MALCOLM V. WILLIAMS, LAURIE T. MARTIN, JESSICA SOUSA

Early Learnings from the Hospital Community Cooperative of the American Hospital Association

Health is increasingly understood to be shaped by more than individual genetics, clinical care, and health behavior. Structural factors that shape the distribution of power and wealth in society are also responsible for health inequities and social determinants of health (SDOH). Certain SDOH—such as education; housing; physical safety; and access to parks, fresh food, and other amenities—have overlapping impacts on health outcomes and well-being that account for approximately 70 percent of the variance in health status among people in the United States (Centers for Disease Control and Prevention, 2018; Office of Disease Prevention and Health Promotion, 2019).

At the same time, hospitals and health systems are facing challenges related to (1) regular use of the emergency department for nonemergency care and social service needs and new payment and (2) new payment and care delivery models that shift financial incentives for providers toward achieving and maintaining the health of their patient populations. Collectively, these trends point to an opportunity to think differently about the role of hospitals and health systems in the improvement of population health through improved

KEY FINDINGS

- Participation in the Hospital Community Cooperative (HCC) increased capacity to address social determinants of health (SDOH) among some teams. Few teams reported an increase in leadership prioritization of health equity; however, several reported an increase in hospital resources provided for such efforts.

- The planning year was intensive for most teams. Developing key partnerships between health systems and community partners and planning for implementation were time intensive.

- Teams participating in the HCC reported strengthened partnerships over time. At the end of first year, eight teams felt that they had the right types of partners.

- Some teams reported strengthened data infrastructure and data systems alignment. Despite the longer time investment, many teams developed solutions that allowed for data-sharing in a manner that promoted a coordinated system of care while maintaining the privacy of individuals.

- Teams appreciated the flexibility of HCC funding and protected time to work on projects.

coordination and alignment between health systems and community partners, particularly with sectors beyond health care and public health, such as housing, transportation, and economic development (Chandra et al., 2016).

Recognizing the value of partnered approaches, the American Hospital Association (AHA), with funding from the Aetna Foundation, launched the Hospital Community Cooperative (HCC) (American Hospital Association, undated-b) to bring hospitals and community organizations together to collectively address key SDOH in their communities and promote health equity. The effort builds on the AHA's #123forEquity Pledge to Act Campaign (American Hospital Association, undated-a), which has challenged hospitals and health systems to adopt one or more of the following health equity goals: (1) increase collection and use of race, ethnicity, language, and sociodemographic data; (2) advance cultural competency training; (3) increase diversity in leadership and governance; and (4) improve and strengthen community partnerships (American Hospital Association, 2017).

The HCC consists of ten teams chosen by the AHA. Each comprises a hospital or health system and one or more community partners to work collaboratively in designing and implementing a project that addresses a need in their communities. Three teams designed projects to address housing through such activities as navigating patients to housing options and providing stipends for some housing costs, coordinating housing services, providing case management, and building new housing options. Three other teams sought to address SDOH related to cancer prevention and outcomes through such activities as disseminating at-home cancer screening kits and providing education, on-site screening services, and outreach to affected populations to identify and address barriers to screening. Finally, four teams set

out to address multiple SDOH through improved coordination or service alignment, such as identifying and coordinating social services for patients with complex SDOH needs, linking patients to social and health care services, and using new technology to identify and eliminate barriers to health care–seeking. The AHA awarded $10,000 to each team for any use in support of project goals. Teams also had access to a range of technical assistance (TA) through three TA partners. HealthBegins worked with teams to support the planning and implementation of their projects, Local Initiatives Support Corporation supported connections between hospital staff and community partners, and the RAND Corporation provided TA to teams on evaluation and data collection. The AHA also provided direct resources to teams through site visits by AHA leadership to meet with hospital executives and team leaders.

In addition, the AHA asked RAND researchers to conduct a comprehensive assessment of the HCC to identify the impact and benefits of the HCC and lessons learned. This report includes key findings and lessons learned that should be of interest to a variety of audiences seeking to expand the capacity of hospital-community partnerships to address SDOH, including other hospitals, other health systems, and community partners seeking to leverage the support and resources of their local health care institutions (whether these approaches are occurring within a formal HCC or not). In addition, this report should be of use to foundations or other funding agencies that might support similar partnered approaches to improve health inequity in their communities.

Approach

We collected data from each of the ten teams at two points in time—in January 2019 for baseline (allowing time for teams to finalize projects) and October

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2019 for a follow-up—to track changes that may have resulted from participation in the HCC. To collect this information at both time points, we contacted the lead staff person at each team to complete a survey and participate in a semistructured interview with our staff. The team lead was given the option to invite other members of the team to complete the data-collection form and participate in the interview. Teams were asked about various topics, including cross-sector collaboration and partnerships; community engagement; implementation and evaluation of their projects; support, resources, and investments for their projects; staff and leadership commitments to addressing SDOH and health equity; policy changes; facilitators and barriers to their efforts; and perceived benefits of participating in the HCC.

Key Findings

It Was an Intensive Planning Year for Most Teams

Teams participating in the HCC sought to develop key partnerships between hospitals or health systems and community partners to collectively address one or more SDOH. This work—including the dedication to build relationships, develop strategies, and align previously siloed systems of work flows and data structures—took time. It also involved working to develop solutions for data-sharing that align with the legal and regulatory protections in place to protect the privacy and confidentiality of patients. As a result, most teams spent time working through these issues and planning for implementation, which several noted took longer than they anticipated. As one team expressed, "We had hoped to have implemented our project by this point, [but] we now have a greater awareness of all of the administrative hurdles it would take to make something like this viable at a [community level]."

Participation in the HCC Increased Capacity to Address SDOH Among Some Teams

We assessed whether participation in the HCC increased a hospital or health system's ability to address SDOH by looking at responses to items related to each leadership team's understanding and prioritization of SDOH and the resources (including financial) from leadership for efforts prior to and over the course of the HCC. We found that half of the teams had a small to moderate change expansion in their capacity or prioritization of addressing SDOH (Figure 1). The other half had no change, but we found that this was because they started with a high capacity to address SDOH.

Teams provided examples of how their capacity to address SDOH had expanded. These included increases in executive leadership support and funding for addressing SDOH and health equity; identification of new partners and a strengthening of existing partnerships to address SDOH; and strengthened data infrastructure, system alignment, and processes for systematically analyzing and approaching SDOH.

Few Teams Reported an Increase in Leadership Prioritization of Health Equity; However, Several Reported an Increase in Hospital Resources Provided for Such Efforts

At both time points, we asked teams to describe the role that a hospital's or health system's executive leadership team currently plays in supporting activities to address health equity in their communities. We

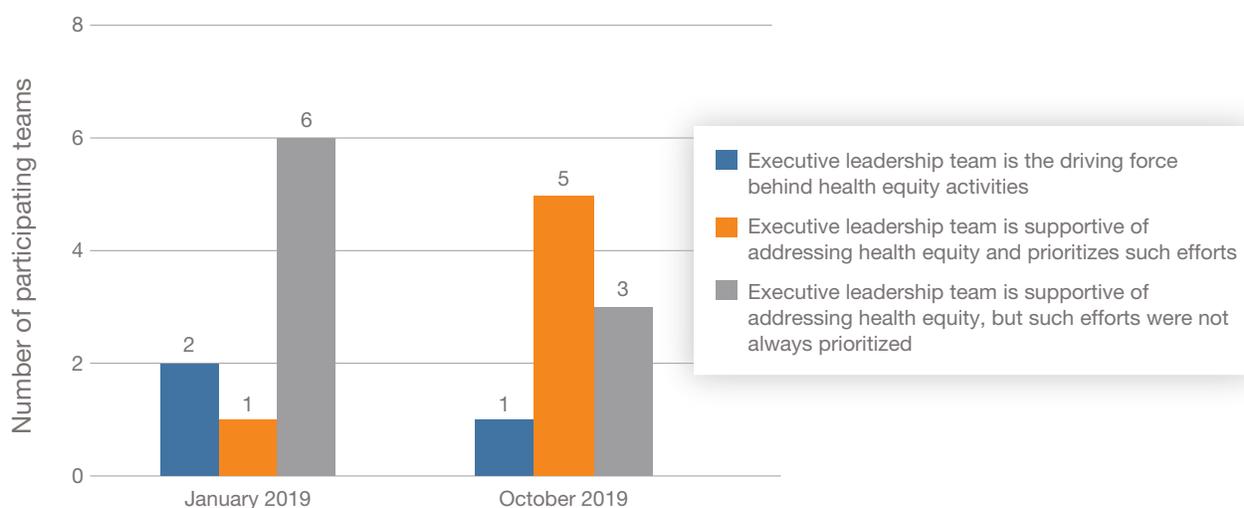FIGURE 1

Change in Capacity to Address SDOH
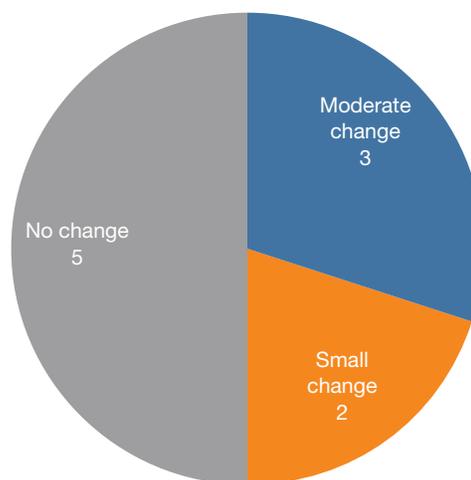
also asked teams to describe, in general, how they would characterize the resources that a hospital or health system executive leadership team provides to address health equity (e.g., personnel time, funding to support or strengthen data collection, or resources to promote community engagement). Over the course of the HCC period, there was a shift toward more leadership engagement and prioritization of health equity activities (Figure 2). In January 2019, six teams reported that their hospital or health system leadership teams were supportive of addressing health equity but did not always prioritize such efforts. By October 2019, three of these teams reported that their executive leadership teams prioritized such efforts. A fourth team noted that although the change was not substantial enough yet to increase its rating, it was seeing movement in a positive direction. One team, which noted in January 2019 that its hospital or health system leadership team was the driving force behind health equity activities, reported a decrease in prioritization over the HCC period, noting that although its leadership team still prioritized health equity efforts, it was no longer the driving force behind them.

Teams also reported an increase in the amount of resources invested in activities related to SDOH specifically and health equity more broadly (Figure 3). Seven out of nine teams reported an increase in the amount of resources that executive leadership provided for health equity activities, while two remained unchanged. Notably, three of the teams reported the establishment of new positions or new titles and job descriptions for staff with a focus on SDOH and health equity, which signaled a shift in both priority and resource allocation from hospital leadership toward addressing health equity.

Teams Participating in the HCC Reported Strengthened Partnerships over Time

Because the HCC was built on the premise of the hospital or health system and community partnerships, all teams included at least one partner. But at baseline, only two teams felt that they had "the right types of partners to address health equity"; the other eight felt they had "some of the right partners." At the end of the first year, eight teams felt that they had the right types of partners and only two still felt that

FIGURE 2

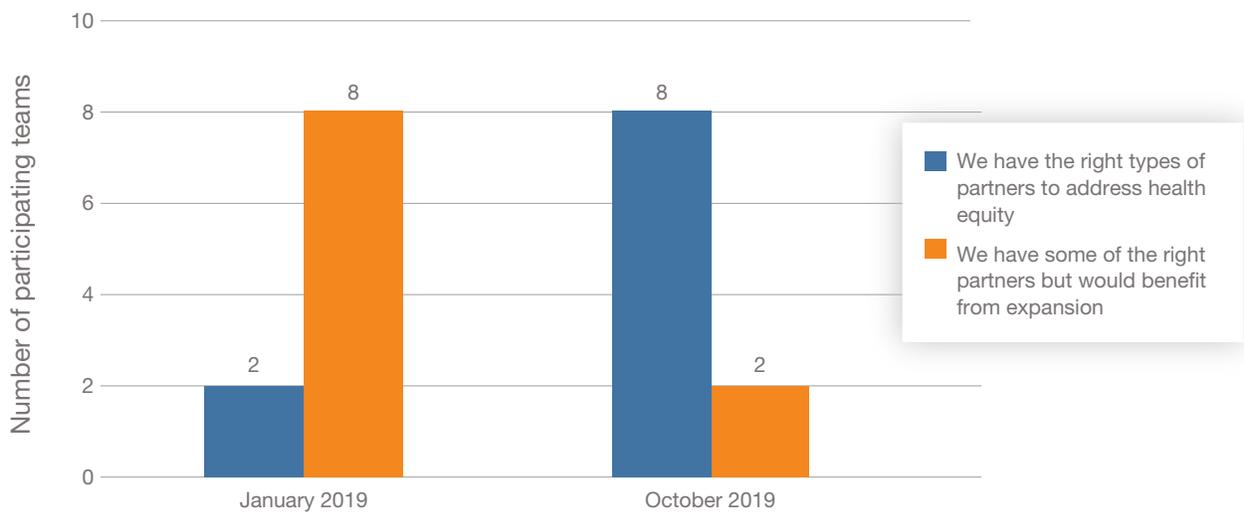Perception of Executive Leadership Support for Health Equity

NOTE: *N* = 9; one site did not answer.

FIGURE 3

Perception of Resources Invested by Executive Leadership to Support Health Equity

NOTE: *N* = 9; one site did not answer.

FIGURE 4

## Perception of Whether Teams Had the Right Types of Partners to Address Health Equity

their projects would benefit from strengthening their networks (Figure 4).

We also assessed the strength of partnerships based on the reported number of partners and level of engagement and involvement of the partners in the design, implementation, and evaluation of the project (Figure 5). We rated three teams as having adequate partnerships, meaning that they had a limited number of partners that largely executed a carved-out piece of the project as directed by the hospital or health system.

Another three teams had partnerships we classified as promising, meaning that there was a diversity in partnerships and some evidence of joint planning and decisionmaking within the project, but there had been little movement to strengthen those partnerships or increase engagement of those partners over time. Four teams had partnerships we classified as strong, meaning that they had partners who were actively engaged and took on substantial, if not equal, roles in the design and implementation of the project. Several teams provided examples of how dedicated time to build and strengthen partnerships increased their capacity to address SDOH and health equity in the community. One team working on housing issues shared that there had been a clearing of a homeless encampment within its community during the HCC project period. Although this effort was independent of the HCC project, the team was able to quickly mobilize in support of its community partners to support housing placement for seven individuals affected in this clearing. Another team felt that participation in the HCC had elevated partner perceptions of it from a participant to a key player. Having the hospital or health systems invest resources and participate in the HCC signaled that addressing SDOH and health equity was a priority. This helped build trust and changed the way many community partners viewed their role. As one interviewee stated:

> I think [participation in the HCC] did increase our presence. Because if I think about the grant, we would have been at the table to identify who the high [emergency department] utilizers were. But they could launch that intervention and have very little support from [us]. They could do that out in the community. So I do think when we invited [a community

FIGURE 5

Strength of Partnerships

FIGURE 5
Strength of Partnerships
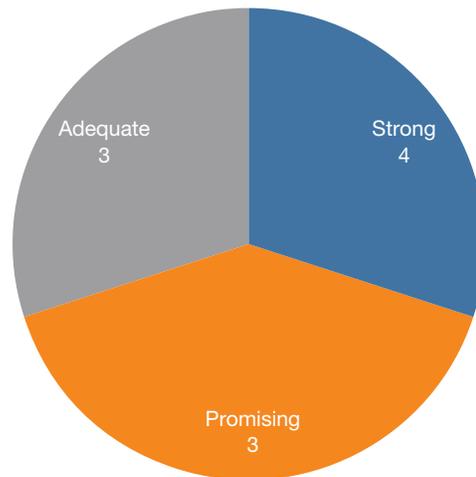
partner] to join us in this Collaborative, it changed their mindset around what role we could play and how we could benefit this work.

Some Teams Reported Strengthened Data Infrastructure and Data Systems Alignment

Some teams noted that their ability to address SDOH and health equity was strengthened because of their work within the HCC to set up more-formalized and systematic approaches to using and sharing data within their hospital or health systems and community partners. Several teams also worked to address barriers to data-sharing because of legal or regulatory protections of patient data to ensure confidentiality. Overcoming these barriers, aligning data systems, and developing procedures that specified what could be shared and with whom took time, but many teams developed solutions that allowed for data-sharing in a manner that promoted a coordinated system of care while maintaining the privacy of individuals.

Benefits of HCC Participation

We asked teams about the value of the HCC at follow-up. A large majority of the teams highly valued the TA and other resources provided as part of the HCC, particularly around partnership-building.

Teams each received $10,000 and valued the ability to invest the dollars in their project with no restrictions on how the funds could or could not be spent. As one team noted, "I like the flexibility of the money, but not having an objective for how they want us to spend that money." Several teams also stated that a benefit of participating in the HCC was that it created a laboratory for innovating around SDOH and helped propel teams from idea to implementation. As one team expressed, "It gives permission and space to think through these and to be a laboratory for ideas."

Finally, although only one team focused explicitly on addressing policy change (data not shown), others were poised to take advantage of policy windows and opportunities for alignment.

Teams Appreciated the Flexibility of HCC Funding and Protected Time to Work on Projects

Each team received $10,000 and valued the ability to invest the dollars in its project with no restrictions on how the funds could be spent. As one team noted, "I like the flexibility of the money but not having an objective for how they want us to spend that money."

Two teams purchased materials and equipment that will stay with the project; these included the direct costs of building a communications platform for sending text messages and costs related to purchasing land to build housing. Three teams used the funds to support personnel time, which enabled protected time for existing staff to focus on the project or to offset the costs of hiring an outside consultant or facilitator. One team used the stipend to pay for costs related to collaborative planning and engagement, which included food for meetings and rental space. These investments supported longer-term capacity-building that will contribute to the project's sustainability. Four teams also spent at least some of their dollars to purchase incentives, such as payments or gifts to those who engaged in screening activities. Most teams also highly valued the opportunity to move their projects from planning to implementation and the potential for their projects to address health equity in their communities.

Several teams reported that protected time to build relationships with community partners meant that they were poised to take advantage of opportunities when they arose. For example, one team focusing on housing started its HCC project without working directly with the city, but when a newly elected mayor created a new initiative around housing, the team was able to quickly mobilize to come to the planning table with the mayor and other stakeholders to discuss how to integrate their work into that of the broader community initiative. Without the leg work completed in the context of the HCC, they might have missed this window of opportunity.

> We have a lot of experience addressing SDOH and were hoping to use this to create that network of community action . . . . Three weeks after we returned from [the kickoff meeting], the city said they want to do Built for Zero where the city would take on the role of multiplying or expanding what we are already doing: taking on the role of convening the stakeholders or examining policy level issues or agency-specific issues and being able to make recommendations to change structural barriers to housing for more-vulnerable community members . . . . The timing of all of this is interesting. This is the perfect convergence.

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Lessons Learned

This inaugural cohort generated some helpful lessons learned for hospitals and health systems looking to develop partnered approaches to addressing SDOH and health equity in their communities. We summarize these lessons as follows:

- **Such efforts will take longer than originally anticipated.** Most teams ran into at least some challenges that caused delays. These challenges included building partnerships and establishing trust, seeking approvals, aligning data systems, and securing funding. Hospitals and health systems looking to address SDOH in their communities should ensure that they are working within a realistic time frame of two to three years.

- **Projects require a financial commitment, beyond funds for project implementation.** Community engagement and partnership-building not only take time but often require additional funds for food, meeting space, and materials that may not be covered by external grants. Teams found the stipend from the HCC invaluable to help offset some of these expenses and to cover the time of staff or consultants to facilitate such meetings. Hospitals and health systems looking to address SDOH in their communities should budget for these expenses.

- **Teams wished they had more opportunities for cross-team connections and learning with those working on similar SDOH.** Teams often encountered challenges and benefited from connecting with others who were working on similar issues. Teams viewed this on-the-ground insight as particularly valuable. Hospitals and health systems looking to address SDOH in their communities should join online communities or look to the AHA to help facilitate knowledge-sharing.

Data collected over the course of this inaugural year suggest that participation in the HCC has had a positive impact for most teams and strengthened the capacity of several hospitals and health systems to address SDOH and health equity in their communities.

Conclusion

Most teams are still in the implementation stages of their HCC projects, and it is too early to tell whether the projects will achieve their goals. However, data collected over the course of this inaugural year suggest that participation in the HCC has had a positive impact for most teams and strengthened the capacity of several hospitals and health systems to address SDOH and health equity in their communities. Teams reported increases in leadership support and resource investment for health equity, strengthening of partnerships, and establishment of data infrastructure and processes for data-sharing necessary for a coordinated approach to supporting vulnerable individuals.

There are some limitations to these analyses. First, the one-year time frame of the HCC precluded an assessment of whether the teams were successful in addressing SDOH or health outcomes related to SDOH. Second, because this pilot involved only ten sites, these results may not be representative of what other hospital or health system partnerships could achieve in the same period. Further compounding this issue of generalizability is that teams came into the HCC at different stages of readiness to implement their projects, which made it difficult to make comparisons about their progress over the course

of the year. Nevertheless, it is clear that these teams benefited from their participation in the HCC, which helped many of them to expand their capacity to address health equity and improve health outcomes in their communities.

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Acknowledgments

About the Authors

Malcolm V. Williams is a senior policy researcher and associate director of the Behavioral and Policy Sciences Department at the RAND Corporation. His background is in health services research, including access to care, disparities in health and health care, and community resilience to disasters.

Laurie T. Martin is a senior policy researcher at the RAND Corporation with more than 20 years of experience in the fields of epidemiology, public health, and health policy. Her primary research interests include issues of health literacy and the consumer experience in health care and social services

Jessica Sousa is a policy analyst at the RAND Corporation with experience in research coordination, project management, and direct patient care. Sousa's research interests include policies to address racial/ethnic disparities in health, interventions to target social determinants of health, such as racism and poverty, and the integration of primary and behavioral health care.

About This Report

The Health Research & Educational Trust of the American Hospital Association is conducting a pilot of a new program called the Hospital Community Cooperative (HCC, formerly the Leading Equity and Accelerating Diversity [LEAD] for Health Challenge), funded by the Aetna Foundation. The goal for the inaugural cohort of this program was for ten teams, each consisting of a hospital and one or more community partners, to develop, implement, and evaluate an intervention to address one or more social determinants of health in their communities. The American Hospital Association asked the RAND Corporation to serve as the evaluator for the pilot and to provide evaluation technical assistance to the teams. Progress toward program goals was measured along three dimensions: (1) facilitating collaboration between hospitals and community partners and engagement of community members to address social determinants of health and health equity in their communities; (2) increasing capacity among HCC participants to conduct this type of work; and (3) identifying promising models and lessons learned that can be shared and spread to other hospitals and health systems interested in pursuing similar efforts.

Teams pursued project-related activities over 12 months (September 2018 to September 2019). A Learning Lab event was held in September 2018 during which teams worked with technical assistance providers to define and refine their projects. RAND researchers collected data at two time points: January 2019 (baseline, allowing time for teams to finalize projects) and October 2019 (follow-up). Data collection consisted of a reporting form and in-depth interviews (conducted by telephone) with at least one representative from each HCC team. These data helped RAND researchers draw conclusions about the approaches that teams took to address a social determinant of health in their communities, the challenges they faced, strategies used to overcome these challenges, and a broad array of lessons learned about the development and implementation of projects designed to address social determinants of health and health equity. These lessons can help inform other community-based approaches to develop cross-sectoral partnerships to address health.

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