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The Board's Role in Addressing Social Determinants of Health

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Introduction

Social determinants of health (SDOH) have a major impact on health outcomes, especially for the most vulnerable populations. It has become explicitly clear that hospitals and health systems need to look outside the walls of their organizations and address the many factors beyond those seen in clinical episodes that are affecting the community's health. Boards play a critical role in addressing SDOH and ensuring they are front and center as a top organizational priority.

This *Elements of Governance* is intended to help hospital and health system boards advance their work to address SDOH and take ownership of important governance issues that extend beyond the quality and safety of the institutions they serve. It highlights the organization's and board's responsibility to work toward health equity and improve the health of the communities they represent, not only those individuals who come to their institutions for care.

Specifically, this *Elements of Governance* focuses on the following:

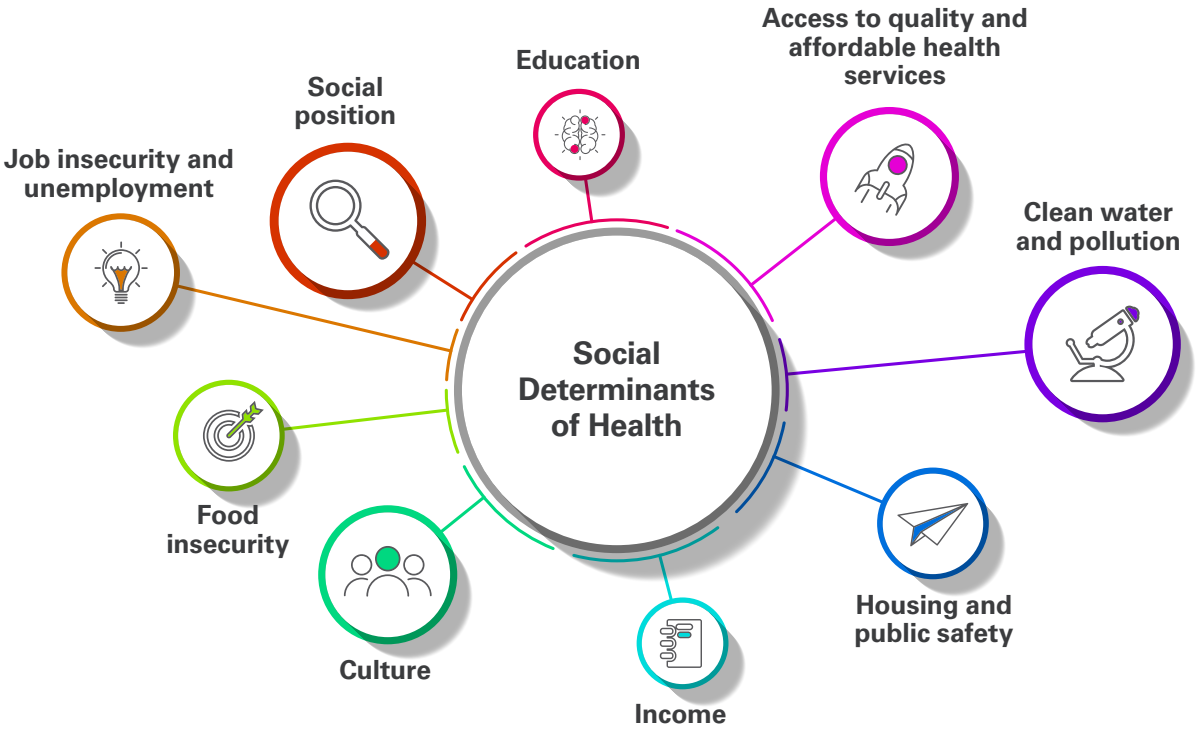
- The hospital or health system's role in addressing SDOH
- The board's responsibility to address SDOH
- The community health needs assessment (CHNA), including the board's role in adopting the assessment and in implementing and monitoring the execution of a plan that addresses the identified needs
- Specific ways to change board and committee structures and the agendas and dialogue at meetings to better serve the needs of the communities they represent

The Basics

What Are Social Determinants of Health?

According to the World Health Organization, SDOH are the non-medical factors that influence health outcomes. They include the conditions we are born, grow, work, live, and age with, and the broader factors impacting the conditions of everyday life.

The following are a few of the many SDOH that influence health equity, both in positive and negative ways:



According to the Centers for Disease Control and Prevention (CDC), addressing SDOH is a primary approach to achieve "health equity." Health equity exists "when every person has the opportunity to attain his or her full health potential, and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances."[1]

Certain studies suggest that SDOH are responsible for 35 to 50 percent of the health of a population. Other studies indicate that the figure is as high as 80 percent.[2] Looking at these percentages from the other side, a hospital or health system may only be responsible for 20 percent of the health of the communities it serves. Thus, how far can the clinical services a hospital provides advance the journey toward health equity?

1 CDC, "Health Equity," National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).

2 Sanne Magnan, "Social Determinants of Health 101 for Health Care: Five Plus Five," National Academy of Medicine, October 9, 2017; National Conference of State Legislatures, *Racial and Ethnic Health Disparities*, 2013.

What is the responsibility of a hospital or health system, and its board, to address and positively impact the SDOH (i.e., the factors affecting up to 80 percent of the health of the population they serve)?

It is the author's opinion that this question must be asked and discussed at the board table. The board and the institution it steers must answer it in a way that recognizes the hospital or health system's obligation to work to minimize the impact of SDOH on the communities they serve.

As discussed below, there are several things, including the following, that highlight the need for hospitals and health systems, and their boards, to own this responsibility:

- An institution's charter and mission statement
- Congress
- Internal Revenue Service
- State law

Fiduciary Duties of the Board

The board must act in furtherance of the institution's mission. It is the governing body of the institution with responsibility from a governance perspective over non-day-to-day operations. Among other things, it is responsible for the quality and safety of the institution, its finances, and its continued existence.

Every board member must be educated to understand that he or she has a daunting responsibility. Certain aspects of their role as a board member should keep them up at night. If someone is not concerned with the quality and safety of the institution and is not ready to work toward health equity, they should not serve on a fiduciary board of a hospital or health system. The directors represent everyone in the communities the institution is there to serve. Those individuals entrust the directors to be responsible for their best interests.

The board's duty to act in furtherance of the institution's mission includes making sure the mission remains relevant or changing it if necessary. Boards that have not refreshed their mission statements should consider the following:

- Can a mission adopted 100 years ago make sense today? What about one that was adopted 20 years ago?
- How can the old mission make sense today when Congress indicates that the board must consider and address the health needs of the community it serves? Was this a requirement when the institution was formed?

Boards should ensure that their mission statements are regularly assessed to align with and support their organization's duty to address SDOH and keep their communities healthy.

Community Health Needs Assessments

An Act of Congress, the U.S. Patient Protection and Affordable Care Act of 2010 (ACA), provides that a CHNA must be adopted by an **authorized body** of the hospital facility. In most cases, this will be its board of directors.

To meet the requirements for tax exemption under Internal Revenue Code (IRC) Section 501(c)(3), among other things, a hospital organization must meet the requirements imposed under IRC Section 501(r). One of the requirements under that subsection is that the organization conducts a CHNA every three years and adopts an implementation strategy to meet the needs identified by the CHNA.

A CHNA allows the organization to analyze community health needs and assets in order to identify, prioritize, and develop strategies to address community needs. It is important to collaborate with public health departments, other hospitals or health systems, or community stakeholders during this process. By conducting a joint assessment, organizations can share resources and information, build relationships, and work together on community health improvement efforts. To conduct a CHNA, a hospital facility must complete the following steps:[3]

1. **Define the community it serves**. This includes the geographic area, target populations, and principal functions, such as a focus on a particular specialty area or targeted disease.

2. **Assess the health needs of that community**. Solicit and consider input received from individuals who represent the broad interests of the community, including those with special knowledge of or expertise in public health. Many methods exist for conducting an assessment, but generally include:[4]
   - Stakeholder meetings
   - Community focus groups
   - Surveys
   - Interviews with community leaders
   - Population health and other health-related data

3. **Document the CHNA in a written report** that is adopted for the hospital or health system by the board (or other authorized body). The report must include:
   - A definition of the community served and a description of how the community was determined.
   - A description of the process and methods used to conduct the CHNA.
   - A description of how the hospital or health system solicited and considered the input it received.

3 IRS, "Community Health Needs Assessment for Charitable Hospital Organizations—Section 501(r)(3)."
4 Center for Rural Health, "Community Health Needs Assessment."

- A prioritized description of the significant health needs of the community identified through the CHNA.
- A description of resources potentially available to address the significant health needs identified through the CHNA.
- An evaluation of the impact of any actions that were taken to address the significant health needs identified in the immediately preceding CHNA.

4. **Make the CHNA report widely available to the public**.

> You are not serving those you have joined the board to serve if your institution is only true to its historic mission and is not addressing the needs of the entire community.

In addition to documenting its CHNA, a hospital must adopt a written implementation strategy. This strategy should outline how the hospital will address the identified significant health needs over the next few years. The organization will also need to determine measurable objectives for continually tracking its efforts in this area. Also, if the hospital determines that it will not address a particular significant health need, the written strategy must explain why the hospital does not intend to do so.

The CHNA is critical to improving SDOH because it provides the hospital or health system with comprehensive information about the community's current health status and issues that need to be addressed so the board knows how and where resources should be allocated to best meet community needs and can create a detailed, measurable plan for improvement.

What are the potential consequences of not conducting a proper CHNA or adopting and adhering to an implementation plan?

- **Loss of tax-exempt status under IRC Section 501(c)(3)**
- **Civil penalties under the Internal Revenue Code**
- **Loss of real estate tax exemption**
- **Liability of the directors for breach of their fiduciary duties to those they serve**

The Board's Ownership of SDOH

SDOH are a crisis in our country and directors, individually and collectively, have a responsibility to address SDOH in their communities. Congress has made it clear that it is a problem directors own. To effectuate change in a positive manner, the board must hold itself accountable. It needs to have an action plan to address SDOH and reduce health disparities.

The board has an important oversight role in this area. While the board has oversight over what management does to eliminate health disparities, it needs to do much more. Boards need to evolve as the institutions they are responsible for evolve and have responsibilities that extend well beyond the clinical services they provide.

Community and Other Partnerships

It is important for hospitals and health systems to partner with other institutions in their service areas to help ensure that community members can access the care they need and deserve even if their own hospital does not provide the necessary services. As leaders in their communities, board members often have contacts and are aware of the needs of their communities and services provided by schools, houses of worship, and various other organizations with whom their hospital or health system should collaborate. It is important for board members to encourage these partnerships, be familiar with and supportive of them, even if it involves collaborating with an organization that is otherwise competing with their own institution. Provided a partnership benefits the patients the institution is there to serve, it probably makes sense.

The following are examples of the types of community needs and questions board members should consider:

- Our son wakes up crying every morning and it is hard to get him out of bed because he seems too sad. Does the hospital have someone who can help? If not, what mental health resources or services outside the hospital can we connect the parents with?
- My husband lost his job and we are struggling to buy enough food to feed our family. Does the hospital have partners that can help, such as a local food bank, church, or career center for those in need?
- My dad cannot find affordable housing and his current living situation is negatively impacting his health. Does the hospital offer resources or work with organizations that assist people in finding affordable housing in their community?

Within its means, the hospital should be a resource and source of information for all health services needed in its community.

Taking Action

In 2015, the American Hospital Association (AHA) launched its #123forEquity pledge campaign.[5] It builds on the efforts of the National Call to Action to Eliminate Health Care Disparities—a joint effort of the AHA, American College of Healthcare Executives, Association of American Medical Colleges, Catholic Health Association of the United States, and America's Essential Hospitals—and asks hospital and health system leaders to begin taking action to accelerate progress in the following areas:

- Increasing the collection and use of race, ethnicity, language preference, and other socio-demographic data
- Increasing cultural competency training
- Increasing diversity in leadership and governance
- Improving and strengthening community partnerships

According to the AHA, our country's hospitals and health systems are working hard to ensure that every person in every community receives high-quality, equitable, and safe care. To do that, we must eliminate health and healthcare disparities that continue to exist for far too many racially, ethnically, and culturally diverse individuals. As of June 2022, more than 1,700 hospitals and health systems nationwide have signed this pledge.

Questions for the board:

- Has your hospital or system signed the pledge?
- Is your board working hard to achieve the goals listed above (increasing socio-demographic data, cultural competency training, diversity in leadership and governance, and strengthening community partnerships)?
- Is management reporting on the progress being made to the board or the appropriate committee?

The AHA's Institute for Diversity and Health Equity recently developed The Health Equity Roadmap.[6] This roadmap contains various online tools for institutions to use to help drive improvements in healthcare outcomes, health equity, diversity, and inclusion. Boards should talk with management about this roadmap and whether these tools would benefit their organizational efforts.

When taking ownership on SDOH, it is also important to take a look at governance practices. For example:

- **The composition of the board:**
  - » Look around the table. Is the board representative of the population it serves?

5 AHA Institute for Diversity and Health Equity, "American Hospital Association #123forEquity Campaign to Eliminate Health Care Disparities."

6 "The Health Equity Roadmap," AHA Institute for Diversity and Health Equity.

» Are there term limits? Is there a succession plan? Are these being used to make the board more diverse and representative of your population?

- **Board dialogue:**
  - » Is the dialogue the same as it was before the enactment of the ACA?
  - » Are you spending as much time discussing SDOH as you are on last month's financials?
- **Chair–CEO dialogue**:
  - » The board speaks with the CEO through its chair. The CEO then carries the board's message throughout the organization.
  - » If working toward health equity is an institutional priority set by the board, as it should be, the chair and the CEO need to work together to deliver this message to the board and throughout the entire institution. Also, achievements in this area should be part of the compensation structure of the CEO and management team.

Examples of Health Systems Addressing SDOH

- **Improve education opportunities**: ProMedica Health is dedicated to creating healthier people and communities through the ProMedica National Social Determinants of Health Institute. Education is one of the SDOH ProMedica is working to address through several initiatives, such as:[7]
  - » Universal Pre-K: ProMedica helped launch HOPE Toledo as an effort to make Pre-K universally available in Toledo in 2021. The $20 million universal Pre-K initiative provides the opportunity to have early childhood education available to all of Toledo's children through a high-rated and high-quality preschool. As of the end of 2021, 167 four-year-old students were enrolled.
  - » Pre-Medical High School: ProMedica teamed up with Toledo Public Schools to provide local students with an opportunity to prepare for careers in the health field. The Toledo Pre-Medical and Health Science Academy will open in fall 2022 and focus on biomedical science, pre-medicine, pre-nursing, and all health science fields. At the academy, students will receive training to begin an entry-level career in the health field upon graduation or choose to attend college and further their education.
- **Eliminate health disparities**: Providence Health launched multiple community and clinic-based efforts aimed at eliminating health disparities in chronic conditions including hypertension and diabetes, as well as mental and behavioral health and access to care, including:[8]
  - » A partnership with Live Chair Health to provide hypertension screenings in salons and barber shops in Los Angeles to reduce inequities in the Black population.
  - » Efforts to increase the Program for All-Inclusive Care for the Elderly (PACE) and hospice enrollment to rates that reflect the communities in which they operate.

7 ProMedica National Social Determinants of Health Institute, *2021 Impact Report*.
8 Providence, *Taking Good Care of Each Other,* 2021 Year in Review.

  - » The launch of a pregnancy and birth outcome network in the greater Seattle area aimed at improving outcomes for Black and Native/ Indigenous populations.
- **Lower the risk of obesity:** Meritus Health ranked obesity as a top priority after conducting its 2022 CHNA. Using data from Feeding America, they found that almost 18 percent of children (under 18 years of age) in their county were living in households that experienced food insecurity.[9] This finding was notable because children who are food insecure are more likely to be hospitalized and may be at higher risk for developing chronic diseases such as obesity as a result of a lower quality diet, anemia, and asthma. Meritus Health set an objective to lose 1 million pounds by 2030 with specific goals and target metrics (see Meritus Health's Community Health Improvement Plan on page 12) and are actively tracking progress.
- **Reduce social barriers to health**: In Allina Health's 2020–2022 CHNA, addressing SDOH is one of their top three systemwide priorities.[10] They set a goal to reduce social barriers by:
  - » Establishing a sustainable, effective model to systematically identify and support patients in addressing health-related social needs.
  - » Forming a sustainable network of trusted community organizations that can support patients with these needs.
  - » Increasing policy and advocacy efforts to improve social conditions related to health.
- **Establish safe and affordable housing**: Providence Health combines safe and affordable housing with comprehensive support services for people with low incomes. It has 18 supportive housing programs designed for elderly or disabled individuals, or individuals who have been homeless. In 2021, Providence added two new properties to their portfolio. It acquired Cal Anderson House Apartments in Seattle, which offers supportive housing apartments for people with disabilities, and took ownership of a motel in McMinnville, Oregon, to run a shelter for families experiencing homelessness and in need of emergency housing. With these acquisitions, Providence now provides 747 units of permanent affordable housing with service coordination for the elderly and people with disabilities, and 98 units of emergency shelter for individuals and families experiencing homelessness.[11]

9 Healthy Washington County, *FY2022 Community Health Needs Assessment*.
10 Allina Health, *Community Health Needs Assessment and Implementation Plan 2020–2022*.
11 Providence, *Taking Good Care of Each Other,* 2021 Year in Review.

How to Measure Success outside the Walls of Your Hospital

For a variety of reasons, success is difficult to measure:

- The data that exists for measuring the quality of care and outcomes within a clinical setting are not as readily available when trying to measure advances in the health of a population that never makes it to the hospital for care.
- It is more difficult to measure success when addressing behavioral health issues than it is when addressing physical illness.
- Outside organizations that rank and rate hospitals have historically been more focused on clinical services and outcomes than on how well hospitals address SDOH and advances they make toward health equity.

Despite these obstacles, the work being done by a hospital or health system on the journey toward health equity must be monitored, tracked, and reported on at the board level and beyond. The following are a few steps to take:

- Place pressure on rating agencies to measure and report on what institutions are doing in this area. Can a hospital be a "best" hospital if it is not doing what it should be doing on this journey?
- Assess what resources are being utilized to improve SDOH. Is your institution allocating more resources toward this journey each year? Of course, spending money alone is not the answer. It is critical to track how money is spent and how resources are allocated to address SDOH. For example, is more money being spent than in the past to develop community partnerships? Is your institution doing more each year to educate and provide care for community members who do not walk through its doors?
- If you have not done so already, develop dashboards to track the progress your institution is making in furtherance of the implementation steps it has set for itself that are a product of the CHNA. For example, this dashboard could include:[12]
  - » Process effectiveness measures: leading indicators such as the number of lives impacted, referrals made, screenings completed, outreach attempts, and goals initiated.
  - » Outcome metrics: including health-related quality of life, mortality rate, and reductions in clinical disparities including blood pressure and obesity.

A critical piece of the implementation plan created from the CHNA is setting goals and identifying metrics that allow the board and/or the appropriate committee to track progress. If hospitals are not measuring the impact of addressing SDOH, that is a major lost opportunity. A data-informed approach to addressing SDOH can help clarify what success looks like for the organization and how to measure it, and it supports continuous improvement efforts.

12 Providence, *Taking Good Care of Each Other,* 2021 Year in Review.

For example, Meritus Health, in collaboration with community partners, conducted a CHNA to identify primary health issues and needs in their service region. The top-ranked community health priorities for Meritus Health's implementation plan include:

1. Obesity; lose 1 million community pounds by promoting increased physical activity, eating a healthy diet, and achieving emotional balance.
2. Improve behavioral health by ensuring timely access to appropriate, quality mental health treatment and support, and reduce addiction and overdose fatalities to protect the health, safety, and quality of life for all.
3. Improve prevention and the management of type II diabetes and reduce mortality.
4. Prevent heart disease, reduce mortality, and manage hypertension.
5. Increase health equity by helping all people attain the highest level of health.
6. Engage and empower people to choose healthy behaviors and make changes to reduce risks.

Based on these findings, Meritus Health developed an implementation strategy, outlining objectives, action steps, goals that will address the prioritized community health needs, and target metrics for tracking progress on these goals and objectives, which was approved and adopted by its board.

Meritus Community Health Improvement Plan FY 2022–2025

HEALTH NEED	OBJECTIVE	GOAL	ACTIONS	AGENCIES	TARGET OUTCOME	BASELINE
Obesity	Lose 1 Million Pounds by 2030	Increase registered users actively logging pounds in the community weight tracker	Improve media promotion of campaign, implement participation incentives, share best practices among partners	Meritus, HWC	≥ 95% user activity	92.3% FY 2021
		Community documents total pounds lost	Implement program for participation incentives	Meritus, HWC	> 100,000 pounds lost	11,200 FY 2021
Disease Management	Prevent and improve management of diabetes and hypertension	Improve management of hbA1c in patients with diabetes	Provider education, care coordination standards, referrals to evidence-based self management	Meritus	≥ 90% of patients hbA1c value ≤ 9	78.3% CY 2019
		Provide Diabetes Prevention Program (DPP)	Expand DPP sites, virtual, add DPP trainers, increase provider referrals	Meritus, COA, WCHD	1,909 patients referred, 191 enrolled	New
		Provide Diabetes Self-Management Program (DSMT)	Expand DSMT services, add virtual option, increase provider understanding and referrals	Meritus	1,413 patients referred, 304 enrolled	New
Health Equity	Attain the highest level of health for all people	Increase racial/ethnic diversity in the workforce that looks like the community	Adopted use of the Rooney Rule for all leadership hire process. Expand to three other organizations with more than 150 employees.	Meritus, HWC	24% minority leadership	New
		Increase access to healthcare and healthy food	Establish downtown health hub with access to primary care, screening, food prep	Meritus, Goodwill	10% reduction in ED visits for Black and Hispanic residents	New
Access to Behavioral Health	Improve access to timely behavioral health treatment and recovery	Establish regional crisis center services	Plan, fund, renovate, recruit	Meritus	Provide walk-in crisis center service 24/7 by June 30, 2023	New
		Decrease number of overdose fatalities in Washington County	Decrease opioid prescriptions, implement buprenorphine in ED, expand MAT services, sustain Peer Support	Meritus, WCHD	Decrease annual overdose fatalities by 25%	100 CY 2020
		Reduce suicide rate	Increase timely access and crisis intervention	HWC	Decrease suicide rate by 25% (goal 10.8 per 100k)	14.4 FY 2019
Wellness & Prevention	Engage and empower people to choose healthy behaviors and make changes to reduce risks	Increase health screening	Mobile Health, Residency, MMG practices; linkage of positive screens, earlier intervention, prevention of chronic illness	Meritus	Complete ≥ 1,095 preventative health screens	New
		Reduce loneliness	Add community partners, dedicated staff, individual contacts, implement home visits	Meritus	Reduce report of loneliness by 50%	1,578 FY 2021

Board Committees

As emphasized throughout this *Elements of Governance,* assessing and addressing the needs of the communities it serves, and working to overcome SDOH on the path toward health equity, should be part of the fabric of every hospital and health system. As the board typically does much of its work through its committee structure, it is important to consider how the work of each committee can help the organization work toward this objective.

Nominating and Governance Committee

This committee is often the point of entry onto the board. A forward-thinking committee should go beyond what is required of it under its charter and make recommendations to the board on any issue within its purview.

The following are important issues for the nominating and governance committee to keep in mind when potential board members are considered:

- Does the candidate understand what his or her role on the board would be as a fiduciary who, together with other board members, is responsible for the quality and safety of the institution?
- Is the candidate willing to learn about healthcare and governance and use his or her acquired knowledge to challenge management and board colleagues, and make sure that the institution is working hard and allocating appropriate resources to address SDOH?
- Will the candidate, and others being considered now or in the future, collectively help the board become more diverse and reflective of the community it serves? The more diverse the board, and the more input it can provide regarding the populations served by the institution (e.g., their barriers to care, how they shop for care, and their expectations regarding the care provided), the better the board will be.

In a healthcare setting, the nominating and governance committee should think about diversity in the broadest sense and not only focus on gender, race, and ethnicity. For example, to best understand and address the health needs of a community, also consider the age diversity of the board. In many cases, boards are getting older while the patients the institutions are competing for and seek to attract are getting younger. Can a 65-year-old board member who has historically called an office to schedule a doctor's appointment truly understand as well as his or her children the new age of healthcare consumerism in which appointments are scheduled online and held via Zoom and there is demand by those seeking care to be seen immediately? If a board does not "get it" and does not even know what questions to ask management, it is likely to be left behind.

Everything else being equal, economic as well as age diversity on a hospital board makes sense. It is common for hospitals to want "marquee" board members who can write big checks to support the institution. Individuals with deep pockets can be great board members. However, if they dominate the board, you may not have a board that best understands the cost of care at the individual level, how it effects the healthcare decisions being made by many in the community, and its effect on the quality of everyday life.

As directors, we know that hospital margins are small and that hospitals need to raise significant funds to invest in the best and brightest clinicians and the latest technology needed to deliver care at the highest level. We also know that directors are often some of a hospital's largest individual financial supporters. Remember, however, that the hospital board may only consist of 10 to 20 members, and hospitals depend on hundreds or thousands of individuals and businesses for their financial support. Directors should be committed and make the hospital on whose board they serve, a charity of choice. However, this must not be a high priority of this committee at the expense of getting dedicated directors who will work to address SDOH. Your institution does not need to and should not "sell" seats on the fiduciary board to raise money. Directors must understand that their role in the journey toward health equity is a top priority.

Board members should be encouraged to give generously within their means, but there should not be a financial barrier for entry to a fiduciary board. Such a barrier, aside from being wrong, would eliminate too many individuals who have the potential to be great board members.

Compensation Committee

A significant portion of CEO and senior management compensation is typically determined under an incentive plan that looks at how well the organization has done in certain areas, including operating margin, quality, and patient satisfaction. While these are important, by definition, these measurements largely focus on those who come to the hospital for care. Also, much of the focus on quality is based on what is done within the four walls of the hospital. Often, the methodology used, and the weight assigned to several factors in determining an executive's incentive pay is done by a board committee working with management and an outside compensation consultant. The compensation models used are often antiquated and do not appropriately reflect the migration of hospital services to outpatient sites in the community or to the responsibility of the hospital to allocate resources and do more to address SDOH.

The following are examples of how the compensation committee can help your institution on the journey to health equity:

- Compensation consultants who are well-versed in the current trends in incentive compensation can be leaders on the journey toward health equity. At every meeting with compensation consultants where the criteria for measuring executive performance is discussed, the consultants should discuss SDOH and how management can be rewarded for their achievements in this area. Similarly, management's failure to do more in this area should adversely affect their compensation. More organizations are beginning to tie metrics and goals from the CHNA and/or SDOH to CEO compensation. This is taking a number of forms, for example, compensation being tied to goals around access to care (e.g., growth or telehealth) or population health (e.g., screening prevalence for conditions or potential outcome measures) or quality indicators.
- While compensation consultants can and should be initiative-taking in advancing the dialogue on this subject, boards should be proactive. As is the case with much of what boards must do, they cannot wait for outside consultants and management to lead the charge from a governance perspective. The board represents everyone in the communities served by their hospital, not just those who use its services. Thus, it is the board's obligation to drive

the process to effectuate change in this area. Congress has clearly told board members that they are responsible for the health of their communities.

Finance Committee

The institution's proposed budgets for the following year are typically reviewed and recommended by the finance committee before they are presented to the full board for approval. Issues for this committee to consider that relate to SDOH include the following:

- To what extent is the hospital committing resources to address SDOH throughout its service areas? Is it clear that appropriate resources are being spent to improve the lives of everyone in the communities served by the hospital, not only those who are cared for by it?
- Is there an acknowledgement that sometimes the right decision will be one that is best for the community but does not improve the bottom line today?
- Is this committee discussing population health? Are members educated on how a population health approach will help position the institution for future financial success as hospitals are paid more to take risks and keep a population healthy, and less for each incidence of care, than was historically the case?

Human Resources

Not every hospital has an HR committee at the board level, as some people view its work as too operational or granular to be reviewed by the board. However, as the HR function deals with the hospital's most important asset—its employees—and deals with payroll, which is probably its biggest expense, it is a key area for the board to ask about, including as it relates to SDOH. Issues for the board to think about in this area include the following:

- Is the hospital or health system doing for its own employees what it should be doing for everyone else in the community? For example:
  - » Is it easy for employees to access behavioral health services?
  - » Is it educating its employees about healthy eating?
  - » No doubt, many of the hospital's employees are living in the communities served by the hospital. Is management hearing from its own employees about the SDOH and health needs in their communities and asking for their input on whom the hospital should consider partnering with in the communities where they reside?

Committee Dedicated to SDOH and CHNA

In view of the importance of the board's obligation to address SDOH, organizations should consider establishing a separate committee to oversee these topics from a governance perspective and report up to the full board on the progress being made (many boards have a population health and/or value-based care committee that cover these responsibilities as they are closely related and overlap). Admittedly, it is difficult to change the focus of a board that has been conducting its meetings in a certain manner for decades or longer. One way of doing so that would elevate the focus of these important issues among the board and throughout the organization would be through meetings of this committee and their reports up to the full board.

Foundation Board or Fundraising Committee

Depending upon the state in which your hospital or health system is located, it may have one or more foundations that are maintained as separate legal entities with their own boards. Alternatively, a separate committee of a hospital or system board may perform the fundraising functions. Typically, the primary purpose of the foundation board or committee is to raise funds to support the needs of the hospital or system as determined by management and approved by that institution's own board as appropriate.

While the foundation board is typically viewed as a "non-fiduciary" board, it cannot overlook its fiduciary obligations to carefully select and educate its directors, and to hold them accountable as financial supporters of the institution and outstanding representatives of the institution outside of the boardroom. With these principles in mind, as it relates to SDOH and the journey toward health equity, it is important that the foundation board or committee keep the following in mind in recognition of the fact that it is difficult, if not impossible, for a hospital to be great if it is not supported by the efforts of a great foundation:

- Much of the work a hospital needs to currently do to address SDOH will not add to its operating margin; at least, not in the short term. Hopefully, one day it will as we move further along with payment models based on keeping a population healthy and providing care at the highest level, rather than getting paid for each incidence of care. Until we get there, much of the work to be done in the community may be a drag on an institution's operating margin and may need to be supported through fundraising efforts. Thus, members of the foundation board must understand the legal obligation of their hospitals and systems to do more good things in the community and encourage their donors to support necessary programs that have a deeper impact in the communities their institutions serve.
- In certain cases, this will be a challenge as long-time supporters of an institution may be accustomed to brick-and-mortar contributions where their names will appear on a building or a room in a hospital. Those donors will need to understand the importance of making gifts that support programs in the community, even if their name is not permanently affixed to a structure.

Boards within a System Structure

Over the last several years, many formerly independent hospitals have merged into and become part of systems containing several hospitals. These transactions have had a profound effect on hospital boards, their committee structures, the expectations and responsibilities of the board, and the ways in which they can add value to their institutions and those they serve.

Often, upon the closing of a merger transaction, certain board committees of the hospital that was merged into a system disappear. For example, if the balance sheet of the acquired hospital becomes part of a single consolidated balance sheet of a system, the audit committee of the previously independent hospital will go away. Similarly, as the compensation of the acquired entity's CEO will be determined at the parent level, there would likely not be the need for a compensation committee. Other committees, including finance, human resources, and retirement planning and investments, may also have reduced roles, or be eliminated as the issues they historically dealt with would now be handled at the system level. All of this may be a rude awakening for previously engaged and important board leaders who are not prepared for these changes.

It is worth examining whether these changes to the composition of the committee structure of the acquired entity is inherently a good, bad, or not meaningful consequence of merger mania in healthcare. It is also worth examining the relevance of these questions to SDOH and the journey toward health equity.

Successfully making the transition from a board of an independent hospital to a subsidiary hospital within a system will require resolute and thoughtful leadership by your board chair and others. While many of the traditional roles of board leaders will disappear in a merger transaction, their role in making sure the acquired institution is true to its mission and is going above and beyond to address the needs of the community should be greater than ever before. The chair, board leaders, and management of the acquired hospital, as well as that of the parent, should look to engage the best and most dedicated members of the acquired hospital's board to lead the journey toward health equity and to oversee, from a governance perspective, the CHNA. Everything else being equal, the board members of the acquired entity, who often live and work in the service area of their hospital, will be the board members who are best able to educate the parent entity about the specific needs of their community and to challenge the leaders of the parent system if they are not doing what they should for the communities served by the acquired hospital.

Conclusion

As board leaders and fiduciaries, our role is governance, not day-to-day operations. When dealing with SDOH and a CHNA, a historic governance model is just the start. By itself, it is not enough. While a board's role remains governance, board members must be the leaders in helping to develop and oversee new models of board behavior for the institutions and populations they serve. Boards cannot wait for management to tell them what to do. We need to do a significant amount of homework and learn and evolve as directors as we expect our management leaders and clinicians to do the same.

In the case of a non-profit hospital or system, the board's ownership of SDOH and its efforts to achieve health equity must be part of the DNA of the institution. You are not serving those you have joined the board to serve if your institution is only true to its historic mission and is not addressing the needs of the entire community. Congress has made this clear and has given us both the obligation and the opportunity to do more to improve the lives of those we represent and serve than everyone who previously served in our roles.

Board members should view their obligation as directors to be daunting. They should also be proud and honored to serve and must help lead their organizations on the journey to health equity. Directors need to recognize that changes in behavior and practices will not happen overnight. We know it is harder to change board practices at an institution that has been around for decades than it is at one that was established yesterday.

Directors do not have the time or luxury to be frustrated if their colleagues are not all on board with the changes that need to be made. It is okay to start small. Any dialogue engaged in by boards and committees that goes beyond what was discussed in the past concerning these topics will be time well spent on the journey to health equity. For those on your board who will not embrace this challenge and opportunity, look to fill their seats with others who will.