Outside the Hospital Walls
An Update on Essential Hospitals' Efforts to Improve the Health of Their Communities

DECEMBER 2019

ESSENTIAL
HOSPITALS
INSTITUTE

ABOUT AMERICA'S ESSENTIAL HOSPITALS

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. We support our more than 300 members with advocacy, policy development, research, and education. Communities depend on essential hospitals to provide specialized, lifesaving services; train the health care workforce; advance public health and health equity; and coordinate care. Essential hospitals innovate and adapt to lead the way to more effective and efficient care.

ABOUT ESSENTIAL HOSPITALS INSTITUTE

Essential Hospitals Institute is the research, education, dissemination, and leadership development arm of America's Essential Hospitals. The Institute supports the nation's essential hospitals as they provide high-quality, equitable, and affordable care to their communities. Working with members of America's Essential Hospitals, we identify promising practices from the field, conduct research, disseminate innovative strategies, and help our members improve their organizational performance. We do all of this with an eye toward improving individual and population health, especially for vulnerable people.

ACKNOWLEDGMENTS

CONTENTS

AUTHORS

Madeline White
Deborah Roseman, MPH
Brian Roberson, MPA
Kalpana Ramiah, DrPH, MSc

Introduction

Essential hospitals, given their missions and community characteristics, always have provided care to vulnerable populations. Patients of essential hospitals often face barriers to accessing and affording health care and struggle with multiple chronic conditions. In 2017, 23.9 million individuals served by essential hospitals were living below the poverty line, and 17.1 million individuals had no health insurance. Essential hospitals are often the first responders and the safety net for these individuals.

Patients of essential hospitals are particularly challenged by negative effects of social determinants of health (SDOH)—the conditions in which individuals live, work, and play that affect health outcomes. In 2017, 10 million people in communities served by essential hospitals had limited access to healthy food, and 360,000 individuals were homeless. We now know that social, economic, and environmental conditions can account for as much as 50 percent of what determines a person's health. A lack of safe housing and healthy food, along with other limitations, can exacerbate existing health problems and create additional ones.

Policy and payment models have started to shift their emphasis from volume to value. The transition from fee-for-service models to value-based payment tasks hospitals with not only providing quality care for their patients but also fostering healthy communities. Essential hospitals have found themselves at the forefront of this change because of their role within vulnerable communities as large employers, care providers, and sources of community support.

Recognizing the correlation between socio-economic factors and health, many essential hospitals have begun to address social needs. Essential hospitals may target such needs as hunger or homelessness in their patient populations by providing free or subsidized resources. For example, essential hospitals may provide vouchers for a local food bank to give patients access to healthy, fresh foods for themselves and their families. Targeting these social needs can help patients better manage their conditions, resulting in improved health outcomes.

While addressing individuals' social needs may result in better health for the patient population, upstream social determinants still pose a challenge to the communities that surround essential hospitals. Public health advocates Brian Castrucci and John Auerbach explain that while social needs interventions are further upstream than medical interventions, such interventions do

not address the underlying causes and conditions. Ultimately, addressing the SDOH factors that perpetuate poor health at the community level can have the greatest impact.[1]

Given the centrality of SDOH for the communities served by essential hospitals, the Essential Hospitals Institute (the Institute)—the research, education, dissemination, and leadership development arm of America's Essential Hospitals— has spent several years supporting members in their efforts to move beyond addressing patients' social needs and toward community-integrated health care (CIHC). The Institute defines CIHC as a strategy in which health care providers work with other sectors, such as government, social service, and community development, in both complementary and collaborative ways to improve health. We envision successful CIHC as a connected system that meets the physical, mental, and social needs of individuals and improves the structures and conditions that influence those needs.

In 2016, with support from the Robert Wood Johnson Foundation, the Institute assessed members' capacity for and efforts toward implementing CIHC, along with assistance they needed to advance their work. Expert and key informant interviews, a survey of essential hospitals, and a deliberative summit informed the development of our resource for essential hospitals: A Roadmap to Community-Integrated Health Care. This document suggested a strategy and steps for essential hospitals looking to move toward CIHC.

At the conclusion of the multiyear research project, our evaluation demonstrated that many essential hospitals are working to address their patients' social needs. With the shift toward value-based care still underway, many essential hospitals were in the process of trying to address patient needs in order to achieve financial viability under this new model. The concept of "community-integrated health care" was a newer term, and hospitals were still shifting to consider social needs of patients.

Such a fundamental change in how hospitals approach health care takes time. However, there is value in gauging intermediate progress of essential hospitals working toward CIHC. To evaluate where member hospitals are on the road to CIHC, and learn how to best continue to facilitate progress, the Institute launched multiple evaluation metrics. The Institute fielded a second survey in 2019, repeating some of the questions from the 2016 survey, to collect comparable information from members of America's Essential Hospitals. Results from this membership-wide survey and qualitative interviews with population health executives helped to illustrate the progress made by essential hospitals, as well as the path forward.

Essential hospitals are addressing patient needs, building the capacity for CIHC, partnering outside of their walls,

and advancing community health. This document presents our findings and highlights how essential hospitals are addressing patient social needs, building capacity to partner across sectors, forming and maintaining partnerships, advancing community health, driving community-integrated health care, and overcoming challenges. The evidence collected through the 2019 survey and interviews with population health executives highlights the successes of essential hospitals and reflects the opportunities that remain.

Addressing Patient Social Needs

The majority of essential hospitals are taking steps to address their patients' social needs through screening and/or referral, as well as providing direct services. Screening and referral take place within the hospital walls to identify social needs of patients and connect them with resources and organizations that can address their needs. Findings from the 2016 evaluation demonstrated that this work was underway; the 2019 survey specifically asked about screening and referral for 11 social needs.

While the 2019 survey findings demonstrated that screening and referral rates were generally high across all social needs, transportation and health behaviors reflected particularly high rates of screening and referral. For these two areas of need, every hospital reported either screening or referral, or both. Additionally, 90 percent of essential hospitals reported referring for food insecurity, and 88 percent reported screening for health behaviors—the highest across all areas of need.

The high rates of screening and referral reflect the continuing effort of essential hospitals to provide needed social resources for their patients. To elaborate on this, we asked essential hospitals whether they were engaged in activities other than screening or referral to improve patient needs, community member needs, or community conditions for the same set of social factors. For every factor, at least 65 percent of essential hospitals reported engaging in an activity to address patient needs. For the social determinant of interpersonal violence, more than 90 percent of essential hospitals reported they were addressing patient needs.

[**FIGURE 1**]

Essential hospitals providing screening and referral for patients' SDOH

*Question: Does your hospital/health system implement screening or provide referrals
for any of the following social determinants of health?*

Housing Instability — Screening 76%, Referral 83%
Food Insecurity — Screening 81%, Referral 90%
Transportation — Screening 79%, Referral 88%
Education — Screening 62%, Referral 38%
Utility Needs — Screening 68%, Referral 73%
Interpersonal Violence — Screening 81%, Referral 88%
Family and Social Supports — Screening 74%, Referral 74%
Employment and Income — Screening 69%, Referral 52%
Health Behaviors — Screening 88%, Referral 83%
Health Literacy — Screening 71%, Referral 45%
Community Infrastructure — Screening 46%, Referral 39%

Legend: Screening, Referral

Axis: 0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Compared with the percentage of essential hospitals addressing patient needs, the proportion addressing community member needs was lower for every SDOH. For example, only 23 percent of essential hospitals reported addressing community member needs related to interpersonal violence. Among all 11 SDOH, hospitals most commonly reported addressing community member needs related to food insecurity, though at 55 percent this was lower than the proportion addressing patient needs for any SDOH.

[**FIGURE 2**]

Essential hospitals addressing SDOH for their patients and communities

*Question: Are you engaged in activities other than screening or referral
to improve specific social determinants of health?*

Social Determinant	Addressing patient needs	Addressing community member needs	Changing community conditions
Housing Instability	76%	26%	47%
Food Insecurity	85%	55%	35%
Transportation	87%	18%	24%
Education	82%	39%	14%
Utility Needs	89%	11%	11%
Interpersonal Violence	91%	23%	23%
Family and Social Supports	89%	32%	18%
Employment and Income	79%	31%	24%
Health Behaviors	82%	50%	29%
Health Literacy	84%	45%	19%
Community Infrastructure	67%	43%	40%

- Addressing patient needs
- Addressing community member needs
- Changing community conditions

While these survey findings show that essential hospitals are primarily addressing patient needs, interviews with population health executives reflect the continuing shift toward addressing community needs. Several participants referenced the expanding national conversation on SDOH. Population health executives acknowledged the cultural shift that is accompanying the financial shift from fee-for-service to value-based care: Emphasis is being placed on wellness over sickness. Interview participants illuminated the findings from the 2019 survey, highlighting the increased focus on the impact of SDOH on communities. These interview participants recognized that the natural progression of their work was to move outside of the hospital walls to consider how they can impact the health of the community at large.

"IT [SEEKING OUTSIDE PARTNERS] WAS A NATURAL PROGRESSION IN THE DEVELOPMENT OF OUR POPULATION HEALTH STRATEGY WHERE WE SAW IN THE SOCIAL DETERMINANTS RESEARCH HAS PROVED THIS TIME AND TIME AGAIN: IF YOU WANT TO GET SOMEBODY HEALTHY, YOU NEED TO DEAL WITH THEIR SOCIAL ISSUES AS WELL AS THEIR MEDICAL ISSUES."

—KEY INFORMANT

Building Capacity

Although fewer hospitals are addressing SDOH at the community level, the interview and survey findings demonstrate clear evidence that essential hospitals are building capacity to do so. To understand this progression, we asked population health executive interview participants what made it easier to increase their capacity to implement CIHC. Specifically, we wanted to see how essential hospitals were increasing their capacity to partner with external organizations to address community needs.

Interview and survey findings reflected that essential hospitals are building capacity for CIHC in several key areas: governance, leadership, workforce, technology, and funding.

GOVERNANCE

Essential hospitals are adjusting their governance structures to create strategic guidance for their SDOH improvement activities. Sixty-four percent of survey respondents reported their hospital's board of directors includes an individual with SDOH expertise. Of these, 24 percent were recruited specifically for this expertise. In addition, 29 percent of respondents reported their hospital board of directors has a committee that is focused on SDOH. Hospital board recognition of SDOH helps establish this work as a strategic priority for the organization.
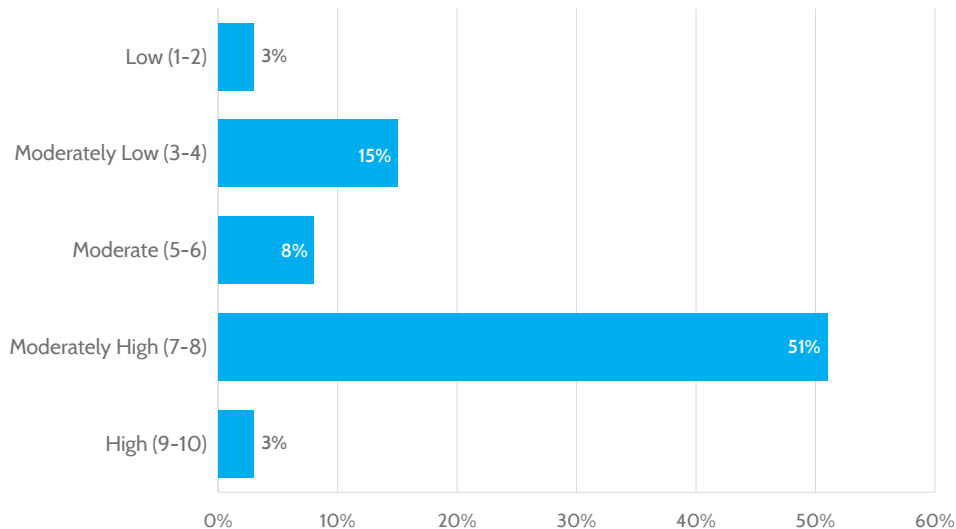
LEADERSHIP

Leadership commitment to SDOH improvement activities at essential hospitals helps demonstrate a long-term dedication to this work and fosters an organizational culture that is invested in the health of the community. Most

[FIGURE 3]

Perception of essential hospital leadership value of SDOH

Question: On a scale of 1-10, how high of a priority is addressing social determinants of health for your hospital leadership (e.g. C-suite executives, board members)? Select one option.

interview participants described how their organization's leadership believes in this work and has helped align the organization to support SDOH improvement activities. Findings from the survey bolstered this idea, with 74 percent of essential hospitals reporting that improving social factors (social needs and/or SDOH) was a moderately high or high priority for hospital leadership.

Interview participants explained that leadership commitment often is evidenced by funding interventions and full-time employees (FTEs) focused on SDOH improvement. Seventy-one percent of survey respondents reported

their organization has a designated staff leader dedicated to addressing SDOH. Dedicating full-time employees and individual leaders to this work was viewed as a sign of commitment and support, helping essential hospitals build their capacity to address SDOH.

Public displays of leadership commitment to improving the health of the community, such as the release of strategic goals, inclusion in the mission statement, or signing of a public pledge also help to establish SDOH improvement as part the foundation of the organization. Most interview participants described how hospital leadership has aligned the

organization to engage in SDOH improvement activities, offering as an example the inclusion of population health improvement as a strategic goal for the organization. Our survey also found 78 percent of essential hospitals have made at least one form of public commitment to SDOH improvement, further demonstrating the dedication that leadership is making to this work.

WORKFORCE

Essential hospitals are hiring and training staff from multiple departments of the organization to create a workforce that is multidisciplinary as well as dedicated to SDOH improvement outside the hospital walls. Eighty-six percent of essential hospitals reported additional individuals at the hospitals who are responsible for SDOH improvement, beyond the identified population health leader. However, interview participants, many of whom were the highest-ranking population health executive at their organization, often explained that the designated population health workforce was relatively new. Interview participants reported being in their roles an average of 4.5 years, with the shortest being only eight months. While the percentage of essential hospitals with a SDOH workforce is on the rise, many designated individuals have only recently come into this role.

> "I'D SAY FROM A HUMAN INVESTMENT SIDE IT ISN'T JUST THE SPECIFIC STAFF KIND OF WORKING IN THE TRADITIONAL SPACES WHERE YOU THINK ABOUT ADDRESSING SOCIAL DETERMINANTS – LIKE A COMMUNITY HEALTH WORKER OR A SOCIAL WORKER. I SEE US TRYING TO FIGURE OUT HOW DO YOU TAP THE HUMAN CAPITAL THAT EXISTS ACROSS THE ORGANIZATION IN A LOT OF DIFFERENT WAYS."
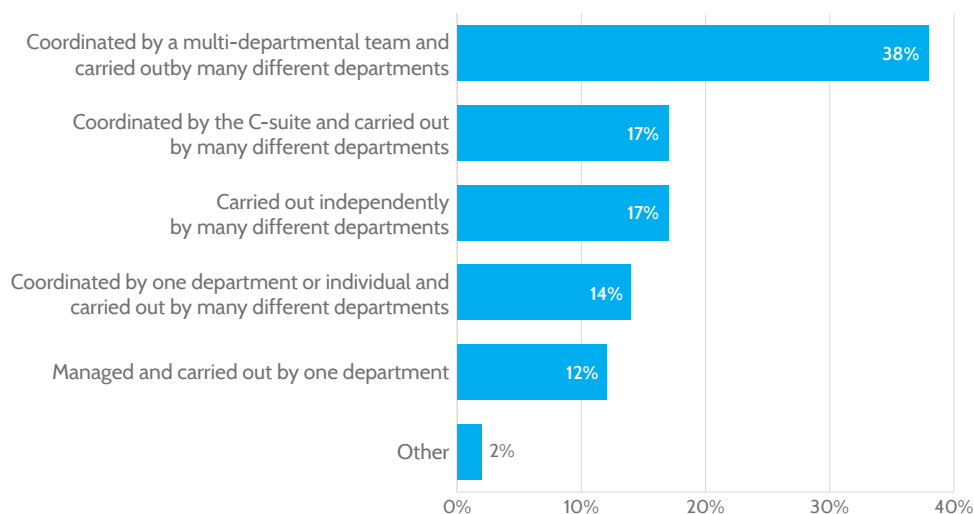>
> —KEY INFORMANT

Many essential hospitals are specifically aiming to build a multidisciplinary workforce, which involves individuals across the organization who have the various skills and knowledge to help drive successful CIHC. Interview participants described engaging staff from multiple departments within the organization, with different staff members managing relationships with external community partners. Specifically, interview participants mentioned the departments of clinical health, community health, marketing, and community relations being involved in SDOH improvement activities. Having multidisciplinary individuals working collaboratively helps essential hospitals effectively form and manage partnerships, driving the organization toward creating CIHC.

[**FIGURE 4**]

Internal structure used to coordinate SDOH improvement activities within essential hospitals

Question: Which statement best describes your hospital/health system?
My hospital/health system's social determinants of health improvement activities are:

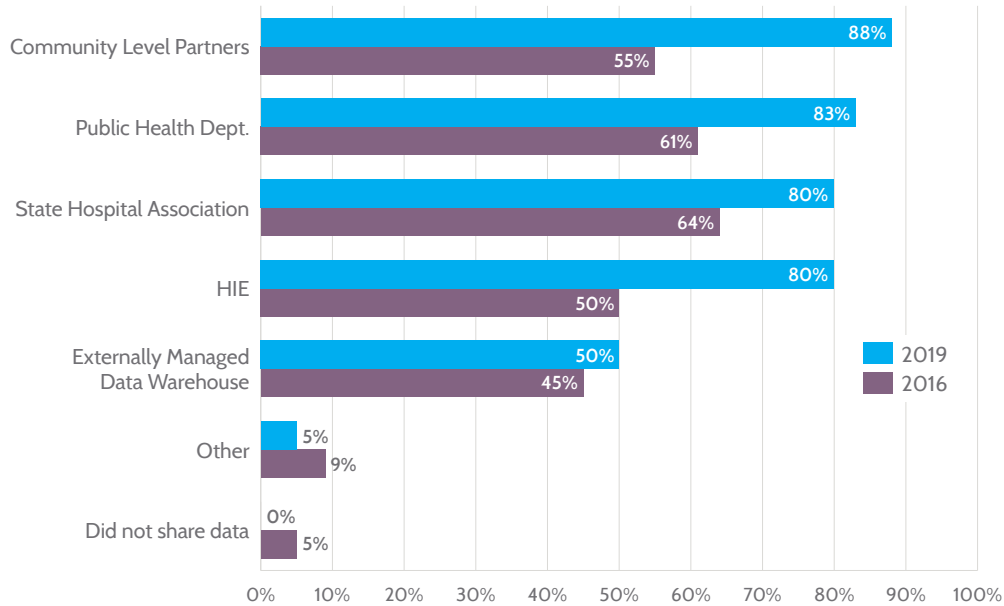| Category	Percentage
Coordinated by a multi-departmental team and carried outby many different departments	38%
Coordinated by the C-suite and carried out by many different departments	17%
Carried out independently by many different departments	17%
Coordinated by one department or individual and carried out by many different departments	14%
Managed and carried out by one department	12%
Other	2%

TECHNOLOGY

Adapting hospital technology to track, monitor, and share data on SDOH is allowing essential hospitals to coordinate and exchange information with external partners to improve the health of the community. Interview participants said their hospitals must be able to use the electronic medical record (EMR) to track clinical and social needs data to help them identify the needs of the population. Additionally, having the capacity to collect data through the community health needs assessment further enables the hospital to understand community needs and advance CIHC.

Essential hospitals also reported using technology to facilitate the exchange of information with community partners. More than 90 percent of survey respondents reported sharing data with external partners as part of their SDOH improvement activities. Commonly reported audiences for data sharing included community-level partners, public health departments, state hospital associations, and health information exchanges. Survey findings demonstrate a significant increase in the percentage of essential hospitals sharing data with external partners across sectors as well. Essential hospitals reporting data sharing with community-level partners increased by more than 30 percentage points from 2016 to 2019.

[**FIGURE 5**]

Essential hospitals' capacity to share data with external partners

Please select the statements below that accurately describe your hospital/health system's data sharing activities for the purpose of population health improvement:

FUNDING

Obtaining initial funding for SDOH improvement activities serves as a catalyst for essential hospitals to begin targeting the needs of the community. More than half of interview participants cited grant funding as the facilitator for bringing external partners together at the table. Initial funding opportunities can also be derived from payment reform, such as a shift to value-based care, Medicaid demonstration project or waiver, and Accountable Care Organization (ACO) incentives. These reformed payment models help essential
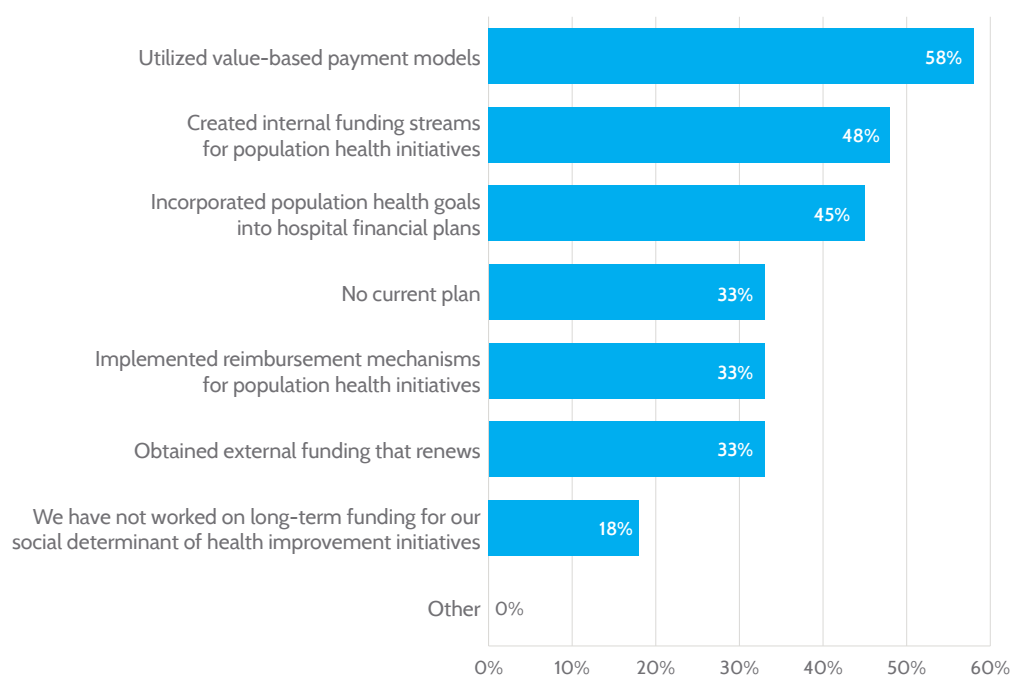
hospitals establish formal partnerships with community agencies and create a dedicated funding stream for SDOH improvement activities.

Internal funding streams also are used to support SDOH improvement activities. Many interview participants stated that internal investment was used to dedicate time for existing staff to focus solely on this work. Additionally, 48 percent of essential hospitals reported creating internal funding streams for SDOH improvement activities as part of their plan to ensure sustainable funding for the next five years.

[**FIGURE 6**]

Methods used by essential hospitals to ensure sustainable funding for SDOH improvement activities over the next five years

Question: How has your hospital worked to ensure sustainable funding for social determinants of health improvement initiatives over the next five years? Select all that apply.

Category	Percentage
Utilized value-based payment models	58%
Created internal funding streams for population health initiatives	48%
Incorporated population health goals into hospital financial plans	45%
No current plan	33%
Implemented reimbursement mechanisms for population health initiatives	33%
Obtained external funding that renews	33%
We have not worked on long-term funding for our social determinant of health improvement initiatives	18%
Other	0%

Forming and Maintaining Partnerships

While building internal capacity through leadership, technology, and other mechanisms is important to initiate SDOH improvement activities, external partnerships are required to achieve truly community-integrated health care. Essential hospitals are engaged in many such partnerships, the depth and breadth of which are increasing over time.

Between 2016 and 2019, the level of partner engagement increased among essential hospitals across multiple sectors. Using a scale from networking to collaboration, essential hospitals were asked to describe their relationships with external organizations. Essential hospitals reported higher levels of cooperation and collaboration[2]—the two highest levels of engagement—with partners in several sectors. For external nonprofit partners, the combined rate of cooperation and collaboration increased across all categories of partners, compared with the 2016 combined rate.

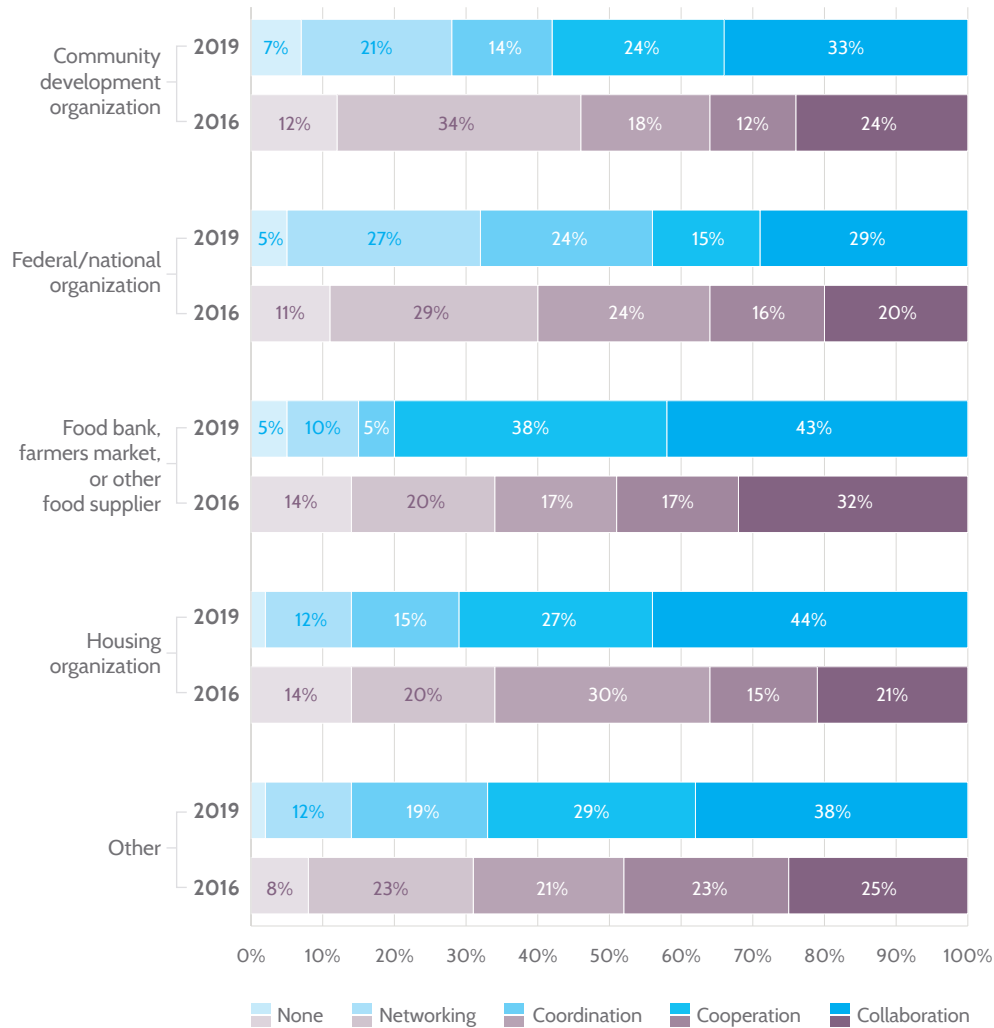In addition to level of engagement, survey data comparison demonstrates increased sharing of resources with external partners. The percentage of essential hospitals sharing resources with their partners increased across all categories; most notably, the sharing of technology increased by 31 percentage points. Survey respondents also reported sharing data, human capital, and funding with partners.

Partnership formation is frequently driven by funding opportunities, specifically incentive- and value-based care models that encourage essential hospitals to decrease cost and improve health outcomes through partnership. Some interview participants said the state Medicaid ACO model incentivized

[FIGURE 7]

Relationship between essential hospitals and external nonprofit partners

Question: Please select the most appropriate relationship between your hospital/health system and these external nonprofit partners.

		None	Networking	Coordination	Cooperation	Collaboration
Community development organization	2019	7%	21%	14%	24%	33%
	2016	12%	34%	18%	12%	24%
Federal/national organization	2019	5%	27%	24%	15%	29%
	2016	11%	29%	24%	16%	20%
Food bank, farmers market, or other food supplier	2019	5%	10%	5%	38%	43%
	2016	14%	20%	17%	17%	32%
Housing organization	2019		12%	15%	27%	44%
	2016	14%	20%	30%	15%	21%
Other	2019		12%	19%	29%	38%
	2016	8%	23%	21%	23%	25%

them to form partnerships with the aim of addressing health outcomes. Essential hospitals also engage external partners to apply for grant funding, creating a collaborative funding effort. Funding through incentive models or grant opportunities served as a catalyst

for many essential hospitals in forming external partnerships.

Once partnership is initiated, essential hospitals work to ensure continued alignment and shared aim over time. When asked about

KEYS TO FORMING SUCCESSFUL PARTNERSHIP

Interview participants noted that successful partnership
often uses these strategies:

1

Partner with organizations that have a shared vision, mission,
or passion for serving the community.

2

Develop a shared aim through common goals.

3

Identify community organizations that already fill the need,
to avoid duplicative efforts.

partnership maintenance, many interview participants stressed the importance of frequent, in-person meetings with community partners. Essential hospitals and their partners use these meetings to communicate about goals, evaluate successes, discuss plans, and provide opportunity for external organizations to network with the hospital. In addition to frequent meetings with partner organizations, many essential hospitals meet with larger collaborative groups, who discuss the needs of the community at large. Ideally, frequent meetings with community organizations or collaboratives allow for transparent conversation about progress toward CIHC.

"TO BE A GOOD PARTNER WE HAD TO BE CONSISTENT AND CREDIBLE IN OUR RELATIONSHIPS WITH THE PARTNER IN ORDER TO BE ABLE TO LEVERAGE THAT TO THE GREATER GOOD."

—KEY INFORMANT

Maintaining partnership also requires consistent commitment from the hospital. Interview participants explained that this commitment may be demonstrated by serving on the board for partner organizations or engaging through town hall discussions. Overall, essential hospitals recognize that successful long-term partnership depends upon being an active, reliable partner.

Advancing Community Health

Essential hospitals have a role in improving the health of the community, and they increasingly recognize and embrace that role. While essential hospitals have widely implemented efforts to address patient needs, building internal capacity and external partnerships demonstrates the continued push to target SDOH in communities at large.

When asked their opinion of the role of their organization in terms of SDOH as a part of the 2016 survey, 52 percent of essential hospitals reported their role was to care for individuals living in a specific geographic area, such as a particular county or city. In 2019, this rose to 62 percent. Essential hospitals increasingly view it as a part of their responsibility to address the needs of individuals in the area surrounding them, in addition to the patients who come through their doors.

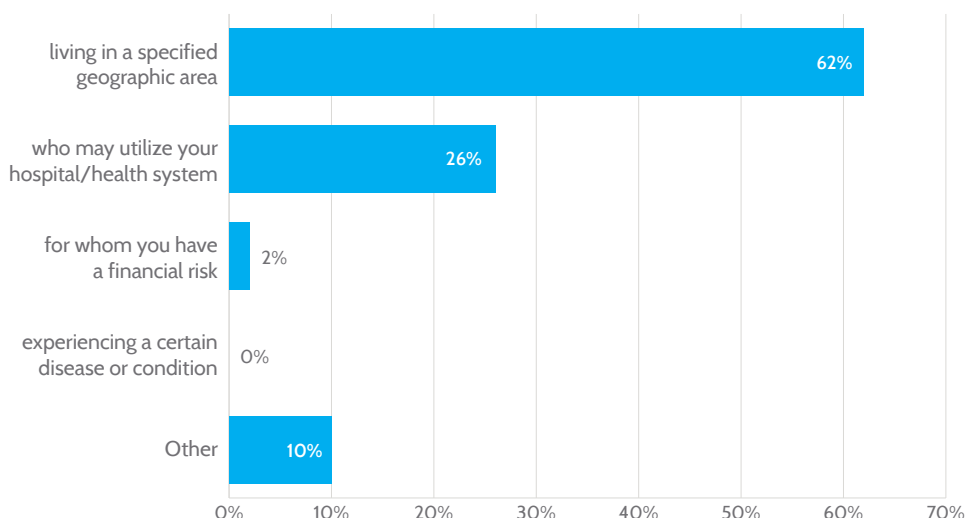Essential hospitals are advancing community health by providing care to the community at large, as well as through investments in community-based organizations (CBOs). Small CBOs may not be able to fund infrastructure needs, such as information technology, making robust partnerships challenging. Interview participants explained that by funding external CBOs, they increased the organizations' capacity to serve the community while enabling stronger partnerships, helping move toward CIHC.

Essential hospitals also are working to change the community conditions that pose challenges to health. This extends beyond addressing community needs: Changing community conditions moves upstream of needs, aiming to alter

[**FIGURE 8**]

Essential hospitals' perception of their role in the community regarding SDOH improvement

Question: In your opinion, what is your hospital/health system's primary role in population health improvement within your community? To care for and/or improve the health of individuals...

living in a specified geographic area — 62%
who may utilize your hospital/health system — 26%
for whom you have a financial risk — 2%
experiencing a certain disease or condition — 0%
Other — 10%

(x-axis: 0% 10% 20% 30% 40% 50% 60% 70%)

the systems, policies, or environments that create these needs. Examples of essential hospitals changing community conditions include advocating for policies that mitigate the impact of SDOH or investing in community safety, walkability, and other revitalization efforts.

Forty-seven percent of 2019 survey respondents reported that they were changing community conditions for housing instability, and 40 percent reported doing so for community infrastructure. While fewer hospitals are changing community conditions than are addressing patient and community needs, this data reflects the growing number of essential hospitals working to tackle the institutionalized barriers to health.

Driving Community-Integrated Health Care

A variety of facilitators drive essential hospitals – from addressing patient needs to addressing community needs and changing community conditions. Through the survey and interviews, the Institute aimed to understand why, how, and when essential hospitals decided to align their work with other partners to improve community health. We also wanted to investigate what made this alignment successful to highlight the driving forces of this work.

Our findings reflected that essential hospitals are motivated to work toward CIHC for several key reasons:

CONTINUING HISTORY AND MISSION

Many key informants stressed that their hospital always has been committed to community-based care because it aligns with their mission to serve the most vulnerable individuals. Some interview participants cited their role as the public health system for their community, explaining that they serve as the primary provider of care for all individuals in the region.

> "WELL THE MISSION [OF OUR ORGANIZATION] IS REALLY TO REMOVE THOSE BARRIERS TO HEALTH SO THAT ALL PEOPLE CAN LIVE THESE HEALTHY LIVES. THAT'S WHAT WE ARE ABOUT, AND WE SPEND MUCH MORE TIME OUTSIDE OF THE HEALTH SYSTEM THAN WE DO WITHIN WITH OUR WORK."
>
> –KEY INFORMANT

Similarly, essential hospitals serve populations with multiple health and social needs. Essential hospitals recognize that not addressing both clinical and social needs of their patients is not viable, financially or operationally. This logic extends to serving the community; essential hospitals view SDOH as something they must tackle to continue adhering to the mission of their organization.

ADVANCING CONVERSATION ABOUT SDOH

The national conversation about SDOH has taken root in recent years, prompting essential hospitals to sharpen focus on the impact of social needs on health. Further, the national health care culture has become increasingly focused on prevention and wellness, which has encouraged health care providers to consider how to shift their culture to address the causes of health disparities, rather than focus solely on immediate clinical solutions.

SHIFTING PAYMENT AND FUNDING MODELS

As a result of the changing health care landscape, payment and reimbursement models also have begun to shift, allowing essential hospitals to pursue alternative methods for staying financially viable. The transition from fee-for-service to value-based payments have facilitated essential hospitals' partnerships with external organizations. Additionally, payment models from the Center for Medicare & Medicaid Services (CMS),

> "IT MEANS THEY ALL START OUT WITH FINANCE, AND THE FINANCE PURCHASES EVERYTHING ELSE. EVEN AS THESE PEOPLE IDENTIFY WHERE THEIR PAIN POINTS ARE, THEY ALL COST MONEY. WE HAD TO INVEST IN THINGS TO BE ABLE TO ACHIEVE THIS STUFF. TRUST ME, WE WOULD NOT BE THIS FAR ALONG WITHOUT DETERMINATION OF NEED. IT WOULDN'T HAPPEN."
>
> —KEY INFORMANT

as well as readmissions penalties, create incentives for health care providers to focus on SDOH improvement.

UNDERSTANDING THE NEED TO PARTNER ACROSS SECTORS

Recognizing that CBOs across many sectors have expertise in providing community resources, essential hospitals have formed strategic partnerships to support the external organizations that fulfill the community need. Additionally, essential hospitals are often resource constrained and may not have the capacity or financial ability to create community resources. Partnering with external organizations is a natural solution for many essential hospitals, maximizing the value provided by each organization.

Overcoming Challenges

Considerable progress has been made toward meeting patients' social needs and developing capacity for CIHC, but essential hospitals still face barriers when establishing and integrating this work.

Our interview and survey findings identified several common difficulties that essential hospitals face when implementing CIHC. Those challenges are detailed in the paragraphs below.

FINANCING CIHC REQUIRES LONG-TERM INVESTMENT

Essential hospitals are faced with the challenge of demonstrating the return on investment (ROI) for upstream interventions that will not have immediate financial results. Preventive measures demonstrate value in the long term, but the long-term risk of funding SDOH improvement activities can be difficult to justify, especially for essential hospitals already facing resource constraints.

In addition to justifying the long-term ROI, essential hospitals struggle to allocate internal funding beyond staff time. Some essential hospitals are able to dedicate funds to allow existing staff to focus on SDOH improvement activities but providing internal funding for additional technology and resources is difficult. Given the limited resources at essential hospitals, funding this work may be a lower priority in the face of competing demands. More than 30 percent of essential hospitals reported not having a current plan in place to ensure sustainable funding for SDOH improvement activities for the next five years.

EXTERNAL PARTNER CAPACITY IS LIMITED

Partnering with outside organizations allows essential hospitals to maximize resources, but many CBOs are limited in scope and abilities. This poses a challenge to essential hospitals looking to partner to fulfill the need of the community; small, local CBOs may not have the capacity to respond to referrals on a large scale. Additionally, for some essential hospitals, there may be no CBOs in the surrounding area. Many hospitals are restricted in their ability to partner by the lack, or lack of capacity, of partners.

COLLECTING AND SHARING DATA IS CHALLENGING

Essential hospitals continue to increase their capacity to collect and share data, but integrating and spreading the information remains a challenge. Many essential hospitals report a sense of "legal nervousness" around integrating data, citing stakeholder concerns about data privacy and patient protection. Additionally, many small, external organizations lack the infrastructure to employ and support data-sharing tools, making it difficult to obtain information from and share data with these partners.

Essential hospitals report lacking a standardized, robust way to collect community-level SDOH data across the organization. Further, visualizing SDOH data to demonstrate the value and ROI is difficult because this information is different in nature, and many health care providers are not used to working with this type of data.

> "WE JUST HAVE TO BE CAREFUL. WE HAVE TO STAGE IT AND PHASE A LOT OF THAT BECAUSE IF WE OVERWHELM OUR COMMUNITY PARTNERS, THEN IT KIND OF FAILS IN THAT THE RESOURCES ARE NO LONGER AVAILABLE."
>
> –KEY INFORMANT

POLICY CHANGE IS STILL UNDERWAY

Although some policy change has facilitated movement toward CIHC, a varied and uncertain policy landscape presents challenges for essential hospitals in planning and implementing CIHC, along with making investments. For many essential hospitals, a lack of Medicaid expansion in their respective states creates high volumes of uncompensated care, further constricting financial resources and thus posing challenges to implementing CIHC. Essential hospitals also express the need for expanding bundled payment models to include medical respite care, mental health, and substance abuse. Changing the policy provisions to include these elements of care would provide essential hospitals with more agency and resources to progress toward CIHC.

Moving Forward

Essential hospitals have made considerable headway confronting social factors that influence the health of their patients and communities. They increasingly are working to meet individual patients' social needs through screening and referral and providing direct services. As essential hospitals continue to progress toward CIHC, the Institute will continue to offer support.

An increasing number of essential hospitals are working toward CIHC by partnering across sectors to address the needs not just of their patients but also those of the community. Compared with the proportion of essential hospitals addressing patients' immediate social needs, fewer are actively working upstream to improve the conditions that precipitate social needs. However, essential hospitals are building the capacities needed to advance this work. From designating population health leaders and engaging board members on SDOH, to developing data and technological capacities, hospitals are shoring up their internal infrastructures and aligning their

work with that of community partners. Notably, essential hospitals are not only forming partnerships across sectors to address SDOH, but these relationships are maturing over time. Hospitals and their partners are working together more formally and blending resources to tackle shared goals and improve community health. These deepening partnerships, bolstered by enhanced internal capacity, can drive collaborative efforts and narrow the remaining gaps identified through our recent research.

Significant progress notwithstanding, cross-sector efforts to improve SDOH are challenging, particularly given essential hospitals' resource constraints

and a lack of financial incentives. Recognizing the importance and challenges of this work, America's Essential Hospitals and the Essential Hospitals Institute have worked to support our members' efforts toward implementing CIHC.

Based upon our 2016 research, we developed and provided education and other resources to member hospitals to help members learn from one another and from the broader field. Our 2019 research provides an update on the progress essential hospitals have made and the challenges they continue to face. Using this new research, we will offer tailored training and resources to help members overcome challenges and advance their efforts. The association also remains committed to advancing policies that facilitate the important work of CIHC. Lessons from essential hospitals' progress and challenges toward CIHC, paired with innovative examples of AEH members' efforts, will continue to inform and advance CIHC— not only among essential hospitals but also in the broader field.

"I THINK WHAT AMERICA'S ESSENTIAL HOSPITALS HAS DONE IS HIGHLIGHTED SUCCESS STORIES. THE REAL BENEFIT OF AMERICA'S ESSENTIAL HOSPITALS IS THAT WE CAN GO THERE, AND WE DON'T HAVE TO REINVENT THE WHEEL … THERE'S ALREADY A FRAMEWORK OF SUCCESS OF WHAT'S WORKED AND LESSONS LEARNED THAT CAN ALLOW OTHER ORGANIZATIONS TO MORE EXPEDITIOUSLY IMPLEMENT SOME OF THESE PROJECTS."

–KEY INFORMANT

Appendix: Methodology

POPULATION HEALTH SURVEY

The population health survey was developed to gain a better understanding of member hospitals' progress toward CIHC and population health improvement. Building on its 2016 study, the Institute developed questions to understand how essential hospitals are assessing community needs, partnering with others, creating internal alignment, and utilizing data and analytics.

Before fielding the survey with members, the Institute conducted testing to collect general feedback on the survey's usability and to pilot test the online format. The final survey was sent to 119 hospital leaders engaged in population health improvement activities. The survey was successfully delivered to 118 of the 119 contacts at member hospitals and health systems either through the initial contact or additional follow-up, resulting in a 99 percent successful delivery rate. We received 42 responses to the survey, for a 35 percent response rate of hospitals that successfully received the survey.

Limitations

Potential limitations of the survey include a shortened survey development and administration period, respondent characteristics, and potential response bias.

Due to the abbreviated survey development time period for this evaluation project, the survey was not cognitively tested with our survey audience, but we did conduct usability testing prior to administration.

Because the survey is focused on population health and community-integrated health care, there is a risk that there was reduced participation in the survey by hospitals less engaged in CIHC, leading to a response bias.

POPULATION HEALTH EXECUTIVE INTERVIEWS

To better understand essential hospitals' progress toward CIHC, the research team recruited population health executives to participate in 60-minute, semistructured telephone interviews. Executives were identified through our database of engaged population health executives and Internet searches to identify the most senior population health staff member at a health system. In addition, we invited a c-suite leader or executive who champions population health at the organization to participate alongside the population health leader.

Hospitals were selected from the subset of members of America's Essential Hospitals who were chosen through an evaluative process. Hospitals were selected with consideration of a variety of factors to achieve a range of

organizational characteristics including geographic location, teaching status, ownership, and number of beds. A progress estimation was used to select hospitals with diverse experience in implementing CIHC. A total of 26 organizations were contacted and recruited to participate. A representative from each organization received an email requesting their participation and detailing the length and structure of the interview. The email also asked the individual to select a time for their interview via an online scheduling system. Five declined to schedule, two did not respond after six contacts by phone and email, and one was unavailable during the interviewing window. We completed 17 group and individual interviews with a total of 25 individuals, from across 16 organizations. The participants were almost entirely at the director or executive level and included two chief executive officers. Characteristics of the organizations and individuals participating in the interviews appear in the figures below.

Organization Characteristics (n=16)

Geography*	Organizations
Northeast	5
Midwest	3
South	5
West	3

Teaching Status*	Organizations
Teaching	13
Non-teaching	3

Hospital Ownership*	Organizations
Public	8
Not-for-profit	8

Hospital Size (# Beds)*	Organizations
0-250	2
251-500	3
501-1000	10
1001+	1

Milestone Score	
0-10 (initiation)	3
11-24 (development)	8
25-32 (maintenance)	5

Based on 2015 AHA Annual Survey categorizations

Individual Participant Characteristics (n=25)

Position	Participants
CEO	2
Executive	12
Director	10
Other	1

Gender	Participants
Male	6
Female	19

The semistructured interview guide was designed around the evaluation research questions and topics designated for exploration as part of the interviews.

1. How and why are essential hospitals partnering with others to support CIHC?
   • What are essential hospitals doing to engage in CIHC?

2. How have essential hospitals increased their capacity to implement CIHC?

3. What are the facilitators and barriers that have impacted hospitals' ability to move along the road to CIHC?

Two experienced interviewers codeveloped the guide and conducted precollection training to make sure the guide was implemented uniformly. In addition, the first four interviews were conducted jointly.

The 17 interviews took place over a period of five weeks, between May 1, 2019, and June 5, 2019. Before the interview, participants were sent 24-hour and 1-hour reminder emails. The interviews were voluntary, and participants received no incentive or honorarium. At the beginning of each interview, the interviewer obtained verbal consent to participate in the project and record the interview. An experienced interviewer conducted each session. The recordings were automatically transcribed using the software NVivo Transcription and cleaned up by the interviewer.

The interviewers met at the conclusion of data collection to discuss key themes and the strategy for coding and analysis. The notes were coded by hand using a deductive code list and employing the use of coding software, Dedoose. To ensure consistent application of the coding system, both coders reviewed the application of codes together for 10 percent of the data collection, or two of the interviews. After coding was complete, we analyzed the data using a variety of qualitative techniques to draw conclusions from the data (e.g., noting patterns and themes, plausibility, and relationships between variables). Analysis was completed using memos, and the memos were then used to prepare a summary of key findings report.

Limitations

The key informant interview approach is not without flaws. As with most qualitative data, this information is not generalizable to every essential hospital, yet there were a number of overlapping themes from across participants. As part of recruitment, the Institute sought to achieve diversity of organizations but not that of individuals.

Endnotes

1. Castrucci, B.C., Auerbach, J. Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health. Health Affairs. 2019. https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/. Accessed August 2019.

2. Definitions for levels of partner engagement provided in 2019 population health survey:

   • Networking: exchanging information for mutual benefit

   • Coordination: exchanging information for mutual benefit 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 organization for mutual benefit and to achieve a common purpose