Hospitals as Civic Engaged Institutions: Emerging Lessons in the Era of COVID and Black Lives Matter

By Kevin Barnett, Dr.P.H., M.C.P., Public Health Institute

A Year to Forget/Remember

As winter approaches, our hospitals prepare for yet another surge of COVID-19 patients in our emergency rooms, intensive care units, and morgues. In some regions of the country, this will once again require the scaling back of elective procedures; deployments of physicians, NPs, and PAs to buttress the exhausted ranks of ICU specialists; and administrative leaders will once again grapple with a catastrophic loss of revenue.

Kevin Barnett, Dr.P.H., M.C.P.
Senior Investigator
Public Health Institute
Board Member
Trinity Health

Low-income communities of color are the most impacted by the pandemic, since they are over-represented as workers in pulic-facing essential services and have a higher prevalence of co-morbidities that increase COVID-19's severity and lethality. This deadly virus finds a rich environment for growth in communities that bear the compounding burdens of a lack of a living wage, poor quality housing and schools, food insecurity, and toxic stress that breeds depression in children and hopelessness in adults.

In the midst of the pandemic, our national conscious was rocked in April by the forced witness of a slow-motion homicide committed by a law enforcement officer in Minneapolis. Our shock at this event has brought into focus the many forms of social injustice endured by people of color in our nation—a revelation that is renewed on almost a weekly basis by yet another extreme use of force by another law enforcement officer in another community in another part of the country.

The politics of grievance and divisiveness that have been unleashed by the current administration have added fuel to this fire, providing encouragement to those who may have previously curbed their racist inclinations. Divisions between Americans are further encouraged by the fragmentation of messaging in the explosion of social media. Ideas and ideologies which would otherwise be debunked by fact checking in mainstream media spread like wildfire, leading so many to come to conclusions without connections to practical realities.

This troubled year comes on the heels of recognition by healthcare leaders of the imperative to accelerate movement towards value-based payment (VBP). As hospitals assume increasing financial risk for keeping people healthy and out of their emergency rooms and inpatient settings, the implications were brought into sharp focus by lost revenue from dramatic reductions in elective, routine, and essential care, while profits among commercial health plans increased dramatically.

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After decades of underinvestment, our public health community has been battered by the pandemic, with local leaders across the country confronting resistance and in some cases hostility as they sought to advance the basic safety measures of the scientific community. Resignations have spiked among local and state public health leaders, and others struggle to coordinate and extend testing to communities despite shortages in equipment and personnel. In a series of key informant interviews conducted with hospital, health system, and health plan CEOs in California in the early summer, there was broad consensus that we have profoundly under-invested in our public health infrastructure.[1]

Mirrored Inequities

The socioeconomic inequities in our urban communities are a constant throughout much of our modern history, driven by residential segregation and capital flight, and contributing to multi-generational poverty where the median wealth of an African American household is 1/10th of the median Caucasian household ($17,100 compared to $171,000).[2]

These inequities are mirrored in the payer mix of hospitals located proximally to low income communities, where most residents are covered by Medicaid. In contrast, hospitals located more proximally to

Key Board Takeaways

There is a consensus among healthcare leaders that we have under-invested in our public health infrastructure. This article highlights important steps boards can take to remedy this.

- Hospital and health system investments in community health should be refocused on the real needs of the community at large rather than undertaken with a competitive nature in mind. Discovering zones of collaboration with competitors and related sectors to address community health have the potential to achieve more significant results.
- If your hospital or health system is located in or near a low-income community, be sure to address any high concentrations of preventable utilization. These drive the escalation of healthcare costs and in a value-based payment environment, should be handled diligently.
- Health improvement strategies should be designed with the help of multiple community sources. This collaboration will provide an entry point for targeted advocacy that is in the public interest.

1 Kevin Barnett, Dr.P.H., M.C.P., *Meeting the Demand for Health: Top Priorities, Challenges, and Proposed Actions for the Private Sector to Support the Workforce California Needs*, California Future Health Workforce Commission.

2 Rakesh Kochhar and Anthony Cilluffo, "How wealth inequality has changed in the U.S. since the Great Recession, by race, ethnicity and income," Pew Research Center, November 1, 2017.

affluent communities within the same metropolitan areas benefit from higher reimbursement for commercially insured patients. Many of the hospitals in more affluent communities share the same charitable obligations as the "safety net" community hospitals that serve a much higher proportion of Medicaid and uninsured populations.

Perhaps the only institutional stakeholders who experienced more financial losses than hospitals during COVID-19 are municipalities, which face the loss of revenue from local taxes on retail sales and a precipitous drop in energy demands by employers, among other challenges. There is a clear and growing need for creativity and courage to align strategies across sectors to meet basic needs and build a more resilient future.

Most hospital investments in community health are undertaken as a competitive enterprise, with an eye towards branding for public visibility and for marketing to current and prospective clients. This is not to say that good deeds have not been done, but that the potential to achieve more significant results at scale are confounded by our struggle to overcome our competitive impulses and discover zones of collaboration with our competitors and with related sectors.

In urban areas in particular, hospital service areas overlap significantly, and there is ample justification for alignment and focus of health improvement interventions in sub-geographic communities within the larger metropolitan footprint. There is also growing recognition of the limits of "panel of patients" care management; that it must be complemented by addressing the social needs of people and inequities in the social, physical, and political environments of our cities. This isn't rocket science, any hospital or health system can conduct a GIS analysis of diagnoses such as AHRQ's Prevention Quality Indicators and they'll find high concentrations of preventable utilization among residents in low income census tracts. We know that these communities are the drivers of the continuing escalation of healthcare costs, and that in a VBP environment, there is an imperative to address those drivers.

Sources of Data/Information	Potential Points of Leverage
Comprehensive/General Plans	**ID and influence** community development priorities that impact health status.
United Ways, Local Philanthropy	**Align and focus** assets in communities with concentrated health inequities.
Chambers of Commerce	**Build shared agendas** for quality of life investments that support workforce retention.
Transportation Planning Boards	**Change** transportation routes for access to care, employment, and basic goods and services.
City Councils/County Boards	**Influence priorities** in development/ enforcement of ordinances, affordable housing, etc.
Parks and Recreation Boards	**Influence resource allocation** for public space development and renovation.
Local Public Health Agencies	**Collaborate to support alignment** across competitive boundaries and focus on low income communities.
Food Policy Councils	**Secure shared investments** across sectors to assess and develop healthy food systems.

Civic-Engaged Health Improvement Systems

External affairs for hospitals and health systems are typically managed by VPs for public affairs, government affairs, or marketing. These individuals play an important role in monitoring public policies that impact the traditional functions of hospitals and advocating for their organization's interests.

As we confront the existential challenge of assuming increasing financial risk and addressing the social determinants of health in the middle of a pandemic, it has become increasingly clear that broader engagement of the senior leadership teams is needed in planning and decision making at the local and regional level.

What does that look like? First and foremost, it involves explicit allocation of responsibility for timely collection of information from multiple sources, ranging from municipal general plans and local private philanthropic initiatives to emerging priorities among city councils, chambers of commerce, and regional transportation boards. That information should inform the design of health improvement strategies and provide an entry point for targeted advocacy that leverages, and where appropriate, positions hospital leadership to advocate for adjustments that are in the public interest.

The table above provides examples of the sources of information that are critically important to hospitals in the era of COVID-19, the movement towards value-based payment, and in recognition of the imperative to address systemic racism.

It has never been more important for healthcare organizations to be places of safety and support in their communities. Hospitals and health systems have a unique opportunity to make a positive impact by ensuring the well-being and safety of all those they serve is a top priority. Ensuring that members of senior leadership and the board are in the position to influence, integrate, and leverage community assets is critical. In these challenging times, the old adage rings true—"If you're not at the table, you're on the menu."

The Governance Institute thanks Kevin Barnett, Dr.P.H., M.C.P., Senior Investigator, Public Health Institute, and Board Member, Trinity Health, for contributing this article. He can be reached at kevinpb@pacbell.net.