

Best Practices for Community Health Needs Assessment and Implementation Strategy Development:

A Review of Scientific Methods, Current Practices, and Future Potential

Report of Proceedings from a Public Forum and Interviews of Experts

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Report of Proceedings from a Public Forum and Interviews of Experts

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ACKNO	OWLEDGEMENTS	
EXECUTIVE SUMMARYiiii		
I. IN	ITRODUCTION1	
A.	Project Purpose1	
В.	Impetus/ Rationale	
C.	History/Background	
D.	Project Design	
1	Expert Panel Meeting	
2	Key Informant Interviews	
3	University of Kansas Compendium	
4	Report of Proceedings10	
E.	Putting it All Together: A Logic Model	
F.	Definitions	
II. C	OMMUNITY HEALTH NEEDS ASSESSMENT	
Α.	Shared Ownership of Community Health	
В.	Defining Community – Jurisdictional Issues	
C.	Data Collection and Analysis	
D.	Community Engagement	
E.	Priority Setting	
III.	IMPLEMENTATION STRATEGY DEVELOPMENT AND EXECUTION	
Α.	Alignment Opportunities	
В.	Monitoring and Evaluation 70	
C.	Institutional Oversight	
D.	Shared Accountability and Regional Governance	
E.	Strategic Investment and Funding Patterns	
F.	Public Reporting: Federal, State, and Local Issues	
IV. CONCLUSION / NEXT STEPS		
APPEN	DIX A BIOGRAPHIES	
APPENDIX B. FINAL AGENDAxi		

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An important theme in the project is the opportunity for collaboration between hospitals and local public health agencies in conducting community health needs assessments and the development of community health improvement strategies. With this in mind, an opening plenary presentation was given by John Bluford, MBA, FACHE, Chief Executive Officer of Truman Medical Centers in Kansas City, MO. Mr. Bluford was also the Chair of the Board of Trustees of the American Hospital Association (AHA). Leaders from health systems and hospitals such as Aurora Health Care, Baylor Health Care System, Catholic Healthcare West, Duke University Medical Center, Kaiser Permanente, Trinity Health, and UMASS Memorial Health Care also participated on expert panels. Important input in the planning of the meeting was also provided by Janelle Gillings from the Association of State and Territorial Health Officers (ASTHO) and Julia Joh Elliger and Barbara Laymon from the National Association of County and Community Health Officers (NACCHO). NACCHO also sponsored a national webinar that provided an opportunity for over 300 public health leaders to address topics covered in the expert panel meeting.

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EXECUTIVE SUMMARY

This project is sponsored by the Centers for Disease Control and Prevention (CDC), and the purpose is to provide insights into the science, methods, and current practices in the community health improvement process. The proceedings summarized in this report are drawn from a two and a half day expert panel meeting held at the Emory Conference Center in Atlanta, Georgia on July 11-13, as well as a series of key informant interviews conducted prior to the expert panel meeting.

The impetus for the meeting was a request from the IRS to the Department of Health and Human Services/CDC for technical guidance to inform the development of regulations pertaining to changes to the Internal Revenue Code with the passage of the Affordable Care Act in 2010. These changes impose new requirements on each charitable hospital beginning in the tax year two years after the passage of the ACA to conduct a community health needs assessments (CHNA) and adopt an implementation strategy which addresses the identified needs. Particular interest was expressed in the identification of best practices in the field, and an examination of challenges and opportunities associated with their implementation.

In addition to the IRS and Treasury, intended audiences for the project and associated products include other federal, state, and local government agencies, the public health community, hospitals, community-based organizations, consumer and community advocacy groups, academicians and researchers, the business community, and policymakers.

In the course of the key informant interviews and the expert panel meeting, representatives from all stakeholder communities examined the current status of scientific methods and their practical application at different stages of the community health improvement process. The meeting was divided into two sections: Community Health Needs Assessment, and Implementation Strategy Development and Execution. Specific sessions included:

Community Health Needs Assessment

- Shared ownership for community health
- Defining community jurisdictional issues
- Data collection and analysis
- Community engagement

Implementation Strategy Development and Execution

- Priority setting (two sessions)
- Alignment opportunities
- Monitoring and evaluation
- Institutional oversight
- Shared accountability and regional governance
- Strategic investment and funding patterns
- Public reporting (two sessions)

Expert panelists and key informants were asked to address a specific set of questions in each topic area, and approximately 30 minutes was reserved in each session for public comments and questions.

The key informant interviews were transcribed and excerpts were selected for inclusion in this report. In the selection of excerpts for inclusion, priority was given to key leaders in the field who were unable to participate in the meeting and/or to capture important points not addressed by panelists or meeting participants. The expert panel meeting was webcast and transcribed to ensure accuracy in the documentation of the proceedings. The webcast and transcribed proceedings are available at http://www.cdc.gov/policy/opth/chna/index.html.

Brief summaries of expert panel sessions are provided below, with more complete summaries and quotes from the presentations, public comments, and key informant interview excerpts in the body of the report.

Community Health Needs Assessment

Shared Ownership for Community Health

The first expert panel session examined the concept of shared ownership for health among diverse stakeholders and how it may be operationalized. Panelists and participants noted that the health of the public is the responsibility of everyone, not just our local public health agencies. Both in this session and throughout the meeting, panelists and participants emphasized the imperative for hospitals to build population health capacity in the coming years. An emerging practice was cited where stakeholders from diverse sectors establish a common agenda, shared metrics, a structured process and a jointly funded infrastructure. One panelist provided practical examples of a health system's commitment to shared ownership for a broad spectrum of health issues in their local community. Participants cited challenges to be addressed in the pursuit of shared ownership, ranging from the time and effort needed to build trust to the lack of institutional capacity and competing priorities.

Defining Community – Jurisdictional Issues

This panel examined key factors in defining community, unique issues to be considered in different kinds of settings (e.g., rural, urban), and how expectations may vary for different kinds of stakeholders. Panelists and participants cited the alignment between the new requirements for hospitals and new accreditation standards for local public health agencies as an opportunity to leverage limited resources, and encouraged the consideration of multi-jurisdictional partnerships. They cited the unique challenges faced by rural hospitals and public health agencies, and the importance of engaging other key providers such as community health centers in the CHNA and implementation strategy development process. Panelists and participants encouraged a global approach to assessments in both urban and rural areas; one that takes into consideration the geographic distribution of facilities and concentrations of unmet health needs.

Data Collection and Analysis

Panelists and participants in this session examined the sources and potential uses of different types of data, and challenges and opportunities in the analysis and sharing with diverse stakeholders. Panelists discussed the importance of the use of U.S. Census data to identify concentrations of unmet needs at the sub-county level, and the use of hospital utilization data and GIS technology to show the geographic distribution and strong correlation between poverty-related metrics and high rates of preventable ED and inpatient utilization. Panelists and participants emphasized the importance of the collection and analysis of social determinants to ensure attention to the causes of persistent health problems. They also identified a variety of data sources, and the importance of engaging community stakeholders in the data collection process. Key informants emphasized the importance of data and new technologies to increase transparency and common understanding of the determinants of health, and to provide the evidence needed to more effectively address health disparities.

Community Engagement

In this session, panelists and participants examined what constitutes meaningful community engagement and the potential roles of diverse community stakeholders at all stages of the community health improvement process. Panelists shared exemplary practices, and emphasized the importance of engaging community stakeholders not simply as sources of input for CHNAs, but as equal partners with shared accountability and investment in addressing health concerns. During public comment, participants cited challenges in terms of a lack of infrastructure and expertise for ongoing engagement, overcoming negative perceptions and a lack of trust, and questions about a commitment to the coordination of efforts across institutions in the wake of CHNAs. Key informants gave particular emphasis to in depth and ongoing community member engagement as an essential part of a sustainable health improvement process.

Implementation Strategy Development and Execution

Priority Setting

There were two sessions addressing the priority setting process, reflecting its importance, its inherent complexities, and the fact that it is often a poorly implemented step in the community health improvement process. Panelists and participants discussed the purpose of priority setting, criteria and processes, how evidence may be used to guide decision making, who should be involved and why, and discussed challenges and opportunities associated with the selection of comprehensive approaches to community health improvement. The first panel examined the latest scientific methods in priority setting, addressing both the contributions and the limitations of different approaches. They also acknowledged a bias in scientific inquiry to towards interventions that are easier to study, which contributes to a reluctance to invest in more complex, comprehensive interventions in the community context.

The second panel focused on practical issues and challenges in priority setting processes, and discussed the implications for collaboration with diverse stakeholders. Panelists emphasized the importance of broad engagement, suggesting a shift from an institutional or agency-based model of priority setting, to one that puts the community at the center. On a similar level, they

encouraged institutions to resist the temptation to limit partnerships to organizational representatives, acknowledging the importance of insights and mobilization of community members. Panelists, participants, and key informants suggested that the engagement of diverse stakeholders in priority setting will lead towards more comprehensive and sustainable approaches to health improvement that address both the symptoms and underlying causes of persistent health problems.

Alignment Opportunities

The seventh panel examined opportunities for hospitals engaged in community health improvement for alignment with priorities in the implementation of national health reform. In addition, panelists discussed the unique characteristics and potential contributions of teaching hospitals and their academic affiliates. Both panelists and participants observed that there is significant alignment and an imperative to build population health capacity in order to both reduce health care costs and address significant health disparities in local communities. The panelists also lauded the expansion of reporting requirements, but pointed to a number of areas where adjustments may be needed to yield optimal results. Panelists, participants, and key informants cited an array of difficult challenges for different types of hospitals in the coming transformation in the delivery and financing of health care and in the broader community health improvement arena.

Monitoring and Evaluation

This panel discussed the relative strengths and weaknesses in current monitoring and evaluation of community health improvement activities, considered audiences and the implications for the selection of metrics, the potential roles of community members, and innovative ways to monitor progress in addressing health disparities. Panelists shared best practices, new tools and technologies, and discussed the relatively underdeveloped status of monitoring and evaluation in the community benefit arena. While noting that there is increasing innovation in the field, panelists lamented that the relative lack of diffusion, as well as the tendency for many institutions to take a proprietary approach to monitoring and evaluation.

Institutional Oversight

The ninth panel examined the issue of institutional oversight, focusing primarily on what internal mechanisms are needed for optimal engagement of hospitals and local public health agencies in community health improvement. Panelists noted that governance and oversight of tax-exempt hospitals has become more important in recent years and outlined key principles and areas of focus. Panelists also described best practices in both urban and rural settings that involve extra-institutional oversight, as well as ways in which governance may appropriately involve the coordination of investments by multiple hospitals within regional health systems. Panelists and participants discussed the emergence of regional priorities in areas such as health workforce development in the context of health reform, and the implications for reporting requirements that focus on responsiveness to local needs.

Shared Accountability and Regional Governance

This panel examined the potential benefits of regional partnerships between hospitals, local public health agencies and other stakeholders, considered existing mechanisms for local and regional accountability, and discussed and array of issues and challenges. Panelists also shared current examples of regional partnerships and tools and resources to guide and support different levels and forms of shared governance. While acknowledging an array of challenges and obstacles to shared accountability and regional governance, panelists and participants stressed the importance of identifying and building on positive examples. As with other issues discussed during the meeting, participants encouraged a more systematic documentation and diffusion of innovations to encourage the advancement of practices.

Strategic Investment and Funding Patterns

This session focused on the potential roles of public and private sector funders in facilitating a more strategic approach to community health improvement, and considered options for public policy development that support and sustain comprehensive approaches. One panelist examined the historical role of the United Way as a national entity that serves as a local funder and partner in CHNAs and community health improvement initiatives, including an increasing emphasis on building community capacity to engage in public policy development. Panelists, participants, and key informants discussed emerging innovations in public and private sector philanthropy, and identified specific mechanisms that will foster mutual accountability for results.

Public Reporting

The final two expert panel sessions focused on the role of public reporting at the local, state, and national level in the advancement of community health improvement practices. Panelists and participants discussed issues for hospitals and local public health agencies in meeting reporting requirements. A common theme was how to move from an emphasis on compliance with minimum standards to meaningful actions that transform institutions and produce measurable health improvement in communities. Panelists and participants also examined the role of local officials, advocacy groups, and the general public in fostering shared accountability for health with hospitals, local public health agencies, and diverse stakeholders.

An important opportunity identified and discussed among panelists and participants is the alignment between the new reporting requirements for hospitals and the release of national accreditation standards for local public health agencies. On a parallel level, participants encouraged the identification of alignment opportunities between public reporting on community benefit and the broader national health reform process. A significant focus of the panel presentation and public comment period in the second session focused on practical issues in local hospital interpretation and implementation of new federal reporting requirements. Participants emphasized the value of increased transparency associated with public reporting and the availability of new technologies (e.g., GIS data mapping) as creating the conditions for increasing focus on local accountability.

Throughout the two and a half day meeting and in prior interviews, panelists, participants, and key informants identified areas of concern in the language in the IRS 990 Schedule H, section 501(r) of the Internal Revenue Code, and Notice 2011-52. The stated concerns and associated dialogue are captured in the body of this report, and a set of recommendations based upon this input has been submitted to Treasury and the IRS as a separate document.

I. INTRODUCTION

A. Project Purpose

This project is sponsored by the Centers for Disease Control and Prevention (CDC), which is located within the federal Department of Health and Human Services (HHS). The purpose of the project is to provide insights into the science, methods, and current practices in the community health improvement process.

The primary audience is the CDC, which is providing input to the Internal Revenue Service to inform the development of reporting guidelines and oversight mechanisms for nonprofit hospital engagement in community health improvement activities. Other government agencies at the federal, state, and local level are also important audiences. At the federal level, agencies such as CMS and HRSA have an interest in hospital engagement of stakeholders such as community health centers in efforts to reduce health care costs through increased investment in prevention activities. State government agencies with oversight responsibilities for hospital community benefit practices are also key audiences.

The hospital community is also a key audience, as well as an important contributor to the project. Many health systems have provided important leadership in the advancement of practices, and the input provided by hospital representatives and other key stakeholders in the meeting is intended to inform and accelerate innovation in the field.

Another key audience is the public health community. In July 2011, the national Public Health Accreditation Board (PHAB) released accreditation standards and measures for local public health agencies that are closely aligned with the new report requirements for nonprofit hospitals. Key elements in the accreditation standards are community health assessments and the development of community health improvement plans. Other key audiences include community and consumer advocates, researchers, and philanthropy, all who have a stake in the practice and advancement of community health improvement.

As the federal agency with the primary responsibility for public health in the United States, CDC is in the unique position to draw upon the expertise of academicians, researchers, and practitioners across the country. In the process, the intent is to address key questions raised by the IRS and provide insights based upon the expertise and experience of leaders in the field. In the process, the central goal is to inform the development of guidelines for reporting that minimize administrative burden, preserve the flexibility needed to foster innovation, and contribute to the advancement of practices in the field.

B. Impetus/Rationale

The passage of the Patient Protection and Affordable Care Act (PPACA), Pub. L., No. 111-148, 124 Stat. 119 on March 23, 2010 established four new federal requirements for tax-exempt hospitals under section 501(r) of the Internal Revenue Code. They include:

- Conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to meet needs identified in the assessment.
- Adopt a written financial assistance policy that includes eligibility criteria, methods used to calculate charges, applications for assistance, and actions associated with billing and collections.
- Limit charges for services to levels equivalent to amounts generally billed for insured patients.
- Make reasonable efforts to determine an individual's eligibility for financial assistance prior to extraordinary measures to secure payment.

Section 6033(b)(15)(A), also amended by the PPACA, requires a hospital organization to report on its Form 990 a description of how the organization is addressing the needs identified in each CHNA and a description of any needs that are not being addressed together with the reasons why the needs are not being addressed. To satisfy this requirement, Treasury and IRS intend to require a hospital organization to attach the most recently adopted implementation strategy for each of its hospital facilities to its annual Form 990.

Hospital organizations must also include 990-Schedule H when submitting Form 990 and their implementation strategies. The IRS released the first draft of a redesigned 990 Schedule H for public comment on June 14, 2007. The impetus for the review and redesign of the 990-Schedule H was an observation by the Acting IRS Commissioner Kevin Brown¹ that the form had not undergone a review and revision for over 25 years, and a judgment that revisions were needed to better reflect the structures and functions of hospitals in the 21st century. This judgment was reinforced by extensive dialogue in the public and policy arena (see section I.C) regarding the charitable activities of tax-exempt hospitals. The Senate Finance Committee in particular had convened a series of hearings, calling upon IRS staff and other key stakeholders to provide testimony to address public expectations and associated public reporting requirements for these organizations.

The IRS received over 600 comments on the first draft of the revised 990 Schedule H, a second draft was released on April 7, 2008, and further revisions have been made in 2009, 2010, with the most recent version released on February 23, 2011.

¹ IRS-2007-117, June 14, 2007

The revised 990, Schedule H and section 501(r) represent a significant expansion in the scope of reporting for tax-exempt hospitals. Areas where IRS requests more detail include:

- Listing of community benefit services/activities by category (Part I)
- Listing of community building activities² by subcategory (Part II)
- Bad debt, Medicare, and collection practices (Part III)
- Management companies and joint ventures (Part IV)
- Facility information (Part V including information on CHNA process)
- Charity care and discounted care eligibility criteria and calculation methods

In addition, Part VI, Supplemental Information asks for additional information on a number of processes, including, but not limited to the following:

- Description of CHNA process
- Description of community(ies) served by the organization
- Description of how the reported community building activities promote the health of the communities served by the organization
- Patient education of eligibility for financial assistance

In the course of the IRS review of input from stakeholders, it was concluded that there were a number of issues associated with the CHNA and implementation strategy development processes where greater clarity and guidance for the field was needed. With this in mind, IRS issued a formal request to HHS/CDC to provide technical guidance. CDC was selected consistent with its mission to "create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability." As such, CDC identified elements and issues along the continuum of a model community health improvement process, with particular focus on the CHNA and implementation strategy development. The analysis did not include an examination of charity care, bad debt, Medicare and Medicaid reimbursement, billing and collections, or other issues associated with hospital financial accounting.

The timing of the request from the IRS was optimal for CDC, as it had been engaged in a review of community benefit issues and was exploring opportunities for involvement and alignment with other initiatives such as the Community Transformation Grant Program. Increased investment by tax-exempt hospitals in community health improvement activities is also aligned with the major goals of national health reform: to improve health and reduce health care costs through more cost effective and strategic allocation of resources. In this context, CDC has a

² Require reporting, but currently prohibit inclusion in financial totals

³ CDC Mission Statement – "Collaborating to create the expertise, information, and tools that people and

critically important role to play in facilitating the rapid dissemination of practices and strategies that will help to achieve these important goals.

The development of guidelines and related resources and tools for "best practices" is intended to support community health planning and implementation activities by diverse stakeholders, including state and local health departments conducting community health assessments and developing community health improvement plans to meet national public health accreditation standards. They may also assist a charitable hospital organization to conduct a CHNA and adopt an implementation strategy. Currently, there is considerable variation in CHNA and related processes, and many available tools lack standards to support their use in fulfilling various regulatory and accreditation requirements.

An important first step is to establish a common understanding of what constitutes a "best practice" in the community health improvement arena. Is a practice deemed the *best* because it is generally viewed as better than others in the field, or because it meets a set of objective measures of excellence? If there are objective measures, in what ways do they accommodate different and distinct circumstances? The institutions, stakeholders, and environments in which they interact in the community health improvement process vary significantly, and any framework for classification and ranking of practices must seek to accommodate this diversity.

With these challenges in mind, a core purpose of the project is to closely examine the current status of scientific methods and their practical application at all stages of the community health improvement process. Through this initial inquiry and dialogue, the field will be in a better position to understand, articulate, and evaluate what constitutes a best practice.

C. History/Background

In 1969, the IRS issued Ruling 69-545, which expanded the concept of charity from an exclusive focus on the poor (IRS Ruling 56-185 in 1956) to the community benefit standard, where "the promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community... provided that the class is not so small that its relief is not of benefit to the community."

The expanded definition begins to move in the direction of a population health orientation, in that it moves beyond care to individuals to consider "a class of beneficiaries," and perhaps more importantly, that it suggests an emphasis on achievement of a measurable impact. That is, the "class of beneficiaries," i.e., the numerator, must be sufficiently large relative to the total population of the community; i.e., the denominator, to produce an aggregate impact. While it is unclear whether it was the intent of the IRS, it began to advance the idea that nonprofit hospitals have a more substantive role in addressing the health needs of community than simply providing acute medical care services.

States began to take a more active role by the mid-late 80s, starting with a legal challenge to the tax-exemption of Intermountain Health Care by the Utah State Tax Commission in 1985. The legal case served as a driver for the development of a state statute in 1990; a second statute was passed in New York State the same year. There are currently community benefit statutes in 17 states. Most require some form of a CHNA; three of the states (PN, TX, UT) have established minimum financial annual commitments. In Massachusetts, the Office of the Attorney General oversees implementation of Voluntary Guidelines for community benefit programming by hospitals and health maintenance organizations. State agencies with oversight responsibilities vary, as does their approach. In Massachusetts, the Office of the Attorney General posts annual community benefit plans of hospitals and managed care plans on a searchable website, providing opportunities for diverse stakeholders to quickly access program information within targeted geographic areas. In most cases, state agency oversight is limited, and has been scaled back in the context of recent budgetary challenges. Emerging evidence suggests that hospitals may be responding to the lack of oversight by giving less attention to quality and completeness in the reporting process.

Hospital trade associations have played an important role in the development and dissemination of information, guidelines, and strategies to enhance community benefit practices. The Catholic Health Association of the United States (CHAUSA) provided early guidance with the release of the Social Accountability Budget in 1989, a set of guidelines and instructions for documentation of charitable practices. These guidelines served as the core framework for the development of the revised 990, Schedule H. Since their 1989 release, CHAUSA has continued to develop and disseminate a wide array of publications to encourage the enhancement of community benefit programming including the conduct of CHNAs, and has hosted numerous educational meetings. Leadership and educational support has also been provided by other trade associations such as VHA, Inc. (formerly Voluntary Hospital Association), the Health Research and Educational Trust (HRET) of the American Hospital Association, and more recently by the Association for Community Health Improvement (ACHI), also based at the American Hospital Association, and the Alliance for Advancing Nonprofit Health Care.

The primary form of charitable contributions by hospitals is the provision of free and/or discounted medical services to uninsured and underinsured populations. While there are a growing number of excellent programs in communities across the country, the program portfolio of many nonprofit hospitals includes a large number of small programs spread over a wide geographic area, most insufficient in scale, targeting, or design elements necessary to produce measurable outcomes.

In recent years, there has been an increasing professionalism in the community benefit function. There is growing recognition that dedicated staffing is needed to develop and manage a portfolio of charitable programs and activities that are guided by a clear and consistent set of standards. There is also increased awareness that an oversight structure is needed to guide and support the management function, and perhaps more importantly, to ensure that the actions of the institution are aligned with its core charitable mission.

Adoption of these practices by a growing number of nonprofit hospitals reflects an understanding that as tax-exempt institutions, they have a responsibility to be good stewards of public resources, and to ensure that there is institution-wide engagement in the fulfillment of their charitable mission. This understanding, however, is not universal among hospitals across the country. There is a need for education, engagement, and increased accountability. A combination of increased public scrutiny, regulatory engagement, and emerging opportunities are providing the impetus for meaningful and broadly implemented reform.

D. Project Design

The project includes five components, each of which are described in this section, including 1) a national expert panel meeting, 2) a series of approximately 50 key informant interviews with key leaders from across the country, 3) the development of this report of proceedings to document the input from the meeting and interviews, and 4) the development of a compendium of tools and resources to support key elements in the community health improvement process.

1. Expert Panel Meeting

CDC hosted a two and a half day expert panel meeting on July 11-13 to examine key process elements in the community health improvement process, with particular focus on issues in community health needs assessments (CHNAs) and implementation strategy/plan development.

There were 13 expert panels of 2-3 presenters, with each panel addressing a specific element in the community health improvement cycle. In putting together each panel of 2-3 people, attention was given to individuals with scientific knowledge in the area and to practitioners in the field who could share specific experiences. Moreover, given a commitment to ensure broad engagement of relevant stakeholders, effort was made to secure the participation of hospital leaders, community and consumer advocates, public health practitioners, and other key community stakeholders.

Panelists were given 10-15 minutes each to cover the requested content (10 minutes each for three panelists, 15 minutes each for two panelists). Panel presentations were followed by 10-15 minutes of questions from the moderator. Approximately 30 minutes was allocated for public comment in each expert panel session. In order to maximize the opportunity for public comment, the moderator solicited 2-3 public comments at a time, encouraging participants to limit themselves to one minute per comment or question. These were summarized by the moderator for responses by panelists as a group.

The purpose of the meeting was to identify issues, challenges, and opportunities, and illuminate lessons from experience in the field. Participants were informed of the request from the IRS, the purpose of the meeting, the breadth of audiences, and encouraged to put all relevant issues on the table. Meeting organizers emphasized the meeting as an early step in an ongoing process, not simply to provide insights and information to the IRS, but to facilitate the advancement of practices in the field.

The meeting was opened by Paul Stange, CDC's lead on the project, and by Chesley Richards, MD, the Director of the Office of Prevention through Healthcare in the Office of the Associate Director for Policy. Opening comments were also provided by Chris Giosa from the IRS. Mr. Giosa described the role of CDC as a technical advisor to the IRS in the development of

guidance for hospitals in the 990 Schedule H reporting process, and outlined a major goal of increased transparency, not only for the IRS, but in the broader implementation of the PPACA.

The opening keynote address was provided by John Bluford, MBA, FACHE, Chief Executive Officer of Truman Medical Centers in Kansas City, MO, and immediate past Chair of the Board of Trustees of the American Hospital Association (AHA). Mr. Bluford emphasized the necessity for hospitals to "think outside the bed," reading language from the AHA Mission and Vision statement of their commitment to support "hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement." He shared a variety of examples of charitable activities supported by Truman Medical Centers that focus on the underlying causes of persistent health problems in low income communities, as well as care management strategies to reduce preventable emergency room and inpatient utilization. At the same time, he cautioned against approaches to federal regulation and reporting that do not accommodate the diversity of hospitals and the communities they serve.

Mr. Bluford was followed by an opening presentation by Stephen Fawcett, PhD from the University of Kansas, who led a team of colleagues to develop a compendium of best practices. Dr. Fawcett provided a brief overview of current practices in the field and the approach taken in the collection of information and data for the development of the compendium. A brief overview of the compendium is provided in D3 below.

Day two of the expert panel meeting was opened by Dr. Judy Monroe, Deputy Director of the CDC, and Director of the Office for State, Tribal, Local, and Territorial Support. Dr. Monroe shared her experiences in health care and as the State Health Commissioner in Indiana, with a key lesson being that health problems in the community context require intersectoral collaboration. She exhorted participants as representatives of their colleagues in the field to "seize the moment" and outline practical strategies that will guide the field.

The content shared in the expert panels, public comments, and key informant interviews is covered in the remainder of this report.

2. Key Informant Interviews

A series of 50 key informant interviews were conducted prior to the meeting with leaders in the field, with attention to the breadth of content expertise and experience to be covered in the expert panels. Most of the interviewees served as expert panelists at the meeting, and thus the one hour interview⁴ provided a focused opportunity to examine the issues in greater depth. Interviews with others provided an opportunity to secure input from key leaders who were unavailable to participate in the meeting.

Interviews focused on a limited set of questions associated with each element in the community health improvement cycle. Questions were selected for each interview based upon

⁴ Expert panel presentations were limited to 10-15 minutes.

the specific areas of expertise and experience of each key informant interviewee. Questions posed to key informant interviewees and expert panelists for each element are listed in sections III and IV of this report. A list of key informant interviewees and expert panelists with brief bios is included as Appendix A.

3. University of Kansas Compendium

CDC engaged a research team from the University of Kansas (KU) led by Stephen Fawcett⁵, with Christina Holt and Jerry Schultz to conduct a review of 12 practices areas in the community health improvement cycle where guidance is needed to enhance implementation in the field. The following 12 practice areas were drawn from the Community Health Improvement logic model (Figure 1) developed by CDC:

- 1. Shared ownership for health among stakeholders
- 2. Community involvement
- 3. Assessments that span jurisdictions
- 4. Small area analysis
- 5. Data on social determinants
- 6. Identify community assets
- 7. Explicit criteria to set priorities
- 8. Shared investment in implementation
- 9. Monitoring and evaluation
- 10. Collaboration across sectors
- 11. Oversight
- 12. Public reporting

For each practice area, the KU team provided: a) key steps and recommendations for implementation, b) a full example reported by a practitioner with experience in the field, and c) other supports (e.g., adaptation of this practice based on resources and context, questions for reflection, and sources). The guidance is intended to support effective implementation, not to prescribe a one-size-fits-all approach. These practices need to be adapted for context, situation, and available resources. However, without clear specification of core tasks and recommended implementation, there is inadequate support and no basis for accountability.

The guidance draws from emerging evidence and expert consensus of what it takes to implement community health improvement efforts, drawing from prominent models, using ecumenical language. The intent is to provide a high-level view of best practices in a manner that helps to fill gaps in practical knowledge, and outline key steps in implementation that harmonize approaches recommended in existing tools and resources. Examples of prominent resources and tools highlighted in the review include the Catholic Health Association (2011),

⁵ Dr. Fawcett's team is a World Health Organization Collaborating Centre, and part of the KU Work Group for Community Health and Development. They are also the founders of the Community Toolbox, an extensive online resource for community health improvement established in 1994.

the National Association of County and City Health Officials (NACCHO) MAPP Framework (2001), and the Association for Community Health Improvement (ACHI) Community Health Assessment Toolkit (2002), as well as other approaches used by government agencies, United Way, and other stakeholders.

The review points to significant gaps in practice, as well as substantial variation in emphasis and approach among different tools and resources. The 12 practices were addressed in detail in the expert panel meeting, as components or the central focus of each session.

4. Report of Proceedings

The report of proceedings is to provide a distillation of the content covered in the 13 expert panel presentations and public comments at the July 11-13 conference, and the key informant interviews conducted prior to the conference. The report serves as input for consideration by CDC staff and leadership in the development of technical guidance to the Internal Revenue Service. It is also intended to serve as a resource for diverse stakeholders in the field including, but not limited to, hospital community benefit staff and hospital/health system leadership, local and state public health agencies, community-based organizations and advocates, philanthropy, and public and elected officials at the local, state, and federal level.

E. Putting it All Together: A Logic Model

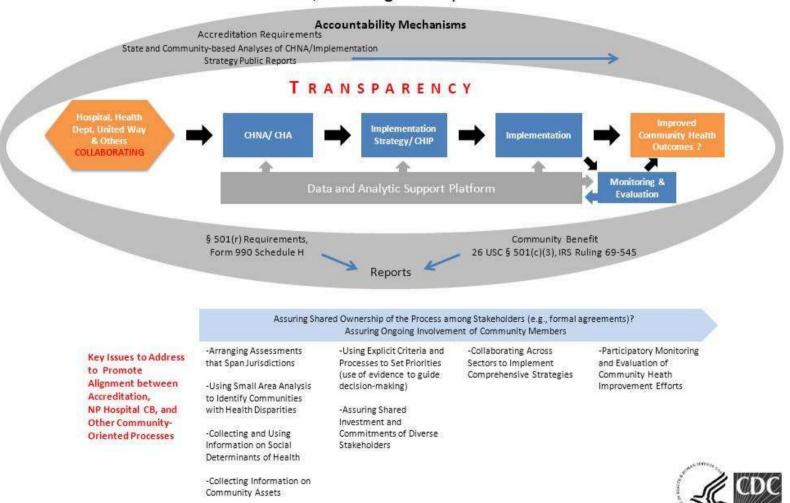
In April 2011, CDC developed a framework for the review to be conducted by the KU team in the development of the Compendium, and to inform the development of the format and key questions to be addressed in the expert panel meeting.

The Community Health Improvement logic model (Figure 1) serves as a graphic representation of that framework. The logic model highlights the alignment between the processes and expectations of tax-exempt hospitals, public health agencies, and other community-based organizations. The intent is to provide guidance and encouragement to hospitals, community organizations and the public health community to take optimal advantage of this alignment, particularly in the context of current resource constraints.

Figure 1. Community Health Improvement Logic Model

Community Health Improvement:

A Framework to Promote Best Practices in Assessment, Planning and Implementation



II. COMMUNITY HEALTH NEEDS ASSESSMENT

Section 501(r) of the Internal Revenue Code requires a tax-exempt hospital to conduct a "community health needs assessment." A "community health assessment" is a prerequisite of public health accreditation under PHAB standards. Other organizations reference a "community needs assessment" for their objectives. Use of particular terminology notwithstanding, the general intent of all such assessments is to secure data and information on a broad spectrum of issues that provide an aggregate profile of the health status and quality of life among residents of our communities. CHNAs are conducted by public and private sector institutions across the country on an individual basis or in partnership with others. At best, a CHNA should serve as a baseline to monitor improvements associated with actions taken to address one or more indices of health.

Local public health agencies have traditionally conducted periodic community health assessments as one of their core functions. Data and information are often aggregated at the county level, but there is increasing recognition of the need to supplement county level data with the collection of data at smaller units of analysis (e.g., zip code, census tract) in order to identify where there may be high prevalence or acuity for particular health conditions. At the same time, a steady downward trend in state and federal funding for these agencies has required a scaled back, and in many cases, abandonment of the assessment process. In recent years, the establishment of a national Public Health Accreditation Board has led to the development of a set of accreditation standards for local public health agencies. One of the prerequisites in the application for accreditation status among local public health agencies is the completion of a community health assessment that meets a set of specific standards.

Under section 330 of the Public Health Service Act (as amended by the Health Centers Consolidated Act of 1996 and the Safety Net Amendments of 2002), community health centers (CHCs) are also required to conduct a community health assessment in order to be eligible for formal designation and federal funding. Key criteria in CHC assessments are numbers and types of health professionals who are available and willing to serve populations within specified geographic areas. The resulting ratios yield designation as Medically Underserved Areas (MUAs) or Health Professions Shortage Areas (HPSAs).

Among nonprofit organizations, local United Ways also conduct periodic CHNAs to help direct funding and resources towards the highest identified priority needs.

As indicated previously, PPACA now requires tax-exempt hospitals to conduct CHNAs every three years. The CNHA is intended to inform the development of an implementation strategy to address identified unmet health-related needs. A number of our larger states (e.g., CA, NY, PN, TX) have had state statutes in place for a decade or more requiring tax-exempt hospitals to

⁶ With funding from the Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention

conduct CHNAs. As such, there is considerable experience in the field to inform the promulgation of this requirement at the national level.

The following six sections summarize content from the expert panel meeting and key informant interviews that address key elements in the CHNA process.

A. Shared Ownership of Community Health

A key overarching concern in the community health improvement process is the degree to which there is shared ownership for health among hospitals, public health agencies, and other stakeholders in local communities. Key questions addressed by the expert panel, key informants, and public participants included:

- What is shared ownership, and how is it operationalized?
- How do we accommodate the needs and priorities of diverse stakeholders?
- What are creative approaches to partnership that address shared priorities?

Building shared ownership for health among diverse stakeholders in local communities offers the benefit of mobilization and leveraging of resources to achieve measurable improvement in health status and quality of life. The process may be arduous and complicated for a variety of reasons, regardless of whether the context is rural, suburban, or urban. Key issues, challenges, opportunities, and lessons from experience in the field shared by expert panelists, meeting participants, and key informants are summarized in the next section.

1. Expert Panel Comments

Paul K. Halverson, DrPH, MHSA – Director/State Health Officer, Arkansas Dept. of Health Dr. Halverson opened the first expert panel session by noting that his professional career started with a decade in hospital administration prior to engagement in public health practice, including a period with the CDC. He observed that while the hospital and public health communities have operated on a parallel basis for most of his career, he "knew there would be a time when these two worlds would collide."

He encouraged hospital leaders to move beyond a compliance orientation and view the new IRS reporting requirements as an opportunity to build population health capacity. He also challenged the notion that public health practice is owned by the local public health agency:

"The reality is the public health system doesn't belong to the health department. It never has. The hospital has and continues to play a very active role in the development of what we call public health because public health, after all, is that collection of organizations and individuals who have a stake in the health of the community."

He encouraged participants to re-conceptualize community benefit in a manner that takes us beyond short term treatment of "charity patients," and suggested replacing the term "public health" with "community health system" to more accurately reflect shared responsibility.

Dr. Halverson also discussed a recent article in the Stanford Innovation Review⁷ that questions the historical approach to addressing social problems where public and private sector funders support innovations by individual organizations, with the assumption that at some point in the future we will replicate and take those innovations to scale. The article points to recent efforts in local educational reform where nonprofits, government, business, and communities establish a common agenda, shared metrics, and a structured process with a dedicated staff and infrastructure in a framework of shared ownership. Halverson suggests that a "collective impact" approach to the CHNA is needed; one that brings together local public health agencies, hospitals, and diverse community stakeholders in an ongoing commitment to achieve shared results.

Halverson referred to an opening statement by John Bluford challenging hospitals to "think outside the bed," presenting a similar challenge to local public health agencies:

"We need to think beyond our shrinking budgets. We need to think beyond where we control and where we provide grants. We need to think ways in which we can capitalize and gain the support of a larger group of individuals and organizations who can move beyond our capability and find ways in which to find that common agenda."

A key step identified by Halverson is the integration of this agenda into the strategy plan of both hospitals and local public health agencies. He expressed bafflement that so many organizational leaders have professed these activities as important, yet they are not reflected in their strategic plan. He suggested this step is one of the most important practical first steps in building a platform of shared ownership.

Mónica Escobar Lowell – Vice President, Community Relations, UMass Memorial Health Care Ms. Lowell described her regional health system in Central Massachusetts under the leadership of CEO John O'Brien, and provided practical examples of their demonstrated commitment to shared ownership for health in their communities. Such commitment is communicated regularly by their CEO, their board of trustees, and a community benefit board committee. She noted that shared ownership for community health is also reflected in their mission statement:

"Make sure that your mission reflects a holistic approach. We have adopted a mission that incorporates socio-economic factors, so we're not just thinking about access to health care."

Ms. Lowell described her organization's approach to community benefit not simply as a moral imperative, but an opportunity to invest in their community. One form of investment has been UMMHC's decision to cover the salary for the local Commissioner of Health when reduction of public funds threatened to eliminate the position, as well as support of public health department nursing programs. The UMMHC CEO and other members of the senior leadership team have worked closely with the city manager of Worcester and other key local leaders on a comprehensive strategy for health improvement and community revitalization.

⁷ Kania, J., and Kramer, M., "Collective Impact," **Stanford Social Innovation Review**, Winter 2011, pp. 36-41

Ms. Lowell also described UMMHC's ongoing support for a youth coalition, providing mentoring support and leadership development. Youth that may typically be viewed as "at-risk" are trained on public health issues, and supported in a process of planning, mobilization, and action to address priority health concerns. The coalition identified advertising of tobacco products in public places in general and in pharmacies in particular as a target of organizing and increasing public awareness. After an extensive campaign that involved presentations at city council meetings and other public events, the city passed an ordinance prohibiting both public advertising and sales in pharmacies. Ms. Lowell noted that the tobacco companies have responded by suing the city, but it has only strengthened the determination of the diverse community partners in the initiative.

Ms. Lowell also shared a major community investment in the Bell Hill neighborhood, a low income community near their flagship medical center. She described a comprehensive approach that includes providing targeted health care services in public housing, developing community gardens, working on violence prevention, housing renovation, and supporting purchasing of housing among low income residents. Supporting renovation and home ownership is viewed as an important part of a comprehensive health improvement strategy:

"We contributed funding and we were able to leverage an opportunity to increase first time home ownerships in this neighborhood. By helping low income people become home owners, you are going to have people invested in their neighborhood and people are going to be safer."

2. Public Comment

Howard Fishbein, Batelle Memorial Institute

Dr. Fishbein summarized the burden of existing obligations for local health departments, and a need for clear guidelines in the implementation of reforms, as well as outside independent evaluation of their progress. "...otherwise, it's going to be business as usual. It will be another folder on their desk that they will get to when they get to it."

Joan Quinlan, Massachusetts General Hospital

Ms. Quinlan pointed to the challenge for large institutions in the engagement of "disempowered" communities. She noted that it takes time to build trust and relationship before you can consider the development of formal agreements such as a Memoranda of Agreement.

Panel response

Ms. Lowell addressed the need for senior leadership, including the CEO to be engaged directly at the community level, to go into neighborhoods and listen to what people have to say. Once that trust has been established, it needs to be reinforced by coming to a collective agreement of what will be done together.

Dr. Halverson emphasized a need to think through how to create a connection between evidence-based solutions and the coalitions who have an interest and who have a stake in the problem, and then establish agreed upon measures of progress.

Vondie Woodbury, Trinity Health System

Ms. Woodbury pointed to language as one of the most significant barriers to engagement of community members, citing the overuse of acronyms and failure to speak in candid terms about the meaning of health.

"...we come from a discipline that requires us to use terms that people don't understand, they don't get, and as a result then they drop out of processes, or they sit there silently."

Ron Bialek, Public Health Foundation

Mr. Bialek posited that "...none of us individually really know how to make a difference within our communities," and emphasized a need for not only shared accountability and shared ownership, but also shared learning.

Nancy Clifton-Hawkins, consultant

Ms. Clifton-Hawkins pointed to a disinclination among some hospitals to share accountability for programs, and the need to create "stages of change" that facilitate movement towards shared accountability that will in turn produce sustained health improvement.

Panel response

Dr. Halverson cited a statewide effort in Arkansas entitled the Home Town Health Initiative, which involves the establishment of one or more local coalitions in each of their 75 counties. One of the issues that have emerged in the process is a lack of literacy in general, but health literacy in particular. As such, there is a need for thoughtful use of language that will help to bridge those gaps and facilitate meaningful engagement.

Dr. Halverson also noted that open engagement and sharing may be difficult for some hospitals:

"I think it is not a given that hospitals want to come together and share accountability. It's not necessarily one of the things that comes natural. They are competing for patients. They are competing for physicians. They are competing for scarce resources. And then we ask them to come together and share. It's not something that they do naturally."

3. Key Informant Interviews

A number of key informants referenced community initiatives underway that have brought together stakeholders with a shared ownership for a broad interpretation of health. For example, Eric Baumgartner, Vice President of the Louisiana Public Health Institute cited an intersectoral initiative in New Orleans:

"We're encouraging neighborhoods to make social compacts with any entity that resides in their neighborhood. The basic tenet is that we as a community will have continuous access to

metrics on how we're doing as a population. We'll know about not only the biological measures, but social equity, income, housing, educational attainment, other measures, and the signatories or participants in the Vital New Orleans Initiative agree, sign on as signatories and say that together we all have responsibility for how those measures will improve."

Dr. Baumgartner noted that all stakeholder partners operate within their mission and means, but work in good faith to provide substantive support at every stage of assessment, planning, implementation, and monitoring. He noted that contributions are not limited to cash, but include infrastructure support, adjustments in services, sharing of staff, and advocacy. The goal, as he outlined it, is to achieve sufficient alignment of priorities and resources to produce and build upon those outcomes. Dr. Baumgartner noted that a number of city leaders in Louisiana have recognized the need for an infrastructure that will support ongoing collaboration:

"We discovered that the mayor of Baton Rouge -- I think that he was encouraged by the League of Cities -- established a new 501(c)(3) that held the Baton Rouge Mayor's Healthy City Initiative, whose whole purpose is the visioning of cross-sector alignment for Healthy Baton Rouge going forward."

Some key informants pointed to a need for capacity building in local public health agencies in areas that support CHNAs, inter-sectoral collaboration, and policy development. **Jonathan Fielding, Public Health Director and Health Officer for Los Angeles County** called for increased investment in epidemiological capacity to support assessments, the development of a shared vision, common measures, and a strategy to monitor progress, but also suggested a need for attention to policy implications:

"I also think there is a need for somebody with background in policy analysis to examine the things that can be done at the local level through ordinances, through city councils and counties to provide the right incentives."

B. Defining Community – Jurisdictional Issues

One of the first major decisions in the community health improvement cycle is defining the community that will be the focus of the CHNA. If community is defined by geographic parameters, what is the unit of analysis? Local public health agencies may start at the county or city level⁸, depending upon their jurisdictional responsibilities. Community hospitals may focus on their primary service area, targeting populations most frequently served by their organizations. Specialty health care institutions such as children's hospitals may define community in terms of their population of focus, with service areas that may encompass multicounty, and in some parts of the country, multi-state regions. Optimally in all situations, data/information is collected at smaller units of analysis (e.g., zip code, census tract, neighborhood) to identify where there is higher prevalence or acuity of health problems.

Given the fact that there are multiple organizations within any geographic area with overlapping responsibilities that conduct CHNAs, in the context of limited resources there is a growing imperative for collaboration. This is particularly the case for smaller organizations such as Critical Access Hospitals (CAHs). In general, different organizations with a stake in community health are accountable for varying services and often rely on targeted funding streams with specific requirements for processes and outcomes. As such, it is important to identify cross-sections of interests and align assessment processes in a manner that contributes to shared efforts to address health concerns in local communities.

Urban and rural areas present both common and distinct challenges and opportunities that generally benefit from collaboration among stakeholders. Issues in rural areas include, but are not limited to a) geographic separation, b) high burdens for a limited number of providers, c) paucity of resources, d) health care provider experience across sectors, e) limited payer mix and ability to cross-subsidize care for medically indigent populations, and f) limited data capacity. Issues in urban areas include, but are not limited to a) high competition among provider organizations (and often adversarial relationships), b) duplication of services, c) inequitable sharing of indigent care burden, d) competition for commercially insured patients, e) overlapping primary service areas, f) concentrated impact of social determinants of health, and g) acute health disparities.

Notice 2011-52 by the IRS outlines their preliminary thinking on key factors to consider in defining community:

"...Treasury and the IRS intend to provide that a hospital organization may take into account all of the relevant facts and circumstances in defining the community a hospital facility serves. Generally, Treasury and the IRS expect that a hospital facility's community will be defined by geographic location (e.g., a particular city, county, or metropolitan region). However, in some cases, the definition of a hospital facility's community may also take into account target populations served (e.g., children, women, or the aged) and/or the hospital facility's principal functions (e.g., focus on a particular specialty area or targeted disease). Notwithstanding the

18

⁸Most local public health agencies in the New England region of the U.S. operate at the level of townships.

foregoing, a community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs."

Treasury and the IRS have requested comments regarding the relative merits of different geographically-based definitions of community, including whether other geographic parameters such as Metropolitan Statistical Area (MSA) or Micropolitan Statistical Area (μ SA) should be used. We questions addressed by the expert panel, key informants, and public participants included:

- How do we define community, and what are the determining factors?
- What are unique issues to be considered in rural communities? In urban metropolitan areas?
- What are issues and options in the apportionment of responsibilities to address health concerns?
- How might expectations vary for different kinds of stakeholders, and why?

1. Expert Panel Comments

Karen Minyard, PhD, Executive Director, Georgia Health Policy Center

Dr. Minyard focused primarily on jurisdictional issues in urban areas, using the Atlanta metropolitan area as a practical example. Over five million people reside in the Atlanta metropolitan area, with multiple counties. She cited two collaborative planning processes underway. One is led by the Atlanta Regional Commission, encompassing a 10 county area and engaged in a "fifty forward" effort to set goals and objectives for the next 50 years. The effort includes subgroups addressing issues ranging from industry and transportation to health. A number of regional health systems were engaged in the health group, and concluded that it made sense to collaborate on a single assessment at the regional level.

Another group is the Philanthropic Collaborative, which has been engaged in planning efforts over the past 12 years. This group is exploring how many counties should be combined to coordinate efforts to strengthen the health and social safety net. The current promulgation of accreditation standards for local health departments creates yet another layer of factors to consider, in addition to ongoing efforts by groups such as the United Way. In summary, there are complex issues to resolve, with potential for substantial duplication of effort:

"...as we began to talk about this and the community benefit assessments for each hospital in each system, the public health's responsibility as it relates to accreditation becoming more involved in community assessments than they already have been, the Philanthropic Collaborative being interested in some type of assessment and partnership with others, the United Way, maybe this could be fifty to a hundred assessments."

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⁹ IRS Notice 2011-52, page 14

¹⁰ Ibid.

Dr. Minyard cited a recommendation by Paul Stange of the CDC for CHNA processes in urban metropolitan areas to put together an overarching picture of what is needed, identify common priorities, then determine what may be opportunities for investment in individual communities.

"What's the county opportunity? What's the public health opportunity? What's the hospital community benefit opportunity? What's the philanthropic opportunity? And how might we leverage all these different investments to move toward the health priorities that we seek?"

Dr. Minyard emphasized the opportunity to achieve the "collective impact" referenced by Paul Halverson, which requires bringing key stakeholders together in a framework of shared responsibility and take advantage of the opportunity to leverage individual investments.

Rebecca Slifkin, PhD, MHA – Director, Office of Planning, Analysis, and Evaluation, HRSA Dr. Slifkin focused primarily on issues in defining community in rural settings, with particular attention to rural hospitals. She noted that small rural hospitals are already engaged in assessments, with a focus on gaps in the availability of different medical care services. She acknowledged that from a hospital's perspective, it would be a natural tendency to define community based upon the location of their patient population.

Dr. Slifkin posited that defining community at the county level (as would be the case for a county health department) would not be a choice they would make independently, unless that hospital received funding from the county. Hospitals are more likely to draw lines at the zip code level, going with those that are the source of 75-90% of their patients, framing it as their market area. The problem, she acknowledged, is the degree to which this framing may leave out patients (or potential patients).

Dr. Slifkin called for an approach where defining the community ensures that all populations are captured, acknowledging that there are a variety of factors that influence how different types of hospitals may view their target populations, citing, for example, a large 600-bed tertiary care medical center who may serve an entire state.

Dr. Slifkin summarized ways in which community is typically defined, including counties, zip codes, and cities or townships. One of the advantages of counties, or aggregations of counties, is that they also serve as geopolitical boundaries and legal jurisdictions, with the exception of areas of the country such as New England and Alaska. As such, they also tend to be relatively stable and unchanging over time. At the same time, Dr. Slifkin noted that they don't necessarily reflect peoples' care seeking patterns. Another issue to be addressed is the substantial difference in size; many states in the southeastern U.S. have very small counties, in contrast to the western U.S., where counties are often quite large.

Dr. Slifkin then addressed the use of zip codes in defining community, noting that they tend to change frequently, and that they cross both city and county boundaries. At the same time, they are useful in defining patient populations based upon their mailing address. She noted further that this is the framework used by the Health Resources and Services Administration (HRSA) for

community health centers. As stated previously, however, if used by hospitals, this may result in leaving out zip codes where there is an insufficient volume of patients. Dr. Slifkin suggested that a more accurate reflection of population needs for health services may result if a hospital were to focus on emergency room visits:

"...you might get a more fair distribution of patients if you take ER visits than if you take inpatient visits. Because hospitals may be targeting their inpatient services to a certain population but they have less control over who comes into their ER."

Turning to small rural hospitals, Dr. Slifkin cited a HRSA program entitled the Medicare Rural Hospital Flexibility Program that provides grant funding to the over 1300 Critical Access Hospitals across the country. She cited a tendency among these facilities to have a strong sense of community membership and responsibility, driven in part by the fact that hospital leadership and staff are also integral members of the community. She noted that they also tend to operate with very tight financial margins; they receive cost-based reimbursement under Medicare, but do not receive disproportionate care payments to cover care for uninsured populations. These practical realities make it very difficult to create special programs to improve health in the community. She noted that they often do, however, driven by the commitment of individual staff and leadership.

Dr. Slifkin closed by citing other HRSA funded programs where assessments are shaped by the nature and focus of the program. For example, the nature of the Ryan White HIV/Aids Program calls for a community needs assessment that will cover a large geographic area, since it is targeted to a specific disease, with a specific set of providers in defined locations.

José E. Camacho, JD – Exec. Dir. / General Counsel, TX Assoc. of Community Health Centers Mr. Camacho opened his presentation by asking about the purpose of the new requirement for hospitals to conduct CHNAs:

"[Is this] a process to help align investments that are being made by diverse organizations or is this a compliance matter? To the extent that we view it as the latter, we're missing a wonderful opportunity here to coordinate resources."

He noted that given its inclusion in the PPACA, it is likely that someone questioned whether investments were being aligned in a manner that effectively benefitted communities.

Mr. Camacho referenced a national committee formed in the past year in which he serves as a member to examine and re-define Medically Underserved Areas (MUAs) and Health Professional Shortages Areas (HPSAs), designations used by community health centers and other entities to target services and inform health workforce planning. He encouraged coordination with this process as a wonderful opportunity to better serve our communities.

In the examination and definition of health in communities, Mr. Camacho noted that community health centers use a broad definition that addresses both health and social service needs. He emphasized that attention to the social determinants of health is of central

importance, citing limited employment options being tied to a lack of insurance coverage, support services needed for single parent households, and the impact of lack of high school education and limited English proficiency on health behaviors.

Mr. Camacho also raised the issue of population density in consideration of the distribution of health care resources, and the degree to which we will follow through on a commitment to address unmet needs in rural areas:

"On Friday, we talked about a community health center that was being closed down because it was only serving three, four hundred patients, and now the patients are going to have to travel an hour-and-a-half, and part of the reason it was closed down was because of the cost per the unit of care. Well, I submit that those three hundred patients thought it was very affordable."

2. Public Comment

Bradford Gray, PhD - Senior Fellow, Urban Institute; Editor, The Milbank Quarterly

Dr. Gray expressed a lament that there had been insufficient solicitation of input in drafting the CHNA provisions in the PPACA, particularly to the degree that there is a suggestion that hospitals should address all identified unmet needs. He noted that this "is a very powerful incentive for hospitals to define their community as narrowly as possible because the bigger it gets, the more complicated it gets."

Citing a related issue, Dr. Gray noted that many multi-hospital systems are highly integrated, and routinely cross-subsidize within a region. In this context, requiring each to separately define their community when the larger organization operates as a single entity may not be a rational and economically feasible approach.

Panel response

Dr. Slifkin called for a more global assessment of need in larger metropolitan areas (as referenced by Dr. Minyard), and then an agreed upon allocation of responsibility that ensures equitable sharing of responsibility. She noted further that this is less of an issue in rural areas where often individual hospitals are sole providers.

Mr. Camacho suggested that states are in a position to contribute to the process, both in terms of collecting data and in helping to establish a framework for equitable sharing of responsibilities.

Moderator Follow up

Dr. Barnett reinforced the comment by Dr. Gray that the current draft IRS language suggests an expectation that a hospital will address all of the unmet needs identified, and cited input from practitioners in the field that they plan to address this issue by narrowing the content scope of their assessment.

Dan Merrigan, Boston University

Dr. Merrigan called for attention in the CHNA process to the conditions and characteristics in neighborhoods that substantially impact the health and health behaviors of people who live there.

Melissa Biel, consultant

Dr. Biel cited a practical challenge that secondary data is often not available at the level and format needed to inform assessment processes, and the need to engage public health to build capacity.

Panel response

Dr. Slifkin noted that secondary data is often out of date, and in some cases, may not be asking the questions that we want to have answered. She encouraged creative approaches to answering core questions without relying on sources such as national surveys.

Paul Epstein, consultant

Dr. Epstein encouraged the IRS in the development of requirements to emphasize a principle-based, rather than a rules-based approach that will accommodate different circumstances. One principle he suggested was for community needs to be defined collectively, rather than by one organization.

Panel response

Dr. Minyard supported the principle-based approach, and suggested that another principle may be the degree to which existing potential investments are being leveraged, including community, philanthropy, and government. She also supported attention to the manifestation of problems at the neighborhood level, and suggested that shared investment in large scale assessments create the potential for the drill down needed to examine issues at the neighborhood level.

Len Syme, University of California at Berkeley

Dr. Syme noted that if a hospital is located in a wealthy community it would be in their self-interest to define its community as narrowly as possible. He noted further that this issue raises a larger problem in that the perpetuation of major inequalities acts as a toxic force for everyone. In this sense, application of a narrow interpretation by more affluent institutions misses the fundamental intent of "community" health improvement.

Julia Joh Elliger, NACCHO

Ms. Elliger pointed to the need to build relationships as the basis for establishing shared agendas, and there is likely a reason why this hasn't occurred yet in many communities. In this context, one has to think about how the community is defined will shape the conversation that is likely to occur. It is also important to recognize that investing the time that is needed to build

substantive relationships is pitted against the predilection to go for compliance and/or accreditation as a quick fix.

Jessica Curtis, Community Catalyst

Ms. Curtis raised a concern that as health systems assert more decision making control, they may set priorities that may not be supported by local community stakeholders.

Panel response

Dr. Slifkin pointed to situations where CAHs are purchased by a larger hospital or system, which may not have the same connection with community stakeholders, and that this presents a challenge that must be acknowledged and addressed.

Mr. Camacho cautioned against an assumption that common ground cannot be established between hospital systems, local facilities, and diverse community stakeholders. He agreed that substantive relationships take time, but suggested that this provides the opportunity to build common cause.

3. Key Informant Interviews

Key informants with experience in leading collaborative CHNAs emphasized the importance of access to quality data that enable the analysis of issues at the sub-county level. **Kristin Garrett is the CEO of the San Diego Community Health Improvement Partnership (CHIP)**, which has led collaborative CHNAs since the passage of California's community benefit legislation in 1994. She pointed to an array of accomplishments by CHIP in the last 15 years, but noted that they are still grappling with how to move from the assessment as a snapshot in time to a framework for ongoing monitoring of progress. She also pointed to language in the new IRS reporting requirements that are causing some to reconsider their participation in a collaborative process:

"We want to stop doing the every three year thing; we want it to be an ongoing practice. I think we're grappling with how to move forward, because we don't know if the hospitals are going to continue to work with us, given the new reporting requirements."

Others such as **Eric Baumgartner, Vice President of the Louisiana Public Health Institute** expressed concern that most hospitals in their region appear to view the new requirements as an annoyance to dispense with, rather than an opportunity to improve practices. He expressed sympathy, however, for concerns about having to allocate substantial resources for CHNAs:

"I think every one of them should be asked <u>not</u> to commit more of their resources than is absolutely reasonable to ask, nor should they be asked to do something that's beyond their mission and scope, but I think they should be working together, openly, committed to work as a sector, with other sector leaders."

Key informants from the public health community suggested that county boundaries are useful parameters, in that they are legal jurisdictions and are relatively stable over time. **Anthony Iton, Senior Vice President of The California Endowment** noted that such parameters are less

awkward than using service-based catchment areas that may change rapidly, lack population denominators, and may not include areas with concentrations of unmet health needs. He also suggested that we may gain insights from thinking about the meaning of the term 'community benefit:'

"When you talk about community benefit, you're not talking about clinical benefit or market share. You're talking about *community* benefit. So again I think it's really important to align these institutions with other core institutions that serve the whole community..."

Other informants addressed the potential drawbacks of county designation in rural settings where regional medical centers may serve multiple counties. **Jeff Spade, Vice President of the North Carolina Hospital Association** cited such a case:

"They are the number one healthcare provider in the next county over. And for them to totally discount that they have an impact on the health of the county next to them simply because they weren't located there is, to me, is missing the point. They have a huge impact on the health of that community."

In large metropolitan areas, Mr. Spade agreed with the need to identify where there are concentrations of unmet needs, and that when there are multiple facilities, there is a need to examine how they will work together to avoid the neglect of particular areas:

"Community should be defined in the broad sense -- the region that they're providing services in. If they carve out that I'm only here or I'm only there then I wouldn't find that acceptable. But on the other hand if they said there are underserved areas they are targeting with their investments within the broader region; that to me would be a great way to do this."

A number of key informants pointed to the disproportionate safety net burdens carried by some hospitals based upon their geographic location, and the need for data and dialogue to more equitably share responsibilities. Romana Hasnain Wynia, Professor, Northwestern University Feinberg School of Medicine expressed concern that some safety net hospitals may be faced with challenges meeting quality metrics due to infrastructure challenges ranging from nursing-patient ratios to the implementation of electronic medical records. She called for analytic approaches that examine hospital performance in the context of the populations and communities they serve.

Dr. Hasnain Wynia suggested that community benefit may be a key mechanism for hospitals to address health disparities, but effective program development requires in depth analysis to understand not just the populations, but the communities where they reside:

"If you want to make a tangible difference, you've got to know the population that you're targeting and for what end. A hospital should know its broader community, whether people are coming to their hospital or not."

Key informant Julia Joh Elliger, Senior Analyst at NACCHO also supported an approach to defining community based upon larger geographic parameters that capture the spectrum of key stakeholders, but include a 'drill down' of data at the community and neighborhood level. She noted that there will be data gaps, but partners should document and explore ways to address those gaps over time, and that an important part of the assessment process is the identification of areas of focus for future efforts.

Ms. Joh Elliger also observed that rural communities tend to work together more efficiently than their counterparts in urban areas, with less of the bureaucratic obstacles, market competition, and political agendas that tend to impede meaningful engagement. She cautioned against the establishment of strict requirements or accreditation standards that may yield more superficial engagement simply for compliance purposes:

"We need to rethink the way that we work together. And some of the evidence of meaningful engagement, what that looks like, is how it's been practiced and showing the benefits of that versus the status quo, I think, is more powerful than any kind of oversight mechanism."

C. Data Collection and Analysis

The quality of a CHNA is directly related to the quality of the data and analytic process. There are a growing array of data sources and analytic tools that enhance the capacity to identify and focus on the spectrum of health related concerns in communities. There is also a growing volume of practical experiences among hospitals and health systems who have conducted assessments in recent years, particularly in states with community benefit statutes that require CHNAs.

IRS Notice 2011-52 indicates the intent to require hospitals to describe the "process and methods used" to conduct their assessment, "including a description of the sources and dates of the data and analytical methods applied." Types of data collected for assessments include, but are not limited to the following:

- Disease incidence and/or prevalence
- Inpatient, emergency room, and/or outpatient utilization
- Household income, unemployment
- Home ownership / rental properties
- Arrests, criminal activity
- Proximity of healthy food sources
- Proximity of basic and social services
- Parks, recreational facilities, open space
- Access to public transportation

Primary data are collected through a variety of methods, including, but not limited to surveys, focus groups, and town hall meetings, as well as direct engagement of community residents in participatory action research efforts. Primary data collection can be costly and/or time consuming, and is best undertaken through the collaborative efforts of partner institutions and community stakeholders. It is often not a feasible option for smaller hospitals or public health agencies, particularly in rural areas.

Optimally, data are of sufficient quality and granularity to serve as a baseline to monitor the impact of interventions developed individually or in collaboration to achieve measurable improvements in health status and quality of life at the individual and/or community level. At the very least, data and information should inform the review and selection of priority content areas of focus and the optimal allocation of limited resources. This is of particular importance in the context of current practices, where broad dispersal of resources across numerous small scale programs often results in limited results or sustainability.

Another key issue is the degree to which programs are designed and targeted among populations and communities with the highest prevalence and acuity for one or more identified health concerns. There are a growing array of data sources and analytic methods to identify

¹¹ IRS Notice 2011-52, page 10

and address these areas of health disparities, and an increasing number of hospitals and health systems are engaged in these efforts.

A more in depth approach to data collection that captures both traditional health status measures and social determinants of health provides the basis for both the identification of these communities and the engagement of diverse stakeholders in the development of comprehensive approaches to health improvement.

While there are a growing range of data sources available online, ¹² there are still many communities where much of the data that are available are two to three years old and/or not specific enough to communities/populations of interest to be actionable (i.e. if focus is at city or neighborhood or blocks levels then county level is too broad; state data is almost irrelevant unless addressing very discrete/small populations).

Key questions addressed by the third expert panel, key informants, and public participants included:

- What are essential data sources and what are the issues in securing them?
- In what ways can we collect data on social determinants?
- In what ways can we identify concentrations of unmet needs (e.g., health disparities) in local communities?
- What are the challenges and opportunities in analysis and sharing of provider utilization data?

1. Expert Panel Comments

Eileen Barsi – Director, Community Benefit, Catholic Healthcare West

Ms. Barsi shared her experience as a system level community benefit director in building CHNA and community benefit programming capacity at Catholic Healthcare West, a large health system with over 40 hospitals in California, Arizona, and Nevada. She noted that all of their hospitals had previously done their assessments differently, and their system level board asked whether there was a more consistent and scientifically rigorous approach that could be developed for broad application.

Ms. Barsi described a collaborative partnership between CHW and Solucient¹³ to develop the Community Needs Index, which combines and maps a set of five social determinants, including income, culture and language, education, insurance, and housing. The five measures are assigned a score of 1-5 at the zip code level, based upon an aggregate total, with 5 representing those who are viewed as at highest risk of needing health services. CHW then mapped admission rates at the zip code level, and found a high correlation between the two measures:

¹² A number of sources were introduced and discussed at the expert panel meeting.

¹³ A division of Thomson Healthcare, part of The Thomson Corporation, a provider of information, software tools and applications for healthcare, law, tax, accounting, scientific research, and financial services.

"The people who lived in those high-risk neighborhoods, when correlated with utilization data, were in the hospital twice more frequently than their more privileged neighbors for ambulatory care sensitive conditions: things like asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease, pneumonias."

Ms. Barsi cited the findings as so compelling that CHW launched a systemwide initiative with financial incentives for local leadership to reduce preventable hospitalizations. Hospitals were challenged to focus in identified high risk neighborhoods with high percentages of uninsured and underinsured residents, and to reduce the demand for preventable hospitalizations. The results have been impressive:

"...between 2008 and 2010 our hospitals invested \$5.7 million in preventive and disease management programs. On the average, 86 percent of the participants in our program were not readmitted to the hospital or avoided an admission altogether. A conservative estimate of cost savings is in excess of \$49 million, based on the cost of care, not the charges."

In addition, Ms. Barsi noted that CHW also directs charitable resources to build community capacity through targeted grants to partner organizations. A community investment program has allocated approximately \$70 million for low interest loans and \$10 million in loan guarantees, and has leveraged another \$160 million in capital, with a focus on addressing social determinants of health. In the current year, loans supported the construction of 16,324 units of low income housing, and emergency loans were provided to 28 community health clinics to maintain operations in the wake of the California budget crisis.

Winston Wong, MD, MS – Medical Director, Community Benefit, Kaiser Permanente Dr. Wong opened by noting that prior to his tenure at Kaiser Permanente he served as a commissioned officer for HRSA and focused on chronic disease management for Federally Qualified Health Centers. As Medical Director of community benefit for Kaiser, Dr. Wong leads work on partnerships and capacity building with FQHCs and public hospitals, as well as environment, healthy eating, active living, research, and workforce development. He focused his comments on Kaiser's use of mapping technology as a means of linking health status, medical care utilization, and social determinants of health.

In presenting a series of maps, Dr. Wong highlighted correlations between social determinants such as employment, educational literacy, and available park space in local communities and the prevalence of obesity. He pointed to these communities as areas for targeted investments in primary prevention, rather than limiting their focus to clinical interventions:

"...what we see in the clinical setting is certainly only in this first circle of individual and family. But our members are part of a larger community, part of school systems and worksites, part of a community that has assets as well as challenges in it, certainly in terms of being impacted by the social determinants. For us to think about our role as a provider, we have to consider the spectrum of where we touch patients across their lives, inclusive of the clinical setting but perhaps more importantly, increasingly more importantly, in the broader community setting."

Dr. Wong noted that Kaiser Permanente has initiated healthy eating and active living coalitions in 40 different communities, each of which engages a broad spectrum of community stakeholders in comprehensive approaches that include work on environmental factors and social policy. In closing, he emphasized the importance of moving in this direction:

"I think the future is quite promising if we think about all the ways that we can really start to associate community and social determinants of what we see in the clinical setting. Let's look at what happens with regards to adverse childhood events, since we know that adverse childhood events are strongly correlated with the bad outcomes for adults as they age. Let's look at economic sustainability in terms of how income within a community stays within a community instead of being exported outwards. These are all opportunities for us to really push across the spectrum of how to consider the overall determinants of what we ultimately see in the clinical setting."

Julie Willems Van Dijk, RN, PhD – Associate Scientist, University of Wisconsin Population Health Institute; Community Engagement Director, MATCH

Dr. Willems Van Dijk focused her comments on her work in the development and dissemination of the County Health Rankings¹⁴ (CHR) website and tools as a resource for CHNAs. In the process, she reinforced the importance of a comprehensive approach addressed by the first two expert panelists, and the integration of all relevant measures in order to develop a complete picture of health in the community.

She emphasized the importance of CHR as a tool to raise awareness, provide a basis for comparison of health measures across counties, and in the process, to stimulate competition to improve an individual's county rankings relative to others over time. She cautioned, however, against viewing the available data, tools, and information as a substitute for a comprehensive CHNA. In doing so, she pointed to a "take action" tool on the website that outlines a basic set of steps for community health needs assessment and planning, as well as a "drill down guide" that points to an array of sources for data at the sub-county level.

As such, Dr. Willems Van Dijk emphasized CHR as a starting point in an assessment, planning, and engagement process. She noted that the next stage is to expand the website into a searchable database that will enable people to find the latest evidence. Sponsors of the initiative are also in the final stages of selecting a set of community grantees across the country who will use CHR to "take action around policy and systems change in the area of social and economic factors."

Moderator Follow up

Dr. Barnett referenced the presentation of mapping technology and the linking of hospital utilization and demographic data by Dr. Wong and Ms. Barsi, and asked if their emphasis suggests that both forms of data are among what might be viewed as essential data sources.

¹⁴ The *County Health Rankings* are a key component of the Mobilizing Action Toward Community Health (MATCH) project. MATCH is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

He also noted that the current IRS Form 990 Schedule H excludes community building activities as financially reportable, including some of those referenced by Ms. Barsi at Catholic Healthcare West, and asked for her comments on the issue. Dr. Barnett also noted that Kaiser Permanente's model of financing already incentivizes keeping populations healthy, and asked Dr. Wong to address how their approach to community benefit is evolving in this context.

Panel Response

Dr. Wong raised the need to increase access to both forms of data and their contribution to transparency in the community health improvement process. He noted that these analyses are key to increase understanding that chronic diseases such as diabetes and asthma are proxies for the underlying causes of poor health in the community context. He noted further:

"For years when we did community health assessments we collected demographic data. And we considered it background data. I think the evolution now is that same demographic data, the socioeconomics, the educational level of your community and data such as that are now actionable elements of your community health needs assessment. As we talk about what we know drives health outcomes, we need to think about that data in a way that those, again, are actionable and core pieces of the assessment, not just background."

Ms. Barsi indicated that utilization data, with a particular focus on ambulatory care sensitive (ACS) admissions have become very important, citing a figure of \$47 million in preventable admissions in their first analysis. She noted that an analysis of socioeconomic barriers is critical to gain an understanding of how to address persistent health problems:

"So we now know where you live, what those issues are. But we also know how to help you. And so it has helped us to become far more strategic in our community benefit program planning to address unmet needs."

On the issue of community building, Ms. Barsi emphasized that their community investment program is primarily low-interest loans and lines of credit, and they also support permanent housing for the homeless who are frequent utilizers of EDs in central Los Angeles.

Dr. Wong indicated that internal leaders are increasingly broadening their definition of what approaches to health improvement should be within their purview, recognizing the need to go beyond service delivery to partner with other organizations to improve health outcomes. He closed with an observation about the opportunities associated with implementation of PPACA:

"I think it's a missed opportunity if the ACOs don't actually actively integrate into their thinking how health care providers think about ways to intervene or provide support for community outside of the medical model and think about investments in the community."

2. Public Comment

Alan Lomax, Community Indicators Consortium

Dr. Lomax referenced local schools as a rich resource for data in areas such as attendance, behavior, and developmental issues, as well as the fact that many communities conduct periodic counts of homeless populations. He encouraged stakeholders to identify and use data sources such as these in developing a complete picture of health in the community context.

Ron Bialek, Public Health Foundation

Dr. Bialek asked the panel to address the issue of "asset" mapping in local communities, moving beyond institutions to identify "community connectors, the gifts and talents individuals bring, the loosely knit associations." He noted that these are important points of leverage and resources for hospitals and public health agencies.

Unidentified

This participant referenced the challenge of moving from the assessment process to collaborative action, and asked the panel to suggest ways of overcoming obstacles to real progress.

Panel response

Dr. Wong noted that one new area of expansion for Kaiser Permanente has been increased investment in minority vendors, with the understanding that it contributes to job creation in low income communities. He indicated that it has forced a recognition that the organization think of itself not simply as a health care provider, but an "economic driver" in local community development.

Ms. Barsi noted that all Catholic Healthcare West hospitals are required to conduct an assets assessment in their communities and that staff have the competencies to engage community partners, in recognition that health improvement is "something we cannot address alone."

Dennis Lenaway, CDC

Dr. Lenaway shared his experience in public health and limits to quality data, and asked the panel to expand on what data should be considered an essential part of an assessment.

Julia Joh Elliger, NACCHO

Dr. Elliger emphasized the importance of qualitative data in building a more in depth understanding of causation in local communities, and that it helps to bring communities and providers together around issues that can be addressed in the near term.

Unidentified

This participant emphasized the importance of investment in building health literacy as a part of any strategy for health improvement.

Panel response

Ms. Barsi indicated that qualitative data has become much more important, and acknowledged that it has taken time to "switch gears altogether to address what is really important to the people in the community." She shared an example in San Bernardino area where they discovered that one of the most significant concerns among parents was about their children after school. In response, they helped to establish a homework club.

Dr. Willem Van Dijk noted that one of the values of qualitative data at the local level is its relevance to policy makers who want to be attuned to the concerns and perspectives of constituents. She cited a tobacco control effort where state level survey findings were not sufficiently compelling to garner the support of policymakers, but they were willing to take local action in response to stated concerns of residents at the district level.

3. Key Informant Interviews

A number of key informants referenced emerging lessons and/or tools in the field to support data collection. **Dr. Brian Smedley, Director of the Health Policy Institute at the Joint Center for Political and Economic Studies** described a tool developed by the Connecticut Association of Directors of Health called the Health Equity Index (HEI). The HEI profiles a standardized set of social determinants and their correlations with specific health outcomes. Dr. Smedley encouraged colleagues to use a different frame for what are currently termed as 'disparities:'

"I'm persuaded that when we talk about disparities, people assume that we're simply talking about simple numeric differences; that Group A has less access than Group B; Group C has lower quality than Group D. Instead, we use the term 'inequities' because it communicates that these differences are unjust and unfair, and we can do something about them. So rather than just disparities in education, we have inequities, in that so many of our kids of color are assigned to failing K-12 schools. Using the term inequities means there are health gaps brought about by policies and practices in communities. They can be undone, because they are policies and practices that human beings put into place. Human beings can undo them as well."

He suggested that if we don't take the necessary steps to better understand and address the profound health inequities in our communities, we as a society face significant challenges in the coming years. There is an opportunity for hospitals to provide leadership in building understanding and awareness of our shared fate. Dr. Smedley pointed to the growing cohort of youth of color, and suggested that their status and relative progress will be a major factor in defining the health of our nation.

Other key informants also emphasized the importance of identifying links between health problems and social determinants. **Romana Hasnain Wynia, Professor at Northwestern University** described a study in Chicago where breast cancer and associated measures were mapped in 77 neighborhoods:

"We showed where the highest incidence of breast cancer both mortality and kind of incidence of breast cancer, and then we also simultaneously showed where the health care resources and the community resources were located. What you see is a stark picture of what I would

call a resource desert where you have a high prevalence of a given health care problem whether it be obesity, whether it be HIV/AIDS and the lack of resources, both community resources and health care resources you know that could them facilitate improvement."

Key informants also identified current initiatives to build an evidence base linking social determinants to medical conditions. Larry Cohen, Director of the Prevention Institute shared that his organization is engaged in a study with funding from the Federal Office of Minority Health entitled THRIVE. In the study, they have identified thirteen community factors that are closely related to medical conditions, as well as the behaviors that are considered the causes of the conditions.

"Some of the great successes in health over generations come from the understanding that changes in community environment, in policy, and in organizational practice are vital for improving health—and will change norms and thus behaviors, which will keep people far healthier as opposed to simply the provision of medical services. As McGinnis and Foege wrote in the Journal of the American Medical Association, the environment and related behaviors account for 70% of health outcomes, while medical services account for 10%."

Mr. Cohen questioned the quality of many of the CHNAs conducted by hospitals, and suggested that many are not living up to the expectation of a best practice based upon the most recent knowledge base. He suggested that just as we expect hospitals to be up to the highest standards in treatment and associated research, we should expect the same in regards to community benefit practices.

Many key informants emphasized the need to include social determinants of health as part of any CHNA, and perhaps even more importantly, address them as part of community health improvement strategies. Len Syme, Professor Emeritus, UC Berkeley School of Public Health, emphasized that we know that there is more to health than individual risk factors and individual medical care, and we need to address these forces that so powerfully influence health. He noted further that one of the most significant determinants of health in our inner city communities is a lack of hope; also termed as 'control of destiny':

"Evidence is now accumulating to support what I call control of destiny; the ability of people to influence events that impinge upon their lives. We now have animal and human evidence that when people are not able to control those events, people become vulnerable to disease. It affects immune functioning and increases the risk of disease. Control is something we can intervene on. We can help people learn how to better to influence events by understanding community resources, by understanding their options."

Dr. Syme also addressed an issue raised by many other key informants, which is the relative health impact of our almost exclusive focus on medical care in health resource allocations:

"We all know that we spend unbelievably more money than anybody else in the world on medical care. And we rank like 35th to 40th on everything that matters. And it turns out when you took just the top 10 percent in our country compared to the top 10 percent in Britain. we still rank lower. My view is that in fact when you're living in this kind of an unequal society it's corrosive on everyone. So, we need to improve our country for all of us to benefit."

Dr. Syme cites a major comparative study¹⁵ of self-reported illness and biological markers of disease among U.S. residents and their British counterparts which demonstrate that U.S. residents are less healthy at all points of the socioeconomic distribution. He also points to Canada for comparison, noting that while they have similar problems with minority groups, they have made a commitment to empower and support people at lower socioeconomic levels. As a consequence, they rank among the top 10 nations on health indices, and we reside at 40th.

Key informants also emphasized the need to engage community, not only in the review of data that are collected, but in the determination of what is important. As described by **Lloyd**Michener, Director of Community Medicine at Duke University School of Medicine:

"...the data that matters to the health system is not necessarily the data that matters to the health department. And actually it's not always the data that matters to communities. So, part of what we've been trying to do with it in Durham is find out what people care about and what information can we collect that they would view as important and will tell us whether we're making progress."

Along the same lines, key informant Christopher Fulcher, Co-Director of the Center for Applied Research and Environmental Systems (CARES) at the University of Missouri-Columbia suggested that the central issue is not the data platform, but how we engage diverse stakeholders in a dialogue to determine how to proceed in collaboration:

"What are the sharing arrangements and protocols, and how to we provide a platform that isn't focused on data, but is really focused on community processes. That's where community health assessments really come in. How do we engage? What audiences do we engage? It's not about a data platform, but it's really about a collaborative management system platform."

In this context, data and information inform and elevate the conversations we need to have in order to determine the impacts we want to have, both to take action and to inform the decisions of policymakers. Dr. Fulcher emphasized that this kind of process will not be possible if we stop at the collection of county level data; that sub-county special variations are needed to more strategically allocate resources.

While there is general agreement that local public health agencies can and should be active and ongoing partners in CHNAs and the development of implementation strategies, it is important to explore creative options to address resource constraints. **Jonathan Fielding, Director of the Los Angeles Department of Public Health** advocated for public health agencies to take a much more proactive role in the assessment process, but noted:

"We've been unfortunately subjected to cuts each year over the last four years, trying to keep our heads above water, but directionally that's exactly what I want us to do, I want us to

35

¹⁵ "Disease and Disadvantage in the United States and England, **JAMA**, May 3rd, 2006, Volume 293, Number 17, Page 2037

become a source, a neutral source of information about hospitals as well as census based and zip code based patterns of care."

Dr. Fielding acknowledged that his own department had not been as engaged as he would have liked in recent years with hospitals, due in part to separate challenges both have faced, but views the new IRS requirements as an important opportunity for collaboration.

A number of key informants reinforced the case made by expert panelists to link hospital utilization data with social determinants. **Anthony Iton, Senior Vice President for The California Endowment** shared his prior work as public health director in Alameda County, CA to develop and pass state legislation providing local health departments with access to hospital discharge data. He pointed out that they needed to allay the concerns of hospitals that they were not interested in individual hospitals; rather, they wanted aggregate data on how residents within specific neighborhoods were using services:

"It's really not about an individual hospital's data, it's about all of the hospitalization data for the jurisdiction. It's just like another comprehensive data, like death certificates. We don't really care what hospital the person died at. We want to create a comprehensive data set of death, just like we want to create a comprehensive data set of hospitalizations."

As such, the focus is on what are the real vulnerabilities, the real problems in the community context—not in the individual hospital. This provides a basis for action, not just on behalf of individual hospitals, but among collaborative partners in the community:

"If there is a high rate of hospitalization for diabetes-related complications that are preventable on a countywide basis, you can develop a community benefit strategy that enhances the quality of primary care and inserts promotores into certain communities to get people better articulated with the health care system. But you can't get to that question without looking at a comprehensive hospitalization database for your jurisdiction."

The need for dispassionate analysis was also shared by key informant **Jeff Spade**, **Vice President of the North Carolina Hospital Association:**

"It has to be understood right at the beginning that this is going to be a transparent process with transparencies about improvement. And the only way we're going to get improvement and commit to improvement is that the transparency doesn't lead to some-- that there is some level of accountability. But it needs to be blame free in terms of how we improve. We do that in the improvement side of our work, so that people will share their dirty laundry, so we can learn improvement."

D. Community Engagement

Local community members are understood to be a key resource in the assessment of community health needs, and the IRS Form 990, Schedule H requires hospital to describe their efforts to secure their input. There is also growing recognition that engaging community members as ongoing partners in community health improvement is an important way to create an environment of shared accountability and to leverage nonprofit hospital resources.

The engagement of local and diverse community members in data collection and analysis offers the immediate value of introducing a wider array of relevant perspectives on a community's health. Community stakeholders have historical knowledge of local experience, issues of concern, and relational dynamics. A diverse stakeholder base can help to contextualize findings from data collection with personal insights and experiences.

The engagement and mobilization of a diverse community both leverages the limited resources of hospitals and public health agencies and contributes to the sustainability of goals and objectives that are achieved in the process. Community stakeholders are more likely to pursue public advocacy and related efforts to sustain positive outcomes in which they have been invested as active partners, rather than simply passive recipients. In addition, skills acquired in the collaborative process are available to direct to other efforts going forward.

For the CHNA, section 501(r)(3)(B) requires hospitals to "take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health." IRS Notice 2011-52 expands on expectations, indicating that hospitals are expected to describe when and how input was solicited, and input from organizations should identify the name and title of at least one individual with whom the hospital consulted. Key questions addressed by the expert panel, key informants, and public participants included:

- What constitutes meaningful community engagement in the broader community health improvement process?
- What are potential roles of diverse stakeholders in data collection and analysis?
- What are the issues and opportunities in the identification and mobilization of community "assets"?

100.4

¹⁶ IRS Announcement 2011-52, page 10 – "A description of how the organization took into account input from persons who represent the broad interests of the community served by the hospital facility (as described in section 3.06 of this notice), including a description of when and how the organization consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc. if the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organization with whom the hospital organization consulted."

1. Expert Panel Comments

Jessica Curtis, JD – Project Director, Hospital Accountability Project; Staff Attorney, Community Catalyst

Ms. Curtis opened by describing the work of Community Catalyst (CC), a national organization that supports community and consumer advocates in 40 states who are engaged in efforts to improve access and quality of care in uninsured and underinsured communities. She noted that the work of CC also involves direct advocacy and engagement of elected officials on hospital community benefit issues, most recently work with the U.S. Senate Finance Committee.

In Ms. Curtis' comments, she noted that the meaning of "to take into account" input from the community, as well as "represent the broad interests of the community" are terms that are less than clear and subject to substantial interpretation. She noted further that CC and community advocates are interested in engagement throughout the community health improvement process, not just the CHNA:

"For most of our advocates the issue isn't really holding hospitals accountable for the sake of holding them accountable. It's really about how do we actually get in a room and work together to address the issues that we're both facing."

Ms. Curtis indicated that the approach for CC and their partners provides the flexibility to respond to local needs and dynamics, and supports work together to address the underlying causes of persistent health problems. Their strategy revolves around engaging those who face the most challenges as partners as "part of the change that's necessary."

Ms. Curtis encouraged colleagues in the field to consider diversity in all its forms in the development of an inclusive process, and make sure to ask participants who may be missing from the table. She also emphasized engagement of stakeholders outside the health care system who can speak to broader determinants of health.

She also noted that while CC has discussed the reporting process with the IRS, the view of her organization is that the central audience in hospital reporting is the local community. In the process, however, it is important to understand that getting community members engaged in a meaningful way will require time, attention, and commitment:

"When you think about extremely vulnerable community members and what they're facing, coming to a meeting at your hospital to discuss community benefit is not on the list of getting food on the table, finding child care, finding elder care, finding transportation to your meeting. These are things that, at a very practical level, hospitals are going to have to consider."

Ms. Curtis closed by emphasizing that CC and hospitals should view community benefit as an opportunity to build leadership in the local community to bring about substantive changes in health status and quality of life.

Michelle J. Lyn, MBA, MHA – Associate Director, Duke Center for Community Research; Chief, Division of Community Health; Duke University Medical Center

Ms. Lyn opened by providing a profile of the Durham community in which Duke University is located. She noted that, like many communities near major academic health centers, there are great disparities, with a concentration of highly educated residents (40% college educated), and a high percentage of uninsured (27%) and 16% living at or below the Federal Poverty Level (FPL). The Duke Division for Community Health was established in 1998 to serve as a bridge between Duke and the communities it serves. Ms. Lyn indicated that the division now has 140 faculty and staff who are engaged in collaborative community health improvement. She described the commitment to change the traditional approach of academic health centers:

"...it's not just about placing new facilities in neighborhoods. It's about getting outside of the facility-bound model of delivering health care."

One example of community engaged health improvement shared by Ms. Lyn was a home care plan for low income seniors and the disabled, most with five or more chronic conditions, and almost half with a mental health condition. Over the course of the six years of working in the community and in the homes of these individuals, they reduced inpatient admissions by 68%, and ED utilization by 49%. They are now working to take the approach to scale, developing care pathways that are tailored to individual neighborhoods, and developing shared accountability measures:

"...we're coming up with performance metrics that we all agree on and that we all agree to hold each other accountable to. It's a fundamental redesign of the way we think about health in our community and the way we think about health care delivery in our community."

Ms. Lyn indicated that the innovations and lessons from the experience in the Division of Community Health are being integrated throughout the health professions school curricula, including structured student placement in a broad spectrum of community engagement activities.

Dory Magasis Escobar – Director, Healthy Communities, St. Joseph Health System – Sonoma County, California

Ms. Escobar provided a brief profile of her community and her regional medical center as part of the St. Joseph Health System, and challenged participants to think about community engagement as a multi-directional process. As such, she emphasized that it's not just about going out and engaging the community, but also being willing to be engaged by the community; a relationship that is both authentic and equitable. Ms. Escobar noted that a central theme is building a common understanding of the social determinants of health, and developing creative ways to address them:

"We focus on initiatives that involve legislative advocacy with city councils and our board of supervisors, and then we look at the social determinants health through our healthy

communities initiatives and programs. And the core of that is a community organizing team, known as the Neighborhood Care Staff and a grassroots leadership development program."

She described these activities as "the heart of our community benefit work," but noted that the community organizing and coalition work is not currently reportable in the 990, Schedule H, since it falls under the category of community building. Ms. Escobar indicated that she is proud to work for an organization that chooses nevertheless to make this investment "because we've seen the difference it makes."

Ms. Escobar described their work as "relationship-based;" the hospital doesn't organize the community around its priority issues, or engage the community to implement its activities. A core activity in the community organizing process is a training program of leadership development, recognizing that residents are along a continuum of interest and engagement, and there is a need to meet them where they are. Priority issues emerge from the community engagement and training process:

"The organizers began engaging folks. They identify who are the leaders. They focus on building that small leadership team and then the leaders go out and make a difference. They engage in direct advocacy but they're really pure educators as well. Then they engage the residents and they decide what they want to address and how they want to address it."

Ms. Escobar closed with a sampling of accomplishments through the work of the organizers and community residents, including the authorization of a community garden in a regional park, land use changes by the city to allow the development of a community garden on sites where public pools had been closed, and re-design of the school menu for the city school district. Each of these small successes reinforces the commitment of community residents that they can bring about meaningful change, and builds impetus to take their work to the next level:

"...they took the idea of a community garden and turned it into a co-op farm. And the school up the street is contracting with them to bring in fresh produce. The community clinic has asked them can they load up a pickup and come and sell produce at the clinic. So it's opening up all kinds of opportunities because we acknowledged that they had the wisdom of what they need to do and then that they also had the wisdom to tell us what they needed from us."

Moderator follow-up

Jessica Curtis was asked to address how Community Catalyst views the potential roles of community members, recognizing that there is a continuum. At one end is a common short term engagement of community members as consumers, most often as a one-time participant in a focus group discussion. Moving from there, community members may be engaged on a more ongoing basis as an informant or advisor, given the opportunity to provide periodic input on a hospital's programs and activities. Some community members may in fact view themselves as "watchdogs," with an eye towards holding hospitals accountable to fulfill their charitable obligations. The approach described by Ms. Escobar moves to the next level, where they are engaged as equal partners, if not leaders of efforts where accountability for results is shared.

Michele Lyn was asked to address the unique role of academic health centers, and how their work contributes to building a more culturally competent health workforce, reduce health disparities, and address complex health problems in the community context.

Dory Escobar was asked to describe the kind of leadership support that is needed in a hospital organization to sustain the kind of work she has led at St. Joseph Health System.

Panel response

Ms. Curtis indicated that most of the groups with whom CC works are at the "grass tops" level; that is, active and engaged community organizers. Moreover, their primary focus tends to be on the financial assistance component of community benefit. Their experience has been that the people affected by these issues tend to be ignored, which often leads to more confrontational approaches to hospital engagement. That having been said, she noted that once they've come together, many of the groups built relationships that enabled them to move to other issues:

"...we've seen groups move very quickly from working on more contentious issues to saying, "Well now this is interesting because the real issue here is access to coverage." For example, we've seen a lot of groups pivot and move from talking about financial assistance to working on expanding Medicaid or other programs together. And then even beyond that, you know I think people are now talking more about what does quality mean to a community, to a community member who has never thought about quality before."

On the issue of the unique contribution of academic health centers, Ms. Lyn addressed the need to provide experiences throughout the entire learning curriculum for physicians and nurses so they gain firsthand knowledge through team-based care of all factors that affect health in the community context.

"...we've come a long way, I think, in trying to break down those silos in terms of true team training. It's not enough to just put people together and say, "Now you're a team," but to actually give them those experiences and ensure that they also see the patient and their families and the community, the population as a member of that team as well. And what does that really mean for them. It's for us, of course, it's meant a good deal of changing in terms of the way that we run our educational programs."

On the issue of leadership support, Ms. Escobar emphasized that there needs to be commitment from the most senior level of the organization, both in terms of administration and governance. She noted that quality measures selected by the executive management team always include at least one in the community benefit arena.

2. Public Comment

Dorothy Cilenti, UNC Gillings School of Public Health, Interim Health Director, Orange County Dr. Cilenti asked the panel to address how some of the innovative approaches to health improvement led by larger systems may be implemented by smaller systems in more rural states such as NC where resource constraints may be more significant.

Abbie Cofsky, Robert Wood Johnson Foundation

Ms. Cofsky asked panelists to address the need for a coordinated approach to assessment and action. She suggested that if someone is being asked to speak on behalf of the community, they would appropriately want to know that there is a larger plan whether there were mechanisms to ensure that coordination is occurring. She also asked the panel to address what other kinds of community stakeholders should be at the table, noting that many efforts involve related sectors such as law enforcement and education.

Lawrence Prybil, University of Kentucky College of Public Health

Dr. Prybil asked Ms. Escobar to address the degree to which their program is led and/or is implemented at the system level and/or at the hospital level.

Panel Response

Ms. Escobar indicated that their regional facilities in Northern CA are the only part of their health system that has an ongoing, permanent community organizing team. That having been said, she noted that there is a community building initiative at the system level supported by their foundation, which supports local partners to do community organizing work. She also noted that relationship building is at the core of their success to date:

"We invest very heavily in time and resources and relationship building. Because from there we can move in a lot of directions. If we go to a city council member and ask for something and don't have a relationship, it's going to be a lot harder to get what we want. "

Ms. Lyn also emphasized the importance of building, but also sustaining meaningful relationships with groups such as law enforcement, schools, social services, and others, noting that turnover and competing priorities present ongoing challenges. On the issue of resources, she encouraged a more creative interpretation:

"I would say to start where you are and to also broaden the definition of resources. Monetary resources are not the only thing that hospitals or others have to give. It comes down to sharing knowledge, sharing skill sets, sharing the relationships you already have. Relationships are also an asset and it's easy for people to forget that."

Claudia Lennhoff, Director, Champaign County Health Care Consumers

Ms. Lennhoff commented that one of the challenges that local grass roots groups face is the perception among local hospitals is that they're just asking for money, rather than seeking to engage the hospital in a more meaningful working relationship. She asked the panel to address the degree to which competition among hospitals in a community impedes efforts to engage in partnership.

Judy Darnell, United Way of California

Ms. Darnell asked panelists to identify trusted leaders in other organizations with whom hospitals engage, and asked if there is the tendency to lead, or is there interest and openness in working together as equal partners?

Joan Quinlan, Massachusetts General Hospital

Ms. Quinlan addressed a realization among hospital community benefit staff and leaders that they are also members of the community, and that they also have an obligation to change themselves.

Panel response

On the issue of hospital competition, Ms. Curtis noted that hospitals typically do not compete for the populations that should be the focus of community benefit programming (i.e., uninsured and underinsured), and hence it is in their interests to collaborate. She also addressed the issue of "trusted leaders," noting that these individuals are "one segment" of the community, and we need to consider and engage others, as well.

Ms. Escobar supported the comment on competition, and noted that it was essential for all the hospitals, local health department, and other stakeholders to come agreement on shared priorities in order to achieve measurable outcomes.

Ms. Lyn indicated that community engagement is an ongoing, intensive, and essential process to ensure that services are designed, evaluated, and re-designed in a manner that addresses changing needs and dynamics.

3. Key Informant Interviews

Key informants reinforced the comments of expert panelists on the need to engage community residents as equal partners. As stated by **Brian Smedley, Director of the Health Policy Institute** at the Joint Center for Political and Economic Studies:

"It doesn't matter what the health outcome is that you're trying to affect, it doesn't matter what the determinant is you're trying to change, doesn't matter what particular health risks you're trying to address; the common thread in successful efforts is that you engender power in the community. You want a community to be better organized and better empowered to advocate for their needs. It doesn't matter whether you're addressing diabetes or stopping a big incinerator plant to the community."

Dr. Smedley's emphasis on community members as equal partners was reinforced by the comments of **Anthony Iton, Senior Vice President of The California Endowment,** who frames health improvement as a political process that requires broad participation of community members. He describes the participation itself as part of the health improvement process:

"Why is it that organizing people to participate in planning and attending council meetings around a city's general plan is a health strategy? Because that's how we decide where parks

get situated, who gets sidewalks and treescapes, where crosswalks are put in and greenways built. All of that has an impact on physical health, obesity, and mental health. Yet we don't see that as a health intervention. And that's a big problem."

Dr. Iton also referenced a philosophical debate in the U.S. that impedes thoughtful consideration of health as a product of the interaction between individuals and physical, social, and political environments:

"The biggest challenges are sort of a narrow understanding of health as health care, and overreliance on individual responsibility as the only important American value. We have a fundamental misunderstanding of how healthy environments are shaped. They're not shaped by individuals. They're shaped by collective action."

The net result is that we allow people to flounder in communities that present obstacles to desired health behaviors, and suggest instead that the problem is with individuals or groups of individuals. Dr. Iton suggests that we need to reassess our values and begin to develop public policy that shifts the emphasis and values from individual to community responsibility."

Dr. Iton's point was reinforced by **Lloyd Michener**, **Chair of the Department of Community and Family Medicine at Duke University School of Medicine**:

"A lot of hospital executives come from a belief in personal accountability and self-reliance, and see issues such as obesity or medication adherence as signs of ignorance or failures of self-discipline. Community members come from different perspectives in which relationship to a larger community can be of great importance. This came up powerfully in Durham in a recent meeting with our hospital CEO, researchers and several hundred folks from across the community. One senior researcher was preaching about individual accountability. A senior black woman got up and said her first accountability was to her children and family, and that she would use her limited resources to meet their needs first, even if it meant she could not afford her own medications. Failing to fill her prescriptions wasn't a sign of ignorance or failure of discipline, but was a considered action based on her deepest values. That dialogue actually starts to shift perspectives. This is a dialogue in which both have much to gain."

Dr. Michener suggested that health care professionals could benefit significantly from increased engagement of the people they're serving, in that their only interactions tend to be when people are sick in bed. He noted that data on health disparities is often useful to initiate the dialogue with hospitals based upon hard evidence.

Other key informants described current efforts to build trust and ongoing engagement in urban areas. **Eric Baumgartner, Vice President of the Louisiana Public Health Institute** described health improvement efforts in New Orleans and the challenges to change historical dynamics:

"Neighborhoods in New Orleans have had intergenerational poverty, poor education, and social inequity. This city is not going to get the transformation that improves the health status of this community without people finding their place to make it the reality in these neighborhoods. They share in the responsibility, but they also have an equal seat at the table as leaders in this community. Among neighborhood associations, some are recognized to be proven neighborhood leaders who have engaged the big powers and there appears to be

understanding of how the two relate. We're trying to get early adopters to model behavior where residents engage with leaders, find common ground, and are able to create positive circumstances that other neighborhood leaders can come to see. They'll start to find that there's a growing mass of folks here in New Orleans that are finding ways to engage in reciprocal accountability and model a better way for us to work together."

Key informants also identified a need for individuals and organizations which are viewed as neutral and with demonstrated skills in facilitation and building consensus. **Julia Joh Elliger, Senior Analyst with NACCHO** indicated that these individuals are needed to guide diverse stakeholders through a meaningful process, noting that some may become overwhelmed or may be preoccupied with their own interests:

"So I think you definitely need someone with these skills, but they have to be affiliated with an organization that is seen as a neutral entity. So you could have a highly skilled facilitator that's with a hospital, and no matter how skilled they are, the rest of the stakeholders see them as a hospital person. And that becomes difficult."

In general, key informants emphasized that community engagement should be an ongoing endeavor throughout the community health improvement process, but needs to be initiated at the outset of the CHNA process. As stated by **Dan Friedman, Principal of Population and Public Health Information Services:**

"There's really nothing to substitute for learning about community health needs by speaking with the members of a community. For example, let's say there's an excess of pediatric asthma. There can be a variety of different reasons for that, and you're only going to learn those reasons by speaking to community members. It can range from lack of primary care providers to a lack of public transportation or environmental issues."

E. Priority Setting

Priority setting is a critically important step in the community health improvement process to select among what are typically a large number of unmet health needs in communities. It serves as the link between the assessment and implementation, optimally using explicit criteria and processes to guide the selection. The selection process enables local stakeholders to focus and strategically invest limited resources, given the impracticality of addressing everything at once.

In practice, however, it is often an overlooked or poorly implemented process. Common results include, but are not limited to a) lack of external support for priorities selected by individual organizations, b) diluted investment in a broad range of activities, c) fragmentation of effort, d) investment in interventions with limited potential for achieving measurable outcomes, and e) a lack of sustainability. Specific benefits of effective priority setting include:

- Builds consensus for the allocation of resources in areas most likely to yield positive and sustainable outcomes
- Clarifies expectations and manages resources in constrained environment
- Helps establish timing and focus on issues based upon an analysis of objective criteria (e.g., size and severity of problem, intervention effectiveness)
- Helps to establish a chain of accountability for stakeholders

Obstacles to the effective implementation of priority setting include, but are not limited to the following; a) lack of quality data, b) conflicting political dynamics and agendas, c) stakeholder fatigue with assessment process, d) poorly developed and/or understood criteria, and e) lack of equity in stakeholder participation and processes.

Effective priority setting offers the potential to address one of the most significant challenges for hospitals in the community benefit arena. Due to a variety of factors, including a commitment to fulfill their charitable mission, tax-exempt hospitals are often engaged in a broad spectrum of small scale program activities. The desire to serve often results in the over-dispersal of resources, yielding many activities, but few measurable and/or sustainable results. Priority setting offers the potential to make important decisions about timing and focus of resources in a manner that is more likely to produce measurable outcomes.

Section 9007 of the Affordable Care Act amended section 6033(b) (15)(A) of the Internal Revenue Code requiring hospitals to provide on Form 990 Schedule H:

"...a description of how the organization is addressing the needs identified in each CHNA and a description of any needs that are not being addressed together with the reasons why the needs are not being addressed." ¹⁷

¹⁷ IRS Notice 2011-52, page 4

Treasury and the IRS intend to require that each hospital provide:

"...a prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs." 18

Guidance continues with the statement that:

"Treasury and the IRS intend to require a hospital organization to specifically address each of the community health needs identified through a CHNA for a hospital facility in an implementation strategy, as described in section 3.08 of this notice, rather than in the written report documenting the hospital facility's CHNA.

For these purposes, Treasury and the IRS intend to provide that an implementation strategy will address a health need identified through a CHNA for a particular hospital facility if the written plan either—

- (1) describes how the hospital facility plans to meet the health need; or
- (2) identifies the health need as one the hospital facility does not intend to meet and explains why the hospital facility does not intend to meet the health need."

Given the importance of the priority setting process, two related expert panels were assembled for the meeting; one focused on the science and current methods, and the other focused on practical application and implications for collaboration. Key questions addressed by the expert panels, key informants, and public participants included:

- What is the purpose of priority setting, and why is it important?
- What criteria, processes, and tools can be used under different circumstances?
- In what ways should we use evidence to guide decision making?
- Who should be involved in the priority setting process, and why?
- What is the scope of content issues to consider, and what are factors in the determination?
- What constitutes meaningful collaboration (in addressing identified priorities)?
- What are the challenges and opportunities associated with comprehensive approaches?

E1. Priority Setting : Science and Methods

Steven M. Teutsch, MD, MPH – Chief Science Officer, Los Angeles County Department of Public Health

Dr. Teutsch opened by posting a few key questions about the priority setting process:

"How good does the evidence need to be, and what kind of evidence do we bring to bear on the question? How do we understand the relevant contextual factors and then how do you integrate all of that information and apply it in a way that makes sense? And particularly then,

¹⁸ IRS Announcement 2011-52, page 11

what are the processes that are needed to amalgamate all of that information to legitimize the decision making process?"

He described a process where "decision makers" frame the decisions to be made, and call for scientists to provide the evidence, science, and associated information, and then find a way to accommodate contextual issues such as economic constraints, values, and preferences. He further described forms of evidence, as framed by Jonathan Lomas, CEO of the Canadian Health Services Research Institute, including a) scientific evidence, framed as context independent, validated knowledge, b) social science evidence, which is also validated, but is more context dependent, and c) colloquial information, which includes the political dynamics and considerations. He emphasized that there is no simple technical path to the selection of priorities, but a key consideration in the context of community health improvement is to ensure that you engage the right stakeholders.

Dr. Teutsch focused on clinical preventive services to exemplify the issues, with particular attention to the concept of preventable burden, or how much of a problem can be avoided by ensuring timely access to preventive services (e.g., mammography screening). He referenced a set of clinical preventive services recommended by the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices as effective to explore how they may assist in selecting priorities.

In an examination of the services, each is ranked based upon their relative ability to prevent the illness and their relative cost-effectiveness. Using these measures, interventions such as daily aspirin use (for cardiovascular patients), childhood immunization, and smoking cessation gain high rankings for their relative low cost and high impact. He also introduced the measure of Quality Adjusted Life Years (index reflecting the combined burden of morbidity and mortality) as another tool to examine the relative effectiveness of clinical services, and the potential impact if they were implemented in a more systematic manner across populations.

Moving from clinical interventions into population, or community-based interventions, Dr. Teutsch referenced the ultimate acknowledgment in the scientific arena that the criteria and standards of excellence were different. Holding up the randomized clinical trial as the "gold standard" for scientific evidence was simply not applicable in the complex environment of the community. The two core questions to be addressed are a) does the intervention work, and b) how big is the potential impact at the population and community level.

He noted that answering these questions is difficult, given that community health improvement interventions lack the precision and specificity of clinical services and that effectiveness may be driven by synergistic interactions among different components. Moreover, contextual factors such as available local resources, community dynamics, and population demographics may vary significantly from one community to another.

Dr. Teutsch referenced the emergence of modeling to support decision making as an alternative to reliance on traditional scientific studies, which take too long (particular for primary

prevention initiatives that may not yield measurable results for years), and do not effectively accommodate the complexity of communities. He encouraged an emphasis on interventions that are supported by strong evidence, but acknowledged that there are other considerations:

"...in areas where we actually don't have very good evidence - and the obesity world is certainly one of those – we should still strongly consider evidence-based interventions rather than going to interventions with weaker evidence in unproven areas. While there may be at times reasons to go to interventions that are lower down on this list, those should only be entertained if the need is high and the harms are likely to be negligible. But when we do, these interventions then need to be subjected to rigorous evaluation."

Dr. Teutsch then described a range of factors that are considered by different kinds of stakeholders in the priority process, noting that regulators, policy makers, institutional leaders, providers, advocates, and end users may think about things in very different ways:

"You can see that if you're a regulator, such as the FDA, you're likely to think about things such as the legal environment, that is your requirement, the efficacy and safety of a drug. Whereas if you're interested in coverage decisions, you may be more interested in the effectiveness."

In closing, Dr. Teutsch encouraged colleagues to consider the scientific, social science, and colloquial forms of information as a way to begin to think about how to make decisions, and then integrate these factors into the broader deliberative process.

Leslie M. Beitsch, MD, JD – Associate Dean for Health Affairs, Florida State University College of Medicine

Dr. Beitsch opened by referencing the new requirement for tax-exempt hospitals to conduct CHNAs, set priorities, and develop implementation plans, and noted the parallels to the new accreditation standards for local public health agencies. He also noted that given our understanding of health in the community context as being much more broad than simply the absence of disease, there is a need for hospitals to engage the public health system:

"And let me tell you what the public health system is. I think you've probably heard it mentioned a few times over the last day or so. But it's government and its partners, public and private, who together provide public health services knowing and unknowing in every community, every city, state and the nation."

In preparation for a priority setting process, Dr. Beitsch noted that local/regional groups need to decide early on whether and how they will devote sufficient time, thought, and resources into the process. He noted that while basic democracy (i.e., one person, one vote) may be the most simple and straightforward way forward, it is wholly inadequate for this purpose. He then shared a sampling of tools and approaches to priority setting.

He described the *nominal group process* as a facilitated approach to list, review, and group issues for priority setting that helps to build common understanding and engagement among diverse stakeholders. Dr. Beitsch also described *strategy maps*, 2 x 2 grids on an X and Y axis that assist in the selection of criteria based upon relative importance and performance, and the

Simplex Method as a way of comparing and weighing the importance of different health problems. While it has the advantage of supporting broad participation of community stakeholders, he noted that many participants may be less informed about the subtleties of associated issues.

Dr. Beitsch described the *Hanlon Method* as a common approach to priority setting with preestablished criteria such as the seriousness and magnitude of a problem, and effectiveness of available interventions. Potential priorities are then run through what is called a PEARL test (propriety, economics, acceptability, resources, legality) to accommodate practical considerations:

"Economics; what is the cost/benefit ratio; does it pay for itself? Is it acceptable in the community? For example sex education or needle exchange programs may not work in some parts of the south that we're in right now. Resources; do you have the resources? Are there grants available? The legality of it, is it lawful in your jurisdiction? And finally, the propriety; which is really the feasibility of doing it in your area."

Dr. Beitsch suggested another couple of tools to support decision making, including a *prioritization matrix* and a *summary matrix*, both which help in the identification and weighting of different criteria to be used in setting priorities. He closed by emphasizing the need to identify, review, and give appropriate weight to criteria on the front end of the process, in part to minimize the potential for one or more individuals to advance hidden agendas.

Moderator Follow up

The panelists were asked to address the interest expressed among an increasing number of stakeholders in the field in comprehensive approaches to community health improvement, and the implications for priority setting processes. The moderator noted that there is a "catch 22" in that the lack of investment in research to date in comprehensive approaches may work against the selection in the priority setting process, given the lack of scientific evidence.

Panel Response

Dr. Teutsch acknowledged this as a dilemma for the field; that our research priorities and investments have often gone towards issues that are easier to study. He emphasized that investment in comprehensive approaches that address the underlying causes of health problems as a priority, and suggested a path forward:

"...we [need] to take advantage of some of the evaluation tools that we have, and modeling has certainly been underutilized. But more importantly, when we implement programs, whether they're policies, multi-component kinds of interventions, we make sure we evaluate them properly and do that early."

He also emphasized the need to put information systems in place on the front end of the process that will enable us to effectively monitor progress towards identified outcomes.

Dr. Beitsch cited obesity as an issue where there is both great interest and a compelling need to take action, despite the fact that scientific evidence around the effectiveness of community interventions is limited to date.

2. Public Comment

Gianfranco Pezzino, Kansas Health Institute

Dr. Pezzino noted that an early lesson in his work in the field was a need to consider the level of concern about any particular issue among community members before seeking to take action. He acknowledged that as quantitative scientists, they may tend to ignore that, and must resist the temptation to do so.

Chris Kochtitski, Centers for Disease Control and Prevention

Mr. Kochtitski asked the panel to address how to ensure public engagement in the prioritization process and the subsequent health improvement process in the community:

"...so that in the end, the prioritization isn't just the public health system's priorities or the hospital's priorities for that matter, but the entire community's priorities and that there's buyin from all the players."

Ron Bialek, Public Health Foundation

Dr. Bialek recommended that the root causes of health problems be considered as an essential part of the priority setting process, and asked the panel to address how groups should factor in the relative control that stakeholders may have over different issues.

Panel Response

Dr. Teutsch indicated that experts in the field are doing a better job of framing issues in a manner that a broader cross section of society is beginning to understand the determinants of health in the community context, and stressed the need to continue these efforts. He noted further that community stakeholders tend to make these kinds of connections:

"... community partners generally understand that the major problems that they face in their communities are very much these underlying determinants that we've got to address them in more coherent ways in partnership with the clinical care system, hospitals, businesses, and schools if we're really going to improve health and move the health indices."

Dr. Beitsch noted that it is important to identify issues of community concern and secure broad stakeholders "buy in" long before the prioritization process. He noted further that prioritization should focus initially on prioritization of problems to be addressed, and then go back to determine which interventions are best, and that addressing root causes is essential. He noted further that it is important to work together and reach beyond those problems for which you have full control, which is the case with most problems in the community context.

Loel Solomon, Vice President for Community Health, Kaiser Permanente

Dr. Solomon emphasized that traditional scientific evidence has often not been in place prior to community interventions that have shown to be effective:

"There was no randomized trial that shows that putting sodas into vending machines in elementary schools was safe and efficacious. There ought not to be randomized trial to engage the community to get those out. So I think that's a really important framework for all of us to get our minds around."

He also emphasized that an important area of focus is the "sweet spot" where there is alignment between community need, opportunities to make a difference, political will, and institutional priorities.

Laurie Cammissa, Vice President for Community Health, Boston Children's Hospital

Ms. Cammissa noted the challenge of getting clinicians involved in community benefit activities, and the need to frame issues in a manner that will tap into their passions. She also emphasized the importance of using the quantitative and qualitative data from the CHNA as a tool for "bidirectional dialogue with internal and external stakeholders to identify opportunities for joint action.

Robert Sigmond, consultant

Mr. Sigmond suggested that some policy people may view prioritization as a selection of what is most important, while managers may view it as an issue of sequence. He noted further that managers generally understand that it may not be appropriate to take action first on the issue that is viewed as most important:

"... it seems to me that the solution there is for every single thing that you think is important, there should be an outline of the steps, the order of the steps to get it going. And almost inevitably the initial steps are very small, don't cost anything, don't disturb anybody. And that I think is the resolution."

Panel Response

Dr. Beitsch emphasized that selecting priorities that do not hit a "sweet spot" for diverse stakeholders is not a viable community health improvement plan. He noted further that community health improvement by design has the community as the unit of analysis:

"The community health improvement plan should do something to improve the health in the community. If it improves only the bottom line of a hospital system or if it only checks off a box for the health department, that's not a community health improvement plan."

He closed with strong encouragement to approach priority setting as a formalized process to ensure full transparency, avoid hidden agendas, and build the trust that is needed to succeed in community health improvement.

Dr. Teutsch indicated that there are significant opportunities for alignment with hospital priorities, and referenced preventable ED and inpatient utilization as a good entry point. He also noted that as hospitals engage in these issues, moving towards addressing social determinants is a natural progression, and while a hospital may not directly address physical environment issues, understanding and being engaged in the process is important.

E2. Priority Setting: Practical Issues and Implications for Collaboration

1. Expert Panel Comments

Tom Wolff, PhD – Principal, Tom Wolff and Associates

Dr. Wolff opened by summarizing a set of principles for effective community health improvement, the core of which focuses on the breadth and manner of engagement. He referenced a categorical framework developed by Arthur Himmelman¹⁹ that outlines four stages of engagement, including networking, coordination, cooperation, and collaboration as the most advanced form. They are described as follows:

"The first is networking. We do this when we exchange cards. We tell each other what our services are. It's the lowest level. It's a very important piece because we don't have the information, but it's a building block. I see many coalitions that stop exactly at that point."

"The next is coordination, exchanging information, each build on each other they get more powerful, they get more complex, they get riskier. And now we're going to modify activities."

"Cooperation is exchanging information, modifying activities, and sharing resources. The resource word is on the table, and things get a little heavier and a little riskier, but we have the chance of creating better change. "

"[In collaboration], the hospital is out in the community working with the neighborhood association, not as charity. They're trying to make the neighborhood association the best they can be. And the neighborhood association is trying to make the hospital the best it can be."

In moving towards action, he emphasized a need for an "ecological approach" that moves beyond community needs and deficits to identify and build on existing assets. He referenced the work of John McKnight and Jody Kretzmann at Northwestern University in this area, and noted that hospitals and other institutions need to make a decision whether they want to have the community engaged as a partner in problem solving. Dr. Wolff noted that the traditional needs assessment does not contribute to partnership in the sense that it asks two questions:

"...what are the problems and how do I, the hospital, fix them? If you had two questions, they should be what are the assets, and how can you contribute to helping us find a solution? If all the assessments we've been talking about for the last couple of days started to do that, at the end of an assessment you'd have a lot of answers. And they [the community] would feel that maybe they had some value to you..."

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¹⁹ Himmelman, Arthur, 1998, Communities Collaborating for a Change

He further described an ecological approach as moving beyond near term interventions to consider and advance policy changes that will reinforce near term gains, referencing issues such as land use and zoning, for example, to bring a supermarket into a neighborhood as part of a community wide effort to address obesity.

Moving directly into the issue of priority setting, Dr. Wolff framed two approaches, "agency-based," and "community-based." In the former approach, he notes that the agency defines the problem, views itself as central to decision making rather than as a resource for positive change, and secures very little community ownership for the prescribed solution. In contrast, the community-based approach mobilizes diverse community stakeholders to determine what will work based upon historical experience, engage formal and informal leaders, build local leadership, and create positive norms in the community. He referenced Arnstein's Ladder of Participation²⁰ as a long-established framework of relative community involvement in decision making that extends from non-participation and manipulation, to more tokenistic approaches such as consultation, to partnership, delegated power, and ultimately, citizen control. Dr. Wolff closed with the following encouragement to colleagues:

"Create a space for residents to come together to define a problem, to define the solutions and then enter into a dialog with us, not the other way around. You better figure out how you're going to get the people affected by the problem at the table, because if you can't do that and you can't support that work, somehow you're not going to get to the solutions you need to get to. When we decide that we are outcome oriented, this has to become our mantra."

Vondie Woodbury – Director of Community Benefit, Trinity Health

Ms. Woodbury opened with a brief description of the Trinity Health System, one of the largest Catholic health systems in the U.S., with 47 hospitals, mostly in the upper Midwest. She also described her own path of working initially as the director of a community health collaborative in Muskegon, Michigan, in a project supported by the W.K. Kellogg Foundation, and its merger with Trinity Health. A key factor to the decision to come together was driven by the recognition that:

"Communities needed to become more directly invested in health and understand what was going on in health care, because in fact they had been left behind. And the easiest way to figure out that communities had been left behind was to watch the ads and sorts of things that really were used to defeat health reform under the Clintons."

The project supported by Kellogg was entitled the Comprehensive Community Health Models of Michigan, and Ms. Woodbury emphasized that one of the reasons for their success was ongoing engagement of the community. One of the key elements of the program was the creation of a county health plan entitled Access Health in Muskegon; known by some around the country as a multi-share program, where health coverage is subsidized with Disproportionate Share funding, yielding premiums of \$46 per month.

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²⁰ Arnstein, Sherry R. "A Ladder of Citizen Participation," JAIP, Vol. 35, No. 4, July 1969, pp. 216-224

While acknowledging the importance of quantitative data, Ms. Woodbury emphasized the need to talk to community members, not only to find out what they know, but also to discover what they don't know. In this sense, you can gain insights into how to build common understanding and shared commitment to address major challenges. That having been said, she noted that people are aware of the major problems:

"...is there a community out there that hasn't identified diabetes, childhood obesity, and disparities? For some of the things it doesn't take any kind of a process. You know it's bad, it's bad all over the country."

Ms. Woodbury described establishment of a policy board at one regional system that includes the county administrator, the country treasurer, the Chamber of Commerce president, the large and small employers, providers, and consumers. She emphasized the need for equal representation and engagement of community members in decision making, and to sustain that engagement over time. Many of the programs previously initiated and/or supported by the hospital are now run by community coalitions. The hospitals serve as fiduciary agent and administrative manager, but community members make the decisions.

Ms. Woodbury cautioned against the formation of "collaboratives" that bring service providers and organizations together, but do not engage community members. She referenced the national organization Communities Joined in Action as a key resource in documentation and dissemination of best practices among hundreds of coalitions across the country. In supporting more inclusive and legitimate coalitions, she lamented that the IRS does not currently allow hospitals to report financial costs associated with these activities:

"I would challenge my friend from the IRS to figure out how you're going to fix things with community if you can't convene them and count that in some way. I really would challenge you to think about how we might do that because otherwise we are going to continue to work in silos. And the true integration of community requires that."

Ms. Woodbury also noted that ongoing engagement of local public health agencies is a challenge, and attributed it to chronic underfunding that impedes the ability to work together in a meaningful way.

Peggy Honoré, DHA, MHA – Director, Public Health System, Finance, and Quality Program, Office of Healthcare Quality, Office of Assistant Secretary for Health, HHS

Dr. Honoré focused her comments on a set of quality principles developed by HHS and their relevance and application to hospital community benefit programming. She also made a strong case for IRS authorization of community building activities as an important part of fulfilling the charitable obligations of tax-exempt hospitals.

The impetus for work by HHS on public health quality principles was documentation of gaps in national guidance and a lack of involvement and/or reference to public health in reports such as Crossing the Quality Chasm by the Institute of Medicine. In 2008, the Office of the Assistant Secretary for Health convened a public health quality forum, and a key product is a set of nine

aims that serve as characteristics of quality in the advancement of public health practices in the field. Dr. Honoré indicated that these aims can be closely aligned with emerging innovations by tax exempt hospitals engaged in community health improvement.

She emphasized the importance of a more comprehensive analysis of health problems and their underlying causes, as well as the cost implications:

"Medicare costs to treat cardiovascular disease in men over age 65 are twice as high if the individual had risk factors at age 45, compared to one who had no risk factors. So the bottom line is, if you have risk factors at an early age, you're going to increase the burden on government twice as much as opposed to if you did not have those risk factors."

Dr. Honoré indicated that effective strategies require attention to the underlying causes of these risk factors, focusing on environmental issues such as limited access to recreation, lack of counseling, inadequate nutrition, and lack of exercise. With the public health quality principles as a conceptual framework and evidence-based resources such as the Healthy People 2020 objectives and the federal guide to community preventive services, Dr. Honoré cited a number of examples of powerful charitable contributions by hospitals that would clearly address risk factors that are currently excluded as community building activities, including:

- Educational preventive programs in primary schools and other learning environments
- Initiatives to reduce alcohol outlets
- Early childcare development programs for at-risk children and low-income families
- Increase walking and bike paths to encourage exercise

Dr. Honoré stressed the importance of encouraging hospital investment in these activities:

"... community building activities can be aligned with public health quality concepts, national objectives such as Healthy People 2020, and evidence – meaning science – to advance improvements in health of the community, while reducing and avoiding Medicare costs. "

She closed by noting that addressing the underlying causes of health problems is a central theme in the Affordable Care Act, and encouraged the IRS to reinforce an approach to community benefit that strengthens alignment between public health and medicine.

2. Public Comment

Mark Huber, Vice President for Social Responsibility, Aurora Health Care

Mr. Huber reflected that a common theme in expert panel sessions was the importance and value of collaborative approaches to community health needs assessment and planning. He referenced a provision in the IRS 990 Schedule H indicating that hospitals will be required to complete and adopt their implementation strategy the same year as they conduct their CHNA. Consistent with the comments of expert panelists, Mr. Huber indicated that it may often be impractical to expect hospitals and community stakeholders to complete collaborative assessments and planning processes in the same year:

"We're at the mercy of everyone's schedule who's involved in the collaborative planning process. Some of our partners have a tax year in July, others have a tax year in January. We've just narrowed down the window for us to be compliant with that provision, just six months to do both the assessment and develop a community health improvement plan. I think it's an easy fix to come to a different solution for that need. And that may be to develop a guideline instead that says, "Within X period of time after the completion of the community health assessment, the community benefit plan would be adopted.

Julie Willems Van Djyk, Associate Scientist, Univ. of Wisconsin Population Health Institute Dr. Willems Van Djyk indicated that among community health improvement interventions, policy-based and systems-based strategies are the most effective and sustainable in changing the environment in communities, and offered it as another reason why the IRS should include community building activities as financially reportable.

She also noted that while local public health agencies are not being regulated by the IRS, the new national accreditation standards establish a similar expectation of accountability and public transparency. At the same time, she pointed out that she often hears from hospitals that they "cannot count" on the health department, given budget constraints and associated loss of skilled personnel. Dr. Willems Van Djyk suggested that given the need for public health systems to be part of the health reform transformation process, it is important for hospitals to support local public health agency capacity building.

Nancy Clifton-Hawkins, Consultant

Ms. Clifton Hawkins pointed to a need to move beyond an "us" and "them" dynamic in the development of intersectoral partnerships. There are different and complementary skill sets among public health and hospital personnel, and a need to build common language and understanding of practical realities confronted by both entities.

Panel Response

Ms. Woodbury pointed out that many public health agency leaders have difficulty because the optimal solution to a community health problem may be philosophically opposed by the elected officials who pay their salary. She noted that more assistance is needed from NACCHO at the national level to educate county elected officials, and from local hospitals to more actively support public health agendas that will yield shared benefits.

Dr. Honoré addressed Dr. Willems Van Djyk's comment, noting that a key reason for her representation of the Office of the Assistant Secretary for Health at the conference is the high level of concern about the exclusion of community building, noting that it is very difficult to explain why these activities could possibly be excluded to anyone who understands the fundamental underlying causes of health problems.

Howard Fishbein, Batelle Memorial Institute

Dr. Fishbein pointed out that some public health leaders will be enthusiastic about engaging in the kind of transformation being discussed, and others will resist it. He suggested that there is a role for CDC to work with states and create incentives for achievement of performance goals that involve collaboration with hospitals.

Dory Escobar, St. Joseph Health System

Ms. Escobar reminded colleagues that as we acknowledge the challenges ahead, it is important to also celebrate and build upon what has been accomplished. In the process our enthusiasm may help to recruit those who have been more hesitant to engage.

Jessica Curtis, Community Catalyst

Ms. Curtis asked panelists to address what might be the role of hospitals in enrollment in Medicaid and screening for subsidies as part of the implementation of the ACA, and what might be potential roles of community health workers in the care delivery process.

Panel Response

On the issue of enrollment assistance, Ms. Woodbury noted that one of the current challenges is that many people who are uninsured are reluctant to seek care or enter the system because they are already carrying significant medical debt. She noted that the provider systems know where people live, and that it is a relatively easy proposition to reach out, let them know that regardless of their medical debt problems they are eligible for coverage, and help them complete all necessary paperwork. Despite the need, Ms. Woodbury recently heard from colleagues that the Michigan State health department planned to reduce enrollment assistance staffing, with the assumption that people will complete applications on line. If true, tax-exempt hospitals may need to step up with additional investments in enrollment assistance through such mechanisms as community health workers.

Dr. Wolff referenced the challenges faced in Massachusetts after the passage of state health reform, and there had been an assumption that people would just go online and enroll. After considerable dialogue and initial push back, he noted that providers, payers, and community stakeholders came together to implement a much more hands on approach involving community outreach to a variety of mechanisms. He also addressed the comment regarding resistance to reform among some in public health agencies:

"If you're building coalitions, just replace the word "health department" with anybody else in your community at any given time, and anybody can be resistant. And the question is, how do you deal with them. It's about a common vision, getting people excited about the direction you're going to go..."

Dr. Honoré addressed the issue of enrollment, referencing an experience in Missouri in the early days of the federal Child Health Insurance Plan implementation, citing reluctance to be associated with what was viewed as a welfare program. She emphasized the need to engage

community members in a language they will understand. She noted further that this applies to how we talk with community members about the issue of social determinants

"...so they'll know that the reason why they're having these health problems is not just because they're getting old and it's something that's going to happen to them, but it's something within their environment, something under their control that they can alter."

3. Key Informant Interviews

Key informants offered a number of observations on the importance of comprehensive approaches to community health improvement in moving from assessment to the development of an implementation strategy. Larry Cohen, President of the Prevention Institute, framed some of these social determinants as "macro issues," in that they influence health on many levels:

"There are macro community issues that really need to be examined. For example, safety is not only a key health issue in and of itself, but is a critical determinant of other community health issues. It has a critical impact on not just where we shop and where we walk, but whether we can walk in our neighborhood, whether there are jobs available, whether there are places to shop, and if children are able to learn. Macro issues like violence prevention affect so many other issues. I understand that there's a question at this point whether environmental issues like violence prevention in fact should be included. I would say they not only should be included, they need to be some of the central issues in this kind of a conversation."

He also discussed the importance of integration of efforts, and questioned the degree to which more narrow programmatic approaches can be viewed as "best practices":

"A best practice is almost never a health fair, community education, or a clinical service. It's about comprehensive approaches for community-wide change. It's about strategy development. It's about partnership. It's about putting pieces together. So there needs to be links between what hospitals are doing, what government groups are doing, what some philanthropic groups are doing, what groups supported by external state or federal grants are doing. This all needs to be brought together in a well thought-out way to effect large-scale impact on community conditions and health outcomes."

As noted by a number of key informant interviewees, **Tom Wolff** cited research over the past two decades indicating that medical care represents only 10 to 20 percent of what produces health and longevity:

"So if you want to talk about community health, and you're only going to negotiate about the 20 percent that's in your ballpark, you're looking at it in remedial terms. We're already in a losing game."

He noted while the current system of health care financing works as a disincentive for hospitals to care about the health of the community, national health reform challenges us to move beyond clinical services and change conditions in communities

"...what you're looking for is community norm change. So you're now addressing obesity from a preventive, systemic, community, school, farm-based approach, you have to make sure that the parents understand they can't keep sending Twinkies in the lunch box. And that's a norm change. You can create Twinkie police, but I don't think that's going to work. So how do you work with parents to get it, and they reinforce it with each other."

Dr. Wolff points out that bringing about this change in norms requires a serious commitment to a common vision among a complex array of organizations and individuals in communities. He laments the lack of funding of the infrastructure needed for collaboration, as well as the lack of understanding among potential funders of what can be accomplished when there is sufficient support.

A number of key informants also addressed the importance of implementing priority setting as a group exercise among diverse stakeholders, rather than as individual institutions. **Dr. Eric Baumgartner, Vice President of the Louisiana Public Health Institute** suggested that the group process contributes to a more complete understanding of health issues, their causes, strategies, and the potential contributions of different stakeholders:

"...we can't know what will be our priorities until we get through the conversation to hear a variety of perspectives, the checks and balances, and we can't know what would be the opportunity, to put it the other way, what's requested of you as a hospital, until we get through that part."

III. IMPLEMENTATION STRATEGY DEVELOPMENT AND EXECUTION

A. Alignment Opportunities

The passage of the Patient Protection and Affordable Care Act (PPACA) has accelerated a process of reassessment and reorganization in the health care arena driven by the recognition that the current system of financing and delivery is unsustainable. Dramatic and sustained increases in health care costs, combined with growing rates of chronic disease and persistently high rates of uninsured and underinsured have demonstrated the inadequacy, if not fundamentally unethical nature of the status quo. The introduction of Accountable Care Organizations, while generally retaining the fee-for-service system, represents an important incremental step towards a system of financing that more closely ties payment to performance. It is increasingly acknowledged that a sustainable system of financing will require a shift in incentives away from filling hospital beds and conducting procedures and towards keeping populations healthy. In this context, hospitals that invest in building population health capacity in the near term may be optimally positioned to thrive economically in the long term.

A more strategic approach to health improvement involves the collection and analysis of data on health status and factors contributing to poor health and collaboration with diverse stakeholders to address both the symptoms and underlying causes of health problems. As such, hospitals are in a position to leverage their charitable resources and build the capacity to address complex health concerns in a cost effective manner in the period prior to expansion in coverage in 2014.

CMS lists the 65 nationally recognized quality measures in five Domain areas that will be used in the first year to establish quality performance standards that ACOs must meet to secure shared savings under the ACO designation. Nonprofit hospitals that are already collecting this data can align their measures to meet ACO data requirements. Domains include a) patient/caregiver experience of care, b) care coordination, c) patient safety, d) preventive health, and e) at-risk populations/frail elderly health.

Under Sec. 4002 of PPACA, the prevention fund was established with funding of \$500 million in fiscal year 2010; increasing to \$2 billion in fiscal years 2015 for transfer to increase funding for programs authorized by the Public Health Services Act in prevention, wellness and public health activities, including prevention research and health screenings. The fund increases the amount available for both clinical and population-based prevention approaches,

Under Sec. 4201 of PPACA, community transformation grants are also to be awarded to state and local government agencies and community-based organizations for the implementation, evaluation, and dissemination of evidenced-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. The list of potential activities include "prioritizing strategies to reduce racial and ethnic disparities,

including social, economic, and geographic determinants of health," and "addressing special populations needs, including all age groups." ²¹ Nonprofit hospitals can partner with CBOs and local public health agencies to develop and implement a multi-pronged approach to addressing these issues.

In contrast to the implementation of programs and incentives to encourage increased investment in prevention and addressing the underlying causes of health problems, the current Schedule H makes a distinction between community benefit and "community building" activities. These include physical improvements, social support systems, coalition development, community health advocacy, neighborhood revitalization, youth leadership development, and workforce development. The IRS has indicated that "more data and study" were required to determine whether all the activities in that category are appropriate for hospitals.

In the examination of alignment opportunities, it is also important to consider the unique contributions of different kinds of hospitals. Of particular interest are the potential roles and contributions of teaching hospitals and their academic affiliates; schools of medicine, dentistry, nursing, and allied health programs. Teaching hospitals are centers for medical innovation and research, but also have the potential to direct their inquiries towards issues in prevention and community health. They are often safety net providers in urban areas, and thus have the potential to contribute to knowledge of low income community residents from diverse racial and ethnic backgrounds. They also provide an avenue of learning and innovation that can and should inform the ongoing review and redesign of the health professions educational process among academic affiliates.

Last, but not least, studies from the IOM²² and the Sullivan Commission²³ offered strategies to increase diversity within the health professions, and noted that both health professions education institutions and their teaching affiliates could play a vital role in leveraging progress through the implementation and support of pipeline programs and the development of tools and resources to increase diversity and cultural competency among the next generation of health professionals. Key questions addressed by the expert panel, key informants, and public participants included:

- What are alignment opportunities associated with national health reform (e.g., ACOs, CMS rules)?
- What are unique characteristics, potential contributions, and expectations of teaching hospitals?
- What are potential contributions and expectations of health professions education institutions?

²¹ http://www.cfpciowa.org/uploaded/Federal%20Health%20Reform%20and%20Children%20May%2024-formatted.pdf

²² In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce, Institute of Medicine, Washington, DC. 2004

²³ Missing Persons: Minorities in the Health Professions, Sullivan Commission, Washington, DC, 2004

1. Expert Panel Comments

Paul Hattis, MD, JD, MPH, FACPM – Professor, Tufts University School of Medicine
Dr. Hattis discussed key elements in national health reform such as Accountable Care
Organizations (ACOs), increased emphasis on prevention, and achievement of specified
measures of quality, as well as the general trend towards global budgeting. He pointed to the
need for financial incentives that encourage adjustments in the care delivery process to keep
people healthier, which will require working more closely with public health and community
stakeholders. He noted that the movement towards universal coverage in Massachusetts has
shifted the focus and thinking on the role of community benefit:

"There's alignment there in concept with this whole notion of public health and community benefits that if that kind of model takes off as we're talking about now in Massachusetts, not only for Medicare patients but more broadly than that as we're discussing some health care costs legislation."

Dr. Hattis shared that the Massachusetts Community Benefit Voluntary Guidelines had recently been revised, and one of the revisions was an increased emphasis on planning, community engagement, and accountability. As such, hospitals and health plans will document what they seek to accomplish in terms of improving health, and at the end of the year, they'll write a report that evaluates what was accomplished.

At the national level, however, he noted that there will still be a substantial number of people who will not be covered in the implementation of health reform, and an imperative for community benefit programming to reduce the demand for treatment of preventable illness:

"...we're going to still have twenty million people uninsured, so how do you care for the uninsured, especially in geographic parts of the country with concentrations of undocumented people. There's still an incentive to keep people healthy to avoid the costs of caring for the uninsured."

Dr. Hattis suggested that the most significant challenge ahead for Massachusetts and the country is to reduce health care costs. While Massachusetts has reduced the percentage of uninsured to 2%, they are still confronted with high costs. He challenged reporting by the national press pointing to their health reform as the cause, noting that prior to the health reform legislation they had the most expensive health care system in the country, with premiums 25% higher than the national average. The focus is now on the implementation of payment systems that incentivize reductions in preventable conditions and the demand for specialty care.

There are a high concentration of teaching hospitals and health professions education institutions in Massachusetts, and Dr. Hattis pointed to the unique roles and contributions they can make in building capacity in primary care and prevention and addressing health disparities in local communities. He noted that Tufts medical school is expanding their focus on public

health and the socio-ecological model for students, as well as on diversity and cultural competence. He noted that both teaching hospitals and their academic affiliates have a responsibility to invest, recruit, and support students from under-represented backgrounds as part of building a health professions workforce that will better serve our diverse communities.

Bradford Gray, PhD - Senior Fellow, Urban Institute; Editor, The Milbank Quarterly

Dr. Gray opened by noting that he began his professional work at Yale with a focus on the broader nonprofit sector, referencing its label as the "third sector," along with government and business. He pointed out that nonprofit hospitals represent approximately 3,000 out of over a million and a half in the larger pool of nonprofit organizations, but because they represent nearly 50% of nonprofit revenues, they tend to get more attention.

He noted further that nonprofits have their own governance structures, and garner substantial revenues from the public sector. There are often conditions associated with government funding, such as EMTALA, the requirement to provide emergency treatment to people regardless of ability to pay. At the same time, he noted that they behave like the business sector, such as raising money for capital needs through borrowing, and that some conditions of government funding such as the Medicare requirement to collect bad debts push them in the commercial direction.

Dr. Gray lauded the overall efforts of the IRS in the revisions to the 990, Schedule H, in terms of increasing accountability, but raised a number of concerns. First, he questioned the decision to exclude community building from what can be counted as a community benefit, indicating that it is hard to imagine how such activities would not be considered a criterion for tax exemption. He noted further that given the fact that many tax exempt hospitals have sustained their commitment to such activities, relegating them in the reporting process to the 'denominator' actually reduces the reported percentage of expenditures that are reported. He attributed part of the issue to a question of the wisdom of having the federal taxing authority provide oversight of nonprofit hospital engagement in community health improvement:

"It has the peculiar effect of having the Internal Revenue Service becoming responsible for overseeing what's being done to improve the health of communities. That's a very strange thing. But it's because these conditions were attached to tax exempt status as opposed to, say, Medicare participation or something else."

Dr. Gray shared some observations from research in Maryland, which is unique in terms of community benefit expenditures, due to the establishment of a rate setting system where hospitals are reimbursed for uncompensated care. He noted that community building expenditures there were less than 2% of total community benefit expenditures, so they weren't of particular concern. He also noted that a significant percentage of community benefit reporting is for health professions education, with major academic institutions such as the University of Maryland and Johns Hopkins. A key conclusion of his research was that despite the fact that hospitals receive little feedback from the state since the statute passed in 2004, for the first time hospital leadership could see how much was being spent, and it had a major

impact. The majority of hospitals he examined had begun to move towards a managerial approach where programming is being informed by assessments, integration into the organizational strategic plan, and engagement of their board of trustees.

Dr. Gray suggested that Schedule H will foster movement towards a managerial approach at the national level, and while it will take some time, it will yield important results in the field. He pointed to California as an example where the passage of time²⁴ has produced an array of exemplary practices. At the same time, he urged caution moving forward:

"I think that this is really pushing things in the right direction and I hope that Congress and our friend from Iowa will give it time to play itself out. There will continue to be a temptation to use tax policy to produce health policy goals. I think that that should be approached with caution."

Dr. Gray also returned to the issue addressed in Panel #2 regarding how to define community, referencing the example of Sloan Kettering Medical Center, which is located in an affluent community in New York. He noted that he did not know how Sloan Kettering defined community, but that they served patients in a broad region of the Northeast. He suggested that it would be inappropriate to penalize hospitals with specialized functions in medium sized cities.

On a more general note, Dr. Gray recommended against moving towards establishment of explicit financial requirements. He noted that there was considerable pressure in Congress to set a 5% minimum investment in charity care, but such a uniform measure would not take into consideration dramatic variations among hospitals, their resources, and the communities they serve.

In regards to the impact of national health reform, Dr. Gray suggested that there will be significant growth in the volume of subsidized services reported by nonprofit hospitals, primarily because current trends indicate that reimbursement for Medicaid will not improve. He noted that there will also be fewer resources available for charity care. He also shared a worry expressed by a colleague; that hospitals may have increased economic leverage over payers, and that higher prices may reduce savings associated with reduced hospital utilization.

In closing, Dr. Gray posed a few research questions for consideration by colleagues in the field, including a) whether reduced focus on charity care will increase an emphasis on achievement of measurable outcomes, b) will scrutiny and reporting requirements be established beyond hospitals to others in the nonprofit sector, c) will the logic of community health improvement lead to an increase in collaboration, and d) will hospital missions evolve towards community health improvement (assuming a shift in financial incentives).

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²⁴ California's community benefit statute SB 697 was passed in 1994.

Moderator Follow up

The moderator raised the issue of the IRS decision to allow hospitals to count research dollars from outside sources such as NIH as their own charitable contributions. He noted that some major teaching institutions had indicated that they are not counting those dollars, but expressed concern that others may respond to the windfall by reducing their charitable investments in addressing unmet community health needs.

Panel Response

Dr. Hattis lauded those institutions which have chosen not to count research dollars as community benefits, and addressed a related issue, which is the exclusion of the Indirect Medical Education subsidy that is part of Medicare reimbursement to teaching hospitals. He noted that it was given because teaching hospitals tend to handle more complicated, complex patients, but that it is not being factored into the community benefit calculation as an offset.

Dr. Hattis also addressed the issue raised by Dr. Gray regarding defining community by noting that while Boston Children's Hospital's service area is the state of Massachusetts, it focuses a good part of its community benefit programming in Boston neighborhoods.

Dr. Gray expressed support for the IRS inclusion of grants secured by hospitals to address community health needs:

"It seemed to me sort of odd that if the hospital goes out and raises money to meet a community benefit type, to provide a community benefit service, that you shouldn't count it unless that you're somehow cross-subsidizing it out of patient revenue. If you don't have a source for it, then you can count it. If you have a source for it, you can't count it. That just seemed peculiar to me. "

Dr. Gray distinguished research grants, however, and also expressed his support to those institutions who deferred their reporting of these funds:

"I do think that community benefit reports have to pass a straight face test, and I don't think they would if you started claiming credit for stuff that you're being paid – that you're receiving research grants to do."

2. Public Comment

Jean Nudelman, Kaiser Permanente

Ms. Nudelman noted that Kaiser is engaged in substantial research and teaching, and asked the panel to address how and whether such issues of concern could or should be reflected in a CHNA. She reflected further that there are a number of issues related to the operations of health systems that are vital, but are unlikely to be reflected in the needs assessment process.

Laurie Cammissa, Boston Children's Hospital

Ms. Cammissa verified that her hospital only counts what they subsidize in research initiatives, and do not report what the IRS allows in this regard. She also noted that they define their community in local terms, rather than the broader region they serve, primarily because they are committed to produce measurable outcomes:

"If I do a broad and shallow approach to community benefits, I can't move the dial, but if I go narrow and deep in the neighborhood, I can make a difference and now I can show data with my program."

Robert Sigmond

Mr. Sigmond questioned whether charity care will decline significantly, and suggested that there is a need to retain focus in this area as a part of the community benefit portfolio. He suggested further that charity care expenditures be given to community benefit departments in order to facilitate more effective management and planning.

3. Key Informant Interviews

Key informants suggested that the implementation of national health reform has spurred many hospital leaders to call for dramatic increases in facilities and providers. As framed by **Lloyd Michener, Professor at Duke University School of Medicine**:

"...their first reaction is often that we need more buildings, more doctors because that's the standard solution to everything. ...as the whole ACO discussion ramps up, the immediate reaction is we're going to increase our number of primary care docs and our number of clinics. As a family doctor I like seeing that. But actually I think they're missing the point. I think many of these visits don't need to happen at all."

Along these lines, Dr. Michener noted that in consideration of options at Duke Hospital in Durham, NC, it was concluded that investment in support of community clinics was a more cost-effective option than expansion of the hospital emergency department. Some of the strongest advocates for this option were the health system leadership, and especially the chief financial officer:

"His analysis was that the community clinics were at worst an equal and at best a huge positive return on the investment. Reaching this point required brokering and it required time. But the hospital invested over \$1million a year for ongoing support of community based clinics because of the reduction in ED care there. It's a straight financial decision, as well as being the right thing to do."

Dr. Michener posited that the role of academic health centers should be "to improve the health of the community," but that not everyone agreed with that position. He suggested further that academic health centers should demonstrate their value by developing experimental models to improve health in proximal communities:

"If we can't do that in our local communities we have no credibility whatsoever. When hospital folks say we have social determinants that limit our ability to improve health outcomes, I ask why that necessarily stops us from seeing what we can achieve. I know it's important. In Durham, through partnerships with community agencies, we have produced better health outcomes among low literacy black women than among Duke faculty members [with similar conditions]."

Dr. Michener also pointed out that a key consideration in hospital alignment with the goals of health reform is the degree to which actions taken reflect core values:

"I just spent two days with the Department of Defense and the Surgeon Generals to discuss health care redesign for the military. What's fascinating to me was that the first question they raised is 'what are our values?' I've never been in health care meetings where we start by reviewing our values. But the Department of Defense leadership said, 'if you don't know what your values are, how do you know how to move forward?""

Others acknowledged that while the current system of fee-for-service will ultimately be replaced by some form of global budgeting, its predominance has strongly influenced hospital operations and investments. As noted by Jonathan Fielding, Public Health Director and Health Officer for Los Angeles County:

"Hospitals have become further removed from communities because increasingly, though not entirely their own fault, providers are trying to take whatever they can out of the hospital, to their own surgery centers and this center and that center, not affiliated with the hospital, so the ambulatory side is atrophied, including some of the low technology procedures."

Dr. Fielding pointed to the composition of hospital governing boards as key to whether the organization seriously assesses their role in addressing unmet health needs in communities. In the current structure of payments, however, works against consideration of health concerns in the community context:

"Unless you provide the right economic incentives you're trying to push a rock up a hill... I think hospitals just have to change the way that they think about their role and I think unfortunately in many cases it doesn't get the level of priority because we haven't established the incentives."

Along the same lines, some key informants question whether hospitals can achieve the level of transformation that is needed to play a substantive role in community health improvement.

Anthony Iton, Senior Vice President with The California Endowment noted that a key premise in the PPACA is that prevention is important, and intensive medical treatment for chronic disease is consuming too many resources. He suggested, however, that there is less agreement on the optimal venue for interventions to prevent chronic disease:

"...when we're talking to hospital community benefit provisions, I would see it from a hospital's vantage point that you can't ask a kangaroo to be an elephant. A hospital has a limited set of interventions available to it... So we're asking the hospital to align their resources with the resources in the community, and to create better interfaces between community-based prevention and hospital-based interventions."

In terms of IRS oversight of tax-exempt hospitals, Dr. Iton pointed to a problem that the IRS appears to have embraced a narrow interpretation of health as the delivery of health care services. He suggested that far more could be accomplished if there was actually strong encouragement for hospital investment in primary prevention, and pointed to K-12 schools as a good entry point for an array of interventions.

Other key informants pointed to the current trend towards measurement of quality in clinical settings as a first step towards establishing accountability for outcomes at the population health level. Steve Shortell, Dean of the University of California at Berkeley School of Public Health suggested that the combination of increased institutional accountability and payment mechanisms that reward providers and hospitals for improved performance on established population health measures will foster increased intersectoral collaboration.

"I give it three or four years at most to see if some of the current initiatives are going to begin to build the case for the population health by bending the cost curve and aligning with health departments, schools, and other stakeholders to reduce preventable emergency room utilization... [Moving into primary prevention] is the hard sell because of the longer run payoff of prevention, but our providers are more short-run oriented."

A number of key informants pointed to regions where definitive steps are being taken to shift financial incentives towards investment in prevention as providing insights for others in the field. For example, **Mike Bonetto**, **Health Policy Advisor to Oregon Governor Kitzhaber**, cited the passage of Oregon House Bill 3650 as an important step forward in the establishment of global systems of payment that incentivize investment in prevention. He notes further that this will encourage more strategic allocation of community benefit resources:

"You're getting global payment to cover a comprehensive set of services, and now you can really focus on some of those community benefit dollars to keep people healthier. Now you've done a better job of aligning incentives, you don't worry as much about the feds as you do about keeping people healthy."

Dr. Bonetto acknowledged that implementation of Oregon's legislation will present providers and payers with some challenges:

"You think of all this trapped equity and that exists in the current system, and now we're turning it upside down and saying you guys have to figure this out and you're going to coordinate differently. So everyone is concerned about the governance of these new types of structures and who is going to control the dollar. There really isn't an organization that exists today that would meet the criteria to do what we're saying."

He suggested that at the national level, when coverage expands to populations who have previously been uninsured or underinsured, providers and payers at the national level will likely seek to buffer the increased risk by increasing rates. These increases will bring additional urgency to move towards financial mechanisms that challenge providers and payers to do things differently. He indicated that this was the impetus for passage of legislation in Oregon;

that in order to be ready for a dramatic increase in coverage in 2014, there needs to be action in 2011 to encourage collaboration among hospitals and community stakeholders.

B. Monitoring and Evaluation

A key concern in the community benefit arena is the relative capacity of hospitals to monitor and evaluate the effectiveness of programs and activities. This becomes more important in the context of health reform, with the anticipation of a reduced demand for charity medical services, and increased emphasis on addressing the underlying causes of persistent health problems.

Recent trends in the field suggest that hospitals are taking definitive steps towards more strategic allocation of charitable resources, building collaborative partnerships, developing evidence-based interventions, and establishing metrics and systems to monitor progress. Many community benefit programs and activities, however, are not rigorously evaluated, in part because they lack the design, focus, and scale to justify the investment. This presents a challenge to hospital community benefit oversight bodies, which may feel pressure to support programs that have not produced measurable outcomes, but are popular with key providers or administrators. While some small scale programs may be appropriate to continue because they are of minimal costs, leverage substantial external resources, and foster good working relationships with community members, there is growing consensus of the need for increased scrutiny.

In the shift towards more strategic allocation of charitable resources, hospitals are moving towards management of fewer, but larger scale, more comprehensive programs in partnership with community stakeholders. This trend offers the potential to concentrate and leverage charitable resources at a scale that is more likely to produce measurable outcomes and is at a scale that justifies investment in monitoring and evaluation. This positive trend is threatened, however, by language in the current IRS 990 Schedule H and section 501(r) that requires hospitals to provide justification for any identified unmet health needs that they are not addressing in their implementation strategies.

Another key challenge in efforts to strengthen the monitoring and evaluation function is the relative paucity of skills and competencies among internal hospital staff. Few hospitals employ a full time epidemiologist or program evaluation specialist, though an increasing number are hiring community benefit staff with graduate degrees in public health. Many external leaders have encouraged hospitals to partner with local public health agencies, schools of public health, and other institutions of higher education to secure needed expertise in monitoring and evaluation. There is growing evidence that hospitals are taking advantage of these opportunities, but chronic budgetary constraints are limiting the ability of local public health agencies to step into these roles.

Key questions addressed by the expert panel, key informants, and public participants included:

- Who are potential "audiences" in evaluation, and what are the implications for the selection of measures?
- In what ways should the community health needs assessment and the monitoring & evaluation processes be linked, and what are the implications?
- What data are needed to monitor progress in addressing health disparities?
- What are potential roles of community members in program evaluation?
- What are collaborative evaluation opportunities for hospitals and other stakeholders (e.g., local health departments, academic institutions, United Way)?

1. Expert Panel

James Walton, DO, MBA – Vice President of Health Equity/Chief Health Equity Officer, Baylor Health Care System

Dr. Walton provided a brief overview of his work at Baylor Health Care System to develop a system to evaluate and reduce health disparities among populations in the Dallas-Fort Worth region. He also described ways in which they are using technology to advance their work, as well as the ways in which they are engaging community members.

A key step in the evaluation of quality and progress in the reduction of disparities has been the initiation of systematic point of service collection of information on race, ethnicity, and primary language at the point of service for both ambulatory and inpatient care. A central focus is to identify excess services as reported in electronic health records. Results are reported on a regular basis to their quality improvement committee at the health system level, as well as to their employed physician group.

In the analysis of data, they calculate mean differences and test for statistical significance to ensure that findings are not random differences. Typical reporting periods are for four to eight quarters. They examine five metrics for ambulatory care sites, and when statistically significant differences are identified, relevant providers are engaged in an effort to address identified problems. Dr. Walton noted that results are reinforced with financial awards for positive results, and financial penalties if problems are identified and improvements are not made within a specified set of quarters.

Dr. Walton also described the use of new health IT data systems to facilitate the real time transfer of clinical data from staff conducting house calls to primary care physicians, reducing the demand for physician house calls and achieving much higher capture rates following hospital discharges.

Last, but not least, Dr. Walton described the use of data technologies to demonstrate return on investment (ROI); a step described as essential to ensure the continuation and where appropriate, the expansion of key initiatives. Using census tract information and focusing on Medicaid and self-pay visits that ended up with inpatient admissions, they focused on congestive heart failure, pneumonia, and cardiovascular disease:

We now have a mobile strategy to basically address that particular hot spot. By doing our hot-spotting, we can illustrate what a patient's direct costs have been for several years before we actually started an intervention, develop a cost curve for that hot-spotted population, develop a trend of where we think those costs are going to go without any intervention, and then do an intervention. What we've been able to demonstrate to our financial people is that post-intervention we have a pretty significant diminishment in hospital-based costs."

Dr. Walton noted that taking these steps had increased their ability to make the case for greater investments "to reduce disparities by virtue of having a robust ROI calculation that takes into account bending of the cost curve plus the costs that it takes to actually bend that curve."

Catherine F. Kinney, PhD, MSW – Principal, Kinney and Associates

Dr. Kinney described her work with multiple systems to provide technical assistance to build capacity for monitoring and evaluation. She observed that while there is substantial evidence of innovation occurring in the field, there appears to be limited diffusion. She attributes some of this to a general tendency for institutions to operate in 'silos,' such that they are reluctant to step outside of their own culture to experiment with new approaches. Another problem is the relative paucity of competencies and staff time to collect, analyze, and use data to evaluate and improve performance:

"Program people in community benefit have not been trained in the basics of data nor are they comfortable with it and so they need nurturing and they need support and, in many cases, they need allocations of time that were not there five years ago. There is not only a competency issue, it is a resource issue."

Dr. Kinney notes that most evaluations of community benefit programs occur because they are supported by external grants. Even in those cases, most of the metrics are process-oriented. She suggested that the dialogue generated by this expert panel meeting should be used to issue a call for a paradigm shift towards what she referred to as a virtual system of monitoring and evaluation. The virtual system transcends individual institutions, and focuses on the community as the unit of analysis. In this context, there are shared aims and shared logic models among participating institutions and sector partners.

Dr. Kinney emphasized that local power structures need to send clear and consistent messages about working together on an ongoing basis:

"We need to identify a few topics for shared systematic pilots across oversight entities, what you would call in quality improvement a practice field; maybe it's childhood obesity, maybe it's one state but to very deliberately design and implement something that does not mean you're cramming the silos together, but that you're redesigning the system."

Dr. Kinney also cautioned against trying to identify the "perfect measure," encouraging a focus instead on measures that are relevant to diverse stakeholders. She also identified a need to educate institutional oversight bodies on outcomes, processes, and time frames for achievement, to ensure continued support and realistic target setting.

Christopher Fulcher PhD – Co-Director, Center for Applied Research and Environmental Systems (CARES) University of Missouri-Columbia

Dr. Fulcher described his work at the University of Missouri as Co-Director of a center that focuses on using geographic information systems, or GIS, to document a broad spectrum of data across sectors (7,000 national source GIS data layers). He noted that their mission is to make public data accessible at no cost to communities across the U.S.

Dr. Fulcher referenced the siloed tendency cited by Dr. Kinney, and presented their data system as a more ecological approach to assessment and monitoring of the full spectrum of community characteristics. He described and demonstrated the system through an online display for meeting participants. Areas of focus included:

"This section is what we call broad community themes. We've looked at a number of websites around the country and you have administrative areas, children and youth, community resources, economic, education, food environment, health, etc. ...We've integrated all of USDA's food atlas data into our system."

"We have all the legislative and congressional district boundaries in the U.S. that we can report on looking at economic income data, unemployment rates we update monthly, etc."

"We have integrated all data from the American Community Survey for the one year, three years and five years. Let's just look at the five year here under age, gender, household income – we have all these different levels of geography. Let's go down to the finest level of geography, block group level. Let's also bring up poverty and we'll bring up poverty down to the census tract and bring that up. Let's bring up other data such as education facilities."

"We have information from the Health Data Initiative, looking at for example health profession shortage areas and clicking on health profession shortages, all of the metadata is tied to this data. We update data monthly, quarterly, annually or as often as it becomes available."

Dr. Fulcher also described what is called a Comprehensive Community Needs Assessment Tool. The tool enables the user to select from available data sources for any particular set of geographic parameters from across the country to produce a baseline report:

"What it's doing is drilling across our engine, pulling across the education, healthcare, employment, etc. to create a Word document. It's the starting point for folks doing needs assessments because for a long time this has taken them weeks of time in pulling together federal databases and local databases. I'm going to go ahead and open it, but in the interest of time, I've just saved it here to the desktop. We have 69 pages that was just generated."

A key objective in the development of this free access, ecological model of data with mapping technology is to free up time and resources in the CHNA process for community engagement, partnership development, priority setting, and the development of an evidence-based implementation strategy.

Moderator Follow Up

Dr. Fulcher was asked to address how the data technologies he presented and the ability to drill down to the community level begin to transform our notions of CHNAs from a point in time snapshot to a baseline for ongoing monitoring and evaluation. A key question is whether the CHNA is something we do at one point and walk away from for three years, or a living resource that is the starting point for ongoing evidence-based work.

Panel Response

Dr. Fulcher noted that use of the tool is already changing the conversation among stakeholder users from focusing on the CHNA to ongoing monitoring of programs and activities:

"Or, for those folks that don't like the word monitoring, taking a pulse of the community, or a region on an ongoing basis. The technologies are there, the databases of how we link the databases provide that kind of framework for an ongoing monitoring of what we're doing."

2. Public Comment

Abby Adkins, Health Resources in Action

Ms. Adkins asked the panel to provide specific examples of how existing data systems can regularly update data moving forward.

Charlotte Kent, Centers for Disease Control and Prevention

Dr. Kent referenced the implementation of the Community Transformation Grants (CTG) that are funded by PPACA, and CDC's interest in aligning CHNAs and evaluations done by hospitals and public health agencies with the CTG process. She identified the three priorities of CTG to a) implement policy environmental and programmatic initiatives, b) improve health equity, and c) increase the evidence base. She asked the panel to address how we work towards common measures that will facilitate a meta-analysis.

Megan Weis, South Carolina Institute of Medicine and Public Health

Ms. Weis noted that one of the challenges facing states is a tendency to advance disease specific initiatives that further reinforce the silos mentioned by panelists. She cited the fact that South Carolina has a diabetes state plan, a cardiovascular state plan, and an obesity state plan. Ms. Weis suggested that the practical realities of responding to a plethora of grant opportunities may create the conditions to break down some of the silos.

Paul Hattis, Tufts University School of Medicine

Dr. Hattis expressed a concern that the tool presented by Dr. Fulcher may lead some hospitals to conclude that they no longer need to engage public health departments to assist with data collection or community outreach.

Panel Response

Dr. Kinney addressed the question of how to break down silos, suggesting the use of "ecumenical language" by opening speaker Steve Fawcett in describing different tools and resources as an important first step. She emphasized a need to be intentional about what innovations are disseminated, and which sites are ready to pilot them:

"It's going to take shared work and a readiness to let go of our individual professional identities and in some cases be ready to move into shared governance with folks that we've sat next to but we haven't been ready to take the next step. I think that's our challenge and our opportunity."

Dr. Fulcher used a farming metaphor to suggest that "the information flows are rotting in our silos," and challenged colleagues to move towards shared governance models.

Dr. Walton noted that in many respects health systems are functioning "behind the learning curve," and the looming financial challenges associated with implementation of the PPACA have prevented many leaders from seriously considering the need to invest in areas such as primary prevention. He noted further that

"A lot of healthcare systems are trying to punch the ticket with regard to community benefits and rounding the bases, but there's not been intentional connections made between the real financial challenges confronting healthcare systems in major metropolitan and rural areas and what we're doing with public health. Our public health system is woefully underfunded and terribly irrelevant in what we're facing as a healthcare system in Dallas Texas."

Dr. Kinney reinforced the point made by Dr. Walton with the observation that the development of ACOs in many hospitals is occurring independently of relevant community benefit programming, representing a substantial missed opportunity.

Mary Pittman, President, Public Health Institute

Dr. Pittman emphasized the imperative for leadership from hospitals, public health, and the communities to build on what has been accomplished, apply emerging tools and technologies, and set the stage for transformation in the field. She suggested further that the development of a consensus statement from diverse leaders in the wake of the meeting would be an important first step in the process:

"Now is the time to have public health, community, hospitals, and all of the leaders that are represented in effective community engagement strategies to make a commitment to moving this agenda forward."

Day Two Closing Comments Len Syme, PhD, Professor Emeritus, UC Berkeley School of Public Health

Dr. Syme opened by paying tribute to the accomplishments to date reflected in the presentations and public dialogue, noting that he had been unaware that there is substantial work by hospitals to address the underlying causes of health problems in communities. He indicated that he would focus on providing some context to frame the discussion going forward, and if possible, to bring additional urgency to the call for action.

His first point was to highlight the limits of medical care in addressing the complex health problems we are faced with in the U.S.:

"We all know that we spend a lot of money on medical care and that we rank 35th, 38th, and 39th in almost every marker of health and this is very uncomfortable. One of the arguments about that is to say, well, we have so many poor people, if we just get rid of those poor people our results would be much better. It turns out as I'm sure many of you have seen, a comparison of health in England and in America in the top 10 percent of our society, we still rank low."

As such, he suggested that something is going on beyond the provision of health care that is negatively impacting health status and quality of life in the U.S. He noted further that additional strains are presented by the large cohort that is turning 65 years of age, and there is an urgent need to think about the prevention of disease earlier in life so people 65 and older will be healthier than they are now.

In closing, he challenged participants to consider the broader impact of inequalities on our society:

"Some people in our community that are in difficult living circumstances, living in underprivileged settings. I think we really need to understand the toxic impact of that kind of inequality on all of us. The inequalities have an impact on our nation and we really need to begin to deal with that."

C. Institutional Oversight

The charitable mission of tax-exempt hospitals is a core element of their organizational identity, and the board of trustees is charged with the responsibility to ensure the optimal fulfillment of that mission. In the 21st century hospital, attention to oversight of the charitable mission is in competition with a plethora of issues such as contracting, physician relations, capital development, vendor management, and mergers and acquisitions, to name a few examples.

Consistent with this observation, research indicates that boards of trustees devote a small percentage of time to oversight of the community benefit function. ²⁵ In response, a growing number have established standing committees to provide oversight, just as they have for other important functions such as quality assurance. Others may leave oversight to administrative leadership, who in turn may delegate responsibilities to selected staff members.

Increased public scrutiny of tax-exempt hospitals in the last decade and the more recent development of new reporting guidelines by the IRS have heightened awareness of the need for oversight and accountability for performance. The net result is growing professionalization of the community benefit structures and functions in tax-exempt hospitals.

A variety of tools and standards have been developed and field tested²⁶ to foster increased oversight and institutional alignment, and a growing number of leading edge hospitals and health systems are experimenting with different approaches. A key question is how best to foster broad diffusion of mechanisms that ensure optimal oversight, given the diversity in size, location, context, and resources of different tax-exempt hospitals.

Key questions addressed by the expert panel, key informants, and public participants included:

- What internal oversight mechanisms are needed to ensure meaningful institutional engagement for hospitals? For local health departments?
- What internal management & operational structures and competencies are needed?

1. Expert Panel Comments

Lawrence Prybil, PhD, FACHE – Associate Dean, University of Kentucky College of Public Health

Dr. Prybil opened the session with the statement that "board oversight of the community benefit function is more than a basic responsibility; it is an ethical imperative." He pointed to serving the community as a central responsibility, and acknowledged that community benefit

²⁵ Prybil, Lawrence, et al, "Governance in Nonprofit Community Health Systems: An Initial Report on CEO Perspectives," W.K. Kellogg Foundation and Grant Thornton LLP, February 2008

²⁶ For example, the Advancing the State of the Art in Community Benefit demonstration included the development of 14 Institutional Policy Measures that facilitate institutional alignment – see www.asacb.org.

was an afterthought in the past among many hospitals. He noted that this has changed in recent years, and there is broad recognition among board members. At the same time, Dr. Prybil addressed the complex array of responsibilities among trustees of today's hospitals:

"This is an enormously difficult and challenging time for them, for those who have stewardship over hospitals and health systems. Just think about it. Think about how much more complex it is today than 5 years ago or 10 years ago or 20 years ago. Think about quality and safety, the expectations on hospitals today, and thus, on the boards who are responsible for them. The level of knowledge and understanding that they must have about quality and safety is enormously greater than it was in the past."

Dr. Prybil then presented five benchmarks of good governance in terms of community benefit oversight among tax exempt hospitals. The first is the adoption of a policy statement that outlines the hospital role, philosophy, and associated obligations in the community benefit arena. He suggested that this provides the foundation for the development of quality programming, and noted that many have taken this step, but some have not.

The second benchmark is a commitment to collaborate with other organizations. Dr. Prybil referenced the CHNA as a tangible manifestation of this commitment:

"In today's world I think it's increasingly recognized that not doing communities needs assessment is simply inappropriate, that doing it informally and sporadically is inappropriate, and really doing it alone is inappropriate for all the reasons we've talked about the last few days. So what has emerged is not only, is collaboration appropriate, it's necessary. It's the benchmark of good governance."

He identified a third benchmark as the formal adoption of a community benefit plan, which includes the identification of priorities and clear objectives:

"The organization's plan in community benefit, laying out what it can do, making clear what it cannot do, based on needs assessment and careful prioritizing, is tied inextricably to the overall strategic plan of the organization. We can't do community benefit planning in isolation of the total picture of the strategic direction and priorities of the organization."

The integration of the community benefit plan and the organizational strategic plan creates the basis for periodic reporting to the board on progress in the implementation process. The last benchmark identified by Dr. Prybil is a parallel process of reporting to the community.

Another central point made by Dr. Prybil was the trend towards consolidation of hospitals into organized health systems. He noted that approximately 65% of hospitals are part of systems, and there is significant diversity in the size, geographic distribution, and approaches to governance. As such, Dr. Prybil offered a cautionary note:

"All of us should understand, and our regulators must understand, as I'm sure they do, that the shape of our industry includes every size, form, and nature of hospitals. Some are very small and simply don't have the capabilities that the larger ones do. So as we think about

community benefit, as we think about regulating – regulations and requirements, we should recognize and honor that diversity."

In closing, Dr. Prybil reflected on a professional career of work in both hospital administration and public health, and acknowledged that communication and collaboration between the two communities had been limited at best. That having been said, he suggested that now is the time for the two communities to come together:

"We are faced with shrinking resources and infinite needs. So we need to use our resources wisely. I think we need to find ways to work together more closely. I think there's some promising starts on that. I hope this conference will help facilitate that. I hope the final IRS regulations will facilitate that, will bring us together in ways that will be creative, innovative, and pragmatic."

Elissa J. Bassler, MFA – CEO, Illinois Public Health Institute

In her opening comments, Ms. Bassler recalled a quote from Paul Weisner, former health department director for DeKalb County, that the role of public health departments is to serve as a catalyst for action; not fulfilling all public health responsibilities, but leveraging resources and expertise to engage others. She identified this as a frame of reference for her comments.

Ms. Bassler focused her presentation on the state-mandated role of Illinois public health departments to conduct CHNAs and develop health improvement plans, referred to as I-Plans. The mandate was established in 1993 as a requirement for certification by the state, and determined eligibility for state funding. As a result, she noted that local health departments have been reaching out to engage hospitals for almost 20 years.

Ms. Bassler provided a case study of Jackson County, Illinois to highlight an example of shared ownership and oversight mechanisms between hospitals and public health. Since 2003, approximately 42 health coalitions have convened under a single umbrella organization called the Healthy Communities Coalition (HCC). The HCC is staffed by Southern Illinois Health Care, a regional health system, which also co-leads the assessment process, adopts the priorities and identifies their role in the implementation of the I-Plan as their community benefit plan. Ms. Bassler also noted that the health department in Jackson County and Southern Illinois Health Care share leadership of the action teams that are working on the elements of the plan. Staff members include nurses and MPH-trained or other Masters level professionals who are working in schools in the faith community, and at the community level on built environments. Ms. Bassler pointed to the experience with collaboration yielding a more strategic allocation of resources that is aligned with the objectives of the I-Plan, with projected outcomes that are reported to a community benefit advisory board:

"They have an external community benefit advisory board that helps them prioritize their needs and assures alignment of their community benefit work with public health in the community. This external advisory board includes both senior Southern Illinois Healthcare – the health system executives as well as the local health departments from across the region, some of them, the federally qualified health centers and a pastor. So they're trying to connect the dots both inside and outside of the hospital through this advisory board."

Ms. Bassler noted that the completed community benefit plan is presented annually to the hospital trustees and adopted by the hospital trustees. She related the benefits of the collaborative structure as described by the health department and the health system:

"They talked a little bit about what were the benefits of this structure and being a part of the coalition. For the local health department, it propels community engagement and ownership in shared accountability. It doesn't seem like the plan is the health department's plan. It's a community plan. And it has the same effect at the health system. They're clearly the biggest player. They have the most money. But because it's done in this community way it's not the health systems coalition, it's a community coalition."

Ms. Bassler pointed out that Southern Illinois Health Care serves a region beyond Jackson County that includes seven jurisdictions. With this in mind, they served as the catalyst to establish the Healthy Southern Illinois Delta Network. In the review of all the I-Plans, it was determined that all identified cardiovascular disease as an issue, so a region-wide cardiovascular disease healthy living plan was developed and is being implemented. The steering committee for the Network includes the county administrators, and is also staffed by Southern Illinois Health Care. Ms. Bassler also noted that Southern Illinois Health Care and the Delta Network are also represented at the state level in a statewide coalition on obesity.

The profile provided by Ms. Bassler highlights creative ways in which hospitals and local public health agencies can work together and effectively leverage their resources and expertise to achieve shared goals and objectives. It also provides an example that highlights the counterproductive nature of the current IRS requirement for each individual hospital within a system to produce its own CHNA. Clearly, this would represent a waste of resources in an environment with significant economic constraints.

Mark Huber, MS – Vice President of Social Responsibility, Aurora Health Care

Mr. Huber opened by summarizing his early experience in the public health community prior to 17 years with Aurora Health Care, the largest health system in Wisconsin. He noted that Aurora serves all of eastern Wisconsin, and described some of the issues they grapple with in defining community:

"When I get to the community health assessment, we have 15 hospitals, so do we do 15 community health assessments? We have 20 counties, do we do 20 community health assessments? Since we identified 90 communities, do we do 90 community health assessments? And the answer is none of those. We do 36, and the reason we do 36 is because we have 36 local public health jurisdictions across our service area."

Beginning in 2003, Aurora Health Care began to partner with local public health departments across their entire service area to do a baseline study:

"We're not doing just secondary analysis; we're doing primary research in each community. So we adapted a questionnaire, a telephone interview process similar to the behavioral risk

factors survey that's done nationally and did 15,000 telephone interviews across our service area for a baseline. Every year we reassess one-third of those 36 communities."

Mr. Huber shared that Aurora has a standing committee of their system Board of Directors called the Social Responsibility Committee. He noted that the committee has been in place for a few years, but they recently revised their charter to align with the new community benefit requirements. They have also developed and integrated community benefit language into core organizational documents, including their mission, values, and strategic plan:

"At Aurora we have nine goals in our strategic plan. One of those is to foster healthy and vibrant communities, and that cascades down for every site, every administrator. Every department has to have goals directly related to this overall objective."

Mr. Huber reports directly to the CEO of the health system, ensuring attention to community benefit priorities and timely feedback on issues to be addressed. As with other hospitals and health systems, part of the challenge is to educate and engage external stakeholders to think more strategically about charitable resource allocations:

"In Aurora what we're trying to do is redirect all of the sponsorship inquiries we're getting which are mainly marketing-type opportunities being presented to us, and have a conversation with our non-profit partners and say, 'We don't really want to sponsor your golf outing. What we want to do is talk to you about how we can work together in service improvement in the community,' and that's been very, very effective. So we have a policy that establishes criteria to move us in that direction."

In the articulation of a coordinated and strategic approach to community benefit at a regional health system, Mr. Huber pointed to some challenges presented by the current IRS reporting requirements:

"In Aurora we tracked \$32 million in community benefit last year. Of that, only half can be reported on the schedule H because only half of it occurred within a hospital budget, the rest occurred in other EINs within the system, whether it was in the medical staff clinic or whether it was in our visiting nurse association or out of a corporate department. So one of the – at least one source has told me that there is a mechanism where you can use general accounting principles to use your allocation process from a corporate department to a hospital to take some of that expenditure that's occurring at the corporate level and actually be able to count it. That's something we need a little more guidance on as to how we can accomplish that."

He noted further that their medical clinics and medical staff are separate from the hospitals, and in a different EIN. The net effect is that approximately 18% of their charity care is provided outside of the 15 hospitals, so what is reported at the system level is not captured in their hospital reporting on Schedule H.

The issues Mr. Huber described are important considerations for a growing number of health systems who strive to more strategically allocate resources in a manner that is more likely to achieve measureable impacts, and that foster the diffusion of innovations:

"An integrated health care system seeks to develop programs and expertise that cascade across the entire system. There are needs that we know are in common across all 15 of our hospitals. And so we've been looking at ways we can have some signature community benefit programs that we do everywhere and we do well everywhere."

At the same time, they allow local hospitals to interpret and tailor activities associated with systemwide initiatives to address their specific needs and take advantage of unique characteristics at the local level.

Moderator Follow Up

The moderator outlined a continuum in the governance and management of health systems, with one end of the spectrum being a more engaged and prescriptive, "operating system" model, and the other end a more hands-off, autonomous system often referred to as a 'holding company' model. He observed that there appears to be a trend among health systems towards the operating system model, driven in part by a need to establish consistent systems and standards that ensure quality and increase efficiency.

Historically, the acquisition of a hospital by a health system was viewed with alarm by local communities, the concern being that the system would gradually siphon resources at the expense of local investment. The moderator noted that in contrast, there is growing evidence that systems have contributed significantly to the competence and effectiveness of individual hospitals in areas such as community benefit. Panelists were asked to address the roles, contributions, and potential risks of hospital membership in health systems as well as the challenges of efforts to accommodate the diversity of health systems in IRS reporting.

Ms. Bassler was asked to address the challenges faced by local public health agencies that lack the capacity to do what we are expecting them to do, both in the context of the new public health accreditation standards and in partnering with tax exempt hospitals. As an alternative to simply asking hospitals to write a check, what are things that can be done (e.g., shared advocacy) to help build capacity among local public health agencies?

Panel Response

Dr. Prybil offered two examples to illustrate the diversity in approaches to health system governance and management:

"Mercy Health is a large system based in St Louis, Missouri that operates hospitals and health facilities in four states; I think 28 counties have them. They have moved their local boards into more of an advisory status as opposed to fiduciary, so they're moving toward an operating company. But in terms of community benefit their local boards are very deeply involved in developing the community benefit plan for their communities, and then they roll up into a Mercy system-wide community plan, which takes into consideration the assessments of all of those communities and captures some priorities they believe are applicable across the board."

Dr. Prybil noted that system level investments include a multimillion dollar charitable contribution to support work with school systems that will be implemented in all 28 communities. In general, he presents Mercy Health as a health system moving definitely

towards an operating company, but one with a balance of local and system level community benefit planning and decision making. He notes further that one of Mercy Health's local facilities is St. John Hospital in Joplin, Missouri:

"What the Mercy Health system has done for Joplin is absolutely breathtaking, and the community is grateful. If St. John were a freestanding hospital, did not have system support, it simply could not do what they're doing. They put a mash-type operation in place in a week. They now have an 80 bed temporary hospital in place. They're committed to rebuild the hospital better than it was before. They're bussing people back and forth to work in the hospital in Springfield, and they're continuing the salary support for staff. It is an example of a strong system demonstrating its commitment to a community."

Dr. Prybil contrasted Mercy Health with Banner Health, a regional health system based in Phoenix. Arizona:

"Banner Health has no local boards. It really is an operating company. So when Banner Health talks about community benefit and board plans and board policy and accountability to boards, there is no local board. So we all have to factor that into consideration as we think about how is that going to work and what regulations are appropriate for that."

Mr. Huber pointed out that the concerns at Aurora about the difficulty in capturing contributions outside of hospital EINs is a similar problem for other systems such as Kaiser Permanente.

Ms. Bassler acknowledged that shared advocacy is an important strategy that can be strengthened through the identification of complementary concerns (e.g., population health, patient care) and framing as common interests. She suggested that local health departments are in a position to connect hospitals to the advancement of environmental policies that will help to codify and sustain community health interventions.

2. Public Comment

Jean Nudelman, Kaiser Permanente

Ms. Nudelman indicated that system offices are providing an increasing volume of technical assistance, clinical expertise, and support to local facilities, but some activities undertaken to deepen local engagement need to be captured in order to justify their continuation. On a related note, she asked the panel to address an earlier question of how system level concerns such as health workforce development and research get reflected as priorities given a reliance on findings from local CHNAs.

Jessica Curtis, Community Catalyst

Ms. Curtis pointed out that the examples cited by the current panel and others represent the kind of commitment that one would like to see among tax-exempt hospitals, but that her organization is exposed to hospitals and systems that are less responsible. She cited examples of hospital closures and/or removal of essential services from vulnerable communities, and suggested that it may be an emerging trend.

She also expressed opposition to any suggestion of easing responsibility for reporting at the facility level, noting that local transparency is essential. Finally, she asked the panel to address how hospital financial assistance programs may be expanded to address medical debt that consumers accrue from physician charges.

John Clymer, member U.S. Task Force on Community Preventive Services

Dr. Clymer extended a plea to panelists and general participants to include scientists in the design of interventions and associated monitoring and evaluation strategies to ensure that they will meet standards for the systematic reviews of evidence required by the community guide.

Panel Response

Mr. Huber addressed the concern raised by Ms. Curtis, noting that he did not suggest that local facilities be excused from local reporting; in fact he agreed that it is essential. He clarified his concern as how to effectively capture charitable contributions from elements in the health system to local hospital facilities. He also shared another positive example of system level support for a local facility that is struggling in financial terms:

"At Aurora we have the sole remaining hospital in downtown serving the central area of the inner city of Milwaukee, Aurora Sinai Medical Center. We lose \$10-20 million a year in that facility. We're not going to close it. We've made a commitment that we're just not going to close it. That's the value of having systems, because we have the ability to leverage resources that we generate out of other parts of the systems to underwire those losses and provide that critical access that's so needed in that part of our service area."

Mr. Huber also took the opportunity to thank the IRS in general for the promulgation of new reporting requirements:

"One of the side benefits of what's happened with this new level of regulation authority is that it has given some very tangible things for us to utilize as we talk to our administrative team about why this is important. This isn't a soft area."

Ms. Bassler addressed the inclusion of health workforce development as a priority in the public health community, and pointed out that the public health system (including CDC) has tools to justify and support an investment. She suggested further that health workforce development is inextricably linked to improving health, as an effective infrastructure is needed to address projected increases in demand in areas such as primary care, chronic disease management, and community-based prevention.

Dr. Prybil addressed the question about hospital closures, suggesting that consideration of these issues be considered in the oversight process as a function of links between community benefit and organizational strategic planning. At the same time, he noted that

"Closing a hospital, if we have to do that, may be a very good thing to do if we replace it with an alternative way of delivering services in a more cost effective way. Health systems today

are not just hospital systems. They include a large and growing spectrum of other kinds of services with maybe much more effective in terms of meeting community needs."

Mr. Huber addressed the question of how to advance system level priorities such as workforce and research, noting that Aurora has aligned their CHNA process with the State health plan, and workforce development is one of the infrastructure priorities in the plan. He described other ways that workforce development has emerged as a priority:

"In community health assessments there are things that come out of that process that everyone agrees, we're going to do this as a priority collaboratively. And then there are things that individual agencies say, you know, we're going to do this that's related to those goals within our own agency because it fits what we want to do and some of our objectives. And then there are what I call 'spinoff projects'. And so many times you can find that there may be two or three or four partners within the broader collaborative that all have a common interest in doing something that may not be of interest to the entire collaborative. We do spinoff initiatives based on that, and that's how we've addressed some of the workforce."

Julie Trocchio, Catholic Health Association

Ms. Trocchio noted first that the IRS allows hospitals to report health workforce development, but as a community building activity. As such, hospitals cannot include financial expenditures. She also referenced the numerous comments of expert panelists on the diversity in the types of hospitals and communities they serve, and cautioned against the advancement of regulations that are too expensive, particularly for smaller hospitals. On the issue of resources, she asked Mr. Huber whether the 36 different local health departments had the necessary skills to support the assessment process.

Mark Horton, ASTHO

Dr. Horton asked whether it is appropriate to consider that a hospital's community benefit plan can be "one and the same" as the local public health department's community health improvement plan. He further inquired whether we may see a natural evolution away from internal community benefit committees to extra-institutional oversight bodies.

Vondie Woodbury, Trinity Health System

Ms. Woodbury asked the panel to address what may be the core competencies needed to build capacity in hospital staff that will enable them to do the work we have been discussing.

Gianfranco Pezzino, Kansas Health Institute

Dr. Pezzino asked the panel to address how local stakeholders may avoid 'coalition fatigue,' noting that, particularly in smaller communities, institutions may be competing for attention from the same group of stakeholders.

Panel Response

Ms. Bassler addressed the issue of costs, suggesting that rather than hiring consultants to meet IRS requirements, hospitals should considering hiring local public health agencies, thereby building local capacity.

Dr. Prybil addressed the question regarding whether a community benefit committee should necessarily be an internal oversight body. He suggested that the most important consideration is whether the body has the right information and right composition and skills to make good decisions. As such, it is less important whether it is internal or extra-institutional, as was the case in the profile in Southern Illinois.

He also noted that there is considerable work yet to be done in building working relationships between hospitals and public health agencies, and that all efforts should be made to explore opportunities to leverage complementary skills. He shared a recent example, however, that highlighted some of the challenges ahead:

"In Kentucky, which is a rural state largely with 120 counties, a lot of health departments, a recent study asked hospitals how they were working with local public health. One-fourth of the hospitals said they reached out and their local health departments were not interested in working with them on community needs assessments and other things. Now I'm not being critical, I'm simply saying that's information. I'm sure that we'll also find situations where health departments reach out to hospitals or systems and they aren't home or interested or are too busy."

Mr. Huber addressed the question posed by Ms. Trocchio regarding the skills and capacity among the 36 local health departments. He noted that there are a wide variety of skills and capacity, but they all are able to provide direct access to secondary data and validity in the collection of primary data:

"When we're doing primary data collection, they improve our outcomes because we're doing this under the aegis of the health department, and so we have a better response rate on our surveys because it's coming from the health department rather than the hospital, there's no question this is not a marketing thing, this is a population health improvement initiative."

Addressing the question regarding needed core competencies, Mr. Huber indicated that training and technical assistance are an important part of his job, both in terms of supporting professional development of staff and education of boards and administrators.

D. Shared Accountability and Regional Governance

Institutional accountability is an important feature of not only tax-exempt hospitals, but all organizations. When organizations engage other institutions to explore potential partnerships, they are typically accompanied by expectations and ultimately agreements varying levels of formality. For hospitals conducting CHNAs and developing implementation strategies, there are a variety of reasons why engagement of other stakeholders makes practical and economic sense, including, but not limited to the following:

- Common interest in CHNA
- Shared responsibility to address unmet health needs
- Needed expertise
- Available financial or in-kind resources
- Political influence with specific stakeholders
- Complementary mission
- Competitor for resources and/or influence

In rural areas with relatively scarce resources and institutional infrastructure, there may be additional impetus to develop partnerships for one or more of the reasons outlined above. Institutions that exist may have broad territorial responsibilities, often encompassing multiple counties, particularly in the Central and Southeastern United States. In many of these regions, extensive experience with limited resources has yielded a higher degree of flexibility and openness to innovative approaches that transcend traditional disciplinary and geographic boundaries. In this context, hospitals, local public health agencies, and other institutions may come together to form regional partnerships to accomplish tasks of shared interest. In some cases, these partnerships build sufficient trust and positive outcomes to evolve into more formalized working relationships.

This session examined the circumstances that contribute to the development of regional partnerships that are characterized by shared accountability, and in some cases, shared governance for community health improvement related functions. Key questions addressed by the expert panel, key informants, and public participants included:

- What are the potential benefits of regional partnerships between hospitals, local public health agencies, and other stakeholders?
- What are options for formal agreements that bind stakeholder financial commitments?
- What are existing mechanisms for local/regional accountability that may be applicable?
- What are potential implications of shared investment and agreements for antitrust concerns?

1. Expert Panel Comments

Gregory J. Dent – President/CEO, Community Health Works

Mr. Dent opened with a brief description of his organization, entitled Community Health Works (CHW), which is a 501(c)3 that serves seven counties in Central Georgia and a population of approximately 365,000. Partners include five hospitals and four clinics, with 2011 revenues of \$2.4 million, and 22 employees, including contractors.

The organization began as a donated care network, in a region that lacked federally qualified health centers or volunteer clinics. After securing commitments from the provider community to provide primary care for the uninsured population, CHW provided care management and pharmaceutical assistance, with particular focus on chronic diseases such as diabetes, hypertension, cardiovascular disease, and depression. Over 4,500 members were served, involving the coordination of over \$50 million in care, \$3 million in free medicines, and \$1 million in Medicare and Medicaid reimbursements were secured for hospital partners.

They estimate that they secured a total of \$1.1 million in annual savings per thousand members through effective care management, the ER utilization was significantly less than the national average, and the hospitalization rate was 45% less than the national average. The conclusion was that they had been successful in achieving a significant impact. In recent years, CHW has begun to focus on creating volunteer clinics and federally qualified health centers that serve as more permanent sites to care for residents in the seven county region.

In the ten years since their incorporation, CHW has secured over \$8.7 million in grants from public and private sector funders. Mr. Dent indicated that CHW has transitioned into a regional center for health innovation:

"We convene partners, we incubate, and we create value. In the convening process, we identify the problems, we engage the partners, and we explore solutions. In incubation we staff and research the startup, we seek seed money, then we advocate for the project, and then we create value."

Mr. Dent notes that his board of directors consists of the hospital CEOs, county commissioners, and other members in the community:

"So we have to express value in three different ways, we have to express it clinically, financially, and socially. The physician communities, they really don't care if the hospitals are making money. The county commissioners want to make sure that there are jobs being created in all this process and that the jobs are being created in their counties, and then the hospitals want to make sure that they are getting a return on their investment. So we have to communicate our value in those three ways."

He shared the most recent three year strategic plan for CHW, which was voted on by their board of directors. While their initial focus was on health care, Mr. Dent indicated that they are increasingly playing more of a public health role. The engagement of the board has created an

opportunity to cultivate local leaders and build a culture of wellness in the region. Mr. Dent envisions an ultimate role for CHW as a regional health foundation, serving as a fiscal intermediary and a convener, both roles that they are already beginning to play.

Gene Matthews, JD – Director, Southeastern Regional Center, Public Health Law Network; Senior Fellow, NC Institute for Public Health

Mr. Matthews noted that he spent 25 years of his professional career as the Chief Legal Officer for CDC, and is now based at UNC Chapel Hill as the Director of one of the regional public health law centers in the Robert Wood Johnson Foundation's Public Health Law Network.

He acknowledged statements by a number of panelists and participants about the current challenges faced by local public health agencies, but also suggested that these challenges and the new requirements for tax exempt hospitals presents an array of positive opportunities. He focused his comments on how these opportunities may play out in terms of regionalization and its implications for accountability.

Mr. Matthews started by sharing a graphic developed by Nancy Kaufman that outlines the continuum of potential agreements, starting with informal arrangements, information sharing, memoranda of understanding, then moving towards service contracts, mutual aid agreements, inter-local agreements, and ultimately consolidation and regionalization. He described regionalization as restructuring county governance into a regional structure with perhaps a board itself that directs it or is directed by a representative from county commissioners. At the core, it is a reconfiguration of the essential local governance unit.

Mr. Matthews noted that there is significant variation from state to state in views on the desirability or repugnance for regionalization among public health agencies:

"in the public health world there's a great deal of skepticism about the threat of being swept up into a local umbrella agency where you lose the public health identity when you're merged in with social services, WIC, Medicaid, childcare, you know, drug prevention, et cetera, et cetera. So there's concern about the loss of identity. And then along this spectrum, again, from informal to full regional mergers, there's a lot of concern about sort of where does our identity fall down on that."

He notes further that when public health capacity is considered at the national level, there are a number of important questions that emerge:

"There are 2,800 local health departments in this country. Pat Libbey, the former executive director of NACCHO says that presents us with three questions. Do we need 2,800 local health departments? Can we afford 2,800 local health departments? And if we were wanting to change any of that, is there the political will anywhere to do it?"

In the consideration of options, Mr. Matthews notes that there are a number of legal issues that must be addressed:

"Almost all states have an intergovernmental agreement act that encourages and puts some meat and bones to the structure of how you collaborate. You need a purpose of the agreement, the duration, the matter of financing, and most important, the methods of termination. It makes sense, if you think about, when partially consenting partners are trying to commit this unnatural act that they know if it comes apart, how do we all get safely back to our homeroom with our resources and with our goals and so forth. It's an important lesson from the public health world that is relevant to hospitals and other non-profits in this area."

Mr. Matthews referenced the first day discussion of regional collaboration in Atlanta, and suggested that whatever geographical alignments make the most sense for a collaborative CHNA between hospitals and local health departments, it doesn't have to match the map drawn for political reasons or for reasons of convenience regarding how public health is organized on a local or regional basis. At the same time, he cautioned stakeholders to look for signs that stakeholders are unwilling to proceed with meaningful engagement:

"In the 25 years I spent in my tattered career across the street, CDC would always be wanting to develop partnerships and arrangements with a lot of players, and sometime they'd come to the legal office and say, 'Hey, we've got a problem. They're telling us that this might create antitrust problems if we do X.' And inevitably, if you drill down into it, it wasn't an antitrust issue, it was the two adults were not ready to commit the unnatural act. They didn't want to play for whatever policy reasons; or they just didn't like each other."

Based upon prior experience, Mr. Matthews advised colleagues to 'push to see if people really want to play with each other.' He closed by noting that the Public Health Law Network is launching an initiative around the evolving legal issues faced by public health departments. The initiative will include technical assistance from the four regional centers to assist with restructuring, consolidations across jurisdictions, regionalization, as well as partnering with FQHCs and non-profit hospitals.

Moderator Follow Up

Mr. Dent was asked to share some of the next steps in deepening the work of Community Health Works. He was also asked to outline any conversations they are having with regional stakeholders about shared implementation strategies.

Mr. Matthews was asked to identify one or two specific examples of regional partnerships that he would share as beginning to move in the kind of directions that we're talking about.

Panel Response

Mr. Dent pointed to the issues mentioned by Dr. Matthews, and noted that the trust established over the last ten years has provided the basis for further formalization of functions and structures, including potential mergers of nonprofits:

"One of the things that we've done is look at how to build the rural health care system if you started from scratch, and if you started from scratch you would not end up where you are. But looking at the pieces you've got, how do you put those together in a more effective way. And in some cases that may mean mergers of hospitals. We have two of those hospitals are critical

access hospitals, one is the second largest in the state, so there's some synergies there that are beginning to move forward in closer collaboration."

Mr. Matthews pointed to Kansas and Montana as two 'home rule' states that have taken important steps in the development of formal agreements to collaborate and regionalize specific functions, as well as collaborative efforts between local health departments and taxexempt hospitals in North Carolina in Wake and Robeson counties.

2. Public Comment

Julia Joh Elligers, NACCHO

Ms. Elligers cautioned against too much emphasis on negative anecdotes about hospitals or health departments, suggesting that it leads to premature assumptions that may impede efforts to work together. She suggested more of an emphasis on successful examples that can provide insights and impetus to overcome obstacles to innovation in other communities:

"I know the MAPP process was talked about a lot while we've been here. NACCHO provides training and technical assistance around that. One of the things that we encourage communities who have bad history or a lot of conflict or turf issues they can't overcome is one of the first things to invest in is dialogue training. This sounds basic, it sounds mushy, but it goes a long way, and in communities who've invested in this training all their staff, their partners on how to have effective conversations, revisit what communication looks like."

Ms. Elligers also cautioned against the conclusion that rural health departments lack the capacity for collaboration:

"I know I've heard several comments that rural, smaller health departments just don't have capacity or resources to participate in the way that maybe some hospitals would like. But, in fact, in rural communities we're seeing a lot of good innovative work because those relationships are so strong because they have to be because there's only a handful of those entities in those communities."

Julie Trocchio, Catholic Health Association

Ms. Trocchio echoed the sentiments expressed by Ms. Elligers on the need to emphasize positive examples. She also encouraged colleagues to give attention to opportunities for partnerships between hospitals and public health education institutions, citing Texas A&M School of Rural Public Health as providing phenomenal services. She noted further that some programs are combining JD and MPH programs, which are producing graduates who look at health policy in their communities "in a whole new way".

Moderator

Dr. Barnett amplified the points made by Ms. Elligers and Ms. Trocchio:

"Just as we have to avoid a "one size fits all" approach to how we do things, we have to also make sure that we're not lumping together the behavior of individual organizations across the board, it applies to hospitals, it applies to public health agencies, it certainly applies to community advocates and others that are stakeholders in the community."

He also pointed to an earlier comment by Dr. Matthews on a need for a clearinghouse of innovative practices, and asked him to expand on what is needed to mobilize available resources and competencies to advance collaboration.

Panel Response

Mr. Matthews suggested that some of the leadership for collaboration will come from hospital leaders; not because of their fear of the IRS \$50,000 penalty, but because of an interest in advancing a positive reputation. He also supported the position that lifting up dynamic leaders at the local and state level who can serve as positive examples for others.

Mr. Dent also addressed the issue of building organizational capacity for collaboration, noting that it is important to have people who can interpret what other potential partners may need. He shared, for example, that his organization is considering adding a director of evaluation to ensure that they can effectively interpret the needs of a funder or academic partner. He suggested similar considerations among local public health agencies:

"A lot of the public health infrastructure may not have the appropriate skill sets or capacities to interact with as the business community, as the local government – the county and city local officials. It may be beneficial to add communication staff who are not focused on communicating public health messages but are communicating to government and business."

Following up on an earlier point regarding federal initiatives, Dr. Matthews expressed concern that local public health agencies won't be able to respond to federal calls for applications on grant programs because of a prohibition of administrative costs:

Some local health departments will not be able to afford the \$5,000 fee, and you try to justify that to county commissioners in Salina, Kansas, or Fishbend, Montana, and you get your head handed to you. So it's important for the enlightened self-interest of the feds to see that their categorical programs will be enhanced by allowing, as part of an administrative cost within that categorical, the needs of a local health department to participate in accreditation which allows them to do their work and the community health assessment which is able to lash up with the hospitals on this.

Paul Hattis, Tufts University School of Medicine

Dr. Hattis pointed to Massachusetts as an example of a state where shared arrangements among government entities is an important consideration:

"We have 351 towns and cities and you can imagine there have been cries over the years for some regionalization from towns and cities because how much local public health can you accomplish when you're a town of a 1,000 people or something like that for very unusual New England."

He also encouraged some circumspection about the near term potential for transformation among hospitals:

"I don't see the new IRS part of the ACA requirement of hospitals being such a watershed moment for hospitals. I mean they're still more focused on how to deal with access changes from ACA. In Massachusetts we've made strides on health care reform 2.0 which is about cost, and we talk of health care reform 3.0 as being about public health. What I'm trying to say is I don't see how from the hospital field's perspective that this change is such – you know, they've dealt with Stark over the years, they've dealt with UBIT over the years, they've dealt with putting the CEOs salary in the 990, people can find the 990, and then there's 990 H. I think this is another step in that realm rather than seeing it as a revolutionary moment. So I'm not trying to throw water onto the fire, I'm just trying to give a reality play-out to the situation."

Bill Barberg, Insight Information

Mr. Barberg suggested that as colleagues in the health sector consider alliances and collaboration that there may be important lessons from the business community. He shared one lesson he gleaned from a recent Harvard Business Review article:

"Often alliances are negotiated by lawyers and it becomes very complicated. But when you shift the focus on developing alliances around strategy and you clearly articulate and communicate that strategy the success is dramatically higher."

Unidentified

Another participant emphasized the need for ongoing attention to the quality of communications in partnership development:

"It's not just putting them together, it's nurturing them, assessing them, keeping the channels open, renewing them. Otherwise they'll fall apart. So while the opportunities are there, and I think they're enormous, we have to be prepared on all sides of that partnership or collaboration to continue to invest in it to make it work, otherwise they'll fall apart."

Dory Escobar, St. Joseph Health System

Ms. Escobar noted that while we are talking about new federal initiatives, reporting requirements, accreditation, and opportunities for collaboration, it's important to recognize that it doesn't always play out well at the local level, particularly where there may already be highly functioning partnerships:

"What's happening now a little bit with the accreditation effort and new requirements for hospitals and both requirements and opportunities for FQHCs is things are starting to, in some regards, come apart in some places because everyone's scrambling to do things according to the new regulations and trying to build what we already have according to regulations, and it's not necessarily enhancing or building what we've worked so hard to create."

Unidentified

One participant asked the panel to address whether there was a role for state organizations and associations to play in support of collaborative efforts.

Panel Response

Mr. Matthews pointed to the North Carolina State Department of Public Health and the North Carolina Hospital Association as examples of state organization leaders who have played a very important role in fostering collaboration and facilitating innovative efforts at the local level. At the same time, he cautioned against too much reliance on state level entities:

"It's a bit of a paradox. You've got to be very careful when the state leadership associations, be it the health departments or the hospital association or whatever, they've got to provide the imprimatur to this and the technical assistance and some of the leadership and the education and clearinghouse function. I would just note parenthetically that I think there is that continuum that you suggested, which is various associations can run the gamut from impeding progress, in part because many associations are driven by lowest common denominator politics -- to being immensely helpful."

1. Key Informant Interviews

Consistent with the comments of Mr. Matthews and others, key informants acknowledged a natural resistance among local public health agencies to regional collaboration. As noted by **Jonathan Fielding, Director of Public Health and Health Officer for Los Angeles County**:

"The obstacles are all the geopolitical considerations; you want us to give authority to some larger body where we don't feel we have control. The big issue is giving up control, but I think for public health departments it's stupid – I was the head of the health department for Massachusetts and there are so many tiny little health departments; and we have some really small counties in California. The dynamic has to change, and with accreditation and the need to demonstrate core capacities, it will push for consideration of MOU's, and in some cases it will push for consolidation."

Key informants pointed out that many local public health agencies view the new accreditation standards as opportunities for regional collaboration to produce a better product, save money, and better address health needs. At the same time, they're grappling with technical issues such as timing. As noted by **Jeff Spade**, **Vice President of the North Carolina Hospital Association**:

"Maybe a bunch of counties want to do this together. Well, they're not even on the same cycle. And they're like alright, well, you did yours last year. And I'm not supposed to do mine until two years from now and somebody's got theirs up now. What are we going to do in terms of gelling this together? So, there are some real issues that are more along the lines of kind of rules that have been laid out a little bit that people are following. And that's going to harm us if those rules get in the way of really what is more sensible and a better approach."

Mr. Spade suggested giving focus to the elements of the ultimate product that is needed, and ensuring that everyone gets what they need.

"I don't think it makes any sense really everybody has to go do their own community health assessment. We should still be at the table and really thinking about how we can be strategic in that context."

Key informants also suggested that city and county governments have a more strategic role to play in the facilitation of collaboration and the development of more formal agreements. As described by **Victor Rubin**, **Vice President for Research at Policy Link**:

"Local government agencies need to articulate community interest in a way that translates into the design of strategies that in which the hospitals could participate. If there's an independent community voice outside of the government making a case for engagement and institutional accountability, this creates a three-way relationship with the city in a position to say, Here's what would make this work; this is what a solution would look like."

Dr. Rubin also suggested that we consider the potential role that regional governmental entities may play in the facilitation of intersectoral collaboration to improve health:

"The there are two kinds of regional governments in the country. The one is councils of governments like the Association of Bay Area Governments (ABAG) and the other is -- county-level let's call them planning organizations. Councils of government often focus at the regional level, and tend not to have enforcement power. They exist primarily for collaboration and planning. They don't preempt the local government's authority except in a rare number of places, in like the Twin cities or one or two other places where they appear to play an important role. There are a lot more functioning than there used to be. There's a lot of potential there."

E. Strategic Investment and Funding Patterns

Many of our local public health agencies are struggling with how, in the context of the constraints of categorical funding, can they effectively carry out their broad functions. Of equal concern is how, given a blizzard of RFPs for a variety of disease-specific or community-specific, content-specific elements, do they fit these pieces fit together, and effectively engage a broad spectrum of stakeholders? How do we do this work in a more coherent, coordinated and potentially far-reaching way in our communities? What are the opportunities in collaborative policy development? In policy advocacy?

Coordinated efforts of large and small stakeholders can specifically inform policy around local issues, and in some instances can move a policy agenda forward more quickly than could be done individually. Local agencies often have more familiarity, credibility, and expertise to inform customized solutions to unique local issues. Working closely with local stakeholders increases the likelihood that policies are acting on the right problem. There is a stronger probability that policy will be well-informed and applicable to the communities/populations it seeks to address. Key questions addressed by the expert panel, key informants, and public participants included:

- What changes in federal and state policy are needed to support investment in comprehensive approaches to community health improvement?
- What are potential roles of private sector philanthropy in facilitating a more strategic approach to community health improvement?
- What are challenges and opportunities in collaborative policy development?

1. Expert Panel Comments

Judy Darnell, MPP - Director of Public Policy, United Ways of California

Ms. Darnell opened by briefly summarizing her work over the last 20 years in leading community collaboratives, and 12 years with United Way. Her current role as Director of Public Policy involves supporting collaboration, policy development, and advocacy in partnership with 36 local United Ways. She also serves as a member of the United Way Worldwide Health Policy Council. She noted that the United Way mission statement had recently been revised:

"Our mission is to improve lives by mobilizing the caring power of communities around the world to advance the common good, and we galvanize and connect a diverse set of individuals and institutions and mobilize resources to create long-term change. It kind of sounds like what we've been talking about the last couple of days. We do this in three areas; education, health, and income, and we don't look at them as silos anymore. We look at them as one system. And these are the things that we think everyone needs to have to have a good life; a quality education that leads to a stable job, enough income to support ourselves and our family through retirement, and healthy communities and healthy people."

Ms. Darnell pointed out that there are approximately 1,200 local United Ways across the country, covering 92% of the United States. She noted that community assessments are the first step in efforts to improve health and quality of life in local communities, and that United Way collaborates and shares ownership with a broad spectrum of stakeholders:

"Hospitals are at every one of our initiatives. It's their community benefit project as well. Public health departments, governmental bodies, we always invite our board or supervisors. We always invite the staff of our state legislators and our congressional members, schools, nonprofits, police departments. Churches, university, especially if you're dealing with something like Together for Youth, which is an alcohol and drug prevention initiative, and neighborhood groups, really the community grassroots folks, and the Parks Departments, and others. We have some collaboratives that have as many as 90 organizations."

The collaborative is viewed as the central mechanism to move from assessment to action, and United Way shares the commitment to look at social determinants and develop comprehensive solutions. Ms. Darnell emphasized, however, that policy advocacy and development needs to part of the strategy:

"Hospitals, foundations, United Ways, and others have to invest in policy advocacy because to be successful, we need systemic changes. It's crucial to have outcome data and to show trends, but we also have to be patient because sometimes we have to wait for that window of opportunity to advance public policy, and you need to build the capacity to take action when the time comes."

Ms. Darnell indicated that United Way conducts a lot of trainings on policy advocacy to overcome peoples' hesitancy and fears, and has invested in research into the best policy alternatives using available science, best practices, and lessons from experience to date. United Way is investing more in the policy and advocacy area in recognition that much of the desired change can't be addressed by programmatic funding; there is a need for systemic change.

Ms. Darnell also pointed out that advocacy for policy change needs to take place at the local, state, and federal level, and stakeholders need to examine what level is most appropriate at what time for different issues. She noted, for example, that you don't want to advocate at the County Board of Supervisors level about immigration policy.

She closed by emphasizing United Way's continued interest in ongoing engagement with the hospital and public health communities:

"Remember that United Way can be a strong partner. We have millions of supporters and volunteers who are our communities. Health is a major impact area of ours. We know how to convene and engage communities. We build coalitions of multi-sector diverse partnerships. We are very strongly nonpartisan. We can talk to both sides. We look at our advocacy as an educational initiative where we give information on how policies affect communities and how it's affecting the lives and in it."

Gary D. Nelson, PhD – President, Healthcare Georgia Foundation

Dr. Nelson opened with a brief description of the Healthcare Georgia Foundation, which was formed out of the conversion of Blue Cross/Blue Shield of Georgia to a for profit health plan in the 1990s. Given a relatively small pool of resources allocated each year (approximately \$5 million), they have a strong focus on policy and advocacy.

While acknowledging the opportunity presented by the new reporting requirements for nonprofit hospitals and the accreditation standards for local public health agencies, Dr. Nelson indicated that there are a number of challenges in the community health improvement arena:

"The current environment in any community is dealing with health reform, a struggling nonprofit sector, and changing demographics of those who don't have access. Mergers and acquisitions are going on in many of our communities, and there's a history of program tombstones and demonstration boutiques. So there's a lot of skepticism and a lot of caution, and I should say in this state [Georgia] particularly, you may find a politically contentious environment for doing some of the work that I think we would want to do together."

In the CHNA process, Dr. Nelson suggested that one of the roles of foundations is to ensure that there are voices heard and faces at the table who are often not part of the process, including groups such as children, migrant workers, and mentally and physically disabled persons. Consistent with other expert panelists, meeting participants, and key informants, he emphasized the importance of addressing social determinants:

"Like most foundations, we have moved beyond an understanding that it's all about behavior, and we're pushing community-based organizations and others to think about the broad social and economic determinants of health. I'm not willing to put everything on the individual patient client or consumer. With that in mind, that's why we fund community-based organizations; because they represent that perspective."

He also noted that we must increase understanding of the institutional culture and systems issues that drive unequal access, unequal treatment, and unequal outcomes. He suggested that it is particularly important to inform that thinking with perspectives of clients, patients, and consumers, which is one of the reasons foundations work with community-based organizations. He noted that the roles of community-based organizations were not sufficiently addressed in some of the meeting discussions, and encouraged in depth engagement in community benefit initiatives.

Dr. Nelson observed that individual versus population health is a constant issue and a choice for many organizations; addressing need versus what works, and addressing the immediate versus delayed. He indicated that from a foundation perspective, there is a need for two kinds of evaluation; one focused on continuous improvement and the other documenting progress and demonstrating accountability. He noted that both are important, and that nothing has been more of an obstacle to high quality community benefit planning in Georgia than timely and complete access to data:

"It makes sense to any community involved in this process to know that the results will matter. It will lead to something. It will change something. It will result in a different way of doing work. It will drive resource allocations if nothing else."

Dr. Nelson closed with an example of a community benefit program effort that began with a conversation between the Grady Foundation, its community benefit committee²⁷, and the Healthcare Georgia Foundation. The initial focus of the discussion was the reduction of inappropriate emergency room utilization for individuals seeking primary care in the emergency room. Based on an agreed upon strategy, a small grant assisted Grady in hiring patient navigators to help channel people to primary care services. Dr. Nelson described how this project evolved into a broader community building strategy:

"The data behind this led to small area analysis in five neighborhoods surrounding Turner Field, and these hot spots were identified for a number of health issues. These 'frequent fliers' were coming from these neighborhoods, but further analysis provided an opportunity to understand more broadly the health needs of this community or these neighborhoods, and what happened was really quite interesting in the sense that the data drove decision making and engagement in the community and it drove community building."

The community members pointed to mental health services as a priority unmet need, and pointed to the physical blight of the community as a major problem. The combination of data, mapping technology, and community input provided a basis for dialogue with city and local government officials, who used existing funds to rid the community of abandoned homes and to redirect those properties to more effective and functional use. This example highlights the potential results of an approach to community benefit programming that combines the use of data, the leveraging of resources, and the direct engagement of community members.

2. Public Comment

Unidentified

One participant suggested there is a need to move from envisioning ourselves as the leader of community benefit for a hospital, or a leader of United Way to a broader definition of leadership, and asked the panel to address what we need to do in order to move in that direction.

Mark Horton, ASTHO

Dr. Horton noted that experience demonstrates that visionary leadership from hospitals or public health departments, as represented in a number of the presentations in the conference, leads to the kinds of practices we'd like to see, but in the majority of communities they do not exist. He suggested that perhaps the IRS regulations should require health departments to serve as a neutral convener of community health needs assessments and planning processes.

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²⁷ Grady Memorial Hospital is the largest medical center in the Atlanta metropolitan area, is a level one trauma center, and a major safety net provider located in the southern section of the city. It was formerly a public hospital, and was incorporated as a private nonprofit 501c3 organization in 2008.

He suggested further that the feasibility, or qualifications needed for the health department to serve in this function could be determined by national or state accreditation.

Barbara Laymon, NACCHO

Ms. Laymon asked the panel to offer suggestions on how might one incentivize hospital investment in prevention, and what might we suggest for the IRS that might be included in their reporting process.

Panel Response

Dr. Nelson addressed the questions on leadership, agreeing that coming together to improve community health requires a new type of leader, and that we have seen evidence of what is needed. He noted that his foundation invests in training of local boards of health, and suggested that similar training would benefit boards for other kinds of organizations, as well. Part of that training should be how an organization and its leaders should go beyond their boundaries to advance broader community goals.

Ms. Darnell shared that when United Way entered the policy advocacy arena, they experienced strong push back from many inside the organization who viewed it as going beyond their mission. She noted that it has taken 10 to 15 years with changes in leaders and board members to solidify their commitment.

Moderator Follow Up

Ms. Darnell was asked to share emerging lessons from the successful policy advocacy efforts she referenced in her presentation, including obstacles, as well as ways in which they overcome the obstacles.

Dr. Nelson was asked to follow up on prior comments regarding the lack of timely data on the impact of current policies as an impediment to bringing about necessary changes, and offer recommendations on ways in which we should demand the data that are needed.

Panel Response

Ms. Darnell shared experience in Santa Cruz County where youth were engaged in policy advocacy on school health and nutrition policies, walkable communities, and public space. The youth were given extensive training on public policy and were given the responsibility to present to school boards and city councils. She noted that they were very intimidated at first, and they had to help them understand that policy makers and public officials are regular people, that they work for us, and that they need to hear from constituents. She also shared that the boards and councils were also initially resistant, not having had the experience of being engaged by young people in these settings. These experiences yielded an important lesson on the importance of engaging community members in policy advocacy:

Once they do it, once they know how it works, once they know that they actually hold the power because they are the ones with the community knowledge, they're the ones who are being affected by policies, and they're the ones that know how the policies are affecting their families, their communities. I think that's been one of the biggest lessons learned and biggest successes in our policy work; to empower the people that are educating and advocating our policymakers and giving them the tools to go in there and talk to them."

Dr. Nelson indicated that the lack of data sharing and transparency and data sharing is an ongoing frustration:

"The timeliness, the equality, the availability, the completeness of data is struggling, and we actually need intermediaries to force the issue. For me it backs up to the social contract that organizations must have with the community to make that an upfront non-negotiable deliverable for any effort, planning effort or investment."

Mary Pittman, Public Health Institute

Dr. Pittman pointed to the fact that there is significant variation in how philanthropy engages in community processes, and a lack of alignment with community priorities that have emerged from meaningful engagement may do harm. She asked the panel to address whether there is dialogue in the philanthropic community about how community assessment and priority setting processes may inform philanthropic grant making, and whether we may see a new way of engaging philanthropy.

Unidentified

One participant called for greater efforts to build a common language, noting that most hospitals and other stakeholders don't understand public health's 10 essential services.

Unidentified

Another participant noted that some hospitals are beginning to express concern about participation in collaborative efforts, to the degree that they be held accountable for results as an organization. He asked the panel to address how, in an environment of shared accountability, do we reinforce that notion?

Panel Response

Dr. Nelson acknowledged that historically, philanthropy hasn't been good about working with others, but that both internal and external pressures have encouraged them to be more responsive, strategic, outcome-oriented, and inclusive. He noted further that there are different political, economic, and social dynamics that also serve as drivers for philanthropic behavior.

He commented further that philanthropy is learning more about its appropriate role in the community, how to foster two-way accountability, and the importance of making sure the investment is substantive and leaves something behind.

On the issue of accountability for results, Dr. Nelson acknowledged that foundations wrestle with the issue of 'attribution versus contribution,' and suggested that they have a responsibility to support both types of measures, particularly in the community benefit arena. He noted further that perhaps we should be focused more on whether changed occurred:

"I understand the political dynamics of everyone wanting to make sure that they claim their share of the success, their share of the contribution made, and I can think of advocacy efforts that we've engaged in in this state, advancing a statewide trauma system, advancing public health. Whose responsibility was it? Who can take credit for it? In the end, it's really about creating the conditions for long-term partnerships and further work. But someone's got to say that this was a shared effort, shared success, and it's worthy of future investment."

Ms. Darnell referenced a 10 year statewide initiative funded by The California Endowment entitled Building Healthy Communities that directly engages community members to set priorities and take action in addressing social determinants of health. She noted that UW and other funders are coming to the table to explore ways in which funds can be leveraged to build on this effort.

Unidentified

One participant pointed to the need to identify a variety of measures that demonstrate progress towards ultimate health outcomes, including institutional systems changes; in essence, the way organizations and stakeholders changed the way they do business.

Chris De Mars - Northwest Health Foundation

Mr. De Mars referenced a project supported by his foundation entitled Community Health Priorities, which is a series of conversations in communities to hear what people want and need. He also noted that an important element of the project is getting youth involved. Pointing to the attendance at the meeting, he estimated that 80% of attendees were over 50 years old, and wondered whether they may define leadership differently than the Baby Boomers do.

Unidentified

A community physician shared a case of a homeless person he sought to assist who had received substandard care with disastrous results, and shared that his personal involvement in cases provides more insights than any other source. With this in mind, he asked whether it may be of some benefit and mechanism for providers and public health leaders to provide timely feedback to philanthropy.

Bill Barberg, consultant

Mr. Barberg referenced a common challenge faced by communities, when there are multiple organizations that pursue a grant, but only one secures it. He describes the net result is that those who were unsuccessful are resentful towards the successful organization, and ended up spending what might tally as a large volume of resources that may have been devoted to more useful purposes. As such, the process may have actually set back the larger cause. He suggested that bringing communities together with funders to develop a more collaborative strategy would yield less time 'chasing dollars' and more time ensuring that the money secured is spend well.

Panel Response

Dr. Nelson addressed the issue raised by the community doctor, agreeing that story telling is critically important, and that there is a need for repositories. Addressing the question regarding grant making, he offered:

"One of the most noticeable gaps and needs that I've recognized over the last ten years is the need for communities to have a central point -- a grant making procurement vehicle or capacity that coordinates, integrates funding opportunities across systems. And in Georgia we've missed so many opportunities."

3. Key Informant Interviews

In a separate key informant interview, **Gary Nelson**, **President of the Healthcare Georgia Foundation** offered additional reflections on the issue of data availability and policy making. He pointed out that there is a large volume of data collected by government and private sector agencies, but is rarely reported and used in a manner that informs public decision making. As such, he noted that:

"You can't leverage existing investments if you don't know the status of what the current investments are and what results are achieved from them. So, you know, you're waiting on the sidelines, you know and frequently with a significant time lapse and with a lot of questions about the credibility or quality of the data to know whether or not [indistinct] decisions can be informed by that data. So, it's a paradox."

He called for more accountability and advocacy to ensure that available data translates into informed decisions and policy development.

Eileen Salinsky, Grantmakers in Health

Some key informants addressed the issue of public sector funding streams, and the degree to which they foster the kind of community problem solving that is needed. Eileen Salinsky of Grantmakers in Health commented on the degree to which federal, state, and local governments are providing the support needed for comprehensive approaches to community health improvement:

"My sense of it is that the states are kind of the weak link in this whole approach. I think there's a lot of really innovative local health departments, particularly in some of the big metro

areas. But I just don't think – maybe a handful of exceptions, I really don't think the states are engaged in this in a meaningful way. And given income inequalities at the local level, I think you have to have some pretty rigorous and robust state support if things are really going to take off."

She also observed that there are challenging dynamics between state and local governments:

"I think throughout the country a real issue is the tensions and sort of animosities that exist between the state and local levels. I think that the local folks understandably feel like they face a lot of kind of mandates and requirements. But there isn't a lot of support for the things that they need the states to do for them."

In response to a question about the degree to which categorical funding streams limit the ability of local public health agencies to innovate, Ms. Salinsky expressed mixed sentiments and suggested that more inquiry is needed:

"There does seem to be a lot of variation, which I don't think is well-documented. In terms of the extent to which states use categorical mechanisms to distribute funds, some states have high rigidity, and in other states it's not as big of a deal. The differences across the states complicate a lot of these conversations. From the federal perspective, I have some sympathy for the categorical program people whose job is tied to that category, although it can get ridiculous when you're talking about one sexually transmitted disease versus another."

Ms. Salinsky also weighed in on the value of shared advocacy in advancing the community health agenda and the potential of hospital engagement:

"I think that just the health advocacy at the state level is getting much stronger. And they're getting more sophisticated. Advocacy groups are thinking about how to network with service providers. I think to the extent that hospitals start to join that coalition, it's a big thing. I mean, in terms of financial support for those people, as well as the political support of saying to their legislators, we stand behind this issue."

Similar sentiments were expressed by key informant **Mike Bonetto**, **Office of the Governor**, **Oregon**:

"If you have a hospital speaking on an issue that is outside reimbursement, it seems to me that it could have particular resonance, because it is clear that it is not about near-term interests."

F. Public Reporting: Federal, State, and Local Issues

A key theme expressed by participants throughout the expert panel meeting was a call for increased transparency. The new IRS reporting requirements for tax-exempt hospitals will certainly increase public access to information on their structures, functions, and processes in fulfillment of their charitable obligations. Similarly, there will be increased public availability of information on local public health agencies that seek to meet national and state accreditation standards. Panelists and participants also suggested a need for greater transparency for other entities in the public as well as other stakeholders in the public and private sector.

In general, the purposes and imperative for public reporting include a) increased public accountability for inputs and outcomes, b) information to inform decision making and resource allocation, c) foster increased engagement, collaboration and support (across sectors), and d) increased visibility and recognition for accomplishments.

Key concerns in the establishment of public reporting requirements are the avoidance of obligations that are irrelevant, costly, and/or otherwise detrimental to the optimal functioning of the targeted organizations. This includes whether such requirements do not accommodate the diversity of the targeted organizations and the physical and political environments in which they operate. Of equal importance is the consideration of conflicts and/or contradictions between regulatory and reporting requirements at different levels or branches of government.

These and other questions were raised and addressed to varying degrees in other sessions of the expert panel meeting, but the final two sessions were set aside to focus explicitly the following set of questions:

- What are essential elements of public reporting processes?
- What are optimal roles of public sector oversight at the state and federal level?
- What are creative alternatives to public agency oversight to encourage desired institutional behavior?
- What are challenges and opportunities in the coordination of public sector agency roles?
- What are key issues for hospitals in meeting national & state requirements?
 What are key issues for local public health agencies in meeting national & state accreditation standards?
- What is the role of local officials, advocacy groups, and the general public?
- What is needed to move from compliance to transformation?

The first session focused primarily on the interactions between federal and state agencies in reporting requirements, with some attention to local dynamics, while the second section focused primarily on the implications and interactions between federal reporting requirements (and implementation of public health accreditation standards) and hospitals, public health agencies, and community stakeholders.

E1. Federal – State Issues

1. Expert Panel Comments

Donna Folkemer, MA, MCP – Senior Policy Analyst, The Hilltop Institute at UMBC

Ms. Folkemer opened by describing the work of the Hilltop Institute in the community benefit arena through a grant from the Robert Wood Johnson Foundation and the Kresge Foundation. She outlined their focus on support of state policy, and referenced two early briefs they've published; one focusing on state experience, and the other on the impact of the ACA. On the state experience brief, she noted that one purpose was to set a baseline. She also pointed to their finding that there is a lack of uniformity across states in terms of the relative attention given to community benefit. She indicated that a major focus going forward in the three year project is to provide technical assistance to state and local policymakers, and to find ways to engage other stakeholders:

"One of the things we're doing is trying to make sure that we include folks in our discussions who are not necessarily always part of the community benefits discussions, and also that we write materials that they can understand and read and use. That is a little bit about what we're doing and I look forward to talking to all of you about that."

Ms. Folkemer offered an observation that state governments are likely to be occupied with a range of issues associated with the implementation of PPACA in the coming years that are outside the community benefit provisions:

"The issues that I am hearing about as I talk to state and local officials, legislators and others is that they're interested in getting some answers and they're not thinking about these issues exclusively as it relates to hospital community benefits."

A key question being examined by the Hilltop Institute is what kinds of benchmarks should be used by states to assess community benefit performance:

"How should we define accountability and how should we set up benchmarks to deal with that? Those are the kinds of things I wanted to ask you to think about. I've been in touch with many of you and we've had wonderful dialogues."

Lois Johnson, JD – Assistant Attorney General, Health Care Division, Office of the Attorney General of Massachusetts

Ms. Johnson opened with an overview of the history in the development of the Voluntary Guidelines for community benefit through a process convened by Attorney General Scott Harshbarger in 1994. She noted that community benefit oversight is housed in the Attorney General's Office because the Attorney General has oversight of charities and is engaged in a range of issues in the health care arena. She noted further that guidelines were developed for hospitals, and two years later for both non-profit and for-profit HMOs.

More recently, Ms. Johnson shared that when the current Attorney General Martha Coakley came into office, she initiated a review and ultimate revision of the Voluntary Guidelines. The review process involved the engagement of a broad spectrum of stakeholders to examine the strengths and weaknesses of the guidelines and practices in the field. She summarized the findings as follows:

"We found in some cases hospitals waiting until the last minute of the reporting year and saying oh what can I count as a community benefit? We found a lack of pre-planning and really a lack of engagement with the community to determine the priorities that we should be focusing on in advance. We found in some cases hospitals doing the same programs over and over without any assessment of their outcomes and without community engagement about whether or not those are still key programs to focus on."

The new guidelines sought to address these issues, as well as to standardize and streamline the reporting process. Ms. Johnson shared a new provision regarding collaboration with the public health community:

"New for us in 2008 was to encourage a focus on statewide priorities. We used the statewide priorities developed by our State Department of Public Health based on their assessment and we tailored those to make sense in the community benefits context. The idea here wasn't meant to be prescriptive; that every hospital needs to focus on these and they are."

She noted that a key consideration was how to encourage alignment of community benefit programming with the goals of state health reform. As such, they suggested an emphasis in areas such as chronic disease management, reducing health disparities, and promoting wellness among vulnerable populations. Ms. Johnson also indicated a strong focus on strengthening processes:

"In this revision, we've emphasized that the process is as important as the expenditures, to sort of get it out of what can we count as a community benefit to how are hospitals kind of coming up with their priorities and what are they doing?"

In terms of balancing state level reporting and the new IRS requirements, Ms. Johnson acknowledged that there are some inconsistencies:

"We acknowledge that there is overlap and they're not always consistent. We explicitly acknowledge that certain things that may count for the IRS may not count in Massachusetts and vice versa. The Medicaid shortfall amounts we don't allow hospitals to report in our form, but for example community building activities we would count as a community benefit. We resolve this by allowing optional reporting so community service programs they can report to us optionally."

She concluded by emphasizing that despite the promulgation of the new IRS reporting requirements, there is still an important role for state oversight. She suggested that in some ways, states may be in a better place to ensure accountability and to work with hospitals and to tailor their reporting requirements to changing circumstances.

Gianfranco Pezzino, MD, MPH – Senior Fellow, Kansas Health Institute

Dr. Pezzino opened by providing a brief overview of his current work with the Kansas Health Institute and prior ten year tenure with the Kansas State Department of Health and Environment. He noted that in his current role, a major focus is facilitating partnerships, convening, and providing technical assistance.

He focused his comments on sharing some of the unique issues faced by states like Kansas with a high concentration of rural areas:

"We have 105 counties, we have 128 community hospitals. There are only 9 counties that do not have a hospital. There are 26 counties including many rural that have more than one community hospital."

He summarized the dynamics in conducting CHNAs, engaging community stakeholders, and developing implementation strategies as follows:

"In a local rural situation you are going to have multiple agencies in the same small community that are competing for the same scarce resources and competing for the same attention from the same stakeholders. Let's face it; there are only a few people who can go to health coalition meetings in a small community. It's all the same people. Perhaps more importantly, they are competing for the attention from the same small group of local elected officials. The last thing you want to do is bombard those officials with five different community health assessments."

Dr. Pezzino described two solutions that have been designed in Kansas to deal with challenges such as a lack of data, stakeholders, and resources. He framed them as a combination of shared ownership and regional cooperation:

"In March 2011, Kansas Hospital Association and the Association of Local Health Departments signed a joint resolution that encourages local health departments and hospitals to work together in conducting community health assessments and developing improvement plans. There has been a lot of talking in the last few days about memorandum of understanding, how important is it. I don't think that is sufficient to create a partnership, but I think it is an important tool. I think when two strong member-based organizations in the state sign a resolution like this it sends a strong message to their constituents."

"An alternative solution we are using is the regional cooperation and that started in 2002 with preparedness money. It is voluntary. Local health departments can pick their partners and they can decide who they want to play with. Each region has to have at least three contiguous counties and it is more than just saying work together. They require inter-local agreements that need to be signed and approved by all the county commissioners involved and then filed with the Attorney General's Office."

Dr. Pezzino contrasted these approaches with consolidation, since each county health department retains their own jurisdiction and power to secure resources. He indicated that 103 out of 105 counties have participated in this process and there are 15 regions. He acknowledged that a region as defined in Kansas may not fit the definitions of community that have been discussed in the meeting:

"A region is not a community. I will agree with you, but that doesn't mean that the regional structure cannot have a role in community health assessments. What we are trying to do in Kansas is to capitalize on economies of scale while retaining a local flavor. That can be done for example by comparing data they collect at the local level, by combining data from smaller jurisdictions where often just single jurisdiction data are not enough to do any meaningful analysis, by comparing trends, by adding defined combinations and perhaps developing common approaches in terms of interventions, and perhaps sharing facilitators, consultants and other resources."

He also discussed ways in which the process is intended to move from individual institutional accountability to shared accountability:

"To push accountability beyond a single agency we have to have a very transparent process and a very public process. If the community health assessment improvement plans are public processes, nobody wants to be embarrassed in public and people will start taking ownership of those pieces. What we really want to do is to maximize the probabilities of success of those plans. We can do that by, for example, providing tools to improve the performance management skills of different agencies in the process."

Dr. Pezzino closed with some suggestions on communicating findings from CHNAs and implementation planning processes:

"The first task in a communication plan would be to identify your audiences and I use a plural there for a reason because there would be more than one. You want to talk to your community, to general public. You want to talk to your stakeholders. You probably want to talk to your elected officials. The way that you talk to them is probably going to be slightly different. You can't just have the same message for everybody. You may have to develop a subset of a communication plan for each of those audiences."

Moderator Follow Up

The moderator observed that having a state statute in place appears to have contributed to the advancement of practices on multiple levels, despite the fact that few resources and effort has been devoted to oversight and/or facilitation. He noted that in this regard, Massachusetts is the exception; both in terms of the recent review and revision of reporting guidelines, as well as the fact that all community benefit reports are posted on a searchable website. He shared that a representative from the AG's office noted that nine of ten inquiries they had received were from hospital representatives who questioned the legitimacy of competing hospital claims.

He noted that a key question in this context is how we deal with the pre-existence of state statutes given the new IRS reporting requirements.

2. Public Comment

Gene Matthews, North Carolina Institute for Public Health

Mr. Matthews asked Dr. Pezzino to address whether the prior establishment of a voluntary regionalization process may have contributed to some political impetus to move towards requirements.

Unidentified

One participant asked the panel to address whether there should be a role for states to assist in the standardization of data that is shared in reports and on websites.

Eileen Barsi, Catholic Healthcare West

Ms. Barsi asked the panel to address how to report and justify continued investment in a current community benefit programs that may be the reason why a particular health problem is <u>not</u> identified in the CHNA. She also pointed to Ms. Folkemer's reference to the need for accountability and asked the panel to address whether AHRQ's Prevention Quality Indicators may be a good place to start.

Panel Response

Dr. Pezzino responded to the question from Dr. Matthews by emphasizing that a key initial impetus was the use of a small pool of funds to incentivize regional planning. The subsequent steps taken were supported by establishing parameters for engagement that preserve local control.

Ms. Johnson pointed out that a key to their relative success to date has been public dissemination of not only reports, but press releases on emerging developments and awards programs, and community comments on any particular report. Of equal importance, she referenced ongoing engagement of community and institutional stakeholders.

Dr. Pezzino noted that Kansas is establishing a centralized system of reporting:

"...to act both as a data depository but also as a data display system and that will be a central system for which you can access information of an individual account so it will be a single portal. It is not just access and information in terms of what are the rates for this or that, but it also very much action-oriented so for each particular county, first of all there will be a dashboard that will show the top issues that the county has decided are top priorities and then there will be best evidence practices that are immediately linked to those priorities."

E2. Federal – Local Issues

Kaye Bender, PhD, RN, FAAN – President/CEO, Public Health Accreditation Board

Dr. Bender opened by pointing out that the new IRS reporting requirements have created an important opportunity for alignment between hospitals and local public health agencies, but a key consideration is how we move from compliance to transformation.

She described the Public Health Accreditation Board's (PHAB) approach to accreditation as consistent to what colleagues have seen with the Joint Commission and other accrediting bodies. As such, a set of practice and evidence-based standards were developed in cooperation with relevant stakeholders and field tested over the last four years. They published a guide to accreditation in July, and will begin accepting applications for accreditation in September. As voluntary standards, there is understanding of the need to assist and incentivize participation.

Based upon their review of other accreditation processes and consideration of practical realities in local public health agencies, PHAB established a five year cycle with annual reporting. Dr. Bender acknowledged that there is variable capacity in the field, and describes their approach:

"Two studies in 1988 and 2003 describe health departments as being fragmented and in disarray; and some of that has been noted here – the lack of funding and the lack of standardization and uniformity. Some health departments have excelled in spite of that, but what the accreditation movement is designed to do is to lend some standardization and uniformity while respecting the local community flavor that makes public health what it is."

Dr. Bender summarized the accreditation standard as follows:

"We have twelve domains with standards and measures and the required documentation under each of those. As has already been adequately stated so I won't belabor; the first ten of these fit the public health ten essential services framework. Eleven and twelve are designed to get at administration and management and the relationship with whoever the governing entity is, whether that is Board of Health, the Governor's Office, the Mayor's Office, the City Council, the Board of Commissioners or whomever."

She referenced the first standard as particularly important and relevant to the discussion of public health agency and hospital collaboration:

"You can see that the first standard talks about participating or conducting a collaborative process resulting in Community Health Assessment. We are looking for comprehensive population focus. We are not prescriptive about the model that the Health Department or its community chooses to use. Rather, the Health Department gets credit if you will for the participatory or collaborative nature of it."

Dr. Bender acknowledged that important feedback in the developmental process was to avoid over-reliance and prescription of specific models, and giving more focus to principles of quality improvement, collaboration and meaningful community engagement:

"Health Departments also get credit in two of the other domains for collaboration particularly with health systems. The one is in a domain that speaks specifically about developing partnerships and coalitions. There is a measure that speaks specifically to those partnerships and coalitions within other stakeholders and other providers of health related services, i.e. health systems."

She noted that there is also a domain that speaks to an analysis of the health care access issues in their jurisdiction that should contribute to ongoing engagement of local hospitals.

Dr. Bender summarized PHAB's approach to accreditation as follows:

"We are trying for this again to be sort of somewhere between Joint Commission and Baldridge. 28 We use that analogy a lot; we are driving toward the quality improvement side holding the health departments accountable; as opposed to crossing the t's and dotting the I's in a regulatory sort of way. We built in a lot of flexibility for public health departments who operate in a variety of political, geopolitical and other environments to be able to accomplish what they need to under the rubric of the ten essential public health services."

Dr. Bender closed by addressing the issues around regionalization addressed by other expert panelists:

"We aren't using the consolidation or the regionalization words because those are certainly up to local jurisdictions to decide. We certainly think that in this day and time that sharing services is not a bad idea, particularly when it might not make a lot of long-term sense to develop robust capacity.

She also noted, however, that State health departments have some responsibilities in the accreditation process:

"We do hold State health departments a little bit more accountable for something that has been alluded to, but I haven't heard the State Health Department mentioned a lot in the last three days; and that is if a local health department, as has been stated, doesn't have the capacity or isn't in that organizational framework for public healthy appropriate place for the data to reside or the analysis expertise to reside, then we hold the State Health Department accountable for providing that kind of technical assistance. "

Mr. Griffith opened by noting that in addition to his role as a partner in the Chicago-based Jones-Day firm, he is also the President of the American Health Lawyers Association (AHLA). He indicated, however, that he was serving as an expert panelist in his individual capacity, and not

Gerald M. Griffith, JD – Partner, Jones Day

on behalf of AHLA. His comments focused initially on feedback associated with the release of IRS Notice 2011-52 on July 8th.

²⁸ The Malcom Baldridge National Quality Award is given to U.S organizations based upon achievements in seven categories of criteria for performance excellence.

Mr. Griffith spent some time addressing the issue of timing on the completion of the CHNA and the adoption of the implementation strategy, ²⁹ as well as the application of requirements to hospitals operated indirectly through LLCs or partnerships and to government hospitals. On the former, he raised the question of whether the timing issue is practical or consistent with the original intent:

"The requirement that the implementation strategy must be adopted in the same year that the CHNA is conducted is one of the aspects that was unexpected in the notice and one that I think is different from what the statute contemplates. If you look at the Affordable Care Act, it requires that the 501(r) provisions become effective for the first tax year (and you have to listen to tax lawyer speak here), the first tax year starting two years after the enactment of the law (it was enacted March 23, 2010) so it is the first tax year starting after March 23, 2012. When you look at 501(r) itself, which outlines the CHNA requirements, Congress was specific about when the CHNA must be conducted."

"The other timing issue to note is that the first tax year starting after March 23, 2012 is not the end of the first year period for doing your first CHNA, it is the end of that period. So that means for calendaring taxpayers, by December 23, 2013, they have to have their first CHNA done and under the notice, first implementation strategy. For a June 30 taxpayer, it would be June 30, 2013. That is when we can expect the optional tag to come off of the CHNA questions on Schedule H and for the IRS to require answers."

On the latter issue of applicability, Mr. Griffith observed the following:

"Another aspect of the notice that may have been unexpected by some but harder to quibble with, is that the IRS believes 501(r) applies to non-profits that operate hospitals indirectly through LLCs or partnerships, though they will entertain suggestions for a small interest exception. 501(r) and the CHNA requirement also applies to dual status governmental hospitals, that is governmental hospitals that also applied for and received 501(c)(3) status. Of course it remains unclear how the IRS will plan to audit government hospitals' compliance since they are not required to file a 990."

Moving on to the issue of soliciting and considering the input of outside stakeholders, he specifically addressed the engagement of local public health agencies:

"Local public health agencies are only one possible source of public health input for 501(r) purposes. Hospitals have options. If they are going to partner with local public health agencies in these efforts, they will need to be persuaded that the partnership will add value to the CHNA process for the hospital, that it will make the hospital's administrative burden or costs lower and not higher. A hospital will also be looking at the speed and agility with which local public health agencies can respond to their data needs and how useable the data is, including whether it can be sliced and diced along the lines of how a hospital defines its community."

Mr. Griffith noted that section 501(r) does not specify who has to provide input, but the IRS did provide additional guidance by identifying three categories of people from whom they expect hospitals to seek input, including a) those with special knowledge and expertise in public health, b) federal, tribal, regional, state, or local agencies, and c) leaders, representatives, or members

²⁹ Issue and concern also raised by Mr. Huber in Panel #9.

of medically underserved, low income, minorities, or people with chronic disease. He indicated that the IRS appears to be taking a flexible approach to the definition, while indicating an expectation that it will be tied to the geographic parameters of the defined community. He acknowledged that the IRS indicated that community cannot be defined in a manner that circumvents the requirement to assess the health needs of the community. He observed that such a principle is reasonable, but it has its limits:

"It would not make sense, for example, to force a cancer hospital to address needs related to other diseases in its CHNA, or to require a critical access hospital to include areas outside of its geographic service area."

Mr. Griffith then examined the issue of what constitutes input in the requirement for hospitals to "take into account" input from the three categories of persons described previously:

"The statute in the notice did not define what constitutes input. Websters defines it as advice, opinion, and comment. In the context of 501(r) though, it seems to include data input so the question is how to go about getting the input. Examples provided in the notice include using focus groups, meetings, interviews, surveys and correspondence. For the data elements though, there are also on-line databases that we have heard about. No one wants the CHNA process to consume so much in resources that little is left for implementation, so use of existing data sets would be helpful in that regard."

In his closing comments, Mr. Griffith address the issue of whether and how we move community benefit practices and associated hospital reporting from an orientation of basic compliance to transformation, where the emphasis is on quality and outcomes.

"Whether or not most hospitals will go the extra mile will likely depend in part on whether they are persuaded that these potential benefits are realistic and what roadblocks, legal or practical, stand in their way. There seems to be a strong sentiment for collaboration on the assessment and implementation phases."

Claudia Lennhoff – Executive Director, Champaign County Health Care Consumers (CCHCC) Ms. Lennhoff opened by introducing the work of her community advocacy group, which was established in 1977 in central Illinois, with a major focus on giving people who are most effected by the health challenges have a voice in the system and in making changes that are needed.

A central theme in the work of CCHCC and in her comments is that all health care is local, and that all people have a stake in improving community's health. Along these lines, she emphasized that while the new IRS requirements are an important step forward, ultimate accountability resides at the local level:

"Another principal that I wanted to talk about is there are legitimate limits to what the law can do, so we're talking about regulations and law but we really need to move beyond that for real. The law is not going to improve the community's health. It is a tool for us to use to get there; and then that local accountability. When I'm talking about accountability today, I'm focusing on local accountability. Local accountability cannot thoroughly be codified in federal

regulations. However, federal and state regulations can provide an important framework and starting point for real accountability. It gives community members resources and tools and a way of understanding what is supposed to be happening."

In the operationalization of local accountability, Ms. Lennhoff emphasized that community input and engagement can and should go well beyond the CHNA process. She cited a programmatic example where ongoing engagement would have yielded much different results:

"One of our hospitals initiated a mall walker program that was supposed to address cardiovascular health. There were clearly real other things that could have been done with the tens of thousands of dollars that went into what was essentially a PR program. If the community had been told we could spend x thousands of dollars to put towards cardiovascular health, I can assure you we would not have come up with a mall walker program."

Ms. Lennhoff also suggested that organizations like hers in the community can be excellent partners in the advancement of shared policy agendas, noting that they had considerable experience. She pointed out that it would be relatively easy to identify and achieve agreement on community health priorities, and that shared advocacy with hospitals, public health, local business and others would send a powerful message to state agencies.

In her closing comments, Ms. Lennhoff shared a brief profile of their experience in efforts to engage Provena Covenant Medical Center, which was one of two hospitals in the Champaign-Urbana metropolitan area. The initial resistance of the Provena hospital leadership to engage CCHCC and community members on issues of concern was the primary impetus for local officials raising concerns with the Illinois Office of the Attorney General, and the resulting legal case was ultimately presented and decided by the Illinois Supreme Court. The most troubling aspect of the experience was that the concerns raised by CCHCC and other community stakeholders were resolvable, and in fact were quickly resolved after a change in the hospital's leadership:

"A new CEO came on, we established dialogue and we worked together on projects of mutual interest. When people start working together, and it could be on a small project; it can be on where do we put the notices that financial assistance is available – that process itself can be very transformative and trust can be built."

By this time, of course, the case had already been referred to State officials, and resulted ultimately in the State Supreme Court ruling against Provena Covenant. This, as well as a long line of other examples in the field, demonstrate the importance of meaningful community engagement, as well as the concept of local accountability.

Moderator Follow Up

Mr. Griffith was asked to address the degree to which hospitals can and should arrive at a shared definition of community with local stakeholders.

Dr. Bender was asked whether local public health agencies would be expected to acknowledge and integrate the role of local hospitals in their area in their CHNA and implementation strategy as a factor in the accreditation process.

In the context of meeting discussions about transformation and continuous quality improvement, Ms. Lennhoff was asked to share any examples in her local engagement of hospitals that highlight some of the challenges moving forward.

Panel Response

Mr. Griffith suggested that it is in a hospital's interest to "avoid the friction of a disputed definition," but acknowledged that there may be some disagreements:

"[Hospitals] may conclude that some requests just don't make sense and don't fit what they can do that may be due to a misunderstanding, a failure to communicate adequately what the hospital is capabilities are, what it's focus is, all the good that it is doing. If people are focusing too much on the negative they may miss the good and they may not understand that the hospital is addressing community need, it may just not be the one that the particular [group or individual] is interested in."

Mr. Griffith supported the reasoning of comments by Dr. Slifkin in Panel #2 that ER visits may be a more accurate reflection of community health needs than inpatient utilization patterns, and thus be a more informative tool to define community for charitable purposes. He also shared the concern expressed that defining a community should not result in the exclusion of a geographically proximal community with substantial unmet health needs (referred to as an 'orphaned' population):

"A population whether it's geographic, whether it's based on some demographic that doesn't fit in any hospital's community, that's a problem. "

Dr. Bender affirmed that local public health agencies will be expected and encouraged to engage and integrate hospitals into the assessment and implementation plan processes as part of their accreditation. She also addressed the issue of the potential need for assessments and implementation plans to span individual public health department jurisdictions:

"[If a] hospital is covering a broader area than a health department might cover, they certainly might reach out to more than one health department and we would also look on the other side that the health departments had participated in that as well. But you know, at the end of the day here's the transformational piece for me, and then I'll go beyond what you asked. It is good to think about what's in this for the hospital and what's in it for the health department, but at the end of the day as a consumer in my community in which I live, I think of nothing better than that I saw all of these very important players along with the advocacy groups come in together to look at what's good for this community."

Ms. Lennhoff shared a local example that highlights the need for further education on what constitutes meaningful community engagement:

"One of our hospitals asked me and several other community members to participate in a CHNA process. They shared with us preliminary results and I asked them to talk a little bit about what's going to happen in terms of prioritizing, what's going to be your process, will you reach out to us to help with that process and so on? Her response was, 'Oh no we'll just do it internally.' I said we would really be willing to help and would like to help with that, and asked how they will prioritize and what are their criteria. Basically it was all about alignment with internal priorities for the hospital."

She shared further that there are similar challenges with the local public health department in their implementation of the Illinois I-Plan process referenced in Panel #9:

"They always bring together all the usual suspects to participate, and then show us what the results are, and we don't hear about it again."

Ms. Lennhoff emphasized the importance of viewing community organizations as supportive partners, rather than adversaries:

"Community organizations really value non-profit hospitals in our community. We value them precisely because of the ethic of giving back to the community and working with the community, but sometimes we've had to push our hospitals to do that. Hospital ownership may change but the community's sense of ownership of that hospital does not change."

Moderator Follow Up

On the issue of defining community, the moderator provided two examples where a focus on geographic areas with concentrations of unmet health needs led hospitals to focus their community benefit programming outside of their immediate municipality or specialty area.

For the first example, Hoag Memorial Hospital Presbyterian is located in the relatively affluent city of Newport Beach, CA, but focuses much of its community benefit programming in other cities such as Santa Ana, where there are concentrations of unmet health needs.

For the second example, Lucile Packard Children's Hospital at Stanford is a regional children's hospital with a focus on tertiary and quaternary focus of specialty care, but they put a significant focus of their community benefits towards an array of primary care and preventative services in the nearby low income community of East Palo Alto. They make this investment despite the fact that it has little impact, for example, on the volume of indigent patients that may come into their emergency room.

2. Public comment

Melissa Biel, consultant

Dr. Biel asked the panel to address the degree to which the requirement for hospitals to identify all unmet needs and provide justification for any identified needs they are not addressing may lead to some hospitals to narrow the scope of their CHNA or to withdraw from collaborative processes.

Julia Joh Elliger, NACCHO

Ms. Elliger pointed out that one of the purposes of the CHNA is to inform how stakeholders can work collectively to improve health. In this context, she suggested that it is counterproductive for hospitals or local public health agencies make advance decisions on whether to partner based upon an assessment of the relative short term benefits for their organization.

Panel Response

Mr. Griffith noted that section 501(r) requires hospitals to document the identified needs it is addressing and provide justification for those it is not addressing, and expressed concern about the practical implications of this requirement:

"I think there is the potential for that incentive and a hospital may be made to look worse or perceived as looking worse if it completes a Community Health Needs Assessment that identifies ten needs and it's only addressing two of them, versus a hospital whose assessment identified three needs and it's addressing all three of them. Just on the sheer numbers, the second hospital tends to look better."

Mr. Griffith noted further that this is an area where consultants may be useful in helping to articulate the needs that one hospital is addressing, and to help get the word out on what other stakeholders are addressing and why this is appropriate; in essence, provide a more complete picture of the hospital in the larger context.

"If you broaden the scope a little bit and if that first situation of the hospital addressing two of the ten, they can also say but the FQHC here is addressing this need, this rural health clinic is addressing this need, the local public health department is addressing this need, this other hospital across town that specializes in these services is addressing these needs – then that hospital starts to look a little better than the one that was just doing a narrower review and confining it to what it can do on its own. It's a question of context I think."

Moderator Follow Up

The moderator pointed to the issue of how many unmet needs identified in a CHNA that are being addressed by a hospital is a major challenge in the public reporting process, to the degree that it pushes them to take on more issues than can be done in an effective manner.

Panel Response

Ms. Lennhoff pointed out that the new reporting process will contribute to the transparency needed for community members to recognize when there is some form of gaming of the CHNA process by hospitals. She also suggested that community members understand that a hospital cannot meet all identified unmet health needs in local communities.

Mr. Griffith posited that the decision on whether to engage in partnership is the same with local public health agencies as it is with hospitals; in essence, it is a question of the relative value:

"What can you do to make the hospital's job easier and to get them in the door so they start to see the value. You are right and it is more than just the dollars and cents and I think value

added is more than that, but you're dealing with hospital administrators in many cases who are very busy people. They have as they say a railroad to run so anything you can do to get their attention and to show how it makes their job easier makes it more likely that they will come to you with open arms and you can start to build that relationship."

IV. CONCLUSION / NEXT STEPS

In addition to the public release of this report of proceedings and the companion report on emerging practices that was developed by the University of Kansas, the Centers for Disease Control and Prevention will continue to engage key stakeholders, conduct inquiries, and develop additional products in the coming months. One process wilol be to convene a panel of experts to develop a targeted set of tools and resources to accelerate and support hospital, public health, and diverse stakeholder participation in CHNAs. The tools will focus in particular on establishing optimal geographic parameters that foster collaboration and shared accountability, and leveraging existing local, state, and national initiatives.

Other products and processes to be initiated through the CDC in partnership with stakeholder groups will be announced in the coming months.

APPENDIX A BIOGRAPHIES

EXPERT PANEL & KEY INFORMANT BIOGRAPHIES

Key P=Panelist K=Key Informant

Eileen Barsi (P, KI)

As corporate Director of Community Benefit for Catholic Healthcare West (CHW), Ms. Barsi has responsibility for planning, developing, coordinating and overseeing community benefit initiatives, including the development and implementation of system policies. Currently, and for the last three years, she has served as the Chairperson of the Community Benefit Committee of the Catholic Health Association.

Elissa Bassler (P, KI)

Elissa Bassler is the CEO of Illinois Public Health Institute (IPHI). Under Elissa's leadership, IPHI has developed several program areas, including the Center for Community Capacity Development, a Policy and Partnership Initiatives program, the Racial and Ethnic Health Disparities Action Council, and Center for Health Information Technology, which is building a new web-based data query system for Illinois.

Eric Baumgartner, MD, MPH (KI)

Eric Baumgartner is the Deputy Director of Policy and Program Development at the Louisiana Public Health Institute. He is also an associate at the Center for Health Leadership and Practice, which is a , leadership training, consultation, and resource center serving domestic and international health leaders and organizations, and in this capacity has designed and implemented a full range of leadership development programs and consultation activities targeted to the public and private health sectors and organizations.

Kave Bender, RN, PhD, FAAN (P)

Dr. Bender is the President and CEO of the Public Health Accreditation Board., a position she has held part-time since January 2009 and full-time since June 2009. Dr. Bender has over 26 years of experience in public health, working at both the state and local levels within the Mississippi Department of Health. Her last position there was as Deputy State Health Officer.

Bill Beery, MPH (KI)

Bill Beery has served Group Health Cooperative in various capacities over his 26-year career. As former director of the Institute's Center for Community Health and Evaluation, Bill successfully led efforts to improve the health of communities in more than 25 states with funding support from health foundations, government, and private organizations. As a senior investigator, Beery continues to work on select CCHE evaluation projects. He was also instrumental in establishing and developing Free & Clear, Group Health's ground-breaking telephone-based smoking cessation program.

Leslie Beitsch, M.D., J.D (P, KI)

Leslie M. Beitsch is a Professor of Health Policy and Director of the Center for Medicine and Public Health at the Florida State University College of Medicine. In addition to his faculty duties at Florida State, he is Adjunct Professor at the College of Public Health, University of South Florida and the Faye Boozeman College of Public Health at the University of Arkansas for the Medical Sciences.

Joe Betancourt, MD, MPH (KI)

Dr. Betancourt currently co-chairs the Massachusetts General Hospital Disparities Committee and the Harvard Medical School Cross-Cultural Care Committee. He also chairs Aetna's External Racial/Ethnic Disparities Advisory Committee, and co-created the nationally used e-learning program, "Quality Interactions: A Patient-Based Approach to Cross-Cultural Care." Dr. Betancourt has served on several Institute of Medicine Committees, including those that produced "Unequal Treatment: Confronting

Racial/Ethnic Disparities in Health Care," "Guidance for a National Health Care Disparities Report," and "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce."

Mike Bonetto, PhD (KI)

Mike Bonetto is currently Oregon Governor-elect Kitzhaber's Health Policy Advisor. He most recently has served as director of Community Benefit and Government Affairs for Cascade Healthcare Community in Bend. Mike is the president and co-founder of HealthMatters of Central Oregon; a Deschutes County Public Health Advisory Board member; a board member of Volunteers in Medicine/Clinic of the Cascades; and an Oregon Health Policy Board member.

José Camacho (P, KI)

As the Executive Director of the for Texas Association of Community Health Centers, José is the primary liaison to the TACHC Board of Directors, designs and implements trainings for members, identifies and responds to funding opportunities and requirements for TACHC, and manages the operations of the association. As General Counsel, José provides in-house counsel to the Board of Directors and members and advocates to the state and federal government to strengthen and preserve the health care safety net and assists in the development of health centers in medically underserved communities.

Carmela Castellano-Garcia, JD (KI)

Carmela Castellano-Garcia is the President and Chief Executive Officer of the California Primary Care Association (CPCA), an organization of over 650 nonprofit, community-based primary health care clinics, whose mission is to promote and facilitate equal access to quality health care for individuals and families through organized primary care clinics and clinic networks. Ms. Castellano-Garcia presently also sits on the Board of Directors for the Chicana/ Latina Foundation, the Latino Coalition for a Healthy California, and Capital Link and is a member of the Prevention and Early Intervention Committee of the Mental Health Services Oversight and Accountability Commission.

Tom Chapel, MA, MBA (KI)

Thomas J. Chapel serves as the Chief Evaluation Officer at the Centers for Disease Control and Prevention (CDC). In this position, he works to strengthen program evaluation at CDC and expand CDC-wide evaluation capacity through standards, training, tools, and resources. Chapel is known nationally for his work in evaluation and his leadership with the American Evaluation Association, and he is a frequent and well-known speaker, presenter and facilitator on the topics of strategic planning and evaluation.

Larry Cohen, MSW (KI)

Larry Cohen is the founder and Executive Director of Prevention Institute, which applies a systems approach to prevention, a strong emphasis on community participation, and promotion of equitable health outcomes among all social and economic groups. Larry established Prevention Institute in 1997 as a national non-profit center dedicated to improving community health and well-being by building momentum for effective primary prevention.

Jessica Curtis, JD (P, KI)

Jessica Curtis serves as the Project Director for Community Catalyst's Hospital Accountability Project (HAP) and as Staff Attorney for the Integrated Care Advocacy Project (ICAP). In her role as HAP Project Director, Jessica provides a broad range of policy-based and legal assistance to consumer advocates and policymakers related to hospital financial assistance and community benefits programs and as ICAP Staff Attorney, Jessica supports consumer advocates and other stakeholders seeking to directly engage consumers and caregivers in making health policy decisions, particularly where they affect vulnerable populations.

Judith Darnell, MPP (P)

Judy is Director of Public Policy at the United Ways of California. IN directing its advocacy efforts, she leads a team that works with local United Ways across California and their volunteers, advocating at both the state and federal level for crucial health and human services issues, including health coverage for all children and the expansion of 2-1-1 Information and Referral services.

Gregory Dent (P, KI)

Gregory J. Dent is President and Chief Executive Officer of Community Health Works (CHW), a non-profit health care company. CHW began as a seven county collaborative whose vision is better health for all residents through communities working together and, under Greg's leadership, has become a regional center for health innovation.

Dory Escobar (P)

Dory Magasis Escobar is the Director of Healthy Communities at St. Joseph Health System – Sonoma County (SJHS-SC) and oversees the organizations' Community Benefit planning and reporting, its Healthy Communities and Community Health programs and clinics, serves as a lead contact for the Healthy Communities Section of Sonoma County Department of Health Services' Public Health Division, is a leader in Sonoma County Health Action's Community Engagement team, and represents SJHS-SC on a number of collaborative community boards and committees, such as Petaluma's Healthy Communities Consortium.

Connie Evashwick ScD, FACHE (KI)

Connie Evashwick is the Senior Director of Academic Programs of the Association of Schools of Public Health (ASPH). In this capacity, Dr. Evashwick sets academic public health priorities and lead ASPH's academic and preparedness programs including issues related to accreditation and certification, diversity, data, and emerging educational technologies.

Jonathan Fielding, MD, MPH (KI)

Dr. Fielding is the Director of Los Angeles County Department of Public Health and the County Health Officer, responsible for all public health functions including surveillance and control of both communicable and non-communicable diseases, and of health protection. He is also Vice-Chair of the Los Angeles First 5 Commission, which grants over \$100 million per year to improve the health and development of children 0-5. Among other positions, Dr. Fielding chairs the US Community Preventive Services Task Force and was a founding member of the US Clinical Preventive Services Task Force.

Donna Folkemer (P, KI)

Donna Folkemer, a senior policy analyst at The Hilltop Institute, directs Hilltop's new Hospital Community Benefit Program. This program is the first ever central resource created specifically for state and local policymakers to improve the reporting and evaluation of tax-exempt hospitals' community benefit activities.

Daniel Friedman, PhD (KI)

Dr. Friedman, of Population and Public Health Information Services, is an expert on population and public health infrastructure development and an adjunct associate professor at the University of Massachusetts Amherst School of Public Health and Health Sciences. He is also the Assistant Commissioner, Bureau of Health Statistics, Research, and Evaluation, Massachusetts Department of Public Health in Boston and co-authored the National Committee on Vital and Health Statistics document "Reconsidering Shaping A Health Statistics Vision for the 21st Century."

Christopher Fulcher, PhD (P, KI)

Christopher Fulcher, co-directs the Center for Applied Research and Environmental Systems (CARES) at the University of Missouri - Columbia. Chris' applied research and systems-based approach to decision making enables local, state, national and international public and nonprofit sector organizations to effectively address social issues using unique collaborative management systems. Chris and his team integrate emerging computer technologies including geographic information systems, data visualization, community engagement tools and Internet accessibility to better serve vulnerable and underserved populations.

Kristin Garrett (KI)

Kristin Garrett is the president and CEO of Community Health Improvement Partners (CHIP), a San Diego-based nonprofit organization of health care and community stakeholders whose mission is to improve the health of all San Diegans through needs assessment, advocacy, education and programs best accomplished collectively. In the past 12 years of her time with CHIP, Garrett has also served as a staff member to the Hospital Association of San Diego and Imperial Counties, working on public advocacy projects.

Bradford Gray, PhD (P, KI)

Bradford H. Gray is a Senior Fellow at the Urban Institute in Washington DC and editor of The Milbank Quarterly, an interdisciplinary journal of health policy and population health. He was previously director of the Division of Health and Science Policy at the New York Academy of Medicine.

Gerry Griffith (P, KI)

Gerald M. Griffith is a partner with the law firm of Jones Day, Chicago, Illinois. Mr. Griffith represents a variety of health care providers in tax, compliance and transactional matters. Mr. Griffith is a frequent speaker and writer on health care legal and tax topics and a series of articles covering various topics including corporate responsibility, fiduciary duties, tax-exemption, bond financing, gainsharing, joint ventures, joint operating agreements, Stark Law and fraud and abuse issues.

Paul Halverson, DrPH, MHSA, FACHE (P)

Dr. Paul K. Halverson serves as Director and State Health Officer of the Arkansas Department of Health in Governor Mike Beebe's cabinet. In this position, Dr. Halverson provides senior scientific and executive leadership for the agency with nearly 5000 personnel with a budget of over 400 million dollars delivering services throughout the state in over 94 different locations. Dr. Halverson also serves as the Secretary of the Arkansas State Board of Health.

Romana Hasnain-Wynia, PhD (KI)

Romana Hasnain-Wynia is the director of the Center for Healthcare Equity and Associate Professor of Research at Northwestern University, Feinberg School of Medicine. She is the principal investigator of a number of national studies examining quality of care for underserved populations.

Paul Hattis MD, JD, MPH, FACPM

Currently, Dr. Hattis serves as Senior Associate Director of the MPH Program at Tufts University Medical School. Dr. Hattis also serves at the Concentration Leader in Health Services Management and Policy and is a faculty member in the Department of Public Health and Community Medicine. Dr. Hattis is also active as a national health care consultant, focusing on the area of health care workforce diversity.

Christopher Holliday (KI)

Christopher Holliday is the CEO of Communities Joined in Action, and has more than 20 years of experience in innovative leadership and management experience in population and clinically-based public health, primary healthcare, and non-profit settings. He brings to CJA nearly a decade of experience in

community-based processes, including community mobilization, community organizing and coalition-building.

Peggy Honoré, DHA (P, KI)

Peggy A. Honoré is Director, Public Health System, Finance, and Quality Program in the Office of Healthcare Quality, Office of the Assistant Secretary for Health. She is leading national efforts to establish and implement concepts for quality in the public health system, develop a field of study in public health finance, and promote public health systems research.

Mark Huber (P, KI)

Mark Huber is the Vice President of Social Responsibility for Aurora Health Care, an integrated non-profit health care provider system serving eastern Wisconsin. Over the past 17 years at Aurora, Mr. Huber has developed and managed the system's Social Responsibility department with oversight for community health assessment, community benefit planning and reporting, and community partnerships and engagement. Currently, Mr. Huber chairs a consortium of six health systems and 19 local health departments developing a collaborative approach to community health assessment and community health improvement planning across southeastern Wisconsin.

Anthony Iton, M.D., J.D., MPH (KI)

Anthony Iton, is Senior Vice President for Healthy Communities at The California Endowment, a private, statewide health foundation whose mission is to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians. Dr. Iton's primary interest is the health of disadvantaged populations and the contributions of race, class, wealth, education, geography, and employment to health status.

Julia Joh Elliger (KI)

Julia is a Senior Analyst for the Mobilizing for Action through Planning and Partnerships (MAPP) and National Public Health Performance Standards projects at the National Association of County and City Health Officials (NACCHO). In addition to working at NACCHO, Julia is pursuing her doctoral degree in Government and Politics at the University of Maryland, College Park. Her academic work focuses on how political institutions and political behavior affect governmental public health capacity.

Lois Johnson, JD (P)

Lois Johnson is an Assistant Attorney General in the Health Care Division of the Office of Massachusetts Attorney General Martha Coakley. She focuses on health care policy, including issues such as health care reform, cost containment and health disparities, and coordinates the Attorney General's Community Benefits Program.

Catherine F. Kinney, PhD, MSW (P)

Cathy Kinney's work at Kinney and Associates focuses on the application of continuous quality improvement and systems thinking to community health. She has assisted many groups in the design and implementation of effective approaches to assessing and engaging the community, utilizing evidence based practices, and developing measurement-based strategic plans for accountability and continuous improvement. Her clients have included large hospital systems, national and local foundations, public health departments, health care organizations, and many multisector coalitions across diverse communities, at local, state, national, and international levels.

Terry Knowles (KI)

Terry Knowles has been registrar of Charitable Trusts in the Department of the New Hampshire Attorney General since 1981. She is president-elect of the National Association of State Charity Officials and serves on the board of directors of the National Council of Nonprofit Associations. Ms. Knowles authored

a bench reference for the New Hampshire Probate Court system analyzing the Uniform Management and Institutional Funds Act, and has written a number of articles including "A Brief History of Charitable Regulation" and "The New Community Benefits Law."

Claudia Lennhoff (P, KI)

Claudia Lennhoff is the Executive Director and a Community Organizer with the Champaign County Health Care Consumers (CCHCC), in Champaign, IL. CCHCC is a grassroots citizen-action consumer health advocacy organization founded in 1977. Claudia has been on staff at CCHCC as a Community Organizer since 1997, and became CCHCC's Executive Director in 1999.

Monica Lowell (P)

As Vice President of Community Relations at UMass Memorial Medical Center, Monica has forged deep and lasting relationships with many non-profit organizations leading to initiatives responding to local identified problems. She manages the hospital's Community Benefits program that supports efforts to improve the health and well-being of the medically underserved in Worcester.

Michelle Lyn, MBA, MHA (P, KI)

Ms. Lyn is the Associate Director of the Division of Community Health in the Department of Community & Family Medicine, and Associate Director of the Duke Center for Community Research of the Duke Translational Medicine Institute. Ms. Lyn began her Duke career in 1998 as a founding member of the Division of Community Health and assumed a leadership role in the creation and expansion of a wide range of collaborative, community-based clinical, care management, research, and educational programs across Durham, the region, and the state of NC.

Gene Matthews, JD (P, KI)

Gene W. Matthews serves as the Director of the newly-established Southeastern Regional Center of the Public Health Law Network, one of five regional centers funded by the Robert Wood Johnson Foundation. This program provides legal technical assistance, training, and outreach activities in order to connect and serve individuals and organizations committed to applying the law to improve public health. In addition, Mr. Matthews is a Senior Fellow at the North Carolina Institute for Public Health, the service and outreach arm of the University of North Carolina Gillings School of Global Public Health.

J. Lloyd Michener, MD (KI)

J. Lloyd Michener, MD, is professor and chairman of the Department of Community and Family Medicine, and director of the Duke Center for Community Research. He is a member of the board of the Association of Academic Medical Colleges, the Association of Departments of Family Medicine, and the National Patient Safety Foundation Board of Governors.

Karen Minyard, PhD (P)

Karen Minyard, Ph.D. has directed the Georgia Health Policy Center (GHPC) at Georgia State University's Andrew Young School of Policy Studies since 2001. Dr. Minyard connects the research, policy, and programmatic work of the center across issue areas including: community and public health, end of life care, child health, health philanthropy, public and private health coverage, and the uninsured.

Gary Nelson, PhD (P, KI)

Gary D. Nelson is President of the Healthcare Georgia Foundation, Inc., a private independent foundation in Atlanta, Georgia. Appointed in 2002, Dr. Nelson is responsible for executive management of the Foundation's program, financial, and management operations. Working with the Foundation's Board of Directors, Dr. Nelson oversees the design and management of the Foundation's grant making program dedicated to advancing the health of all Georgians and to expand access to affordable, quality healthcare for underserved individuals and communities.

R. Gibson Parrish, MD (KI)

Dr. Parrish is considered an expert on population health systems and is an adjunct associate professor at the Dartmouth Medical School. He co-authored the National Committee on Vital and Health Statistics document "Reconsidering Shaping a Health Statistics Vision for the 21st Century."

Gianfranco Pezzino, MD, MPH (P)

Dr. Pezzino is currently a senior fellow and Strategy Team Leader at the Kansas Health Institute in Topeka, Kansas, where he oversees a wide variety of projects, including assisting local health departments in their bioterrorism and emergency preparedness activities, supporting local health departments in preparation for national accreditation, and investigating options to improve childhood immunization in the state. He also leads KHI's public health systems and services strategy team, working to identify and implement the best public health policies, programs and practices to improve health outcomes in Kansas.

Mary Pittman (KI)

Mary A. Pittman is PHI's president and chief executive officer. Before joining PHI in 2008, Pittman was president of the Chicago-based Health Research & Educational Trust (HRET), an affiliate of the American Hospital Association. As such, she led the growth and development of HRET, synchronized the efforts of board members and research and educational professionals, and served on the executive staff of the American Hospital Association. Before taking leadership of HRET, she was president and chief executive officer of the California Association of Public Hospitals.

Lawrence Prybil PhD, FACHE (P, KI)

Larry Prybil presently serves on the National Board of Advisors for the AHA Center for Healthcare Governance. He has authored or co-authored many publications on healthcare systems, ethics, and governance, and recently completed a study of governing boards in nonprofit community health systems. He has served on the governing boards of hospitals, multi-unit healthcare systems, state hospital associations, and the American Hospital Association.

Rob Restuccia (KI)

In 2000, Robert Restuccia became the Executive Director of Community Catalyst. Under his direction, Community Catalyst has established an impressive track record working with low income communities and state and local partners to achieve health care reforms in more than 40 states. He is an adjunct professor at the Boston University School of Public Health. He also serves on the Board of Directors of the Blue Cross Blue Shield of Massachusetts Foundation, RealBenefits Inc., Health Care for All, and the Commonwealth Care Alliance.

Victor Rubin, PhD (KI)

Dr. Rubin is the Vice President for Research at Policy Link. A leader in using innovative tools to make the case for equity, Dr. Rubin guides PolicyLink efforts to reframe infrastructure and transportation debates. He works on issues ranging from school overcrowding and transportation equity to water access and the challenges facing unincorporated communities. He also explores how land use planning affects health and directs an effort to assess the community engagement strategies of state universities.

Eileen Salinsky (KI)

Ms. Salinsky is currently a principal research associate at the National Health Policy Forum (NHPF), a nonpartisan organization that provides educational programming to federal policy makers. Her work at NHPF has involved close collaboration with congressional staff, experts from congressional support agencies, and senior officials from the executive branch.

F. Douglas Scutchfield, MD (KI)

F. Douglas Scutchfield is the initial incumbent in the Peter P. Bosomworth Professorship of Health Services Research and Policy at the University of Kentucky. He holds faculty appointments in Public Health (Health Services Management), Preventive Medicine and Environmental Health, Family Practice and the Martin School of Public Policy and Administration.

Steve Shortell, PhD (KI)

Stephen M. Shortell is the Blue Cross of California Distinguished Professor of Health Policy and Management and Professor of Organization Behavior at the School of Public Health and Haas School of Business at the University of California-Berkeley. He is also the Dean of the School of Public Health at Berkeley. Dr. Shortell also holds appointments in the Department of Sociology at UC-Berkeley and at the Institute for Health Policy Research, UC-San Francisco.

Rebecca Slifkin, PhD, MHA (P)

Rebecca Slifkin is the Director of the Office of Planning, Analysis and Evaluation (OPAE) within the Health Resources and Services Administration (HRSA). In this role, she serves as HRSA's liaison to other components of HHS on Affordable Care Act implementation activities as well as HRSA performance measurement activities, intergovernmental affairs, trans-HRSA research and evaluation, agency-wide data strategy, policy analysis, liaison with other HHS operating divisions, and special projects such as the Healthy Weight Collaborative and linking public health and primary care.

Brian Smedley, PhD (KI)

Dr. Brian D. Smedley is Vice President and Director of the Health Policy Institute of the Joint Center for Political and Economic Studies in Washington, DC. In this position, Dr. Smedley oversees all of the operations of the Institute, which has a dual focus: to explore disparities in health and to generate policy recommendations on longstanding health equity concerns.

Jeff Spade (KI)

Mr. Spade is the Executive Director of the North Carolina Center for Rural Health Innovation and Performance, a resource center supported by the North Carolina Hospital Association (NCHA) as well as the Vice President of NCHA. The mission of the NC Center for Rural Health is to assist rural health providers in addressing local and regional health needs and to lead and promote the development of innovative, collaborative, community focused health initiatives that improve the health status of North Carolina's rural residents and communities.

TJ Sullivan, Esq., (KI)

TJ Sullivan is a partner at the Drinker Biddle Law Firm, focusing on health care transactional and tax and with more than 20 years' experience advising tax-exempt organizations on complex regulatory and business issues. Until 1996, T.J. was special assistant (health care) to the Internal Revenue Service assistant commissioner (employee plans and exempt organizations). At the IRS, he specialized in matters involving the tax treatment of hospitals, HMOs, clinics, and other tax-exempt organizations.

Len Syme, PhD (KI)

Dr. Syme is Professor of Epidemiology and Community Health (Emeritus) in the School of Public Health at UC Berkeley. During more than 20 years as Co-Principal Investigator at HRA, he has worked on developing community interventions to prevent disease and promote health.

Steven M. Teutsch, MD, MPH (P, KI)

Steven M. Teutsch became the Chief Science Officer, Los Angeles County Public Health in February 2009 where he continues his work on evidence-based public health and policy. He had been in Outcomes Research and Management program at Merck since October 1997 where he was responsible for scientific

leadership in developing evidence-based clinical management programs, conducting outcomes research studies, and improving outcomes measurement to enhance quality of care

Julie Trocchio (KI)

Julie Trocchio is senior director of community benefit and continuing care for the Catholic Health Association of the United States. She coordinates CHA activities related to planning and reporting community benefits and leads CHA advocacy on the charitable purpose of not –for-profit health care. She also coordinates CHA programs and advocacy related to the well-being of aged and chronically ill persons in need of long term care and home and community-based services.

James Walton, DO, MBA (P, KI)

Jim Walton is vice president and chief health equity officer for Baylor Health Care System in Dallas. In this role, he is charged with overseeing health care equity improvement throughout the System including the ambulatory care centers operated by Health Texas Provider Network, Baylor's physician group. He also chairs the BHCS Health Equity Advisory Council.

Robin Wilcox, MPH (KI)

Robin Wilcox is the Associate Director of the Public Health Accreditation Board (PHAB). PHAB is a new organization, responsible for the development and implementation of an accreditation program for state and local health departments.

Julie Willems Van Dijk, RN, PhD (P, KI)

Julie is an Associate Scientist and the Community Engagement Director for the Robert Wood Johnson funded Mobilizing Action Toward Community Health (MATCH) project at the University of Wisconsin Population Health Institute. Prior to joining the Population Health Institute, Julie worked in local public health for 21 years as a public health nurse, director of nursing, and a health officer.

Tom Wolff, PhD (P, KI)

Tom Wolff, Ph.D., is a community psychologist committed to issues of social justice and building healthy communities through collaborative solutions at Tom Wolff and Associates. A nationally recognized consultant on coalition building and community development, he has a lifetime of experience training and consulting with individuals, organizations, and communities across North America. As the founder of Healthy Communities Massachusetts, Tom worked with Attorney General Scott Harshbarger and his staff on the Massachusetts' Hospital and HMO Community Benefit Guidelines.

Winston Wong, MD, MPH (P, KI)

Dr. Winston Wong leads Kaiser Permanente's efforts in developing and cultivating community partnerships that address the needs of the underserved and the pursuit of health equity. Dr. Wong guides investments and partnerships to support the country's community health centers, public hospitals and public health systems, with a particular emphasis on the promotion of population management strategies and the elimination of health disparities.

Vondie Woodbury (P, KI)

Vondie Moore Woodbury has been Director of the Muskegon Community Health Project, one of the oldest community health networks in the US and has been credited with the development of one of the most innovative and successful community programs for the working uninsured – Access Health. Ms. Moore Woodbury is co-author of Out of the Box and Over the Barriers, a book describing Muskegon's community driven process.

APPENDIX B. EXPERT PANEL MEETING AGENDA

Best Practices for Community Health Needs Assessments and Implementation Strategies:

A Review of Scientific Methods, Current Practices, and Future Potential

Public Forum Centers for Disease Control and Prevention

Monday, July 11, 1:00 p.m. – Wednesday, July 13, 4:00 p.m. Emory Conference Center Atlanta, GA

Meeting Structure

13 Panels – 2 on day one (1:00pm-5:30 pm); 6 on day two (8:00 am-5:00 pm); 5 on day three (8:00 am-4:00 pm)

10 minutes per panel presentation Address key questions in context of project/experience 15 minutes for interaction with moderator 30 minutes for public discussion

Day 1

Opening Remarks

Welcome 1:00 – 1:30

Chesley Richards, MD, MPH – Director, Office of Prevention through Healthcare, Office of the Associate Director for Policy, CDC

Chris Giosa – Advisor to the Commissioner, Tax-Exempt and Government Entities Division, IRS

Hospital Leadership in a New Era

1:30 - 2:00

John W. Bluford – President/CEO, Truman Medical Centers; Chair, American Hospital Association Board of Trustees

The State of Affairs in the Field

2:00 - 2:45

Steve Fawcett, PhD – Professor and Director, Work Group on Community Health and Development, University of Kansas

Moderator Overview 2:45 – 3:00

Kevin Barnett, DrPH, MCP - Senior Investigator, Public Health Institute

Community Health Assessment

Panel #1 - Shared Ownership and Accountability

3:00 - 4:15

Questions to be addressed:

What is shared ownership, and how is it operationalized? How do we accommodate the needs and priorities of diverse stakeholders (e.g., hospitals, local health departments, community health centers, United Ways)?

What are creative approaches to partnership that address shared priorities?

Panelists

Paul Halverson, DrPH, MHSA, FACHE – Director, Arkansas Department of Health Monica Lowell – Vice President for Community Health, UMASS Memorial Health System

Panel #2 - Jurisdictions and Geographic Parameters

4:15 - 5:30

Questions to be addressed:

How do we define community, (e.g., geo parameters), and what are the determining factors? What are unique issues to be considered in rural communities? In urban metropolitan areas? What are issues and options in the apportionment of responsibilities to address health concerns? How might expectations vary for different kinds of stakeholders, and why?

Panelists

Karen Minyard, PhD – Executive Director, Georgia Health Policy Center
Rebecca Slifkin, PhD – Director, Office of Planning, Analysis, and Evaluation, HRSA
Jose Camacho – Executive Director and General Counsel, Texas Association of Community Health Centers

Adjourn	5:30
Reception	6:00 – 7:30
Day 2	

Day 2

Community Health Needs Assessment

Welcome 8:00 – 8:05

Judy Monroe, MD – Deputy Director, Office for State, Tribal, Local, and Territorial Support, CDC

Overview of Day 2 sessions 8:05 – 8:15

Kevin Barnett, DrPH, MCP - Senior Investigator, Public Health Institute

Panel #3 – Data Platform: Scope and Transparency

8:15 - 9:30

Questions to be addressed:

What are essential data sources and what are the issues and opportunities in securing them? In what ways can we collect data on social determinants and link to health status measures? In what ways can we identify concentrations of unmet needs (e.g., health disparities) in local communities? What are the challenges and opportunities in analysis and sharing of provider utilization data?

Panelists

Eileen Barsi – Director, Community Benefit, Catholic Healthcare West
Winston Wong, MD, MS – Medical Director, Community Benefit, Kaiser Permanente
Julie Willems-Van Dijk, RN, PhD – Associate Scientist and Community Engagement Director, MATCH

Panel #4 - Community Engagement

9:30 - 10:45

Questions to be addressed:

What constitutes meaningful community engagement in the broader community health improvement process? What are potential roles of diverse stakeholders in data collection and analysis?

What are the issues and opportunities in the identification and mobilization of community "assets?"

Panelists

Jessica Curtis, JD – Project Director, Hospital Accountability Project and Staff Attorney, Community Catalyst Michelle Lyn, MBA, MHA – Associate Director, Duke Center for CH Research, Duke University SOM Dory Escobar – Director, Community Benefit, Santa Rosa Memorial Hospital

Break 10:45 – 11:00

Implementation Strategy / Plan Development

Panel #5 - Stakeholder Roles and Contributions: Alignment Opportunities

11:00 -12:15

Questions to be addressed:

What are alignment opportunities associated with national health reform (e.g., ACOs, CMS rules)? What are unique characteristics, potential contributions, and expectations of teaching hospitals? What are potential contributions and expectations of health professions education institutions?

Panelists

Paul Hattis, MD, JD, MPH – Professor, Tufts University School of Medicine Brad Gray, PhD – Senior Fellow, Urban Institute

Panel #6 - Setting Priorities: Methodologies

1:00 - 2:15

Questions to be addressed:

What is the purpose of priority setting, and why is it important? What criteria, processes, and tools can be used under different circumstances? In what ways should we use evidence to guide decision making?

Panelists

Steven M. Teutsch, MD, MPH – Chief Science Officer, LA Department of Health Services Les Beitsch, MD, JD – Associate Dean for Health Affairs, Florida State University

Panel #7 - Setting Priorities: Selection Processes, Collaboration, and Accountability

2:15 - 3:30

Questions to be addressed:

Who should be involved in the priority setting process, and why?

What is the scope of content issues to be considered, and what are key factors in the determination?

What constitutes meaningful collaboration (in addressing identified priorities)?

What are the challenges and opportunities associated with comprehensive approaches?

Panelists

Tom Wolff, PhD – Principal, Tom Wolff and Associates

Vondie Woodbury - Director, Community Benefit, Trinity Health

Peggy Honoré, DHA – Director, PH System, Finance, and Quality, Office of HC Quality, Office of HHS Assistant Secretary for Health

3:30 – 3:45

Questions to be addressed:

Who are potential "audiences" in evaluation, and in what are the implications for the selection of measures? In what ways should the community health assessment and the monitoring & evaluation processes be linked, and what are the implications?

What types of data are needed to identify and monitor progress in addressing health disparities? What are potential roles of community members in program evaluation (e.g., PAR)?

What are collaborative evaluation opportunities for hospitals and other stakeholders (e.g., local health departments, academic institutions, United Way)?

Panelists

Jim Walton, DO – Chief Health Equity Officer, Baylor Health Care System

Catherine Kinney, PhD - Principal, Kinney and Associates

Chris Fulcher PhD – Co-Director, Center for Applied Research and Environmental Systems University of Missouri at Columbia

Adjourn 5:15

Day 3

Implementation/Reporting and Compliance

Welcome/Overview of Day 3 sessions/Questions to be addressed

8:00 - 8:15

Kevin Barnett, DrPH, MCP - Senior Investigator, Public Health Institute

Panel #9 - Institutional Governance and Oversight

8:15 - 9:30

Questions to be addressed:

What internal oversight mechanisms are needed to ensure meaningful institutional engagement – For hospitals – For local health departments (e.g., accreditation)?

What internal management & operational structures and competencies are needed?

Panelists

Lawrence Prybil, PhD – Associate Dean, University of Kentucky College of Public Health Elissa Bassler, MFA – President/CEO, Illinois Public Health Institute

Mark Huber – Vice President of Social Responsibility, Aurora Health Care

Panel #10 – Strategic Investment and Funding Patterns

9:30 - 10:45

Questions to be addressed:

What changes in federal and state policy are needed to support investment in comprehensive approaches to community health improvement?

What are potential roles of private sector philanthropy in facilitating a more strategic approach to CHI (e.g., engaging other stakeholders such as health plans)?

What are challenges and opportunities in collaborative policy development?

Panelists

Judy Darnell – Director of Public Policy, United Ways of California; Member, Health Advisory Council, United Way Worldwide

Gary Nelson, PhD – President, Healthcare Georgia Foundation

Panel #11 – Shared Accountability	and Regional Governance
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10:45 - 12:00

Questions to be addressed:

What are the potential benefits of regional partnerships between hospitals, LPHAs, and other stakeholders? What are options for formal agreements that bind stakeholder financial commitments? What are existing mechanisms for local/regional accountability that may be applicable? What are potential implications of shared investment and agreements for antitrust concerns?

Panelists:

Greg Dent – CEO, Community Health Works, Macon, GA Gene Matthews, JD, Director, Institute of Public Health Law, NCIPH, UNC

Lunch 12:00 – 1:00

Panel #12 - Reporting and Compliance: State Level Oversight

1:00 - 2:15

Questions to be addressed:

What are essential elements of public reporting processes?

What are optimal roles of public sector oversight at the state and federal level?

What are creative alternatives to public agency oversight to encourage desired institutional behavior?

What are challenges and opportunities in the coordination of public sector agency roles?

Panelists:

Donna Folkemer, MCP – Director, The Hilltop Group, University of Maryland Lois Johnson, JD – Assistant Attorney General, Office of the Attorney General, MA Gianfranco Pezzino, MD, MPH – Senior Fellow, Kansas Health Institute

Panel #13 –Reporting and Compliance: Local and Regional Dynamics

2:15 - 3:30

Questions to be addressed:

What are key issues for local hospitals in meeting national and state reporting requirements? What are key issues for local public health agencies in meeting national and state accreditation standards? What is the role of local officials, advocacy groups, and the general public? What is needed to move from compliance to transformation?

Panelists:

Kaye Bender, RN, PhD, FAAN – President/CEO, Public Health Accreditation Board Gerry Griffith – Jones Day, Chicago, IL Claudia Lennhoff, Executive Director, Champaign County Health Care Consumers

Closing Comments 3:30 – 4:00

Adjourn 4:00