

## COMMUNITY BENEFITS PROGRAM COMMITTEE RECOMMENDATIONS

---

### Meeting Dates

- May 19, 2014
- June 2, 2014

### Committee Members

- **Richard Ardery**, Vice President, Marketing and Maryland Community Relations, MedStar Southern Maryland Hospital
- **Pam Creekmur**, Health Officer and Director, Prince George's County Health Department
- **Paul Grenaldo**, Executive Vice President and CEO, Doctors Community Hospital
- **Malcolm Joseph, MD**, Medical Director, CareFirst Blue Cross Blue Shield
- **Dushanka Kleinman**, Associate Dean for Research, Professor and Chair, Department of Health Services Administration, University of Maryland
- **Verna Meacham**, President & CEO, Nexus Health Inc.
- **Neil Moore**, President and CEO, Dimensions Health System
- **Judy Mitchell**, Corporate Director, Communications & Marketing, Nexus Health, Inc.
- **Raquel Samson**, Deputy Director Health Systems and Infrastructure Administration, Maryland Department of Health and Mental Hygiene
- **Ingrid Turner**, Council Member, District 4, Prince George's County Council
- **Julie Wagner**, Vice President, Community Affairs, CareFirst Blue Cross Blue Shield

### Objectives

The overarching goal of the Community Benefits Workgroup was to explore the possibility of developing a collaborative, countywide community benefits strategy across the hospitals that operate in Prince George's County. New Internal Revenue Service (IRS) Schedule H regulations require that all hospitals work in collaboration with the County Health Department and other community health stakeholders to conduct a community health needs assessment (CHNA) and to develop an associated community health benefits plan (CHBP) every three years. This presents a great opportunity for collaboration among the County's hospitals to identify common priorities and maximize their collective impact.

The key questions addressed by the workgroup were:

- a. Is there overlap in the community health priorities identified by the hospital CHNAs?
- b. Assuming there is overlap in community health priorities, how could the hospitals collaborate? Are there models of collaboration from around the nation that can be replicated in the County?
- c. Are there barriers that would challenge or prohibit collaboration with respect to a centralized community benefits plan for the County?
- d. What structures might be necessary to facilitate collaboration across the hospitals with respect to community benefits?

### Outcome

The following recommendations were agreed to, at least in principle by all Committee participants.

# Prince George’s Primary Healthcare Strategic Plan: Final Recommendations from Hospital Community Benefits Programs Committee Workgroup

---

## A. Overarching Community Health Assessment and Planning Systems/Infrastructure

### Recommendation 1: Work collaboratively to conduct a Prince George’s County Community Health Needs Assessment.

Prince George’s County’s five hospitals, in partnership with the County’s Health Department, should work collaboratively to conduct a Prince George’s County Community Health Needs Assessment (CHNA) and then work collectively to implement community health benefits activities.

**Time Frame:** Medium-Term – 2 years (Activity to be conducted in 2016)

Rationale and Supporting Data	Roles and Responsibilities	Resources Needed
<ul style="list-style-type: none"> <li>• IRS regulations require that hospitals conduct a CHNA every three years.</li> <li>• Center for Disease Control (CDC) supports the implementation of a national voluntary accreditation for local Health Departments. The Public Health Accreditation Board (PHAB) serves as the independent, nonprofit, accrediting body and encourages Health Departments to conduct a CHNA every 3-5 years.</li> <li>• IRS regulations require that hospitals work with state, county, and local Health Departments to conduct their CHNAs.</li> <li>• IRS regulations strongly encourage hospitals to work collectively to conduct their CHNAs.</li> <li>• Rigorous CHNAs, that fully engage the community, can be resource intensive. Collaboration promotes greater rigor and efficiency.</li> </ul>	<p>County/Private:</p> <ul style="list-style-type: none"> <li>• Develop a CHNA Steering Committee.</li> <li>• Develop and implement a centralized CHNA approach that collects quantitative and qualitative data on community need, service system capacity, barriers to care, possible strategic responses, and other relevant information.</li> <li>• Engage residents and health/social service providers through surveys, interviews, community meetings, and/or focus groups.</li> <li>• Facilitate a strategic planning process that identifies leading healthcare priorities, along with a series of agreed upon community health strategies that community partners will strive to implement to address priority issues.</li> <li>• Develop a centralized, countywide CHNA report and Community Health Benefits</li> </ul>	<p>County/Private:</p> <ul style="list-style-type: none"> <li>• All major partners will need to participate on steering committee and planning/ implementation workgroup sessions.</li> <li>• Hospitals, the Health Department, and other key stakeholders will need to work collectively to capture quantitative/ qualitative data and engage community residents and health/social services stakeholders.</li> </ul> <p>County:</p> <ul style="list-style-type: none"> <li>• The County Health Department will need to build on their existing epidemiologic/needs assessment capabilities and provide all available quantitative data on community need and service capacity.</li> <li>• The Health Department will need to work independently, drawing from the County CHNA and CHBP, to develop their own County CHNA and CHBP.</li> </ul>

# Prince George's Primary Healthcare Strategic Plan: Final Recommendations from Hospital Community Benefits Programs Committee Workgroup

Rationale and Supporting Data	Roles and Responsibilities	Resources Needed
<ul style="list-style-type: none"> <li>• Collaborative CHNAs can lead to a more coordinated response a greater impact.</li> <li>• Collaborative CHNAs can be designed in ways that promote greater community awareness and collaboration across stakeholders.</li> </ul>	<p>Program (CHBP) that summarizes needs, priorities, and high-level strategic goals.</p> <ul style="list-style-type: none"> <li>• All parties agreed in principle to start this process no later than 2016 so as to comply with IRS requirements.</li> </ul> <p>County:</p> <ul style="list-style-type: none"> <li>• Participate in Steering Committee.</li> <li>• Take leadership role to compile and analyze quantitative secondary data from local, state, and federal sources.</li> </ul> <p>Hospitals:</p> <ul style="list-style-type: none"> <li>• Take leadership role to compile and analyze hospital utilization data and other related hospital data.</li> <li>• Develop tailored, hospital-specific CHNA reports and CHBP that draw from the countywide CHNA/CHBP and report on the needs/priorities of residents from each of the hospitals' defined service areas, as well as the hospitals' specific community benefit strategy.</li> </ul>	<p>Hospitals:</p> <ul style="list-style-type: none"> <li>• Hospitals will need to provide financial resources and/or staffing to conduct CHNA.</li> <li>• Hospitals will need to provide utilization data and other existing data to support quantitative data review.</li> <li>• Hospitals will need to work independently, drawing from the County CHNA and CHBP, to develop their own hospital-specific CHNAs and CHBPs.</li> </ul>

# Prince George’s Primary Healthcare Strategic Plan: Final Recommendations from Hospital Community Benefits Programs Committee Workgroup

## **Recommendation 2: Create a Prince George’s County Community Health Benefits Partnership**

Create a Prince George’s County Community Health Benefits Partnership (CHBP) made up of representatives from the five hospitals and the Prince George’s County Health Department. The CHBP could be an informal partnership governed by memoranda of agreement and managed by existing hospital/Health Department staff or a full 501(c)(3), nonprofit entity with its own staff funded collectively by private/public resources in the County.

**Time frame:** Short- to medium-term – depending on level of partnership

Rationale and Supporting Data	Roles and Responsibilities	Resources
<ul style="list-style-type: none"> <li>• Extensive precedent and research that shows the benefit of broadly representative stakeholder partnerships that promote collaboration and coordination with respect to community health benefits initiatives.</li> <li>• There are numerous approaches for creating these partnerships. Some are highly resource intensive and others are less intensive.               <ul style="list-style-type: none"> <li>○ Montgomery Cares <a href="http://www.montgomerycares.org/">http://www.montgomerycares.org/</a></li> <li>○ DC Healthcare Alliance <a href="http://dhcf.dc.gov/">http://dhcf.dc.gov/</a></li> <li>○ San Diego Community Health benefits Partnership <a href="http://www.sdchip.org/">http://www.sdchip.org/</a></li> <li>○ Community Health Partnership of Santa Clara and San Mateo County <a href="http://www.chpscc.org/programs.html">www.chpscc.org/programs.html</a></li> <li>○ Community Health Partnership of Sarasota County (FL)</li> </ul> </li> </ul>	<p>County/Private:</p> <ul style="list-style-type: none"> <li>• Convene the County’s five hospitals and the Health Department and agree on how to proceed in the short- and long-term with the assumption that the group will operate informally in 2014 and 2015.</li> <li>• Facilitate agreement on a series of short-term, medium-term, and long-term strategic community health initiatives, upon which the CHBP will agree to work collaboratively. <i>(Focus should be on identifying one or two initiatives that will be the focal points of the partnership).</i></li> <li>• Coordinate the County’s CHNA activities and community health benefits planning processes as a starting point and pilot activity for the CHBP.</li> <li>• Implement and coordinate collaborative community health benefits activities that are aligned with best practices.</li> <li>• Develop an evaluation plan that tracks</li> </ul>	<p>County/Private:</p> <p>Resource needs dependent on the level of partnership and collaboration that is agreed to by participants.</p> <p>Low Intensity:</p> <ul style="list-style-type: none"> <li>• Participation in periodic meetings/calls.</li> <li>• Agreement to work collectively on one to two community health initiatives.</li> <li>• Agreement to conduct a collaborative, countywide CHNA.</li> <li>• On-going partnership and collaboration in targeted ways.</li> </ul> <p>High Intensity:</p> <ul style="list-style-type: none"> <li>• Participation in periodic meetings/calls.</li> <li>• Agreement to work collectively on one to two community health initiatives.</li> <li>• Agreement to conduct a collaborative, countywide CHNA.</li> <li>• Provide funding to support a staff member</li> </ul>

## Prince George's Primary Healthcare Strategic Plan: Final Recommendations from Hospital Community Benefits Programs Committee Workgroup

Rationale and Supporting Data	Roles and Responsibilities	Resources
<p><a href="http://www.chip4health.org/whatwedo/index.htm">http://www.chip4health.org/whatwedo/index.htm</a></p> <p>This link is a document on the merits of collective, collaborative action.</p> <p><a href="http://www.ssireview.org/articles/entry/collective_impact">http://www.ssireview.org/articles/entry/collective_impact</a></p>	<p>progress and the impact of the collective community health activities.</p> <ul style="list-style-type: none"> <li>Promote awareness of the partnership's efforts and work to build broader collective action among other stakeholders.</li> <li>By the end of 2015, agree on a formal structure for the CHBP</li> </ul>	<p>and to develop needed infrastructure/ systems that coordinate the partnership's activities.</p> <ul style="list-style-type: none"> <li>Develop a shared measurement system.</li> <li>CHBP staff works with participants to facilitate and coordinate partnership, data collection, and reporting</li> </ul>

**Recommendation 3: Develop a shared measurement system.**

Develop a shared measurement system that facilitates program alignment, tracks progress and impact, and helps to hold programs accountable.

**Time frame:** Short-term, 1 year

Rationale and Supporting Data	Roles and Responsibilities	Resources
<ul style="list-style-type: none"> <li>Shared data systems that facilitate the collection of a set of measures across the participating stakeholders have been shown to increase efficiency, reduce costs, improve the quality and credibility of the data collected, and increase overall impact.</li> </ul>	<p>County/Private:</p> <ul style="list-style-type: none"> <li>The County Health Department, hospitals, and other community stakeholders agree to track a series of measures related to their community health strategies.</li> <li>To the extent possible, ensure that measures are aligned with the Maryland State Health Improvement Process (SHIP)</li> <li>Once measures are defined or have an agreement, participants need to track and report data to a central entity or individual for aggregation and analysis.</li> </ul>	<p>County/Private:</p> <ul style="list-style-type: none"> <li>Resource needs dependent on the level of partnership and collaboration that is agreed to by participants.</li> </ul> <p>Low Intensity:</p> <ul style="list-style-type: none"> <li>Hospital and Health Department partners will need to identify relevant measures (related to priorities identified in CHNA and CHIP) and agree on a simple system that aggregates data for reporting.</li> <li>Hospital and Health Department partners will need to meet periodically to track progress, review data that is being</li> </ul>

## Prince George's Primary Healthcare Strategic Plan: Final Recommendations from Hospital Community Benefits Programs Committee Workgroup

Rationale and Supporting Data	Roles and Responsibilities	Resources
		<p>reported, and analyze/report results.</p> <p>High Intensity:</p> <ul style="list-style-type: none"> <li>• Hospital and Health Department partners will need to identify relevant measures (related to priorities identified in CHNA and CHBP) and agree on a simple system that aggregates data for reporting.</li> <li>• Hospital and Health Department partners will need to agree on an electronic tracking and reporting system that automates reporting, data management, tracking, analysis, and reporting functions.</li> <li>• Hospital and Health Department partners will need to meet periodically to track progress, review data that is being reported, and analyze/report results.</li> </ul>

# Prince George’s Primary Healthcare Strategic Plan: Final Recommendations from Hospital Community Benefits Programs Committee Workgroup

---

## B. Collective Action for Community Health benefits

### Recommendation 4: Work collectively to reduce the prevalence/burden of chronic disease.

Work collectively to reduce the prevalence/burden of chronic disease with a particular emphasis on diabetes and hypertension by: promoting general wellness and behavioral change, promoting appropriate engagement in primary care, and increasing the number of adults with diabetes/hypertension who receive evidence-based counseling/coaching and treatment.

**Time frame:** Short-term, 1 year

Rationale and Supporting Data	Roles and Responsibilities	Resources
<ul style="list-style-type: none"> <li>• High rates of diabetes and hypertension in Prince George’s County.</li> <li>• High rates for the leading risk factors for diabetes and hypertension.</li> <li>• Health department and hospitals have all identified addressing diabetes, heart disease, and hypertension, as well as the leading risk factors for these conditions, as health priorities.</li> </ul>	<p>County/Private:</p> <ul style="list-style-type: none"> <li>• Develop or support evidenced-based programs that educate the public about health risk factors, health promotion, and basic wellness.</li> <li>• Develop or support evidenced-based programs that promote physical activity and healthy eating.</li> <li>• Develop or support community screening events that identify and screen residents for diabetes, pre-diabetes, and hypertension with the goal of linking those with new or uncontrolled cases of diabetes and hypertension to appropriate education, behavior change, primary care, and/or specialty care services.</li> <li>• Collaborate with community partners to develop evidence-based diabetes and hypertension education, health promotion, behavior change, care</li> </ul>	<p>County/Private:</p> <ul style="list-style-type: none"> <li>• Hospital and Health Department partners will need to agree on a set of evidence-based strategies or activities that they will work together on to implement and coordinate.</li> <li>• Partners will need to work collectively to implement and/or coordinate the agreed upon strategies, with an emphasis on hospital emergency department(ED)-based initiatives or those promoting better care transitions.</li> <li>• Partners will need to work collectively to identify a series of measures that all participants will collect and report.</li> </ul> <p><i>(Not all partnership participants would have to agree to implement the same activities, but the group would agree on the menu of evidenced-based activities that would be considered.)</i></p>

## Prince George's Primary Healthcare Strategic Plan: Final Recommendations from Hospital Community Benefits Programs Committee Workgroup

Rationale and Supporting Data	Roles and Responsibilities	Resources
	<p>management, and treatment programs.</p> <ul style="list-style-type: none"> <li>• Hospitals would work with community partners to implement emergency department-based initiatives aimed at reducing inappropriate (preventable/avoidable) ED utilizations and promoting greater chronic disease management.</li> <li>• Hospitals would work with community partners to implement care transition initiatives aimed at promoting better follow-up and care coordination for those with chronic disease.</li> <li>• Work collectively to measure impact and ensure that measures are aligned with the Maryland CHIP/Local Health Benefits Coalition (LHBC).</li> </ul>	



# Prince George’s Primary Healthcare Strategic Plan: Final Recommendations from Hospital Community Benefits Programs Committee Workgroup

---

**Recommendation 5: Work collectively to promote access to primary care.**

Work collectively to promote access to primary care and ensure appropriate primary care engagement among county residents, particularly those most at-risk.

**Time frame:** Short-term, 1 year

Rationale and Supporting Data	Roles and Responsibilities	Resources
<ul style="list-style-type: none"> <li>• Major gaps in primary care in some geographic areas and among certain demographic and socioeconomic target populations.</li> <li>• Substantial gaps or lack of capacity exist for certain types of primary care providers</li> <li>• High rates of inappropriate ED utilization.</li> <li>• Unacceptable and costly rates of inappropriate inpatient readmission.</li> </ul>	<p>County/Private:</p> <ul style="list-style-type: none"> <li>• Hospitals would work together in partnership with the County and other partners to expand access to primary care in certain geographic areas and for low-income, Medicaid–insured, and uninsured residents more generally.</li> <li>• Hospitals would work with primary care providers to develop ED diversion programs for those without a regular source of primary care who access hospital ED services for care that is best provided in the primary care setting, or for health issues that could have been prevented via more regular primary care services.</li> <li>• Hospitals would work with primary care providers to facilitate appropriate, timely, primary care follow-up after discharge from the hospital so as to reduce inappropriate hospital readmission.</li> <li>• Hospitals would work collectively in partnership with the Health Department to measure the impact of their activities.</li> </ul>	<p>County/Private:</p> <ul style="list-style-type: none"> <li>• Hospital and Health Department partners will need to agree on a set of evidence-based strategies or activities that they will work together on to link people to primary care and/or promote more appropriate engagement in primary care.</li> <li>• Partners will need to work collectively to implement and/or coordinate the agreed upon strategies, with an emphasis on hospital ED-based initiatives.</li> <li>• Partners will work together to fill specific gaps in primary care either for specific geographic regions, for specific demographic/socio-economic groups, or for specific types of primary care services.</li> <li>• Partners will need to work collectively to identify a series of measures that all participants will collect and report.</li> </ul>