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The Role Of Nonprofit Hospitals In Identifying And Addressing Health Inequities In Cities

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ABSTRACT For nonprofit hospitals to maintain their tax-exempt status, the Affordable Care Act requires them to conduct a community health needs assessment, in which they evaluate the health needs of the community they serve, and to create an implementation strategy, in which they propose ways to address these needs. We explored the extent to which nonprofit urban hospitals identified equity among the health needs of their communities and proposed health equity strategies to address this need. We conducted a content analysis of publicly available community health needs assessments and implementation strategies from 179 hospitals in twenty-eight US cities in the period August–December 2016. All of the needs assessments included at least one implicit health equity term (such as *disparities*, *disadvantage*, *poor*, or *minorities*), while 65 percent included at least one explicit health equity term (*equity*, *health equity*, *inequity*, or *health inequity*). Thirty-five percent of implementation strategies included one or more explicit health equity terms, but only 9 percent included an explicit activity to promote health equity. While needs assessment reporting requirements have the potential to encourage urban nonprofit hospitals to address health inequities in their communities, hospitals need incentives and additional capacity to invest in strategies that address the underlying structural social and economic conditions that cause health inequities.

Nonprofit hospitals have always been required to provide some form of community benefit to maintain their federal tax-exempt status. Starting in the mid-1900s, hospitals satisfied this requirement by offering care at reduced or no cost to patients financially unable to pay for it. In 1969 the Internal Revenue Code replaced this "charitable care" standard with a more general requirement that hospitals engage in activities that benefit the communities they serve. In recent years, questions have been raised about whether nonprofit hospitals are providing adequate community benefit to justify their tax exemptions.[1] In 2011 less than 8 percent of community benefit spending went toward community improvement activities.[2] The current standard has also been criticized for categorizing community building, or activities that address social and economic determinants of health, as nonreportable for community benefit exemptions.[3]

The Affordable Care Act (ACA) encourages hospitals to go beyond traditional community benefit activities (such as providing charity care) and address underlying causes of health inequities. Section 501(r) of the Internal Revenue Code requires tax-exempt hospitals, beginning in

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2012, to conduct and make public a community health needs assessment at least every three years, in which each hospital evaluates the health needs of the community it serves. Subsequent regulations specify that hospitals should involve in their needs assessments people who represent broad interests of the community beyond health care, including community members and those with special knowledge of or expertise in public health. Hospitals are also required to adopt a corresponding implementation strategy annually, in which they propose plans to address identified needs.[4] The final rule clarifies that to maintain federal tax-exempt status, hospitals should consider not only the unmet medical needs of the communities they serve but also the structural social and economic conditions that influence health.[5] Hospitals are allowed to collaborate on their assessments with other hospitals within their health systems, or with other hospitals or health systems, but each hospital must submit its own implementation plan. Hospitals may report certain community-building expenses as community benefit if they are identified in a hospital's community health needs assessment and clearly linked to health.[3]

Case studies and reviews of community health needs assessments conducted in the period 2011–13 found that the broad latitude given to hospitals to interpret the regulations has resulted in inconsistent assessment methods, public reporting, and quality.[6–9] Despite early challenges, the reporting requirements have the potential to substantially improve community health.[10,11]

Previous content analyses of community health needs assessments have evaluated hospitals' approaches to identifying community health needs. Cara Pennel and colleagues evaluated Texas hospitals' attention to determinants of health and the potential of these assessments for population health improvement.[12] Two national community health needs assessment content analyses examined hospitals' prioritization of social determinants of health and highlighted examples where hospitals used this process to inform interventions.[13,14] Community health needs assessments have been identified as a viable strategy for hospitals to use as they begin to address health inequities.[6,10,11] However, there has been little systematic study of the extent to which health equity is explicitly addressed in these needs assessments or implementation strategies.

The definition of *health equity* proposed by Paula Braveman and Sofia Gruskin captures the generally agreed-upon core elements of the construct: "the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige."[15(p254)] A key construct of this definition is the explicit link between health and the underlying structural social and economic conditions.[16]

In 2013 more than 198 million people in the United States, or 62.7 percent of the country's population, lived in cities, and the populations of urban areas are growing more rapidly than the overall population.[17] Cities are also places where large social and health inequities exist.[18–20] Thus, the requirement that urban nonprofit hospitals complete community health needs assessments and implementation strategies provides a unique opportunity to make visible not only these health inequities but also the concrete strategies that such hospitals could adopt to address them.

We assessed the extent to which urban nonprofit hospitals used a health equity lens when assessing and addressing community health needs. Our specific aims were to determine whether and how the hospitals identified health equity as a priority in their community health needs assessments and to identify the activities the hospitals proposed in their implementation strategies to promote health equity. To our knowledge, our study is the first to systematically evaluate the presence of health equity priorities and strategies in urban nonprofit hospitals' community health needs assessments and implementation strategies.

Study Data And Methods

STUDY PROCEDURES We conducted a content analysis of publicly available community health needs assessments and implementation strategies for 179 nonprofit hospitals in the twenty-eight cities of the Big Cities Health Coalition, a group of the largest public health departments in the United States.[21] The residents of these cities account for roughly 17 percent of the US population.[17] We used the 2014 American Hospital Association (AHA) Annual Survey of Hospitals to identify nonprofit, nonspecialty general medicine and pediatric hospitals in these cities. We excluded government-owned facilities (which are not required to conduct a community health needs assessment) and specialty hospitals (because the services they provide are often too narrowly defined to allow them to address health inequities broadly).

In the period August–December 2016 we obtained the most recently published community health needs assessments and implementation strategies from each hospital's website. These were largely from the most recent round of

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ACA-required reports, published in either 2015 or 2016. Using literature on health equity and previous community health needs assessment content analyses,[12–14] we created a preliminary coding framework that consisted of a priori coding categories and definitions (particularly of implicit and explicit health equity terms) that were related to our research objectives. Three coders reviewed the same forty community health needs assessments (24 percent of our sample) and the same forty implementation strategies (35 percent of our sample) to pilot-test the coding instrument and test for interrater reliability. Kappa statistics were calculated for each coding category, and those with greater than "moderate agreement" (>0.6) were retained.[22] After discussing differences and revising categories with less than moderate agreement, the three coders independently coded each of the remaining documents.

STUDY MEASURES Hospital characteristics were drawn from the 2014 AHA Annual Survey of Hospitals. Each hospital was classified by geographic location as defined by census regions and divisions. Each hospital's primary service type was coded as general medical/surgical if it served the general population and as general pediatric if it provided nonspecialty pediatric care. Hospitals were classified as belonging to an accountable care organization (ACO) if they answered "yes" to a question about ACO membership. They were classified as a faith-based organization if they reported being "Catholic controlled" or "church operated."

To indicate the scope of possible hospital services, hospitals were coded according to the facilities and services they provided—emergency department, trauma center, psychiatric care, and indigent care clinic. Hospital size was captured through the following continuous measures: number of beds (all general adult and pediatric medical/surgical and psychiatric beds), average daily census (the average number of inpatient patients served), total facility expenses (excluding bad debt), and number of full-time personnel (staff members on the payroll who worked at least thirty-five hours per week).

The study variables in the next set were drawn from the content analysis codes of the community health needs assessment and implementation strategy reports. Each report was coded according to whether it was conducted for a single hospital, a single health system with multiple hospitals, or multiple hospitals or health systems. Each was also coded for whether any of four explicit health equity terms (*equity*, *health equity*, *inequity*, and *health inequity*) was used in the text and for whether any of the fifteen implicit health equity terms (*disparities*, *health disparities*, *disadvantage*, *low income*, *poor*, *minorities*, *ethnic*, *race*, *disenfranchised*, *vulnerable*, *social determinants of health*, *structural*, *equal*, *inequalities*, and *underserved*) was used. The implicit terms were derived from Braveman and Gruskin's definition of *health equity*[15] in an iterative process of identifying new terms from reports that referred to health equity without using the explicit terms listed above.

Nonprofit hospitals have the ability and responsibility to address health inequities in the communities they serve.

Using Braveman's work clarifying the core conceptual elements of *health equity*,[16] we also created a framework of six broad health equity elements: health disparities or inequalities, disadvantaged groups (broadly or specifically by race, income, or education), disparities in access to material resources (such as income, healthy food, and safe streets), disparities in access to health care, disproportionate burden of stress and trauma among disadvantaged groups, and structural or systemic factors as causes of health inequities (that is, social determinants of health). We coded each community health needs assessment for whether or not it included any of these elements. Use of the elements in descriptions of community health needs or hospital strategies to address them indicates a deeper understanding of health equity than is suggested by simply using the correct terms.

We coded a community health needs assessment as having identified health equity as a need of external stakeholders if it mentioned that any party external to the hospital (for example, focus groups or community partners) had proposed the need to address health equity, regardless of whether or not the hospital considered health equity to be a priority. We also coded each needs assessment according to whether or not it identified causes of health inequities and identified health equity as a priority to be addressed. We coded an implementation strategy as containing activities to address health equity if the strategy

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Learning best practices could help hospitals increase their use of a health equity lens in addressing poor health outcomes.

explicitly mentioned equity. Implementation strategies were not coded for implicit equity terms or activities because we were interested only in activities explicitly linked to health equity.

ANALYTIC METHODS All variables were merged at the hospital level, so that the hospital was the unit of analysis. Descriptive statistics were generated to examine frequencies, percentages, and distributions of all study variables. Bivariate analyses were conducted to examine associations between document content and hospital characteristics. All data were analyzed using Stata, version 13.1.

LIMITATIONS Our study had several limitations. First, it was limited to urban hospitals in the twenty-eight cities of the Big Cities Health Coalition. However, major health inequities also exist in rural areas served by nonprofit hospitals. And while health inequities exist in all twenty-eight cities, it is likely that some of the hospitals in our sample largely served affluent populations and that health inequity would not be an expected priority for them.

Second, we were unable to obtain implementation strategies for a third of the hospitals that publicly posted a community health needs assessment. It is possible that health equity was a prominent theme in some of the implementation strategies that were not publicly available.

Third, the documents that we reviewed were produced in different years, and it is possible that the magnitude of health inequities varied modestly over time.

Finally, we recognize that these documents are not the only measure of a hospital's commitment to health equity. Some hospitals might be deeply engaged in health equity activities that were not reflected in these documents—activities that were not captured in our analysis.

Study Results

As of 2014 the 179 nonprofit, nonspecialty hospitals in our study were spread across all census regions, but the largest share of them (33 percent) were in the West and the smallest share (14 percent) were in the Northeast (Exhibit 1). The hospitals were located in eight of the nine census divisions, with the largest share in the Pacific division (28 percent) and no hospital in the east south central division. General medical/surgical hospitals accounted for nearly 90 percent of the sample, and general pediatric hospitals accounted for the rest. Forty-six percent of the hospitals in the sample belonged to an ACO, and 14 percent were faith based. Over three-quarters had an emergency department, and nearly half had a trauma center, provided psychiatric care, or had an indigent care clinic. The mean number of beds was 411, with an average daily census of 291 patients. The mean number of full-time personnel was just under 3,000, and mean total facility expenses were approximately $650 million.

Of the 179 hospitals' community health needs assessments, 169 (94 percent) were publicly available (Exhibit 2). Because the Internal Revenue Service requires that needs assessments be made publicly available, we assumed that the remaining ten hospitals did not conduct an assessment. Only 113 implementation strategies were publicly available. Because public reporting of implementation strategies is not required, we could not determine whether these implementation strategies had simply not been made publicly available or had not been produced. About two-thirds of the community health needs assessments we reviewed had been conducted by a single hospital, a quarter had been conducted by a single health system with multiple hospitals, and just under 10 percent had been conducted by multiple hospitals or health systems.

At least one of the fifteen implicit health equity terms listed above was found in all 169 of the community health needs assessments, with a mean of nearly eight of the fifteen terms used per assessment. Just under two-thirds (110) of the documents mentioned at least one of the four explicit health equity terms, with a mean of approximately 1.5 of the four terms used per assessment.

The vast majority of community health needs assessments included at least one of the six health equity elements, with a mean of 4.5 elements included per document. Just over three-quarters of the assessments indicated that external stakeholders had identified health equity as a need. Nearly half of the assessments identified and discussed the causes of health inequities (for example, social determinants of health), and

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EXHIBIT 1

Characteristics of nonprofit, nonspecialty hospitals in selected urban areas, 2014

	Number	Percent
CENSUS REGIONS AND DIVISIONS[a]		
Northeast region	25	14.0
New England	7	3.9
Middle Atlantic	18	10.1
Midwest region	40	22.4
East North Central	31	17.3
West North Central	9	5.0
South region	55	30.7
South Atlantic	33	18.4
East South Central	0	0.0
West South Central	22	12.3
West region	59	33.0
Mountain	10	5.6
Pacific	49	27.4
PRIMARY SERVICE		
General medical or surgical	160	89.4
General pediatric	19	10.6
AFFILIATION		
ACO	83	46.4
Faith based	25	14.0
FACILITIES AND SERVICES		
Emergency department	151	84.4
Trauma center	83	46.4
Psychiatric care	77	43.0
Indigent care clinic	80	44.7
	Mean	**SD**
Number of beds	411.4	29.1
Average daily census	290.9	241.6
Total facility expenses	$647,594,466	$677,155,444
Number of full-time personnel	2,998.8	3,362.8

SOURCE Authors' analysis of data for 2014 from the American Hospital Association Annual Survey of Hospitals. **NOTES** There were 179 hospitals. Urban areas are those in the Big Cities Health Coalition (listed in Note 21 in text). Percentages may not sum to 100 because of rounding. SD is standard deviation. [a]Appendix Exhibit A3 presents a list of states associated with each census division (see Note 23 in text).

nearly half identified health equity as a priority.

Of the 113 implementation strategies that were publicly available, a third mentioned at least one of the four explicit health equity terms, and just over half included at least one of the six health equity elements. Explicit health equity activities were proposed in only ten implementation strategies, or just under a tenth. Additional details are shown in online Appendix Exhibit A1.[23]

Of those strategies that did propose explicit health equity activities (data not shown), five proposed collaborating with cross-sector partners such as schools, community-based organizations, businesses, and other providers to achieve social, economic, and health equity. Specific activities included offering support to organizations that were already performing health equity work through the provision of resources and development of interventions. Three proposed to increase educational attainment as a way to address structural determinants that create inequities, including one that proposed to address racial inequities through access to early childhood education. Three proposed reducing barriers to quality health care for patients from groups who experience social and health inequities.

In bivariate analysis, we found that hospitals in the Northeast were more likely to identify the causes of health inequities and use explicit health equity terms in their implementation strategy, compared to hospitals in other regions (Appendix Exhibit A2).[23] Hospitals in the West were more likely to mention health equity terms in their community health needs assessments and implementation strategies, compared to hospitals in other regions, and more likely to report that external stakeholders had identified health equity as a need but less likely to identify the causes of health inequities. Hospitals in the South were less likely than hospitals in other regions to use any explicit health equity term in their community health needs assessments and implementation strategies, and they used fewer implicit health equity terms in their community health needs assessments. Southern hospitals were also less likely than those in other regions to include at least one health equity element in their community health needs assessments.

Compared to community health needs assessments conducted by a single hospital or health system, assessments conducted by multiple hospitals or health systems were more likely to use explicit health equity terms, were more likely to identify causes of health inequities, and included larger numbers of health equity elements and implicit and explicit health equity terms (Appendix Exhibit A2).[23] Compared to other hospitals, those belonging to an ACO were more likely to identify causes of health inequity and prioritize health equity in their community health needs assessments.

Discussion

Ninety-four percent (169) of the hospitals in our sample adhered to the ACA requirement to conduct and make publicly available a community health needs assessment. Among these hospitals, health equity was commonly mentioned when describing the health needs of the communities the hospitals serve: 100 percent mentioned health equity implicitly, and 65 percent mentioned it explicitly. Yet only 9 percent (10) of the hospitals that had a publicly available implementation strategy described any activities to address health inequities. Among these pro-

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posed strategies was reducing barriers to care, a strategy that we argue is not upstream enough to address the underlying structural social and economic inequities that drive health inequities.

More than 75 percent of the hospitals reported that external stakeholders identified health equity as a need. However, only 46 percent prioritized health equity in their community health needs assessments. This suggests that while hospitals may be comfortable identifying health inequity as a community health issue, they may be reluctant to state it as a priority. Furthermore, the lack of explicit health equity activities in implementation strategies suggests that prioritization is not translating into actual community benefit activities. This could be attributed to a variety of reasons, including the challenges inherent in identifying activities to address inequities. Because health equity is determined primarily by structural social and economic factors that occur upstream from health care, the goal of addressing inequities is more likely to be embraced by hospitals that have made the paradigm shift toward population health strategies to reduce health care costs and improve outcomes.[24]

Of note, about 5 percent of all community health needs assessments and about 85 percent of those using explicit health equity terms did not mention core elements of their definitions of health equity (Exhibit 2). This means that these community health needs assessments were using terms that refer to health equity issues either implicitly or explicitly but included no other substantive context related to health equity. Similarly, only 49 percent of the community health needs assessments provided any discussion of the causes of health inequities in the communities they serve. This may suggest that mentions of health equity in community health needs assessments are perfunctory and do not reflect a clear understanding of the causes of health inequities, which is necessary to develop strategies that address them.

Our bivariate results suggested that there are regional patterns in terms of hospitals' embracing health equity in their community health needs assessments and implementation strategies. There is also evidence that community health needs assessments that were the result of collaboration among multiple hospitals or health systems are more likely to focus on health equity than those conducted by a single hospital or health system. This may suggest that collaboration allows for enhanced capacity to understand population health inequities. However, because the ACA requires hospitals to create their own implementation strategies, consideration should be given to ways in which regional nonprofit hospital collaboratives can be equipped and motivated to move from collaborative assessments to collaborative health equity strategies.

EXHIBIT 2

Characteristics of community health needs assessments (CHNAs) and implementation strategies (ISs) of nonprofit, nonspecialty hospitals in selected urban areas

	Number or mean	Percent or SD
Public availability of CHNA and IS (n = 179)		
Both CHNA and IS	113	63.1%
Only CHNA	56	31.3
Only IS	0	0.0
Neither	10	5.6
CHNA conducted (n = 169)		
For single hospital	113	63.1%
For single health system with multiple hospitals	43	24.0
For multiple hospitals or health systems	13	7.3
Use of health equity terms in CHNA (n = 169)		
Implicit health equity terms mentioned	169	100.0%
Mean number of implicit terms used	7.9	2.8
Explicit health equity terms mentioned	110	65.1%
Mean number of explicit terms used	1.4	0.9
Inclusion of health equity elements in CHNA (n = 169)		
At least one health equity element included	163	96.5%
At least one health equity element included among those using explicit health equity terms (n = 110)	28	15.6%
Mean number of health equity elements included	4.5	1.3
Health inequity causes identified	83	49.0%
Health equity prioritization in CHNA (n = 169)		
Health equity identified as a need by external stakeholders	132	78.1%
Health equity identified as a priority	78	46.2%
Explicit health equity in IS (n = 113)		
Explicit health equity terms mentioned	40	35.4%
Mean number of explicit health equity terms used	1.3	0.7
At least one health equity element included in IS	62	54.9%
Mean number of health equity elements included	1.3	1.6
Explicit health equity activities proposed	10	8.9%

SOURCE Authors' analysis of data from publicly available community health needs assessment and implementation strategy reports from nonprofit, nonspecialty hospitals in the urban areas in the Big Cities Health Coalition (listed in Note 21 in text). **NOTES** There were 179 hospitals. The fifteen implicit health equity terms, the four explicit health equity terms, and the six health equity elements are listed in the text. SD is standard deviation.

Policy Implications

Nonprofit hospitals have the ability and responsibility to address health inequities in the communities they serve, beyond the provision of uncompensated medical care. Our analysis of community health needs assessments and implementation strategies supports the idea that this ACA mandate can encourage hospitals to address health inequities and improve community health by identifying inequities within the populations they serve and developing strategies to address these drivers of poor health outcomes. The retention of this mandate is critical, regardless of

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the future of the ACA itself. If the ACA is repealed, a requirement to produce a community health needs assessment or an implementation strategy could be tied to funding or reimbursement (for example, from Medicaid or Medicare) or be a provision in the legislation that replaces the ACA.

The discrepancy between identifying health equity as a need and the development of strategies to address inequities might also be explained by community benefit reporting requirements that do not encourage hospitals to invest in upstream solutions, such as affordable housing programs or job training. Strategies that affect structural social and economic conditions qualify as community building activities for community benefit only if they are identified in a hospital's community health needs assessment as having a direct link to health.[3] Hospitals are unlikely to pursue complex upstream strategies to address inequities if they are incentivized to perform and report only clinically focused community benefit activities.

This discrepancy also raises questions about how nonprofit hospitals' capacity to address health equity could be enhanced. Our results suggest that these hospitals—particularly the ones that work collaboratively on their community health needs assessments or coordinate care through an ACO—might have the will to promote health equity but not necessarily the know-how. A hospital's collaboration with other hospitals and health systems or with public health systems already oriented toward population health solutions[25] might increase its capacity to participate in more upstream health equity solutions that would be difficult for it to implement by itself. Data sharing among nonprofit hospitals that serve overlapping geographic areas could help streamline the process of creating a community health needs assessment and enhance hospitals' ability to monitor patterns of health inequities, thus strengthening their population-level health equity strategies.[26,27] Capacity building could also help address the gap between identifying health inequities and adopting strategies to address them. In particular, learning the best practices of nonprofit hospitals that are meaningfully engaged in health equity activities could help other hospitals increase their use of a health equity lens in addressing poor health outcomes.

Areas Of Future Study

A logical next step is the creation of a standardized quality metric for community health needs assessments and implementation strategies on health equity and related domains (such as collaboration with external stakeholders, scientific

Our study provides evidence that urban nonprofit hospitals are using a health equity focus in their community health needs assessments.

quality of data analysis and reporting, and dissemination and use of reports). Such a metric would enable a more detailed comparison of community health needs assessments and implementation strategies across hospitals and could be used to establish quality standards. Also important is a deeper analysis of state-specific community benefits laws and the sociodemographic characteristics of city populations or hospital catchment areas—and how these characteristics relate to hospitals' health equity focus. Finally, it will be important to track the content of community health needs assessments and implementation strategies over time to assess trends in health equity prioritization and intervention strategies and to evaluate successes.

Conclusion

Hospitals have a role to play in health equity. Community health needs assessments and implementation strategies are a promising mechanism through which to play this role. Our study provides evidence that urban nonprofit hospitals are using a health equity focus in their community health needs assessments, and some are adopting strategies that are more aligned with a population health approach by expanding the provision of community benefits beyond just charity care. Hospitals should continue to be incentivized to address health equity by strengthening the ties between these reporting processes, community building, and community benefit. The pervasive and growing health inequities that drive high health care costs and poor health outcomes among the most vulnerable communities can be addressed by nonprofit hospitals' devoting more attention to population health strategies across health systems and in partnership with public health organizations. ■

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