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From Compliance to Alliance: Breaking the Cycle of Parallel Play

By **Kevin Barnett, Dr.P.H., M.C.P.,** Executive Director, Center to Advance Community Health and Equity**,** *Public Health Institute*

Challenge and Opportunity

As we near the end of our second year with the COVID pandemic, the healthcare sector is processing a wave of revelations with significant implications for our functions and roles in society. While facing challenges of rising costs and workforce shortages, there is growing recognition among healthcare leaders that there are profound socioeconomic and health inequities in our communities. These inequities are a product of historical racist policies and practices whose deleterious impacts are perpetuated to this day through unfair labor practices, poor living conditions, and differential access to influence in a political system awash in contributions from corporations and a growing class of billionaires.

Hospitals and health systems have the potential to play a significant role in raising the voice of communities for positive change, and some are already moving in this direction. Our fitful and uneven evolution towards risk-based reimbursement creates a clear incentive to do more than provide high-quality medical care services. Increasingly, we must find a way to reduce the demand for treatment of preventable conditions. The key challenge and opportunity, particularly for hospitals with overlapping service areas in urban areas with historically redlined communities, is how to balance the drive for zero-sum competition for patients with more strategically aligned investments and advocacy.

With some laudable exceptions, most hospital strategies to improve community health could be labeled as what child psychologists call "parallel play"; in essence, engaging in separate, small-scale activities in the same "sandbox," but not pursuing a more explicit strategy to align and leverage their respective efforts. Of equal importance, hospitals often fail to strategically focus their efforts in sub-geographies where

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health inequities are concentrated. These also happen to be communities with high percentages of people enrolled in Medicaid, with limited access to primary care and inadequate reimbursement.

Hospitals are typically among the largest employers in their communities. This offers the potential for the assertion of considerable influence in the local/regional policy arena. What would happen if otherwise competing hospitals in an urban community were to link arms, not only in making strategic investments in low-income communities, but in advocating for local policies that improve living conditions and access to basic services? For a growing number of healthcare leaders, the imperative for engagement and alignment across both competitive lines and sectors is compelling.

Moving beyond the Paralysis of Analysis: From CHNAs to Aligned Investment

Non-profit hospitals across the country have led and/or conducted community health needs assessments (CHNAs) since the passage of the Affordable Care Act in 2010. Many others were doing so for a decade or more earlier to meet requirements of newly passed state statutes. The intent of these requirements is to both increase tax-exempt hospital knowledge of the scope, depth, and geographic concentrations of health problems, and to provide a baseline from which to measure improvements achieved through interventions. After decades of experience, there are numerous examples of CHNAs conducted by hospitals that meet high standards of scientific inquiry. One might say that we do an exquisite job of defining health problems in communities.

The IRS requires hospitals to define the geographic parameters of their community benefit responsibilities, and in so doing, ensure that they do not define it in a manner that may exclude proximal communities where health inequities are concentrated. For collaborative assessments, groups of hospitals have often established a common parameter such as a county. More recently, some hospitals no longer participate in collaborative CHNAs and set their own geographic parameters, often selected zip codes that align with their primary service area. Parameters that are tied to commercially insured patients may be at risk of excluding proximal low-income communities.

With notable exceptions, most hospitals withdraw from collaborative processes in the development of their implementation strategies. The IRS permits a collaborative

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implementation strategy, but hospitals are required to provide details that would enable a reviewer to distinguish the specific contributions of different reporting entities. In contrast, an individual hospital's implementation strategy can meet the basic requirements of reporting to the IRS without the details (e.g., activities, location, timing, and partners). The net result? Most implementation strategies are general descriptions of priorities and programs, representing a missed opportunity to identify opportunities to align efforts across competitive and sector lines, and to focus them in communities where health inequities are concentrated.

There has been increasing attention over the last decade to the value of geographic information systems (GIS) analysis as a tool to provide compelling visualizations of where health and illness and associated contributing factors are concentrated. Some healthcare leaders have argued that these visuals are "old news," implying that these geographically concentrated inequities are an immutable reality that is not a responsibility shared by organizations with a historical focus limited to the delivery of acute care medical services. This argument, of course, is erroneous on multiple levels.

There is some basis for the judgment that geographic health inequities in the U.S. are immutable. Most urban neighborhoods originally redlined in the 1930s as the only options for Black citizens are still the most socioeconomically challenged, though low-income neighborhoods in western cities such as Los Angeles are now predominantly Latinx. GIS analyses of utilization patterns at the census tract level indicate significantly higher rates of preventable emergency room and inpatient care, in some cases, by a factor of five or more for chronic diseases such as diabetes, cardiovascular, and respiratory diseases. These higher utilization rates are driven in part by limited access to primary care and preventive services. They are also driven by social and environmental conditions such as poor-quality housing, limited access to affordable healthy food, and toxic stress associated with daily struggles to meet basic needs with a lack of a livable wage.

Are these challenges the sole responsibility of hospitals and health systems? Of course not. Large employers across sectors have a role to play in fostering health and well-being for their workforce and their families. At the same time, movement of healthcare towards risk-based reimbursement leads to the inevitable conclusion that hospitals have much to lose if they do not play a meaningful role in improving health. This requires moving beyond care for patient populations and to the community and societal level to address the drivers of poor health in their communities. What does that look like? To start with, it is a more integrated approach to building population

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health capacity; complementing strategies to coordinate care with referrals to social support services and coordinated approaches to address environmental conditions in targeted sub-geographies. Moving in this direction requires a change in mindset, and perhaps more importantly, a commitment to take action.

Key Questions for Board Members

As the responsible entity for non-profit hospitals to ensure optimal fulfillment of our roles as healthcare charitable trusts, boards should proactively engage senior leadership in both the design and approval of CHNAs and the delivery of implementation strategies. Key questions from board members for our senior leaders include:

CHNA

- Do we have an opportunity to provide input on a *draft* CHNA workplan?
- Are we identifying sub-geographies where health inequities are concentrated?
- In defining our community, are we sure we have *not* excluded proximal sub-geographies where health inequities are concentrated?
- Are we analyzing our utilization data to identify sub-geographies (i.e., census tracts) with higher concentrations of preventable ED/inpatient services and/or readmissions?
- Are we sharing data[1] to identify common areas for potential investment with other providers?

Implementation Strategy

- Are we focusing our interventions in communities where health inequities are concentrated?
- How do our community benefit programs align with our patient care coordination strategies?
- Are we establishing baseline measures to document changes in service patterns? What other measures of success are we using?
- Are we aligning patient care coordination and support service referrals with place-based strategies to address the social determinants of health in targeted communities?
- Have we identified opportunities to align prevention strategies and leverage assets with competing hospitals for Medicaid and underinsured populations?

1 While ensuring protection of patient confidentiality and compliance with HIPAA requirements.

- Are we exploring opportunities to align policy advocacy on social determinant of health issues at the local and regional level with other key institutional and community stakeholders?
- What is our theory of change (i.e., are we thinking beyond "one-off" projects)? What are the steps in the process that reflect our commitment to transformation in the coming years?

If board members are prepared to ask these kinds of questions (and senior leaders are prepared to respond), we will be better positioned to address health inequities at scale in our communities. Of equal importance, our organizations will be in an optimal position to meet our fiduciary responsibilities in an emerging risk-based reimbursement environment.

The Governance Institute thanks Kevin Barnett, Dr.P.H., M.C.P., Executive Director, Center to Advance Community Health and Equity, Public Health Institute, and Board Member, Trinity Health, for contributing this article. He can be reached at kbarnett@thecachecenter.org.

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