Panel 12: Reporting and Compliance

The panelists that we will have presenting and in this order -- first will be Donna Folkemer who is a Senior Analyst at the Hilltop Institute at University of Maryland. If there is anybody that is not aware of the Hilltop Group, you should be aware of the Hilltop Group. They are doing terrific work in the community benefit arena with funding from the Robert Wood Johnson Foundation and the Kresge Foundation with a particular focus on state level oversight. And so Donna will give us a bit of a scan of what is going on and what are some of the issues at hand.

Then as has been the case with other panels, we're going to get a drill down and we're privileged to have Lois Johnson who is the Assistant AG at the Healthcare Division at the Office of the Attorney General in Massachusetts. Massachusetts is unique among states in that it has a set of voluntary guidelines, and I would put in quotes voluntary in the way that many I've discussed in the field have viewed them. There is pretty much a universal adoption and application of those guidelines by the hospitals and HMOs that are affected by those guidelines. Massachusetts also represents; I think some of the things that they have done reflect more in-depth and ongoing engagement of the oversight agency than I've seen in most states as well and a focus on transparency. Last but not least, we'll hear from Gianfranco Pezzino who is the Senior Fellow at the Kansas Health Institute, a former state official who will share with us some of the different models and approaches to state oversight and collaboration in particular between the hospital and the public health community. With that I'll turn the mic over to Donna Folkemer to get us started. My name is Donna Folkemer as you just heard. I don't have any slides today. I always have slides and today I don't have them, but you're going to have some wonderful slides from my colleagues on the panel. You're probably thinking then she better be short if we don't have nice pictures to look at and I will be. There are four things I want to talk about today, but they all come within the framework of wanting to have a dialogue with everybody in this audience and with everybody who is listening to the webcast or watching the webcast or whatever it is.

So I'm going to first talk a little bit about Hilltop and what we're doing and why we're doing it then I'm going reframe the questions a little bit, reframe the questions that Kevin gave me to talk about. And then I'm going to make a plea for thinking about this issue within some of the broader Affordable Care Act implementation that states have underway, and then try to connect that up a little bit more with some things I would like you to think about as we go along with that dialogue. I first should tell you something about myself. Everybody has been talking about the smart people in this room and that is definitely the case. I think I should probably tell you that I don't have a public health degree and I've never worked for a hospital, but I've worked for over 35 years on state policy issues, primarily on healthcare financing issues and that is really the focus of my discussion today. If anybody is passing out a test on the ins and outs of Medicaid waivers, I'm your person. My colleague Martha Summerville is with me. Martha Summerville has both a law degree and a public health degree so I get by with a little help from my friends. The Hilltop Institute is very honored to have been given funding by the Robert Wood Johnson Foundation and the Kresge Foundation to think through some of the issues related to hospital community benefits, as they relate to state and local policy makers. We have a great fact sheet out on the table, it's easy to carry two pages, so I encourage you to pick up that fact sheet. It tells you a little bit more about what we're doing and then it leads you to a couple of the papers that we've written so far. In one of those, we talked about the emerging federal framework -- hospital community benefits after ACA and in the other one, we talked about building on state experience. In that second brief, you'll find information that we discovered through our research about what states are doing as it relates to community health needs assessments; as it relates to financial assistance, and as it relates to reporting. One of the purposes of that brief was to set a baseline; what's going on out there?

And the bottom line of course on a lot of these discussions is that there is not uniformity across the states as we think about the amount of attention given to the hospital community benefit issues; as we think about the type of attention; as we think about the information that is collected. I'll refer you to our paper to learn more about that and as I said you can easily get to that paper. We want to provide technical assistance to state and local policy makers during the three year life of our project. As I said, I'll be seeking your help on that as we go along. When we think about state and local policymakers, we're thinking about the folks in this room and

also an additional group of folks. We have on our advisory committee a representative from the National Association of State Budget Officers. We're talking here about some provisions that are part of the Affordable Care Act and state budget officers care about those provisions. We have those on our advisory committee for this project on hospital community benefits. We have a representative on the advisory committee from the National Conference of State Legislators, which is where I worked for 10 years before joining Hilltop. State legislators care about the Affordable Care Act and its implementation and they care about this part of it too, or if they don't, they should. One of the things we're doing is trying to make sure that we include folks in our discussions who are not necessarily always part of the community benefits discussions, and also that we write materials that they can understand and read and use. That is a little bit about what we're doing and I look forward to talking to all of you about that. I wanted to reframe the questions a little bit as I look ahead. Building on the questions that Kevin set forth for us and that are on the agenda as you see it, and I can't decide which of these reframed questions I like best or perhaps all of them. As we look ahead, how do we get the community health outcomes we want with the help of public sector oversight?

How do we get the community health outcomes we want with the help of public sector oversight?

Or maybe thinking about that and wording it a little bit different -- how do we get greater community health improvements from public sector oversight?

How do we use public sector oversight to get greater community health improvements?

Then kind of restating it in a broader frame which reflects kind of how I want to talk about this during the rest of my discussion. How do we create a public sector role related to hospital community benefits, and then let me say here a state and local public sector role; to reach the promise of the Affordable Care Act on transparency and accountability?

How do we create a public sector role related to hospital community benefits to reach the Affordable Care Act promise of transparency and accountability?

And I want you to answer all these questions for me today. These are difficult questions and I am glad we have three years to think them through. But I wanted to put the questions in this framework, which then leads me into the next part of my discussion and the things that I hope you'll help me think about as we think about these things over time. What do I mean then by thinking about hospital community benefits and the state role in hospital community benefits within the broader framework of the Affordable Care Act?

I think what we're seeing here is that as we have the provisions related to hospital community benefits in the Affordable Care Act, we also have an entire range of other things happening in the Affordable Care Act that are going to be occupying the time of state governments, in particular, over many years. I think then what the Affordable Care Act provides is additional incentives or additional opportunities for state governments to look at the hospital community benefit issue within their broader implementation of the Affordable Care Act. I just want to mention then thinking about it that way, the issues that I am hearing about as I talk to state and local officials, legislators and others is that they're interested in getting some answers to; and they're not thinking about these issues exclusively as it relates to hospital community benefits. But I want to set out those issues and sort out some of this for you, or get you to sort it out for me because I need a lot of help on this. I think the first issue, of course, is transparency and how do we think about transparency for our discussion today in the hospital community benefits issue. One of the things that strikes me as we look at broader Affordable Care Act implementation is the emphasis on transparency. As you know, states are going to set up health insurance exchanges and all that information is going to be available on the web so that people can sort through things and find what they want. There is going to be a much more robust and public complaint resolution process around insurance payments; a much more robust process around insurers

spending money on medical care rather than on other things. What that does is emphasizes the public's interest in knowing things and getting information and using it. I think that the question I want to pose for you is how do we think about transparency in the area of hospital community benefits?

There will be increasing interest in the public knowing more things, and in some states they certainly can get a lot of information; but I think what you'll see especially from state policymakers is an interest in even more information. All of you have already taught me that we don't want to have information just for information's sake. What kinds of things should we be talking to state policymakers about as they say, We want more transparency?

So I put that out there as a question for you. Similarly, the issue of accountability -- we've talked a lot about accountability. As you know, with many of the things that are happening with the Affordable Care Act, there are an entire set of new benchmarks being developed. There are benchmarks related to how quickly states can get health information technology systems up, health information exchanges built around health information technology. There are benchmarks related to getting health insurance exchanges up; to this whole range of things that are part of the Affordable Care Act. What kind of benchmarks should we have; if we think of benchmarks as proxy for accountability to public officials -- what kind of benchmarks should states consider?

What should they set up as benchmarks when we're looking at the hospital community benefit arena?

It is interesting because when I look at these benchmarks out there related to other aspects of the Affordable Care Act, what they're talking about is change. They are talking about the pace of change. They are talking about sorting out how quickly things change and what you are trying to get them to change to. In all of the discussion that we've had so far, everybody in this room, it seems to be -- there seems to be a consensus that we don't want some kind of one size fits all set of benchmarks; but we do need benchmarks in this area, and as we think about tying things together and tying this issue more closely to other aspects of the Affordable Care Act where there is implementation, where there is enormous pressure on the states, we need to think about benchmarks in this arena too. I kind of pulled together there the discussion of accountability and benchmarks. The issues that seem most important when I talk to people out there are transparency in this issue so the public can know essentially everything there is to know about what is going on with community benefits around the state; the notion of accountability and what do we mean by accountability, resting on the assumption that the kinds of things we're getting in Schedule H certainly are not sufficient for accountability, or maybe the wrong things. But what kinds of things should we think about -- how should we define accountability and how should we set up benchmarks to deal with that?

Those are the kinds of things I wanted to ask you to think about. I've been in touch with many of you, we've had wonderful dialogues. I've gotten lots of questions from state folks and have often talked to some of you to sort them through. I look forward to talking to you further about these issues. Good afternoon. I am very pleased to be here to talk about Massachusetts' Community Benefit Guidelines, and many of the themes that you've heard probably throughout the conference and this morning; transparency, accountability, measurement benchmarks -- are those themes that we're trying to put in place in Massachusetts as well?

The Massachusetts guidelines are in fact voluntary and were developed with stakeholder engagement and do rely on transparency to foster accountability and community partnerships. Today, I'm going to describe briefly how the guidelines were developed, the key principles and how we use reporting in Massachusetts to support those key principals. We've had the guidelines in place since 1994. At that time, Attorney General Scott Harshbarger convened a very large group of stakeholders from public health advocates, community advocates, hospitals, insurers; a range of folks together to say what should hospitals be doing in terms of community benefit activities. It was housed in the Attorney General's Office because the Attorney General

has oversight in our state of charities, and is very engaged in a whole range of areas in the healthcare marketplace.

So put together a set of guidelines that have been in place ever since. It followed two years later with similar guidelines for HMOs, which applied not only to non-profit HMOs but for-profit HMOs as well. As Ken mentioned, the guidelines in Massachusetts are voluntary, they set up our expectations, but we have had very robust compliance with those expectations. The AG in our state, as I said, is a compelling figure always and can command response from the hospital community, which is great. What we do to make this information available is we rely on that public reporting process, we have an on-line reporting form and we make those reports available to the public. They are searchable in a database so you can search by hospital and by program. We use the naming and shaming so if your hospital doesn't have community benefit report online, hasn't reported the activities or the expenditures, members of that community can inquire as to what that hospital has been doing. In the past, we used press releases and we've had awards programs to highlight good programs. We have been successful. You've heard already this week from Monica Lowell; some excellent programs and some really -- taking this as not just a reporting obligation, but a mission obligation, which has been great. When our current Attorney General, Martha Coakley came into office and as part of her review of a whole range of her priorities, did undertake a major revision of our guidelines. And we convened another task force with a similar broad array of stakeholders to really look at what has been working, what hasn't been working, strengths and weaknesses of our reporting guidelines. We have found over the years some inconsistency as found across the country in terms of what people report as community benefits. We wanted to improve the standardization, especially around the categories of expenditures that we collect. We found in some cases hospitals waiting until the last minute of the reporting year and saying, Oh, what can I count as a community benefit?

We found a lack of pre-planning and really a lack of engagement with the community to determine what are the priorities that we should be focusing on in advance. We found in some cases hospitals doing the same programs over and over without an assessment of their outcomes and without community engagement about whether or not those are still key programs to focus on.

So the goals of our revisions were to address those things, to improve program measurement, to improve the pre-planning approach of hospitals, to encourage community collaboration; and to try our best to standardize reporting and streamline the reports from a hospital perspective. New for us too in 2008 was to encourage a focus on statewide priorities, rather. And there, we used the statewide priorities developed by our State Department of Public Health based on their assessment and we tailored those to make sense in the community benefit context. The idea here wasn't meant to be prescriptive; that every hospital needs to focus on these and they are rather broad; but to balance the tension between wanting community benefit activities to come from the ground up at the community level with a desire to get hospitals in our state to be able to row together -- if I could mix a metaphor, to move the dial on some key public health concerns so supporting healthcare reform. And that was intended to continue to support healthcare reform in our state, which was enacted in 2006 Chronic disease management; to focus on that in many communities, to reduce health disparities; and in general, to promote wellness of vulnerable populations. We wanted to continue to emphasize that the goal of community benefits is really to address disadvantaged populations' unmet health needs. The guidelines are based around a set of core principles, which we didn't change very much in 2008, but we tried to update them.

The community benefits mission statement -- we're asking hospitals to develop a specific mission statement for community benefits to identify one or more target populations and issues that they are going to address, to make that mission statement public. We were asking hospitals to really have leadership support at the highest levels, and to tell us how they executive community benefits. We want to bring community benefits out of the PR office and bring it up to the CEO level of a hospital. We want to encourage community involvement, participation in all phases of the process, from the needs assessment process to the

development of the priorities, to the execution of the programs and feedback and evaluation. The community health needs assessment, I'll talk about that in a minute. Community benefits plan, we are asking as I said, that this be developed in advance and that the hospital execute according to that plan. And the community benefits report -- we articulate in our guidelines how they should report to us. The community health needs assessment, which is very similar to the requirement now by the IRS, we're asking that hospitals conduct a comprehensive review of their community's unmet health needs.

This can be done in a variety of ways. We're not prescriptive here, but we ask that they use available public health data especially disparities data which our Department of Public Health is now collecting, to get community input, to evaluate existing programs whether done by that hospital or others, make sure there's no overlap, revisit programs that you've been doing. We acknowledge that there is a range of resources available to hospitals across our state and encourage the use of public data. Use information from your own patients, your own doctors. Great if you can hire a consultant and do a significant evaluation; but use the information that you have and we recognize that, and our guidelines acknowledge that. In terms of our report, how state oversight reporting is trying to encourage the principles that we've articulated, we're really trying to focus on three areas; process reporting, program reporting, and expenditure reporting. We've used our report to gather information about the process of community benefits. In this revision, we've really emphasized that the process is as important as the expenditures, to sort of get it out of what can we count as a community benefit to how are hospitals kind of coming up with their priorities and what are they doing?

We asked for information on their community partners, for the leadership of the hospital; do you have a community benefits team, when were your meetings?

In terms of programs, we want to get more standardized information about the programs so we're asking for a hospital community benefit program, a specific program -- what are the short-term goals, what are the long-term goals?

How are you measuring that, what are the outcomes?

In terms of expenditures, we tried to standardize there what we're reporting in terms of program activities, charity care. We're also collecting information about the financial status of the hospital so that there can be an assessment of whether or not there is an adequate investment in community benefits. One of the things that Kevin asked to describe was the interaction between our state oversight and the new IRS oversight of community benefit activities. We do acknowledge that there is overlap certainly, and they're not always consistent. We explicitly acknowledge that certain things that may count for the IRS may not count in Massachusetts and vice versa. The Medicaid shortfall amounts, we don't allow hospitals to report in our form; but for example, community building activities we would count as a community benefit. We resolved this by allowing optional reporting so community service programs they can report to us optionally. Those are programs, other good works charity things that aren't necessarily related to a target population or a specific identified need. Bad debt -- hospitals have long urged us to allow them to report bad debt as a community benefit. We said, you can report to us as an option if you agree to follow our recommended medical debt collection practices and many have done so. We also recognize that the IRS reports will be filed and may have a different total so we are allowing as an option hospitals to report their IRS totals on our form and we acknowledge that they are different. I will just conclude by saying that alongside the IRS reporting process, there is still an important role I think for state oversight and encouragement of community benefit activities.

In some ways, states may be in a better place to ensure accountability and to work with hospitals and to tailor their reporting requirements to changing circumstances. With that, I will look forward to your questions. For more information check out our website, you'll be able to see all of our hospitals and their great programs. Good afternoon. I am glad to see there a few survivors at the end of these three long days.

Panel 12: Reporting and Compliance

Let me get started with a little disclaimer. I want to tell you what lenses I'm going to use today to share my thoughts with you. First of all, I am a public health physician so my focus is on population health and not individual healthcare. I work for a non-government organization, the Kansas Health Institute, although I did work for about 10 years prior to that with the Kansas Department of Health and Environment. In my current function, I work primarily on building bridges with many different partners, doing convening and providing technical assistance in different ways. I am a medical epidemiologist by training, so I love data. If you can feed data to me I will be happy. Finally, as I am sure you have guessed by now from my typical Midwestern accent, I come from Kansas, which is a rural state as I will describe in a minute, but seriously speaking, I have been there for about 17 years now. My wife is from Kansas so I really feel like I have good roots in that state despite my accent. You really have to take my word for that. There is rural and there is rural. Nature describes a rural county or a rural health department as one who serves 50,000 people or fewer. You see on this map, the yellow counties that are the least populated, some of them have not 50,000 but 5,000.

Some of them have 2,000 people. Those in yellow have a population density of 6 people per square mile. Think about that folks, 6 people per square mile.

So we are really talking rural here. How is the public health in the hospital system network distributed in that state?

I like to describe this state as no county left behind. We have 105 counties, we have 128 community hospitals. There are only 9 counties that do not have a hospital. There are 26 counties including many rural that have more than one community hospital. Each dot by the way is one community hospital; and you can see some of the counties who were in yellow earlier on the left side, on the western part of the state -- some of them have actually two hospitals. By the same token, public health -- we have 105 counties and we have 105 county boards of health. We have 100 local departments that serve all 105 counties, which means that only five counties actually are served by a multi-county health department.

So why does this matter?

First of all, it matters because in a local rural situation like that you are going to have multiple agencies in the same small community that are competing for the same scarce resources. They are competing for the same attention from the same stakeholders. Let's face it; there are only a few people who can go to health coalition meetings in a small community. It's all the same people. Perhaps more importantly, they are competing for the attention from the same small group of local elected officials. The last thing you want to do is to bombard those officials with five different community health assessments. They are going to get so confused that they don't know where to go from there. It also means that local data are really hard to find so one has to become a little bit more ingenious. Last but not least many, not all, but many rural states like Kansas have a home ruling system. They are strong home-ruled states. These challenges are common to other states and I don't think there is a solution that can fit them all even though the challenges are in common. There are two solutions that we are using in combination as an approach in Kansas. It is combination of shared ownership and regional cooperation.

What I wanted to do in the remaining time that I have left is to briefly describe these two approaches; these two strategies, and then discuss the implications for community health assessments and then I will describe the implication in particular for accountability and reporting. If I seem like I'm not on track just bear with me, I hope that by the end of the seven minutes I have left, I will be more on track. In March 2011, let's talk about shared ownership first, the Kansas Hospital Association and the Association of Local Health Departments signed a joint resolution that encourages local health departments and hospitals to work together in conducting community health assessments and improvement plans. There has been a lot of talking in the last few days about memorandum of understanding, how important is it. I don't think that is sufficient to create a partnership, but I think it is an important tool. I think when two strong state-based

organizations -- member-based organizations in the state sign a resolution like this, it sends a strong message to their constituents. Another solution that we could use as an approach is the C word. Does anybody know what the C word is in a home-ruled state?

Consolidation. Okay, folks, that's a known starter. By consolidation in this context, I mean multiple agencies that merge across jurisdictional lines. It's just not public health agencies; it is hospitals, schools, libraries. In many cases, they define a community. And I think we need to respect that even when we have data -- and I'm a data person, remember -- that would suggest that is not very efficient, that it's not the best approach, that that's not going to work. There are very strong feelings in Kansas and they will swear about home ruling and we need to keep that in mind.

So an alternative solution that we are using is the regional cooperation and that started in 2002 with preparedness money. It is voluntary. Local health departments can pick their partners and they can decide who they want to play with. Each region has to have at least three contiguous counties and it is more than just saying work together. They require interlocal agreements that need to be signed and approved by all the county commissioners involved and then filed with the Attorney General's Office. Each county will provide one member to a regional board. The difference with consolidation is that each county and county health department retains its own jurisdiction; and very important, his power to allocate resources. A region per se does not have any power to allocate resources from the county health departments. Those have to be approved still by the individual local boards of health. This is the result of a process. We have 103 out of 105 counties that participated in this experiment and we have 15 regions -- different size, different extension but they are trying to work together.

So does it mean we are going to have a regional community health assessment?

I listened to all of the proposed definitions of a community health assessment the past few days and region was not one of them and I'm not surprised. A region proper is not a community. I will agree with you, but that doesn't mean that the regional structure cannot have a role in community health assessments. What we are trying to do in Kansas is to capitalize on the economy of scale while retaining a local flavor at the local level. That can be done, for example, by comparing data they collect at the local level, by combining data from smaller jurisdictions where often just single jurisdiction data are not enough to do any meaningful analysis, by comparing trends, by adding defined combinations and perhaps developing common approaches in terms of interventions, and perhaps sharing facilitators, consultants and other resources.

So there is still a role for the region even though it is not necessarily a regional community. I promised I would come to it and here I am. What are the implications for accountability?

Well, the first approach of course; this is one example of accountability, is the checkbox example. With all due respect I think this is necessary, but I don't think it's efficient. The reason is that we need to go beyond that. If ownership is shared, so should be accountability. It can't just be accountability for one single agency. It is a shared accountability. To push accountability beyond a single agency, we have to have a very transparent process and a very public process. If the community health assessment improvement plans are public processes, nobody wants to be embarrassed in public and people will start taking more ownership of those pieces. What we really want to do is to maximize the probabilities of success of those plans. We can do that by, for example, providing tools to improve the performance management skills of different agencies in this process. The flip side of the coin is when everybody is responsible, who is accountable?

Shared ownership does not negate individual responsibilities. The accountability needs to be built on multiple levels in a single agency, but the way that that is done is by translating -- one way to do that by translating the improvement plans at a community level into strategic plans at the agency level. And FAB has done a marvelous job in that respect in spelling out how the process works. If you think about that in that

sense, it doesn't matter at that point if the improvement plan is regional or local, as long as there are activities from those plans that are translated into strategic plans that are agency-specific, it can work. How about communication?

Again there is a checkbox approach. Print report, distribute it and post it on your website. It needs to be done. It is important, but I think that we can do better than that. I would argue that the community health improvement plan without a good communication plan is probably set up for failure. A communication plan is going to be as important as the quality of the improvement plan overall. The first task in a communication plan would be to identify your audiences and I use a plural there for a reason because there would be more than one. You want to talk to your community, to general public. You want to talk to your stakeholders. You probably want to talk to your elected officials. The way you talk to them is probably going to be slightly different. You can't just have the same message for everybody. You may have to develop a subset of a communication plan for each of those audiences. This is one case where I believe the user professionals can be helpful. It's a tricky science and sometimes an art. In this case, the C word becomes consultant. I don't think that is a dirty word. I think there are good consultants and there not so good consultants, but in this field I have really found it very helpful to rely on the opinion of those good consultants that know how to craft an effective message to a targeted audience. That is all I have for you and time is up. Perfect.

Thank you. I want to go questions pretty quickly, but I just want to offer a couple of comments. As we put together this panel and thought about this issue, at least one person has observed over the course of this last two and a half days, that in fact having a state statute has at least appeared to contribute to hospitals being more engaged in this than if there hadn't been a statute. I think it is hard to contest that statement. It has certainly been my observation. It is also true in many states, and I think Massachusetts in a number of ways is the exception; is that we have often run to get legislation passed, but then did not provide the funding and intention to provide oversight, to provide technical assistance, to really advance practices. That has certainly been the case in my own state of California. Just recently, as a part of the work that we are doing with California Endowment on the Building Healthy Communities Initiative as referenced earlier, we reviewed approximately 50 community benefit reports. They were submitted annually by hospitals. What we found was a little startling and we weren't looking for it, but when I looked and re-reviewed the original legislation, SB 697 and the reports, over two-thirds of the reports were not in compliance with not individual but multiple elements of the legislation. That doesn't mean they weren't doing those things because many of them I knew by first-hand experience were doing excellent work. But what it seems to imply is that many haven't concluded the truth, which is that nobody is looking at those reports. They're being sent and put in a filing cabinet and put away. I think what Massachusetts has done is a wonderful and relatively low-cost alternative, which is to put them up there on a website. It is searchable and people can look at that. It facilitates not just state level oversight but kind of the oversight at a local level. I will recall an earlier conversation I had with one of your predecessors and she told me that nine out of the 10 calls that they got after posting that site were from competing hospitals who said, such and such says they're doing this and they're not really. Part of the question here is, particularly in the context of the rollout of the IRS Guidelines; we have approximately 18 states that have statutes or a variation thereof. How do we deal with that in those 18 states?

Lois has talked about looking at ways in which you can accommodate those differences and/or just provide differential reporting. Do we want to see other states step into this or is what we have out there at the federal level sufficient?

I would like to get your thoughts and insights on these and related issues. Again, just pointing to Dr. Pezzino's points -- the essential point is getting the data out there and building on ways in which people have already come together. In our discussion, you referenced a lot of work that had been done, collaborations that have been built around emergency preparedness that may have laid the ground work for the kind of collaboration that we want to encourage. I am interested in getting folks' perspective on what is the role of

state oversight in the context of all the things that we have been talking about. Let's get your questions and comments. Gene Matthews, this is I guess for Gianfranco. It is really interesting seeing how Kansas has built this regional cooperation approach in a stone cold home-rule state. Looking at what some state like North Carolina is facing the possibility of a legislatively-forced regionalization with some other less appealing choices, and also how you're matching up your hospitals; you have that advantage of matching your hospitals up with your county jurisdictions so this seems to fit neatly. My question is, was there ever a threat politically in Kansas that regionalization would be forced?

And the second part is now that you are this far evolved from preparedness through to this Regional cooperation concept, with each county still retaining its autonomy; do any of your colleagues feel that that is a threat; that the next step may be some type of forced regionalization without the county autonomy?

It is late in the day. I am going to let you folks respond to each question as it comes in. The answer to the first question is relatively simple because that is history and it's no. There was never a threat in the past. Is this on?

Can you hear me?

In fact, regionalization was very much a grass roots process in Kansas; the way that we organized it. You'll notice that there are two counties that to-date are not part of any regions out of 105. I think it is still a very good markable result, but those two counties maybe one day they will come to the realization that there are some benefits there. No, it was totally a grass roots process. The way it started was with preparedness money. There was a little pot of money set aside for regional incentives and that is how the region started. The association of local departments and the state department told local departments, you can access this money only as a region and the way you form a region is, and go back to the slide I showed you earlier. That was incentive at the beginning to convince 103 out of 105 counties to form regions. Is there going to be a threat in the future?

I don't see any sign of that. I think after about 10 years of experience with that experiment, there is still a lot of work to do. The regions are not fully functional. They work better in a preparedness field because that is where they started and they are still struggling sometimes to expand those boundaries. I don't think there is any interest from either the local or the state authorities to force anything down. If anything perhaps, accreditation will bring a new dimension to the process by forcing the regions to think in terms of standards. Whether you are a regional or local department now, if you want to be accredited, you have a set of standards that you need to meet. What does it mean as a region to meet those standards?

I really don't see any sign that it would be a top-down approach. That would be counter-productive probably at this point. I really appreciate the way you have highlighted the importance of a thoughtful and strategic communications plan as we are advocating and trying to achieve more and more transparency and accountability. We do have different audiences. We do have different reporting requirements that can be quite confusing to us, even more so to the stakeholder groups and the residents we are trying to reach. I am do if you think there is a role from the state level for helping these diverse stakeholder groups and residents understand what could look like incongruent data that is being presented to them in these reports and in these websites. If so, what are you doing to help folks understand this?

I think the communications plan is related to the issue of how we think about hospital community benefits issues connecting to state health improvement goals. That is one thing that people are trying to think through. I think the communications plan about community benefits ought to be about something broader, and I think that is kind of one of the questions that I've been thinking about and looking for help on. How do you think about connections between and also communications about the extent to which you've got state

health improvement goals and what the hospitals are doing through their community benefits is really making a difference on those things?

So I think it is a broader question. Lois, do you want to weigh in on that?

Just to say that we do our best to try to publicize our community benefit program with as I've mentioned sort of press releases or awards programs and so on, and we do have a process where if community groups or individuals want to comment on a particular report, we have a process to do that and we can make that public. Throughout this process, the key to our success I think in Massachusetts is the continuous engagement with stakeholders of all kinds, including the hospitals. We have conducted numerous trainings with our Massachusetts Hospital Association and our Association of Insurers on the HMO side and also with our community partners. We have a great group, Healthcare for All, and other advocates in Massachusetts. We are committed to continuing to do that. I do think forums and letting people know about the community benefit process and that consumers and patients have a voice in their own communities. Great, next. Lois, I have a follow-up to you because I think your reflections on this will be useful to this group. In 2008, when Attorney General Coakley and you and others came in to the office, you made some important changes you noted. One was even though technically it was there before in the guidelines, you emphasized that it wasn't good enough just to file a report at the end of the year. You had to do planning and be explicit about that and then ultimately your report reflects about how well you did or didn't do vis a vie your plan. I know it's earlier on, so I want you if you would to comment on any thoughts about has that change been successful?

The other change you did was to really; again, it was there before, but I think intensified the importance of there really being at the local hospital level community engagement in that planning process and have to describe it in the report. Again, any thoughts or reflections there and what you are hearing or seeing differently as a result of those 2008 changes. Sure. We made the changes in 2008 and the first reporting year was 2010, hospital fiscal year 2010 so those reports were just made public in July. We are hoping that folks can see for themselves. We have noticed that hospitals really did take it very seriously and reported to us who their community partners were, what their leadership teams; that hospitals that hadn't had advisory committees had put them together, that they really did take it seriously and do that. I think we haven't undertaken a full assessment. We do kind of QC review when the reports come in and we follow up if things are missing, but people did identify goals for their programs, which they hadn't done before, reported on status which they hadn't done before and I hope that it will only continue to get better. It is definitely a work in progress and if we see that this really isn't working, we can retool it. Eileen Barsi from Catholic Healthcare West. Dr. Pezzino, I want to applaud the stewardship of your state as you demonstrated to us.

Thank you for that model; and Lois, I am very grateful for hearing about your report. Giving the hospitals the opportunity to share where they are doing other community services that may not show up in the community health needs assessment, we have had a conversation about that in the hallways; about where is the place to talk about the things we are doing to sustain the health of the community that may not show up in a health needs assessment, so I applaud that as well. Then Donna, you talked about accountability and what we might be looking at. I am wondering why we don't look at the AHRQ Prevention Quality Indicators as a place to start?

I would like to suggest that. We have been trying to keep up with what is going on in states. If there are states that have somehow incorporated those measures into their reporting, I don't know about it. Now, perhaps there are. I guess you're saying that would be feasible you think, for a state to take that kind of initiative?

I think that is the kind of thing we will be hearing more about from policymakers. We want to make sure that the things that are being done are the things that matter the most and the things that make the most

difference. Good point. If I can go back to your question about communication and what can we do to help people understand information?

One thing that we are doing at the coalition in Kansas is doing is actually acquiring a centralized system that will act both as a data depository but also as a data display system. And that will be a central system from which you can access information of an individual account so it will be a single portal. It is not just access and information in terms of what are the rates for this or that, but it also very much action-oriented so for each particular county, First of all, there will be a dashboard that will show the top issues that the county has decided are top priorities and then there will be best evidence practices that are immediately linked to those priorities so people not only will have access to the information in their county but will start thinking what can we do as a next step. I think it is a good example of how a state or a coalition -- a statewide coalition can have a role that is of one that is facilitating without mandating or taking more drastic steps. Any other questions?

Coming to you, Cathy. Sure. Just a couple of observations and I think it is sort of part of where do we go from here. As I listen to the variations between Minnesota and Kansas both structurally and in terms of process; and then we think about the IRS, as Larry reminded us this morning 65% of the hospitals in the country are part of a system and most of those systems are not within a state. I think if we step back and say what are we trying to accomplish, we are trying to accomplish accountability, transparency, and we are trying to move the field. Collectively, I think it's really contingent on all of us to come together and say in which cases will more inspection add or confuse those real objectives?

In terms of your opening question about should more states get into this business, I hope not in isolation. I think we need to pull all of this together or we will be fragmenting on the inspection side and may be losing some opportunities to reach our real goals. Great point. I want to echo the comments of my colleagues. I thought the presentations were wonderful. I am going to put on my epidemiologist hat just for a second and inquire whether or not in any of the states that you are aware of or the ones that you work in, it seems to me there is a treasure trove of information here being gathered in these reports. Wouldn't it be nice to know that you could look statewide and decide whether it is speed bumps or cardiovascular disease turned out to be the topic of priority and on and on?

Has anybody thought about maybe coalescing the data and doing some analysis?

How do you do it in Massachusetts?

I think as Kevin pointed out in some states, California as an example, you can look on the web and find some things, but in terms of the analysis there isn't much analysis done. And then connecting that to sort of the health priorities of the state is the extent to which particular community benefits reports are responsive to the health priorities of the states or the health needs in the state. That is the kind of thing we'll be getting into more and trying to look at some comparisons. We right now are just looking at who requires reports but I think the content of those reports is really important and connecting them up in broader ways to health needs. One of the advantages of having our data on-line and searchable by hospital or by program and searchable by population is to aid researchers and other hospitals to say, Oh I've got this disparities program; a problem in my community, how can I address it?

What are other hospitals doing?

What has been successful?

To be able to say, look at the reduction in the smoking rate in this population, I want to do just that in my community; and really try to leverage that information. We do want this to be a public health resource of

what are the programs that are working and how. We don't do that at the AG's office, but we do make that information available and we hope that others will use it to their benefit. Great. Good thoughts. Please join me in thanking our panel.