Measuring Hospital Contributions to Community Health with a Focus on Equity

Response to Comments

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Introduction

In August 2020, we proposed a draft measure to assess how hospitals contribute to community health, with a focus on equity. Our goal was to develop a new kind of measure, different from traditional assessments of patient satisfaction and the quality of clinical care – a measure reflecting changing expectations for the relationship between hospitals and their communities. Our draft proposal included four components: health outcomes at the county level, and best practice standards for hospitals in their roles as clinical providers, community partners, and anchor institutions.

We solicited public comment online and through more than a dozen meetings with hospital representatives and others. More than 100 people and organizations responded, among them urban and rural hospitals and hospital systems, hospital associations, housing, health equity researchers and advocates, departments of health, and health plans. Collectively, we received more than 600 discrete elements of feedback.

Many of these comments were positive. Some hospitals expressed that the proposed practices are "very much aligned with things we … are doing" and others appreciated the recognition of "the important role of hospitals as key community stakeholders." Some comments noted that this measure could encourage hospitals to "leverage our operations and resources in partnership with [the] communities we serve." Several comments also lauded the innovation of the measure and highlighted the significance of this proposal, noting that the measures reflect hospitals' responsibilities to their communities more than other existing recognition programs.

Other comments provided constructive suggestions or expressed concern about the draft proposal. This document provides our responses to these comments, including numerous revisions made in response. This document is organized into a section on general topics, followed by sections corresponding to each of the four proposed components.

We would like to share three general observations.

First, the breadth and depth of the response to the draft measure reflects broad interest in hospital contributions to community health and equity and validates the importance of including such a measure in major hospital rankings. We have done our best to update the proposal, but we respect that there is plenty of room for alternative decisions.

Second, there is an urgent need to develop reliable and valid data sources for hospital contributions to community health and health equity. Multiple comments noted that many elements of our proposed measure leave room for interpretation and rely on self-report by hospitals. Others pointed out that the standards rarely assured that efforts to advance community health specifically addressed equity considerations. These criticisms are fair, and where it has been possible to address them, we have made changes. In numerous instances, however, data on community health and equity are lacking. Fixing these gaps should be an urgent priority, and the approach should be improved and adapted each year.

Third, many comments expressed the view that the traditional measures of patient satisfaction and the quality of care incorporated in hospital rankings do a poor job of measuring and incorporating accountability around hospitals' success in advancing equitable healthcare across access, quality, outcomes, and patient experience. Cited gaps include inadequate assessment of clinical data by race and ethnicity, preferred healthcare language, and other relevant patient characteristics. While outside of the scope of our effort, these comments deserve careful consideration and a robust response. IBM Watson Health 100 Top Hospitals and other leading hospital assessment

programs should consider establishing a cross-disciplinary steering committee on measurement and accountability for advancing equitable healthcare to inform current recognition and award programs and incorporate equity as a central pillar for future programs. In other words, hospitals and health systems that are making strides towards delivering equitable healthcare and eliminating healthcare disparities should be identified and rewarded.

We appreciate all of the comments, and we look forward to continued engagement in the future.

Major Topics

Equity

Several comments recommended that, at the outset, equity needs to be defined and that the proposal should more clearly distinguish community health, equity, health equity, and healthcare equity/equitable healthcare. The revised proposal further clarifies the definitions already included. In particular, it clarifies distinctions between the terms equity, health equity, and equitable healthcare. Accordingly, the new title is "measuring hospital contributions to community health–with a focus on equity."

Equity focuses on just and fair access to what people need, which is distinct from equality, which emphasizes uniformity or access to the same resources for everyone, without consideration for individualized needs. Health equity is achieved when everyone has a fair and just opportunity to be as healthy as possible. Progress towards health equity is **measured** in terms of reducing health disparities, which are **defined** as "meaningful differences in health status closely linked to disadvantage."

Equitable healthcare is one of the six aims for optimizing healthcare quality outlined in the landmark quality and safety report, **Crossing the Quality Chasm**, which defines equitable healthcare as healthcare that "does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status." In keeping with contemporary definitions of equity, an equitable healthcare system is one that would provide every patient with what they need to achieve optimal health.

For the proposed measure, the focus is not on equitable healthcare, which, as noted in the introduction, deserves a serious examination from hospital recognition programs. Rather, our focus is on applying equity and health equity principles within the context of a proposed measure of community health. As the proposal indicates, many of the standards directly relate to core issues of equity in access to the environments, partnerships, and community resources that represent essential pre-conditions for achieving optimal health. Advancing community conditions to reduce disparities within and between communities is a driving focus that is intended to carry across all domains and metrics.

Within this focus, many comments asked that the measure reference equity, health disparities, and racial justice considerations more explicitly across the proposed metrics. One comment stated, "As applicable, all of these standards should seek to assess relevant equity gaps and measure closure of these gaps by race/ethnicity and income." At the same time, several comments pointed out challenges related to measuring disparities between groups directly, including the availability and reliability of data, and the difficulty identifying measures that work across different types of hospitals and communities. For example, some comments noted that assessment may be particularly challenging in communities where the population is less racially diverse. We strongly support development and adoption of metrics and standards that work through these challenges and ensure that progress advances health equity, including racial equity. Fundamentally, an equity-driven approach requires attention to populations of greatest need, marginalized populations, and populations disproportionately at risk of disparate outcomes.

Fairness

Comments generally acknowledged that hospitals have a role in promoting community health and equity, but many comments questioned the fairness of a measure devoted to this topic. Concerns about fairness included the following:

- Whether hospitals have a responsibility to address "societal problems." Comments suggested that the responsibility also lies with the government, the private sector, and individuals; and that these institutions should also be encouraged to invest in public health. Specifically, there was concern that further engaging in the responsibilities associated with improving community health might impose undue financial burden on health care systems and reduce the urgency of action on the part of others.
- Whether hospitals should be concerned about so many aspects of community health. Some comments noted that many of the domains covered by the proposed measure fall outside of a hospital's traditional healthcare skill set, and should best be handled by others.
- Whether hospitals can make a meaningful impact on community health at all, given the vast scale of social challenges in many communities.
- Whether resource-poor hospitals would be disadvantaged by this measure, because they have less ability to invest in community health and equity. As one comment stated, "emerging evidence suggests that hospitals disproportionately serving patients with social risk factors for poor health outcomes may be more likely to fare poorly on care quality rankings and to receive financial penalties, and less likely to receive financial rewards etc."
- Whether it is fair to apply one set of standards to a very heterogeneous hospital industry. Comments noted differences in density of hospitals within the county geographic measurement area, rural versus urban location, not-for-profit versus for-profit, strength of safety net and support services (like nonprofits), and population served (pediatric vs adult, insurance status, underlying risk factors, prevalence of different health conditions). It was noted that several of the standards do not apply to pediatric hospitals.

We appreciate these concerns, but do not think the difficulty of the task should preclude getting started in measuring hospital contributions to community health with a focus on equity. Indeed, clinical healthcare only contributes to approximately **10-20%** of health outcomes. However, as healthcare providers, community partners, and anchor institutions, hospitals have opportunities to make major impacts on the health of their communities, through clinical care and beyond. As stated in one comment, "We appreciate the basic concept of the framework – that is, to reflect the enormous efforts that hospitals and health systems undertake to contribute to the health and well-being of their communities, and to reduce health care disparities." Indeed, the mission of many hospitals specifically references community service, and hospitals have implemented model programs for every aspect of the measure that we proposed.

We do not believe that greater hospital focus on community health will reduce the urgency of a public sector response to community health concerns. Our view and experience is that to the contrary, hospital engagement often leads to greater demands on the public sector to move forward. We have added language e noting that hospital engagement in these issues should inspire and not discourage others from addressing key contributors to community health and equity.

In general, we do not believe the proposed measure will disadvantage resource-poor institutions. Many public and safety net hospitals are pioneers in developing programs to address critical

community needs. Many of the proposed best practice standards do not require significant resources to implement. The approach of measuring progress in community health – rather than the absolute value – provides greater room for improvement for hospitals in areas where there is much progress to be made.

The proposed measure provides significant flexibility for hospitals of different kinds to identify the standards that are most applicable in their communities. The measure does not require "one size fits all"; rather it provides a menu of valuable steps informed by evidence that can save lives.

Community Priorities

A number of comments raised the question of whether the measure could accurately assess the match between hospital activities and community priorities. As one comment stated,

We do not take issue with the standards proposed; however, there is risk in prescribing standards without knowing the unique needs of the community in which the standards would be applied. In many ways, the community must dictate the unique standards that will lead to better outcomes for that community.

To address this issue, one comment proposed rewarding hospitals for aligning the interventions they choose with the findings of the community needs assessment. Another idea was to adjust the way that hospitals are scored based on the focus areas identified in the community health needs assessment. One respondent suggested that there be explicit language emphasizing that standards should be implemented based on community and patient need. Also suggested was that hospitals report the top one to three health conditions and top one to three social determinants of health-related needs of their hospital, and then explain what interventions they are using to address these needs.

We agree with the premise that hospital activities should meet community needs. However, it is not feasible for a ranking system to assess community activities of many hospitals, ascertain the priorities of each community, and compare the two. It would be possible, however, for a measurement process to involve the public disclosure of hospital activities and to encourage local community organizations to engage with hospitals around them. In this way, a ranking system can spark critical local conversations. We have updated the proposal to recommend such disclosure as part of the ranking process.

Measurement and Scoring

Several comments called for greater clarity in how hospitals would be scored on this new measure. For Component 1, we proposed giving hospitals full points if the counties fall into the top tertile of improvement in decanal trend in any of the measures used. Hospitals in counties without health improvements to this standard would not receive points. We plan to continue with this approach, with some modifications to potential measures as noted in the discussion for Component 1.

For each of the Components 2 to 4, we proposed providing full credit for hospitals that report meeting at least half of the best practice standards. Upon adding new standards, we also incorporated an opportunity for partial credit in component 4, which contains best practice standards that are widely applicable to many different types of hospitals and health systems. We propose that hospitals can receive half credit for meeting more than four of the eight standards, or full credit for meeting more than six of the eight standards.

Some comments expressed concern about relying on self-report. To improve accountability, we have modified the approach by recommending that the self-report form include an optional link to a website that explains how the hospital meets the standard. We also recommend that the hospital self-report forms be available on a website that is publicly accessible. Other comments recommended identifying specific outcome data for each sub-component in the report, and encouraged hospitals to collect and report data on these measures. We agree that identifying data for each standard is a good idea that would offer a more rigorous way to evaluate the quality of hospital efforts. However, it is our view that this would be too burdensome an effort at this time, especially for lower-resourced hospitals.

Many comments outlined additional limitations of collecting data on the proposed best practice standards through a survey. Some emphasized the difficulty of distributing the survey to appropriate individuals at each institution who would be able to respond, and others expressed concern that initial response rates would be low. We recognize that robust evaluations would yield more accurate data than self-report on surveys, but such an undertaking is unrealistic at this time. Despite their limitations, surveys provide helpful information, and will illustrate a hospital's efforts to contribute to health equity as outlined in the report. We will endeavor to define the measures as precisely as possible in the survey to ensure standardized interpretation and responses. We also recognize that it is unlikely that a single individual at a hospital will be able to complete the entire survey; this information may take some effort to collect, but it is a surmountable challenge given enough time.

Other comments requested clarification on how these equity measures will be integrated into IBM methodology, with some expressing concern that these measures might be implemented too rapidly without giving hospitals a chance to understand and respond to them. We will pass these concerns to IBM.

One comment suggested a phased roll out of the measure, where hospitals would be rewarded for just submitting the self report measures, and then in the second year hospitals would be scored on the content of their submission. We believe that given the existence of standards in this area, it is fine to begin scoring this year.

Relationship with Community Benefit

Several comments noted that the proposed measure does not track federal standards for community benefit reporting for nonprofit hospitals. One comment expressed concern that hospitals could score poorly on this measure despite having high levels of community benefit spending. Conversely, others noted that hospitals could invest heavily in implementing practices in this measure without getting credit for community benefit spending. Several comments also were concerned about potential confusion surrounding differences in what activities are reported for this measure versus those reported for community benefit purposes on the federal and state levels.

We agree that the standards in this measure do not align directly with current community benefit spending requirements. Much of community benefit spending is focused on providing healthcare for individuals in financial need, which is beyond the scope of this measure. However, to the extent that hospitals use community benefit spending to support important community health efforts based on evidence, hospitals are likely to fare well on component 3 of the measure. Additionally, several comments appreciated that the proposed measure was far more broad than community benefit reporting and could be applied to all hospitals, public or private. Our view is that this type of measure complements, but does not compete with, community benefit requirements.

Component 1

Summary

In component 1, we proposed outcome metrics for community health: the trend in life expectancy and trend in preventable hospitalizations at the county level over time.

Many comments pointed out the limitations of these metrics for equity, which we recognize. Identifying outcome metrics of community health equity applicable to US hospitals should be a high priority.

We remain supportive of using these outcome metrics so that one component of the overall measure is based on health improvement. Based on a comment, we support using years of potential life lost as an alternative to life expectancy.

We recommend that this component be reviewed each year for potential changes based on the emergence of alternative data sources and methodologies.

General Comments

Many comments supported the idea of including a component devoted to improvement in community health outcomes as a complement to process metrics reflected in the other 3 components. One stated, "I appreciate the wording that 'improvement' would be part of a measure" as "it is difficult to assess any intervention with varying populations, resources, and starting points of health."

One comment asked whether it would be more appropriate to look for improvements in the health of patients seen by the hospital, rather than the health of the surrounding community. We disagree. Our purpose with this metric is to explore hospital contributions to their community, including but not limited to acute care provided to patients.

Several comments questioned the use of county as the geography for improvement. These comments noted that there are vast disparities even within counties, and that census tract or zip code may be most appropriate for understanding health. Emphasizing this point, one comment stated:

For example, Cook County is the 3rd largest county in the country. Cook County has over 5 million people and nearly two dozen hospitals.

We chose the county level for two reasons: it is relevant to all hospitals, and data is readily available. There is no available mechanism to attribute the catchment area of all hospitals to specific zip codes or census tracts. In our view, the right question is not whether there might be a better way to examine health for a specific hospital, but rather whether there's value in looking at county health for all hospitals. We see value in hospitals caring about the trajectory of their county in overall population health, even if there are many millions of people who live there.

Several comments called for risk adjustment, with one noting that "smaller safety-net hospitals working with the most vulnerable populations will score lower (or not receive credit) if their service area has the worst disparities and/or worse-than-average outcomes." Similarly, another comment noted that safety net hospitals will have more preventable hospitalizations than hospitals in wealthier areas. However, the proposed metric assesses improvement over time, not the state of population health. Hospitals in areas with lower population health metrics at baseline have the greatest room for improvement.

One comment suggested assessing improvement in these metrics for a decanal trend was too long and suggested five years. Another comment supported the decanal trend. A third suggested that shifts in life expectancy are more likely to happen over generations. We chose the decanal trend based on its use in other research looking at shifts in life expectancy over time.

One comment expressed concern about a free rider problem – that hospitals might get credit as the county's health improves even when other local hospitals contributed much more to the improvement. Such hospitals should fare worse on other components of this metric. We appreciate this concern, but still think it is justifiable to have all counties oriented towards improved population health.

One comment suggested using an average of county metrics when hospitals are on the border between two counties. We appreciate the rationale, but there is no standard for determining which hospitals would merit this adjustment.

Many comments expressed concern about a rating holding hospitals accountable for outcomes outside of their control. One comment stated "Both measures will be difficult for hospitals to control the outcomes, therefore I am not confident the fairness to the hospitals in utilizing this measure for Top 100." Without a doubt, there are many factors that are partially or primarily outside the control of hospitals that affect both life expectancy and preventable admissions. For life expectancy, these include community efforts to reduce inequality, community investments in prevention, changes in unhealthy behaviors in the population, and others. For preventable admissions, the quality of and access to primary care is critically important. In all of these cases, hospitals can play a constructive role, through direct activities and advocacy for more effective public policy. The purpose of having a small portion of this metric align with community health outcomes is to recognize this connection and incentivize hospitals to contribute where they can.

A number of commenters pointed out the limitation of the proposed metrics of population health for equity. Their concern is that overall population health improvements may mask growing inequalities, as the healthy get healthier and communities at risk continue to suffer. As one comment stated,

> **"You simply can't claim to focus on equity if you're relying on county level data, which effectively masks profound inequities at the zip code, and particularly at the census tract level in urban communities across the country."**

This comment and others suggested utilizing metrics that assess disparities by geography within the county or by race and ethnicity. We support adding a metric or metrics of equity at the population level. Unfortunately, we did not identify a readily available metric that could be applied to all hospitals. We consider identifying such a metric a high priority for the advancement of equity generally, not just for hospital rankings.

One comment suggested exploring a metric of disparities in the rate of infant mortality or low birthweight by race; such a metric is not readily available but could be calculated from vital statistics data. Another potential approach would be to assess racial and ethnic disparities in the two metrics proposed here; however, such data are not available presently. A different way of tackling this problem might be to identify a metric at the state or regional level for equity; however, these would be less directly connected to a specific hospital's efforts. A number of comments suggested using metrics of economic, social inequality or deprivation rather than health metrics.

We considered whether the absence of a compelling equity metric at the county level should keep us from using these two available and broad metrics of population health. Our conclusion is that it

is better to start moving on population health outcomes than to wait. Doing so rewards hospitals that have supported improvements in community health by improving equity, supporting specific populations and communities with the greatest needs.

Life Expectancy

Several comments supported the use of life expectancy, recognizing that "life expectancy is a slow-moving outcome and can take years to see improvement."

One comment suggested the alternative of premature death or years of potential life lost, on the grounds that it is a better measure of healthy life. The comment stated "The goal is not to extend life 'at all costs' but to decrease avoidable premature death." We chose life expectancy because it is considered a standard metric in population health, but we agree that premature death or years of potential life lost could be acceptable alternatives.

One comment pointed out that there are "many confounding factors [that] can impact life expectancy (gentrification, epidemics, pandemics, natural and/or political disasters) – if we cannot account for these confounding factors, life expectancy is not viewed as a useful measure." The comment suggested using a metric of economic inequality to assess for gentrification. We agree that a limitation of life expectancy is the potential for major demographic shifts to lead to changes, especially over a decade. A methodology could be developed to not credit a hospital when metrics change in the face of large demographic shifts. However, we are not aware of a methodology to do so at this point in time. It is also the case that the COVID-19 pandemic will affect life expectancy in unpredictable ways. This metric should be reassessed as the data from the COVID-19 era are considered.

Avoidable Hospitalizations

One comment stated that preventable hospitalizations are a "meaningful health outcome", and suggested combining it with a metric of economic inequality to provide a "population view of impact".

Another comment suggested that instead of preventable hospitalizations, we should assess inappropriate emergency department utilization. We chose the former because it is a metric of health status, whereas the latter is a metric of healthcare resource utilization.

Alternative Metrics

The most commonly recommended alternative metrics were related to birth outcomes, including infant mortality and low birthweight. As one comment pointed out, infant mortality is a standard metric of population health. The major challenge with using these metrics for this purpose is small numbers in many counties. Addressing this challenge requires a methodology that aggregates over time. An alternative is low birthweight, which because of small numbers still requires six years of aggregated data by County Health Rankings. This metric could be utilized with the caveat mentioned. As noted above, racial disparities in birth outcomes are promising metrics for health equity.

Alternative metrics proposed include maternal mortality, which is a critical population health issue but even more subject to challenges of county level measurement. Some comments recommended social and economic metrics, which are critical upstream contributors to health. We support using health metrics to keep the focus on health outcomes, understanding that these social and economic factors do have their expression in core health metrics.

Component 2: Hospital as a Healthcare Provider

Summary

In component 2, we proposed eight best practice standards that hospitals can engage in under the role of healthcare provider to promote community health. In general, there was strong support for these best practice standards, with all of them earning an average score of at least 4 out of 5 in our survey, with 4 being "agree" and 5 "strongly agree." The majority of the comments recommended changes, updates, or clarifications to specific best practice standards. One comment described component 2 as "well organized from patients entry to hospital to exit from the hospital."

Based on the comments, we clarified language about what practices and populations are included, and in some cases added additional elements to the standards. We also added new best practice recommendations addressing screening for alcohol use, ways a hospital can support resilience among older adults, and social needs screening and follow-up. We also identified suggestions for development of future best practice standards in this category.

2.1 Hospital is a comprehensive tobacco-free campus

One comment stated "by providing a tobacco-free campus, hospitals can protect their patients, visitors and employees from secondhand smoke, reinforce tobacco-free norms, and demonstrate their commitment to a healthier community." The average score for this standard was 4.7 out of 5, with 4 being "agree" and 5 "strongly agree."

Two comments pointed out that having a smoke-free campus may already be implemented by many hospital campuses. Another comment brought attention to the importance of and **recommendation for** inclusion of electronic cigarettes in tobacco-free policies. Electronic cigarettes are of particular risk to young people, and youth who smoke **e-cigarettes** are more likely to smoke cigarettes in the future. We adjusted the language to explicitly reflect a ban on all tobacco containing products, which includes electronic cigarettes.

One comment stated that reducing tobacco consumption may not be a priority intervention for some communities. Smoking continues to be the **greatest contributor** to preventable mortality and morbidity in the United States, leading to 1 out of 5 deaths, and with up to 25% of US adults continuing to smoke. Hospitals that focus on other interventions can still support a smoke-free campus and improve health.

One comment expressed concern that since enforcement is not defined in this best practice standard, there may be "gamesmanship by way of interpretation." However, there is no recommended standard for enforcement of campus smoking restrictions. When one becomes available, it could be added to this best practice standard.

One comment suggested there might be potential negative impacts on community relations by such a standard, and emphasized the importance of redirecting those who wish to smoke to smoking cessation resources or off campus smoking locations. We are not aware of evidence of negative impacts of these policies on community relations.

2.2: Hospital has a tobacco use screening and cessation program that is initiated while the patient is hospitalized

One comment stated that "by including tobacco cessation screening and treatment as a best practice standard to be measured, hospitals will likely increase the number of patients who receive evidence-based interventions, help more patients to quit and reduce the terrible toll of tobacco in the community." The average score for this standard was 4.3 out of 5, with 4 being "agree" and 5 "strongly agree."

One comment noted that few children are smokers, therefore establishing a smoking cessation program would be a low-yield investment at childrens' hospitals. We disagree. Pediatric use of tobacco products, including electronic cigarettes, is a significant public health concern, as many consider nicotine addiction to be a pediatric disease.

One comment emphasized the importance of identifying and reaching population groups that are known to be most impacted by tobacco use. We have added this concept to the background section.

One comment suggested mentioning the 2012 Joint Commission and 2008 update to the Public Health Services' Guidelines surrounding the importance of "identifying and documenting tobacco use status" in addition to treatment in the health care setting. Screening is already included as a recommendation in the best practice standard, however we have updated the name of the best practice standard to reflect the screening portion in addition to treatment. Additionally, we updated the language of the best practice recommendations to reflect the actions that can be taken in the inpatient hospital environment, directly quoting the US Surgeon General smoking cessation recommendations.

One comment requested clarification on the meaning of designated treatment coordinator. The intention behind this recommendation is the development of a job position that will allow for at least one person to have dedicated time to work on the development and implementation of a tobacco cessation program. After updating the language as described previously, the designated treatment coordinator reference was removed, so we did not include clarifying language.

2.3: Hospital encourages healthy food choices

Several comments supported the inclusion of this best practice standard, saying it "leads by example" and that "healthy food choices and education on healthy nutrition [helps] to avoid and reverse overweight and obesity." The average score for this standard was 4.4 out 5, with 4 being "agree" and 5 "strongly agree."

One comment noted that a healthy food policy does not necessarily address food insecurity. Recommendations included inclusion of a hospital based food pantry and/or connecting with community partners to better implement programs that address food insecurity. Community partnership to improve food access is addressed in Component 3. We did not add this to the standard because the NYC Department of Health and Human Services standard did not include food pantries, and further food pantries are included in 3.7.

Several comments called for additional aspects to be included in the best practice recommendation including adding that the hospital cafeteria should employ "targeted subsidies using [a] behavioral economics approach" (nudges, signage, pricing), add post-operative meal delivery or food boxes with follow up appointments, incorporate the American Heart Association Food and Beverage

Toolkit recommendations, and incorporate a physical activity related recommendation. These are all good ideas, and indeed, there are a multitude of interventions that may support healthy food choices and a healthier lifestyle. However, for the sake of creating an impactful yet reasonable expectation of hospitals, we propose that hospitals meet at least five of the eight New York City Department of Health and Human Services best practice standards for cafeteria food. As evidence develops, some of these other ideas can be considered for future incorporation.

Several comments addressed the specific recommendations within the best practice standard: including "full sugared beverages" in the fourth recommendation, directly addressing whether the establishment has deep fryers, and removing the reference to salad bars given current COVID-19 eatery restrictions. We did not make these changes, rather we updated the standard to reflect the New York City Department of Health and Human Services guidelines, which have more precise language surrounding what is required of hospitals.

2.3 Hospital encourages healthy food choices was renumbered as 2.7.

2.4: Hospital provides buprenorphine treatment for opioid use disorder in the emergency department

Multiple comments supported a standard for treatment of opioid use disorder. The score for this standard was 4.2 out of 5, with 4 being "agree" and 5 "strongly agree."

Three comments identified the need for broader opioid use disorder services, such as improving access to case management; or increasing the number of waivered providers in primary care, and naloxone provision through the emergency department. These are important ideas that should be implemented on a wider scale to respond to the overdose crisis. Our goal here is to start with an easily measured and important intervention that can be one piece of a comprehensive approach. Some of the additional suggested best practice standards would involve healthcare entities outside the hospital (e.g. primary care physicians). Prescribing buprenorphine is an easily accessible solution for the majority of hospitals and can be paired with additional actions. In the future, this best practice standard should be expanded to a more full set of services for opioid use disorder.

One comment argued that this standard is not relevant to pediatric hospitals, as overdose in the pediatric setting is rare. While it is true that the prevalence of opioid use disorder is greater in adults than children and adolescents, opioid use disorder exists in the pediatric population, where it is often underappreciated— even after cases of overdose. Ensuring access to evidence-based medication for people of all ages is an important part of hospital care within the context of the overdose epidemic.

Two comments addressed the challenges related to buprenorphine prescribing, including the need for individual clinicians to obtain waivers to prescribe buprenorphine, and the mosaic of state laws that regulate prescribing. These challenges are real, but can be overcome. Buprenorphine initiation from the emergency department is becoming increasingly widespread, with multiple expert associations recommending its widespread implementation.

2.4 Hospital provides buprenorphine treatment for opioid use disorder in the emergency department was renumbered as 2.3.

2.5: Hospital runs a hospital-based violence prevention program

Multiple comments supported the idea of a best practice standard on violence prevention. The average score for this standard was 4.2 out of 5, with 4 being "agree" and 5 "strongly agree."

Several comments emphasized the value of incorporating wrap-around supports, partnering with community organizations and resources, and ultimately working towards system-level change. The best practice standard from the national network already includes linkage to community based services. We have clarified that these community based services can include mental health services as described in the best practice standard.

One comment asked for clarification on what defines interpersonal violence. Interpersonal violence refers to bodily or other harm inflicted on an individual by one or more other people. We have added this definition to the best practice standard.

Several comments indicated that some hospitals do not have the financial resources to support such a program. We placed this best practice standard in component 2: hospital as a healthcare provider because many believe these services are a necessary part of clinical care, critical to preventing further violence. There are emerging models for reimbursement for violence intervention programs. Including this best practice standard should be helpful to efforts to strengthen reimbursement.

2.6: Hospital screens for intimate partner violence and refers to services and supports as needed

Several comments supported the idea of a best practice standard for screening and referral for intimate partner violence. The average score for this standard was 4.5 out of 5, with 4 being "agree" and 5 "strongly agree."

One comment suggested that guidance should be given regarding the age to begin screening for Intimate Partner Violence (IPV). We have updated the language to include this information.

One comment suggested broadening the language to include people of all gender affinities. Indeed, all people are at risk of IPV - at least 1 of 3 men are affected by intimate partner violence, and transgender individuals are up to 1.7 times more likely than cisgender individuals to experience any type of IPV. Despite this high prevalence, the US Preventive Services Task Force reported that there was "no valid, reliable screening tools in the primary care setting to identify IPV in men without recognized signs and symptoms of abuse," nor are there widely accepted screening tools for transgender individuals. We encourage hospitals to adopt broader screening approaches and support updating this best practice standard as guidelines become available.

One comment suggested including a clear outcome, such as number of resolved referrals. Tracking sch an outcome metric is a good idea for a hospital to adopt. However, for the purpose of this best practice standard, it is not possible to require or include a standard approach for data reporting.

2.7: Hospital offers an infant safe sleep education program

Comments expressed support for a safe sleep education program, including that "screening for safe sleep practices post-discharge is important." The average score for this standard was 4.6 out of 5, with 4 being "agree" and 5 "strongly agree."

One comment emphasized the importance of family education, citing that the behaviors modeled by nurses in the hospital influence home family behavior. We have incorporated **language** to reflect the importance of both modelling safe sleep behaviors and family education in the inpatient **setting**: "Health care professionals, staff in newborn nurseries and NICUs, and child care providers should endorse and model the SIDS risk-reduction recommendations from birth."

One comment recommended that the best practice standard be narrowed to specify that only staff who work on mother-baby units should be required to be trained on safe sleep practices. We updated the language to reflect this point.

2.7 Hospital offers an infant safe sleep education program was renumbered as 2.9.

2.8: Hospital adopts 10 practices to support breastfeeding

There was support for inclusion of this "lead by example" standard to encourage the practice of breastfeeding. The average score for this standard was 4.5 out of 5, with 4 being "agree" and 5 "strongly agree."

One comment suggested that the name of the best practice standard should be renamed to be more reflective of the fact that the goal is to increase breastfeeding rates. We updated the name to improve clarity.

One comment addressed whether hospitals had to receive the official "baby friendly" status label in order to get credit for promoting breastfeeding. The concern was raised that receiving this official designation may require hospitals to expend financial resources, which could be limiting to hospitals in low resource settings. We have clarified the proposal language to make clear that hospitals may receive points for this practice by implementing all 10 recommended practices; however, they do not need to receive official "baby friendly" recognition from the WHO.

One comment suggested that it is unreasonable to expect that mothers and babies should be able to co-room in all hospitals, particularly in neonatal intensive care units of some hospitals which may be open bay. We have clarified that this recommendation does not include the neonatal intensive care unit if not designed for parents.

One comment suggested that the recommended baby friendly policies should be balanced with considerations of the mother and her emotional needs. The comment stressed the importance of encouraging aligned messaging from clinical providers that come into contact with the mother. Consideration of mothers and their emotional needs is entirely consistent with practices that support breastfeeding.

2.8 Hospital adopts 10 practices to support breastfeeding was renumbered as 2.10.

Component 2: Suggested Best Practice Standards

We received many suggestions of new best practice standards. Our criteria for adopting new standards were the same for our original list of standards, and include a basis in evidence, a defined best practice, an example of a hospital or hospitals that meet the standard, and applicability nationwide.

Several comments suggested best practice standards related to alcohol use disorder. Alcohol contributes to significant preventable **mortality** (estimated cause of 255 deaths per day in the US from 2011-2015) and morbidity (for example, use is associated with poor **mental** health outcomes in children/adolescents). Further, there are racial **disparities** in the accessibility of alcohol, with liquor stores more likely to be located in neighborhoods that have low income and Black residents. We have added a new practice for hospitals to screen all patients in the emergency department for alcohol use disorder using the screening, brief intervention, refer to treatment (**SBIRT**) approach recommended by the **ACEP** and **SAMHSA**. SBIRT screening in the **emergency department** has been associated with decreased levels of alcohol use, injury, and return emergency department visits. The role of emergency medicine physicians to screen patients for alcohol using the SBIRT approach is supported by the **American College of Emergency Physicians**.

Other comments recommended interventions to address other substance use challenges. These included that hospitals calculate total morphine equivalent dose per patient encounters, have opioid disposal at the hospital,provide disposal kits with opioid prescriptions, and implement patient education about opioid use. They also included hospitals having a mobile tobacco cessation program, and tobacco cessation education for community and health professionals. We have already included some best practice standards on opioids and tobacco and believe additional steps should be considered as evidence and practice standards evolve.

A number of comments recommended a best practice standard addressing the unique health needs of the elderly population. This age group has a **disproportionately** high number of preventable hospitalizations, which can pose serious health risks. Thus, it is more important than ever to develop interventions aimed at optimizing preventative care and quality of life for this age group. The **Age Friendly Health** system approach is an evidence-based set of recommendations to improve healthcare services through a four-pronged approach developed for the hospital setting addressing mobility, mentation, medication, and considering what matters to the patient. We have incorporated a new best practice standard based on several of the Age Friendly Health recommendations that relate to the prominent community health challenges of **fall** prevention and optimizing **mobility**. These health issues all significantly contribute to quality of life and preventable health consequences for people of advanced age.

Several comments recommended developing a best practice standard around screening patients for social needs and connecting patients to resources based on this assessment. The impact of social needs such as **food insecurity**, **transportation**, and **housing** on **health** is well documented. Screening for social needs and connecting patients with appropriate resources has been implemented in both **pediatric** and adult healthcare settings, and is associated with improved health outcomes. We incorporated a new best practice standard based on **an American Hospital Association** recommendation that patients in hospital settings be assessed for social needs using a validated screen. Hospitals can develop these programs also using recommendations about social needs screening and response by the **NASEM**. Screening tools include the American Heart Association screening tool and Centers for Medicaid and Medicare Services Social Needs Screening **Tool**. We encourage hospitals to connect patients

with appropriate resources based on this screen. One way which hospitals can do this is by using a closed loop referral system; however, the evidence base for this approach is still emerging. Other proposed ideas about how hospitals can address social needs include that hospitals identify community specific needs, provide appropriate equipment, and develop staff competencies in these areas. Future iterations of this best practice standard can build out upon the response of the hospital to the findings of the screening.

One comment suggested the inclusion of a best practice around initiation of long acting reversible contraception in order to reduce unintended pregnancy. Becoming pregnant less than one year after giving birth can have negative health consequences for the pregnant individual and baby (preterm delivery, low birth **weight**, **gestational diabetes**, and **infant** and **maternal mortality**). Initiation of long acting reversible **contraception** (LARC) at the time of giving birth to patients who do not want to become pregnant has been shown to reduce the risk of having a short interpregnancy interval. We have incorporated a standard that hospitals implement the **recommendations** about initiation of LARC made by the American College of Obstetricians and Gynecologists.

A number of comments recommended best practices that address important areas impacting community health; however these do not yet have well established best practice standards or evidence base that we are aware of. In these cases, we believe further development of the evidence and development of a best practice standard will make these ready for consideration in future years. These proposals related to the following:

- Mental health. There were several ideas proposed to have a best practice focused on mental health, a very important community health issue. Suicide in particular is a major health issue - it is the 2nd most common cause of **death** for 10-19 year olds and led to over 48,000 **deaths** in the US in 2018 along with associated morbidity. While suicide impacts all age, sex, and demographic groups, it disproporatinately affects people of **Amerian Indian/ Alaska Native** race/ethnicity, **older white males**, and increasingly **Black children**. Currently the **Joint Commission** requires that hospitals screen all patients presenting for a behavioral or mental health related complaint to be screened for suicidality. We recommend that future iterations of this best practice standard consider implementation of a best practice addressing universal suicide screening for children between ages 10-21 in the emergency department once more definitive guidelines are established. There is strong evidence to support the efficacy of such an intervention, however no best practice standards currently exist. Other ideas related to mental health that were suggested included mental health first aid training and access to mental health services in the hospital.

- Adolescent healthcare services. Care for adolescents that is confidential, developmentally appropriate, equitable, comprehensive, safe, and respectful per recommendations by the **WHO** and **National Academies** can significantly improve not only the health of each adolescent, but also the health of those in the adolescent's social network and community. While there are many well supported approaches to improving adolescent health provision, it is unclear which specific interventions should be prioritized by hospitals. We recommend future development of a best practice standard that incorporates the tenets listed above. Such a best practice standard may include behavioral risk factors assessment, suicide screening, and/or substance use screening and treatment. Other ideas included that the hospital provides transition planning, has an adolescent-specific unit and medical-psychiatric unit for mixed medical/behavioral health issues (eg: eating disorders, substance use disorders), has adolescent medicine staff faculty, has appropriate internal referral resources to link adolescents/families to services, measures adolescent relevant health related outcomes, and is connected to/supports school health services.

- Chronic disease management. Such a standard might include education and counseling services in hospitals for common chronic conditions such as chronic heart failure, diabetes, and chronic obstructive pulmonary disease. This measure already includes two best practice recommendations in component 3 addressing ways that hospitals can partner with local organizations to support community diabetes and hypertension prevention. Chronic disease imposes a significant **health burden**, contributing to an estimated 70% of deaths in the US every year. We recommend further investigation into the area of chronic disease management in future iterations of this measure, as chronic disease is a major cause of morbidity and mortality in the US.

- Removing armed police from hospital emergency departments. One proposed idea was to remove police from emergency departments as policing has been linked to adverse health outcomes, particularly in the realm of **mental health**, and may contribute to health **disparities**. We did not include a best practice addressing this in the current hospital measure because there are not well established standards in this area. A future best practice standard could identify ways that hospitals can utilize effective alternatives to armed police in the emergency department to create a safer environment for patients and clinicians.More broadly, a future best practice standard could address how hospitals can attenuate the negative community health impacts of over-policing, particularly in minority communities.

- Providing health literacy level sensitive, linguistically appropriate, and culturally appropriate care. Ideas for best practice standards in this area included staff education, providing **timely**, professional interpretation services, providing translated clinical and financial navigation materials, assessing patient language proficiency, compensating staff members qualified to provide non-English services appropriately, and following the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care. Other ideas included involving patients with disabilities and their families in discussions to improve accessibility. Care accessibility is a very important topic, as linguistic barriers may contribute to care disparities for impacted groups. There are existing federal accessibility standards that require hospitals to provide linguistically appropriate services, and hospitals are required to follow these federal standards. Thus, , to avoid duplicating federal requirements, we are not including a best practice in this area. Accessibility should be included in core metrics of hospital care quality.

- Care continuity and discharge for people experiencing homelessness. Ideas included that the hospital has provisions in place to prepare for patients experiencing homelessness to return to the community upon discharge by connecting them to applicable supportive services and following the **housing first model** which prioritizes providing housing to people experiencing homelessness. Access to well-maintained housing is key to health - people without access to housing have poorer health compared to those with housing, and further, housing first interventions have been shown to be potentially associated with **superior** health outcomes. We already have included one best practice that addresses hospital investments in housing. A future housing related best practice standard could have a more clinical focus to be included in component 2, such as addressing identifying patients experiencing homelessness in the hospital and connecting these patients to housing at discharge.

- LGBTQ inclusive hopsital environment. Comments suggested best practice standards including providing LGBTQ equitable care, non-discrimination LGBTQ policies, LGBTQ focused cultural competency training, improving inclusivity for LGBTQ patient care as well as for employees, demonstrating engagement with and public commitment to the LGBTQ community, and having an electronic medical record that is amenable to collection of

sexual orientation and identity information. People that identify with the LGBTQ community experience significant health **disparities**, and developing supportive healthcare systems and practices to support well being for these individuals is very important. Once standards are developed, they should be considered in future versions of this best practice standard.

There were several proposed best practice standards that lacked adequate detail for us to understand the specific proposal, or to see how they might meet our goal of assessing how hospitals promote community health with a focus on equity. These related to issues that include physician assisted suicide, holistic ways of providing prenatal care, physical activity education and couselling, trauma informed services, and community paramedicine programs. We encourage the further development of these and other ideas for the future.

Component 3: Hospital as a Partner

Summary

For Component 3, we proposed eight best practices that hospitals can engage in under the role of community partner to promote community health. There was broad support for these practices, with an average score greater than 4 out of 5 for each in our survey, with 4 being "agree" and 5 "strongly agree." The majority of the comments addressed changes, updates, or clarifications to specific best practice standards. Based on these comments, we clarified language about what practices are included, and in some cases added additional elements. We suggested several best practice best practice standards that we will not consider for immediate inclusion into this component, but that may be included in the future.

General Comments

Several comments noted that hospitals can contribute substantially to community health through advocacy and lobbying for effective public health policies, such as policies focused on tobacco control, extreme risk protection orders, and affordable housing. Some pointed out that these efforts may even be more effective than programmatic efforts reflected in the proposed best practice standards.

We agree that hospitals can be enormously influential in the policy sphere, and success with policy can have substantial impact. There are, unfortunately, no standards for assessing how hospitals contribute to advocacy or policy on key issues for community health. Identifying ways to reward hospitals for major contributions to community health policy should be a high priority for future measure development. Perhaps someday, policy-related work could become a fifth component of this measure.

Many comments were concerned that many of the best practice standards in this section called for "meaningful" contributions, noting that "meaningful" is a vague term. We have attempted to provide guidance throughout component 3 regarding what types of efforts should count as meaningful. We also have added transparency by publicly posting hospitals' self reported practices, so communities can provide feedback on whether the hospitals' efforts are indeed meaningful.

We received many comments on the ways hospitals are expected to partner with community partners. One comment suggested that programs such as the ones described in this component already exist in many communities and that hospitals should partner with their community organizations in these cases to improve those programs. We agree and have drafted the best practice standard to recognize these partnerships.

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

Many comments supported the idea of a best practice standard related to the community needs assessment, even for for-profit hospitals that are not required to do so by law. "Great, if this is accepted as a norm," one comment stated. The average score for this standard was 4.6 out of 5, with 4 being "agree" and 5 "strongly agree.".

Many comments called for the best practice standard to require not just the department of health, but also community-based organizations and community residents. We have therefore changed this best practice standard from requiring participation of health departments alone to requiring participation of the health department, community based organizations, and community residents. We also added that the most recent plan and list of participants must be publicly available on the hospital's website.

A few comments called for specific review of the community needs assessment and community benefits plans, while others objected to the idea of such specific review. There are many ways to attempt to judge the merits of needs assessments and community benefit plans, but these are beyond the scope of an easily assessed best practice standard for the purpose of a hospital measure. We hope that the new transparency component will provide support for community efforts to engage with hospitals on whether community benefits plans are meeting their needs.

One comment noted that in some areas of the country, there is not just one local health department for a hospital. We have adjusted the text to be clear that hospitals should include relevant and appropriate local health departments in the needs assessment.

Other suggested areas of future expansion of this best practice standard included reporting rationale behind investment decisions and connecting to the community health needs assessment, reporting breakdowns of community benefit spending, holding hospitals to directing a minimum level of their tax exempt status towards community health improvement and community building, and setting a minimum proportion of investment that is directed towards socially disadvantaged populations. This is too complex, however, to be considered for the current version of this best practice standard.

3.2: Hospital provides meaningful support for a community based hypertension control program.

No comments referred specifically to this best practice standard. The average score for this standard was 4.3 out of 5, with 4 being "agree" and 5 "strongly agree."

3.3. Hospital provides meaningful support for a community based diabetes prevention program.

Several comments supported this best practice standard, with the average score for this standard 4.3 out of 5, with 4 being "agree" and 5 "strongly agree."

Several comments noted that hospitals can support community-based prevention programs, rather than manage the programs themselves. We agree, which is why credit is available for hospitals that support these efforts.

3.4: Hospital provides meaningful support for an evidence-based home visiting program

Many comments supported the idea of home visiting programs and wanted to ensure appropriate implementation of the best practice standard in the overall proposal. The average score for this standard was 4.4 out of 5, with 4 being "agree" and 5 "strongly agree."

A few comments suggested that the hospital could work with local governments or community partners to implement a stronger home visiting program. One noted that rural communities already have similar programs, housed in the local rural health department, allowing the hospital to avoid building a new program from scratch. In cases like this the hospital would provide program support to ensure success and improve the health of the patients served.

One comment suggested that we consider new technologies to improve home health, including telehealth and remote patient monitoring. Although still nascent technologies, already some of the benefits of these technologies to reaching patients are becoming apparent. However, home visiting is different in telemedicine; the social support provided goes far beyond remote patient monitoring.

One comment suggested including evidence based programs to monitor the health of older adults. This is a good idea and could be included in future expansions of this best practice standard.

One comment noted that its policy statement references in the background on the best practice standard have been revised. This has been corrected in the final proposal draft.

3.5: Hospital provides meaningful support for training and work of community health workers

There was significant support for this best practice standard, with one comment stating "Increasing the number of community health workers and supporting their training is an opportunity to 1) build the leadership capacity of individuals within communities most in need of critical health and social services AND 2) build relationships and trust within such communities who may view institutions like a hospital with mistrust." The average score for this standard was 4.4 out of 5, with 4 being "agree" and 5 "strongly agree."

A few comments considered the definition of a health worker and questioned whether community leaders could constitute as health workers. We reaffirm our definition from the draft proposal: "community health workers are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served." In a revision to the best practice standard proposal, we acknowledge the potential geographic differences in this definition.

One comment suggested adding language to the best practice standard around creating pathways for community health worker advancement. This is an important concept, which can be pursued in further iterations of the measure as best practices materialize.

A few comments included suggestions to measure patient health needs in new ways, such as through longitudinal health records and self-reported social needs. These are interesting points but outside the scope of this best practice standard.

3.6: Hospital makes meaningful contributions to supporting school success

Many were interested in this best practice standard and its potential to support community health, with one comment going so far as to say that the best practice standard was "critical for the success of hospitals improving in their ability to support the community." Many other comments shared studies confirming the importance of school success for child and community health across the life course. The average score for this standard was 4.4 out of 5, with 4 being "agree" and 5 "strongly agree."

Some comments focused on health-related education in school and community settings including dietary education for parents and exposure to health professions careers. These suggestions are less focused on promoting overall school success and thus are not responsive to the proposed best practice standard.

One comment suggested that hospitals can support school success in their communities by focusing on schools that are over a certain threshold of unmet need. This group could be defined based on key student demographics such as the number of children within a school who have free and reduced lunch. We encourage hospitals to prioritize programs and partnerships on the community schools with the highest unmet need and to work with local community groups to direct those resources.

3.7: Hospital meaningfully supports expanding access to fresh, healthy foods in the community

Many commenters were interested in this best practice standard and the ability of hospitals to affect community health through its implementation, with one comment saying they "love the suggestion of hospitals contributing to the development of grocery stores or bodegas in low food access neighborhoods." The average score for this standard was 4.5 out of 5, with 4 being "agree" and 5 "strongly agree.".

Several comments suggested adding a hospital food pantry as a way to demonstrate commitment to access to fresh and healthful **foods**. This option is another great way to support community health, especially with those who are also patients at the hospital. Easy access to nutrition for patients undergoing treatment can give much needed financial and health support while they are experiencing significant instability and uncertainty. We have added a hospital food pantry as an option in the best practice standard.

A few comments recommended changing the wording of the best practice standard to add additional concepts to the standard. These included ensuring the food is affordable, adding access

to safe physical activity as part of the best practice standard, requiring a focus on communities that are food insecure, or including a community garden or other sustainability policies. We believe affordability is included in the idea of access so we have added it to the standard. There are many ways for hospitals to make meaningful contributions, including through large community gardens. We believe the best practice standard should provide some flexibility to hospitals in how to best contribute. We support focusing efforts on communities that are food insecure.

One comment addressedthe definitions of "community groups" and "affordable items" from the standard. We leave them general enough for the hospital and local community groups to define together.

3.8: Hospital invests in expanding or improving healthy, affordable housing in the community

There was significant interest in this best practice standard, with several comments stressing the importance of housing as a social determinant of health. The average score for this standard was 4.2 out of 5, with 4 being "agree" and 5 "strongly agree."

One comment suggested including state finance housing agencies such as the New Jersey Housing and Mortgage Finance Agency (NJHFA) as potential partners, and to include NJHMFA's **Hospital Partnership Subsidy Program** as an example. We have included that example as a resource in the best practice standard.

One comment asked for the removal of the terminology of "chronic homelessness" and to simply use the term "homeless" when discussing possible options for hospital contributions. We have correspondingly edited the best practice standard.

A few comments recommended adding the opportunity for hospitals to invest in modifying homes to allow the elderly a safer and more fulfilling way to age in place. There are significant **benefits** to elderly people having the opportunity to live in their own home, and hospitals can work with community institutions such as the **Area Agencies on Aging** to implement these modifications. We have added in this best practice standard an option for hospitals to invest in home modification services to support aging in place.

One comment suggested splitting this best practice standard into three parts: Community Development, Affordable Housing, and Supportive Housing. here is worth in recognizing and supporting the multiple facets contained within the sphere of housing. Future iterations of the measure may expand this best practice standard or include additional affordable housing related standards.

Two comments raised questions into how specifically the hospital would contribute their support, whether through direct investment, setting up subsidy pools, or by other means. The proposed best practice standard seeks to allow flexibility within best practice standards for hospitals to meaningfully invest in expanding access to healthy, safe, affordable housing in their communities. As evidence develops, there may be value in greater specificity in the future.

One comment suggested measuring quantitative residential standards such as Index of Isolation, Index of Dissimilarity, Index of Neighborhood Disinvestment, and Heat Vulnerability Index. We agree that these are important outcome metrics for housing, and we have added mention of them in the background of this best practice standard.

Two comments suggested that community organizations may be better suited to support improved access to safe, affordable housing in the community housing than the hospital. We agree that, consistent with recommended best practices, hospitals should partner with government, non-profit, and community-based organizations, recognizing these institutions' expertise in designing and implementing programs that are responsive to community affordable housing need. Hospitals have the capital and weight in the community to support in their own way to increase access to safe, healthy, affordable housing in their communities. As such, we highlight best practice examples with a focus on appropriate partnership with organizations with established expertise and experience in affordable housing and community development.

Component 3: Suggested Best Practice Standards

We did not identify any suggestions for new best practice standards that met our criteria for inclusion in the current measure, but several may be considered for future incorporation. These proposals related to the following:

- Community Development. We received many comments suggesting ways to support community development as a broader concept than just through housing. Suggested areas included transportation, environmental cleanup, and other development investments. Transportation is a large area of study intertwined with many other social determinants of health. As one comment put it, "lack of access to affordable and reliable transportation affects access to health care and exacerbates other SDOH [social determinants of health], such as the ability to purchase healthy food." Access to transportation can also be important in the process of receiving care, as the American Hospital Association has found an **association** between available transportation and lower readmission rates, as well as fewer complaints from patients. Environmental health has been identified as an important **determinant of health** as well. Future iterations of the measure could include best practices in some of these areas when more rigorous research is available.

- Crisis Hotline Support. We received several comments to suggest best practice standards relating to community safety and mental health. Especially interesting was an idea to support underfunded crisis hotlines to reduce the burden these hotlines place on the police and emergency department clinicians. There has been some **evidence** demonstrating the immediate positive impact of crisis lines on suicide risk and depressive symptoms. The potential role of hospitals in these programs warrants further investigation.

- Bridging the divide between primary care and emergency medical services. Several suggestions arose supporting collaborations between healthcare providers and paramedicine. For communities without easy access to primary care, local **paramedics** can fill this divide, providing primary care services at patients' homes. There have been some successful **partnerships** formed between providers and emergency medical services as well. We would support adding a best practice standard in this area in the future when there is evidence to show community health improvement from such a practice, and further when there is a model for nationwide adoption.

- Mental and Behavioral Health. Comments expressed significant support for new best practice standards around community programs around mental and behavioral health. Proposed best practice standards included school based programs, improving community mental health care infrastructure, and integrating behavioral health services into physical health services with a goal of addressing the root cause of disease and injury rather than onlysymptom management.

We would support further work into a best practice standard for hospital contributions to these efforts.

- Elder Health. We received suggestions to support elder health in the community in a variety of different ways, including through social programs pairing elderly people with young people, and caregiver support. One or more of these ideas can be incorporated into new standards in the future as best practices for hospitals evolve.

Comments also proposed several proposed best practice standards that lacked adequate detail for us to understand the specific proposal or see how they might meet our goal of assessing how hospitals promote community health with a focus on equity. These suggestions related to promoting healthy lifestyles, supporting financial literacy, and other types of hospital activities at the community level.

Component 4: Hospital as an Anchor Institution

Summary

In component 4, we proposed six best practices that hospitals can pursue in their role as anchor institutions to promote community health. The majority of the comments addressed changes or clarifications of specific best practice standards. Based on these comments, we have included more expansive language in some components, and clarified definitions of others. We also adopted three new best practice standards based on comments from respondents, including providing a pathway to employment for returning citizens, and encouraging environmentally sustainable practices. Finally, we revised the scoring method so that hospitals can get partial credit for component 4 by meeting at least four of the eight standards, or full credit for meeting six or more.

General Comments

There were many supportive comments for inclusion of component 4: hospitals as anchor institutions, including that it is a "welcomed approach," that "highlighting economic assets and levers at disposal of health systems as drivers of community health equity and well being is a critical step," and "these may be some of the most important standards in the entire proposal." All of the proposed best practice standards averaged more than 4 out of 5 in our survey, with 4 being "agree" and 5 "strongly agree."

Another comment emphasized the importance of developing trust between hospitals and the surrounding community, which is done by "building an organizational culture to facilitate trust; focusing on person-centered care; cultivating a physical environment to support trust; and engaging the community", and suggested that the measure better reflect these trust building priorities.

4.1. Hospital has a five-year plan for achieving diversity in board and top management

Many comments agreed that proposing a 5-year plan for achieving diversity in leadership was an important goal. The average score for this standard was 4.4 out of 5, with 4 being "agree" and 5 "strongly agree."

Several comments added that we should expand the definition of diversity to include identities beyond race and gender, for instance income level or insurance status. We agree that this is an important goal, and have edited our text to clarify that hospitals should aim to have diversity across different social identities represented in leadership.

One comment suggested that the standard "focuses on measurable and achievable goals against milestones." We agree that including language to measure the progress against the plan would be useful. Therefore we have integrated a requirement that hospitals track progress towards their diversity goal.

Four comments emphasized that boards should not emphasize diversity, but rather representativeness of their local communities. We agree that having robust representation from local communities is important. Beyond broad representation of communities, however, the emphasis on diversity is in part to encourage hospitals to prioritize representation of community members and populations that have been historically marginalized. Incorporating a specific focus on meeting the needs of historically marginalized populations within the hospital catchment area not only demonstrates institutional values, but it may also have important implications for ensuring that the healthcare delivery and community partnerships a hospital implements support health equity and reduce health disparities.

There were also comments on the specificity of this best practice standard. One comment argued that the standard was too prescriptive, and another argued that it was not achievable. We believe that drafting a 5-year plan to achieve diversity and inclusion in top management is an achievable goal for a range of institutions. As a separate comment noted, creative strategies like pipeline programs may be helpful for achieving this best practice standard and overcoming obstacles such as the absence of traditional candidates: "Best practice standards for diversity of top management also include pipeline diversity ensuring diversity at the director and VP [vice president] levels and investing in mentorship and professional development of those individuals so they can be strong candidates for top management roles." Additionally, given consistent evidence of bias in the hiring and promotion process across multiple disciplines, it could be reasonable to suggest that institutions incorporate best practices for hiring and promotion as part of their roadmap to achieving diversity in management over 5 years.

One comment encouraged us to create a more specific best practice standard, by stating that hospitals should aim for 40% of the board to have diverse representation. Given the range of communities that hospitals serve, it may be difficult to define specific targets for board representation. We have not incorporated this suggestion, as we want to preserve flexibility for hospitals to achieve this goal in partnership with their communities.

One comment suggested that we incorporate the "Rooney Rule," a policy that requires teams in the National Football League to interview ethnic minority candidates for certain positions, into this best practice standard. We agree that intentional interviewing practices are important and may be a component of the plans that hospitals outline. It is also important to hospitals to maintain the goal of achieving board diversity in practice, in addition to the processes utilized in pursuit of this goal.

Finally, one comment who agreed with the best practice standard recommended that hospitals also collect data and report on these metrics. Such assessment could well be part of the plan itself.

4.2. Hospital has a minority owned business purchasing and procurement goal and measures progress towards this goal

Many comments agreed that procurement goals would be a helpful best practice standard. The average score for this standard was 4.4 out of 5, with 4 being "agree" and 5 "strongly agree."

Some comments suggested refining the best practice standard to indicate that hospitals should emphasize local procurement. Others identified sustainable and environmentally conscious procurement as an important goal. Finally, four comments suggested that we should replace the term "minority" with the term "historically under-resourced."

One comment helpfully illustrated multiple examples of hospitals and other healthcare institutions changing their procurement practices to support community health: "For example, Kaiser Permanente has an executive director for impact spending and managers reporting to that position focused on sustainability and economic impact as well as supplier diversity itself. Johns Hopkins Medicine has a local sourcing and business development lead focused on identifying and executing upon sourcing opportunities with vendors located and operational within the jurisdiction of Baltimore City, Maryland…and identifying and negotiating with vendors outside Baltimore City to locate to and operate in Baltimore City. Lastly, many health systems have an emphasis on sustainable and environmentally preferable procurement .."

We agree that a more expansive description of procurement goals, including an emphasis on local procurement and environmentally sustainable sources, would support community health. However, local procurement and environmental sustainability sourcing were not part of the NAACP best practice standard and are better addressed in 4.8.

Finally, one comment encouraged us to identify the specific procurement goal that we recommend,for instance, a certain percentage of all suppliers. Identifying specific targets may be too prescriptive to meet the needs of a wide range of hospitals, not all of whom may have access to similar suppliers.

4.2 Hospital has a minority owned business purchasing and procurement goal and measure progress towards this goal was renumbered as 4.3.

4.3. Hospital pays all employees a minimum hourly rate based on the local living wage

Multiple comments echoed their support of this best practice standard and some identified it as an existing aim for their institutions. One respondent noted, "this is a good one, we are on path to get to minimum wage of $15 per hour …currently a year away." The average score for this standard was 4.6 out of 5, with 4 being "agree" and 5 "strongly agree."

Three comments suggested incorporating equity into this best practice standard, for instance by limiting the highest salary paid by the hospital, or by examining the pay ratio between the highest and lowest paid employees. At the moment, this may be too prescriptive a best practice

standard given the range of target hospitals this report addresses. Regardless of the highest salary at a hospital, it is clear that ensuring a livable minimum wage for all employees will help support community health.

Two comments sought guidance on defining a living wage, and another emphasized that living wage varies geographically. We appreciate the challenges of identifying locally relevant living wages. For this reason, we recommended the use of the **MIT Living Wage Calculator**, a well-established tool that has been used by municipal and corporate agencies to identify local living wages. We recognize that the living wage in this calculator is indexed to family size. For that reason, we have clarified the report to indicate that hospitals should set a minimum goal of providing a living wage to all employees as identified by the MIT Living Wage Calculator for a single adult with no children.

One comment stated that this may be difficult for some hospitals to afford paying all employees a liveable wage. We recognize that the best practice standards we outline in this report may be challenging to achieve. However, it remains important for hospitals as leading institutions to aim for these evidence-based approaches, as they have proven impacts on community health via impacts on poverty for healthcare workers.

One comment encouraged us to identify best practice standards to track this metric, such as the percentage of individuals earning a living wage. This level of tracking is not possible for this project, but could be organized by others.

4.3 Hospital pays all employees a minimum hourly rate based on the local living wage was renumbered as 4.2.

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

Several comments supported this best practice standard, with the average score 4.4 out of 5, with 4 being “agree” and 5 “strongly agree.”

Four comments expressed concern about this best practice standard, emphasizing the difficulty of offering on-site child care for all employees. For example, one respondent said “we have evaluated this….the costs and regulatory requirements and staffing requirements and infection control requirements are enormous.” We appreciate the detailed feedback on this best practice standard, especially from institutions that have already explored expanding access to affordable childcare.

Our intention with this best practice standard is to encourage hospitals to support affordable childcare, which can be achieved by multiple mechanisms. These could include providing on-site child care but could also include subsidies or benefits to make child care more affordable for lower wage workers that is provided offsite. The focus in the recommendation is on affordability and quality. For example, another comment recommended an alternative mechanism to support affordable care: “Hospitals should use purchasing power to work with high quality child care providers to address affordability of care.” We have clarified the language in the proposal to emphasize that there are multiple avenues through which hospitals may support affordable childcare, of which on-site care is just one modality. The recommendations were updated to reflect the International Finance Group best practice standard to be more specific.

4.5. Hospital provides paid sick leave to all employees

Three comments responded to this component, all enthusiastically endorsing the best practice standard. The average score for this best practice standard was 4.7 out of 5, with 4 being "agree" and 5 "strongly agree."

One comment recommended clarifying that the policy for sick leave should apply to all staff, including food service and environmental cleaning staff. The comment also recommended that the practice include that hospitals should establish mechanisms to ensure that sick leave policies can be utilized without repercussions. We agree that these are helpful clarifications, and have incorporated them in the final proposal.

4.6. Hospital adopts a "do no harm" collections policy

One comment agreed with the best practice standard, and recommended that we add that the process for applying to charity care not only be available, but also easily accessible. We agree with this suggestion, and have edited the proposal to reflect this text. The average score was 4.5 out of 5, with 4 being "agree" and 5 "strongly agree."

One comment disagreed with this best practice standard, arguing that it is not feasible to stop debt collection from indigent patients. Another comment asked what impact this best practice standard may have on hospitals themselves. We recognize that providing financial assistance to patients who cannot afford care may be an expensive endeavor for hospitals, but this effort will save costs and support community health over time. As we point out in the proposal, medical debt is one of the primary reasons cited for delaying care; as patients delay care for chronic or preventable conditions, their treatment may be significantly more costly when they do return to a hospital. It is in the interest of hospitals to reduce these long-term costs. Furthermore, hospitals have significant lobbying power to advocate for policies that increase access to insurance or to advocate for increased funding from Medicaid to support charity care.

One comment pointed out that a patient's ability to pay is also based on insurance plan structuring, and that states and local policies can impact debt collection. The comment pointed out that in some cities, the municipality can put a lien on a patient's property in the setting of unpaid medical bills. We recognize that a patient's ability to pay is multifactorial, and that multiple actors may be implicated in medical debt collection. Nevertheless, hospitals can control aspects of their own debt collection and can meet a best practice standard.

Three comments discussed hospital involvement in insurance policies. One recommended that hospitals should advocate for universal health care, another that hospitals should be required to report if their physicians or departments deny care based on insurance status, and a third that hospitals should provide or connect patients to health insurance. These are important comments that lie outside the intended scope of this best practice standard. We recommend that they be considered in depth at a later time.

Component 4 Suggested Best Practice Standards

Multiple comments strongly recommended developing a strategy to increase broader diversity within the hospital workforce. One important avenue towards increasing diversity in health care is increasing employment opportunities for people with histories of incarceration. The **National Employment Law Project** estimates that 70 million adults in the United States have an arrest or conviction record. People with criminal records – **especially people of color** – are unemployed at higher rates than the general population, limiting their opportunities to support the health of their families and communities. The development of returning citizen employment programs for individuals who were recently incarcerated is an effective way at connecting people in this situation with employment. The **NAACP** has a set of best practice guidelines about actions employers can take to provide employment programs that are inclusive of returning citizens. These recommendations include removing complete bans on hiring individuals with a prior felony conviction, removing automatic termination of people convicted of felonies, and developing partnerships with other organizations to support returning citizens' return to the workplace. Some **hospitals** have already implemented such programs. We have added a best practice standard for hospitals to implement the NAACP returning citizen hiring practices.

There were recommendations to include a best practice standard addressing sustainability practices. The **CDC** has stated that "climate change…influences human health and disease in numerous ways." Indeed, climate change is a public health issue, and is expected to disproportionately impact people with lower socioeconomic **status**, further **reinforcing** social inequalities. In addition to climate change, **air** and **water** pollution have also been shown to negatively affect population health, with socioeconomically disadvantaged populations bearing a **disproportionate** share of these consequences. Many businesses have already followed the call to develop better sustainable practices, including **following** the goals of the Paris Agreement or becoming LEED **certified**. We have added a best practice standard for hospitals to follow the American Hospital Association's **model** for improving sustainability.

A number of comments recommended best practices that address important areas impacting community health. In these cases, we believe further development of the evidence and development of a best practice standard will make these ready for consideration in future years. These proposals related to the following:

- Youth Summer Employment Programs. There were many suggestions about how hospitals can contribute to employment equity and workforce development. Summer youth employment programs, in addition to developing job skills and providing an income source, have been associated with a reduction in engagement in **violence**. Hospitals can host or support summer youth employment programs or internships with or without a focus on promoting healthcare career pathways. The **Brookings Institute** has made recommendations surrounding the component of a program, however there are not currently best practices around the implementation. We recommend that a best practice of hospitals hosting or supporting a youth summer employment program should be considered for incorporation as a best practice in the future.

- Antiracism and Implicit Bias Training. Several comments recommended a best practice that addresses providing implicit bias and anti-racism training. **Bystander** training and development of anti-racist social norms have been shown to be effective ways of reducing racism. There is also some evidence that implicit bias training is effective at increasing awareness of individual implicit bias and that this may **impact** care provided to patients. However, there are not well established best practices for integrating these types of training into the hospital environment

at this time. A future best practice in this area could be developed around hospitals hosting anti-racism and implicit bias trainings for faculty, leadership and trainees.

- Affordable health insurance for all employees, including contractors and part-time employees. Having health insurance is associated with greater use of **preventative** care and improved health **outcomes**. Standards for offering insurance to part-time employees and contractors are emerging and could be considered for a best practice standard in the future.
- Expanded access to public transportation. Encouraging employees to take public transportation can improve safety, as riding on public transportation can be 60 times **safer** than driving to work. Providing subsidies for employee public transit can improve equity and is a good way to support the community, as investments in public transportation have been cited to yield a 5x **return** on economic output. Public transportation also reduces environmental health and risk of climate change. This topic should be further developed for a best practice standard in the future.

There were several proposed best practice standards that lacked adequate detail for inclusion at this time. These include ideas related to the content of hospital mission statements, involvement of community stakeholders in hospital decision making, the existence of a patient-family advisory council, maternity and paternity leave for employees, support for employee housing near the hospital, and the specific contents of employee health benefits. We encourage further development of these and other ideas in the future.

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