Panel 9: Institutional Governance and Oversight

So with that I want to move to our first panel of this morning. They're addressing an issue that's been really a passion and focus of mine for the second 10 years of my research and field work in community benefit. I spent a lot of time during my first ten years of work coming from a public health and city and regional planning background and looking at this issue of community benefit programming, looking at ways in which we can move it in an evidence-based direction, looking at it in ways in which we can work with hospitals in that regard. What I've found often is I would present to colleagues at conferences about the elements of programming and ways in which to begin to be more strategic; and so often folks would come up to me at the end of the session and say, That is great, these are really good tools, really good ideas. Can you talk to my boss because he or she doesn't get this stuff?

And so what really became a much more central focus of the work -- and you're going to hear from some colleagues that really can help provide some insights into this -- is how we get alignment at the institutional level to move this work forward in a substantive way.

So it's not this marginal set of activities that one individual is doing in a cubicle somewhere in the organization. We're going to address it not just from the standpoint of hospitals, but as has been the case throughout this meeting, from the public health perspective as well, because we have a need for transformation in all quarters.

So with that, a quick introduction of my panel, and then I will turn over the podium to the first panelist. We're going to hear from a long-time colleague who's done an immense amount of research in this area, Lawrence Prybil is the Associate Dean at University of Kentucky, College of Public Health. Larry will be followed by Elissa Bassler who is the CEO of the Illinois Public Health Institute. And then Mark Huber will share, again, the practice on the ground. He's the Vice President for Social Responsibility for Aurora Healthcare. Please join me in welcoming Larry Prybil. Well, thank you very much, Kevin. It's really a pleasure to be part of a conference on such a timely and important topic as this. It really is the moment to have this kind of gathering and dialogue about the subject of this event. It's also a pleasure to be here with some very good friends who I have admired and respected for years, Mary Pittman, Bob Sigmond, Julie Trocchio, and many others.

So it's really nice to be back with all of you. I'd first like to ask a question of the audience, how many of you have served on a local or state Board of Health, raise your hands?

A few. How many of you have served on a hospital board, raise your hand?

A few. How many on a health system board, raise your hand?

Okay.

So we have a number of people who have had that experience. I'm going to cover four points today, and hopefully in a dialogue manner; and the first is that in my perspective, board oversight of community benefit policy and programs is not only a basic responsibility of boards, hospitals, and health systems, but also really is an ethical imperative. When you think what our hospitals and the systems that bring them together are all about, it's serving the communities to which they have a responsibility. It cannot be an afterthought. I think it's fair to say in some places, in years past, community benefit was an afterthought. It was not up front. It was not prominent. Today that can't be the case. It really is a basic responsibility. When we think about our boards, this is an enormously difficult and challenging time for them, for those who have stewardship over hospitals and health systems. Just think about it. Think about how much more complex it is today than 5 years ago or 10 years ago or 20 years ago. Think about quality and safety, the expectations on hospitals today, and thus, on the boards who are responsible for them. The level of knowledge and understanding that they must have about quality and safety is enormously greater than it was in the past. The

same in the world of finance -- we are talking about this later -- resources are scarce, stretched, and getting more so.

So those who govern hospitals and health systems are very concerned about where they're going to find the resources to keep their missions alive, keep their facilities in business so they can serve the communities to which they have that ethical and legal responsibility.

So we say, then, that for those who are charged with governing our hospital systems today that real board oversight is a fundamental basic duty and responsibility. The second point is there are benchmarks of good governance in this area. When we talk about benchmarks, we're talking about characteristics or features of governance structures, practices, and policy that are appropriate given the times. They're the bar to which we should stretch or try to excel, benchmarks of good governance. There are benchmarks of good governance in all the areas of governance, but there certainly are some that are emerging in the area of their oversight of community benefit. I'm going to share five today that I think have emerged as benchmarks of good governance. First is that the boards of hospitals or systems, in my judgment, to meet us a benchmark of good governance should adopt a policy statement that outlines what is their role, what is their philosophy, what are their obligations in the area of community benefit. Many have done that, some have not. We can talk about numbers later. But to express the shape and nature of their view on what their institution's role and obligations are provides a foundation from which then we can build programs. A second benchmark is collaboration with other organizations. Here, too, past is spotty; but in today's world I think it's increasingly recognized that not doing communities needs assessment is simply inappropriate, that doing it informally and sporadically is inappropriate, and really doing it alone is inappropriate for all the reasons we've talked about the last few days.

So what has emerged is not only, is collaboration appropriate, it's necessary. It's a benchmark of good governance.

So on the foundation of a statement of policy and philosophy, and with the understanding that collaboration with others to define needs and then carve out what your institution can do in addressing them provides a basis for the third element or third benchmark of good governance in this area; and that is the board adoption of a community benefit plan, including priorities and clear objectives. Now, it goes without saying but must be said nonetheless, that the organization's plan in community benefit, laying out what it can do, making clear what it cannot do, based on needs assessment and careful prioritizing, is tied inextricably to the overall strategic plan of the organization. We can't do community benefit planning and isolation of the total picture of the strategic direction and priorities of the organization. A community benefit plan may be a separate document, but it must be an integral part of the organization's strategic plan.

So having that in place is a benchmark of good governance. Then with that in place, with a plan that lays out priorities and objectives, then you can build reporting and accountability mechanisms to come back to the board and make it very clear how are we doing in relation to that plan? Are we carrying out our priorities? Are we achieving our objectives?

So reporting back to the board is only possible if you've got a plan on which that reporting can be based. And fifth and finally, in my view, is regular reports to the community that we're serving. Now the nature of that report can be, obviously, somewhat different in form than the report that goes to the board, but it should contain the same essential information. What is our institution, our system all about in community benefit?

What are our priorities, and how well are we doing in achieving our objectives?

So I believe, then, there have emerged some basic benchmarks of good governance for the area of community benefit. I believe the evidence suggests that we're moving toward more organizations being

consistent with those benchmarks. The CHA with Julie's leadership has done tremendous work in their own terms in expressing these as aspirational benchmarks for systems, but I think we still have a way to go. We'll get back to that in a minute. The third point that needs to be made -- although I think everyone in this room understands it -- is that the structure of our health industry has changed dramatically in the last 10 or 15 years. We've had systems around for a long time. They are growing, probably 65%, Kevin, of hospitals, they are part of systems, maybe more, that is increasing because of the nature of the environment calls us to come together, work together more closely. Freestanding hospitals can and will exist, probably always will exist, but it's a shrinking number. That is our reality A; that hospitals are aggregating in the systems. The second is that those systems are extremely diverse in every way. They differ in their geographic coverage. They differ in how they view governance.

Some include mainly large, complex medical centers. Many include the full gamut of institutions.

So as we think about regulations, we must take into mind that the systems are extremely large and growing, and they are very diverse. Our country is diverse. Our country is populated also with many, many small hospitals, critical access hospitals, small and rural hospitals that don't have the capacity and the capability that our larger medical centers do. In the last few days we've heard some wonderful vignettes, illustrations about work that's being done by our larger systems, and it's very heartening. But all of us should understand, and our regulators must understand, as I'm sure they do, that the shape of our industry includes every size, form, and nature of hospitals.

Some are very small and simply don't have the capabilities that the larger ones do.

So as we think about community benefit, as we think about regulating -- regulations and requirements, we should recognize and honor that diversity. My fourth point is the one that is increasingly clear to me personally. I spent roughly half of my career in hospitals and systems in executive roles and half in academic medical centers, university medical centers; and the last 12 years, in schools of public health, helping to build two new schools of public health. I think it's fair to say and unfortunate to say that over the decades there have not been the levels of communication and collaboration between the public health community and the hospital and health system community as we would like. They're spotty. I believe there's evidence that we are beginning to come together more closely to understand each other better. I think the presentations yesterday underscore that, and some later today will as well.

So there's evidence of a bridging between the public health community and hospitals and systems. But there are still gaps and we need to close them. I think this is the moment for the public health community and the hospital and system community to work together more closely than we ever have in the past. As Peggy said yesterday, we share so much in common, we the public health community and we the hospital health system community, we share so much in common. We're all about trying to improve the health of our society, of our communities, the communities for which we are responsible to serve, and families. At the bottom level, we're all there, that's our foundation for all of our activities. We have different traditions, we have different funding mechanisms, we have some different perspectives, we have some different histories. But I think there is the moment now, an opportunity that's maybe unique for us to at every level, national, state, and local, to reach out to our colleagues on the other community and look for ways we can work together in common. The resource constraints I talked about that are such a challenge for our boards and leaders and for all of you are not going to get less, the challenges are going to get greater. We simply are faced with shrinking resources and infinite needs, infinite needs.

So we need to use our resources wisely. I think we need to find ways to work together more closely. I think there's some promising starts on that. I hope this conference will help facilitate that. I hope the final IRS regs will facilitate that, will bring us together in ways that will be creative, innovative, and pragmatic.

So it's a pleasure to be with you today. These are some thoughts on board oversight, of community benefit, and the surrounding environment. And I look forward to hearing from my colleagues on the panel.

Thank you very much.

Thanks very much, Larry. My name is Elissa Bassler. I'm the CEO of the Illinois Public Health Institute. And coming here, actually talking with Kevin, and coming here yesterday I was wrestling with this sort of existential question of why am I here?

What am I doing here?

And as I listened to the conversation yesterday about local health departments I suddenly had -- the light bulb went off and I knew what I needed to talk about.

So since we're here in Atlanta I'm going to invoke Paul Wiesner who was the health department director in the DeKalb County for a long time, and something I learned when I first got into public health somebody quoted Paul Wiesner to me and it's sort of been something that I've looked at as a key factor in how I think about public health, which is the role of health departments as a catalyst in the community. A catalyst for action by the public health system, not doing all of public health, but catalyzing action. And thinking at the institutes, as we do, about the public health system and what that means, so you all may think you're in the healthcare system and your hospitals, but if you ask us you're part of the public health system and contributing to what we call the 10 essential public health services; and the sort of broad set of stakeholders in a community that need to be engaged together and collaborating together to improve the health at the population level.

So that's sort of our -- my sort of frame of reference when I'm talking, so just to understand that. In Illinois -- and I've already been accused last night at the reception of sort of rose-colored glasses and things like that in my presentation, so I'm going to acknowledge that this is not universal what I'm going to talk about. But in Illinois, we have a history in our health departments of community health assessment and community health improvement planning. Since 1993, local health departments, as a component of being certified by the state health department and, therefore, eligible for certain state funding, have been required to do community health assessments and community health improvement planning, and the standards require community engagement in that.

So our health departments in Illinois, in many cases, have been reaching out to hospitals routinely for almost 20 years to participate in this work at the community level. And the Public Health Institute, for the last 10 years, has been able to help to foster that collaboration and support those collaborations in those community health assessments. And I think public health institutes may be positioned to do that around the country and the other thing that is going to drive this nationally.

So we've been doing this as a routine thing in Illinois for almost 20 years, but nationally the development of public health accreditation and the requirement, at least for accredited health departments, that they also do community health assessments and community health plans that have those features of community engagement; and therefore, ideally reaching out to hospitals and aligning those activities with their local hospitals, that's going to drive more of this, like we've been doing in Illinois for a long time, all around the country.

So I think there's a lot of opportunity there with health departments. I'm going to do a little bit of a case study. I spent a lot of time -- I have 10 minutes to do this presentation and I must have spent, I don't know, two, two-and-a-half hours talking to people in Jackson County to put this presentation together.

So hopefully I'm distilling it. Chris won't let me keep going, I don't think. In Jackson County health departments, since 1995 or so, since they first started working on their very first IPLAN -- IPLAN is the Community Health Assessment, Community Health Improvement Plan that our local health departments are required to do -- has had engagement from their local health system, Southern Illinois Healthcare. And then in 2000 -- oh, I'm sorry, when I talked to the community benefits VP at Southern Illinois Healthcare he talked about how in 1995 community benefit was really a nice thing, it was part of sort of their PR and their marketing work; and now he talks about it being as a very disciplined activity, very outcome-based. The local health departments, I think, helped to bring the idea of an evidence-base to them and the use of data-driven planning because they were required to do that. Since 2003, in Jackson County they've convened about 42 health-specific coalitions under one umbrella called the Healthy Communities Coalition. And what's, I think, really interesting about this is it isn't the health department that staffs that coalition, it's the health system.

So the Southern Illinois Healthcare co-leads the Healthy Communities. They co-lead the assessment. They adopt the assessment and the priorities that come from that assessment, the plan, as their own, and then they identify their own role in that community health improvement plan, and that becomes their community benefit plan. And they talked about it at Southern Illinois Healthcare as the strategic alignment of priorities across the community toward achieving common health outcomes at the population level. Oh, I'm sorry, and of course, that same plan becomes the IPLAN for the health department and the health department turns that in to state regulators, so it becomes useful for all of those. And we have other communities where the United Way is very involved, and this becomes also the United Way's health assessment and health improvement plan. In Jackson County the Southern Illinois Healthcare provides the lead staff for the Healthy Communities Coalition.

So they pay a staff person on their staff to do all the logistics, the meeting agendas, the minutes, and so on. The health department and the Southern Illinois Healthcare together share leadership of the action teams that are working on the elements of the plan. And then in Southern Illinois at the system they also staff and conduct several interventions.

So they have -- Kevin asked me to talk about sort of competencies and so on -- so they have staff who are nurses and MPH-trained or other Masters levels, and they have at least three sort of intervention areas that they are working on. They are working in schools, especially on physical education. They're working in the faith community. They're organizing parish nurses across their whole service area. I'm going to talk a little bit more about their larger service area as well as Jackson County. They're working at the community level on built environment and bike paths and so on, and they're working at the workplace level on workplace wellness through their community benefit department. The Southern Illinois Healthcare folks and the health department sit on the steering committee for the Healthy Communities Coalition. And then Southern Illinois Healthcare also funds interventions aligned with the plan at the community level, so they give some funding to the health department, but they also fund other community-based organizations. And it was interesting, I spent an hour and a half with Woody Thorne at Southern Illinois Healthcare talking to him about all of these things, and he never once mentioned that they give away money. It wasn't key to what they do. What he talked about was all of the staffing and all of the work and the collaboration. It was the Health Department that talked about the resources. And they also talked about how early on that's what Southern Illinois Healthcare did, was they gave away money. And this evolution of collaboration has had sort of two affects. It's the resources that they bring to the work in terms of interventions, but they're are also much more strategic about the money that they give away, and the money that they give is also aligned with the plan and meant to achieve the outcomes that they're reporting to their board as part of their community benefit. The way that Southern Illinois Healthcare governs the work that they do, they have an external community benefit advisory board that helps them prioritize their needs and assures that their alignment of their community benefit work with public health in the community. They review their annual community benefit plan, so I want to just say that this is annual, even though at the periodicity, I'm going to talk a little bit about

that at the end. But the health department requirement and the accreditation requirement is going to be every five years, and we know that the IRS regulations are going to be every three years. But there seems to be some mechanism for updating this assessment and the plan annually at Southern Illinois Healthcare, so they don't seem too worried about those periodicity issues. This external advisory board includes both senior Southern Illinois Healthcare -- the health system executives as well as the local health departments from across the region, some of them, the federally qualified health centers and a pastor.

So they're trying to -- he talked about trying to connect the dots both inside and outside of the hospital through this advisory board. And then, as Larry described, that community benefit plan is presented annually to the hospital trustees and adopted by the hospital trustees, so there's all the way up through the infrastructure and the governance structure, there's utilization in the community benefit plan. To talk about sort of external to the health system, the structures that support this, the Healthy Communities Coalition has the overall coalition, which really provides a place for networking and training for all those 42 sub-coalitions that are a part of the Healthy Communities Coalition. They then divide into action teams where that's where the work of the plan gets done. They do projects and align the work across these different coalitions. By the way, their action teams from the current plan, there's some that are still working from previous plans, are community -- or, sorry, cardiovascular disease access to healthcare, which is focusing specifically on oral health because of some of the data they got from the hospital about visits to the ER around -- for people -- repeat visits for people with oral health problems, and then sexually-transmitted disease, this is a college town. They also have a steering committee that sets the agenda and so on. And the steering committee for the Healthy Communities Coalition is the local health department, Southern Illinois Healthcare, the park district, Head Start, the health center, and the mental health agencies.

So there's a pretty broad group of folks really representing that public health system. They talked a little bit about what were the benefits of this structure and being a part of the coalition. For the local health department, it propels community engagement and ownership in shared accountability. It doesn't seem like the plan is the Health Department's plan. It's a community plan. And it has the same effect at the health system. They're clearly the biggest player. They have the most money. But because it's done in this community way it's not the Health System's coalition, it's a community coalition. And the other benefit is that through this coalition they feel like -- the Health System feels like they're moving towards integration and are going to get to some of those imperatives around reducing readmissions and improving population health. Their structure is very informal in this case, other places there are memorandum of understanding and so when they don't have officers in this, it's a much more informal structure because, as the Jackson County Health Department director to me, that works for us.

So why change it?

Why reinvent that wheel?Southern Illinois Healthcare serves more than Jackson County, they serve the entire region, and they were the catalyst for -- and there's seven local health department jurisdictions within the region that they serve, so they were the catalyst for creating the Healthy Southern Illinois Delta Network, which they looked at all of the IPLANs around those seven health jurisdictions, and cardiovascular disease appeared in all of them, so they have a region-wide cardiovascular disease healthy living plan, and they share the objectives and action steps aligned toward that. The steering committee of that is the administrators, and Southern Illinois Healthcare provides the staff for that as well. And I will say, the other thing is is that they are also, the Southern Illinois Healthcare and the Delta Network, are also represented at the state level in our statewide coalition on obesity.

So this starts to roll up into effecting state policy in environments as well. I just want to just touch -- I talked to one other health department, and sort of picking up on what Cathy said yesterday, they use the community balance scorecard, which is an online system for aligning and measuring and keeping track of the activities

of all of the coalitions, and I think there are mechanisms for doing that together. And the question of so what -- I'm trying to hurry, I'm sorry, Chris -- is -- I'll just give a couple of results.

So at Southern Illinois Healthcare they're working with 41 schools. They've measured how much time is spent in moderate to vigorous physical activity in PE classes. Before they started, 48% of the time in PE class was in moderate to vigorous physical activity, it's increased to 66% of the time; so they have real outcomes in terms of physical activity. They also did a diabetes project and saw 50% of the participants lowered their BMI, 90% had improved fasting blood glucose, not higher, but improved, 63% had improved HDL, and 60% had lower LDL.

So the real outcomes -- and that was in the African American community in very close partnership with the Health Department. And then just a few questions that I got asked last night, too, How common is this?

Is this something that all of our health departments are doing?

No. I would say most of the mid to large health departments are doing this in some way or another. It gets more challenging where there are multiple hospitals. There's only one health system here. And I would say that a large proportion of the Illinois population is covered by health departments that are working in this way. It's an unfunded mandate, so sometimes this is work that's done and then just put on a shelf, and you take it off as a compliance. There's lack, I think, of understanding of what is the public health system in communities.

So the role that folks play together; the question of the periodicity that I already mentioned; and the issue of, in the IRS guidance, about separate assessments and plans for each facility.

So in Southern Illinois Healthcare, they have two hospitals and multiple clinics and so on. Woody said, if I have to do two plans and two assessments for both of my hospitals instead of one across the whole system, it's really going to be a barrier to our success. And then the last thing I would add based on conversation yesterday was just it sounds like a lot of what they're doing might fall under that -- what was the word -- it was community building instead of community benefit. And so we want to really look at how do we count this kind of work because it's really important.

So thank you. Good morning. My name is Mark Huber and I'm Vice President of Social Responsibility with Aurora Healthcare. My assignment this morning is to really look internally at a hospital or health-care system, what are the structures that need to be put in place to effectively govern a community benefit process?

And I'm going to be doing that by giving some examples from our own experience over the past 20 years. A little bit of my background, if you looked at Paul Halverson's bubble chart on the first day of this conference, my career has span three of those bubbles. I started in public health actually at the age of 16 when I did a summer internship with my local public health department working on a colorectal cancer screening initiative. And it was quite an experience at age 16 talking to 70 and 80-year-olds about colorectal cancer, let me tell you, especially when the public health officer tested positively. My second phase was working the voluntary health sector working with the Heart, Lung, and Cancer

Societies in Wisconsin. And then from that I went back to the State Division of Health and finally worked in the past 17 years in the healthcare system, Aurora Healthcare, which is the largest healthcare system in Wisconsin. I want to point out right away, one of the structures we put in place that I'll be talking about is integrating and messaging throughout all the core documents in the organization. This is our purpose statement. We help people live well at Aurora Healthcare. We have a very comprehensive mission statement, but we wanted something that was short, that people can remember because nobody remembers

your mission statement. And this is something that speaks right to wellness and health improvement from the outside.

So a little background on Aurora Healthcare, we serve all of Eastern Wisconsin. We call is the Eastern Seaboard of Wisconsin. We've identified 90 communities in a 20-county area; and how did we identify those communities?

Well, actually, they identified themselves through some marketing research we did as to how do they view their community. And what's interesting, when I get to community health assessment, so we have 15 hospitals, so do we do 15 community health assessments?

We have 20 counties, do we do 20 community health assessments?

If we identified 90 communities, do we do 90 community health assessments?

And the answer is none of those. We do 36, and the reason we do 36 is because we have 36 local public health department jurisdictions across our service area.

So this is a little high. We wanted to start in Aurora by having a framework for our community benefit program. And in the Catholic Health system they use their mission as their framework; and at Aurora we created a thing we call social responsibility, and this is a concept that we've borrowed and adapted from the for-profit sector. You often hear of corporate social responsibility, and we thought that if you look at a couple of the working definitions that we've identified here in the components of there, you can see how you can adapt that and align it into a non-profit healthcare provider system, and really have it fit well with how you govern your process and your responsibility -- your ethical commitment to community benefit as a healthcare system. I have Aurora's definition listed on the bottom. And basically what this principle of social responsibility does within Aurora Healthcare is it guides our administrator's day-to-day actions to assure that we're responsibly using our resources and aligning where we're spending our money on fulfillment of our mission. Governance starts at the top. You'll hear some common themes here with Larry's presentation. We have created a standing committee of the Aurora Healthcare Board of Directors, the Social Responsibility Committee, and this is a committee we've had for quite a while. But we revised the charter early last Fall to come directly in alignment with the new community benefit requirements.

So we pointed directly at the IRS schedule H requirements and have charged this committee specifically with oversight of that function for Aurora Healthcare, and I want to thank Kevin for his assistance with us in reviewing this process.

So the three main components -- woops, too fast -- the three main components that you see on the three bullets -- I did it again. I'm not going to try the pointer. First, oversee an annual community health assessment. I mentioned we do 36 of those. In 2003, Aurora Healthcare partnered with local public health departments across our entire service area to do a baseline study. We're not doing just secondary analysis, we're doing primary research in each of those communities.

So we adapted a questionnaire, a telephone interview process similar to the behavioral risk factor survey that's done nationally and actually did 15,000 telephone interviews across our service area for a baseline. Every year we reassess one-third of those 36 communities.

So at this point now, 10 years later, we have three points of reference that gives us some trending data across a wide range of information for each of those communities. That's been very helpful. It is an unfunded mandate for local public health departments to do that. It's been a great assistance to them for us to develop this tool with them to create that information. Secondly, to oversee the community benefit plan. Now this is

one you see it doesn't say that they have to approve the community benefit plan. I have to tweak this one. Coming out of this conference, I looked at this last night, and I said, you know, this isn't strong enough. It has to say, Approve the community benefit plan to be in compliance, and that's a change we're going to make. Third, review and approve our community benefit report. And you see, we have a whole component around evaluation that I'll talk about in a little bit. What's the composition of our governance committee of the board of directors?

We wanted to assure that we were diverse geographically across a total service area, we want to assure that we are diverse in terms of race and ethnicity, and in terms of perspective, their professional backgrounds that they bring to the table. You can see that we have some gaps we're trying to fill on the committee, and currently we have 12 members, and we want to grow that to about 16 to have representation from all those different areas.

So what are some of the specific internal operating structures that need to be in place in any health institution in order to be effective?

Some of this you've heard so I'll go through this rather quickly. Integrate your community benefit messaging throughout all the core documents, your mission, your values, your strategic plan. At Aurora we have nine goals in our strategic plan. One of those is to foster healthy and vibrant communities, and that cascades down for every site, every administrator. Every department has to have goals directly related to this overall objective. Secondly, where do you align your community benefit department, your community benefit staff in the organization?

This is a question I've asked many people because there's a lot of different ways of doing this. There's no one best answer. In the Catholic Health System it fits, obviously, very well with admission, but we've seen it in a lot of different places. I happen to report directly to the CEO of Aurora Healthcare. The one thing that we know that's important is you need to have a report to that senior management level within the organization. Third, since we're a healthcare system, we know that we need to have that local presence, that local vision, that local experience and knowledge engaged directly in this activity.

So every hospital we are creating a community benefit team, and you can see some of the representation that we might suggest be on that team. And this is to look at the internal side of the question, the question of once you do your community-wide collaboration or while you're doing it, what is the hospital's best role, where do we best fit, what are we most equipped to address within that plan?

Establishing a dashboard, this is something that's new for us. We're borrowing from our quality initiatives where we have some very stringent dashboards, and we're really looking at population health improvement mechanisms or measures that we can include and monitor at the board level and at the administrative level. And finally looking at some transparent mission-related policies. This is something that the board -- that was one of the functions of our board committee, but every -- as Larry mentioned in the onset, every hospital needs to have very clear policies around charity care, their billing and collection processes. One that probably you're scratching your head about is why am I saying anything about sponsorships, that has nothing to do with community benefit. In Aurora what we're trying to do is redirect all of the sponsorship inquiries we're getting which are mainly marketing-type opportunities being presented to us, and have a conversation with our non-profit partners and say, We don't really want to sponsor your golf outing. What we want to do is talk to you about how we can work together in service improvement in the community, and that's been very, very effective.

So we have a policy that establishes criteria to move us in that direction.

So what are some of the governance challenges presented to a healthcare system to become in compliance with the new requirements?

One in particular that I wanted to address is the requirement that we report at each hospital each EIN level, and that does create some challenges for a healthcare system and how we structure ourselves. First of all, you have to align your budgets with the hospital budget for your community benefit account. And let me give you an example of why that's so critical. In Aurora we tracked $32 million in community benefit outreach last year. Of that, only half can be reported on the Schedule H because only half of it occurred within a hospital budget, the rest occurred in other EINs within the system, whether it was in the medical staff clinic or whether it was in our visiting nurse association or out of a corporate department.

So one of the -- at least one source has told me that there is a mechanism where you can use general accounting principles to use your allocation process from a corporate department to a hospital to take some of that expenditure that's occurring at the corporate level and actually be able to count it. That's something we need a little more guidance on as to how we can accomplish that. And I'm looking over at you, Chris, on that question, thank you. And two other quick points, reporting at the EIN level doesn't assure apples to apples measurement between systems because systems, as Larry mentioned, are really different in how they're structured. In our system, the medical clinics and medical staff are separate from the hospitals in a different EIN. That means that about 18% of our charity care occurs outside of our hospitals; and so what we're reporting at the system level and what rolls up through the Schedule H are two different things, so that's a challenge for us. And then finally, some of the benefits of reporting of a healthcare system -- an integrated healthcare system is to really develop programs and expertise and have that cascade across the entire system. There are needs that we know are in common across all 15 of our hospital, and some are on the board here. And so we've been looking at ways we can have some signature community benefit programs that we do everywhere and we do well everywhere. There was a question raised the first day, well, where's the local autonomy when you have a healthcare system?

And the way we approach that in Aurora is that we allow the hospital team to supplement the system-wide activities with localized initiatives that address their specific needs at the local level.

So with that I'll wrap up, and we can go to questions.

Thank you, panel, for a great set of presentations. I'm going to go pretty quickly to questions, but just to -- I want to touch on a couple issues quickly. In fact, Mark, you sort of brought it up right at the end. In my experience, and Larry noted appropriately, that there is increasing system-ness, as well as the fact that there are a broad variety of systems. Systems such as Mark's and others tend to be more regionally-focused, and some are multi-state and have a broad spectrum of regulatory environments to operate under; and vastly different kinds of communities that are being served. And there are also different dimensions of governance and approach on a systems level.

Some tend to be much more involved, and some might view as being more prescriptive in the sense -- and they tend to be more framed as operating companies, as, you know, very much involved in the operations of individual facilities. On the other end of the spectrum is much more hands-off orientation. I'm seeing that end of the continuum much less these days, seeing systems to be much more involved in the operations and trying to get alignment. In general, particularly when we've talked about -- years ago we talked about hospitals, the perspective of a local community often was, Gosh, we want our local hospital to be totally autonomous. We're concerned about the system out there and whether or not there are actually extracting and taking away from this hospital. My experience has been increasingly in recent years that systems have contributed substantially to the effectiveness and the competence of local hospitals and their efforts. I know that's not universal, but I think as we look at, and Mark raised this issue of, how do we capture what it is that systems contribute to local hospitals help advance this work, both in financial terms and in broader -- to

build a broader understanding and consistency about what systems can contribute. Larry and Mark, in particular, could you expand on that a little bit?

Well, the diversity is a very important reality, Kevin, as you were just saying. Let me give a couple of examples to maybe illustrate. Mercy Health is a large system based in St. Louis, Missouri, operates hospitals and health facilities in four states, I think 28 counties, Kevin. And they have moved their local boards into more of an advisory status as opposed to fiduciary, so they're moving toward an operating company. But in terms of community benefit, their local boards are very deeply involved in developing the community benefit plan for their communities, and their real, and then they roll up into a Mercy system-wide community plan, which takes into consideration the assessments of all of those communities and captures some priorities they believe are applicable across the board. For example, a very major multimillion dollar corporate level investment in working with school systems that is going to be applicable in every one of those, I think, 28 communities.

So that's an example of a system that's moving toward being an operating company with limited local board decision-making authority, but with deep engagement locally and system-wide in community benefit. A great example of that was you all were aware of the terrible tornado that hit Joplin, Missouri, and the St. John there is a Mercy Hospital, and I happened to do my interviews for this new study they were doing just before and just after that. And what the Mercy Health system has done for Joplin is absolutely breathtaking, and the community is so grateful. If St John were a freestanding hospital, did not have system support, it simply could not do what they're doing. They put a MASH-type operation in place in a week. They now have a, I think, 80 bed temporary hospital in place. They're committed to rebuild the thing even better than it was before. They're busing people back and forth to work in the hospital in Springfield, if they want to do that, they're continuing the salary support for staff. I mean it is really touching. But it is an example of a strong system demonstrating its commitment to a community that was ravaged by this tornado that Healthcare has remained intact. And, by the way, they have electronic medical records so all the patients still have their records even though the paper is long gone.

So it's just an example. One other quick example, Banner Health based in Phoenix, another significant system has no local boards at all -- no local boards at all. It really is an operating company.

So when Banner Health talks about community benefit and board plans and board policy and accountability to boards, there is no local board.

So we all have to factor that into consideration as we think about how is that going to work and what regulations are appropriate for that?

And there are the systems that have very strong, strong local boards with a lot of fiduciary responsibility. Just a few examples. I think Mercy Health is very timely and appropriate though because it's a system that's moving toward being an operating company, but with deep, deep commitment to assessing community needs and serving those community needs and doing something system-wide. And, again, Mark, in your follow-up, any thoughts on how we capture this information, how we capture these important contributions?

I think I'd like to start by going back to John Bluford's opening comments to this group is the very fact that there is so much diversity in the structures of health systems and hospitals structures across the country; that there is no cookie-cutter approach to these activities, and that's why he was calling for flexibility in the guidelines, and I would certainly agree with him in that. You know, but large or small, some of the challenges that exist there are in parallel. I know that the issues that I raised about the EIN structure for us as a regional health system have the same impact on Kaiser. I was talking to Gail from Kaiser earlier and she said that half of their community benefit activity, likewise, was not contained within the hospital EINs in their structure. The way that I think that we approach this challenge of system versus local within Aurora is

that my team, at the system level, serve as facilitators. We bring in the expertise on best practices, if you'll allow me to use that term. I'm sorry I did that, Kevin, I apologize to you. I know you don't like that term. But we bring in the expertise as to what's working and how we can approach the processes and then some of the specifics on how to address specific issues once they're identified.

But we really leave it up to and rely on our local teams to provide the local relationships that are so essential to this process and the local knowledge in terms of needs. And so the specifics come out locally, and I think that's how you find that balance point in those two processes. One more quick question to Elissa, and I know -- I'm guessing other folks are going to want to follow-up on that initial question. But, Elissa, in your sharing of this example sort of reminds me is my experiences, there are a number of areas, particularly rural areas, around the country where the hospital in question or hospitals are the only providers in those communities, which presents an immense opportunity to really look at ways in which we can, in those contexts, bend the cost curve. But you referenced appropriately that the IPLAN operates as an unfunded mandate. And we have in so many of our communities this challenge faced by local public health agencies without the capacity often to do what we're expecting them to do. And even though the core public health functions of monitoring assurance are often just not carried out in many of these communities because of a lack of capacity. As alternatives to simply go into the hospitals and asking for money, what are ways in which -- what is it that hospitals and other community partners can do in the realm of advocacy or other efforts to help move this agenda in the public health arena to build capacity?

Any thoughts on how that can proceed?

Well, I think people talked a little bit about this yesterday. I mean we do need our partners in the public health system to support the core role that local public health agencies can and should play if they're -- if they have the capacity -- support the capacity with state regulators and state legislators and so on.

So I think that advocacy role is important because I think that local public health brings sort of a variety of things to the hospital that the hospital may not have on its own, which is that sort of population health focus and an understanding about how do you work at a population level to improve health. I know that hospitals are committed to evidence-based practice in the practice of medicine in the clinical evidence-base, but the population level evidence-base is situated in health departments; and to sort of share that information is, I think, important, and to rely on that. And I think most often local health departments are also units of local government, and so I think that that connects the hospital to the sort of larger policy environment that they're operating in. And I think we talked a little bit back the sustainable public health -- sustainable population health improvements are going to come at the policy and environmental level. I mean if we're -- Julie talked about this yesterday -- I mean, if we're doing programs that last 10 weeks and then go away, we're not going to have the long-term effects that we want on population health. And so tying this work into what are effectively units of local government can have a larger impact, the hospitals, I think, can have a larger impact on some of those policy and environmental changes that are going to have sustainable impact on the health of the population. Let's get our first three questions and comments from the audience. Jerry. Jean, please, go ahead. You're so energetic. Good morning. Jean Nudelman from Kaiser Permanente in Northern California, and this is mainly a comment with a question. I just wanted to say how much I really appreciate and how resonant the comments from, in particular Mark, about the systems process. And I think it's -- my question has to do, I guess, with how do we convey the richness of the experience?

In Northern California we've evolved since '94, really, when we first were required to do needs assessments, and in the beginning we had a great deal of variety among our facilities. And increasingly we're providing a great deal of support from the regional level; and we're able to leverage resources that are available to us as a system; technical expertise, clinical expertise from our medical group from our research, and we're able to provide that to our local community benefit managers who coordinate these needs assessments.

So I'm seeing a great deal of richness, but I also see a potential challenge that some of the activities, which are being done to support and deepen and enhance the engagement at a local level need to be built in somehow into the process so that we're able to continue and not really have to replicate unnecessarily. An example, which I said before and we didn't have a chance to talk about it, was the local needs assessment don't tend to identify community -- rather system health needs such as the workforce and research, and yet it's really important to ensure the effectiveness of what happens at a local community, so a mixture of comment/question. Hi, Jessica Curtis from Community Catalyst. I really appreciated the comments of the panel, and with that said, I think that this is an issue where having the best students in the room really effects the answer.

So just a couple of comments because I think, you know, what you all are doing -- I really like the approach that you're taking, Mark, in Aurora of having -- of leveraging the power of the system to really bring effective change and bring change to scale, and then allowing for that local control. But I just want to flag that one of the things that we are seeing is that we tend to work with hospitals that aren't doing that; and so we're very concerned about the vulnerable communities that are being left behind, hospital closures, hospitals moving certain services out of really vulnerable communities. And that's just the trend that we're facing.

So that's definitely a huge concern for our communities. And when we think about reporting when it's not local, I think that's something where we would disagree. We do want to see that reporting and transparency at the local level simply because it's been really difficult for our people to get information that they need.

So I just wanted to flag that as an issue and think about how we address that moving forward. And then also to agree that one of the other issues that we commonly hear from consumers who are struggling, particularly with medical debt, is a lot of that is coming from physicians, from other services that they receive inside the hospital. And so we're very interested in thinking about how hospital financial assistance programs, community benefit programs could extend to those other services in the hospital, and I'd welcome your ideas about how to do that.

Thanks. Third comment/question. Hi, I'm John Clymer with the Alliance to Make US Healthiest, but as a member of the Task Force on Community Preventive Services that I want to issue a little plea. I was struck by Elissa's comment about the public health or population health evidence-base, and earlier in her presentation by the data about the change in PE involvement. Often, as a task force, we're stymied in our desire -- carrying out our desire to issue recommendations and guidance to practitioners on interventions, particularly those involving physical activity and nutrition. And so my plea to everyone is that as you undertake different interventions, as you put together your teams and collaborations, please involve scientists who can do the kinds of evaluations that will meet the standards for the systematic reviews of evidence required by the community guide so that your good work can be brought into the public health evidence-base, and that will make it easier for it to be replicated and adapted to communities all across the country.

Thank you. Great.

So three comments; first, how do we capture the richness and variety, what's going on in our individual facilities; and for our systems, how do they coordinate; how, in fact, do we capture what they're doing?

And as they facilitate system-wide approaches, often we've been talking more and more about it, grabbing two or three areas where a system really provides that leadership and a priority that may not emerge such as workforce development at the local level. Please address that. Second is how do we deal with this trend in some areas to actually close facilities that are part of systems, in part because it's a poor payer mix, because they're losing money. Certainly, in early research, Brad Gray and others, it's one of the ways that we

distinguished ourselves in the non-profit sector is that there was less of an inclination to close a facility. But it is -- there are financial realities, but how do we grapple with that, particularly in the context of health reform?

And then last is this plea that I think is certainly something we've heard along the way in this meeting is -- and I've challenged my colleagues so much -- is let's capture what you're doing because people are not aware of it. But let's also make sure that we have people with the competencies that are capturing it in a way that really builds the evidence-base because that's the way we're going to get the traction that we need to advance this. Panel?

I'll start. At first I want to correct a possible misperception. In speaking about the challenges related to local reporting at the EIN level, I didn't mean to imply that we disagreed that that was an important thing to do. I was just trying to address how it challenges a health system to report at that level. And the critical message I was trying to get there is what structures can we put in place to assure that all of the activity that is occurring out of a health system can be included in that local reporting; and what do we need to do to accomplish that?

The question about local closures, we did have a hospital that closed in Central City, Milwaukee, just a couple years ago, and it is an issue. At Aurora we have the sole remaining hospital in downtown serving the central area of the inner city of Milwaukee, Aurora Sinai Medical Center. We lose $10 million, $20 million a year in that facility. We're not going to close it. We've made a commitment that we're just not going to close it. That's the value of having systems, because we have the ability to leverage resources that we generate out of other parts of the systems to underwire those losses and provide that critical access that's so needed in that part of our service area. The interesting thing -- one of the interesting things about having a facility like that though is it's a real good testing ground for ACOs for us because all the dynamics are already there for us. We're losing money with every patient we provide services for, so our incentives are already reversed in those facilities where it pays for us to collaborate with a community to improve access to primary medical homes, to assure that there is care coordination of people with chronic disease that are showing up in our ED repeatedly over time.

So that's, I guess, it's a benefit, if you will, for us as a testing ground moving forward. Boy, there are so many different questions here. I'd like to say, one of the things Jean said was how do you get credibility, if you will, locally, for this work we're doing?

How do we accomplish that and make this a real priority in every facility that we have?

I think I want to thank the IRS right now because was one of the side benefits of what's happened with this new level of regulation authority is its given some very tangible things for us to utilize as we talk to our administrative teams about why this is important. This isn't a soft area. This is a very solid area. It's very similar to quality as we look at it within the healthcare systems and how we approach that. And I think in particular this requirement for transparency of having a community benefit strategy that we are out front within the public is a huge opportunity for hospitals. It is an opportunity to correct something that we haven't done very well, and that is really to define what our appropriate role is in population health improvement. What our specific role is that we're going to take on in the community. And in not having done that historically as an industry very well, we've been approached by every member of the community with expectations that anything remotely related to our broad mission is something that we should take on. And this will allow us to focus our efforts; and I think, have more direct impact on population health outcomes. I just want to speak to a couple of the questions. Since I'm not from a health system I can't speak to all of those. But I want to speak specifically to this question of sort of system priorities, workforce, and that sort of thing, and how those can get worked into this.

Again, this is coming from public health. In governmental public health or in public health ,we have tools. There's a planning and assessment process MAPP, the Mobilizing for Action through Policy and Partnerships in Planning, and one of the assessments within that, is not just looking at health status, it's using the national public health performance standards that evaluates those 10 essential services, one of which is workforce, another is policy, another is data systems, another is how are we doing collaboration and partnership and raising those up as things that also need to be improved as part of community health improvement. And so I think Public Health has some tools for doing what you're talking about if we're working with Public Health. And then Public Health performance standards is CDC tools, so CDC has a tool as well. But that does ask the whole system to come together and look at these infrastructure components, as well as what is the health status. And it would be interesting -- I'd be interested in knowing whether the health -- the IRS would be willing to include as improving the workforce as another part of community health improvement and community benefit that doesn't necessarily address, today, cardiovascular disease; but may in the long run build the infrastructure to address cardiovascular disease.

So that's something that's coming out of Public Health that I haven't heard any conversation yet about until you asked that question that I'd just sort of like to elevate because I think it should be part of what hospitals are working on together with Public Health. And what gets recognized is the work that's being done to improve population health through community benefit. I guess I would just pick on those thoughts and say that, first of all, we all have to understand that health systems today are not just hospital systems. And, in fact, in terms of cost control and in terms of quality of care, we have to move away from hospitals as the primary place where services are rendered and care is provided, and move beyond that into forms of ambulatory care and other types of services that are not hospital-based.

So that is why, from a board standpoint, thinking about providing community benefit to our communities has to be linked directly to our strategic and financial planning and thinking. And so closing a hospital, if we have to do that, maybe a very good thing to do if we replace it with an alternative way of delivering the services that are needed in a more cost effective way.

So that's the first point, health systems today are not just hospital systems. They include a large and growing spectrum of other kinds of services with maybe much more effective in terms of meeting community needs. Secondly, I think that in hearing my two colleagues in the panel talk about their respective environments, one from a public health institute perspective and one from a hospital system or health system perspective, you really have two examples where those benchmarks, Kevin, of good governance are being met. And if we can move forward in that direction and in partnership with the public health community, I think we're on the right track. What we've got to do is not do things that stupidly get in the way of that and intelligently help us to facilitate that in all kinds of ways. And that certainly includes building better partnerships between the public health community and the hospital system community.

Thank you. I'd like to just add one thing. I didn't really address the question about workforce and research, and I want to get to that. I don't know how to get research at a local community health level, it's just not going to come up. I think you have to address it directly as a side issue. In terms of workforce development, we've aligned our community health assessment process with the state health plan, and workforce development is one of the infrastructure priorities in that plan.

So we have had the ability to have that at the table. And what my experience has been in community health improvement processes is there are things that come out of that process that everyone agrees, we're going to do this as a priority collaboratively. And then there are things that individual agencies say we're going to do this that's related to those goals within our own agency because it fits what we want to do and some of our objectives. And then there are what I call spinoff projects. And so many times you can find that there may be two or three or four partners within the broader collaborative that all have a common interest in doing something that may not be of interest to the entire collaborative. And so we do spinoff initiatives based on

that, and that's how we've addressed some of the workforce. Another round of questions and comments, please. We've got a lot. Let's try to get four quick comments and questions, please. I'm Julie Trocchio with Catholic Health Association. And, Elissa, I wanted you to know that the IRS does let us report workforce development, but as community building, not as a community benefit. Right, thank you. And that's come up. Larry, I wanted to thank you so much for talking about Mercy Health system, but I think as you know, it isn't just Mercy Health system, the generosity of hospitals throughout the country to Joplin has just been outstanding. They've sent teams. They sent money. And it happened at Katrina. It happened with Haiti. And it's very spontaneous, which is great. I wanted to pick up on something that several of the panelists mentioned, and that is the diversity of the type of hospitals and community -- and health departments, and it just speaks to one size won't fit all, is that we don't want to have anything so prescriptive that will work for all organizations. There was a cartoon in The New Yorker last week that brought this to mind because we also have to be careful that whatever is -- the guidance that comes out is not too expensive for our organizations. This cartoon showed a fort -- many people mentioned The New Yorker -- showed a fort, and outside the fort -- I think Kevin is nodding, I think he's seen it -- is this huge horse, and one guard says to the other, How can we be sure it's not full of consultants?

And we don't want the Affordable Care Act or the guidance to be sort of a Trojan horse for this whole industry that comes up. We want hospitals and health departments to be able to do community health needs assessments and develop plans. Now some of my best friends are consultants, and many are in this room, so I mean no disparaging comment; but I think we have to be careful that organizations can use the tools that are available and do these themselves. And I am interested, Mark, you said you had 32 separate assessments, and I'm wondering if they're able to do it using their own internal skills in their health departments. Great. Next. Hi. Mark Horton. I'm recently with the California Department of Public Health. I'm here on behalf of ASTHO. And I really appreciated the presentations today, particularly the Jackson County example and the challenges -- the governance challenges related to the Aurora Healthcare system, and I guess it crystallized for me a question that still may reflect my poor understanding of what the IRS requirements are all about. But I guess to put it all succinctly, what my question is, yet this week CDC is soliciting proposals for community transformation grants that I'm hoping and expecting will generate true community health improvement plans that are really owned by the community. My question is can, in fact, a community benefits plan the emanates out of a hospital or system in fact be one and the same as a community health improvement plan?

In other words, that's owned by the community?

And is that allowable under the IRS?

And, you know, I'm looking at Jackson County for example, I'm seeing that they still have their own advisory committee. Will the natural evolution of that be that they no longer need their own advisory committee, and in fact the steering committee for the community health improvement plan is in fact what's giving direction to the community benefits resource?

And I think that's a fair question, particularly in communities where there is that single hospital provider, more complicated, obviously, in multiple hospital collaborative assessments. Yes. Yes. Vondie Woodbury, Trinity Health. And I think this question is probably for Mark, although I'd be interested in everyone's perceptions on this. We've talked a lot about the core competencies of boards of trustees, for instance, and all that they have to do. I know from where I sit in looking at our local hospitals, the core competencies of the staff that I have at the local hospital level, I'm seeing a wide array of skills there, and I would be interested in your thoughts about core competencies that we need to build into the staffing patterns that we have at hospitals so that they're actually able to do a lot of what we've been talking about.

Thank you. Great. Last one here. Hi. Gianfranco Pezzino, Kansas Health Institute. I have a quick question for Elissa -- actually for anyone if you have any time. I think I heard you say there were 42 health coalitions in a certain period of time in Jackson County. In Jackson County, yes. And my question is how do we avoid coalition fatigue?

How do we what?

Avoid coalition fatigue, and is that a way to make the process more efficient?

Are we competing for attention from the same small group of stakeholders?

That's my experience, especially in small communities, and is that a way that -- are we replicating the silos mentality also coalition, this process that we are trying to move away from?

Great. Panel?

Could I just jump in on the consultants question and try to answer Gianfranco.

So I saw that cartoon, too, and so -- I'm going to ask the panel, please be as brief as possible because we're real low on time. Okay. Really quickly then, if a hospital is going to spend money on consultants, why not hire the Health Department to do that work, right, and build the capacity in the Health Department to be the consultant, and then you have an organization that's embedded in the community as part of your consulting team. And I would just to plug us, the public health institutes are also in a lot of states doing a lot of this kind of work and can help your Health Department build their capacity with a broader systems perspective of what is the whole state moving toward.

So I would say that you have resources that can be built -- the capacity can be built to not have consultants, but have consultation. And you stay put and you don't leave, and they're there to execute the plan, not just put together the assessment and walk away. And then, Gianfranco, I think the point about the 42 coalitions was they came together under the umbrella of the Healthy Communities Coalition and formed one big meta-coalition to do this work and engaged the folks on these different action teams toward a common community plan.

So I don't think they all exist anymore because they've come together. I would just comment on two parts of two of the questions. In terms of if there's a community steering committee, does the hospital health system board need its own committee?

I think that depends. In a single hospital community or single system community such as Elissa's described, I think it's very conceivable that there could be a community-based committee that also served to provide the advice directly to the board, which has the fiduciary responsibility to allocate resources and make decisions, so I think it would work there. It obviously gets far more complicated in Chicago or in New York or in Boise where there's multiple facilities.

So the important point is that information that enables boards to make good solid decisions about committee benefit plans and priorities needs to come from a broadly-based group of people who care and have the expertise.

So form follows function, a lot of ways to get from here to there. The second point I'd like to make in terms of the partnerships, we just have a lot of progress to make in building coalitions between public health institutes and departments and hospitals and systems, and we have to reach out to each other. I think it would be wonderful if local health departments were so staffed with expertise that that could be provided in some

manner to the hospital or system, or maybe it could flow the other way. I think, in fact, it probably will flow both ways. But there has to be an openness. I want to cite an, as yet, unpublished small study in Kentucky, which is a rural state largely with 120 counties, a lot of health departments. And a recent study involved asking hospitals how they were working with local public health, in some cases regional public health departments. And it's growing, it's growing. It's heartening, yet one-fourth of the hospitals said they reached out to their local health departments and the local health departments were not interested in working with them on community needs assessment and other things. Now I'm not being critical, I'm simply saying that's information. And I'm sure that we'll also find situations where health departments reach out to hospitals or systems and they aren't home or interested or are too busy.

So it flows both ways. I think what we've got to do is lift the whole thing up. We have so much in common and so much we can do better together than separately and serve our communities better.

So we need to lift up the whole world of collaboration at all levels, in my judgment, between the public health community and the hospital so that everyone answers the phone and everyone is willing to share resources and find the best way to get from here to there; and not, again, unintelligently duplicate efforts or dis-coordinate efforts, try to use our resources the best way we can and coordinate our efforts. Great point. Mark, you get the last word. Okay. I'll try to make it brief. First, on health departments, of the 36 health departments, there's a reason why there's different levels of accreditation for health departments. There's a wide variety of structures and skill sets in there.

So, no, they don't all have the same competencies in terms of how they can be of assistance in the community health assessment process. What they all do, though, is provide us with direct access to secondary data that exists within their communities. And in our case, where we're doing primary research, they improve our outcomes because we're doing this under the egress of the health department, and so we have a better response rate on our surveys because it's coming from the health department rather than the hospital, there's no question, this is not a marketing thing, this is a population health improvement initiative. In terms of the community transformation grant question, interesting politics get in the way there. I was part of a group of 50 people in a room a few weeks ago that were trying to do exactly what you suggested, and we were coming forward with a grant proposal for the city of Milwaukee; we had all the right people around the table, we had their plan in place, and the governor has blocked the required letter from the Division of Health to support that effort.

So we are unable to apply for any of those grants in Wisconsin. In terms of core competency training at the local level, I'll just say that's my job. My job is to assure that I can develop that type of core competency. One of the ways I've approached that, in our structure we have subsidiary boards in many of our regions, and so I've gone in and done presentations to those boards, which has all the senior leadership for that area present; and we've spent a couple hours doing some training, if you will, at the board level and senior administrative level at the same time, and that really gives you, again, an instant level of credibility as to the organizational -- the importance we're placing on this at an organizational level. Please join me in thanking our panel.