

Successes and Challenges in Community Health Improvement: Stories from Early Collaborations

Introduction

Under the Patient Protection and Affordable Care Act (ACA), the Internal Revenue Service (IRS) requires tax-exempt hospitals to implement [community health needs assessments](#) (CHNAs) and strategies. Although governmental public health, hospitals, and other community organizations have collaborated for years, these assessments and strategies create an important opportunity to improve the health of communities. CHNAs help ensure that hospitals have the information they need to provide community benefits that meet their communities' needs. They also provide an opportunity for community engagement and improved coordination of hospital community benefits with public health and other efforts to improve community health.

This issue brief provides a system-wide view of the challenges and opportunities that CHNAs and population health improvement present by sharing the perspectives of those in health systems, nonprofits, and other community organizations, along with those of public health officials, from three states: Massachusetts, Maryland, and North Carolina.

MASSACHUSETTS

Background

Starting with the passage of the Determination of Need (DoN) regulations in 1971, Massachusetts adopted multiple statutory, regulatory, and policy strategies to promote accessible, cost-effective, quality health services. Collectively, these laws, regulations, and policy initiatives provided infrastructure supports and a context in which new community health planning provisions of the ACA advanced.

One example of these strategies is the Massachusetts [DoN program](#), which requires program and funding linkages between capital investments in health services and public health planning. Additionally, the Massachusetts attorney general maintains [guidelines](#) for nonprofit hospitals and health plans on how their community benefit obligations should be met, including direction on community engagement, needs assessment processes, and standardized public reporting of community benefit investments.

Although many of the elements of CHNAs existed in Massachusetts prior to ACA's implementation, ACA offers new CHNA reporting requirements, as well as new opportunities to align and evaluate the existing state practices aimed at promoting effective and efficient population health improvement.

TWO PERSPECTIVES ON SUCCESS

Central Massachusetts Regional Public Health Alliance: A Lasting Partnership Begun by Visionary Leaders Facing an Economic Crisis

The [Central Massachusetts Regional Public Health Alliance](#) is a health improvement collaborative involving the City of Worcester and five surrounding towns of Holden, Leicester, Millbury, Shrewsbury, and West Boylston. The alliance is led by the City of Worcester Division of Public Health, University of

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Massachusetts (UMass) Memorial Medical Center, and Common Pathways, a healthy communities coalition.

The collaborative preceded ACA's implementation, arising in large part due to severe economic decline and budget cuts that the City of Worcester confronted in 2008. Leaders in city government and at UMass Memorial Medical Center, recognizing the economic downturn as a serious threat to the health of local residents, were spurred to develop what has become a long-term, meaningful partnership. The hospital system's chief executive officer (CEO) and the city manager were highly influential decisionmakers and were able to see sustained opportunities for health improvement in the economic downturn. The hospital co-funded the Greater Worcester CHNA and the ensuing [Community Health Improvement Plan \(CHIP\)](#) and provides funding to the city to support the position of city health commissioner, a physician colleague for the director of the city's Division of Public Health.

The hospital used the region's [CHNA](#) and CHIP as the foundation for its IRS-required implementation strategy, with recommendations for hospital investments developed through an interactive process involving public health officials and hospital leadership.

While the collaborative aims to make the Greater Worcester region the healthiest in the state by 2020, it has also been successful in securing additional funding through private philanthropies. In early 2014, it won a multiyear award from the [Massachusetts Prevention and Wellness Trust Fund](#) to address three key local priorities: pediatric asthma, fall prevention, and hypertension. Examples of clinical and community interventions to address these priority health conditions include:

- Pediatric asthma: care management for high-risk asthma patients and home-based multi-trigger, multi-component interventions.
- Fall prevention: comprehensive clinical multi-factorial fall risk assessment and home safety assessment and modification for falls prevention.
- Hypertension: evidence-based guidelines for diagnosis and management of hypertension and chronic disease self-management programs.

Another product of the collaboration has been the development, with significant financial support from UMass Memorial's community benefits budget, of an academic health department at Clark University in Worcester. The former CEO of UMass Memorial Health Care, who drove the initial hospital-city partnership, is now on the faculty at [Clark](#), where a new department will work with the city's health department to focus on community engagement for population health, workforce development, practice-oriented research, and shared funding opportunities.

In summary, the region's economic crisis demanded that all available community health improvement assets and interventions be aligned and data-driven. Public health and hospital leadership recognized the fiscal circumstance as an opportunity for reframing their organizations' traditional boundaries and operating spheres. An inclusive and sustained collaboration has yielded concrete gains for the region's health and economy.

Massachusetts General Hospital: A Major Teaching Hospital Confronts a Substance Use Epidemic and Examines Its Internal Culture

Massachusetts General Hospital (MGH) is a nationally recognized 900-bed academic hospital in Boston, located in an urban area with dozens of general and specialty hospitals. MGH's [mission statement](#) reads, "Guided by the needs of our patients and their families, we aim to deliver the very best healthcare in a safe, compassionate environment; to advance that care through innovative research and education; and to improve the health and well-being of the diverse communities we serve."

MGH's Center for Community Health Improvement focuses on the mission statement's final clause: improving the well-being of diverse communities. The center targets three area neighborhoods of long-standing need—Chelsea, Charlestown, and Revere—and supports three approaches to community health improvement:

- MGH functions as the backbone organization for community coalitions working on policy, system, and environmental strategies to build healthier communities.
- The center offers healthcare navigation and supports community health workers to guide vulnerable patients through the healthcare system.
- The center offers youth programs to generate interest in science and health careers.

From 2012 to 2013, MGH collaborated with these communities to develop three separate [CHNAs](#). By a wide margin, each of these communities identified substance use as the top priority. They also identified issues such as obesity, violence, high-risk behaviors, teen pregnancy, and cancer prevention as long-standing priorities.

In response, the center is now embarking on a comprehensive hospital- and community-wide effort to address the communities' pervasive substance use epidemic with a longitudinal chronic disease management plan, much like that applied to other chronic conditions. The hospital's approach is to work through coalitions and its own vast institutional resources to implement evidence-based interventions that correspond to all levels of the [Health Impact Pyramid](#).

The hospital conducts strategic planning every 10 years. For its plan completed in spring 2014, it took into account CHNA results for the first time. Looking at data on patients from the communities with substance use disorders, it became clear that they have higher rates of hospitalization longer lengths of inpatient stays, and higher readmission rates. As a result, the hospital adopted a comprehensive overhaul of care for patients with substance use disorders as a major initiative.

More traditional approaches to preventing substance use disorders have focused on the upper level of the Health Impact Pyramid, with measures such as individual counseling and youth education. However, mid-level clinical interventions, such as early diagnosis, evidence-based treatment, and anticipatory supports to promote treatment adherence, have not been systematically applied to substance abuse disorders. MGH plans to consistently apply clinical interventions to prevent, detect, and treat substance use among its thousands of patients as a means of addressing this community priority.

The center's ability to leverage MGH's extraordinary array of institutional patient care, education, and research resources was greatly enhanced when MGH adopted community health improvement as a fourth pillar in its mission statement. To operationalize this commitment, the hospital's governance structure was amended to create the Executive Committee on Community Health as a parallel to the Executive Committees on Research and Education. Like the other executive-level committees, the Executive Committee on Community Health reports to the hospital president and trustees through the General Executive Committee. The purpose of this new governance structure is to make the hospital's community health commitment more internally explicit and more aligned with patient care, research, and teaching. The objective is for community health improvement to become essential the organization's systems, processes, and culture.

STRATEGIES FOR MANAGING EMERGING CHALLENGES

Challenge: Community Health Improvement Demands Resources

Financial Resources and Organizational Bandwidth

Maintaining robust community engagement in comprehensive CHNAs and CHIPs requires a significant commitment of resources. Necessary resources include both direct funding and organizational focus. Both Massachusetts efforts described above faced resource challenges: Worcester with a serious funding shortage and MGH with multiple competing organizational priorities. Both have been successful by searching out existing parallel assets or activities—one with shared objectives—to be leveraged toward community health improvement. UMass Memorial's fiscal investments in community health leveraged private foundation support, major new grant awards, and an unanticipated new academic partnership. MGH's internal governance changes not only reflect an institutional commitment, but also are seen as strategies to partner with other institutional leaders to instill population health improvements in setting the organization's research agenda and teaching priorities.

Data Resources

Accurate and timely small-area health data are another type of resource that community health improvement processes require. Often, conditions that are of key importance to community coalitions are ones with a dearth of supporting behavioral, prevalence, or morbidity data. Indicators available from official state and federal sources may be delayed, applicable only to county or larger populations, and limited to mortality data. The [Massachusetts Community Health Information Profile](#) (MassCHIP) is an information service that provides community-level data to assess health needs, monitor health status indicators, and evaluate health programs.

Strategic active partnerships between public health and hospitals can yield new ways to frame data inquiries and new data sharing agreements to better monitor population health.

Community Engagement

To maximize the promise of population health improvement, CHNAs and CHIPs need to be conducted in an open manner with full community participation. There is a risk that hospitals may perform CHNAs

and CHIPs in a perfunctory manner intended to minimally satisfy federal requirements. There is also a concern that hospital may steer CHNAs and CHIPs to prioritize preferred programs and interventions. A related concern is that hospitals may select target communities that do not truly reflect the most vulnerable populations in their service areas.

To counter these risks, public health officials can vigorously educate and engage their communities and assertively seek partnerships with local hospitals' top leadership to share data, assessment methodologies, evidence-based interventions, and community coalitions. Given the opportunities presented by the fundamental health system changes presently underway across the country, public health should not wait to be invited to partner with hospitals in this work.

Finding Efficiencies in Community Health Improvement Processes

The concern that hospitals may seek shortcuts in complying with federal CHNA/CHIP requirements has a flip side. Hospitals are finding that some public health methodologies for community engagement and CHNA/CHIP are extremely time- and resource-intensive. Hospitals serving multiple communities may report that multistep comprehensive assessment, prioritization, and action planning sequence, with full community engagement, requires a very high level of institutional resource commitment. Even more concerning is the potential strain and disengagement by community members who are asked to volunteer for these efforts every three years. Hospitals seeking to truly engage with their communities, rather than hire consultants to produce required CHNAs and implementation strategies, are asking public health officials for streamlined assessment/reassessment tools in order to adhere to the frequency of ACA schedules while maintaining community input.

Another inefficiency identified by Massachusetts hospitals, as well as other states, is the overlapping but uncoordinated field of community assessments that are required of hospitals, local and state health departments, federally qualified health centers (FQHCs), community action agencies and other federal grantees, United Way affiliates, and banks subject to Federal Reserve requirements. The amount of duplication of assessment in a given community may be very significant. An even greater concern is the inability of hospitals, as potential partners, to easily identify and map relevant agencies' priorities, implementation strategies, and outcome measures across shared constituent populations.

Massachusetts has taken steps to align CHNA requirements of the DoN program to allow hospitals to jointly satisfy reporting responsibilities for its attorney general. There may be opportunities for even greater state regulatory flexibility in coordinating with various IRS-mandated assessments, the commonwealth's attorney general, and the DoN program. Other states with regulatory requirements related to community health processes may find efficiencies in allowing some or all portions of federally mandated CHNAs or implementation strategies to substitute for certain state mandates.

Challenge: Implementation Is Difficult

Change Can Be Disruptive and Requires Evidence

As is the case around the country, Massachusetts public health agencies and hospitals are moving toward the second round of ACA-required CHNAs and implementation strategy reporting. This

progression signals a shift from attention on assessments to implementation strategies—more energy and focus on “doing” rather than “planning.”

There are several factors contributing to the difficulty of this transition. In some communities, public participation has been exclusively centered on developing the CHNA, while the work of developing hospital implementation strategies has not been widely understood or is regarded as the hospital’s prerogative. Aligning community benefit investments to CHNA priorities, as was done in the two Massachusetts examples, may be disruptive to past community benefit expenditures and threatening to previous interests and grantees. Moreover, the field of evidence on the health and economic returns on investments in many population health interventions is still in early stages and continues to evolve.

There are several resources available to those working on community health improvement that provide authoritative guidance on evidence-based community health interventions, including:

- [The Guide to Community Preventive Services \(The Community Guide\)](#).
- [Trust for America’s Health](#).
- [CDC’s Healthy Communities Program](#).
- [National Prevention Strategy](#).

This emerging field of evidence is of high value to many, including hospital leaders seeking to make the business case for community health improvement to operating boards and foundation trustees. This is ripe for active technical assistance partnerships between public health, hospitals, providers, health plans, and businesses at national, state, and local levels.

Public Health Jurisdictions and Hospital Service Areas Often Do Not Align

Massachusetts has 351 local health boards and departments serving towns and cities. In part, the 1990s effort by the state health agency to define community health network areas was to regionalize health planning and program development and support inclusive stakeholder engagement in ways that typically exceeded the capacity of small boards of health. Over the past four years, the state health agency has used funding from the National Public Health Improvement Initiative to create several public health districts to promote shared staffing and services among groups of cities and towns. Each of the districts has conducted CHNAs for their combined populations, typically in cooperation with hospitals. The disconnect between public health agencies’ geopolitical boundaries and hospitals’ service area can be a partnership challenge, along with a striking imbalance in local public health and hospital resources. The geographic problem was accommodated in Central Massachusetts by including five towns with the City of Worcester in the target population for the collaborative planning work. Moving autonomous jurisdictions to join a regional collaborative while preserving local identity and engagement may be politically sensitive and call for negotiated accommodations in the collaborative’s structure and deliverables.

Conversely, like other major metropolitan cities, the Boston Public Health Commission, which is the health department for Boston, serves a jurisdiction with an abundance of hospitals, some of which have historically competed or operated in specific neighborhoods without shared engagement. While these urban hospitals may engage with community residents in their traditional service areas around CHNA

and CHIP work, the result may be a highly fragmented array of uncoordinated interventions across the city's neighborhoods. The [Community Benefits Committee](#) of the Boston Conference of Teaching Hospitals, a coalition of 14 teaching hospitals, shares best practices and is considering approaches to this fragmentation. One approach under development is for all member hospitals to agree to undertake at least one shared intervention for a period in order to evaluate the synergistic effectiveness of collective effort.

Anchor Institutions and Social Determinants

The [anchor institution initiative](#) is an emerging model relevant to community health improvement work at MGH and other major hospitals. Anchor institutions are nonprofit organizations (e.g., hospitals, universities) that, once established, do not move locations in order to leverage their employment, procurement, business practices, and environments to produce targeted community benefits.

As one of Boston's long-term, place-based major employers, MGH represents a key determinant of the metropolitan area's health, economy, housing, education, transportation, and overall well-being. Nationally, hospitals, universities, libraries, and other major urban institutions are examining their roles as engines of economic and community development in their respective communities, along with the implications and opportunities associated with that central role. The relationship of the institution to its community and the ensuing civic contributions are related to community health improvement efforts. Through a magnifier effect, the impact of an anchor institution's deliberate or unintentional actions may far exceed the gains achieved through its compliance with statutory obligations for community benefit. The Center for Community Health Improvement at MGH is exploring the anchor institution model and its potential to strengthen the Boston metropolitan area by leveraging MGH's untapped potential to positively impact an array of social determinants of community health.

Maryland

Background

Since the mid-1970s, Maryland has held a unique, federally approved hospital rate-setting arrangement known as the Hospital Waiver Program. Under the program, all payers, including Medicare, Medicaid, and private insurance plans, pay the same hospital-specific rates for inpatient care and hospital-based emergency and ambulatory care. Each hospital's rates are determined by a state commission based on costs, revenues, and other factors. In January 2014, the federal Centers for Medicare and Medicaid Services (CMS) approved a modernization of [Maryland's waiver](#) to allow for new policies that reduce per capita hospital expenditures and improve health outcomes as encouraged by ACA. By shifting away from traditional fee-for-service payment, the new model encourages collaboration between hospitals and community providers to improve patient care, promote innovative approaches to prevention, and avoid unnecessary admissions and readmissions.

Maryland has adopted other measures impacting public health and health systems that provide foundational support to community health improvement collaboration. The Maryland Health Services Cost Review Commission, which establishes hospital rates, also has statutory authority to collect, standardize, audit, and report [annual community benefit data](#) for each Maryland hospital.

In 2012, Maryland's Department of Health and Mental Hygiene (MDDHMH) launched a state health improvement process (SHIP) to provide a framework for accountability, local action, and public engagement to advance the health of Maryland residents. SHIP serves as the framework and support for hospitals performing CHNAs. Based on an iterative process of expert interviews and best evidence, 39 health indicators were selected as priorities for state and local action. Seventeen multisector community collaboratives, known as [local health improvement coalitions](#) (LHICs), were established statewide with seed funding, data, and technical assistance provided by MDDHMH, with supplementary startup funding from the state hospital association.

Another important state innovation that is promoting local integration of public health and hospitals is the Maryland Health Enterprise Zone (HEZ) Initiative. The [HEZ Initiative](#) is a four-year pilot program designed to: (1) reduce health disparities; (2) improve healthcare access and health outcomes in underserved communities; and (3) reduce healthcare costs and hospital admissions and readmissions. To receive designation as an HEZ, community coalitions identified contiguous geographic areas with measurable economic disadvantage and poor health outcomes and proposed a creative plan for targeted investments in community health.

TWO PERSPECTIVES ON SUCCESS

MedStar: A Hospital System's Approach to Addressing the Needs of Vulnerable Populations

MedStar is a not-for-profit health system that operates seven hospitals in Maryland and three in the District of Columbia. MedStar was founded in 1999 and has progressively increased the number of previously independent hospitals joining the system. Member hospitals range from major metropolitan tertiary care centers to small community hospitals that serve rural populations. These member hospitals serve widely different communities and bring different histories and internal cultures to conducting CHNAs and implementing strategies for improvement.

MedStar's hospitals published their first round of ACA-compliant CHNAs in June 2012. The process was led by a community-based advisory task force (ATF) at each hospital. The ATFs review community health data and local, state, and national community health goals. A community benefit service area (CBSA) was identified for each hospital—a discrete geography with a high volume of preventable illness, premature mortality, poverty, unemployment, low literacy, and other social conditions linked to poor health. Surveys distributed to community members helped the hospitals identify and prioritize key health priorities within the CBSAs. Based on the hospital's clinical expertise and capabilities, three-year implementation strategies were developed. The strategies were written by the hospital lead and supported by the executive sponsor, with final approval by the MedStar Health Board of Directors. The strategies serve as roadmaps for how community benefit resources will be allocated, deployed, and evaluated. The first round of CHNAs largely focused on outcomes of participants enrolled in education and screening programs that were evidence-based or promising practices. Although the hospitals had unique priorities, heart disease was identified as a system-wide priority.

Within the context of addressing root causes of poor health among vulnerable populations, the next round of implementation strategies will emphasize process measures and strategic partnerships that help cultivate a robust network of wraparound services. By analyzing charity data by race, ethnicity, age,

gender, health condition, and Zip code, implementation strategies will better target specific demographics and neighborhoods of need. Hospitals will partner with colleges and universities and provide internships for students who assist with neighborhood-level asset mapping.

Each MedStar hospital's CHNA and implementation strategy are posted online. These documents are considered to be valuable to all community stakeholders and important to share. They were not developed or intended to serve as marketing or proprietary documents, but rather as a resource for the community.

Worcester and Allegany Counties: Rural Culture of Collaboration Promotes Innovation

Worcester County is a largely rural jurisdiction on Maryland's Eastern Shore with a population of approximately 55,000 and a single community hospital, Atlantic General Hospital (AGH), which opened in 1993. Worcester County Health Department and AGH have enjoyed strong partnerships between the organizations and their respective individual leaders. For instance, the LHD director serves as an ex-officio member of AGH's board of directors.

Local public health and the hospital anchored collaborative community health improvement work for years prior to ACA's passage. In fact, several years ago, the capacity of the community coalition to produce high-quality population health assessments presented a challenge to the cadre of private-sector hospital vendors to develop true population-based analytics and recommendations rather than marketing analyses. As a result, however, the private vendors who had previously focused exclusively on hospital utilization and market share indicators are now learning about, using, and appreciating broader population health indicators, such as those that are used in Maryland's SHIP.

Shared governance of health improvement coalitions can be an effective level-setting strategy, particularly when there is an imbalance of resources between public health and the hospitals. Moreover, when Worcester County's public health agency and hospital joined with those of two surrounding counties for a [regional assessment](#), all six entities contributed equally to fund a consultant. Despite significant relative differences in available resources, the public health members felt strongly that equal investments provided for equity in the direction and ownership of the effort.

Collaboration in Worcester includes the community college, businesses, housing and community action agencies, school system, the area health education center, and many others. Active engagement by coalition members is closely monitored, and deliberate steps are taken to ensure all sectors have a voice. Both areas have weathered difficult economic downturns in recent years, and members of both coalitions express the view that local economic challenges produced lasting positive change to the partnership. The breadth of active membership in these rural coalitions is reflected in the recognition of socioeconomic and environmental health priorities.

Both counties have successful collaborations and share features that may be unique to rural areas, including a single nonprofit hospital and long-serving, highly respected local public health leadership. In addition to certain structural and leadership advantages, Maryland's new hospital rate-setting initiative puts powerful incentives in place for hospitals to reduce admissions through improved population health. Many rural hospitals, with well-defined noncompeting service areas, voluntarily elected to

participate in the state's global payment system prior to CMS approval of the new rate-setting program. Beyond collaborating for shared CHNA purposes, Worcester County Health Department and AGH are actively developing new accountable care organization (ACO)-like partnerships around care transitions, home visiting, and secondary prevention.

As seen in other states where high-performing collaboratives are readily apparent, success spawns success. Both of these small rural counties have been successful in securing state and federal recognition grants that will further drive health improvement. Allegany County received a state Care Delivery Integration Award, and Worcester County was awarded a CMS Patient-Centered Medical Home grant and state Diabetes Care Management and Behavioral Health/Primary Care Integration grants. These initiatives are validating improved outcomes through integrated prevention and care.

STRATEGIES FOR MANAGING EMERGING CHALLENGES

Challenge: Community Health Improvement Activity Is Increased But Still Siloed

CHNAs Are Not Coordinated

Most CHNA and CHIP efforts in Maryland are still conducted independently and without meaningful integration, according to public health and hospital sources. For instance, MedStar hospitals convened advisory task forces to inform their CHNAs, often in counties where the LHICs were underway, to conform to state SHIP and Public Health Accreditation Board (PHAB) expectations.

There are many reasons for this disconnect in Maryland, including differing assessment schedules and target populations. Practices in other states, such as agreeing to synchronize assessments and developing regional assessments that can be disaggregated, may be strategies to integrate various community assessments performed to meet IRS, PHAB, or other external requirements. Where awarded, special grant programs such as HEZs, CMS Innovations, and other initiatives are serving to spur new local partnerships and modeling positive outcomes. To disseminate awareness of these models among hospitals, LHDs, and others, MDDHMH supports an [Innovations website](#) that highlights financial, clinical, and integrated innovations, many of which include community health improvement models.

Hospital and Public Health Leaders Need Continued Support To Reframe Roles and Relationships

Both hospital and public health sources referenced difficulties introducing and maintaining culture change, rethinking old norms, shifting from individual medical models to population-based prevention strategies, and extending personal invitations for new relationships. Public health officials may be reluctant to engage with hospital leadership due to perceived political or economic imbalances. Some leaders find it difficult to substitute the appeal of individual community programs with less visible but more effective environmental and policy changes. Public health can continue to provide guidance to hospitals on selecting evidence-based interventions, such as the [The Community Guide](#).

Regarding hospitals' efforts to advance CHNAs, care coordination, and data analytics, one representative noted, "Hospitals have three ways to meet our goals. We can buy it, build it, or partner." Some hospitals still find it is easier to buy a CHNA through a consultant than to partner with public health and the

community. The new rate-setting incentives make this a pivotal time for hospital/public health relationship-building in Maryland.

MDDHMH and the state hospital association are teaming up to develop active assistance for their constituents to overcome these challenges. A series of meet-and-greet sessions are planned for local hospitals and public health agencies to share strengths and interests in forming partnerships to improve health, avert unnecessary admissions, and reduce costs.

Legal Barriers Can Impede Partnerships

Some of Maryland's most motivated public health leaders have been stymied by legal, regulatory, and policy barriers as they've sought more collaborative relationships with hospitals. Conflict-of-interest provisions, procurement law and policy, and indemnification protections have slowed formal agreements between Maryland public health and private entities, including hospitals. For example, establishing 501(c)(3) status for a coalition or serving in a governance role may be challenging for public health officials bound by state ethics and other restrictions. MDDHMH has recognized this as a significant challenge for state and local public health and supports a full-time attorney to develop and apply model language and otherwise streamline contracting processes.

Challenge: Maryland's FQHCs Could Contribute More to Community Health Improvement

There are 16 FQHCs in Maryland, generally operated independently of hospitals. FQHCs are required by their federal funder, the Health Resources and Services Administration (HRSA), to assess their own communities' health needs. Maryland FQHCs participate to varying degrees in LHICs and other community coalition meetings. However, it was noted that many FQHCs seem to derive most direction from HRSA and have very limited strategic engagement with hospitals and public health around community health improvement. MDDHMH is working to bring FQHCs more closely into community health improvement efforts.

Challenge: Sustained Funding for Community Health Improvement Is Needed

Virtually all hospitals and public health officials acknowledged that effective community health improvement outcomes require some form of dedicated funding and staff. Maryland has yet to identify sustained funding sources for the LHICs and is closely following practices in other states, such as Massachusetts' Prevention and Wellness Trust Fund and DoN Program.

North Carolina

Background

North Carolina has a decentralized public health system, and for more than 30 years, hospitals and public health agencies in the state have worked together on a spectrum of public health initiatives. Prior to the new IRS CHNA requirements for nonprofit hospitals, the state health director and the CEO of the North Carolina Hospital Association convened a public health/hospital collaborative, including

representation from the North Carolina Institute for Public Health (NCIPH), the practice core of the University of North Carolina at Chapel Hill (UNC) Gillings School of Global Public Health.

The [North Carolina Public Health/Hospital Collaborative \(PHHC\)](#) is a partnership of local and state public health leaders, hospital leaders, and community-based stakeholders created to focus health improvement initiatives, unify health advocacy, share data and information, and capture and disseminate best practices. PHHC is particularly involved in community health assessments (CHAs) and developed the following goals regarding CHAs:

- To create a common understanding of changes in CHA and community benefit laws among hospital and health department leaders to promote collaboration among North Carolina hospitals and health departments on these activities.
- To create models of effective community collaboration that integrate CHAs and community benefit into an improvement cycle that advances Healthy North Carolina 2020 outcomes.
- To develop a national model for conducting collaborative CHAs among local public health agencies, hospitals, and other partners.

In the last several years, various PHHC partners have led [initiatives](#) to accomplish these goals and create effective community collaboration, including synching of CHA and CHNA assessment cycles and implementing a learning collaborative to model effective community collaboration.

North Carolina has many assets and a history that is supporting collaborative community health improvement. For example, virtually all of the state's decentralized LHDs have experience working in collaboration with hospitals and others toward community health improvement. A previous statewide program known as Healthy Carolinians established strong coalitions that continue in many parts of the state, despite being defunded several years ago. The state developed and administers a system of mandatory local public health accreditation that includes requirements for regular CHAs. There is a strong and visible collaboration between the state health agency and the state hospital association, which has yielded numerous joint advances, and there is an active state public health institute engaged in improving the quality and outcome of public health practice.

All of these traditions, assets, policies, and practices, along with others, serve to support and advance community health improvement collaborations across the state.

TWO PERSPECTIVES ON SUCCESS

State Public Health Mobilizes To Support Collaborating Communities

North Carolina's Division of Public Health (NCDPH) is "leaning forward" to support local partnerships in realizing the full potential of public health/hospital collaboration. The state is developing or leveraging resources on practice challenges, training needs, policy, and other barriers as community health improvement work goes forward across the state. Early on, NCDPH leadership reached out to the state hospital association to explore common ground and found a very receptive partner. Hospital association leadership responded in kind and actively endorsed the full integration of hospitals' CHNA work with that of LHDs and their communities. With the passage of ACA, the disconnect between the frequencies

of LHDs' community health assessments mandated by North Carolina policy and hospital CHNA required by the IRS under ACA was recognized by NCDPH and steps were taken to synchronize those assessments.

Extensive community health improvement activity is now underway across the state, including at the state level with the completion of [Healthy North Carolina 2020](#), the SHIP that features extensive guidance on evidence-based interventions.

With the unprecedented level of community health improvement activity underway, NCDPH recognized the need to balance local flexibility in priority setting with aligned action to impact certain complex entrenched conditions (e.g., diabetes, heart disease, hypertension and precursors including tobacco use and obesity) that have burdened many North Carolina counties for year. One of the many topics developed in the learning collaborative organized by the [North Carolina Institute for Public Health](#) was the approach to community change through collective impact.

Recognizing the complex nature of many of the social, economic, and environmental determinants of chronic diseases and other key health concerns, the collective impact model sets forth a systematic approach to link the agendas, measures, activities, communications, and backbone support for related efforts to maximize success.

To put collective impact concept into practice, NCDPH has called on any community effort that identifies diabetes, hypertension, or obesity as a top priority to adopt the single evidence-based intervention developed by consensus for that health concern. For instance, a community identifying obesity as a top local priority would need to implement evidence-based interventions for improving early childhood nutrition and physical activity along with any other interventions adopted. The intent is to test the collective impact of multiple efforts around the same action strategy between 2014 and 2020.

Pitt County Health Department and Vidant Health Team Up to Build on Strong Traditions

Vidant Health is a regional hospital system operating nine hospitals in 29 counties. Its flagship hospital is in Greenville in Pitt County and is an academic hospital affiliated with East Carolina University. The hospital converted from Pitt County Memorial Hospital to nonprofit status within the Vidant system, formerly University Health System of East Carolina, but retained many of its former community commitments, such as support to school health, pediatric asthma case management, and Pitt Partners for Health, among other ongoing initiatives.

Pitt County Health Department has been recognized by state colleagues as demonstrating model practices. The department is a full partner, along with active resident input, in [Pitt Partners for Health](#) in developing the community needs assessment, a document that also served as the hospital's CHNA.

The local public health director is committed to advancing the already strong partnership through frequent and open communications with hospital operating and foundation executives, as well as the dean of the medical school. One example included a recent effort by the hospital to convene regional partners to introduce the concept of population health and explore its value across multiple social, economic, and business sectors. Although there were no clear solutions presented, it was clear the

entire system is aware of the need to reframe its scope and is reaching for guidance. The director emphasizes the importance of grassroots representation throughout the entire community health improvement process and sees pathways for more stakeholder input in developing the hospital's implementation strategy.

STRATEGIES FOR MANAGING EMERGING CHALLENGES

Challenge: Hospital Implementation Strategies and Community Benefit Investments Are Not Tied to Shared Community Health Assessments

Several communities report a disconnect between hospital implementation strategies and community/local health department action plans. NCDPH, which reviews all LHD community assessments, reports that it does not appear hospital community benefit funds are being invested in implementing these plans. Further, there are many hospitals that do not publicly post their implementation plans that ensue from CHNAs. Even in Pitt County, the shared community health assessment resulted in three different sets of issue priorities: those selected by the hospital, the hospital foundation, and the board of health. There is interest in many quarters to work toward harmonizing not only a community's multiple assessments, but also the top priorities for action and, as discussed above, selected evidence-based strategies to address the top priorities.

Also, as identified in other states, even hospitals with strong community health improvement collaborations may compartmentalize population health principles in the community benefits office such that this framework is not at the core of the institution's strategic decisions.

Challenge: LHDs Are Unfamiliar with New Models of Care Delivery and Financing, Limiting the Scope and Depth of Partnerships with Hospitals

Innovations in care delivery, including patient-centered medical homes, chronic disease care management, ACOs, hot-spotting and shared savings, and consumer-directed health technologies, could serve to advance population health if more widely understood and implemented with community supports. NCDPH is aware of this knowledge gap and is in the process of developing training to assist public health officials in acquiring an understanding of the background, language, quality and performance measures, and financing options specific to participating in ACOs.

Challenge: Sustained Funding for Community Health Improvement Is Needed

Previous state budget cuts, along with elimination of the federal Community Transformation Grants, jeopardize the already strained infrastructures for community health improvement in many communities. Population health improvement is still regarded in many hospitals as a discretionary option for community benefit expenditures, one that competes with bad debt, Medicare allowances, uncompensated care, and various established educational and community service interests. Responding to the need for models that make the business case for community health improvement to hospital and other decisionmakers, the [North Carolina Institute of Public Health](http://www.ncdhhs.gov/north-carolina-institute-of-public-health) is focusing on developing such models.

Issue Brief



CONCLUSION

The IRS requirement to implement CHNAs and strategies provides an important opportunity for tax-exempt hospitals to work with state public health to improve overall population health. This issue brief was intended to provide an overview of current practices, experiences, and lessons learned in building and sustaining these important partnerships. While a number of challenges still remain, in an era of transformative change, these partnerships are important and worth pursuing. Massachusetts, Maryland, and North Carolina have demonstrated that these partnerships are yielding new opportunities for innovative and sustainable strategies to improve community health.