Why Don’t Hospitals Prioritize Substance Abuse in Their Community Benefit Programming?

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ABSTRACT
The goal of this study was to understand whether Appalachian Ohio hospitals prioritized substance abuse in their IRS-mandated community health needs assessments (CHNAs) and if not, what factors were important in this decision. Analysis of CHNA reports from all 28 hospitals in the region supplemented interview data from in-depth phone interviews, with 17 participants tasked with overseeing CHNAs at 21 hospitals. The CHNA reports show that hospitals in this region prioritize substance abuse and mental health less often than access to care and obesity. Interviews suggest 4 reasons: lack of resources, risk aversion, concern about hospital expertise, and stigma related to substance abuse. Hospitals are playing a larger role in public health as a result of CHNA requirements but resist taking on challenging problems such as substance abuse. The report concludes by summarizing concrete steps to ensure that community benefit efforts address pressing health problems. The implications of this study are manifest in concrete recommendations for encouraging hospitals to address pressing health problems in their community benefit efforts.

KEY WORDS: community health needs assessment, hospitals, opioids, stigma, substance abuse

Appalachia is ground zero in the opioid epidemic, claiming 3 out of the 5 states in the nation with the highest rates of overdose deaths. Further compounding this public health problem is secondary illnesses resulting from intravenous drug use. In Central Appalachia, for example, hepatitis C infection rates rose 364% between 2006 and 2012 and now greatly exceed national averages. At present, the Appalachian region is bracing for a potential human immunodeficiency virus outbreak as the Centers for Disease Control and Prevention has identified counties in the region that are considered high risk. Overlaying these trajectories is the fact that rural hospitals are more likely to have critical access, which is associated with comparatively poor financial performance. Appalachian hospitals, specifically, are less likely to be profitable and are at higher risk of closure, making it difficult for them to take on entrenched problems. In the meantime, a lack of will to take on the opioid epidemic, at least in any sustained manner, has characterized the political response. For example, while President Trump recently declared the opioid epidemic a “national emergency,” it is unclear that Congressional appropriations will follow, especially as the Congress plans to turn next to tax reform and cuts. In addition, Ohio’s Republican senator voted to repeal large sections of the Affordable Care Act, with large cuts to the Medicaid programs that fund a large percentage of services for addressing the opioid epidemic.

Although the opioid epidemic is national, its consequences are felt locally and will need to be addressed on this level. As health care providers, nonprofit hospitals play an important role in addressing local health problems such as substance abuse. Yet, these institutions’ increased role as anchor institutions within communities suggests the need for them to collaborate with community partners by offering preventive programming within communities. As a result of the Affordable Care Act, all nonprofit hospitals are subject to new measures of accountability in exchange for nonprofit tax status under internal revenue service code. As of 2012, hospitals must undertake community health needs assessments (CHNAs) to identify...
local health needs, prioritize problems that the hospital will address, and develop strategies for implementing programs. Hospitals must document this process and file annual progress reports with the internal revenue service. Hospitals may choose not to address community-identified problems in their implementation process but must provide a rationale for excluding certain community-identified issues. Since the prioritization process provides an important window into the role that hospitals intend to play moving forward, we analyzed whether they were taking on substance abuse in Appalachian Ohio. If not, we sought to understand why. See Figure 1 for an overview of the CHNA process.

**Methods**

**Approach**

Using constructivist grounded theory, 3 researchers conducted a qualitative study of Appalachian Ohio nonprofit hospitals. Grounded theory is an inductive approach that aims to allow theory to develop through data collection and analysis rather than simply confirm or reject existing hypotheses. The constructivist variant was developed as a response to perceived positivism in Glaser and Strauss’s original grounded theory. Specifically, we follow Charmaz’s approach in acknowledging that research is never truly inductive, but rather researchers always bring experiences and biases to bear on projects.

**Study population**

Our study population included all nonprofit hospitals in the Appalachian Ohio Region. Thirty-two out of 88 counties in Ohio are designated as Appalachian and are located along the Southern and Eastern edges of the state. In total, 28 hospitals met these criteria.

**Data collection and analysis**

We contacted the individuals overseeing CHNAs at all 28 hospitals in the summer of 2016. We found contact information on CHNA reports or by calling the hospital directly. Of the 28 hospitals, 21 agreed to participate in in-depth semistructured phone interviews. There were 17 participants in total because 4 participants represented multiple hospitals within a system. Of these participants, 15 were full-time hospital employees and 2 were external consultants hired to complete CHNAs. Participants were not compensated and provided consent verbally at the beginning of the interview. Hospitals that did not agree to participate did not differ significantly from the sample. In these cases, individuals stated that they did not want to participate because of a lack of time.

Interviews were conducted jointly by the first 2 authors, audio-recorded, transcribed verbatim by a research assistant, and lasted approximately 30 to 60 minutes. An interview guide was used that covered the hospitals’ CHNA methods, findings, and early challenges in adopting this new reporting requirement. The first 2 authors coded the transcripts following a 3-phase process that is typical in grounded theory studies. All coding was carried out using the Web-based qualitative analysis software, Dedoose (Sociocultural Research Consultants, Los Angeles, California). The researchers met regularly during this time to identify code redundancies and resolve any disagreements regarding emerging themes. Specifically, memos and cross-coding were used to ensure accuracy across the 2 coders. The ultimate goal of this process was to produce a thematic structure that allows for a better understanding of hospital perspectives on completing CHNAs in the Appalachian region. The use of human subjects was approved by the Ohio University institutional review board in May 2016.

In addition to in-depth interviews, we analyzed the most recent (2013) CHNA reports for all 28 hospitals in Appalachian Ohio. We recorded the top 5 health concerns identified by the community and the areas that the hospital prioritized. Next, we calculated the 3 most common health concerns across the sample, in addition to substance abuse. The goal was to compare whether common health concerns were prioritized at
the same rate as substance abuse in their implementation planning.

Findings

Our analysis of prioritization frequencies in hospital CHNA reports suggests that Appalachian Ohio hospitals do not prioritize substance abuse at the same rate as other nonbehavioral health problems. Of the 28 hospitals, 25 were located in communities whose stakeholders rated substance abuse as a primary concern. Of these, 48% (12) prioritized substance abuse in implementation plans. To assess whether hospitals prioritized substance abuse less than other issues, we compared this finding with the top 3 community health concerns across the sample: access to medical care, obesity, and mental health. Of the 16 hospitals that identified access to care as a community concern, 100% (16) prioritized it in their implementation plans. Eighty-seven percent (13) of the 15 hospitals that listed obesity as a top community concern prioritized it. Finally, of the 12 hospitals whose communities ranked mental health a primary concern, 50% (6) prioritized it for follow-up (see Figure 2).

The fact that less than half of the hospitals prioritized substance abuse was surprising, however, because this issue appeared consistently in community contributions to CHNAs and was strongly supported by residents for inclusion in implementation plans. Several participants described the climate of discussions with communities and the salience of substance abuse in residents’ rankings of local problems. For example, participant 7 explained, “I don’t think you’re gonna be surprised. Drug abuse is by far what everybody considers to be a priority.” Similarly, participant 16 expressed the following:

I have to say that it was surprising just based on how it has moved up in the rankings. As a group, we were surprised, like in drug abuse, prescription and non-prescription drug abuse, moved up the ladder in terms of priority and incidence and problems for the community to address. And it was identified by focus groups, stakeholders, the community survey, just a common theme over and over again.

Despite strong statements from community members and leaders, a majority of hospitals did not prioritize substance abuse in their implementation plans. Four themes emerged that help explain why: lack of resources; risk aversion in taking on challenging problems; concern about the scope of hospitals’ expertise; and stigma related to substance abuse.

Lack of resources

Many hospitals noted a lack of resources necessary to take on complex problems such as substance abuse. These financial concerns were a key reason why hospitals chose not to prioritize substance abuse, especially in early rounds of CHNAs. Participant 4 reported, “We certainly couldn’t take on everything or we wouldn’t exist any longer.” Other participants similarly described financial concerns as an important factor in the decision-making process. Participant 1, whose hospital debated whether to include substance abuse, and ultimately did, explained,

I think one of the big ones for hospitals is identifying needs, but you don’t have resources to tackle…. And you’ve got a hospital that’s got 150 employees, they don’t have a psych ward, they don’t have … the financial resources or people resources that have the capability to attack that.

A consultant (participant 17) added that prioritizing substance abuse was challenging because hospitals that are financially struggling could not expect to profit on this work. She explained, “Quite frankly,
most health systems don’t want to tackle it because there’s no money in it.” Our interviews suggest that some hospitals feel that all programming and efforts must yield financial benefits, beyond addressing important problems. In the case of the hospitals whose employees we interviewed, financial yields were not a form of profit seeking, as such, but a response to a lack of resources more generally.

In some cases, however, changes in perceptions about the urgency of the problem have altered the extent to which financial considerations guide hospital programming considerations. One hospital (participant 9) shared a story of financial concerns preventing the prioritization of substance abuse in 2013 but was reconsidering the issue because of the severity of opioid abuse and overdose:

And in 2013, substance abuse and mental health were noted to be problems, but at that time we did not feel that we had the resources to affect those. In 2016 was the increase in substance abuse and the effect that it’s had as far as, you know, persons coming into our ED and babies being born to mothers that are abusing drugs, of a variety of sources. Substance abuse has increased to a point where in 2016, we don’t feel that it’s something that we can’t—in some way we have to find the resources to try to combat that.

Regardless of whether hospitals ultimately prioritized substance abuse, financial resources were closely tied to decisions to offer new programming in this area.

**Exceeding hospital expertise**

Many hospitals felt that addressing substance abuse required skill sets that their hospital did not currently have. For example, one hospital’s implementation plan notes that despite the importance to the community, hospitals were unable to address substance abuse because of “limited capabilities.” The report concludes: “the hospital organization is not equipped to provide services or address these issues at the competency or resource level required to impact these high level needs.”

Participants interviewed also suggested that including substance abuse or another issue in their implementation plan meant that they would be responsible for taking the lead in planning new interventions. Some participants, accordingly, lamented the fact that hospitals were often expected to take the lead of new projects, even when they did not currently have expertise in that area. Participant 16 stated: “I believe that the hospitals are looked at as the lead agencies for improving population health. Most of them are nonprofit, you know, you have a minimal bottom line.” Participant 3 similarly questioned whether hospitals, that do not have formal public health or behavioral health training, had the expertise to start new substance abuse interventions:

Yeah. I mean, for instance, we had one health department ask us to start up a syringe exchange program because another health department is doing that. And they think that we were the leaders of that in the other community, and we’re not. While we support what they’re doing, we’re not leading that effort.

Such hospitals, instead, preferred to be partners in addressing substance abuse, rather than leaders, due in large part to concerns about expertise.
Other participants felt that hospitals should explicitly prioritize issues that are medical in nature and that they are clearly trained to address. As participant 12 explained, “I think our first and foremost responsibility is making sure that we have the access to health care that people need, which is why we put a lot of focus on recruiting physicians to come into the community.” Participant 10 noted, “For hospitals that were smaller or not connected in a big urban environment, they were like, ‘Look at everything else on the list, we can barely attack the medical things where we have expertise.’” Participant 13 spoke to the challenges of hearing suggestions from the community where the hospital did not have expertise:

And I can tell you that it’s challenging, you know, in some communities it took a lot of—it was more challenging for us as a hospital system because we were hearing things that we didn’t necessarily feel were things that a hospital system should address.

Small hospitals found it particularly difficult to commit to working in new areas such as substance abuse when they already struggled to address medical needs that were more in line with their training and expertise.

### Stigma

Some hospitals seemed to treat substance abuse differently than other health issues because of a belief that substance abuse wasn’t as important as other local problems. Participant 11 described being surprised that local residents would rank substance abuse as high as they did, despite acknowledging that the community does have a substance abuse problem. She explained:

I think the first time that we did the survey, we of course in Appalachia and especially in this area...unfortunately is known for the drug trafficking problem, and I was surprised that that took number one priority in most people’s viewpoint...to me, that’s just not my number one priority.... But my life is not as touched by it as other people’s are and maybe that’s just my own perception.

In this case, stigma was manifest in a hospital employee’s sense that substance abuse did not deserve the full attention and resources of hospitals’ community benefit work.

Other participants, however, took specific issue with potential residual harm that could be caused by developing new programs to combat opioid overdose deaths. Participant 6, for example, was reluctant to prioritize substance abuse because he thought that many common interventions being used in the state would enable existing opioid users. He took particular issue with the increasing availability of Naloxone (Narcan), an opioid reversal drug:

You hear stories about how parents are treating their children now, they give them a shot. This is like a free pass to do heroin; you don’t have the fear in the back of your mind that you might die from it.

For participant 6, stigma regarding opioid users resulted in an emphasis on personal responsibility, rather than hospitals working on new initiatives to curb use. Most important, both of these statements suggest that employees’ and institutions’ views on substance abuse are instrumental in the prioritization process in addition to community preferences.

### Discussion

Although most hospitals in our sample grappled with whether to prioritize substance abuse, less than half opted to commit to new programming to take it on. This was in spite of the fact that community members at 89% (25) of hospitals identified substance abuse as a top health concern. The CHNA reports and our interviews provide insight into why Appalachian hospitals omit substance abuse more than other health concerns from their implementation plans. We found that among hospitals in this region, both substance abuse and mental health were prioritized less often than other common health issues such as obesity and access to care. Substance abuse, however, was about as likely to be prioritized as mental health—another commonly cited health concern. While not all hospitals were dissuaded from addressing substance abuse, many regarded this issue as comparatively intractable and possibly not appropriate for hospitals to address. In particular, participants raised concerns about the lack of financial resources at small, Appalachian hospitals as well as the risk they would take on if they are held accountable for showing progress in reducing use or rates of overdose. The ambiguity over potential Internal Revenue Service penalties raises particular concerns about the consequences of not showing improvement in outcomes and how to properly evaluate new programs.

Participants also suggested that substance abuse transcended hospitals’ traditional expertise and may be best left to experts. Several hospitals acknowledged that substance abuse was an important and pressing public health problem but desired to serve as partners and not leaders in the development of new interventions. Finally, substance abuse seems to be stigmatizing in ways that other traditional medical issues are not. In particular, the emphasis on personal
responsibility was applied to substance abuse in a way that was different from other health issues such as obesity or diabetes. The presence of stigma among hospital personnel tasked with community health suggests that structural stigma may be an important factor in the prioritization process and, therefore, must be addressed.  

Despite these factors, some hospitals did prioritize substance abuse, in part because of strong community pressure and the acknowledgement that the opioid epidemic continues to escalate. Some hospitals that did not prioritize substance abuse in 2013 stated that they might be able to prioritize this issue in subsequent years once they have more experience with the CHNA process and have time to develop partnerships and summon resources to address this issue. With support, hospitals may be better equipped to prioritize substance abuse in subsequent rounds of CHNAs.

Public health implications

Our data raise questions about how nonprofit hospitals can gain the support and encouragement necessary to take on pressing and often seemingly intractable problems facing their communities. Of course, there are limits to the number of new activities that hospitals can take on, especially small and/or rural hospitals. Nonetheless, opportunities exist for increasing hospitals’ efficacy in addressing substance abuse in their communities.

Several participants reported that Appalachian hospitals are neither incentivized nor adequately supported in taking on substance abuse. Incentives and support will be necessary as a counterweight to risk aversion, beyond addressing acute patient needs in the emergency department. For example, on the level of incentives, considering that CHNAs require action on the part of hospitals, one could imagine the introduction of new financial incentives for achieving certain metrics in the promotion of wellness and early disease interventions, perhaps by way of financial awards for the expansion of new programs, especially for small and/or rural hospitals. However, direct supports and not incentives will likely be most important since these institutions are likely to lack initial capital. It will be challenging for hospitals to commit to new programming for substance abuse when this issue is not part of their core budgets. In times when Medicaid reimbursements are decreasing in rural areas and rural hospitals are at risk of closure, the problems revealed in CHNAs are particularly challenging.

Perhaps most powerfully, hospitals will need to collaborate with community partners on substance abuse prevention and recovery services. Such collaborations may not only be necessary but are likely to be more successful than what can be accomplished through single institutions. Hospitals may be able to commit to noncore issues such as substance abuse with external funding and new partnerships in their communities if they know that they are doing so as part of a concerted, multi-institution effort. The CHNA requirements point in this direction insofar as they not only establish requirements for hospitals but also encourage them to foster innovative community partnerships and provide data that could be useful for securing external grant funding. Our data suggest not only the need for increased financial resources for implementation projects addressing substance abuse but also partnerships to maximize and share resources, not only among hospitals but also public health departments, community health centers, and other community organizations. Ultimately, new CHNA requirements may stimulate hospital involvement in public health but may not be able to motivate hospitals to address substance abuse or other nonmedical issues if appropriate attitudes and material support do not follow suit. We have offered some possible avenues for doing so here.

Implications for Policy & Practice

- Although recent policy changes that expand hospital community benefit requirements have encouraged hospitals to collect information on community needs, critical problems such as substance abuse are not being addressed in new programming despite data and community preference.
- To incentivize hospitals to take on substance abuse, increased financial resources and partnerships will be important to mitigate risks.
- Hospital programs to combat stigma related to substance abuse will also be necessary.

References


