AMGA Health Equity Forum

Meeting Summary

September 11–13, 2024

*Nearly a year after the inaugural **AMGA Health Equity Forum**, Danielle Casanova, vice president, Population Health Initiatives and Health Equity, with AMGA, welcomed participants from healthcare organizations (HCOs) of all sizes and geographic locations to Atlanta for the second annual event.*

She introduced resources developed over the past year:

- **A Health Equity Framework** outlining six research-informed domains, developed by AMGA and the Health Equity Steering Committee

- **A Health Equity Playbook** focused on infrastructure, with a web-based, enhanced version scheduled to launch in 2025

- **A Health Equity member needs assessment**, a concise 20-question survey designed to explore organizational efforts in health equity data, strategy, and leadership, as well as to identify ways AMGA can provide targeted support.

- **The Health Equity Trailblazer Pledge**, which encourages AMGA members to undertake one health equity initiative or activity in 2024 and share data, stories, and outcomes.

- **A Health Equity webinar series** exploring topics such as implementing LGBTQIA+ care in health systems, hiring with equitable outcomes in mind, and collecting and leveraging social drivers of health (SDOH) data.

AMGA offers opportunities to collaborate on vaccinations, chronic conditions, health screenings, and more through *Quality Improvement and Population Health Best Practices Collaboratives* and research studies. To find more information, visit here.

"Health equity is a topic that we are all deeply passionate about," Casanova said. "Our goal is to ensure you learn from each other and leave with actionable steps to implement within your organization."

Keynote: Where Mission & Margin Align

Advancing Your Health Equity Strategy to Increase Patient-centric Care, Improve Clinical Performance, and Achieve Financial Success

Nzinga Lowe
Founder and CEO, Pygmalion Health

Lowe began with a question for the audience: "How much reimbursement do you believe you can receive for the social determinants of health?" The answer: A hypothetical HCO with 100,000 patients could generate $8.6 million by strategically and proactively utilizing Centers for Medicare & Medicaid Services (CMS) Z codes to document and report SDOH. This includes activities such as identifying barriers to care, conducting social needs assessments, and addressing unmet needs through care navigation or community health workers.

Such reporting begins with a blend of high tech and human data collection and analysis. As an example of the former, Lowe talked about how the Alvee AI-driven data management platform can pull structured and unstructured data into an organization's electronic health record (EHR) for reimbursements they can start billing for.

"Z codes have grown and been updated since they came out in 2021," Lowe said, reminding participants of the Z-code list in their meeting packets.

But Z-code reporting is just one potential way to fund SDOH and health equity activities, she explained. Medicare Advantage and Managed Medicaid partners are reassessing current contracts and launching new ones, she pointed out, and care coordination fees and payer partnerships represent other potential revenue opportunities. "Take a look at what your health equity initiatives offer you now and get the additional funding you need," she said.

But such tools are just one piece of the puzzle. "Data also exist in the experiences of the providers who see these patients every day," she explained. Such a provider would understand that telehealth might not be the best option for engaging rural patients, who may not have good internet access, and that five-a-day produce recommendations might play out in reality as deep-fried vegetables and fruit pie in the South.

> *"There's no such thing as a noncompliant patient. There's a patient who lives too far away from a doctor, who mistrusts healthcare providers due to bad experiences, who were told that their health doesn't matter unless it's an emergency."*
>
> **– Nzinga Lowe, Founder and CEO, Pygmalion Health**

"Once we understand how our patients engage with their health, then we are able to best engage with them," Lowe explained, then walked through how engagement strategies play out across three patient types:

- **Proactive patients**, "advocating for their own health and really managing their care," are good candidates for digital innovation and remote monitoring.

- **Passive patients** "see doctors when they can and keep up with medications if a condition's serious." Support and engagement are key for these patients. Why are they passive? Could they be good candidates for gym gift cards through insurers or resources through community partners?

- **Reactive patients**, high utilizers of care, require a multipronged approach to SDOH.

Partnerships

Partnerships are key for identifying and addressing such SDOH needs, Lowe said, providing examples such as the senior-focused Medicarian movement and Hope Bound, which she called an "amazing partner" in the area of mental health resources for teens. "Providers have to manage so much already. Understanding available resources is essential to avoiding burnout," she said.

It's also important to understand each resource's strengths and limitations, she said. A church could be rich in community trust and knowledge but lack the resources to sustain or scale a food pantry, for example. A big insurer might be able to fund thousands of gift cards for groceries but lack local knowledge of community preferences and nuances.

Attendees participated in a workshop activity through which they shared commonalities and differences across their organizations and talked about patient population types at their HCOs. In the concluding full group, the conversation circled back to AI. How are groups thinking about it beyond data collection tools like Alvee? Participants mentioned gamification and tracking applications for behavioral health, along with AI support systems for social isolation.

Monitor, Maintain, and Adapt

Lowe shared activities participants can schedule throughout the year to keep SDOH initiatives on track.

Q1 (January–March): Audit patient panels, annual initiative planning, patient education and outreach, HEDIS Scoring.

Q2 (April–June) and Q3 (July–September): Once a month, schedule communications campaigns and take a look at quality initiatives.

Q4 (October–December): Close out care gaps, final appointments, and final data submission. "Fourth quarter can be busy due to flu and COVID," Lowe noted. Consider initiatives for social isolation. Complete final data submissions, "so you're not scrambling in January."

Twice a year: Review chronic conditions and conduct an SDOH assessment.

Panel Discussion: Varied Approaches to SDOH Utilization

Henna Qureshi, DO, FAAP
Pediatrician, Inova Cares Clinic for Children; Associate Ambulatory Peds Clerkship Director, UVA SOM Inova Campus; Health Equity-Physician Lead, Community Health and Health Equity, Inova Health System

Sarah Gordon, MBA, PMP
Director, Clinical Analytics, Clinical Effectiveness, and Outcomes, Inova Health System

Eileen Alexopoulos
Senior Director, Health Equity and DEIB Liaison, BlueCross BlueShield of Massachusetts

Screening for Social Drivers of Health: Lesson from the Field

As of January 2024, hospitals have been required to report the portion of their population aged 18 and up they've screened for SDOH and how many have one or more positive screens for social risk factors (positive screens) in the CMS domains of food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Inova Health System is meeting this requirement through collaboration led by its Health Equity Steering Committee and a three-pronged strategy: Incorporating SDOH screening into MyChart eCheck-in for all appointments, having team members conduct screenings during a clinical encounter and making questions available electronically, and identifying

where validated SDOH screening questions could be integrated into existing assessments and mapped to the wheel.

Continued communication across the system on the why and how as well as providing patient impact stories is essential. "The bread and butter of this is getting team members comfortable with asking these questions," Qureshi said. Some tactics to do so include lunch and learns, provider education about interpersonal violence, and socialization of questions like, "How are you getting to your next appointment?" across the care team.

Throughout, Inova has been undergoing a CEO-led shift from "determinants" to "drivers" of health ("because these things are not predetermined") and prioritizing storytelling in its efforts. Throughout healthcare facilities, for example, an animated video plays showing one patient with headaches. Is stress the cause? Meanwhile, another patient misses his appointments because of a late bus. The team has also been telling stories about food insecurity—a need often missed in Northern Virginia's wealthy communities—educating patients about nutrition with Healthy Plate Clubs, cooking classes, and culturally appropriate interventions.

Collaboration is fundamental in these efforts as well. Inova effectively collaborates with the health equity steering

Three-Pronged Strategy

Incorporating SDOH screening into MyChart eCheck-in for all appointments

Action items:

- Provide your list of departments
- Consider how you might notify your patients of the importance of completing it
- Prepare your team to review the wheel

Identifying team members/workflows to conduct screenings with the patient during a clinical encounter and or create opportunities to be answered electronically

Action Items:

- Identify opportunities for active screening, workflows

Identifying where validated SDOH screening questions could be integrated into existing assessments and mapped to the wheel

Action Items:

- Share assessments that could be adapted to include screening questions

---

Community Health and Health Equity · **Inova**

Food insecurity

SDOH	FOOD ACCESS
Current status	• At Inova, 6% of screens for food insecurity have been positive • At the Inova Cares Clinics, 55% of screenings are positive for food insecurity
Strategy	We addressed this higher prevalence of need by creating in-house food pantries, providing referrals to community organizations for ongoing support, and displaying bulletin boards with SDOH resources which worked to normalize the need and encourage conversations with the care team.

committee, care transformation, nursing, IT, and analytics. There is an ongoing sharing of data in order to maintain momentum in screening efforts. Additional collaboraton includes obtaining provider buy-in, building trust with patients through equitable screening, asking if resources are needed and transparent reporting, and finally partnering with community based organizations.
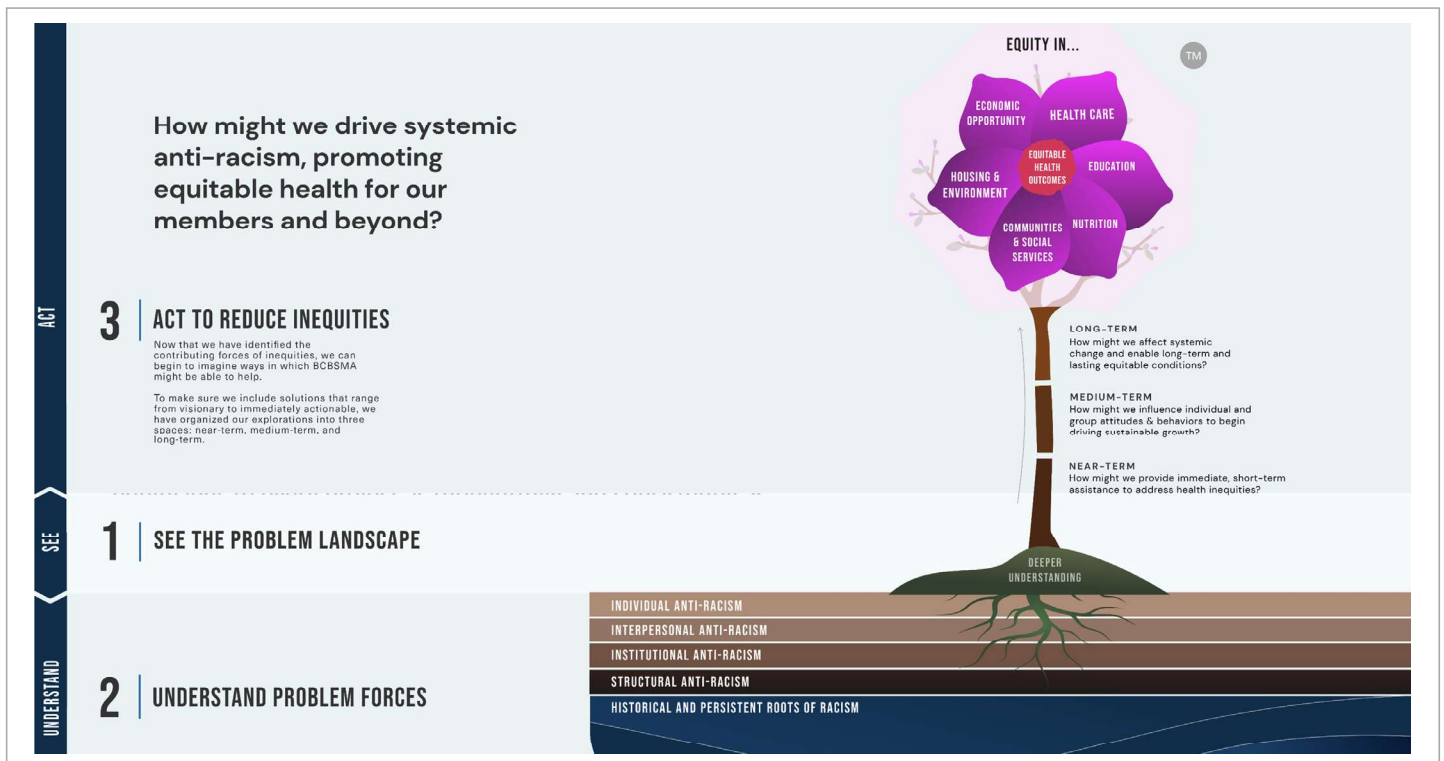
Gordon talked about Inova's data analytics journey, from determining who asks the questions to integrating screening into workflow to making results available to all via the patient chart. She emphasized that SDOH screening rolled out across the organization from the very beginning—there was no pilot or phased implementation. "Monitoring screening is an organizational KPI and signals a strong organizational focus on understanding the SDOH component of patient experience."

Inova Takeaways and Tips

- Involve the Epic/analytics team up front
- Let patients answer questions themselves
- Prioritize data—it's very important for buy-in
- Look at patients as whole people
- Get strong leadership behind this work—this can't be emphasized enough

Alexopoulos began her presentation with an overview of how SDOH is woven into the many facets of health equity work at Blue Cross Blue Shield Massachusetts (BCBSMA) Foundation. Since 2001, the Foundation has provided millions of dollars of health equity grants to community-based organizations serving people in Massachusetts who are economically, racially, culturally, or socially marginalized, with a mission of equitable healthcare access.

BCBSMA leaders at the highest level are involved in both BCBSMA's health equity council and broader initiatives such as Massachusetts Health Equity Compact. The Magnolia Model™ guides interventions through the following three steps: Seeing and acknowledging a current inequity, understanding the systemic drivers of the problem, and acting to prevent inequities. "A blend of targeted funding, tech support, and community-building has helped and accelerated this work," Alexopoulos said.

Nearly a million members have provided data so far, she said, pointing out that, "it's important to collect the right data." BCBSMA uses the Fast Healthcare Interoperability Resources (FHIR) standard for race. "It allows for multiple levels of data. You can go up a level or drill down into deeper levels of granularity."

She noted that her team has been expanding this data collection to include sexual orientation and gender identity (SOGI) information, and that putting these data to use is the next step. "We show each provider a confidential health equity report: Where they are, where they've made an impact, and how their interventions have improved."

BCBSMA Takeaways and Tips

- Start with gold-standard data. Garbage in, garbage out.
- You have to be transparent if you want buy-in.
- Collaborate, incentivize, and support providers.
- Interventions and communications in multiple languages creates trust. People feel that you're talking to them.
- This work takes a village. Everyone has to be involved.

Q&A and Roundtable Highlights

Have you seen any physician resistance to using Z codes?

Noting that providers "shudder at a BPA [best practice advisory] or anything that's disruptive in the first place," Qureshi explained that they've offered a system in which "the codes just pop up. It doesn't ask them to do anything outside of usual documentation."

Tying Z codes into a reimbursable requirement helps as well, she continued, "and we're already asking physicians to do that diagnosis documentation anyway."

Further efforts include socializing awareness of where the codes live on Epic and making it part of the organization's incentives and bonuses.

What about pushback to conducting screenings through the Unite Us platform?

To increase physician buy-in, Inova proactively gathered feedback on the platform and communicated the tool's advantages. It offers a closed loop, for example, and it's easy to add resources in the after-visit summary or access resources via QR code.

Concluding Roundtable

Participants talked about the parts of the presentation that caught their attention, including data analytics, building a culture of safety, and understanding the patient experience. Inova Healthy Start was one example. The program provides days' worth of food for patients who need it—in an Inova-branded bag with no notes in the chart, acknowledging that recipients may feel embarrassed that they can't provide for their families.

Participants also talked about program sustainability. "You don't want to start something and then take it away, because patients will remember that," one participant cautioned. "Find out what's out there, what's available, and partner up," another suggested.

The conversation turned to experiences with state government initiatives, namely "money tied to a defined election cycle and an outcome where we actually need data to drive what we do to get the outcome we need," in the words of one participant. "This makes it challenging to get to a point where the data show what works and what doesn't."

"That's why we do our own funding, initiatives, and measurement instead of waiting for government with all its intricacies," Qureshi replied. She advised HCOs to "do the work, inform state agencies, and remember that they're allies. Keep up the collaboration—the more prepared you are, the more action you can take."

Finally, participants talked about technology. Whatever specific EHR you use—Epic, Cerner, IDX, Allscripts—be sure to put the information you gather to work. In the words of one participant, "It's one thing to collect data, but what are you going to do with it?"

Case Studies: Mercy Clinics and Augusta Health

Maternal Health Equity: A Multidisciplinary Approach for Success
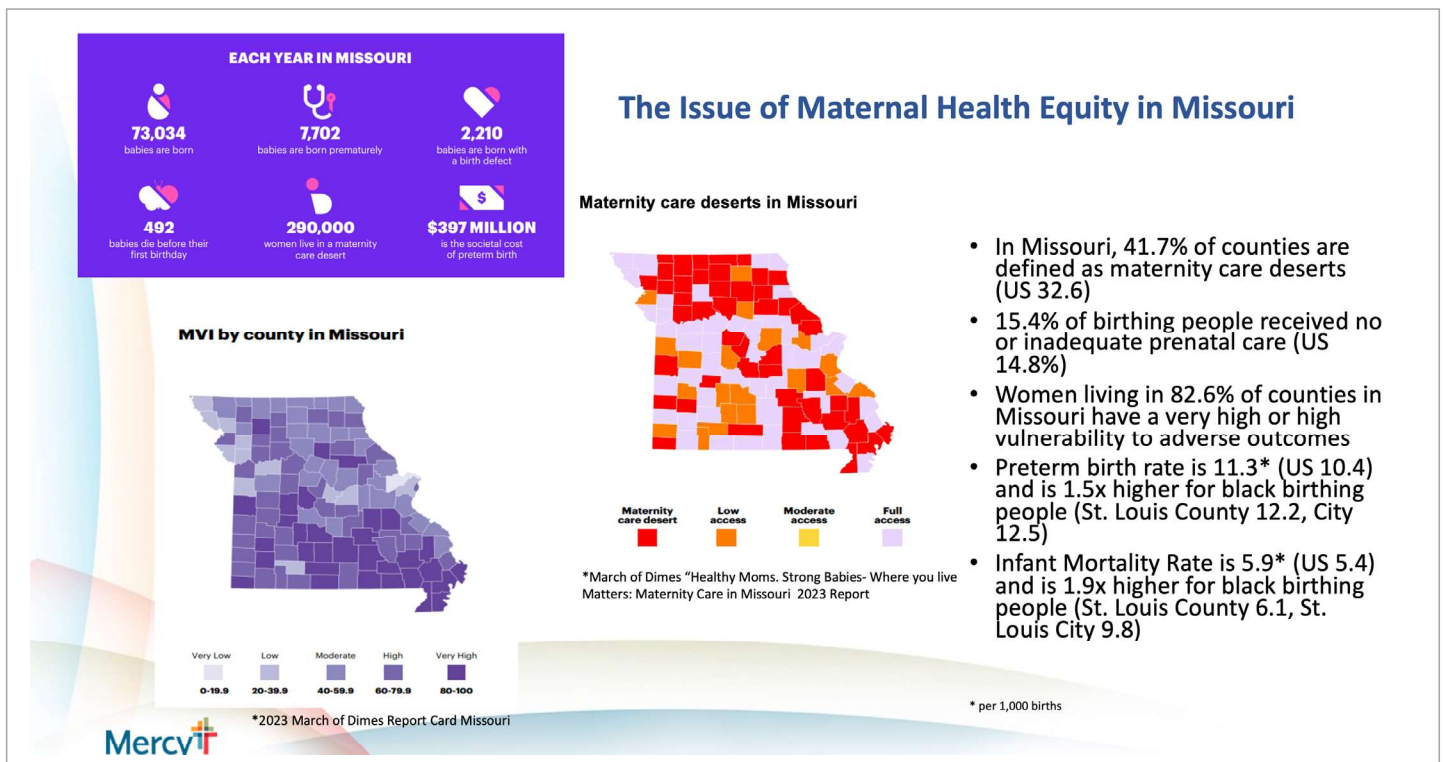
Dara Webb, FACHE, CMPE
Vice President Operations - Women's and Children

Becky Floyd, MSW, LCSW
Manager Ambulatory Social Work - Women's and Children, Mercy

With high vulnerabilities to adverse outcomes that are even higher for Black patients, along with over 40% of counties considered maternity health deserts, "Missouri has a lot of opportunity for maternal health equity," Webb said.

She and Floyd talked about how Mercy has been engaging multidisciplinary teams, including social workers and community health workers working at the top of their licenses, in its health equity work. Their work begins with an SDOH assessment,

The Issue of Maternal Health Equity in Missouri

EACH YEAR IN MISSOURI
- 73,034 babies are born
- 7,702 babies are born prematurely
- 2,210 babies are born with a birth defect
- 492 babies die before their first birthday
- 290,000 women live in a maternity care desert
- $397 MILLION is the societal cost of preterm birth

Maternity care deserts in Missouri

- In Missouri, 41.7% of counties are defined as maternity care deserts (US 32.6)
- 15.4% of birthing people received no or inadequate prenatal care (US 14.8%)
- Women living in 82.6% of counties in Missouri have a very high or high vulnerability to adverse outcomes
- Preterm birth rate is 11.3* (US 10.4) and is 1.5x higher for black birthing people (St. Louis County 12.2, City 12.5)
- Infant Mortality Rate is 5.9* (US 5.4) and is 1.9x higher for black birthing people (St. Louis County 6.1, St. Louis City 9.8)

*March of Dimes "Healthy Moms. Strong Babies- Where you live Matters: Maternity Care in Missouri 2023 Report

MVI by county in Missouri

Maternity care desert / Low access / Moderate access / Full access

Very Low / Low / Moderate / High / Very High
0-19.9 / 20-39.9 / 40-59.9 / 60-79.9 / 80-100

*2023 March of Dimes Report Card Missouri

* per 1,000 births

conducted in a "culturally competent, holistic" fashion. Referrals to community and social resources follow to connect patients to care and support for better health outcomes and quality of life.

Collaboration and connection are a focus throughout, between physicians and nurses, with community partners, and through a wide range of patient engagement channels (phone, video, email, the patient portal, and a Women's Welcome Center) to "meet patients where they are."

Language matters during these engagements, Floyd said, illustrating her point with the following example: "If you call patients and say, 'I'm a social worker,' many will immediately shut down. Instead, we say, 'I'm from your physician's office,' or 'I'm part of your healthcare team' instead."

Through their assessments, they found that 60% of their patients have a behavioral health need. To address this, they launched the Perinatal Psychiatry and Therapy Program in 2023.

For example, a social worker and community health worker met with the mother of five children. "The mom had been experiencing negative thoughts. An assessment revealed financial strain—she was behind on her mortgage. So they connected her to resource that could help, and now she feels this stress alleviated and feels supported."

According to Webb, Mercy's program was initially Medicaid-only, but organizational leadership soon opened up participation to any payer. "Referrals skyrocketed,"she said.

She and Floyd shared lessons learned along the way. They established the Community Health Worker Women's Welcome Center, which is the point of entry for any pregnant woman at Mercy Hopsital St. Louis. An integrated community health worker screens pregnant women for social needs and facilitates access to essential healthcare and social resources. Community health workers can be difficult to hire, for example, and community partnerships are vital for extending reach and getting pregnant patients the resources they need.

"There's a lot more we want to do," Webb concluded, sharing a long list of next steps, including a maternal focus group, a postpartum visit program, diversity recruitment strategies, and training on unconscious bias and trauma-informed care.

Q&A

What work has Mercy been doing in the area of unconscious bias?

Webb said that Mercy created "a safe space" for residents, nurses, and the chaplain to talk about topics like unconscious bias and race. And if someone experiences bias in their interactions with Mercy, "any Black or Brown patient knows they can call me, any time of day or night," Webb said.

Does Mercy's maternal SDOH screening include patients' partners?

The program has protocols for domestic violence issues, and the team is working on sexually transmitted infection (STI) testing for patient partners, Webb said.

Sustaining Our Mission, Expanding Community Access to Healthcare

Isaac Izzillo, RN, MSN
Director of Public and Primary Care Services, Augusta Health System

Mark LaRosa
Chief of Staff, Business Development and Strategy, Augusta Health System

Questions to the Communities

- Who is not doing well in our communities?
- Where are the disparities?
- What are the local drivers underlying health disparities?
- Who are our partners in resolving health disparities?

Through Augusta Health's health equity interventions in northwest Virginia, a church classroom turned into a popup neighborhood clinic. Emergency department (ED) visits decreased by 22%, urgent care visits by 41%, and hospitalizations by 66%. And a patient who'd been living in a campground was able to get long-needed new glasses and treatment for an infection.

"How did this get started? We listened to our communities," LaRosa declared. During the COVID-19 pandemic, this listening at vaccination centers led to relationships with community groups and churches to learn more about the community's needs. Mental health and substance abuse emerged as priorities, along with more questions. Who's not doing well? What are the disparities and underlying drivers? And where do we go to help?

Augusta dove into the data, mapping emergency room statistics for Medicaid patients against University of Wisconsin Neighborhood Atlas data for areas of disparity, "We saw needs but wanted to put some science behind it," LaRosa said. "This gave us the ability to know where to focus."

Neighborhood Clinic Growth and Trends

PATIENT VOLUME TO DATE

- We have seen over 1,250 patients in the neighborhood clinic since launching in September 2022.

PATIENT HISTORY

- 848 patients had a previous encounter with Augusta Health either in an outpatient office, Emergency department, or inpatient setting.

NEW PATIENT VOLUME

- 32% growth in new patients to the Neighborhood clinic and organization.

IMPACT ANALYSIS

- We analyzed the 848 established patients to determine what kind of impact was experienced by the patients two years before the implementation of the Neighborhood clinic and two years after, in regards to emergency room visits, urgent care visits, inpatient admissions, inpatient costs, hypertension diagnosis and management, and diabetes diagnosis and management.

Izzillo continued with the next step: getting into the trenches to meet with community partners. "They're out there in every community. You just have to hit the road and develop relationships with them."

Such partnerships extend the team's reach. Augusta offers vaccines at no cost thanks to its "phenomenal" foundation support, for example, and work with Strength in Peers, a local mental health service provider, has taught the team about trauma-informed care. "It's education to connect better with our patients," Izzillo said.

Because "traditional models of primary care are archaic and challenging to people with SDOH barriers," Augusta's services, clinics, and partnerships adapt to the communities they serve.

"You've got to go to these patients," Izzillo said. Meanwhile, access to financial support is a focus for the underinsured patients "we don't talk about a lot. They're weighing copays against groceries."

Augusta has seen more than 1,250 patients in the neighborhood clinics since its launch in 2022; 848 of those patients experienced a previous encounter with Augusta Health in an outpatient office, ED, or inpatient setting. That is a 32% growth in new patients to the neighborhood clinic and organization.

> *What best practices are you using to scale your work with community providers? "Learn, listen and let the community partners lead," Izzillo advised. "If you're intentional about that, they'll lead you in the right direction."*

Izzillo and LaRosa concluded with an update on the patient from the campground, who had learned about Augusta Health's local clinic from a flyer at the laundromat. The immediate need he reached out for was simple—a dry sleeping bag. But these resources, and the overall healthcare relationship, grew over time. With greater stability and support in his life, this patient now has a job, apartment, and vehicle.

Solution Room Highlights

Solution room sessions bring meeting participants together in intensive, facilitated discussions to share problems and ways to solve them. The AMGA Health Equity team introduced them into the 2024 Forum to encourage more collaboration and interactive problem-solving. One of the session facilitators explained the rationale behind this approach: "It's easy to come to these type of meetings and feel like you're being talked at—and the entire time, your mind is going through what's going on in your organization. You want to roll up your sleeves."

Participants of the 2024 Health Equity Forum gathered in multiple breakout rooms to do just that, equipped with rolls of blank paper, multiple markers for notetaking, and a room full of like-minded, energetic, and inquisitive peers. They posed questions, like, "Who should serve on a SDOH task force?" They shared challenges, such as overloaded community partners ("they tell us they don't need us to send them more people with food insecurities") and discussed their group's top barriers for moving forward with health equity work.

Funding came up frequently in group conversations, particularly about grant programs and their challenges. "We have an operational clinic, but a lot of grants are directed toward startups." To further complicate matters, grants are often focused on one specific area, one participant pointed out. "Use grants to build your clinic and infrastructure, then make a business case for services," was one piece of advice.

Several participants connected on the challenge of serving communities with diverse languages. At what point in the patient journey do you bring in an interpreter—especially when resources are limited and an interpreter can double the time of a patient visit? What other tools and tactics can help? Some ideas included recruiting physicians fluent in common community languages and using phone trees similar to those used in customer service, where a caller can "push 2" for their language of choice.

Participants also talked about helping LGBTQIA+ patients feel more welcome throughout the touchpoints of their organization, with care team members and front-office staff from the community who can share their personal stories, proposed as one solution.

However, because an organization can't overtly require LGBTQIA+ status in their job postings or recruiting tactics, and because many LGBTQIA+ employees aren't open about their status, such engagement is easier said than done.

"Maybe it's about organizational messaging, letting your community know you are an equitable workforce," one participant offered, as other suggestions followed: Put your values on your website. Have a strong DEI team and committee. "You can't directly ask colleagues who may not be out to participate in this fashion, but you can say, 'We're focusing on this, if anybody wants to share.'"

Throughout solution group conversations, participants referenced specific case studies and interventions from other sessions, like early hypertension screening in pregnancy care and medication-assisted treatment for opioid use disorder.

They also shared activities from their own organizations. One example was a "cocoon service center" for high-risk pregnant patients, where SDOH data captured "as early as possible" informed resources "layered around the patient"—nurses, dieticians, licensed clinical social workers, and so forth. "Patients are telling us here's what we loved, here's what we hated. We're taking their feedback and rolling with it. It's valuable and eye-opening."

"Getting the voice of the patient" was a priority throughout, from meeting CMS SDOH requirements to getting that valuable ongoing insight into what communities want and need. While one conversation explored a high-tech approach for gauging patient sentiment—ambient listening technology—most groups focused on the human element: Helping care teams and patients alike feel comfortable and engaged.

Screening in potentially sensitive areas like maternal mental health requires training, one participant reminded peers. Videos explaining the "why" of screening can help patients open up, another suggested.

To build trust and engagement beyond SDOH screening, invite people from the community to join the organization's committees. Engage community members through resource groups and community listening sessions. "We did that with breast cancer screening. It was key to have someone from that specific patient group be a part of it. If it was just me," the male participant noted, "they wouldn't have opened up."

And one participant noted that the most powerful trust-building channel for their organization was right there in plain sight: a neighborhood restaurant and its well-liked owner. "That's where people will open up."

Creating Health Equity Through Representation— No More Excuses

Dr. Veronica Mallet, MD, MMM
Chief Administrative Officer, More In Common Alliance, CommonSpirit Health, Morehouse School of Medicine
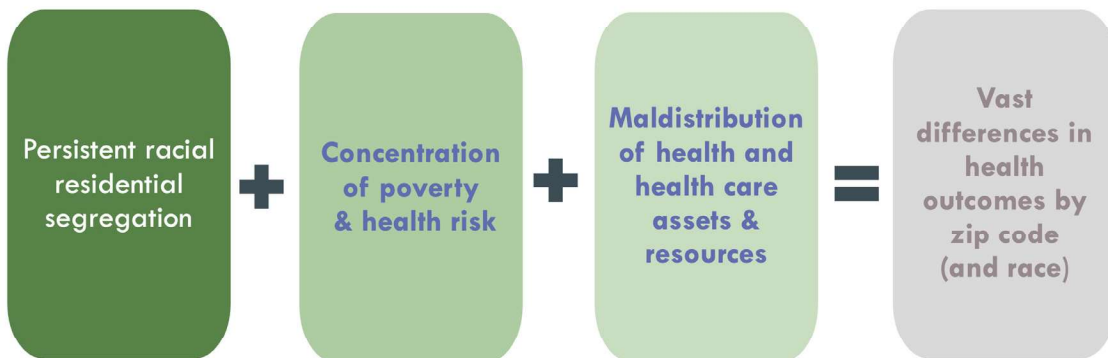
Mallet began her presentation with a definition of systemic racism, when racially unequal opportunities and outcomes are inbuilt or intrinsic to a society's operations and structures, and its historical context in the United States.

"A democracy cannot thrive where power remains unchecked, and justice is reserved for a select few. Ignoring these cries, failing to respond to this movement, is simply not an option. Peace cannot exist where justice is not served."

– U.S. Congressional Representative and Civil Rights Leader John Lewis on the George Floyd Justice in Policing Act

Social Drivers, Racism, & Place

- The ongoing practice **of structural racism** has resulted in enormous racial and ethnic health disparities
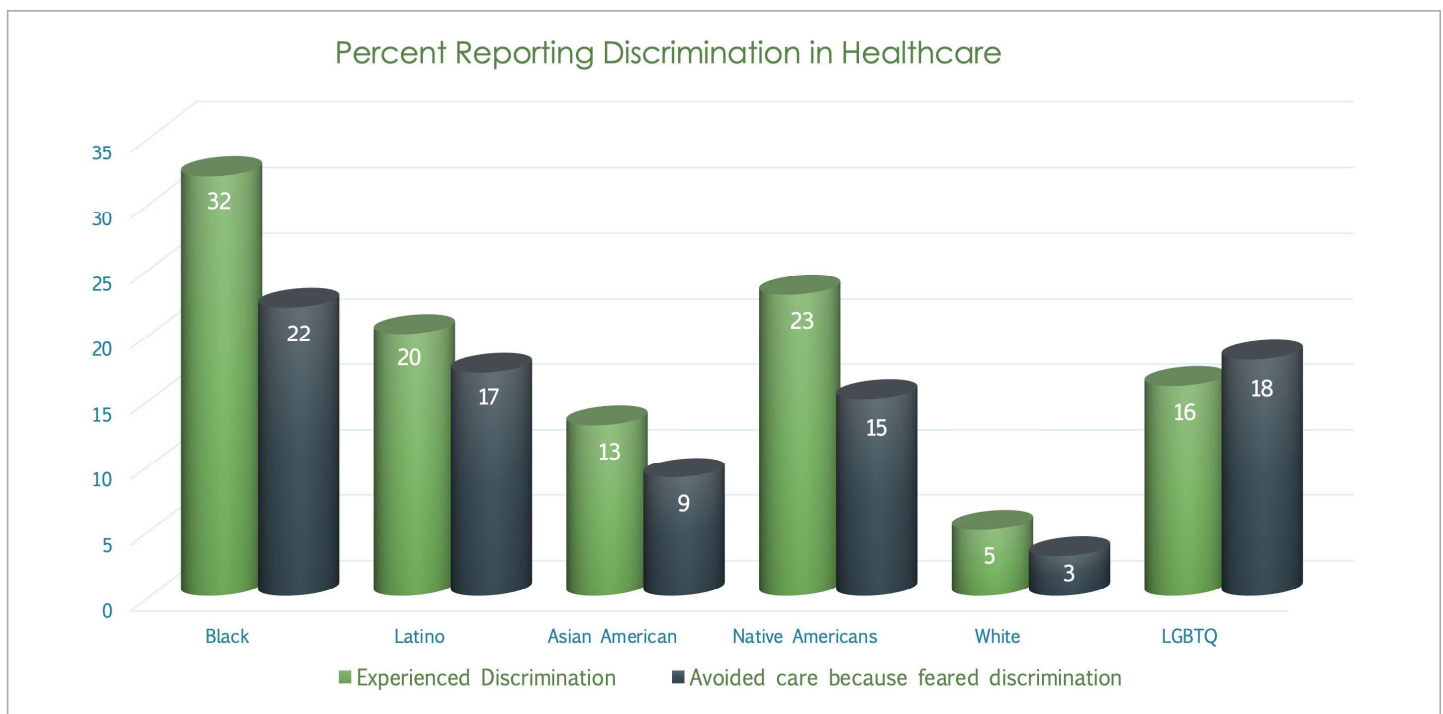
Persistent racial residential segregation **+** Concentration of poverty & health risk **+** Maldistribution of health and health care assets & resources **=** Vast differences in health outcomes by zip code (and race)

Concentrations of poverty, along with maldistribution of health, education, and wealth, have been the result, and have led to vast differences in health outcomes.

She then made the connection to the need for diversity in medical education. People seek out physicians of their same race, ethnicity, and religion, Mallet explained. Reasons include comfort and familiarity, language concordance, psychological and physical safety, a proximal location, a perceived shared worldview, and trust and respect.

When this trust and respect are lacking, care suffers. A migrant patient didn't feel entitled to speak up when her recommended medication wasn't covered by insurance, for example, or Black patients chose not to access COVID vaccines and prenatal care because they feel disrespected by the health system.

Racially concordant care, by contrast, addresses the barriers of discrimination, disrespect, and historically poor treatment. It also delivers several benefits, including heightened intention to adhere to medical advice, higher patient satisfaction, and improved clinical outcomes.

Percent Reporting Discrimination in Healthcare

Group	Experienced Discrimination	Avoided care because feared discrimination
Black	32	22
Latino	20	17
Asian American	13	9
Native Americans	23	15
White	5	3
LGBTQ	16	18

The More in Common Alliance

The More in Common Alliance, a partnership of Morehouse School of Medicine and CommonSpirit Health, is investing over $115 million over 10 years toward the following goal: Increase diversity in physician education so that more Black clinicians and clinicians from other underrepresented minority groups return to practice in underserved communities, resulting in more patient trust and compliance and better patient outcomes.

"We are working toward a future where medical education and training is accessible, representation is a reality, and health equity is realized at the scope and scale necessary to transform health for all," Mallet declared.

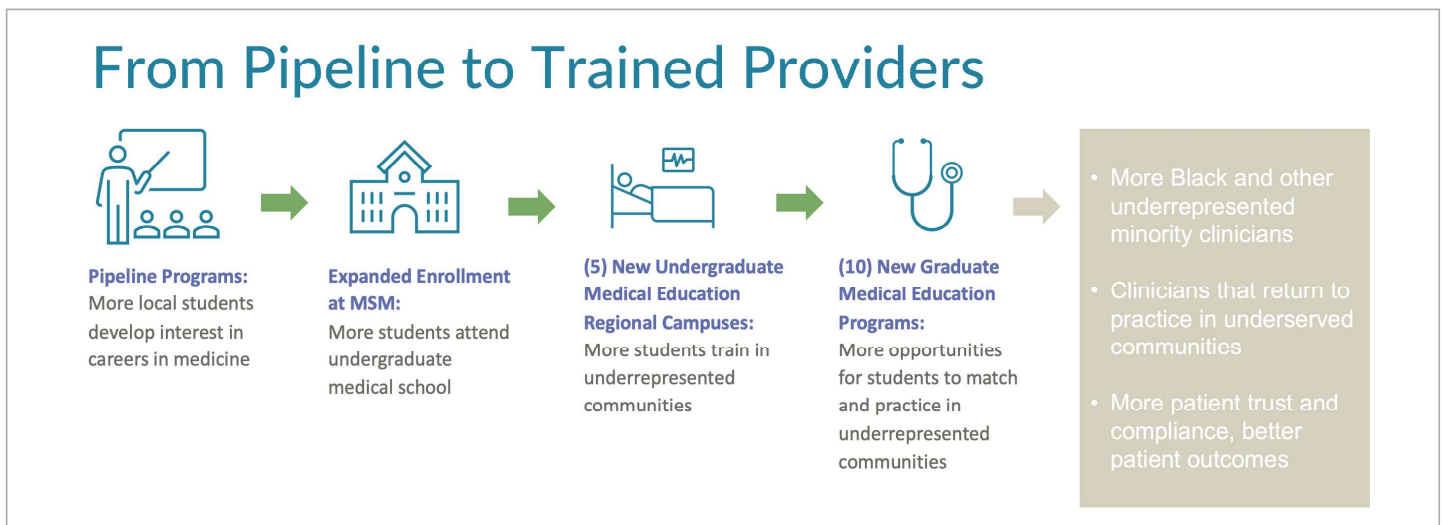She walked through the Alliance's strategic initiatives:

Recruit students from historically marginalized communities: Students would spend their first two years at Morehouse School of Medicine in Atlanta.

Establish at least five new Regional Medical Campuses: Third- and fourth-year medical students would continue their clinical education at these new campuses, which would bring together CommonSpirit's vast national reach to highly diverse patient populations and Morehouse School of Medicine's commitment to cultural-competency-centered curriculum, experiential learning, and training.

Expand graduate medical education (GME) programs in at least 10 diverse CommonSpirit markets: This would triple GME slots to nearly 400 over the next 10 years, so more learners would have the opportunity to complete their residency training.

Build robust pathways to healthcare careers: Targeted toward middle school, high school, and undergraduate students of color, these activities would expand professional opportunities in students' own communities while giving students the exposure and preparation to become competitive medical school candidates.

Promote a national model of training, knowledge creation, and care: With a focus on innovation and driving health system change, this model would be informed by tools, data, and evidence-based research that support culturally competent clinical decision making.

From Pipeline to Trained Providers

Pipeline Programs: More local students develop interest in careers in medicine

Expanded Enrollment at MSM: More students attend undergraduate medical school

(5) New Undergraduate Medical Education Regional Campuses: More students train in underrepresented communities

(10) New Graduate Medical Education Programs: More opportunities for students to match and practice in underrepresented communities

- More Black and other underrepresented minority clinicians
- Clinicians that return to practice in underserved communities
- More patient trust and compliance, better patient outcomes

Q&A

How have Historically Black Colleges and Universities (HBCUs) been responding to the SCOTUS decision on affirmative action and proposals to ban federal funding to medical schools with DEI programs?

"Our first response after SCOTUS was to examine our mission criteria—would Morehouse be at risk for litigation in admissions?" Mallet said. She pointed out that "race is never considered" in the school's admissions decisions. Instead, criteria such as "commitment to social mission" and "distance traveled" have created the school's diverse student population.

Her advice to others: "Use language, like health justice or underrepresented populations, that doesn't bring a target." And make your case with data and statistics, such as differences in life expectancy, a comparative lack of services in a specific area, and expected savings with improved health outcomes.

Have you seen any motion to change policies on how residencies are funded, as this can be a stopgap for residents of color?

"It's absolutely a focus, having conversations to have fully funded, multiyear-funded residency programs," Mallet said, noting that "the way we fund medical school education has been stuck since 1996."

Is there any space and place for us in today's world to name racism as present and active? Where and when do we acknowledge it?

"We have to understand disparities and their historic origins," Mallet emphasized. This is vital when working with patients and considering barriers to care. You need to check tendencies to blame patients for their circumstances. "I can be no other way but direct," she declared.

Breakout Session: SOGI Data and the LGBTQIA+ Community

Jorge Ramallo, MD, MPH, FACP, FAAP
Medical Director, Inova Pride Clinic, Inova Health System

Inova Health System shared challenges and tips for collecting sexual orientation and gender identity (SOGI) data—and for delivering informed, respectful care to LGBTIA+ patients overall, especially in the area of gender-affirming and transition-related care.

Inova, which opened the first LGBTQ+ Pride clinic in Northern Virginia, uses SOGI data for several purposes, Ramallo explained: To address health equity initiatives at federal level, to provide a lens on LGBTQIA+ health disparities, to assess healthcare gaps and opportunities, and to evaluate programs and improvement processes. "SOGI champions" with clinical

expertise in LGBTQIA+ health are instrumental in collecting these data.

His lessons learned so far: "Reduce the red tape" for these workers. Know that staffing may take time. And take a "gradual methodical approach" to SOGI data collection, with engagement and buy-in at the highest levels.

One HCO reported patient hesitancy and resistance to

How to support your champions?

- Invest the resources
- Invest in training and professional development
- Be adaptable
- Reduce red tape

sharing SOGI data. One thing that would have helped, they reflected: "Sending out patient notifications ahead of time that we were going to collect this data, instead of making it seem so taboo."

Let people know why data are being collected, Ramallo agreed. Lectures, webinars, online communications, staff ambassadors, and patient stories can help. Weave this information into existing patient communications, rather than make it seem like a big deal. On the HCO side, educate care teams about SOGI data's importance. "Staff should understand the why behind it."

The discussion moved into other complexities related to LGBTQIA+ care. "Our biggest challenge is an 18-year-old coming in saying 'I'm ready to transition, but you can't bill my insurance, and my mom and dad can't know.' There's no set clinical pathway," one participant shared.

How do you make sure LGBTQIA+ patients connect with informed, supportive providers, especially in cases of gender transition? One suggestion was a provider directory. Another was educating the organization's own care team—teaching the basics of areas like hormonal therapy and bringing colleagues on rotations to see the work and understand the reasoning behind it.

Finally, even seemingly small nuances like language can make a big impact for helping members of the LGBTQIA+ community feel more comfortable at an organization and with its care. Ramallo noted that a facility with the name "Women's Clinic" on the front door might not be very affirming for a patient identifying as transmasculine.

"When our hospital moved, we intentionally renamed our women and children's unit to family and delivery," one audience member shared.

Breakout Session: Social Isolation and Loneliness as a Social Driver of Health

Brisa Urquieta de Hernandez, PhD
System Director, Operations for the Lloyd H. Dean Institute for Human Kindness and Health Justice, CommonSpirit Health

In recent years, and especially since the COVID-19 pandemic, "there's been a decrease of engagement—within family units, with friends, and more broadly," Hernandez said. "The only thing that's increasing is social isolation."

Research illustrates the health consequences. A lack of social connection increases the risk for premature death by an average of 27.5%, the risk of heart disease by 29%, and the risk of stroke by 32%. Social isolation also increases a person's risk for anxiety, depression, dementia, and susceptibility to viruses and respiratory illness.[1] Many groups are at risk: People with poor physical or mental health, those experiencing financial insecurity, and people who live alone, along with single parents, rural residents, victims of domestic violence, and people experiencing discrimination or marginalization.

"How does it play out in your experience?" Hernandez asked. Participants cited remote work and the rise of social media in older people, underrepresented groups, and adolescents. "They won't talk to their parents, but they'll talk to a stranger like

---

[1]Source: https://www.mcginley.co.uk/news/a-d-v-i-c-e-topic-5-isolation-and-loneliness-covid-19-and-beyond/bp372/

me." The increasingly digital experiences of everyday life are another contributor. "We're literally not talking. It's not the same emotional attachment."

The pandemic took its toll, participants agreed. Mothers with small children had "a lot of fear and anxiety" about going back to public spaces, and adult males aren't re-engaging, even as churches and other groups make efforts to bring them back. As families relocated to other areas, older patients might consider their doctor's visit their primary social outing.

Certain groups are particularly vulnerable, participants noted. Students receiving their education through homeschooling might need to be more intentional about activities for socialization, for example. And newer immigrants to the United States might find language standing in the way, especially if there isn't an established community from their background where they live. "The U.S. is not as inclusive as other parts of the world in terms of language," one participant noted.

To address these challenges, Hernandez shared a six-pillar framework by the Department of Health and Human Services for advancing social connection overall. She also provided recommendations for three types of stakeholders (health workers, healthcare systems, and insurers) to advance social connections.

- Screen patients for loneliness and isolation
- Establish social connection as a social driver of health
- Evaluate, develop, and implement sustainable interventions and strategies to promote greater connection and prevent social disconnection
- Connect patients to resources
- Develop and support public education programs
- Connect with your care teams about their own connection

Participants also talked about things their own organizations or teams could do, such as screen patients for loneliness and isolation, connect them to resources, and develop and support public education programs.

"It's not a required CMS domain right now, but our community health workers and social workers are talking about it and asking about it," one participant noted.

Another important focus: connect with their own care teams about isolation. Several participants brought up a cautionary tale from just weeks before the meeting: A bank employee died on the job—and wasn't found until four days later.
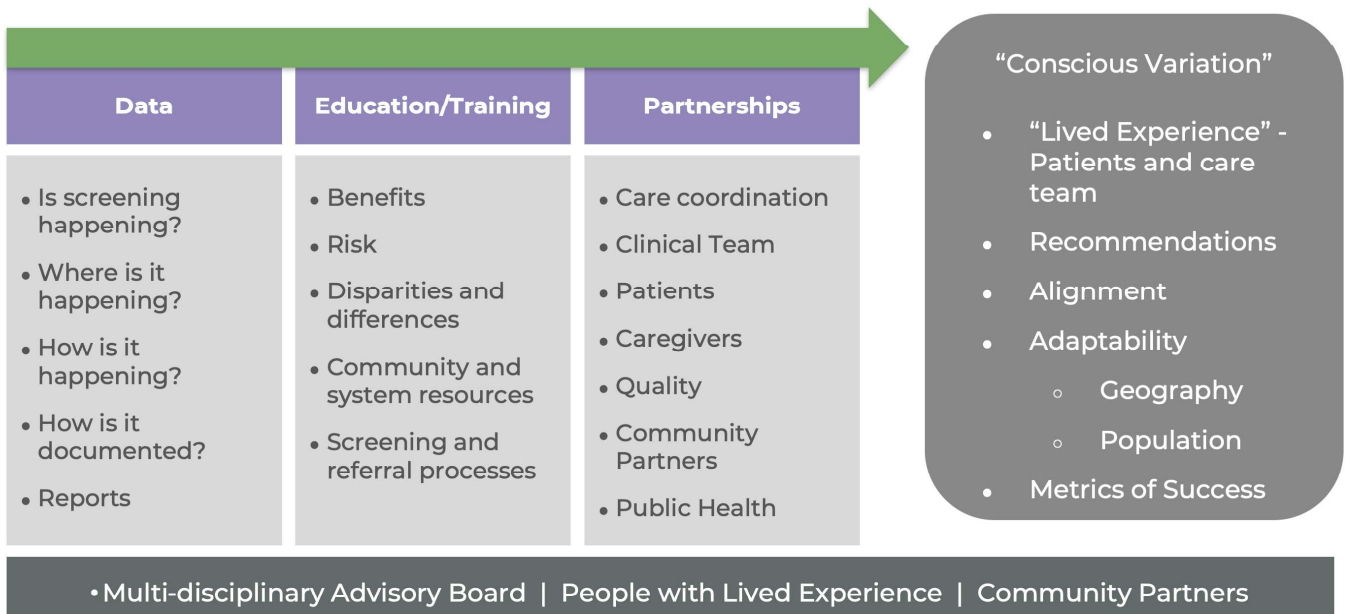
Whatever patient or employee group you're dealing with, it's important to proceed with thoughtfulness and nuance, Hernandez cautioned. "If you're screening for social isolation and someone comes up positive, it's important to have a conversation."

"Is it impacting their health? What else is going on? Be careful not to label or stigmatize people," she said.

Enriched Care Coordination and Education to address Social Isolation and Loneliness (EnCarE)©

Data	Education/Training	Partnerships	"Conscious Variation"

• Is screening happening?
 • Where is it happening?
 • How is it happening?
 • How is it documented?
 • Reports
	• Benefits
	 • Risk
	 • Disparities and differences
	 • Community and system resources
	 • Screening and referral processes
		• Care coordination
		 • Clinical Team
		 • Patients
		 • Caregivers
		 • Quality
		 • Community Partners
		 • Public Health
			• "Lived Experience" - Patients and care team
			 • Recommendations
			 • Alignment
			 • Adaptability
			     ○ Geography
			     ○ Population
			 • Metrics of Success

• Multi-disciplinary Advisory Board | People with Lived Experience | Community Partners

Concluding Words of WISDOM

Casanova concluded the second annual AMGA Health Equity Forum with a final discussion prompt: "Share one key thing you've heard or learned that you plan to bring back to your team—or what should I do on Monday (WISDOM)."

Many participants mentioned tactics for funding, including Z codes, endowed funds, finding allies, and thinking strategically amid the current environment of pushback. Participants called out specific case studies from their peers, such as regional medical centers and mobile care to meet patients where they are and multifaceted interventions for maternal health screening. "We don't have to reinvent the wheel," one participant observed.

Some participants shared new things they learned. "I did not know that social isolation was a SDOH, or about the terminology in SDOH shifting from *determinants* to *drivers*," one noted.

In areas like SOGI data collection, participants said the forum "reaffirms some of the good work we're doing." One plans to "let folks back home know that we're a little farther along than we think." Many said they were leaving the event feeling inspired, engaged, and encouraged, seeing "the work still being done" despite "waning momentum around DEI due to public backlash."

Feedback was positive on the event's structure. "Great breakout discussions, and the solution rooms were a great way to have like-minded individuals give you feedback and to learn from each other."

"This conference came at perfect time for planning goals for 2025," one participant concluded. "We're taking away inspiration from all the work you're tirelessly doing to support patients and improve well-being and health outcomes for so many who really need it."

AMGA Health Equity Steering Committee

Karen Berube, MSW, LCSW, CSAC
Chief, Community Health and Health Equity, SVP, Inova Health System

Ryane Jackson, MLA
Vice President of Community Health Strategy, Memorial Hermann System

DeAnna Minus-Vincent, MPA
*Founder and Managing Director
The Outcomes Architect*

Ashok Rai, MD
*President and CEO
Prevea Health*

Brisa Urquieta de Hernandez, PhD
System Director, Operations, Lloyd H. Dean Institute for Humankindness & Health Justice

Mission:

Drive change in integrated healthcare delivery in order to improve the lives of patients.

Vision:

A thriving healthcare system that delivers the best care.

AMGA™

One Prince Street
Alexandria, VA 22314-3318

amga.org