



Measuring Hospital Contributions to Community Health and Equity

A Proposed Approach for
Public Comment

**Bloomberg
American
Health Initiative**

**Johns Hopkins
Center for
Health Equity**

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Contributors

Caroline Plott, M.S.

M.D. Candidate

Johns Hopkins School of Medicine

Trevor Wroblewski, B.A.

Joshua M. Sharfstein, M.D.

Professor of the Practice in Health Policy and Management

Director, Bloomberg American Health Initiative

Rachel L.J. Thornton, M.D., Ph.D.

Associate Professor of Pediatrics

Associate Director for Policy, Johns Hopkins Center for Health Equity

Background: The Role of Hospitals in Community Health and Equity

Health and illness arise from many factors that reach beyond the exam room walls into the community and occur over the course of a lifetime and across generations. Beyond caring for patients with advanced illness, hospitals and health systems can play an important role in addressing these critical community contributors to health. Assessing and recognizing these contributions is as important as measuring other measures of hospital quality, such as patient satisfaction and medical errors.

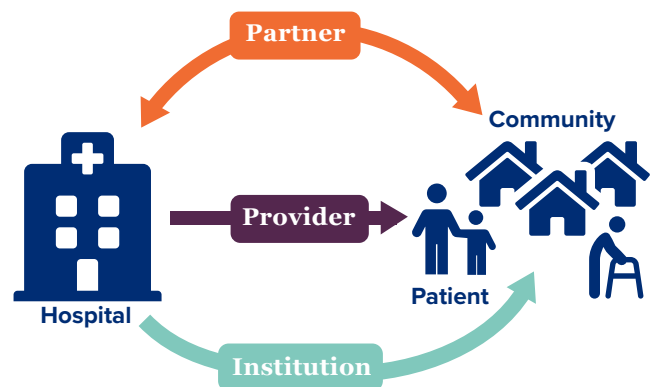
Community health refers to the health of a defined population, such as all who live in a neighborhood, city, or county. Health equity is the principle that everyone should have a fair and just opportunity to be as healthy as possible. Progress in achieving health equity is measured in terms of reduction or elimination of disparities in health and upstream **determinants** that adversely affect specific groups, such as racial and ethnic minorities.

The case for hospitals and health systems to promote community health and equity has three components.

Profound gaps in health across the United States. Life expectancy has stagnated, with the **decline** from 2015 to 2017 the first three-year drop since the time of World War I and the Great Influenza. There are enormous disparities in health and social well-being, with minority and rural communities experiencing high rates of **poverty**, **unemployment**, **chronic illness**, and **premature death**. Addressing these challenges is an urgent national priority.

A troubling historical legacy. From early in the nation's **history**, many U.S. hospitals explicitly supported the institution of slavery and later discriminated in hiring, established **segregated wards**, and offered unequal treatment based on income and race. These actions had **lasting** effects for trust in the medical system and the health of communities. Righting these wrongs requires engagement and investment in community health and equity.

The opportunity to make a difference. There is **growing** appreciation that hospitals and health systems can play a critical and galvanizing role in advancing community health and equity. This role includes acting as a healthcare provider, offering critical preventive services; acting as a community health partner, teaming up with local organizations to implement critical programs; and acting as an anchor institution supporting local economic and social progress. (Figure).



Some of these activities are captured by the concept of “community benefit”; under the Affordable Care Act, nonprofit hospitals must conduct community needs assessments and document the financial value of certain programs. A central element of most community benefit plans is covering the cost of medical care for the uninsured and underinsured. Community health and equity are broader concepts, reflecting the perspectives and needs of communities themselves.

In recent years, the American Hospital Association has highlighted many ways that hospitals and health system can advance [population](#) health, impact social [determinants](#) of health, and reduce [disparities](#) and inequities in health and healthcare. Incorporating a measure of these actions into a major hospital ranking system is a natural step.

Measuring Hospital Contributions to Community Health and Equity

National hospital ranking systems and awards incentivize [continued](#) improvement in hospital performance and accountability. As yet, however, no major hospital ranking system includes a quantitative [measure](#) of community health as a comparable measure to other parts of overall ranking, such as inpatient outcomes, operational efficiency, and patient experience.¹

IBM Watson Health, the Bloomberg American Health Initiative, and the Johns Hopkins Center for Health Equity are working together to develop a community health and health equity measure. The goal is for such a measure to be added to the [Fortune/IBM Watson Health 100 Top Hospitals Program](#) with comparable weighting with other ranking domains.

Key principles for this process include:

1. Components of the measure should be based on evidence, existing standards, and best practices.

In this document, we have first sought standards to assess the ways in which hospitals are working to improve community health. Where specific existing standards were not available, we propose straightforward metrics based on best practices and published research. Further, we have provided examples of hospitals that have implemented such programs.

2. The underlying data should be publicly available or easily and transparently collected from hospitals and health systems.

¹ Examples of specialized rankings and awards related to community benefit or community health include the [Foster G. McGaw Prize](#), and the [Lown Institute Hospitals Index](#).

We are proposing a four-component approach to measuring hospital contributions to community health and equity. Data for the first proposed component are publicly available through websites that track health outcomes by county. Data for the other three proposed components would be derived from a survey to be filled out by participating hospitals. We envision that hospital responses would be made publicly available on a single, easily searchable website.

3. Hospitals and health systems, community organizations, and the general public should have the opportunity to suggest and comment on all elements of the proposed measures.

Public comment on each component can be provided at bit.ly/hospitalmeasure by September 10, 2020.

Component 1: Population-Level Outcomes

Because the goal is improved community health and equity, we propose that one component of a measure should assess progress in population-level outcomes.

Key design questions for this component include:

- *What is the right level of geography?* We propose the county level, as this is the smallest level of geography for which community health data is routinely available.
- *What is the right time period to measure?* We propose to measure improvement over a decade, a period of time that reflects the long-term investments needed to improve community health. To avoid fluctuations at each end, we propose a three-year smoothed average at each end of the decade.
- *What qualifies for credit under the measure?* We propose that hospitals located in counties in the top tertile of community health progress by any of the selected measures should receive points in this component.

For the component, we have identified two available measures of community health:

- **Life expectancy** by county, from the Institute for Health Metrics Evaluation
- **Preventable hospitalizations** by county, from County Health Rankings

It is foreseeable that factors outside the direct control of hospitals and health systems will affect the trends in these measures. We propose them as one component of the overall community health and equity measure because hospital efforts can, over time, make a difference, in coordination with the

action of other community partners. One effect of adopting this component will be to encourage such cooperation focused on important health outcomes. The other three proposed components focus on specific actions steps for hospitals and health systems to realize these improvements in health at the community level.

Component 2: Hospital as Healthcare Provider

Given the critical role hospitals play as direct providers of healthcare, we propose that a component of the measure assess whether available services include best practices that prevent challenges in community health. Key design questions for this component include:

- *Should the expectation be the same for all hospitals?* Given the variability of community health needs, and the variety of hospital structures, we propose that there should be a variety of best practice standards for hospitals, with full credit for meeting at least half of the standards.

We have proposed seven specific standards here for public comment and are interested in hearing about additional options through public comment.

2.1. Proposed Best Practice Standard: Hospital is a comprehensive tobacco free campus.

Background. Smoking negatively contributes to almost all health conditions. **Decreased** rates of smoking are associated with fewer cardiovascular events and decreased asthma morbidity. **Comprehensive** smoke-free policies are associated with reducing secondhand smoke by half, decreasing the prevalence of tobacco smoking, tobacco consumption.

Best Practice Standard. Hospitals can establish and enforce a completely smoke free campus as recommended by the American Medical Association (AMA). The **AMA** supports that “all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, 40 and educational institutions, including medical schools.” Key elements of a tobacco **campus** include: prohibition of smoking and smokeless tobacco use in all indoor and outdoor areas.

Example. Many hospital campuses have established smoke free policies including the **Veteran Health Administration** and **University of Wisconsin Hospital and Clinics**.

2.2. Proposed Best Practice Standard: Hospital has a tobacco use cessation program that is initiated while the patient is hospitalized.

Background. The [Centers for Disease Control and Prevention](#) estimate that 480,000 people die every year as a result of tobacco product use and exposure in the US alone. Furthermore, tobacco use puts patients at increased risk of [lung](#) cancer, chronic conditions like [cardiovascular](#) disease and [hypertension](#), and harm to the fetus in pregnancy including decreased [lung](#) function. Hospitalization can be an opportunity support tobacco cessation by providing patients that use tobacco products with access to evidence-based smoking cessation supports.

Studies have shown that initiation of a smoking cessation program during hospitalization is associated with a decrease in smoking related [readmission](#), and a longer post-discharge [cessation](#) period. Effective programs use screening to systematically identify patients that use tobacco, initiate conversations and counselling regarding tobacco cessation, and provide access to effective treatments to support tobacco cessation.

Best Practice Standard. Hospitals can implement the strategies noted by the 2020 report of the U.S. Surgeon General on smoking cessation. These are summarized in the report's [Table 7.2](#) and include:

Expanding the review of vital signs to include tobacco use or implement an alternative universal identification system.

- Educate all staff on a regular basis by offering training.
- Designate a nicotine dependence treatment coordinator for every clinical site.
- Offer nicotine dependence treatment to all hospital patients who use tobacco.

Example. The University of Wisconsin-Madison [developed](#) an inpatient tobacco cessation intervention which provides each patient who has reported that they smoke an option to have brief counselling and to meet with a pharmacist who can offer the patients tobacco cessation medications. This program is available regardless of a patient's insurance status.

2.3. Proposed Best Practice Standard: Hospital encourages healthy food choices.

Background. More than 2 in 5 US [adults](#) are considered obese, and, as a result, are at greater risk of developing [diabetes](#), hypertension, [cancer](#), and overall higher risk of [death](#). [Diets](#) rich in fruits and vegetables, low in trans fat and added sugars such as the Mediterranean diet pattern are associated

with less weight gain and other health benefits. [Access](#) to affordable healthy food is also associated with improvements in chronic disease outcomes among people with [cardiovascular](#) disease and other conditions.

Best Practice Standard. Hospitals can implement five recommendations set by the American College of Cardiology (ACC) and National Prevention Strategy (NPS) for cafeterias and onsite restaurants. The guidelines include:

1. Serving a variety of vegetables and fruits in all cafeterias (ACC)
2. Offering at least one plant-based main dish that is low in fat, sodium, and added sugars and promoted at every meal in all cafeterias and onsite restaurants (ACC)
3. Insuring that no trans fats are used in cafeterias or onsite restaurants (ACC)
4. Eliminate high-calorie, low-nutrition drinks from vending machines and cafeterias (NPS)
5. Update cafeteria equipment (remove deep fryers, add salad bars) to support provision of healthier foods (NPS)

Example. A set of food [standards](#) was developed by the New York City Department of Health and Mental Hygiene. A group of both public and private hospitals in New York City incorporated these standards voluntarily. Many of the hospitals were able to provide a healthy, affordable meal in the cafeteria, incorporate more whole grains, decrease calories in some side items, and reduce the number of unhealthy items present at the cashier area.

2.4. Proposed Best Practice Standard: Hospital provides buprenorphine treatment for opioid use disorder in the Emergency Department.

Background. [Opioid](#) use related drug overdoses resulted in 46,802 deaths in the US in 2018. Buprenorphine is a medication that helps people decrease their use of heroin, fentanyl and other illegal or prescribed opioids -- and is associated with a reduction in the risk of death by 50% or more. A randomized controlled trial [showed](#) that initiation of buprenorphine in the Emergency Department was associated with a doubling of the rate of treatment engagement one month later. On this basis, the [American College of Medical Toxicology](#) and other professional associations have endorsed for “the administration of buprenorphine in the emergency department as a bridge to long-term addiction treatment.”

Best Practice Standard. Hospitals can follow the guidelines established by the [Massachusetts Hospital](#)

Association for the administration of buprenorphine in the Emergency Department. These guidelines cover staffing, clinical protocols, and follow-up for patients.

Example. A number of hospitals, including **Johns Hopkins Hospital** and the **Massachusetts General Hospital** have trained clinical providers and provide buprenorphine access in the emergency department.

2.5. Proposed Best Practice Standard: Hospital runs a hospital-based violence prevention program.

Background. **Interpersonal** violence resulted in more than 19,000 **deaths** in 2016 and 1.6 million **non-fatal** assault injuries from assault in the US in 2018. Homicide ranks among the top 5 causes of death for young men ages 15-34 years-old in the U.S., and in the top 10 causes of **nonfatal** injury for all individuals 10-64. Survivors of interpersonal violence experienced increased risk of interpersonal violence victimization in the future.

Hospital medical teams can improve outcomes for victims of interpersonal violence requiring hospital-based services by deploying evidence-based violence prevention programs. Hospital-based violence programs can decrease the number of **repeat** violence-related injuries among victims of violence, and increase rates of **employment** and use of community services,.

Best Practice Standard. The **National Network of Hospital-based Violence Intervention Programs** recommends that trauma centers and hospitals treating more than 100 assaults per year develop programs that **include** on-site crisis intervention services, development of a discharge plan, linkage to community based services, mentoring, home visiting, and long-term case management.

Example. The Detroit Medical Center Sinai-Grace Hospital in Michigan has developed the **Detroit Life is Valuable Everyday** (DLIVE) program. This program has violence intervention specialists who engage with survivors of interpersonal violence who are 14-30 years old.

2.6. Proposed Best Practice Standard: Hospital screens for intimate partner violence and refers to services and supports as needed

Background. **Intimate partner violence** refers to physical, sexual, and/or psychological harm in an intimate or dating relationship. Approximately 1 in 3 **people** living in the United States will experience intimate partner violence during their life. Intimate partner violence led to at least 2,340 **deaths** in the US in 2007, 70% of which were women. Intimate partner violence is associated with **detrimental health** effects, including physical injury, psychological illness, increased rates of female prepartum and intrapartum smoking, and worse pregnancy outcomes. Fewer than half of clinicians routinely report screening for intimate partner violence. Screening for intimate partner violence in the **emergency department** has been

shown to significantly **increase** detection and provision of patients with appropriate resources, without an increase in intimate partner violence as a result of the screening. The **American College of Emergency Physicians** recommends that “emergency personnel assess patients for intimate partner violence, child and elder maltreatment and neglect and emergency physicians are familiar with signs and symptoms of intimate partner violence, child and elder maltreatment and neglect.”

Best Practice Standard. Hospitals can implement the approach recommended by the **American College of Obstetrics and Gynecology** for screening and response for intimate partner violence (IPV). This approach states:

- Screen for IPV in a private and safe setting with the woman alone and not with her partner, friends, family, or caregiver.
- Use professional language interpreters and not someone associated with the patient.
- At the beginning of the assessment, offer a framing statement to show that screening is done universally and not because IPV is suspected. Also, inform patients of the confidentiality of the discussion and exactly what state law mandates that a physician must disclose.
- Incorporate screening for IPV into the routine medical history by integrating questions into intake forms so that all patients are screened whether or not abuse is suspected.
- Establish and maintain relationships with community resources for women affected by IPV.
- Keep printed take-home resource materials such as safety procedures, hotline numbers, and referral information in privately accessible areas such as restrooms and examination rooms. Posters and other educational materials displayed in the office also can be helpful.
- Ensure that staff receives training about IPV and that training is regularly offered.

Example. **Kaiser Permanente Northern California** has a multifaceted approach to intimate partner violence, including routine screening and intervention in clinical setting, electronic health record clinical decision support, behavioral health clinical services, and partnership with advocacy organizations. At least 11 **Veterans Health Administration** medical centers have increased screening and risk assessment for intimate partner violence, provision of mental health resources, partnerships with community organizations, and availability of resources to support patients who have experienced intimate partner violence.

2.7 Proposed Best Practice Standard: Hospital offers an infant safe sleep education program

Background. Every year in the US approximately 3,500 infant deaths occur as a result of unsafe sleep practices. Hospitals can play a critical role in teaching, modeling, and reinforcing safe sleep practices with primary caregivers of neonates and infants during hospital admissions before discharge. The CDC developed the “Back to Sleep” guidelines for safe infant sleep in 1994. A study done in 1999 showing an increase in appropriate sleep practices in the 13 states studied.

Best Practice Standard. Hospitals can offer an infant safe sleep education program for all parents with a newborn that meets the recommendations of the American Academy of Pediatrics. These recommendations include:

1. Staff in NICUs should model and implement all SIDS risk-reduction recommendations as soon as the infant is medically stable and well before anticipated discharge.
2. Staff in newborn nurseries should model and implement these recommendations beginning at birth and well before anticipated discharge.
3. All physicians, nurses, and other health care providers should receive education on safe infant sleep. Health care providers should screen for and recommend safe sleep practices at each visit for infants up to 1 year old. Families who do not have a safe sleep space for their infant should be provided with information about low-cost or free cribs or play yards.
4. Hospitals can ensure that hospital policies are consistent with updated safe sleep recommendations and that infant sleep spaces (bassinets, cribs) meet safe sleep standards.

Example. In the [Georgia Safe to Sleep Hospital Initiative](#), hospitals provide safe sleep education for caregivers while the baby is still in the hospital, information on safe sleep practices, and travel bassinets to low-income families. The initiative was found to increase the rate of safe sleep practices, including decreasing the practice of bed sharing.

2.8. Proposed Best Practice Standard: Hospital is “baby friendly”

Background. Breastfeeding is associated with a multitude of benefits to newborn babies and population health, including lower rates of neonatal and infant mortality and decreased rates of childhood obesity. Hospitals are in a unique position to assist mothers and babies with initiation of feeding patterns to optimize health outcomes.

The Baby Friendly Hospital Initiative was developed in 1991 to help hospitals increase breastfeeding rates. Each of the ten components of the Baby Friendly designation is **evidence** driven, and has been associated with an **increase** in short, medium and long term breastfeeding rates at healthcare institutions that have implemented the full set of recommendations.

Best Practice Standard. Hospitals can follow the following **World Health Organization** standards to become “baby friendly”:

1. Facility breastfeeding policy (following the International code of marketing of Breast-milk substitutes, breastfeeding policy that is shared with parents, data monitoring of rates of breastfeeding)
2. Staff training in breastfeeding support
3. Clinical discussion of breastfeeding before birth
4. After birth skin to skin contact and initiation of breastfeeding as soon as clinically possible
5. Continued support of mothers to breastfeed
6. Only providing supplemental infant formula when clinically necessary
7. Allowing mothers to stay in the same room as baby
8. Providing teaching for mothers to identify baby feeding cues
9. Providing instruction on use and risks of non-breast objects into baby’s mouth (such as pacifiers)
10. Coordination of follow up outpatient appointment at time of hospital discharge

Example. Boston Medical Center **successfully implemented** these policies to become certified as a Baby Friendly hospital and increased initiation of breastfeeding among new mothers.

Component 3: Hospital as Community Partner

Many community health activities have enormous value for preventing adverse outcomes and advancing equity. As major healthcare institutions, hospitals and health systems can play a direct or indirect role in supporting this work. We propose this third component of the Community Health and Equity measure to

reward these contributions. Key design questions for this component include:

Should the expectation be the same for all hospitals? Given the variability of community health needs, we propose that there should be a list of best practice standards for hospitals, with full credit for providing at least half of the standards.

We have proposed seven specific standards here for public comment and are interested in hearing about other options.

3.1. Proposed Best Practice Standard: Hospital performs a community needs assessment in collaboration with the department of health.

Background. As part of tax reporting requirements established by the Affordable Care Act, all non-profit hospitals are required to conduct a community health needs assessment every three years. Research on the [quality](#) of community health needs assessments has shown that collaboration with local health departments and consultant-led community health needs assessments are associated with higher-quality reports.

Best Practice Standard. Hospitals can follow the standard set by the [APHA](#) and collaborators stating that “hospitals should consult with both the state health department where the facility is licensed and the local health department where the facility is located.”

Example. The [Health](#) Planning Council of Northeast Florida is an example of a collaboration between several hospitals (the Mayo Clinic, Shands Jacksonville Medical Center, St. Vincent’s HealthCare and others) and health departments (including the Clay County Health Department, Duval County Health Department, and Putnam County Health Department). This group worked together to compile clinical and community data to develop a community health needs assessment for the area. Similar approach was taken by the [Health](#) Collaborative in Cincinnati, which included 20 hospitals, the Cincinnati Health Department, and the Hamilton County Public Health Department, among others.

3.2. Proposed Best Practice Standard: Hospital provides meaningful support for a community based hypertension control program.

Background. [Hypertension](#) affects almost 50% of the American adult population, and [African Americans](#) have earlier onset and more severe hypertension compared to whites. There are many modifiable risk factors leading to hypertension including diets high in salt and fat, lack of activity, and being overweight.

Given the high number of patients impacted by hypertension, and that it is largely treatable, hospitals have an opportunity to have high impact interventions. Further, as hypertension is largely a chronic

illness, and stems from many modifiable risk factors, several successful hypertension related interventions have stemmed from community and healthcare institution collaborations. Evidence based programs include: **community** led hypertension screening programs at **barbershops** and beauty salons, at **churches**, and a multifactorial community hypertension health **education** initiative. The **American Heart Association** Hypertension Practice Guidelines call for “population-based initiatives ...to reduce the global burden of raised blood pressure.”

Best Practice Standard. Hospitals can provide meaningful support for community-based hypertension control programs at barbershops and beauty salons and churches based on established evidence-based models. The standard can be met by major contributions of personnel and staff time, clinical coordination, or financial investments.

Examples. Initiatives in **New Orleans** and in **Dallas County** involved local barbershops and beauty salons for blood pressure screenings, health promotion, and referrals to care. The program in Texas showed a significantly higher percentage of people in the intervention barber shops had controlled blood pressure compared to others.

3.3. Proposed Best Practice Standard: Hospital provides meaningful support for a community based diabetes prevention program.

Background. One in ten US children and adults have type 2 diabetes mellitus, a number that has continued to increase over time. **Diabetes** contributes significantly to morbidity and mortality, increases the risk of vascular disease, and is the seventh leading cause of death in the US. Diet and activity modification programs such as those done in the **Diabetes Prevention Program** trial have been shown to decrease the incidence of this disorder. The group of participants with impaired glucose tolerance in the Diabetes Prevention Program trial had over a 50% decrease in the incidence of diabetes in participants within 2.8 years of the intervention. The **CDC** has developed a diabetes prevention curriculum from this intervention, which has been implemented in many communities through partnerships with nonprofit groups.

Best Practice Standard. Hospitals can provide meaningful support for implementation of a community based diabetes prevention program. The standard of meaningful support can be met by major contributions of personnel and staff time, clinical coordination, or financial investments.

Examples. The **Montefiore Health System** in New York, which includes 11 hospitals integrated the Diabetes Prevention Program into its health system through a partnership with the Young Men’s Christian Association of Greater New York. Several hospitals in West Virginia **partnered** with the state health department to implement the National Diabetes Prevention Program for employees or surrounding

communities, demonstrating significant return on investment and incentivizing hospital/health system investment in continuing these programs.

3.4. Proposed Best Practice Standard: Hospital provides meaningful support for an evidence-based home visiting program.

Background. Home [nursing](#) visit programs for new mothers and their babies have been shown to result in many positive health outcomes including: a reduction in child abuse and neglect, decreased prenatal maternal smoking, improved child cognitive performance, and lower likelihood that the mother has another birth while in her teenage years or early twenties.

The Nurse Partnership program in [Memphis](#) found that the participants in the program had lower risk of hypertension during pregnancy, mortality, suicide, drug overdose, and homicide. Babies in the program had lower rates of preventable mortality, homicide, and hospitalization during their first 2 years of life. The [American Academy of Pediatrics](#) recommends that pediatricians “be willing to participate in the planning, implementation, and evaluation of home-visitation programs in their communities.”

Best Practice Standard. Hospitals can provide meaningful support for an evidence-based home visiting program such as nurse-family partnership. The standard of meaningful support can be met by major contributions of personnel and staff time, clinical coordination, or financial investments.

Example. The [Welcome Baby program](#) through the Maternal and Child Health Access partnership with California Hospital Medical Center provides home visit services to new mothers, beginning when the baby is first born in the hospital. Since its inception in 2009, the program has been expanded to 14 hospitals.

3.5. Proposed Best Practice Standard: Hospital provides meaningful support for training and work of community health workers.

Background. Community health workers [are](#) “frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served.” Generally, community health workers are from the community that they serve, and share the attributes and life experiences of their clients. These individuals are trained to work with patients at home and in their places of work, study and worship to further health through education, support, and connecting patients to resources. Community health workers can engage with patients via multiple communication modalities including telephone contact and home visits.

There is substantial evidence supporting the use of community health workers in improving outcomes for patients with [diabetes](#) and [hypertension](#), among other conditions. Programs involving community

health workers to assist recently hospitalized patients may reduce potential for [readmission and](#) improve patients' ability to effectively engage with [preventive](#) care. The [American Hospital Association](#) recommends that “hospitals and health systems can incorporate community health workers into their workforce, extending care beyond the hospital or clinic walls to help bridge gaps in care, expand access to care and, ultimately, improve health outcomes for high-risk patients.”

Best Practice Standard. Hospitals can provide meaningful support to community health worker programs in the context of value-based care initiatives and in coordination with primary care services in the community. This standard can be met by the hospital itself hiring and training community health workers, or by making significant financial contributions to community organizations for a community health workforce.

Example. The [Greenville Health System](#) PASOs program, established in 2005, connects community members with community health workers, social workers, and health care providers with an emphasis on working with the Latino community in South Carolina.

Penn Medicine has provided financial support for the development of the [IMPACT](#) program at the [Penn Center](#) which has allowed community health workers to engage with thousands of patients in Philadelphia.

3.6. Proposed Best Practice Standard: Hospital makes meaningful contributions to supporting school success.

Background. Education and health are intrinsically linked. Higher levels of educational attainment are associated with lower risk of being overweight, smoking, and early death. [Chronic](#) absenteeism is associated with risky behavioral choices and poor school performance. A low literacy level is associated with worse health [literacy](#) and health [outcomes](#). Yet, across the United States there are great disparities in childrens' access to elementary and higher education. The [American Academy of Pediatrics](#) notes that “pediatricians and their colleagues caring for children in the medical setting have opportunities at the individual patient and/or family, practice, and population levels to promote school attendance and reduce chronic absenteeism and resulting health disparities.”

Best Practice Standard. Hospitals can make meaningful contributions to supporting school success through one or more of three types of activities:

1. Direct services, such as comprehensive school health services;
2. Collaborative work with education system officials to improve outcomes such as third grade reading or absenteeism; and

3. Strategic partnerships with schools to provide training and employment for graduates.

Example. A [program](#) in a Maryland county school system to provide the flu vaccine to children in school resulted in a significant decrease in elementary school absenteeism compared to the control group. The [Akron Children’s hospital](#) developed a partnership with the local school system to provide more in-school healthcare services. The [Dell Children’s Hospital](#) provided financial assistance to the Austin Independent School District, when it was facing a budget shortfall that could potentially necessitate laying off school nurses.

3.7. Proposed Best Practice Standard: Hospital meaningfully supports expanding access to fresh, healthy foods in the community.

Background. Food insecurity and limited access to healthy food is associated with worse cardiovascular disease outcomes and exacerbates health inequities in chronic diseases including cardiovascular disease and diabetes. Socioeconomically disadvantaged, rural, and racially segregated black and brown communities are disproportionately impacted by limited access to healthy affordable food. Furthermore, improving health food availability in communities is associated with improvements in chronic disease management for conditions including diabetes and cardiovascular disease. The Robert Wood Johnson Foundation’s Commission to Build a Healthier America has [recommended](#) that the health care system “create public-private partnerships to open and manage full-service grocery stores in communities without access to healthful food.”

Best Practice Standard. Hospitals can make significant investments to increase access to affordable healthy food in their communities consistent with recommendations from the [Commission to Build a Healthier America](#) through one or more of these activities:

1. Investing in development of grocery stores in low food access neighborhoods;
2. Providing financial support to community groups working on food access; and
3. Providing on-campus farmers markets with a majority of affordable items, acceptance of food benefits, and advertising to the surrounding community

Example. Kaiser Permanente supports a network of [farmers markets](#) at their clinical locations and in the community. Another example is the [St. Mary Medical Center Farm to Families Initiative](#) which provides affordable, healthy food to 1,000 families. The medical center also developed Fresh Connect, a healthy food delivery service and mobile open market to individuals in need of these services.

3.8. Proposed Best Practice Standard: Hospital invests in expanding or improving healthy, affordable housing in the community.

Background. The U.S. is experiencing a growing housing crisis. Since the great recession, the proportion of U.S. residents facing worst case housing needs, **defined** as people that do not receive housing assistance from the government, pay over half of income towards housing and have inadequate living conditions, has increased. Lack of access to affordable, safe housing contributes to poor **health** including increased risk of respiratory illness, toxic exposures, fall and **premature** death. Furthermore, research suggests that when housing costs consume a disproportionate share of household financial resources, individuals and families may forego other needed resources that support health such as purchasing healthy **foods** or paying for needed **medications**. The American Hospital Association that “hospitals and health systems can implement strategies and programs to improve housing stability.” Investments in housing fall into three categories: 1) financial support for **expanding** high quality, affordable housing 2) financial support for **assessment** and renovation of existing affordable housing and 3) **partnership** with local **community development financial institutions** or other community agencies to increase the supply of safe, affordable housing through redevelopment or revitalization initiatives

Best Practice Standard. Hospitals and health systems can make meaningful investments in increasing access to safe, affordable housing in safe and economically vibrant communities. To meet this standard, hospitals can make major contributions to one or more of the following:

1. Creating and sustaining community partnerships to improve economic and housing stability;
2. Conducting home safety and environmental hazards assessments, repairs, and renovations to improve housing stability, housing quality, and health;
3. Developing ;affordable housing units for disabled, elderly or chronically homeless individuals and families, and ;low-income families with children in their catchment area;
4. Partnerships with public housing authorities, nonprofit affordable housing developers, and others to increase access and availability of safe, affordable housing in safe, economically vibrant communities within their catchment area; and
5. Providing or supporting co-location of health services to meet the needs of chronically ill and high-needs populations in settings such as transitional housing and permanent supportive housing.

Example. The **Bon Secours** Baltimore Health System has invested in affordable housing units in the community. **Children’s** Mercy Kansas City’s Healthy Homes program provides assessments of home

safety and environment. [Nationwide Children’s Hospital](#) “Healthy Homes” program provides funding for renovation of existing properties and new homes for affordable rent. The initiative is [funded](#) through the Center for Community Investment grant program. Through the [Better Health Through Housing](#) program, the University of Illinois Hospital partners with the Chicago Center for Housing and Health to provide social and economic supports to connect patients with housing.

Component 4: Hospital as Anchor Institution

Hospitals and health systems are often among the largest employers and businesses in their communities. There are a number of actions that they can take as anchor institutions to advance and promote community health and equity -- as well as inspire other leading businesses in the community to do the same. We propose the fourth and final component of the Community Health and Equity measure to recognize these activities.

Key design questions for this component include:

Should the expectation be the same for all hospitals? Again, we propose that there should be a list of standards for hospitals, with full credit for providing at least half of the standards.

We have proposed six specific standards here for public comment and are interested in hearing about other options.

4.1. Proposed Best Practice Standard: Hospital has a five-year plan for achieving diversity in board and top management.

Background. Racial and ethnic minorities and women have significantly [lower representation](#) in hospital leadership, and disproportionately perform [lower paying jobs](#) in the United States healthcare industry. Reasons include institutional factors such as biased recruitment, hiring, and promotion practices. Diverse hospital leadership is likely better able to understand and effectively address community health and health equity.

Best Practice Standard. Hospitals can follow the recommendations of the [NAACP](#) to “develop a measurable and achievable goal for diversity in...top management ... and a five-year plan to accomplish it.” Key [components](#) of such plans can include:

1. Voluntary diversity targets;

2. Selecting a diverse candidate pool;
3. Providing mentorship to board candidates;
4. Consideration of non-CEO, non “traditional pipeline” candidates;
5. Term and age limits;
6. Larger board size; and
7. Board performance evaluation.

Example. Christus Health has worked to increase racial, ethnic, gender and age diversity in its leadership in several ways, including making leadership board diversity and inclusion goals in its organizational plan, monitoring diversity of the board, a requirement that at least 33% of the candidates in a board member hiring pool are “diverse.” These efforts among others have resulted in an increase in the percent of trustees identified as diverse racially (from 10 to 35%) and as women (from 10 to 40%). Equally importantly, a member of the board reported that the diversity of the board has improved its impact with “greater focus on community needs.”

4.2. Proposed Best Practice Standard: Hospital has a minority owned business purchasing and procurement goal and measures progress towards this goal.

Background. Income inequality has a **deleterious** effect on health outcomes, especially for those at the lower end of the income spectrum. Historically, minority communities have had less opportunity for economic development and investment due to governmental loan practices and systemic racism. Hospitals have enormous purchasing power, and thus have an opportunity to contribute to equitable economic opportunities by intentionally investing in minority owned businesses.

Best Practice Standard. Hospitals can make minority owned business purchasing and procurement goals and measure their progress towards these goals. This standard is based on the **NAACP** recommendation that “healthcare firms can begin tracking supplier diversity in greater detail and ask primary suppliers to include a specific level of diversity in their subcontracted work as well.”

Evidence. Several hospitals including the **University of Pittsburgh Medical Center**, the **Mayo Clinic**, and **Hopkins Hospital**. have stated minority owned business procurement policies and goals. **Kaiser hospital system** has such a policy and also requires that suppliers provide certification that they have diverse ownership including “minority, woman, LGBT, veteran, veteran-disabled, and disabled” individuals.

4.3. Proposed Best Practice Standard: Hospital pays all employees a minimum hourly rate based on the local living wage.

Background. A **living wage** is defined as the amount that a full-time working person needs to earn to cover basic living expenses and health needs of themselves and dependents. The living wage is generally higher than the federal minimum federal wage of **\$7.25** per hour. For every **\$1 increase** in earnings above the federal minimum wage is associated with a decrease in **low birth weight**, post-neonatal mortality, and rates of **smoking**. A minimum wage of \$15 per hour would reduce the **poverty** rate of female health workers by 27.1%. The Institute for Healthcare Improvement has **concluded** that “A living wage for healthcare workers is essential to achieve health equity.” ”

Best Practice Standard. Hospitals can establish a minimum wage based on the **MIT living wage calculator** for all hospital employees. This wage should be close to or exceeding \$15 per hour. This wage should apply to hospital contractors, such as cleaning services.

Example. The **University of Arkansas for Medical Sciences** established a minimum wage of \$14.50 per hour for all employees of the institution in 2018. This figure was based on the living wage in its home county of Pulaski County, Arkansas.

4.4. Proposed Best Practice Standard: Hospital supports access to affordable high-quality child care for children of all full and part-time employees.

Background. Access to high quality childcare and early childhood programs is a well-established strategy to improve **educational outcomes**, health, and economic productivity over the lifespan. Not only are such programs proven to improve educational outcomes and school **readiness**, they also support short- and long-term **long term** health outcomes and healthy behaviors such as decreased rates of smoking, hypertension, and increased self-reported healthy food choices. Women make up 76% of the healthcare workforce. Lack of childcare is associated with decreased **participation** of women in the workforce as in most western societies women have typically been charged with the financially uncompensated job of raising children. Thus, having access to childcare improves the economic opportunities for women. The **American Academy of Pediatrics** policy emphasizes the benefit of universal early childhood programs.

Best Practice Standard. Hospitals can provide meaningful support for all full- and part-time employees to support access to quality, affordable early education child care for their children. Hospitals can meet this standard by providing affordable, quality child care on site to all employees or by providing meaningful financial benefits to assist employees in obtaining quality and affordable childcare.

Example. **University Hospital Parma** provides childcare early childhood education and care to children of employees and physicians, and recently expanded the service to children of people not employed by the

hospital. Beyond hospitals and health systems, some [federal](#) government workplaces provide childcare for employees at registered on-site locations, with federal funding available to help lower wage earners afford the care.

4.5. Proposed Best Practice Standard: Hospital provides paid sick leave to all employees.

Background. Paid sick leave has both immediate and long term health benefits. Individuals with an acute illness are more likely to stay [home](#) if they have paid sick leave, which would decrease the spread of contagious illnesses to others. Further, employees with paid sick leave are more likely to have [preventative](#) health care (pap test, mammography, endoscopy, flu [vaccine](#)) and see a doctor compared to those without paid sick leave. Employees without paid sick leave are also more likely to [delay](#) seeking medical care for themselves and for family members such as their [children](#). The [AMA](#) “supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member.” In addition to the [AMA](#), the [National Association of County and City Health Officials](#) supports paid sick leave policy based on its positive impacts on public health.

Best Practice Standard. Hospitals and their contractors can provide paid sick leave to their employees, based on the [policy](#) adopted by the federal government for covered employers for COVID-19:

1. Two weeks (up to 80 hours) of **paid sick leave** at the employee’s regular rate of pay where the employee is unable to work; and
2. Two weeks (up to 80 hours) of **paid sick leave** at two-thirds the employee’s regular rate of pay because the employee is unable to work because of a bona fide need to care for others; and
3. Up to an additional 10 weeks of **paid expanded family and medical leave** at two-thirds the employee’s regular rate of pay

Example. [University of Rochester Medical Center](#) provides [10 days](#) of paid sick leave to all employees yearly. [Barnes Jewish Hospital](#) in St. Louis provides 23 days of paid time off to employees which can be used for vacation, sick leave, or other purposes.

4.6. Proposed Best Practice Standard: Hospital adopts a “do no harm” collections policy.

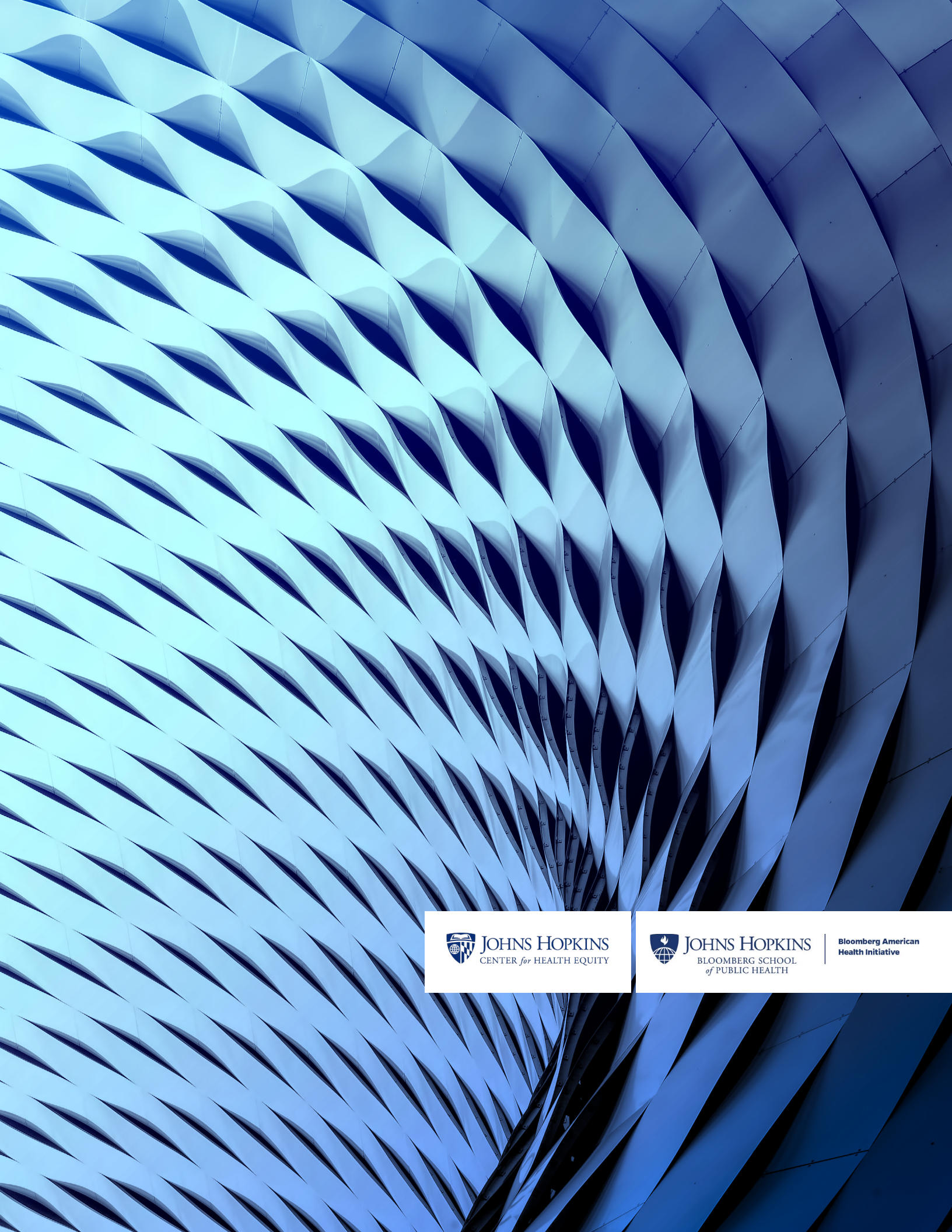
Background. An article from the New York Times in 2019 reported that “hospitals across the country are increasingly [suing](#) patients for unpaid bills, a step many institutions were long unwilling to take.” Medical [debt](#) is associated with delays in medical care and treatment. Further, among individuals who experience

homelessness or have less than a 12th grade education, debt collection is **associated** with a decrease in healthcare utilization. Importantly, medical debt can affect patients regardless of their insurance status. The **American Association of Medical Colleges** has stated, “The mission of every hospital in America is to serve the health care needs of people in its community – part of that commitment includes treating patients with dignity and respect from the bedside to the billing office.”

Best Practice Standard. Hospitals can adopt four **recommendations** made by Community Catalyst to assure that their billing practices are reasonable. These are:

1. Base eligibility for financial help on need, not insurance status;
2. Adopt a Do-No-Harm collections policy, which prioritizes establishing reasonable payment plans over legal actions;
3. Stop wage garnishments; and
4. Provide training to hospital staff about financial aid policies and legal requirements.

Example. The **St. Luke’s University Health Network** in Pennsylvania provides a financial assistance program which includes patients with insurance.



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