Title: Navigating Barriers: Healthcare Anchor Institutions and Population Health Advancement

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ABSTRACT

Background: Many United States hospitals explicitly pursue “anchor missions” by committing to intentionally apply place-based economic power and human capital in partnership with the community. Little is known about how hospital-community partnerships are implemented or whether they impact social determinants of health (SDOH) and population health. We qualitatively analyzed healthcare institutions from a national network to understand barriers and facilitators while implementing hospital-community partnerships that aim to improve population health.

Methods: We used qualitative analysis of responses to open-ended items on a cross-sectional survey to explore how hospitals with anchor missions address SDOH. We administered the survey to healthcare systems participating in the Healthcare Anchor Network (HAN), a national network of hospitals with explicit goals to address SDOH and improve population health.

Results: Responses were from 16 organizations. Two themes emerged: 1) healthcare systems faced many demands (i.e., COVID-19, financial stability), which competed with prioritization of the anchor mission, and 2) senior leadership engagement was critical for impact of the anchor mission and efforts to address SDOH and population health. Strategies to engage leadership included peer networking and providing repetitive education on community health inequities to hospital leaders.

Conclusions: Although health systems show enthusiasm for population health, competing priorities often constrain anchor mission efforts to improve SDOH and population health outcomes. With external encouragement, such as changes to federal or state quality metrics reporting, payment incentives to address community health, or other policy changes, health systems will engage more with communities and be able to address SDOH.

Key Words: Anchor Mission, Quality and Safety, Population Health, Social Determinants of Health, COVID-19

INTRODUCTION

United States hospitals recognize the importance of addressing social determinants of health (SDOH) that influence their communities.[1–3] The Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) recognize that the SDOH includes non-medical factors like where people live, their environment, education, food stability, working life conditions, and structural barriers influencing health outcomes[4,5]. Hospitals that have prioritized SDOH and attempted to connect with their communities through invested capital, population health initiatives, and relationships with consumers, employees, and vendors[6–9] have been labeled "anchor institutions" pursuing "anchor missions." The Democracy Collaborative defines an anchor mission as "a commitment to intentionally apply an institution's place-based economic power and human capital in partnership with community."[10] In other words, an anchor mission grounds a healthcare institution to support its local community beyond providing medical care. However, little is known about how hospital-community partnerships are developed and implemented or whether they genuinely impact SDOH and population health. Our study uniquely addresses this gap in the existing literature by sampling member organizations of the Healthcare Anchor Network (HAN) and exploring hospital-community partnerships. HAN is a multi-institution, membership-based network comprising health systems with stated goals to bring together champions from health systems across the country, facilitate shared learning, and support collaborative initiatives to accelerate the adoption of practices that will narrow inequities for low-income families and communities of color.[11] We qualitatively analyzed anchor mission leads from health system members of this network to understand barriers and facilitators while implementing hospital-community partnerships to improve population health.

METHODS

Study Population

We used qualitative analysis of responses to open-ended items on an electronic, cross-sectional survey to explore how hospitals with anchor missions address SDOH. All study activities were reviewed and approved by Northwestern University's Institutional Review Board. We administered the survey to all 60 member organizations in the Healthcare Anchor Network in June 2021.

Deployment and Data Collection

We recruited individuals listed as their healthcare organization's point of contact for the HAN's Anchor Mission Leads Group; these individuals are responsible for advancing their organization's goal to adopt and implement an anchor mission. Administration at the HAN aided recruitment by distributing a link to the online survey and study risks and benefits via email. Participation was confidential, with no monetary incentive. The data collection period lasted three weeks in total in June 2021. The goal of the current study is to report our qualitative analysis of answers to seven open-ended questions (Supplemental

Digital Content) about the following topics: the role of a hospital in addressing economic and racial inequities in community conditions; ways that anchor mission strategy does or does not align with other population health efforts; and questions about the challenges faced as part of the anchor mission journey. See the complete questions as supplemental material.

Data Analysis

We exported and de-identified responses to the open-ended survey questions for hand coding to categorize and analyze responses to see patterns and themes. Three study team members who were trained in qualitative analysis independently reviewed the data. An initial draft of the codebook was developed from a literature search that included relevant peer-reviewed publications and white papers about healthcare organizations' community health initiatives, engagement, and anchor missions, and themes that emerged directly from the data. The literature used to help develop the survey questions was also used to create the codebook. After applying the initial set of predefined codes, we compared and discussed each code and revised the codebook to include emerging codes and themes. The team continued an iterative coding and analysis process until a consensus was reached on disagreements in the codes and final themes. To ensure data integrity, we created an analysis audit trail to document decisions and adhered to the Standards for Reporting Qualitative Research (SRQR)[12].

RESULTS

Sample Characteristics

Sixteen organizations (Table 1) completed the open-ended questions. These included nine academic health systems, six children's hospitals, five multi-state systems, and four safety net systems. Eight organizations reported urban settings, three reported rural settings, and five did not report a practice setting.

Themes

Two predominant themes (Table 2) emerged in our analysis of building hospital-community partnerships about anchor missions: 1) healthcare systems faced many demands, which competed with prioritization of the anchor mission, and 2) engagement of senior leadership was critical for the impact of the anchor mission and efforts to address SDOH and population health.

Competing Priorities

Across the data, respondents noted the potential value of their organizations as anchor institutions. One leader stated, "as an anchor institution we could have a significant role in addressing economic and racial inequities" (7). They were committed to advancing an anchor mission to positively impact their communities and address SDOH. Still, respondents described difficulty prioritizing the work necessary to implement anchor missions in their health systems. One respondent said, "[there are] too many other

immediate and pressing priorities" (13). While another organization actively implementing anchor work exemplified these struggles with a quote: "although the various leaders understood and bought into the anchor mission framework, they did not prioritize this work" (3). Most respondents described competing priorities for leadership (e.g., battling a pandemic, meeting quality metrics, and financial stability) that got in the way of championing anchor mission work.

Prioritization Issues Due to COVID-19

This survey was administered amid the COVID-19 pandemic. Multiple respondents described the pandemic as a competing priority for focusing on anchor mission work. One respondent exemplified this by stating, "[challenging] attention to anchor strategies while battling a pandemic" (12). Another mentioned, "I anticipate we will have challenges getting sufficient financial support to move the work forward, especially due to the financial costs incurred as a result of COVID" (7).

Business Constraints

Despite many institutions' intention to implement strategies that advance an anchor mission, a shared competing priority in the data was the bureaucratic challenges of running a hospital. These challenges include the financial responsibilities that healthcare organizations have to remain functional. One respondent described this challenge: "The dollar flow. Budgeting for long term and keeping with the commitment when [times are] lean" (10). Similarly, providing the necessary staffing required for implementing anchor strategies was commonly mentioned by participants. Supporting comments include one participant who said, "Our biggest challenge at the moment is staff to support the work" (14). Another respondent mentioned difficulty with "identifying personnel resources and assigning responsibilities early" (4).

Leadership

The most common and notable theme to emerge from the data was that the ceiling for community benefit activities depended on the strength of leadership investment in advancing an anchor mission. One respondent with a fully resourced anchor mission stated, "Without leadership support, the remaining efforts don't get the traction needed for success" (6).

Strategies to Engage Leadership

Given the significance of leadership, multiple strategies to engage leadership in anchor mission work were identified. Several respondents discussed the value of peer networking for motivating and engaging leaders in learning about anchor work, including three who specifically noted the potential to activate leadership through peer connections. One respondent stated: "Senior leaders are most receptive to hearing from other senior leaders about anchor mission" (7), while another shared: "Using examples of other health systems and tying the anchor work to [the] mission" (6). Anchor mission leads found it

beneficial to provide leadership with successful examples of others completing this work. One respondent put it bluntly when referring to how to engage leadership successfully, “Peer pressure is effective” (17). As discussed by several respondents, another strategy employed to engage leadership was providing repetitive education on community health inequities to leaders. Organizations were successful in educating leadership about the role they could have in addressing social and health inequities. An Urban/Rural health system noted, “We were successful in engaging senior leaders and board members by helping them understand the health inequities that exist in our communities” (3). Finally, the implementation of data collection protocols was discussed as a strategy because it can provide evidence for the value of an anchor mission. One respondent said, “Data that the strategies work and don’t cost much is critical” (19). Health system leadership must ensure their decisions benefit the community and their organization's well-being. Therefore, the data to support these efforts is vital.

Discussion

We examined the perspectives of anchor mission leads from healthcare systems whose institutions are explicitly committed to advancing their anchor mission via membership in the national Healthcare Anchor Network (HAN) and found that, although there is enthusiasm about population health and addressing social determinants generally, even health systems committed to the mission are constrained by competing priorities. This limits the implementation of strategies to address SDOH and the impact these institutions can have on population health. We also found that healthcare system leaders are essential in implementing anchor missions.

Previous quality and safety literature studies have examined the success of complex, successful organizational change and described a requirement for top-down leadership engagement and organizational culture buy-in.[13,14] Mullin et al. also concluded that healthcare leaders committed to the principles of DEI enhance organizational performance and are more successful in attracting and retaining employees who are likeminded in contributing to accountability within the broader healthcare ecosystem.[15] Similarly, our findings suggest that strong leadership engagement is required if anchor institutions commit resources and time to initiatives to improve community health. However, leaders struggled to stay engaged and often were distracted by competing (urgent) demands, including the COVID-19 public health emergency. Many still feel the impact of the COVID-19 pandemic, and its toll on hospitals across the United States is enormous. For example, in the first year of the pandemic, the hospitals in the state of Pennsylvania experienced an estimated loss of more than $5 billion[16]. As discussed by many participants in this study, it is more difficult for health systems to prioritize initiatives that address SDOH without financial stability. Conversely, the pandemic disproportionately harmed minority communities, which highlighted the importance of investing in initiatives that address SDOH.

Many competing priorities highlighted by respondents involve continuously monitored activities that create a heightened sense of accountability. Examples include the need to comply with regulatory, accreditation, and quality metrics required by the Centers for Medicare and Medicaid Services, Health and Human Services, and the Joint Commission on Accreditation of Healthcare. This suggests that one way to increase the prioritization of community engagement and population health would be to include these activities in quality measurement or accreditation standards[17,18]. In a recently published study by Brown et al. examining the relationships between health and social sector organizations, the authors conclude that the more the health sector engages at the policy level, the stronger the adoption and sustainability of community-driven socioeconomic initiatives will be[19]. Furthermore, looking at lobbying disclosures of healthcare organizations, a 2021 study found that from 2015 to 2019, very little lobbying was done by the ten healthcare organizations that spent the most on federal lobbying related to the social determinants of health[20]. More substantial or deliberately structured requirements for community-focused metrics could enable more health organizations to distribute resources effectively.

Our study has several strengths, as well as some notable limitations. To our knowledge, we sampled the largest known national network of anchor healthcare organizations. However, sampling a group of hospitals that had already committed publicly to an anchor mission may be missing essential barriers that non-participants encountered. This may have created a response bias. Further, social desirability bias may lead respondents to appear more engaged in anchor activities than they are. Although we found similar themes across respondents, the small sample size creates the potential for thematic saturation that can affect our study results. Finally, because participation was confidential and was intended to encourage complete and honest responses, we did not collect demographic data from individual survey respondents, preventing any specific follow-up with participants. Still, our findings introduce new information about hospital participation in population health efforts, an essential addition to the literature. This data provides evidence for further investigating barriers and facilitators for hospital-community partnerships.

In conclusion, even among a subset of health systems committed to population health, competing priorities and variable engagement from leadership influenced the potential impact of anchor mission activities. It is possible that without external encouragement (in the form of quality metrics, payment incentives, or other policy changes), health systems will continue to have limited engagement with communities and limited ability to address social determinants of health.

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Table 1. Characteristics of Participating Healthcare Systems

Organization ID	Characteristics
2	Multi-State System
3	Urban and Rural Academic Health System and Children's Hospital
4	Urban Children's Hospital
6	Multi-State System
7	Academic Health System
9	Urban Academic Health System and Children's Hospital
10	Urban and Rural Academic, Multi-State System and Children's Hospital
11	Urban and Rural Children's Hospital
12	Academic Health System
13	Safety Net System
14	Safety Net System
16	Academic Health System
17	Urban Academic and Safety Net System
19	Urban Multi-State System
20	Urban Academic and Multi-State System
22	Academic, Safety Net Health System and Children's Hospital

Table 2. Themes and Subthemes Supported by Participant Responses

Theme	Exemplary Quotes
Competing Priorities	(13) Many, many believe [anchor missions] to be important, but higher priorities persist. (3) Although the various leaders understood and bought into the anchor mission framework, they did not prioritize this work (13) Too many other immediate and pressing priorities. (2) Some organizations are more resistant to change than others
Leadership	(6) Without leadership support, the remaining efforts don't get the traction needed for success (7) Leadership support - this is essential to ensuring that time and money are allocated towards collecting baseline data and moving forward anchor strategies (17) There are elements of anchor mission that can be accomplished without strong high-level support, but without it, there will be a limitation on achievement. (12) Conceptual leadership support at the highest levels. You won't make progress without that
Subthemes	
Prioritization Issues Due to COVID-19	(7) I anticipate we will have challenges getting sufficient financial support to move the work forward, especially due to the financial costs incurred as a result of COVID. (12) [Challenging] attention to anchor strategies while battling a pandemic.
Business Constraints	(10) The dollar flow. Budgeting for long term and keeping with the commitment when [times are] lean. (14) Our biggest challenge at the moment is staff to support the work. (17) Changing entrenched business patterns and routines. To avoid them, new incentives need to be in place.
Strategies to Engage Leadership	(7) awareness in leadership that as an Anchor Institution we could have a significant role in addressing economic and racial inequities (16) our CEO and Senior leadership team is really beginning to see the next steps of success involve our organization moving into the communities we serve (3) We were successful in engaging senior leaders and board members by helping them understand the health inequities that exist in our communities. In particular, looking at life span differences across our metro area as well as the demographic and other indicators in those neighborhoods. (7) It seems that senior leaders are most receptive to hearing from other senior leaders about anchor mission. (17) Peer pressure is effective, as is the motivation to show corporate leadership in our city. (19) Competitive analysis (what our peers are doing) has also proved compelling (19) Data that the strategies work, don't cost much, is critical

* The number in parentheses identifies a unique respondent