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Hospital Community Benefits after the ACA: Partnerships for Community Health Improvement

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Introduction

The Hospital Community Benefit Program, established in 2010 by The Hilltop Institute at the University of Maryland, Baltimore County (UMBC), is the central resource for state and local decision makers who seek to ensure that tax-exempt hospital community benefit activities are responsive to pressing community health needs. One of the program's functions is to publish a series of issue briefs on promising practices, new laws and regulations, and study findings on community benefit activities and reporting.

This is the third issue brief in a series, funded by the Robert Wood Johnson Foundation and the Kresge Foundation, to be published over three years. The first and second issues brief in the series (Folkemer et al., January 2011; Folkemer et al., April 2011) outlined the new requirements for nonprofit hospitals established by § 9007 of the Affordable Care Act (ACA), and posed policy questions they suggest: How can states and localities ensure (1)

that community needs assessments accurately identify priority community health problems, (2) that community health improvement plans are responsive to the health needs thus identified, and (3) that public health agencies, community stakeholders, and hospitals address these problems in a collaborative, coordinated, and non-redundant way?

This third brief examines ways in which states and localities have responded to these challenges by participating in diverse collaborations, or partnerships, that are centered on community health needs assessments, priority setting, strategic planning, and the implementation of health improvement initiatives. These examples demonstrate that effective partnerships among public health agencies, nonprofit hospitals, and the communities they serve can be powerful forces for promoting community health improvement and systemic change.

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Community Health Partnerships and Nonprofit Hospitals

Community health partnerships have long been viewed in the public health community as an essential element of meaningful processes for community health improvement. Partnering to solve a community's health problems is mutually advantageous to health departments and other public health agencies, health care providers, local businesses, community-based organizations (CBOs), and other community representatives. Collaboration among these sectors can avoid duplication of services, leverage public with private resources, and focus available resources on a community's most important health needs (Weech-Maldonado, Benson, & Gamm, 2003).

The relative credibility, engagement, and influence of each partner—that is, the extent to which collaboration occurs among equal partners—affects the value and sustainability of health department/hospital/community partnerships. This way of thinking about collaboration builds on a model set forth by the Institute of Medicine (IOM) more than a decade ago. In 1996, the IOM noted that community participation through advisory groups or community coalitions had been mandated for a variety of government-funded public health programs. These requirements cast CBOs in the role of advising or partnering with public health agencies. The IOM (Institute of Medicine Committee on Public Health, 1996) observed that, in order to be successful, such partnerships require “a long-term mutual commitment, a genuine desire of each partner to understand the other, benefits to each partner that outweigh the costs of the partnership, and meaningful collaboration in defining agendas and action strategies” (p. 34). Although community integration into

health improvement initiatives may be more prevalent today than it was 15 years ago, the IOM's construct remains useful as a way of thinking about community partnerships. Today, whether or not health improvement collaborations are “meaningful” may depend even more on the partners' shared decision-making responsibility. Decision-making power and ownership of change processes have been recognized as being “among [collaboration's] most important characteristics” and “fundamental indicators of whether collaborative initiatives will have sustainable benefits” (Himmelman, 2002, at p. 5; also see CHA, 2011, Appendix C).

Section 9007 of the ACA establishes the criteria for nonprofit hospitals' federal tax exemption, requiring periodic community health needs assessments and the adoption of implementation strategies to meet identified community health needs (ACA §9007(a), IRC §501(r)(3)(A)). The needs assessments must “[take] into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and ... [must be] made widely available to the public” (ACA §9007(a), IRC §501(r)(3)(B)). The Treasury Department and the Internal Revenue Service (IRS) have stated clearly their intention to promulgate regulations requiring hospital community health needs assessments to take into account, at a minimum, input from (IRS, 2011, pp. 15-16):

- Public health experts
- Representatives of underserved and low-income populations, minorities, and pop-

ulations with chronic diseases in the community served by the hospital facility

- “Federal, tribal, regional, State or local health or other departments or agencies with current data or other information relevant to the health needs of the community served by the hospital facility”

This federal emphasis on hospital engagement in consultative processes with relevant public health agencies, public health experts, and community representatives is intended to ensure that hospital community benefit activities reflect an inclusive planning process that represents real dialogue with the community (The Hilltop Institute, October 2011). It also creates opportunities for encourage nonprofit hospitals to develop and implement community benefit activities that are aligned with public goals and health improvement strategies for their jurisdictions.

The inclusion of public health agencies in nonprofit hospitals’ needs assessment and planning processes, as well as in the hospitals’ community benefit programs and activities, offers a number of advantages to hospitals seeking to satisfy their community benefit responsibilities and comply with the ACA’s “Additional Requirements for Charitable Hospitals” mandate (ACA §9007).

Local health departments are a source of public health expertise: one of the “core functions” and “10 essential public health services” performed by local health departments is community health needs assessment (Institute of Medicine Committee for the Study of the Future of Public Health, 1988; Centers for Disease Control and Prevention, 2010a). Sixty percent of the nation’s local health departments have completed a community health needs assessment within the past five years (National Association of County and

City Health Officials, 2011, December). Needs assessment and other health department functions require the gathering and analysis of community health data. Local health departments are also experienced in reaching out to community stakeholders for health department assessment and planning activities (Brown, 2010). They are well-positioned to assist nonprofit hospitals that seek to identify and attract the participation of representatives of vulnerable populations in hospital needs assessment and community benefit planning—participation the IRS has indicated it likely will require (IRS, 2011).

- Increase assessment quality
- Reduce overall costs borne by all partners
- Lead to shared accountability for outcomes
- Promote trust and relationship-building among hospitals, local health departments, and members of the community

From the perspective of public health agencies, collaboration with hospitals for community needs assessment and health improvement planning can benefit a health department’s efforts to attain accreditation. National public health department accreditation, implemented on a voluntary basis by the Public Health Accreditation Board (PHAB) in 2011, is intended to foster improvement and protection of the public’s health by enhancing health department quality and performance (PHAB, n.d.). Community needs assessment is a threshold requirement of national health department accreditation; PHAB Standards 1.1-1.4 require health departments that seek accreditation to conduct or participate in “a collaborative process resulting in a comprehensive community health assessment,” to include the collection and

analysis of health data, identification of public health problems, and the development of recommendations on “policy, processes, programs, or interventions” (PHAB, 2011). Such collaboration between health departments and hospitals for community needs assessment and health improvement planning

can provide opportunities to leverage limited public resources with the private resources of nonprofit hospitals and the contributions of other community partners. Local health department-hospital collaborations may (Network for Public Health Law, 2011):

Partnerships for Needs Assessment and Health Improvement Planning

Community needs assessment and health improvement planning can be conducted in accordance with established assessment and planning tools or based on processes that are developed locally to take into account the resources that are available locally, as well as to reflect the individual characteristics and culture of the community. Communities can—and often do—embrace and combine both approaches to developing individual needs assessment processes with input from multiple sources.

The Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO) have developed a variety of assessment and planning tools, including Mobilizing for Action through Planning and Partnerships (MAPP), an interactive, staged process for community health improvement by means of enhancing local public health system performance (CDC, 2010a-b; NACCHO, 2012a-b; 2011, December; 2011a). The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute’s County Health Rankings and Roadmaps program provides reliable, county-level data and other resources for needs assessments and planning processes, along with evidence-based program strategies for community health improvement. Private nonprofit hospital-linked organizations have also developed tools and toolkits for mem-

bers’ use in assessments, priority setting, and planning processes. The tools developed or identified by the Catholic Health Association (CHA) are notable for their quality and public availability (CHA, 2012; 2011, March; 2008).

Examples of needs assessment and planning partnerships from Will County, Illinois, and Cecil County, Maryland, are described below.

Will County, Illinois. Beginning in 2008, the Will County Health Department (Will County) and Provena Saint Joseph Medical Center (Provena Saint Joseph) co-chaired Will County’s Community Health Plan Committee, which adopted the community-driven MAPP process. This multi-stage framework for prioritizing public health issues also helps communities identify existing resources for addressing such issues, as well as for developing and implementing community health improvement plans.

In Illinois, mandatory state certification of local health departments requires that a community needs assessment be conducted every five years, resulting in a community health plan. Will County adopted the MAPP assessment and planning process to fulfill these requirements for the 2010 planning cycle. Provena Saint Joseph was in the process of updating its annual community benefit plan in 2008 when it offered to collaborate

with Will County and co-lead the MAPP process.

At the beginning of the first phase of the process, a core planning team comprised of health department and hospital staff identified key community leaders who could assist in the planning process and identify additional participants. The result was a Steering Committee of 25 members representing a broad-based cross section of 20 local organizations, including all local hospitals. The Steering Committee led Will County's MAPP process through its six stages:

1. Planning for Success
2. Visioning
3. Assessments of Local Public Health Systems, Community Themes and Strengths, Forces of Change, and Community Health Status
4. Identifying Strategic Issues
5. Formulating Goals and Strategies
6. Action Cycle, including evaluation of progress made

The resulting community health plan, approved by Will County in January 2011, is a comprehensive strategic plan to improve the local public health system and community health. To provide ongoing data collection, assessment, and monitoring of plan implementation, the county established a Monitoring and Evaluation team (Will County Health Department, 2009; 2011a-c).

The assessment and planning process that Will County followed facilitated resource sharing among partners, allowed the partners to address community health issues broadly, and aligned hospital community benefit planning with community priorities for a healthier community (Will County, 2009;

2011a). Currently, four Action Cycle teams continue to address strategic issues in the areas of access to care, awareness of services, prevention and management of chronic care issues, and systems collaboration and linkages. Team initiatives include identifying and recognizing best practices, addressing obesity and promoting workplace wellness, and creating independent, dynamic community health collaborations.

Shared benefits resulting from Will County's collaborative assessment and planning process include:¹

- *For the hospital:* Participation in the county's assessment and planning process provided information on which the local hospitals could base their community benefit planning and effective use of hospital resources to maximize their positive impact on community health.
- *For the health department:* The collaborative process can satisfy the health department's community health needs assessment and planning responsibilities, resulting in a meaningful action plan for community health and local public health system improvement.
- *For the community:* The process can enhance the community members' ability to make their health needs and priorities known and participate in public health planning and the development of effective programs to improve community health.

Cecil County, Maryland. Cecil County's Health Department initiated an inclusive community-based approach to determining the county's health needs and priorities. The Cecil County Community Health Advisory Committee (CHAC), along with its four task forces (addressing, respectively, Healthy

Lifestyles, Cancer, Alcohol and Drug, and Tobacco), is a coalition composed of representatives from Union Hospital (the sole nonprofit general hospital in Cecil County); the health department and other local public agencies; the local United Way; and other community-based organizations, local businesses, and private citizens. CHAC and the task forces hold open community meetings at which health data and other relevant information are presented and analyzed as the basis for identifying community health priorities. The task forces periodically are reconstituted to reflect the community's changing health needs and priorities. CHAC is charged with developing and implementing a health plan for each identified health priority, using available community resources. It functions as a focal point of community collaboration for health improvement. The local hospital is an active participant in CHAC and in the task forces. The hospital's contributions to CHAC's processes have been substantial; for example, the hospital funded CHAC's comprehensive community-wide health survey in 2009,² which provided essential data for the 2010 County Health Plan (Cecil County Health Department, n.d.; 2010).

Benefits for the Partners include:³

- *For the hospital* – Participation in CHAC and the county needs assessment process provided a means of identifying priority community health needs; the hospital viewed CHAC as an external work group for its community benefit planning.
- *For the health department* – Private funding facilitated and enhanced the health department's collection of qualitative needs assessment data. Community involvement enriched health programming and planning for environmental change, and collaboration and information sharing among partners facilitated the direction of funding opportunities to appropriate entities within the community.
- *For the community* –The community's meaningful participation in needs assessment and community health planning processes established a forum conducive to partnership-building, health advocacy, and policy change. Benefits to the community were maximized, and duplication of effort was minimized, as a result of community-based agencies and organizations sharing resources and participating in one another's health improvement projects.

Community Partnerships to Develop and Implement Health Improvement Programs

In addition to its community health needs assessment requirement, §9007 of the ACA established new community benefit reporting requirements that are now incorporated into the IRS Schedule H (Form 990). These requirements mandate that hospitals submit audited financial statements as evidence of the community benefits that they report (ACA §9007(d)(1); IRC §6033(b)(15)). Although the law does not base federal tax ex-

emption on a nonprofit hospital's provision of community benefits at any specific quantitative level, the IRS will apply a "facts and circumstances" test to determine whether the benefits a hospital provides to its community are sufficient to warrant its federal tax exemption (IRS, 2009). Clearly, maintaining federal tax exemption status is a powerful incentive for nonprofit hospitals to provide community benefits at meaningful levels.

Collaborations to facilitate community health improvement provide a meaningful outlet for hospitals' community benefit expenditures and resource allocation in a context that includes community engagement and the input of public health experts, avoids duplication of effort, and aligns hospital community benefits with public health planning. Specific examples of collaborations for implementation of community health improvement programs follow.

Buncombe County, North Carolina: Project Access. The Buncombe County Health Department is the main provider of primary health care services to uninsured county residents. The need to identify specialists who would accept referrals of patients with low incomes who needed specialist services strained health department resources. Project Access, originally formed by the Buncombe County Medical Society Foundation in 1996, has developed into a partnership of the county health department, local physicians, county service agencies, Mission Hospital, and pharmacists (NACCHO, n.d.-a; Buncombe County Medical Society Foundation, n.d.). Through this partnership, Project Access provides a broad range of specialist and other services to any uninsured county resident with an income up to 200 percent of the federal poverty level who is referred by a physician, regardless of citizenship (Hall & Hwang, 2010).

Project Access's system of volunteer physicians provides specialty health care services to qualifying patients who are served by county health clinics. The burden of providing this free specialty care to the target population is distributed across the local medical community; no single physician is required to see more than 20 of these patients annually (less than 1 percent of the average practice),

and patients are assigned to physicians on a rotating basis. Ninety percent of the county's practicing physicians donate services to 10 to 20 patients per year who are referred through Project Access. The county covers the administrative costs and direct costs of drugs dispensed. The hospital does not charge these patients for hospitalizations, and program oversight is provided by the County Medical Society (NACCHO, n.d.-a; Buncombe County Medical Society Foundation, 2011). Durable medical equipment is donated by a local provider, and, in addition to waiving inpatient hospital charges, Mission Hospital donates Project Access patients' outpatient lab and radiology services (Hall & Hwang, 2010).

Project Access serves approximately 3,000 individuals annually. County primary care clinics now serve more than double the number of patients they served in 1995; this change is attributed in part to increased clinic capacity as a result of Project Access referrals to specialists of patients whose relatively serious conditions would otherwise have been managed in the primary care setting. Project Access has inspired more than 50 similar programs nationwide (Hall & Hwang, 2010).

Benefits for program partners include:

- *For the hospital:* Emergency department utilization by the target population has been reduced, as has charity care (Communities Joined in Action, n.d); the hospital's share of program costs can contribute to meeting the clinical care needs of the community's uninsured, low income population and provide a well-targeted outlet for discharge of the hospital's community benefit responsibilities.

- *For the health department:* The costs associated with providing clinical care to the county's low-income, uninsured population have been reduced; and primary care capacity and specialty care support for the county clinics' primary care operations have expanded.
- *For the community:* Physicians have embraced the opportunity to volunteer services in a system that spreads the burden of providing uncompensated services across the medical community. Access to health care services for uninsured individuals with low incomes has improved.

Richland County, Montana Diabetes Project. The Richland Health Network (Network), a consortium of the Richland County Health Department, the Richland County Commission on Aging, and the Sidney Health Center, conceived the Richland County Community Diabetes Project (Project) to provide coordinated health screening, assessment, health education, and case management services for older county residents at risk for preventable hospitalizations (Rural Assistance Center, 2005).

In the first year of its planning phase, the Project established an Advisory Board that included county residents with diabetes, medical providers, hospital representatives, dietitians, public health nurses, an aging services representative, local LIONS Club members, business representatives, and a Migrant Health Director. The Board conducted focus groups of individuals with diabetes, their families, and health care providers, which identified a desire within the community for more information about diabetes and a need for practical, understandable information for individuals with diabetes to use in their daily lives. In response, the Project opened a Diabetes Education Center (housed

at the Sidney Health Center and coordinated by the health department) and formed an education and support group to discuss diabetes-related topics at free monthly meetings that were open to the public. Other diabetes self-management, health education, and health promotion interventions were initiated, including a walking club, weight-loss programs, and worksite wellness activities (Diabetes Initiative, 2009). In-kind support from the Network included staff time, meeting space, equipment use, and outreach assistance. A formal diabetes education program was implemented at the hospital and coordinated by the health department (NACCHO, n.d.-b). The Project sought ongoing community input through regular meetings with other community health projects, the Richland County Senior Coalition, and the local Volunteers in Service to America program. The involvement of the larger community enabled the Project to continually update its programs to reflect current community needs and incorporate new approaches and collaborations to address those needs (Diabetes Initiative, 2009).

Benefits for program partners include:⁴

- *For the hospital* – Prevention resources for patients with diabetes were enhanced, there were fewer hospitalizations and re-hospitalizations of these patients, and the hospital had an outlet for effective community benefit activity.
- *For the health department* – Communication between the health department and the community improved, enhancing their ability to identify and address health problems in the community. The health department experienced reduced costs associated with treating chronically ill diabetes patients who, as a result of the

Project, may adopt healthier behaviors for improved health status.

- *For the community* – Coordination of health programs in the community improved their effectiveness, and there were increased opportunities for the diabetes-affected population, families, and

providers to effectively make their health care needs known and access diabetes and nutrition education and counseling. The community as a whole benefited from diabetes awareness education and screenings in local schools and businesses.

Partnerships for Policy Change: Community Health Improvement Strategies for Addressing Social, Economic, and Environmental Determinants of Health

The health improvement programs profiled in the previous section of this brief focus on improving access to clinical services and educating the community to promote healthy behaviors. This section explores community health improvement programs that aim to address social, economic, and environmental health determinants, often referred to collectively as “social determinants of health”—defined by the World Health Organization as “the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness,” which are “shaped by economics, social policies, and politics” (World Health Organization, 2012). The section begins with a brief description of resources that communities can access through the County Health Rankings and Roadmaps program, and in this context examines the themes underlying its support of initiatives to address multiple health determinants. Because of the immense scope of health-determining factors embedded in a community’s social, economic, and physical environments, meaningful improvement in these areas may depend upon systemic policy change.

Next, the section profiles two examples of partnership activity in pursuit of policy change to address negative social, economic, and environmental health factors in these

communities. The success of these programs can be attributed to broadly based collaborations of hospitals, public health agencies, and other community partners.

County Health Rankings and Roadmaps.

This program promotes public and policy-maker awareness that multiple determinants influence population health and longevity. Principal project activities include developing County Health Rankings for all 50 states, increasing community involvement and accountability for population health improvement, and developing incentives to encourage communities to implement evidence-based programs for population health improvement (Kindig, Booske, & Remington, 2010). County Health Rankings and Roadmaps is a source of county-specific health data and evidence-based action steps to address the multiple factors that determine community health (County Health Rankings, 2011a). County Health Roadmaps provides tools and resources for assessment, planning, and advocacy. The Roadmaps to Health Community Grants initiative supports two-year projects undertaken by partnerships of business, education, health care, public health and community organizations, as well as state and local policymakers. Grantees (profiled on the County Health Rankings and Roadmaps websites⁵) work to create positive policy and

system changes to address the social, environmental, and economic factors that influence community health (County Health Rankings, 2011b).

Quad City Health Initiative.⁶ The regional Quad City Health Initiative (Initiative) aims to improve community health through collaborative health promotion projects in the region that encompasses the Iowa cities of Davenport and Bettendorf, and the Illinois cities of Rock Island and Moline. Participants include health departments, health systems and providers, insurers, social service agencies, educators, businesses, media, law enforcement, and foundations. The Initiative's goals include (Quad City Health Initiative, 2012):

- Increasing public awareness of issues critical to community health
- Developing projects that address unmet needs or gaps in health services
- Fostering collaboration to coordinate and maximize resources
- Facilitating the collection, tracking, and reporting of data relevant to assessing community health status and needs

Significant financial support for the Initiative is provided by the Genesis and Trinity Regional Health Systems (Initiative, 2012). One project, "Creating a Healthy Workplace," is aimed at improving the health of the region's workforce." Partners in the program include the Activate Quad Cities (AQC) program (with parent organizations Scott County Family YMCA in Iowa and the Two Rivers YMCA in Illinois), and the Rock Island and Scott County health departments. The program develops guidelines and policies for adoption by local employers that encourage modifying workplace environments to pro-

mote increased physical activity, make healthy foods more available, and institute healthy workplace vending policies (AQC, n.d.).

The City of Davenport Parks and Recreation Department has worked to address negative environmental health determinants by establishing well-maintained and accessible parks and an extensive recreational trail system (Hauman, 2010). It has joined the Initiative, AQC, health departments, and local United Way organizations to develop an umbrella group (modeled after "Live Well Omaha"⁷) intended to facilitate sustainable funding and support from multiple sources and to foster alignment of the individual organizations' efforts to address their shared strategic goals

Benefits for program partners include:

- *For hospitals* – Large-scale prevention activities and health awareness at the community level enhance hospital capacity to initiate and support well-targeted and effective activities that promote community health.
- *For health departments* – Collaboration with multiple entities in a single forum creates a coordinating force to articulate and address community health needs.
- *For the community* – Community engagement supports partners sharing strategic policy goals to promote systems and environmental changes for community health improvement.

Boston, Massachusetts: Community Asthma Initiative.⁸ A 2005 study by the Massachusetts Department of Public Health reported that nearly 10 percent of Massachusetts children in kindergarten through the eighth grade had been diagnosed with asthma, including more than 24 percent of the student

population of several Boston schools (Massachusetts Department of Public Health, 2005). In response to these findings and to better meet the needs of patients with asthma, Children's Hospital Boston (Children's) undertook a multipronged approach to address this issue.

Children's developed its Community Asthma Initiative (CAI) in 2005 for two reasons: to provide needed services to its pediatric patients and to bring about systemic change using a model of care that addresses children's health needs more globally, including environmental health determinants. Its CAI program targets and abates environmental factors that exacerbate the disease, provides intensive asthma education to families, and provides enrolled children with appropriate primary care and specialty services. The program identifies children who are hospitalized or visit the emergency department for moderate to severe asthma, and who live in one of the eight Boston zip codes with the highest incidence of pediatric asthma. Eligible children are enrolled in the CAI program for a period of 12 months. Community-based nurse case managers conduct an assessment of each child's home environment and identify appropriate and effective modifications to that environment. These are often simple solutions, such as providing a vacuum cleaner, mattress encasement, or food storage containers to prevent rodent and insect contamination. When needed, CAI provides integrated pest management through a local "green" pest control provider. CAI can refer patients to the city's inspectional services department and legal services to assist clients' families in compelling their landlords to make the changes necessary to mitigate conditions in the home that can trigger asthma attacks.

Evaluation of the CAI program has established the program's effectiveness: As of September 30, 2011, the 800 children who had completed the program experienced fewer asthma-related hospitalizations (reduced 81 percent), fewer emergency department visits (reduced 62 percent), fewer missed school days (reduced 41 percent), and fewer missed work days for parents/caregivers (reduced 46 percent). These children's health care costs have decreased by 40 percent, demonstrating the intervention's cost effectiveness (Children's Hospital Boston, n.d.). These documented successes strengthened Children's efforts to promote replication of the program and expand its impact by reaching children across the city, state, and region. They also facilitated Children's partnering with additional organizations sharing that goal.

In 2007, the Asthma Regional Council of New England (a coalition of federal and state health, environment, education, and housing agencies that work to address environmental contributors to asthma) used data from CAI to develop the "business case" for cost-effective CAI-type interventions. This information was provided to health payer organizations and policy makers in search of opportunities to reduce the burden of asthma at a reasonable cost. (Hoppin, P., Jacobs, M., and Stillman, L., 2007; 2010).

Armed with the "business case," Children's then partnered with the Boston Urban Asthma Coalition, Massachusetts Asthma Advocacy Partnership, and the Asthma Regional Council to advocate for policy changes to ensure Massachusetts children access to the types of asthma services CAI provides. The partnership's advocacy activities were successful in that the Massachusetts legislature earmarked \$3 million in the fiscal year 2011

Medicaid budget to fund and evaluate a demonstration project to provide case management services to children with asthma. In January 2012, the Centers for Medicare & Medicaid Services (CMS) approved Massachusetts' Medicaid 1115 waiver renewal proposal, which included the proposed pilot program. In the near future, Massachusetts Medicaid is expected to issue a request for proposals and select six pediatric practices to participate in the asthma pilot program.

Benefits for program partners include:

- *For the hospital* – Working with its community and public health partners to develop and implement CAI advances the hospital's mission of advocating for systemic change that improves community health. CAI's demonstrated cost effectiveness (through the documented reduction of preventable emergency depart-

ment visits and hospitalizations) has created opportunities to scale up the care model upon which CAI is based, potentially through the program's replication in the state Medicaid program.

- *For the health department* – Interagency involvement and coordination facilitate the identification and abatement of environmental conditions that negatively impact children with asthma, and there is better asthma education and awareness in the community.
- *For the community* – Partnerships between public health agencies, hospitals, and community advocates have reduced the health care costs associated with preventable health care utilization by program participants. The targeting and abatement of environmental disease catalysts may be significant drivers of community health improvement.

State Policy Fostering Community Health Partnerships

The previous section provided examples of partnerships for community health improvement that have been initiated at the local level. This section focuses on state-level policies of various forms, including legislation, agency directive, and modification of existing state policies to facilitate, encourage, or even require local-level collaboration.

North Carolina Local Health Department Accreditation Board. The ACA requires nonprofit hospitals to complete a community health needs assessment every three years. Until recently, North Carolina's state accreditation-driven local health department community needs assessment cycle was every four years. The North Carolina Local Health Department Accreditation Board, part of the North Carolina Department of Health and

Human Services, recognized that inconsistent needs assessment cycles for North Carolina health departments and nonprofit hospitals would challenge their ability to conduct collaborative needs assessments. As a result, the state modified the accreditation standard to require local health departments to conduct needs assessments "every three to four years" (emphasis added) (North Carolina Local Health Department Accreditation Board, September 2011). This revision allows local health departments and nonprofit hospitals to collaborate in conducting their community needs assessments on a cycle consistent with both the hospitals' federal community needs assessment responsibility and the state's assessment requirement for local health department accreditation.

Maryland State Health Improvement Process.

The goal of Maryland's state health improvement process is to provide a framework for accountability, local action, and public engagement, leading to statewide health improvement. The state health department has established 39 health objectives in six vision areas: healthy babies, health social environments, safe physical environments, infectious disease, chronic disease, and health care access. For each objective, the state health department provides current baseline benchmarks and a target for improvement by 2014. It also provides data on critical health measures, broken down by race and ethnicity, to facilitate local planning efforts to target key health disparities, which is another state health improvement goal (Maryland Department of Health and Mental Hygiene [DHMH], 2011a).

Maryland's state health improvement process has established local health improvement coalitions (LHICs) led by local health officers. LHICs provide a forum for county health departments, nonprofit hospitals, and CBOs to analyze and prioritize community health needs and select appropriate health tracking measures from among those established by the state health department. These selected tracking measures are then used to inform community level decision-making.⁹ LHIC participants include health care providers, schools, and the business community. Each LHIC is tasked with developing a basic, short-term work plan for the county or region. Local hospitals contribute to these efforts by providing LHIC start-up funding through the state hospital association (Howard County Health Department, 2011) and make use of state-provided data to inform their community benefit activities. LHIC action items address local health priorities through clinical, environmental, policy, and

legal initiatives. The state health department will provide ongoing updates of the data, resources, and tools it provides for local action by LHIC partnerships to improve population health (DHMH, 2011b).

Minnesota Statewide Health Improvement Program.

In Minnesota, both hospitals and health maintenance organizations (HMOs) are required, in effect, to provide community benefits. Legislation enacted in 2011 requires the state Health Commissioner, in consultation with nonprofit hospitals and HMOs, to develop, by February 15, 2012, a plan "to implement evidence-based strategies from the statewide health improvement program as part of hospital community benefit programs and health maintenance organizations collaboration plans" (2011 Minn. Laws, 1st Sp. Sess., Ch. 9, H.F. 25, Art. 10, Sec. 4, Subd. 2, Statewide Health Improvement Program (b)). The Commissioner's plan must establish an advisory board charged with determining priority needs for health improvement, specifically directed toward the reduction of obesity and tobacco use in the state. The advisory board also will be charged with review and approval of HMO "collaboration plans" and hospital community benefit activities proposed and reported under applicable statutes (Id.).

Discussion is underway to determine the composition of this Community Benefit/Collaboration Advisory Board (Advisory Board), which will represent hospitals, health plans, local public health agencies, community organizations serving populations with disparate health needs, state-level advocacy organizations addressing health conditions, and at least one representative from the Healthy Minnesota 2020 Partnership. The Healthy Minnesota 2020 Partnership, which consists of local public health agencies, busi-

ness communities, and health care providers, works with the Commissioner of Health to establish statewide public health priorities for the Healthy Minnesota 2020 plan (Minnesota Department of Health, 2011).

The Minnesota Department of Health has convened town hall collaboration meetings to solicit stakeholder feedback on the development and implementation of evidence-based strategies for inclusion in the Commissioner's plan. Stakeholder participants include nonprofit health plans, hospitals, community-based organizations, advocacy groups, and local health departments. At the first meeting, participants discussed the opportunities and challenges of collaborating for communi-

Policy Implications

The ACA's watershed community benefit framework presents opportunities for policy makers at the federal, state, and local levels to consider how they can encourage and support ongoing, effective partnerships for community health improvement, as well as form new ones. A number of issues arise in this context.

Through IRS Notice 2011-52, the IRS has clarified how it will require nonprofit hospitals' collaboration with public health experts (including health departments) and the community to satisfy the ACA's community needs assessment requirement. In terms of ACA-required "implementation strategies," nonprofit hospitals and their partners in some communities are leading the way in identifying workable strategies. Their work should guide the IRS as it further defines the scope and limits of federally-defined "community benefits."

As hospitals begin to focus on compliance with the ACA's community health needs assessment requirement (effective for tax years

ty health improvement. Initial stakeholder feedback has emphasized the "alignment of work" as an opportunity for advancing state health improvement. Identified challenges include differing assessment and reporting timelines, lack of common language, and uncertainty regarding whether the new state requirements will conflict or align with hospitals' federal community benefit reporting requirements under IRS Schedule H (Form 990). A draft plan was disseminated at a town hall meeting on January 30, 2012. The Commissioner is legally required to finalize and implement a plan by February 15, 2012.

beginning after March 23, 2012), state and local policy makers are taking steps to encourage productive local partnerships of nonprofit hospitals, health departments, and their communities for needs assessment, health improvement planning, and to enhance the quality and effectiveness of their communities' public health infrastructure. Considering the application of these practices in other communities and looking at the resulting health improvement outcomes may contribute to achieving the express and implicit ACA goals of community engagement and robust, effective stakeholder partnerships.

State decision makers want to ensure that local and statewide health improvement priorities are aligned. At the same time, they want to support effective local collaborations that endeavor to address community-specific health needs and priorities. As illustrated by many of the endeavors described in this brief, integrating collaborative efforts aimed at community health improvement requires the

focused leadership and sustained commit-

ment of many groups and individuals.

Conclusion

For its tax years beginning after March 23, 2012, the ACA requires each nonprofit hospital to report that, either during that tax year or during one of the two immediately preceding tax years, it has conducted a community health needs assessment and adopted an implementation strategy to address the identified needs of the community it serves (ACA §9007(f)). The ACA's watershed community benefit framework presents opportunities for state and local health departments to initiate and participate in partnerships with nonprofit hospitals through which hospitals can satisfy their federal community benefit responsibili-

ties. With the inclusion of CBOs and other members of the community, such partnerships can harness diverse community perspectives, strengthen community assessment and planning processes, engage new and valuable sources of community expertise, and facilitate sharing of data sources.

Successful partnerships among public health agencies, nonprofit hospitals, and communities can leverage public and private resources to develop and implement effective, coordinated, and non-redundant initiatives to improve community health.

Endnotes

¹ Hilltop Communication with Vanessa Newsome, MAPP Project Coordinator, January 29, 2012.

² Interview, Cecil County Health Officer Stephanie Garrity, August 8, 2010.

³ Hilltop communication with Rangika Fernando, Epidemiologist, Cecil County Health Department, January 17, 2012, and Jean-Marie Donahoo, Community Benefits Coordinator, Union Hospital, January 13, 2012.

⁴ Hilltop communication with Theresa Livers, Continuum of Care Administrator, Sidney Health Center. In addition to providing information about the experience of Sidney Health Center, Ms. Livers contacted and relayed the comments of Rajohn Karanjai, MD, who holds positions as both Sidney Health Center's Medical Director and Richland County's Health Officer.

⁵ For case profiles of community health improvement projects led by Roadmaps to Health Community Grant recipient organizations and case studies of projects incorporating the County Health Rankings, see "County Health Roadmaps" at <http://www.countyhealthrankings.org/roadmaps> and <http://www.countyhealthrankings.org/your-stories>.

⁶ Except as otherwise indicated, information is derived from Hilltop communication with Christy Filby, Community Wellness Executive, Activate Quad Cities, January 25, 2012.

⁷ For an explanation of Live Well Omaha, see <http://livewellomaha.org/about/>.

⁸ Hilltop communication with Patricia Adams, Director, Minnesota State Health Improvement Initiatives, Minnesota Department of Health.

⁹ Hilltop communication with Madeleine Shea, Office of Population Health, Maryland Department of Health and Mental Hygiene.

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The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized policy and research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. To learn more about The Hilltop Institute, please visit www.hilltopinstitute.org.

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