Panel 11: Shared Accountability and Regional Governance

Our final panel before lunch is going to have a particular focus on the issues around -- that play out most frequently in the rural setting, but we want to explore the degree to which they are applicable in other settings. We're talking about shared accountability and regional governance. We have two outstanding panelists to address those issues for us. We're going to hear first from Gregory Dent who is the President and CEO of Community Health Works. Greg has a great model. He's going to talk to us about a particular practice and stimulate us to think about how it maybe applied more broadly. He'll be followed by Gene Matthews who is the Director of the

Southeastern Regional Center, Public Health Law Network and a senior fellow with the North Carolina Institute for Public Health. Gene's really going to challenge us to think more broadly about some of the implications as we try to do this work around the country. Greg, you want to kick us off?

I guess I'm here to talk about the real. We have been a community-based organization, focused on the health in Central Georgia for 10 years. And I'm excited about the opportunity to tell you about what we've been doing and the benefits that we've been distributing to our community. Community Health Works is a 501(c)(3) focused on seven counties in Central Georgia; five hospitals, four clinics, revenues this year of $2.4 million, employees -- 22 employees including contractors. Tell you a little bit about the past, the present, and the future of Community Health Works. We started with a donated care model, there were no federally-qualified health centers, no volunteer clinics. And so we approached our physician community and asked them to see the uninsured in their practices for free. We focused on four disease states -- diabetes, hypertension, cardiovascular disease, and depression. And what we asked these physicians to do is we asked these physicians to provide primary care. We would provide care managers, work with the patients on pharmaceutical assistance, so we in effect established a primary care home for the uninsured. We tracked hospitalization and ER utilization. We served over 4,500 members. We coordinated over $50 million in care, $3 million in free medicines, and $1 million in Medicaid and Medicare was recovered for our hospital partners. And just looking at the money that was saved for the system, $1.1 million in annual savings per thousand members in care management. The ER utilization was significantly less than the national average, hospitalization rate was 45% less than the national average.

So we had a major impact in Central Georgia. The seven counties that we represent had population of about 365,000, so we thought it was in our strategic interest to focus more on creating sites.

So over the past couple years, we've focused on creating volunteer clinics and fairly qualified health centers in our seven county region. Our board of directors decided that -- we started in '99. We were incorporated in 2001. Around 2003, our board of directors decided to use the infrastructure in place and not to come to another meeting but to use the board of directors, the management, the systems that were in place to house the Central Georgia Cancer Coalition. The Georgia Cancer Coalition is a statewide initiative focused on cancer, so our initiative is a 25-county region focused on education, prevention, and screening of cancer in these 25 counties in Central Georgia. That's a population of around 650,000 people, and about an hour and a half south of here. Since inception we've received over $8.7 million in grants, federal grants, RWJ grants, Doctor Nelson's been a great partner with healthcare Georgia Foundation, cancer, every initial in state government, I say, and then a local hospital partner has been a large funder. But these are grants not coming from the hospitals, but from other entities. I'll talk a little bit about the present. We have transitioned over time into what I call a regional center for health innovation. We convene partners, we incubate, we create value. In the convening process, we identify the problems, we engage the partners, we explore solutions. In incubation, we staff and research the startup, we seek seed money, and then we advocate for the project, and then we create value. My board of directors consists of 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. Serving as a hub, we've managed the Cancer Coalition, just recently, the Central Georgia Stroke Coalition, which is a 13-county region in Central Georgia. We work with the regional extension center here in Georgia, and have carved out a 25 county region that we're working with local physician community on electronic health records. A multi-share project we worked on and continue to explore, which is an insurance look-alike project for the small businesses in our area. And then we participated with the Georgia governor on a rural health safety net project that explored the seven counties in Central Georgia and tried to develop a -- if you were to start from scratch and create a safety net, what would it look like in Central Georgia; and out of that came a massive needs assessment, and a detailed work plan that's over 800 pages, and we are continuing to implement that now. This slide reduces the needs assessment to basically one slide. We looked at the regional challenges. We looked at areas of focus, and then we created a strategic plan based on the areas of focus. Our board voted on the areas that they wanted to focus on and then worked with us to create this strategic plan. This is a three-year strategic plan, and this slide shows it in the goal areas. We've got goals around access, around health and health literacy, around small business insurance coverage, electronic health records, coordination of resources, and then we've got a goal around expanding our efforts and expanding our ability to respond. Looking at the present, we started basically focused in the hospital area and focused on care; and as there's been more discussion on prevention, we've transitioned in our work more into public health. And we're focused on creating a community of wellness in Central Georgia and we're doing that by annual summits and also quarterly meetings in each one of these counties. We're creating a network of sharing through emails, newsletter, we just started a Twitter page, Facebook, and all of that, and to try to communicate with a broad segment of the community. We're creating an opportunity to cultivate and encourage local leaders in their efforts. And local leaders, they want to represent their community; and in some cases they don't know the best way to do it in the health area, and we're giving them that opportunity.

So we're creating a community of wellness in Central Georgia. Looking at the future, I see us transitioning over time into a regional health foundation, also serving as a financial intermediary, being sort of that convening partner around grants. We're beginning to serve that function more and more now. We're stepping out more into policy, more into research; and as we focus on primary care, there's no reason to have a lot of primary care unless you can do something about it once you find the problems, so we're going to end up having to focus on specialty care over the next couple of years. That is 10 years in a very short period of time. We're good. Good morning. Good morning. Okay. I'm Gene Matthews. It's nice to be back here. I've served for 25 years across the street as the Chief Legal Officer for CDC, and I knew Paul Stange when he was a brunette, okay.

So I've seen a lot of public health go by. I will come back to that in a minute, but I did -- I received parole about five years ago, I'm now at UNC Chapel Hill where I run one of the regional public health law centers for RWJ's Public Health Law Network, and I will talk about that in a minute. There's -- and I'm sort of the utility outfielder at this part of the program standing between you and lunch, so I'm going to try to keep it to the point, and if not educational, at least be entertaining about this. You've heard a lot about local public health is falling off the cliff. I certainly disagree with that, but we're in a very difficult area, very difficult time in public health.

So you in the hospital community, are coming to this organizational moment of change in public health, which there are a lot of things going on. Kaye Bender is going to follow after lunch and talk about the public health accreditation initiative, which is also -- has the same challenge of implementing a -- they're going to launch a program in September in the midst of all this fermentation that's going on.

So I want to take this discussion just one level deeper about what I see is going on with respect to regionalization and accountability, and this very charged political discussion that's going on, both inside the public health silos as well as externally. And what I want to do is use a graphic, there's some wonderful work. I don't know how visible this is, but I'll walk you through it and I'll show you a bigger version in a minute. This is from Nancy Kaufman of Wisconsin who's doing work for RWJ on sort of the spectrum that's going on in various type of arrangements between -- this would apply in all of government, but it certainly applies in public health and how public health units are sharing their service delivery in this time of change. And you see starting on the left-hand side the informal arrangements, MOUs, sharing of information going to lunch with each other, etc., the basic colligation. Then service contracts, how to come up with mutual aid agreements, how to provide assistance to each other, inter-local agreements, which get more over into this would be like, say, in preparedness, mutual aid agreements, agreements to help each other. In North Carolina they're RACs, Regional Advisory Committees. These things form the basis for regional arrangements, but they've started out rather innocuously. The CDC preparedness grants in 2002 and 2003 encourage regionalization efforts around emergency preparedness, and that took root in Iowa, as an example. I guess I should say, I'm just coming off doing 18 months of rather intense legal research, if that's an oxymoron, I apologize; but doing legal research on the accreditation legal structures.

So I had the opportunity to talk with a lot you, to talk with Elissa who was on the previous panel, and a number of you about what's going on in these states regarding accreditation, so I saw a lot of it. Then moving on across consolidation and regionalization, I'm going to talk a little more about that. But in my definition consolidation is the umbrella agency sweeping up public health inside an umbrella, human service agency at the local level, it also occurs at the state level as well, where it becomes merged in with other subspecies in the health-related and serving the medically underserved, and people that are falling through the net itself, the social net. And then the right-hand thing is regionalization, which is taking county governance and restructuring it into a regional structure with perhaps a board itself that directs it or is directed by a representative from county commissioners or whatever. But it is a reconfiguring of the essential local governance unit. And so Nancy Kaufman had also pointed out there are a couple of other spectrums that run through this. As you move from left to right you probably get a higher return on investment, but you get a decrease in local autonomy. You have your best autonomy staying in your county health unit and being the health director of your county. As you move to the right and you go into the regionalization model there's less autonomy. Simple-ness to complexity as you move to the right, and higher risk of how is this going to happen, how are you going to put the people together?

Also in this construct there are also boards of health, and we probably haven't talked enough about them at this meeting. There was a nice discussion the first day about how boards of health provide a lot of political cover, a lot of good advice, a lot of managerial assistance to the public health system.

So that's sort of the way this thing shakes out. What I then want to do, I've got four messages to four of your subaudiences; to the hospital community, to the feds, to the public health people, and then sort of a general to all you all.

So let me get to it here. To the health departments, there's certain issues that public health now brings to the table regarding accreditation and regarding partnerships, and so you get this dilemma between regionalization or local autonomy shown there. These were some quotes that we got from our case study. From a rural state, it's a region that enables the counties to do what they need to do, not the other way around. You go one state over and it's regionalization is a dirty word, okay. And I think what's really important to me is this quote, In a home rules state. Don't pretend that the need to share service doesn't exist. As we look at accreditation, it's the elephant in the room.

So there's a wide variety; and as you probably know, too, there is a spectrum of how centralized state health departments are in, say,

South Carolina, which is centralized. All local public health people work for the State of

South Carolina, as opposed to a home rule state where they work for the county and then you may have an umbrella public health department that is trying to herd the cats, but it's a home rule state. And so in home rule states you get those kinds of quotes. Just to sort of take it another way of looking at it, 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, drug prevention, etc., etc..

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 how -- where does our identity fall down on that?

I think it's fair to say that there's a good deal of angst in the public health world about being driven by the politics and the economy towards this right hand side of the spectrum. We have 20 -- what we'd hear, 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 because of the local politics and county commissioners and county government that sets that?

So there's that. There are also legal issues imbedded in this as you start to move into these horizontal arrangements, the documentation. I'll talk a minute about the prenup, funding arrangements, and how do public health control measures -- powers be exercised in a regional type of structure?

How we doing for time?

Are we looking all right?

Great. I'm going. You awake out there?

Let's talk about the prenup because someone earlier on the first day talked about a collaboration as being an unnatural act between partially consenting adults. Okay.

So I can't let it go. I can't let it go.

So this is Martie Ross, a brilliant lawyer from Kansas. Kansas has done a lot of really interesting work on regionalization and shared service delivery, and they're a stone cold home rule state, but it's been a very interesting experience. And she says it's important for the people in a collaboration to have a meeting of the minds when they go into it. Okay. You need to know -- and many states like Kansas, almost all states have an intergovernmental agreement act that encourages and puts some meat and bones to the structure of how you collaborate. And so you need a purpose of the agreement, the duration, the matter of financing; and most important, the methods of termination, okay, so that, she says, it makes sense, if you think about it when partially consenting partners are trying to commit this unnatural act, that they know if this thing comes apart; how do we all get safely back to our homeroom with our resources and with our goals and so forth?

So it's an important lesson coming out of the public health world that I think bears importance to working with hospitals and other non-profits in this area. Benefits at health departments have found that I think on the accreditation world that particularly with dealing with community health assessments and the

implementation plans and develop a strategic plan, and hopefully Kaye will talk a little more about this. But this was a great quote that came from Montana, We're working towards accreditation, but for me that's not the goal, that's a side benefit. The goal is to operate more efficiently. It makes us better. Okay. It makes us more effective. And that's really in a context of doing that needs assessment. The other one is the political aspect of this. Not only does it make us better, but it gives us more political traction. We get recognition from the local governance structure. It can mean more money or better access to the mayor's office.

So, again, in this world of a very difficult political environment and where public health has not been very good in maintaining its political skill set for about 40 years, there are lessons here. This is why I'm driven towards working in this accreditation area. It's a very important and vibrant piece that's coming in. You'll hear more on that after lunch. Let me go on. Let me talk about the alignment piece for a minute. Five minutes and we're gold, folks, don't worry.

Someone gave the Atlanta example the first day of the different hospitals and all of the different regional arrangements and county arrangements around here. Nobody gave that answer. I think that maybe the mother of all alignment issues, if you can solve Atlanta, you can solve any of them on this. But it's important to keep in mind in this regionalization an accountability discussion; that when we put together whatever geographical alignments for community health needs assessment between hospitals and local health departments, that doesn't have to match the map drawn for political reasons or reasons of convenience regarding how public health is organized on a local or regional basis.

So we will have mixing and matching going on as this process goes forward, and I think it's important to keep that in mind. That's essentially part of the collaboration. Okay. Now I was asked to talk about anti-trust, and I'll give that a minute, and you'll see my view on that. And I want to give due deference to Jerry Griffin of AHLA. I hope he's still here. But there's the issue -- well, 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 such. 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 pay for whatever policy reasons, personal reasons, reasons of they just didn't like each other. And so keep that in the back of your mind. Now that being said, you can't use this community health assessment opportunity of coming together to then fix prices or divide a monopolistic markets, that didn't repeal the Sherman Act or the Antitrust Act.

So if you get into that area, my advice is, first, push to see, are these people really wanting to play with each other, what is the real problem?

You may smell a red herring there. But -- and there are ways through this clearly for accountable care organizations there's has already been an FTC ruling on that matter that helps provide clarity. And while all of the good language that's in the IRS notice that just came out last week regarding collaborations between hospitals and other hospitals as well as with public health, that's from Treasury and IRS, that's a separate silo from Federal Trade Commission. I think your first advice is to look at what's really going on and then -- again, you can't fix prices when you're doing this, no more than you can go have a conspiracy to rob a bank or create investment fraud in the process while you're together. Okay. Let me wrap up then. This is my message for really the public health people listening to this. I mean there is an enforcement clock ticking for the hospital community. It's clear to me the trains are leaving the station, the shot clock is really already running, but it begins in earnest on March 23rd of next year; and by the close of the following calendar year, all of those hospitals are going to have to do this.

So the hospitals, it's clear to me, are going to be reaching out. They can read plain black and white English, and IRS says collaborate to the extent you can with public health authorities that have data that will assist in

this community health assessment matter, so they're going to do it. But if they don't, if Public Health doesn't answer the bell, okay, then nature will abhor that vacuum, and we've already talked about some of our best friends are consultants, and I may resemble that myself, okay, but that void will be filled by vendors who will have product to sell and public health is going to be setting by the side of the track watching those trains roar by wondering what happened.

So you're going to have to get up to speed despite the fact that there's a lot going on in the public health world right now, but it is also an opportunity. Let me say one thing to my good friends in the feds. How many feds we got left in the room?

Come on. Yes. Okay. I know what it's like from the fed side, when you've got your categorical grant programs and your funding streams are -- your budget is shrinking back; and you tend to be more prescriptive because you want those dollars -- those declining dollars to have the most effect for my immunization program, my STD program, my breast and cervical cancer screening program, yada, yada, yada, which are all done by who?

Ultimately those are carried out at the local level, okay. If CDC, HRSA, the feds, don't pick up their head and look at what's going on here in this economic and political challenges, there are not going to be those grant recipients at the local level to carry out your STD, your immunization, your breast and cervical cancer categorical program because what, they disappear. I mean, you can go look at the NACCHO website at what's going on. There are good health departments out there; and, again, accreditation, I think, is doing a lot to help that along, and it's not the size. In North Carolina, the state accreditation program has found plenty of very small health departments with good leadership that are dynamite. It's not the size that counts, it's how good you are.

So, anyway, all right. Let me give you one plug and then one final rant on this. I'm part of the Public Health Law Network of Robert Wood Johnson. We are launching an initiative around what I just talked about, the evolving legal issues that are being faced by public health departments at this time.

So I've got some handy-dandy handouts. They'll be provided to you in the meeting materials. There's a two-page fact sheet on that. But we're provide to bring technical assistance from all four of our regional centers to bear on health departments that are restructuring themselves to deal with consolidations across jurisdictional collaborations, regionalizations, working with FQHCs like we were talking about with my colleagues here, working with non-profit hospitals, data sharing, etc..

So let me close then with one last plea because this is something I can't do; and it goes to your -- how am I for time?

Did you throw me the one minute signal?

You're just stunned. He's stunned, folks. He's riveted. Okay. I've got two minutes. I'm going to finish up ahead of time and on budget. In chemistry we talk -- and I have seen this, I have felt this. I know what this moment feels like. I have been here before. I have built things. I have been part of what have been built in this public health law initiative. It's like a super saturated solution. You remember how crystals precipitate out, you heat up something and put the salt or whatever it is, the chemicals in and you let it cool down, and the solution is super saturated. It is ready to precipitate out. And then somebody just taps on the beaker; and, boom, there come these beautiful crystal fall right in. Well this is one of those moments, okay. There's an important driver just came out of Affordable Care Act through the revenue IRS to bind together. There's Kaye Bender setting there with the whole issue of accreditation and health departments doing community assessments, taking that to a whole level. We are going to need a clearinghouse of best practices. Okay. I can't -- the lawyers can't do that. I am more than willing to help make it work, but all it takes -- believe me,

I've seen this before -- it takes somebody planting a flag in the ground and say, Let's build it here. Now whether it is CDC or Robert Wood Johnson or Catholic healthcare or American Hospital Association or a collaboration, okay. We need that clearinghouse of what regional agreements look like, what assessments are done, how they're done in different jurisdictions. That's my plea to make this happen. I'm sorry to have been indecisive and not saying what I feel; but, anyway, thank you very much.

Thank you both for terrific presentations. I have a couple quick questions for myself and I'll go right to our participants. Greg, you certainly are participating in leading in what we call a fairly advanced stage of trust building at the regional level. We've had a number of discussions over the course of the last couple days that you haven't had the opportunity to hear, but there's been a lot of talk about collaboration throughout this meeting. And, in fact, one of our colleagues, Tom Wolff, shared the work of another longtime colleague, Arthur Himmelman in actually defining what collaboration means; getting beyond networking, coordination, and cooperation, and actually actively sharing resources and taking risks for the benefit of others and/or for shared purpose. With that broad definition in mind, I'd be interested in your -- if you can share with us candidly, what do you view as some of the next steps of deepening the work that you're doing with Community Health Works?

Actually, I think some of the next steps are going to key off what Gene just mentioned. A lot of what we've been doing has been built off trust that in some cases has taken 10 years to build. But to go to the next level, we're going to need to start signing some things. And having those structures in place -- I mean, right now we have a de facto prenup because if one of us wants to stop, we stop, and that can happen tonight, it can happen two years from now, it could happen whenever. But we're going to start putting some documents in place that will allow us to take our work to the next level, and we're working on the possibility of merging some other non-profits into one organization; and what that looks like yet, we don't know. And let me just follow up a little further. Now that we have these more explicit expectations of nonprofit hospitals, a number of which are part of your organization, what conversations are you having with folks about really looking at what shared implementation strategies might be and/or how their respective implementation strategies may be interlocking?

One of the things that we've done is looked at how to build the rural healthcare system if you started from scratch, and if you started from scratch you would not end up where you are now. 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. And our table served as the table that started those discussions.

So that's the answer. Gene, I certainly second your plea for a more systematic clearinghouse, but I know you've been scanning the horizon and looking at a number of specifics. I wonder if there's one or two specific efforts that you might give us a quick snapshot of that you think are beginning to move in the kind of directions that we're talking about. Yes, I mean I find that there are a number of states. It's actually the home rule states that I find to be quite innovative on this, Kansas and Montana come to mind. If you want a copy of a prenup that, two, three pages in the can, Martie -- I can give you a copy -- but Martie Ross from Kansas, they use that quite regularly and they've developed a culture of how to do those connections.

So you have opportunities like that. And then I think we need to be continuing to look -- as this process goes forward there's been, like in North Carolina, there have been a lot of very interesting collaborations, Wake County and Robeson County, and so forth; and just like what Gary talked about, of local health departments working with local nonprofit hospitals to do these kinds of assessments. And so we need to pull those -- their examples together on how they do it as well as how the FQHCs fit into this. And you see some areas like

Gaston County, North Carolina, where you walk in there and it's hard to tell -- you really can't tell whether you're going into a FQHC or a local health department when you walk in. That's pretty powerful. Great.

So I'll open it up for questions, comments for our panel. Hi. Julia Joh Elligers with NACCHO. I appreciate the comments around collaboration and I think we see a lot of variability, I mean, we hear some of the exemplary communities and we all are aware of those that don't have a lot of capacity. Based on my experience working with communities around the country, I think those that have been successful have a lot of skills and competencies -- and since , Ron, you had brought that up, what other the skills and competencies do we need in order to make collaboration work?

And I think a lot of it is around dialoguing and facilitation and the ability for us to figure out why collaboration hasn't occurred in the past. And I think there's a lot of assumptions about the other, I think we've heard a lot of them through the last three days about hospitals do this or don't do this, health departments do that, don't do this; and that creates barriers into how we work together and because we make these assumptions. And I think the communities that are very successful, they identify what those tensions are, they bring them out and address them head forward. And you may not need a prenup or some kind of formal agreement if there is that dialogue awareness that everyone has their individual interests and missions; but there always is common ground, and there is a process for actually identifying what that is. And so I know the MAPP process was talked about a lot while we've been here. NACCHO does provide a lot of training and technical assistance around that. And one of the things that we encourage communities who have bad history or a lot of conflict or turf issues and don't know how to overcome that is one of the first things to invest in is dialogue training. I mean this kind of 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, really revisit what communication looks like, they really are seeing things like assessment improvement work really pan out to be very successful among a lot of different other areas. And, in fact, this works really well in rural communities. 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. And so they can easily build upon that history of having to work together. Great. Next comment or question.

Thank you. Julie Trocchio with Catholic Health Association. I do agree with what Julia just said. I think it's very helpful to look at the positives, what hospitals and health departments are doing as opposed to sort of circulating some folklore about where their problems are. Gene, I really appreciated what you said about this is the moment for health departments and hospitals to work together. But I see another opportunity, and that is hospitals and academic public health. We are seeing some wonderful partnerships, Texas A&M School of Rural Public Health has phenomenal services. The Duke example from yesterday. Wonderful examples. And a number of programs are combining JD and MPH programs, and out of that are coming very valuable people who can look at health policy in their communities in a whole new way.

So I think this is the opportunity for hospitals and academic public health to work together too. Yes, if I could just respond. The leadership on this, sometimes it will come from the hospitals. I think the hospitals have -- I mean they've got a compliance issue on their neck. They are not -- it's not the $50,000 penalty. It's that I do not want to tarnish my brand by not having done this.

So that's a powerful motivator for the discussion. But you're right, you have in some areas you will have some very dynamic leaders from local or state health step up, you will have them, like the example yesterday, from academic centers setting up. You have the example here of a local non-profit stepping up and doing the job.

So it's going to be a patchwork, a grassroots type of alignment. I'm not sure this is very good for a top down, but point well taken. Let's stay for a minute on the points of both Julie and Julia have raised, and this is important. We have to avoid stereotyping. We have to avoid -- 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. Local boards of health can also be a very powerful driver. There's leadership there. They would have traction in their community like the person from Kansas City talked about on the opening plenary. Absolutely. About how you've got a President of the chamber of commerce, you got traction. Absolutely. The emphasis on how we both identify -- you've identified this need for a clearinghouse, as Julie's noted, let's build -- let's identify and build on the positives that are out there, there are a lot of positives to build on. I want to go back, too, and make sure that we address the other issue that Julie raised, which is how we do this work effectively, how do we do collaboration?

It does take the people with the competencies, and it also takes resources. Can you comment on those issues?

Yes, well let me go back and finish because I didn't quite complete my rant about the feds and the role of the feds. And so -- if you didn't slink out of the room CDC folks, let me -- I mean, I know what it's like. It's important for the resources for local health to be able to answer the bell on this, to be moving forward with accreditation model. And the linchpin, the starting point of accreditation, other than the motivation to do it, is doing that first community health assessment. And there's some states that already require it for other reasons. But it is important for the feds in those categorical grant programs -- and I've written on this -- to allow an administrative cost for participation in feds.

Some local health departments right now will not be able to afford the $5,000 or whatever the fee would be, they're not going to have that money, and you go try to justify that to the county commissioners in Salina, Kansas, or Fishbend, Montana, or whatever 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. Her question was about building -- I think about building capacity to expand the opportunities for collaboration. I think one thing that we're doing and looking at is making sure that you've got the right people that can interpret what the other person needs. In dealing with our academic medical centers and our academic institutions, I know our organization, we're light on -- we don't have a PhD or anything like that that works for us.

So when we get far out on some of these academic-specific type programs or evaluation components, we may not speak the same language.

So what we're considering doing is adding a person that would be a director of evaluation to make sure that we've got that person that can interpret what the needs are from the funder or from the academic partner. But I think Public Health also needs to do that inside their walls. A lot of the public health infrastructure in Georgia, I believe, may not have the appropriate skill sets or capacities to interact with -- they don't speak the same language as the business community, as the local government -- the county and city local officials, in some cases, so adding communication staff inside the public health walls that are not focused on communicating public health messages but are communicating to government business. Next set of questions and comments. Paul Hattis, Tufts Medical School. Gene, in listening to your discussion of the watershed moment, for me, I think that rings true a little more when you think where state and local, especially local, public health is in terms of being so underfunded; and the opportunity, perhaps, that

accreditation brings to maybe encourage not only efficiency, but shared arrangements between governmental entities. In Massachusetts we have 351 towns and cities and you can imagine there's 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. But my comment is is that 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 are they going to deal with access changes from ACA around the country?

And in Massachusetts where we've sort of made strides on that, we're talking about healthcare reform 2.0, which is now about cost. And we talk in terms of healthcare reform 3.0 as ultimately being about public health. I guess what I'm trying to say is I don't see how from the hospital field's perspective that this change is such -- 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 more conspicuously on the 990, people can find the 990, and then there's 990 H. This is just I think another step in that realm rather than seeing it as a revolutionary moment.

So I'm not trying to throw water onto your fire, I'm just trying to give a reality play-out to what the situation. Next. Bill Barberg from Insightformation. One of my favorite quotes is that Smart people learn from their own mistakes, but wise people learn from other people's mistakes. And as hospitals move into a much greater level or heightened level of collaboration, I think there's a lot of lessons that can be learned from the business community. And about two years ago there was a Harvard Business Review article that said, 50% of corporate alliances fail, but you can increase your partnership's odds of success by applying these techniques. That was the subtitle of the article, Managing Alliances with the Balance Scorecard. And it goes through and talks about oftentimes alliances are negotiated by lawyers and it becomes very complicated. But when you shift to focus on developing alliances around strategy and you clearly articulate and communicate that strategy, the success is dramatically higher. And the article features a case study and one of the companies in the case study sponsored the article, so it's one of those few Harvard Business Review articles you can share for free, legitimately.

So it's got some great points in it, and just the idea that as moving into heightened collaboration in alliances and partnerships with not only local health departments and hospitals, but other community members, there's some valuable lessons that can be learned; they have to be modified appropriately, but, again, some valuable lessons that can be learned. And if anyone wants a copy of that article, like I said, it's a sponsored -- it's one of those rare sponsored HBR articles, I'd be happy to send a copy to you.

Thank you. Let me know.

Thanks, Kevin. I was going to essentially make the same point. Looking at that list that Gene put together, consolidation is where two things or three thing becomes one, there's one board, there's one CEO. The rest of it are all various forms of partnerships and they are not easy to make work and they require constant nurturing, and I really appreciate the point. 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. Everyone knows that, but it's important to remember. Yes, it's a good reminder.

So three quick comments, I think, that are very much in line. We'll go back, we'll get some more comments and questions. But really some -- as Paul offered some circumspection about the degree at which that alignment is here. We do have some continued work to do to build that alignment, to get the common language. But also we have this issue of the degree to which -- and I think this is -- I think Bill's comment is consistent with your framing of a prenup; that is, do we go to governance right away, do we go to the issue

of formal agreements, and what are some of the -- how do we focus, for example, on strategy, how do we begin to focus in the areas where we have that outcomes?

How, before we get married, can we have some dating and some successes that we can build on.

So any particular response to those before we go?

Well, on the comment about how big a deal is this to the hospitals, I mean point is well taken. The big deal to the hospital is the Affordable Care Act and how are we going to shake out on all of this; and is it going to be held -- is the mandatory insurance provision going to be three or five Justices of the Supreme Court, we're probably a year out from that. But I think despite Judge Vinson's ruling in Florida on that particular piece of the Affordable Care Act, most hospital attorneys, as well as most folks in the advocacy community don't think that this provision of the Affordable Care Act, which is an amendment to the revenue code that's completely separatable from the mandatory insurance provision; and so it's going to go forward. And in any event, March 23rd is coming, and I think most hospitals realize it's something that you don't want to soil your brand by not having done this. In going back to the bigger lessons learned by public health departments that have done community health assessments, it makes you better and it builds you community traction, which you need, all of which are good ideas. With all of the dust in the air in both the hospital side and on the public health side, whether people can focus that this is something to jump on or not, not everybody will, but I think it's merit; and again, we need to put that flag in the ground and build a clearinghouse, and if you build it, I think they'll come. Greg, any follow-up?

I think you're right, but I see it as opportunity. I mean, I think there -- I think there're opportunity for community-based organizations and health departments to meet that need for the hospitals. I'll just note, I had this conversation with a number of you. In my spare time, I co-direct a statewide health workforce alliance in California, and I will tell you that it is becoming increasingly difficult to get hospitals and health systems and other partners to really take a look at this issue in a coordinated way given the kind of constraints that folks see down the road, so not just workforce development, but broader health improvement. They're looking at the fact that MediCal, our Medicaid reimbursement is already well below costs, and looking at further constraints down the road.

So as we look at how you build capacity, primary care and preventive service capacity in the many medically underserved areas and health profession shortage areas in California, it's going to be very difficult in the context of the kinds of adjustments we're seeing in reimbursements.

So we've got to be realistic as we engage our hospitals about these kinds of issues. It's fundamental. We can't get alignment if people are basically losing money hand over fist.

So next set of questions and comments. Hi. Dory Escobar with Saint Joseph Health System in

Sonoma County. I'm very excited about of the conversations that have been going on and the big conversation, and where it's going to potentially go from here. I also have some concerns like some other folks; and in this regard, I'm representing a county that has a long history of successful relationship-based collaboration between a lot of the sectors that have been mentioned. And we're geographically large, not a lot of people in our county, and we've got three major non-profit health systems, who are very involved with the community and with each other, an innovative and strong public health department, four healthcare districts, and seven FQHCs with a long history of strong collaboration. And what's happening now and a little bit with the accreditation effort and the new requirements at the 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 this according to the new regulations and basically trying to build what we

already have but according to regulations, and it's not necessarily enhancing or building what we've worked so hard to create. And do you have any thoughts on that?

What's your state -- what state?

Study?

What state?

It's California.

Sonoma County, California. Okay. Next. Gene, Gary Nelson, Healthcare Georgie Foundation. I'm curious if you see a role for state level membership of organizations in pursuing this kind of collaborative model you speak to, specifically the Hospital Association, Public Health Association, city and county government entities?

Yes, is the question the role of the state hospital association?

The role of the state membership organization and associations. Yes. Yes. Well, I mean -- As enablers or obstacles?

Yes, well, I don't want to be too much of a Tar Heel booster, but I left here and went to North Carolina because it was about the -- it was in that sweet spot of it had resources, it had capacity, but it wasn't so big that it got into the kind of gridlock that you have in Illinois and California and New York. And so there you've got -- I mean I stumbled into this very late in the game; but Dorothy and Greg and the folks in both the State Department of Public Health as well as the local health leaders and the North Carolina Hospital Association immediately saw this and we're out in front of it so they've had a series of collaborations and how do we do this and how do we divide up the task. And so clearly, it's a bit of a paradox. You've got to be very careful when the state leadership associations, be it the health department 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. But how you partner up at the local level, at the grassroots level, you hear that loud and clear out of the home rule states, you need to build that out of -- from the ground up. Let the folks decide who wants to partner with who. And certainly here in Atlanta area it's going to be a very difficult and complex issue. It's easier in those middle size jurisdictions where there's some capacity, there are nodes of leadership in academia or wherever. And you can then work both -- the best of both worlds where you've got some state leadership and grassroots motivation to get it done. I would just note parenthetically that I think there is that continuum that you suggested, which is various associations can run the gamut from being -- impeding progress, in part because many associations are driven by lowest common denominator politics to be immensely helpful. And, in fact, I'd point to the Hospital Association in North Carolina under Bill Pully's leadership and with Jeff Spade, in providing immensely important leadership and bringing the hospitals and the public health community together. Greg, anything you'd like to add?

We've raised this issue -- Dory's raised this issue, for example, about the degree to which we already have good working relationships in the elevation of new regulations, to what extent -- is that taking us deeper or potentially distracting the work that's underway?

I would imagine that for those working relationships to be as good as they are and to have lasted as long as they've lasted, you're a creative bunch, and I would assume that you could become creative to reach what standards or regulations need to be met. And do that in a way with as little harm to the existing alliances as you can make. I point to a specific partnership to address this question that Dory has raised. And what it

calls for, and I think one of the reasons there was a particular urgency in this meeting, as we began to talk to a number of partnerships around the country, one of particular, in which we spoke with were the folks of the Community Health Improvement Partnership in San Diego County as one of the more robust partnerships going well beyond assessment that we've seen around the country in working together. And what we began to hear as we talked to colleagues there is they also have a 501(c)(3), they have hospitals investing in a variety of efforts. They are struggling to keep public health department at the table, and that's a whole other set of issues. But a lot of other stakeholders are at the table. What they're struggling with is, to some degree, the misinterpretation of the hospitals of the new IRS reporting requirements that's making them being to say, Gosh, maybe we shouldn't be collaborating as deeply as we are because we're going to be held ultimately accountable for our implementation strategies.

So we have to find a way to, in fact, support and deepen these kinds of engagements in that context. Since you have the mic in your hand, you can make one more quick comment, but we want to break on time, and I'll explain why. Okay. I'll make it quick. This -- picking up -- and I think it addresses your point, at least in part -- picking up on Greg's response before that his organization wants to bring on a PhD evaluator, and I'm sure other organizations need to have them or want to get expert evaluators, and I'd say that's great for the rigor, but don't turn the evaluation over to them. It has to be the collaborations, the community's evaluation, the collaboration's evaluations, the partner's evaluation. You can engage community members in so many different ways in evaluation from training them to rigorously collect data to helping to analyze and interpret it. That way the community owns the evaluation and the results, the partners own the evaluations and results, the whole collaboration owns it so when the midterm evaluation in a year or six months says, We got to change some of these things, some of these things aren't working,they own it and they'll make the changes. You get the last word. Please join us in thanking our panel. I have two quick and very important points to make before we leave. One is we have our last two panels. We've set them up to be slam, bang panels, so the folks involved are going to really help us grapple with some of these issues.

So I'm looking forward to seeing all your faces back in here after lunch. And secondly, our lunch is right across the way. We want to break right at time because we're competing with another group and we need you to get in there first before they get in there.

Thank you.