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A national overview of nonprofit hospital community benefit programs to address the social determinants of health

Berkeley Franz[1,*], Ashlyn Burns[2], Kristin Kueffner[3], Meeta Bhardwaj[1], Valerie A. Yeager[2], Simone Singh[3], Neeraj Puro[4], Cory E. Cronin[5]

[1]Department of Social Medicine, Ohio University Heritage College of Osteopathic Medicine, Athens, OH 45701, United States
[2]Department of Health Policy and Management, Richard M. Fairbanks School of Public Health, Indiana University—Indianapolis, Indianapolis, IN 46202, United States
[3]Department of Health Management and Policy, School of Public Health, University of Michigan, Ann Arbor, MI 48109, United States
[4]Department of Health Administration, College of Business, Florida Atlantic University, Boca Raton, FL 33431, United States
[5]College of Health Sciences and Professions, Ohio University, Athens, OH 45701, United States

*Corresponding author: Department of Social Medicine, Ohio University Heritage College of Osteopathic Medicine, Athens, OH 45701, United States.
Email: franzb@ohio.edu

Abstract

Decades of research have solidified the crucial role that social determinants of health (SDOH) play in shaping health outcomes, yet strategies to address these upstream factors remain elusive. The aim of this study was to understand the extent to which US nonprofit hospitals invest in SDOH at either the community or individual patient level and to provide examples of programs in each area. We analyzed data from a national dataset of 613 hospital community health needs assessments and corresponding implementation strategies. Among sample hospitals, 69.3% ($n = 373$) identified SDOH as a top-5 health need in their community and 60.6% ($n = 326$) reported investments in SDOH. Of hospitals with investments in SDOH, 44% of programs addressed health-related social needs of individual patients, while the remaining 56% of programs addressed SDOH at the community level. Hospitals that were major teaching organizations, those in the Western region of the United States, and hospitals in counties with more severe housing problems had greater odds of investing in SDOH at the community level. Although many nonprofit hospitals have integrated SDOH-related activities into their community benefit work, stronger policies are necessary to encourage greater investments at the community-level that move beyond the needs of individual patients.

Lay summary

Social determinants of health (SDOH) refer to the "conditions in which people are born, grow, live, work, and age." SDOH have an outsized effect on the health outcomes of individuals and communities, above and beyond formal medical care. For this reason, health care organizations such as hospitals are facing new requirements to screen patients for their individual health-related social needs and invest in improving SDOH in the communities where they are located. In this study, we investigated what approaches nonprofit hospitals use to address both patients' health-related social needs and community-level SDOH, and present data from a national sample of 613 hospitals. We found that 44% of hospital programs addressed patients' health-related social needs, while 56% addressed community-level SDOH, such as improving economic conditions or investing in local schools. The most common programs to address community-level SDOH were aimed at increasing social support and improving local infrastructure such as housing, parks, and transportation. Stronger policies and regulation may be necessary to encourage hospitals to invest in improving community-level SDOH above and beyond addressing individual patients' health-related social needs.

Key words: nonprofit hospitals; community benefit; Community Health Needs Assessment (CHNA); social determinants of health (SDOH); health-related social need (HRSN).

Introduction

Health inequities and lagging health indicators represent a significant and pressing policy challenge in the United States. A growing body of evidence suggests that medical care alone is not sufficient to address the underlying causes of illness and drive meaningful improvements in health outcomes.[1] Instead, health experts are increasingly acknowledging the pivotal role of social factors in shaping health and well-being. In response, new policies are encouraging health care systems and other large anchor organizations to invest in addressing these social factors both at the individual patient and community level.[2,3]

It is hard to overstate the significance of upstream social determinants of health (SDOH), which are responsible for as much as 50% of community-level variation in health outcomes.[4,5] Defined by the World Health Organization as "the conditions in which people are born, grow, live, work, and age" and "the fundamental drivers of these conditions,"[6] SDOH include factors like education, employment, neighborhood and physical environment,[7] and social support.[8] Case studies of health care organizations show new patterns of investing in community-level initiatives for housing, targeted employment programs, and bolstering school quality to improve the overall health of the community.[9-11]

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The majority of health care organizations also screen patients for individual-level, health-related social needs (HRSNs) that can be addressed through health care partnerships and health-promotion efforts.[12] Beginning in 2024, the Centers for Medicare and Medicaid Services (CMS) will require hospitals to report the percentage of patients screened for HRSNs, underscoring the significant role of social factors in shaping overall health care needs.[13] The HRSNs of an individual can be defined as the downstream manifestations of SDOH within a community.[14] For example, food insecurity is an HRSN that is often addressed at the individual level through short-term strategies, such as linking patients to food-distribution programs or federal initiatives to supplement food budgets. While initiatives that provide food to patients have seen some success, patient-centered assistance fails to address the underlying social and economic factors that affect the health of a community,[14] and interventions to improve SDOH at the community level remain less common and underfunded.[15]

Nonprofit hospitals in the United States are required to identify and respond to the most pressing health needs in the communities they serve in return for tax exemption. These organizations must also document these efforts through a community health needs assessment (CHNA) every 3 years, along with an implementation strategy (IS) to address the needs identified in the CHNA.[16] Hospitals have historically provided most of their community benefit through uncompensated or subsidized care rather than through investment in SDOH; however, whether these trends are changing is unclear.

Experts estimate that hospitals invested approximately $2.5 billion between 2017 and 2019 to address social factors.[17] Previous research found that 69% of nonprofit hospitals identified social factors among the top 5 community health needs in their CHNA and 67% implemented at least 1 program to address social factors in the corresponding IS.[18] Despite promising evidence that hospitals recognize the value of investing in SDOH, little is known about the nature of these investments, including the extent to which hospitals are addressing patients' HRSNs rather than investing in broader social factors in the communities they serve. Again, addressing SDOH requires targeted upstream, or macro-level, approaches to health planning that aim to improve the underlying social and economic factors that affect the health of everyone in a community.[14] While these interventions can be challenging for health care institutions, they are among the most needed to impact the key institutions, social systems, and public policies that drive health inequities.[7]

Using a nationally representative database of hospital CHNAs, we assessed hospitals' strategies to address social factors using the Kaiser Family Foundation's (KFF's) 6-category framework, conducted a content analysis of commonly adopted programs, and identified significant predictors of hospitals that invest in SDOH at the community level. These findings are the first to operationalize what hospitals mean when they publicly commit to addressing SDOH. This study has significant implications for policy development in the United States and may inform how private organizations invest in SDOH.

Data and methods

Data and sample

We analyzed data from a national dataset of nonprofit hospital community benefit documents, which is representative at the state level. This dataset includes CHNAs and ISs from hospitals' third post-Affordable Care Act round of reporting, spanning the years 2018–2021. To build this dataset, we obtained publicly available documents from over 600 US nonprofit hospitals' websites and coded them for identified health needs and corresponding investments. The sample was drawn utilizing a 20% random sample of nonprofit hospitals nationally, stratified by state ($n = 613$).[19] Stratifying by state ensured that a random set of hospitals (20%) were included from every state in proportion to the total number of hospitals in the state. After excluding hospitals with missing community benefit documents, there were 538 hospitals remaining in the analytic sample. This sample was similar to the entire universe of hospitals nationally, with the exception of bed size; the average number of beds of hospitals in our sample was higher than the national average.[18]

Our coding strategy was developed using a previous round of community benefit documents and is reported elsewhere.[20] We coded CHNAs for the top 5 health needs identified, and then coded the top 5 health needs addressed in the corresponding IS. The coding team underwent structured training on the coding strategy, and we tested for interrater reliability with a set of 15 test documents. This process yielded 100% reliability, which is not surprising given the structured nature of community benefit documents. The coding team also met weekly to identify CHNAs/ISs that were not structured clearly, and collaboratively coded these documents.

In this first round of coding, we identified the hospitals that included SDOH as a top-5 community health need and subsequently presented a plan to address SDOH in their IS. Needs and strategies were coded as SDOH if they specifically referenced the social determinants of health or referred to disparities based on social identities. Specific key words included, but were not limited to, social determinants of health, structural factors, racism, disparities, equity, housing, homelessness, poverty, employment, and transportation.

We next created a subset of hospitals that addressed SDOH with at least 1 strategy in their IS and collected all strategies to address SDOH in a secondary dataset. The KFF breaks SDOH down into 6 categories: economic stability, neighborhood and physical environment, education, food, community and social context, and health system.[8] Using this framework, coders assigned each strategy to 1 of the 6 categories. When the 2 coders disagreed on categorization, they met to discuss these strategies until they reached consensus. Because we were most interested in whether hospitals addressed SDOH at the individual-patient level or the community level, we created 2 additional dichotomous variables for whether the SDOH strategies addressed (1) individual patients' HRSNs (health system–related activities focusing on individual social need interventions) or (2) SDOH at the community level (activities and programs related to economic stability, neighborhood and physical environment, education, food, and community and social context).

We combined data on hospitals' strategies with data on hospital organizational characteristics from the 2018 American Hospital Association (AHA) Annual Survey[21] and data on county characteristics from the 2018 County Health Rankings and Roadmaps Study.[22] We included a measure of county rurality from the US Department of Agriculture (USDA), which was last updated in 2013.[23]

From the AHA data, we utilized the total number of beds, teaching status, and system membership status. From the USDA, we included a county density measure of urban,

suburban, and rural sourced from the rural-urban continuum codes (1–3 were coded as urban, 4–6 were coded as suburban, and 7–9 were coded as rural). From the County Health Rankings data, we included the percentage of the county residents with severe housing problems (ie, overcrowding, high cost, and/or lack of kitchen or plumbing facilities); food insecurity (defined as the percentage of the population that lacked access to a stable source of food over the last year); the percentage of single-parent households in a county; as well as rates for uninsurance, unemployment, and high school graduation. We also included a measure of social capital, which was defined as the number of membership associations per 10 000 residents. To assess regional variation in hospital location, we used the 4-region classification (West, Midwest, South, and Northeast) from the US Census Bureau.[24]

Analytic strategy

We first calculated descriptive statistics for each of the 6 strategies defined above. We then used content analysis to identify the most common types of strategies within each of the 6 categories. Using *t* tests and chi-square analyses, we next compared hospital and community characteristics among hospitals that addressed SDOH at the individual-patient vs community level. Finally, we used multivariable logistic regression to identify organizational and community-level factors associated with hospitals investing in SDOH at the community level as compared with those addressing SDOH at the individual-patient level or not addressing SDOH at all. Because hospitals are often clustered within counties and states, we conducted the logistic regression model with 1 level (no clustering), 2 levels (hospitals clustered within states), and 3 levels (hospitals clustered with counties and states). Based on fit statistics and a likelihood ratio test, the 2- and 3-level models were not significantly better than the 1-level model, which we report in the Results section. All statistical analyses were conducted using Stata 17 (StataCorp).[25]

Results

Descriptive statistics

Of the 538 nonprofit hospitals in our final sample, 69.3% ($n = 373$) identified SDOH as a top-5 health need in their CHNA. A total of 60.6% ($n = 326$) of hospitals also addressed SDOH with at least 1 corresponding strategy in their corresponding IS. Of the 326 hospitals with at least 1 planned investment in SDOH, the average number of SDOH strategies per organization was 7.9, with a range of 1–246. The most common number of strategies per hospital was 1. Of the combined total of 2196 planned strategies across the 326 hospitals, 43.8% ($n = 962$) of strategies addressed individual patients' HRSNs (Figure 1). The remaining 1234 strategies represented SDOH investments at the community level in the following categories: 16.5% ($n = 362$) addressed the community and social context, 15.9% ($n = 348$) addressed the neighborhood and physical environment, 12.6% ($n = 276$) focused on food, 5.8% ($n = 129$) related to economic security, and 5.4% ($n = 119$) focused on education.

Comparison of hospitals with community-level SDOH vs individual-level HRSN strategies

As Table 1 shows, hospitals that addressed SDOH at the community level were significantly larger, with an average of 273.5 beds as compared to 187.7 beds among hospitals only addressing individual patients' HRSNs ($t_{[324]} = -2.19$, $P < .05$, $g = -0.29$). Hospitals addressing SDOH at the community level

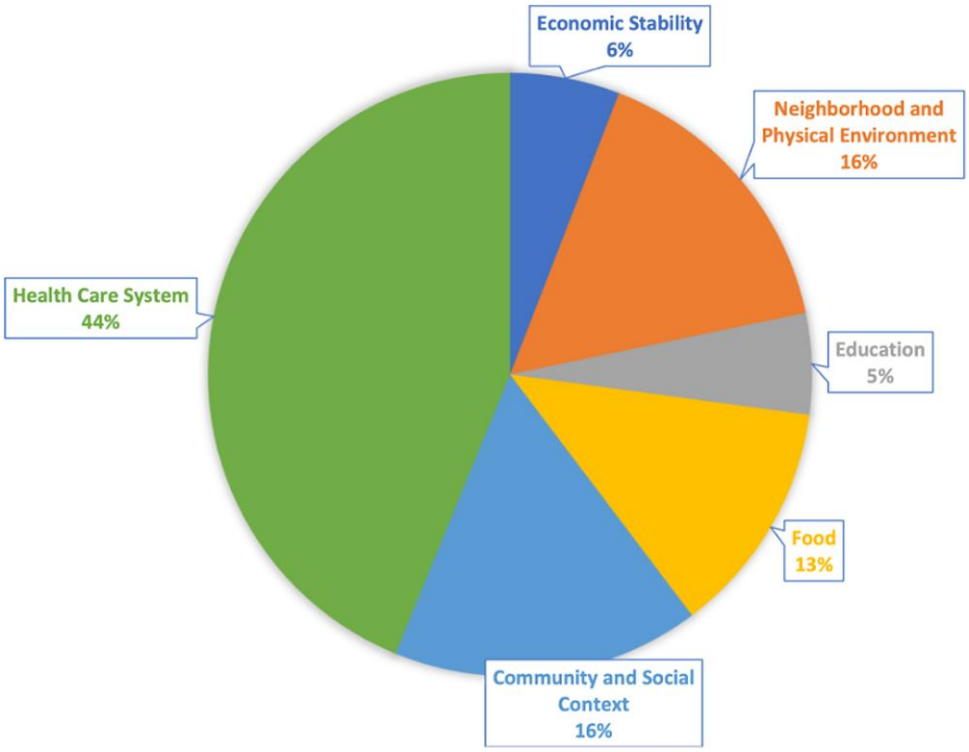

Figure 1. Percentage of hospital programs in each of the Kaiser Family Foundation's 6 categories of social determinants of health. Source: Authors' analysis of hospital implementation strategies to address the social determinants of health.

Table 1. Comparison of hospital and county characteristics among hospitals with community-level vs health care SDOH strategies ($n = 326$).

Variable	Hospitals with community-level SDOH strategies (min-max)	Hospitals with health care strategies alone (min-max)	*P*
Average hospital beds	273.53 (6-2829)	187.68 (6-1002)	.015
Percent major teaching hospitals	15.75 (0-1)	2.78 (0-1)	.004
Percent system member	73.62 (0-1)	75 (0-1)	.814
Percent of county households with severe housing problems	18.75 (6.4-39.1)	15.45 (6.3-34.4)	<.001
Percent of ninth graders who graduate in 4 years in county	83.29 (59.9-96.3)	86.04 (63.8-94.4)	.007
Percent of county residents experiencing food insecurity	12.99 (4-21.7)	13.85 (5.3-23.4)	.049
Percent of children living in single-parent homes in county	32.77 (14.3-61.3)	32.70 (11.4-64.3)	.478
No. of membership associations per 10 000 residents in county	10.26 (0.9-32.2)	12.29 (3.4-34.5)	.003
Percent uninsured in county	11.83 (3.5-30.7)	11.88 (3.5-25.8)	.937
Percent unemployed in county	4.85 (2.1-10.3)	4.91 (2.5-10.8)	.629
Percent hospitals in each county type			.087
Rural	9.06 (0-1)	15.28 (0-1)	
Suburban	16.93 (0-1)	18.06 (0-1)	
Urban	74.02 (0-1)	66.67 (0-1)	
Percent of hospitals in each region			.031
Northeast	22.44 (0-1)	19.44 (0-1)	
Midwest	27.17 (0-1)	38.89 (0-1)	
South	20.47 (0-1)	30.56 (0-1)	
West	29.92 (0-1)	11.11 (0-1)	

The table reports differences in organizational and county characteristics only among hospitals addressing SDOH in their implementation strategies.
Abbreviations: max, maximum; min, minimum; NS, not significant; SDOH, social determinants of health.

were also more likely to be major teaching hospitals, with 15.8% carrying this designation as compared to 2.8% of hospitals who only addressed patients' HRSNs ($\chi^2_{[324]} = 8.41$, $P < .01$, $\phi = 0.16$). Hospitals investing in SDOH at the community level were also more likely to be in counties experiencing greater social challenges, such as housing shortages, lower educational attainment, and limited social capital. For example, 18.8% of residents experienced serious housing problems in communities where hospitals addressed SDOH at the community level as compared to 15.5% of residents in communities where hospitals invested in patients' HRSNs only ($t_{[324]} = -4.14$, $P < .001$, $g = -0.55$). Of ninth graders, 83.3% graduated in 4 years in counties where hospitals addressed SDOH at the community level as compared to 86.0% in counties where hospitals addressed only patient-level HRSNs ($t_{[324]} = 2.72$, $P < .01$, $g = 0.37$). The average number of social associations in communities where hospitals addressed SDOH at the community level was 10.3, which was significantly lower than the average of 12.3 social associations in communities where hospitals addressed patient-level HRSNs only ($t_{[324]} = 2.96$, $P < .01$, $g = 0.39$). Finally, hospitals in the West were significantly more likely to address SDOH at the community level, with 29.9% of hospitals doing so ($\chi^2_{[324]} = 13.04$, $P < .01$, $\phi = 0.20$).

Logistic regression results

After controlling for organizational and community-level factors, few significant relationships remained. Hospitals that were major teaching organizations (adjusted odds ratio [aOR] = 2.44; 95% CI: 1.16, 5.12) and those in the Western region (aOR = 2.14; 95% CI: 1.14, 4.00) had greater odds of addressing SDOH at the community level (see Table 2). Hospitals in counties with more severe housing problems also had greater odds of addressing SDOH at the community level (aOR = 1.05; 95% CI: 1.00, 1.10).

Content analysis of hospital strategies

Examples of programs in each category are presented in Table 3. Among hospitals' strategies that focused on addressing patient-level HRSNs, the majority focused on increasing access to health coverage and quality of care through financial assistance and insurance enrollment efforts. There was wide variation in the types of strategies that hospitals invested in to address SDOH at the community level. For community and social context, most strategies focused on increasing community engagement and addressing chronic stress and discrimination through partnerships with community-based

Table 2. Multivariable regression results of hospital and county characteristics associated with hospital investments in SDOH at the community level ($n = 538$).

	OR	SE	*P*	95% CI
Beds				
>50	Ref	Ref	Ref	Ref
50-199	1.02	0.26	0.928	0.62, 1.69
200-399	0.78	0.25	0.431	0.42, 1.45
400+	1.19	0.42	0.619	0.59, 2.40
Hospital system member (yes/no)	1.20	0.25	0.378	0.80, 1.81
Teaching hospital (yes/no)	2.45	0.92	0.018	1.17, 5.12
Percent of county population experiencing severe housing problems	1.05	0.02	0.037	1.00, 1.10
Percent of county uninsured	0.98	0.02	0.495	0.94, 1.03
County population				
Urban (yes/no)	Ref	Ref	Ref	Ref
Rural yes/no)	0.61	0.20	0.136	0.32, 1.17
Suburban (yes/no)	0.97	0.26	0.909	0.57, 1.64
Region				
Northeast (yes/no)	Ref	Ref	Ref	Ref
Midwest (yes/no)	0.84	0.23	0.539	0.49, 1.45
South (yes/no)	0.74	0.25	0.371	0.38, 1.43
West (yes/no)	2.14	0.68	0.018	1.14, 4.00
_constant	0.41	0.21	0.077	0.15, 1.10

The table reports hospital and county characteristics associated with hospitals addressing SDOH at the community level as compared with hospitals addressing SDOH at the individual-patient level or not addressing SDOH at all.
Abbreviations: OR, odds ratio; Ref, reference; SDOH, social determinants of health.

organizations. Community-engagement strategies implemented by hospitals frequently included engaging with community members from other community-based organizations through a task force, community board, alliance, or coalition. As an example, 1 hospital collaborated with other community partners to form a Task Force to reduce Adverse Childhood Experiences. Fewer strategies were related to developing support systems for vulnerable populations. One strategy developed social support by implementing an evidence-based peer-to-peer model, which connected high school students with peers to increase their willingness to reach out for help related to mental health challenges and bullying. Under neighborhood and physical environment, the most common strategies aimed to provide housing for individuals experiencing homelessness. Less common strategies included increasing access to parks, playgrounds, and walkability throughout communities.

Under the food category, most strategies focused on screening for food insecurity in the community and increasing access to healthy foods via partnerships with food banks and other community-based organizations. Fewer strategies were related to community gardening and food literacy efforts. The most common strategies addressing economic stability were related to increased pathways to employment for historically marginalized populations. Hospital strategies less commonly focused on debt reduction and providing direct financial support. Under education, most strategies were related to early childhood education and literacy efforts, as well as scholarship opportunities for high school students pursuing higher education. Fewer strategies were related to increasing access to vocational training and language education.

Discussion

This study sought to understand the types of programs that nonprofit hospitals invest in as part of their community benefit activities to address SDOH. In examining the strategies implemented by hospitals, we found that hospitals implemented strategies targeting a broad range of needs, including in each of 6 core SDOH categories. Yet, nearly half of all implemented strategies focused on individual patients' HRSNs rather than SDOH in the broader community.[4] Even when hospitals publicly commit to addressing SDOH as part of their CHNA process, a significant portion of hospitals focus solely on the needs of their individual patients, rather than those of the communities they serve.

Internal Revenue Service guidelines state, "The health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community, such as particular neighborhoods or populations experiencing health disparities."[26] Strategies that only address health care needs of individual patients are inconsistent with the spirit of community benefit policies, which are intended to ensure that hospitals take the broad interests of the community into account when assessing community health needs, and adopt strategies that benefit the community at large. Although many nonprofit hospitals have integrated SDOH programs into their community benefit activities,[27] stronger guidance on addressing SDOH as requisites of health could encourage upstream, community-level investments that move beyond the HRSNs of individual patients.

In terms of hospital characteristics, we found that larger hospitals and academic medical centers were more likely to address SDOH at the community level, as were hospitals located in more vulnerable communities. The total number of investments also varied considerably, with 1 large health system investing in 246 strategies to address SDOH, yet the most common number of strategies per hospital was 1. Hospitals are uniquely positioned to contribute significant investments at the community level,[28] and it is encouraging that many hospitals in communities that are already experiencing higher disparities are implementing strategies at the community level. This has important implications for health equity, and these organizations may serve as a model for smaller and less-resourced hospitals. Smaller organizations, as well as those

Table 3. Examples of hospital social determinants of health (SDOH) programs in each Kaiser SDOH category.

Category[a]	Category description	Example 1	Example 2	Example 3
Economic Stability ($n = 94$, 28.83%)	Access to stable, sufficient income to meet basic needs. Factors affecting this include: employment, income, expenses, debt, and financial support.	Create hiring pipelines for youth and adults in hardship communities to connect to jobs through training programs, targeted outreach and partnerships, and inclusive, local hiring practices. *(Northwestern Medicine Woodstock Hospital)*	Increase investment of resources into local community businesses through supplier contracts and sponsorships. *(Children's Hospitals and Clinics of Minnesota)*	Support financial literacy training to small, diverse businesses seeking to increase their capacity and access new sources of funding. *(Kaiser Permanente San Rafael Medical Center)*
Neighborhood & Physical Environment ($n = 161$, 49.39%)	The neighborhoods people live in have an impact upon their health. Factors affecting this include: housing, transportation, safety (eg, environmental contaminants), parks, playgrounds, walkability, and zip code/geography.	Provide shelter or transitional housing to unsheltered homeless individuals and families. *(Providence Medford Medical Center)*	Fund/partner/implement initiatives that improve infrastructure and support local walking/biking and physical activity programs annually. *(Saint Joseph Mercy-Oakland)*	Fund incentive programs and subsidies for public transportation. *(Cassia Regional Medical Center)*
Education ($n = 82$, 25.15%)	Individuals with higher levels of education are more likely to be healthier. Factors include: literacy, language, early childhood education, vocational training, and higher education.	Support the public school district to improve early literacy and third-grade reading by offering quality improvement and data analytic support. *(Cincinnati Children's Hospital Medical Center)*	In partnership with Akron Public Schools: develop pathways in computer programming and software support, education professions and leadership, sports medicine and health care professions, and culinary careers. *(Summa Akron City Hospital)*	Provide scholarships on behalf of the Medical Staff Leadership Council to local high school students seeking advanced studies in health care. *(Aurora Lakeland Medical Center)*
Food ($n = 136$, 41.72%)	Access to healthy nutritious foods and food security.	Review hospital food-production processes, and identify ways to distribute safe, unused food into the community. *(Avista Adventist Hospital)*	Advocate developing and strengthening the community physical/social infrastructure to support low-income families in accessing fresh fruit and vegetables. *(Boston Children's Hospital)*	Increase access to healthy and affordable food options through community health workers, community gardens, and access to safe green spaces. *(Loma Linda University Medical Center East Campus)*
Community & Social Context ($n = 157$, 48.16%)	Individuals' relationships with family and community members can have a major impact on their health. Factors include: social integration (eg, interpersonal violence), support systems (eg, trauma), community engagement, discrimination, and stress.	Expand sources of strength (SoS) to rural high schools across service area. SoS is evidence-based peer to peer model proven to address suicide, mental health, substance abuse, and bullying. Increases the willingness to reach out for help and build social connection. *(ThedaCare Regional Medical Center–Neenah)*	Expand and refine injury-prevention activities to address injury issues with the greatest racial disparities (eg, gun violence, sleep-related death, child abuse, drownings, traumatic brain injury) and other emerging hazards. *(Ann and Robert H. Lurie Children's Hospital of Chicago)*	Collaborate with Tarrant County community partners on the Adverse Childhood Experiences (ACES) Task Force to reduce the occurrence of adverse childhood experiences through policy, practice, and parent support. (*Cook Children's Medical Center)*
Health Care System ($n = 273$, 83.74%)	Access to health care; factors including: health coverage, provider availability, provider linguistic and cultural competency, and quality of care.	Identify best practices, and assess need for cultural competency and nondiscrimination training to improve health care delivery that is sensitive to gender, race and sexual orientation. *(Mid Coast Hospital)*	Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs. *(MedStar Montgomery Medical Center)*	Provide patients with expanded options for transportation to medical appointments or upon discharge from the emergency department, including medical Lyft, e-vouchers, and bus passes. Support nonprofit organizations that assist underserved populations in need of reliable and/or consistent transportation to/from provider visits. *(UNC Rex Healthcare)*

[a]Frequency and percentage of hospitals included in the category.

located in the South and Midwest, may benefit from additional technical assistance or policy support in addressing SDOH at the community level.

Considerable evidence has demonstrated that social capital and cross-sector partnerships play a significant role in improving community health and addressing disparities.[29-31] Hospitals looking to address SDOH may want to leverage partnerships with organizations that have expertise in addressing SDOH in their community, such as their local health department, social services providers, community nonprofits, and grassroots organizations. Furthermore, policymakers should consider ways to promote such efforts by hospitals, such as providing hospitals in underserved and socially vulnerable communities with additional resources and encouraging hospitals to partner with other community-serving organizations in implementing strategies to address SDOH through policy change.

This study has several limitations. We reviewed CHNAs/ISs from a national sample of nonprofit hospitals, which provide only limited information on the types of strategies hospitals are implementing to address SDOH. Since we were limited to the information hospitals report in their administrative documents, it is possible that hospitals are implementing additional activities outside of those captured in this study. As such, the strategies identified in our coding are not an exhaustive list of SDOH-related efforts by hospitals. Additionally, this study reports associations only, and is not able to generate insight into the decision-making process of hospitals, including decisions around whether to address SDOH and how to do so. Future research should examine how hospital resources and partnerships with other community-based organizations shape their decision making around community benefit strategies, especially when it comes to addressing community-level SDOH.

Conclusion

Although many nonprofit hospitals have integrated SDOH programs into their community benefit activities, nearly half of these programs are targeted towards individual patients' HRSNs rather than community-level SDOH. Given that larger and academic training hospitals are more likely to address SDOH at the community level, hospitals may need additional guidance, community-based partnerships, and technical assistance to make effective community-level investments. Partnering with hospitals who are key anchor institutions in their communities holds potential for improving health equity, but encouraging hospital organizations to address SDOH beyond traditional health care services remains a considerable policy challenge.

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Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Notes

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