

Panel 1: Shared Ownership and Accountability

Well, here we go. I would ask our first panel to come up. I'm going to do a quick run-through of ground rules. While I appreciate the fact that folks are putting the kinds of questions and topics on the table that we need to begin to address right off the bat, and for Steve beginning to move us into that deep dive that we want to take here, many of you know because it's been on the agenda, I just want to recap our approach to each of the 13 panels. Each of the panelists will have, for three-person panels, 10 minutes each, for two-person panels, 15 minutes each, to offer their comments, their perspectives on the set of questions that relate to each panel from their experience and in their context. As a public forum, our primary focus is on public questions and comments, so after I do some brief follow up with each of the panels to flesh issues out a little further, we'll have 30 minutes of public comment and question. We're going to have three folks with mics who are going to be available. What we're going to try to do is to get three comments or questions in a row from folks.

So what I'd ask you to do is if you want to make a comment, please stand up so our folks can identify you quickly and get to you. As you've already done because you know good behavior, you've given your name and your affiliation so we -- so we can have that on the record as well. And what we're asking you to do is to please limit your questions and comments to one minute so we can get around to as many folks as possible; and again, to get all of the issues on the table. I would also ask, to the degree that you can, I would ask if you identify a problem, identify a solution for that problem. There are not solutions to every problem, but it is -- it would certainly be good to get your perspective on that.

So, again, the purpose here is not to achieve consensus, but to move towards a common language that will enable us to help move forward and help support the field. It is rare that we have this much brain power or this much experience together in a focused area as we do for this meeting. I want to honor that and honor all of you who have taken time to participate in this process.

Some of you are particularly venerable. I want to just note a few folks, just to reflect the seriousness. We heard just a few moments ago from the back from Bob Sigmund, who is the godfather, in my view, of the community benefit movement and has been a powerful and incisive voice throughout my entire work in this arena. We also have Len Syme, who is professor emeritus at UC-Berkeley and is the father of social epidemiology. Who better to get the perspective of how we get at this issue of social determinants?

So we've got a lot of terrific folks in the audience, so those of you that have worked with as practitioners, have rolled up your sleeves, have confronted so many of these issues, we need to hear from you. No shrinking violets, please put your issues on the table. In my introductions of the panels, I will note that we have bios for each panelist in your packets, and I note that because I'm not going to take our time with giving extensive introductions of each panelist. In fact, what I'm going to do is to give you their names and their affiliations and turn it over to them. And with that, our first panel addresses an issue we've already begun to discuss, which is this concept of shared ownership for health and how does that -- how is that operationalized. Our two panelists are Paul Halverson, a long-time public health leader and researcher in the field, currently the State Health Officer for the Arkansas Department of Health; and Monica Escobar, who is the Vice President for Community Relations at the UMass Memorial Health System and also a great leader in the work that she does. Paul, can you get us started?

You can be either place. Would you rather have the podium?

Come on up.

Thank you very much, Kevin, and thanks. I feel like this has been 20 years in the making. This day is very important to me. When John was describing his work as an epidemiologist at CDC, I was trying to kind of trace back the time, that was my time as a hospital administrator. And I spent the first 10 years plus of my

Panel 1: Shared Ownership and Accountability

career as a hospital administrator, and I remember well a time when I called colleagues in the School of Public Health and I told them about my interest in public health, and they said, I can't hardly imagine why anyone from hospitals would be interested in public health. And I talked to my colleagues at CDC and they - they said, well, you're from a hospital. Why do we care about what you're interested in?

But probably even more revealing was when I talked with my colleagues from hospitals, additional CEOs from institutions that I had competed against and worked with, and they said, What in the world are you thinking about going to public health?

It would be like walking in molasses. Why would you want to move into that arena?

And so for someone that came to public health 20 years ago from the acute care side, I knew this day was coming. I knew it. I knew that there would be a time when these two worlds would collide, and in fact, it's not been 20 years that it had been waiting. It has been 20 years of occurring and some really special things happening. And in many ways, frankly, I feel like this is a choir convention. You know, you've heard the expression of preaching to the choir, as I look around this room, I see a lot of choir members. And I think we'll hear over the course of the next three days some inspiring stories of really exciting things that are happening in public health, in hospitals; and most importantly, around the health of our communities. I wanted to frame my remarks, really, not so much about the assessment, although that's, to be sure, an important first step. But really to think about the strategic imperative and the strategic opportunities for -- particularly for public health and hospitals as we look forward to the future. And I'm going to suggest a transformation model that I'm quite excited about in terms of potential for us to consider as we think about the inter-organizational relationships between and among organizations in the community who have a shared interest.

And so I'm going to go pretty quickly. I call my talk Check Box or Collective Impact, and I do that because, as was alluded to by others, I think there is an opportunity to check the box and fulfill the requirement. I think that's entirely, strategically missing the point. But I do think that there are going to be a number of hospitals in particular who will see the IRS requirement as the opportunity to spend a couple hundred thousand dollars with consultants who haven't learned how to spell epidemiology but now will sell those services, so they can write a report and put it on a shelf and be able to describe their compliance. And for those of you who laugh at that comment, I was at the CDC at a time when we developed the concept around awareness for bioterrorism. People that couldn't spell bioterrorism became bioterrorism consultants when millions of dollars were now available to be spent. And so, again, I would suggest that there will be a number of people who have an interest in the legalistic part of wanting to achieve compliance. And yet I think that we have an opportunity to create collective impact, which we will certainly not want to miss. I think the conversation starts with again, describing this notion of health protection as a system and this comes from my colleague Bobby Milstein, a great friend who I think has done a nice job in describing where the health system is at today, and as you see on the far right, we have people afflicted with the complications of disease that they're dying from, and this, my friends, is where we spend 97% of all of the health dollars in this country. If we back up a little bit, we have people that are afflicted without complications; and again, if you'll look at the hypertension crisis in my state alone, we have more adults with hypertension than without; and those that have enormous opportunity for improvement with really no complications currently or signs of their complications, and yet we have great opportunity to intervene.

But more importantly, we need to think through how do we back up even further to reduce the vulnerability so that, in fact, what we're talking about are safer and healthier people, not people who are -- we're having to treat the disease; but in fact, people who we can create a relief from their vulnerability. We have enormous disparities, as has been pointed out already. The issue, for us, is trying to move upstream; and that, in my view, is where the collective impact should be. There is this really -- this focus on disease that we -- we all

Panel 1: Shared Ownership and Accountability

have, I think, have got our attention. And from the perspective of reality, it reminds me of the fact that every time we as a society will spend our last dollar on treatment. It reminds me of going to visit a public health officer in an unnamed state, and I was there to talk about how we might improve the investment in prevention. And she looked at me and she said, You know it's pretty simple and yet difficult because she said, the reality is you pass Mrs. Jones on the way into my office. She's here because she needs a kidney transplant. The reality is that we'll spend the money on the kidney transplant but we wouldn't have spent the same amount of money that would have prevented someone from getting hypertension in the first place; and in fact, we could have touched 10,000 people for the amount of money that we're going to spend in treating that one -- that one individual.

So the public health system, and I was warned not to put this slide up because it's hard to read, but beyond that, the thought was is that our hospital colleagues might feel that they're not -- they don't -- can't see themselves in this slide. Well, I know it's hard to read all the labels. You'll see the Health Department sort of in the middle, but you'll also see hospitals and doctors and EMS and a whole variety of individuals and organizations. 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. It's not the property of the Health Department. And yet, it takes all of these organizations working together to, in fact, impact on the health of the community. And it is therefore, our need to find ways in which to work together that is the opportunity.

So, I want to give a lot of credit to Kevin Barnett, the moderator for this panel, because there is a couple of documents that I'm going to reference today, and one of them is his, and if you haven't read his paper on community benefit in the era of health reform, you need to get it and read it because there's some great pearls. Part of the issue here is that community benefit really comes from an IRS ruling, which redefines the charitable obligations of nonprofit hospitals. Remember nonprofit was the -- society's essentially grant that, in fact, the benefit to the community would exceed the taxes that would be paid. And so, in fact, as we think about the IRS and their rulings, it's important because it is, in fact, trying to help us get some guidance as it relates to where we ought to be headed. The redefinition broadened the interpretation of the charitable purpose beyond the historical concept of relief from poverty to the promotion of health for a class of persons sufficiently large enough to constitute benefit for the community as a whole. I think a lot of people missed this when we started thinking about the notion of charitable and community benefit. To call -- the call to identify a cohort of sufficient size to produce tangible impact at the aggregate level suggests an emphasis on achieving measurable outcomes. It seems to me this is, in fact, now calling for a different prescription for how we might have otherwise conceptualized community benefit. In other words, this is more than just classifying patients that you would have already -- already taken care of as a charity patient who wouldn't have paid the bill and calling that community benefit and calling it done. There are a number of current strategies, and I think Kevin did a nice job in his paper.

He described, and I think in some cases the model of community benefit program that I was involved with when I was a hospital CEO may have fit into this, I thought I was being quite charitable, but the reality is that the institutional model is really designed and implemented with our own view of our enterprise, of our hospital as our own unique individual organization. And somehow in many cases this is -- really fits into our competitive business strategy. That's okay. I mean I think the reality is to the extent that we do good and it does good for us in terms of our business, that's a -- that's a win-win and we need to pursue that. However, it also seems to me, as Kevin has described, the geographic model of community benefit really does provide us with more granular analysis of data at a subcounty level, and allows us to better understand the real disproportionate unmet needs of populations, the sub-populations that we need to come together to address. There are a lot of perhaps failings of historical efforts, and again, I'm reluctant to say, well, look, all of this -- all of the stuff that hospitals have been doing, it just scratches the surface. The reality is we've all been trying

Panel 1: Shared Ownership and Accountability

in many ways in our own way to try to find that spot where we could, in fact, give back and to do some really important things. The reality is that it is, as I think Kevin describes in his article, a scattering of small scale, uncoordinated services and activities.

Now again, there are wonderful examples, and I know over the next couple of days you're going to show me how these comprehensive systems have worked. The reality is that we still have a long ways to go. To say that we're doing this across the country wouldn't be true. We -- we really have seen some great examples. We need to think through how do we create that as where it is, in fact, the majority of our efforts. Currently most uninsured and under-insured populations enter our healthcare system through the emergency rooms of our hospitals as well as our community health clinics. In many cases high cost services are provided for conditions that could have been prevented with timely access to quality primary care and preventive services. And so, here's where we're going to get to the point where I'm going to make people a little uncomfortable who are my former colleagues, the CEOs of hospitals, as they look at the fact that we've spent, at least according to one study, \$40 billion in a year taking care of people who could have -- in an emergency room or inpatient setting -- whose -- where those conditions could have been prevented and treated in a far less costly environment. And so I think probably one of the greatest part of Kevin's article is boiled into this particular passage where he says, "To those who charge that expanding coverage will lead us to healthcare rationing, it must be understood that we are already rationing healthcare services. The current rationing method is to limit access to primary care and preventive services until they stagger into our emergency rooms. Aside from the fact that it's immoral, it's an extremely inefficient way to serve the people of the US. Given the fact that community benefit calls for nonprofit hospitals to make optimal use of limited public resources, the provision of charity medical care in emergency room and inpatient settings for preventable conditions is simply poor stewardship."

So in other words, as we think about community benefit, if we really want to be good stewards of charitable dollars, then we need to think beyond how do we classify taking care of patients in our emergency room and inpatient settings who could have been cared for in less costly settings and, in fact, whose diseases or exacerbation of disease could have been ameliorated for lack of the fact that they -- they couldn't find an alternative.

So maybe this should be called the community health system, and maybe we'd all feel better, for those of us in public health, don't despair. It still is public health. But if we feel better because we call it community health, that's okay. The reality is it is, in fact, all of our responsibilities. Now, let me just take a few minutes, and I know I'm going to run out of time, to describe what I find is to be one of the most exciting pieces of work that I think has enormous potential for public health and community health; and that is something that's occurred particularly in the education sector that might have applicability for us. Large scale social change requires broad cross-sector coordination if the social sector remains focused on the isolated intervention of individual organizations. That could be the Health Department. It could be the hospital. It means how can we work together. This comes from work from John Kania and Mark Kramer and some really important work that was just published in the Stanford

Social Innovation Review. And it really, I think, challenges all of us to think differently. The scale and complexity of the US public education system has thwarted attempted reforms for decades. We were at one time the global leader in education -- we the US, and now we rank 18 out of 24 industrialized nations with more than one million students dropping out every year. Does this sound somewhat familiar to our healthcare dilemma?

Heroic efforts of countless teachers, administrators, and non-profits together with billions of dollars in charitable contributions may have led to important improvements in individual schools and classrooms, yet system-wide progress has seemed virtually unobtainable. And again, I think that if we were to look at many

Panel 1: Shared Ownership and Accountability

of the areas related to our work in public health and community wide improvement, I think much could be said in the same way. There was a program called STRIVE. Anyone heard of STRIVE?

It's really a terrific example of collective action. It occurred, as I understand it, in northern Kentucky and Ohio areas. Focused the entire educational community on a single set of goals measured in the same way. That'll be important as we come to health. Participating organizations were grouped into 15 different student success networks, and each student's success network had been meeting with coaches and facilitators for -- listen to this -- two hours every two weeks for the past three years, developing shared performance indicators, discussing their progress, and learning from each other about how to align their efforts to support each other. That sounds like a lot of work. The reality is that STRIVE made huge impact in, not just one school, but in the collective of the environment for education. And it changed lives for students and changed -- and turned back the trends in education for not just a school. Not just a neighborhood, but for the community as a whole. The commitment of a group of important actors from different sectors to a common agenda for solving specific social problems is what is described in this piece as collective impact. It involves -- now here's the important ingredients -- it involves centralized infrastructure, a dedicated staff, a structured process that leads to a common agenda; and this is the tie-in, basically, to -- in my view -- our work together in community assessment. It creates and leads to a common agenda, shared measurement where we all have the same measure we're working with, continuous communication, and mutually reinforcing activities among everyone.

So large-scale social change comes from better cross-sector coordination rather than from isolated intervention of individual organizations. There is substantially greater progress that could be made in alleviating many of our more serious problems if we really could find ways in which to bring together nonprofits, government, business, and the public towards a common agenda for a common impact. The nonprofit sector, and this is, I think, interesting because it speaks, I think, to some of the dilemmas that we face -- the nonprofit sector most frequently operates using an approach called isolated impact. It's an approach oriented towards finding and funding a solution embodied with a single organization combined with the hope that more effective -- most effective organizations will grow or replicate to extend their impact more widely.

So if we want to change, then we need to find ways in which we can collectively work as organizations in a way that allows us to actually be successful in a sustained way and to shift towards collective impact.

So the five conditions of collective success, here they are: A common agenda. A shared measurement system. We all need to understand what it is we're trying to impact and have a measurement system that we have in common. Mutually reinforcing activities, doesn't mean that we're all doing the same thing but it means that we are doing it in a way that coordinates and supports each other. There is continuous communication. And -- and to make sure that that happens, there is a backbone support organization, that doesn't necessarily mean that we need to create all kinds of new organizations or new bureaucracy, what it means is an organization whose job it is to focus on bringing the other organizations together and moving towards effective action. We need, according to these authors, and I think it's well considered, if we're really going to fund large scale change, and this goes to our foundations and to the government; if we really want to take -- to change, we need to take responsibility for assembling the elements of a solution. We need to create a movement for change, include solutions from outside the nonprofit sector, and use actual knowledge to influence behavior and to improve performance.

Again, this comes from John, actually it was recently published in an AHA publication describing his view of the world, and he said prevention education social support which relates to social disparities and chronic disease management is really the sweet spot for bending the cost curve. Our hospitals need to think about getting outside of the bed. I would also suggest that same advice for public health. We need to think beyond

Panel 1: Shared Ownership and Accountability

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. You know when I first presented that egg slide to public health officials 15 years ago, they were aghast at the idea that the world did not necessarily all fit neatly in its realm. In fact, many of them said, you know what, I don't like your idea because if we don't control it, if we don't regulate it, if we don't fund it, if there's no way in which we can gain our control, how can we be responsible?

And I said, you know, that is the essence of our work. It is, in fact, creating a system which we don't necessarily control, fund, regulate or can effectively tell them what to do. But it is, in fact, our opportunity to collectively find ways in which we could come together to have a shared ownership; but to do it in a way that has a realm of possibility of success. I think that what I shared from the educational sector in terms of collective impact has important opportunities for us in health because, in fact, we need to get outside of our own individual organizations, whether it's hospitals or public health or community health centers, collectively we need to find a way to dance together in a way that's purposeful; and that will, in fact, change the world. And that's, in my view, why we need to do community assessments. It's not to fulfill a requirement. It's not to check a box. But it is, in fact, to change the world so that we can, in fact, change and create the world in which people are less vulnerable and where this new health system will work because we are, in fact, reducing the demand for services.

So, thank you for the opportunity to visit with you and to celebrate this 20 years in the making opportunity for our worlds to come together.

Thank you.

Thank you, Paul. I was reflecting as you were talking about the discomfort among our public health leaders so we actually hear a similar kind of discomfort among our physicians about the inability to control the circumstances outside of the clinical arena. And it's a discomfort we have to -- to grapple with as -- as we begin to build common cause. I'd like to turn it over to Monica who will -- who will share with us her practical experience in building shared ownership. Monica?

Thank you, everybody. I'm Monica Escobar Lowell and I'm the Vice President of the Community Relations program at UMass Memorial Healthcare, and I'm going to tell you a little bit about what we've been doing to increase our shared ownership within our system.

So, UMass Memorial Healthcare is located about 50 miles west of Boston, and we are the largest employer in central Massachusetts, close to 14,000 employees. We also have a Level 1 trauma. We have five hospitals that are part of the system. UMass Memorial Medical Center being the one that where I am anchored at. And then four community hospitals. We also have a medical practice -- group of physicians, fairly large; and also we are the clinical partner of UMass Medical School.

So we work very closely with them.

So when I was asked to come here and talk about shared ownership, I thought a little bit about okay, shared ownership is about working within our system to make community benefits more accountable, but it also is about thinking about shared ownership outside in the community. And I think it's in our own best interests to really think that community benefits is the right thing to do, but it also it is what I see an incredible opportunity. It's an investment in our community. When we see this kind of data where it says that without any intervention, our per capital expenses is projected to nearly double by 2020. That I find pretty scary. And when we think about the accountable care organizations and we think about global payments, we really

Panel 1: Shared Ownership and Accountability

can see an opportunity for community benefits to play an incredible role to make -- to contribute to the wellbeing of the community.

So what are the things that we can do to improve community benefits shared ownership within our system?

The most important thing is you need to make sure it starts from the top down. You need to make sure that your CEO understands community. John Bluford indicated that you need to feel the community, understand the community, see the community. So you need to make sure that your CEO is out in the community. We happen to be really blessed with a wonderful CEO who, maybe some of you know him, his name is John O'Brien; and he understands how community benefits public health connect the dots with what's happening out in the community. So it's not just the CEO, but it's also your governance board. You need to make sure that your governance board is also connected to community benefits. So what we started to do is, not too long ago, we also did look at ourselves and say okay, what do we need to do to strengthen? What are the pieces that are missing?

So we did a self-assessment, and we needed to tighten things up. And we got our -- our board leadership to be more engaged in our community benefits. It was important for them to be more active in the governance and oversight. So we organized -- we formed our community benefits committee. It wasn't just about coming and reporting. You can report, but also having them fully engaged. So we did that and we thought that we had to also make it diverse. It wasn't just about our board, but also other key stakeholders that are participating in this community benefits committee. So our committee is diverse. It has the -- our CEO. It has members of our senior executive team. We have physicians. We have board members of the other hospitals; and like I said, we're five hospitals. Each of those hospitals has their own community benefits program and their own staff.

So we have a presentation from that. And we also have community representatives. They also bring different expertise. We also have the dean of the medical school participating in our community benefits. And then we talk and look at our charter and say, okay, what else do we need to reinforce here?

All these key stakeholders in our community benefit committee need to have roles and responsibilities. And if we don't have all the expertise, how are we going to make sure that we get that? We also looked at some of the guiding principles that we're going to be guiding our community benefit program, and then looking at decision making and goal setting. And we needed to make sure that this committee reports to the board of trustees. In addition to that, we thought it was very important to also have a community benefits advisory committee, so not everything is coming from the top down. So I have a community benefits advisory committee that I work very closely. These folks are people from the community. I report to them and say these are the things that we are doing. Are we on target? What other issues are happening?

They are also participating some of our allocations of funding. And also, when there are opportunities to work together with other initiatives that are happening in the community and opportunity to leverage funds, they're the ones that are giving me a call and saying hey, heads up, we have this happening. Check it out. The other thing that is really important is to have our staff -- the staff leadership who is doing community benefits really engage. Make sure that they are at the senior level. Not just a little office that's plopping aside.

So that everybody else, inside the hospital, outside the hospital, recognizes that it's important that this is an investment in the community benefits, is something that the whole system, your CEO and your board of trustees, think it's important. The other thing that we've -- also are looking at right now, is, how do we incorporate our community benefits into our strategic plan?

Panel 1: Shared Ownership and Accountability

So we are looking at some of the disparities that we have, the opportunities there, and then trying -- then working with quality. This past year I've gotten to know quality people that before used to kind of cross paths but now we are working together. We have certain goals we're going to be reporting to our board of trustees. Looking at data realizing, gee, you know, we need this other data. And it just -- it's been a wonderful opportunity, so we're synchronizing everything together. And then the other thing that is really important is working with our colleagues, looking at what needs to -- data needs to be collected, tracking that data and planning for it. Critical is to, maybe, you know, sounds like pretty plain, but I think critical is the importance of your mission. Making sure that your mission engages a holistic approach. We have adopted a mission that incorporates those socio-economic factors, so it's -- so that we, when we're thinking about it, we're not just thinking about access to healthcare. But we're also looking and saying, you know, there are some housing issues there. There are some foot issues that are impacting the community. There's a problem with the mobility rate in some of these low income schools.

So we're also thinking of that and seeing how they bifurcate and impact our community benefit program. And then the other thing that is important is to have a dedicated community benefit department where you have this senior leadership staff accountable for community benefits. Not that everything's going to be that gateway into your whole system, but in sort of -- it's the office that is also towing the line, reporting, working with your CEO, your senior leaders, in making sure that community benefits are doing what it's supposed to be doing. The other thing that is important is the shared ownership is not just about us. The shared ownership is also about working with our community key stakeholders. We have taken initiative to work closely together with our local public health department. We don't want to work with them in a vacuum, so as a result of that, we have begun to support financially our public health. We paid for the Commissioner of Public Health salary, and we also have invested in some public health nursing programs. And then the most important thing is - when our -- our Commissioner of Public Health just retired. Our CEO made a point that he was going to be engaged in that job search with that Commissioner of Public Health. It was really important that whoever's going to come in, our CEO is going to be able to work -- and then look at things in a more broader perspective. The other thing that happened was in 2009, when the economy was really presenting challenges for our city government, the economy went bust. Our city manager called our CEO and said, I need your help. We have cuts happening in this community. Would you be able to round up other key stakeholders and work on helping me figure how we're going to develop and look into a new vision for the Department of Public Health. And for about, between May of 2009 and November, there was great work done by over 20 -- close to 25, 28 community stakeholders that got together. It was a marathon that looked at how to help the city manager bring in and reinforce the public health department.

So they came up with a wonderful report that looked and said how do we move this into 21st century, and there were some wonderful recommendations, but that meant our CEO and staff were going consistently, frequent meetings, working with our community and fleshing things out. It was a huge investment of his time and also staff at our leadership level that were making sure that the agenda got moved. It also brought other stakeholders. Our for-profit hospital in the city was a co-chair of this task force. It also brought the community health centers' directors. The -- some grassroots organizations, some funders, all working together to see how we move that agenda forward. And a result of that, there was a report that was produced and presented to our city manager, and it was presented also to our city government, and they adopted it. The other thing that we're doing very closely together is -- oops, five minutes.

Sorry. I didn't know I was so fast. We are also developing our community needs assessment. Anyway, just to make a story short, so we are doing some unusual programs in the community. We've invested in youth. We think it is really important that youth work in this community. As a result of that, we have this wonderful coalition of youth, they are all inner city urban kids, that they've learned public health research methods, and they've looked at smoking, they looked at lung cancer, and they looked at the advertisement and display of tobacco products. And they saw that these tobacco products were in low-income neighborhoods. That started

Panel 1: Shared Ownership and Accountability

about four years ago. They did these drop dead presentations for the last three years, and everything that they've done culminated two months ago in this -- in the city council, Worcester City Council. Here's some of -- excuse me, some of the research that they did, presented. They would go and speak to the different folks. They did drop deads in the pharmacies. But the most important thing is they went to the local health department, they worked with our -- with -- with -- with our Commissioner of Public Health, and they also got city government official to listen to what was the issues here. And after a really emotional presentation for several weeks, a vote was passed, an ordinance was passed, where we were -- the coalition managed with all their -- what they were pushing through, tobacco products are being pulled out of the pharmacies. But most important is the advertising of tobacco products from public places. That has not been done anywhere.

So here we have these youth all trained in these public health, going in and speaking about tobacco and cancer, and making history in our city. Now the tobacco companies, two weeks ago, are coming full force and they are suing our city, but that's not going to stop us. This is an example of where we found that it was important to empower the community, work with community, to make a change. The other thing we've done is we worked very closely in the Bell Hill neighborhood, low income neighborhood. We have an outreach liaison working there. We're doing community gardens. We have a physician going to a public housing. But one of the things that happened was that safety was an issue. Another neighborhood was pushing people out and they were coming into their neighborhood. And there was an opportunity that presented itself that said, with the city of Worcester, the -- other public, privates, where we contributed funding and we were able to leverage an opportunity to increase first time home ownerships in this neighborhood. Because by having low income first-time home ownerships, you are going to have people who are invested in their neighborhood and people are going to be safer.

So these are our Key West houses. We don't do anything, we just contributed the money, but we work in developing the model. As a result of this, there were over like 22 homes that were bought, first-time homeowners, and it leveraged over \$4 million. And then last but not least, in Worcester, we don't have fluoridation in the water supply. Twice it has been turned down. The voters think it's not healthy, that it's a communist plot.

So we figured out a way to work together with our local foundation, the community health centers, the Worcester Public Schools, where we were going to deliver preventive dental care and oral health to children who were at risk. And as a result of that, we provide preventive dental care at 16 elementary schools, and we work very closely with the community health centers. We fund some of their programs for oral health. And also we are continuing the coordination of the oral health initiative so that we meet and we say what else is happening, what are the gaps, how can we move forward?

Because the last time that fluoridation came up for voters, the local foundation spent \$0.5 million and it did not pass. So we have found a way that we're still going to take care of the children that need the fluoride and dental care. So in a nutshell, the CEO and the board of directors need to be fully engaged and be knowledgeable on what's happening in the community. What are our investments in the community. I think it's important that we also be able to do like self-assessment and say are we on track, what else is missing or needs to take place so that we make sure that we don't get into bad habits. Also, we must communicate with our community. We need to work with them, educate them, and feel like they are part of the solution. And as we move into the global payments, I think it's really important that the community benefit becomes a shared ownership. It's not just about the hospital, but it's also about the community all coming together, bifur -- you know, like in bifurcation, and working on a solution. We -- if we don't do this, I don't think we're going to be able to survive. Our healthcare system is going to be in a lot of trouble.

So we need to be on this together because we don't have a choice.

Panel 1: Shared Ownership and Accountability

So that's it.

Thank you.

Thank you, Monica. We've run into a little bit over time so, I do just want to ask one question myself before we go to public comment, directed initially to you, Paul, and have Monica follow up as well. Having heard this, and as we discussed earlier, it's important to know that we're not in many of these cases just talking about an abstract concept, but something that's being applied in very practical ways. And I didn't hear Monica talk about MOUs or MOAs. There may very well be some formal agreements, but clearly there's a commitment to shared ownership. Having had extensive experience at multiple levels, Paul, I'm wondering your reflections on what are the elements; and what, in your view, may be the steps in building the kind of shared ownership that Monica describes?

Well, I, again, I go back to the notion of having a shared agenda. I think that's really important, and again I think it can start with a community health assessment. Like all good public health folks and epidemiologists, we want to understand what the baseline data is so that we understand what the need is. That should then drive priority setting and an agenda that can be shared. I think secondly having a common measurement is important because too often I think organizations come together and it's -- it's sort of like this notion of we're doing this cause it's the right thing to do. Well that's nice, but how will we know whether we've been successful; and so having a common measurement is critical. Writing it down and committing to it. I think one of the important practical first steps is putting it in the strategic plan. Interestingly enough, as we've talked with organizations that have been involved in this kind of activity, the number of organizations that say it's important and yet don't have it in their strategic plan baffles me. If it really is important, then it needs to be part of what the organization holds itself accountable to. And I think, again, public health, hospitals, all of us need to think through ways in which to make this the reality of the work that we're doing. And having a commitment, frankly more than just the dollars, it is, in fact, the time, the time of senior leadership to make this happen. I was impressed by the fact that in looking at the education materials of the -- what I presented in terms of the STRIVE organization, that -- that has been working towards collective action. They took an enormous amount of time and effort of senior leadership and collectively made it a priority to work together. The reality is having a lot of organizations with great intentions is important. Having a common agenda is crucial, but unless and until you find ways and mechanisms by which you actually can operationalize the work that needs to be done, it frequently will go by the boards. Even public health organizations, frankly whether it's local health departments or state health departments across the nation, if we don't take the time to figure out a way in which to convene, to communicate, coordinate our efforts, it doesn't happen. And so large organizations with great intentions but without the mechanism by which to monitor and create that continuous communication, coordination, and feedback I think will not be successful.

So those are, I think, important ingredients towards coming up with a sense of shared ownership and commitment. Does it help to write it down?

Absolutely. Putting it in a strategic plan is important. Coming up with an MOU and putting some money on the table, so much the better. But I -- I don't know that I would start with the MOU. I think I'd start with the shared agenda. Anything to add, Monica?

Yes. I think I agree with everything that has been said, but I also think that it's important that people or different organizations really understand that they can make a difference in what their role is. The -- the agenda -- all of these factors contribute to it, but I also -- the actual reporting, how well have we done, is indispensable. And other -- looking at non-traditional partners. Maybe they're not at the table, but maybe they can be found and brought in so that they can have the role to make a difference. And now we'd like to go to you for questions and comments. Please stand up so we can find you.

Panel 1: Shared Ownership and Accountability

Thanks, Jerry. Howard Fishbein from Battelle Memorial Institute. By training I'm an epidemiologist and by practice I'm an evaluator, so maybe I'm one of those outside parties you just mentioned. But having worked for -- in my earlier career -- the Department of Health in Rhode Island and Massachusetts for maybe 10 years and worked as a consultant with maybe 20 different health departments, I just had a couple of comments, but I also have a couple of solutions because I know that's what you asked for. Well just keep in mind our -- our one minute limit. Right.

So I'll talk quickly. I -- I -- we -- we were hedging on using the word evaluation. I hadn't heard it yet.

So let me put that on the table. It's assessment, it's reporting, but it's evaluation. And I would suggest what you want to have is outside independent evaluation be able to take a look at what the Health Department is doing, it will just lend that much more credibility to your findings. Second point I would make is that Health Department staff right now are so burdened down with different work, you have got to keep this simple, straightforward. You've got to explain to them, this is how you do it, and this is why you do it, and here's the authority and we want you to do it. In fact, you need to do it. CDC wants you to do it. You're going to be holding -- withholding -- beholding to them because that's what they're asking for. 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.

So some kind of authoritative review and evaluation is very critical and also to show them the good merits of what all the work is going to end up in. And I would suggest for the solution that as you come through the process, and I know we're going to get more into the specifics in the next day or so, but that a task force be set up to talk about implementation and that there's a task force that talks about evaluation. Otherwise, I don't think they're going to get this, and it'll -- it's a good idea. There's a lot of good ideas that just never get implemented. Great points. We're going to get two more quick ones before our panel responds. Joan?

My name's Joan Quinlan. I'm from the Massachusetts General Hospital in Boston. Okay. I wanted to talk about shared accountability, and I was struck by John Bluford's comments talking about reducing emergency department utilization, etc. I think if we have shared accountability with communities, in my experience, they, in general, gravitate towards the social determinants of health. I remember the first community health assessment we did 16 years ago. A physician stood up and presented data on heart disease in that community, and the people from the community said very politely, thank you very much, doctor, now we want to talk about how substance abuse is ravaging the quality of life and killing our young people.

So I think we have to be willing to have that flexibility. And I just wanted to comment on MOUs. I think the other factor in here is that when big institutions come to communities who have been disempowered, there's a lack of trust and relationship and they have to be built over time, and you can't build trust through an MOU. An MOU might be helpful; I'm not saying it's not. But you can't build trust through an MOU, that just takes time and experience. And -- and, a final comment on I think if communities want to gravitate toward social determinants of health, then we have to be able to do some community building because that's the very nature of that work directly.

Thank you. Third comment or question?

My question is directed at Monica. In your really wonderful program, one of the best I've ever heard, have you given any thought at all to involving the community benefit department in uncompensated care?

My experience is that if your department took that over, you would suddenly have another hundred billion -- hundred million dollars to spend, which is now being spent by the business office that doesn't understand any of this, and you would provide much better care, or much more humane care, and you would be ending

Panel 1: Shared Ownership and Accountability

up with many fewer uncompensated care patients and patient days, and would make all the difference in the world. Have you given any thought to that?

No, but -- not really. It kind of sounds like a monumental -- thank you -- monumental charge. But what we have done is we are working with community agencies making sure that our financial benefit advisors go out into the community, work with community regarding insurance enrollment; and let us know where there's some access to healthcare needs and educating also the community about that they have a right to have care. Yes?

Take it over, Monica. Prospectively budgeting for this. I want to make sure we don't lose other questions and comments that came up. Dr. Fishbein talked about the importance of evaluation on the front end, looking at ways in which we have the capacity of the task force that will -- whatever we call it -- there needs to be that infrastructure, and Joan Quinlan's comment about how we hear the community voice, how we build trust and how we go to where -- to the issues that are important to the community. Joan, is so right. Oh my God. You know, going out into the community, making sure that that community doesn't feel that it's the big gorilla coming down and knows it all. There are several steps you can do. Number one is your CEO really needs to be accessible and be able to understand the community and be -- our CEO is, for example, goes down to the neighborhoods, talks to -- talks to the neighborhood folks. You need to develop that trust. You need to be a good listener. You need to be able to recognize the coalition in having your CEO be in a task force that is addressing a need is a good investment. Taking that time out of running the hospital and being out in a community meeting is incredible. It says a lot. It says that you care and that you want to hear what the problems are.

So you need -- I would say that is the most important thing is to have your leadership really connected with the community. And so I would say that the -- that capacity building is a critical ingredient for us who are working in these big hospitals. And that we have staff that are respected in the community that when they want -- that when people call and say hey, you know, we have a problem, that we are there and that we try to figure out a way that we can work with them or pass on some kind of opportunity for a solution. It's all about that. It's listening, good communication, having meetings out in the community. Don't make your meetings in the board room of your hospital, but go out to the community. Touch the people. Talk to them. I would say that is one of the most critical ingredients that are needed. I just want to say how much I appreciate and agree with the notion of building trust and creating a sense of community and coalition. That's really a very, very important first step. I guess the next step that I'm advocating is to say once we have the trust and where we have a common ground, we need to take it to the next step and that is to say, What is it collectively that we are going to agree to do?

And find ways in which to measure whether we'll be successful. And this is where I believe that coming together of hospitals and health departments can yield great and terrific results, and that is there are things that we know can be done about a number of circumstances whether it's hypertension or breast or cervical cancer or any number of things that create for us enormous health challenges in our -- in our local communities and our state and our nation. We need to think through how to create a connection between those evidence-based solutions and the coalitions who have an interest and who have a stake in the problem. And then measure how well we do and what kind of progress that we can achieve. I don't think that we're going to achieve what we need to do though one hospital at a time, one health department at a time. As well meaning as we might be, if we really want to see the health of the community change, I think we need to think through a different model that, in fact, allows us to see large scale change. And I believe when we change the incentives at the hospital and physician level towards keeping people healthy to begin with, I think that's when we will begin to see a serious investment in the notion of a shared agenda. Frankly, I remember the very first discussion around capitation and hospitals being responsible for the health of a

Panel 1: Shared Ownership and Accountability

population group. You know the first thing that we said, because I was among them. I said that's not fair, what do we know about keeping people healthy.

The reality is that maybe we don't know a lot today, but we know a lot of things that we can do collectively with our partners in public health that will, in fact, make a difference; and so, again, I think it's moving beyond the coalition, and it is a crucial first step, you can't get anywhere without it, but we need to move beyond that as well. Three more one minute questions or comments, please. Okay, we have over here the -- Bonnie Woodbury, Trinity Health. We've talked a lot about community in -- in -- throughout since one o'clock, and one of the things that, as a practitioner, I know about community, is that you really want to get them invested. That one of the most difficult things to do is to get beyond the barriers that we create with our own language. Truly getting community members engaged in health at the community level means that we stop talking in acronyms and we begin to talk bluntly with one another about what health means and we define things. And over my years of doing this, frankly the biggest barrier issue is we talk at each other but not to each other and we -- 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 move away from the process, they drop out of processes, or they sit there silent. What has been your experience or what recommendations can you make as to how, in fact, we can improve communications if we are, in fact, invested in bringing community members into these processes?

Great. Next question or comment. Ron Bialek with Public Health Foundation.

Thank you very much. Enjoyed both presentations. It strikes me in looking at hospitals who are engaged in community benefit initiatives, health departments, United Ways, etc. addressing issues like, say, obesity. That -- that none of us individually really know how to make the difference within our communities. And that we need to be learning from one another as we're working with one another.

So, in addition to the shared accountability and the shared ownership, it strikes me that there needs to be shared learning. And learning from one another, but also from other fields, and can we and should we identify a set of competencies for anyone who's engaged in community benefit, whether they are in the health department, the hospital, community organizations, etc.; and that could start us off with understanding what we need to learn, how to teach it, and bring in the academic institutions as well, do the research around it, etc. Ron, that was exactly what they learned in the -- in the work and education was the need to have cross-sectoral conversation and learning. And that is, in fact, one of the essence of that success. Terrific. One more question or comment?

Hi, I'm Nancy Clifton-Hawkins, and I consider myself a health educator in private practice out in California. And what I want to say is this is about shared accountability. And some would reference the fact that some hospitals are further along than others; but in order to have shared accountability, we have to get the hospitals to share. And a lot of times they think they have to go in and completely own a program or a problem, and it freaks their staff out a lot of times. The hospital doesn't have the infrastructure.

So we also have to -- I don't know, stages of change or something over the years to get them to learn how to share accountability with the community so that they can build sustainable change that will last forever. I would say that's how you empower your community is that you give that opportunity so that we don't come in real forceful and say we know it all. But also give the community the opportunity to be empowered and what they have to say, and maybe have some degree of ownership is important.

So how do we create that -- that environment where we can learn from each other?

Panel 1: Shared Ownership and Accountability

That's a question. Another question is -- is what language do we use and how we use that language is critical to get beyond talking at each other?

Right. Let me just mention about the issue around language because I think it is a critical ingredient to moving forward. In Arkansas, one of the things that we have developed is what we call our Home Town Health Initiative. It -- it is, in fact, neighbors and what amounts to a community coalition in each of our 75 counties. And in some cases we have multiple Home Town Health Coalitions, and they really are made up of people of all walks of life from both leaders, formally and informally, and I think one of the most important issues is getting beyond the jargon and really speaking plainly to each other, and so I wholeheartedly agree. I think the other thing that's a subcontext for those of us in public health and in hospitals, is the notion around health illiteracy. We have a huge problem in this country with literacy in general, but in health literacy, I think we have got a tall hill to climb. And we don't really even understand what we don't understand in that regard. And coming from a state that I think has enormous disparities, the issues around health literacy, I think, are yet to really fully be appreciated.

So, I think having the common language is important, and being able to allow our neighbors, our informal leaders, to be the leaders in these efforts I think is really important and to have them communicated in a language that they understand and that's meaningful to them, with -- and -- and working together in that way is important. As it relates to shared accountability, again, I think that you're absolutely correct. I think it is not necessarily a given that hospitals want to come together and share this data and share their joint accountability. It's not necessarily, if you think about it, 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 necessarily something that they do naturally; and so we, I think, by having a shared agenda and a common measurement and some common agreed benchmarks of success will engender that sharing when, in fact, we can have a shared agenda and shared measurement. Please join me in thanking our first panel.