USE WITH FY23 DATA COLLECTION

longer to return to their previous employment figures.[18] Similarly, worker owned businesses (such as cooperatives and ESOPs) are far less likely than their private counterparts to experience layoffs and job losses.[19]

Additionally, other studies suggest that local economic growth is more robust in areas that have a higher prevalence of locally owned businesses, compared to areas with a prevalence of nonlocal ownership.[20] One such study published in Economic Development Quarterly suggests that this is true for rural and urban areas alike.[21]

Thus, supporting locally owned and democratically owned businesses enables anchor institutions to foster resilient communities that are more likely to withstand the downswings of the national economy that are beyond their control.

Jobs & Employment

While it is true that large firms tend to pay higher salaries to their employees than small businesses, much of the gap is explained by the difference between the best-paid employees of both categories, whereas the low- and medium-skilled workers of both small and large companies, typically earn salaries at comparable levels.[22]

Furthermore, one must consider the community-wide effects on employment and wages that large corporations might unintentionally have. Several studies point to companies like Walmart having a negative effect on overall community retail wages, benefits, and employment.[23]

A study by UC Berkeley Center for Labor Research and Education suggests that every new Walmart in a county can reduce "aggregate earnings of retail workers by around 1.5%"[24]

Individual Wealth Building

Contracting with locally owned vendors has the additional benefit of contributing to individual wealth building, as the profits of a locally owned business are accrued directly by community residents (who are often the patients of the local health systems), as opposed to publicly-traded or large corporations with absentee owners, which extract the profits from the community to distant locations.

---

[18] Moscarini, Giuseppe, and Fabien Postel-Vinay. 2012. "The Contribution of Large and Small Employers to Job Creation in Times of High and Low Unemployment." American Economic Review 102 (6): 2509–39. https://doi.org/10.1257/aer.102.6.2509.
[19] "The Impact of Employee Ownership and ESOPs on Layoffs and the Costs of Unemployment to the Federal Government | NCEO." Accessed June 25, 2020.
https://www.nceo.org/observations-employee-ownership/c/impact-employee-ownership-esops-layoffs-costs-unemployment-federal-government.
[20] Rupasingha, Anil. n.d. "Locally Owned: Do Local Business Ownership and Size Matter for Local Economic Well-Being?," no. 01: 38.
[21] Fleming, David A., and Stephan J. Goetz. "Does Local Firm Ownership Matter?" Economic Development Quarterly 25, no. 3 (August 2011): 277–81. doi:10.1177/0891242411407312.
[22] Mueller, Holger M., Paige Ouimet, and Elena Simintzi. 2015. "Wage Inequality and Firm Growth." SSRN Scholarly Paper ID 2540321. Rochester, NY: Social Science Research Network. https://doi.org/10.2139/ssrn.2540321.
[23] Basker, Emek. n.d. "JOB CREATION OR DESTRUCTION? LABOR MARKET EFFECTS OF WAL-MART EXPANSION." THE REVIEW OF ECONOMICS AND STATISTICS, 11.
[24] Dube, Arindrajit, T William Lester, and Barry Eidlin. 2007. "A DOWNWARD PUSH: THE IMPACT OF WAL-MART STORES ON RETAIL WAGES AND BENEFITS," 10.
http://laborcenter.berkeley.edu/pdf/2007/walmart_downward_push07.pdf

Other Anchor Strategies Principles

Prioritizing locally owned businesses is also in line with other anchor strategies, such as place-based investing and inclusive, local hiring. In all three strategies, local has the capacity to move beyond the geographic dimension and embeds important equity considerations that make these strategies powerful tools for positively impacting the upstream determinants of health, particularly for the populations that need it the most.

The table below breaks down the geographic and equity dimensions of place-based investment, local employees, and local & regional spend:

Principle	Geography	Equity
Impact Hire	At the time of hire, employee resides in an economically disadvantaged zip code and…	…the position meets several job quality criteria.
Place-based Investment	Investment project is located within the health system's catchment area and…	…investment project has a triple bottom line (financial, environmental, and social)
Neighborhood Spend	Vendor is located in an economically disadvantaged zip code and…	…vendor is local.
Regional Spend	Vendor is located in the health system's catchment area and…	…vendor is local.