20 YEAR ANNIVERSARY
ESTABLISHED IN 1999

VIE HEALTHCARE® CONSULTING
MARGIN IMPROVEMENT EXPERTS

VOLUME 2 EDITION 10

OPTIMIZING THE PATIENT EXPERIENCE BY WORKING TOWARDS HEALTH EQUITY

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VIE HEALTHCARE® CONSULTING
RESEARCH REPORT

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EXECUTIVE SUMMARY

James Cagliostro brings over a decade of critical care nursing experience to VIE Healthcare®. This gives him a unique insight and understanding into patient care which he brings to our clients. He has observed for himself and throughout his career that hard work makes a tangible difference in the lives of patients and applies that approach and insight to his work with healthcare organizations.

Most health experts agree that the current global pandemic is temporary.

Whether through herd immunity, the development of a vaccine or the establishment of effective treatments, the virus and its devastating effects will eventually come to an end. Unfortunately, the health disparities which have come to light as a result of the COVID-19 crisis will remain.

As increasing amounts of data become available, the full extent of these health disparities will be revealed. The truth is, however, that this crisis has not necessarily created any new disparities - it has simply exacerbated the underlying condition of the US healthcare system.

These health disparities inevitably impact the patient experience, which has become a point of emphasis in recent years for all healthcare organizations. Patient experience officer positions have been created, consultants have been hired, data collection surrounding the patient experience has escalated and reimbursement has increasingly relied on patient satisfaction scores.

A hospital may provide safe, quality care for some of its patients, but if it consistently fails to meet the long-term health needs of its most vulnerable patients then change is needed. The purpose of this report is to better understand those health disparities and explore how the existing healthcare system often fails to “bridge the gap” to meet the needs of more vulnerable communities.

LETTER FROM THE CEO

The issue of health disparities in the US has evolved into a much larger and more significant issue than we as a nation are comfortable admitting. For a nation that prides itself on the latest medical advancements, acknowledging areas where we have historically fallen short can be difficult.

Research from states and regions that have reported data by race and ethnicity have shown that certain communities bear a disproportionate burden of COVID-19 - related outcomes. The reasons why some communities are impacted more than others by particular health issues are many and varied.

This is an issue which we continue to draw attention to in our work at VIE Healthcare®, namely Social Determinants of Health (SDOH). These are defined as:

"..conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."

Many of these conditions lead to serious and potentially life-threatening complications. Furthermore, they increase the mortality rates related to COVID-19, as well as other illnesses. *It must be noted that COVID-19 did not create new health disparities, it simply magnified them.*

Simultaneously it has created a window of opportunity to identify innovative ways to address those inequities as we move forward.

In this report our aim is to encourage healthcare organizations across the United States to create and implement strategies and tools to effectively address health disparities for their communities. These strategies will ultimately deliver an enhanced patient experience.

At VIE Healthcare® we successfully partner with hospitals to transform the patient experience and establish your hospital as a thought leader in patient care.

We are committed to helping hospitals build vital and much needed momentum within their community to drive change.

Please reach out directly to me to discuss the ways in which we can support your organization in creating and implementing new strategies.

I look forward to hearing from you.
Sincerely,

Lisa T. Miller, MHA
Healthcare Margin Improvement Expert, CEO

AN INTRODUCTION TO HEALTH DISPARITIES

Health disparities are defined by the CDC as:

''...preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations."

Populations can be defined by multiple factors such as race or ethnicity, gender, education or income, disability, geographic location (eg, rural or urban), or sexual orientation.

The term ''health disparity'' was first used in the United States in the 1990s when the intention was to identify lower standards of health among:

''... socially disadvantaged people and, in particular, members of disadvantaged racial/ethnic groups and economically disadvantaged people within any racial/ethnic group.''

In addition, Healthy People 2020 offers the following definition:

"If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health."

A disparity implies that varying health outcomes exist, for example illness, injury, disability or mortality, that are directly related to an unequal distribution of resources. These can be described as obstacles or barriers that individuals must overcome because they belong to a particular group of people.

If the underlying condition is health disparity, then the ultimate goal must become health equity.

According to the Robert Wood Johnson Foundation (RWJF), health equity means that:

"...everyone has a fair and just opportunity to be as healthy as possible."

This must include the removal of obstacles that may prevent individuals and communities from gaining optimal health.

The issue of health disparity in the US begins with acknowledging that certain groups of people are forced to overcome obstacles that other groups do not face. This significant first step must take place before any effort can be made to minimize hindrances to individuals achieving and maintaining good health.

Hospitals and health systems that embrace a sense of responsibility to the most vulnerable communities are best positioned to eradicate barriers and improve outcomes for the people they serve.

IDENTIFYING THE PROBLEM: AN HISTORICAL APPROACH

1979

In 1979, The Surgeon General of the US issued the Healthy People Report on *Health Promotion and Disease Prevention.**(1)*** This landmark report focused on reducing preventable death and injury and highlighted the need for a national effort to improve the health of the American people.

A national agenda was developed and refined over the following years, resulting in the launch of the science-based Healthy People 2000 program. This evolved into a ten year initiative to address the health needs of the US population with three specific goals defined as follows:

"The purpose of Healthy People 2000 was to commit the Nation to the attainment of three broad goals. These goals were to increase the span of healthy life, to reduce health disparities among Americans, and to achieve access to preventive services for all Americans. Attaining these broad goals would bring the Nation's health to its full potential."(2)

2001

In 2001, the Institute for Medicine published Crossing the Quality Chasm: A New Health System for the Twenty-first Century ***(3)*** This document set forth specific aims for quality improvement in US healthcare. It noted that patient care should be:

- ***Patient-centered—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.***
- ***Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.***

2003

A 2003 article published in the American Journal of Public Health by Kindig and Stoddart defined Population Health and encouraged further study in the discipline, combining determinants and policies that impact the health of a population:

"we propose that population health as a concept of health be defined as "the health outcomes of a group of individuals, including the distribution of such outcomes

within the group." These populations are often geographic regions, such as nations or communities, but they can also be other groups, such as employees, ethnic groups, disabled persons, or prisoners. Such populations are of relevance to policymakers. In addition, many determinants of health, such as medical care systems, the social environment, and the physical environment, have their biological impact on individuals in part at a population level...

...We have offered a clarification of the term that combines the definition and measurement of health outcomes and their distribution, the patterns of determinants that influence such outcomes, and the policies that influence the optimal balance of determinants."(4)

2005

The term SDOH (Social Determinants of Health) was introduced by the World Health Organization and played an important role in the development of the framework for the Healthy People program.

"In the spirit of social justice, the Commission on Social Determinants of Health was set up by the World Health Organization (WHO) in 2005 to marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it.(5)

2008

Berwick et al, ***(6)*** from the Institute for Healthcare Improvement (IHI), published a paper introducing the Triple Aim as a framework for Healthcare Improvement.

"IHI created the Triple Aim, a framework for optimizing health system performance by simultaneously focusing on the health of a population, the experience of care for individuals within that population, and the per capita cost of providing that care."(7)

2010

In December of 2010, the next 10 year initiative, Healthy People 2020, was established. Its mission included efforts to increase public awareness of the disease process, coupled with social and environmental factors that impacted health. The program addressed various health disparities and created measurable objectives on the Federal, State and Local level:

"Although the term disparities is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations. Healthy People strives to improve the health of all groups" (8)

2020

Healthy People 2030 is the fifth iteration of the Healthy People program and builds on lessons learned in the last 40 years. Goals include:

- ***Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.***
- ***Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.***
- ***Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.***
- ***Promote healthy development, healthy behaviors and well-being across all life stages.***
- ***Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all (9)***

A BETTER UNDERSTANDING OF SOCIAL DETERMINANTS OF HEALTH (SDOH)

Historically, the data regarding health disparities, especially as it relates to racial and ethnic minorities, has been under studied, and as a result, under reported.

In relation to the COVID-19 crisis, this type of data is available and serves the more immediate and pressing needs of those groups that are being disproportionately affected by the illness. The data below illustrates this point:

- In Chicago, approximately 72% of the city's deaths due to COVID-19 involved black residents, a group that comprises 30% of the city's total population.

- In Richmond, VA, 94% of deaths due to COVID-19 were in black residents who comprise just 48% of the city's population." (https://www.texasnurses.org/news/508119/Practice-Tip-of-the-Week-COVID-19-Shines-a-Light-on-Racial-Inequalities.htm).

Furthermore, a Johns Hopkins University and American Community Survey indicated that, as of mid-April 2020, out of 131 predominantly black counties:

The infection rate was 137.5/100,000 and the death rate was 6.3/100,000.

- These figures represent an infection rate three times higher and a death rate six times higher than predominantly white communities.

The statistics confirm that underrepresented minorities have been developing COVID-19 infection and dying from it more frequently than other groups of people.

Ongoing research is needed to determine exactly why these rates are so different, but Social Determinants of Health (SDOH) undoubtedly play a significant role.

Dr Clyde W Yancy, Vice Dean for Diversity and Inclusion and Chief of Cardiology in the Department of Medicine at Northwestern University Feinberg School of Medicine, believes that it is likely that the majority of the discrepancies in disease and death rates can be explained by concomitant comorbidities. Certain comorbidities, such as older age, hypertension, diabetes, obesity, and cardiovascular disease, are associated with worse outcomes. In addition, the incidence of these comorbidities is higher in more vulnerable populations.

Access to testing and treatment has also been raised as a potential cause of health disparities during the COVID-19 crisis.

Black patients were also six times less likely to secure treatment or testing than white patients. Moreover, in many locations across the country, coronavirus screening was carried out predominantly in white, wealthy suburbs, rather than the more vulnerable or hardest hit communities.

While we acknowledge that the choice of testing sites can be influenced by many factors, the location in greatest need should weigh more heavily than others if the ultimate goal is to provide the best quality care for the greatest number of people.

A further health disparity that emerged during the COVID-19 crisis was the fact that many individuals in these at-risk communities are considered "essential workers." Many work in service sector jobs in industries including health care, elder care, child care, transportation, food services, public utilities and delivery services. The nature of this work makes social distancing impossible, even if they were considered high risk individuals.

People in more vulnerable communities do not have the advantage of being able to work remotely or the financial freedom to take time off of work.

Additionally, the relationship between minority communities and the healthcare system may affect the delivery of care.

Regardless of the availability of services, a level of mistrust exists in some communities, based on a combination of historical realities and perceptions arising from past experiences. As the most trusted profession for the last two decades, nurses - and other frontline healthcare workers – have a crucial role to play in rebuilding the trust that is needed to optimize care.

The health disparity equation is extremely complex - and it is widely acknowledged that race in this country still greatly influences where an individual might be born and live much of their life. As a result, the communities where many of these vulnerable individuals live are often characterized by poverty, high housing density, high crime rates, and poor access to healthy foods.

12 VARIABLES OF SDOH

12 variables (SDOH) that have more deeply impacted vulnerable populations during the crisis include:

1. Underlying comorbidities (eg, diabetes, cardiovascular disease, asthma, HIV, morbid obesity, liver disease and kidney disease).

2. More crowded conditions (both by neighborhood and household assessments).

3. More likely to be employed in public facing occupations (e.g. service and transportation) which limit or prevent social distancing and make it impossible to work from home (little control over their work environments).

4. Lack of trust in the health system based on past experiences.

5. Loss of health insurance (which leads to less continued care, poor management of chronic illness and poorer health outcomes).

6. Poorer quality of care (due to geography, insurance, access, etc).

7. Unequal distribution of scarce testing and other hospital resources (actual tests, PPE, etc).

8. Digital divide (insufficient internet access meant individuals not able to take advantage of telehealth services during the crisis).

9. Food insecurity (availability of healthy and affordable food).

10. Housing insecurity (often closely connected with food insecurity).

11. Inequities in education (less education leads to poorer health and poorer health leads to less education).

12. Juggling all of these variables leads to chronic stress (which compromises immunological processes and blood pressure and blood sugar regulation).

Tony Iton, Lecturer of Health Policy and Management and Senior Vice President for Healthy Communities at The California Endowment, has described these vulnerable communities as "*incubators of chronic stress.*"

Social determinants of health can lead to chronic stress which deeply impacts an individual's journey toward better health, creating the perfect storm. Healthcare leaders must navigate this storm in order to meet the needs of the most vulnerable.

A BETTER UNDERSTANDING OF HOW THE HEALTHCARE SYSTEM MAY CONTRIBUTE TO HEALTH DISPARITIES

"Policies have the power to enhance health but also to exacerbate health disparities." (https://jamanetwork.com/journals/jama/fullarticle/2766098)

The tools historically used by the US health system to deliver patient care have proven inadequate in many communities. While a particular system may have previously been adequate for the majority of people, it has proven ineffective for many living in higher risk communities.

Health care leaders who are genuinely concerned for the communities they serve are beginning to recognize that the current system is flawed, and they refuse to accept it as an unchangeable reality.

System problems require system solutions.

Acknowledging that there may be a system problem is the first step to finding a system solution. In his book Upstream, Dan Heath states: "A well-designed system is the best upstream intervention."

The principle behind upstream thinking is to prevent problems before they happen, ie, to address issues in the system that may be contributing towards the problem. The goal is to change the system rather than work around it.

This approach is more challenging, however, in that it often requires major shifts in strategy and can take much longer for the benefits to be realized.

The current health system may exacerbate health disparities by various means, including:

- A lack of decision makers who are intimately connected with the vulnerable communities.
- Failing to act in the best interest of the most vulnerable because it is not profitable.
- Providing care that is not patient-centered. It both fails to meet the patient where they are and fails to understand how to promote health within the family, culture, community of the patient.
- Maintaining the traditional mindset of fixing health problems rather than preventing them from occurring in the first place.
- Failing to make health services more accessible (eg, availability of testing/supplies, access to telehealth services and smoking cessation programs, location of community resources, affordability, etc)

WHAT HAS WORKED? 9 EXAMPLES OF HOSPITAL SUCCESS

1. COMMUNITY COLLABORATION

- Chicago West Side United & Rush University Medical Center https://westsideunited.org/our-impact/metrics-dashboard/
- Healthy Chicago 2.0 https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/HC2.0Plan_3252016.pdf

https://www.rush.edu/about-us/rush-community

"Chicago's West Side has been Rush's home since 1873. ..But for too long, much of the West Side has been overlooked and under-resourced. People who live in the neighborhoods at the center of Rush's service area are working through the effects of decades of structural racism and economic deprivation, including higher levels of poverty and unemployment; crowded housing; and lower rates of education and health insurance.

The resulting inequities in health, employment, income, education and other areas have a far-reaching impact on community well-being — an impact starkly illustrated by the fact that life expectancy for a resident of Chicago's Loop is 85 years, while six miles west the life expectancy for a resident of the West Garfield Park neighborhood is just 69 years.

Together with residents, community leaders, nonprofit organizations and other health care institutions, our goal is to be a catalyst for community health and vitality by dismantling barriers to health, and by promoting health equity both within and outside of Rush."

- Main Line Health/Lankenau Medical Center - https://www.mainlinehealth.org/blog/2019/02/27/addressing-health-and-wellness

"Main Line Health's mission is to meet the health care needs and improve the quality of life in the communities we serve. In order for us to be successful, we must understand the unique health needs of every member of our community, and that includes acknowledging where disparities of care exist and how we can close these gaps," says Jack Lynch, President and CEO of Main Line Health. "By virtue of its location bordering Montgomery and Philadelphia counties, Lankenau Medical Center serves a very diverse patient population. It is with this in mind that we have worked with our community partners to develop several new initiatives that improve access to care, including Together for West Philadelphia, our Heart Smart Corner Store program, Philly Food Bucks, and the Medical Student Advocate Program."

2. FOOD INSECURITY/AVAILABILITY

- Johns Hopkins - Center for Health Equity – Our Impact: Retrieved at: https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-health-equity/what-we-do/our-impact/

"Since our formation in 2010, we've made considerable contributions to reduce health disparities through our evidence-based interventions, partnering with health systems and communities, and changing practices and policies to improve population health. Research outcomes included below have provided valuable input for new health care practices and treatment protocols along with encouraging targeted future research."

- Showed that a program providing dietary advice, help with grocery ordering, and $30/week of high-potassium foods increased consumption of fruits, vegetables among African American patients with controlled hypertension who live in a food desert

- Showed that clinic-based care management improves blood pressure control BP control among both African-American and white patients and is a cost-effective strategy for African Americans and elderly patients. However, problems with limited reach and challenges with program completion among patients from socioeconomically disadvantaged communities should be addressed in future programs to address disparities in hypertension.

- Showed that a context-adapted community health worker intervention is correlated with improvements in blood pressure control among socially disadvantaged African Americans. Neither the addition community health worker intervention further improves BP control.

3. SENIOR POPULATION

- Sohum Health- Getting in Front of COVID-19: Addressing Social Determinants of Health to Save the Lives of Seniors https://www.aha.org/system/files/media/file/2020/04/getting-in-front-of-covid-19-addressing-social-determinants-health-to-save-lives-seniors-sohum-health-case-study.pdf

"SoHum Health intervenes with seniors proactively so they may shelter-in-place. Specifically this is accomplished through direct contact with senior residents and follow-up by volunteers and as necessary, clinicians."

Hospital staff and trained volunteers make calls to seniors to determine their needs – groceries, pharmaceuticals, errands – and schedule visits to keep seniors home and safe. Using a 16-question script and action plan, SoHum Health has organized a broad coalition of support from the Humboldt County Department of Health, Office of Emergency Services, Chamber of Commerce, local banks, fire districts, service groups such as Rotary International and others to provide for their needs.

4. UTILIZATION OF COMMUNITY HEALTH WORKERS

- Penn Medicine Center for Healthcare Innovation -Implementation of the IMPaCT Community Health Worker Intervention https://chw.upenn.edu/

"The Penn Center for Community Health Workers is a national center of excellence focused on improving population health through effective community health worker programs. We developed IMPaCT, a standardized, scalable program that leverages community health workers –trusted laypeople from local communities– to improve health. IMPaCT has been tested in three randomized controlled trials and improves chronic disease control, mental health and quality of care while reducing total hospital days by 65%. IMPaCT has a $2:1 annual return on investment to payers and has been delivered to over 10,000 high-risk patients in the Philadelphia region. In the last three years, IMPaCT has become the most widely disseminated community health worker program in the United States; it is being replicated by organizations across 18 different states including Veterans Health Administration, state Medicaid programs; integrated healthcare organizations and even retailers such as Walmart."

"Interventions by a health system–based community health worker can improve patient-perceived quality of care while reducing hospitalization."

Shreya Kangovi, MD, MS; Nandita Mitra, PhD; Lindsey Norton, MSS, MLSP; Rory Harte; Xinyi Zhao, MPH; Tamala Carter, CHW; David Grande, MD, MPA; Judith A. Long, MD, Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities JAMA Intern Med. 2018; 178(12):1635-1643. doi:10.1001/jamainternmed.2018.4630

- Center for Healthcare Strategies (A non-profit policy center dedicated to improving the health of low-income Americans). Article on the value of community healthcare workers https://www.chcs.org/media/CHCS-CHCF-CHWP-Brief_010920_FINAL.pdf

Financial return on investment (ROI).

"Since CHW/Promotores are typically a lower-cost workforce than licensed health care professionals, several studies have demonstrated the financial value of these non-traditional health workers, including:

- ***CHW/Ps in the Salud y Vida program in South Texas, run by MHP Salud, provide health education efforts focusing on diabetes management. An evaluation of the program's 12- month diabetes self-management course showed improvements in participating patients' hemoglobin A1c levels while achieving a nearly 10 percent ROI from improved disease management.***

- ***In New Mexico, Molina Healthcare's Medicaid managed care organization contracts with a community-based organization and the state university to use CHWs to identify individuals with complex medical and social needs in the community and connect them to needed resources. The program saved an estimated $2 million in health care costs in one year across 448 patients, suggesting close to a 4:1 ROI."***

5. SCREENING FOR SDOH

- Common Spirit Health COO Marvin Quinn interview: https://www.healthleadersmedia.com/strategy/answering-call-commonspirit-strives-end-health-inequalities

"Each of our organizations throughout the country have strong community outreach programs where we work with local leaders to put together resources and programs that help people in their homes and in their communities, as well as once they get to the hospital. We have implemented, in some of our emergency rooms, a software system that tracks every available resource in a community, so that when a patient comes in and needs something, we're able to make a referral right there....

...We've been involved in programs for what we would call managing the social determinants of health. This is not done with physicians or nurses, it's done with social workers and case managers ... to assess [patients'] living conditions: how many medications are they on? Do they have dental issues? Do they even have transportation to get to a physician's office?...

"We don't just live in a community and exist there. We are part of that community, and if we are called upon for service...we're going to answer that call"

- AHA Screening Tool for SDOH: https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf

- AHA Coding for SDOH: https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

6. DATA ANALYTICS

- Grady Health System, Atlanta, GA - "Integrating Social Needs into the EHR" https://www.aha.org/system/files/media/file/2020/03/value-initiative-members-in-action-study-grady-health-system-atlanta-ga-3-16-2020.pdf

"Grady Health System uses artificial intelligence and predictive analytics to provide proactive care management and coordination for high-risk patients"

"Being able to have that data, that extra layer of information, has been really helpful," Now we are able to target and use that data in a powerful way

...Lesson learned - making sure staff are in place to act on the data and support patients' recovery. "That high touch – whether it's a navigator, community health worker or social worker – has to be in place and have the right interaction with the patient to make it meaningful and have the right outcome," Shannon Sale- Grady/Chief Strategy Officer

- National Center for Complex Health and Social Needs, An Initiative of the Camden Coalition, Camden, NJ https://www.nationalcomplex.care/our-work/who-we-serve/

"Who are people with complex health and social needs?

People with complex health and social needs typically experience poor outcomes despite repeatedly cycling through multiple healthcare, social service, and other systems. Although significant resources are spent on these individuals, the care they receive has not made them healthy or well.

These individuals are some of the most expensive consumers in our healthcare system – but this doesn't have to be the case. With data-driven, person-centered approaches, we can provide better care at lower costs, improve outcomes, and build healthier lives."

7. ACCESS TO CARE

- Montefiore Medical Center (11 hospital system - primary service area is the Bronx- the nation's poorest urban county). https://www.montefiore.org/documents/communityservices/MMC-Community-Services-Plan-2019-2021.pdf

"The Bronx remains a hotspot for excess mortality, diabetes, obesity, asthma, drugs/ opioids, and HIV/AIDS in New York City."

There multiple community programs address health disparities and prevent chronic disease. Examples include:

- Montefiore Mobile Dental Van - ***"The Mobile Dental Van provides dental care to patients at MMC affiliated schools that do not have permanent dental services. Staffed by a dentist and a hygienist and equipped with two dental chairs, a digital X-Ray system and a billing system, the van operates five days per week and visits schools on a rotating schedule."***

- Montefiore School - Based Health Program - ***"MSHP is the largest and most comprehensive school-based health care network in the United States. It has 27 school-based health center sites that provide primary care, mental health, oral health and community health services to patients regardless of citizenship status and ability to pay. All sites are federally qualified or partially qualified health centers. Included in MSHP is the Healthy Kids program, comprised of an array of evidence-based prevention activities focused on increasing physical activity and healthy eating in Bronx children and their families."***

8. HOUSING BARRIERS

- From an AHA report: "What is the role of hospitals in addressing housing barriers?" a few examples of hospital intervention were listed: https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/housing-role-of-hospitals.pdf

  - ***Bon Secours Baltimore Health System developed more than 700 affordable housing units for individuals and families in in need.***

  - ***Children's Mercy Kansas City's Healthy Homes program offers environmental health assessments and repairs and renovations to improve housing stability in the community.***

  - ***St. Joseph Health, Humboldt County, in California, has a medical respite program for chronically homeless individuals who have been recently discharged from the hospital.***

  - ***St. Luke's Health System and Saint Alphonsus Health System are developing a single-site Housing First program in Boise, Idaho, part of a collaboration with the city and local organizations.***

  - ***University of Illinois Hospital & Health Sciences System is partnering with the Center for Housing and Health in Chicago to provide stable housing and supportive services to homeless individuals.***

9. VIOLENCE

- Detroit Medical Center /Sinai Grace Hospital with the Wayne State University Department of Emergency Medicine: -Detroit Life is Valuable Every Day (DLIVE) http://detroitlive.org/what-is-dlive/

"Detroit Life is Valuable Everyday (DLIVE) was created to address a significant medical issue in its community: Homicide is the number one cause of death for Detroit residents ages 15 to 34, and violent injury recurrence rates have been reported to be as high as 30 to 45 percent at several trauma centers.

DLIVE is a Hospital-based, Community-focused Violence Intervention Initiative.

A CUSTOMIZED APPROACH TO DRIVE CHANGE

''Health interventions that are adapted for local contexts and community characteristics are more effective than standard approaches."

(https://jamanetwork.com/journals/jama/fullarticle/2766098).

To put it another way, healthcare delivery must be designed specifically for the individuals and communities receiving the care.

As demonstrated by examples in the previous section, there is no ''one-size-fits-all'' approach when it comes to meeting the health needs of vulnerable communities. The obstacles that a group of people face in one location may be completely different when compared to the obstacles that a similar group of people face in another location.

At the same time, two communities may experience similar health disparities, but one may not have the appropriate resources to empower individuals to overcome specific barriers to health.

A thorough analysis of health disparities will naturally equip healthcare leaders and policymakers to:

- Gain a better understanding of why health disparities exist among specific groups of people.
- Learn how to more effectively address the health needs of vulnerable groups.

Organizations should not only develop and work with employees to raise awareness of specific disparities in certain communities; they should also address existing policies that may unintentionally impede the care of at-risk communities.

Health systems must approach these disparities with a focus on community-engaged interventions and partnerships with community health centers, non-profits, and local organizations to successfully improve long term outcomes for vulnerable populations. Furthermore, the US healthcare system is obligated to address these disparities using evidence-based interventions. Too often, however, the challenge lies in determining the most effective methods for the population being served.

Adapting interventions to meet the specific needs of a community has always been more effective than implementing a standard of care that works best for the population at large. Unique communities with specific needs require unique interventions that address the specific needs appropriately.

REINVENTING THE PATIENT EXPERIENCE

According to a May 2020 article published by the Journal of American Medical Association,

"Understanding the reasons for the initial reports of excess mortality and economic disruption related to COVID-19 among health disparity populations may allow the scientific, public health, and clinical community to efficiently implement interventions to mitigate these outcomes, particularly if substantial disease emerges in the fall of 2020 or beyond."

The same conversation has been repeated for decades, if not for centuries: **social inequalities impact a person's health**. COVID-19 has forced us to listen once and for all.

Where and how people live (in isolated rural communities or urban/crowded spaces, exposure to environmental hazards, limited access to healthy foods, loneliness); class, ethnic, sexual orientation, and racial-based bias, lack of education, and access and cost of quality health care are all part of the continual conversations we must listen to.

The pandemic, coupled with the heightened exposure of sustained racial tension, places a magnifying glass on the healthcare system and calls for healthcare leaders to rise to the occasion.

Actions speak louder than words, and we need a call to action.

At VIE Healthcare® we are committed to helping hospitals build vital and much needed momentum within their community to drive this change.

Our customized program creates an actionable roadmap to reinvent the patient experience in your hospital or health system by addressing social needs as a high priority.

Our laser focused goal is to “bridge the gap” by understanding the needs of your patient population and improve the health of your community.

CONCLUSION

Prioritizing the patient experience means prioritizing the needs of your entire patient population, especially the most vulnerable.

The COVID-19 pandemic has both revealed and confirmed the reality of health disparities in the United States. Our healthcare system – and our healthcare leaders - must recognize it as an opportunity to change the way it cares for its most vulnerable and at-risk populations. As observed in this report, SDOH means that achieving good health is a greater challenge for some individuals.

Strategies must be customized to meet the needs of every patient that walks through your hospital doors.

Two patients may have the same diagnosis but require care that is radically different, based on SDOH. It is no coincidence that the push for patient-centered care has expanded as the patient experience has been prioritized. Quality patient-centered care delivers an optimal patient experience by considering the needs of your patients, understanding what your hospital can offer in response to their specific needs, and developing a plan that delivers the best health outcomes for the individual.

At VIE Healthcare® , we recommend a three step approach to accomplish this immediate and long-term need:

1. Gain a better understanding of the SDOH that lead to health disparities among the vulnerable populations that you serve

2. Gain a better understanding of any system issues that exist that may contribute to these health disparities

3. Plan, Create, Implement, and Evaluate a customized approach that will effectively “bridge the gap”.

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RECOMMENDATIONS FOR FURTHER READING

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EXPERT GUIDANCE ON HEALTH EQUITY

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   "Healthy People is a national effort that sets goals and objectives to improve the health and well-being of people in the United States."

   "Although much progress has been made, the United States lags other developed countries (such as other members of the Organisation for Economic Co-operation and Development [OECD]) on key measures of health and well-being, including life expectancy, infant mortality, and obesity, despite spending the highest percentage of its gross domestic product on health. A challenge for Healthy People 2030 is to guide the United States in achieving our population's full potential for health and well-being so that we are second to none among developed countries."

   "Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy."

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   "Goal 3: Achieve Health Equity and Enhance Population Health

   In 2019 – 2022, HRSA will focus efforts to increase access to health care and improve health outcomes for vulnerable populations by enhancing community partnerships with entities from diverse geographic areas, groups needing or offering particular health care services, professional organizations, and others that support the populations HRSA serves.

   HRSA efforts will include activities such as leveraging advisory councils to better understand community requirements, integrating public health and primary care services, using evidence-based decision-making to guide efforts to address health disparities, and promoting illness prevention and healthy behaviors.

   OBJECTIVE 3.1: Leverage community partnerships and stakeholder collaboration to achieve health equity and enhance population health

Sub-objectives

3.1.1 Increase linkages of people to services and resources that improve population health through the development and support of community-based partnerships.

3.1.2 Support community actions that address social determinants of health and improve health-related infrastructure.

3.1.3 Improve health outcomes by supporting integration and coordination of health services, primary care providers, and the public health sector.

3.1.4 Expand outreach and communication, and develop stakeholder partnerships that lead to sustainable initiatives that eliminate health disparities.

OBJECTIVE 3.2: Promote health and disease prevention across populations, providers, and communities

Sub-objectives

3.2.1 Increase community-based disease prevention efforts.

3.2.2 Address emerging community health needs, including public health emergencies, by supporting adaptable, innovative, outcome-focused, sustainable programs."

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8. The National Medical Association (NMA) is the collective voice of African American physicians and the leading force for parity and justice in medicine and the elimination of disparities in health: https://www.nmanet.org/page/Fact-Sheets

   - **"Maternal Health in the African American Community**

     ''African-American mothers are three to four times more likely to die from pregnancy-related causes than White mothers, with 40.0 deaths per 100,000 live births for Black women and 12.4 deaths per 100,000 births for White women. This racial disparity has persisted for the past 60 years. Due to racism, sexism and other systemic barriers that have contributed to income inequality, Black women are also typically paid just 63 cents for every dollar paid to White, non-Hispanic men."

   - 6/11/2020 - National Medical Association https://www.nmanet.org/news/512553/COVID-19-Treatments-Must-Work-for-Communities-of-Color.htm

     "As a result of the Coronavirus pandemic, a bright light has RECENTLY been shown on the health disparities that have always existed in America," said Dr. Oliver Brooks, President of the National Medical Association (NMA). What the world is witnessing is that Black, Hispanic, Native American, Pacific Islander, and Asian patients are severely overrepresented among those who have suffered the morbidity and mortality of COVID-19."

   - Guidance from the AHA re: Food Insecurity- the role of hospitals - http://www.hpoe.org/Reports-HPOE/2017/determinants-health-food-insecurity-role-of-hospitals.pdf

"Because health care providers are trusted by patients for their knowledge and recommendations, encouraging food-insecure individuals and families to seek help may reduce the stigma associated with food insecurity.

Hospitals and health care providers can:

- Screen for food insecurity.
- Educate their patients about available federal nutrition program.s
- Guide patients and families to local departments of human services during wellness check-ups or visits.
- Connect patients and families with dietitians and nutritionists for counseling services.
- Provide free food or healthy snacks at clinics on-site food pantries or hosting summer or year-round feeding programs.
- Enlist patients in free onsite education class » Promote existing resources such as food trucks, food shelters, food shelves, food pantries, emergency food programs, community kitchens, and more.
- Develop on-site food pharmacies, food pantries and community gardens » Collaborate with existing grocery stores and farmers market.s
- Support or fund the development of local grocery stores and farmers markets.

9. IRS requirement to conduct a Community Health Needs Assessment (CHNA) Retrieved at: https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

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Section 501(r)(3)(A) requires a hospital organization to conduct a community health needs assessment (CHNA) every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA.

Section 501(r) (3) (B) provides that the CHNA must:

- ***Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and***

- ***Be made widely available to the public."***

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WHAT OUR CLIENTS SAY ABOUT VIE HEALTHCARE®

The experts at VIE Healthcare® provided not only covered every clinical area of the perioperative environment, but also all the critical areas that support their processes. VIE Healthcare's collaborative approach allowed a real time education opportunity throughout the assessment process. From clinical, financial, supply chain and process experts, you managed to cover all the bases.

David M. Johnson, VP Operations Improvement, Inspira Health Network

I have worked with VIE Healthcare® on more than one project and found Lisa and her team to be subject matter experts in the perioperative environment. They have an affinity for details and picks up things that many have missed in prior reviews. They have access to a variety of experts within the hospital environment.

Amy Smith, Vice President, Perioperative Services at Robert Wood Johnson University Hospital

We engaged VIE Healthcare® to assist us in evaluating and reducing our purchased services spend, a growing segment of our operating expenses. Their patented methodology to compare actual spend to contract spend, using line-item invoice detail, helped us recover hundreds of thousands of dollars related to inaccurate billing. Further, they've been responsible for well over a million dollars in savings by partnering with us to evaluate our rates against market rates for services, ultimately leading to re-negotiated terms with our vendors and I anticipate more to come as we continue our work with VIE Healthcare®. This all happened within the first 6 months of the engagement. I couldn't be more pleased with their approach and results.

Christine Pearson | Chief Financial Officer, AnMed Health

We have been overly impressed with VIE Healthcare's approach to our purchased service agreements. We begin with a retroactive audit of our existing agreements and reconciliation of any discrepancies and overpayments through VIE Healthcare's Invoice ROI™ Technology. From there VIE Healthcare's Invoice ROI™ Technology continues to review invoices regularly to help avoid any future discrepancies. VIE Healthcare® has been able to identify hundreds of thousands of dollars in discrepancies. Because they analyze invoices at the line item level, VIE Healthcare® have the ability to quickly take utilization and usage trends to produce RFPs allowing us to re-negotiate new agreements resulting in further cost reductions. This includes consolidating contracts and service providers across multiple hospitals in different regions.

Luis R. Martinez | VP Supply Chain, Cornerstone Healthcare Group

ABOUT VIE HEALTHCARE® CONSULTING

JAMES CAGLIOSTRO, MED, BSN, RN
VIE HEALTHCARE® CONSULTING

Just as a sports team would not walk onto a field without a meticulous playbook and without a coach to lead them, nor should an organization enter into an outsourced service provider arrangement without an expert coach.

VIE Healthcare® is an experienced strategic outsourcing advisor to hundreds of hospitals. We have assisted hospitals and organizations with outsourcing decisions and benchmarking strategies since 1999. We are committed to your priorities.

James Cagliostro, MEd, BSN, RN
VIE Healthcare® Consulting

James joined VIE Healthcare® Consulting in 2018 and brings to the role over a decade of critical care nursing experience at highly regarded medical facilities across three states. During that time, he observed both the 'good and bad' of hospital operations in a number of regions, giving him a unique insight and understanding which he brings to our clients.

That insight means he prioritizes patient care. He has observed for himself and throughout his career that hard work makes a tangible difference in the lives of patients. While at Stanford, he was extensively involved in training staff on patient care with Ventricular Assist Devices and Total Artificial Hearts, which reinforced the importance of education and preparation in order to excel.

It is this, coupled with his experience at the bedside in reputable facilities, that has prepared him to be flexible and work on a 'patient first' basis. Underpinning that drive for meeting patient needs is an understanding of the critical requirements for clear and direct communication within and between healthcare organizations.

James has a BSc in Nursing from Messiah College and a Master's in Health Education from Penn State.

He also has 7 years of critical care experience at Hershey Medical Center (PA) and Stanford Hospital & Clinics (CA) and 3 years of PACU/perioperative/surgery center experience in NJ.

He also serves as chair of unit education council at Hershey.

Lisa T. Miller, MHA
Founder and CEO, VIE Healthcare® Consulting

Lisa Miller launched VIE Healthcare® Consulting in 1999 to provide leading-edge financial and operational consulting for hospitals, healthcare institutions, and all providers of patient care.

She has become a recognized leader in healthcare operational performance improvement, and with her team has generated in excess of $674 million in financial improvements for VIE's healthcare clients.

Lisa is a trusted advisor to hospital leaders on operational strategies within margin mprovement, process improvements, technology/telehealth, the patient experience, and growth opportunities. Her innovative projects include VIE Healthcare's EXCITE! Program, a performance improvement workshop that captures employee ideas and translates them into profit improvement initiatives, and Patient Journey Mapping™, an effective qualitative approach for visualizing patient experience to achieve clinical, operating, and financial improvements.

Lisa has developed patented technology for healthcare financial improvement within purchased services; in additional to a technology that increases patient satisfaction through front line insights.

Lisa received a BS degree in Business Administration from Eastern University in Pennsylvania and a Masters in Healthcare Administration from Seton Hall University in New Jersey. She is a member of the National Honor Society for Healthcare Administration – Upsilon Phi Delta.

Her book *The Entrepreneurial Hospital* is being published by Taylor & Francis.

HOW TO WORK WITH US

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