One Impact

Coming together, one community at a time.

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Healthcare Transformation in the COVID Era: The Governance Institute's One Impact Initiative

Special Commentary

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Overview

After three decades of engagement with hospitals, health systems, and diverse stakeholders to develop comprehensive strategies to address the drivers of poor health, it is clear to me that the healthcare sector is at a major crossroads. For hospitals, historically focused on the delivery of acute-care services, what progress can we claim in the strategic allocation of resources and partnerships with diverse stakeholders to improve health and well-being in communities? Despite the potential benefits of investment in comprehensive interventions to reduce the demand for increasingly high-cost clinical treatment, is such diversification desirable and/or an appropriate role for hospitals and health systems?

One of the many ironies of the COVID pandemic is that it highlighted the profound health inequities in geographically defined communities, *and* it has eroded the capacity of our hospitals to play an important role in addressing them. In numerous conversations over the past two years with senior leaders of hospitals and health systems, colleagues have cited a deeper awareness of the profound disproportionate negative effects on the residents in their most socio-economically challenged communities. The high COVID incidence and mortality in these communities illuminates the powerful impact of social and physical environmental factors at the individual, family, and community levels. At the

same time, despite substantial allocations of COVID-related funding from federal and state agencies, hospitals face some of the most significant financial challenges in their history. In response, many are scaling back on proactive investments in community health.

The Governance Institute, with the support of the Center to Advance Community Health and Equity (CACHE) at the Public Health Institute, launched the One Impact initiative in early 2022, just as the healthcare industry was grappling with the full financial impacts of COVID, as well as its disproportionate impact on communities at the lower end of the socio-economic spectrum. Our initial intent with the initiative was to document the evolution over four decades of hospital and health system engagement in efforts to address the social determinants of health (SDOH), now reframed and supported across federal agencies as Vital Conditions.[1]

One of the goals was to move beyond documentation of "one-off" case examples to better understand how organizations were measuring their impacts and fostering institutional alignment and accountability. This required a more systematic collection of data across institutions to build a better understanding of common conditions, principles, and policies (both institutional and public) necessary for near-term success and long-term sustainability. Of central importance, the intent was to provide a structural framework and to better describe what inspired leadership looks like, both among executive leaders and governing boards. Finally, the intent was to help identify what is needed in the policy arena at the local, state, and federal levels to build health and well-being in a more equitable manner in communities across the country.

For obvious reasons, the COVID pandemic required a pivot in strategy. It became clear that our hospitals and health systems were necessarily focused on addressing the catastrophic conditions in their communities and keeping their doors open in almost impossible circumstances. There was no question of collecting data at scale, nor was it realistic to engage leaders on broader issues.

Thus, for our One Impact initiative, we needed to shift the focus from a broader, quantitative survey across the sector to a set of in-depth, qualitative interviews with executive leaders. We wanted to reflect on the impacts of the pandemic and explore the implications for hospitals returning to a focus on proactively addressing health inequities in their communities in a more strategic, integrated manner that has greater potential to result in broader and more sustainable results. Insights were shared by a variety of colleagues who observed a downscaling of investments in addressing the drivers of poor health, as well as the elimination of system leadership positions responsible as part of a strategy to stem financial losses.

1 See Community Commons, "Seven Vital Conditions for Health and Well-Being."

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Challenges and Key Drivers

There are multiple drivers behind the current financial challenges faced by hospitals, including, but not limited to a dramatic loss of workforce; exacerbating shortages that existed prior to the pandemic; continuing escalation of costs for labor, equipment, and pharmaceuticals; continuing downward pressure on reimbursement; monopolistic behavior by commercial health plans; and a failure of state and federal agencies to move forward with risk-based payment structures that reinforce and reward strategic investments in prevention. On the prevention front, non-profit hospitals are confronted with disincentives from both payers and the IRS; the former due to a reluctance to engage in shared-risk payment arrangements, and the latter due to a bias towards traditional charity care and against primary prevention interventions.[2]

Just as the COVID pandemic has emphasized the inequities in our communities, it has also highlighted the parallel inequities in our regional healthcare markets. In most urban areas with two or more competing hospitals, there is typically one institution that is in a dominant market position, and it has been in that position for many years. In many cases, it is a large teaching facility. Because of its dominance, it is in an advantageous position to negotiate higher rates with payers, which helps to keep faculty salaries competitive.

Hospitals that are second or third in the regional market often have a less favorable payer mix and higher percentages of public pay patients, in part because they are more proximal to lower-income communities. Because these hospitals have more low-income patients on Medicaid who arrive each day in their emergency departments, they have less discretionary dollars to strategically invest in prevention interventions.

Of equal importance, the second- and third-place hospitals face obstacles with payers in negotiating competitive rates or shared-risk arrangements. While the Disproportionate Share (DSH) Medicaid program has eased some of the immediate burden for hospitals that are most impacted, limits to the reimbursement rates and higher acuity among the patient populations erodes their financial stability over time. The net result is ever increasing expenditures for acute-care medical services, and fewer dollars available (both from the public and private sectors) for more strategic investment in building healthier communities.

2 Among primary prevention activities, "community building" was proposed as a category of community benefit programming in a 1997 monograph entitled "The Future of Community Benefit," and was integrated into the Catholic Health Association's Social Accountability Budget. It included actions to improve the quality of housing, increase access to affordable healthy foods and other related activities, but was rejected as a financially reportable category by the IRS in their Revised Form 990 in 2010. Stated objections by internal IRS staff included a concern that non-profit hospitals could use the category to gentrify proximal neighborhoods; a concern that could have easily been addressed with clear guidelines and periodic reviews.

Recent trends are particularly concerning, with the accelerating acquisition of medical practices by private equity firms[3] showing a seven-fold increase in the last 10 years, and now exceeding 50 percent of market share in over 50 MSA markets. Acquisition of provider practices and various forms of specialty care have a net effect of removing components of hospital functions with higher returns on investment, leaving higher-cost, low-return functions, and for those with less favorable payer mixes, increasing financial pressure. For example, one health system we spoke to has experienced private equity funding of outpatient clinics in the market that have diverted significant volumes of profitable services away from the health system.

Many non-profit hospitals in urban inner cities have closed in recent decades due to the impact of long-term financial declines resulting in deteriorating infrastructure, loss of providers, and higher percentages of Medicaid, underinsured, and uninsured patients. Market dynamics are equally challenging for rural hospitals across the country, particularly in states that have still resisted the Medicaid expansion. Closures are accelerating, driven most significantly by the inability to negotiate reimbursement rates with payers that are sufficient to keep their doors open.

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Community Health and Professionalism

It is worthwhile to reflect on the progress made by hospitals in building capacity to address the drivers of poor health in local communities. This work has been led primarily, though not exclusively, by the non-profit hospital sector as a function of their fulfillment of their charitable obligations.

An underlying ethic for these institutions is a commitment to optimal stewardship of their charitable resources. Stewardship in this context translates into resources and strategies

3 O. Abdelhadi, B. Fulton, L. Alexander, and R. Scheffler, "Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012–2021," *Health Affairs*, Vol. 23, No. 3, March 2024.

that proactively improve health and well-being and reduce the demand for high-cost treatment of preventable conditions. Building capacity to be good stewards requires investments in a workforce with the required expertise and establishing accountability to produce desired results.

Over the last four decades, we have seen a steady increase in hospital engagement in community health improvement, driven in part by professionalization at the staff level, and increased accountability at the senior leadership level. Multi-state initiatives such as the Advancing the State of the Art in Community Benefit (ASACB) demonstration[4] established a set of standards for hospitals and systems, including core principles that emphasized primary prevention and a focus in communities where health inequities are concentrated.

It also moved oversight (in many cases) from marketing departments to executive leadership, often with vice presidents or senior vice presidents of population health or related functions, and established performance metrics at the CEO level for review by governing bodies. At the staff level, given a high rate of turnover driven in part by a lack of clarity about the scope of responsibilities, standard job descriptions, each with an associated percentage of FTE, helped educate and illuminate what was needed to ensure excellence in function.

A key challenge in advancing practices in community health has been to effectively integrate timely patient care navigation, helping people connect with organizations to meet their social needs, and implementing place-based strategies to address drivers of poor health. While progress has been made, among the most significant obstacles is our fitful and uneven movement at the federal policy level towards risk-based payment.

It is startling that after decades of promises, encouragement, and threats, fee-for-service is still the dominant form of payment, with the exception of a few states (e.g., MD, OR, MN). The net effect is that hospitals are in a bind as it relates to upstream investments. If they are effective in reducing preventable admissions at scale, for example, by implementing comprehensive strategies to reduce hospitalizations for diabetes, the result is a reduction in revenue.

Rebuilding Public Trust

The "honeymoon" of public appreciation for hospitals during the COVID pandemic was a short one, and it has been replaced by a plethora of bad news (and selective bad behavior) that largely erased public goodwill. It doesn't matter that the bad institutional behavior is the exception rather than the rule; the continuing escalation in healthcare costs, excessive

4 ASACB was implemented by the Public Health Institute between 2002 and 2006, with braided funding from multiple national, state, and regional foundations, and participation of 75 hospitals in CA, TX, AZ, and NV.

compensation of executive leaders, accrual of medical debt among nearly half of the adult population, facility closures in low-income communities, and growing challenges to timely access are being laid at the feet of our hospitals. It isn't fair, but here we are.

Data from The Governance Institute's 2023 Biennial Survey[5] shows a stark decline in activity at the board and senior leadership level in this work, along with a decline in performance of the core responsibility of community benefit and advocacy, an area that has historically ranked last for boards, both in performance and adoption of recommended practices. We see this as a lack of board and leadership understanding about the central importance of community health to the role, mission, and ultimately success of non-profit hospitals and health systems.

This trend is extremely concerning, as much of this work is required to enable organizations to transform their delivery system away from a focus on inpatient, acute care. Outside disruptors are continuing to make the job of providing integrated care at the right settings for the right costs more and more difficult for legacy health systems. While general survey data for the field highlights a lack of board and senior management leadership about the central role of community health in the current environment, it is not universal.

As compellingly articulated by Michael Sandel in his recent book,[6] our cultural values of small government, hyper-individualism, and lack of societal investment in meeting peoples' basic needs has contributed to a variety of social ills and poor health conditions, not to mention grievance that has been manipulated and misdirected by some political leaders. Expecting hospitals and health systems to solve these issues on their own is inappropriate and destructive. We must come to grips with the societal failure in the most affluent nation on the planet to improve living conditions for our most socio-economically challenged.

Some, not surprisingly, are seeking to make the case that hospitals' involvement in addressing the drivers of poor health is inappropriate.[7] It is certainly the case that one approach to healthcare delivery in the future is to narrow, rather than expand, the scope of interventions by hospitals. Such a scenario would likely further limit both the scope of services provided by hospitals and their negotiating leverage with payers, among a range of other outcomes.

The alternative scenario is one of increasing integration within and across sectors. One of the silver linings of the COVID pandemic was the establishment of new working relationships between hospitals and a variety of related organizations, ranging from local public health agencies and federally qualified health centers to community development organizations, advocacy organizations, educational and religious institutions, and local

5 K. Peisert and K. Wagner, *Think Bold: Looking Forward with a Fresh Governance Mindset*, Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute, 2023.

6 M. Sandel, *The Tyranny of Merit: Can We Find the Common Good?*, Penguin Books Limited, 2020.

7 C. Pope, "Is Everything Health Care? The Overblown Social Determinants of Health," Manhattan Institute, July 2024.

elected officials. In many cases, these new relationships have illuminated new ways in which to more effectively and proactively address health needs *and* build civic capacity.

In the coming months, we will share examples of positive deviant stories where boards and senior leaders have helped to accelerate decisions, launch initiatives, allocate resources, and engage in targeted advocacy that focuses on addressing inequities and improving vital conditions in our communities—despite the many COVID and unrelated challenges. We will share profile perspectives from executive leaders as well as emerging practices from forward-thinking (and acting) governing bodies. On this difficult and illuminating journey, we have heard from so many people experiencing firsthand the pausing or shrinking of these efforts both due to COVID. Now that we have entered the post-COVID era, we will share the thinking of leaders on how to leverage what we've learned to work more cooperatively with diverse stakeholders to redefine and elevate the role of hospitals and health systems in America.

The Governance Institute thanks Kevin Barnett, Dr.P.H., M.P.H., M.C.P., Executive Director, Center to Advance Community Health & Equity and Principal Investigator, Public Health Institute, for contributing this special commentary. He can be reached at kbarnett@thecachecenter.org. For more information on the One Impact campaign visit www.governanceinstitute.com/OneImpact.