Envision HEALTHCARE

Disparities in Healthcare:

Addressing the Problem and Finding Solutions

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We, the authors, thank the Envision Healthcare Diversity, Equity and Inclusion Advisory Council and the Healthcare Disparities Working Group for their contributions. This is the first step in our mission to reduce healthcare disparities. As a national medical group, we have the opportunity to impact the lives of millions of patients and drive positive change in the healthcare system.

About Envision Healthcare

Envision Healthcare is one of the nation's leading medical groups, delivering care when and where it's needed most. Operating in more than 740 facilities in 45 states, Envision provides care mainly in the areas of emergency medicine, hospital medicine, anesthesiology, radiology, trauma surgery and neonatology. It is also a leader in office-based and ambulatory surgical care.

Envision Healthcare is a national medical group of thousands of clinicians and the preferred health solutions partner for 1,250 healthcare practices around the country. Its nearly 25,000 clinicians, which include physicians, physician assistants, advanced practice registered nurses and certified registered nurse anesthetists, complete more than 32 million patient encounters annually.

A Commitment to Providing High-Quality Care When and Where It Is Needed Most

Across a broad range of healthcare services, Americans continue to receive unequal treatment based on their race, ethnicity, religion, disability status, sexual orientation and the intersection of these identities. These healthcare disparities stem from multiple factors across the healthcare ecosystem; however, as a leading national medical group, we are using our expertise and resources to reduce these disparities across the U.S.

Our mission is to provide high-quality care when and where it's needed most, including in underserved, minority and diverse communities; therefore, we cannot ignore these health inequities. This paper outlines cornerstone research on healthcare disparities with an emphasis on the areas where Envision Healthcare can have an impact. We cannot address healthcare disparities until we quantify the ways in which the healthcare ecosystem perpetuates biases and delivers sub-optimal care to marginalized groups.

While we are committed to enacting positive change, the entire healthcare ecosystem must work together to eliminate these disparities completely.

Defining the Systemic Challenges to Reducing Healthcare Disparities

Historically, healthcare disparities have been wrongly attributed to genetic predispositions and lifestyle choices. During the past four decades, researchers and policymakers have developed a number of frameworks to measure and conceptualize these effects. Most of these frameworks continue to focus on individual-based factors, such as demographics, personal health beliefs and health insurance status. However, there is growing appreciation that factors beyond individual characteristics also affect disparities in healthcare access.[1]

Social determinants of health, such as race, ethnicity, religion, sexual orientation, gender identity, age, disability, socioeconomic status and geographic location, contribute to individuals' health outcomes. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play and worship that affect a wide range of health, functioning and quality-of-life outcomes. Conditions (e.g., social, economic and physical) in these various environments and settings (e.g., school, church, workplace and neighborhood) and the patterns of social engagement, sense of security and well-being are also affected by where people live. Resources that impact these social and environmental conditions can have a significant influence on health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, presence of local emergency/health services and environments free of life-threatening toxins. Social determinants of health also play a significant role in one's ability to access high-quality care.[2]

Healthcare impacts one's overall physical, social and mental health and quality of life. Accessing care has typically depended on insurance coverage, financial status and geographical location.[3] Barriers obstructing access include the cost of care, inadequate or lack of insurance coverage, lack of availability of services and culturally competent care or even fear of deportation. These burdens can lead to unmet health needs, delays in receiving appropriate care, inability to get preventive care, financial burdens and preventable hospitalizations. Uninsured populations are less likely to receive medical care and are more likely to be diagnosed later and die prematurely. When people have a reliable source of care, health outcomes improve and disparities between groups diminish. Access to care or lack thereof and healthcare disparities, including social determinants of health, tie into public health as a whole.

[1] Sankar, P., Cho, M., Condit, C., Hunt, L., Koenig, B., Marshall, P., Spicer, P. (2004, June 23). Genetic research and health disparities. Retrieved December 17, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2271142/

[2] Social Determinants of Health. (n.d.). Retrieved December 17, 2020, from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

[3] Access to Health Services. (n.d.). Retrieved December 17, 2020, from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

The Effects of Prejudice, Stereotypes and Racism in Medicine

The American Medical Association (AMA) recently recognized racism as a serious public health threat and laid out a plan to mitigate its effects, starting with recognizing race as a social construct and ending racial essentialism – the belief in a genetic or biological essence that defines all members of a racial category. The AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and healthcare delivery have caused and continue to cause harm to marginalized communities and society as a whole.[4]

Perhaps the most notorious example of systemic racism within healthcare is the Tuskegee experiment, called the "Tuskegee Study of Untreated Syphilis in the Negro Male," which took place from 1932 to 1972. In the highly unethical experiment, members of the U.S. Public Health Service, a division of the U.S. Department of Health and Human Services, studied the symptoms of Black men infected with syphilis. The Black men were misled and not made aware of the study's intent to observe the disease's progression untreated, nor did they receive adequate treatment even when penicillin became the standard treatment for syphilis in 1947.[5] The effects of the study are still being felt today as Black patients distrust the healthcare ecosystem.[6]

Racism and unconscious bias within medical research and healthcare delivery have caused and continue to cause harm to marginalized communities and society as a whole.

Evidence[7] has shown for decades that Black people are treated worse than White people in the U.S. healthcare ecosystem, resulting in higher levels of chronic illnesses. For example, Black women's maternal mortality is three times that of White women's[8] and Black patients in the U.S. are less likely to receive proper care for diabetes[9], kidney disease[10] and various cancers.[11]

[4] AMA: Racism is a threat to public health. (2020, November 16). Retrieved December 17, 2020, from https://www.ama-assn.org/delivering-care/health-equity/ama-racism-threat-public-health

[5] Tuskegee Study - Timeline - CDC - NCHHSTP. (2020, March 02). Retrieved January 15, 2021, from https://www.cdc.gov/tuskegee/timeline.htm

[6] Swetlitz, I., & Swetlitz, I. (2017, January 19). Mistrust after Tuskegee experiments may have taken years off black men's lives. Retrieved January 15, 2021, from https://www.statnews.com/2016/06/16/mistrust-tuskegee-black-men/

[7] Aaron E. Carroll, M. (2020, June 18). Health Disparities Among Black Persons in the US and Addressing Racism in the Health Care System. Retrieved December 17, 2020, from https://jamanetwork.com/channels/health-forum/fullarticle/2767595

[8] Rabin, R. (2019, May 07). Huge Racial Disparities Found in Deaths Linked to Pregnancy. Retrieved December 17, 2020, from https://www.nytimes.com/2019/05/07/health/pregnancy-deaths-.html

[9] K;, C. (n.d.). Diabetes in the African-American Medicare population. Morbidity, quality of care, and resource utilization. Retrieved December 17, 2020, from https://pubmed.ncbi.nlm.nih.gov/9653601/

[10] Epstein, A., Ayanian, J., Keogh, J., Noonan, S., Armistead, N., Cleary, P., . . . Conti, R. (2000, November 23). Racial disparities in access to renal transplantation--clinically appropriate or due to underuse or overuse? Retrieved December 17, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4598055/

[11] Imperato, P., Nenner, R., & Will, T. (1996, September). Radical prostatectomy: Lower rates among African-American men. Retrieved December 17, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2608105/

Another example of an underserved group is the LGBTQ+ community. The LGBTQ+ population sees healthcare disparities in the areas of physical health, mental health and care access. Stigmas, lack of awareness and insensitivity to the unique needs of this community – which encompasses every race, ethnicity, religion, age and socioeconomic group – result in a poor quality of care, refusal of care or harassment by healthcare providers. These disadvantages are a serious threat to public health and the advancement of health equity and are a barrier to appropriate medical care. A lack of specific education and training, clinical research on health-related issues of the LGBTQ+ community and restrictive health benefits for a group that is less likely to be insured in the first place are just some of the causes of these health disparities.[12]

Finally, undocumented immigrants in need of care often postpone or forgo seeking care for fear of being deported. This fear results in extreme delays to receiving sometimes urgent care, which can result in poor outcomes, such as worsened symptoms, the necessity for more serious treatments and interventions and more expensive care. Avoiding annual physicals and preventative care because of the potential threat of deportation puts this group at an immediate disadvantage.

The healthcare ecosystem is long overdue in rebuilding the trust within underserved communities, owning past mistakes and ensuring they never happen again. Clinicians should be educated on how to eliminate implicit and explicit bias and help make sure everyone has access to care throughout the healthcare ecosystem, including preventive care. All groups must be treated and cared for with integrity and the same high-quality of care.

Envision Healthcare Is Making a Difference

Our working group on healthcare disparities identified the following areas in which there are measurable disparities and, as a national medical group, we can make an impact due to the breadth and depth of our clinical expertise.

PAIN MANAGEMENT

Black Americans are systematically undertreated for pain relative to White Americans. This racial bias is based on false beliefs that Blacks have a higher pain tolerance than Whites.[13] Research shows that healthcare providers who believe biological differences exist between White and Black patients' pain perception results in differential care based on these incorrect notions. Among White medical students and residents, half of a sample group endorsed these harmful beliefs.

[12] Lesbian, Gay, Bisexual, and Transgender Health. (n.d.). Retrieved December 17, 2020, from https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

[13] Hoffman, K., Trawalter, S., Axt, J., & Oliver, M. (2016, April 19). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Retrieved December 17, 2020, from https://www.pnas.org/content/113/16/4296

The research also showed that those medical students and residents who rated the Black patients' pain as lower than White patients' made less accurate treatment recommendations. These findings demonstrate how inaccurate beliefs impact health outcomes and contribute to racial disparities in pain assessment, treatment and quality of life.[14]

As one of the leading medical groups in the nation composed of thousands of physicians and advanced practice providers, we are committed to educating our clinicians about these biases by identifying resources that root out these harmful assumptions to improve the quality of care among Black communities.

CANCER

According to the American Cancer Society, racial and ethnic minorities are more likely to develop cancer and die compared to the general population of the United States. For instance, Black women are more likely to die from breast cancer at every age.[15]

Additionally, disparities in the incidence and mortality of colorectal cancer (CRC) continue to persist between Black and non-Hispanic White patients despite the provision of widespread screening for CRC. The reduction in CRC mortality has been more significant for both non-Hispanic White men and women than all other racial groups in the country.[16] Racial disparities in death rates from CRC vary considerably across cities in the U.S.[17]

CRC is the second leading cause of cancer death in the U.S.[18] It is also one of the most preventable cancers, and when detected early, patients often have better outcomes. Black patients have a 43 percent higher CRC mortality rate than White patients. There are also significant race-based disparities in prostate cancer care and outcomes. Recent research has shed more light on the divergent causes of these disparities, including the finding that "African-Americans have a disproportionately higher burden of prostate cancer compared to European-Americans."[19]

[14] Hoffman, K., Trawalter, S., Axt, J., & Oliver, M. (2016, April 19). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Retrieved December 17, 2020, from https://www.pnas.org/content/113/16/4296

[15] Yedjou, C., Sims, J., Miele, L., Noubissi, F., Lowe, L., Fonseca, D., . . . Tchounwou, P. (1970, January 01). Health and Racial Disparity in Breast Cancer. Retrieved December 17, 2020, from https://link.springer.com/chapter/10.1007/978-3-030-20301-6_3

[16] KJ;, J. (n.d.). Health disparities in colorectal cancer among racial and ethnic minorities in the United States. Retrieved December 17, 2020, from https://pubmed.ncbi.nlm.nih.gov/27034811/

[17] AMA: Racism is a threat to public health. (2020, November 16). Retrieved December 17, 2020, from https://www.ama-assn.org/delivering-care/health-equity/ama-racism-threat-public-health

[18] Colorectal Cancer Mortality and Racial Disparity Varies Across U.S. Cities: News Releases. (2019, November 30). Retrieved December 17, 2020, from https://www.aacr.org/about-the-aacr/newsroom/news-releases/colorectal-cancer-mortality-and-racial-disparity-varies-across-u-s-cities/

[19] Addressing the Disparities in Prostate Cancer Care and Outcomes. (n.d.). Retrieved December 17, 2020, from https://www.cancernetwork.com/view/addressing-disparities-prostate-cancer-care-and-outcomes

As one of the nation's leading providers of colonoscopies and an advocate for CRC awareness and early detection, we are working to ensure all Americans have a better understanding of digestive system health and follow the recommended routine screening guidelines and preventative treatment.

CARDIOVASCULAR AND STROKE CARE

Data has shown that Black men and women in the U.S. are more likely to have heart attacks than White men and women.[20] [21] In addition, death rates from coronary heart disease remain higher for Black people compared to White people. Racial disparities in cardiovascular care have resulted in Black patients being less likely to receive effective treatments, such as cardiac catheterization, percutaneous coronary intervention and surgical revascularization, in the acute care setting. Likewise, minorities have been shown to be less likely to receive newer technologies like drug-eluting stents.

Black patients also face greater levels of long-term disability after stroke compared to White patients in the U.S. It is unclear if this is related to access and quality of acute care or the quality of outpatient follow-up care and rehabilitation efforts.[22] The utilization of mechanical thrombectomy and IV-tPA is lower among Black and Hispanic populations compared to Whites.[23]

As the nation's largest group of emergency medicine clinicians, with hospitalists and critical care team members who also treat stroke and cardiovascular patients, we provide quality cardiovascular and stroke care to all patients, regardless of race. Envision is committed to reducing these racial disparities by researching more equitable practices, developing best practice guidelines in line with national diversity, equity and inclusion initiatives and providing systemwide education to support our clinicians' core knowledge.

[20] Popescu, I., Cram, P., & Vaughan-Sarrazin, M. (2011, June 14). Differences in admitting hospital characteristics for black and white Medicare beneficiaries with acute myocardial infarction. Retrieved December 17, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3142883/

[21] Arnold, S., Chan, P., Jones, P., Decker, C., Buchanan, D., Krumholz, H., . . . Cardiovascular Outcomes Research Consortium. (2011, July). Translational Research Investigating Underlying Disparities in Acute Myocardial Infarction Patients' Health Status (TRIUMPH): Design and rationale of a prospective multicenter registry. Retrieved December 17, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3376532/

[22] LA;, F. (n.d.). Explaining and addressing racial disparities in stroke care and outcomes: A puzzle to solve now. Retrieved December 17, 2020, from https://pubmed.ncbi.nlm.nih.gov/31554651/

[23] Rinaldo, L., Lorenzo Rinaldo From the Department of Neurosurgery, Rabinstein, A., Alejandro A. Rabinstein Department of Neurology, Cloft, H., Harry Cloft From the Department of Neurosurgery, . . . Cruz-Flores, S. (2019, August 01). Racial and Ethnic Disparities in the Utilization of Thrombectomy for Acute Stroke. Retrieved December 17, 2020, from https://www.ahajournals.org/doi/10.1161/STROKEAHA.118.024651

MATERNAL-FETAL

Many structural, systemic and environmental factors influence the health of mothers and babies, especially for Black, American Indian and Alaska Native people. When looking at factors, such as access to maternity care, financial stability and health insurance status, these disparities persist. Systemic racism and the wealth gap in the U.S. deepen many health inequities in our society. The onset of COVID-19 has further magnified preexisting health disparities. In the U.S., the preterm birth (birth with less than 37 weeks gestation) rate among Black women is 50 percent higher than the rate among all other women.[24] Additionally, the nationwide infant mortality rate, regardless of race or ethnicity, is 5.7 per 1,000 live births; for Black women, it is 10.8 per 1,000 live births.

In the U.S., the preterm birth (birth with less than 37 weeks gestation) rate among Black women is 50 percent higher than all other women.

Rates of maternal death and morbidity continue to be unacceptably high in the U.S. Maternal morbidity, social determinants of health, availability of state health insurance policies and the availability of surveillance and research data affect the health and survival of both mom and baby.

As one of the nation's leading providers of maternal-fetal medicine, we need to better understand the causes of severe maternal morbidity and those most impacted by it and the racial and ethnic disparities. This research will help prevent maternal and infant deaths.

SURGICAL CARE AND OUTCOMES

Racial disparities in health outcomes exist across many surgical disciplines, including colorectal surgery. Black patients experience more postoperative complications with higher mortality, longer postoperative lengths of stay and more unplanned readmissions than similar White patients after colorectal resection. With colorectal operations accounting for nearly 25 percent of all complications in general surgery, these disparities result in worsened health outcomes for an already vulnerable population.[25]

[24] March of Dimes Report Card. (n.d.). Retrieved December 17, 2020, from https://www.marchofdimes.org/mission/reportcard.aspx

[25] Wahl, T. S., Goss, L. E., Morris, M. S., Gullick, A. A., Richman, J. S., Kennedy, G. D., . . . Chu, D. I. (2018). Enhanced Recovery After Surgery (ERAS) Eliminates Racial Disparities in Postoperative Length of Stay After Colorectal Surgery. Annals of Surgery, 268(6), 1026-1035.

Among the factors that can affect disparities in postoperative care and rehabilitation are the timing, duration and quality of rehabilitation as well as whether patients receive rehabilitative care postoperatively. Race, ethnicity, locality and insurance status affect whether trauma and joint replacement patients receive rehabilitation and how intensive it is. Additionally, women are less likely than men to be referred for cardiac rehabilitation after angioplasty, as are non-White patients.[26]

SEPSIS

Sepsis affects more than 1 million Americans every year, resulting in significant morbidity and mortality rates and healthcare spending.[27] As is true of nearly all medical conditions in the U.S., sepsis imposes public health burdens unevenly across demographics.[28] Academic hospitals tend to have lower sepsis mortality rates among Black patients versus White patients, which goes against the aggregated data from hospitals that shows White patients have lower mortality rates.[29] This might be due to poorer compliance with protocols for Black patients versus Whites in non-academic hospitals. Individuals who live in medically-underserved areas and individuals from specific socioeconomic groups – including racial and ethnic minorities – suffer disproportionately high sepsis incidence and morbidity rates.[30]

Envision is working to implement a standardized sepsis performance feedback system for its sites to reduce the variation in care and outcomes.

COVID-19

The COVID-19 pandemic has wreaked havoc across the globe, particularly in underserved communities of the U.S. A Journal of American Medicine Association (JAMA) analysis estimates that in the five months between March 1 and Aug. 1, 2020, there were 225,000 excess deaths. Of these deaths, they estimate that 65 percent can be attributed to COVID-19 and the remaining 35 percent to other conditions like diabetes, heart disease, Alzheimer's disease and brain disease.

[26] Disparities in Surgical Care Have Multilevel, Interconnected Causes. (n.d.). Retrieved December 17, 2020, from https://www.facs.org/media/press-releases/jacs/disparities061016

[27] IJ;, B. (n.d.). Disparities in Sepsis Outcomes: A Problem in Need of Solutions. Retrieved December 17, 2020, from https://pubmed.ncbi.nlm.nih.gov/32568903/

[28] IJ;, B. (n.d.). Disparities in Sepsis Outcomes: A Problem in Need of Solutions. Retrieved December 17, 2020, from https://pubmed.ncbi.nlm.nih.gov/32568903/

[29] Chaudhary, N., Donnelly, J., & Wang, H. (2018, June). Racial Differences in Sepsis Mortality at U.S. Academic Medical Center-Affiliated Hospitals. Retrieved December 17, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5953774/

[30] Analytics, 1. (n.d.). Racial Disparities in Sepsis-Related In-Hospital Mortality: ... : Critical Care Medicine. Retrieved December 17, 2020, from https://journals.lww.com/ccmjournal/Abstract/2017/12000/Racial_Disparities_in_Sepsis_Related_In_Hospital.28.aspx

By the end of 2020, it is likely that the total number of excess deaths compared to the previous years will be greater than 400,000 – primarily attributable to the COVID-19 pandemic.[31] The implications of these excess deaths are sobering yet are even more profound for communities of color. Whether these excess deaths are due to non-respiratory complications of COVID-19 or societal disruptions that reduced or delayed access to healthcare and worsened other social determinants of health, it is certain that individuals living in the U.S. who are Black, Indigenous, Latinx or Pacific Islander experience the highest per capita hospitalization and death rates.

On Aug. 18, 2020, the American Public Media Research Lab reported that individuals who are Black, Indigenous, Latinx or Pacific Islander have experienced higher death rates than individuals who are White or Asian. **If those individuals had died from COVID-19 at the same rate as White U.S. residents, about 19,500 Black, 8,400 Latinx, 600 Indigenous and 70 Pacific Islander individuals in the U.S. would still be alive.** As startling as these numbers are, the reality is likely worse because these numbers do not include the excess deaths estimated or projections for all of 2020.

As a leading national medical group deploying to hot spots to treat COVID-19 patients, we are committed to eliminating healthcare disparities so all people affected by the disease can access and receive high-quality care.

MENTAL HEALTH

Mental health disparities are equally as serious as physical health disparities and can often lead to or coincide with physical ailments. Non-White people are less likely to receive medication for mental health or substance abuse disorders. There are noted variations in reported medical provider behavior based on the sociodemographic characteristics of the patient. Uninsured patients are less likely to obtain mental health treatment, raising concerns about the access, quality and content of care.[32]

A review of 615 studies on mental health and disparities between 2011 and 2014 was categorized into five pathways underlying mental healthcare and three pathways underlying mental health disparities. Identified studies demonstrate that socioeconomic mechanisms and demographic moderators of disparities in mental health status and treatment are well described, as are treatment options that support diverse patient needs.[33]

[31] Lisa A. Cooper, M. (2020, October 20). Excess Deaths From COVID-19, Community Bereavement, and Restorative Justice for Communities of Color. Retrieved December 17, 2020, from https://jamanetwork.com/journals/jama/fullarticle/2771762

[32] TL;, M. (n.d.). Disparities in assessment, treatment, and recommendations for specialty mental health care: Patient reports of medical provider behavior. Retrieved December 17, 2020, from https://pubmed.ncbi.nlm.nih.gov/25470767/

[33] Cook BL;Hou SS;Lee-Tauler SY;Progovac AM;Samson F;Sanchez MJ;. (n.d.). A Review of Mental Health and Mental Health Care Disparities Research: 2011-2014. Retrieved December 17, 2020, from https://pubmed.ncbi.nlm.nih.gov/29877136/

There is evidence identifying racial and ethnic disparities in mental health, but more research is needed. In particular, research on community- and policy-level predictors of mental healthcare disparities links discrimination- and trauma-induced neurobiological pathways to disparities in mental illness. Additionally, more research is needed to assess the cost-effectiveness of disparity-reduction programs and scale up culturally adapted interventions.

As a national medical group providing care in COVID-19 hot spots and communities throughout the U.S., Envision has been enhancing the crucial and effective wellness resources it provides its clinicians and clinical support teammates, including peer-to-peer support programs, leadership training and formal mental health services.

HOSPICE

Most patients prefer not to be in the hospital when they are at the end of their life. Hospice care is a defined Medicare benefit that enables patients who are determined to have less than six months to live to receive their care at home. Despite benefits, such as enhanced quality of life and increased duration of life for some conditions, most patients still do not engage with hospice services, and this is especially prominent in non-cancer diagnoses for non-White patients.[34] [35] The differences in utilization of hospice services may be related to a lack of providers educating minorities about the benefits, but mistrust of the healthcare ecosystem, a perceived conflict between spiritual/cultural and hospice goals and cultural preferences for aggressive therapies have all been described as potential explanations.[36] Given the breadth of the healthcare ecosystem that Envision covers, we have the ability to engage more patients in hospice and give our providers the tools to explain the benefits of early hospice evaluation.

[34] Rowland, K., & Schumann, S. (2010, December). PURLs. Palliative care: Earlier is better. Retrieved December 17, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3183935/

[35] Katherine A. Ornstein, P. (2020, August 24). Racial Disparities in Hospice Use and End-of-Life Treatment Intensity. Retrieved December 17, 2020, from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769692

[36] Rhodes, R. (2006, September 01). Racial Disparities in Hospice: Moving from Analysis to Intervention. Retrieved December 17, 2020, from https://journalofethics.ama-assn.org/article/racial-disparities-hospice-moving-analysis-intervention/2006-09

How Envision Addresses Healthcare Disparities to Reduce Inequity in Care

Our communities are stronger and healthier when there is equal and equitable access to care. Advancing health equity ensures everyone has the opportunity to achieve the highest level of health.[37] Although there have been some effective approaches within the healthcare ecosystem to address healthcare disparities, they have been fragmented, small and underfunded. Approaches that leverage community involvement would be most effective at improving healthcare outcomes and reducing disparities.[38]

Community collaborations will require a level of commitment and organization that surpasses current models of intervention but show great promise in eliminating disparities. These collaborations include creating regional health authorities, community-development corporations, university-community partnerships, community-based participatory research practice networks and new forms of health plan districts or networks. This approach can identify root causes, build on local assets, devise novel, clinically and environmentally sensible designs, inspire robust research participation and disseminate results so they drive policy and inspire further change.

To support a community-level approach and, ultimately, reduce disparities in healthcare access and improve population health, we need a larger evidence base for public health action and reform.[39] This way, we can address downstream disparities in healthcare access, which is likely to have the greatest benefits for those in poor health and without access to quality care and is also likely to show short-term gains.

Although research exists on healthcare disparities, we have much to learn about the root causes of disparities and effective solutions to eliminate them. As a national medical group caring for more than 32 million patients annually, we have a role to play in improving healthcare disparities. More specifically, we will educate our team about the importance of healthcare equity and obtaining patient demographic data to identify areas of opportunity and track improvement. Our data can then be used to determine communities of need and dispatch resources, working closely with community leaders to improve access to care and inequality gaps. Addressing these disparities must begin with the fundamental step of bringing the nature of the disparities and the groups at risk for those disparities to light by collecting healthcare quality information stratified by race, ethnicity and language data. This data gathering can be a challenge, and a simple solution is to include permission to obtain demographic data in contracts. Envision encourages hospitals to augment their patient intake protocols to allow for the gathering of helpful patient information that can result in more optimal care down the line.

[37] https://www.apha.org/-/media/files/pdf/factsheets/advancing_health_equity.ashx?la=en&hash=9144021FDA33B4E7E02447CB28CA3F9D4BE5EF18

[38] Institute of Medicine (US) Roundtable on Health Disparities. (1970, January 01). Community Approaches to Addressing Health Disparities. Retrieved December 17, 2020, from https://www.ncbi.nlm.nih.gov/books/NBK215366/

[39] Derose, K. P., Gresenz, C. R., & Ringel, J. S. (2011). Understanding Disparities In Health Care Access—And Reducing Them—Through A Focus On Public Health. Health Affairs. doi:https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0644

Envision is committed to:

1. **Recognizing race, institutional racism and other forms of discrimination as social determinants of health**
2. **Educating our clinicians and patients on the issues and remedies of healthcare inequities**
3. **Informing our team on how implicit biases and health inequities can be detrimental to patients' care**
4. **Researching healthcare disparities and identifying solutions and best practices to address those disparities**
5. **Developing screening tools to identify patients with social and structural determinants of health, e.g., access to safe drinking water, healthy food, stable housing, transportation, technology, health insurance and employment**
6. **Advocating for local, state and federal policy changes that improve health equity**

As a leading national medical group, we're committed to raising awareness of the disparities that plague the healthcare ecosystem both internally and publicly through regulatory asks, advocating for solutions that have broad effects (such as transitioning to value-based care) and using our resources and clinical expertise to educate, train and lead. Value-based care is a healthcare delivery model that determines pay – for hospitals, physicians and other providers – based on patient outcomes. A shift to value-based care will encourage the elimination of healthcare disparities to boost health outcomes across the board, and thus economic incentives. When reimbursement and hospital profits are tied to better healthcare outcomes, working to end disparities while advancing health equity is a win-win for both patients and providers. With these efforts, we will improve outcomes and efficiencies so that everyone will be able to access and receive the same high-quality care and contribute to the improved health of our communities. This paper is a first step in developing best practices and tracking the outcomes of those best practices.