The Evolving Role of Hospitals and Health Systems

in Community Health and Emergency Preparedness

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A white paper from the USC Schaeffer Center – Aspen Institute advisory panel on the evolving role of U.S. hospitals.

Nancy-Ann DeParle
Sister Carol Keehan
Erin Trish
Julian Harris
Mitchell Katz
Sandra Lindsay
Jonathan B. Perlin
Thomas M. Priselac
Scott Serota
Mike Trachta
Reed Tuckson
Melissa A. Frasco
Ruth Katz

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Additional author information, including titles and affiliations, can be found on page 15.

This report captures the conversations of the group, but no specific section or statement in the report should be considered to represent the opinion of any individual group member.

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TABLE OF CONTENTS

LIST OF ACRONYMS

ASC	Ambulatory Surgery Center	**HHS**	Department of Health and Human Services
CMS	Centers for Medicare & Medicaid Services	**LoS**	Length of Stay
COVID	SARS-CoV-2	**SDoH**	Social Determinants of Health
EHRs	Electronic Health Records	**U.S.**	United States
FFS	Fee for Service	**VBP**	Value-Based Payment

POLICY CONTEXT

Hospitals and health systems play a prominent role in healthcare in the United States. While unprecedented demands stemming from the SARS-CoV-2 (COVID) pandemic demonstrated these organizations' dedication and resilience, they also revealed limitations in emergency preparedness. Moreover, the COVID experience exacerbated longstanding trends affecting financial pressures, workforce stability, and shifts in the nature and expectations of care.

There is a growing recognition that hospitals and health systems must continue to transform to meet simultaneous societal needs for delivery of high-value care, resiliency and preparedness, and improvements in community health and health equity. Stakeholders have called on hospitals and health systems to coordinate with nonclinical social service agencies that address social determinants of health (SDoH), such as food insecurity, housing and transportation. Ultimately, new demands must be balanced with continuing pressures related to costs, efficiency, payment adequacy and closure. In addition, expectations must be sensitive to the considerable diversity among hospitals and health systems across the country.

The USC Schaeffer Center and the Aspen Institute partnered to convene an advisory panel to assess the evolving role of U.S. hospitals and health systems in improving community health and emergency preparedness. The advisory panel included leading experts spanning hospital and health system executives, payers, industry leaders, researchers and policy specialists. This paper reflects a consensus of the expectations for hospitals and health systems within the health ecosystem, recommendations for what hospitals and health systems should act on, and related policy recommendations to achieve these goals.

KEY TAKEAWAYS

- **The core function of hospitals and health systems is to deliver high-value healthcare services for a diverse range of circumstances and conditions.**
- **Hospitals and health systems should collaborate with other health ecosystem participants to develop a shared vision of health.**
- **We recommend a multi-pronged approach for improving community health and emergency preparedness: side-by-side monitoring of public health surveillance measures and hospitals' operational data, uniform screening for social determinants of health, a system for linking patients to social services in the community, and career-development opportunities to prioritize the healthcare work force.**
- **Concurrent policy changes are necessary to achieve these goals. We recommend reforms to increase labor supply, improve efficiency, and ensure that payment adequately supports investment in community health and emergency preparedness.**

EXECUTIVE SUMMARY

Hospitals play a critical and central role in healthcare delivery in the U.S. and its communities, accounting for about 1 in 3 healthcare dollars spent in the U.S.[1] Hospitals not only provide essential maternity and emergency services, but are also often a significant local employer. However, there is no single hospital prototype; hospitals around the country have experienced a wave of consolidation[2], and differ along several dimensions, including profit status, number of beds, urban or rural location, affiliation with academic medical centers and affiliation with a health system. For this white paper, we consider the term "health system" to include at least one hospital and at least one additional provider organization, such as additional facilities and/or a group of physicians providing primary and/or specialty care, which are connected with each other and with the hospital through common ownership or joint management.[3]

The country's experience with the COVID pandemic underscored the resilience and dedication of hospitals, but also exacerbated longstanding trends in care delivery, patient expectations, finances and workforce staffing. Further, starting before the COVID pandemic but accelerating in its wake, there has been a growing expectation that the healthcare system—including hospitals, nursing homes, physicians and other clinical providers—should deliver more than high-quality clinical care at the individual patient level. To improve community health, some policymakers and other stakeholders have encouraged hospitals and the entire U.S. healthcare system to coordinate with nonclinical social service agencies that address SDoH, such as housing and food insecurity, often without dedicated reimbursement. Alongside the goal of improving community health is the desire to advance health equity, including holding hospitals and the larger healthcare system accountable for helping achieve these broader outcomes.

Within this landscape, the USC Schaeffer Center and the Aspen Institute partnered to create an advisory panel to develop recommendations to guide U.S. hospitals and health systems as we move beyond the acute phase of the COVID pandemic. First, the panel defined the function and role of hospitals and health systems in the health ecosystem. Then, the panel developed eight consensus recommendations for hospitals, health systems and policymakers to consider to improve community health and advance health equity. These recommendations are intended to reflect the vision and goals of what is possible within the realities of what is practical. Moreover, they reflect the need for greater dialogue and collaboration between policymakers and the delivery system to achieve this vision.

The Function and Role of Hospitals and Health Systems in the Health Ecosystem

Function: The function of hospitals and health systems is to deliver high-value healthcare services for conditions that require medicine, care, monitoring and medical treatment, and to coordinate care for chronic conditions while operating as the backstop provider and responding to unexpected public health emergencies.

Role: Hospitals and health systems are one part of the health ecosystem—of which public health services, social services and public officials (including policymakers and regulators) are also participants. Within this ecosystem, the role of hospitals and health systems should include active participation in planning and coordinating services to address the health needs of their communities. Hospitals and health systems should also exert leadership by working collaboratively to develop a shared vision of health for their communities. Lessons learned during COVID about the value of such a shared vision should be a foundation for a new compact between hospitals and health systems and their communities.

Recommendations for Hospitals and Health Systems

1. A means for sufficient side-by-side monitoring of public health surveillance measures and the operational data of hospitals should be created at the regional and possibly national levels to be better prepared for future public health emergencies. This infrastructure would improve monitoring of equipment shortages, labor shortages and resource utilization to identify priority target areas of public health concern, direct resources accordingly and assess progress.
2. Validated questionnaires and standardized coding instruments for screening SDoH should be integrated into the patient-encounter process to assess individual patient needs, organize appropriate interventions, and monitor equity in the availability and application of health-enhancing resources. Data collection efforts should be transparent, interoperable, shared with appropriate entities and conducted with appropriate privacy safeguards in place.
3. Hospitals and health systems should provide equitable quality healthcare within their walls, support the comprehensive health needs of their patients by systematically linking them to social services in the community and lead coalitions of stakeholders to obtain adequate funding for health-promoting social services. Hospitals and health systems, together with organizations working to address social needs, should formulate separate and distinct roles for improving the health of the community.
4. Labor shortages should be viewed as a strategic constraint that demands immediate attention at all levels of employment—engagement, retention and recruitment. Hospitals and health systems should invest in career-development opportunities for their diverse workforce.

Related Policy Considerations

5. Workforce policies that exacerbate labor shortages such as scope of practice and site of service limitations, nurse staffing ratios, and barriers to recruitment and training should be reformed.
6. Payment policy should encourage the use of high-value care and discourage the use of low-value care. To improve efficiency, administrative requirements should be aligned and promote meaningful improvements in safety and quality of care (avoiding, e.g., excessive documentation and patient paperwork requirements, overlapping inspections, onerous surveys and certificate of need processes).
7. Payment policy should support efforts beyond the acute provision of care, such as investing in emergency preparedness for future public health emergencies, caring for patients with social needs and advancing health equity in the healthcare system.
8. Greater experimentation with significant payment reform—including across payers and potentially at the state or regional level—is necessary to transform care delivery and investments in community health.

INTRODUCTION

Hospitals play a prominent role in healthcare delivery, accounting for about 1 in 3 healthcare dollars spent in the U.S., or nearly 6% of U.S. gross domestic product.[1] They have become increasingly diverse, encompassing independent hospitals and hospital and health systems. In general, hospital systems include organizations where two or more hospitals share ownership and/or management, while health systems include hospitals or hospital systems that are vertically integrated with primary and specialty physicians or other types of healthcare providers and facilities.[2,3]

Prior to the COVID pandemic, financial pressures on independent hospitals required many to shrink, merge or close.[4] Rural areas were disproportionately affected by hospital closures.[5,6] Longstanding trends in care delivery[7-9]—including reduced length of stay (LoS) and a shift toward more outpatient procedures—have changed the nature and expectations of hospital care. At the same time, there was growing interest among policymakers and others in rethinking healthcare delivery and improving the provision of efficient, equitable and high-value care.[10] In particular, hospitals and health systems in pre-pandemic times were facing mounting scrutiny of commercial prices and demands to restrain price growth and improve efficiency, including the hospital price transparency rule and new payment models from public and private payers.[11]

Thrown into pandemic crisis mode, hospitals and health systems demonstrated their dedication and resilience, but were also forced to grapple with demands and challenges unique to the COVID era. The cost per case and average LoS increased and labor shortages drove an approximately 17% increase in overall expenses over pre-pandemic levels.[12] While recent indicators suggest a trend toward improved patient engagement after initial declines in healthcare utilization and easing labor costs, at least in some areas, changes in payer mix and trends toward shifting less acute services out of the hospital appear to be more sustained.[13] The resilience of hospitals and health systems continues to be tested with demand affected by delayed or forgone care and evolving patient preferences, in conjunction with financial and workforce challenges.

A shift in the expectations of the entire healthcare system also appears underway, with an emphasis on improving community health and advancing health equity. While public and private payers alike are implementing policy and reimbursement changes designed to hold providers accountable for outcomes and equity, it must be recognized that hospitals and the entire healthcare system are only part—albeit a fundamental part—of the broader network of stakeholders in the health ecosystem. That is, health outcomes reflect not only access to quality healthcare, but also other factors that affect the health of communities and their residents, such as SDoH like housing, employment and education.[14] Effectively resolving the root causes of poor health will require sweeping and broad policy changes, beyond simply connecting patients to clinical care or temporary housing.

Other forces at play include healthcare labor regulation constraints that are affecting an increasingly burned-out and dwindling healthcare workforce.[15] In addition, value-based payment (VBP) models[16] have proliferated, with some already showing success at reducing healthcare costs while improving health outcomes.[17,18]

Overall, hospitals and health systems have become more complex organizations. They are adapting to societal needs for resiliency and preparedness for public health emergencies, but these new demands must be balanced with continuing pressures related to costs, efficiency and closure.

The convergence of affordability pressures, unprecedented demands stemming from the COVID pandemic, and evolving societal expectations regarding improvements in community health and advancements in health equity have prompted careful review of the role of hospitals and health systems in the U.S.

With this context in mind, the USC Schaeffer Center and the Aspen Institute partnered to create an advisory panel to develop recommendations and policy considerations to guide future operations of hospitals and health systems in the U.S. Chaired by three leading experts—Nancy-Ann DeParle, Sister Carol Keehan and Erin Trish—the panel convened additional expert participants spanning hospital and health system executives, payers, industry leaders, researchers and policy specialists to discuss the future of hospitals and health systems given the pressures and changes brought on by the COVID pandemic. The panel focused on issues related to the role that hospitals and health systems should and should not consider playing in providing high-value healthcare and promoting community health, including their respective responsibilities as part of the broader network of health-related community stakeholders. Panelists reflected on lessons learned from the unique experience of a shared vision and leadership engagement presented by the COVID pandemic and discussed the extent to which that experience could or should translate to future expectations and policy approaches. The advisory panel's recommendations were developed through deliberations at a two-day, in-person meeting in 2022, and incorporated feedback from additional discussions and comments.

The panel's discussions and consensus recommendations reflect the diversity among hospitals and health systems across the country. They also reflect the universal commonality of the fundamental role hospitals and health systems play in their communities—beyond being providers of healthcare services—and their capacity to be a leader in efforts to provide access to high-value care, advance health equity and improve community health.

The remainder of this paper frames the advisory panel's recommendations regarding policy considerations for the future role of hospitals and health systems in the U.S. To provide context for our recommendations, the document begins with an overview of ongoing forces impacting hospitals and health systems, including longstanding industry trends; their role in emergency preparedness and resilience; enhanced focus on health equity; and workforce challenges. Following that overview, we discuss the panel's eight recommendations intended to guide the future of U.S. hospitals and health systems, including related policy considerations.

FORCES IMPACTING HOSPITALS AND HEALTH SYSTEMS

Longstanding Trends

While the last few years have presented financial and operational challenges unique to the COVID pandemic, longstanding trends have also shaped hospitals and health systems and their evolving role in U.S. healthcare delivery.[19] Over time, care delivery has shifted away from the inpatient hospital setting to alternative sites of care, propelled by medical and technological advances along with payment incentives. For example, low-acuity diagnostic services and minimally invasive surgical procedures have migrated to hospital outpatient departments and ambulatory surgery centers (ASC). Although there is considerable variation in the extent to which care has shifted to ASC,[8] overall utilization has grown significantly, particularly with payment policy changes such as the Centers for Medicare & Medicaid Services (CMS) permitting reimbursement for total knee replacement outside the hospital inpatient setting.[20-22] In addition, emergency care has seen a shift to ambulatory settings with the growth of urgent care centers and freestanding emergency rooms.[7,9]

This evolution in the site of care delivery, coupled with reductions in Medicare and Medicaid reimbursements, contributed to declining financial health among hospitals in the last decade prior to the COVID pandemic.[5] The number of community hospitals in the U.S. has shrunk over the last few decades, and research suggests that hospitals in the lowest 10% of operating margins were more likely to close or be acquired.[4] Rural hospitals have been particularly susceptible to financial challenges as a result of lower patient volumes, higher rates of uncompensated care, higher proportion of Medicare patients and physician shortages.[23] The Affordable Care Act's Medicaid expansions reduced the likelihood of hospital closures—particularly in rural areas where a higher proportion of patients were uninsured prior to these expansions.[24] However, 10 states still have not expanded Medicaid,[25] leaving hospitals in their states more vulnerable to closure.[24] Moreover, rural hospitals have suffered a disproportionate rate of closures in the last decade. Between 2015 and 2019, these hospitals accounted for 59% of the decline in the number of U.S. community hospitals.[6]

Financial pressures and other policy and market trends have fueled the proliferation of hospital systems and health systems, which have grown substantially over the last few decades.[1,26] Consolidation through system membership has received considerable scrutiny related to its impact on hospital prices paid by commercial insurers. For example, studies have documented associations between market concentration[27] and vertical integration[28] and prices paid by commercial insurers, as well as the role of hospital price growth in spending growth

among commercially insured patients in recent years.[29] While such associations do not necessarily hold in every market or transaction, nonetheless these trends have led to increased antitrust scrutiny, as well as realized and/or proposed policy interventions by states,[30] the federal government[31] and private-sector actors to address prices.[32]

At the same time, health systems offer the benefit of scale, may help to preserve an adequate hospital network and physician supply in communities to meet growing demand for healthcare services, and may also be better equipped to adopt and promote VBP models. Pressure to address rising healthcare costs has prompted review of waste in the healthcare system and misaligned payment incentives. A recognition that the traditional fee-for-service (FFS) reimbursement system does not align with reducing waste has stimulated a shift toward alternative payment models, such as VBP models,[16] which attempt to reduce costs while simultaneously improving outcomes. While there are examples where VBP models have been successful at improving value and quality,[17,18] numerous challenges still must be addressed.[33]

Emergency Preparedness and Resilience

The COVID pandemic revealed broad concerns related to emergency preparedness. COVID exposed the limitations in practice of the emergency planning policies imposed by CMS, The Joint Commission, and the Office of the Assistant Secretary for Preparedness and Response within the Department of Health and Human Services (HHS). By February 2021, the toll of operating in sustained "survival mode" was made known through a nationwide survey of hospital administrators conducted by the Office of Inspector General. "Difficulty balancing the complex and resource-intensive care needed for COVID patients with efforts to resume routine hospital care," staffing shortages and financial instability were the top concerns of hospital administrators.[34] Additionally, respondents found that "many of these challenges were more severe for rural hospitals" and "raised concerns that the pandemic has exacerbated existing disparities in access to care and health outcomes." Of particular note, disengagement from routine health services and concerning gaps in care were observed by the end of 2021 among pediatric populations[35] and Medicaid beneficiaries.[36] The effects of delayed or forgone care are still unclear, but are likely to worsen preventable hospitalizations, morbidity and mortality in the U.S.,[37] especially among disadvantaged communities.

Hospitals and health systems have also grappled with cost structures unique to the COVID era. Federal financial support tied to the public health emergency had a positive impact on reducing hospital closures. After a peak of 46 hospital closures in 2019, the number fell to 25 in 2020 and 10 in 2021.[38] However, financial challenges reflecting industry shifts, such as longer hospital stays and increased labor expenses—outliving federal support—contributed to concerns about hospital financial viability in 2022.[39] For example, the average LoS during coronavirus surges was 17% higher than the pre-pandemic average LoS.[40] Increased wage rates resulted from the need for traveling nurses or overtime pay to cover staff shortages. As such, labor shortages drove an approximately 17% increase in overall expenses over pre-pandemic levels.[12] While recent trends indicate some of these financial pressures may be easing,[13] they remain indicative of the types of challenges hospitals and health systems may expect to face in future emergencies.

Health Equity

The COVID experience underscored the growing recognition that medical care alone cannot fully address health improvement goals at the community level.[41] The longstanding strategy of expanding access to quality medical care as the main approach for improving community health fails to address an individual's social needs that affect disease and disability. For example, unreliable transportation and financial strains are associated with an increased risk of 30-day readmission rates, hospital stays and emergency department visits.[42] Similarly, public health systems prioritize protections for vulnerable groups to prevent disease, but they cannot always effectively anticipate and address the social needs that keep communities healthy.

Social services are the appropriate mechanisms to help mitigate poor health outcomes driven by SDoH, but these services and the organizations that provide them often suffer from inadequate funding. Community-level health is the product of several components, including access to quality healthcare and medical interventions, robust public health systems, well-funded community-based social services and strong health-promoting policies. While addressing the social needs of a population is critical, community health also requires new or revised policies designed to address root causes of poor health.[41]

Societal expectations around the role of the healthcare system in promoting health equity are also evolving. Health equity prioritizes social justice in healthcare based on need.[43] Under the Biden administration, CMS has included "advancing health equity by addressing the health disparities that underlie our health system" as one of six pillars in its strategic plan.[44] Changes in policy can directly encourage moving beyond the traditional bounds or lanes of the healthcare system. For example, recent CMS policy changes now allow Medicare

Advantage plans to offer "nonmedical" supplemental benefits to beneficiaries, such as food, nonmedical transportation, pest control and rent subsidies. Such plans, particularly those designated as special needs plans, have increasingly opted to offer these benefits.[45] These trends reflect a potential broadening of the scope and expectations of the healthcare system, which may also reflect the historically low public investments in social services relative to healthcare services in the U.S.[46]

Workforce Challenges

The COVID pandemic intensified longstanding workforce shortages across care settings from hospitals to nursing homes, and positions from nurses and respiratory therapists to patient care assistants and home health aides. Due to COVID pressures, hospital staff turnover has reached record highs among nursing, emergency and intensive care unit departments.[47] Further, a high prevalence of nurses have reported job burnout.[48] One estimate predicts a national shortage of 3.2 million healthcare workers by 2026.[49] In addition, an increase in chronic diseases and behavioral health conditions as well as an aging population all contribute to growing demand for care.[49]

A FRAMEWORK FOR THE FUTURE ROLE OF HOSPITALS AND HEALTH SYSTEMS AND RELATED POLICY CONSIDERATIONS

Panelists deliberated at a two-day meeting in fall 2022 on defining the responsibilities and roles of hospitals and health systems. The following section reflects a consensus of the expectations for hospitals and health systems within the health ecosystem, recommendations for what hospitals and health systems should act on, and recommendations policymakers should consider going forward.

The Function and Role of Hospitals and Health Systems in the Health Ecosystem

Function: The function of hospitals and health systems is to deliver high-value healthcare services for conditions that require medicine, care, monitoring and medical treatment, and to coordinate care for chronic conditions while operating as the backstop provider and responding to unexpected public health emergencies.

The core function of hospitals and health systems is to deliver high-value healthcare services for highly technical care and emergency care, and to coordinate care for chronic conditions under normal and extreme circumstances. The caveat is that high-value healthcare in the inpatient setting requires other care-delivery units operating outside the hospital setting (e.g., skilled nursing care, post-acute at-home care, mental health services) to be available and functional. Expectations for hospitals and health systems to deliver high-value healthcare services should vary according to size, capability and service offerings. For example, vertically integrated health systems are adept in distributing patients across care delivery units according to their medical needs. Smaller, rural hospitals do not have either the depth or breadth to strengthen operations for other care-delivery units. In many cases, smaller hospitals do not have the agency to transfer patients to more appropriate service facilities for noncritical care and therefore need to rely more heavily on other providers and service agencies.

Hospitals are a trusted source in the community for high-level care no matter the circumstance. Societal expectations of hospitals are vast, ranging from service provider of last resort to on-call medical professionals of acute emergency care. In the words of one physician quoted in a recent New York Times article: "The hospital ends up being the place you go when all else fails."[50] In addition, hospitals are expected to scale up delivery to meet the needs of the community under public health emergencies.

Role: Hospitals and health systems are one part of the health ecosystem—of which public health services, social services and public officials (including policymakers and regulators) are also participants. Within this ecosystem, the role of hospitals and health systems should include active participation in planning and coordinating services to address the health needs of their communities. Hospitals and health systems should also exert leadership by working collaboratively to develop a shared vision of health for their communities. Lessons learned during COVID about the value of such a shared vision should be a foundation for a new compact between hospitals and health systems and their communities.

Hospitals and health systems provide clinical care, which on its own is not sufficient to ensure community health. Community health is the responsibility of several parties, with hospitals and health systems playing a prominent role in efficiently scaling and coordinating services related to patients' social needs. Other parties include professionals and organizations working with the community to provide services for social needs (e.g., social workers, public health

workers, community-based organizations) and those creating community conditions to support good health for all people (e.g., policymakers, regulators).

To support community health, hospitals and health systems should be active participants in planning and coordinating services to address the health needs of their community. Aligning medical care and social care based on a person's needs should be a fundamental role of hospitals and health systems. Hospitals and health systems are well-suited to coordinate services for SDoH and may choose to work with community partners as appropriate. Lastly, hospitals and health systems should draw on the shared vision of an organizational commitment to saving lives during the heights of COVID waves while working collaboratively with community organizations to develop a shared vision of community health. Policy should build on the lessons learned from bridging clinical care, public health and social services in strengthening community health.

Recommendations for Hospitals and Health Systems

RECOMMENDATION 1:
A means for sufficient side-by-side monitoring of public health surveillance measures and the operational data of hospitals should be created at the regional and possibly national levels to be better prepared for future public health emergencies. This infrastructure would improve monitoring of equipment shortages, labor shortages and resource utilization to identify priority target areas of public health concern, direct resources accordingly and assess progress.

Emergency preparedness and scalable delivery require monitoring public health data and medical resources in a region. Public health surveillance measures, such as wastewater pathogen detection and the Centers for Disease Control and Prevention's National Syndromic Surveillance Program,[51] can serve as early warning systems for public health outbreaks and other health-related concerns. Side-by-side monitoring of public health surveillance data and operational data from hospitals and health systems (e.g., hospital and nonhospital equipment, staff, resource utilization) will improve the resilience of the healthcare system during public health emergencies in real time. An interface of public health surveillance measures and operational data from hospitals and health systems to understand resources and limitations in both sectors should be considered moving forward.

RECOMMENDATION 2:
Screening for social determinants of health (SDoH) using validated questionnaires and standardized coding should be integrated into the patient-encounter process to assess individual patient needs, organize appropriate interventions, and monitor equity in the availability and application of health-enhancing resources. Data collection efforts should be transparent, interoperable, shared with appropriate entities and conducted with appropriate privacy safeguards in place.

Identifying the burden of unmet social needs (e.g., housing instability, food insecurity, transportation barriers, utility help, interpersonal safety instability) is an important step to advancing health equity. Timely and accurate identification of SDoH is important to assess individual patient needs and organize appropriate interventions. These data could be used internally to improve clinical care and shared with organizations that work to address social needs. In addition, deidentified files would be useful to agencies responsible for monitoring health equity in the healthcare system and to conduct research to inform policy interventions.

Several groups have provided frameworks for collecting a set of measures to capture SDoH in the clinical setting.[52-54] Standardized and validated questionnaires have been developed for assessing SDoH, such as the Accountable Health Communities Screening tool.[55] The sensitivity around these types of questions has triggered the development of a guide to avoid unintended consequences of screening for social needs.[56] In addition, existing electronic health record (EHR) systems have modules to integrate data on SDoH in the community, known as community vital signs.[57,58]

Hospitals and health systems should integrate standardized assessments of SDoH into their EHRs.[54] Efforts to facilitate this are underway. For example, in conjunction with the Office of the National Coordinator for Health Information Technology, the Gravity Project is working to "guide the development of standards to support SDoH data capture and exchange" within the following domains: food insecurity, housing instability and homelessness, inadequate housing, transportation insecurity, financial strain, social isolation, stress, interpersonal violence, education, employment and veteran status.[59,60] In time, HHS could consider requiring such data collection as part of meaningful-use certification.

RECOMMENDATION 3:
Hospitals and health systems should provide equitable quality healthcare within their walls, support the comprehensive health needs of their patients by systematically linking them to social services in the community and lead coalitions of stakeholders to obtain adequate funding for health-promoting social services. Hospitals and health systems, together with organizations working to address social needs, should formulate separate and distinct roles for improving the health of the community.

Health equity within the walls of all hospitals and health systems should be a fundamental principle for these—and indeed, all—providers. Health equity for providers means prioritizing treatment and care based on need. Such a targeted focus will help improve health outcomes for disadvantaged groups and, in turn, improve the health of the community.

To advance health equity, hospitals and health systems should use their status as community anchor institutions to be a connector to services for social needs. The healthcare encounter should also be an opportunity to coordinate patients' needs outside the healthcare system and within the health ecosystem. Hospitals and health systems should create partnerships to link patients to services for behavioral health and social needs outside of the inpatient setting. Approaches and frameworks to implement such efforts have already been developed.[43,53]

Responsibility for improving community health should be expanded to include organizations working with the community to provide support for social needs. Hospitals and health systems can then focus on what they do best—providing highly technical care. Directing patients to other resources or sites of care will also allow hospitals and health systems to create buffer capacity to maintain readiness for public health emergencies. None of this is possible, however, unless these community groups are adequately funded to take on the job. Thus, hospitals and health systems should leverage their status as community and political "influencers" and economic engines to help the community secure adequate funding for social services and advocate for enhancement of critical health services that are unavailable.

RECOMMENDATION 4:
Labor shortages should be viewed as a strategic constraint that demands immediate attention at all levels of employment—engagement, retention and recruitment. Hospitals and health systems should invest in career-development opportunities for their diverse workforce.

Strategies to address labor shortages should include a multipronged approach addressing engagement, retention and recruitment. Workforce diversity is an asset to the healthcare system, where people of different backgrounds come together to strengthen the organization. During this critical time of labor shortages, particularly in the hospital setting,[15,48] reimbursement should partially support higher pay for hospital staff. In addition, mentoring programs and paths for promotion are especially critical for workforce engagement and retention.[61,62] Retention strategies should evolve to meet the demands and interests of the healthcare workforce, including flexible work schedules and self-scheduling.[63] Some institutions are now even offering student-debt relief and infertility benefits as recruitment strategies.[64] In addition, administrative tasks with limited value for improving care are an important drain on the workforce and can lead to burnout and retention challenges.[65,66] Recruitment challenges are twofold: Both trainees and teaching staff are dwindling. Policies and programs must be developed and implemented to address each.

Related Policy Considerations

RECOMMENDATION 5:
Policymakers and regulators should address policies that exacerbate workforce restrictions (e.g., scope of practice and site of service limitations, nurse staffing ratios, and barriers to recruitment and training).

Healthcare is a heavily regulated industry with policymaking and regulatory oversight occurring at the national, state and local levels. At each level, policymakers and regulators should work with hospitals and health systems as well as other stakeholders to review existing requirements, such as scope-of-practice laws governing clinician practice, to ensure high-quality, safe and efficient care delivery. While the COVID pandemic placed unprecedented stresses on the healthcare system, it also spurred innovations in care delivery (particularly telehealth), remote patient monitoring and hospital-at-home initiatives. Policymakers should consider how technological advances can increase efficiency by creating, for example, virtual emergency departments through which a patient is connected directly to a remote physician—an approach in contrast to the current practice of physical emergency departments where triage and other activities are performed in part to comply with regulatory requirements.

As policymakers consider pulling back on flexibilities granted to providers through the public health emergency, they should seek ways to remove regulatory hurdles to innovation that can potentially improve patient care and support healthcare workforce recruitment and retention

efforts. In particular, telehealth may play a critical role in expanding access for patients at rural hospitals and Critical Access Hospitals, as well as easing workforce challenges and avoiding closure. This is important due to the special role these facilities play as a "provider of only resort" in many parts of the country. Nurse staffing ratio requirements are another example of regulation limiting innovative models of care and compounding workforce supply challenges. Static, mandated, nurse staffing ratios limit experimentation that can potentially improve patient care, such as interprofessional care teams, data-driven decision-making and advances in technology. Furthermore, patients may be turned away or have to delay care at hospitals that are understaffed and cannot meet the required nurse-to-patient ratios.

Given the growing demands on the healthcare system as the last of the "baby boomer" cohort—76 million strong—ages into Medicare by 2030, policymakers must prioritize eliminating structural and financial barriers to train an adequate supply of healthcare workers for the country. In short-term practice, overseas recruitment is likely to be part of the solution to meet U.S. workforce needs, though there are important concerns about the impact that enlisting healthcare workers from other countries could have on the countries of origin. Longer-term solutions will require prioritizing training of an adequate number of healthcare workers. Federal policies to widen the nursing bottleneck have been suggested, such as the appropriation of funds for the National Healthcare Workforce Commission, loan-forgiveness programs for trainees, a nurse faculty corps program and expansion of the CMS Graduate Nurse Education demonstration project.[67] In addition, investment in programs to increase the supply of healthcare workers may be achieved by implementing targeted scholarships or tuition support.

RECOMMENDATION 6:
Payment policy should encourage the use of high-value care and discourage the use of low-value care. To improve efficiency, administrative requirements should be aligned and promote meaningful improvements in safety and quality of care (avoiding, e.g., excessive documentation and patient paperwork requirements, overlapping inspections, onerous surveys and certificate of need processes).

Low-value services are defined as services that provide little or no benefit to patients, have potential to cause harm, incur unnecessary costs to patients or waste limited healthcare resources.[68] Reducing the use of low-value services could ensure cost savings and more efficient care, but holding providers accountable for this will also require effective patient engagement.[69]

To maximize the potential of payment models that promote high-value care and discourage low-value care, policymakers must pay close attention to eliminating unnecessary costs in hospital and health system operating models. Excessive documentation, lack of uniformity for billing and other regulatory requirements can be a drain on the workforce and drive up administrative costs without adding significant value for patient care. Hospitals and health systems will struggle to address workforce concerns, sustain surge capacity and succeed in VBP models unless they can work with policymakers and stakeholders to reduce costs that do not have a meaningful impact on improving patient care.

RECOMMENDATION 7:
Payment policy should support efforts beyond the acute provision of care, such as investing in emergency preparedness for future public health emergencies, caring for patients with social needs and advancing health equity in the healthcare system.

Alternative payment models, such as VBP models, are designed to improve efficiency and quality of care, but can be at odds with other investments, such as preparing for public health emergencies or caring for patients with social needs. While exercising prudent use of taxpayer-funded resources, Congress, the Medicare Payment Advisory Commission, HHS and other participants in the payment policy process should consider adopting policies that support an adequate and reliable source of funding for hospitals to meet the community need for rapid response to unexpected public health emergencies. Furthermore, population-based payments are likely needed to fund investments in community health and disease prevention interventions. Thus, the goal is not to reduce payment to the minimal level of simply covering the costs of efficiently providing care for a given service, but rather to provide a predictable source of revenue that also covers broader responsibilities of hospitals and health systems, including those under extreme conditions.

RECOMMENDATION 8:
Greater experimentation with significant payment reform—including across payers and potentially at the state or regional level—is necessary to transform care delivery and investments in community health.

VBP models are proliferating, but more innovation and experimentation is needed across payers and regions. The multi-payer structure of the U.S. healthcare system makes it challenging for any single payer to implement a model with high-powered incentives. Testing multi-payer VBP

models would expand the scope to improve health outcomes at the community level and could reduce administrative burden. In the absence of multi-payer experimentation, hospitals and health systems that can provide coordinated care are best suited to benefit from VBP models. However, the capacity and capability of hospitals and health systems to provide coordinated, comprehensive care to improve health outcomes will inevitably vary; thus, payment schemes should be developed to take such differences into account. More experimentation with significant payment reform is needed to transform care delivery and ensure investments in community health.

CONCLUSION

Challenges confronting the healthcare system are multifaceted. The expectations of hospitals and health systems are changing in the COVID era to include surge-capacity plans under public health emergencies and constitute greater connection points between healthcare and public health systems and social services. At the same time, affordability pressures are driving innovation for alternative payment models to increase the efficiency and efficacy of the healthcare system. In addition, public and private payers alike are implementing policy and reimbursement changes to encourage better community health and health equity. It is important to acknowledge that simply expanding access to quality medical care will not be a cure-all for improving community health because it fails to address underlying social needs and structural injustices that directly affect disease and disability.[43,53]

As accountable parties in improving community health, hospitals and health systems should provide equitable, quality healthcare within their walls, support the comprehensive health needs of their patients by systematically linking them to social services in the community and lead coalitions of stakeholders to obtain adequate funding for health-promoting social services. Such efforts should include various entities working with the community to address social needs (e.g., social workers, public health professionals, community-based organizations), as well as public officials with the power and authority to act to drive better health for all.

The diversity among these providers is vast; however, at their core, hospitals and health systems should deliver high-value healthcare services for conditions that require medicine, care, monitoring and medical treatment, and should coordinate care for chronic conditions while also operating as a backstop provider and maintaining capacity to respond to unexpected public health emergencies. Policymakers should recognize the complex role of hospitals and health systems and support funding for required operations that go beyond reimbursed services. Moreover, alternative payment models are needed that encourage high-value care, improve health equity, and provide hospitals and health systems with a secure source of funding to serve as the last resort health provider and invest in emergency preparedness. Finally, regulatory hurdles that hinder healthcare workforce recruitment and retention should be reevaluated.

The COVID pandemic acutely revealed the resilience and dedication of our hospitals and health systems, while simultaneously exposing the limitations of our healthcare system. As we emerge from the pandemic to an era of ongoing challenges and opportunities—and reevaluate pandemic-era policies and flexibilities—the lessons learned offer an opportunity to improve outcomes by realigning incentives and removing regulatory hurdles to innovation that can potentially improve patient care and support healthcare workforce recruitment and retention efforts. The USC Schaeffer Center and Aspen Institute advisory panel believes that if hospitals, health systems and policymakers pursue these recommendations with urgency, community health will improve and preparedness for future public health emergencies will be strengthened.

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Additional Authors

Melissa A. Frasco, Research Scientist, USC Schaeffer Center for Health Policy & Economics

Ruth Katz, Vice President and Executive Director, Health, Medicine & Society Program, Aspen Institute

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USC Schaeffer

Leonard D. Schaeffer Center
for Health Policy & Economics

Stephanie Hedt
Associate Director of Public Affairs
Schaeffer Center for Health Policy & Economics
University of Southern California
hedt@usc.edu
213.821.4555