

ARTICLE

Equitable access to care: Five critical questions health system boards should ask

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One of the most fundamental elements of delivering healthcare is ensuring timely, convenient, and affordable access.¹ Yet most health systems struggle to do this well—as evidenced by long wait times, care deferred, and universal frustration by patients. Nowhere is this felt more than among patients from under-resourced communities.

Even among organizations that have smoothed access for other populations, most still fail to provide equitable access to patients of all racial, ethnic, cultural, and socioeconomic backgrounds.²

Health equity is an issue that directly correlates to access.³ Reducing disparities and increasing access to quality care is both a moral imperative and a strategic business solution. Health inequities cost the industry nearly \$320 billion and, if left unaddressed, could skyrocket to \$1 trillion in annual spending by 2040.⁴

As the industry grapples with its health equity evolution, boards of directors should play a key role in ensuring access to care is equitable across all demographic groups served by the organization. Boards who understand the answers to five key questions can help advance their organization toward providing optimal access to all people in their communities.

1. Does our health system partner with providers and other community-based organizations to reduce or remove barriers to access?

Health systems play a critical role in reducing and removing barriers to access. They can do this by offering timely and affordable care close to and easily accessible by the communities they serve.

The board should seek to understand the barriers to care the community faces. They also must recognize that the systemic barriers to equal access cannot be addressed by health systems working alone. Reducing food insecurity, providing transportation assistance, and addressing health literacy are all examples of approaches to eliminate systemic barriers that impact health equity. Health systems seeking to expand

equitable access must partner with other providers (including Federally Qualified Health Centers, safety net hospitals, and social service agencies) and community-based organizations to eliminate systemic issues related to social drivers of health.

convening and collaborating to improve access to healthcare services

In certain urban communities (particularly those with large minority populations), racial inequities and health disparities have grown because of shortages in primary care and behavioral health services and inadequate insurance coverage.

In some areas, leading health systems have played the role of convener to coalesce multiple healthcare organizations and community organizations. Their goal is to improve access to care, quality of care, and financial sustainability for all participating organizations.

A recent successful example is in Chicago, where several leading health systems brought together multiple hospitals and community organizations to reexamine and redesign healthcare and social services on the south side of the city. The resulting coalition, the South Side Healthy Community Organization, is a group of 13 healthcare entities, including safety net hospitals, larger health systems, and Federally Qualified Health Centers. The group first applied for and secured financial support from the state. Then, they collaboratively redesigned the local healthcare delivery system to improve access to primary care and specialty services. The design also incorporated nurse care coordinators and social workers who could help direct patients to the right providers and coordinate services across multiple entities.

Recently, the group announced it would invest nearly \$1 million in local organizations that provide stable housing options, nutritious food, emergency financial support, and transportation services to help members of the community go to and from medical appointments.

A powerful role for health systems is to drive transformational change as a convener of organizations. In this role, the health system can influence, make economic investments, build trust, and share power among other entities that have a vested interest in improving economic, social, educational, and political drivers of health. These entities include community-based organizations, corporate entities, philanthropic organizations, governmental agencies, health plans, health advocacy groups, and others.

2. How do we ensure we have sufficient supply of mental health, specialty, and primary care providers to meet demand?

Many communities lack sufficient access to primary care, mental health care, and critical specialties, such as obstetrics and cardiology. Patients in these communities face a difficult choice: either travel to another community for care (often with great expense in time and resources) or forego care until their health problems become acute.

These “healthcare deserts” are common in rural America: the federal government designates nearly 80% of rural communities as “medically underserved.”⁵ Healthcare deserts also are increasingly common in urban areas, where lower-income communities have few primary care and behavioral healthcare options and patients often depend on emergency rooms for care. Some of the largest urban health deserts are in New York City, Los Angeles, and Chicago.

It’s important to consider your health system’s geographic footprint and how its sites of care are distributed within and across the market—including in communities of color and low socioeconomic and under-resourced areas within your primary service area. Alleviating healthcare deserts and expanding equitable access requires, in part, sustained commitments in the communities you serve, including place-based investments (i.e., resource commitments made within socially vulnerable zip codes).

Your health system can also be a convener or provide direct services to further alleviate healthcare deserts through key efforts. Such efforts can include economic development, affordable housing initiatives, educational pipeline and workforce programs, health advocacy and policy influence, racial and social justice partnerships, health promotion, and behavioral health programs.

3. Do our compensation plans and scheduling practices contribute to inequitable access?

Compensation plans for employed providers may inadvertently favor scheduling patients with commercial insurance over those with Medicare or Medicaid. For instance, factoring in revenue contribution versus work production may lead individual providers to cherry-pick patients with more lucrative insurance plans. Health systems may also create practices that restrict access for Medicaid patients.

One healthcare organization established a policy to restrict access for Medicaid patients to a few days per month. In this case, business leaders were concerned with poor reimbursement and high no-show rates associated with the Medicaid population. This created a second-tier system for patients who already were most often burdened with chronic disease and impacted by social drivers of health. In addition to producing disparities in outcomes for an already under-resourced population, this policy also led to improper utilization in the higher-cost setting of the Emergency Department.

A consistent consequence of restrictive policies or practices is that access for patients from racially and socioeconomically disadvantaged populations—those who would stand to benefit most from medical interventions—becomes limited. This may result in delayed care and exacerbation of illness.

Although white Americans constitute the single largest racial group of Medicaid and CHIP enrollees, people of color across ethnic groups collectively make up a higher percentage of enrollees. Based on recent enrollment data, approximately 60% of Medicaid enrollees are from ethnic or racial minorities.⁶ As such, the collective access impact to communities of color can be greater, especially when also considering the social drivers of health that disproportionately impact these groups.

Health systems can protect against cherry-picking by equalizing the dollar value payment across all payer types and utilizing a relative value unit (RVU)-based plan.

4. How do we ensure that our access initiatives are not further compromising access for communities that have been marginalized?

There are many ways in which well-intended improvement efforts can instead further exacerbate access issues for communities that have been marginalized. For example, predictive analytics models are a popular tool to reduce patient no-shows and last-minute cancellations. The models use machine learning and data mining to forecast the future behavior of patients. On the surface, predictive modeling is useful for optimizing clinician capacity and scheduling efficiency.

At one health system, the model worked well to identify patients with high, medium, and low risk of not showing. Upon deeper analysis, the patients' reasons for not showing often related to nonclinical social needs, such as inadequate transportation, lack of childcare, and inability to pay co-pays.

If a health system has not established a means to collect and act on this type of information, then disparities in care and outcomes are more likely to occur. (For instance, a new policy won't improve show rates if it penalizes patients who no-show but fails to address the nonclinical issue.) Addressing social needs of patients has not traditionally been within the scope of provider organizations, yet studies show that 80% of health outcomes are driven by social drivers of health.

The solution for this health system was to establish referral relationships to social service agencies, provide free transportation to and from patient visits through a partnership with Uber, and systematically track transportation needs data over time to inform future interventions.

5. Does our organization have a specific access strategy for patients from communities that have been under-resourced or marginalized?

Good intentions are not enough. Without a cohesive strategy for how your health system can help achieve equity in care and outcomes for patients who have been marginalized and under-resourced, your organization is unlikely to deliver the impact that is needed.

Organizations that effectively and intentionally address inequities related to access have targeted approaches to resource deployment, explicit goals, and measured performance. An example application of these approaches is setting up health equity care navigators. These navigators assist patients in coordinating appointments, solidifying transportation, navigating financial barriers, and directing them to

virtual care access points. One of the most impressive health system approaches to improving equity in access is the creation of a network of community resource centers that address many social needs, including support and guidance for enrollment in state Medicaid programs.

Organizations should also factor equity considerations into their decisions about the location of ambulatory clinics, how they advance digital health assets (such as nurse triage lines and virtual provider visits), and how they develop their hospital at home model. These interventions and decisions should aim to increase access, reduce the need for in-clinic visits, and illuminate social needs organizations and their partners can proactively resolve.

Building programs to improve health equity

Leading health systems across the country are developing programs and initiatives to expand under-resourced communities' access to healthcare services.

At the University of Pennsylvania Health System, nurses at all levels are trained and given resources to lead and engage with other providers to:

- Improve knowledge around health equity issues and drivers.
- Develop innovative care models to meet the needs of racial, ethnic, and cultural populations.
- Incorporate health equity into strategic planning.
- Encourage an organizational culture that embraces diversity, tolerance, civility, and inclusivity.

In Michigan, Spectrum Health is the fiduciary of the federally funded Strong Beginnings Healthy Start program, which also receives funding from the W.K. Kellogg Foundation. Through the partnership, a team of community health workers, nurses, and therapists seek to improve maternal health and reduce infant mortality by providing education, research, and support services to minority communities.

True access opens doors to better health for everyone

The disparities in healthcare access are systemic, deeply entrenched, and often multifaceted. They touch the lives of individuals and communities in ways that ripple through our society—impacting not only the quality of life but the very essence of what it means to live in a just and equitable world. Health systems can

play a pivotal role.

The first step is to ask the right questions. Do you know how well your health system is enabling access to care? Do you understand current performance, existing and new initiatives to expand access, and goals for improvement? And do you know how under-resourced racial and ethnic communities in your area will be impacted?

Even the best-intentioned efforts can produce negative results if not constructed with a specific eye toward the effect they will have on these communities. Additional strategies to better serve these populations in your health system are likely also necessary. Start the dialogue with your health system's senior executives to ensure your organization is advancing access for all.

Sources

¹ Access is ensuring healthcare consumers can get the right care or information at the right time and place.

² Douglas B. White, MD; Lisa Villarroel, MD; and John L. Hick, MD, "Inequitable Access to Hospital Care—Protecting Disadvantaged Populations during Public Health Emergencies," New England Journal of Medicine, Dec. 9, 2021, <https://www.nejm.org/doi/full/10.1056/NEJMp2114767>.

³ Health equity is the ability for individuals to achieve an optimal level of health.

⁴ Thomas A. LaVeist, PhD, et al, "The Economic Burden of Racial, Ethnic, and Educational Health Inequities in the U.S.," JAMA, May 16, 2023, <https://jamanetwork.com/journals/jama/fullarticle/2804818>.

⁵ Between 2010 and 2023, more than 140 rural hospitals closed, mostly due to unsustainable financial performance. Roughly 20% of the American population resides in rural areas, but only 10% of physicians practice there. On average, patients who are able would have to travel an additional 20 miles for common services and 40 miles for more complex specialty services.

⁶ KFF, "Distribution of the Nonelderly with Medicaid by Race/Ethnicity," <https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=2&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> Estimates do not include seniors, so dual-eligibles are not reflected.

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