Panel 2: Jurisdictions and Geographic Parameters

I'll ask my second panel to step up to the table and we can switch our table tents. While they're coming up, I want to note -- acknowledge something that many of you have already realized, which is we don't have any breaks today. We do have breaks the next two days. We are assuming you are adults and will find your way to the bathroom or wherever else you need to go. If you need to take a quick break, the bathrooms are directly behind this room. But we are going to continue right into the next panel.

So, with that -- with that, I would ask folks to come back together. This is our last panel of the day, and it is a critically important one. This panel deals with the -- the issue of how we define community fundamentally. This is one of those core questions that is being raised as we look at the responsibilities of nonprofit hospitals. And we have three very qualified individuals to help begin to explore this -- this issue with us. Again, each -- in this case we have a panel of three. Each of them will have 10 minutes to address the questions that have been raised in the context of their own experience. I'm sure you will appreciate what they have to put on the table. I will start, and again, as a couple of panelists just arrived, we have indicated to the audience they have extensive bios for each of you. In the interests of time what I'm going to do is briefly introduce your name and affiliation and then we'll get right to it. First to speak to us will be Karen Minyard, who is the Executive Director of the Georgia Health Policy Center, Rebecca Slifkin, who's the Director of the Office Planning, Analysis, and Evaluation at the Health Resources and Services Administration; and Jose Camacho, who is the Executive Director and General Counsel of the Texas Association of Community Health Centers. Karen?

Thank you. I'm happy to be here this afternoon. I'm going to talk a little bit about an urban example of jurisdictions and geographic parameters; and tell a little bit of a story about some of the opportunities, possibilities, and a challenge that we face in this work. Over the last few years, we at the Health Policy Center have been working with various different groups who are thinking about health in the Atlanta Metro area. Atlanta, the metro area, has nearly five million people, there are a lot of different county lines that are part of this. And there are a lot of different groups who have been involved in health. For example, the Atlanta Regional Commission, which is a group representing counties for a ten-county area, is interested in health, and they launched a 50 forward effort in which they were looking at what do we want for Atlanta 50 years from now?

And part of that included what do we want for transportation, what do we want for industry; and there was a component, what do we want for health?

And one of the things that came out of the work that was done related to health was a group of people talking about so how do we plan for what we want regionally, what's our vision for what we want to do, and how do we all participate in making that happen?

And several hospital systems were a part of that conversation, and they brought up in one of the meetings that they would be interested in thinking about how to combine their responsibility for assessment within the broader context and working with others in that.

So that was a really positive kind of thing that emerged from that group.

So they're multiple public health districts in this region. The multiple health systems, each with multiple sites. There's also a group called the Philanthropic Collaborative for a Healthy Georgia. This is a group that has been together for the last, probably 12 years, and has done multiple projects in Georgia related to health, rural health, school health, cancer, childhood obesity, and their project right now is the safety net in Atlanta; and they're looking at what they might want to do to individually and collectively invest in high performing safety net. And one of the challenges that they've had in thinking about this is well, do we want to look at two counties, do we want to look at five counties, do we want to look at seven counties?

And really kind of thinking through how to bring together the partners and how to begin to think about this.

So we have this other group that's involved in this. The other thing that we have that is a major event-- upcoming event in our landscape is that Fulton and DeKalb County, both of those counties, have 30 year contracts with our large hospital, Grady.

So those contracts were negotiated in 1953, 1983, and are up for renegotiation in 2013. And this is a large amount of money that the county invest in the sustainability and operation of our large hospital. And so this is kind of beginning to be on people's minds, and people are thinking about this investment, and that's part of why the Atlanta Regional Commission is thinking about this because it's a county commission kind of an issue. We also have multiple FQHCs with multiple sites who are in the process of working with the hospital and the Philanthropic Collaborative to do a needs assessment related to primary care for the future. And we have the United Way of Metropolitan Atlanta, which represents 13 counties who is interested in these counties and has health as a goal and works with counties in various different ways.

So as we began to talk about this and the community benefit assessments for each hospital in each system, the public health's responsibility as it relates to accreditation of becoming more involved in community assessments than they already have been, the Philanthropic Collaborative being interested in some type of assessment and partnership with others, the United Way; I mean, you could imagine, maybe this could be 50 to a 100 assessments.

So the idea that we would come together and think about this as a collective effort and look at a large assessment that people contributed to; and then sort of, as Paul Stange says, go large and then go small so that you in a large way look at what we're seeking to happen in our county, our communities, our multi-county area, and what the priorities are, and then to think about what is the opportunity for investment on each part. What's the county opportunity? What's the public health opportunity? What's the hospital community benefit opportunity? What's the Philanthropic opportunity?

And how might we leverage all these different investments to move toward the health priorities that we seek.

So that's kind of the overview of the situation and the opportunity. Now a challenge can be seen in these maps that -- that Paul Stange already developed that show -- and it's not that you're supposed to look at every detail of this, but just to see there are several of the hospital systems, though not all of them represented here, with their multiple sites, with the FQHCs, and a -- and the community health department clinics.

So, sort of the lines, the gray lines that you see in the background are the county lines, so there's a kind of a geographic jurisdiction that we cross. And then if you add on top of that and look at this, you can see the -- the public health districts, which are not the same as the hospitals or the same as the counties. And so -- so what we have here is a very complicated set of partners. And a very -- very much of a challenge as it relates to the way people are used to thinking about the geography for what they are -- for which they are responsible.

So some of the folks representing these organizations came together and began to talk about, so what do we want to do about this?

And the one theme that emerged from the folks that came together around the table representing these organizations was that we would like to explore the possibilities that exist for us with collective impact. How can we structure our work together, who are the key people that need to come together, and how can

we set this up in a way that we can be clear about what it is we want to happen, think about our priorities, and then make way for each partner to invest in the way that meets their criteria?

And we -- we have an example of this in working with the Philanthropic Collaborative. I don't know how many foundations we have represented in the room or how many of you have worked with foundations, but you know that each foundation has its own goals, its own board, its own way of operating. And the idea that you could bring the money of multiple foundations together is not always the -- the natural way that things happen. But we have experience with these foundations in that they've been working together in this Philanthropic Collaborative for a Healthy Georgia; and they have figured out how to put their money together and satisfy the responsibilities of each of their foundation boards, sometimes. Sometimes they -- they fund separately. But sometimes they put it together.

So what we've been talking about is the possibility of expanding that to include not only putting the philanthropic dollars toward a common goal, because sometimes they don't put their money in the pot but they say I can only to give to this piece, or I can only give to this county, or I can only give to this particular organization. But it's all toward a common vision of what's trying to be accomplished. And some might be able to give a little teeny bit of money and some might be able to give a lot.

So using that as a basis for how to move forward, I see a future where this set of partners can think about the -- think about what's desired and each figure out the way that they can contribute to moving that. I learned a lot about the power of community and the power of working together when I had what I call my rural immersion experience. And I learned from rural communities the way that people can come together and make things happen when they're really challenging. And I think that probably leads very nicely into Becky's focus on rural. Good afternoon. No slides, sorry. I was introduced as being from HRSA, which is, in fact, where I am right now; but mostly what I'm going to talk about comes from the job that I left about nine months ago, which was directing a rural health research center that focused very strongly on hospitals and geography.

So, what I wanted to do first, before I get into the rural specifics was just raise some issues that I think we're going to face with how do we actually define what the community is?

And you can tell from Karen's comments, that in a big metropolitan area this is a really difficult exercise; but actually in a rural area it is too. And I'm going to get a little bit into the nuts and bolts of geography and different ways that we can define borders. I think the first starting point is we have to ask, what needs are we talking about when we talk about doing a community needs assessment?

And a lot of the discussions so far today has been very public health focused; but the thing that's important to realize, particularly when we talk about hospitals, and especially when we talk about small and rural hospitals, is that they quite often are already doing needs assessment, but they're asking questions like what inpatient services do people need that they don't have access to?

What outpatient services do people need that they don't have access to?

What specialty services?

What EMS services?

And each of these needs might have its own intrinsic catchment area that's going to be a little different than some other set of needs.

So I just put issue on the table that we haven't really said what we mean by needs, and this is -- this is a really broad subject. The second question is, whose perspective are we taking here?

And a lot of this forum was driven by ACA and the requirement on hospitals. From a hospital's perspective, I believe for many hospitals, the simplest way to define community is based on where their patients come from. Okay. A county is -- is arbitrary to a hospital unless that hospital gets money from the county, there's a taxing authority. And the way that a lot of hospitals define their community and define their market area, is they look at the zip code that their patients come from. Typical way to do this, and there are different lines drawn depending on, you know, who's looking at it, is to say we're going to take the top 80%. The zip codes that account for the top 80% of our patient admissions. And we draw the line there and we consider that our market area. You know, other people draw it at 75%, other people draw it at 90%. But, from the hospital's perspective, you know, this is the way that they can identify who they serve and they have a familiarity with that set of patients, those communities, they have referral patterns with the doctors, they have discharge patterns with the providers. You know, to the extent that this reflects current practices, this is a relatively easy thing for a hospital to do. Part of the problem with looking at it from this perspective is if there are patients who are being left out, they're still left out. And if there are hospitals that choose or prefer not to serve a group of patients, defining how -- how we're going to say what community is from the perspective of the hospital basically leaves those disenfranchised populations out.

So there's a real danger here. The other issue that happens here, and I'll come back to this when I discuss rural in particular, is what this -- what this means is, from the hospital's perspective, they are looking at the patients in the areas that are important to them. That's a very different question than from the patient's perspective, which hospital is important to them. And when you have a very small community that contributes only a very few patients to a large hospital, the hospital is not necessarily at all concerned with that community because it doesn't provide much of their volume; but, to the community that hospital may be where everybody goes.

So that raises the question of -- if we take this from the perspective of the community rather than from the perspective of the hospital, would we draw these lines differently?

You know, do we need to define community in such a way that every place falls into somebody's community needs assessment. Or, are we okay allowing a community to be defined around a provider in such a way that the smaller, more remote places may not get included anywhere. You know, I'm not answering that, I'm just raising that as something that I -- I think needs to be considered. Along the same vein, how we geographically define a community, I think differs depending on what type of hospital we're talking about. You know, if you think about a big tertiary care center -- before I moved to D.C., I was in North Carolina, the big hospitals there, they pull from the whole state. If you think of a small rural hospital; if you think of a sole community hospital, they really do serve a much more defined community.

So can we come up with a way, and is it realistic to think that the definition of a community for a 60 bed, a thousand bed tertiary care center is going to be the same as the definition of a community for a six bed critical access hospital.

So I think, you know, those -- those are the prospective issues in terms of big hospital, little hospital, from the people who live out there. I think the Public Health Department probably has another perspective. I'll get to community health centers in a minute, and I know Jose will talk about them more as well. Then there are also some just basic definitional considerations; and forgive me, it's going to get kind of -- just into the technicality, but sooner or later we have to go there. How do you define a community?

The three most obvious ways are counties or aggregations of counties, zip code areas or aggregations of zip codes, or by the city/town name. All of these methods have pros and cons. When we're talking about counties or aggregations of counties, the advantage is that they do match geopolitical borders. They do match legal jurisdictions. They're fairly stable over time. For some hospitals, they do get county levied tax support, so that creates also a more logical length. There's also some real disadvantage with counties, and the first is that they don't necessarily reflect at all what people's care seeking patterns are. The second is that there are areas of the country that really don't use counties as their political jurisdictions. New England and Alaska being -- being the places. And then the third big issue is -- and I'm sorry I don't have a map to put up -- counties here in Georgia are very small. Counties out in the west are huge. You know, you have counties in California that are hundreds of thousands of miles -- I'm sorry, hundreds, hundreds, of miles from one side to the other, and the idea that in LA they're going to do a community needs assessment for a little town on the other side of the desert probably doesn't make a whole lot of sense.

So, you have huge variation in how big counties are depending on what part of the country that you look at. Then we get to zip code areas. First thing to realize about zip code areas is zip codes were designed for mail delivery. Okay?

And people tend to forget that. But they're a postal route. And what has happened is we have put geography around that postal route so that you can actually create a map of zip code areas that does have dimension to it, but really what you're talking about are lines where the mail truck goes. Okay?

So, there are a number of issues with zip codes. One is they cross county boundaries. They cross city boundaries. They change a lot. Zip codes get added. Zip codes get aggregated. Zip codes get taken away. Now the pro is that they do, in fact, you can use zip codes to capture where your patients come from because you have their addresses. And when I get to community health centers, that is, in fact, at HRSA, how we define community, for community health centers. The cons of zip codes is they capture where your patients come from. And so we're back to the issue of if the hospital chooses not to serve a zip code, do we really want them left out. And, you know, I think there are going to be sessions later on about data, I'm not sure, but, you know, this is where if you really want to get into the weeds later on, there are issues like if we allow people -- if we allow hospitals to define markets by zip codes, whose zip code are we talking about. For example, you might get a more fair distribution of patients if you take ER visits than if you take inpatient visits. Because hospitals may be targeting their inpatient services to a certain population but they have less control over who comes into their ER.

So then we have city and town name. City and town name may not relate to zip code, may not relate to political jurisdiction. Before I moved to DC I lived in Carborough, North Carolina, my mailing address was Chapel Hill, North Carolina, I paid Carborough tax. This is -- this is not an unusual situation.

So any definition we choose is going to have issues. If, in fact, something is chosen, and it may be that the decision is -- is to allow communities and providers to make their own choice. I got my little two minute card so I just want to turn real quickly to HRSA programs and rural communities. The important thing to remember about rural communities is that they are served by very small providers. There is a program called the Medicare Rural Hospital Flexibility Program that is administered in HRSA. It provides grant funding that helps support critical access hospitals. There are over thirteen hundred of these. They are nonprofit. They fall under the IRS provision for community needs assessments. In many states when these hospitals were converting, they were actually required to do a community needs assessment and quite a few of them continue to do this. As Karen mentioned, a lot of them have a strong sense of community membership and community responsibility because the CEO is in the grocery store with all of his or her patients. They are also very limited. They tend to have much worse financial margins than big hospitals. They're cost based by Medicare, which means you don't have extra money to play with. And a really important thing here is that

unlike other hospitals who are paid differently under Medicare, they don't get disproportionate share payments to cover care for the uninsured.

So it makes it very difficult for these hospitals to go out and create programs because of funding. On the other hand, a lot of them do huge amounts in their community, and it's quite often force of personality. You know, where they have staff members who latch onto an issue and feel like it's really important. It's very common for their CEOs to be head of the chamber of commerce in their communities. I'm not sure what Jose is going to cover; but let me just say real quickly in terms of definition of communities, critical access hospitals have been allowed to define it as they choose. Community health centers, when they put in for their 330 grants, they typically tend to define community by zip codes. And it's the zip codes where the patients they serve come from. I spoke with Jim McCray, who runs that program, before I came down here, and in his words "counties are irrelevant." The other thing to realize here for community health centers is they need to either be located in or serve medically underserved areas or medically underserved populations. And when we're talking special populations, there's no geography there at all. Okay, we're talking groups of patients. Then the last program at HRSA that has to do community needs assessment is our Ryan White HIV/Aids Program, and this is a whole other dimension of community needs assessment, and goes back to my very original comment about what needs are we talking about. All right, because that program, they're required to do community needs assessment, but it's a much huger geography because it's targeted to a very specific disease, with very specific providers, so it requires quite a large catchment area for the grant programs. And I'm way over, so I'm going to stop and we can come back to these things with a question.

Thank you. You're doing exactly what we hoped, which is to stimulate our -- our brain cells about the kinds of things we need to consider. Jose, please.

Thank you. Let me go ahead and get started even though the slides aren't up. I represent federally qualified health centers, community health centers in Texas. Community health centers serve about a million people. Approximately a million people last year. We're -- out of 254 counties, we serve a 151 with 300 -- over 300 sites. What interests us in -- in these discussions are that we've discovered, and it hasn't been all that long ago that we discovered this, that the high functioning centers have relationships with their hospitals. They've entered into some coordination with their hospitals, and this just gives an ability to expand on those relationships. I would submit to you in these discussions, and I'm relatively a man off the street considering some of the experience that you all have, but it strikes me that the first thing that has to be discussed is the end goal of these assessments. Are we viewing these as a process to help align investments that are being made by diverse organizations or is this a compliance matter?

Something that hospitals have to submit in order to maintain a status or meet a requirement. To the extent that we view it as the latter, we're missing a wonderful opportunity here to coordinate resources. And we're -- we're at fault of this also. Developing reports and submitting them, and not really reading them or coordinating them.

So my comments are going to concentrate on where the coordination points are. The definitions that can be applied and how things can be coordinated. First of all, and this -- this was covered -- are we looking at a rational service area for the hospital in which their investment is to be made?

And I submit to you that this whole process started because someone, Congress, since it was included in the Accountable Care Act, probably didn't believe that the investments were occurring as they should. And those investments very much go around places where the hospital has traditionally served people. Or can we look at this as a method of targeting community need, which would benefit from investments or an expanded -- expansion of services?

I tend to think that a combination of processes may be necessary where not only do we identify areas and populations currently served by the hospital, but also identify areas of need for services. The needed healthcare services within that population and -- or areas to be served. Now, one of the things is that a year ago, a matter of fact a year ago this July, the Secretary also appointed, at the national level, a committee that I'm privileged to serve on on negotiated rulemaking to define MUA and HIPSA. And the definition of MUA and HIPSA also contributed -- contributes to need. But I think it has to be coordinated with something like this. There's a wonderful opportunity to coordinate a definition of need, and what I'd like to do is urge not only that coordination, but also talk to you about some of the things that the committee is considering in terms of those definitions. And all of these, believe me, have been broad ranging discussions on what can be done, how it should be done, by 28 members over a 34 day period during the last year.

Some of the common points are access, usually defined in terms of population-to-provider ratios for an identified community. Now, if we go back to zip codes and census tracks, etc., I think that artificially limits it, but we're looking -- the committee is looking at both geographic and population definitions, so that there is that flexibility to address identified needs. Ability to pay. This is going to be something that changes in the next four or five years depending on the impact of the Accountable Care Act. This is usually termed in terms of percent of population under an identified percent of poverty. Currently poverty is used at a 100%, but I'd submit that probably in January 1, 2014, we're going to change that view to under 400% poverty. Health centers have to provide sliding fee scales, for example, under 200%. Let me give you an example of how I think this has got to be a broad enough definition that not only considers health services but also social services that are needed. And, of course, this -- this is going to change from state to state. Massachusetts is probably not going to have this problem. But these are estimates that are provided by our Health and Human Services Commission, which is the Medicaid agency in Texas. Currently we have 26% uninsured, 13% are undocumented -- of that percent, 13% are undocumented, 12% are eligible but unenrolled, mainly children under 200% of poverty. 64% are adults that will become eligible under an expansion of the ACA, and 11% are over 400% of poverty. After January 1, 2014, we're going to see the percentage lowered considerably to 9% will be estimated to be uninsured. 36% of those are going to probably be undocumented. 12% are going to be eligible for but unenrolled in Medicaid. 35% will be eligible for a subsidy, but not receiving one. Basically about 47% of our uninsured are either going to be eligible but unenrolled or eligible for a subsidy and not receiving it. I submit that this is going to cause a refocusing. Maybe instead of health services, we should be talking about outreach and enrollment. There are problems, also. We assume that people are going to be able to afford the subsidies they're required to pay. Yet many providers are not allowed to -- to waive those -- those copayments and really the subsidy; so what are we going to do in those situations where the person is really not able to pay because of the income?

And 16% of the uninsured, it's estimated in Texas will be over 400% of poverty. Other determining factors. Health status. And we've had just extended conversations on how this should be defined. Whether it's standard mortality ratio, low birth weight, prevalence of diabetes and obesity has been a large discussion. Discharges for ambulatory care sensitive conditions, which would indicate some lack of access in the community. And I apologize but there should be a sub-bullet there entitled

Social Determinants of Care, which have been examined and are very closely correlated to the health of a population. Such things as percentage of population that is not employed which, of course, leads to uninsurance or underinsurance. Percentage of population from single parent households and percentage without high school education, which correlates highly to the understanding of some of the -- some of the information that's presented to them. Another factor in terms of determining the definition of community or barriers to care. Population density being a big one. Rural urban differentiations. Percent of population with limited English-speaking proficiency. Well, if 36% are going to be undocumented, then we're looking at a problem. We're looking at that barrier differently in Texas than some of the other states may be looking at it. The other thing is that the highest growing population in terms of percentage growth is the Asian population.

Vietnamese, Chinese, etc., in Texas, so we're going to have not just barriers caused by inability to understand any language other than Spanish, but other languages. Percentage of population that is a racial minority. Percentage of population with a disability, and percentage of population without a usual source of care. The other -- the other thing that we're looking at, and I think something that ought to be considered, is identifying facilities as eligible for investment.

Those facilities that are serving a large number of patients that meet those criteria of need, of community need. And there are some definitions out there. And this is where, I think, that -- that we have to start paying attention to definitions beyond just the healthcare field. This is an IRS definition that drives investment in new market tax credits. They're looking at not only poverty, but a trigger in the number or the minimum percentage of poverty that would trigger an investment, and also income. And that's a -- that's a floating type of indicator. In terms of rural and urban, population density drives quite a bit. In terms of scope of availability of services, from no services at all to not enough of what we need. And the traditional barriers that we've had in rural areas in Texas have been travel, travel times, transfer patients, which are also, although longer travel distances are also a problem in urban areas. And cost per unit of delivery of care. On Friday, we talked about an AIDS center that was being closed down because it was only serving 300, 400 patients, and now the patients are going to have to travel an hour-and-a-half; and part of the reason it was closed down was because of the cost per the unit of care. Well, I submit that those 300 patients thought it was very affordable. But now are going to have to travel a large distance.

So, in terms of the apportionment of responsibilities, it may make too much sense to sit down with funders and have those funders coordinate the investment. Matter of fact there may be laws that prohibit that type of coordination in a greater scheme, anti-trust comes to mind. But there is nothing that prohibits the coordination of data. The definitions, the data sets, how they're being applied to -- to identify need. And I think that that's where some of this has to focus. We've had coordination before -- I don't know if any of you are old enough to remember the Certificate of Need process that allocated investments with a community that became so burdensome in Texas, it was summarily dismissed.

Some of you may still have it your state, and I am not at all advocating for setting up that type of process. It has to be simpler, it has to be seamless and more transparent. But at least we can coordinate some of these definitions and then allow investors, if you would, from different organizations, to coordinate their investments.

Thank you.

Thank you. Wow, what a lot to think about. The panel has done a great job of -- of queueing up the issues that we have to confront. I want to get to questions pretty quick. I was, along with Karen, looking at these slides and maps of Atlanta and all of the complexities therein; and one of the questions that comes up is this notion of apportionment of responsibility, so I think closer to home, a similar dynamic, but different -- different issues at play. LA County is a county of 10 million people, and in addition to downtown LA there are 87 other cities, each that are looking to the degree to which the hospital in their municipality is fulfilling their charitable obligations associated with their property tax exemption. Grappling with that, they've broken apart into eight SPAs, or Service Planning Areas, to begin to -- to break it up into chunks; but it's open to question whether or not some of the criteria raised in this panel are really addressed. I have a note that another specific hospital in southern California, Hoag Memorial Hospital Presbyterian is located in Newport Beach. Pretty affluent city. They devote probably 80% to 90% of their community benefit resources to two other cities that are, generally speaking, would be viewed as outside of their primary service area, because that's where the unmet needs are concentrated.

So we've got to sort through these, and I guess one question I had before turning it over to -- and Karen or any of the panelists that want to address this -- in the Atlanta example that you've described, we clearly have some hospitals and systems that are located in the more affluent parts of the metropolitan area and subsequently would be inclined to define their community in those terms. How do we begin to have a dialogue with -- with those systems about a more equitable apportionment of responsibilities. And I guess we need to turn on the mics for the table. Can we make sure that's done?

Are we good?

Is this mic on?

Okay. I don't think I really ever turned it off. Well, that is a challenging question. In an -- in an ideal world, we'd be looking at the big picture of need, and we'd be looking at what we want for our region; and each player would be able to make their contribution in the way that works for them, so they'd segment their portion and think about how they make their contribution. The things -- the thing that would be different, though, is that the contribution, the priorities, would be -- would be collectively determined; and so we'd all be working toward a similar goal and just figuring out what's our part in making a contribution. In the ideal world, future, that I see. Um hmm. Any of the panelists care to comment on that issue?

Okay. All right. Well let's -- let's get some questions. Again, we want to try to have a minute each to get questions or comments on, three of them forward for our panelists. We have -- we're starting right here. Brad Gray, Urban Institute. Two questions. I loved the points that Rebecca was making. I loved Rebecca's points. I don't know whose mic is doing the feedback. Anyway. About all of the challenges of what -- of actually defining a community, and I'm wishing that the people who had drafted the Affordable Care Act had talked to you before they put these provisions in, because I think the IRS has got a terrible challenge in front of them trying to define communities and then with the idea of needs, and you're going to have to say how you're going to address every need. One of the things that occurs to me is this is a very powerful incentive for hospitals to define their community as narrowly as possible because the bigger it gets, the more complicated it gets, the needs assessment, all the rest.

So they've really created a very -- there's a very powerful incentive to do that. The other thing that I wanted -- I thought the point about hospitals, communities being different for the different services that they provide, there are hospitals that are, you know, provide local services and statewide, you mentioned UNC, huge problem for trying to define community rationally. The other thing that I wanted to mention is, and this comes back to the point that Kevin was making here at the end, is that there are multi-hospital systems. I wanted to ask this earlier about the one -- UMass -- that actually operate. Now a lot of multi-hospital systems don't operate as, you know, highly integrated. But there are some that do. About 25% of the systems in a study I did routinely cross-subsidize within the system. They may be all located in a metropolitan area, some are in suburbs, one is in a central city. Having to have each one of those separately define the community it serves and what those needs are and how it's going to meet those when the organization is operating as a single entity is just -- you know, I hope IRS can figure out a way to allow that. Right now, though, the way the draft is written, each individual hospital has to act like it's its own -- has its own community. And that's not necessarily the way it works.

So Brad has just done -- put three questions on, so I'm going to turn to the panel, because I can't hold six questions in my head.

So I'll give folks the opportunity to respond. I think you might need to move it closer. That better?

Yes. Okay.

So in terms of your first comment about you wish I had talked to them, that's actually what I used to do before I took the job in Washington, but I think the difficult was -- you didn't talk loud enough. Well, no, I mean, I think the difficulty is I couldn't tell you the right way to do this.

So even if I'm up on the hill and a staffer says, well how should we do it, it's not like I can go, oh, well this is how. Because I'm not sure that there is one easy solution that's going to meet the need of little places, big places, little hospitals, big hospitals, independent hospitals, systems; and so I wouldn't have had the answer even if I had been asked.

So. In terms of your comment about narrowness, I actually really like what Karen said, which is the idea in a bigger metropolitan area that there is some global assessment of need, and then every hospital, regardless of whether or not they serve a rich little enclave, has to step up and say what piece of that are they going to take on. In rural areas, I don't think this is a problem because where you have a critical access hospital, that whole community is theirs.

So I guess I'll stop there. Please, Jose. I think one of the critical issues is how you set up the framework so you don't incentivize trying to save resources and define something very narrowly. And I think that's the opportunity, is to set that framework up; and at some point you go to a different type of input, the focus groups, etc., that further help define that. But states are in a great position right now to contribute in some way, shape or form to not only collecting the data; but also helping build that framework that avoids several of the pitfalls in this. Please. I was going to affirm the comment about the incentives. I know I'm talking about people working together and thinking about their part, but there is going to be the challenge of the incentives. And I had a person from a hospital in a smaller community call me and say, Karen, would the Health Policy Center do our assessment?

And before you get started I'd like to talk a little bit about what we'd like to see as the priorities and -- and we want to be careful because we know we're going to be held responsible for those priorities; and, I mean, so there is that incentive to have very clear priorities that could be addressed in a legitimate way that make it easy as it relates to the IRS reporting. And I understand that that's there, and I think you're -- you're wise to recognize it because sometimes the incentives can be very powerful. I would just note, and we'll get -- we'll get to this more tomorrow, we have two sessions dealing with priority setting -- is the -- the language suggests an expectation that a hospital will address all of the unmet needs identified. And -- I've already heard from a number of groups that they -- that they plan to deal with that by narrowing the scope, content scope of the assessment.

So we have to be cautious of an array of potential unanticipated consequences of -- in part as -- as many have observed, we are often spread quite thin in terms of community benefit programming. And our challenge, for those of us that are working in the field, is how do we begin to focus our efforts. And that involves setting priorities. That involves saying, Here are the things we're going to do now because we need to focus our resources.

So, but we'll get into much more detail into that tomorrow. We have folks set up for some other questions?

Please. Hi. I'm Dan Merrigan, Department of Community Health Sciences at the Boston University School of Public Health, and I -- I would like to thank you for this presentation. I think it's necessary, it's very thoughtful and -- and provocative in a very positive way. I'm intrigued by the idea of an efficiency and collective impact of having multiple partners do assessments rather than doing several different assessments. But the conversation about the limitations of zip code and the way we think about perspective in the context of what are we assessing, who are we assessing, and where are we assessing comes very much to mind. And

I think we are probably all well aware, and Paul Halverson's notion of a community health system rather than a hospital health system or the Public Health Department's health system as a broader context is helpful. But there's a really robust literature on the importance of the impact of the context of the characteristics of where people live. And we know that it's not necessarily, particularly in urban areas, it's not about the region or the zip code or the county. Or the catchment area of a service organization. And so if we're really thinking about what protects health as well as how can we help people who are vulnerable and need health care, it seems to me that we really have to -- before the horse gets too far out of the barn, we have to think about, my comment is, how do we begin to assess where people live, how do we begin to take seriously in the assessment process the neighborhoods that people live, and the characteristics of those neighborhoods?

And you can be four streets away and to be able to -- how do we think about assessing social capital. How do we think about assessing the economic vitality of that neighborhood, and the like.

So that's my comment. And my question is, will we be able to pursue that in the next three days, those considerations?

Next. Hi. Melissa Beal, and I work in Los Angeles, California, specifically with hospitals and communities doing community health needs assessments; and I think a really important, very practical thing that we also need to consider in this discussion about geographic parameters is the data -- the secondary data hasn't necessarily kept up with the community.

So we can say all we want, well, we're going to define our community a certain way, but then when you go to look for secondary data to describe what's going on in the community, it ain't there.

So, in California, for instance, the state reports birth and death data by zip code.

So guess what -- that's how we have to define the birth -- you know, report the birth and death data in community health needs assessments by zip code because that's the way it's available.

So I just want to throw that out as a very practical consideration that as we move along defining what communities are, the data has to keep up and I think we really need to look to public health to help us with that. Great. Third quick question or comment so we can -- Can I respond to that?

No. No, you want to -- No, I -- go ahead. You're from LA, so boy, my mileage thing was really off, and you knew the truth. Yes. No, the whole data issue -- as somebody who used to do rural health research, obviously it's huge. And in little places it's not even a question of zip code versus county, it's a question of you just don't have the sample size at all. But I guess my counter to that would be I think there's some really good lessons from programs like the Ryan White Programs, who by definition have had to go out and collect their own data because the things they're asking about are not things that are in the big national surveys, and they've figured out very creative and not very expensive ways to do it. And one of the issues that we always have with secondary data is by the time we get them, they're old. And they may not actually ask the question that we want to ask.

So, I guess I would encourage us to think more broadly about what are the real questions, and can we find creative ways to ask them without relying on national surveys that, you know, might be two years old by the time we get them and aren't quite to the point?

And we will address that issue in more depth tomorrow as we look at a panel on assessment. Another question, comment?

Panel 2: Jurisdictions and Geographic Parameters

Hi. I'm Paul Epstein, Results That Matter team. I'm a consultant who can spell epidemiology only because health departments have assigned them to work with me on quality and strategy. But from actually listening to the opening this whole first day, something's been striking me from a previous client, the Governmental Accounting Standards Board, and I'm not an accountant either. I worked with them when they went into a whole new field of instead of looking at financial reporting, looking at setting standards for government performance reporting. And they came to a conclusion which went whole counter to accounting rules in this country is that -- is that we needed to have guidelines for performance reporting that were principle based, not rules based. And every -- a lot of things I'm hearing, has been striking me that that's where this whole discussion, if it's going to be -- if all this is going to lead to requirements promulgated by the IRS, by the CDC, whomever, those requirements or standards really need to be principle based, not rules based, so you can account for all this variation. As long as you follow the principles -- big deal. One of the principles that came to me, and it made -- it's just been Kevin putting these two panels together, is that community needs to be defined collectively, not by any one organization. That's the only way it's going to work when you think of all the problems you've put out there. Okay, great point.

So I'll turn to the panel now. We've -- we've partially addressed the issue on shortcomings on data. The initial question, how do we accommodate the unique characteristics of neighborhoods?

And this question on -- on should we be looking at principles rather than rules in terms of how we -- how we define communities, how we define responsibilities?

I'll say one thing. I love the idea of thinking about principles. That is -- when you say we want to have a collective decision making about defining the geography or the county. I mean, that's a principle about this. If you say we want to leverage all the possible investments that might be available in the community from philanthropic to government to hospital, that's another potential principle. If you say we want to get a big picture of what's desired and then go small and let each -- each partner make the contribution that they can make, that's sort of a principle.

So that the concept of building on principles, I think is a very valuable one. And I guess as far as the neighborhood is concerned, I share that concern because health is so personal and so local. And when you think about a large assessment and each one taking their part, then there has to be some looking at each specific small geography and attending to the needs of the folks that live in that geography.

So I think that is a challenge that needs to be addressed in this. Great.

Thank you. Jose?

What she said. The only thing I would ask you to think about is that those two approaches are not mutually exclusive. You can set the principles or the framework and then work within those to address specific identified needs. Great. Next?

I'm counting on my folks with the mics to wave their hand who's next. Please. My name is Leonard Syme. I'm a Professor of Epidemiology at University of California Berkeley. I've never thought about this issue before and it's really been fascinating. As I think about it, we're talking about things like if a hospital is located in a wealthy community, it would be to their self-interest to define that community as narrowly as possible. It seems to me this issue raises an important problem that I think we should be discussing, and that is that when we have major inequalities in our society, it's a toxic force for all of us. All of us are affected by it.

So for a hospital in a rich community to think of their community as being a special area that they need to focus on, I think really misses the whole community point of this thing. I think we need to raise our thoughts to a much larger context about this toxic force. Hi, my name is Julia Joh Elligers and I'm with the National Association of County and City Health Officials, and we represent the public health departments across the country. And one of the things I've been thinking about and thinking about this panel and the panel before is that this work takes a lot of time. All of it's based in relationship building. You can have all of the guidance that you want. We can talk about shared agenda, shared goals, collective interests, but all of this is based in how we develop relationships. And this takes years. And if communities aren't already doing this work, there's probably a reason why that they haven't collaborated in the past; and so, you know, thinking about how to define the community, what is that conversation going to look like?

And that's really pitted against this desire to be compliant, to become accredited and finding a quick fix.

So yes, thinking about community in a very, kind of measurable way kind of goes against the process, the time, the energy that's required in order for us to do this right, and so I think as we think about the guidance and all these various aspects of the elements of a good assessment and improvement process, acknowledging that the time invested made up front really turns out as real benefit at the end and how can we not compromise that. And so, it's kind of general to all panels but it's really something that's resonating with me as we talk about these specifics. Great. One more?

Hi. I'm Jessica Curtis from Community Catalyst, and I just have a question because we work with community-based groups and organizations; and one of the things that we're starting to hear when they're trying to work with hospitals, either on financial assistance, billing and debt collection or the community health needs assessment requirement, is that as we see more control shifting to systems, and as more decisions are being made by -- at the system level rather than the local level, how do you account for the reverse, accountability going back to the community in a situation where you've got a system deciding to prioritize one issue over another?

That's one thing that we're seeing coming up, and I'm just curious if any of you have seen that addressed in a successful way. Okay, so we've got Dr. Syme raised this issue of how can we raise this to a different level. I think it's a variation on shouldn't we be thinking about broader principles in how we define this. Time investment. How do we make sure that we've taken the time to do this well?

And that's reflected in what we are -- what the public expectations. And this notion of accountability as it relates to systems, who are -- are certainly asserting increasing control over the operation of local facilities. Yeah, it's a really excellent point, and I think it's a good counter to -- I can't remember, some gentleman down here who raised the issue of should systems have to do a separate needs assessment for each of their sites; and we have certainly seen this with critical access hospitals when they get bought out by a bigger hospital because the bigger hospital does not have the same connection with the community that that little hospital had when it was its own creature.

So I mean I think you're exactly right, and I think it's going to be a real challenge to make sure that that local community voice stays heard when the big system owns. I'm sorry, but I still don't view these as mutually exclusive. You can have inputs of data that are uniform across the board. Yes, it's going to take time to develop. When -- when I first started working with community health centers, I remember confronting the problem of 22 definitions of what a migrant was. And that -- that just became overwhelming in terms of how do you coordinate these data sources, etc. Well, it became so overwhelming and there were so many silos built around those definitions that today we still have 22, if not 23 definitions of what a migrant is. And we've left it alone. This presents an opportunity to at least coordinate those within a framework. And then the second type of input is the input that you would get from the community. Once needs are at least

generally identified, how you would delve down into that through focus groups or through an advisory panel to the hospital. But you have to avoid -- I think a gentleman over here raised it that -- that whole idea that we're going to define community as we traditionally have defined community because those -- that's the way the data sets are -- are collected right now. That's -- that's a very large problem, but I don't see it as an insurmountable problem. I'm going to bring this to a close and emphasize I know there are a number of folks that had comments and questions. And I want to emphasize this for the rest of the meeting. Each of you have notepads, and we would -- we would greatly appreciate it, particularly if you were unable to share a particular comment or question, you could take the time to write it down, put your name and contact information on it, and get it to us, and we will do our best to respond directly and/or integrate that information into the -- the report of proceedings. Quick directions to the reception in Silver Bell Pavilion. Upon going out of this room you will turn right and go up the stairs to the lobby. Go across the lobby. Follow the signs. Go outside and up either -- up either walkway that is outside to Silver Bell. I hope you all join us for the reception.

Thank you very much.