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Consumer Standing Advisory Committee
August 2020 Meeting

8/26/2020

Strategy for Revising Hospital Community Benefit Reporting

Step 1

Assess the community's level of involvement in the Community Health Needs Assessment process

Step 2

Revise the hospital's community benefit reports to identify spending focused on community-identified needs

Step 3

Report the amount of community benefit spending that is allocated to community-identified needs

Identifying CHNA Priorities in Hospital Community Benefit Reporting

- Per 2020 Legislation, this workgroup was asked to crosswalk the current Hospital Community Benefit (HCB) reporting categories with CHNA priorities and activities for each hospital.
- Initial staff analysis found a severe undercount of CHNA-related activities in the HCB reports for a number of reasons:
  - Mission Driven Health Services is the only HCB category that prompts hospitals to fill in specific names of activities/line items,
  - The HCB narrative reporting only asks for three example CHNA activities,
  - Standardized sub-categories may include CHNA priorities and related programs, but there is no way to discern individual programs and initiatives, and,
  - There is extensive usage of general reporting catchalls, such as “Other Community Health Services.”
- Updating reporting templates and guidelines will allow for further clarity on which HCB spending is addressing community health needs and public input.

Maryland's Current Community Benefit Categories

HCB Category	Description	Subcategories	
Community Health Services	Activities carried out to improve community health that extend beyond traditional patient care activities.	Community Health Education Support Groups Self-Help Free Clinics	Community-based Clinical Services Screenings Mobile Units Health Care Support Services
Health Professions Education	Net costs associated with providing teaching and training services.	Physicians/Medical Students Nurses/Nursing Students	Scholarship/Funding for Professional Education Other Health Professionals
Mission Driven Health Services	Mission driven health services are services provided to the community that were never expected to result in cash inflows.	N/A, all self-reported	
Research	Includes clinical and community health research as well as studies on health care delivery.	Clinical Research Community Health Research	
Cash and In-Kind Donations	Donations to individuals and/or the community at large.	Cash Donations Grants	In-Kind Donations Cost of Fund-Raising for Community Programs
Community Building Activities	Cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships.	Physical Improvements and Housing Economic Development Community Support Environmental Improvements	Leadership Development/Training for Community Members Coalition Building Advocacy for Community Health improvements Workforce Development
Community Benefit Operations	Costs associated with dedicated resources for Community Health Needs Assessment and community benefit strategy operations.	Staff CHNA Development	
Charity Care	Provider's policy to provide health care services free of charge, or on a discounted fee schedule, to individuals who meet certain financial criteria. *Supported in Rates, provided for reporting by HSCRC.		
Medicaid Deficit Assessment	Total amount of the Deficit Assessment Fee paid to the Maryland Medicaid Program in the previous fiscal year. *Supported in Rates, provided for reporting by HSCRC.		
Foundation Community Benefit	Separate not-for-profit organizations affiliated with the health care organization that conducts fundraising.	Community Services Community Building	

Developing a Crosswalk Between the CHNA and HCB

- When HSCRC staff review CHNAs, mapping to annual HCB reports is not precise enough to go between ascertain a CHNA related activity and aggregate categories or subcategories.
- Some hospitals do happen to report specific initiatives or programs in both their CHNA and HCB in a way that makes them easily identifiable.
- However, this identification is not uniform across hospitals. The following examples will illustrate the various ways hospitals have reported CHNA-related activities in their HCB.

Example: Sometimes CHNA investments are identifiable in the HCB Reports

Mercy Medical Center 2018 CHNA and Implementation Strategy

Providing support to victims of violence and addiction

Hospital Initiatives & Objectives

- **Maintain Forensic Nurse Examiner Program:** The Forensic Nurse Examiner (FNE) Program (formerly the SAFE Program) provides care to victims of sexual, domestic, child, elder and institutional violence. The centerpiece of Mercy's program is a skilled team of Forensic Nurse Examiners (FNEs) who document the details of the assault, collect crucial time-sensitive evidence and perform medical exams, tests and treatments. In order to raise awareness and reduce violence, the program's leadership and certified nursing staff provide community education about domestic violence and sexual assault to law enforcement and the community. The FNE Program is the designated site for forensic patients in Baltimore City and the only comprehensive program of its kind in Maryland.
- **Maintain Inpatient Substance Abuse and Medical Detoxification Services:** Mercy offers one of two inpatient detoxification units in Baltimore City and provides physician subsidies for the professional component of these inpatient services. Of note, a number of diseases and medical conditions are over-represented in patients with substance abuse. Consultative and follow up care with appropriate specialists also are supported.
- **Maintain Family Violence Response Program:** The Mercy Family Violence Response Program provides confidential services to patients and employees who are victims of violence, abuse and neglect, including domestic violence, sexual assault and vulnerable adult abuse. The program offers counseling, crisis intervention, safety planning, danger assessment, counseling/legal resource linkage, advocacy, documentation and free short-term individual follow-up counseling regarding domestic violence.
- **Maintain Screening, Brief Intervention and Referral to Treatment (SBIRT) services:** SBIRT is a proven-effective public health approach to identifying and providing early intervention among individuals at risk for developing substance use and other behavioral health disorders.
- **Continue Family Violence Training:** Mercy's Family Violence Program develops training curriculums and provides training sessions for Baltimore City Federally Qualified Health Centers.

Key Partners & Resources: **Baltimore City Health Department, Behavioral Health System Baltimore, Baltimore City Sexual Assault Response Team (SART), Mercy Emergency Department.**

Mercy Hospital FY2019 HCB Financial Report

MISSION DRIVEN HEALTH SERVICES	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit
SBIRT Program	$155,083	$113,366	$109,578	$158,871
Healthcare for the Homeless	$176,250	$128,839	$136,051	$169,038
Forensic Nurse Examiner	$551,229	$402,948	$228,725	$725,453
Psych Coverage	$157,877	$115,408		$273,285
Detox Program	$572,300	$418,351		$990,651
Dental Clinic Services	$184,182	$134,637		$318,819

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Disparate Reporting of HCB Qualifying CHNA Activities

- CHNA-related activities, like Screening, Brief Intervention and Referral to Treatment (SBIRT) initiatives, are activities most hospitals likely implement.
- However, SBIRT programs are not systematically reported by all hospitals likely because HSCRC reporting standards do not specify this level of detail or CHNA overlap.
- HSCRC staff went to other hospitals to determine how they translate their CHNA into their annual HCB reporting.
- The following processes and experiences are ones this workgroup can utilize when developing new HCB guidance and reporting formats.

Johns Hopkins Hospital

Sharon Tiebert-Maddox, MM, MBA

Director, Strategic Initiatives

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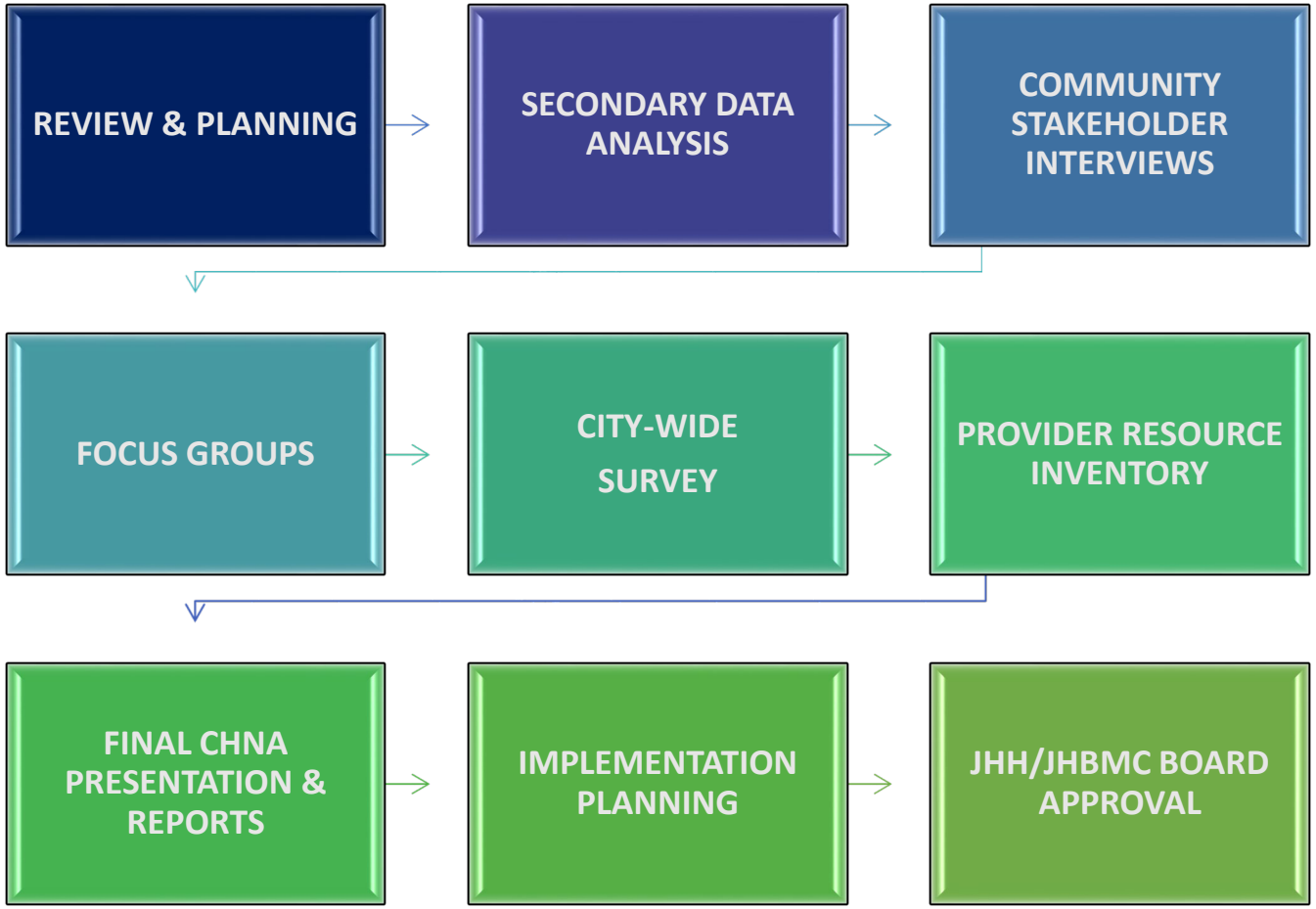
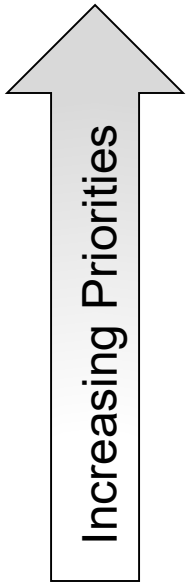
CHNA Year-long Process and Accountability



Identified Health Priorities
Johns Hopkins Hospitals

CHNA 2018 COMMUNITY HEALTH NEEDS

SOCIOECONOMIC NEEDS	DIRECT HEALTH NEEDS
EMPLOYMENT	BEHAVIORAL HEALTH - SUBSTANCE ABUSE
CRIME/NEIGHBORHOOD SAFETY	BEHAVIORAL HEALTH - MENTAL HEALTH
HOUSING/HOMELESSNESS	CHRONIC DISEASES (Incl. Health Education/Mgmt)
EDUCATION	UNINSURED/UNDERINSURED ACCESS TO CARE
FOOD ENVIRONMENT	DENTAL SERVICES



Implementation Strategy Program Examples

Employment

- Baltimore Population Health Workforce Collaborative
- Summer Jobs Program
- General Services Healthcare Internship Program

Crime/Neighborhood Safety

- Operation P.U.L.S.E. (People United to Live in a Safe Environment)
- Safe Streets Baltimore
- Office of Juvenile Justice Delinquency Prevention Safe and Thriving Communities Grant

Behavioral Health - Substance Abuse

- Buprenorphine and Methadone Treatment Services
- Broadway “911” Center for Substance Abuse
- Helping Up Mission and Wilson House

Behavioral Health – Mental Health

- Behavioral Health Intervention Team (BHIT)
- ED-based Community Health Workers (CHW)
- COSTAR Rehab/Mobile Treatment Assertive Community Treatment (ACT)

Implementation Strategy Employment

SOCIOECONOMIC NEED 1: EMPLOYMENT			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/External Organizations**
GOAL: Increase employment opportunities to local and minority communities	**Strategy 1**: Improve career development among youth	• Number of youth participating in career development programs and/or number of programs available	• CBSA schools • Historic East Baltimore Community Action Coalition (HEBCAC) • Civic Works • P-TECH Partners (JH, Kaiser Permanente, UMB, Dunbar HS, BCCC)
	Strategy 2: Create new employment opportunities for local communities and minorities; increase youth and adult workforce training programs	• Number of new employees hired living within CBSA • Job opportunities for residents in the CBSA • Number of participants in workforce coaching and training programs	• East Baltimore Jobs HUB • Historic East Baltimore Community Action Coalition (HEBCAC) • Baltimore Population Health Workforce Collaborative • Turnaround Tuesdays/BUILD (Baltimoreans United in Leadership Development) • Center for Urban Families • Men & Families Center • Biotechnical Institute - Lab Associates Program
	Strategy 3: Support/Contract with local and minority vendors to improve the local economy	• Number of contracts with local vendors • Amount spent with local and minority contractors	• Minority Contractors Associations • East Baltimore Jobs Hub • BLocal companies/BUILD college

Implementation Strategy
Employment Program Examples

- **Summer Jobs Program** – In conjunction with the Baltimore City Government and the State of Maryland, Johns Hopkins employs over 450 Baltimore City School students each summer offering workforce education sessions, in addition to paid internships.
- **P-TECH (Pathways in Technology Early College High Schools)** – The P-TECH program is a partnership between the state of Maryland, Johns Hopkins University and Health System, Dunbar High School, the Baltimore City Community College (BCCC), University of Maryland (UMB) at Baltimore, and Kaiser Permanente. P-TECH is creating a school-to-industry pipeline for Baltimore students interested in the healthcare industry.
- **BLocal BUILD College –** BLocal partner companies have developed a program that provides training for small, local, minority-owned, women-owned, and/or disadvantaged businesses in design and construction industries. Training sessions focus on design, construction, and business related topics to build key competencies and relationships for grown.
- **TurnAround Tuesdays –** A program offered through a partnership with BUILD to provide job training to returning citizens to increase basic job skills and qualifications for employment.
- **General Services Healthcare Internship Program** – In partnership with Baltimore City Department of Social Services, a 20 week internship is offered to residents on public assistance. Hands-on and curriculum based training is conducted at JHH, rotating through various departments. Over 234 residents have enrolled, 147 completed the program with 131 placed in permanent positions at Hopkins.
- **Baltimore Population Health Workforce Collaborative (formerly Hospital Employment Program)** – Maryland hospitals are creating new jobs for residents of communities with high rates of poverty and unemployment. These community-based jobs are focused on overall population health and include community health workers, peer recovery specialists, peer outreach specialists, and CNAs/GNAs (certified and geriatric nursing assistants).
- **HopkinsLocal** – Johns Hopkins is leveraging its economic power to expand participation of local and minority-owned businesses in construction opportunities; increase our hiring of city residents, with a focus on neighborhoods in need of job opportunities; and enhance economic growth, employment, and investment in Baltimore through our purchasing activities.

Example: Sometimes CHNA investments are identifiable in the HCB Reports

Johns Hopkins Hospital FY2019 HCB Financial Report

MISSION DRIVEN HEALTH SERVICES	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit
Broadway Center IOP/OP Grant	$201,700	$87,881	$137,217	$152,364
Wilson House	$165,355	$72,045	$123,953	$113,447
Social Work Services @ JHCP Locations	$710,131	$0	$0	$710,131
CB Community Services @ JHCP Locations	$6,963,770	$0	$0	$6,963,770
Eating Disorders Day Hospital Supportive Housing	$69,710	$30,373	$9,500	$90,583
Supportive Housing for Male Substance Abuse Patients	$666,792	$102,819	$0	$769,611

CY18 CHNA GOAL: Increase access to housing and healthy homes in the CBSA

Helping Up Mission – Johns Hopkins is committing support to the Helping Up Mission to fund transitional housing space for homeless discharged patients in need of continuing care.

Health Leads – JHH/JHBMC supports three on-site Health Leads desks for social services support (including housing).

Transition Guides and Neighborhood Navigators screen for social determinants needs and connect to resources, including housing support.

Wilson House – The Wilson House is a certified halfway house for female patients in recovery who are attending the Broadway Center. It provides supportive housing, counseling (at Broadway Center) and leisure activities.

Or, CHNA Investments are only identifiable in the aggregate…

CB Spending Category	CY2018 CHNA Program	In FY19 HCB?
COMMUNITY HEALTH SERVICES		
Community Health Education	• **Burn Prevention Program** – This intervention program, based at the JHBMC Burn Center, educates participants referred by the justice system on the severe consequences that could occur without proper fire prevention behavior. Additional sessions are conducted in local schools where students are taught emergency actions in case of fire. • **Rales Health Center** - The Ruth and Norman Rales Center for the Integration of Health and Education is redesigning school-based health programs to improve the health and thus the academic achievements and lifelong prospects for youth from low-income communities. Established in 2014 as a program of the Johns Hopkins Children's Center, the Rales Center is a fully integrated school-based health model at the KIPP Charter School in Baltimore City serving over 1500 students. Weaving comprehensive health services and wellness programming into the school environment, the program breaks down silos between educational and health-related activities helping children thrive and achieve academic success. • **Dental Health Education Outreach** – Education and reference materials for dental health will be produced and added to other health information distributed to the community.	**TOTAL $440K** **Specific programs not identified**

Otherwise, CHNA investments are typically unidentifiable in HCB reports

CB Spending Category	CY2018 CHNA Program	In FY19 HCB?
COMMUNITY HEALTH SERVICES		
Self-Help	• **FRESH** – The FRESH (Food Re-education for Elementary School Health) program offers 3rd and 4th grade students a nutrition and exercise program aimed at encouraging healthy behaviors. Lessons include healthy weight guidelines, meal planning, healthy snacks, exercise, and reading food labels. • **Active Lifestyle Outreach programs** – Johns Hopkins Hospital and Bayview Medical Center support many programs to help residents maintain a healthy lifestyle. Among those are the "Stepping Out for Health" program, a network of walking programs with over 100 participants throughout the year. • **Food and Faith** – Lessons on nutrition and health are combined with a biblical mandate to change to healthy cooking and eating habits using African heritage diet.	**$0 Reported**

Community Health Needs Assessment and Community Benefit Reporting Overview

Sharon McClernan- Vice President for Clinical Integration

Dr. Susan Mani- Chief Population Health Officer

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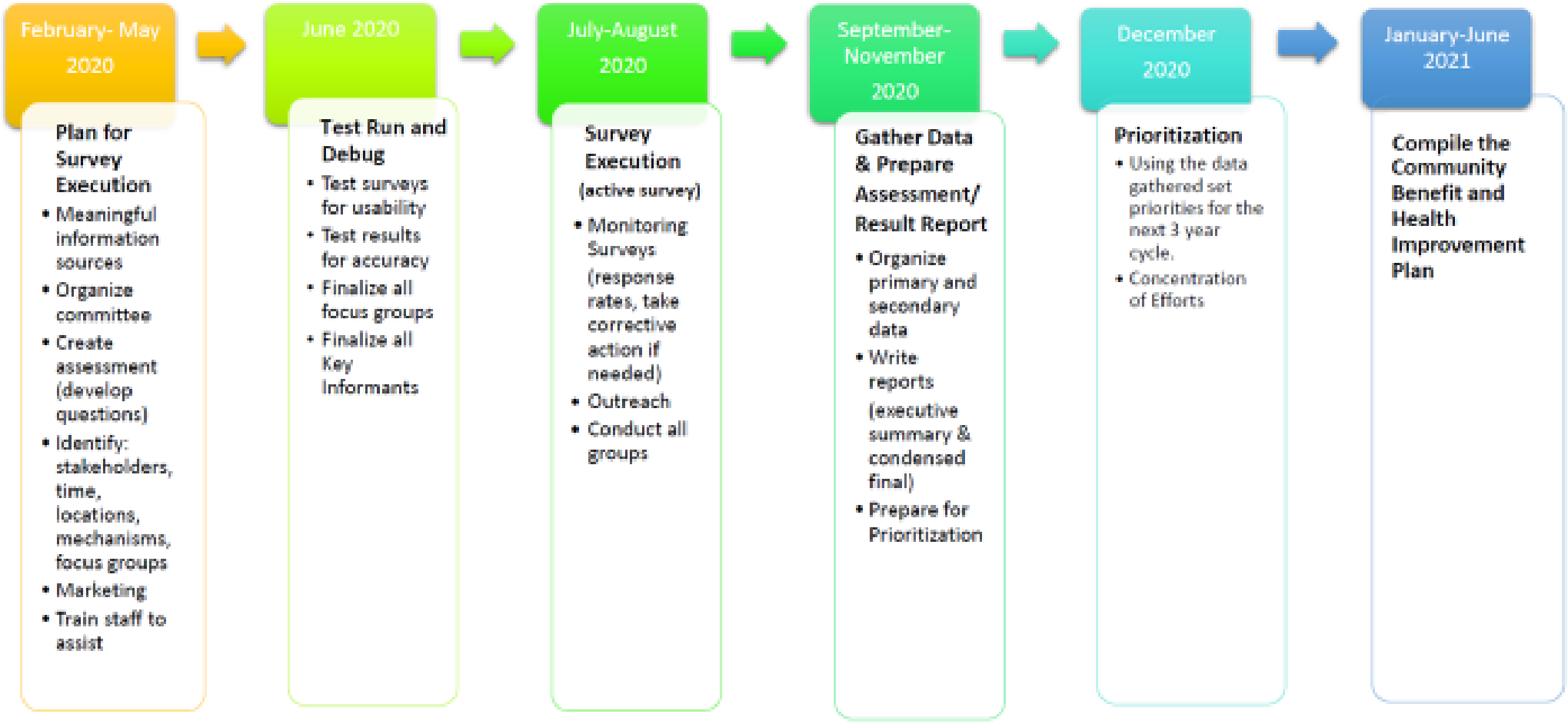
LBH CHNA Timeline



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Community Surveys

- Community Surveys
  - Baltimore City- Collaboration with Baltimore City Hospitals and Health Department.
  - Baltimore County- Collaboration with the Baltimore County Hospitals and Health Department
  - Carroll County- The Partnership for a Healthier Carroll County

Focus Groups and Key Stakeholders

Focus Groups

- LGBTQ
- Disabled
- Older Adults
- African American
- Single Parents
- Spanish Speaking
- Latino/Hispanic
- Men & Women Homeless
- Men Temporary Housing
- Cancer
- Population Health Client
- Transitional Youth
- Low Income

Key Stakeholders

- Community Organizations and Neighborhood Association Leaders and Members
- Key population and public health experts
- Key resource organizations that support residents
- Faith Based organizations
- Public officials
- Community and Hospital based providers

Reporting and Prioritization

- Secondary data researched and collected- Includes Social Determinant measures and data from a variety of resources.
- Primary data collected from stakeholders is reviewed.
- Written report is Completed
- Prioritization Process that looks at the data in each hospital service area
  - Takes into consideration primary and secondary data collected during the CHNA process. Priority areas are reviewed by LBH Community Mission Committee consisting of board members and community stakeholders for each organization.
  - Moving to a specific prioritization process for each hospital that includes key community representatives from each hospital service area.

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Planning and Final Report

- Plan is Created to address prioritized needs
  - Considers feedback from key stakeholders
  - Community Health and Wellness Steering Committee/Partnership for a Healthier Carroll County collaborate on the plan
  - Programs and Services are created around the prioritized needs
  - Goals and outcomes are set for each of those programs

- Opportunity Exists to do targeted follow up communication in each of our communities on results and ACTIONS around CHNA

Example

Category	Prioritized Needs	Strategies for Sinai
Health	*Behavioral Health*	Implement SBIRT (Screening, Brief Intervention and Referral to Treatment) in Emergency Department and Sinai Community Care
		Implement, Partner and Advocate for a Citywide Behavioral Health/Housing strategy
	Chronic Disease	Implement Diabetes Wellness Series
		Continue to implement Changing Hearts Program
Social/ Environmental	*Job Opportunities*	Implement workforce readiness trainings for existing Population Health program clients
Access	*Health Education/ Knowledge of available resources*	Add Pastoral Outreach Coordinator and Community Educator to Community Health Education team
		Implement Pimlico Elementary/Middle School Wellness Series
		Implement Pediatric resident home visits
	Insurance Signups	Continue training Application Counselors who can assist patients with insurance signups
		Encourage use of outside community organizations providing insurance signups

Community Benefit Reporting

- 156 questions on the report
- Current report allows for hospitals to insert 3-4 “examples” of programs that meet community benefit needs
- Current report does not capture all that hospitals do related to community benefit

Q78. Section IV - CB Initiatives Part 1 - Initiative 1

Q79. Name of initiative.

Diabetes Medical Home Extender Program

Q80. Does this initiative address a community health need that was identified in your most recently completed CHNA?

- (●) Yes
- ( ) No

Q81. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Community Unity, Diabetes, Disability and Health, Educational and Community-Based Programs, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, HIV, Immunization and Infectious Diseases, Injury Prevention, Lesbian, Gay, Bisexual, and Transgender Health, Nutrition and Weight Status, Physical Activity, Respiratory Diseases, Sexually Transmitted Diseases, Tobacco Use, Violence Prevention, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention

Baltimore has approximately 620,000 residents, 63 percent of whom are African American, and 23 percent of whom live below the poverty line. Baltimore residents suffer from high rates of disease and unhealthy behaviors: 20 percent of African Americans in Baltimore report having an unmet medical need in the last 12 months; and 34 percent of residents are obese, with significantly higher rates among those with the lowest incomes. Community leaders have voiced their desire for health services to help them make better lifestyle choices. Sinai Hospital of Baltimore launched the Diabetes Medical Home Extender Program to help program participants learn to manage their diabetes and become active participants in their overall health. 1- Program eligible clients will be assessed for initial health status and needs. 80 clients will receive services from the Diabetes Medical Home Extender Program (MHE), by June 30, 2019 2- : 90% of clients who begin to receive MHE services will be visited by CHWs at least 3 times within the first 30 days of program enrollment to identify and address barriers to health improvement, promote adherence to ambulatory care plans, and gather client health data to be entered into CERNER by June 30, 2019. 3-By June 30, 2019, 90% of clients will have their health status checked every 3 months by reviewing available A1C, kept medical appointments and glucose levels; to include number of routine versus emergency medical encounters, monitored for improvement on a quarterly basis. If improvement is not shown, then the Individual Service Plan will be modified accordingly. 4- Clients participating in the MHE for 6 months will be assessed to determine if they meet the criteria for successful program completion or display an ongoing need to continue to receive program services 5-With the assistance of program RN, 90% of Clients participating in the MHE program will work to identify areas of need in health self-care management and receive education and support to advance their personal health knowledge and health self-care management skills. Typical Nursing Diagnosis: Readiness for enhanced self-health management and readiness for enhanced knowledge as evidenced by voluntary program participation.

Q85. Enter the estimated number of people this initiative targets.

550

Q86. How many people did this initiative reach during the fiscal year?

49 individuals accepted services and received a Start of Care. The 49 new clients joined the 27 existing clients receiving services totaling 76 clients who were enrolled in the DMHE program during the year

Q87. What category(ies) of intervention best fits this initiative? Select all that apply.

- [ ] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [ ] Acute condition-based intervention: treatment intervention
- [x] Acute condition-based intervention: prevention intervention

- [x] Biophysical health indicators: cumulative changes in maintaining and improving behavioral and biometric outcome
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ] Other

Q92. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

We track success of the program by comparing the number of inpatient admissions and ED visits for each client in the 90 days prior to entering the program and the 90 days after entering the program.

Q93. Please describe how the outcome(s) of the initiative addresses community health needs.

Baltimore has approximately 620,000 residents, 63 percent of whom are African American, and 23 percent of whom live below the poverty line. Baltimore residents suffer from high rates of disease and unhealthy behaviors: 20 percent of African Americans in Baltimore report having an unmet medical need in the last 12 months; and 34 percent of residents are obese, with significantly higher rates among those with the lowest incomes. Community leaders have voiced their desire for health services to help them make better lifestyle choices. Sinai Hospital of Baltimore launched the Diabetes Medical Home Extender Program to help program participants learn to manage their diabetes and become active participants in their overall health.

Q94. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Grant $250,000 Non Grant $94,000

What is Community Benefit?

Services or activities that are intended to address community needs primarily through improvement in health status and disease prevention, including:

- Health services provided to vulnerable or underserved populations
- Financial or in-kind support of public health programs
- Donations of funds that contribute to a community priority
- Health education screening and prevention services

Community benefit programs typically,

- Require a financial subsidy from the hospital
- Would be discontinued if decision was based solely on financial considerations

Community Benefit Categories

Category A – Community Health Services

Support services subsidized by hospital that extend beyond traditional patient care activities

Examples:

- Chronic disease management clinics throughout LifeBridge
- Community complex care management throughout LifeBridge
- Community health education and screenings

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Community Benefit Categories

Category B – Health Professions Education

The provision of a clinical setting and expertise for vocational training

Examples: Essential to promote access in communities

- Residency program- Residents provide services at Sinai Community Care for community members who would not otherwise have access to Care
- Nursing students
- Other Allied Health Professionals

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Community Benefit Categories

Category C – Mission Driven Health Services

Subsidized services designed to address unmet community needs

Examples:

- Opioid Response to HOPE Act- Peer Program
- Partnership with regional and state complex care coordination entities to co-manage population
- Mobile Clinic
- Partnership with Davita to manage high cost/high utilization end stage renal patients in our communities

Community Benefit Categories

Category D – Research

Clinical and community health research, as well as studies on health care delivery

Examples:

- Research on treatment protocols (includes pediatric oncology and orthopedic research)
- Cancer registry
- Innovation Center at LifeBridge

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Community Benefit Categories

Category E – Donations

Cash or in-kind services donated to the community

Examples:

- Cash donations/sponsorships made by the hospital (e.g. Park Heights Renaissance)
- Financial assistance to indigent patients, including funds for:
  - Medications
  - Transportation assistance
  - Housing assistance- Baltimore City Supportive Housing Program

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Community Benefit Categories

Category F – Community Building Activities

Development of community health programs and partnerships to address assessed need

Examples:

- Community housing support and coalition building (e.g. HUBS)
- Workforce/leadership development (e.g. Kuji Center, VSP)
- Partnership with all County and City Health Departments to meet community-based needs- (e.g. Partnership for a Healthier Carroll County)

Community Benefit Categories

Category G – Community Benefit Operations

Costs associated with administrative staff in the operations and development of programs in Categories A-F

Other Items Included in Community Benefit Report

- Hospital charity care
  - ➢ Free or discounted care for uninsured and under-insured

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Summary

- Community Benefit is MORE than just 4 examples
- Reporting should allow for a summary of all programs that make up the dollars spent for community benefit- not just 3-4 examples
- Community Benefit reporting should tie to the identified and prioritized community needs that fall under each of the community benefit categories.

Best Practices for Community Benefit Reports

What takeaways and processes should the State incorporate into HCB reporting guidance?

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Understanding How We Got Here

- Recent policy towards HCB Reporting formats has not strictly required program or activities to be listed as line items, instead allowing initiatives to be grouped into sub-categories.
  - The HSCRC opted to move towards more general reporting as an effort to reduce hospital administrative burden.
  - Standardization occurred prior to CHNA IRS regulations created opportunity for detail and community input.
- As a result, the community benefit reporting requirements do not include sufficient transparency into how much hospitals invest in their community health needs.
- With the current HCB reporting format, there is no way to systematically detail the investments hospitals make in response to community input.
- After systematic review of other states and expert opinion, NASHP has released guidance on best practices for identifying the CHNA within Community Benefits.

NASHP Best Practice Recommendations

Two-fold focus of:

- Granular reporting of hospital expenditures:
  - How much net spending was allocated to address each specific need identified in the assessment?
  - Is that money spent by the hospital directly, or does the hospital give the money to an organization or wellness fund to use to address those needs?
  - How much spending is in cash, and how much is in staff time or other in-kind donations?
- Program outcomes tracking and reporting:
  - What are the goals of the activities designated to address community health needs?
  - What kind of data or information is the hospital collecting to gauge its impact?
  - Who are the hospital's partners in that work?
  - How does its investment and outcome align with state priorities?

NASHP Template: Financial Reporting

Hospital Community Benefit and Building Reporting: Hospital Expenditures

Spending on Needs Identified in the Community Health Needs Assessment				Spending on Needs Not Identified in the Community Health Needs Assessment*				
Community health needs identified in the implementation strategy section of the most recent assessment Prioritize the needs numerically, with #1 representing the highest priority *States could pre-populate some identified needs based on their health improvement plan or other state priorities.*	**Specific actions** taken by a hospital to address the identified community health needs *Each hospital should describe how its actions or initiatives address the needs identified by its community. Include more rows for additional actions as needed.*	**Net dollar amount** applied toward each action or effort Indicate if the amount is paid by the hospital to outside organizations to implement specific actions or efforts. *Hospitals should not include outside funding sources here.*	**Other resources**, such as in-kind donations or staff time, applied toward each action or effort	**Actions** or efforts to address a community health need not identified in the implementation strategy in the most recent assessment *Hospitals should describe actions or initiatives that the IRS would consider community benefits or community building but are not tied to the assessment.*	**Community needs addressed** that were not identified in the assessment	**Net dollar amount** applied toward each action or effort	**Other resources**, such as in-kind donations or staff time, applied toward each action or effort	**Justification** - why was a need addressed when it was not identified by the assessment?
Identified need #1	Action 1: Action 2:	Action 1: Action 2:	Action 1: Action 2:	Other action #1	Need addressed #1			
Identified need #2	Action 1: Action 2:	Action 1: Action 2:	Action 1: Action 2:	Other action #2	Need addressed #2			
Identified need #3	Action 1: Action 2:	Action 1: Action 2:	Action 1: Action 2:	Other action #3	Need addressed #3			
Etc.	Action 1: Action 2:	Action 1: Action 2:	Action 1: Action 2:					

*Hospitals are encouraged to tie community benefit and building expenditures to needs identified in their community health needs assessments (CHNA). This section informs policymakers about how much a hospital's spending addresses needs other than those identified in the CHNA.

1. Splits out CHNA and non-CHNA Spending

2. Categorizes CHNA spending based on identified needs

3. "Actions" or programs/initiatives intended to address the need

4. Net dollar amount, similar to Maryland's structure and 990 form

5. Other resources or offsetting revenue type addition

6. Asks for justification or reasoning behind a non-CHNA expenditure. MD could use this to address physician subsidies, Medicaid Deficit Assessment, Medical Education and other State-specific public goods

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NASHP Template: Outcomes

- HSCRC sees as a partial roadmap for the Narrative report

1. Follows the structure of the suggested Financial Report
2. Goals allow stakeholders and the State to see how "actions" progress
3. Allows for non-CHNA "actions" to integrate with outcomes reporting

Hospital Community Benefit and Community Building Program Reporting: Outcomes

Community health needs identified in the implementation strategy of the most recent assessment Prioritize the needs numerically, with #1 representing the highest priority *States could pre-populate some identified needs based on their health improvement plans or other state priorities.*	**Specific actions** taken by a hospital to address the identified community health need *Each hospital should describe how its actions or initiatives address the needs identified by its community.*	**Goal of action**	**Target populations and/or regions** *States could ask hospitals how they identified the target populations or regions.*	**Partners engaged**	**Outcomes to date** *States could give hospitals a menu of outcomes, such as those in Metrics for Healthy Communities, the Social Intervention Research and Evaluation Network's Social Need Screening Tools Comparison Table, and the Centers for Disease Control and Prevention's Hi-5 initiative.*	**Data used to measure outcomes**	**Statewide health priority addressed**
Identified need #1							
Identified need #2							
Identified need #3							
Etc.							
This section is for programs whose needs were NOT identified in the assessment's implementation strategy*							
Other need #1							
Other need #2							
Etc.							

*Hospitals are encouraged to tie community benefit and building expenditures to needs identified by their community health needs assessments. This section is designed to inform policymakers about how much current hospital spending addresses needs other than those in the assessment.

4. Target populations help elucidate which stakeholders to engage and efforts towards equity
5. Can help inform community engagement in "actions"
6. Outcomes to date and data allow the State and Stakeholders to view progress annually
7. Could tie to Statewide Integrated Health Improvement Strategy (SIHIS), TCOC Model Goals or other State health priorities

Discussion Questions

- Would the NASHP reporting structure help stakeholders more effectively understand where HCB investments respond to the community?
- Are there additional changes and areas of reporting that would benefit from more detail or less?
- How do we ensure that hospitals can easily understand and report across HCB and CHNA?

Next Steps

- The HSCRC would like to form a technical subgroup to work on reporting guidance, accounting formats and HCB reporting processes
  - Who would be best to advise on these topics?
- Next Agenda Items:
  - Ensuring Community Engagement is Meaningful
  - Physician Subsidy Reporting and Health System Losses
  - Developing Report to Legislature on Extent of HCB Investment in CHNA priority areas