Panel 13: Reporting and Compliance

While they are being seated, I'll introduce my panel. First, you have heard her referenced a number of times since the theme of public health accreditation has been something we've talked about throughout the meeting; is Kaye Bender, who is the Present and CEO of the Public Health Accreditation Board. Second, is Gerald Griffith, who is a partner with Jones Day; and as he'll explain to you has a high level of expertise and engagement with hospitals and other stakeholders on this issue. Last but certainly not least Claudia Lennhoff, a longtime friend and colleague who is the Executive Director for the Champaign County Health Care Consumers. The key issue we're talking about here is the relationship between higher level oversight and expectations, and how that plays out at the local and regional level. We have talked about state level oversight and we have talked about federal level oversight and that interplay, but what we haven't talked about as much although it has been an underlying theme as we've talked about accountability; is what are the implications of that and what are the opportunities for engagement and oversight and the kind of transparency we are talking about at the local and regional level?

With that, I'll ask Kaye who has just sat down to come right back over here to the podium.

Thank you.

Thanks, Kevin. Gene Matthews talked about how difficult it was to be between you and lunch and three of us are between you and whatever you're doing next ,so we'll try to make it worth your while. I never thought I would thank the IRS for much of anything and I'm sure you hear that all the time, but what a wonderful three days; what a wonderful window of opportunity to have this discussion and the Public Health Accreditation Board is pleased to certainly be here and be a part of that. I am a nurse. I worked for a period of time as Vice President for Nursing on the health system side. Those of you who are on that side of this dialogue probably are sitting there for this last three days as you've heard allusions to public health accreditation with some degree of excitement. You are probably sitting there thinking, they have lost their minds. Because accreditation to you, if you have been Joint Commission accredited is routine, I would imagine, a little bit of a pain in the foot, or whatever and that sort of thing. But for us, it is a new and a transformational moment that has been about 15 years at least in the making.

So, if we sound a little bit delusional it's because we haven't walked quite as many years through this as you have. Kevin asked me to talk about our national approach to Public Health Department Accreditation, the role of local officials, advocacy groups, and the general public; and then how we move from compliance to transformation. We are using the same definition of accreditation in public health as you are used to in the Joint Commission and other accrediting bodies in that we have a set of nationally-recognized practice focused and to the extent possible evidence-based standards. We spent the last four years actually developing those and then alpha and beta testing those in the field. We just finished that process with a formal evaluation; and of course, the usual recognition of achievement once the Health Department has reached those and then the continual and ongoing development and revision. And again, the result of many years of work. Nobody would select this year with the economy as it is and with government as fragmented as it can be to rollout accreditation, especially with fees attached. We have done that because that is where we are with the development of the program. We are a non-profit organization. We are based in Alexandria, Virginia. Our goal is to administratively handle the Public Health Department Accreditation Program, but not as the end of itself but a means to the end of advancing and improving the quality and performance of state, local, tribal and territorial health departments in this country. Our development has been funded by the Centers for Disease Control and Robert Wood Johnson Foundation.

We are about to launch the program. Just this last week we have published the Guide to Accreditation. This has the process in it; and in September, as you've already heard alluded to, we will officially say we're open for business to accept applications. The Public Health Department Accreditation is voluntary and so health departments need to be both prepared and incentivized to walk along this path. We certainly think that this kind of dialogue in the discussions will help do that, and I will hopefully cover that shortly. As is typical of

most accreditation programs, we have steps in the series. If you look through these and I won't read them to you, they're pretty typical of any accreditation program. We have systematically studied Joint Commission, Academic Accreditation, K-12 Accreditation, and most of them have a self-study phase and a team of reviewers, of peers who review on a site visit with result and report. Our accreditation cycle will be a five year cycle with annual reporting in between, and that annual reporting will be based on what was deemed to be something that even though a credit to the health department needs to continue to work on; and therefore, keep that quality improvement aspect alive and well. I think we've all probably walked through those steps of preparing for accreditation, going through the process, being very glad when the team left, getting our report, putting the book on the shelf or on the share drive or wherever it goes, and not looking at it again until time to do the next self-study.

That is exactly what the Public Health Accreditation Board is trying not to do; that is the living breathing process that really advances quality and performance improvement. There is no doubt that health departments -- two student medicine studies, 1988 and 2003, describe health departments as being fragmented and in disarray; and some of that has been noted here -- the lack of funding and the lack of standardization and uniformity. Some health departments have excelled in spite of that. But what the accreditation movement is designed to do is to lend some standardization and uniformity while respecting the local community flavor that makes public health what it is. This is what you have heard about for the last three days from other speakers. We are basing following some of our colleagues who have been at this business in states like Illinois, you heard from Elissa Bassler, North Carolina, Michigan, Missouri; states like that. We followed their recommendations in that with the application for accreditation, the Health Department has to send to us a Community Health Assessment, Community Health Improvement Plan and a Health Department Strategic Plan. Our definition of community health assessment talks about a collaborative process for collecting and analyzing data for use in mobilizing the community, developing priorities, garnering resources and planning action to improve the population's health. The Health Department; and I'll show you this standard in a minute; can either participate or lead it. They get credit either way. The point is that it addressed the jurisdiction that the Health Department's responsible for as a whole. Then from that the Community Health Improvement Plan emerges and then as Gianfranco adequately talked about, we're looking at what the Health Department's role in that is. These prerequisites need to have been done within the previous five years before submitting the application, not five years before.

So, the three year time frame that the IRS is looking at would set very well. If Illinois wants to do it annually, that is fine with us too. It just has to be updated and looked at within that five years. The way that the team of site reviewers will look at the quality of those prerequisites then occurs in our standards and measures. We have 12 domains with standards and measures and the required documentation under each of those. As has already been adequately stated, so I won't belabor; the first 10 of these fit the public health ten essential services framework. 11 and 12 are designed to get at administration and management and then the relationship with whomever the governing entity is, whether that is Board of Health, the Governor's Office, the Mayor's Office, the City Council, the Board of Commissioners or whomever. There are measures under each of these. I'm only going to talk about the measures though that relate to the prerequisites because that is the nature of the conversation today, and you would be here all night if I talked about all twelve of them. The first domain talks about the dissemination of assessments focused on population health status. You can see that the first standard talks about participating or conducting a collaborative process resulting in community health assessment.

We are looking for comprehensive population focus. We are not prescriptive about the model that the Health Department or its community chooses to use. Rather, the Health Department gets credit if you will for the participatory or collaborative nature of it. Again, in the spirit of QI, it needs to work for that community. We were well advised, I think , that if we decided that there was a particular fill in the blank kind of model to this, it flies in the face of everything that we know about working with the community. I am really anxious

to hear my fellow panelists from the consumer standpoint talk about that. It would thrill us greatly to see a community health assessment and improvement plan actually be community driven, but we know that communities vary in their resources and their capabilities at this juncture to do that. That is the direction that the Public Health Accreditation Board would like. That would be transformational, Kevin, we do believe. We also believe in this particular case that for a community that is just coming together and has not yet as one of our other speakers I believe yesterday talked about; if they are just now exchanging business cards, then why not start with the data that are available. It is perfectly great to gravitate and I applaud the speakers that talked about collecting primary data.

What the Public Health Accreditation Board will be interested in is that they start somewhere and that they come to some kind of collaborative arrangement where those priorities are set and owned by the community. Domain five is the place where the criteria for reviewing the Community Health Improvement Plan and the Health Department Organizational Strategic Plan comes into play; and again, we're looking here in the improvement plan for a long term, systematic process to address issues that were identified in the community health assessment. Again, the more community driven it is, the happier that we are about it. I might also say here that while I am not discussing other domains, the Health Departments also get credit in two of the other domains for collaboration particularly with health systems. The one is in a domain that speaks specifically about developing partnerships and coalitions, there is a measure in there that speaks specifically to those partnerships and coalitions within other stakeholders and other providers of health related services, i.e. Health Systems. There is a place where it speaks specifically about the inclusion of the consumer. We specifically also in that case, call for customer satisfaction surveys and results of those, much like Joint Commission has asked Health Systems to do in the past. There is also a domain that speaks about the Health Department's knowledge of and participation in the analysis of the healthcare access issues in their jurisdiction, and participates in driving priorities and solutions toward addressing the access. Again, not that the health department owns that, but they're at least at the table and are serving as the convener in many cases or maybe the provider of information and certainly the provider of population focused information. Kevin knows this.

One of my coworkers in looking at the title of this panel reacted to the fact that compliance was in the title. Those kinds of things don't bother me at all. I'm just happy to be invited to the party. It is a good point that we have deliberately developed our approach to accreditation of health departments to not be compliance-oriented. Having said that, there is a certain amount of obvious review and passing of some judgment about the Health Department's performance; and their own self-rating in the self-study component of Public Health Department accreditation. But we are trying for this again to be sort of somewhere between Joint Commission and Baldridge. And we use that analogy a lot; that we are driving toward the quality improvement side holding the health departments accountable for that; as opposed to crossing the t and dotting the i in a regulatory sort of way. Therefore, we have built in a lot of flexibility for public health departments who operate in a variety of political, geopolitical and other kinds of environments to be able to accomplish what they need to under the rubric of the 10 essential public health services. I would like to use the remaining couple of minutes to dispel a couple of rumors that have sort of come up during the last three days. That is, we don't have levels of accreditation. Our Standards Development Work Group, which was composed of public health practitioners and academicians from all over the country decided that we'll have one set of Public Health Department Accreditation Standards and Measures, and as Gene Matthews and Gianfranco and others and Elissa have talked about, it may take small health department jurisdictions sharing services across geopolitical lines in order to qualify or to be able to demonstrate conformity with accreditation standards.

We aren't using the consolidation or the ritualization words because those are certainly up to local jurisdictions to decide. But we certainly think in this day and time that sharing services is not a bad idea, particularly when it might not make a lot of long-term sense to develop robust capacity. We don't have levels of accreditation. We have one set of standards and measures. We do, however, hold the State Health

Department a little bit more accountable for something that has been alluded to, but I haven't heard the State Health Department mentioned a lot in the last three days; and that is if a local health department, as has been stated, doesn't have the capacity or isn't in that organizational framework for public healthy appropriate place for the data to reside or the analysis of data expertise to reside, then we hold the State Health Department accountable for providing that kind of technical assistance. I worked in a state where that was the case and I realize that is not ideal, but from the public health accreditation standpoint, it is certainly better than nothing. For those of you who are looking at community assessments in small areas where there might not be that expertise at the local health department, understand that the Public Health Accreditation Board will be holding the State Health Department accountable for reaching out to those local and to the tribal health department.

This is my last comment. We also are not focusing just on needs, although we very much understand to develop service lines in hospitals and that sort of thing, that may be very appropriate; but it is a comprehensive health of the population, health status of the population, which includes both needs and assets that the Public Health Accreditation Board will be looking for. I thank you for your attention this afternoon and look forward to your questions. Good afternoon, everyone. My name is Gerry Griffith and I am a partner at the Jones Day Law Firm in Chicago. I am also President of the American Health Lawyers Association, the largest professional association of health lawyers with over 10,000 members. I am speaking today to you, however, in my individual capacity and not on behalf of AHLA. Before we get into the four questions, I would like to thank our friends at CDC and the Public Health Institute for inviting me to be on the panel. I am a tax and business lawyer by training rather than a public health expert, so my viewpoint and my perspective on community health needs assessments or CHNAs is a little different. As you heard, a week ago today the IRS released Notice 2011-52 outlining the provisions that the service expects to include in proposed regulations related to the CHNA process. After I read the notice, the length of my slide deck more than doubled, maybe close to tripled so most of those slides are for your reference. Kevin mentioned that the materials will be available hopefully within a week if anyone would like a copy of the deck before then, please give me your business card or send me an email at ggriffith@jonesday.com and I would be happy to send you a copy.

Again, that is ggriffith@jonesday.com. I want to keep the focus for the most part on the four questions that Kevin outlined shown here on slide two, with two exceptions. First, I want to say a few words about the notice and a couple of surprises that were buried in there. Second, I want to outline briefly a four-part framework for how I see the CHNA process playing out. Slides 3 through 17 summarize the provisions of the notice. The IRS is allowing comments until September 23rd. Since these are not yet even proposed regulations, there will be at least one more comment opportunity when the proposed regulations come out so there should be plenty of chance to point out any areas where the rules could be improved. Given the lead time that some hospitals need to complete their first 51R compliant CHNA, the IRA is allowing hospitals to rely on this version of the proposed rules until at least six months after further guidance is issued. Although that is helpful, hospitals really have to both complete the CHNA and as we heard adopt an implementation strategy before that six month period ends under the notice or they may have to restart the entire process or at least the implementation strategy under new guidance. The requirement that the implementation strategy must be adopted in the same year that the CHNA is conducted is one of the aspects that was unexpected in the notice, and one that I think is different from what the statute contemplates.

If you look at the Affordable Care Act, it requires that the 51R provisions become effective for the first tax year, and you have to listen to tax lawyer speak here, the first tax year starting two years after the enactment of the law, it was enacted March 23, 2010; so that is the first tax year starting after March 23, 2012. When you look at 51R(3) itself, which outlines the CHNA requirements, Congress was specific about when the CHNA must be conducted. It has to be done once every three years. The paragraph requiring an implementation strategy however has no date restriction. It is simply not addressed. To its credit, the IRS did recognize some transition relief maybe necessary at least in the first cycle, but if that is the only change

every year, several hospitals could get caught in a serious deadline problem by not starting the CHNA early enough in the year, particularly as we heard if they are doing a collaborative assessment with hospitals that have different fiscal years. The other timing issue to note is that the first tax year starting after March 23, 2012 is not the end of the first year period for doing your first CHNA, it is the end of that period.

So, that means for calendar year taxpayers, by December 23, 2013, they have to have their first CHNA done and under the notice, first implementation strategy. For a June 30 taxpayer, it would be June 30, 2013. That is when we can expect the optional tag to come off of the CHNA questions on Schedule H and for the IRS to require answers. Another aspect of the notice that may have been unexpected by some but harder to quibble with, is that the IRS believes 51R applies to non-profits that operate hospitals indirectly through LLCs or partnerships, though they will entertain suggestions for a small interest exception. 51R and the CHNA requirement also applies to dual status governmental hospitals, that is governmental hospitals that also applied for and received 501(c)(3) status. Of course it remains unclear how the IRS will plan to audit government hospitals' compliance since they are not required to file a 990. Now I want to move on to the four-part framework I mentioned.

So, we are going to skip ahead here for those of you following at home to slide 18, which is in the re-numbering 165 in the materials. This is what I call the four phases of CHNAs on this slide and the next four slides: design, conducting the assessment, developing an implementation strategy and implementation and reporting. CHNAs are really, in my view, a cyclical iterative and evolving process. The CHNA also needs to be part of a flexible process so that hospitals can adapt the process to their particular circumstances, their resources, and their areas of expertise. Getting the process right is certainly important for compliance purposes including giving hospitals enough guidance so they know what needs to be done to comply with 51R and equivalent state requirements. As we have heard from prior panels, though, it is also important from a broader public policy perspective in that it can provide an opportunity to improve the health of the community, thereby containing rising healthcare costs and it also dovetails with the move by public and private payers toward quality-based payments for healthcare. With that, and about halfway through the deck already, I want to turn to the four questions that Kevin posed.

The first question involves issues relating to hospital reporting requirements. The aspect of reporting is at the forefront of most peoples' minds when thinking about CHNAs is Schedule H to the Form 990 filed by non-profit 501(c)(3) hospitals, other than governmental. The CHNA questions summarized on these next two slides are optional as I said for 2010 tax year, and the questions may be changing in the future to more closely mirror the CHNA guidance; for example, to say more about the implementation strategy and requiring it to be attached to the 990. There is a fair amount of variation in the state reporting requirements, from whether reporting is required at all to what must be reported when and to whom. These variations are summarized on slide 25 in my original deck, number 172 in these materials. If you are interested in more detail about state reporting requirements in the community benefits space, there is a book out there from Aspen that you maybe interested in called Charity Care for Non-Profit Hospitals that I wrote with my partner Jim King and Professor John Columbo from the University of Illinois. For our immediate purposes though, I want to focus on some of the key challenges that these reporting requirements, particularly for Schedule H, pose for hospitals. First, is the difficulty that hospitals often face in distinguishing bad debt from charity care. Bad debt used to be more significant for Medicare reimbursement purposes when hospitals were paid on a reasonable costs basis.

The shift to Prospective Payment Systems or PPS changed the stakes for bad debt, even to the extent that bad debt was or is reimbursed from a purely financial perspective. Charity care arguably was relevant only to the extent of getting to a proper bad debt number. That too began to change after the wave of uninsured class actions in the summer of 2004 with legislation in Illinois and other states to mandate greater transparency in charity care policies and billing practices; and similar attempts on the federal level that eventually found their way into Section 51R. Now it is in hospitals' interest to make sure that they capture all

of their costs associated with charity care and other community benefit, including identifying as many patients as possible who qualify for charity care under the hospital's policies. We have also seen an evolution in the infrastructure and tools available to hospitals to track community benefit activities. Many healthcare systems today, for example, have a community benefit department, something that was largely unheard of in 2004. Many hospitals, whether or not they are members, have also adopted some form of the CHA VHA Guidelines for Identifying, Tracking and Reporting Community Benefit Activities. In 2008, the IRS of course added its own version of these standards in Schedule H. Even with these changes, hospitals still have to struggle with getting the right inputs. If patients do not provide financial information or do not apply for charity care, there is a risk that cases, which could qualify for free or discounted care, will end up instead in the collection process or treated as bad debt.

So, how can hospitals determine who maybe eligible for financial assistance under their policies without those inputs?

Some hospitals have attempted to address this challenge by using software designed to predict the probability of eligibility by looking at the known facts, such as patient's zip code, history of Medicaid eligibility and other facts. Taking that step also may have an economic benefit in avoiding some costs associated with processing accounts for collection where payment may be highly unlikely, and in assisting patients in applying for Medicaid coverage if they are eligible. The other part of the input that can be difficult to obtain is an accurate breakdown of all of the direct and indirect costs associated with the hospital's financial assistance program. Historically, the tracking mechanisms for those costs were not very robust, but now I believe hospitals are getting a better grasp on those costs. There are also some significant challenges in the reporting process itself, including for systems reconciling what it means to provide a community benefit on a coordinated basis among related entities with the requirement to report various components on Schedule H on a single hospital or entity basis; leaving out many beneficial non-hospital activities as we heard from an earlier panelist. The duplicative reporting requirements between Schedule H and various state reporting also can put a strain on hospital tax departments and accountants. If hospitals with state reporting requirements for example could file a simplified version of Schedule H, a Schedule H-EZ if you will, or if states as Massachusetts for some purposes would accept Schedule H numbers in lieu of a separate state filing, that should help to ease the burden on hospitals. I want to turn now to the accreditation standards for local public health agencies that Kaye addressed.

This slide outlines some challenges that I believe these agencies face in becoming or remaining active players in the CHNA process. First, local public health agencies are only one possible source of public health input for 51R purposes. Hospitals have options. If they are going to partner with local public health agencies in these efforts, they will need to be persuaded that the partnership will add value to the CHNA process for the hospital, that it will make the hospital's administrative burden or costs lower and not higher. The hospitals will also be looking at the speed and agility with which local public health agencies can respond to their data needs and how useable the data is, including whether it can be sliced and diced along the lines of how the hospital defines its community. Going beyond what is required for 51R compliance, if local public health agencies can meet this challenge, there can be benefits to all stakeholders, from having folks with a broad community perspective contributing to the CHNA process if that input allows hospitals to streamline the process and to tailor it more to their circumstances. Not just data from their community, but data that is relevant to the hospital's strengths, such as need data related to centers of excellence or key specialties at the hospital.

he third question covered in these next four slides concerns the roles of various community stakeholders in the CHNA process, including local officials, advocacy groups and the general public. I'm going to take these slides slightly out of order. First, I want to start with this slide actually. We see that Section 51R(3) requires that non-profit hospitals seek input from people representing broad interests of the community served by the hospital facility, including people with special knowledge or expertise in public health. The statute does not

specify who has to provide this input. Congress did not mandate that hospitals consult with particular sources to get the community and public health input. The IRS however in Notice 2011-52 has said that it intends to require hospitals to seek input from at least three categories of people; first, those with special knowledge or expertise in public health. The notice did not define who qualifies here, but the IRS did ask for comments on appropriate qualifications. Second, we have federal, tribal, regional, state or local agencies so hospitals have a choice as to which agencies to consult. They don't have to go to all of them, though I suspect the IRS would be skeptical if hospitals consult agencies that do not have much relevant data or if there are other agencies known to the hospital that would have more useful data and insights. I think it is incumbent on the agencies to educate hospitals as to their capabilities in terms of providing input for the CHNA process.

Third, hospitals must seek input from leaders, representatives or members of medically underserved, low-income or minority populations or people with chronic disease. Hospitals can go beyond these categories and get input from consumer advocacy groups, from private employers in the area and others. In fact, hospitals may be reaching out to many stakeholders already in market surveys for strategic planning. The public input also needs to come from people in the relevant space, i.e. the community served by the hospital. Before a hospital can conduct its community outreach, it must define the parameters of the community. The notice takes a flexible approach to that definition, but also expresses an expectation that it will be primarily geographic, which is often based on zip codes for planning purposes, for discharges, ER visits, and outpatient visits. The IRS also recognized that in some cases the definition may take into account targeted populations served and the particular hospital's principal functions. In practice though the range of variables that go in to defining communities served is even broader and some of them are listed here on this slide. Ultimately, the definition of communities served needs to be flexible to accommodate the differing circumstances at each hospital. The IRS however did state in the notice that community cannot be defined in a way that circumvents the requirement for conducting a CHNA of and consulting with persons who represent the broad interests of the community served by the hospital. That principle sounds reasonable, but it does have its limits. It would not make sense, for example, to force a cancer hospital to address needs related to other diseases in its CHNA, or to require a critical access hospital to include areas outside of its geographic service area.

Once the hospital has determined which stakeholders it will approach for input, the next question is what form the contact will take. The statute in the notice do not define what constitutes input. Websters defines it as advice, opinion, and comment. In the context of 51R though, it seems to include data inputs; so the question is how to go about getting the input. Examples provided in the notice include using focus groups, meetings, interviews, surveys and correspondence. For the data elements though, there are also online databases that we have heard about. No one wants the CHNA process to consume so much in resources that little is left for implementation, so use of existing data sets would be helpful in that regard. Here on this slide, we have a list of some of the on-line sources available to hospitals. No one site is necessarily best for all. Some of the associations like CHA and AHA have devoted substantial time, resources, and efforts to helping the hospital community in this regard; but each hospital will have to judge for itself what sources are the most useful as they come to grips with some of these key challenges outlined here for the Community Health Needs Assessment process. Public health agencies may also have input and experience to help with some of these key decision points outlined on slide 179 from the combined materials. Finally, we have what Kevin labeled as going from compliance to transformation. What does that mean?

Well from a broader policy perspective, it means looking at opportunities for improving community health through a more cost-effective collaborative approach, to assessing and implementing strategies to address community health needs. From my viewpoint as a business and tax lawyer, it means identifying first of all what must be done to meet 51R(3) requirements, given that non-compliance can result in a $50,000 per facility, per year excise tax and potentially jeopardize exempt status. The baseline for 51R(3) compliance is that the hospital must conduct a CHNA once every three years, including input from the community as

defined by the hospital and from public health experts and make the CHNA widely available. The first CHNA has to be done no later than the end of the first tax year, starting after March 23, 2012; and an implementation strategy must be adopted and the required disclosures made on Form 990. To accomplish these tasks, most hospitals will also need to prioritize which needs to address, which includes considering not just the absolute degree of need but also the hospital's resources, areas of expertise and services available elsewhere in the community. That's it.

Going beyond the compliance baseline, getting to the transformational part is what is outlined in the remaining slides. There are potential benefits to going above and beyond the baseline, including containing costs of care, having a healthier workforce, positioning the hospital to earn quality incentive payments from payers, and providing stronger support for community benefit missions if challenged by the IRS or Congress. Whether or not most hospitals go the extra mile will likely depend in part on whether they are persuaded that these potential benefits are realistic and what roadblocks, legal or practical, stand in their way. There seems to be a strong sentiment for collaboration on the assessment and implementation phases. However, there are also challenges including potential anti-trust risks as outlined in the last couple of slides in my deck. These concerns may include sharing competitively sensitive information or allocating service lines for geographic areas among competitors, particularly outside of a fully integrated system of related entities, there may be significant questions about what joint activities are permissible. To that end, hospitals will need to work with anti-trust legal counsel to identify the parameters of what is acceptable and ways perhaps to break through the roadblocks, such as with cooperation of states or potentially favorable guidance from federal anti-trust regulators. With that cheery though, I would like to turn the podium over to the next panelist.

Thank you. Good afternoon. My name is Claudia Lennhoff and I'm the Director of the Champaign County Health Care Consumers in Champaign, Illinois and I wanted to thank Kevin for inviting me to present; and specifically for inviting me to be the very last panelist of this entire conference. I want you to know I'm not stressed at all or anxious. What I want to do is present a perspective from a grass roots organization that has a long history of working with hospitals and health departments and so on in our community. In particular, I know as we look at transforming to real collaboration, towards real health improvement, I want to share with you that I am coming from the perspective of an organization that has actually had unfortunately some very adversarial relationships; not just no relationships but adversarial relationships with different healthcare providers and we've actually had real transformative experiences. That is how I will be talking about things. Just real quick, we were founded in 1977 so we've been around for a long time and my job is to give consumers a voice in the healthcare system, so I am always working to make sure that people in our community especially the people who are most effected by the healthcare problems get to have a voice in the system and in making the changes that are needed. I am going to review some principles that I think about in relation to what we are talking about here today then briefly talk about why the community really must be engaged, some tools for community members, and then really focusing on this process of moving from mere compliance into transformation, and real transformation of course for the purpose of improving community health. That is really what we are talking about. The first principal that I just wanted to share from a consumer perspective is that all healthcare is local. We get our healthcare some place so it is very local, it is very personal to us.

That is one of the things to keep in mind. Also, all of us have a stake in improving our community's health whether it is the people who are affected or even hospitals as employers of future employees who may be coming from that very same community. You want people to be healthy. You want children to be healthy so that they can go to school and be prepared to learn and have good experiences and be great employees in the future. This is sort of a no-brainer, but we always want to observe the principal of do no harm. One of the reasons that I wanted to bring this up is because a lot of our work started initially focusing on medical debt and financial assistance or the lack thereof. Our community is sort of famous for our hospitals were featured in a Wall Street Journal article back in 2003 that showed that low income consumers were being

incarcerated as a result of medical debt owed to our local non-profit hospitals. When we tried to talk to the hospitals about their debt collection practices, one of the principles that we approached them with is that as an institution you are dedicated to improving health, all of your policies and practices including debt collection need to number one, do no harm; and sort of start with that. Certainly when people are being incarcerated over medical debt or being sued when they can't pay and not getting financial assistance, it is harming them.

It's harming their credit. It's harming their health and so on. They are also not likely then to seek care when they need it and we all pay the price for that. Another principle that I wanted to talk about is there are legitimate limits to what the law can do, so we're talking about regulations and law, but we really need to move beyond that for real. The law is not going to improve the community's health. It is a tool for us to use to get there, and then that local accountability. When I'm talking about accountability today, I'm focusing on local accountability. Local accountability cannot thoroughly be codified in federal regulations. However, federal and state regulations can provide an important framework and starting point for real accountability. It gives community members resources and tools and a way of understanding what is supposed to be happening. Many people have mentioned this, but accountability is not a one-way street. We are all accountable. One of the things to consider, I know we're talking about hospital accountability or health provider accountability, but one of the things to consider when working with community groups, is that community groups are accountable. I work for a 501(c)(3) that operates at the will of the community. If I am screwing up, if we're doing the wrong things, we are going to lose our funding and we won't be there.

So, I am also accountable as a member of our organization. Also, we feel that government agencies and public sources should provide the information and tools necessary for local communities to engage in health improvement activities and I really commend Massachusetts for doing a great job to make those kinds of tools available to the local communities, and Illinois has some very positive things going as well. Community benefits should be driven from the ground up. If community benefits are real health improvement activities and they should be driven from the ground up. One example in my experience is one of our hospitals had this mall walker program to address supposedly cardiovascular health. They might be watching this I don't know, but anyway they had a mall walker program, and there were some real other things that could have been done with the tens of thousands of dollars that went into this program and it was essentially a PR program. If the community had been told we have X of tens or thousands of dollars to put towards cardiovascular health, how would you like to use it, I can assure you we would not have come up with a mall walker program. I also really wanted to emphasize that financial assistance programs are fundamental to community benefits and ignoring that should not be -- community benefits should not come at the cost of ignoring financial assistance. If people are being harmed by the lack of financial assistance and aggressive debt collection practices, it is very hard to get the community to work on community benefits. We have talked a lot about why the community must be engaged.

You can look at this later but I'll leave it there. One thing I wanted to say is that we're also great partners in doing shared advocacy to the state and federal governments. Here are some tools for the local community. I won't belabor these points right now, but people can look at the slides if they want. One thing I did want to point out in our community is courthouse data on lawsuits so we can see if hospitals are suing poor people and so on. Some of the things that are required; good faith, respect, patience, ground rules, transparency every step along the way. Several people have talked about that, but every step along the way; and of course, accountability. I wanted to very quickly just say that sometimes there are challenges, the community challenges healthcare and public health providers. And I wanted to say while these are unpleasant, they usually happen for a principled reason. In our situation it happened because when we tried to reach out to talk to the healthcare providers to let them know something is going wrong, people are being harmed, they wouldn't talk to us and so we had to escalate things; but it started for a principled reason. Also just to say that as a member of a community organization, we would rather make improvements and win than fight. My job is partially to make real improvements in people's lives. Very quickly, I just wanted to take you through

a quick presentation that I did with a hospital executive where we had started out; I'm just going to whip through this very quickly; with an adversarial relationship and then it transformed.

This was a few years back and it was with Provena Covenant Medical Center who was the subject of the Illinois Supreme Court Property Tax case and they lost their property tax case. We had a lot of struggles, so you see there was a lot of media, a lot of talk about being unable to talk to each other. The hospital cut off the talks that we already were not having, actually. Then they actually took out a full page ad in our local newspaper sort of slamming us and then that backfired on them because we are a trusted community organization so that was poor strategy. The damage was done in terms of hospital property tax exemption and so on. Then we started working together to transform this. A new CEO came on, we established dialogue, and we started together on projects of mutual interest. One thing I wanted to say is when people start working together; just working together, and it could be on a small project; it can be on where do we put the notices that financial assistance is available -- that process itself can be very transformative and trust can be built and so on. You see this ad. They said, You spoke and we listened; not for several years, but this past year you spoke and we listened. And then you can see here is one of our community members who was quoted in an ad that the hospital took out so that is sort of good press for the hospital and we are happy to do that. Then the hospital lost its tax exempt status, but I had a quote in the paper saying that they had transformed and become really a model for the way hospitals should treat the uninsured. You can't buy press like that really.

Then the editor of the News Gazette said, Hooray, you all should be working together. That is great. Then we put together this list of lessons learned; that we are not natural adversaries, our interests are generally aligned; and also very important -- community organizations really value non-profit hospitals in our community. We value them precisely because of the ethic of giving back to the community and working with the community, but sometimes we've had to push our hospitals to do that. Hospital ownership may change but the community's sense of ownership of that hospital does not change. It takes time, people have said that; and it is important to give credit and recognize efforts. There is a Buddhist saying that says, One candle can light a thousand candles without diminishing its own light; and we believe that as well. Lastly, I just want to conclude by saying that it really is important to celebrate successes and victories along the way, even the small ones. It helps people feel good and gets you moving on to the next thing. With that, I am out of time.

Thank you very much. I told you we were going to take you out with a bang. Great panel, great set of issues raised. Gerry, I didn't think there was anyway you could do this, but thank you for taking your charge seriously and for all of the information. I need to get my hand on those slides right away.

Thank you. I do have just a note, Gerry, on your point around as hospitals define their service area, I think what you've and, again thank you for being here for the duration, you've proved there has been a lot of talk about ways in which we define community and the importance of that being a dialogue in the exploration. I'm interested in your reflections on particularly what we've heard acknowledging that hospitals have their own business responsibilities, but do you believe that hospitals can and should arrive at a shared definition with their partners and local communities?

I think overall it's in hospital's interest to avoid the friction of a disputed definition where possible there are going to be some that they may conclude, some requests that just don't make sense and don't fit what they can do that may be due to a misunderstanding, a failure to communicate adequately what the hospitals' capabilities are, what it's focus is, all the good that it is doing, if people are focusing too much on the negative, they may miss the good; and they may not understand that the hospital is addressing community need, it may just not be the one that the particular group is interested in.

So, that's sort of a general principle. Two specific things that I've heard over the course of these three days that resonated were one, one of the panelists, I believe the lady from HRSA pointed out that the zip code approach, if you're using that you may get a different result if you are looking at ER visits as compared to inpatient visits. I focused on inpatient versus outpatient before, but I think that's a legitimate observation about ER's that that is a different -- potentially a different definition of community if you're a trauma center than if you don't have an ER, or if it's a lower level trauma center. The other point that resonated is, and I don't have an answer for it, but it would be interesting what the folks here think or those following along at home, that is the concept of what I would call an orphaned population. A population whether it's geographic, whether it's based on some demographic that doesn't fit in any hospital's community, that's a problem. Everybody needs to fit in some community and I don't have a good answer for that because there may be some populations that are really outside of what any hospital within the vicinity feels they can do, but something needs to be done to address that. Maybe it's more FQHCs, maybe it's a new critical access hospital or rural health clinics, but somewhere it needs to fit and the FQHCs; and rural health clinics not being hospitals are not subject to 501R(3), so actually that may the answer for some of them there, they may be orphaned in terms of a hospital despite geographic distance, but their healthcare needs can be met through other ways.

And one of the benefits of a collaborative approach would be perhaps more easily identifying what those other resources are. I would just note something that hasn't been referenced previously, New Hampshire's committee to benefit law applies to all healthcare charitable trusts, so it applies to FQHCs and visiting nursing associations and long term care associations. One of the things we've seen there as a result is there has been significant increase in collaboration between hospitals and FQHCs. We are also seen as a function of ACA as well as additional funding from HRSA for FQHCs. A lot of hospitals are beginning to look outward and see how they engage those. I would just also note, I referenced one hospital in particular in California, the Hope Memorial Hospital Presbyterian, which is located in a more affluent community but focuses primarily outside of its immediate service area. And it's community benefit is an example of ways in which hospitals by region and/or specialty may in acknowledgement; and in fact, anticipating their role in fulfilling their charitable obligations as being a way in which they can effectively fulfill that. Another example of more close to the Bay area is the Lucile Packard Children's Hospital, which is a regional Children's Hospital and the specialty focus; and as a children's hospital tends to have a tertiary and quadrinary focus of specialty care. But they put a significant focus of their community benefits towards an array of primary care and preventative services in the nearby community of East Palo Alto, a very impacted community. None of those, very few of those folks would have come into their emergency room, but they basically concluded that in order for us to really effectively address concentrated unmet needs in our communities this is where we need to focus.

So, again, this is a part of how we emphasize those ways in which hospitals go beyond and say we have compliance is one thing but out roles and ways in which we move to transformation is something else again. One more quick question to Kaye, I'm wondering, a little bit of a provocative question; but are there any circumstances under which a local public health agency were to seek their accreditation where there are one or more hospitals in their area now given this requirement for community health needs assessments and the development of implementation strategies?

And in submitting their information did not acknowledge or did not factor in the role of that institution, would they be required to take that into consideration?

Absolutely, as I said earlier, the role that public health departments have with hospitals and health systems is we think strongly stretched throughout this first version of the standards and measures, that is not to the exclusion of -- as has been pointed out, there are other public health organizations in the community. And we look to the Health Department to reach out to those as well but especially too given this environment. We think there is mutual benefit. I might just sort of add to something that you asked about the hospitals.

Here's a place where, as I think one of the other speakers mentioned, that the hospital in covering a broader area than the county, let's just say Health Department might cover, certainly might reach out to more than one health department. And we would also look on the other side that the health departments had participated in that as well. But you know, at the end of the day here's the transformational piece for me, and then I'll go beyond what you asked. It is good to think about what's in this for the hospital health systems side and what's in it for the Health Department; at the end of the day as a consumer in my community in which I live, I think of nothing better than that I saw all of these very important players along with the advocacy groups coming together to look at what's good for this community; and I just -- to be a little provocative back, see a real difference in a community health assessment needs based or not, and a product line marketing strategy. They are related, but I believe they are different. Absolutely, absolutely. Quick question for you Claudia, we're talking in this concept of transformation about continuous quality improvement, I'm guessing your work is not done, and I'm interested if you can share with us perhaps an example of how there is more work to be done both with local hospitals and with your local public health agency?

Our work is not done. I have an example just from last week actually. While we've progressed a lot with our hospitals in terms of debt collection and financial assistance and one of our hospitals had asked me and several other community members to participate in a Community Health Needs Assessment process that they were doing and they have reporting requirements for that. They shared with us some preliminary results, and I was at a meeting with the hospital and I asked the person sort of in charge of the community benefits work; I said, Can you just talk a little bit about what's going to happen in terms of prioritizing, what's going to be your process, will you reach out to us to help with that process and so on?

Her response was like, oh no we'll just do it ourselves and we'll just do it internally. I said, Well, we would really be willing to help and would like to help with that. And, no, no. I said, well how will you be prioritizing then, what are your criteria?

Basically it was all about alignment with internal priorities for the hospital.

So, we do have a long ways to go. In terms of our health department, actually we have a similar situation where our health department does the IPLAN; always brings together all the usual suspects to participate in that and then shows us what the results are, and then we don't hear about it again and we're not part of it again. People have talked about silos and that is happening.

So, we really want to try to move beyond the compliance into the actual how you use those tools to work for community health improvement. Great. Let's get some questions, comments. Hi, Melissa Beal. This question is for Mr. Griffith. I wanted to know if you would feel comfortable commenting on the IRS notice that came out, specifically on the implementation strategy?

The notice asked that the implementation strategy address each of the community health needs identified through a CHNA.

So, the hospital has to either describe how the facility will address the need that was identified, or if they're not going to address it why they are not going to address it?

My question really comes to do you feel that this will; the tendency of the hospital maybe then to narrow the community health needs assessment to not throw out as wide of a net, to not be as collaborative because if the obligation is to address each need identified in the CHNA, that could be huge. I think those are very good points and although what you described is what the notice would require, it is really paraphrasing and maybe just putting things in a different order of what Congress required in the statute, so it's not the IRS

creating this requirement. 51R itself requires that the hospital disclose on Form 990 the identified needs that it's addressing, those that it's not addressing and why.

So, the IRS was first of all just paraphrasing and putting in a different order what Congress required. I think there is the potential for that incentive and a hospital maybe made to look worse, perceived as looking worse if it completes a community health needs assessment that identifies 10 needs and it's only addressing two of them, versus a hospital whose assessment identified three needs and it's addressing all three of them. Just on the sheer numbers, the second hospital tends to look better. And I think that's a challenge. One of the prior panels, someone mentioned that this is an area where our distinguished gentleman from Kansas mentioned; this is an area where consultants, not a dirty C word all the time, can be useful in designing questions, but they can also be useful in the PR aspect in getting the message out and explaining that why the first hospital actually looks better. That they did a more conscientious job in trying to address the needs but they also have to be realistic in what they have the resources to address and what they're qualified to address; and to help get the word out about other resources in the community and other people that are addressing those other eight needs.

If you broaden the scope a little bit, and if that first situation of the hospital addressing two of the 10, they can also say but the FQHC here is addressing this need, this rural health clinic is addressing this need, the local public health department is addressing this need, this other hospital across town that specializes in these services is addressing these needs -- then that hospital starts to look a little better than the one that was just doing a narrower review and confining it to what it can do on its own. It's a question of context, I think. There is certainly the potential for some hospitals to want to do less so they will look better, but that is not the only way to look better. You can look better by working with others in the community, working within your means, within your resources; but working with others to the extent permitted by law to address the needs on a broader spectrum. You can end up looking just as good or better than that second hospital that had a 100% score. With an increased emphasis on outcomes rather than just inputs, we get at the degree to which you just have a program or you have a program that is actually effectively addressing those unmet needs. Which does of course go beyond what 51R requires. 51R does not require results -- the process and the disclosure, transparency not the results -- even though there are good public health policy reasons as we've heard over the last three days to emphasize the results and to work towards good results. I think you've put your finger really on one of the challenges that we have in this regard to the degree that it suggests that you should be addressing as many unmet needs as possible. There are more unmet needs than we can effectively address, and one of our challenges in the community benefit arena. And anybody that has been out there in the field will tell you that our resources are already spread too thin across programs, so we've got to grapple with how we are able to articulate in terms of reporting and how it is reflected in the reporting requirements, acknowledging the need to be able to effectively focus our resources in partnership with other stakeholders. Claudia?

I just wanted to comment. I know the question wasn't for me, but I just wanted to comment from the community perspective. I agree with you. I think it's much better to have a community needs assessment that has integrity because community members are going to recognize when there is some kind of gaming of the needs assessment process in order to come out looking good, and that doesn't build trust in the community. And I think that doing the second approach like what you were talking about; you know, identifying needs and then the ones that you aren't involved and -- just talking about what's happening in those; community members understand. and we do understand that a hospital can't meet all of the needs. In fact, Health Care Consumers has a fact sheet on community benefits that we've had for years and years, it's up on our website. The very last question on the Q&A is about hospitals and that we know they can't address every single need, but I think the process really needs to have integrity in order to move towards that community building part of it. Julia?

Hi, Julia Joh Elligers from NACCHO. I just had comments on reflecting to Gerry your analysis and being married to an attorney, I have an appreciation for what you've presented, and I am very familiar with the way that you've presented that information. I did have a little bit of concerns though about how hospitals should think about who they should partner with in thinking in terms of resources that health departments have and how those partnerships can reduce administrative costs. And I think looking at partnerships in that way is -- it results in kind of a myopic view of the overall purpose of this assessment work. If we're really thinking about the purpose of assessment is to really be informative about how we can collectively work towards improvement, I think characterizing our partnerships based on kind of short term gains of what you have, what I have, what will make our more immediate costs make more sense; I think really will undermine this transformative goal. Knowing that there is a lot of pressure on hospitals right now because there are actual penalties associated with not meeting these requirements, that is one thing and I understand that and I'm not saying compliance is not important; but I really think that we should be thinking very big picture because in implementation, you need to have everyone on board. None of these issues is something that any one entity can tackle; and even if you did address into a way where you could say well, I saw it in my assessment and this is what I am doing, the likelihood of you making impacts in actually the health of the community is going to be very low because these are going to be short term reactive measures and not really comprehensive looking at the really root causes of why we have issues in our community. There was a lot there. Hopefully I can hit all of the points.

Let's start with the last one first -- short term versus long term. I know I'm going to butcher this quote but it's something like A long journey starts with a single step. You have to start somewhere in getting the process in place and finding ways; what I would call the path of least resistance for more folks to work together, I think is the way that you start to turn the short term into the long term. In addition to the administrative costs, I think I also said that local public health agencies have to demonstrate that they add value. Adding value is more than just the administrative costs. It is also can they get data, can they get insight that they can't find or can't get as readily other places. Local public health agencies, I think, have to do a little bit of a sales job as to why they should be involved. It is not pre-ordained that hospitals need to consult local public health agencies. You need to find a way to get in the door. It's sort of like retail marketing with loss leaders and stores putting something on sale just to start getting people's business; to start working with them to start building relationships.

And one of the ways you do that if you are trying to get hospitals to work with you and to use the public health agencies is to do what you can. It is sort of like the way I relate to my clients. I want to do what I can to make their job easier. I think it is the same concept for local public health agencies. What can you do to make the hospital's job easier and to get them in the door so they start to see the value. You are right, it is more than just the dollars and cents; and I think value added is more than that, but you're dealing with hospital administrators in many cases who are very busy people. They have as they say a railroad to run so anything you can do to get their attention, to show how it makes their job easier, makes it more likely that they will come to you with open arms and you can start to build that relationship. Gerry, in the interest of two way accountability, do you think it is appropriate that hospitals provide their ED and utilization data, and look at ways in which the public health department can link that to the population health data social determinants to generate for their joint analysis?

Kevin, I'm not sure I follow your question. In the interest of two way accountability and commitment to partnership -- I don't disagree at all with your notion that public health departments have to be at the table and have to demonstrate their value; and in many of our public health departments, particularly in rural areas, capacity is definitely an issue. As you have heard over the course of this meeting, many folks and primarily hospitals themselves have shared ways in which they are linking utilization data to census track, to other social determinants as a way of beginning to guide their efforts to the degree that public health agency has the capacity to provide that support; do you believe that hospitals can and should work with them to get that kind of analysis done?

I think a number of hospitals do that to have data sharing arrangements as a general concept. There may be specific factors for specific hospitals; but as a general concept, it seems to be in hospitals' general interest to be cooperative and to provide that data as long as we're not talking about competitively sensitive data and I don't think what you're talking about generally is; to provide that data because if you are providing better input, you are going to get better outputs. That is just the way it works. Hi, Ron Bialek, Public Health Foundation. In hearing you Kaye, Gerry, and Claudia we heard about the how the Public Health Accreditation Board standards and the IRS regulations and even IPLAN begin to create some buzz around the possibility of health departments and hospitals working together in a particular area. They don't necessarily have an absolute requirement, but at least there is the discussion and the movement towards that. We know that the more stars that are aligned the better. I am wondering about JCAHO and CMS. Is it time for JCAHO, for instance, to have a standard around the Community Health Assessment that may align with FAB and in turn align with the IRS?

Is it time for CMS to address this issue?

It seems to me the more the merrier. Anybody want to take that. I'm going to defer to my colleagues. No, I didn't plant this question, but we did have a discussion at the reception briefly along these lines. I think what you are getting at is something similar to perhaps the deemed status that hospitals have under Medicare if they satisfy the Joint Commission Accreditation Requirements if they're deemed to meet the conditions of participation for Medicare. And that is something that although a little before my time; something that was talked about back in the 60's, at least in some circles with the advent of the community benefits standard whether there should be come certification that hospitals meet the community benefits standard and then they're good for IRS purposes. I think the receptivity in the hospital industry to something along those lines would depend on how the process would be implemented; what the standards are because some minimum standards runs the risk of getting towards a one size fits all, which we have heard several panelist say just doesn't work and doesn't take account of the differences from one hospital and one community to the next, so that is one issue to grapple with.

There is also the question of who would administer it. Is it the Joint Commission to the extent that it is something that could be done as part of the normal accreditation process on the same cycle then it may be something hospitals are more receptive to because it would seem less likely to disrupt the normal routine; and maybe less likely to add more cost to the system when they're being stretched thinner and thinner with declining reimbursement; and to the extent again it can be done at the same time, maybe less disruptive to operations. But it is going to depend a lot of what the standards are. To say that you are accrediting people just for doing the community health needs assessment and making it available to what people have referred to somewhat derisively as the check the box approach. And I think that is a little derisive because there is substance behind each of those boxes. If that is all we're talking about accrediting, I think it is probably a waste of time and money and effort to set up some sort of accreditation process. If you go beyond that, you run the risk of getting to a one size fits all approach that is just not workable; or having so many local variations that you develop this whole other complex infrastructure, which detracts from people actually getting out there, building the partnerships and doing the work to improve the health of the community. And we don't want to get so heavily involved in the process that we lose sight of providing healthcare to the patients. That is a good summation of the challenges. Quick follow up over here?

A community benefits centers program that I had made reference to yesterday, we did propose the concept of accreditation built around that. The thing I would like people to walk away from this meeting thinking about is here is the IRS, not public health experts -- they're going to get ultimately some attached maybe needs assessments, maybe implementation plans -- they don't have the expertise or the time to review that in detail. You mentioned California they're not read. Our Massachusetts AG has an interesting process to at least put it out for the public to hopefully read; but it does raise the question again whether the field would

actually be advanced by having an accreditation process built around it that again, it's not a policing but just assures that there really is some kind of a quality improvement approach to this whole needs assessment implementation plan report writing process. I leave you with that thought. Fair point. Do we have another question over here?

A question and this maybe wishful thinking after your comments about accreditation. I would particularly appreciate Claudia's thought on this. We all know that over the last 20 or 30 years that the proportion of hospitals that are not for profit has declined and in many cases, therefore, there are resources that were in healthcare that are now in proprietary structures. When we have these conversations they are not at the table. I am wondering whether you see that there will be community advocates that will be starting to raise questions about not only the bad debt policies but the community investment in relation to the level of taxes that they are paying because I don't think within this conversation we're able to bring them in. I do think that you are right. I do think that we are going to see; especially if there is communities where people are not being treated well or being harmed through debt collection practices and so on. And in our own community we started to once we had established good working relationships with our non-profit hospitals, we started turning our attention to the for-profit physician clinics. And I know you're talking about hospitals, but just as an example, for-profit physician clinics. And I think the reason that there might be consumer involvement and community pressure is because of course healthcare is; well, we view it as a basic human right, but it is an essential human need. Also, we do have models. Banks are subject to the Community Reinvestment Act, and so that provides a very strong model for advocates to look at for-profit healthcare providers. And also even when hospitals are for-profit, they do derive as you said a lot of benefits from the community. It may not be in the form of property tax exemptions, but there may be other benefits -- tiff districts or other kinds of things that basically help them financially and in other ways -- so I do think we will be seeing some of that. Any other questions?

Thanks. My question is related to the previous questions about the reflection on how incorporating into non regulatory bodies like the public health accreditation, JCAHO and these things and I'm thinking of the class standards, the cultural competency standards put out by the Feds in 2001; and currently JCAHO only has incorporated language access; CMS is mandating language access, everything else is a guideline to a recommendation and I think we fall into the risk then of hospitals who are stretched trying to meet all of the needs of their communities and meet all the demands of the regulators only doing again trying to comply, and I have a little bit of anxiety about that. Hi. Jessica Curtis from Community Catalysts. Now I really am going to sound like a broken record. But I just wanted to add a comment to the last question about where community groups will start to challenge and what will this move pass tax exempt hospitals. I think one thing that is really interesting from our perspective is that tax exemption is really just one hook, one angle. I think in a lot of communities it has been the most powerful one that we have. Certainly, we also look at the social; I really appreciated Mark Huber's comments earlier that their hospital system has deliberately put this in the frame of social responsibility; because, of course, that does extend beyond hospitals, certainly beyond the non-profit hospital sector. And one other thing to the question about where I think this does connect with CMS and where it may be of interest is thinking about what is happening with disproportionate share hospital payments, and the extent to which the requirements or lack thereof around DISH money should track or follow, or not track or follow what is happening on community benefit, and what the service is contemplating. That is another really interesting angle and I think that is something that community groups particularly those engaged on immigrant issues and working with safety net populations are really concerned with in the coming years as that money is going to dwindle; so I just wanted to put that out there. Any response?

Please join me in thanking our thirteenth and final panel. I want to offer a couple very brief and fairly straight forward final closing comments. First, I am confident I speak not only on behalf of myself but my partners at the Public Health Institute, the National Network of Public Health Institutes, ASTHO, NACCHO; and last but certainly not least our host and sponsor, the CDC. When I say I am humbled and gratified by the

thoughtfulness and the seriousness that you all brought to the dialogue that we have had for the past three days. It was much needed and it will certainly inform our thinking going forward. I should have added one other term and that is endurance. For those of you that have hung in there the whole way, thank you; and those of you that have come later but then active participants, we thank you very much. The last thing I want to say. It is something I said in the beginning and it is something that I am going to close with, and that is that we view this meeting and the report that will come out of it as a first step in a process. We did not achieve consensus and that was not the intent of this meeting. What we did was to provide a lot of thoughtful reflection on the issues, the challenges and the opportunities that we have to move together and to help advance the field.

So, with that, thank you and safe travels, everyone.