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Building Community Capacity for Prevention:

A Plan to Implement

Statewide Strategies through Hospitals and Health Plans

Community Benefit Investments

Minnesota Department of Health

Report to the Minnesota Legislature 2012

February 15, 2012

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Executive Summary

With the goal of achieving a collective impact that will reduce chronic disease, improve health and decrease costs for all communities in Minnesota, the 2012 Minnesota Department of Health Report to the Minnesota Legislature: Building Community Capacity for Prevention (BCCP) seeks to align Minnesota non-profit hospitals' and health plans' community health and community building investments with state community primary prevention investments.

In July, 2011, the Minnesota Legislature adopted legislation directing the Minnesota Department of Health (MDH) to develop a plan to implement evidence-based strategies from the statewide health improvement program as part of hospital community benefit programs and health plan collaboration plans.

Per the legislation, the MDH sought input from hospitals and health plans, as well as a wide range of stakeholders including community-based organizations, local public health, and the public. The resulting BCCP report more fully integrates local public health and community groups as collaborative partners in the process. The BCCP report also aligns with existing federal and state reporting requirements for hospital community benefit programs and health plan collaboration plans. Three keys to success that were identified through the process were:

- **A strong local focus** regarding priority setting and addressing health disparities and other community needs. Local communities are in the best position to identify their priority health needs and strategies for solutions. Health disparities within a community are best understood by that community. Therefore, it is vital that local communities have a strong voice in setting local hospital and health plan BCCP plan priorities.
- **Active community engagement and partnerships** where efforts reflect *cooperation* and *collaboration*. A desired outcome of this process is building public awareness, partnerships, collaboration and local investments toward mutual health improvement goals.
- **Use of health improvement strategies** that have been documented to be effective in a community-based setting. These strategies will be compiled by MDH and made available for sharing through a clearinghouse. This resource will include health assessment tools, evidence-based and promising innovative strategies and evaluation tools to help inform strategy selection and implementation plans.

Reporting burden

MDH recognizes the complex and overlapping nature of existing state and federal reporting requirements. It is the intent of MDH and the BCCP Advisory Board to minimize additional reporting burden and align BCCP plans with existing reporting requirements and timelines.

Scope

The BCCP report seeks to provide guidance on a very limited portion of Community Benefit resources expended by hospitals. The portion under discussion involves investment in community health, specifically those activities addressed in the categories of *Community Health*

Services and Community Building Activities. These two areas constituted six percent of all Minnesota Hospital Community Benefit expenditures in 2009.

There are distinct differences between hospital Community Benefit programs and health plan Collaboration Plans. The Collaboration Plans submitted by health plans are prospective plans, covering a four year period of time, and provide detailed information about health plans' support for priority public health goals and activities.

In contrast, the Community Benefit reports filed by hospitals are retrospective, representing the investments from the previous year. The majority of hospitals' Community Benefit spending has focused on charity care and underpayments, as well as in-kind contributions and operating expenses from these services. Other areas of Community Benefit spending have included education and research and Community Benefit operation. These investments will not be a subject of the BCCP report.

Advisory Board

For assembly of the BCCP Advisory Board, MDH ensures equal participation for local officials and public health, hospitals and health plans, and community members. The Advisory Board will be made up of five representatives from the State Community Health Services Advisory Committee, five representatives from community-based organizations and five representatives from hospitals and health plans. Members of the Advisory Board will be appointed by the Commissioner of Health.

Next steps

From February through May 2012 MDH will work with the Advisory Board to refine the implementation plan, including review and alignment of all existing assessment and reporting tools and requirements. Subcommittees of the board may be formed and meet as necessary to address specific aspects of the plan. Within the implementation plan, the Advisory Board will provide recommendations on the content, format and timing of Community Benefit and Collaboration Plans to be submitted to MDH. The implementation plan will be submitted to the Commissioner of Health by May 31, 2012 and will be implemented by July 1, 2012.

Introduction

Minnesotans, on average, are healthy and enjoy a high quality of life. Much of this is credited to the state's prosperity, a high level of education, and a high-quality health care system offering quality services to Minnesota's five-million residents. However, while Minnesota enjoys the status of being one of the healthiest states in the nation, there are trends that are troubling and need to be addressed. Recent national health rankings suggest that Minnesota's status as a leader in health is in jeopardy: in overall rankings, the state fell from first in 2006 to sixth in 2011.¹

The downward trajectory of Minnesota's health ranking is linked to individual risk factors and low investment in public health that portends a further deterioration in the overall health of Minnesotans. Minnesota is experiencing high rates of tobacco use, binge drinking and obesity. In 2009 approximately 63 percent of Minnesotans were overweight or obese, and 17 percent of Minnesotans used tobacco products.² In 2011, 18 percent of Minnesotans also experienced problems with binge drinking. Tied to the state health rankings, Minnesota's investment in public health is among the lowest in the United States, investing only \$45 per person while the top state invests \$244 per person. Minnesota also has troubling and persistent health disparities that impact the health of the State. Health disparities refer to health differences between groups of people. Health disparities include how a disease or illness disproportionately affects a group. As a result of all these risk factors, many Minnesotans are at increased risk for chronic diseases, such as cancer, coronary heart disease or angina, stroke, diabetes, chronic obstructive pulmonary disease and asthma. Chronic diseases are among the most prevalent, costly and preventable of all health problems.

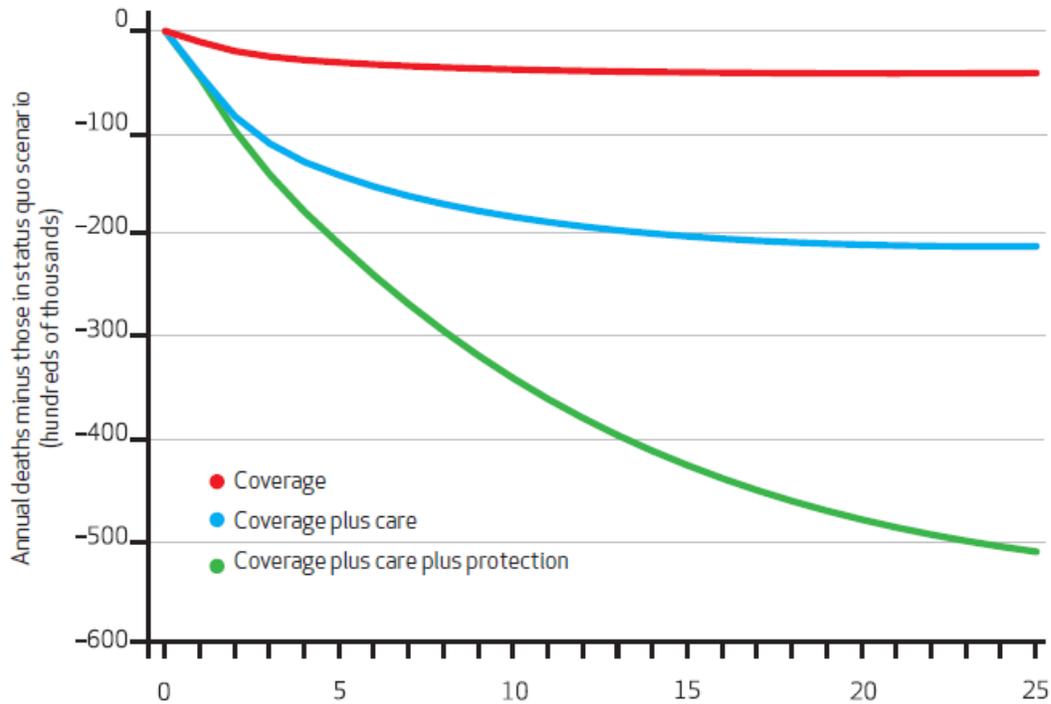
No single solution can reverse these trends. Effective action requires a multi-sector approach including expanding health insurance coverage, improving the quality of health care, expanding the use of clinical preventive services, and investing in community primary prevention (Figure 1). The focus of this report and plan is to improve the health of communities throughout Minnesota and prevent the development of chronic disease and disability. While Minnesota health care leaders and policy makers are determined in their efforts to improve preventive and chronic care, their focus remains on *care*. There has not been equal attention to community primary prevention, which encourages and enables healthier behavior and safe and healthy environments. There is a particular urgency to increase efforts in the arena of primary prevention with a focus on prevention of the risk factors that lead to disease. Substantial research shows environmental and health behaviors are leading influences on health status, and supports the necessity to invest in primary prevention and public health (Figure 2). The support for community primary prevention lies in knowing "only prevention and protection (defined as Community Primary Prevention in this report) slow the growth in the prevalence of disease and injury" by preventing their onset and thereby reduce the demand on the health care system (Figure 3).

¹ The American Public Health Association, Partnership for Prevention, & United Health Foundation. (2010). America's Health Rankings. Retrieved from <http://www.americashealthrankings.org/measure/2010/overall.aspx>

² Centers for Disease Control and Prevention. (2009). Behavioral Risk Factor Surveillance System Prevalence and Trends Data. Retrieved from: <http://apps.nccd.cdc.gov/brfss/>

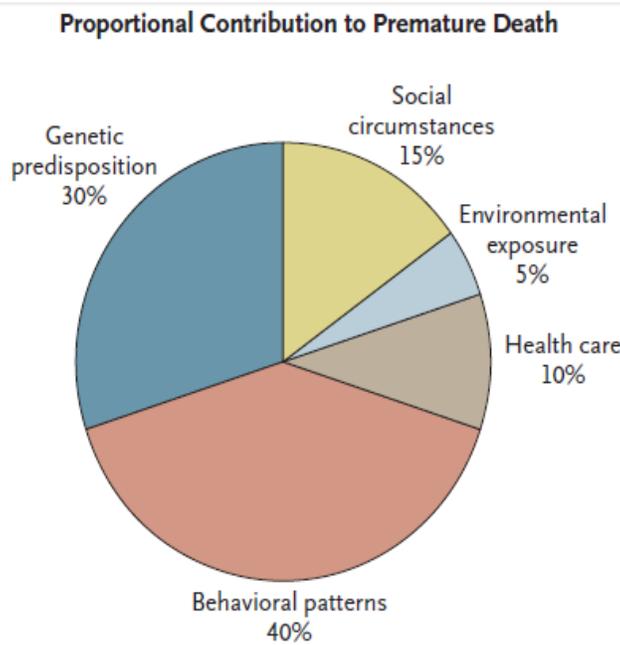
Figure 1. Death outcomes of combining three approaches to improve health: expanding coverage, improving health care and investing in community primary prevention.

Annual Deaths, Three Layered Intervention Scenarios, Year 0 To Year 25



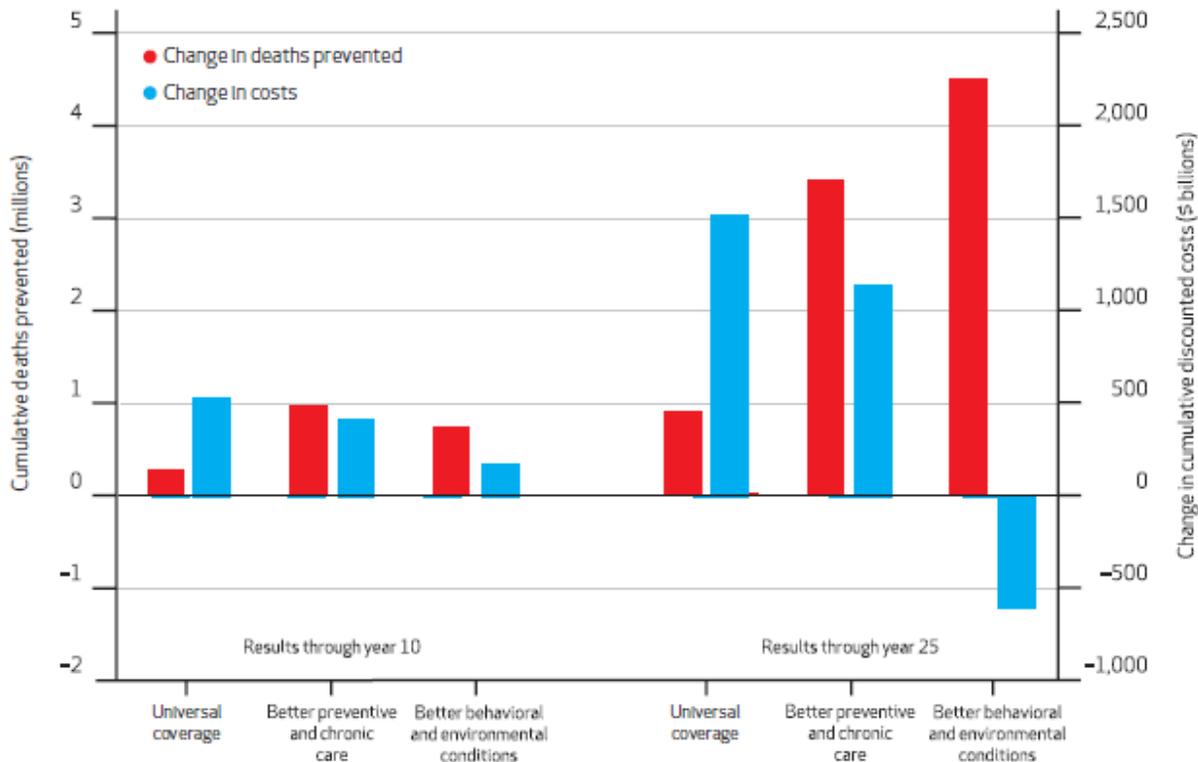
Milstein et al. (2011) Why Behavioral and Environmental Interventions are needed to Improve Health at Lower Costs. *Health Affairs*. 30, No. 5 (2011): 823-832.

Figure 2. Proportional Contribution of Premature Death in the United States (2007)



Schroeder, S. We Can Do Better – Improving the Health of the American People. *N Engl J Med* 2007; 357:1221-8.

Figure 3. A comparison of changes in deaths prevented and costs associated with expanding health coverage, improving care and investing in community primary prevention.



Milstein et al. (2011) Why Behavioral and Environmental Interventions are needed to Improve Health at Lower Costs. *Health Affairs*. 30, No. 5 (2011): 823-832.

Nationally, studies show that investment in community primary prevention is small compared to health care.³ In 2008, Minnesota policy makers recognized that containing the spiraling costs of health care in our state could not be impacted by changes in medical care alone; investments in prevention were needed. Minnesota passed a ground-breaking health reform law consisting, among other things, of a comprehensive package of reforms designed to achieve the goals of improving the health of the population, the patient experience of care and the affordability of health care. An important part of this health reform effort was a substantial investment in primary prevention activities designed to improve community health through reducing the risk factors most contributing to chronic disease. This aspect of the 2008 Minnesota Health Reform legislation was called the Statewide Health Improvement Program (SHIP). SHIP fell subject to a 70 percent cut in funding availability in 2011. In response the Legislature directed the Minnesota Department of Health to develop a plan to implement evidence-based strategies from the statewide health improvement program as part of hospital community benefit programs and

³ Center for Disease Control and Prevention, University of California at San Francisco, Institute for the Future

health maintenance organizations collaboration plans. For the purposes of this document the plan the Department was directed to develop will be referred to as the Building Community Capacity for Prevention (BCCP) report.

Background

The term community benefit, when used in the context of health care organizations (providers and health plans) refers to initiatives and activities that are outside but often related to their principle business purposes. The concept of community benefit relates to the policy expectation that exempting these organizations from certain taxes should produce socially desirable results, e.g. community benefit. The 2011 legislative directive to the Minnesota Department of Health to develop a plan to implement evidence-based strategies focused on community primary prevention is consistent with both of these descriptions of community benefit.

Community Benefit originated as “charity care” through the Hill-Burton Act of 1946, which provided for the establishment of a large number of hospitals in the post-war period, to meet needs for acute care services. In 1965, the introduction of Medicare and Medicaid increased insurance coverage, so hospitals were caring for fewer uninsured individuals and therefore rendering less uncompensated care. To respond, an Internal Revenue Service (IRS) ruling required nonprofit hospitals to provide “community benefit” to retain their federal tax-exemption. Under the ruling, “community benefit” broadened the scope beyond charity care to include activities that benefit the community as a whole but did not specify a required volume.

The tax exempt status of hospitals and health plans conveys an obligation for “community benefit” due to the impact on the community of the tax deferral. The non-profit hospitals and health plans benefit from four types of tax deferral, local property tax, State sales tax, State income tax and federal income tax.⁴

As part of the ruling, tax-exempt nonprofit hospitals should be operated under a community board of trustees, further emphasizing the community’s pivotal involvement and ownership of Community Benefit. On an annual basis nonprofit, non-governmental hospitals and health plans have been required to submit a Form 990 to the IRS to report financial information to the IRS. Hospitals and health plans also submit their Form 990s to the Minnesota Department of Health on an annual basis.

Hospitals and Health Plans Community Benefit Investments

As non-profit entities, hospitals and health plans have focused on providing quality and value to the community while offering innovative approaches to both primary care and community health. Minnesota hospitals have made substantial investments in the community.

Minnesota hospitals provide community benefits in nine categories listed below in Table 1. In the 2009 reports filed with the Minnesota Department of Health, hospitals reported investing over \$781 million dollars in Community Benefit. The majority of hospital Community Benefit

⁴ Public Health Institute. November 2004. Advancing the State of the Art in Community Benefit

spending has focused on charity care, and underpayments, as well as financial and in-kind contributions and operating subsidized services from these services. Other areas of Community Benefit spending have included education and research, Community Benefit operation. **These seven categories of expenditures are not the subject of the Minnesota Department of Health's BCCP report.** The Minnesota Department of Health has chosen to limit its guidance and the BCCP report to only two of these categories, *Community Building Activities* and *Community Health Services*. These two categories of Community Benefit totaled six percent, (approximately \$45 million) of hospitals total expenditures.

**Table 1:
Minnesota Hospital Community Benefit by Category 2007-2009**

	Community Benefit			% of total 2009
	2007	2008	2009	
Charity Care	\$ 98,015,014	\$ 117,044,453	\$ 132,979,363	17.0%
State Health Care Programs Underpayments	282,775,479	325,272,664	334,426,151	42.8%
Operating Subsidized Services	100,709,968	101,636,580	111,445,442	14.3%
Education	86,461,661	80,970,463	113,702,521	14.5%
Research	6,895,732	6,565,581	11,977,983	1.5%
Community Health Services	36,437,137	33,306,938	40,355,103	5.2%
Financial In-Kind Contributions	15,288,966	25,718,920	22,779,310	2.9%
Community Building Activities	3,705,123	3,488,196	4,169,217	0.5%
Community Benefit Operations	8,335,231	8,820,487	9,789,711	1.3%
Total	\$638,624,311	\$702,824,282	\$781,624,801	

Source: MDH analysis of hospital annual reports <http://www.health.state.mn.us/divs/hpsc/hep/index.html>

Similarly, Minnesota's health plans have made substantial investments, spending nearly \$75 million in community benefit in 2007 (Table 2). \$40 million was directed toward *Supporting Public Health* (also referred to as the "Collaboration Plan"). It is this category, *Supporting Public Health, of the health plan's community benefit expenditures addressed in the BCCP report.*

**Table 2
Minnesota Nonprofit Health Plan Community Benefit**

	2007
	(Millions of dollars)
Supporting Public Health	\$39.7
Improving the Art and Science of Medical Care	\$27.0
Providing financial Assistance to access Ongoing Coverage	\$6.4
Other	\$1.7
Total	\$74.9

Source: MDH analysis of data collected from Minnesota nonprofit health plan companies

2010 Affordable Care Act

The 2010 Affordable Care Act (ACA) imposed four new requirements for hospitals to attain and maintain tax-exempt status under Code 501(c) (3). The ACA requires nonprofit hospitals to:

- Complete community health needs assessments at least every three years;
- Take into account input from persons representing community interests, including public health experts, when developing the assessment;
- Adopt a plan to meet the community health needs identified through the assessment;
- Report on how it is addressing the needs identified in the most recent community health needs assessment and explaining why any identified needs are not being addressed.

The IRS is still refining its section 501(1) requirements.

The US Department of Treasury will review hospitals' Community Benefit activities every three years, and, in consultation with the Department of Health and Human Services, provide an annual report and trend study (charity care, bad debt collections, Medicare/Medicaid reimbursement shortfalls). Outside of the new ACA requirements, explicit federal or uniform state-level requirements of health care organizations about the scope and volume of community benefit do not exist. This is part of the reason why the Legislature directed MDH to guide hospitals and health plans through this revised Community Benefit process.

History of Community Benefit in Minnesota

Hospital Community Benefit

In 2007, MDH conducted a legislatively required study of trends in hospital uncompensated care,⁵ the amount of Community Benefit provided by Minnesota's nonprofit hospitals, and the value of nonprofit tax exemptions. As part of this study, MDH made recommendations on the need for more uniform charity care and bad debt collection policies and the need for more uniform reporting of hospital Community Benefit. Picking up from recommendations from MDH's study on reporting and standards for reporting of community benefit, the Minnesota Legislature in 2007 required Minnesota hospitals to annually report this data and for MDH to publish an annual report summarizing community benefit data and trends (see Table 1).⁶

Health Plan Community Benefit

In 2008, the Minnesota Legislature required MDH to make recommendations on Community Benefit standards for health plans, including recommendations for a public reporting process and an enforcement and remediation mechanism. Prior to 2008, the only requirement of health plans was to file collaboration plans with the State (Minnesota Statute 62Q.075). The purpose of these plans is to establish what activities health plans will undertake to meet public health goals for communities in the areas they serve. Local public health agencies and other community organizations in the health plan's service area provide input to the collaboration plan.

⁵ <http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/uc2007report.pdf>

⁶ MDH is in the process of finalizing the 2011 version of this report that uses data for 2009. The 2010 version is available online: <http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/communitybenefits2008.pdf>

Collaboration plans are filed by health plans with MDH's Office of Performance Improvement every four years and updates are filed every other year. (Prior to 2004 the collaboration plans were filed every two years.) The most current collaboration plan is for 2010-2014. In addition:

- The purpose of these plans is to describe the ways in which health plans collaborate with local public health departments to meet public health goals for communities in the areas they serve.
- In the past, each health plan filed its own Collaboration Plan. However, with MDH approval, the most recent plan, using information provided by its member plans and with input from its members, representatives of local public health agencies around the state, and MDH, the Minnesota Council of Health Plans compiled all collaboration activities into one document, addressing broad public health goals and strategies.
- Collaboration plans are available online on the MDH website:
<http://www.health.state.mn.us/divs/cfh/ophp/system/collaboration/colplans.html>

Because there are no explicit federal requirements related to nonprofit health plans' Community Benefit as part of Collaboration Plans, and only a few states have addressed this issue, there are currently no widely accepted definitions of Community Benefit and reporting categories designed specifically for health plans. MDH's 2009 report to the Legislature *Community Benefit Provided by Minnesota Health Plans*⁷ relied on standards developed for hospitals and included the following information:

- An industry-wide analysis of reported Community Benefit in 2007, based on data collected from health plan companies.
- Options for developing Community Benefit standards for Minnesota nonprofit health plans.
- Recommendations on Community Benefit definitions.

Development of the Building Community Capacity for Prevention (BCCP) Report

The purpose of BCCP report is to identify the opportunities to align expenditures and investments made by Minnesota non-profit hospitals and health plans in the categories focused on community health and community building with State community primary prevention investments, with the goal of achieving a collective impact that will reduce chronic disease, improve health and decrease costs for all communities in Minnesota.

2012 Legislation

The Minnesota Legislature adopted legislation in 2011, (1st Spec. Sess. Chapter 9, Article 10, Sec. 4), directing the Minnesota Department of Health (MDH) to:

- By February 15, 2012, the commissioner shall develop a plan to implement evidence-based strategies from the statewide health improvement program as part of hospital community benefit programs and health maintenance organizations collaboration plans.

⁷ <http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/hlthplancommbenefit.pdf>

The implementation plan shall include an advisory board to determine priority needs for health improvement in reducing obesity and tobacco use in Minnesota and to review and approve hospital community benefit activities reported under Minnesota Statutes, section 144.699, and health maintenance organizations collaboration plans in Minnesota Statutes, section 62Q.075. The commissioner shall consult with hospital and health maintenance organizations in creating and implementing the plan. The plan described in this paragraph shall be implemented by July 1, 2012.

Public Input Processes

In response to the legislation, MDH sought input from a wide range of stakeholders and completed the following steps:

- Developed a set of guiding principles for incorporating evidence-based public health strategies into hospital and health plan BCCP plans.
- Outlined responsibilities and membership of a new BCCP Advisory Board to advise the commissioner of health on the work authorized by the new law.
- Identified the need to review existing reporting requirements to determine how they can be made more efficient.

The development of this plan has been informed by input from a variety of stakeholders, such as representatives from hospitals, health plans, community-based organizations, local public health agencies and community members. Four public meetings were held to gather public input. First, the Town Hall Meeting on Building Community Capacity for Prevention plans, attended by approximately 110 stakeholders and interested citizens, was held December 20, 2011, focusing on a broad discussion, initial identification of opportunities and issues of potential concern. At that meeting, volunteers were solicited to form an ad hoc work group. This group of 30 community members and representatives from hospitals, health plans and community-based organizations met January 18, 2012, to discuss and give feedback on intent, guiding principles and scope/role of an Advisory Board. A meeting specifically for community-based organizations was held on January 25, 2012, to provide an opportunity for discussion and questions. Finally, a second Town Hall Meeting on the BCCP report attended by approximately 50 stakeholders and interested citizens was held January 30, 2012, to provide an opportunity for feedback and input on draft components of the plan, with written public comments accepted through February 3, 2012.

From this community input process, a set of guiding principles was developed to guide MDH in the creation of the final plan:

1. The health improvement goals that hospitals and health plans consider for the portion of their community benefit covered in the BCCP plan investments should align with state health improvement goals, including goals beyond obesity and tobacco.
2. Addressing the needs of those groups in a community experiencing the greatest health disparities is a priority for BCCP investments.
3. Collaboration between community partners, including local public health agencies, hospitals, health maintenance organizations and populations with disparate health needs is strongly valued and encouraged.

4. A broad range of evidence-based strategies and promising innovative practices with defined outcome measures should be priorities for consideration for BCCP investment.
5. The plan will provide for local flexibility, based upon the local assessment of community health needs.

Recommended Building Community Capacity for Prevention (BCCP) Plan Review Process

MDH Implementation Plan

In year One, MDH will work with the BCCP Advisory Board to 1) identify community-level primary prevention best practices and look for opportunities in Minnesota to implement such practices by health plans and hospitals, and 2) collect data on the approaches hospitals and health plans are using to improve community health through the Community Health Services and Community Building categories of their existing community benefit expenditures. MDH will review and use the information to inform recommendations to hospitals and health plans.

In year Two, MDH will report on hospital and health plan's BCCP related investments. In doing this, MDH, hospitals, and health plans will have new tools to identify local opportunities and effective strategies and align their preventive strategies in ways to improve the health of their communities and the State. The following criteria will guide the review and feedback to hospitals and health plan on the investments they are making that relate to BCCP plans:

Critical elements for Building Community Capacity for Prevention Plans include:

1. A strong focus on local priority setting and addressing health disparities

Working from the premise that local communities are in the best position to identify their priority health needs and determine which strategies will be effective to improve the community's health, MDH and the BCCP Advisory Board will work from a framework that encompasses the inter-related federal and state assessment and reporting requirements for hospitals, health plans and local public health agencies (Appendix B). By coordinating these seemingly disparate processes, new opportunities will be identified to create better health in Minnesota. An important aspect of this local planning is an emphasis on identifying and addressing the health needs of those communities and groups experiencing the greatest health disparities. Health disparities within a community are best understood by that community. Therefore, it is vital that local community representatives have a strong voice in setting local hospital and health plan BCCP plan priorities.

2. Active community engagement and partnership

In the development of hospital and health plan BCCP plans, an emphasis should be placed on authentic community engagement. Arthur Himmelman⁸ has identified four levels of community engagement, including:

- Networking – exchanging information for mutual benefit.

⁸ Himmelman, A. 1992, "Communities Working Collaboratively for a Change," Humphrey Institute for Public Affairs, University of Minnesota.

- Coordination – exchanging information and altering activities for mutual benefit and to achieve a common purpose.
- Cooperation – exchanging information, altering activities and sharing resources for mutual benefit and to achieve a common purpose.
- Collaboration – exchanging information, altering activities, sharing resources and enhancing the capacity of another for mutual benefit and to achieve a common purpose.

For the purpose of the BCCP plans, engagement efforts should reflect “cooperation” and “collaboration.” A desired outcome of this process is the building of public awareness of partnerships, collaboration and investments made locally toward health improvement goals.

3. Use of health improvement strategies

Between February 15 and June 30, 2012, MDH will develop a platform or clearinghouse for sharing community health assessment tools, evidence-based and promising innovative strategies and evaluation tools to inform strategy selection and implementation plans. By August 2012 MDH will publish the statewide health improvement goals as developed by the Healthy Minnesota 2020 Partnership. These tools will be made available to hospitals and health plans as they work with their local community partners. MDH staff will be available to provide technical assistance to hospitals and health plans as they build collaborative relationships with local public health and community partners.

Advisory Board

MDH seeks to ensure active participation of local officials and public health, communities affected by health disparities, and hospitals and health plans on the Advisory Board. The Advisory Board will be made up of five representatives from the State Community Health Services Advisory Committee, five representatives from community-based organizations representing communities experiencing health disparities and five representatives from the health care industry. Members of the Advisory Board will be appointed by the Commissioner of Health for alternating terms of two years.

The work of the Advisory Board will be informed by the State Community Health Assessment and the statewide health improvement goals established by the Healthy Minnesota Partnership.

Reporting requirements

MDH recognizes the current numerous, yet necessary, reporting requirements. With the Advisory Board, MDH will aim to streamline existing and minimize additional reporting burden to the extent possible. It is the desire of MDH to align and leverage existing resources, tools and processes related to BCCP plans and ensure alignment with IRS Community Benefit categories and requirements where feasible.

See Appendix B. for a list of existing community assessment, planning and reporting requirements.

The BCCP Advisory Board will establish processes for reviewing and commenting on hospitals' and health plans' BCCP plans. The frequency of review will be based upon the respective reporting cycle for the hospital or health plan. Hospitals' BCCP plans would be submitted on the same cycle as their federally required community needs assessment. Health plans' BCCP plans would be submitted every four years, as currently required by Minnesota Statute 62Q.07. It is recommended that the following processes be utilized for this review process.

Recommended Process for Review of Hospital's BCCP Plans

As discussed previously, aligning state and local public health and hospital Community Benefit programs will focus only on *Community Health Services* and *Community Building* categories of Community Benefit under the BCCP plan.

- A. Hospital submits IRS Form 990 Schedule H including IRS supplemental information to the Advisory Board every 3 years, based upon the tax year in which the hospital is required to complete a community health needs assessment.
- B. Hospital identifies the state health improvement goals that are aligned with the *Community Health Services* and *Community Building* activities included in Part II of Schedule H. (This represents the only additional reporting requirement beyond existing state and federal reporting requirements).
- C. Advisory Board reviews the hospital's documentation on community health needs assessment, implementation plan and IRS Form 990 Schedule H, Part V. 1 – 7 (needs assessment process, engagement of the community including populations with health disparities, implementation strategies).
- D. Advisory Board reviews and provides comments and suggestions back to the hospital based upon criteria established by the Board.

Recommended Process for Review of Health Plan's BCCP Plan

- A. For Health plans, BCCP plans will focus only on the *Supporting Public Health* portion of their Community Benefit Expenditures. Health plan submits a BCCP Plan to the Advisory Board every 4 years.
- B. Health plan's BCCP plans should meet criteria outlined in 62Q.075, including identification of high priority public health goals, measurement strategies, description of process for coordination with local public health and other community organizations, documentation of community involvement in plan development, and evaluation of progress measures from previous collaboration plan.
- C. Working through the Minnesota Council of Health Plans, Health Plans may submit one document that is a compilation of information provided by its member health plans and represents a higher degree of collaboration between health plans, local public health and community organizations than is possible through the use of single health plan collaboration plans.
- D. Advisory Board reviews the health plan BCCP plan(s) with attention to needs assessment process, engagement of the community including populations with health disparities, implementation strategies.
- E. Advisory Board reviews and provides comments and suggestions back to the health plan based upon criteria established by the Board.

Next steps for this plan

To assure full integration of existing assessment and reporting tools and requirements, from February through May, 2012, the Advisory Committee will study these tools to assure streamlined approaches for documentation that will minimize administrative reporting burden on hospitals and health plans. The Advisory Board will also refine the framework for the implementation plan and make recommendations to the Commissioner of Health by May 31, 2012. Subcommittees of the Board may be formed to meet as necessary to address specific aspects of the plan. The adopted plan will be implemented by July 1, 2012.

See Appendix C for a timeline for further development of the plan.

APPENDIX A: Definitions

Community: All persons and organizations that have a sense of interdependence and belonging within an encompassed subject.

Community Benefits:

Programs or activities that provide treatment and/or promote health and healing and tend to generate little profit or lose money; respond to needs of low income or underserved people; provide services that would not be provided or would need to be provided by the government or other nonprofits if the decision was based on financial terms; respond to public health needs; or involve education or research that furthers community health.

Community building:

Costs that the hospital incurs to support programs or activities intended to improve the overall community's strength and security. Typical activities include addressing homelessness and poverty, supporting economic development or environmental protection efforts, or improving public spaces through revitalization, art, streets or lighting, or graffiti removal.

Collaboration plans:

The collaboration plan is required by Minnesota Statutes 62Q.075, which states that all health maintenance organizations in Minnesota must file a plan with the commissioner of health describing the actions the organization intends to take to contribute to achieving one or more high priority public health goals.

Community health needs assessment (CHNA):

A process undertaken to identify the strengths and needs of the community, enable the community-wide establishment of health priorities and facilitate collaborative action planning directed at improving community health status. The Internal Revenue Service requires that hospitals' CHNAs takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and is made widely available to the public and includes and implementation plan.

Community health improvement services:

Community health improvement services are defined in IRS Schedule H, Worksheet 4 as "activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding scale fee for these services." For example, services such as community health education, support groups, transportation, smoking or weight-loss programs that are provided by a hospital for little or no fees to improve community health.

Health disparities: Health disparities are persistent differences in the burden of disease and other health status indicators between different population groups (e.g., race/ethnicity, gender, income, geography, or disability status).

Health system:

Includes hospitals, health plans, community-based health organizations and the local and state health departments.

Healthy Minnesota 2020: A statewide health plan for engaging and energizing all sectors in the state in strategies to improve the health of all Minnesotans (to be developed by August 2012).

Healthy Minnesota Partnership: The Healthy Minnesota Partnership is a multi-sectorial community leadership team convened to guide the development of a Minnesota-focused statewide health assessment and public health goals, and to lead the implementation of a statewide health plan to improve the health of all Minnesotans. Partners include state agencies, communities of color, local public health departments, elected officials, non-profits, hospital and the community.

Implementation Strategy:

Treasury and the Internal Revenue Service intend to define an implementation strategy for a hospital facility as a written plan that addresses each of the community health needs identified through a CHNA for such facility.

Community Primary Prevention:

Community Primary Prevention includes processes and initiatives that enable people to increase control over, and to improve, their health. Community Primary Prevention also includes policy, system and environmental change strategies that encourage healthy lifestyles and foster healthy and safe environments. The purpose of Community Primary Prevention is to create the conditions in a community that will support health and slow or reverse the growth in prevalence of disease and injury by preventing the onset of disease and injury.

According to the World Health Organizations, the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Improvement in health requires a secure foundation in these basic prerequisites.

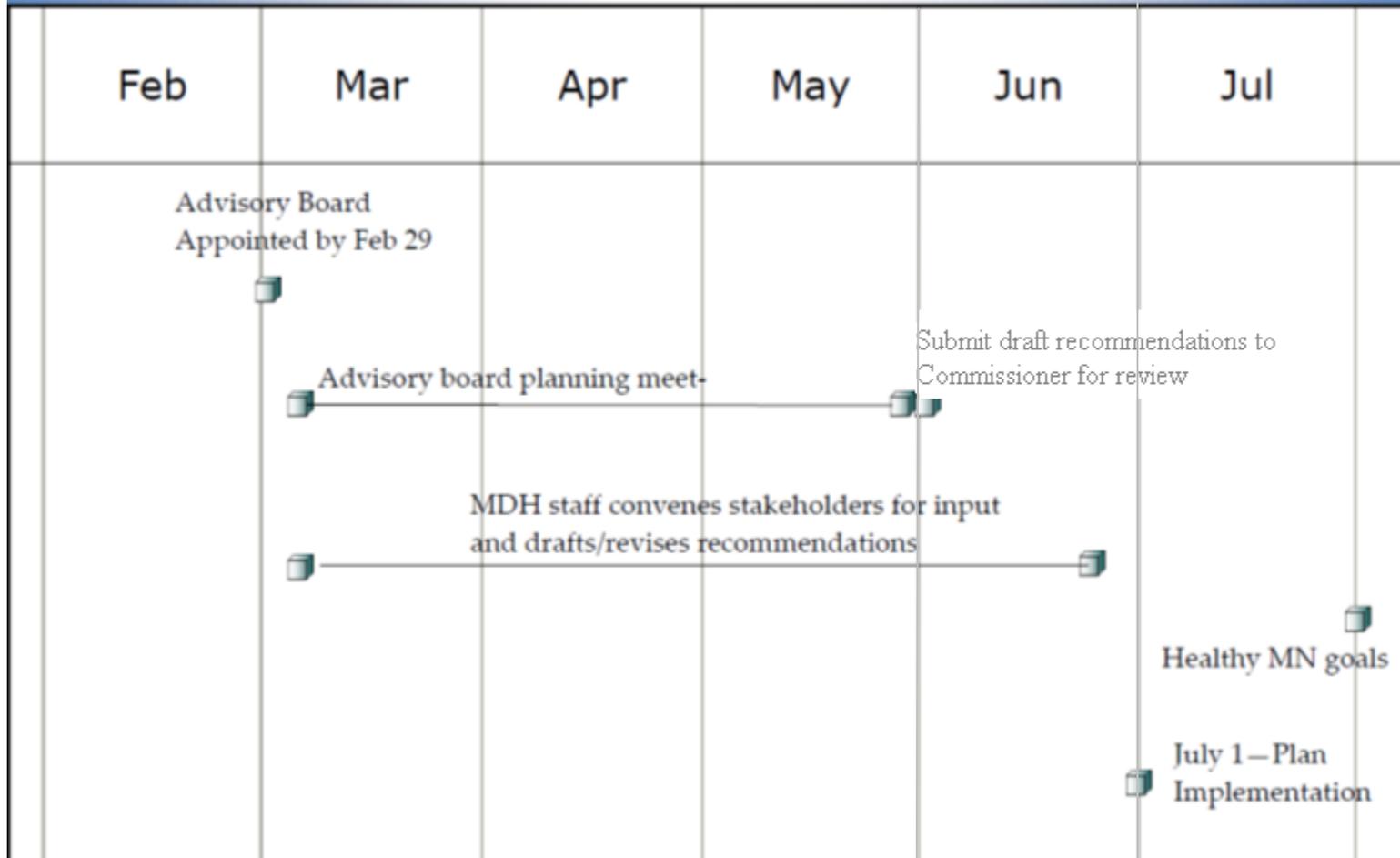
Community Primary Prevention may also be referred to as health promotion, primary prevention or health protection.

Appendix B: Existing Community Assessment, Planning and Reporting Requirements

Related Reporting or Planning Process	Scope	Frequency/Affected Organizations
The Internal Revenue Service	Form 990, Schedule H Community health needs assessment (CHNA) and implementation plan. Requires community input to CHNA.	Annual: Schedule H (Form 990) Every 3 Years: CHNA and implementation plan for hospitals Required for non-public, non-government hospitals. Reporting occurs at the hospital system level.
Medicare Cost Report	Schedule S-10 includes reporting on a subset of what is typically considered community benefit.	Annual. Hospitals that are Medicare certified.
Hospital Community Benefit Reporting to MDH	Retrospective report that summarizes spending in nine categories of Community Benefit.	Annual. All Minnesota community hospitals are required to submit this information. Reporting occurs at the hospital site level.
Health Plan Collaboration Plan Submission to MDH	Describes the ways in which health plans collaborate with local public health departments to meet public health goals for communities they serve.	Every 4 years (The current plan covers 2010-2014). The trade association for Minnesota's nonprofit health plans (HMOs and BCBS of MN) prepare this report for their members.
Health Plan Collaboration Plan, reporting to MDH	Retrospective report on financial information on community benefit.	Annual: Form 990
Local Public Health Assessment and Improvement Plan	Utilizes a community needs assessment and planning process to collect health data, identify priority local health issues and develop a 5-year implementation plan. Requires community input.	Every 5 years
MDH Statewide Health Assessment	Collect, analyze, and use data to educate and mobilize communities, develop priorities, and plan actions to improve public health. Community input processes required for national public health accreditation	Every 5 years (A process is currently underway. A draft Statewide Health Assessment is completed)
Healthy MN Statewide Goals	Establish statewide health improvement goals. Community/partner input required for national public health accreditation.	Every 10 years (statewide health goals are expected to be finalized by August 2012.)

APPENDIX C: Timeline

Building Community Capacity for Prevention Planning Process Timeline 2012





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