The Clinical Executive's Role in Reducing Disparities at the Point of care

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Covid-19 has not been an equal-opportunity disease. It's hit certain communities—people of color, transgender individuals, and non-English-speakers—especially hard. This pandemic has put a spotlight on social disparities of health that have been around forever.

Health care organizations across the country have pledged to address these issues, but that's not easy. Disparities exist not only in health care, but throughout our society. Clinical executives need to determine where to prioritize their efforts to reduce disparities in care. Here's our take on four things clinical executives can do that can have an outsized impact on addressing disparities at the point of care.

Advisory Board

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The conventional wisdom

Every clinician strives to comprehensively address patient's individual biopsychosocial needs. In a perfect world, delivering on this commitment would result in equitable care that meets all patients' needs. And yet, ample evidence indicates that disparities in care delivery and outcomes persist at the point of care.

22%	less likely that Black patients report receiving pain medication than white patients
70%	of transgender or non-binary patients report experiencing discrimination in health care
3x	more likely that a Black newborn dies in the hospital, compared to a white newborn, when cared for by a white physician[1]
0.75-1.47	days longer LOS for patients who do not receive professional interpretation services
50%	of readmissions are caused by social determinants of health

This unwarranted variation in care is often the result of pervasive systemic and societal challenges that go far beyond any particular caregiver, setting, or health system. In light of the stark patient population disparities revealed by Covid-19 and the national dialogue around historical and modern-day inequities, every health care organization has a renewed mandate to address disparities.

Source: "Is bias keeping female, minority patients from getting proper care for their pain?" The Washington Post, 2019, https:\\www.washingtonpost.com\health\is-bias-keeping-female-minority-patients-from-getting-proper-care-for-their-pain\2019\07\26\9d1b3a78-a810-11e9-9214-246e594de5d5_story.html; "Healthcare Equality Index 2019," Human Rights Campaign Foundation, 2019, https://hrc-prod-requests.s3-us-west-2.amazonaws.com\files/assets/resources/HEI-2019-FinalReport.pdf; Greenwood, B, et al., "Physician–patient racial concordance and disparities in birthing mortality for newborns," Proceedings of the National Academy of Sciences Sep 2020, 117 (35) 21194-21200;DOI: 10.1073/pnas.1913405117; Lindholm, M, et al., "Professional language interpretation and inpatient length of stay and readmission rates," Journal of General Internal Medicine, 27(10), 1294–1299. https://doi.org/10.1007/s11606-012-2041-5; Gooch, K, "Social determinants of health contributed to half of hospital readmissions, study finds," Becker's Hospital Review,2018, https:\www.beckershospitalreview.com\care-coordination\social-determinants-of-health-contributed-to-half-of-hospital-readmissions-study-finds.html#:~:text=1,than %2050 %20percent%20of %20readmissions.&text= Patients%20with%20higher %20 %22transportation%20access,with %20low%20 transportation%20access%20risk; Advisory Board interviews and analysis.

CONVENTIONAL WISDOM (CONT.)

Many organizations are invested in advancing health equity, diversity, and inclusion within their organizations and communities. Their efforts to date have typically focused on increasing workforce diversity and staff training.

The theory behind increasing workforce diversity is: a workforce that more closely matches the demographics of a local population may be able to provide more culturally sensitive care. Staff with more diverse backgrounds may better understand patients' realities and identify organizational blind spots.

The goal of training is to help staff recognize their own innate biases, thus enabling them to provide culturally sensitive care to all patients, especially those whose background and culture are different. Typical training topics include diversity and inclusion, implicit bias, and patient care guidance for specific non-dominant populations.

Source: Advisory Board interviews and analysis.

Our take

The clinical executive's role in reducing disparities at the point of care must go beyond increasing workforce diversity and staff training. These initiatives are important but not sufficient to close the massive disparities that persist in our industry.

Increasing workforce diversity to match local community demographics will take years, if not decades. It is a worthy ambition that will yield dividends: more diverse and inclusive teams have a 17% increase in team performance, 20% increase in decision-making quality, and a 29% increase in team collaboration. But organizations can't afford to wait to achieve "ideal" workforce demographics before turning to additional strategies to reduce disparities at the point of care. And even if an organization achieves a diverse workforce that perfectly mirrors the local patient population, this diversity alone won't solve health disparities. Systemic issues within organizations and pervasive inequities beyond the point of care will persist.

Thoughtful training can help staff become more aware of disparities and their own innate biases. But even the most rigorous, widespread training will not eradicate systemic issues contributing to disparities. Organizations must go beyond workforce initiatives to make progress in reducing disparities.

Since this work will require additional investment, all clinical executives must be able to make a strong business case for reducing disparities, in addition to the moral and mission-based arguments for equitable care.

Source: Larson, E, "Diversity Inclusion = Better Decision Making At Work."
Forbes, September 23, 2017; Advisory Board interviews and analysis.

Making the business case for reducing disparities at the point of care

Consider one example of a disparity at the point of care: inconsistent and inadequate language services (such as interpretation and translation) for limited English proficiency (LEP) patients. Language barriers often prevent meaningful communication between clinicians and patients, which compromises care quality. When compared to English-speaking patients, LEP patients have a higher risk of adverse medical events,[1] longer hospital stays,[2] and higher readmission rates.[3]

One study found that LEP patients who did not receive professional interpretation services at admission or discharge had an increase in their length of stay of up to 1.47 days.[4] By providing comprehensive interpretation and translation services to LEP patients, organizations can begin to reduce the disparity and provide a more equitable experience.

There are additional financial benefits for the organization. To demonstrate the effect of reducing this particular disparity, the table below shows the number of "new" beds in virtual capacity that can be added by eliminating the excess length of stay for LEP patients.[5]

Based on the model, reducing the average length of stay for LEP patients by 1.47 days generates over $923,000 annually for a 100-bed hospital. And that number grows with bed size: $4.8 million for a 500-bed hospital, and almost $2 billion across the country.[6]

This analysis is one of many examples of how eliminating disparities can simultaneously improve both care quality and efficiency.

1. Adverse medical events include a greater risk of line infections, surgical infections, falls, and pressure ulcers. About 49.1% of adverse events among LEP patients involved some physical harm, but only 29.5% of adverse events for patients who speak English resulted in physical harm.
2. When professional interpreters were not used at admissions and/or discharge, LOS difference ranged from 0.7 to 4.3 days, depending on the condition.
3. Compared to English speakers, Chinese and Spanish speakers had 70% and 50% higher adjusted odds of readmission at 30 days post-discharge. Higher readmission rates are attributed to difficulty understanding how to manage conditions, take medications, or identify symptoms that signal a need for follow-up care.
4. Range of LOS between 0.75 and 1.47 days longer when compared to patients who had an interpreter on both day of admission and discharge (P < 0.02).
5. Assumes LEP refers to anyone above the age of 5 who reported speaking English less than "very well," as classified by the U.S. Census Bureau.
6. Assumes 924,107 staffed beds in all U.S. hospitals.

Source: "Overcoming the challenges of providing care to LEP patients," The Joint Commission, 2015, https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/joint-commission online/quick_safety_issue_13_may_2015_embargoed_5_27_15pdf.pdf?db=web&hash=390D4DDA38EF28D1243CE5 3A9C274B1A; Divi, C, et al., "Language proficiency and adverse events in US hospitals: a pilot study," Int J Qual Health Care, 2007 Apr;19(2):60-7, doi: 10.1093/intqhc/mzl069, Epub 2007 Feb 2, PMID: 17277013; Karliner, LS., et al., "Influence of language barriers on outcomes of hospital care for general medicine inpatients," J Hosp Med, 2010 May-Jun;5(5):276-82, doi: 10.1002/jhm.658, PMID: 20533573; John-Baptiste, A., et al., "The effect of English language proficiency on length of stay and in-hospital mortality," Journal of General Internal Medicine, 19(3), 221–228, https://doi.org/10.1111/j.1525-1497.2004.21205.x; Advisory Board interviews and analysis.

MAKING THE BUSINESS CASE FOR REDUCING DISPARITIES AT THE POINT OF CARE (CONT.)

Virtual capacity gains and revenue impact of a 1.47-day reduction in average length of stay among LEP patients, by hospital bed size[1]

Bed size[2]	Total virtual capacity gained	Revenue Impact (annually)[3]
100 beds	1.4 beds	$900K
200 beds	2.9 beds	$1.9M
300 beds	4.3 beds	$2.8M
400 beds	5.7 beds	$3.8M
500 beds	7.2 beds	$4.8M
924,107 (staffed beds in all U.S. hospitals)	165,663 beds	$2.9B

Source: Lindholm, M, et al., "Professional language interpretation and inpatient length of stay and readmission rates," Journal of General Internal Medicine, 27(10), 1294–1299, https://doi.org/10.1007/s11606-012-2041-5); Freeman WJ, et al., "Overview of U.S. Hospital Stays in 2016: Variation by Geographic Region," HCUP Statistical Brief #246, 2018, Agency for Healthcare Research and Quality, www.hcup-us.ahrq.gov/reports/statbriefs/sb246-Geographic-Variation-Hospital-Stays.pdf; "2020 AHA Hospital Statistics," American Hospital Association, 2020, https://www.aha.org/statistics/fast-facts-us-hospitals; "Length of hospital stay," OECD, 2019, https://data.oecd.org/healthcare/length-of-hospital-stay.htm; Zong, J, et al., "The Limited English Proficient Population in the United States in 2013," Migration Policy Institute, 2015, https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-2013#:~:text=Overall%2C%20the%20LEP%20population%20represented,population%20ages%205%20and%20older; Advisory Board interviews and analysis.

1. Assumes LEP patients receive no translation services at admission or discharge; a targeted decrease of 1.47 days among LEP patient population; average midnight bed occupancy of 85%.
2. Assumes 8% of beds are occupied by LEP patients (8% of the U.S. population is defined as having LEP).
3. Assumes cost per stay of on all-payer basis of $11,700, an average national LOS of 5.5 days, and an average LOS of 6.97 days for LEP patients.

Assessing organization-wide opportunities to advance health equity

Data-driven examples such as the analysis shared above can rally stakeholders around the need to address health disparities. We recommend that all organizations looking to reduce disparities build their strategy around the following dimensions.

- **Governance**: Do we have a leadership structure that can develop an organizational strategy to address health equity?

- **Social needs and community outreach**: Are we addressing community-wide social determinants of health and their root causes?

- **Data collection**: Do we collect quantitative and qualitative patient data to improve care and support identification of disparities at the population level?

- **Data analysis**: Do we analyze our data to identify health disparities in our patient population?

- **Goals**: Do we set measurable goals for reducing disparities?

- **Staff knowledge, skills, and attitude**: Do we provide comprehensive skill-building training for our staff?

- **Culturally sensitive care delivery**: Do we provide culturally sensitive care to every patient who enters our system?

- **Workforce diversity, equity and inclusion**: Do we employ people from our community and build a workforce and organizational culture that reflects our patient population?

We recommend executive teams use our maturity model for reducing health disparities to assess their current level of maturity for each of these dimensions.

Clinical executives should take an active role in helping to set strategy and drive implementation across several, if not all, of these dimensions. However, reducing health disparities is a massive, long-term, multidisciplinary challenge, so it's important to identify exactly where clinical executives should prioritize their personal efforts. This publication details where clinical executives should focus.

Source: Advisory Board interviews and analysis.

The clinical executive's role in reducing disparities at the point of care

Clinical executives must focus disproportionally on four strategies. These are areas where they can have an outsized impact on organizational strategy, either through direct leadership or advocacy.

01
STRATEGY

Clarify executive accountability for reducing disparities

02
STRATEGY

Leverage existing patient and staff feedback channels to address disparities

03
STRATEGY

Address barriers to SDOH screening at the point of care

04
STRATEGY

Track metrics with the biggest impact on long-term ability to reduce disparities

01 Clarify executive accountability for reducing disparities

Reducing health disparities is every clinician's and every health system executive's responsibility. However, the scale and scope of this challenge demand clear and specific accountability. Every clinical executive needs to be able to answer the question: Who owns health equity issues at the organization?

An organization that designates a specific leader to set and drive its health equity strategy is better positioned to make meaningful progress in reducing disparities. A single leader with the seniority to convene their executive counterparts can align the organization's strategy around addressing specific disparities and ensure each department's strategic plan supports equity goals. Progressive organizations generally have a chief health equity officer who reports to the chief executive and/or board with adequate funding to staff projects and implement interventions. At a minimum, we recommend designating a single leader, ranging from Director to Executive level, whose purview and responsibilities are solely over issues related to health equity. This ensures the minimally viable seniority and funding to begin to make meaningful progress.

In the absence of a dedicated leader, we recommend that the chief nursing and medical officers form a dyad leadership model to set strategy and coordinate implementation. Such a partnership will help ensure that health equity rises to the level of a true organizational priority, on par with clinical quality and safety.

One challenge for organizations with a designated leader over health equity is making sure all clinical executives also engage in the work to achieve equity. When there is a single leader who "owns" most of the work involved in reducing disparities, other leaders may actively or passively disengage from wrestling with thorny health equity issues.

Source: Advisory Board interviews and analysis.

1. CLARIFY EXECUTIVE ACCOUNTABILITY FOR REDUCING DISPARITIES (CONT.)

Even if every leader at the organization agrees that they all have a responsibility to reduce disparities, it is easy to see addressing health equity issues as "someone else's job." Leaders must address this pitfall proactively.

Clinical executives must articulate how their department's priorities advance the organization's broader efforts to reduce disparities. A close, collaborative partnership between clinical and formally designated health equity leaders is essential. Executives should have regular one-on-one meetings with their counterpart over health equity to ensure that they align their strategic priorities and they are taking advantage of synergies whenever possible.

Source: Advisory Board interviews and analysis.

02 Leverage existing patient and staff feedback channels to address disparities

Identifying disparities at the point of care requires thorough data analysis. But figuring out what to do about identified disparities requires a more qualitative approach. Clinical executives typically oversee a wide variety of mechanisms for collecting input from patients, community members, and staff. These channels can help source ideas for reducing disparities and are also an important way to further embed ownership of health equity throughout the organization. Most organizations can get the feedback they need by making moderate adjustments to existing channels for listening to patients and staff. Some organizations will decide to invest in new infrastructure to gather feedback specifically on targeted interventions to reduce disparities.

Patient and family advisory councils

The time-tested patient and family advisory council is an effective way to solicit the qualitative input you need to design culturally sensitive and effective interventions to reduce disparities.

Community boards

Some provider organizations invite community leaders to serve on the institution's board of directors. Other organizations invite local leaders to serve on special "community boards," which report to the chief executive or board of directors. These community boards have budgetary power. These positions should be filled by diverse leaders who have the trust of local communities.

Make sure these listening channels reflect the diversity in the organization's community. Clinical executives should push their organizations to seek out the hardest feedback to source, recognizing that this is the feedback they likely most urgently need to hear. For example, clinical executives should make a point to engage with LEP patients and community members through an interpreter.

Source: Advisory Board interviews and analysis.

2. LEVERAGE EXISTING PATIENT AND STAFF FEEDBACK CHANNELS TO ADDRESS DISPARITIES (CONT.)

Meeting logistics should facilitate rather than hinder the participation of underrepresented voices. Unless specifically addressed, meeting logistics can easily pose a real barrier to their involvement. Key details to consider include:

- Compensation: Do you compensate advisors for their valuable time and input?

- Meeting time: Can someone who does not work a traditional 9-to-5 job attend?

- Digital divide: Can someone without access to home internet easily communicate with organizers? Do you provide the necessary technology for virtual meetings (e.g., computer, Wi-Fi, webcam) for those who need it?

- Transportation: Is the meeting location easily accessible for someone who does not own a car? Do you cover transportation expenses?

- Language: Do you make language services available for advisors with limited English proficiency (e.g., in-person interpretation)?

Shared governance

We recommend establishing, at the facility level, multidisciplinary governance councils to advance health equity. Best practice shared governance councils have executive-level sponsorship and representation from a wide variety of staff, both clinical and non-clinical.

Some organizations already have a role-specific shared governance infrastructure—such as nursing or physician shared governance councils. If that's the case at your organization, consider creating role-specific health equity councils that report up to a multidisciplinary, organization-wide equity council.

Employee resource groups (ERGs)

Some organizations have employee resource groups (ERGs) for underrepresented identity groups and their allies—such as people of color, Black, or LGBTQ employees. If these groups exist at your organization, invite them to participate in equity councils and create opportunities for them to provide ongoing feedback to help shape council strategy.

An organization's infrastructure for listening to patients, community, and staff will only be as effective as the power and voice they have in decision-making for the health system. To maximize the positive impact of these listening channels, ensure they receive executive-level sponsorship and the resources to effect meaningful change.

Source: Advisory Board interviews and analysis.

03 Address barriers to SDOH screening at the point of care

Screening patients for social determinants of health is an essential part of reducing disparities at the point of care and ensuring that every patient receives culturally sensitive care.

The World Health Organization defines social determinants of health (SDOH) as "the conditions in which people are born, grow, live, work and age." These non-medical factors have direct impacts on health. For example, researchers estimate that 60% of a patient's overall health is determined by SDOH and individual behavior, while only 30% is determined by genetics, and 10% is determined by the care they receive. Left unaddressed, these SDOH can drive avoidable utilization and unnecessary spending. Patients with unmet social needs have 10% higher annual health care expenditures, approximately $2,400 per year.

Factors that contribute to a patient's overall health

Clinical care
10%

Patient's genetics
30%

SDOH & individual behavior
60%
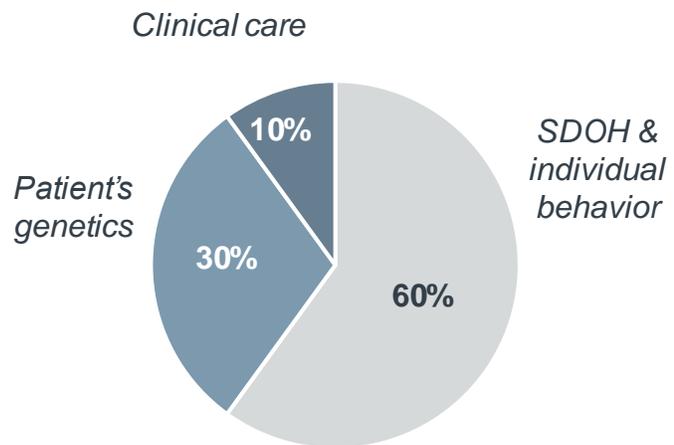
To improve health outcomes and reduce disparities at the point of care, overall health care must encompass the social factors that influence health. Yet there remains a high degree of variability in how organizations are screening for and addressing SDOH. This variability is due to three underlying barriers that prevent organizations from screening for SDOH at the point of care: funding, screening logistics, and clinician discomfort.

Source: Schroeder, SA, "We Can Do Better – Improving the Health of the American People," New England Journal of Medicine, 2007; Pruitt Z, et al., "Expenditure Reductions Associated with a Social Service Referral Program," Population Health Management, 21, no. 6 (2018); Advisory Board interviews and analysis.

3. ADDRESS BARRIERS TO SDOH SCREENING AT THE POINT OF CARE (CONT.)

Barrier 1: Funding

There are two main funding challenges. The first is reimbursement. The fee-for-service payment for SDOH screening is minimal. Additionally, there is not a universally accepted SDOH screening tool that organizations can use to meet the billing requirements. Second is justifying the investment in screening. Many organizations hesitate to adopt SDOH screening practices out of concern that it is difficult to address the social issues identified. It's easier to screen patients for SDOH if an organization has organization- or community-led resources to direct patients to. But to justify the investments or partnerships those resources require, organizations need data to make the financial case. The clinical executive's role here is to help the organization identify which data points will make the most compelling case.

72%

of hospitals **do not** have dedicated funds to address patient social needs

Barrier 2: Screening logistics

Once an organization commits to SDOH screening, the next barrier is overwhelming screening logistics. A common initial instinct is to collect as much information as possible—leading to very long questionnaires that take too much time to complete. Focus the screening process on the social factors that:

- Have an outsized impact on a patient's health status (e.g., housing, food security)
- Are already known to be present in the community and contributing to patients' health status
- Will help you build the case for partnerships or homegrown initiatives to address the need

70%

of hospital electronic medical records **do not** screen for patient's social and behavioral needs

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Sample SDOH screening tools

- The Accountable Health Communities Health-Related Social Needs Screening Tool
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

Source: "Health Care's Blind Side: Unmet Social Needs Leading To Worse Health," Robert Wood Johnson Foundation, 2011, https://www.rwjf.org/en/library/articles-and-news/2011/12/health-cares-blind-side-unmet-social-needs-leading-to-worse-heal.html; Ohanian, A, "The ROI of Addressing Social Determinants of Health," 2018, https://www.ajmc.com/view/the-roi-of-addressing-social-determinants-of-health; Lee, J, et al., "Social determinants of health: How are hospitals and health systems investing in and addressing social needs?" Deloitte Center for Health Solutions, 2017, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-addressing-social-determinants-of-health.pdf; Advisory Board interviews and analysis.

3. ADDRESS BARRIERS TO SDOH SCREENING AT THE POINT OF CARE (CONT.)

Barrier 3: Clinician discomfort

The third barrier clinical executives must directly address is clinician discomfort with talking about SDOH. Many frontline clinicians feel ill-equipped to address patients' social needs. This discomfort can stem from:

- Lack of or insufficient resources to address patients' social needs
- Discomfort discussing issues that feel too personal
- Lack of training or tools to identify or discuss social issues with patient
- Lack of education and/or fluency around social determinants of health

The clinical executive's role here is to directly acknowledge this potential discomfort, while reinforcing how critical social determinants are to overall health. With proper training in communication on what can be sensitive topics and the rationale behind the data collection, staff can feel well equipped to screen for and discuss SDOH with patients.

80%

of providers feel uncomfortable addressing their patient's unmet social needs[1]

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1. Social needs surveyed include socioeconomic status, housing, transportation, literacy, hunger, safety, and social support.

Source: "How to address social determinants of health and improve medical outcomes," Advisory Board, 2019; Advisory Board interviews and analysis.

04 Track metrics with the biggest impact on long-term ability to reduce disparities

Most organizations currently lack a data-driven approach for identifying disparities at the point of care. Clinical executives should help their organizations establish an infrastructure to identify and address disparities.

Start with collecting complete and accurate patient demographic data. Use this data to stratify clinical outcomes and process-of-care metrics to identify opportunities to reduce disparities at the point of care. (This organization-specific data can also powerfully reinforce the case for focusing on disparities.)

We recommend all organizations aim to collect REGAL data:

- **R**ace
- **E**thnicity
- **G**ender identity & sexual orientation (commonly referred to as 'SOGI' data)
- **A**ge
- **L**anguage preference

Use a self-reporting methodology whenever possible so patients feel comfortable providing the information and are reporting the most accurate data, free of outside influence or assumption. Leverage the patient portal to push such questionnaires to patients ahead of planned care or at the beginning of an interaction with the health system. If self-reporting is infeasible, we recommend assigning data collection responsibilities to registration staff or a similar role present across care settings. Choosing a role standardized across settings allows for streamlined training and rollout of the demographic data collection protocol across a system.

4. TRACK METRICS WITH THE BIGGEST IMPACT ON LONG-TERM ABILITY TO REDUCE DISPARITIES (CONT.)

Once the data is routinely collected, you can begin to proactively identify disparities occurring at the point of care. We recommend stratifying outcomes and process-of-care metrics at least twice a year, focusing on the organization's top clinical morbidities and nursing-sensitive indicators. Disparities in nursing-sensitive indicators are some of the clearest examples of disparities at the point of care. Disparities in these indicators show that unwarranted care variation is occurring and resulting in inequitable patient outcomes, including adverse events and hospital-acquired conditions.

Examples of data to stratify in this way include:

- Quality performance indicators (e.g., LOS, admissions, readmissions)
- Outcomes (e.g., experience data,[1] PROMs, top clinical morbidities)
- Delivery of preventive services (annual physical, mammogram)
- Department-specific indicators (e.g., nursing-sensitive indicators, instances involving use of physical or chemical restraints, activation of security)
- Process of care measures (e.g., time to admit, ED wait times)

For more on institution- and community-oriented metrics, access:
Health disparity metric picklists.

Beware of "analysis paralysis" at this stage. You may uncover many more disparities than you can possibly begin to tackle. Identify one or two significant disparities to focus on in the short term.

Ask the following questions for each disparity to determine which to prioritize across the clinical enterprise.

- Is the disparity clinically significant?
- Is reducing this disparity a priority of the community we serve?
- Are there solutions within our sphere of influence?
- Will addressing this disparity drive value for our organization (e.g., lower costs of care)?
- What investments in new technology, roles, or community supports are needed to address the disparity?

1. Due to significant disparities in response rates across patient demographics, experience data does not offer a complete picture. Do not use such data as evidence of the absence of a problem, and do not use such data in isolation to set strategy. Supplement experience data with sources of valuable qualitative feedback from listening channels for patients and community.

Source: Advisory Board interviews and analysis.

4. TRACK METRICS WITH THE BIGGEST IMPACT ON LONG-TERM ABILITY TO REDUCE DISPARITIES (CONT.)

Identifying one or two disparities to focus on system-wide should not preclude local service line leaders from establishing additional, area-specific goals. However, we urge all leaders to prioritize making meaningful progress on reducing one to three disparities rather than spreading their efforts thinly across so many disparities that little progress is made.

Parting thoughts

Reducing disparities at the point of care is a critical first step toward providing better care for everyone. But an organization won't make real change in the community unless its leaders commit to addressing the structural root causes of SDOH: poverty and inequity. Addressing these root causes is an essential commitment for any organization that embraces its role as an anchor organization in their community. Anchor organizations invest in long-term health equity by considering what business, workforce, and culture changes they must make to address the root causes of SDOH. These organizations actively reinvest in their communities to improve their socioeconomic status. This involves advocating at the local, state, and federal level for policies that address structural barriers to health care access, socioeconomic advancement, and equity, as well as investing in local economies to build sustainable and equitable wealth.

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