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Rural Policy Brief

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Partnerships to Address Social Needs across Metropolitan and Non-Metropolitan Prospective Payment System Hospitals and Critical Access Hospitals

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Purpose

Partnerships between hospitals and other organizations, such as public health departments and social service organizations, are essential to address monumental challenges like managing pandemics, improving patient outcomes, meeting patients' social needs, and successfully moving from volume-to-value models in health care. The purpose of this brief is to examine how the number and types of partnerships with community-based organizations (e.g., local public health groups, faith-based organizations, K-12 schools) vary across non-metropolitan and metropolitan hospitals and by hospital type (Prospective Payment System [PPS] vs. critical access hospital [CAH]), region, ownership status, and Accountable Care Organization (ACO) participation.

Key Findings

- The highest mean community partnership scores were seen in metropolitan PPS hospitals (24.0), followed by non-metropolitan PPS hospitals (20.4) and CAHs (16.8).
- Except for non-metropolitan PPS hospitals in the West, the Northeast had the highest mean partnerships across hospital types.
- Regardless of geography or type (CAH or PPS), non-profit hospitals and those participating in ACOs had higher mean partnership scores.
- Most hospitals had partnerships with state and local agencies, though compared to other types of hospitals, a higher proportion of metropolitan PPS hospitals had partnerships with organizations that address specific social needs (e.g., food insecurity).

Introduction

In recent years, the U.S. has observed a remarkable growth in health systems' interest in addressing social determinants of health (SDOH) and health-related social needs.[1] This growth can be attributed, in part, to the shift to value-based care and payment. Extensive research links SDOH with improved patient care, enhanced population health, and

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reduced health care costs,[2] thus impacting value-based care and payment. In addition, the pandemic underscored the importance of addressing social needs within the health care delivery system.[3] Previous studies suggested that social needs screening is often followed by referring patients to community resources or social services by establishing clinical community linkages (CCL). These linkages are essential to connecting health care providers, community organizations, and local social service and public health agencies to ensure patients can access critical services.[4] There is evidence that CCLs improve patient care and outcomes, reduce health care expenditures, increase patient access to community-based programs, and address the SDOH by meeting patients' health-related needs.[5]

In addition to the policy mandate for non-profit hospitals to engage public health and community organizations through community health needs assessments (CHNAs), hospitals take many approaches to achieve community partnerships and maintain CCLs.[6] Examples include social prescriptions administered through community referrals or direct support (i.e., social services) inside the health care setting, which addresses the social needs of the patient,[1] and hospitals/health care professionals who work with community connectors or social workers who refer patients with social needs to community resources. In some hospitals/clinics, the patients who screen positive for social needs are provided with handouts and contacts containing resources that address their needs.[7] Overall hospital-based social needs screening and subsequent referrals through community partnerships have been associated with increased access to social services and improved health outcomes.[8] Given the importance of these referrals and partnerships, there is a demand to evaluate patient outcomes in hospitals that screen for social needs and have community referrals or partnerships in comparison to hospitals that do not have these partnerships.

The extent to which partnerships between rural hospitals and community organizations exist is unclear.[9] Additionally, the level of engagement within these partnerships may not have been considered. Some rural hospitals may experience unique challenges in establishing and sustaining these important linkages due to distances between hospitals and potential community partners.[10] Other rural hospitals may be better suited to address social needs due to their collaborative nature and the dynamics of their hospital-community relationships.[11] The shock of the COVID-19 pandemic has further revealed the patchwork nature of our public health-health care system, making it especially important to assess how hospitals have partnered with public health departments, social service organizations, and others to address these long-term and acute needs.[12] Our objective is to leverage newly available data from the American Hospital Association (AHA) to determine the extent to which non-metropolitan and metropolitan hospitals partnered with outside organizations to address social needs.

Methods

We used the 2021 AHA Social Determinants of Health (SDOH) Supplement data to assess hospitals' efforts to address health-related social needs and conduct CHNAs through partnerships between rural hospitals and community organizations. We restricted this analysis to general medical and surgery, non-federal hospitals in the 50 U.S. states who were in operation for the full fiscal year and who completed the supplemental survey. In essence, we excluded those hospitals that provided a narrow scope of services or group of patients, such as children's hospitals or specialty hospitals providing only cardiac, cancer or other services, as well as excluding VA and HIS hospitals. Of these 3,220 general medical and surgery hospitals, 2,089 (64.8%) responded to this supplement.

The AHA SDOH supplement asked questions about the extent to which hospitals were partnered with 16 types of external partners to address population and/or community health needs as well as the nature of those partnerships. The types of external partners include:

- Health care providers outside your system
- Health insurance providers outside your system
- Local or state public health departments/organizations
- Other local or state government agencies or social service organizations
- Faith-based organizations
- Local organizations addressing food insecurity
- Local organizations addressing transportation needs
- Local organizations addressing housing insecurity
- Local organizations providing legal assistance for individuals
- Other community non-profit organizations
- K-12 schools
- Colleges or universities
- Local businesses or chambers of commerce
- Law enforcement/safety forces
- Area Behavioral Health Services Providers
- Area Agencies on Aging (AAA)

For each of these potential external partners, the AHA survey asked about what types of partnerships these hospitals had, noting no partnership with that organization type or providing three potential, non-exclusive options: partnerships on CHNAs, partnerships for referrals to address social needs, and/or other community-level collaborative initiatives to address SDOHs. Following an approach used by Figueroa and colleagues, we created a partnership score for each hospital by assessing the extent to which hospitals were partnered with the 16 types of external partnership noted above.[13] We assessed the breadth of partnerships by determining whether a hospital had Potential partnership score values ranged from 0-48, with higher scores indicating more extensive partnerships. For example, if a hospital had no partnership at all they would have had a score of 0. Hypothetically, if they were engaged with all 16 partner types noted above in each of the 3 partnership types, they would receive a partnership score of 48. We examined partnership scores and the number and types of partnerships across hospital types: CAHs, non-metropolitan PPS hospitals, and metropolitan PPS hospitals. Non-metropolitan hospitals were those that were part of a micropolitan community-based statistical areas or were considered to be rural as determined by the Office of Management and Budget. We compared mean scores across rural hospital characteristics including region (see Appendix Table 1 for list of states by region), ownership status, and participation in ACOs. If a hospital or the system they are a part of was leading or participating in an ACO, they were considered to a part of an ACO.

Results

Our analysis included 2,089 hospitals, including 1,316 metropolitan PPS hospitals (63.0%), 316 non-metropolitan PPS hospitals (15.1%), and 457 CAHs (21.9%). Additional descriptive statistics of the hospitals completing the survey are in Appendix Table 1. Nationally, metropolitan PPS hospitals had the highest mean community partnership scores (24.0), followed by non-metropolitan PPS hospitals (20.4) and CAHs (16.8) (Figure 1). This pattern occurred across three of four Census regions, the exception being the West region, where non-metropolitan PPS hospitals had the highest scores. Regardless of hospital type, partnership scores tended to be highest in the Northeast and West. Hospitals currently participating in an ACO had higher partnership scores regardless of hospital type (Figure 2). CAHs participating in ACOs had higher partnership scores than metropolitan PPS hospitals

that did not participate in an ACO. Regardless of geography, non-profit hospitals reported the highest partnership scores, followed by non-federal government and for-profit hospitals (Figure 3).

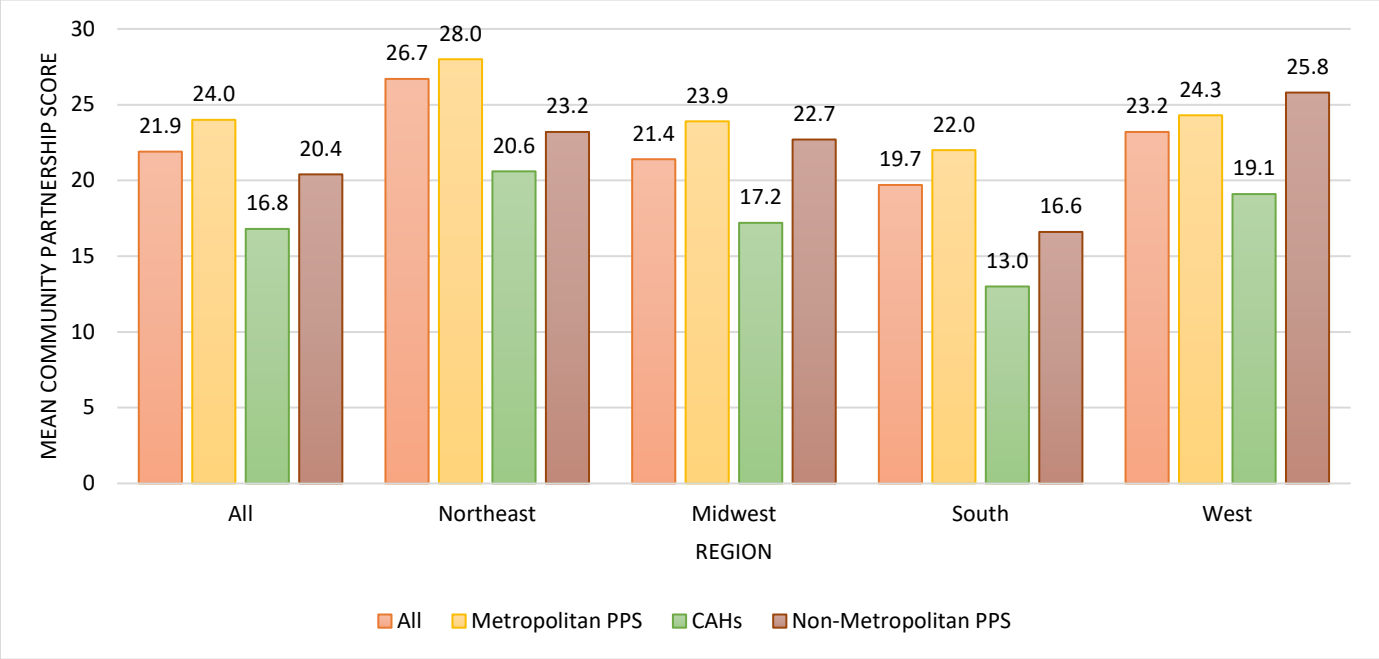

Figure 1: Mean Partnership Scores Overall and by U.S. Census Region

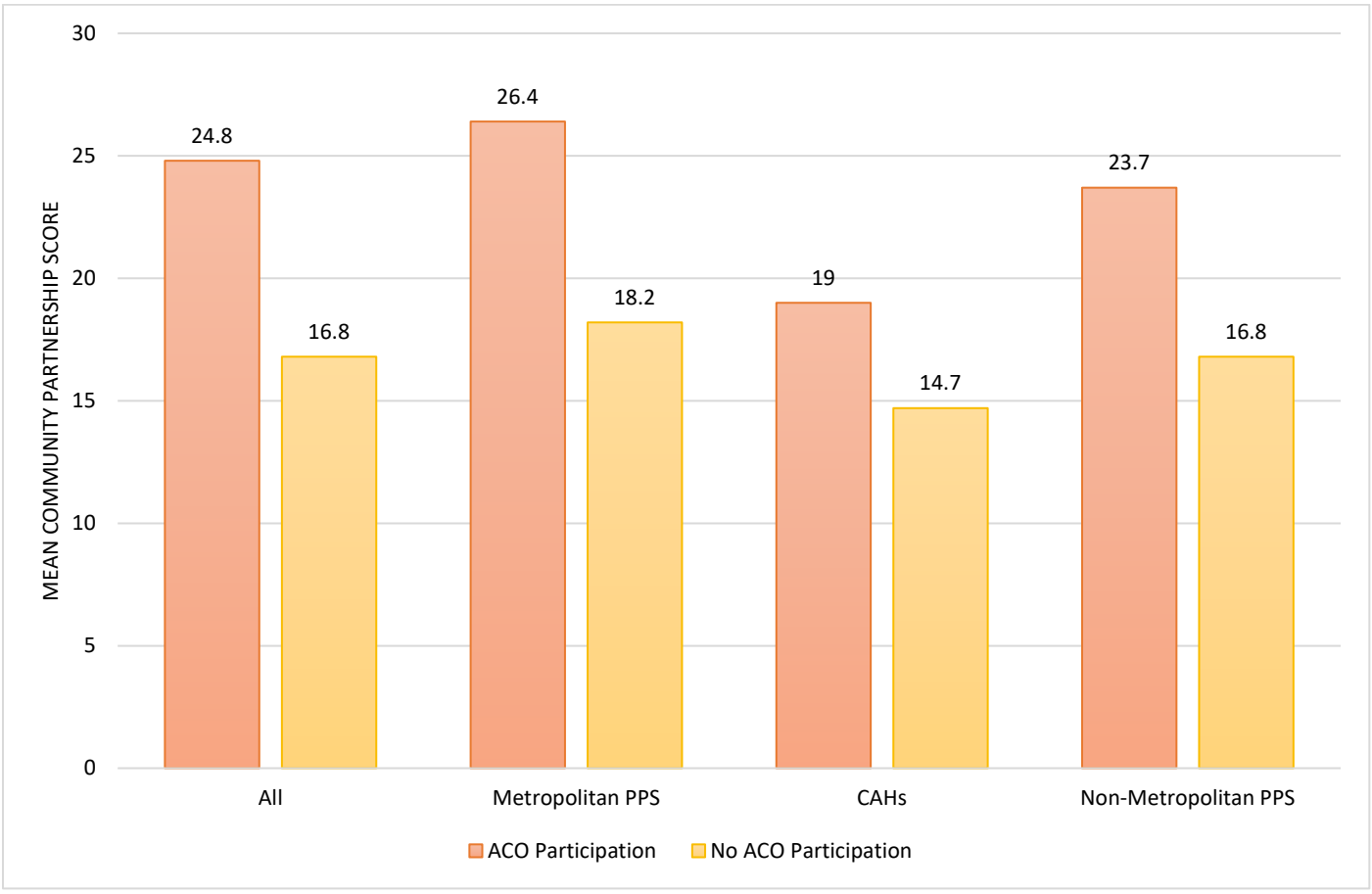

Figure 2: Mean Partnership Score by ACO Participation

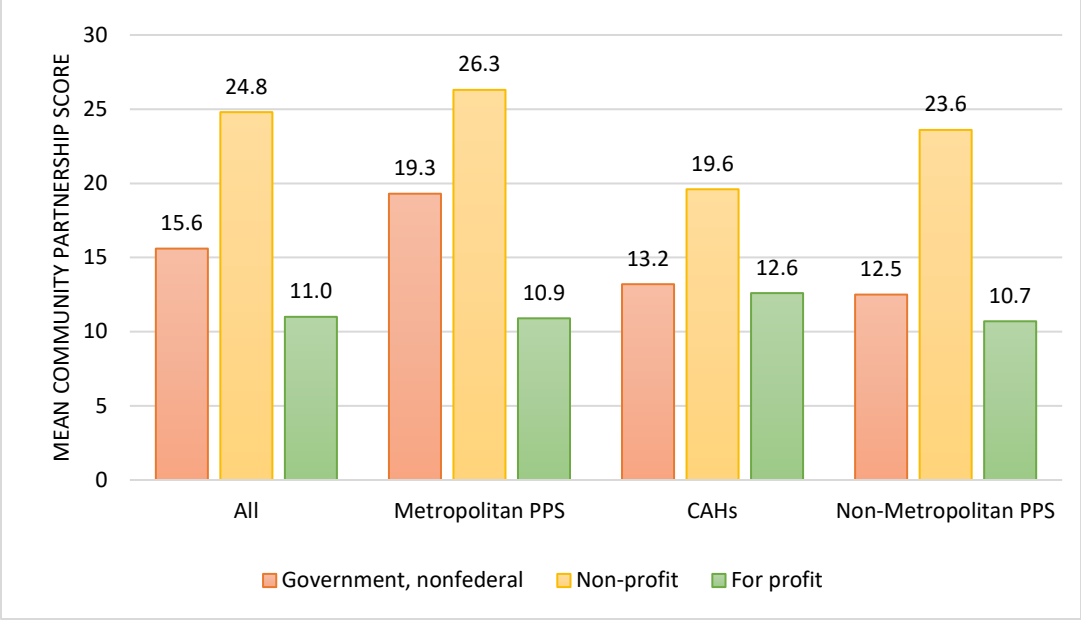

Figure 3: Mean Partnership Score by Ownership Status

Appendix Table 2 displays the number of types of partnerships across hospital types. More than 75% of all hospital types had at least one type of partnership with outside systems, health insurers, local public health departments, other state and local public agencies, community non-profit organizations, K-12 schools, local businesses or chambers of commerce, and area behavioral health service providers (Figure 4). Metropolitan hospitals tended to have more partnerships with organizations specifically focused on addressing food insecurity, housing insecurity, transportation, and legal assistance as well as with colleges/universities and area agencies on aging, state designated public or private agencies that address the needs and concerns of older adults.

More than half of CAHs had specific partnerships with organizations to address social needs, including the following: health care providers outside their system, local and state public health departments, other local and state agencies, law enforcement agencies, and area behavioral health providers (Table 2). More than 50% of non-metropolitan PPS hospitals had partnerships with the following types of organizations to address social needs: health care providers outside their system, local and state public health departments, other local and state agencies, local organizations addressing food insecurity, local organizations addressing transportation needs, local organizations addressing housing insecurity, law enforcement agencies, and area behavioral health providers.

Engagement with community-based organizations for CHNAs or community-level initiatives was less frequent across all hospital types (Appendix Table 2). For CAHs, CHNA partnerships ranged from 11.6% of CAHs partnering with health insurers outside the system to 44.6% partnering with local/state public health agencies. Similarly, for non-metropolitan PPS hospitals, CHNA partnerships ranged from 17.6% of hospitals partnering with health insurers outside the system to 51.3% partnering with local/state public health agencies. The patterns of partnerships for community-level partnerships to address SDOHs were similar among CAHs and non-metropolitan PPS hospitals, with the highest percentage of partnerships being with local/state public health agencies and a low percentage of CAHs partnering with health insurers. Non-metropolitan PPS hospitals, however, showed the lowest percentage of hospitals partnering with organizations that provide legal assistance.

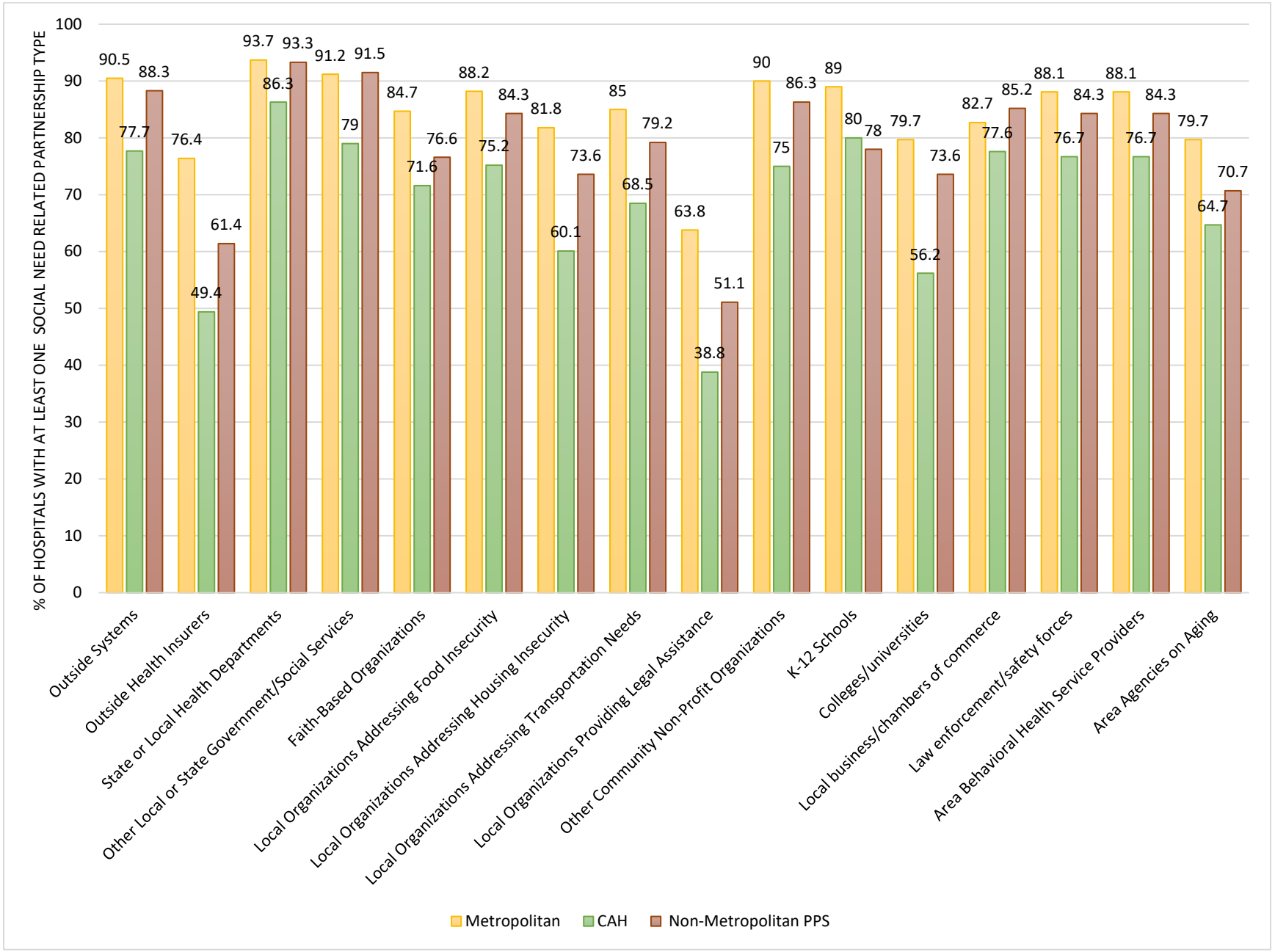

Figure 4: Percentage of Hospitals with at Least One Social Needs Related Partnership Types

Table 2: Types of Partnerships between Hospitals and Outside Organizations

Partnership Type	All (n=2,089)	Metropolitan PPS (n=1316)	CAH (n=457)	Non-Metropolitan PPS (n=316)
Address Social Needs				
Health care providers outside system	1298 (61.7%)	854 (64.6%)	263 (56.7%)	181 (55.9%)
Health insurers outside system	1147 (54.5%)	810 (61.2%)	189 (40.7%)	148 (46.5%)
Local/state public health depts/orgs	1298 (61.7%)	841 (63.6%)	266 (57.3%)	191 (60.1%)
Other local/stage agencies/orgs	1331 (55.6%)	876 (66.2%)	258 (55.6%)	197 (62.0%)
Faith-based orgs	1183 (56.2%)	799 (60.4%)	218 (47.0%)	166 (52.2%)
Local orgs addressing food insecurity	1310 (62.2%)	897 (67.8%)	230 (49.6%)	183 (57.6%)
Local orgs addressing transportation needs	1307 (62.1%)	908 (68.6%)	216 (46.6%)	183 (57.6%)
Local orgs addressing housing insecurity	1210 (57.5%)	853 (64.5%)	193 (41.6%)	164 (51.6%)
Local orgs providing legal assistance	920 (44.1%)	675 (51.3%)	130 (28.5%)	115 (36.5%)
Other community non-profit orgs	1302 (61.9%)	896 (67.7%)	228 (49.1%)	178 (56.0%)
K-12 schools	930 (44.2%)	584 (44.1%)	212 (45.7%)	134 (42.1%)
Colleges or universities	828 (39.3%)	569 (43.0%)	141 (30.4%)	118 (37.1%)
Local businesses or chambers of commerce	847 (40.2%)	536 (40.5%)	182 (39.2%)	129 (40.6%)
Law enforcement/safety forces	1114 (52.9%)	699 (52.8%)	248 (53.5%)	167 (52.5%)
Area Behavioral Health Service Providers	1306 (62.0%)	870 (65.8%)	249 (53.7%)	187 (55.8%)
Area Agencies on Aging	1072 (50.9%)	722 (54.6%)	201 (43.3%)	149 (46.9%)

Discussion

We analyzed AHA survey data to examine the extent to which non-metropolitan PPS hospitals and CAHs and metropolitan PPS hospitals were engaged in partnerships with external organizations to address social needs. Metropolitan PPS hospitals had the highest average partnership score regardless of region, with the highest scores in the Northeast and the lowest scores in the South. Regardless of hospital type, those participating in an ACO had higher partnership scores than those that did not. Similarly, non-profit hospitals had higher partnership scores than government or for-profit hospitals. Most hospitals had partnerships with state and local agencies, though more metropolitan PPS hospitals had partnerships with organizations addressing individual social needs. A higher proportion of metropolitan PPS hospitals had partnerships across all examined areas—social needs, community health needs assessments, and community-level initiatives—compared to non-metropolitan hospitals. Regardless of hospital type and geography, fewer partnerships were related to community-level initiatives.

Metropolitan PPS hospitals had higher partnership scores than did CAHs or non-metropolitan PPS hospitals, and regardless of type, the Northeast typically had the highest partnership scores. The smaller number of partnerships in CAHs corroborates other recent AHA survey analyses.[14] Metropolitan hospitals may have more nearby available partners to engage with than do their non-metropolitan counterparts. Similarly, the Northeast, with greater population density in metropolitan areas and greater proximity to metropolitan areas in non-metropolitan areas, had more partnerships than other regions, which corroborated previous studies.

Our findings may underscore an opportunity for the Flex Program, which supports CAHs in quality, financial, and operational improvements, to provide additional technical support—particularly around population health—in addressing the social needs of their patients.[15] Previous studies suggest that support of hospital leadership, adequate funding, and a

greater staff focus on community engagement are needed to facilitate partnerships to address social needs.[15] Additionally, with the recent Centers for Medicare & Medicaid Services' (CMS') health equity guidelines around quality reporting for PPS hospitals, it is important to ensure that rural hospitals have the resources they need to address patients' social needs.[16]

We also identified differences across metropolitan and non-metropolitan PPS hospitals and CAHs concerning the types of partnerships. Partnerships with local health departments were common across hospital types, while more metropolitan PPS hospitals had partnerships with organizations that addressed specific social needs (e.g., food insecurity). These findings may reflect the fact that there are few specific formal organizations to address such needs in more rural areas or that these needs are addressed through informal or personnel connections.[17] The findings may also indicate an opportunity for rural hospitals to increase their partnerships with additional types of organizations across the range of potential activities related to addressing social needs that can leverage existing strategies without unnecessary duplication.[18]

Across all hospital types we found that hospitals that participated in an ACO reported higher partnership participation scores than those that did not. Previous studies have shown that hospitals that participated in ACOs report higher levels of community partnerships and involvement in community social needs.[19,20] CMS forecasts that participation in ACOs will increase in rural areas in 2024 and beyond due to changes to the Medicare Share Savings Program incorporated into the 2023 new physician fee schedule rule.[21] As community partnerships are vital to facilitating ACO activities and value-based care, growth in ACO-participating partnerships is anticipated.

Limitations

The national nature of the AHA survey is a great strength, but it also has limitations. First, the AHA SDOH supplement was completed by only a portion of U.S. medical and surgical hospitals. Second, while the survey assessed a comprehensive set of partnership types and organizations, it did not assess the intensity and depth of those partnerships. Also, previous research has shown that hospitals' and partners' perceptions of the partnership sometimes differ.[22]

Conclusions

Both non-metropolitan PPS hospitals and CAHs tended to have fewer partnerships than their metropolitan counterparts, with hospitals participating in ACOs having more partnerships across geographies. Providing additional technical and financial support to CAHs to address social needs and partnership development/engagement may facilitate more partnerships. In addition to assessing the number and types of partnerships, further research should assess the extent and level of engagement of partners. Changes to quality reporting around health equity for PPS hospitals and payment incentives for both PPS hospitals and CAHs may also prompt a similar need for resources to enable hospitals to address social needs through partnerships. Additionally, with continued growth in hospital ACO participation, growth in partnerships may follow to facilitate shifts in value-based care. Understanding the value added of these partnerships to better address the SDOH in rural communities will be important moving forward.

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Appendix

Appendix Table 1: Characteristics of Hospitals who Responded to the Social Determinants of Health Supplement of American Hospital Association Survey

Hospital Characteristics	All (n=2,089)	Metropolitan PPS (n=1316)	CAH (n=457)	Non-Metropolitan PPS (n=316)
Rurality				
Micropolitan	353 (16.9%)	0 (0%)	120 (26.3%)	233 (73.7%)
Rural	420 (20.1%)	0 (0%)	337 (73.7%)	83 (26.3%)
Urban	1316 (63.0%)	1316 (100%)	0 (0%)	0 (0%)
U.S. Census Region*				
Northeast	315 (15.1%)	245 (77.8%)	30 (9.5%)	40 (12.7%)
South	747 (35.6%)	498 (67.0%)	106 (14.3%)	139 (18.7%)
Midwest	677 (32.4%)	334 (49.3%)	238 (35.2%)	105 (15.5%)
West	354 (17.0%)	238 (67.5%)	83 (23.5%)	32 (9.0%)
Ownership Type				
Public (Govt., Non-Federal)	410 (19.5%)	163 (12.3%)	187 (40.3%)	60 (18.9%)
Non-Profit	1525 (72.5%)	1033(78.1%)	263 (56.7%)	229 (72.0%)
For Profit	170 (8.1%)	127 (9.6%)	14 (3.0%)	29 (9.1%)
Hospital/system established an ACO				
Leads ACO	839 (40.8%)	659 (51.3%)	98 (22.0%)	76 (24.5%)
Participates but doesn't lead	444 (21.8%)	245 (19.1%)	116 (26.0%)	83 (26.8%)
Once participated but doesn't currently	128 (6.3%)	80 (6.2%)	27 (6.1%)	21 (6.8%)
Never participated/lead ACO	636 (31.2%)	301 (23.4%)	205 (46.0%)	130 (41.9%)
Hospital medical home, yes	476 (23.0%)	327 (25.1%)	90 (19.7%)	59 (18.8%)
System medical home, yes	976 (46.4%)	682 (53.4%)	139 (31.0%)	121 (39.5%)

*Regions: **Northeast:** Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont; **Midwest:** Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Wisconsin; **South:** Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia; **West:** Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

Appendix Table 2: Number of Types of Partnerships between Hospitals and Outside Organizations

Types and Numbers of Partnerships	All (n=2,089)	Metropolitan (n=1316)	CAH (n=457)	Non-Metropolitan PPS (n=316)
With outside systems				
0	264 (12.6%)	124 (9.5%)	102 (22.3%)	37 (11.7%)
1	950 (45.5%)	552 (42.0%)	230 (24.2%)	168 (53.2%)
2	307 (14.7%)	211 (16.0%)	52 (16.9%)	44 (13.9%)
3	568 (27.2%)	428 (32.5%)	73 (12.9%)	67 (21.2%)
With outside health insurers				
0	664 (31.8%)	311 (23.6%)	231 (50.6%)	122 (38.6%)
1	954 (45.7%)	625 (47.5%)	186 (40.7%)	143 (45.3%)
2	217 (10.4%)	171 (13.0%)	23 (5.0%)	23 (7.3%)
3	254 (12.2%)	209 (15.9%)	17 (3.7%)	28 (8.9%)

Types and Numbers of Partnerships	All (n=2,089)	Metropolitan (n=1316)	CAH (n=457)	Non-Metropolitan PPS (n=316)
With state or local public health departments				
0				
1	161 (7.7%)	82 (6.3%)	58 (12.7%)	21 (6.7%)
2	951 (45.5%)	548 (41.6%)	246 (53.8%)	157 (49.7%)
3	246 (11.8%)	169 (12.8%)	38 (8.3%)	39 (12.3%)
	731 (35.0%)	517 (39.3%)	115 (25.2%)	99 (31.3%)
With other local or state government/social services				
0	239 (11.4%)	116 (8.8%)	96 (21.0%)	27 (8.5%)
1	942 (45.1%)	547 (41.6%)	233 (51.0%)	162 (51.3%)
2	247 (11.8%)	168 (12.8%)	43 (9.4%)	36 (11.4%)
3	661 (31.6%)	485 (36.9%)	85 (18.6%)	91 (28.8%)
With faith-based organizations				
0	405 (19.4%)	201 (15.3%)	130 (28.4%)	74 (23.4%)
1	888 (42.5%)	522 (39.7%)	229 (50.1%)	137 (43.4%)
2	294 (14.1%)	217 (16.5%)	35 (7.6%)	42 (13.3%)
3	502 (24.0%)	376 (28.6%)	63 (13.8%)	63 (19.9%)
With local organizations addressing food insecurity				
0	321 (15.3%)	156 (11.8%)	115 (24.8%)	50 (15.7%)
1	891 (42.3%)	507 (38.3%)	231 (49.8%)	153 (7.3%)
2	281 (13.4%)	203 (15.4%)	38 (8.2%)	40 (12.6%)
3	612 (29.1%)	457 (34.5%)	80 (17.2%)	75 (23.6%)
With local organizations addressing housing insecurity				
0	510 (24.2%)	241 (18.2%)	185 (39.9%)	84 (26.4%)
1	905 (43.0%)	564 (42.6%)	195 (42.0%)	146 (45.9%)
2	264 (12.5%)	195 (14.7%)	36 (7.8%)	33 (10.4%)
3	426 (20.2%)	323 (24.4%)	48 (10.3%)	55 (17.3%)
With local organizations addressing transportation needs				
0	411 (19.5%)	199 (15.0%)	146 (31.5%)	66 (20.8%)
1	1010 (48.0%)	639 (48.3%)	220 (47.4%)	151 (47.5%)
2	263 (12.5%)	182 (13.8%)	40 (8.6%)	41 (12.9%)
3	421 (20.0%)	303 (22.9%)	58 (12.5%)	60 (18.9%)
With local organizations providing legal assistance				
0	909 (43.6%)	476 (36.2%)	279 (61.2%)	154 (48.9%)
1	803 (38.5%)	548 (51.7%)	134 (29.4%)	121 (38.4%)
2	156 (7.5%)	128 (9.7%)	8 (1.8%)	20 (6.4%)
3	218 (10.5%)	163 (12.4%)	35 (7.7%)	20 (6.4%)
With other community non-profit organizations				
0	298 (14.2%)	132 (10.0%)	116 (25.0%)	50 (15.7%)
1	879 (41.8%)	497 (37.6%)	228 (49.1%)	154 (48.4%)
2	263 (12.5%)	195 (14.7%)	36 (7.8%)	32 (10.1%)
3	665 (31.6%)	499 (37.7%)	84 (18.1%)	82 (25.8%)
With K-12 schools				
0	441 (21.0%)	278 (21.0%)	93 (20.0%)	70 (22.0%)

Types and Numbers of Partnerships	All (n=2,089)	Metropolitan (n=1316)	CAH (n=457)	Non-Metropolitan PPS (n=316)
1	977 (46.4%)	556 (42.0%)	257 (55.4%)	164 (51.6%)
2	237 (11.3%)	177 (13.4%)	35 (7.5%)	25 (7.9%)
3	450 (21.4%)	312 (23.6%)	79 (17.0%)	59 (18.6%)
With colleges/universities				
0	556 (26.4%)	269 (20.3%)	203 (43.8%)	84 (26.4%)
1	189 (21.3%)	551 (41.7%)	189 (40.8%)	149 (46.9%)
2	32 (6.9%)	219 (16.6%)	32 (6.9%)	38 (12.0%)
3	40 (8.6%)	284 (21.5%)	40 (8.6%)	47 (14.8%)
With local business or chambers of commerce				
0				
1	308 (18.1%)	229 (17.3%)	104 (22.4%)	47 (14.8%)
2	1145 (54.4%)	686 (51.9%)	267 (57.5%)	192 (60.4%)
3	254 (12.1%)	185 (14.0%)	37 (8.0%)	32 (10.1%)
	326 (15.5%)	223 (16.9%)	56 (12.1%)	47 (14.8%)
With law enforcement/safety forces				
0	344 (16.3%)	206 (15.6%)	86 (18.5%)	52 (16.4%)
1	1079 (51.3%)	644 (48.7%)	267 (57.5%)	168 (52.8%)
2	283 (13.4%)	201 (15.2%)	38 (8.2%)	44 (13.8%)
3	399 (19.0%)	272 (20.6%)	73 (15.7%)	54 (17.0%)
With Area Behavioral Health Services Providers				
0	316 (15.0%)	158 (11.9%)	108 (23.3%)	50 (15.7%)
1	1000 (47.5%)	578 (43.7%)	252 (54.3%)	170 (53.5%)
2	289 (13.7%)	208 (15.7%)	42 (9.1%)	39 (12.3%)
3	500 (23.8%)	379 (28.7%)	62 (13.4%)	59 (18.6%)
Area Agencies on Aging				
0	526 (25.0%)	269 (20.3%)	164 (35.3%)	93(29.3%)
1	924 (43.9%)	561 (42.4%)	215 (46.3%)	148 (46.5%)
2	297 (14.1%)	222 (16.8%)	38 (8.2%)	37 (11.6%)
3	358 (17.0%)	271 (20.5%)	47 (10.1%)	40 (12.6%)
Hospitals may have up to three types of partnerships: (1) addressing social needs; (2) involvement in community health needs assessments; (3) community-level initiatives to address SDOH				

Appendix Table 3: Types of Partnerships between Hospitals and Outside Organizations

	All (n=2,089)	Metropolitan PPS (n=1316)	CAH (n=457)	Non-Metropolitan PPS (n=316)
Community Health Needs Assessments				
Health care providers outside system	983 (46.7%)	677 (51.2%)	169 (36.4%)	137 (43.1%)
Health insurers outside system	444 (21.1%)	334 (25.5%)	54 (11.6%)	56 (17.6%)
Local/state public health depts/orgs	1130 (53.7%)	760 (57.5%)	207 (44.6%)	163 (51.3%)
Other local/stage agencies/orgs	1034 (49.1%)	715 (54.0%)	170 (36.6%)	149 (46.9%)
Faith-based orgs	979 (46.5%)	683 (51.6%)	165 (35.6%)	131 (41.2%)
Local orgs addressing food insecurity	993 (47.2%)	677 (51.2%)	178 (38.4%)	138 (43.4%)
Local orgs addressing transportation needs	788 (37.4%)	520 (39.3%)	150 (32.3%)	118 (37.1%)
Local orgs addressing housing insecurity	802 (38.1%)	562 (42.5%)	125 (26.9%)	115 (36.2%)
Local orgs providing legal assistance	471 (22.6%)	330 (25.1%)	76 (16.7%)	65 (20.6%)
Other community non-profit orgs	1063 (50.5%)	732 (55.3%)	181 (39.0%)	150 (47.2%)
K-12 schools	898 (42.7%)	585 (44.2%)	184 (39.7%)	129 (40.6%)
Colleges or universities	894 (42.5%)	642 (48.5%)	131 (28.2%)	121 (38.1%)
Local businesses or chambers of commerce	1015 (48.2%)	666 (50.3%)	197 (42.4%)	152 (47.8%)
Law enforcement/safety forces	893 (42.4%)	595 (45.0%)	170 (36.6%)	128 (40.3%)
Area Behavioral Health Service Providers	909 (43.2%)	636 (48.1%)	156 (33.6%)	117 (36.8%)
Area Agencies on Aging	790 (37.5%)	547 (41.4%)	147 (31.7%)	96 (30.2%)
Community-Level Initiatives to Address Social Determinants of Health				
Health care providers outside system	1010 (48.0%)	740 (55.9%)	130 (28.0%)	140 (44.0%)
Health insurers outside system	577 (27.4%)	463 (35.0%)	45 (9.7%)	69 (21.7%)
Local/state public health depts/orgs	1231 (58.5%)	850 (64.3%)	180 (56.6%)	201 (43.3%)
Other local/stage agencies/orgs	1078 (51.2%)	762 (57.6%)	153 (33.0%)	163 (51.3%)
Faith-based orgs	844 (40.1%)	619 (46.8%)	113 (24.4%)	112 (35.2%)
Local orgs addressing food insecurity	986 (46.8%)	710 (53.7%)	139 (30.0%)	137 (43.1%)
Local orgs addressing transportation needs	704 (33.4%)	484 (36.6%)	108 (23.3%)	112 (35.2%)
Local orgs addressing housing insecurity	699 (33.2%)	508 (38.4%)	93 (20.0%)	98 (30.8%)
Local orgs providing legal assistance	378 (18.1%)	288 (21.9%)	49 (10.8%)	41 (13.0%)
Other community non-profit orgs	1035 (49.2%)	756 (57.1%)	143 (30.8%)	136 (42.8%)
K-12 schools	973 (46.2%)	677 (51.2%)	168 (36.2%)	128 (40.3%)
Colleges or universities	858 (21.8%)	630 (47.6%)	101 (21.8%)	127 (39.9%)
Local businesses or chambers of commerce	769 (36.5%)	523 (39.5%)	130 (28.0%)	116 (36.5%)
Law enforcement/safety forces	835 (39.7%)	568 (42.9%)	144 (31.0%)	123 (38.7%)
Area Behavioral Health Service Providers	863 (41.0%)	625 (47.2%)	117 (25.2%)	121 (38.1%)
Area Agencies on Aging	730 (34.7%)	549 (41.5%)	84 (18.1%)	97 (30.5%)